Outline

- **Defining "scale up"**
- Experience and conceptual frameworks
- Scaling up DSD

The Science & Practice of
SCALE-UP

Defining "scale up" – 1

"The process of reaching large numbers of a target population in a broader geographic area by institutionalizing effective programs."

- Cash *et al. From One to Many,* 2011

Defining "scale up" – 2

"Deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis."

- WHO/ExpandNet 2010

Defining "scale up" – 3

- Both definitions highlight two key dimensions:
  - Expansion ("horizontal scale-up")
  - Institutionalization ("vertical scale-up")
- Goal = maximum impact
  - "Small is beautiful but large is necessary" - BRAC

Defining "scale up" – 4

Examples of expansion (horizontal scale-up):

- Increasing geographic coverage
- Expanding to reach more people in existing sites/regions
- Expanding the 'depth' or diversity of services provided to those already enrolled

Defining "scale up" – 5

Examples of institutionalization (vertical scale-up):

- Policies, political commitment and legal frameworks
- Regulations, norms and guidelines
- Financing and budgets
- Information systems
- Standardizing training, supervision, support

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Differentiated Service Delivery Dashboard: Draft 2.0

ICAP
GLOBAL. HEALTH. ACTION.
Columbia University
Mailman School of Public Health

Policies	National HIV treatment policies prohibit or impede differentiated service delivery models (DSDM)	National policies do not mention DSDM	National policies include DSDM but do not actively promote these models of care	National policies actively promote the use of DSDM for stable patients	National policies actively promote the use of DSDM for diverse patient groups[1]
Guidelines	National HIV treatment guidelines do not include DSDM		National HIV treatment guidelines include DSDM but do not provide detailed and specific implementation guidance		National HIV treatment guidelines provide detailed and specific guidance on implementation of DSDM
Diversity of DSDM services	No DSDM services have been implemented	DSD is available for stable patients only and only one model has been implemented[2]	DSD is available for stable patients only, and only two models have been implemented	DSD is available for stable patients only and ≥ 3 models have been implemented	DSDM is available for diverse patient groups
National DSD Scale-up Plan	None	DSD scale-up plan discussions and meetings ongoing	DSD scale-up plan draft available	DSD scale-up plan developed and approved by MOH	DSD scale-up plan being actively implemented
Coordination	None	DSD activities fall under the purview of existing groups; progress updates are presented in standing meetings not focused on DSDM (e.g., a care and treatment technical working group [TWG])	DSD activities are coordinated by a dedicated group (e.g., a sub-TWG or equivalent)	National DSD Focal Person spearheads DSD planning and coordination	DSD progress reported in annual program reports and/or annual national review meetings in place
Community Engagement	None	Representatives of people living with HIV/AIDS (PLHIV) and/or civil society are engaged in DSD implementation	PLHIV and/or civil society representatives are engaged in both DSD implementation and design of DSDM	PLHIV and/or civil society representatives are engaged in both implementation, design and evaluation of DSDM	PLHIV and/or civil society representatives are systematically engaged in DSD policy development, design, implementation, and evaluation
Training Materials	DSD training materials are not available	Some DSD training materials have been developed by organizations piloting DSD / implementing partners	National DSD in-service curricula for either professional health workers or lay health workers (but not both) available & in use	National DSD curricula for both professional health workers and lay workers available and in use	National DSD pre-service and in-service curricula available and in use
SOPs and Job Aides	None	Implementing organizations have piloted SOPs and job aides for stand-alone DSDM projects	National SOPs and job aides available for only one DSD model	National SOPs and job aides available for two DSD models	Step-by-step national SOPs and job aides available for ≥ 3 DSD models
M&E System	No M&E system elements for DSD are in place or in development	Development of new M&E tools and systems for DSDM is planned or underway	Some new or adapted tools (e.g., registers, patient cards, monthly reports) and/or M&E guidelines have been implemented	A majority of DSDM M&E elements are in place, but they are not comprehensive or fully integrated into routine M&E	All elements of an M&E system for DSD are in place and integrated into one national M&E system for HIV /ART services

8

Coverage without Quality will not achieve goals

Utilization x Quality = Impact
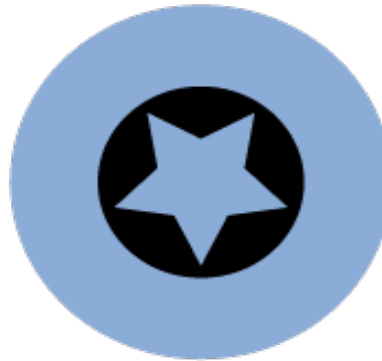
Access   **Acceptability**   **Quality**   **Coverage**   **Effectiveness**

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The Sc

RESEARCH — Open Access

'The stars seem aligned': a qualitative study to understand the effects of context on scale-up of maternal and newborn health innovations in Ethiopia, India and Nigeria

METHODOLOGY

A framework for scali...
interven...
improve...

Pierre M. Barker[1,2*],

Nine steps for scaling-u...

DEBATE — Open Access

Scaling up ART adherence clubs in the public sector health system in the Western Cape, South Africa: a study of the institutionalisation of a pilot innovation

...ventions
...care

...: what are

...endricks Brown[4]

Hayley MacGregor[1*] , Andrew McKenzie[2], Tanya Jacobs[3] and Angelica Ullauri[4]

Sc
t

A Management Framework
for Practitioners

...up of Health Practices
and Interventions

The Science of Intervention
SCALE-UP

THE INNOVATION
Relative advantage
Compatibility
Low complexity
Trialability
Observability
Potential for reinvention
Fuzzy boundaries
Risk
Task issues
Nature of knowledge
  required (tacit/explicit)
Technical support

**COMMUNICATION
AND INFLUENCE**
DIFFUSION
(Informal, unplanned)
  Social networks
  Homophily
  Peer opinion
  Marketing
  Expert opinion
  Champions
  Boundary spanners
  Change agents
DISSEMINATION
(formal, planned)

OUTER CONTEXT
Sociopolitical climate
Incentives and mandates
Interorganizational
  norm-setting and
  networks
Environmental stability

SYSTEM ANTECEDENTS FOR INNOVATION
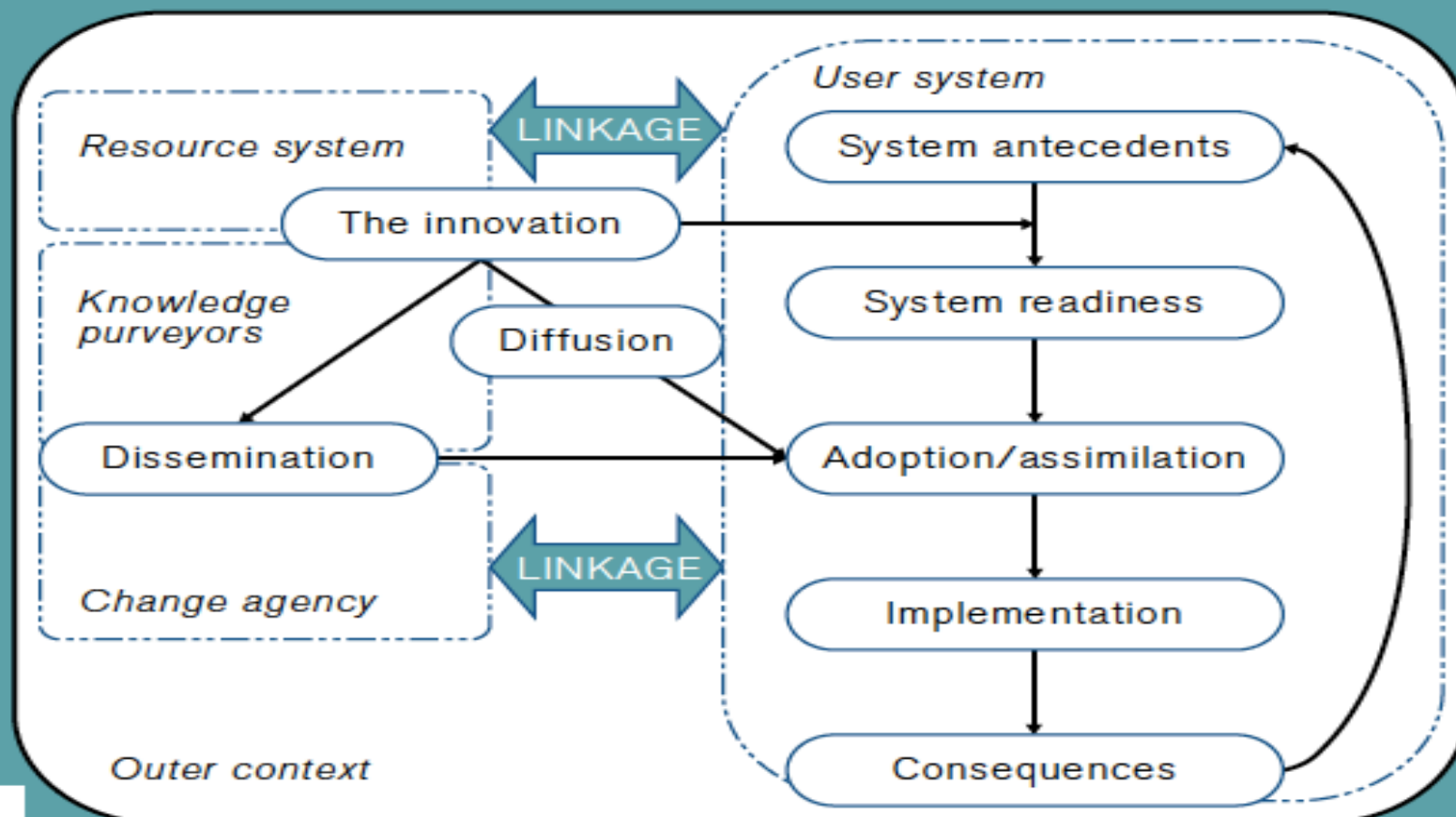
Structure
  Size/maturity
  Formalization
  Differentiation
  Decentralization
  Slack resources

Absorptive capacity for new knowledge
  Preexisting knowledge/skills base
  Ability to find, interpret, recodify,
    and integrate new knowledge
  Enablement of knowledge sharing
    via internal and external networks

Receptive context for change
  Leadership and vision
  Good managerial relations
  Risk-taking climate
  Clear goals and priorities
  High-quality data capture

**SYSTEM READINESS
FOR INNOVATION**
Tension for change
Innovation-system fit
Power balances
  (supporters v. opponents)
Assessment of implications
Dedicated time/resources
Monitoring and feedback

Resource system

Knowledge purveyors

Change agency

Outer context

The innovation

Diffusion

Dissemination

LINKAGE

LINKAGE

User system

System antecedents

System readiness

Adoption/assimilation

Implementation

Consequences

ADOPTER
Needs
Motivation
Values and goals
Skills
Learning style
Social networks

ASSIMILATION
Complex, nonlinear
  process
"Soft periphery" elements

**IMPLEMENTATION
PROCESS**
Decision making devolved
  to frontline teams
Hands-on approach by
  leaders and managers
Human resource issues,
  especially training
Dedicated resources
Internal communication
External collaboration
Reinvention/development
Feedback on progress

LINKAGE

Design stage
  Shared meanings and mission
  Effective knowledge transfer
  User involvement in specification
  Capture of user-led innovation

Implementation stage
  Communication and information
  User orientation
  Product augmentation e.g. technical help
  Project management support

Evidence informed framework of scale-up

STAGE	ACTIONS	CONTEXT
Designing for scale-up	• Planning, assessment & sensitisation • Designing scalable innovations	Health governance Prioritisation of health issues Development partner coordination
Decision making	• Presenting strong evidence • Harmonisation , alignment & country ownership • Invoking powerful individuals • Responsiveness and flexibility	
Delivery at scale	• Supporting 'transition' to scale • Review & modification • Strengthening health systems capacity	Health systems capacity Security
Demand & uptake	• Engaging community 'opinion leaders' • Engaging media	Socioeconomic and cultural contexts Geographical contexts

The ExpandNet/WHO framework for scaling up

Environment

The innovation

Resource Team

Scaling up Strategy

User organization(s)

The institution(s) expected to implement at scale

The elements of scaling up

Type of scaling up

Dissemination and advocacy

Organizational process

Costs/resource mobilization

Monitoring and evaluation

Strategic choice areas
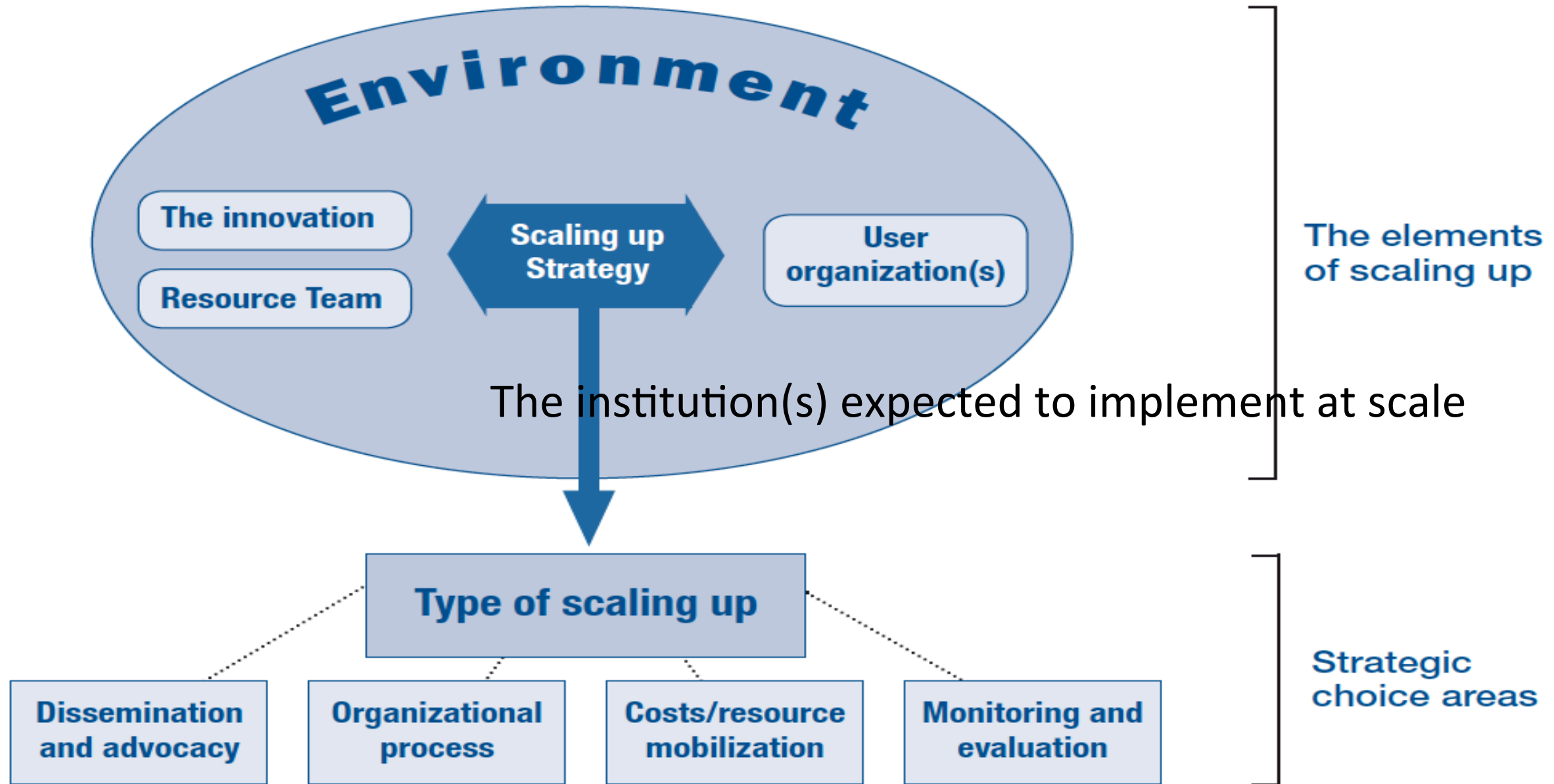
ExpandNet: Strategic Choice Areas

- **Types of scaling up:**
  - Expansion *and* institutionalization
- **Dissemination and advocacy:**
  - Training, TA, policy dialogues, review meetings > > papers, briefs and guidelines
- **Organizational process:**
  - Phased approaches are often most successful
- **Resource mobilization:**
  - Look for economies of scale, potential to link to other health system reforms
- **Monitoring and evaluation:**
  - Critical to understand both process and impact

ExpandNet: Guiding Principles

✓ Systems thinking

✓ Sustainability

✓ Determinants of success

✓ Integration of human rights initiatives

Credibility
Observability
Relevance
Relative advantage
Ease of implementation
Compatability
Testability

The Science & Practice of
SCALE-UP

The ExpandNet/WHO Framework

"Scaling up is a complex organizational, managerial political and policy task….and requires strategic planning and management."

"Scaling up…is fundamentally about introducing and managing change, which implies significant departures from standard routines, protocols, and norms."
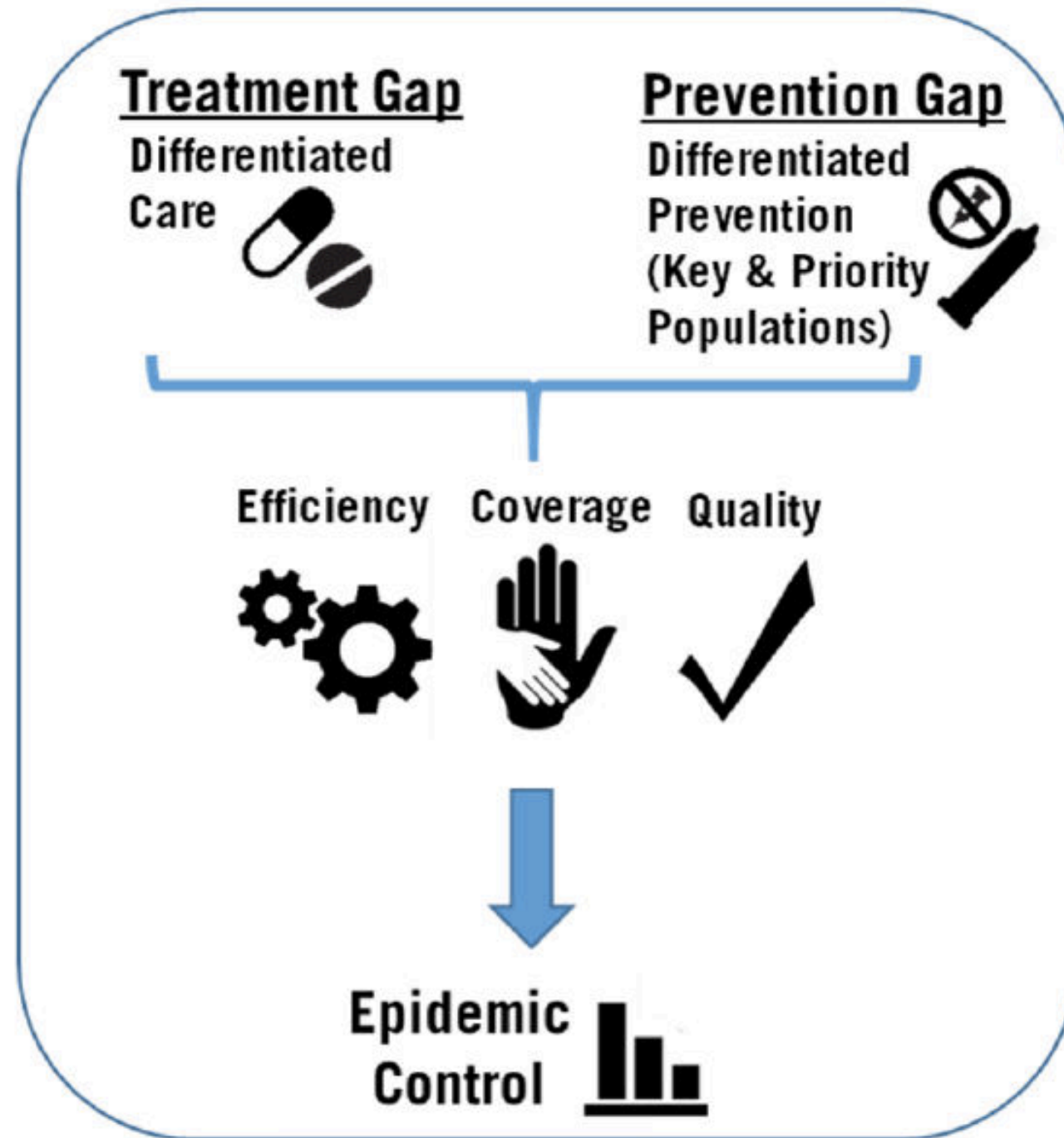
The Science & Practice of
SCALE-UP

Outline

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- **Scaling up DSD**
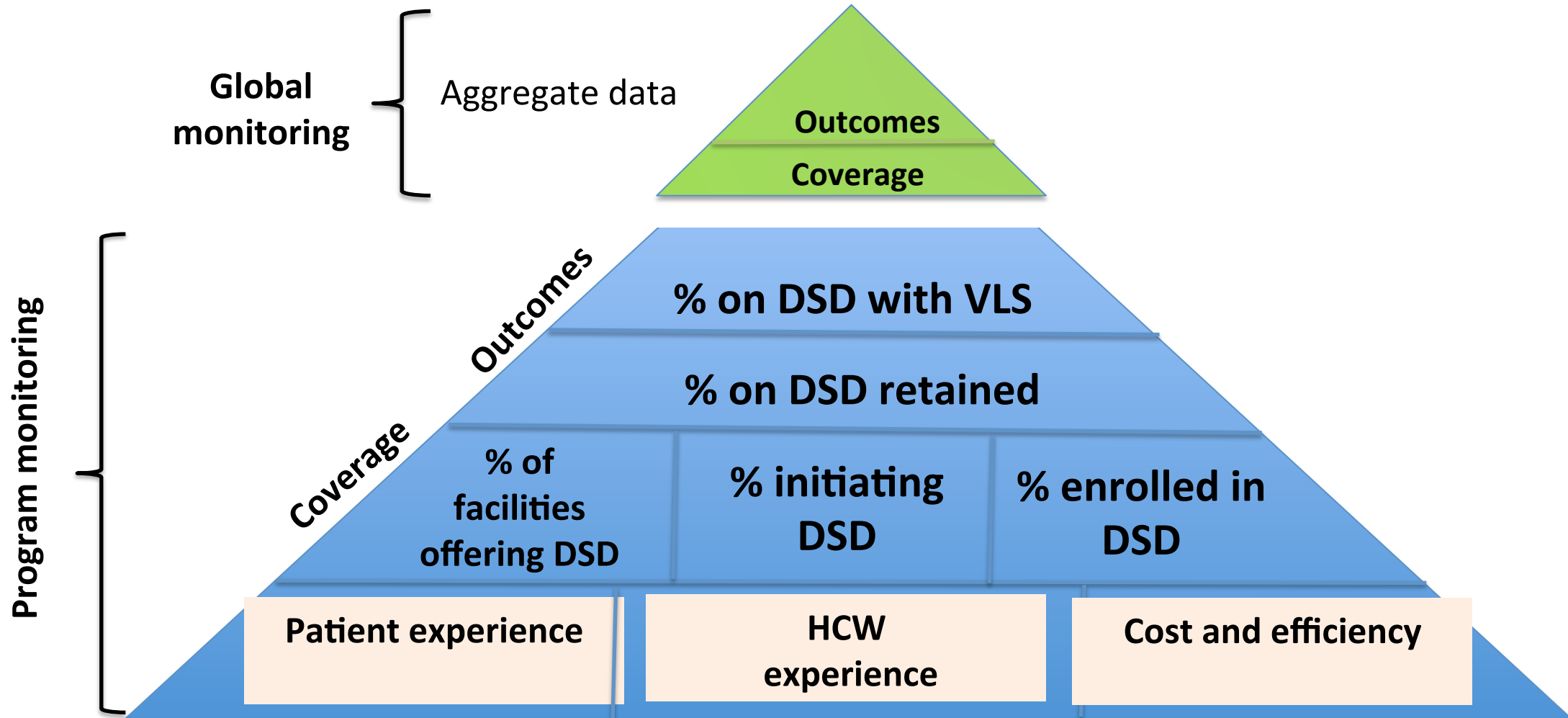
Why do we need to take DSD to scale?

- Small is beautiful but large is necessary
- Coverage x quality = impact
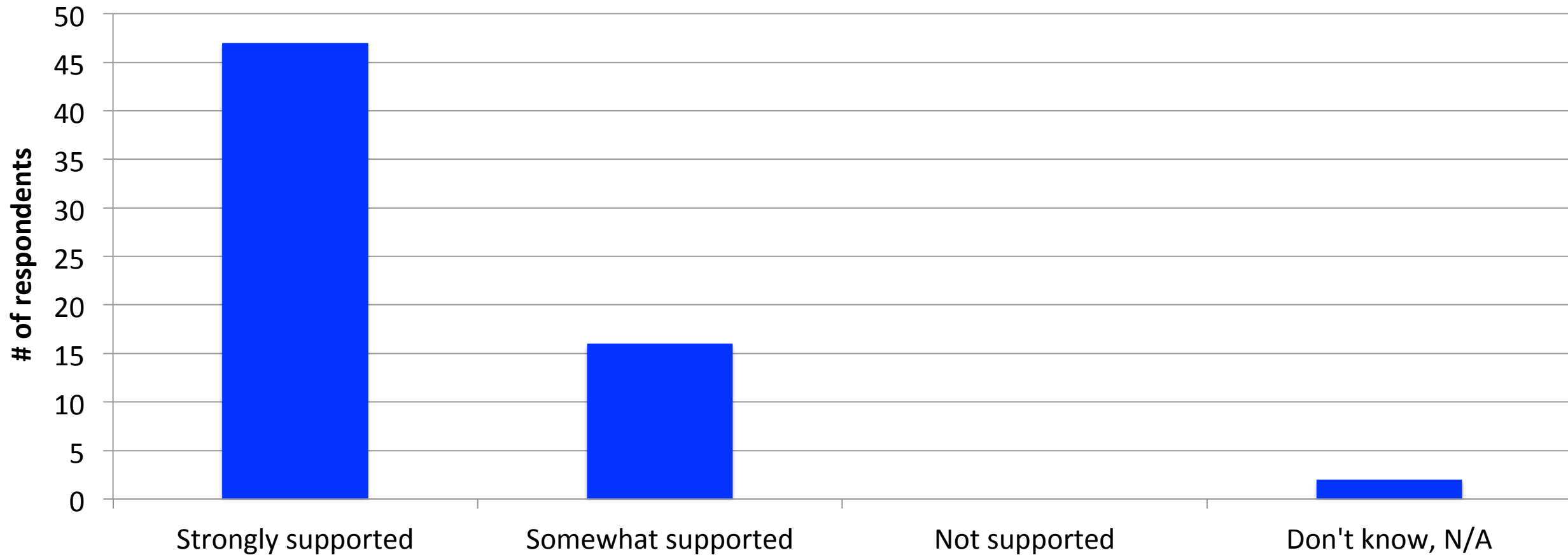
Why do we need to take DSD to scale?

- Our goals for DSD are very ambitious
  - To simplify and adapt HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV while reducing unnecessary burdens on the health system
- Our shared hypothesis is that scale up of differentiated ART delivery models will lead to:
  - improved clinical outcomes of VL suppression and retention,
  - improved patient and HCW experiences, and
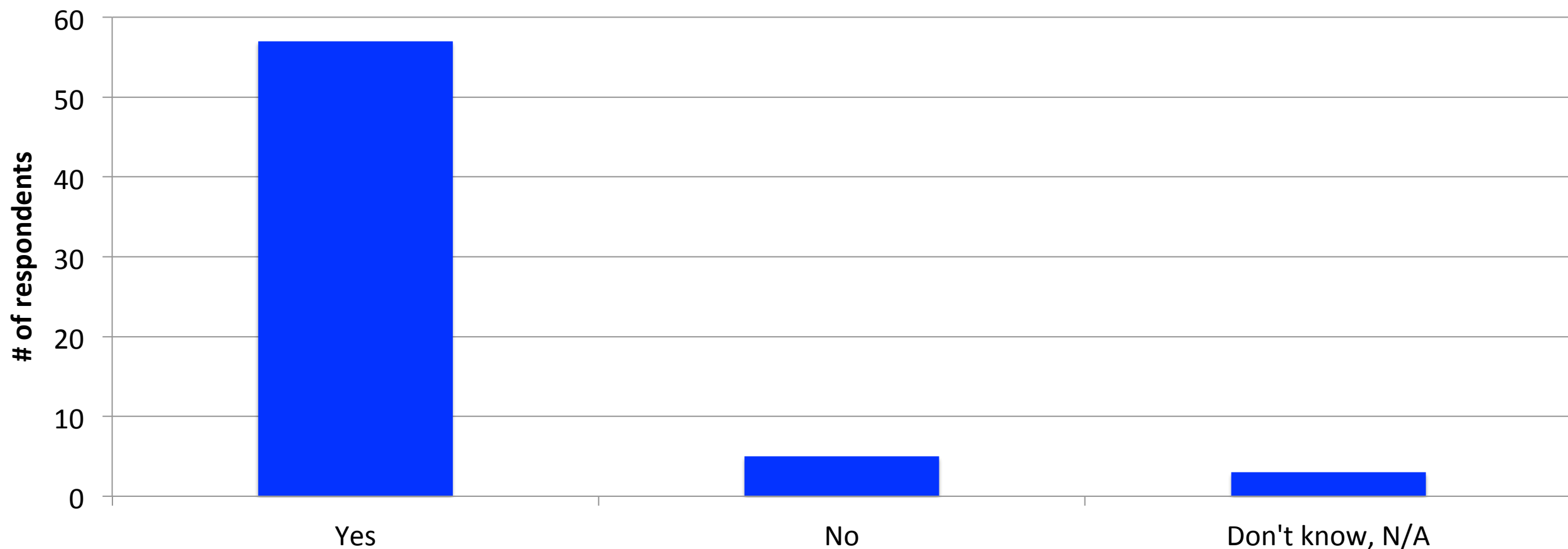 - reduced costs for patients and providers

How will we measure success?

Global monitoring — Aggregate data
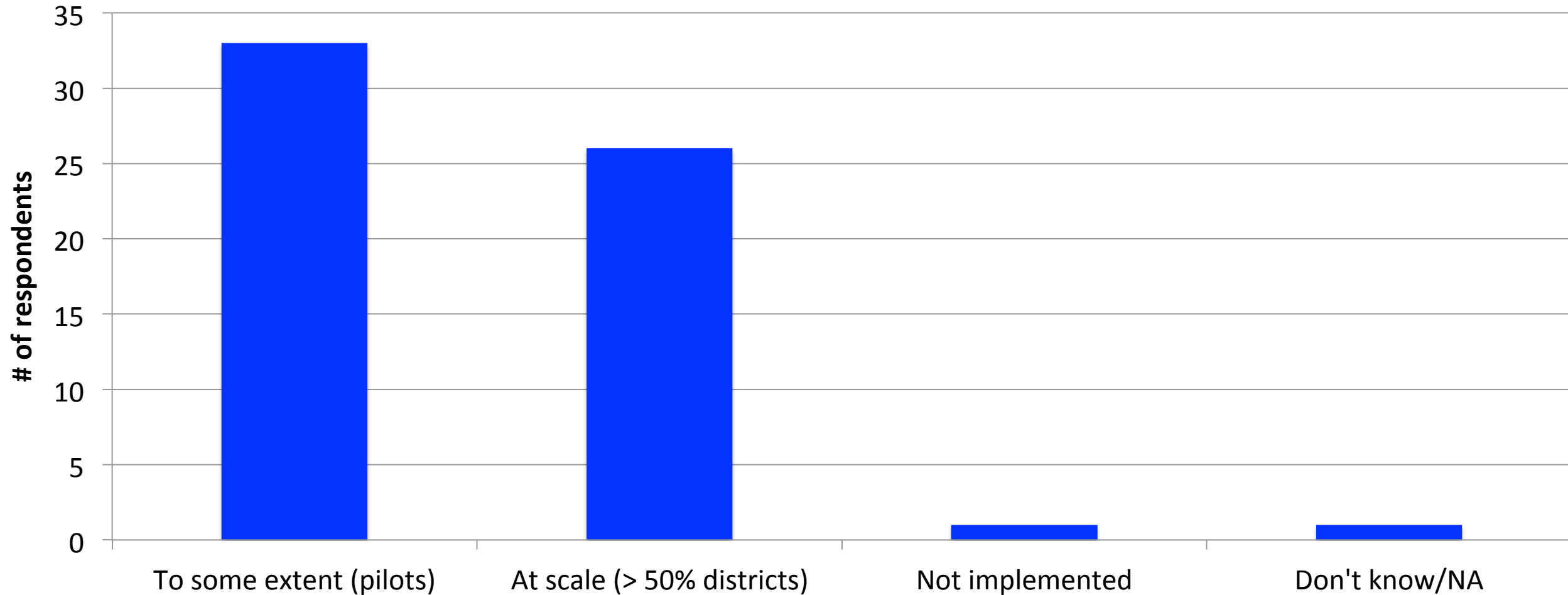
Outcomes
Coverage

Program monitoring

Outcomes

Coverage

% on DSD with VLS

% on DSD retained

% of facilities offering DSD | % initiating DSD | % enrolled in DSD

Patient experience | HCW experience | Cost and efficiency

To what extent is DSD supported at the <u>policy</u> level in your country?

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The Science & Practice of
SCALE-UP

Is DSD included in national HIV treatment <u>guidelines</u> in your country?

To what extent is DSD <u>implemented</u> in your country?

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SCALE-UP

How do we reach the goal?

- Enhance credibility and create demand
- Streamline and simplify
- Work with strengths in the user organization
- Address environmental constraints
- Strengthen the resource team
- Provide hands-on support (not just guidelines)
- Advocate for supportive policies
- Adjust the pace
- Mobilize resources
- Ensure effective M&E

Registration survey question: What would make it easier to implement DSD in your country?

- Development of clear operational guidelines
- Optimizing M&E systems for DSD
  - Standardized reporting of DSD indicators
  - Electronic medical records
  - Facility based DSD targets
- Building health worker capacity
  - Training HCW
  - Supportive supervision and mentoring
  - Elaboration of a post-implementation supervision plan

Registration survey question: What would make it easier to implement DSD in your country? – 2

- Increased VL coverage

- Realignment of ARV procurement planning to support DSD roll out

- More community involvement

- Buy-in from provincial and district managers

- Better dissemination of policies from national to local levels

How will we explore some of these issues?

- We'll hear more about frameworks and strategies
- We'll hear directly from "resource people" – national DSD coordinators
- We'll focus on three priority constraints
  - Demand generation and client/community engagement
  - Laboratory barriers and constraints
  - Health workforce challenges
- We'll share selected case studies – community observatories in West Africa, scaling up VL in Swaziland
- We'll spend a lot of time in breakout sessions
- Output of meeting = revised action plans and next steps for country scale-up

Thank you