Harnessing the power of partnership to share and exchange knowledge globally, to foster change and scale up locally to improve reproductive health
Implementing Best Practices Consortium

FOUNDING PARTNERS
- World Health Organization / Department of Reproductive Health and Research [www.who.int/reproductivehealth]
- United States Agency for International Development [www.maqweb.org; www.globalhealthlearning.org]
- United Nations Population Fund [www.unfpa.org]
- EngenderHealth [www.engenderhealth.org]
- Family Health International [www.fhi.org]
- International Planned Parenthood Federation [www.ippf.org]
- IntraHealth International [www.intrahealth.org]
- Jhpiego [www.jhpiego.org; www.accesstohealth.org]
- Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs [www.jhuccp.org; www.k4health.org]
- Management Sciences for Health [www.msh.org]
- Pathfinder International [www.pathfind.org; www.esdproj.org]
- Public Health Institute [www.phi.org]

OTHER PARTNERS
- Academy for Educational Development [www.aed.org]
- Bill and Melinda Gates Institute for Population and Reproductive Health [www.jhsph.edu/gatesinstitute]
- Care International [www.care.org]
- Centre for African Family Studies / Kenya [www.cafs.org]
- Centre for Development and Population Activities [www.cedpa.org]
- CORE Group [www.coregroup.org]
- East, Central and Southern Africa Health Community [www.ecsahc.org]
- ExpandNet [www.expandnet.net]
- Family Care International [www.familycareintl.org]
- Institute for Reproductive Health, Georgetown University [www.irh.org]
- International Council of Management for Population Programmes [www.icomp.org.my]
- John Snow, Inc. [www.jsi.com]
- Marie Stopes International [www.mariestopes.org]
- Partners for Population and Development [www.partners-popdev.org/]
- Population Council [www.popcouncil.org]
- Population Reference Bureau [www.prb.org]
- Program for Appropriate Technology in Health [www.path.org]
- Regional Centre for Quality of Health Care, Makerere University / Uganda [www.rcqhc.org]
- University Research Co., LLC [www.urc-chs.com]
- White Ribbon Alliance for Safe Motherhood [www.whiteribbonalliance.org]
Implementing Best Practices Initiative: Our First 10 Years

- In Kenya the Ministry of Health obtains a budget line item for family planning commodities.
- In Ethiopia an interagency team identifies and documents local “practices that make programmes work”. The Ministry of Health intends to build identifying and scaling up best practices into its official annual planning process.
- In Jordan the Ministry of Health and its partners introduce a comprehensive approach to post-abortion care in public hospitals, adapting guidelines, training providers, supplying contraceptives and communication materials, and issuing a policy directive.
- In India management teams from all 22 districts in the state of Jharkhand learn to apply a structured process of Performance Improvement to improve health care services.
- The IBP Knowledge Gateway for Reproductive Health hosts nearly 475 virtual communities of practice. From its launch in 2004 to 2010 the Knowledge Gateway grows to over 18,000 members involved in reproductive health.

Over the past 10 years the Implementing Best Practices (IBP) Initiative has catalyzed these achievements and many others like them. In the course of these efforts, the IBP partnership has helped establish a new vision of how to improve reproductive health care.

What is the IBP Initiative? It is—at the same time—an organization, a concept, a network of people, and a way of working.

As an organization, the IBP Consortium, which oversees the Initiative, has grown to 32 partners in 2010, from the original 9 agencies that first met in 1999. In general, IBP members are organizations offering technical assistance, materials, and, in some cases, funding to support reproductive health care in countries around the world. (See list of IBP Consortium members on inside front cover.) Many more organizations and agencies in countries participate in activities organized under the IBP banner. These include government ministries, non-governmental organizations, faith-based organizations, advocacy groups, community organizations and health professionals’ organizations.

As a concept, the IBP Initiative asserts the crucial importance of continuously identifying, adapting, and scaling up practices demonstrated to improve reproductive health and the quality of service delivery. It contends that this process deserves organized, coordinated effort and concerted support. In other words, collaborative energy needs to focus on identifying what works and taking that to scale rather than reinventing it in every locale. The IBP concept declares that, in the progression from research to practice, the last mile is just as important as the first.
As a network, the IBP consists of and connects reproductive health professionals, policy-makers and advocates in their countries, their regions and worldwide. With this connection, they can share their knowledge both face-to-face and, through appropriate technology, virtually.

As a way of working, the IBP recognizes the importance of creating networks, drawing on their knowledge and building on their experience. In countries the IBP Initiative builds a network of all stakeholders that works in support of the ministry of health. These principles—networking and building on experience—are fundamental to learning and to improving performance. The IBP exemplifies egalitarian collaboration. The IBP believes that everyone has knowledge and experience worth sharing, everyone has something to learn, everyone can contribute to improved performance, and everyone deserves credit for their contribution. Collaboration among people and organizations with complementary strengths and different perspectives produces greater results than working independently and without communication. The IBP’s way of working is in keeping with the tenets of Knowledge Management.

In all these dimensions the IBP has evolved and grown as it has learned over its 10-year history. While learning and adapting, the IBP has nonetheless stayed true to its original purposes and founding principles. A number of themes emerge from a look back at the IBP’s first decade. Like petals growing from a flower bud, these themes have taken shape and colour as they have emerged:

- Growing the IBP partnership
- Evolving strategy
- Fostering change
- Working collaboratively in support of ministries of health
- Developing methods and tools for sharing knowledge in and among countries.
Before IBP: the challenge of promoting guidelines

At the World Health Organization, Department of Reproductive Health and Research (WHO/RHR) the IBP Initiative emerged from an earlier initiative, known as the Dissemination, Adaptation, and Utilization Process, or DAU. In the late 1990s the Department sought to improve access to information and ensure that its technical guidelines actually affected reproductive health care. When WHO/RHR and the then Department of Organization and Health Systems (WHO/OSD) analysed the distribution of WHO/RHR documents, they found that the documents were not necessarily received and/or read by the people who needed them, and they may not have suited local policy or cultural norms.

Three sources of information pointed to the need for organized support to take WHO/RHR reproductive health care guidelines into practice. First, in 1999 nine organizations convened by WHO found that their guidance sometimes covered the same topics, and thus was duplicative, while at the same time the guidance sometimes conflicted. When, however, organizations worked together to develop and introduce guidance, they avoided these problems. As in the case of WHO/RHR’s *Medical Eligibility Criteria for Contraceptive Use*, collaboration assured consistent guidance, avoided duplication of effort and, in fact, accelerated the uptake and use of the materials.

Second, an analysis of the successes and challenges in seven countries with introducing guidelines compiled 57 lessons. These could be boiled down to two key points.

- There are no magic bullets that make implementation of guidance simple and easy, but people are more motivated to act when the guidelines meet their needs.
- Development and introduction of technical guidance documents into countries must be strategically and systematically supported in order to address barriers to change and adoption of effective practices. The evidence also showed support for this approach.

Third, a review of the literature since 1990, conducted by the Cochrane Effective Practice and Organization Group (EPOC), found a large body of literature that identifies barriers to implementing best practices. Before best practices can be successfully implemented, these barriers—which can exist to varying degrees in any health care setting—must be strategically addressed using an interactive process. The review concluded that simply distributing published guidelines or even presenting them generally had little or no effect on the health care system or providers’ practices.

Early in 2000 WHO/RHR held another meeting with the same nine partners to develop a conceptual framework for such a process. The result was the DAU Process—Disseminate, Adapt and Utilize. The DAU framework drew not only from WHO’s analysis but also from the work and thinking of partners who also were part of the USAID-led Maximizing Access and Quality (MAQ) Initiative, which was exploring the same issues. The DAU framework built on a generic process for the systematic management of change. That process begins with creating awareness and advocating acceptance of a best practice and continues through its adaptation, adoption and application (see box).
With the development of this strategy, the DAU partnership was launched. Partners agreed to harmonize approaches and base their roles in implementing the DAU process on the MAQ Initiative’s synergy of interventions (see illustration).

The DAU partners also developed a set of principles of operation:

- promote coordination and collaboration
- network with networks
- foster ownership through active engagement
- serve as a catalyst for change
- support a strategic and systematic approach
- be practical and realistic
- promote harmonization of approaches
- share costs
- maintain momentum through effective follow-up.

These principles remain fundamental and integral to the IBP Initiative today.

The journey from evidence to practice: the 6 A’s

The course from research evidence to better health care is a journey of many steps. Developing practice guidelines based on the best available evidence is only the first of these. Steps must be taken to create awareness of the evidence-based practice and to advocate its acceptance and use.

Information based on evidence can be used to advocate change, but to gain acceptance requires champions within the health care system who can enlist their peers and create the critical mass of people committed to taking action. Achieving this level of acceptance requires co-ordination and teamwork. This collective action provides a powerful lobby, not only for change in policies, but also for actions that translate those policies into practice.

For technical guidelines to affect practice, they must be adapted to suit local conditions. A collaborative process of adaptation is itself a vehicle for building consensus and developing champions. In particular, guidelines must be translated into specific protocols or behaviours that guide provider’s actions.

Constraints and inertia exist in any health care system, however. Application of a new practice requires management of a strategic process of change. A systematic analysis of the gap between actual and desired performance will inform the choice of interventions that, working together, will best close that gap. Training and job aids to support providers’ new behaviors often are necessary parts of this process but often not enough.

Only through change in both the infrastructure of the health care system and the practices of providers can new practices become routinely adhered to and sustained. Clearly, virtually all in the health care system, from the international arena to the local clinic, have to make changes.
The Nepal DAU meeting

The first event to introduce the DAU process to countries took place in Katmandu, Nepal in 2000. It brought together teams from four countries—Bangladesh, India (Uttar Pradesh), Indonesia and Nepal—countries where the organizing partners had ongoing projects and so could follow up after the meeting. For each country team, the partner organizations invited managers and policy-makers who worked on reproductive health with their ministry of health, but they did not necessarily work with one another. By bringing the team members together, the organizers sought to develop a network for collaborative planning and decision-making once the team returned home.

In total, 77 participants attended from 14 countries—not only the country team members but also individuals representing China, Malaysia, Maldives, Myanmar, Sri Lanka and Turkey.

The meeting was prepared through a collaboration involving WHO/RHR, USAID, and the DAU partners with the WHO Country Office, the WHO South East Asia Regional Office and the USAID Mission in Nepal.

“From the IBP partners”

To mark the 10th anniversary of the IBP Initiative, IBP partners responded to questions from the IBP secretariat: “What have been your most important contributions to the IBP Initiative?” and “How has your organization benefited from participation in the IBP Consortium?” Excerpts from the partners’ answers appear throughout this report in boxes like this one.

From IBP partner Jhpiego

Jhpiego is proud to have been a founding member of the IBP Consortium. All of us at Jhpiego have benefited from the collaborative “power of partnerships” that the IBP Initiative has harnessed.

In 1999 initial meetings were held in Baltimore to discuss the formation of the Consortium with Maggie Usher-Patel. Since that time Jhpiego staff have been active participants in every IBP regional and country launch meeting, and helped spearhead the “Technology Café” at all of these meetings. We are also proud to have developed a number of “Communities of Practice” on the IBP Knowledge Gateway and have led numerous online global forums on topics such as postpartum family planning and pre-service education. The IBP Initiative has been introduced in a number of our field offices, and our work in Kenya on IBP with the Division of Reproductive Health led to a significant increase in contraceptive prevalence in a number of districts.

Our role in chairing the Consortium has been a rewarding one, and we look forward to working with this important initiative for years to come. Congratulations to WHO, USAID and IBP for a great ten years.
Preparing for the meeting, the DAU partners concentrated on developing interactive educational activities. These activities became hallmarks of subsequent IBP events. They included:

- the Country Fair (later called the Information Exchange Bazaar), where each country could present its guidelines and related materials and explore opportunities to harmonize messages, share information, or collaborate on production or dissemination of materials;
- the “no-lecture” interactive Mini-University, where participants discussed technical guidance documents and tools from international and national perspectives; and
- the Technology Café, where participants could gain hands-on experience using multimedia tools.

The partners designed the meeting to promote collaboration and networking, to build on experience and to introduce change management and Performance Improvement processes. During the meeting the country teams used a simple Performance Improvement process to plan how to tackle the implementation of new practices following the six A’s of the DAU process. At the close of the meeting they described their plans and made a public commitment to applying the DAU process in their countries.

All four teams conducted follow-on activities after the meeting. For example, the Nepal Country Team formed the DAU Club and worked collaboratively under the leadership of the MOH to revise the family planning service delivery guidelines. Within a year the first volume of the new guidelines was published. The India Country team also formed a DAU Club and later reported:

*India experienced a great benefit from participation.... A good example is the revision and promotion of the no-scalpel vasectomy. Doctors have been trained and services have been made available. A strong advocacy programme has been implemented and vasectomy has tripled in three States. This programme is a best practice and seven doctors from Ghana, Kenya and the Philippines have come here for training.*

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**From IBP partner Pathfinder International**

As a founding member of the IBP Consortium, Pathfinder International is especially inspired to salute the significant contributions of this organization on its tenth anniversary. It is impossible to separate Pathfinder’s contributions over the past decade from the knowledge, learning, and collaborative strength we have acquired in making them.
Beginnings of the Implementing Best Practices (IBP) Initiative

The Nepal meeting won the praise of participants. Still, the meeting began the changes that transformed the DAU into a much broader, more comprehensive initiative—the Implementing Best Practices (IBP) Initiative. Comments from some participants became a catalyst for re-thinking the focus of the strategy.

One observation was that countries should decide what new technical guidelines to introduce, based on their own needs and priorities, and not simply introduce every new global guideline as it is issued. Furthermore, some participants pointed out that implementing new technical guidelines, while important, will not solve all problems. Programmes need to build on and strengthen what exists in a wide variety of ways. In particular, participants expressed the need to strengthen programme operations and to solve programmatic problems that limit the extent and quality of services.

At the same time, the partners supporting the DAU process expressed concern that the DAU process appeared too one-way, too top-down and too focused on the introduction of technical guidelines. They were concerned that the emphasis on local application of international guidelines implied that all wisdom resided in the international arena, while countries were empty vessels, waiting to receive knowledge. More importantly, too much emphasis on implementing international guidelines could miss opportunities to learn from countries’ own experiences. As focus shifted from clinical guidelines, which are based on medical research, to programmatic issues, recognition grew that best practices in management, training and programme operations, although seldom fully evaluated, emerge from the experience of service delivery programmes.

The China meetings. A second meeting occurred under the banner of the DAU—in Beijing, China, December 2000. The Director of China’s State Family Planning Commission had attended the Nepal meeting and invited WHO/RHR to bring the DAU process to China. The meeting focused on updating China’s administrative instructions for family planning services to reflect the WHO/RHR Medical Eligibility Criteria, principles of evidence-based practice and good client-provider interaction. These revised instructions were later adopted as policy.

A second meeting in China, 12 months later, introduced what had become by then the Implementing Best Practice (IBP) Initiative. This meeting involved all 34 provincial managers and their assistants. It built on local experience to discuss leadership, the management of change and how to apply the key steps in the Performance Improvement process. Making use of a well-established knowledge-sharing practice, the State Family Planning Commission formulated a plan to pair three provinces that had more advanced reproductive health services with three provinces that could benefit from the experience of their “twin”. The State Commission committed to following up each province.
Implementing Best Practices in Reproductive Health

Becoming the IBP Initiative

By early 2001 the partnership was attracting new members, such as the Public Health Institute (PHI). At a February partners’ meeting, PHI contributed its vision and experience to the debate on how to reorient the DAU process.

The partners decided that, rather than focusing largely on introducing and implementing technical guidelines, the revised process would embrace a larger range of issues. A country’s needs and priorities would decide which issues received attention. The DAU process itself would become less linear. Experience in country would receive more attention, and best practices already developed would be identified, highlighted and shared. Knowledge would be shared and exchanged in all directions. Approaches to identifying programme needs and developing plans would be further adopted from the MAQ Initiative and from methodologies already tried and tested by various USAID-supported organizations, such as Performance Improvement, COPE (Client-Oriented, Provider-Efficient services), and Quality Assurance.

By early 2001 the partners had adopted the new name—the Implementing Best Practices (IBP) Initiative. In a May meeting partners worked on a new conceptual framework built on the principles of leadership and change management, Performance Improvement and Knowledge Management. The vision of the Initiative was succinctly stated:

The Implementing Best Practices (IBP) process is a collaborative global effort to identify best family planning/reproductive health practices and support the development of learning and creative programmes to apply them.
From IBP partner **USAID**

**USAID contributions include:**

- Support for IBP staff based in Geneva
- Support for the development of the Four Cornerstones of Family Planning and in particular for the development, printing, and distribution of the Global Family Planning Handbook
- Support for IBP Launch events, for example in India and Uganda, both directly and through the work of USAID’s many partner organizations
- Support for USAID partners to engage in IBP activities, for example serving as IBP Chair, developing and implementing the “Managing Change” guide, developing and managing the IBP Knowledge Gateway, and supporting the development of the Family Planning Advocacy Toolkit.
- USAID support for important research on topics like healthy timing and spacing or community based distribution of injectable contraceptives has provided areas for collaboration among IBP partners.

**How USAID has benefited:**

- Streamlining assistance and encouraging collaboration among USAID partner organizations via the IBP partnership.
- IBP launch meetings have served as a model for USAID to organize similar meetings with its field staff and partners (for example, recent Rwanda regional meeting organized as a follow-up to the Kampala meeting, Bangkok regional meetings organized by the Extending Service Delivery Project).
- Participation in IBP and working closely with WHO has given USAID more credibility as a research organization.
- IBP has provided a platform for promoting and advancing Global Health technical priorities that directly link to maternal-child health and child survival like healthy timing and spacing, comprehensive post-abortion care, and injectables/Uniject.
- IBP has provided a vehicle for better collaboration between USAID, WHO and other partners and helped to harmonize approaches.
Meeting in Cairo

The IBP Consortium unveiled its new face and enhanced processes at a meeting in Cairo, February 2002. Some 152 participants attended, including country teams from Egypt, India, Jordan, Lebanon, Pakistan, Palestine, Turkey and Yemen. Other countries represented were India, Tunisia, Kenya, South Africa, and Uganda. IBP partners facilitated the meeting. Other regional, local and international organizations that were not official partners also were represented. The IBP partners organized the meeting in collaboration with the WHO and USAID regional offices.

In Cairo differences from the Nepal meeting reflected the new, more locally focused approach of the Initiative:

- Country teams from Egypt and Jordan formed before the meeting, with support from their ministries of health and local organizations and agencies.
- A survey assessing information needs was undertaken to tailor the agenda of the meeting to local information and managerial priorities.
- The meeting agenda put more emphasis on leadership, the management of change, and how to use the Performance Improvement process.
- A more structured follow-up programme intended to assure ongoing support. In each country a follow-up organization—generally, an IBP partner already working in the country—committed to support the ongoing work of a country team.

Task teams, which consisted of representatives from various IBP partner organizations, prepared the process, materials and tools for the Cairo meeting. Based on findings of the survey on information needs, the partners assembled a tool kit of best practices reference materials. Participants received the tool kit on CD-ROM. In addition, a brochure summarized the electronic tools demonstrated during the Technology Café and explained how to obtain them.

The Cairo meeting sparked ambitious activities in several of the participating countries, particularly Egypt (see box), Jordan (see box) and Turkey.
Country stories

Egypt’s Leadership Development Program
born at the Cairo IBP meeting

In 2002 Dr Morsi Mansour, the Coordinator of Population and Family Planning Projects in Upper Egypt for the Ministry of Health and Population (MOHP), attended the Implementing Best Practices Conference in Cairo, where he heard a plenary talk on “Best Practices for Developing Managers Who Lead”, presented by IBP partner Management Sciences for Health (MSH). Impressed by the approach, he organized the many stakeholders present to meet with representatives of USAID and the Ministry of Health, asking USAID to fund MSH to work with ministry managers and conduct a one-year Leadership Development Program (LDP) in Aswan.

Health results. In 2003, after participation in the LDP, the districts of Aswan, Daraw and Kom Ombo increased the number of new family planning visits by 36%, 68% and 20%, respectively. The number of prenatal and postpartum visits also rose. After USAID funding ended, local doctors and nurses scaled up the programme to 184 health care facilities, training more than 1000 health workers.

From 2005 to 2007 the LDP participants in Aswan Governorate focused on reducing the maternal mortality rate as their annual goal. They succeeded. The maternal mortality rate fell from 85.0 per 100,000 live births to 35.5 per 100,000. This reduction was much greater than those in similar governorates. Managers and teams across Aswan thus demonstrated that their commitment and willingness to take responsibility and manage change enabled them to scale up effective maternal health interventions.

Scaling up globally. In 2005 Ministry of Public Health officials from Afghanistan went to Aswan to learn the LDP approach. They replicated the programme in five Afghan provinces that year. Now the LDP is used to improve service results in over 100 health facilities in 13 provinces across Afghanistan. In all, the LDP has been adopted in 36 countries around the world and used to scale up a variety of proven public health interventions. LDP tools and approaches are also being introduced into medical and public health curricula in Africa, Latin America and the Eastern Mediterranean.

— Contributed by Management Sciences for Health
The Cairo meeting proved to be the first of several large meetings that introduced the IBP Initiative and launched activities in various regions. The organization, management and follow-up of these meetings evolved with experience. Their large size had a point—to bring together people who had common interests but did not necessarily communicate, either within their own country or across borders with neighboring countries. Bringing many people together maximized opportunities to share experiences and to learn from each other. For the longer term, bringing together large numbers of people could help create networks for collaboration and build a critical mass of expertise, resources, and commitment to achieve common goals.

Country stories

Jordan country team improves reproductive health care

At the Cairo meeting the Jordan team set itself the goal of improving reproductive health and family planning (RH/FP) counselling. As a first step, the country needed to write national standards for reproductive health care. The team set this as its first objective. Its second objective was to develop a comprehensive RH/FP counselling curriculum, and its third, to train service providers using the curriculum.

Returning home, the team formed the “Cairo Club”. The Cairo Club met for nine months to review and adapt RH/FP guidelines, and before the end of the year the Ministry of Health had approved and published national RH/FP standards. In June 2003 IBP partner EngenderHealth began to prepare the counselling curriculum, with a multi-sectoral task team providing feedback. A training-of-trainers in January 2004 served as a pre-test, prompting further changes to suit the Jordanian context. In March the new curriculum was launched under the patronage of the Minister of Health.

The work has continued, led by partners through the Extending Service Delivery Project. More recently, the team in Jordan has introduced effective practices to improve counselling for women with high-risk pregnancies as well as counselling, testing and treatment for pregnant women with anemia. The team has updated the Essential Obstetrical Care Clinical Guidelines and trained staff at the Hussein Askal Hospital to use the Risk Scoring Card for Current Pregnancy. At the Prince Faisal Hospital training sessions about preconception and antenatal care began in September 2009 for nurses and midwives. Also, health education sessions about the importance of good health before pregnancy, the diet needed to avoid anemia, iron supplementation and birth spacing address both women attending the clinic and nursing students. The fostering change methodology has been integrated into curricula at nursing/midwifery colleges.
The formation of the IBP Consortium

As early as 2001 the IBP partners began to discuss formalizing their partnership through a memorandum of understanding. In mid-year 2002 partners agreed to form a consortium—not a new organization, but rather a commitment among existing organizations to work together, using a common methodology, to pursue a common goal.

A strategy document entitled Implementing Best Practices in Reproductive Health, published in 2002, described the partnership and spelled out its process. This process was later refined and republished in a brochure in 2004, as follows:

1. **Mobilize networks** of reproductive health advocates and professionals.

2. **Create a culture of knowledge sharing** in and between countries to share local and international experience on best and working practices, issues, success stories, concerns and lessons learned in reproductive health.

3. **Use innovative approaches** to identify, recommend and introduce evidence-based guidelines and proven effective practices that can be adapted to meet specific requirements of country programmes.

4. **Promote the use of proven effective managerial, training and Performance Improvement models** that support the change process required to implement best practices and improve reproductive health.

5. **Support the formulation and implementation of collaborative strategies** that accelerate taking to scale evidence-based and proven-effective practices.

6. **Share progress and acknowledge success** by providing mechanisms that offer supportive follow-up and empower individuals to gather, reflect on and share progress, innovations, experience, success stories and lessons learned.

With the consortium agreement came the logo for the IBP—a globe spinning off arrows symbolizing this 6-step process (see Figure 1).

Figure 1. The IBP logo showing the 6-step IBP process
After much discussion, the partners agreed on the language of the memorandum of understanding (MOU), which the 12 founding partners of the IBP Consortium, along with eight other organizations, signed in September 2003 at the India IBP Launch in Agra (see list of partners on inside front cover). By 2010 the IBP Consortium has grown to 32 partner organizations (see Figure 2).

From the start the IBP Consortium envisioned expanding the partnership to include “a wide variety of stakeholders from country programmes in developing and developed countries.” Organizations and agencies at country level worked in collaboration with the partnership and were acknowledged for their contributions and support. The first two regional nongovernmental organizations joined the Consortium in 2004—the Centre for African Family Studies (CAFS), based in Kenya, and the Regional Centre for Quality of Health Care, Makerere University, Uganda.

The MOU codifies the vision, goal, guiding principles and objectives of the Consortium—and of the Initiative—which already underpinned the partnership. The principles and objectives laid out in the MOU continue to guide the Consortium. The MOU also spells out the structure of the Consortium and the roles and responsibilities of the rotating Chair, the secretariat based at WHO/RHR and the members. The MOU made clear that IBP activities do not call on partners to commit new funds but rather to integrate IBP-related activities into their work under current mandates and existing funding. All partners designate staff members to serve on the Coordinating Committee, which directs and manages the Initiative. Each of the founding organizations in alphabetical order holds the chair of this committee. The smaller Steering Committee, comprising representatives of the 12 founding members, plus three other
organizations elected from the new membership to represent the views of all parties, oversees management of the Consortium and must agree any change in structure and governance. The MOU also established the concept of Task Teams, consisting of Co-ordinating Committee members, formed to address specific, often time-bound assignments linked to the programme of work and supported by the secretariat.

Initially, the MOU had to be signed again, and commitment to the partnership, renewed every two years. In 2007 all partners agreed to sign an indefinite MOU. They also voted to increase the rotation of the Chair from every year to every two years and published updated IBP Consortium Membership and Operational Guidelines.

When the Consortium was first launched, the partners agreed that WHO/RHR would coordinate the IBP programme of activities and serve as the secretariat at least for the first two years. To this day two staff members based in Geneva in WHO/RHR, Technical Cooperation with Countries team, continue to fill that role. Maggie Usher-Patel, who first led development of the DAU process at WHO/RHR, has held a WHO/RHR-supported position on the secretariat from the start. The second secretariat post was created with support from USAID beginning in 2003. Susan Monaghan served in that post in 2003 and 2004. Suzanne Reier has held the post since January 2005. Both came as senior fellows of the USAID-funded Population Leadership Program (PLP), later called the Global Health Fellows Program (GHFP), managed by the Public Health Institute, an IBP partner. This position was absorbed as a WHO/RHR staff position in January 2010.
Financial support

Financial support for IBP activities in countries comes from the partners on a cost-sharing basis, since IBP activities advance a partner’s programme of work. WHO/RHR and USAID have provided funds to support the IBP secretariat and activities for many years. The secretariat also receives USAID funding to support implementation of the programme of work. This funding is supplemented by WHO/RHR and from time to time by other international donors as well—for example, the Japan International Cooperation Agency (JICA) in Jordan and, in Jharkhand, India, the United Kingdom’s Department for International Development (DFID), the European Union and the Hewlett Foundation. Specific funding has been obtained to support specific global activities. In particular, the secretariat has received funding from within WHO/RHR and WHO/Information Technology and Telecommunications (WHO/ITT) to undertake the research, design and development of the IBP Knowledge Gateway.

Debating “best practices”

With “best practices” a part of the partnership’s name, the IBP partners involved themselves in the larger debate then raging over how to define a best practice and how to identify it. This debate had begun in industry, where the concept was born, and moved into the international health arena. Such questions were debated as: Is there a global, objective standard for best practices? Does the term “best practice” mean that the practice is always preferable to other practices? Does the success of a practice have to be replicated elsewhere to qualify it as a best practice? And, inevitably, who decides what is a best practice? The debate revealed a great variety of perspectives and was often time-consuming and contentious. What became clear is that all parties accept evidence-based best clinical practices as defined by WHO/RHR. In contrast, there are many programmatic, training and managerial practices with some evidence of effectiveness but not fully evaluated and not likely to be. It also became clear that what was a “best practice” for one group or place usually had to be adapted for use by another. Recognizing this, the IBP partners agreed a working definition (see box).

This practical definition of “best practice” recognizes that programmatic best practices usually can be found within the country. The realization emerged that, in fact, “best practices” are relatively easy to find. Implementing, scaling-up and sustaining the practice over time is the more challenging task and deserves the focus of attention.
India launch

A small team from Uttar Pradesh had participated in the Nepal meeting in 2000. They formed the “India DAU Club” and had continued to meet and work together. Indian representatives from the central Ministry of Health became interested in the IBP Initiative and attended the Cairo meeting.

To organize an IBP launch in India, in 2002 the Secretary of Health and Family Welfare, India invited IBP partners to work with a local steering committee and selected four high-priority states as the focus of the meeting—Andra Pradesh, Uttar Pradesh, Uttarakanchal (now Uttarakhand) and Jharkhand. With support from the partners, the local steering committee took responsibility for organizing and managing the meeting and defined its theme, “Creating an enabling environment to prevent unwanted pregnancy and STIs”.

The four states selected are home to vast populations and have diverse needs. Therefore, a team of three representing the IBP secretariat, the WHO Country Office and the lead international agency working in that state visited each state before the meeting. They met the Secretary of Health and Family Welfare for each state and with local organizations to foster commitment to the IBP process, mobilize a team, identify specific programmatic and managerial needs and leverage local funding. The strategy for organizing the meeting was to network with existing networks in the states, thus bringing organizations and agencies together, under the leadership of the Ministry of Health.

The planning also defined, more specifically than before, a programme of mentorship and follow-up, to be supported by a partner agency facilitator, the state team leader, WHO Country Office and the IBP secretariat. This follow-up succeeded to varying degrees. For example, the follow-up programme continued in Jharkhand for over three years and in Uttar Pradesh for less than a year.

Over 250 health professionals attended, not only from the four high-priority states, but also from other Indian states. The group also included representatives from several African countries, who met there with IBP partners for the first time as the Africa Launch

IBP’s definition of “best practice”

A process, procedure, tool or principle that is based on scientific evidence and/or programmatic experience and has improved the quality of health programmes. For our purposes, a best practice is broadly identified as “best” at this moment in time in a particular situation. It refers to evidence-based practices or proven, effective practices and considers lessons learned to help in the adaptation of the best practices to other settings.

Source: 5-Year Strategic Vision and Direction, January 2006
Organizing Committee. It was at the India meeting, as well, that the IBP Consortium was formally launched, as 20 organizations signed the memorandum of understanding.

Like earlier meetings the meeting in Agra, India, 21-25 September 2003, was fully interactive. It used the Mini-University, Technology Café, Scavenger Hunt and Information Exchange Bazaar as vehicles for the state teams to discuss best practices and share experience, successes and challenges. The partners developed both a Facilitator Guide and a Participant Guide for the small-group sessions at the meeting. The guides combine leadership principles, change management techniques and the Performance Improvement process (see Tools and Publications, p. 48). As in previous DAU and IBP meetings, teams reviewed their action plans in plenary sessions and made public commitments to continue their work.

The launch meeting in Agra led to a number of accomplishments. For example, an Uttar Pradesh team convinced the state Ministry of Health to raise the housing subsidy for auxiliary nurse-midwives, thus encouraging them to live where they worked (see box).

UP team’s advocacy raises housing subsidies to improve rural health care coverage

Uttar Pradesh teams set out “to improve the quality of service delivery in order to increase access to and acceptance of family planning services at all sites.” Their root-cause analysis led them to the observation that only 25% of auxiliary nurse-midwives (ANM) lived in the sub-centres where they served. When ANMs did not live at the sub-centres, people’s access to services was more limited. Underlying the low residency rate was the low level of housing subsidy that the ANMs received. Central government policy called for higher subsidies, but state-level decision-makers had yet to act. Following the Agra IBP launch meeting, the team took up an advocacy campaign, directed to the Secretary of Health and Family Welfare, involving letter-writing, meetings and workshops. By the end of November 2003 the Department of Family Welfare had issued a Government Order increasing the subsidy from 100 rupees to 250 rupees per month, and in mid-December the funds were released. The team had accomplished its goal in just four months. The next 5-year health plan called for improving housing facilities for ANMs.
After the IBP launch the Jharkhand Secretary of Health and Family Welfare decided to apply an IBP-like approach to a challenge facing his department: the central government’s mandate to devolve management of the health care system to the district level. In Jharkhand the state Secretary of Health, inspired by the IBP launch meeting, set up the Jharkhand Health Society (JHS), bringing together health organizations from all sectors to collaborate. (The JHS was a dynamic committee. By 2006 it had become the official nodal body of the Department of Health and Family Welfare. The JHS functions today as the Jharkhand Rural Health Mission Society.)

To help prepare the districts for increased responsibilities, the Jharkhand Secretary of Health asked the IBP partners to help with strengthening the technical knowledge and management skills of district managers. Led by the Centre for Development and Population Activities (CEDPA)/India, the IBP partners and secretariat, along with other international organizations and the WHO Country Office, helped the ministry and the JHS organize a 3-day meeting for district management teams and local nongovernmental organizations based in each of the state’s 22 districts, which served 27 million people. The Secretary contributed funds for the workshop. The “Management to Action” meeting took place in October 2006, with 130 participants. It introduced the district staff members to management methodologies such as Performance Improvement, fostering change, and SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis. UNFPA and the WHO Country Office prepared a National District Planning Manual, which was introduced at the workshop. Workshop participants took these techniques and tools back to their districts and applied them (see box, next page).
Implementing Best Practices in Reproductive Health

Country stories

Strengthening district management in Jharkhand: The co-ordinator’s view

by Kiran S. Kamble

It was a mere two months of my joining the Jharkhand Health Society (JHS) under the Department of Health, Government of Jharkhand, as a consultant for public-private partnerships that the Secretary Health, Dr. Shivendu, called me to his office and informed me of the IBP “Management to Action” workshop. . . . My immediate reaction was: ‘Oh no! Not another workshop!’ . . . But as I started to look at the work of IBP and its partners across the world and in India and Jharkhand, I started feeling an excitement that precedes a successful endeavour. Then followed two months of hectic logistic management with CEDPA. . . . These mundane tasks didn’t bother me much owing to the support I received and also due to the feeling of being a part of an important “movement”. The most difficult part was convincing the civil surgeons, the heads of the public health system at the district level, of the pertinence of this workshop and the value that these three days would add to their management skills.

The workshop was a hectic affair. . . . The best part of this workshop was its interactive nature and the group work sessions. The participants, particularly the civil surgeons, were seen taking active interest in the activities. I got so involved in the superb sessions and the invaluable knowledge being disseminated that I had to be reminded quite often that I am the coordinator and not a participant. . . . I was amazed by the insights that came out of the civil surgeons, who otherwise, in any other forum, would act like typical bored bureaucrats. My most important lesson learned from this workshop was that honest initiatives like IBP and their way of managing knowledge dissemination are imperative for rejuvenating the healthcare cadre, who are usually so handicapped and overburdened by administrative work that they do not find time for personal and professional development.

True icing on the cake came for me a month later when I was travelling to a remote district in Jharkhand. While visiting a PHC (Primary Health Center), I saw a medical officer sitting in his chamber beyond his duty timings—a rare occurrence—working on a piece of paper with obvious interest. When asked, he showed me the paper with four boxes on it—strengths, weaknesses, opportunities, and threats—and told me that the civil surgeon had conducted a training session for all the medical officers of the district on performance management and SWOT analysis (presentations from the workshop had been provided to the participants) and had asked each officer to do a SWOT analysis of their PHCs and work environments! I regret not having availed of this excellent photo opportunity. I guess I was too overwhelmed! I felt like I also had played some role in bringing about this change. Thank you, IBP, for paving the way.
Africa launch

In June 2004 a meeting in Entebbe, Uganda, launched the IBP in Africa. The meeting gathered teams from five focus countries—Ethiopia, Kenya, Tanzania, Uganda and Zambia. Each of these countries sent a team of about 30 participants. Angola, Cameroon, Democratic Republic of Congo, Ghana, Mozambique, Nigeria, Rwanda and South Africa sent smaller teams as part of the newly launched WHO/UNFPA Strategic Partnership Programme (SPP), which focused on introducing WHO technical guidelines (see box). In all, over 320 people attended.

At the IBP Africa launch partners were introduced to the WHO/UNFPA Strategic Partnership Programme (SPP). The purpose of this programme is to promote the introduction and adaptation of guidelines from WHO’s Departments of Reproductive Health and Research (WHO/RHR) and Making Pregnancy Safer (WHO/MPS) through enhanced linkages with in-country and regional UNFPA teams. The SPP and the IBP are complementary—while the SPP focuses on introducing the guidelines at the regional and national levels, the IBP partners have the mandate to take guidelines into the field and can ensure follow-up. The SPP workshop for Africa, held in Tanzania and involving representatives from Angola, Cameroon, Democratic Republic of Congo, Ghana, Mozambique, Nigeria, Rwanda and South Africa, was planned to capitalize on the IBP Launch in Uganda with the same countries to discuss the adaptation of guidelines. Support to the SPP programme continued for the next four years, with regional workshops held in all regions of the world. Follow-up activities supported by IBP partners have been undertaken in a number of countries such as Benin, Philippines, South Africa, Tanzania and Zambia.

Building on lessons learned from previous launch meetings, the African launch and its participants were thoroughly and carefully prepared (see box, p. 24). IBP partners visited the focus countries before the meeting and, in collaboration with the Ministry of Health, identified country teams. Each team worked together before the meeting to determine their common performance goal, map who was doing what where, and identify the contribution that they could make to achieving their goal.

The meeting focused on “Repositioning reproductive health in the context of HIV/AIDS in Africa”. The objective of the meeting was to acquaint programme managers, policy-makers, and implementing organizations with tools and practices that can help them to address major challenges in reproductive health. Capacity-building opportunities were planned to help participants learn techniques for strengthening leadership, Performance Improvement and change management.
In the meeting the teams used the management of change and Performance Improvement methodology to address the problems that they had identified before the meeting, and they drew up action plans. Uganda and Ethiopia (see box below) set goals that involved integrating family planning and HIV/AIDS services. Tanzania planned to increase the number of facilities providing essential obstetric care. Zambia sought to improve use of family planning services through revised guidelines. Kenya set a dual goal: in six districts, reduce stock-outs of contraceptives and increase use of family planning (see box).

The meeting also created opportunities for networking and sharing experience and lessons learned. For example, participants from the Kilimanjaro Christian Medical Center in Moshi, Tanzania, learned how other countries had increased access in hospitals to antiretroviral drugs for HIV treatment and to services for preventing mother-to-child transmission (PMTCT) of HIV. Returning home, they applied what they had learned and have been able to extend services to more women and their families, particularly during delivery and in the postpartum period.

From IBP partner Pathfinder International

During the IBP meeting in Entebbe, Uganda, in 2004, the Ethiopia team developed an action plan to incorporate family planning into HIV/AIDS voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) services throughout the country. Pathfinder’s Ethiopia office and 25 Ethiopian organizations were inspired to establish their own IBP Steering Committee. Drawing on structures and processes from the Consortium, they launched a strategy for integration in seven regions of the country. This was followed by Pathfinder’s implementation of an IBP Plus project to conduct research on the integration effort in 12 facilities, seeking lessons learned and focusing on best practices.

During the Uganda meeting, the Ethiopia team recognized that their country did have many “best practices”. These had not been documented, however, and were not being shared throughout the country. After the conference the Ethiopia IBP team asked their partners throughout the country to collect reproductive health “best practices”. With support from the IBP secretariat, these have been analysed, documented and in 2006 published under the title Documenting Reproductive Health Practice in Ethiopia.

Later, the local IBP team introduced the fostering change framework to help with scaling up the documented practices. The process and lessons learned from activities have served as a basis for the IBP’s work in other countries on identifying, documenting, sharing and scaling up effective local practices.
Kenya initiative increases contraceptive use in focus districts

The launch of the IBP Initiative in Uganda in June 2004 catalysed new ways of thinking as well as new ways of approaching problems in participating countries. For Kenya it clarified how the Kenya IBP team could address the fact that Kenya’s success with family planning had faltered, rates of contraceptive use were plateauing, fertility rates were increasing, and maternal mortality rates remained high.

At the Uganda meeting the Kenya team chose as their performance goal to reduce maternal mortality through increased use of family planning. With the Ministry of Health leading the team, activities were rapidly pursued after the meeting. Challenges persisted, however. Waning support for family planning called for increased advocacy. Providers and supervisors needed training and updates. Inadequate logistics management at the district level made it imperative to strengthen systems and increase funding for family planning commodities.

The Ministry of Health formulated plans for implementation in six districts of an initiative that included:

- demand creation
- advocacy for support to family planning
- capacity building (human resources and infrastructure)
- logistics management.

The various components were implemented simultaneously. By about 12 months later a number of outcomes were clear. These included an overall increase in uptake of family planning of over one-third in the initiative districts. In addition, for the first time, the national health budget included a line item for RH commodities.

Some factors facilitating the success included the leadership and coordination of the Ministry of Health, a common performance goal, and identification of one organization, Family Health International, to act as the secretariat and to support the Ministry’s leadership. Also, IBP partners were able to extend their activities to cover the six districts with existing funds.

The initiative has since been scaled up in Kenya to increase the uptake of family planning in other districts. Following the success of this activity, a compendium of reproductive health best practices has been compiled to inform programmes across the country of practices that can enhance their effectiveness and efficiency.
An underlying premise of the IBP Initiative is that ensuring the use of best practices is an ongoing, multi-stage process of managing change. This process requires sustained local commitment, access to essential knowledge and a full range of tools, and, often, ongoing support. The Africa launch was designed with this premise in mind.

Planning for the Africa launch began nearly nine months before the meeting, starting with the first meeting of the Africa Launch Organizing Committee at the India IBP meeting in September 2003. This committee, consisting of approximately 30 individuals on four continents, continued to meet each month via teleconference. In early February 2004 a small team from WHO/RHR and USAID visited five countries selected as priority countries by the partners. This team sought to identify key stakeholders, to ascertain their commitment to leading the IBP process in their country, and to undertake an information needs assessment. During this visit the Organizing Committee met in Kampala, Uganda, and via teleconference and agreed on the specific assumptions related to planning the meeting and on its overall objectives.

Throughout the preparation as well as in the meeting, international, regional and country experts supported a core team of facilitators. They helped all presenters and facilitators prepare. Mini-University presenters’ guidelines ensured that their sessions would be interactive: “No lecture, no way” was the rule. Presenters were given examples of powerful approaches to message delivery. Time was allocated for facilitators to work together to prepare each session. Some facilitators helped the country teams work through the many analytical steps in preparing an action plan. These facilitators benefited from both a Performance Improvement Pre-conference Workshop and a half-day session to explain the specific exercises. Lastly, the partner facilitators, who would continue to work with the country teams, were oriented to their role by a group of regional coordinators from IBP partner organizations, who routinely provide ongoing support to programme managers and policy-makers.

The meeting was highly interactive and participatory. Topics and themes reflected the findings of the information needs assessment conducted in the five focus countries. Key components of the launch included 30 Mini-University sessions, a Technology Café, an “Info Baraza”, a “Bright Ideas” poster session and numerous other information-sharing opportunities, capacity-building plenary sessions, and country team work. The most important part of the meeting was the emphasis on sustaining momentum through ongoing mentorship and follow-up.
Evolution of IBP Initiative strategy

Over the history of the IBP Initiative, trends can be seen in the evolution of the Initiative’s strategy in five interrelated areas:

- **In information and knowledge:** Away from focusing narrowly on introduction of international guidance and towards the exchange of knowledge generally, meeting information needs, and improving access to and use of information;

- **In best practices:** Away from global technical/clinical best practices and towards locally identified effective programme practices;

- **In processes:** Away from a process for adapting and introducing guidance and towards processes to improve leadership and change management skills and to identify, document, demonstrate and scale up local effective practices;

- **In way of working:** Away from individual action towards collaborative efforts and networks supporting country-specific activities, through the Ministry of Health, to accelerate reaching common goals. Engaging collectively in advocacy and action.

- **In use of management tools:** Away from a smorgasbord of tools and towards a holistic process of fostering change that applies appropriate tools at each step in that process.
Strategy development process

In 2004 the Population Leadership Program, Public Health Institute, contracted a strategy development group known as Group Jazz to help the partnership revise its mission statement and to develop new strategic directions. Much of this process was undertaken through virtual discussions among the partners, supplemented by three face-to-face meetings, over 18 months. These strategy discussions also provided the basis for revising the IBP mission statement and objectives, which are still in use today.

2006 mission statement and objectives

Mission:
Support countries to fulfil their reproductive health agendas by strengthening international, regional and country co-operation to share experiences aimed at improving the introduction, adaptation, utilization and scaling-up of best practices in reproductive health.

Objectives:
1. To create and sustain an effective network of collaborating international, regional and national reproductive health organizations and institutes willing to maximize resources, avoid duplication of services and support the use of best practices to improve reproductive health.
   - Sub-objective a: Define operational policies and guidelines of the IBP Consortium
   - Sub-objective b: Expand resource base to support innovative activities related to knowledge sharing, coordination and utilization of best practices
   - Sub-objective c: Implement systems to monitor progress, acknowledge success and document IBP’s effect/value added.

2. To promote a multi-sectoral approach to the provision of reproductive health care to strengthen programmatic and technical linkages and activities.

3. To identify, study and adapt new and existing models for knowledge sharing between partners for the management and application of best practices in reproductive health.

4. To identify, recommend and provide evidence-based tools and proven-effective approaches that will help support countries to implement and/or scale up best practices in reproductive health.
A key aspect of the new strategy that emerged was to apply alternative models for achieving IBP objectives. Part of this aspect of the new strategy was more active promotion of the IBP itself, such as presenting the IBP partnership and strategy at international, regional and country meetings, developing the Initiative’s public website and revising the branding and advocacy materials.

The revised strategy recognized that keeping country activities going requires more than a partner organization providing follow-up advice and support. The initial strategy report declared, “IBP needs to find a way to ensure activity at the country level after a meeting,” not just through the partners, but also through local capacity to facilitate and manage change, scale up best practices, and sustain programmes. Thus, the revised strategy emphasized more focused input and a longer commitment to a country-specific strategy.

A shift in direction emerging from these discussions was towards country-specific activities that foster the change needed to scale up effective local practices. The key difference from the earlier strategy is that the focus is on locally identified best practices, their documentation, and fostering change.

The partners had learned from the experience of country teams that the best place to look for effective practices is close to home. There are many pilot projects and local practices that should be identified and scaled up rather than re-invented when one project finishes and another starts. Furthermore, locally developed and locally identified best practices often are more quickly adopted than those coming from far away. Such country-specific activities often involve strengthening managerial skills, a need identified during the strategic discussions.

From IBP partner Population Council

In 2002, a consortium of international and national partners including Population Council and WHO initiated a Post Abortion Care (PAC) Initiative for Francophone Africa to increase access and quality to PAC services in this West African region. As programs were replicated in the following years, dissemination of materials and information was noted as a main challenge. In response, IBP served as an ideal forum to share scientific evidence, standardized guidelines and best practices between Initiative members.

IBP’s role in the PAC Initiative for Francophone Africa was pertinent to the success of this regional commitment to PAC services; IBP allowed communication and exchange of best practices between colleagues and organizations working on similar issues and overcoming similar challenges. This network also reinforced the collaborative regional effort the Initiative intended.
According to the new strategy, the power of the IBP partnership would lie in convening, communicating, connecting and catalyzing action, both within the partnership and with other groups and organizations. This was depicted during the discussions as ripples spreading in a pond (see Figure 3). Principles would still include using implementation strategies such as the 6 A’s (see p. 4), reducing duplication and harmonizing approaches.

The strategy emphasizes networking and support for networks. To elucidate its vision, the strategy statement asks, “How do we see the IBP Initiative in 5 years?” and answers:

*The IBP initiative will strengthen and maintain networks of international and regional organizations and establish new networks committed to working together at the global, regional and country levels, to ensure that best practices are shared and utilized with reproductive health programmes worldwide.*

The new IBP strategy also called for innovation to improve access to information and for exchange of knowledge in and among countries. Such innovations include online networking and communities of practice (see page 34).

**IBP Consortium’s “value added”**

In 2007 the Consortium undertook an internal audit and evaluation, using an appreciative inquiry technique. One of its outcomes was a statement of the IBP’s “value added”—unique contributions to the reproductive health field. In summary, the IBP offers:

- A shared vision for maximizing the dissemination of reproductive health best practices and resources
- A wide variety of participants with a variety of expertise and experience that can be shared among partners and with countries
- Coordinated effort, achieving more than the sum of individual efforts
Pooled expertise and resources/funding that increase the potential to:

- Re-ignite interest and political will in reproductive health
- Influence global, national and local reproductive health agendas
- Link and/or integrate reproductive health interventions to reduce duplication of effort and maximize resources.

- Recognition by WHO/RHR and by partners that IBP activities must be included in workplans and programme of work. IBP activities are not separate, but in fact a component of core work.

At this same time, in mid-decade, USAID was funding other initiatives that were undertaken in collaboration with the IBP partnership, such as the Repositioning Family Planning Conference, held in Ghana, 2005, and the Extending Service Delivery Project (ESD). The ESD project embraces the principles and purposes of the IBP Initiative: partnerships, collaboration and networking, and scaling up best practices. The IBP partnership shared its materials, tools and planning frameworks, which ESD has adapted and remoulded for its own use. In addition, ESD received specific funding to follow up the implementation of country-specific activities, thus avoiding a challenge that the IBP partners were not always able to address. In Africa ESD activities have been undertaken in Angola, Burundi, Democratic Republic of the Congo, Ethiopia, Guinea, Kenya, Nigeria, southern Sudan and Tanzania. In Asia and the Near East, the ESD project has worked in Egypt, India, Indonesia, Jordan, Nepal, Pakistan and Yemen. The IBP partnership has supported each launch meeting, and the IBP secretariat has followed up activities with financial and technical support in Jordan, Afghanistan and Pakistan.

From IBP partner Pathfinder International

As the lead partner in the Extending Service Delivery (ESD) Project, which focuses on the identification and dissemination of best practices in reproductive health, Pathfinder is especially positioned to appreciate IBP’s important role in proactively disseminating knowledge, tools, and information to professionals in reproductive health at every level around the world. From their highly useful Knowledge Gateway to their conferences, tools, reports, and other publications, the IBP Consortium has made enormous contributions to advancing access to quality reproductive health care in developing countries around the world.
The secretariat has continued to assist and support large knowledge-sharing events organized by others, such as ESD’s two conferences in Bangkok, 2007 and 2010, for the Asia-Near East region and the “ESD in Africa” Exchange and Conference in Nairobi, May 2010. In November 2009 the Bill and Melinda Gates Institute for Population and Reproductive Health led the International Conference on Family Planning: Research and Best Practices in Kampala, Uganda, and the IBP partners organized a day of activities on taking “Knowledge into Action” (see p. 43).

### Fostering the management of change

The IBP Partners had long recognized that improving or strengthening services and introducing and scaling up new practices requires changes in infrastructure, systems and practices. Therefore, change management has always been a key component of the IBP strategy. “The missing link between introducing and effectively implementing best practices”, declared an IBP Task Team, is “the ability to foster, lead, and manage the change process…”.

In a collaborative effort between USAID’s MAQ Initiative and the IBP, this Task Team, led by Management Sciences for Health (MSH), set out at first to collect and organize the

### Afghanistan team boosts demand for vaccinations

Using the fostering change framework, an Afghanistan team is working to increase vaccinations and in-facility deliveries through demand-side financing, including cash payments offered to community health workers and women. In the province of Kapsia the team carried out a community awareness campaign that included addressing public health officers and influential community figures. Preliminary data from the ongoing pilot project show an increase in DPT3 vaccinations and in numbers of institutional deliveries.
managerial tools and approaches that IBP partners offer to help countries improve and increase access to services. In the process, the team realized that fostering change is a continuum of activities, supported by a variety of management practices, which in the past have usually been taught separately. The team reviewed various managerial and change management theories, evidence on what works, and managerial guidelines and tools produced by the partners.

The result was a practical guide, the *Guide to Fostering Change to Scale Up Health Services*, published in 2007. As the team described it, “The Guide provides a clear pathway that links proven change practice to “how to” steps for successful change”. It takes the reader through the steps to identify, champion, demonstrate and scale up a proven-effective practice. The guide links these steps with the corresponding management tools from the IBP partners. These tools support such processes as leadership development, change management, and Performance Improvement.

The steps in the process of fostering change are these:

**Phase I: Defining the Need for Change**
- a. Identify the problem
- b. Identify and agree on the desired change

**Phase II: Planning for Demonstration and Scale-Up**
- a. Select a dedicated change agent and change team
- b. Identify and analyze relevant effective practices from other settings
- c. Choose and adapt an appropriate effective practice
- d. Plan to implement and monitor the desired change at test sites
- e. Plan for scaling up a successful change effort

**Phase III: Supporting the Demonstration**
- a. Help create and maintain an encouraging environment for change
- b. Continually assess, monitor, and modify the change effort

**Phase IV: Going to Scale with Successful Change Efforts**
- a. Evaluate lessons learned and decide whether or not to scale up
- b. Select an appropriate scale-up strategy
- c. Engage stakeholder commitment and secure resources
- d. Implement the scale-up strategy
- e. Measure and communicate results.

The guide is now available in English and French (see Tools and Publications, p. 48). Accompanying the manual is a CD-ROM containing the managerial tools from IBP partners that are applied at each step. A 3-hour skills-building workshop and presentations have introduced the Fostering Change process at numerous meetings around the world.
Country stories

Zambia scales up contraceptive choice

Partners in Zambia have worked together to scale up a best practice for expanding contraceptive choice. The Ministry of Health determined that the effort of the Pilots to Regional Programmes (PRP) to expand contraceptive choice in the Copperbelt is a best practice and should be scaled up. The Ministry requested and received funding from WHO/RHR for the scale-up. Initial steps included a national IBP partners’ meeting in August 2007 followed by short-term technical support to provinces and partners interested in adopting the model. The MOH selected two provinces, Luapula and Northwestern, as the initial sites for scaling up the PRP model. These two underserved provinces were chosen because the scale-up and MOH/UNFPA efforts to strengthen family planning services reinforce each other. Scale-up was challenging due to the lack of contraceptive supplies. Therefore, the MOH together with USAID and other partners have focused their efforts on strengthening procurement and logistics management and obtaining a national budget line for reproductive health supplies.
The East, Central and Southern Africa Health Community (ECSA-HC) and five of its member countries developed action plans in a workshop on fostering change that took place in Arusha in 2009. The subjects of their plans are:

- ECSA-HC: Strengthening financial sustainability through resource mobilization
- Kenya: Preventing postpartum hemorrhage in provincial hospitals
- Tanzania: Infection control in maternity wards
- Swaziland: Referral system through midwives for high-risk deliveries
- Uganda: Contraceptive security in tandem with family planning outreach camps
- Zimbabwe: Youth-friendly family planning services in nursing schools.

As of March 2010 all teams had work underway. The ECSA-HC and Swazi teams have received donor funding specifically to support their efforts to foster change.

MSH, in collaboration with the IBP secretariat and other IBP partners, has developed a Fostering Change e-learning course and a Fostering Change virtual training programme to follow up and support countries identifying and taking best practices to scale. The programme incorporates the steps for scaling up of the ExpandNet collaboration into the implementation step in the Fostering Change process. WHO/RHR and ExpandNet had undertaken extensive research to identify evidence for the essential steps in scaling up effective practices. ExpandNet joined the IBP Consortium in 2008. The Virtual Fostering Change Programme uses a blended method of learning that combines e-learning, virtual networking and knowledge-sharing to support practical implementation of the plans.

As of mid-2010 a number of country teams are making use of this programme—seven countries that attended a workshop on scaling up best practices in post-abortion care—Burkina Faso, Guinea, Mali, Niger, Rwanda, Senegal and Togo—and four country teams—one each from Afghanistan and Yemen and two from Jordan—that had attended the first ESD conference in Bangkok, in 2007. Participants have maintained a high level of interest and engagement.

From IBP partner Management Sciences for Health

The Virtual Fostering Change Program has allowed the IBP to reach more health professionals and provide technical assistance in introducing and scaling up change through the participation of member organizations as facilitators and technical experts. The teams in these programs have achieved results. The Togo team from the Ministry of Health is training health providers in delivering PAC services as well as family planning and reorganizing services in order to make contraceptives and counseling available in the PAC rooms. The Prince Faisal Hospital team from Jordan is testing, counseling and treating pregnant women with anemia in their community. They have also integrated the Fostering Change methodology into the courses that team members teach at the local nursing/midwifery college.
Exchanging, sharing and communicating knowledge—the IBP Knowledge Gateway for Reproductive Health

The IBP Knowledge Gateway for Reproductive Health is an electronic platform on the Internet that supports virtual knowledge networks—that is, it enables people with a common purpose to exchange knowledge, information and experience, regardless of where they live and work. The Knowledge Gateway has made possible communities of practice that can link to the users’ workplace around the world. Because the Knowledge Gateway uses e-mail and low-bandwidth technology, it is easily accessible in diverse settings, even where Internet access is poor. The simplicity, adapted low resolution technology, e-mail capability and methodologies used by the Knowledge Gateway are proving to be a best practice for supporting virtual knowledge networks around the world.

Beginnings of the Knowledge Gateway. As early as mid-2002 the IBP secretariat was considering how an Internet-based tool could facilitate coordination and planning among the participants in the Initiative—Consortium members, the Coordinating Committee, Task Teams, country team leaders and members, and mentors. The emphasis was on creating a widely accessible repository of IBP materials and the tools for collaborating across distances to develop them. To be usable by IBP participants around the world, the platform had to function in a wide variety of situations, including slow, unreliable, and expensive access to the Internet and the variety of computers and software used by a large number of different organizations.

At the same time, an IBP Task Team was exploring how best to contribute to closing the knowledge-to-practice gap. Many health workers lack access to the information they need, when they need it, to make informed decisions. Virtual communication tools for worldwide knowledge-sharing and communication could help close this gap and were worth exploring, the Team concluded.

Over time the vision emerged of one system that achieved two goals: better access to information for those working in reproductive health and a collaborative learning environment for the exchange of knowledge and experience.

Results from the 2006 evaluation of the IBP Knowledge Gateway for Reproductive Health

- **82%** had already used or planned to use resources or practices shared through the Knowledge Gateway in their own work.
- **73%** had shared e-mails received through the Knowledge Gateway with colleagues or coworkers.
- **81%** reported that participation in the Knowledge Gateway improved their own knowledge and practices.
Several CCP staff members worked closely with WHO/RHR staff on developing the requirements for the Implementing Best Practices (IBP) Knowledge Gateway and then pretesting early versions of the Knowledge Gateway. ... In collaboration with the WHO/RHR IBP Secretariat, CCP continues to manage the IBP Knowledge Gateway, including training new users on the platform and informing the Knowledge Gateway members about new publications, announcements, and events related to reproductive health. The development of the Knowledge Gateway platform has enabled rapid large-scale information exchange and transfer within the reproductive health community that was not previously possible.

Given its common goals with IBP, CCP’s global and country projects benefitted from IBP’s pioneering work in information exchange through dynamic on-line networks, which often focused on issues and technical advancements that contributed to shared objectives to improve reproductive health in developing countries. CCP also gained expertise and built capacity internally through working with IBP on a wide range of information-sharing challenges. Working together to improve access to reproductive health through the introduction, adaptation, implementation and scaling-up of best practices has limited duplication of effort among partner organizations and has resulted in greater achievements.

The IBP Secretariat and partners reviewed existing electronic tools and found none that met their requirements. WHO/RHR then awarded a contract to a small firm called WA Research to develop the envisioned platform, which became known in time as the Knowledge Gateway. Initially, WHO/RHR funded development, and the IBP partners contributed their time and expertise. WA Research continues today to work with the IBP secretariat on enhancements, technical hosting, administration and technical backup of the platform.

The Knowledge Gateway does not require software installed on users’ computers, and its chief mode of communication is e-mail, which suits how the majority of people use the Internet. Through e-mail the system links all members of each knowledge network to a virtual workspace, which automatically stores and archives all e-mails sent within that network. The workspace provides a discussion board, events calendar, announcements, and the space and structure to create a library and to review and revise documents. People can communicate with each other by either following an e-mail thread or through the discussion board in the workspace of the community. The platform also offers rapid searches of 133 selected websites of reproductive health organizations. This selectivity improves the specificity of search results and the accuracy of the information retrieved.
Launching the IBP Knowledge Gateway. In mid-2003 the system was pilot-tested in Geneva, three African countries—Ethiopia, Kenya and Uganda—and among several IBP partners. It also was introduced at the IBP India launch. There, a virtual community was set up for each of the participating States to test what, and how much time, is required to manage an online community. The system, with the URL of http://my.ibpinitiative.org, was formally launched in September 2004 at the IBP Africa regional meeting in Entebbe. The ceremony heralded the arrival of the new communication technology with an age-old communication technology—drums played by local drummers.

From an initial 300 registering to join the system, membership grew to nearly 1000 within six months. By June 2010 the IBP Knowledge Gateway for Reproductive Health had 18,350 users from over 200 countries in over 400 communities. As just one recent example, Jhpiego, with the help of other IBP partners, is supporting active communities on the Knowledge Gateway to share information and discuss issues on the topics of pre-service competency-based education in low-resource settings and of postpartum family planning (see Figure 4).

Since its launch in 2003 the IBP Knowledge Gateway for Reproductive Health has held more than 15 global discussion forums. In total, these forums have involved over 6000 participants in more than 140 countries. On average, over 60% of the participants are from developing countries. Sponsored by IBP partners, each forum lasts two to three weeks. Moderators summarize the discussion in daily and weekly digests. Forum
participants receive these digests via e-mail. The digests also can be used later for policy and practice dialogue. Each forum has been evaluated. Participants say that they find the discussions relevant to their work and that they use the resources shared. In fact, they share these resources with colleagues who have no Internet access.

**Sharing the technology and methodologies.** The communication system soon caught the eye of others. In 2006 WHO’s IT/MIS Department adopted the system as a corporate tool for WHO under the branding of EZcollab. At the same time a crucial strategic decision was made to open the platform to other organizations and groups, who could display their own logos and designs to “brand” a space of their own on the system, customize it, and launch and manage it themselves (see Figure 5).

Thus, all organizations and communities use the same Knowledge Gateway platform and make use of the same functions, but to all appearances each “owns” its own customized space. WHO/RHR, in collaboration with the Knowledge for Health Project and its predecessor, the INFO Project, the WHO Knowledge Management team and other partners have trained and assisted other organizations to set up and run their own knowledge networks and independent communities of practice (see box, next page). Thus, all the resources and tools developed to support the IBP Knowledge Gateway have been shared with others.

**Figure 5. Examples of customized community sites on the IBP Knowledge Gateway for Reproductive Health**
In 2006 the first of these independent communities was launched as the Global Alliance for Nursing and Midwifery (GANM). Formed, with the help of IBP partners, by WHO’s Department of Nursing and Midwifery and seven WHO Nursing and Midwifery Collaborating Centres around the world, the network supports the professional development of nurses and midwives.

GANM now reaches 2152 members in 76 countries. It is an active community and supports many topic-specific subcommunities. One of the most active has been a Spanish-language community on making pregnancy safer. The development of this community led the IBP secretariat to help establish a Latin American regional knowledge hub for nurses and midwives, supported by a WHO Collaborating Centre in Chile. Soon after the January 2010 earthquake in Haiti, nurses and midwives working there were sending regular updates through the Knowledge Gateway. The Gateway provided a means to share information resources and encouragement with those working in Haiti.

By far the largest group to adopt the Knowledge Gateway technology is Dgroups, with over 100,000 members. Dgroups is a consortium of 23 international agencies led by the United Kingdom’s Department for International Development and the Canadian

“The IBP Knowledge Gateway has the potential to bring all stakeholders together to help address the world’s most important health challenges, thereby contributing to the achievement of the Millennium Development Goals and Health For All.”

— Neil Pakenham-Walsh, Coordinator, Health Information for All by 2015 (HIFA2015)
International Development Agency. Dgroups addresses a wide range of development issues. The addition of Dgroups in 2009 made the Knowledge Gateway the largest virtual networking platform in the nonprofit sector, with more than 200,000 members.

Support from these larger organizations has enabled an annual programme of enhancements, such as an updated interface to be launched by the end of 2010 and multiple language facilities, including French, Spanish, Portuguese, Russian, Chinese and Ukrainian as well as English. All enhancements are made available to all organizations and agencies using the Knowledge Gateway platform, regardless of whether or not they have contributed financially to them.

The IBP Initiative today: Selected activities

On the 10th anniversary of the IBP Initiative, its impact is felt around the world. In regions where the launch meetings introduced the IBP in the first half of the decade, the spirit of teamwork and networking inspired by the IBP lives on, and activities continue in many places. Meanwhile, new countries have welcomed IBP approaches and applied them to address a variety of specific needs.

Current activities of the IBP Consortium, its partners, and the secretariat are many and varied. They include activities in fostering change, as discussed above. Among other prominent activities are these:

Community-based reproductive health care

In 2006 the partners, led by the IBP secretariat and the social science research team within WHO/RHR, identified a number of challenges that have consistently limited the effectiveness of community-based programmes over the last 30 years. In June 2007 partners including USAID, UNFPA, and ESD supported a workshop in Mali for representatives of five African countries with different models of community-based reproductive health services and a strong government commitment to scaling up—Cameroon, Ethiopia, Ghana, Madagascar and Mali. The participants analysed the issues facing community-based health services in general and particularly reproductive health services. Participants then identified effective practices worth scaling up. IBP partners such as ESD and the Reproductive Health Institute supported follow-up activities. Participants expressed a need for up-to-date, simple tools for community-based health workers. This led to the development, now underway, of a version of WHO’s Decision-Making Tool for Family Planning Clients and Providers for use in the community. The teams from Ethiopia, Madagascar and Mali attended the IBP meeting in June 2008 and reported to partners on progress, co-facilitated a capacity-building session on community reproductive health at the Global Health Council conference, and met with the Gates Foundation to discuss their new strategies. As of mid-2010 work continues on scaling up effective practices.
EngenderHealth was actively engaged in planning and conducting the IBP meetings in Egypt, India and Uganda and in supporting country teams in carrying out their action plans. We were also an active partner in developing the Fostering Change Guide and providing technical support in rolling it out. In Ethiopia, we were active partners in the documentation of best practices and in planning and conducting a national stakeholders’ consultative meeting, Implementing Best Practices to Support National Reproductive Health Goals (April 2006), to discuss the preliminary DHS findings and proven/promising RH practices.

At the country level, IBP-supported country action plans advanced our work in Ethiopia, Jordan, India and Kenya.

Globally, we have benefited enormously in terms of knowledge exchange from the IBP network and regular meetings, and from the Knowledge Gateway and its various communities.

**Family planning: A global handbook for providers**

This manual on contraceptive methods was published in 2007, and updated in 2008, by WHO/RHR and the INFO Project at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, an IBP partner, with support from USAID. An intensive, collaborative consensus-development process created the contents of the handbook, which incorporates current WHO/RHR guidance on contraceptive methods. WHO’s invitation to collaborate went out to all IBP partners, who then contributed the core expertise required to prepare the content. The participating partners use this one manual to support their family planning programmes, and many have distributed it in the countries where they work.

After publication of the handbook, a series of international discussions took place in 2008 through the IBP Knowledge Gateway. Each discussion addressed a contraceptive method covered in the handbook. The INFO Project and the IBP secretariat organized and managed these discussions, with the help of expert commentators from other IBP partner organizations. Earlier, in 2007, the INFO Project, in collaboration with the IBP secretariat and other partners, undertook a virtual survey and discussion forum to identify “10 elements of successful family planning programmes”. The results, published in 2008, have been useful to many organizations assessing programme needs.

**Family planning advocacy tool kit**

USAID and the WHO Africa Regional Office (WHO/AFRO), supported by IBP partners, led the Repositioning Family Planning Meeting held in Ghana, 2005. A key need identified at this meeting was for consensus-based advocacy materials for family planning.

WHO/AFRO, supported by USAID, the IBP secretariat and IBP partners, undertook an extensive consultative process and prepared the **Family planning advocacy tool**
kit for policy-makers. The tool kit was published in English and French and launched in collaboration with the West African Health Organization (WAHO) in Burkina Faso, September 2008. Initially, eight country teams were trained to use this tool kit. The most recent advocacy training workshops took place in Lomé, Togo, in 2009, for 11 West African countries, with financial and technical support from USAID, WHO/AFRO, the IBP secretariat and WAHO. As of mid-2010 IBP partners are identifying ways to support countries’ plans to update their own advocacy strategies, using the tool kit.

**Promoting sexual and reproductive health for persons with disabilities**

In support of the Convention of the Rights of Persons with Disabilities, the IBP partnership identified sexual and reproductive health and disability as a neglected area of health care. In 2007 a task team led by the IBP secretariat and UNFPA initiated the formulation of guidance for the full inclusion of people with disabilities in sexual and reproductive health activities. The guidance, for policy makers and programme managers, was published in 2009 after extensive consultation with representatives of organizations of persons with disabilities and other experts.

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**From IBP partner John Snow, Inc.**

Through the IBP, JSI and the USAID | DELIVER PROJECT have been able to collaborate with partners on programmatic and technical activities. Through these partnerships, we have been able to leverage our respective core competencies and harmonize our efforts. We have been able to participate in IBP-hosted events at the global, regional and country level to learn and contribute best practices in reproductive health. In particular, since 2001, the IBP community has helped us to broaden understanding and appreciation of the importance of supply chain management in achieving public health objectives. Our tag line, “No product, no program,” is widely accepted now, and contraceptive (or RH commodity) security has become an organizing framework for many of us working together for reproductive health from the perspectives of service delivery, policy, advocacy, logistics, and research. IBP and IBP partners have been instrumental in expanding the reach of those messages.

Through the IBP Knowledge Gateway, we have been able to launch and support a community of practice—the International Association of Public Health Logisticians (IAPHL). The IAPHL is a community of practice dedicated to facilitating the exchange of professional experiences and innovations in the areas of public health logistics management and commodity security, supporting continued learning, sharing tools and resources, promoting the use of local and regional expertise, and expanding members’ professional network. This community has nearly 500 members from 73 countries.

What has been very useful for many of us in general is the participation in different on-line Global Forums through the different communities of the IBP Knowledge Gateway. Most JSI colleagues consider these communities a great source of information.
Reproductive health essential medicines and contraceptives

Access to good-quality contraceptives and other reproductive health supplies is crucial to nearly every RH/FP programme, including those of IBP partners. WHO, UNFPA and the IBP secretariat have collaborated to add specific contraceptives and other RH supplies to WHO’s list of essential medicines, which often guides government procurement policies. IBP partners in such countries as Kenya, Uganda and Zambia have helped local advocates argue for a line item in government budgets for the purchase of contraceptives. The partnership is a strong advocate for linking improved access to reproductive health essential medicines and contraceptives to all projects and programmes.

Global consultation: The contribution of health professions to primary health care and the global health agenda

This consultation brought together for the first time 60 representatives from 50 health professional associations and organizations, including the International Council of Nurses, the International Confederation of Midwives and the International Federation of Gynecology and Obstetrics. The IBP secretariat, in collaboration with WHO’s Department of Human Resources for Health (WHO/HRH) and an international steering committee, planned the consultation, held at WHO headquarters in Geneva, June 2009. Topics discussed pertained particularly, but not exclusively, to reproductive health. The virtual Health Professions Global Network was launched on the Knowledge Gateway to follow up the recommendations of the consultation. As of mid-2010 the network is reaching nearly 3000 members in 130 countries. A virtual discussion on the challenges of interprofessional education and collaboration in March 2010 attracted over 1000 participants from 120 countries. The outcome of this forum informed discussions with the leadership of these professional associations when they held a video conference in April 2010 involving sites in nine countries. This network will continue to identify the contribution of different

From IBP partner Family Health International

A pioneer in promoting evidence-based practices, the IBP Consortium has been instrumental in improving reproductive health around the world. FHI’s participation as an IBP Consortium partner has contributed to many important achievements. We promoted critical global family planning standards, such as the WHO Medical Eligibility Criteria, and helped various countries update their family planning guidelines based on these standards. We identified and promoted local evidence-based practices to strengthen family planning programs in Kenya. And we helped make the 2009 International Conference on Family Planning in Kampala the resounding success that it was. These and many other accomplishments would not have been possible without the strong partnerships and commitment to quality that IBP has championed over the past 10 years.
health professions to resolving global health issues, such as gender-based violence. Links between the IBP partnership and the Health Professions Global Network are designed to increase attention to reproductive health on the global health agenda.

**WHO Eastern Mediterranean Office (WHO/EMRO): Scaling up effective practices in reproductive health**

National reproductive health programme managers from 18 countries in WHO’s Eastern Mediterranean region met in Amman, Jordan, September 2009, for an introduction to fostering change and scaling up effective practices and to develop action plans. The IBP secretariat, in collaboration with IBP partners, supported WHO/EMRO to organize the workshop, with additional support from the regional office of the International Planned Parenthood Federation.

IBP partners conducted a more intensive Fostering Change training programme for representatives from eight high-priority countries in Rabat, Morocco, May 2010. The participating countries were Afghanistan, Djibouti, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen. This programme was designed to enhance the capacity of these countries to carry out their action plans by apply the Fostering Change process.

**International Conference on Family Planning: Research and Best Practices**

In November 2009 the IBP secretariat and partners organized the third day of activities at the 3-day International Conference on Family Planning: Research and Best Practices. The Bill and Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health led the organizing of the overall meeting,
with collaboration from some 50 other organizations including WHO/RHR and many IBP partners. More than 1300 policy-makers, researchers and other health professionals from 61 countries came to Kampala, Uganda, to review recent research findings. In a natural segue IBP partners sponsored the third day of the conference, which focused on discussing and sharing strategies for transforming existing knowledge into actions that improve access to family planning.

To maintain the momentum of the conference, in April 2010 a discussion forum on the Knowledge Gateway entitled “Kampala Conversations” engaged over 600 people in discussing how to move from knowledge to action and what must be done differently to improve family planning services. The IBP secretariat in collaboration with Family Health International, USAID and other partners have prepared a report, entitled Family Planning For Health and Development: Actions for Change, 2010, which synthesizes the issues and actions discussed at the conference into five key challenges, three essential managerial processes and five key actions that will improve access to good-quality family planning services and help achieve the Millennium Development Goals.

Why IBP?

Many projects and partnerships come and go, having served their purpose. In contrast, the Implementing Best Practices (IBP) Initiative is about to begin its second decade. What explains this longevity and continuing growth and vitality? Five factors may contribute:

Collaboration accomplishes more. Alone, each of the IBP partners is an individual centre of excellence. Together, the partners have complementary strengths that support each other, thus creating a powerful partnership for change, dedicated to improving reproductive health. Together, the coordinated efforts of the partners accomplish more than the sum of the work by individual agencies.

The IBP Initiative is worth joining. Organizations participate in the IBP partnership because they are committed to its vision and welcome working according to its principles—collaboratively, toward common goals. The IBP is one of only a handful of ongoing vehicles for working like this. Partners see the opportunity both to enhance their own impact through collaborations with like-minded organizations and to contribute their own skills and expertise to the collective resources of the partnership. (See statements from partners throughout this report.) The partners meet, plan, and work together with a sense of community characterized by mutual respect, equality, willingness to contribute, and recognition of everyone's contributions.

The partnership is a learning organization. Partners discuss, debate and address challenging issues. Together, the partners challenge themselves to think in new ways and to innovate, asking what should be done differently to be more effective as a partnership and to improve activities. In a sense, the IBP partnership has engaged in a
continuous process of root-cause analysis to find the issues that lie behind the problems. Through this process the IBP has changed in response to its experience in a changing environment—a necessity for any living organism.

**The IBP is uniquely positioned.** As a partnership of many members, the IBP Consortium can offer countries a range of expertise and technical resources that go well beyond what any one organization could offer. Furthermore, the IBP offers a big tent, with room and roles for organizations at international, regional, country and even state or provincial levels. The IBP seeks to bring all stakeholders under this tent and engage them in the collaborative process designed to identify, document and scale up effective practices.

**The IBP Consortium’s home at WHO gives it leverage.** Throughout the world health professionals and policy-makers perceive WHO both as the ultimate authority on technical/clinical matters and as an impartial convener “above the fray”, thus able to bring together disparate stakeholders and to foster collaboration and consensus. The situating of the IBP Secretariat in WHO/RHR makes it possible to engage a wide range of people and organizations in countries around the world that otherwise might never come together. Crucially as well, the committed and energetic secretariat at WHO has consistently and effectively coordinated, organized, and championed the Initiative throughout its existence.

In summary, then, what has the IBP Initiative accomplished?

**At the global level** the IBP has championed collaboration: When undertaken with good will and mutual respect, collaboration is the most productive way to work. The IBP has helped awaken the field of reproductive health to the value of knowledge and the importance of sharing knowledge and building on experience. It has created and shared with the world effective tools and techniques for doing so.

**At the country level** the IBP Initiative has been a catalyst for action. The partnership has fostered networking, teamwork, collaboration and coordination among organizations, avoided duplication of effort, introduced or reinforced concepts of evidence-based technical practices and proven-effective managerial and training practices. The partnership has developed processes to identify and document local effective practices and to foster and manage the change necessary to scale up these practices.

People around the world know of many best practices that can improve reproductive health care. What was needed was a systematic way for stakeholders to identify those best practices and put them to use throughout the health care system. The IBP Initiative has accomplished much in this direction. The task is far from done, however. More can be accomplished by scaling up worldwide the concept, commitment and process embodied in the IBP Initiative.
Annex I. Selected regional meetings and country activities supported by the IBP Partnership
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<th>Community-Based Reproductive Health Programmes</th>
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* IBP Regional Spanish Knowledge Hub
Annex II. Tools and publications of the Implementing Best Practices (IBP) Initiative

Interactive tools and guides from the Implementing Best Practices (IBP) Consortium


Presents a pathway that links proven change practices with evidence-based clinical and programmatic practices to cross the barriers of resistance to change. A self-guided virtual learning program on fostering change is available through USAID’s Global Health eLearning Center website at http://www.globalhealthlearning.org.


This is a facilitator and participant guide for the virtual training programme in fostering change to scale-up proven-effective practices.

Guides for use of the IBP Knowledge Gateway:

Easy guides for using the Knowledge Gateway and planning on-line forums:

   IBP Knowledge Gateway Quick-Start Guide.
   IBP Knowledge Gateway Help.
   Quick-Start Guide for Facilitators & Experts of Online Forums.
   IBP Knowledge Gateway INFO Facilitators Checklist for Organizing an Online Forum.

How-to guides:

A set of guides to support the planning and organizing of IBP’s interactive methodologies.

   How to Plan and Organize a Mini-University.
   How to Plan and Organize an Information Exchange Bazaar.
   How to Plan and Organize a Poster Session.
   How to Plan and Organize a Technology Café.
How to Plan, Organize, Manage, Launch and Facilitate Virtual Knowledge Networks and Discussion Forums.
Management and Performance Improvement training:

Other Implementing Best Practices (IBP) Publications

Annual reports.

Best Practice Tool Kits:
CD-ROMs created for the Cairo, India and Africa IBP launches. These tool kits were developed to inform policy-makers, program managers, clinicians, and staff working in reproductive health about the materials and resources that are produced by WHO/RHR, USAID and partner agencies in the IBP Consortium.


Promotional brochure to introduce the IBP and its mission and members.

Memorandum of Understanding 2003 and IBP Consortium Membership and Operating Guidelines.
Updated 2007.

The Memorandum of Understanding (MOU) formalizes the establishment of the Implementing Best Practice Consortium and lays out its goals, objectives and guiding principles of operation.

The IBP Consortium Membership and Operating Guidelines documents the structure and functions of the Consortium and the roles and responsibilities of its members.

Technology Café brochures
Brochures created for the Cairo, India and Africa IBP launches. These included lists of CD-ROMs and web-based resources produced by the IBP partners, reflecting best practices in clinical care, training and programme planning and management.
IBP partners have supported the publication and dissemination of the following technical guidance documents:

**Family Planning: A Global Handbook for Providers.**
WHO/RHR and INFO Project, JHSPH. Updated 2008.
This handbook offers evidence-based guidance developed through worldwide collaboration. It focuses on the latest guidance on the provision of contraceptive methods.

http://info.k4health.org/globalhandbook/

This guidance note addresses issues of programming in the area of sexual and reproductive health for persons with disabilities. It is intended for experts and advocates within UNFPA and WHO/RHR as well as those in other development organizations and partners.


**Repositioning Family Planning: Guidelines for Advocacy Action.**
WHO Regional Office for Africa and USAID. 2008.
This tool kit aims to help those working in family planning across Africa to effectively advocate renewed emphasis on family planning; to enhance the visibility, availability, and quality of family planning services; and to increase contraceptive use and healthy timing and spacing of births. It was developed in response to requests from several countries to assist them in accelerating their family planning advocacy efforts.

Country “best practices” publications

*Documenting reproductive health practice in Ethiopia.*

This document is a result of an initiative in Ethiopia to identify and document successful practices in reproductive health. Its purpose is to share knowledge, facilitate discussion and inform strategic planning for scaling up practices and programmes.

*Best practices in reproductive health in Kenya.*

This is a compendium of best practices documented in Kenya and intended for application and scaling up in areas of critical need in reproductive health. It is also intended to orient service providers and program managers to the value of documenting best practices and how to manage change in services.
Acknowledgements from the IBP secretariat

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Our First 10 Years

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This is an advance edition of the report on the first 10 years of the Implementing Best Practices (IBP) Initiative. We will revise and republish this report once all partners have had an opportunity to provide their feedback and, if they wish, to provide a statement that we can include in the text.

PLEASE SEND YOUR FEEDBACK TO: ibpusherreier@yahoo.com