16

Stakeholders' Involvement and Service Users' Acceptance in the Implementation of a New Practice Guideline

Comfort Adeosun, Lorna McKee and Hilary Homans

Introduction

Background

The adoption and implementation of clinical guidelines has a positive impact on quality, service effectiveness and patient care (David and Taylor-Vaisey 1997; Grimshaw et al. 2004). However, implementing evidence-based practice and practice guidelines is complex and challenging (Taylor et al. 2011). These challenges have been shown to range from individual provider behaviour, quality and characteristics of the guidelines, patient characteristics to organisational characteristics, settings and health system-level factors (David and Taylor-Vaisey 1997; Greenhalgh et al. 2004; Francke et al. 2008; Urquhart et al. 2014). One way of surfacing the factors that impact on the uptake and effective implementation of clinical guidelines is to undertake comparative

C. Adeosun (✉) · L. McKee · H. Homans
University of Aberdeen, Aberdeen, UK
e-mail: Comfort.adeosun.08@aberdeen.ac.uk

A.M. McDermott et al. (eds.), *Managing Improvement in Healthcare*,
Organizational Behaviour in Health Care,
https://doi.org/10.1007/978-3-319-62235-4_16

studies of the same guideline as it is rolled out in different contexts (Yin 2003; Helfrich et al. 2007).

There is currently strong evidence that both the internal and external context of the organisation influence the implementation and utilisation of guidelines, confirming that implementation processes are complex, interactive and iterative in nature (Johns 2001, 2006; Fitzgerald et al. 2002; Krein et al. 2010; McDermott and Keating 2012). It has been further suggested that to ensure successful implementation, appropriate customised implementation policies and practices must be deployed by local healthcare organisations (Klein and Sorra 1996; Weiner et al. 2008). Increasingly, it is argued that there is a need to develop an in-depth appreciation of the formation and role of these localised implementation policies and practices.

According to Helfrich et al. (2007), implementation policies and practices are 'the formal strategies (that is, the policies) the organisation uses to put the innovation into use and the actions that follow from those strategies (that is, practices)' (p. 284). Some of these strategies may include: the quality and quantity of training; rewards, including promotion, incentives, praise or improved working conditions; effective communication about the goals of the implementation; sufficient time for users to experiment or learn new skills related to the innovation; and the quality, accessibility and user-friendliness of the innovation itself (Helfrich et al. 2007; Weiner et al. 2008). An organisation's implementation policies and practices will influence innovation implementation and use by shaping the organisation's implementation climate (Klein and Sorra 1996) irrespective of the type of guideline. However, the importance of stakeholder and especially patient involvement in implementation and improvement activities should not be overlooked.

Whilst the need for patient involvement or participation in quality improvement activities is increasingly gaining attention (Donetto et al. 2014b; Vahdat et al. 2014; Wiig et al. 2014), within the organisational literature, there is only a limited number of studies which capture the impact and significance of stakeholders and in particular patient involvement in implementation and improvement (Damschroder et al. 2009; Urquhart et al. 2014). In this chapter, we address this acute gap

in knowledge and use the broad concept of stakeholders to include the whole mix of healthcare providers, policymakers, as well as end users, patient groups, the public and funders. The new insights added by this chapter include the influence of stakeholders, end users and the community on the complex implementation of a new guideline dependent on context and system-level factors.

This focus on patients and end users is timely because patient involvement in healthcare decision-making is becoming increasingly promoted as an important tool for improving quality of care (Parsons et al. 2010; Vahdat et al. 2014). It is suggested that the more patients are involved, the more they can help to co-design their care and improve it. Recent studies have been conducted using the experience-based co-design method in healthcare improvement (Donetto et al. 2014a, b; Locock et al. 2014). The method encourages staff, patients and carers to reflect on their experience of care and look for ways to improve the process and assess the achievements of any changes implemented (Donetto et al. 2014b). Other methods include patient participation and shared decision-making (Wiig et al. 2014), and the shared ambition is to create services and innovations that are as 'user- and carer-led as possible' (Sheldon and Harding 2010, p. 5).

Focused Antenatal Care (FANC) Model

In this chapter, the focus is on the implementation of the Focused Antenatal Care (FANC) model, a clinical practice guideline developed by the World Health Organisation (WHO) to improve the quality of antenatal care (WHO 2006). In 2007, the Federal Ministry of Health in Nigeria adopted the WHO standards and guidelines to improve maternal, neonatal and child health. The available evidence suggests incomplete and weak implementation of the FANC model in Nigeria (FMOH 2011). In general, the coverage and content of care provided during antenatal care are regarded as sub-optimal across the nation (Osungbade et al. 2008; Okoli et al. 2012). This chapter addresses this puzzle as to why such variation occurs, both drawing on the need to

understand local implementation policies and practices as well as focusing on how stakeholders and end users impact implementation and uptake. In this chapter, terms such as the successful implementation or effectiveness of the intervention, the FANC model, are used interchangeably with intervention or innovation use. They are all used to mean the committed, consistent and routine utilisation of the new practice guideline in the organisations studied.

The overall study upon which this chapter is based draws upon a theoretical framework first developed by Klein and Sorra (Klein and Sorra 1996; Klein et al. 2001) and later revised by Helfrich et al. (2007). The theory suggests that the presence or absence of factors such as management support, resources and appropriate implementation policies and practices can facilitate or hinder the successful implementation of innovation. As an organisational-level framework, it is concerned with innovations requiring coordinated use by multiple organisational members. The model was adapted to accommodate other factors from the extant literature. Significantly, the context of the healthcare organisation and system-level factors are stressed as important influencing factors (Johns 2006; McDermott and Keating 2012; Urquhart et al. 2014). The adapted framework is shown in Fig. 16.1.

Methods

The overall study adopted a case study research methodology (Creswell 2007; Yin 2003). It employed a multi-method qualitative approach to data collection which is both descriptive and exploratory in nature (Patton 1990; Fitzgerald and Dopson 2009). Four comparative case studies in one state in the Niger Delta area of Nigeria were purposively chosen and provided an opportunity for contemporaneous study of implementation of FANC in a range of diverse local contexts.

Four healthcare settings were selected across the three levels of healthcare provision in the state (tertiary, secondary and primary healthcare levels) based on the levels of ownership (private and public) and teaching status (teaching and non-teaching). Attempts were also made to access secondary data from the local and state governments on the

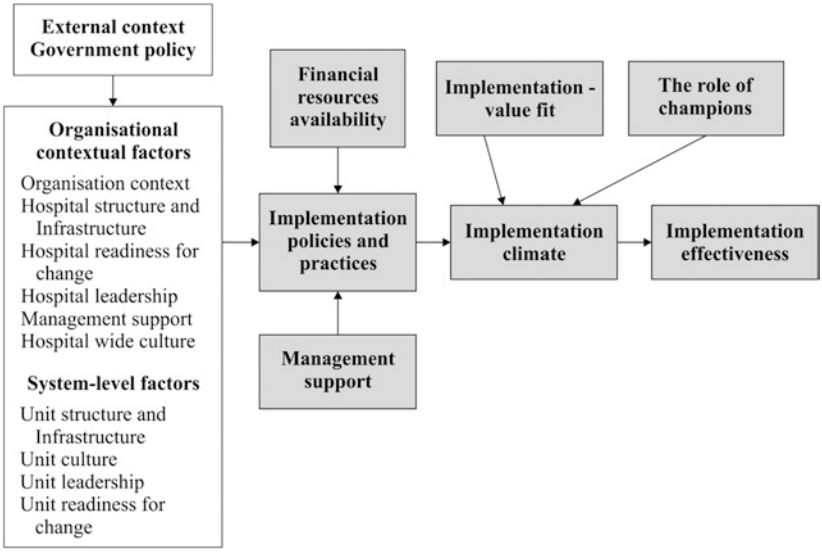

Fig. 16.1 Theoretical model for complex innovation implementation. Adapted from Klein and Sorra 1996; Helfrich et al. 2007. *Shaded* original model. *Unshaded* proposed extension to model

adoption and utilisation of the FANC guideline by the selected hospitals and healthcare facilities.

The overall study protocol summary, consent form and ethics approval form were approved by the University of Aberdeen College of Arts and Social Sciences Research Ethics and Governance Committee. Subsequent ethical approvals were obtained from the Niger Delta State Primary Health Care Management Board, and from each case study site management team.

Three predesigned research instruments were used to collect data from the healthcare providers and policymakers, and importantly it was an explicit objective of the study to gather data directly from the end users of the services. A sample of pregnant women across the four case study sites was interviewed about their perceptions and knowledge of the FANC initiative and its goals. For the providers, the interview and focus group discussion schedule included questions on the adoption/adaptation and implementation of the FANC model. The schedule also

included questions on how the model guideline was generally perceived and promoted in the organisation, amongst other issues surrounding improving the quality of antenatal care. The questions were open-ended in order to give room for other themes to emerge during the interview.

For the pregnant women, the interview and focus group discussion guide included topics such as the pregnant woman's gestational age, number of antenatal care visits, awareness and perception of the FANC model, information received during health talks and the intention to deliver in the facility. The interviews lasted between forty and ninety minutes.

The prescribed FANC guideline checklists were also used to obtain data during substantial time spent in non-participant observation of antenatal care clinic sessions. The data were collected from January to May 2013. In order to assess the factors and variables of interest, different cadres of staff were invited to participate, and the pregnant women also came from different backgrounds in terms of age, number of previous pregnancies, proximity to the facility and health status. Appropriate secondary data and policy documents related to the implementation of the new guideline were collected from each facility's medical records.

A thematic framework analysis (Ritchie et al. 2014) was used to analyse the qualitative data. Data analysis began when the first data were collected. Codes and categories were generated from the data using inductive and deductive approaches (Guest et al. 2012). The framework was flexible, and codes and themes were reassessed as new codes or themes emerged. The coding process was guided by the coding principles proposed by Braun and Clarke (2006) and Ritchie et al. (2014). Each code contains evidence from the manuscripts with links to the data. The *NVivo 10* qualitative data management software was used to support the analysis stage. The secondary data were obtained from document reviews on antenatal clinic utilisation, and checklists were analysed using descriptive statistics. Data from each case study site were analysed separately before comparison with other study sites. The results were integrated and triangulated at the data analysis and interpretation stage (Bryman 2006). A stage-by-stage data analysis and triangulation helped to gain deeper meanings and insights into the implementation

Table 16.1 Total number of participants, role and facility

Data sources		Case A Comprehensive health centre	Case B Tertiary hospital	Case C Primary health-care	Case D Private hospital
Interviews					
Providers	Antenatal care staff	3	4	3	3
	Management level staff	5	3	2	4
Policymakers		1	2	2	2
Pregnant women (Includes first visit and revisits)		9	10	8	6
Total interviews		18	19	15	13
Focus group discussion					
	Providers	1(n = 5)	1(n = 5)	1(n = 5)	
	Pregnant women	3(n = 16)	2(n = 11)	1(n = 5)	2(n = 10)
Non-participant observation (hours)		124	80	45	40

Source Authors

process in each local context. The cross-case analysis was conducted to enhance the findings' generalisability or transferability to other contexts and deepen understanding and explanation of the phenomenon being studied (Fitzgerald and Dopson 2009; Miles et al. 2014; Yin 2003). The analysis compared and contrasted themes between and within the case study sites. The following table summarises the participants in the study (Table 16.1).

Case Description

Case A is a public and comprehensive healthcare facility. It provides general outpatient care, maternal and child healthcare services, amongst

others. The facility is fully implementing the FANC guideline as recommended by the WHO. It has a community health insurance scheme for service users.

Case B is a tertiary and teaching hospital. The hospital has a local protocol for antenatal care similar in content to the FANC guideline. The facility is not implementing the FANC model. The antenatal care visits follow the traditional model with ten to twelve visits in one pregnancy.

Case C is a public primary healthcare centre funded by the state ministry of health. It receives supportive supervision from the primary healthcare board. The facility is partially implementing the FANC model due to pregnant women's rejection of a reduction in the number of antenatal care visits. Free medical care is provided by the state government.

Case D is a private and non-teaching hospital providing primary and secondary care. Most of the pregnant women receiving care in this facility are graduates. The content of the antenatal care is incongruent with the FANC guideline. For financial reasons, the number of antenatal care visits follows the traditional model. Notably, pregnant women pay for consultation each visit.

Findings

In the following section, we present the findings on the FANC guideline implementation. In particular, we aim to show the complex interplay of different levels of influence in each case from local policy, and providers' adaptive behaviours to the local pregnant women's action on implementation policies and practices. Notably, the implementation team members were prescribed in the implementing facilities. They were responsible for fulfilling specific roles in line with the new guideline in each organisation. The impact of this on the implementation process is that each facility had to demonstrate that they were aiming to comply with the government policy on the FANC model as a top-down strategy. However, the private hospital implemented the FANC model in response to the need for evidence-based practice.

Table 16.2 Cross-case matrix: implementation policies and practices

Implementation policies and practices	Case A	Case B	Case C	Case D
Training (on prevailing antenatal care practice)	Y	Y	Y	Y
Communication of FANC model	Y	-	Y	Y
72-hour roster	-	-	Y	-
Community involvement and engagement	Y	-	Y	-
Employment of key staff	Y	-	Y	Y
Adaptation and innovation to FANC	Y	-	Y	Y
Innovation in antenatal care, e.g. health insurance scheme, multiple informants for health talk	Y	Y	Y	Y
Protocol or Standard Operating Procedures	Y	Y	-	Y
Audit and feedback mechanisms	Y	Y	Y	Y

Y = Present; - = Absent
Source Authors

Implementation Policies and Practices (IPPs)

The cross-case analysis revealed various effective implementation policies and practices (IPPs) that affected the FANC model (or the local protocol) implementation and routine utilisation across the cases. The IPPs adopted across cases to facilitate implementation are shown in Table 16.2. The findings are divided into common and distinctive IPPs.

Common and Effective Implementation Policies and Practices: Similarities Across Cases

The data revealed *three* similar implementation practices across all cases, as described below.

Training

The four facilities provided training for their staff. Participants from Cases A and C reported that the local government organised training for staff on the FANC model guideline at the start of the implementation process. The adoption of the FANC model as a government policy

meant that healthcare facilities were mandated to accept and use it. The training created the awareness and knowledge needed by staff to provide care in line with the new model.

> The Focused Antenatal Care model was introduced to us as a policy. A workshop was organised and the concept of Focused Antenatal Care was explained to us. From there we started the implementation. [State Reproductive Health Manager, Board]

Training was also organised for antenatal care staff at Case D, the private hospital, in order to embrace the WHO best practice for quality antenatal care.

Innovation in Antenatal Care Practices

Numerous innovative ways were used to support the implementation process. In Case A, the introduction of the Community Health Insurance Scheme enhanced the implementation process. The scheme is perceived to be one of the key facilitators for implementation and continuous utilisation of the FANC guideline in the hospital.

> The Community Health Insurance Scheme, I will say, is one of the major facilitating factors. Because I know that Focused Antenatal Care, even in other health facilities like the primary health centres, ought to use Focused Antenatal Care, but most of them you can see that mothers are not embracing Focused Antenatal Care there. [Case A, Senior Manager 2]

Each facility engaged multiple informants for health talk on antenatal care clinic days. At Case B, different healthcare professionals presented health talks. This included antenatal care staff, family planning consultants and physiotherapists.

Audit and Feedback Mechanisms

Audit and feedback tools were used as a mechanism to monitor and evaluate FANC model use in Cases A and C. In Case B, regular clinical audits were conducted in addition to Tuesday weekly clinic meetings. Also, in Cases B and D, feedback tools were used to monitor performance and indicated needed improvements in the quality of care being provided to pregnant women.

Distinctive Effective Implementation Policies and Practices Across Cases

Distinctive policies and workplace practices were also observed in the four facilities. Table 16.2 above shows that Cases A and C engaged several implementation policies and practices to implement the FANC model. Also, both facilities were under the state government supervision mechanism (a form of top-down strategy for policy implementation).

Community Engagement and Involvement

Community engagement and involvement were embarked upon by the management in Cases A and C. Involving the local community chiefs to communicate about the importance of antenatal care to reduce maternal mortality, and where the facilities were situated, may have facilitated community ownership and patronage. This is in line with the model's recommendation (WHO 2006).

> The impact on the antenatal programme has been positive. When it came we went to the paramount Ruler who is the custodian of this place and told him of the new model. He mandated his town crier to take the announcement round the community. And that was the first step in the initial enlightenment campaign. [Case C, Senior Manager, Doctor]

The community chiefs and religious leaders play an important role within the community. Many times matters of faith and tradition

conflict with conventional medicine; hence, the need to engage the leaders to understand the importance of quality antenatal care. This strategy proved to be effective as many women visited the facilities for antenatal care.

Staff Employment

The data revealed the employment of key staff to support the model implementation in three facilities—Cases A, C and D.

Communication of FANC Model by Appropriate Authorities

The communication of the FANC model and training received by providers at Cases A, C and D are perceived to be key implementation practices in gaining the support of staff to use the guideline. This further shows that the structure of the healthcare system and the management processes in each facility affected the effectiveness of guideline implementation.

> We get information from the Western world and we want to see how we can improve. Through adaptation, we want our people to get the best so we have to improve on our own and on the knowledge we have. It is done worldwide; why should we be left behind? It is the drive to get evidence-based practice into the system. [Case D, Senior Consultant, Obstetrician and Gynaecologist]

Staff Adaptive Innovative Behaviour

The adoption of a seventy-two-hour shift by the midwives at Case C was exceptional. It was one of the internal implementation policies put in place to ensure that the model was implemented as a state policy.

Without this strategic action, pregnant women may not have reported for care if they were unsure that staff would be available to care for them.

The Use of Standard Operating Procedures and Protocols

The use of appropriate antenatal care protocols and appropriate staff at Cases B and D appeared to have had an impact on the implementation of the antenatal care protocol in use in each facility. The hospitals' compliance to protocol utilisation was assessed through observation and interview.

Adaptation and Innovation to FANC

Many pregnant women in Nigeria seek care exclusively in the church or with traditional birth attendants because they believe that through prayers and sometimes with traditional medicine, complications leading to Caesarean sections may be averted. Responding to this challenge, many providers now invite religious leaders to incorporate prayer sessions into the antenatal care schedule to encourage attendance and willingness to deliver with the aid of skilled birth attendants.

A pregnant woman summarised the antenatal care clinic at Case C thus:

> The first thing we do is to pray. After that they preach. This is followed by the health talk and after the health talk we get our folders, then we go upstairs for our laboratory test. [Case C, PW 6]

Due to the rejection of the FANC model's recommended four antenatal care visits, the providers at Cases A and C encouraged pregnant women to visit the facility when they were sick. This was aimed at discouraging pregnant women from using mission homes, faith-based organisations and traditional birth attendants. As a result, more women embraced the new guideline in these facilities.

> They [midwives] said we should come four times during our pregnancy … If they check you and everything about you is okay, your visit here is to be four times, depending on the condition of the pregnancy. They said if you have any complication you can come before the date given to you. [Case A, PW 7]

In addition, pregnant women receiving care at Case C were offered free medical care in order to encourage antenatal care attendance. This suggests that free medical care is a key contextual factor facilitating the implementation of the FANC model in the state.

Despite pregnant women's refusal of the reduction in the number of antenatal care visits, these implementation strategies employed by the facilities to encourage guideline use in the facility and win pregnant women's trust helped to facilitate continuous innovation use. These adaptive behaviours influenced the implementation climate in each case study site. When these distinctive factors are linked together with reports from pregnant women (these findings are reported in another chapter), it appears that the ongoing effective implementation of the FANC model at the public facilities, particularly Cases A and C, are due to the support received from the state and local governments and community involvement. The providers' response to service users' preference for antenatal care boosted implementation efforts.

It appears that there are diverse interpretations of what constitutes successful or effective implementation of the FANC model for the various actors in each facility. For the pregnant women, it was their ability to visit the antenatal care clinic frequently in defiance of the optimal number of visits laid out in the policy guideline. For the providers, effective implementation meant providing quality antenatal care despite limited resources in line with the new guideline. At the private hospital, more visits meant more money and profit maximisation. The policymakers and the local chiefs perceived effectiveness as the increase in the total number of pregnant women accessing antenatal care in the healthcare facilities with the aim of reducing overall maternal and infant mortality in their communities and the state at large. The religious leaders perceived effectiveness as supporting more pregnant women in receiving conventional care in addition to prayers and faith.

Discussion

This chapter has examined the implementation policies and practices that influenced the implementation of the FANC model in four healthcare settings. The findings revealed three common IPPs across the cases studied—training, innovation in antenatal care practices, and audit and feedback mechanisms. Distinctive IPPs were observed in the four cases. Interestingly, community involvement and engagement prompted other practices observed in two cases. Stakeholders' involvement and service users' acceptance/resistance led to staff adaptive innovative behaviour and adaptation to the FANC model implementation. These findings showed that external and internal organisational context and the healthcare system influenced the implementation policies and practices engaged. The data indicate that a range of different contextual factors and internal policies interacted to facilitate implementation, as also observed in other studies (Dixon-Woods 2014; Fitzgerald et al. 2002; Hovlid and Bukve 2014).

As stated earlier, two of the four cases, Cases A and C, demonstrated the importance of community engagement and stakeholder involvement in innovation/intervention implementation. The findings showed that the increase in the number of attendees and improvement in the facilities were the result of collaboration between the healthcare organisation, the community and religious leaders and other stakeholders. The importance of stakeholder involvement has been documented in other healthcare studies (Damschroder et al. 2009; Hovlid and Bukve 2014; Urquhart et al. 2014). However, the interaction between them in this study on FANC model implementation was a unique finding.

In addition to stakeholders' involvement, the findings show that service users' (pregnant women's) acceptance or resistance to the FANC model had an impact on implementation effectiveness. Pregnant women's perception of care and dislike of the reduced number of visits as recommended in the model influenced the organisational responses and providers' implementation efforts. This is a contextual influence neglected in previous studies (Johns 2006; Pettigrew et al. 1992). This factor influenced implementation practices in Cases A and B. For

example, the providers' inclusion of prayer into the antenatal care practice was in response to service users' religious beliefs and the importance attached to prayer. Also, the sociocultural influence of the traditional birth attendant on pregnant women's health-seeking behaviour generated varied responses from each organisation. All these demonstrate that external contextual factors, including service users' acceptance, influence implementation of evidence-based practice in healthcare facilities. This creates the need for patient involvement in improving implementation efforts and should go beyond involvement in guideline development (Sheldon and Harding 2010; Wiig et al. 2014).

It also indicates that end users or service users are not passive in the implementation process. They are active change agents to co-shape implementation effectiveness together with management support, model champions, community and stakeholders. A new publication by the WHO has increased the recommended number of visits to eight (WHO 2016).

Implications

The chapter shows the need for stakeholder and patient involvement in the adoption of new innovations or interventions. The purpose and the expected outcomes of interventions should be explained in order for end users—including practitioners and patient groups—to express their opinions about changes that may be explored as a result of the new interventions. Practitioners/providers should continue to provide evidence-based practice.

Conclusions

This chapter contributes to and fills the research-knowledge gap and evidence-based practice-implementation gap in the implementation of a maternal health clinical practice guideline in Nigeria. A major finding is the broader nature and extent of external context in guideline implementation. It showed that stakeholder involvement, the role of wider

community involvement and service users' acceptance/resistance all influenced implementation climate and effectiveness. It also affected the continuous innovation or intervention use.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research, 6*(1), 97–113.

Creswell, J. W. (2007). *Qualitative inquiry and research design: The five approaches*. Thousand Oaks: Sage.

Damschroder, L. J., Banaszak-Holl, J., Kowalski, C. P., Forman, J., Saint, S., & Krein, S. L. (2009). The role of the 'champion' in infection prevention: Results from a multisite qualitative study. *Quality and Safety in Health Care, 18*(6), 434–440.

David, A. D., & Taylor-Vaisey, A. (1997). Translating guidelines into practice: A systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines. *Journal of Canadian Medical Association, 157*(4), 408–416.

Dixon-Woods, M. (2014). *Perspectives on context: The problems of context in quality improvement*. London: The Health Foundation.

Donetto, S., Tsianakas, V., & Robert, G. (2014a). *Using Experience-based Co-design to improve the quality of healthcare: Mapping where we are now and establishing future directions*. London: King's College London.

Donetto, S., Pierri, P., Tsianakas, V., & Robert, G. (2014b). *Experience-based Co-design and health care improvement: Realising participatory design in the public sector*. Fourth Service Design and Innovation Conference. Retrieved from http://www.servdes.org/wp/wp-content/uploads/2014/06/Donetto-S-Pierri-P-Tsianakas-V-Robert-G.pdf. Accessed 22 Feb 2016.

Federal Ministry of Health. (2011). *Saving newborn lives in Nigeria: Newborn health in the context of the Integrated Maternal, Newborn and Child Health Strategy* (2nd ed.). Abuja: Federal Ministry of Health, Save the Children, Jhpiego.

Fitzgerald, L., & Dopson, S. (2009). Comparative case study designs: Their utility and development. In A. Bryman & D. A. Buchannan (Eds.),

Organisational research in the SAGE handbook of organisational research methods. London: Sage.

Fitzgerald, L., Ferlie, E., Wood, M., & Hawkins, C. (2002). Interlocking interactions, the diffusion of innovations in health care. *Human Relations, 55*(12), 1429–1449.

Francke, A., Smit, M., de Veer, A., & Mistiaen, P. (2008). Factors influencing the implementation of clinical guidelines for health care professionals: A systematic meta-review. *BMC Medical Informatics and Decision Making, 8*(1), 38.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organisations: Systematic review and recommendations. *Milbank Quarterly, 82*(4), 581–629.

Grimshaw, J., Eccles, M., & Tetroe, J. (2004). Implementing clinical guidelines: Current evidence and future implications. *Journal of Continuing Education for Health Professions, 24*(Suppl. 1), S31–S37.

Guest, G., MacQueen, K. M., & Namey, E. M. (2012). *Applied thematic analysis*. London: Sage.

Helfrich, C. D., Weiner, B. J., McKinney, M. M., & Minasian, L. (2007). Determinants of implementation effectiveness: Adapting a framework for complex innovations. *Medical Care Research and Review, 64*(3), 279–303.

Hovlid, E., & Bukve, O. (2014). A qualitative study of contextual factors' impact on measures to reduce surgery cancellations. *BMC Health Services Research, 14*(1), 215.

Johns, G. (2001). In praise of context. *Journal of Organisational Behavior, 22*(1), 31–42.

Johns, G. (2006). The essential impact of context on organizational behavior. *Academy of Management Review, 31,* 396–408.

Klein, K. J., & Sorra, J. S. (1996). The challenge of innovation implementation. *The Academy of Management Review, 21*(4), 1055–1080.

Klein, K. J., Conn, A. B., & Sorra, J. S. (2001). Implementing computerised technology: An organisational analysis. *Journal of Applied Psychology, 86*(5), 811–824.

Krein, S. L., Damschroder, L. J., Kowalski, C. P., Forman, J., Hofer, T. P., & Saint, S. (2010). The influence of organisational context on quality improvement and patient safety efforts in infection prevention: A multicenter qualitative study. *Social Science and Medicine, 71*(9), 1692–1701.

Locock, L., Robert, G., Boaz, A., Vougioukalou, S., Shuldam, C., Fielden, J., Ziebland, S., Gager, M., Tollyfiled, R., & Pearcey, J. (2014). Testing

accelerated experience-based co-design: A qualitative study of using a national archive of patient experience narrative interviews to promote rapid patient-centred service improvement. *Health Services and Delivery Research, 2*(4). doi:10.3310/hsdr02040.

McDermott, A. M., & Keating, M. A. (2012). Making service improvement happen: The importance of social context. *The Journal of Applied Behavioural Science, 48*(1), 62–92.

Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative data analysis and methods sourcebook* (3rd ed.). London: Sage.

Okoli, U., Abdullahi, M. J., Pate, M. A., et al. (2012). Prenatal care and basic emergency obstetric care services provided at primary healthcare facilities in rural Nigeria. *International Journal of Gynecology & Obstetrics, 117*(1), 61–65.

Osungbade, K., Oginni, S., & Olumide, A. (2008). Content of antenatal care services in secondary health care facilities in Nigeria: Implication for quality of maternal health care. *International Journal for Quality in Health Care, 20*(5), 346–351.

Parsons, S., Winterbottom, A., Gross, P., & Redding, D. (2010). *The quality of patient engagement and involvement in primary care*. London: The King's Fund.

Patton, M. Q. (1990). *Qualitative evaluation and research method* (2nd ed.). London: Sage.

Pettigrew, A., Ferlie, E., & McKee, L. (1992). Shaping strategic change—The case of the NHS in the 1980s. *Public Money & Management, 12*(3), 27–31.

Ritchie, J., Lewis, J., Nicholis, C. M., & Ormston, R. (Eds.). (2014). *Qualitative research practice: A guide for social science students & researchers*. London: Sage.

Sheldon, K., & Harding, E. (2010). *Good practice guidelines to support the involvement of service users and carers in clinical psychology services*. Retrieved from http://www.ispraisrael.org.il/Items/00289/Service_user_and_carer_involvement.pdf. Accessed 22 Feb 2016.

Taylor, S. L., Dy, S., Foy, R., Hempel, S., McDonald, K. M., Øvretveit, J., Pronovost, P. J., Rubenstein, L. V., Wachter, R. M. & Shekelle, P. G. (2011). What context features might be important determinants of the effectiveness of patient safety practice interventions? *BMJ Quality & Safety, 20*(7), 611–617.

Urquhart, R., Porter, G. A., Sargeant, J., Jackson, L., & Grundfeld, E. (2014). Multi-level factors influence the implementation and use of complex

innovations in cancer care: A multiple case study of synoptic reporting. *Implementation Science, 9*(1), 121.

Vahdat, S., Hamzehgardeshi, L., Somayeh, H., and Hamzehgardeshi, Z. (2014). Patient involvement in heath care decision making: A review. *Iranian Red Crescent Medical Journal, 16*(1), e12454. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3964421/pdf/ircmj-16-12454.pdf. Accessed 22 Feb 2016.

Weiner, B. J., Lewis, M. A., & Linnan, L. A. (2008). Using organisation theory to understand the determinants of effective implementation of worksite health promotion programmes. *Health Education Research, 24*(2), 292–305.

WHO. (2006). *Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa.* Geneva: World Health Organisation. Retrieved from http://www.who.int/pmnch/media/publications/oanfullreport.pdf. Accessed 31 Mar 2012.

WHO. (2016). *WHO recommendation on antenatal care for a positive pregnancy experience*. Luxembourg: World Health Organisation. Retrieved from: http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf?ua=1. Accessed 01 Jan 2017.

Wiig, S., Storm, M., Aase, K., Gjetsen, M. T., Solheim, M., Harthug, S., Roberts, G., Fulop, N., & QUASER Team. (2014). Investigating the use of patient involvement and patient experience in quality improvement in Norway: Rhetoric or reality? *BMC Health Services Research, 13*, 206. Retrieved from http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-206. Accessed 22 Feb 2016.

Yin, R. K. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.