DEVELOPMENT OF A TOOLKIT FOR INSTITUTIONALIZATION OF INTEGRATED COMMUNITY CASE MANAGEMENT (ICCM)

PREPARATORY PHASE REPORT

8th April 2022

USAID FROM THE AMERICAN PEOPLE

CDC Centers for Disease Control and Prevention

U.S. President's Malaria Initiative

PMI IMPACT MALARIA

Advancing Malaria Service Delivery

CHILD HEALTH TASK FORCE

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ACRONYMS

CHTF	Child Health Task Force
HSS	Health System Strengthening
iCCM	Integrated Community Case Management
MNCH	Maternal Newborn and Child Health
PMI	President's Malaria Initiative
QA	Quality Assurance

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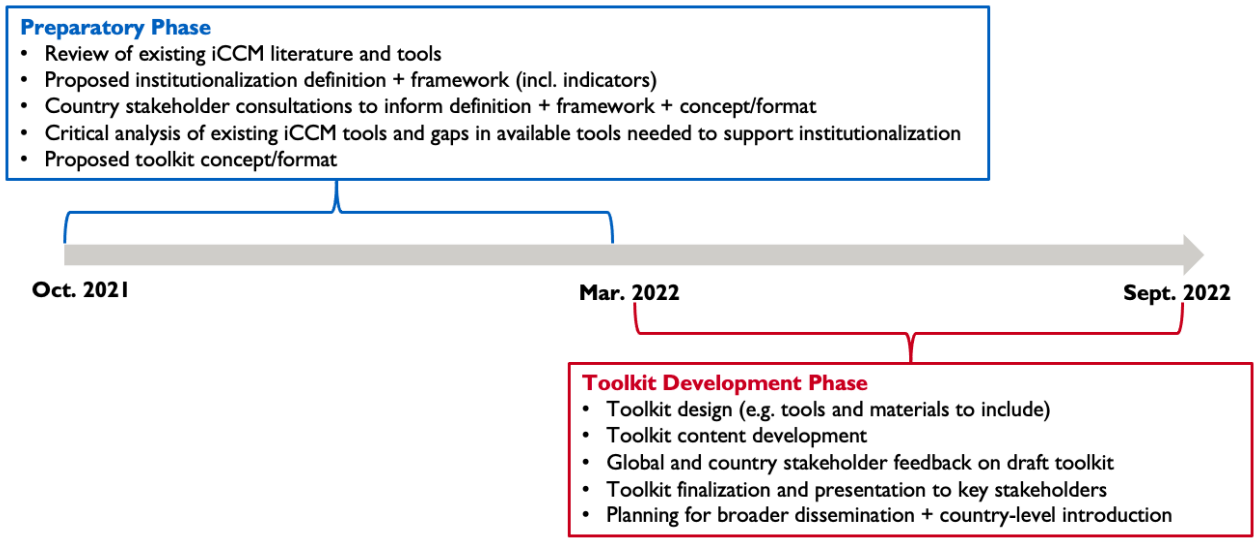
INTRODUCTION

The Institutionalizing Integrated Community Case Management (iCCM) Subgroup of the global Child Health Task Force (CHTF) is currently developing a toolkit to support country stakeholders to institutionalize iCCM. This work is being supported by the U.S. President's Malaria Initiative (PMI) Impact Malaria program through PSI's Health System Accelerator and has been divided into two distinct phases - a preparatory phase from October 2021 to March 2022, followed by a toolkit development phase from April to September 2022 (see figure 1).

Figure 1: Project Overview



The preparatory phase of the toolkit development process focused on the development of a definition and framework for institutionalization of iCCM in order to guide development of the toolkit. A critical review of the iCCM literature was undertaken to achieve the following: **1)** to understand how institutionalization of iCCM has been conceptualized and defined; **2)** to identify existing tools, guidelines and frameworks to support iCCM institutionalization; and **3)** to identify gaps in resources or tools that would need to be filled by the toolkit. Based on this review of literature a definition and framework for institutionalization was proposed.

Finally, consultations with members of the global iCCM Subgroup and with purposefully selected country stakeholders in three countries (i.e. Ghana, Malawi and Rwanda) were conducted to receive feedback on the proposed definition and framework as well as to gather broader insight into country stakeholder experiences in implementing and working towards institutionalization of iCCM. In all consultations, sharing of relevant tools and resources to support institutionalization of iCCM were requested as well as suggestions for the types of tools and resources that would be useful. This Preparatory Phase Report was prepared by PSI's Health System Accelerator with review and feedback from PMI Impact Malaria, PMI, USAID Contracting Officer's Representatives team, USAID Africa Bureau, CHTF Secretariat, and the Institutionalizing iCCM Subgroup Co-Chairs.

DEFINITION AND FRAMEWORK

REVIEW OF LITERATURE

No agreed upon or commonly used definition and framework for iCCM institutionalization could be found in the existing literature on iCCM. Therefore, the literature review was expanded to include wider literature on institutionalization from a variety of fields in order to inform the development of a definition and framework for institutionalization of iCCM to guide the toolkit development.

Two key documents provided insight to the conceptualization of iCCM institutionalization to date and a starting point for development of a definition and framework. One of the two documents is a journal article published in 2019 that presents findings of a scoping review of relevant searchable policy documents and publications to identify models of, and gaps in, institutionalization of benchmark components of iCCM into national health systems of low-and-middle-income countries with the aim of drawing lessons for future iCCM implementation and sustainability.[1] The other is a technical consultation report that presents a range of recommendations to advance institutionalization of iCCM, which were agreed by technical experts convened by United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) at a technical consultation in Addis Ababa in 2019.[2]

These documents provide important insight to how iCCM institutionalization has been conceptualized by relevant technical experts to date, but with notable limitations. First, both documents emphasize the importance of integration of iCCM into national health systems and principles of health system strengthening, but neither document puts forward an explicit definition of institutionalization, broadly or specifically in relation to iCCM. Secondly, both documents use a version of the previously defined iCCM benchmark components (i.e. coordination and policy setting; costing and financing; human resources; supply chain management; service delivery and referral; communication and social mobilization; supervision and performance quality assurance; M&E and health information systems) as an organizing framework for their scoping review or recommendations.[3] However, neither document addresses how institutionalization happens (i.e. processes of institutionalization) within or across the benchmark components.

A wider review of literature on institutionalization found that much of the existing literature links back to the work of Jepperson (1991)[4] and Scott (2008)[5] on institutional theory. According to Jepperson, "Institutions are characterized by a multidimensional basis of compliance, order, and indicators of their presence and are largely resistant to change."[6] According to Scott, "Institutions

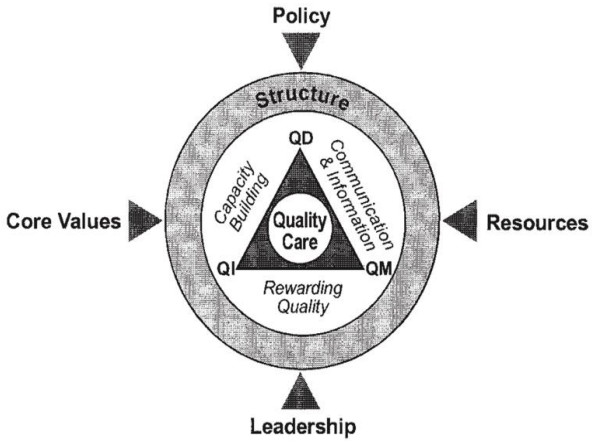
[1] Nanyonjo A, Counihan H, Siduda SG, Belay K, Sebikaari G, Tibenderana J. Institutionalization of integrated community case management into national health systems in low- and middle-income countries: a scoping review of the literature. Glob Health Action. 2019;12(1):1678283.
[2] Institutionalizing integrated community case management (iCCM) to end preventable child deaths: a technical consultation and country action planning, 22-26 July 2019, Addis Ababa. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020.
[3] McGorman L, Marsh DR, Guenther T, et al. A health systems approach to integrated community case management of childhood illness: methods and tools. Am J Trop Med Hyg. 2012;87(5 Suppl):69-76.
[4] Jepperson R. Institutions, institutional effects, and institutionalism. In: DiMaggio PJ, Powell WW, editors. New Institutionalism Organ. Anal. Chicago: University of Chicago Press; 1991. p. 143–63.
[5] Scott WR. Institutions and Organizations: Ideas and Interests. 3rd ed. London: SAGE Publications; 2008.
[6] Jepperson 1991 via USAID, 2017.

are comprised of regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life."[7] These dimensions have been summarized as follows: Regulative dimensions of institutionalization highlight the role of incentives for motivating efficient behavior. Normative dimensions of institutionalization occur by increasing commitments of individuals to behave according to established order (identity). Cultural-cognitive dimensions of institutionalization entail the conversion of shared beliefs into routines, protocols, language, and other artifacts.[8] The literature highlights that these dimensions infuse value and affinity for stability within institutions.

Building on the theoretical work on institutionalization, efforts have been made to define and assess institutionalization within the context of health systems. Work by Goodman et al (1993) developed a framework and tool for this purpose, which has since been adapted and applied in a variety of contexts.[9] For example, assessing the level of institutionalization of donor-funded anti-retroviral therapy programs in health facilities in Uganda.[10] However, very little has been published on processes of institutionalization within health systems with the notable exception of work on institutionalization of quality assurance by Silimperi et al (2002)[11] and institutionalization of knowledge-informed policy making by Zida et al (2017).[12]

The work of Silimperi and colleagues presents a conceptual framework to help healthcare systems and organizations analyze, plan, build, and sustain efforts to produce quality healthcare. The framework synthesizes more than ten years of Quality Assurance (QA) project experience assisting in the design and implementation of QA activities and programs in over 25 countries. The framework outlines essential elements for institutionalization of QA, which includes the internal enabling environment (i.e. policy, leadership, core values and resources); structure; and support function elements (i.e. capacity building, information and communication, rewarding quality) (see figure 2). According to Silimperi et al (2002), *experience has shown that the*

Figure 2: Institutionalization of Quality Assurance (Silimperi et al 2002).



[7] Scott 2008 via USAID, 2017

[8] Koon AD, Windmeyer L, Bigdeli M, et al. A scoping review of the uses and institutionalisation of knowledge for health policy in low- and middle-income countries. Marshalling the Evidence for Health Governance Thematic Working Group Paper, USAID, 2017.

[9] Goodman RM, McLeroy KR, Steckler AB, Hoyle RH. Development of level of institutionalization scales for health promotion programs. Health Educ Q. 1993;20(2):161-178.

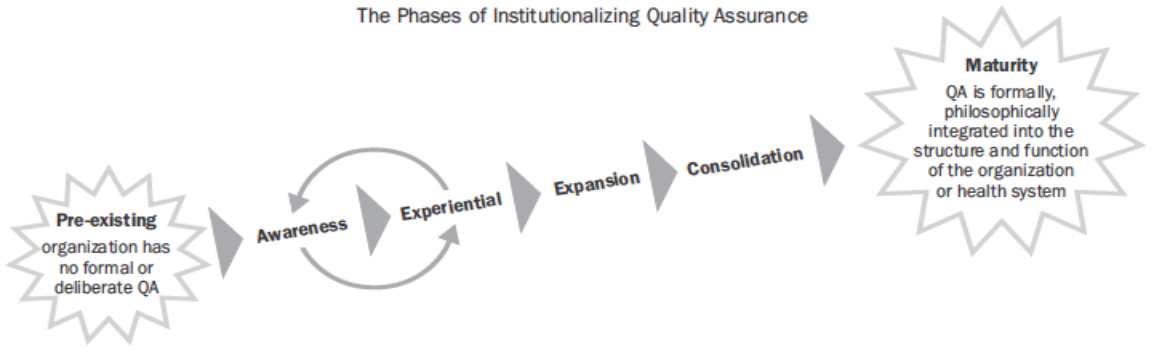
[10] Henry Zakumumpa, Japheth Kwiringira, Joseph Rujumba & Freddie Ssengooba (2018) Assessing the level of institutionalization of donor-funded anti-retroviral therapy (ART) programs in health facilities in Uganda: implications for program sustainability, Global Health Action, 11:1, 1523302.

[11] Slimperi D et al. *A framework for institutionalizing quality assurance.* International Journal for Quality in Health Care 2002; Volume 14, Supplement I: 67-73.

[12] Body of work comprised of three papers: 1) Zida A, Lavis JN, Sewankambo NK, Kouyate B, Moat K, Shearer J. Analysis of the policymaking process in Burkina Faso's health sector: case studies of the creation of two health system support units. Heal. Res. Policy Syst. Health Research Policy and Systems; 2017; 15:1–17. 2) Zida A, Lavis JN, Sewankambo NK, Kouyate B, Moat K. The factors affecting the institutionalisation of two policy units in Burkina Faso's health system: a case study. Heal. Res. Policy Syst. Health Research Policy and Systems; 2017; 15:62. 3) Zida A, Lavis JN, Sewankambo NK, Kouyate B, Ouedraogo S. Evaluating the Process and Extent of Institutionalization: A Case Study of a Rapid Response Unit for Health Policy in Burkina Faso.Int J Health Policy Manag. 2018;7(1):15-26.

key institutionalization question is often not so much a technical one—how to "do" QA activities—but rather, how to establish a culture of quality within the organization and make QA an integral, sustainable part of the health system. Silimperi and colleagues emphasize that institutionalization is not a linear process, but one that passes through phases leading to an end state (i.e. maturity). The process of institutionalization is presented as a maturity model spanning the pre-existing status quo to awareness, experiential, expansion, consolidation and maturity (see figure 3).

Figure 3: The Phases of Institutionalizing Quality Assurance (Silimperi et al 2002).



The work of Zida and colleagues adapts a World Bank framework for institutionalization of national health accounts to analyze elements of institutionalized structures for knowledge-informed policymaking in Burkina Faso. Elements include the following: existence of an institutional framework (i.e. the policy unit's government mandate); consistent data production and report preparation; adequate financial and human resources; and infrastructure capacity to routinely produce and use data in policymaking (see figure 4). Zida et al (2018) analyze the framework's elements by five phases of institutionalization: awareness, experimentation, expansion, consolidation, and maturity (i.e. using a maturity model similar to Silimperi et al 2002). The work of Zida and colleagues is notable for the extent to which it implicitly addresses all three dimensions of institutionalization (i.e. regulative, normative, and cultural-cognitive) and provides a detailed view of institutionalization as a dynamic social process. According to Zida et al (2018), *"Institutionalization is the process by which a set of activities becomes an integral and sustainable part of a formal system. It can be seen as a sequence of events leading to 'new practices becoming standard practice.'"*[13] This is a rare instance of authors articulating an explicit definition of institutionalization.

Figure 4: Indicators of Policy Unit Institutionalization

Institutionalisation elements	Indicators
1. Existence of an institutional framework (the policy unit's mandate from government)	• Law/regulation providing a mandate for the policy unit • Institutional home identified for the policy unit • Protocols/public norms set out for data or information production
2. Consistent production of data and preparation of reports	• Explicit process designed for data gathering, compilation and transmission for decision-making • Policy unit activities are regular and ongoing • Protocol exists for validating reports • Minimum set of globally agreed data is produced
3. Adequate financial and human resources, and infrastructure capacity to routinely produce and make use of data in policymaking	• The policy unit has an annual plan of action • Government budget is earmarked for the policy unit's activities • Sufficient material and human resources are available for the policy unit's activities • The unit's annual action plan is at least half funded

Source: based on the World Bank framework [3]

[13] Zida A, Lavis JN, Sewankambo NK, Kouyate B, Ouedraogo S. Evaluating the Process and Extent of Institutionalization: A Case Study of a Rapid Response Unit for Health Policy in Burkina Faso.Int J Health Policy Manag. 2018;7(1):15-26.

PROPOSED DEFINITION FOR ICCM INSTITUTIONALIZATION

"A process and end state by which iCCM becomes an integral, routine and stable part of both community and health systems."

The definition of institutionalization put forward for the toolkit is grounded in a broad review of literature spanning a number of fields and disciplines, and was validated by the Institutionalizing iCCM Subgroup of the global CHTF during a consultative call in January 2022.

As highlighted in the findings from the literature review above, institutionalization is *both a process* and *an end state of stability*, so this duality is made explicit in our proposed definition. The terms "integral" and "routine" are intended to reflect aspects of the normative, cultural-cognitive and regulative dimensions of institutionalization described in the literature. The term "stable" is intended to reflect the nature of the end state. However, this end state of stability should not be viewed as a perpetual fixed state, but one that can still change through a new process of institutionalization overtime. The terms "integral," "routine" and "stable" appear in many of the definitions or descriptions of institutionalization in existing literature, particularly both the work by Silimperi et al (2002) and Zida et al (2017; 2018).

When referring to "iCCM" within our definition, we intend to refer to the globally recognized definition, *"The iCCM approach provides integrated case management services for two or more illnesses - including diarrhoea, pneumonia, malaria, severe acute malnutrition or neonatal sepsis - among under-fives at community level (i.e. outside of healthcare facilities) by lay health workers where there is limited access to health facility-based case management services"* (WHO/UNICEF 2012). This means that at least two interventions must be combined to be considered "iCCM." Additionally, our use of the term "iCCM" assumes the inclusion of all eight essential health system components of iCCM as reflected in the globally recognized iCCM benchmark components.[14]

Finally, the language of "community and health systems" is intended to make the importance of community stakeholders and dynamics explicit, similar to how it has been noted that CHWs function "at the intersection of two dynamic and overlapping systems – the formal health system and the community" in wider Community Health Worker literature.[15] A community health intervention such as iCCM involves community members themselves. In particular, caregivers of children under five years of age must be aware and accepting of the iCCM services provided by the health worker, so that these services are not just available and accessible, but actually used. As with other community level interventions, communities have important roles to play in governance, monitoring and quality of iCCM activities. Across country contexts these elements of collaboration or partnership between the "formal health system" and "community system" are articulated and conceptualized differently, perhaps even as one health system extending from national to subnational to community levels. The definition of iCCM institutionalization does not intend to dictate these specifics, but underline the essential involvement of communities.

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[14] McGorman L, Marsh DR, Guenther T, et al. A health systems approach to integrated community case management of childhood illness: methods and tools. Am J Trop Med Hyg. 2012;87(5 Suppl):69-76. doi:10.4269/ajtmh.2012.11-0758

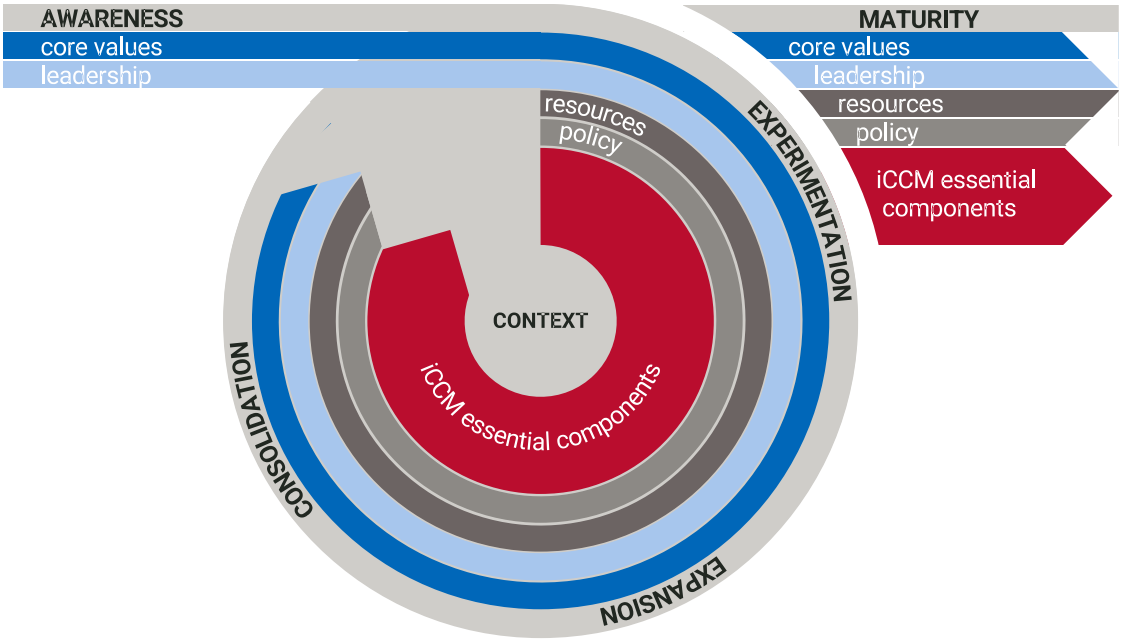
[15] Naimoli, J.F., Perry, H.B., Townsend, J.W. et al. Strategic partnering to improve community health worker programming and performance: features of a community-health system integrated approach. Hum Resour Health 13, 46 (2015).

PROPOSED FRAMEWORK FOR ICCM INSTITUTIONALIZATION

A substantial proportion of the literature on institutionalization in health systems focuses on methods of defining and assessing an end state of institutionalization, while less is documented (and known) about processes leading to the end state of institutionalization. This is true of iCCM specifically where great efforts have gone into defining and documenting the essential components of iCCM as well as benchmarks for assessing scale, but less is known about the processes involved in successful scale-up or institutionalization. It is important to underline that the focus of the toolkit for iCCM institutionalization will be on the process of institutionalization, since it is intended to support country stakeholders to progress towards the end state of institutionalization of iCCM, not only assess the status of their progress towards it. Therefore, the proposed framework will focus on conceptualizing the process rather than the end state of iCCM institutionalization.

Our proposed framework (see figure 5) conceptualizes the process of institutionalization through a maturity model of phases as articulated by Silimperi et al (2002) and applied by Zida et al (2018) with a focus on the four internal enabling environment components put forward in Silimperi's institutionalization of QA framework. Additionally, the *Maternal and Child Survival Program (MCSP) Supporting Country-Led Efforts to Systematically Scale-up and Sustain Reproductive, Maternal, Newborn, Child and Adolescent Health Interventions: Scale-up Coordinator's Guide* provides a compelling visual representation of the iterative process that interventions go through from initial evidence to scale-up, which we adapted to convey the similarly iterative/non-linear process of institutionalization. The country context is depicted at the center since the process of institutionalization starts with and must be responsive to dynamics within the country context (e.g. cultural values, political systems, etc.).

Figure 5: Proposed iCCM Institutionalization Framework



Within our proposed framework, the process of institutionalization starts with awareness expressed through the components of core values and leadership, which then progress alongside changes in resources and policy across the experimentation, expansion and consolidation phases. These changes in the four components of the internal enabling environment allow the iCCM benchmark components to develop also through phases of experimentation, expansion and consolidation to the point of reaching maturity (i.e. the stable end state of institutionalization). It should be noted that the iCCM benchmark components are comprised of elements that align with the structure and support functions elements outlined in the Silimperi et al (2002) framework, so are captured in the proposed framework (in red). Furthermore, the end state of institutionalization can be assessed by the status of the iCCM benchmark components, using existing "Institutionalization Tracker" tools (see the Critical Analysis of Existing Tools section of this report).

The four enabling environment components (in blue and gray scale) within our framework can be described as follows:

- **Core Values:** The creation and acculturation of values that motivate support for the iCCM approach, such as recognition of the importance of community partnership, equity, innovation and continued improvement.
- **Policy:** A policy environment that explicitly recognizes the importance of iCCM for reaching Ministry of Health and/or health system goals, and that provides support, guidance, and reinforcement for the benchmark components of iCCM implementation.
- **Leadership:** Leaders at all levels of the health system demonstrate core values and provide the vision and strategies for transitioning from 'the way we work now' to 'the way we want to work in the future' to enable the iCCM approach.
- **Resources:** Adequate resources – both financial and human – are allocated for high-quality implementation of iCCM, but also for capacity building, communication, and other key support functions.

The phases of institutionalization (in lightest gray) are defined as follows:

- **Awareness:** Individuals within the Ministry of Health (especially key decision-makers) become conscious of the need to change their approach to the management of childhood illness, and become aware of iCCM as a possible approach. Awareness can result from seeing data on poor child health outcomes, from discussions with someone who sees the need to change how child health is currently being addressed, or from complaints/pressure from communities.
- **Experimentation:** Implementation of iCCM begins with learning from those experiences and development of evidence that iCCM leads to measurable improvements in key child health indicators. At the end of this phase, sufficient momentum exists to move into the expansion phase, as indicated by increased support by community members and within MoH leadership.
- **Expansion:** Implementation of iCCM activities increases based on knowledge and experiences gained in the previous phase. Expansion includes both increases in scale (e.g. number of cases managed; geographic and population coverage) and effectiveness of approaches (e.g. data management, training, supervision, etc.).

- **Consolidation:** iCCM activities and programming are simultaneously being strengthened and anchored into standard operations, while at the same time being made more 'solid' by addressing any implementation gaps, missing structures or support functions.
- **Maturity:** Maturity is not a phase, but a state in which iCCM is formally integrated into the structure and function of the health system. Core values, leadership, policy, and resources continue to reinforce iCCM as an integral, routine and stable part of both community and health systems.

Changes within each of the four enabling environment components must progress to enable transition through each of these phases. Institutionalization may progress, regress, oscillate between two phases, or even stagnate at any one of these phases.

CRITICAL ANALYSIS OF EXISTING iCCM TOOLS

When we began this work on the iCCM institutionalization toolkit, we approached it through the lens of the existing literature and thinking on iCCM, which is largely structured around the iCCM benchmarks components – Policy; Financing; Human Resources; Supply Chain Management; Service Delivery & Referral; Communication & Social Mobilization; Supervision and Performance Quality Assurance; and M&E and HMIS. As such, the literature review uncovered many tools aimed at supporting and improving the quality of iCCM implementation across these technical components. As iCCM services are delivered by Community Health Workers, we also reviewed tools more broadly focused on improving CHW programs and services. Finally, as tools were gathered and reviewed, we recognized a dearth of tools relevant to supporting processes of institutionalization and expanded the review to include tools developed to support institutionalization of other interventions in health or broader areas of social impact. The matrix below provides an overview of the tools identified. It is important to note that this matrix does not include other resources, which might provide helpful guidance and recommendations, but do not include a defined tool. Descriptions of these tools and other resources identified can be found in the accompanying annotated bibliography.

Summary Matrix of Tools According to Area of Relevance

TOOL NAME	CROSS-CUTTING				ESSENTIAL iCCM COMPONENTS							
	CHW Programs	iCCM Implementa-tion	Institution-alization	Scale-up	Policy	Financ-ing	HR	Supplies	Service Delivery & Referral	Comms & Social Mobiliza tion	Super-vision & QA	M&E + HMIS
A Guide for Fostering Change to Scale Up Effective Health Services				X					X			
A conceptual framework for measuring community health workforce performance within primary health care systems	X											
Caring for Newborns and Children in the Community: Planning Handbook for Programme Managers and Planners		X					X	X	X	X	X	X
Community Case Management Essentials: Treating Common Childhood Illness in the Community		X					X	X	X	X	X	X
Community Dialogues for Healthy Children: Encouraging Communities to Talk										X		

TOOL NAME	CROSS-CUTTING				ESSENTIAL iCCM COMPONENTS							
	CHW Programs	iCCM Implementa-tion	Institution-alization	Scale-up	Policy	Financing	HR	Supplies	Service Delivery & Referral	Comms & Social Mobilization	Super--vision & QA	M&E + HMIS
Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs) Program Functionality Assessment: A Toolkit for Improving CHC and HFMC Programs										X		
Community Health Planning and Costing Tool (version 2.0) Handbook: To help managers develop effective, sustainable, and comprehensive community health services	X					X						
Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving CHW Programs and Services	X											
Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policy makers	X				X	X	X	X	X	X	X	X
The Community Score Card (CSC): A generic guide for implementing CARE's CSC to improve quality of services										X		
How to Mobilize Communities for Improved Maternal and Newborn Health										X		
Indicator Guide: Monitoring and Evaluating Integrated Community Case Management												X
Institutionalizing community-focused maternal, newborn, and child health strategies to strengthen health systems: A new framework for the Sustainable Development Goal era	X		X									
Making Products Available in the Community: A Manager's Tool to Improving Community Health Supply Chains.								X				
The Pathway to Supply Chain Sustainability: A Planning Tool for Scaling & Institutionalizing Innovations within Public Sector Supply Chains.								X				

TOOL NAME	CROSS-CUTTING				ESSENTIAL iCCM COMPONENTS							
	CHW Programs	iCCM Implementa-tion	Institution-alization	Scale-up	Policy	Financi ng	HR	Supplies	Service Delivery & Referral	Comms & Social Mobilizati on	Super--vision & QA	M&E + HMIS
Tools to Introduce Community Case Management (CCM) of Serious Childhood Infection		X										
Scaling Up: From Vision to Large Scale Change - Tools for Practitioners, Second Edition 2021			X	X								
Supporting Country-Led Efforts to Systematically Scale-up and Sustain Reproductive, Maternal, Newborn, Child and Adolescent Health Interventions: Scale-up Coordinator's Guide, 2020			X	X								
Updated Program Functionality Matrix for Optimizing Community Health Programs	X				X	X	X	X	X	X	X	X
USAID Flagship CHW Resource Package	X				X	X	X	X	X	X	X	X
User Guide for the Community Health Worker Coverage and Capacity Tool	X								X			
WHO guideline on health policy and system support to optimize community health worker programmes	X				X	X	X	X	X	X	X	X

Notable among the tools listed above is the *Maternal and Child Survival Program's (MCSP) Supporting Country-Led Efforts to Systematically Scale-up and Sustain Reproductive, Maternal, Newborn, Child and Adolescent Health Interventions: Scale-up Coordinator's Guide (2020)*, which is itself based on the *Scaling Up: From Vision to Large Scale Change - Tools for Practitioners*, developed by Management Systems International (MSI) to inform the scale-up of development interventions more broadly (second edition, published 2021). While these toolkits often use the terms "scale-up" and "institutionalize" interchangeably and seem to imply at times that institutionalization is an inevitable outcome of scale-up, they provide the most robust guidance and set of tools relevant to supporting ***processes of institutionalization*** across all tools identified and reviewed in our landscaping.

The *Scaling Up: From Vision to Large Scale Change* toolkit was updated in 2021 and is based on over 10 years of development and research. It includes a set of tools that can be used flexibly across three defined "scaling up steps." While the focus of the toolkit is scale-up, there is an orientation toward "sustainable change" and "sustainable scale" with reference to tracking institutionalization at national scale (or sub-national scale in a decentralized national context). An overview of the scaling up steps, defined tasks and associated tools included in the toolkit are outlined in the table below (see figure 7). Within the toolkit, "Step 2: Establishing the Preconditions for Scaling" deals essentially with shifting necessary elements of an enabling environment for "sustainable change" or "sustainable scale," which could be equated to a stable end state of institutionalization. Finally, "Tool 13: Institutionalization Tracker," provides a set of indicators, maturity model and tracking process for planning and assessing institutionalization (see Annex 1).

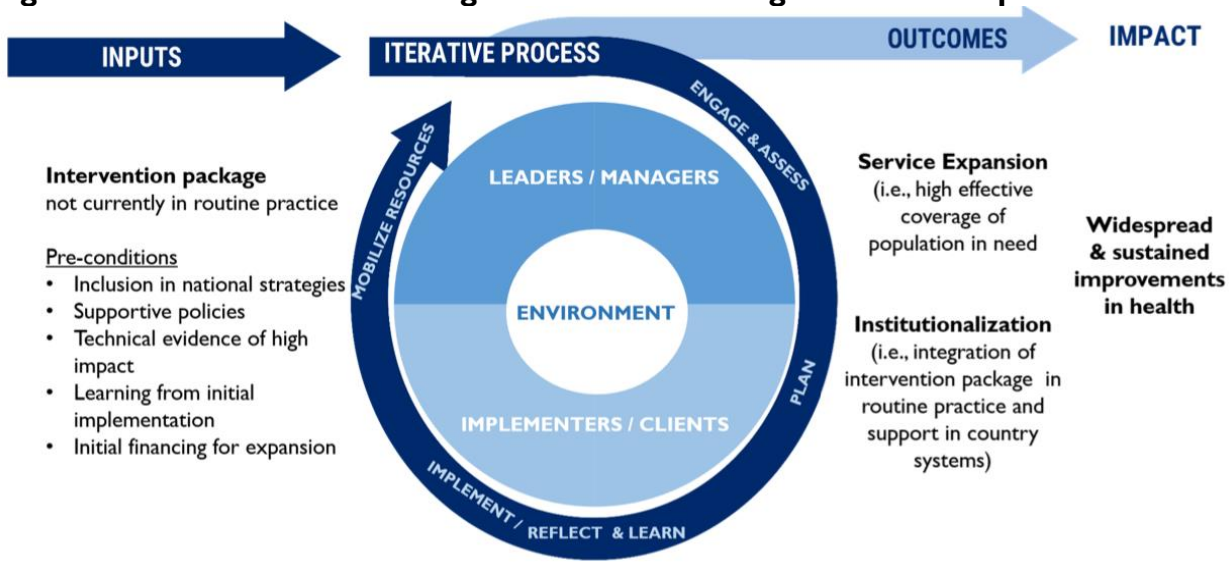
Figure 7: Scaling up Steps, Tasks and Tools

Scaling Up Steps	Tasks	Associated Tools
Crafting an Overall Scaling Strategy		Tool 1: Scaling Task Model Tool 2: Scaling Plan Template Tool 3: Real-time Scaling Lab
Step 1: Developing a Scaling Up Plan	Create a Vision Assess Scalability Fill Information Gaps Prepare a Scaling Plan	Tool 4: Second Theory of Change Tool 5: Intervention Profile Tool 6: Scalability Assessment Checklist
Step 2: Establishing the Preconditions for Scaling	Legitimize Change Build a Constituency Realign and Mobilize Resources	Tool 7: Drivers of Change Analysis Tool 8: Stakeholder Analysis Tool 9: Advocacy Strategy Profile Tool 10: Scale Costing Protocol
Step 3: Managing the Scaling Process	Modify Organizational Structures Coordinate Action Adapt Strategy and Maintain Momentum	Tool 11: Guidelines of Evidence Generation and Use Tool 12: Adaptive Management Protocol Tool 13: Institutionalization Tracker

Source: Scaling up: From Vision to Large Scale Change, MSI, 2021.

The *Supporting Country-Led Efforts to Systematically Scale-up and Sustain Reproductive, Maternal, Newborn, Child and Adolescent Health Interventions: Scale-up Coordinator's Guide*, adapts a selection of the tools from the *Scaling Up: From Vision to Large Scale Change* toolkit, but focuses explicitly on the "advanced stages" of scale up (see Figure 8 below).

Figure 8: Framework for Driving the "Advanced Stages" of Scale-Up



Source: Scale-up Coordinator's Guide, MCSP, 2020.

The guide assumes the "pre-conditions" or "readiness gaps" (e.g. supportive policies; government endorsement; an empowered "scale-up coordinator") are addressed prior to working through the "advanced stages" of scale-up, although the authors acknowledge that these gaps are often the eventual downfall of scale-up efforts. An excerpt from the guide explains this with specific reference to an example related to iCCM as follows:

> *This guide recommends we uncover such "readiness gaps" in the assessment stage and address them. Moving to the stages of expansion and full scale-up without first ensuring this "scale readiness" will almost certainly result in failure to achieve expansion and sustainable impact at scale. This has happened repeatedly in Kenya with integrated community case management (iCCM) of child illness, because despite numerous successful small and medium scale trials there over the last 15-20 years, there are not policies supportive of it. Finally, we feel that the systematic and system-oriented process of scale-up we present here is more likely to result in sustainable impact at scale, rather than "empty scale-up" (i.e., far-reaching nominal spread of an effective intervention but with little impact) as happened in a number of countries with the integrated management of childhood illness (IMCI) strategy 15 years ago when they relied mainly on training health personnel but without sufficient focus on other critical system supports. In several countries the IMCI Multi-Country Evaluation showed no impact at all because of weak implementation strength.*

Finally, the guide proposes a tool to "Assess Institutionalization of Intervention Package" (i.e. Tool 11), which is based on Tool 13 of the *Scaling Up: From Vision to Large Scale Change* toolkit, but adapted to be specifically relevant to Maternal Newborn and Child Health (MNCH) interventions and align with the WHO Health System Strengthening (HSS) building blocks (see Annex 2). This tool could be applied to assessing institutionalization of iCCM (either as is or with adaption to the iCCM benchmark components).

PROPOSED TOOLS TO BE ADAPTED AND DEVELOPED

The aim of the iCCM institutionalization toolkit will be to provide country level policy makers, national program managers and key influencers with guidance, resources and tools to progress through the process of institutionalization, rather than design and implement the technical aspects of an iCCM program. This intended audience and focus for the toolkit was discussed and agreed with members of the Institutionalizing iCCM Subgroup of the CHTF in consultations held in October and November 2021. The resources in the iCCM institutionalization toolkit will ideally enable the user to identify lessons learned about the process and management of institutionalization itself, focusing on what tools and approaches readers can use to shift the enabling environment (i.e. core values, leadership, policy and resources) to support iCCM institutionalization across each phase of the process (i.e. awareness, experimentation, expansion, consolidation and maturity) within their own country context. Tools will focus on assessing the landscape and strategizing approaches appropriate to a given country context as there is no standard path toward institutionalization and every country context is unique.

The toolkit will have a particular focus on inspiring new ways of thinking about influencing health system change to advance institutionalization of iCCM. Feedback from stakeholders suggested broad agreement on the proposed definition and framework for institutionalization of iCCM, particularly the importance of the four internal enabling components (i.e. core values; leadership; policy; resources). However, few stakeholders could identify options, opportunities or strategies for influencing these components. Discussion of institutionalization efforts often reverted to discussion of implementation challenges, particularly lack of supplies, indicating a project-oriented mindset that limits possibilities for influence. The toolkit will encourage readers/users to apply a broader health systems lens (beyond individual project or program concerns) to consideration of options, opportunities and strategies for advancing iCCM institutionalization (e.g. examining how iCCM fits within the overall health service delivery models and national health financing mechanisms).

Based on the critical analysis of existing tools, the following tools will be adapted or developed, in order to elaborate a toolkit along the parameters of the proposed institutionalization framework:

- Tools to be adapted:
    - From the *Scaling Up: From Vision to Large Scale Change:*
        - Second theory of change
        - Drivers of Change Analysis
        - Stakeholder Analysis
        - Advocacy Strategy Profile
        - Scale Costing Protocol
    - From the *Scale-up Coordinator's Guide and Basic Toolkit:*
        - Assess Institutionalization of Intervention Package (adapted to provide indicators or metrics of iCCM institutionalization)

- Tools to be developed:
    - Tools for mapping the landscape, understanding options and devising strategies for progressing across institutionalization phases for each of the four enabling environment components:
        - Core Values
        - Policy
        - Leadership
        - Resources

This list may change and/or expand based on further consultations with global and country iCCM stakeholders. User-friendly modes of delivery for the toolkit, including digital channels, will also be considered with feedback from stakeholders.

Annex 1. Tool 13 Institutionalization Tracker (Scaling up: From Vision to Large-Scale Change, 2021)

System Building Block	Element	Question	Low Institutionalization	Emerging Institutionalization	Significant Institutionalization	Full Institutionalization	Explanation of Score Selected
			Score = 1	**Score = 2**	**Score = 3**	**Score = 4**	
Governance	Leadership		No prominent champions at senior levels within the government	One or more prominent champion(s) at senior levels within the government, but champion(s) are not yet engaged in active advocacy	Prominent champions at both political and technical levels in the government who are advocating actively for the intervention	Expressed interest by government in institutionalizing the intervention and personnel assigned to oversee it	
	Policy		Intervention not mandated or implied in any major policy document	Intervention mandated in one or more major policy documents, but without implementation guidelines, regulations, standards or consequences for noncompliance	Intervention mandated in one or more major policy documents and implementation/regulatory requirements	Intervention mandated and implementation required	

Governance (cont'd)	Coordination		No temporary or permanent structure, person or process assigned responsibility to coordinate rollout and compliance	Temporary or permanent structure, person or process assigned responsibility to coordinate rollout and compliance, but with minimal authority, limited resources and no integrated information system	Temporary or permanent structure, person or process with authority, resources and information to coordinate rollout and compliance	Effective system for coordination firmly established or no longer required	
Planning, Budgeting and Finance	Planning		Intervention not included in national or subnational plans	Intervention included in national and/or subnational plans, but without clear metrics, milestones or timetables	Intervention included in national and subnational plans and metrics	Intervention fully integrated into government programming and no longer viewed as a standalone intervention	
	Budgeting and Finance		Funding exclusively from Originating Organization and/or donors	Credible estimates for costs of implementing the intervention on a pilot basis, but no credible estimates of the investment and recurrent costs to implement the intervention at scale	Credible estimates of investment and recurrent costs to implement the intervention at scale and some of the relevant costs included in budget of the Adopting Organization	Full funding for (phased) implementation and sustained operation of the intervention provided in approved budgets or have other reliable income sources	
Human Resources	Staffing		No credible estimates of the additional staffing and skills required to deliver and manage the intervention at scale	Credible estimates of the additional staffing and skills required to deliver the intervention at scale, but no allocation or retraining of permanent staff	Deployment of staff from Adopting Organization on a time limited or partial basis	Plan for full staffing with permanent employees completed or under active implementation	
	Training and Supervision		No plan for sustainable in-service or pre-service training of personnel needed to implement the intervention	Plan in place for sustainable in-service and/or pre-service training of the needed personnel and for their supervision	Staff benefit from regular supervision by either the Originating or Adopting Organization	Permanent arrangements under active implementation for training and supervising at scale and over time	
Infrastructure and Materials	Physical Infrastructure		Key infrastructure unavailable, borrowed or donor funded	Credible estimates for the additional infrastructure needed to implement the intervention at scale	Approved plan for providing and maintaining the needed infrastructure	Needed infrastructure available and operational	
	Procurement and Distribution		Originating Organization fully responsible for development, purchasing and distribution of materials and supplies needed to support the intervention	Credible plans for development, procurement and distribution of materials and supplies needed to implement the intervention at scale	Procurement systems and budgets of Adopting Organization include provision of some of the materials and supplies needed to implement the intervention	Responsibility for development, funding, procurement and distribution of materials and supplies fully mainstreamed within Adopting Organization	

Accountability and Learning	Standards		No officially approved standards	Approved standards exist, but with no positive or negative performance incentives	M&E and human resources systems incorporate approved standards as rating criteria	Standardized quality control and quality improvement systems in place and operational	
	Monitoring, Evaluation and Learning (MEL)		Originating Organization maintains responsibility for monitoring, evaluation and data management related to the intervention	Adopting Organization conducts or participates in MEL activities related to the intervention	Adopting Organization takes concrete action to integrate monitoring, evaluation and data management of the intervention into established systems	MEL activities fully integrated into established systems of Adopting Organization	

Source: Scaling up: From Vision to Large Scale Change, MSI, 2021.

Annex 2. MCSP Basic Toolkit for Systematic Scale Up Tool 11: Assess Institutionalization of Intervention Package

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 arees 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.	