MAXIMIZING ENGAGEMENT FOR READINESS AND IMPACT (MERI): MERI APPROACH TECHNICAL OVERVIEW

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Maximizing Engagement for Readiness and Impact (MERI)

An approach that builds system readiness while delivering effective interventions in districts, health facilities and communities.
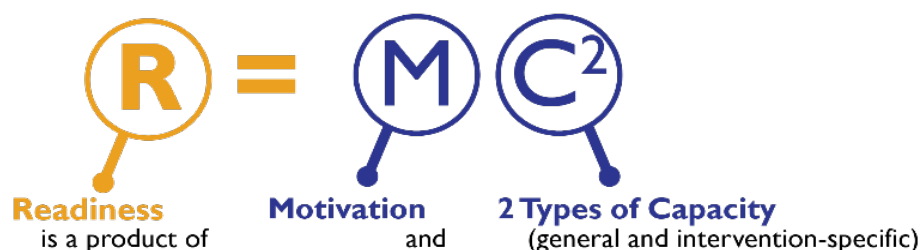
PART 1: Describing System Readiness

Despite major investments in developing effective global health interventions, sustained and meaningful improvements in population health in low-income contexts remain hindered due to challenges in the uptake and the delivery of these interventions (Brownson et al., 2017). While policymakers, researchers, and practitioners in global health have long advocated for system strengthening approaches to enhance effectiveness, little attention has been made to ensuring that governments and development partners are actually *ready* to deliver and support implementation (Dearing, 2018). *System readiness* approaches provide an option to understanding and managing these challenges.

What is system readiness?

While *system readiness* is not a widely used term, it taps into a key aspect of the system implementers tend not to assess – that is, whether or not the system is both *psychologically* and *structurally* prepared for change. By "psychologically" prepared, we mean that system actors at multiple levels have the motivation to change. By "structurally" prepared, we mean that capacities are in place to change. The term *system readiness* is used rather than *system strengthening* in implementation science because readiness theory suggests that *motivation factors* are critical in implementation. *System strengthening* focuses solely on capacity, and has been tried and limited in the past since it doesn't target change as effectively.

Readiness can be summarized in a simple heuristic, 'R=MC^2' (Scaccia et al., 2015):

Readiness is a product of **Motivation** and **2 Types of Capacity** (general and intervention-specific)

When we talk about a "system" being *motivated*, what we mean it that there is willingness of players within the system to adopt a specific intervention because the characteristics of that intervention are optimal. There is also the motivation of individuals working with the system to consider, and this can be

their motivation to use a specific intervention or their motivation to innovate in general. *Intervention-specific capacity* relates to things like the knowledge and skills people have for that intervention, or what resources or champions are in place. *General capacity* refers to general characteristics of the setting – what kind of culture and climate and resource management are in place, what the type of leadership the setting has, etc.

What is a *system readiness* intervention?

A *system readiness* intervention is one that aims to assess and accelerate readiness through targeting both *general* and *intervention-specific* factors plus *motivation,* thus increasing system readiness throughout implementation. In our experience, with simultaneous focus on the uptake of a specific intervention <u>and at the same time</u> emphasis on building general capacity and motivation for change during programming, increased readiness is feasible, even in a short implementation period.

For example, in a program/project that is only being implemented once (for example, a research study or targeted project), one can use a recognized readiness assessment tool (like the R=MC^2) to identify gaps where readiness might need to be strengthened. Once this assessment is complete, implementation planning can prioritize the general readiness areas suitable for potential change during the period of implementation by adding what we call "change strategies" alongside regular implementation activities (i.e., performance of the clinical intervention). For example, if there are gaps identified in leadership capacity, one would incorporate and emphasize strategies within implementation activities to build leadership skills and encourage leader buy-in.

If implementers are lucky enough to have an opportunity to repeat cycles of implementation within the same setting, using a readiness-oriented approach means that the first implementation might be an uphill battle; but in future cycles, implementation becomes easier. Because *general capacity* and *motivation* are improved, beneficiaries are more 'ready' to take on other interventions (not just the first one selected). Additionally, a more 'ready' system can better respond to emerging challenges and needs related to implementation as well as those for new specific-capacity areas, promoting sustainability and future system success. In essence, a readiness-oriented approach enables the system to succeed in the future by targeting readiness at the present moment.

PART 2: The 'Maximizing Engagement for Readiness and Impact (MERI)' Approach to System Strengthening and Specific Intervention Implementation

The Maximizing Engagement for Readiness and Impact (MERI) Approach can be understood using Scaccia et al's 'R=MC^2' as a theory of change. MERI is comprised of several components that work together to optimize intervention implementation. MERI was developed by implementers for implementers. This approach incorporates real-world best practices and has been carefully evaluated to document its effectiveness. The core focus of the MERI Approach is to foster readiness and thus system strengthening and sustainability.

The MERI APPROACH is novel because:

MERI is a multi-level initiative, incorporating activities and targeting outcome changes at all levels. In the East African health system, levels include the district, health facility and community. MERI takes a whole-system, 'population health approach' (Frolich & Potvin, 2008; McLaren et al., 2010), acknowledging that health change is accelerated when barriers are addressed at *all* levels and the health system is capable of supporting *all* system actors (without gaps) - leaders, managers, providers, communities, partners and districts - to do their work optimally.

MERI builds readiness for a *specific* intervention, while at the same time building *general* readiness for the system to implement *any* intervention and respond to emerging needs. As such, MERI aims to improve system readiness. This makes future implementation efforts easier and more manageable.

Most implementation efforts expect a setting (for example, an organization, community, or system) that is *ready at start of implementation* in order to implement successfully. This can be a barrier to implementers in low-resource settings since requiring a system to be 'ready' for effective implementation is not practical and often deters implemention in settings where change is needed most (i.e. the most vulnerable settings). MERI, on the other hand, does not assume that a setting (i.e. district) has maximal 'readiness' for implementation from the start; instead, this approach invests in creating readiness as a structured part of the intervention. In settings which are 'not' ready, purposeful components of the MERI Approach help to stimulate readiness.

MERI encourages sustainability from the beginning. The MERI Approach is informed by almost 20 years of working in complex systems in low-income countries (LICs). The Approach incorporates experiences, evaluation and reflection on practical challenges faced in maintaining change over time and meeting emerging needs where readiness and the context are dynamic.

The Three Core Components of the MERI Approach

The MERI Approach consists of three components that strengthen overall health system readiness while implementing a selected (focused) intervention geared towards the ultimate goal of establishing a system primed to respond to emerging issues and interventions when identified and prioritized by districts, health facilities and communities which is especially relevant in low and middle income countries.
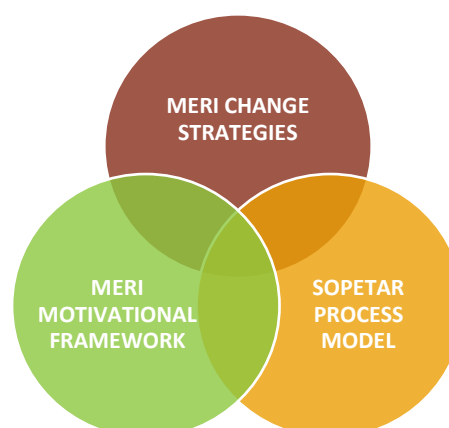
Component 1: MERI CHANGE STRATEGIES

A set of **change strategies** (collaborative and consensus building meetings, equipping, training, technical assistance-mentorship) improve _general capacity_ (i.e., the capability to adopt and implement any intervention) and _intervention-specific capacity_ (i.e., the capability to adopt and implement specific selected interventions).

STRATEGY	EXAMPLE: INTERVENTION-SPECIFIC CAPACITY	EXAMPLE: GENERAL CAPACITY
Collaborative and consensus building meetings	Developing a maternal, newborn and child health strategy with district health managers	Supporting communities in developing action plans
Equipping	Equipping all health facilities with bag and mask to conduct newborn resuscitation	Equipping a district with an ambulance to transport patients requiring emergency referral
Training	Conducting clinical training for facility staff in management of obstructed labour	Conducting data manager training on health management information analysis and dissemination
Technical assistance & Mentorship	Conducting mentorship visits to primary health facilities to review sick child case management	Supervising and supporting Community Health Workers

Component 2: SOPETAR PROCESS MODEL

A comprehensive **process model** called SOPETAR describes the sequence and operationalization ('how-to') of the change strategies. The goal of SOPETAR is to guide each level of implementation (e.g., districts, health facilities, communities) through an implementation cycle. SOPETAR was developed based on practical field experience, best practices and lessons learned to reduce common implementation 'gaps' and maximize engagement at each level using *purposeful, timed*, and *ordered* steps while paying specific attention to *implementation quality*.

The SOPETAR Process

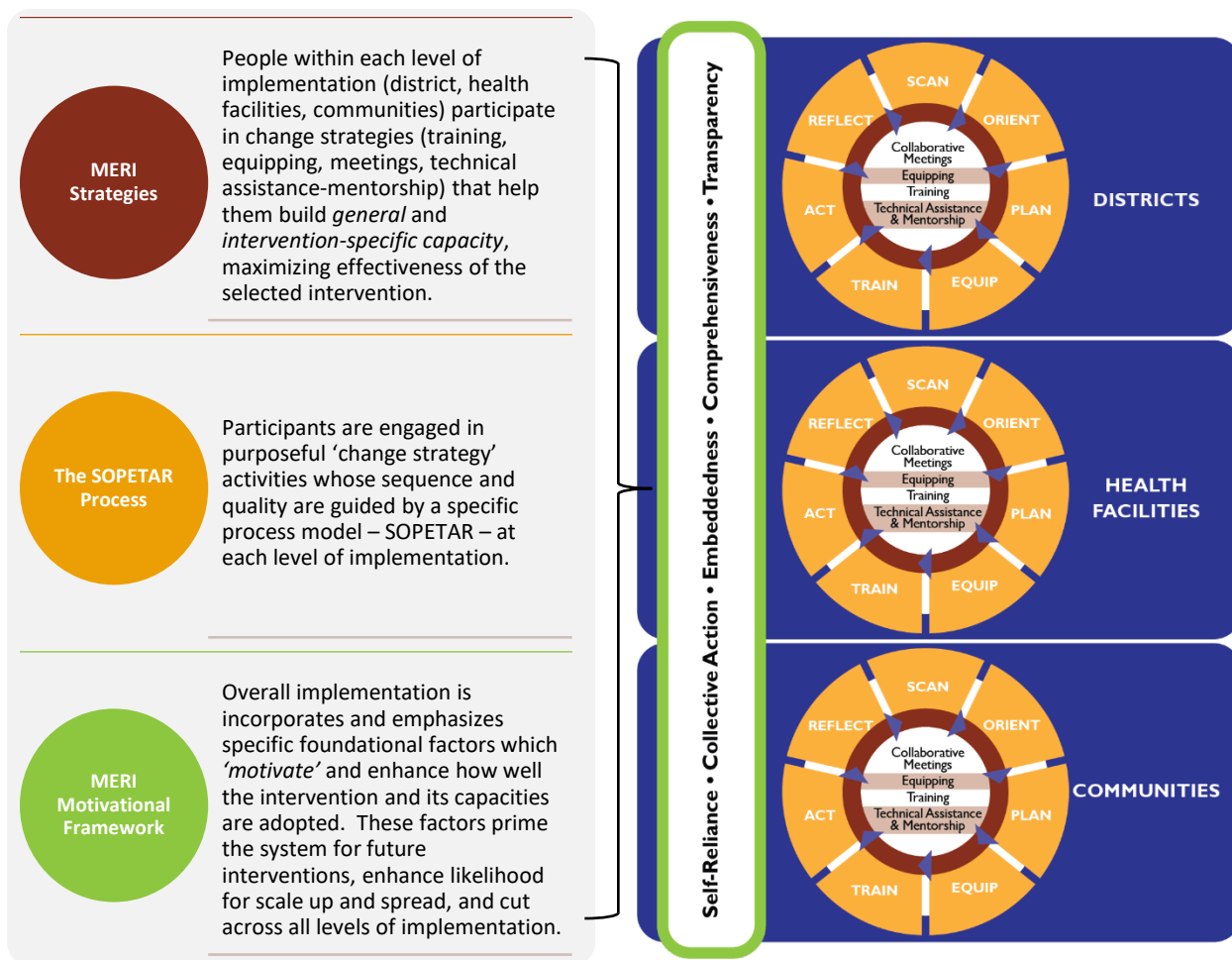|	
SCAN	to understand available resources, personnel, structures, and relevant policy to steer strategy, operations and ensure appropriate stakeholder involvement.
ORIENT	a broad range of key stakeholders providing sequential ('cascade'), early and clear introduction to the upcoming intervention, to promote early engagement and improve transparency.
PLAN	implementation details with all key stakeholder groups during dedicated, focused, action-oriented sessions, considering strengths, gaps and priorities.
EQUIP	based on locally-driven prioritization and plans with materials, supplies and equipment to enable training and action, ensuring a maintenance strategy is in place.
TRAIN	using a participatory, train-the-trainer approach, to build general and specific capacity at all levels.
ACT and INNOVATE	to reach ultimate beneficiaries.
REFLECT	within key user groups on implementation challenges, successes, facilitators and barriers to reinvigorate the SOPETAR cycle and its steps for the sustainability phase.

Component 3: MERI MOTIVATIONAL FRAMEWORK

A **framework of foundational factors** key to maximizing motivation for adopting, implementing and sustaining the intervention ground its implementation when following the MERI Approach. Five 'Motivational' factors core to MERI have been identified and synthesized reflecting on two decades of implementation experience. Motivational factors cut across different levels (e.g., district, health facilities, communities), optimizing the change strategies and SOPETAR Process Model process during implementation. These factors were developed to stimulate positive perceptions of the intervention (Damschroder et al., 2009; Rogers, 2003) and promote self-determination (Ryan & Deci, 2017).

FOUNDATIONAL MOTIVATION FACTOR	DEFINITION
Embeddedness	The MERI Approach aims to maximize its compatibility with the local district priorities, structures, and processes to effectively embed the change strategies. This includes leveraging existing structures and systems and aligning with ongoing programs and policies in the district. Promoting district leadership is critical to foster embeddedness, where engagement is facilitated through existing structures and reporting relationships. A 'cascade approach' involves building readiness for implementation initially amongst district stakeholders, who, in turn, support health facilities, whose representatives then engage communities. The more compatible the change strategies are with what is already existing, the more likely that district will be motivated to implement them.
Comprehensiveness	The MERI Approach uses a 'whole system' approach which ensures that the intervention is compatible with each level of the existing system. Therefore, implementation is district-wide with broad coverage and reach, permeating multiple levels of the system. Comprehensive engagement ensures full coverage of all areas of the district and levels of the health system, leaving none out; everyone is involved in implementing changes.
Self-reliance	The MERI Approach fosters motivation by encouraging districts, health facilities, and communities to take responsibility for making changes by themselves for themselves. Autonomy is cultivated at all levels, promoting innovation, creation of local solutions for local needs, resourcefulness and a "use what you have" philosophy. The MERI Approach employs participatory facilitation methods that are grounded in community development principles to promote skill development, meaningful dialogue, critical thinking and encourage self-reliance.

Transparency	Promoting transparent communication among all stakeholders from the outset is important, ensuring clarity related to expectations and roles. Transparency motivates people to act when they have more certainty around all of the stakeholders' roles and responsibilities for implementation.
Collective action	The MERI Approach involves establishing meaningful engagement with all stakeholders to cultivate constructive relationships and teamwork. By focusing on developing a culture of teamwork among stakeholders and champions, there is a shared vision and resolve for change. Having a unified goal to work together towards enhances the connection among stakeholders, within and between levels, motivating them to work together in implementation.

How the three core components of the MERI Approach work together

MERI Strategies	People within each level of implementation (district, health facilities, communities) participate in change strategies (training, equipping, meetings, technical assistance-mentorship) that help them build *general* and *intervention-specific capacity*, maximizing effectiveness of the selected intervention.
The SOPETAR Process	Participants are engaged in purposeful 'change strategy' activities whose sequence and quality are guided by a specific process model – SOPETAR – at each level of implementation.
MERI Motivational Framework	Overall implementation is incorporates and emphasizes specific foundational factors which *'motivate'* and enhance how well the intervention and its capacities are adopted. These factors prime the system for future interventions, enhance likelihood for scale up and spread, and cut across all levels of implementation.

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