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Bibliography
Systematic approaches for scale up of best practices

Version 2

A resource of the Community of Practice on Systematic Approaches for Scale up of Family Planning/Reproductive Health Best Practices

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EXPANDNET

Authors

This bibliography was compiled by ExpandNet, a core partner of the Evidence to Action (E2A) Project.

E2A Overview

E2A is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A will continue for eight years until September 2019. E2A is led by Pathfinder International in partnership with ExpandNet, Intrahealth International, Management Sciences for Health (MSH), and PATH.

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Systematic Approaches for Scaling Up:
Bibliography of the Community of Practice, Version 2

Introduction

The bibliography below is a curated selection of key peer-reviewed articles, reports, briefs, and other grey literature that address systematic approaches to scaling up and provides key insights to enhance our understanding of the scale-up process. It constitutes literature of relevance to the discussions of the Community of Practice on Systematic Approaches to Scaling Up. It is neither complete, nor does it represent the results of a formal systematic review on the topic of systematic approaches to scaling up health interventions. Rather, it is a work in progress and will continue to be expanded as additional relevant articles are identified, whether through further literature reviews or through other mechanisms, including suggested articles by members of the Community of Practice.

Several sources were reviewed in the process of building this bibliography. We began by reviewing existing bibliographies relevant to scaling up. These included one developed by the ExpandNet Secretariat available on the ExpandNet website; another developed by the Futures Group Policy Project for the AME Bureau of USAID; FHI360's bibliography on research utilization on the K4Health website; and one entitled "Scaling-Up Health Systems: An Annotated Bibliography," developed in 2007 by Gillespie and colleagues at Johns Hopkins University. In reviewing and identifying papers considered relevant for a bibliography on systematic approaches to scaling up, we also reviewed the selected articles' reference lists and identified additional papers. Additionally, we began a process of more systematically searching published literature, for example, utilizing the POPLINE website. However, these searches produced literally thousands of articles with scaling up in the title or as a key word, but the majority of these articles did not address or describe a systematic process of scaling up or describe in detail the lessons being learned. At the same time, we found many articles that did not contain the term scaling up in their title or abstract, but yet were highly relevant to the topic and should be included. Furthermore, more restrictive search strategies tended to eliminate many articles that we knew to be relevant. Thus, it was necessary to review multiple abstracts and select articles in this bibliography using the following criteria for inclusion/exclusion:

- ***Definitions of scaling up*:** We included articles which dealt with scaling up in the two senses that the word is being used: (1) In the sense of moving from small-scale research, pilot or demonstration to larger-scale implementation, as reflected in the definition "deliberate efforts to increase the impact of health innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy or program development on a lasting basis,"[1] and (2) in the sense of "doing more" or increasing

[1] ExpandNet, World Health Organization. *Practical guidance for scaling up health service innovations*. Geneva, World Health Organization, 2009. (http://whqlibdoc.who.int/publications/2009/9789241598521_eng.pdf and www.expandnet.net/tools.htm)

coverage of health interventions and thus improving health outcomes at the regional, national, or sub-national level without necessarily starting the process with small-scale in-country research, pilot, or demonstration projects. In both cases, our focus has been on papers that address issues related to the process of scaling up rather than the specific content of interventions or the outcomes achieved.

- ***Focus on special issues or components of scaling up:*** In addition, we included articles that focus on specific relevant issues or components of scaling up, for example, on innovative approaches for addressing the human resource challenges, the role of innovation complexity in scaling up, and on monitoring and evaluation needs and methodologies. However, general articles on the importance of implementation research, systems strengthening, or policy that do not specifically address scaling up and in particular the process, were largely excluded.

- ***Focus on low- and middle-income countries:*** Although there is considerable literature on scaling up that discusses case studies from industrialized countries, these references were for the most part excluded at this stage but may be considered for inclusion at a later date.

- ***Main focus on family planning/reproductive health:*** Since the community of practice for which the bibliography was developed is focused on family planning/reproductive health (FP/RH), this bibliography mostly includes articles that deal with scaling up of FP/RH interventions. However, scaling up is predominantly an organizational, managerial, and policy task, and not a narrowly technical one. Thus, we have incorporated a considerable number of non-FP/RH resources because a great deal can be learned about systematic approaches to scale up from this broader literature, where much of the writing on scaling up has taken place.

- ***Timeframe:*** The major emphasis here is on articles produced within the last decade; however, some key articles from earlier are also included, particularly when they continue to be widely cited in recent literature.

For this bibliography's current and second edition, we consulted a recent doctoral graduate who, as part of her doctoral research, produced an extensive list of resources focused on scaling up. She was requested to review her bibliography using the above criteria to propose additions for inclusion, as well as to review all issues of several specific journals over the last ten years for relevant articles. These were Bulletin of the World Health Organization, Global Health Science and Practice, Health Policy and Planning, and Implementation Science. Finally, this edition includes citations derived from consultations with other experts in the fields of public health and scale up.

Note: Citations newly added since the first April 2014 version of this bibliography are marked with an asterisk (*).

Table of Contents

(Click reference below to see abstract and web link in document)

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Author's Summary
Several resources have been developed to assist program implementers with the process of scaling up. However, once scale-up is underway, few resources exist to help ensure continuous and systematic monitoring of the process to track progress toward sustainability of these innovations. This guide is intended to provide governments, donors, country organizations, and implementing partners with a low-cost and replicable approach to monitoring the process of scaling up innovations in health.

*** Appadurai AN, Chaudhury M, Dinshaw A, Ginoya N, McGray H, Rangwala L et al. 2015. Scaling Success: Lessons from Adaptation Pilots in the Rainfed Regions of India. World Resources Institute. Washington DC.**

http://www.wri.org/publication/scalingsuccess

Authors' Executive Summary
As climate change threatens India's food security, adaptation in the agriculture sector is becoming increasingly important. However, for too long, adaptation has been characterized by individual efforts and by small, time-bound pilot projects. Although these projects often have a strong grassroots focus, their capacity to benefit larger populations and to contribute to policy reform is limited (Reid and Huq, 2014).

In India, scaling adaptation is of particular importance in rainfed agricultural areas, where crops depend on monsoon rains. Projections indicate that, without adaptation, climate change will stress rainfed agricultural systems, with potentially significant decreases in yield and a loss in farm-level net revenue of between 9 percent and 25 percent in the South Asia region (Manava and Robert, 2011).

This report aims to accelerate scaling of adaptation in rainfed India by providing a framework to enable project implementers, funding agencies, and policy makers to identify good adaptation practice, determine what is ready to be scaled, and understand the process of scaling and the conditions necessary to support it. The authors applied the framework to twenty-one adaptation projects and conducted four deep dive case studies to assess the scaling potential of adaptation projects in rainfed regions of India.

*** Awoonor-Williams JK, Sory EK, Nyonator FK, Phillips, JF, Wang C, & Schmitt ML. 2013. "Lessons learned from scaling up a community-based health program in the Upper East Region of northern Ghana."** ***Global Health: Science and Practice*****, 1(1), 117-133.**

http://www.ghspjournal.org/content/1/1/117.full.pdf+html

Authors' Abstract

Ghana's Community-Based Health Planning and Service (CHPS) initiative is envisioned to be a national program to relocate primary health care services from subdistrict health centers to convenient community locations. The initiative was launched in 4 phases. First, it was piloted in 3 villages to develop appropriate strategies. Second, the approach was tested in a factorial trial, which showed that community-based care could reduce childhood mortality by half in only 3 years. Then, a replication experiment was launched to clarify appropriate activities for implementing the fourth and final phase—national scale up. This paper discusses CHPS progress in the Upper East Region (UER) of Ghana, where the pace of scale up has been much more rapid than in the other 9 regions of the country despite exceedingly challenging economic, ecological, and social circumstances. The UER employed 5 strategies that facilitated scale up: (1) nurse recruitment from their home districts to improve worker morale and cultural grounding, balanced with some social distance from the village community to ensure client confidentiality, particularly regarding family planning use; (2) prioritization of CHPS planning and continuous review in management meetings to make necessary modifications to the initiative's approach; (3) community engagement and advocacy to local politicians to mobilize resources for financing start-up costs; (4) a shared and consistent vision about CHPS among health administration leaders to ensure appropriate resources and commitment to the initiative; and (5) knowledge exchange visits between new and advanced CHPS implementers to facilitate learning and scale up within and between districts.

*** Baker, E. 2010. "Taking programs to scale: a phased approach to expanding proven interventions."** ***J Public Health Management Practice*****, 2010, 16(3), 264–269**

http://journals.lww.com/jphmp/Fulltext/2010/05000/Taking_Programs_to_Scale__A_Phased_Approach_to.12.aspx

Relevant Paragraphs

Research literature on taking a project to scale has been developed, which draws on a range of program experiences, thus leading to the development of various models for the process. This monograph identifies the critical success factors at various stages of program replication and provides insights that may be useful to those seeking to take programs to scale.

Previous research and experience on taking programs to scale has identified five phases that should occur sequentially. At each phase of the process, the implementation team must make a conscious decision about the advisability of moving on to the next stage

based on the outcome of the previous stage. The five phases, which are discussed in detail below, are:

1. preexploration
2. exploration
3. installation
4. initial program implementation, and
5. ongoing program operations

Throughout this phased approach, care must be taken to ensure that replication activities are well thought out and the conditions for successful replication are carefully examined. As a result of this careful examination, a "go-no-go" decision should be made following the exploration phase to avoid proceeding ahead on the basis of "wishful thinking." Further, this phased approach provides for greater clarity of roles and responsibilities as the process unfolds. Finally, this approach allows for progressive development of relationships that are central to effective partnerships in taking programs to scale. A few examples may help to illustrate this approach.

*** Bangser M. A Funder's Guide to Using Evidence of Program Effectiveness in Scale-up Decisions. 2014.**

http://www.mdrc.org/sites/default/files/GPN_FR.pdf

Relevant Paragraphs

This Guide provides funders with practical advice on how to think about and use evidence of effectiveness when considering investments in scale-up opportunities. The Guide does not seek to turn private funders into evaluation experts or to delve into the methodological details of particular research approaches. Rather, the focus is on the right questions that funders should ask and the pitfalls they should avoid, including how to recognize the limitations of certain kinds of evidence.

The Guide is divided into three sections: Section I, Eight Key Questions to Ask Throughout the Scale-Up Process, presents what funders should look for to determine whether programs are effective. These questions provide the building blocks for the discussion in the following section. Section II, Application of the Eight Questions to Scale-Up Decisions, shows how the questions apply to the different stages of a program's evidence-building and scale-up. Section III, Next Steps for the Field, highlights some remaining challenges for the field to consider in using evidence of effectiveness to guide scale-up decisions.

The stages of scale-up used in this Guide (early → developing; developing → promising; promising → effective; effective → scaling) are depicted in Tables 1 through 4 (on pages 17 to 20) and in the Appendix. The accompanying text includes suggestions for (1) what the focus of evaluation efforts should be at each stage; (2) how funders can help; and (3) what's needed for the program to move to the next stage of growth. This should help funders to integrate evidence-building into their strategic grant-making process, while recognizing that other factors

(such as a grantee's business planning and ability to raise capital) will also influence the prospects for effective scale-up. There are times when scaleup can proceed more quickly and might not require the same level of evidence described in this Guide; however, funders should carefully consider the risks and uncertainties associated with making decisions with more limited evidence.

*** Bao, J., Rodriguez, D. C., Paina, L., Ozawa, S., & Bennett, S. 2015. "Monitoring and Evaluating the Transition of Large-Scale Programs in Global Health."** ***Global Health: Science and Practice*****, 3(4), 591-605.**

http://www.ghspjournal.org/content/3/4/591.full.pdf+html

Authors' Abstract

Purpose: Donors are increasingly interested in the transition and sustainability of global health programs as priorities shift and external funding declines. Systematic and high-quality monitoring and evaluation (M&E) of such processes is rare. We propose a framework and related guiding questions to systematize the M&E of global health program transitions.

Methods: We conducted stakeholder interviews, searched the peer-reviewed and gray literature, gathered feedback from key informants, and reflected on author experiences to build a framework on M&E of transition and to develop guiding questions.

Findings: The conceptual framework models transition as a process spanning pre-transition and transition itself and extending into sustained services and outcomes. Key transition domains include leadership, financing, programming, and service delivery, and relevant activities that drive the transition in these domains forward include sustaining a supportive policy environment, creating financial sustainability, developing local stakeholder capacity, communicating to all stakeholders, and aligning programs. Ideally transition monitoring would begin prior to transition processes being implemented and continue for some time after transition has been completed. As no set of indicators will be applicable across all types of health program transitions, we instead propose guiding questions and illustrative quantitative and qualitative indicators to be considered and adapted based on the transition domains identified as most important to the particular health program transition. The M&E of transition faces new and unique challenges, requiring measuring constructs to which evaluators may not be accustomed. Many domains hinge on measuring "intangibles" such as the management of relationships. Monitoring these constructs may require a compromise between rigorous data collection and the involvement of key stakeholders.

Conclusion: Monitoring and evaluating transitions in global health programs can bring conceptual clarity to the transition process, provide a mechanism for accountability, facilitate engagement with local stakeholders, and inform the management of transition through learning. Further investment and stronger methodological work are needed.

*** Barker PM, Reid A, Schall MW. 2016. "A framework for scaling up health interventions: lessons from large-scale improvement initiatives in Africa."** ***Implementation Science*****, 11:12**

Authors' Abstract

Background: Scaling up complex health interventions to large populations is not a straightforward task. Without intentional, guided efforts to scale up, it can take many years for a new evidence-based intervention to be broadly implemented. For the past decade, researchers and implementers have developed models of scale-up that move beyond earlier paradigms that assumed ideas and practices would successfully spread through a combination of publication, policy, training, and example. Drawing from the previously reported frameworks for scaling up health interventions and our experience in the USA and abroad, we describe a framework for taking health interventions to full scale, and we use two large-scale improvement initiatives in Africa to illustrate the framework in action. We first identified other scale-up approaches for comparison and analysis of common constructs by searching for systematic reviews of scale-up in health care, reviewing those bibliographies, speaking with experts, and reviewing common research databases (PubMed, Google Scholar) for papers in English from peer-reviewed and "gray" sources that discussed models, frameworks, or theories for scale-up from 2000 to 2014. We then analyzed the results of this external review in the context of the models and frameworks developed over the past 20 years by Associates in Process Improvement (API) and the Institute for Healthcare improvement (IHI). Finally, we reflected on two national-scale improvement initiatives that IHI had undertaken in Ghana and South Africa that were testing grounds for early iterations of the framework presented in this paper.

Results: The framework describes three core components: a sequence of activities that are required to get a program of work to full scale, the mechanisms that are required to facilitate the adoption of interventions, and the underlying factors and support systems required for successful scale-up. The four steps in the sequence include (1) Set-up, which prepares the ground for introduction and testing of the intervention that will be taken to full scale; (2) Develop the Scalable Unit, which is an early testing phase; (3) Test of Scale-up, which then tests the intervention in a variety of settings that are likely to represent different contexts that will be encountered at full scale; and (4) Go to Full Scale, which unfolds rapidly to enable a larger number of sites or divisions to adopt and/or replicate the intervention.

Conclusions: Our framework echoes, amplifies, and systematizes the three dominant themes that occur to varying extents in a number of existing scale-up frameworks. We call out the crucial importance of defining a scalable unit of organization. If a scalable unit can be defined, and successful results achieved by implementing an intervention in this unit without major addition of resources, it is more likely that the intervention can be fully and rapidly scaled. When tying this framework to quality improvement (QI) methods, we describe a range of methodological options that can be applied to each of the four steps in the framework's sequence.

*** Basri C, Bergstrom K, Walton W, et al. 2009. "Sustainable scaling up of good quality health worker education for tuberculosis control in Indonesia: a case study." *Human resources for health*, 7:85.**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2785746/pdf/1478-4491-7-85.pdf

Authors' Abstract

Background: In 2000, an external review mission of the National Tuberculosis Control Programme of Indonesia identified suboptimal results of TB control activities. This led to a prioritization on human resource capacity building representing a major shift in the approach following the recommendations of the external review team.

Case description: The National Tuberculosis Control Programme (NTP) used a systematic process to develop and implement two strategic action plans focussing on competence development based on specific job descriptions. The approach was a change from only focusing on training, to a broader, long term approach to human resource development for comprehensive TB control.

A structured plan for capacity building, including standardized competency based training modules and curricula, was developed in the first phase. This was supported by an organisational system comprised of a training focal point, master trainers, and regional training centres in which nationwide training of supervisors was implemented. Training was expanded to the health service delivery level in the second phase, as well as broadened in the scope of activities beyond training to also include other aspects of human resource development.

Discussion and evaluation: The result was improved technical and managerial capacity of health workers for TB control at all levels. The impact on case detection and treatment outcome was spectacular, with major improvements in quality of all aspects of service delivery.

Conclusion: The strategic decision by the NTP in 2000 to put the highest priority on capacity building has resulted in impressive progress towards TB control targets, a progress that despite many challenges has been sustained.

*** Bellows B, Nambao M, Jaramillo L, Fanaiayan R, Dennis M, and Hardee K. 2016. "Scaling Up Family Planning in Zambia – Part 1: Assessment and Feasibility of Maintaining and Innovative Program," Research Report. Washington, DC: Population Council, The Evidence Project.**

http://evidenceproject.popcouncil.org/wp-content/uploads/2016/08/Zambia-SUFP-Report-Part-1.pdf

Authors' Executive Summary Results

Rather than scale up a new innovation, the core approach of SUFP was to work within the existing health system and family planning program to strengthen supply of and demand for

family planning. SUFP did not provide FP services, but focused on improving demand for and supply of services provided by the public sector. SUFP focused on several important aspects of decentralizing and integrating FP service delivery into the public sector health system at district, facility, and community levels, with an emphasis on reaching poor and underserved women and adolescents.

The findings from the qualitative assessment show that respondents had a positive view of the contribution of SUFP and its engagement with the health system in Zambia. SUFP has been successful in scaling up increased access to FP commodities and services in the 26 districts reached under the project and emphasizing the importance of FP within the selected communities. This report highlights the respondents' perceptions of the implementation of the overall SUFP program, including the Camping Approach, and their suggestions for moving the approach forward at the close of the project. While SUFP was widely viewed by respondents as successful in expanding access to FP and in strengthening services, they noted barriers to FP service delivery that generalize beyond SUFP and remain features of the health system that policymakers, researchers, and service providers need to be aware of when working to scale up family planning services.

Together with the Part 2 of the study (Collins et al., 2016), these recommendations provide vital information for the government and donors to develop programming to continue the advances made under SUFP and to expand the approach to reach more districts in order to reach the country's FP2020 goal. Recommendations from respondents are organized under the themes of the six health systems building blocks, and demand.

*** Bergh A, Allanson E, Pattinson R. 2015. "What is needed for taking emergency obstetric and neonatal programmes to scale?" *Best Pract Res Clin Obstet Gynaecol*., 29(8):1017-27.**

https://www.researchgate.net/publication/275661952_What_is_needed_for_taking_emergency_obstetric_and_neonatal_programmes_to_scale

Authors' Abstract

Scaling up an emergency obstetric and neonatal care (EmONC) programme entails reaching a larger number of people in a potentially broader geographical area. Multiple strategies requiring simultaneous attention should be deployed. This paper provides a framework for understanding the implementation, scale-up and sustainability of such programmes. We reviewed the existing literature and drew on our experience in scaling up the Essential Steps in the Management of Obstetric Emergencies (ESMOE) programme in South Africa. We explore the non-linear change process and conditions to be met for taking an existing EmONC programme to scale. Important concepts cutting across all components of a programme are equity, quality and leadership. Conditions to be met include appropriate awareness across the board and a policy environment that leads to the following: commitment, health systems-strengthening actions, allocation of resources (human, financial and capital/material), dissemination and training, supportive supervision and monitoring and evaluation.

Berwick DM. 2004. "Lessons from developing nations on improving health care," *BMJ,* 328:1124-1129.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC406330/

Author's Introductory Paragraphs
Improvement is, I believe, an inborn human endeavour. My belief arises mostly from watching children. You cannot find a healthy child who does not try to jump higher or run faster. It takes no outside incentive. Children smile when they succeed; they smile to themselves. And so, it is my premise that almost all human organizations contain in their workforce an internal demand to improve their work. It saddens me how few organizations seem to know that, and fewer still act on it. Improvement is not forcing something; it is releasing something.

Nevertheless, improving organizations is not easy. The barriers are many, and those barriers can produce a sense of helplessness and futility. Failing to improve, we feel unfortunate and wish that someone, somewhere, would give us that extra missing resource that we imagine would make change possible. "We want to make care better," goes the complaint, "but they won't let us."

It might help us in the wealthy world to pause for a moment and reflect not on what we lack but on our good fortune. And the best way to do that is to look at those with less in their hands. In the past few years, I have been fortunate to do some work in resource poor countries, which have 90% of the people but only 10% of the world's wealth. My work in these settings has convinced me not only that it is possible to improve health care in resource poor settings but also that improvement may even be more feasible than it is in wealthy ones. Two remarkable projects in progress in the developing world show the tremendous resourcefulness, innovation, and potential for improvement in that resource constrained context, with potentially important lessons for caregivers in richer places.

*** Bhandari N, Kabir AKMI, and Salam MA. 2008. "Mainstreaming nutrition into maternal and child health programmes: scaling up of exclusive breastfeeding." *Maternal and Child Nutrition*, 4, 5-23.**

https://www.researchgate.net/profile/Nita_Bhandari/publication/5563335_Mainstreaming_nutrition_into_maternal_and_child_health_programmes_scaling_up_of_exclusive_breastfeeding/links/54364b3e0cf2bf1f1f2b6c24.pdf

Authors' Abstract
Interventions to promote exclusive breastfeeding have been estimated to have the potential to prevent 13% of all under-5 deaths in developing countries and are the single most important preventive intervention against child mortality. According to World Health Organization and

United Nations Children Funds (UNICEF), only 39% infants are exclusively breastfed for less than 4 months. This review examines programme efforts to scale up exclusive breastfeeding in different countries and draws lesson for successful scale-up. Opportunities and challenges in scaling up of exclusive breastfeeding into Maternal and Child Health programmes are identified. The key processes required for exclusive breastfeeding scale-up are: (1) an evidence-based policy and science-driven technical guidelines; and (2) an implementation strategy and plan for achieving high exclusive breastfeeding rates in all strata of society, on a sustainable basis. Factors related to success include political will, strong advocacy, enabling policies, well-defined short and long-term programme strategy, sustained financial support, clear definition of roles of multiple stakeholders and emphasis on delivery at the community level. Effective use of antenatal, birth and post-natal contacts at homes and through community mobilization efforts is emphasized. Formative research to ensure appropriate intervention design and delivery is critical particularly in areas with high HIV prevalence. Strong communication strategy and support, quality trainers and training contributed significantly to programme success. Monitoring and evaluation with feedback systems that allow for periodic programme corrections and continued innovation are central to very high coverage. Legal framework must make it possible for mothers to exclusively breastfeed for at least 4 months. Sustained programme efforts are critical to achieve high coverage and this requires strong national- and state-level leadership.

Billings DL, Crane BB, Benson J et al. 2007. "Scaling-up a public health innovation: A comparative study of post-abortion care in Bolivia and Mexico," *Social Science & Medicine,* 64:2210-2222.

http://www.ipas.org/~/media/Files/Ipas%20Publications/BillingsSSM2007.ashx

Authors' Abstract

Post-abortion care (PAC), an innovation for treating women with complications of unsafe abortion, has been introduced in public health systems around the world since the 1994 International Conference on Population and Development (ICPD). This article analyzes the process of scaling up two of the three key elements of the original PAC model: providing prompt clinical treatment to women with abortion complications and offering post-abortion contraceptive counseling and methods in Bolivia and Mexico. The conceptual framework developed from this comparative analysis includes the environmental context for PAC scale-up; the major influences on start-up, expansion, and institutionalization of PAC; and the health, financial, and social impacts of institutionalization. Startup in both Bolivia and Mexico was facilitated by innovative leaders or catalyzers who were committed to introducing PAC services into public health care settings, collaboration between international organizations and public health institutions, and financial resources. Important processes for successful PAC expansion included strengthening political commitment to PAC services through research, advocacy, and partnerships; improving health system capacity through training, supervision, and development of service guidelines; and facilitating health system access to essential technologies. Institutionalization of PAC has been more successful in Bolivia than Mexico, as measured by a series of proposed indicators. The positive health and financial impacts of PAC

institutionalization have been partially measured in Bolivia and Mexico. Other hypotheses—that scaling-up PAC will significantly reduce maternal mortality and morbidity, decrease abortion-related stigma, and prepare the way for efforts to reform restrictive abortion laws and policies—have yet to be tested. *Accessed online 6.2.13*

*** Binagwaho A, Wagner CM, Gatera M. et al. 2012. "Achieving high coverage in Rwanda's national human papillomavirus vaccination programme."** ***Bull World Health Organ*****, 90, 623–628. doi:10.2471/BLT.11.097253**

http://www.who.int/bulletin/volumes/90/8/11-097253/en/

Author's Abstract

Problem: Virtually all women who have cervical cancer are infected with the human papillomavirus (HPV). Of the 275 000 women who die from cervical cancer every year, 88% live in developing countries. Two vaccines against the HPV have been approved. However, vaccine implementation in low-income countries tends to lag behind implementation in high-income countries by 15 to 20 years.

Approach: In 2011, Rwanda's Ministry of Health partnered with Merck to offer the Gardasil HPV vaccine to all girls of appropriate age. The Ministry formed a "public–private community partnership" to ensure effective and equitable delivery.

Local setting: Thanks to a strong national focus on health systems strengthening, more than 90% of all Rwandan infants aged 12–23 months receive all basic immunizations recommended by the World Health Organization.

Relevant changes: In 2011, Rwanda's HPV vaccination programme achieved 93.23% coverage after the first three-dose course of vaccination among girls in grade six. This was made possible through school-based vaccination and community involvement in identifying girls absent from or not enrolled in school. A nationwide sensitization campaign preceded delivery of the first dose.

Lessons learnt: Through a series of innovative partnerships, Rwanda reduced the historical two-decade gap in vaccine introduction between high- and low-income countries to just five years. High coverage rates were achieved due to a delivery strategy that built on Rwanda's strong vaccination system and human resources framework. Following the GAVI Alliance's decision to begin financing HPV vaccination, Rwanda's example should motivate other countries to explore universal HPV vaccine coverage, although implementation must be tailored to the local context.

Bitar S. 2011. "Increasing HTSP knowledge and postpartum contraceptive use among the urban poor: Scaling-up best practices in Nepal," Best Practices Brief No. 4. Washington DC: Extending Service Delivery Project, Pathfinder International.

http://www.google.com/url?q=http://www.esdproj.org/site/DocServer/ESD_Legacy_NTAG_Nepal_Brief_6-3-11_v1.pdf%3FdocID%3D4121&sa=U&ei=P_v_UYHROISMyAGC8oCAAQ&ved=0CBgQFjAA&sig2=E42NFBou0p0v2763nBsUrA&usg=AFQjCNEweV3gmcfJMLcvLwE142ju-I9sfw

Author's Abstract
This paper shows how the ESD Project – an international leader in scaling up best practices in reproductive health and family planning – helped the Nepali Technical Assistance Group (NTAG) deliver birth spacing messages, increase Lactational Amenhorrea Method use, and improve knowledge of postpartum contraception in Kathmandu Metropolitan City and Surkhet Municipality. As a result of this successful low-cost intervention, NTAG expanded its program to ten additional sites with a renewed emphasis on community and municipal level engagement.

*** Bornstein T. 2011. "The Improvement Collaborative in Yemen: A scale-up approach for expanding access to postpartum maternal and newborn care and family planning: Scaling-up best practices in Yemen." Washington DC: Extending Service Delivery Project, Pathfinder International.**

http://www.esdproj.org/site/DocServer/ESD_Legacy_Improvement_Collaborative_Yemen_Brief_7-13-11.pdf?docID=4181

Author's Introductory Paragraph
This paper shows how the Extending Service Delivery Project – a global leader in family planning – is scaling-up best practices in reproductive health and family planning in partnership with the Yemen Ministry of Public Health and Population, using an approach that combines traditional interventions and quality improvement with a shared learning methodology.

Bradley EH, Curry L, Pérez-Escamilla R et al. 2011. "Dissemination, diffusion and scale up of family health innovations in low-income countries" – Abridged. Yale Global Health Leadership Institute, New Haven.

http://docs.gatesfoundation.org/global-health/documents/yale-global-health-report.pdf
Executive Summary
In this report, we present the AIDED model for guiding dissemination, diffusion, and scale-up of family health innovations in low-income countries. The model was developed using in-depth interviews with experts and practitioners, a systematic review of peer-reviewed and

gray literature, and pressure testing with multiple audiences. The AIDED model posits five interrelated components to the complex process of scale-up: 1) assess, 2) innovate, 3) develop, 4) engage, and 5) devolve. We identify key activities in the five components that have been linked to successful scale-up efforts of selected family health innovations: Depo-Provera, exclusive breastfeeding, community health worker approaches, and social marketing.

The model represents scale-up as a complex adaptive system in which the several interlocking parts interact in diverse and sometimes unpredictable ways. Nonetheless, the in depth interviews and literature synthesis suggests important patterns that are prominent in successful scale-up efforts and less apparent in failed efforts. These include explicit, early investment in assessment of community receptivity to the innovation and of the key environmental forces that may promote or limit scale up; tailoring of the innovation to fit target user groups; development of political, regulatory, socio-cultural, and economic support for the use of the innovation in target user groups; deep engagement with target user groups to ensure that the innovation is translated, integrated, and replicated effectively; and devolving of efforts to spread the innovation from the index user groups to additional sets of user groups often through social and professional networks and relationships. We found only limited evidence for differences in effective scale-up approaches across the different innovation types.

Bradley EH, Curry LA, Taylor LA et al. 2012. "A model for scale up of family health innovations in low-income and middle-income settings: A mixed methods study," *BMJ Open,* Aug 24;2(4).

http://www.ncbi.nlm.nih.gov/pubmed/22923624 (click on free PMC article)

Authors' Abstract
Background: Many family health innovations that have been shown to be both efficacious and cost effective fail to scale up for widespread use, particularly in low-income and middle-income countries (LMIC). Although individual cases of successful scale-up, in which widespread take up occurs, have been described, we lack an integrated and practical model of scale-up that may be applicable to a wide range of public health innovations in LMIC. OBJECTIVE: To develop an integrated and practical model of scale-up that synthesise experiences of family health programmes in LMICs.

Data sources: We conducted a mixed methods study that included in-depth interviews with 33 key informants and a systematic review of peer-reviewed and grey literature from 11 electronic databases and 20 global health agency web sites.

Study eligibility, criteria, participants, and interventions: We included key informants and studies that reported on the scale up of several family health innovations including Depo-Provera as an example of a product innovation, exclusive breastfeeding as an example of a health behaviour innovation, community health workers as an example of an organisational innovation and social marketing as an example of a business model innovation. Key informants

were drawn from non-governmental, government and international organisations using snowball sampling. An article was excluded if the article: did not meet the study's definition of the innovation; did not address dissemination, diffusion, scale up or sustainability of the innovation; did not address low-income or middle-income countries; was superficial in its discussion and/or did not provide empirical evidence about scale-up of the innovation; was not available online in full text; or was not available in English, French, Spanish, or Portuguese, resulting in a final sample of 41 peer-reviewed articles and 30 grey literature sources.

Study appraisal and synthesis methods: We used the constant comparative method of qualitative data analysis to extract recurrent themes from the interviews, and we integrated these themes with findings from the literature review to generate the proposed model of scale-up. For the systematic review, screening was conducted independently by two team members to ensure consistent application of the predetermined exclusion criteria. Data extraction from the final sample of peer-reviewed and grey literature was conducted independently by two team members using a pre-established data extraction form to list the enabling factors and barriers to dissemination, diffusion, scale up and sustainability.

Results: The resulting model-the AIDED model-includes five non-linear, interrelated components: (1) assess the landscape, (2) innovate to fit user receptivity, (3) develop support, (4) engage user groups and (5) devolve efforts for spreading innovation. Our findings suggest that successful scale-up occurs within a complex adaptive system, characterised by interdependent parts, multiple feedback loops and several potential paths to achieve intended outcomes. Failure to scale up may be attributable to insufficient assessment of user groups in context, lack of fit of the innovation with user receptivity, inability to address resistance from stakeholders and inadequate engagement with user groups.

Limitations: The inductive approach used to construct the AIDED model did not allow for simultaneous empirical testing of the model. Furthermore, the literature may have publication bias in which negative studies are under-represented, although we did find examples of unsuccessful scale-up. Last, the AIDED model did not address long-term, sustained use of innovations that are successfully scaled up, which would require longer-term follow-up than is common in the literature.

Conclusions and implications of key findings: Flexible strategies of assessment, innovation, development, engagement and devolution are required to enable effective change in the use of family health innovations in LMIC.

Brady M. 2011. "Taking programs for vulnerable adolescents to scale: Experiences, insights, and evidence promoting healthy, safe, and productive transitions to adulthood," Brief no. 36, Population Council, New York.

http://www.popcouncil.org/pdfs/TABriefs/36_ScaleUp.pdf
No abstract or summary

Brugha R, Simbaya J, Walsh A et al. 2010. "How HIV/AIDS scale-up has impacted on non- HIV priority services in Zambia," *BMC Public Health*, 10:540.

http://www.biomedcentral.com/content/pdf/1471-2458-10-540.pdf

Authors' Abstract
Background: Much of the debate as to whether or not the scaling up of HIV service delivery in Africa benefits non-HIV priority services has focused on the use of nationally aggregated data. This paper analyses and presents routine health facility record data to show trend correlations across priority services.
Methods: Review of district office and health facility client records for 39 health facilities in three districts of Zambia, covering four consecutive years (2004-07). Intra-facility analyses were conducted, service and coverage trends assessed and rank correlations between services measured to compare service trends within facilities.
Results: VCT, ART and PMTCT client numbers and coverage levels increased rapidly. There were some strong positive correlations in trends within facilities between reproductive health services (family planning and antenatal care) and ART and PMTCT, with Spearman rank correlations ranging from 0.33 to 0.83. Childhood immunization coverage also increased. Stock-outs of important drugs for non-HIV priority services were significantly more frequent than were stock-outs of antiretroviral drugs.
Conclusions: The analysis shows scale-up in reproductive health service numbers in the same facilities where HIV services were scaling up. While district childhood immunizations increased overall, this did not necessarily occur in facility catchment areas where HIV service scale-up occurred. The paper demonstrates an approach for comparing correlation trends across different services, using routine health facility information. Larger samples and explanatory studies are needed to understand the client, facility and health systems factors that contribute to positive and negative synergies between priority services.

*** Bryce J, Victora CG, and MCE-IMCI Techanical Advisors. 2005. "Ten methodological lessons from the multi-country evaluation of integrated Management of Childhood Illness." *Health Policy and Planning, 20 Suppl 1*, i94-i105**

http://heapol.oxfordjournals.org/content/20/suppl_1/i94.full.pdf+html

Authors' Abstract
Objective: To describe key methodological aspects of the Multi-Country Evaluation of the Integrated Management of Childhood Illness strategy (MCE-IMCI) and analyze their implications for other public health impact evaluations.

Design: The MCE-IMCI evaluation designs are based on an impact model that defined expectations in the late 1990s about how IMCI would be implemented at country level and below, and the outcomes and impact it would have on child health and survival. MCE-IMCI studies include: feasibility assessments documenting IMCI implementation in 12 countries; in-depth studies using compatible designs in five countries; and cross-site analyses addressing the

effectiveness of specific subsets of IMCI activities. The MCE-IMCI was designed to evaluate the impact of IMCI, and also to see that the findings from the evaluation were taken up through formal feedback sessions at national, sub-national and local levels.

Results: Issues that arose early in the MCE-IMCI included: (1) defining the scope of the evaluation; (2) selecting study sites and developing research designs; (3) protecting objectivity; and (4) developing an impact model. Issues that arose mid-course included: (5) anticipating and addressing problems with external validity; (6) ensuring an appropriate time frame for the full evaluation cycle; (7) providing feedback on results to policymakers and programme implementers; and (8) modifying site-specific designs in response to early findings about the patterns and pace of programme implementation. Two critical issues could best be addressed only near the close of the evaluation: (9) factors affecting the uptake of evaluation results by policymakers and programme decision makers; and (10) the costs of the evaluation. *Conclusions*: Large-scale effectiveness evaluations present challenges that have not been addressed fully in the methodological literature. Although some of these challenges are context-specific, there are important lessons from the MCE that can inform future designs. Most of the issues described here are not addressed explicitly in research reports or evaluation textbooks. Describing and analyzing these experiences is one way to promote improved impact evaluations of new global health strategies.

*** Bryce J, Victora CG, Boerma T, Peters DH, and Black RE. 2011. "Evaluating the scale-up for maternal and child survival: a common framework."** ***Int. Health,*** **3 (3): 139-146**

https://www.researchgate.net/profile/David_Peters15/publication/256612446_Evaluating_the_scale-up_for_maternal_and_child_survival_A_common_framework/links/55468b700cf24107d397ed31.pdf

Authors' Abstract

Programs to reduce mortality among women and children are the target of new resources and redoubled commitment as the 2015 date for achieving the Millennium Development Goals approaches. The need for a common evaluation framework to guide the collection, analysis and synthesis of evidence is increasingly evident. This paper presents such a framework in four parts: (1) a conceptual model for the scale-up to MDGs 4 and 5 for maternal and child survival; (2) recommended indicators for each part of the model that bring together the work of various existing technical groups and prioritize a limited number of indicators for standardization and common use; (3) guidelines for documenting program implementation and contextual factors that may affect program implementation and its effectiveness in reducing maternal and child mortality; and (4) design considerations in evaluating the scale-up. We first present an overview of what is known and/or agreed upon within each of these areas, and in the discussion highlight areas of uncertainty or where there are gaps to be addressed.

*** Centre for Epidemiology and Evidence. Milat AJ, Newson R, and King L. Increasing the scale of population health interventions: A guide. Evidence and Evaluation Guidance Series, Population and Public Health Division. Sydney: NSW Ministry of Health, 2014.**

http://www.health.nsw.gov.au/research/Publications/scalability-guide.pdf

Relevant Paragraphs

The guide describes a 4-step process for scaling up interventions. Step 1 is to complete a scalability assessment to assess the suitability of the intervention or interventions for scaling up. The outcome of this assessment will determine whether the remaining steps in the guide should be followed. Step 2 describes how to develop a scaling up plan which should create a vision of what scaling up will look like and a compelling case for action. Step 3 describes how to prepare for scaling up by securing resources and building a foundation of legitimacy and support for the scaling up plan. Finally, Step 4 describes some of the main tasks that should be addressed during scaling up.

The guide is written in a linear way, as if the user is starting from the point of assessing the scalability of an intervention. However, the entry point for each user may vary. For example, the latter steps in the guide could be used by those already involved in scaling up interventions to reflect on and review their current implementation processes. It may also be necessary for all users to revisit earlier steps in the process to find solutions to problems that arise during scaling up. At each step in the process the project team will be required to make decisions that are not always clear cut; some judgement on the part of the project team is required. These decisions may result in revisions to the scaling up process and changes in direction over time. It may also be necessary to discontinue the scaling up process if a way forward cannot be found, or desired outcomes are not being achieved. If such a decision is made, an exit strategy should be implemented that includes management of likely risks for all key stakeholders. Ultimately, scaling up is a significant process that requires time and resources to ensure that it is managed successfully.

The guide has grown out of experience in the field of population health and as such is written from a population health perspective; however, the core concepts within the guide could be applied to other human service endeavours. It is designed to be used by health practitioners, policy makers, and others with responsibility for scaling up evidence-based population health interventions. It has been written primarily for use within the public sector in high resource environments but could also be used by non-government organisations tasked with such processes.

The guide may also be useful to researchers. For example, the scalability assessment may assist researchers to design research studies that are potentially suitable for scaling up, particularly in circumstances where research-practice collaborations are encouraged. Step 1 could also be used to identify research gaps, and guide researchers towards seeking funding to How to use this guide address such scalability information gaps. Similarly, this guide may be used to assist

researchers to present intervention research findings, so the information necessary for health practitioners and policy makers to assess the scalability of an intervention is available. In addition, the later stages of the guide can be used by researchers to identify opportunities for partnering in evaluation and monitoring efforts when interventions are scaled up.

*** Chambers, DA and Norton WE. 2016. "The Adaptome: advancing the science of intervention adaptation."Am J Prev Med. (In press).**

http://dx.doi.org/10.1016/j.amepre.2016.05.011

Authors' Abstract

In the past few decades, prevention scientists have developed and tested a range of interventions with demonstrated benefits on child and adolescent cognitive, affective, and behavioral health. These evidence-based interventions offer promise of population-level benefit if accompanied by findings of implementation science to facilitate adoption, widespread implementation, and sustainment. Though there have been notable examples of successful efforts to scale up interventions, more work is needed to optimize benefit. Although the traditional pathway from intervention development and testing to implementation has served the research community well—allowing for a systematic advance of evidence-based interventions that appear ready for implementation—progress has been limited by maintaining the hypothesis that evidence generation must be complete prior to implementation. This sets up the challenging dichotomy between fidelity and adaptation and limits the science of adaptation to findings from randomized trials of adapted interventions. The field can do better. This paper argues for the development of strategies to advance the science of adaptation in the context of implementation that would more comprehensively describe the needed fit between interventions and their settings, and embrace opportunities for ongoing learning about optimal intervention delivery over time. Efforts to build the resulting *adaptome*(pronounced "adapt-ohm") will include the construction of a common data platform to house systematically captured information about variations in delivery of evidence-based interventions across multiple populations and contexts, and provide feedback to intervention developers, as well as the implementation research and practice communities. Finally, the article identifies next steps to jumpstart adaptome data platform development.

Chandy L, Linn JF. 2011. "Taking development activities to scale in fragile and low capacity environments," Global Economy & Development Working Paper 41, The Brookings Institution, Washington, DC.

http://www.brookings.edu/~/media/research/files/papers/2011/9/development%20activities%20chandy%20linn/scaling%20up%20fragile%20states.pdf

Executive Summary
Fragile states present one of the greatest challenges to global development and poverty reduction. Despite much new learning that has emerged from within the development community in recent years, understanding of how to address fragility remains modest. There is growing recognition that donor engagement in fragile states must look beyond the confines of the traditional aid effectiveness agenda if it is to achieve its intended objectives, which include state building, meeting the needs of citizens, and managing risk more effectively. Current approaches are constrained by relying heavily on small-scale interventions, are weakened by poor coordination and volatility, and struggle to promote an appropriate role for the recipient state.

Chandra-Mouli V, Baltag V, Ogbaselassie L 2013. "Strategies to sustain and scale up youth friendly health services in the Republic of Moldova," *BMC Public Health*, 13:284.

http://www.biomedcentral.com/content/pdf/1471-2458-13-284.pdf

Authors' Abstract
As part of a multifaceted effort to respond to the needs of young people more effectively, the Ministry of Health of the Republic of Moldova established pilot Youth Friendly Health Centres (YFHC) in 2001. In 2005, after 12 YFHC were set up and implemented, the MOH identified that while they were serving a useful function, four problems remained needed to be addressed - the lack of an operational definition of the term youth friendly health services, the lack of objective data on the added value of the existing YFHC, the low coverage of the existing YFHC and the almost complete reliance on donor agencies for funding the effort. The MOH addressed each of these problems systematically. While challenges still exist, the MOH has taken important steps to ensure that all young people in the country can obtain the health services they need.

*** Chandra-Mouli V, Mapella E, John T, et al. 2013. « Standardizing and scaling up quality adolescent friendly health services in Tanzania." *BMC Public Health*, 13(1), 1.**

http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-579

Authors' Abstract
Background: Adolescents in Tanzania require health services that respond to their sexual and reproductive health – and other – needs and are delivered in a friendly and nonjudgemental manner. Systematizing and expanding the reach of quality adolescent friendly health service provision is part of the Tanzanian Ministry of Health and Social Welfare's (MOHSW) multi-component strategy to promote and safeguard the health of adolescents.

Objective: We set out to identify the progress made by the MOHSW in achieving the objective it had set in its National Adolescent Health and Development Strategy: 2002–2006, to systematize and extend the reach of Adolescent Friendly Health Services (AFHS) in the country.

Methods: We reviewed plans and reports from the MOHSW and journal articles on AFHS. This was supplemented with several of the authors' experiences of working to make health services in Tanzania adolescent friendly.

Results: The MOHSW identified four key problems with what was being done to make health services adolescent friendly in the country – firstly, it was not fully aware of the various efforts under way; secondly, there was no standardized definition of AFHS; thirdly, it had received reports that the quality of the AFHS being provided by some organizations was poor; and fourthly, only small numbers of adolescents were being reached by the efforts that were under way. The MOHSW responded to these problems by mapping existing services, developing a standardized definition of AFHS, charting out what needed to be done to improve their quality and expand their coverage, and integrating AFHS within wider policy and strategy documents and programmatic measurement instruments. It has also taken important preparatory steps to stimulate and support implementation.

Conclusion: The MOHSW is aware that the focus of the effort must now shift from the national to the regional, council and local levels. The onus is on regional and council health management teams as well as health facility managers to take the steps needed to ensure that all adolescents in the country obtain the sexual and reproductive health (SRH) services they need, delivered in a friendly and non-judgemental manner. But they cannot do this without substantial and ongoing support.

*** Chau K, Seck AT, Chandra-Mouli V, Svanemyr J. 2016. "Scaling up sexuality education in Senegal: integrating family life education into the national curriculum," *Sex Education*, 16:5, 503-519**

http://dx.doi.org/10.1080/14681811.2015.1123148

Authors' Abstract

In Senegal, school-based sexuality education has evolved over 20 years from family life education (FLE) pilot projects into cross-curricular subjects located within the national curriculum of primary and secondary schools. We conducted a literature review and semi-structured interviews to gather information regarding the scale and nature of FLE scale-up. Data were analysed using the ExpandNet/WHO framework, conceptualising scale-up from a systems perspective as composed of interrelated elements and strategic choices. Key enabling factors that facilitated the scale-up of FLE included (1) programme clarity, relevance and credibility; (2) programme adaptability to young people's evolving sexual and reproductive health priorities; (3) the engagement of a strong and credible resource team comprising government and civil society agencies; (4) a favourable policy environment; and (5) deliberate

strategic choices for horizontal and vertical scale-up. Barriers included sociocultural conservatism that creates resistance to content areas deemed to be culturally sensitive, resulting in partial scale-up in terms of content and coverage, as well as structural barriers that make it difficult to find space in the curriculum to deliver the full programme. Lessons learned from Senegal's experience can strengthen efforts to scale-up school-based sexuality education programmes in other culturally conservative low and middle-income countries.

*** Collins, D and Gilmartin, C. 2016. "Scaling Up Family Planning in Zambia – Part 2: The Cost of Scaling Up Family Planning Services." Research Report. Washington, DC: Population Council, The Evidence Project.**

http://evidenceproject.popcouncil.org/wp-content/uploads/2016/08/Zambia-SUFP-Report-Part-2.pdf

Authors' Abstract

In Zambia, the Scaling Up Family Planning project, funded by DfID and implemented by Abt Associates with the Ministry of Health, was a four year project that started in 2012 with a goal of strengthening public sector provision of family planning (FP) services to 26 under-served districts by improving and expanding key demand and supply functions, in particular through an innovative approach to strengthen outreach activities. In the 26 districts where SUFP was implemented, there was an increase of 150% in Couple-Years of Protection (CYP) from 2012 to 2014, compared with an increase of 84% in districts that did not have SUFP support (figures from MCDMCH database) (Table 1). In 6 districts where support was reportedly only provided by SUFP, the number of CYP increased by 227% over the same period. A more detailed analysis of utilization in individual facilities and related communities supported by SUFP in one of the two study districts showed an increase in CYP of 37% over the same period. While SUFP was not the only project providing support to family planning in most districts and the government actually provided the family planning services, it does appear that some of this increase can be attributable to SUFP support. The project's package of scaling-up activities appears, therefore, to have been successful in contributing to increased service utilization within and across districts, and the gains appear to have been largely maintained during the project period. The interventions appear to have contributed to significant increases in family planning counseling visits in general and visits for long acting reversible contraceptives (LARC) in particular, resulting in increases in CYP. The average expenditure by the project per district for implementing the initial start-up family planning strengthening activities was USD 46,092. Support for an 18 month period after the start-up was approximately USD 32,860, plus the salary of a half-time district coordinator for 18 months, which was estimated at an average of USD 7,192. Some of the support costs were reportedly for addressing district-level bottlenecks, such as financing repairs and fuel for vehicles needed for resupply of commodities and supervision. The full cost (project and government) of the initial start-up package of project-type activities for one district (2015 population 271,503), was approximately ZMW 1.7 million (USD 282,000) which comes to an average of ZMW 29 (USD 4.74) per woman of reproductive age (WRA). The annual recurrent costs (excluding equipment) needed to provide

the expanded package of community, outreach, and facility-based services would be around ZMW 4.9 million (USD 795,000) in 2015, which comes to ZMW 80 (USD 12.96) per WRA. Replacement equipment for community-based distributors (CBDs) would cost an additional ZMW 59,000 (USD 9,500) every year, and replacing all equipment would cost an additional ZMW 591,000 (USD 95,000) every third year. The annual recurrent cost reflects the provision of services that would result in 38,876 CYP, which would amount to ZMW 126 (USD 20) per CYP. If the costs of the commodities, facility staff time, management and supervision staff time, and transport costs can be covered by the government within its existing budget, then the additional recurrent costs needed for scaling up would only be around ZMW 1.5 million (USD 250,000) per district. These figures can be used as a rough guide for estimating the cost of replicating the package in other districts in Zambia. Challenges included attrition of CBDs, lack of equipment and space in some facilities, facility staff shortages, and irregular access to supplies of oral contraceptives and condoms at the community level. Sustainability of interventions after the end of the project has been a major concern, with doubts over the ability of the government to cover the costs of outreach, supply chain, and CBD support costs that have been funded by the project. Finding solutions to high CBD attrition was identified as a key challenge given the important role that CBDs have in extending FP services to the community.

Colombini M, Mayhew SH, Ali SH et al. 2012. "An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up," *BMC Public Health,* 12:548-557.

http://www.biomedcentral.com/1471-2458/12/548

Authors' Abstract

Background: Malaysia has been at the forefront of the development and scale up of One-Stop Crisis Centres (OSCC) - an integrated health sector model that provides comprehensive care to women and children experiencing physical, emotional and sexual abuse. This study explored the strengths and challenges faced during the scaling up of the OSCC model to two States in Malaysia in order to identify lessons for supporting successful scale-up.

Methods: In-depth interviews were conducted with health care providers, policy makers and key informants in 7 hospital facilities. This was complemented by a document analysis of hospital records and protocols. Data were coded and analysed using NVivo 7.

Results: The implementation of the OSCC model differed between hospital settings, with practise being influenced by organisational systems and constraints. Health providers generally tried to offer care to abused women, but they are not fully supported within their facility due to lack of training, time constraints, limited allocated budget, or lack of referral system to external support services. Non-specialised hospitals in both States struggled with a scarcity of specialised staff and limited referral options for abused women. Despite these challenges, even in more resource-constrained settings staff who took the initiative found it was possible to adapt to provide some level of OSCC services, such as referring women to local NGOs or community support groups, or training nurses to offer basic counselling.

Conclusions: The national implementation of OSCC provides a potentially important source of support for women experiencing violence. Our findings confirm that pilot interventions for health sector responses to gender based violence can be scaled up only when there is a sound health infrastructure in place - in other words a supportive health system. Furthermore, the successful replication of the OSCC model in other similar settings requires that the model - and the system supporting it - needs to be flexible enough to allow adaptation of the service model to different types of facilities and levels of care, and to available resources and thus better support providers committed to delivering care to abused women.

Cooley L, Ved R. 2012. "Scaling up - from vision to large-scale change: a management framework for practitioners, second edition," Management Systems International (MSI), Washington DC.

http://www.msiworldwide.com/wp-content/uploads/Scaling-Up-Framework.pdf
No abstract or executive summary available.

Cooley L, Ved R, Fehlenberg K. 2012. Management Sciences International (MSI) 2012. "Scaling up—from vision to large- scale change: Tools and techniques for practitioners," Washington DC.

http://www.msiworldwide.com/wp-content/uploads/MSI-Scaling-Up-Toolkit.pdf

Authors' Foreword
In response to increasing interest across the international development community in scaling up field tested models and approaches for addressing widespread and persistent problems, Management Systems International (MSI), with support from the John D. and Catherine T. MacArthur Foundation, published Scaling Up—From Vision to Large- Scale Change: A Management Framework for Practitioners (the "FRAMEWORK") in March 2006. The impetus was to address the gap between the numerous successful projects and innovations in the field of development, and those precious few that were actually taken to scale.

From MSI's perspective, scaling up can and should be a systematic process through which promising approaches or models are identified and transferred to new contexts (and often, new organizations) to be implemented on a larger scale.

This document is intended to be a companion document to the FRAMEWORK and includes fifteen tools for use with selected tasks outlined in that publication. The materials in this document were developed, refined, and applied over a nine year period in twenty- two projects in India, Mexico, and Nigeria and integrate several case studies, mostly drawn from the health

sector to demonstrate how the tools were applied. The TOOLKIT is designed as a practical resource for field practitioners.

Curry L, Taylor L, Pallas SW et al. 2013. "Scaling up depot medroxyprogesterone acetate (DMPA): A systematic literature review illustrating the AIDED model." ***Reproductive Health,*** **10:39.**

http://www.reproductive-health-journal.com/content/pdf/1742-4755-10-39.pdf

Authors' Abstract
Background: Use of depot medroxyprogesterone acetate (DMPA), often known by the brand name Depo-Provera, has increased globally, particularly in multiple low- and middle-income countries (LMICs). As a reproductive health technology that has scaled up in diverse contexts, DMPA is an exemplar product innovation with which to illustrate the utility of the AIDED model for scaling up family health innovations.

Methods: We conducted a systematic review of the enabling factors and barriers to scaling up DMPA use in LMICs. We searched 11 electronic databases for academic literature published through January 2013 (n = 284 articles), and grey literature from major health organizations. We applied exclusion criteria to identify relevant articles from peer-reviewed (n = 10) and grey literature (n = 9), extracting data on scale up of DMPA in 13 countries. We then mapped the resulting factors to the five AIDED model components: ASSESS, INNOVATE, DEVELOP, ENGAGE, and DEVOLVE.

Results: The final sample of sources included studies representing variation in geographies and methodologies. We identified 15 enabling factors and 10 barriers to dissemination, diffusion, scale up, and/or sustainability of DMPA use. The greatest number of factors were mapped to the ASSESS, DEVELOP, and ENGAGE components.

Conclusions: Findings offer early empirical support for the AIDED model, and provide insights into scale up of DMPA that may be relevant for other family planning product innovations.

Díaz J, Simmons R, Diaz M et al. 2007. "Scaling up family planning service innovations in Brazil: the influence of politics and decentralization." In: Simmons R, Fajans P, Ghiron L, eds. ***Scaling up health service delivery: from pilot innovations to policies and programmes.*** **World Health Organization, Geneva, Switzerland, 135-156.**

http://expandnet.net/PDFs/Scaling_Up_HS_Delivery_Chapter_7.pdf

Authors' Abstract
The principles of strategic management suggest that a major step in ensuring effective scaling up is to understand the diverse environments in which health service innovations are expanded. When service innovations are expanded in the public sector, the political and administrative institutions, as well as the health sector setting constitute major environmental influences. This chapter analyses these factors in Brazil, using the experience of a project which sought to enhance equitable access and improve the quality of care in public sector family planning services. Nongovernmental organizations acted as the resource team that facilitated the testing of the original service innovations in one municipality and then assisted with their expansion to others. The chapter shows that scaling up is influenced by an ongoing process of decentralization and by the politics of family planning. Scaling up family planning innovations faces special challenges, which would not be encountered in other areas of reproductive health in Brazil.

Díaz M, Cabral F. 2007. "An innovative educational approach facilitates capacity building and scaling-upto address the Cairo agenda in Latin America." In: Simmons R, Fajans P, Ghiron L, eds. *Scaling-up health service delivery: from pilot innovations to policies and programmes.* World Health Organization, Geneva, Switzerland, 157–177.

http://expandnet.net/PDFs/Scaling_Up_HS_Delivery_Chapter_8.pdf

Authors' Abstract
As governments seek to meet the global health agendas of thepast decade, new approaches to the training of health professionalsare needed. Training must move away from an exclusive focuson technical skills and begin to incorporate educational strategiesthat empower providers, programme managers and communityleaders to become agents of change. This chapter describes amethodology for in-service training that builds on Paulo Freire'seducational philosophy and explains how the capacity to provideinnovative training was scaled up in public sector reproductivehealth services in Brazil, Bolivia and Chile. Statistics on the trainingsessions demonstrate the reach of this training initiative, andtestimonials show its profound impact on newly trained trainers.

*** Dickson KE, Kinney MV, Moxon SG, et al. 2015. "Scaling up quality care for mothers and newborns around the time of birth: an overview of methods and analyses of intervention-specific bottlenecks and solutions." *BMC Pregnancy and Childbirth, 15*(2), 1.**

http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-15-S2-S1

Authors' Abstract

Background: The Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality targets cannot be achieved without high quality, equitable coverage of interventions at and around the time of birth. This paper provides an overview of the methodology and findings of a nine paper series of in-depth analyses which focus on the specific challenges to scaling up high-impact interventions and improving quality of care for mothers and newborns around the time of birth, including babies born small and sick.

Methods: The bottleneck analysis tool was applied in 12 countries in Africa and Asia as part of the ENAP process. Country workshops engaged technical experts to complete a tool designed to synthesise "bottlenecks" hindering the scale up of maternal-newborn intervention packages across seven health system building blocks. We used quantitative and qualitative methods and literature review to analyse the data and present priority actions relevant to different health system building blocks for skilled birth attendance, emergency obstetric care, antenatal corticosteroids (ACS), basic newborn care, kangaroo mother care (KMC), treatment of neonatal infections and inpatient care of small and sick newborns.

Results: The 12 countries included in our analysis account for the majority of global maternal (48%) and newborn (58%) deaths and stillbirths (57%). Our findings confirm previously published results that the interventions with the most perceived bottlenecks are facility-based where rapid emergency care is needed, notably inpatient care of small and sick newborns, ACS, treatment of neonatal infections and KMC. Health systems building blocks with the highest rated bottlenecks varied for different interventions. Attention needs to be paid to the context specific bottlenecks for each intervention to scale up quality care. Crosscutting findings on health information gaps inform two final papers on a roadmap for improvement of coverage data for newborns and indicate the need for leadership for effective audit systems.

Conclusions: Achieving the Sustainable Development Goal targets for ending preventable mortality and provision of universal health coverage will require large-scale approaches to improving quality of care. These analyses inform the development of systematic, targeted approaches to strengthening of health systems, with a focus on overcoming specific bottlenecks for the highest impact interventions.

*** Dickson KE, Simen-Kapeu A, Kinney MV, et al. 2014. "Health–systems bottlenecks and strategies to accelerate scale-up in countries."** ***Lancet,*** **384(9941) 438-454.**

http://pdf.usaid.gov/pdf_docs/PA00JVG3.pdf

Authors' Abstract

Universal coverage of essential interventions would reduce neonatal deaths by an estimated 71%, benefit women and children after the first month, and reduce stillbirths. However, the packages with the greatest effect (care around birth, care of small and ill newborn babies), have

low and inequitable coverage and are the most sensitive markers of health system function. In eight of the 13 countries with the most neonatal deaths (55% worldwide), we undertook a systematic assessment of bottlenecks to essential maternal and newborn health care, involving more than 600 experts. Of 2465 bottlenecks identified, common constraints were found in all high-burden countries, notably regarding the health workforce, financing, and service delivery. However, bottlenecks for specific interventions might differ across similar health systems. For example, the implementation of kangaroo mother care was noted as challenging in the four Asian country workshops, but was regarded as a feasible aspect of preterm care by respondents in the four African countries. If all high-burden countries achieved the neonatal mortality rates of their region's fastest progressing countries, then the mortality goal of ten per 1000 live births by 2035 recommended in this Series and the Every Newborn Action Plan would be exceeded. We therefore examined fast progressing countries to identify strategies to reduce neonatal mortality. We identified several key factors: (1) workforce planning to increase numbers and upgrade specific skills for care at birth and of small and ill newborn babies, task sharing, incentives for rural health workers; (2) financial protection measures, such as expansion of health insurance, conditional cash transfers, and performance-based financing; and (3) dynamic leadership including innovation and community empowerment. Adapting from the 2005 Lancet Series on neonatal survival and drawing on this Every Newborn Series, we propose a country-led, data-driven process to sharpen national health plans, seize opportunities to address the quality gap for care at birth and care of small and ill newborn babies, and systematically scale up care to reach every mother and newborn baby, particularly the poorest.

*** Duvall, S., Thurston, S., Weinberger, M., Nuccio, O., & Fuchs-Montgomery, N. 2014. "Scaling up delivery of contraceptive implants in sub-Saharan Africa: operational experiences of Marie Stopes International."** ***Global Health: Science and Practice*****, 2(1), 72-92.**

http://www.ghspjournal.org/content/2/1/72.full.pdf+html

Authors' Abstract

Contraceptive implants offer promising opportunities for addressing the high and growing unmet need for modern contraceptives in sub-Saharan Africa. Marie Stopes International (MSI) offers implants as one of many family planning options. Between 2008 and 2012, MSI scaled up voluntary access to implants in 15 sub-Saharan African countries, from 80,041 implants in 2008 to 754,329 implants in 2012. This 9-fold increase amounted to more than 1.7 million implants delivered cumulatively over the 5-year period. High levels of client satisfaction were attained alongside service provision scale up by using existing MSI service delivery channels—mobile outreach, social franchising, and clinics—to implement strategies that broadened access for underserved clients and maintained service quality. Use of adaptive and context- specific service delivery models and attention to key operational components, including sufficient numbers of trained providers, strong supply chains, diverse financing mechanisms, and implant removal services, underpinned our service delivery efforts. Accounting for 70% of the implants delivered by MSI in 2012, mobile outreach services through dedicated MSI provider teams played a central role in scale-up efforts, fueled in part by the provision of free or heavily subsidized

services. Social franchising also demonstrated promise for future program growth, along with MSI clinics. Continued high growth in implant provision between 2011 and 2012 in all sub-Saharan African countries indicates the region's capacity for further service delivery expansion. Meeting the expected rising demand for implants and ensuring long-term sustainable access to the method, as part of a comprehensive method mix, will require continued use of appropriate service delivery models, effective operations, and ongoing collaboration between the private, public, and nongovernmental sectors. MSI's experience can be instructive for future efforts to ensure contraceptive access and choice in sub-Saharan Africa, especially as the global health community works to achieve its Family Planning 2020 (FP2020) commitments to expand family planning access to 120 million new users.

*** Evelia, H., Nyambane, J., Birungi, H., Askew, I., Trangsrud, R., Muthuuri, E., Omuruli, J. 2008. From pilot to program: Scaling up the Kenya Adolescent Reproductive Health Project. FRONTIERS Final Report. Washington, DC: Population Council.**

http://pdf.usaid.gov/pdf_docs/Pnadp418.pdf

Authors' Executive Summary

In 1999, the Population Council's Frontiers in Reproductive Health Program (FRONTIERS) and the Program for Appropriate Technology in Heath (PATH) collaborated with three Government of Kenya ministries – the Ministry of Education (MOE), the Ministry of Health (MOH), and the Ministry of Gender, Sports, Culture and Social Services (MGSCSS) to design and implement a multisectoral project with the following goals:

- To improve knowledge about reproductive health and encourage a responsible and healthy attitude towards sexuality among adolescents;
- To delay the onset of sexual activity among younger adolescents;
- To decrease risky behaviors among sexually active adolescents.

Three interventions were piloted in Vihiga and Busia districts in the Western Province over a period of 30 months. The intervention implemented by MGSCSS addressed the sensitivity of adolescent sexual and reproductive health (ASRH) within the community, by improving support and promoting dialogue around this topic among parents and adolescents. The MOE educated in- school adolescents about ASRH issues through a life-skills curriculum presented through extracurricular sessions and peer educators. The MOH addressed the information and service needs, primarily of sexually active adolescents, by increasing access to adolescent friendly services and through peer educators.

Key findings from the pilot project demonstrated that the three ministries could successfully implement the interventions with minimal support from FRONTIERS and PATH. Parent to child communication increased significantly and there was increased awareness about contraceptive methods, especially condoms, pills and injectables. Condom use for dual prevention of STIs and pregnancy became better known among adolescents. The level of awareness of specific STIs among all adolescents also increased significantly. The interventions reinforced disapproval of

premarital sex and childbearing, and a particular disapproval for teen pregnancies. Some changes were also noted in behavioral indicators, including delayed onset of sexual activity, reduced number of sexual partners, reduced incidences of sexual violence, reduced levels of unplanned pregnancies as well as fewer school dropouts.

The positive results of the pilot phase prompted a 20-month phase of adaptation and expansion of KARHP throughout the two pilot districts to enable the ministries to gain experience of implementing the services at the district level. Pilot materials and tools were revised and inter-sectoral committees set up at district and provincial level. The approach was then further scaled up throughout the remaining six districts of Western Province from June 2005 to May 2006.

This province-wide scaling-up experience led to a further 13-month phase of replication, during which the model was introduced in two districts each of Eastern and Nyanza provinces in June 2006 to May 2007. This was followed by province-wide expansion by the USAID-funded APHIA partners. From June 2007 to May 2008, KARHP was introduced in Nairobi and Central Provinces. Despite the challenges of working with public sector, this program proved that multisectoral approaches that build the capacity of government ministries to mainstream ASRH services can lead to wide-scale expansion and sustainability of effective pilot models.

ExpandNet, World Health Organization. 2009. "Practical guidance for scaling up health service innovations." World Health Organization, Geneva, Switzerland.

http://www.who.int/reproductivehealth/publications/strategic_approach/9789241598521/en/index.html

Authors' Summary

Calls for scaling up successfully tested health service innovations have multiplied over the past several years. Many acknowledge that pilot or experimental projects are of limited value unless they have larger policy and programme impact. Moreover, there is increasing recognition that proven innovations cannot simply be handed over with the expectation that they will automatically become part of routine programme implementation. While there has been progress, there is still little practical guidance on how to proceed with scaling up. This document, Practical guidance for scaling up health service innovations, can begin to fill this gap. One of the important contributions of the document is that it both identifies general principles and makes very specific, concrete suggestions. Guidance is organized around a framework that highlights the interrelationships among the central elements and strategic choices involved in scaling up.

ExpandNet, World Health Organization. 2010. "Nine steps for developing a scaling-up strategy." World Health Organization, Geneva, Switzerland.

http://expandnet.net/PDFs/ExpandNet-WHO%20Nine%20Step%20Guide%20published.pdf
or http://www.who.int/reproductivehealth/publications/strategic_approach/9789241500319/en/

Authors' Summary
The aim of this guide is to facilitate systematic planning for scaling up. It is intended for programme managers, researchers and technical support agencies who are seeking to scale-up health service innovations that have been tested in pilot projects or other field tests and proven successful.

ExpandNet, World Health Organization. 2012. "Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up." World Health Organization, Geneva, Switzerland.

http://www.expandnet.net/PDFs/ExpandNet-WHO%20-%20Beginning%20with%20the%20end%20in%20mind%20-%202011.pdf

Authors' Summary
This guide contains 12 recommendations on how to design pilot projects with scaling up in mind, as well as a checklist that provides a quick overview of the scalability of a project that is being planned, proposed, or in the process of implementation. Based on a combination of a comprehensive review of multiple literatures, field experience and a conceptual framework, the guide is intended for use by researchers, policy-planners, programme managers, technical-assistance providers, donors and others who seek to ensure that pilot or other programmatic research is designed in ways that lead to lasting and larger-scale impact. It is written with reference to the health field but its recommendations can be applied to other areas as well. In this guide, pilot or field tests include demonstration projects, implementation or operations research, tests of policy changes, proof-of-concept studies, etc. The guide is deliberately brief and can stand alone, but using it in conjunction with other ExpandNet/World Health Organization (WHO) resource materials will be helpful.

Fajans P, Thi Thom N, Whittaker M et al. 2007. "Strategic choices in scaling-up: introducing injectable contraception and improving quality of care in Viet Nam." In: Simmons R, Fajans P, Ghiron L, eds. *Scaling up health service delivery: from pilot innovations to policies and programmes.* World Health Organization, Geneva, Switzerland, 31–51.

http://expandnet.net/PDFs/Scaling_Up_HS_Delivery_Chapter_2.pdf

Authors' Abstract
This chapter analyses the process of scaling up introduction of the injectable contraceptive depot-medroxy progesterone acetate(DMPA) as part of a package of interventions to improve quality of care in the provision of all contraceptives in the Vietnamese family planning programme. After a strategic assessment of the need for contraceptive introduction and pilot testing of the interventions in three provinces, these interventions were scaled up to21 of Viet Nam's 64 provinces. Although DMPA was widely introduced, going to scale did not fully achieve the gains in quality of care for all methods found in the pilot phase. Three interrelated variables affected this outcome: the degree of change required in the service delivery system, the pace of expansion, and available resources to support expansion. In this case, scaling up proceeded faster than was desirable, given the extensive changes entailed by the interventions and the limitations in resources. Before embarking on rapid expansion involving complex programmatic changes, planners of scaling-up strategies should carefully assess the balance between these three variables.

Fajans P., Simmons R., Ghiron L. 2006. "Helping public sector health systems innovate: the strategic approach to strengthening reproductive health policies and programs," *American Journal of Public Health*, 96:435-440.

http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/srh_guide/Docs/Strategic_Approach/SA_AJPH.pdf

Authors' Abstract
Public sector health systems that provide services to poor and marginalized populations in developing countries face great challenges. Change associated with health sector reform and structural adjustment often leaves these already-strained institutions with fewer resources and insufficient capacity to relieve health burdens. The Strategic Approach to Strengthening Reproductive Health Policies and Programs is a methodological innovation developed by the World Health Organization and its partners to help countries identify and prioritize their

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reproductive health service needs, test appropriate interventions, and scale up successful innovations to a subnational or national level. The participatory, interdisciplinary, and country-owned process can set in motion much-needed change. We describe key features of this approach, provide illustrations from country experiences, and use insights from the diffusion of innovation literature to explain the approach's dissemination and sustainability.

*** Fernandez-Cerdero A, Vernon R, Hossain S, Keesbury J, and Khan M. 2009. "Introduction and Scaling-up of Emergency Contraception: Lessons Learned from Three Regions." *Population Review*, 48(1).**

https://muse.jhu.edu/article/264734/pdf

Authors' Abstract
Emergency contraception (EC) has been around for decades, but the first serious introduction and scale-up efforts started in the mid 1990's. This paper reviews programmatic experiences that sought to expand access to emergency contraceptive pills (ECP) in Africa, Asia and Latin America over the last decade. This multiregional review identifies the individual phases of the introductory processes as well as facilitators and barriers to successful scale-up of ECP service provision. Characteristics of successful projects included conduction of multi-sector diagnostic assessments; careful consideration of legal and policy issues; collaborative advocacy and technical assistance for inclusion in public family planning programs by national and international institutions; as well as attention to programmatic areas such as capacity-building, supply-chain and awareness-raising. Lessons learned from varied developing country experiences are discussed as is the need for increased attention to evaluating and disseminating project results.

Fixsen, A. 2013. "Monitoring and Evaluating Scaling up of health system Interventions: Theory and Practice." Draft manuscript.

http://irh.org/resource-library/theory-and-practice-monitoring-evaluating-scale-up-of-health-system-innovations/

This briefing paper was prepared in advance of the Monitoring and Evaluation of Scale-up Technical Consultation, held December 2012.

*** Franco LM, Marquez L. 2011. "Effectiveness of collaborative improvement: evidence from 27 applications in 12 less developed and middle income countries". *British Medical Journal Quality Safety*, 20-658-665.**

http://www.salzburgglobal.org/fileadmin/user_upload/Documents/2010-2019/2012/489/Session_Document_Effectiveness_489.pdf

Authors' Abstract
Introduction The improvement collaborative approach has been widely promoted in developed countries as an effective method to spread clinical practices, but little has been published on its effectiveness in developing country settings. Between 1998 and 2008, the United States Agency for International Development funded 54 collaboratives in 14 low- and middle-income countries, adapting the approach to resource-constrained environments.

Methods The authors analysed data on provider compliance with standards and outcomes from 27 collaboratives in 12 countries that met study inclusion criteria (at least 12 months of data available for analysis and indicators measured as percentages). The dataset, representing 1338 facility-based teams, consisted of 135 time-series charts related to maternal, newborn and

child health, HIV/AIDS, family planning, malaria and tuberculosis. An average of 28 months of data was available for each chart.

Results Eighty-seven per cent of these charts achieved performance levels of 80% or higher, and 76% reached at least 90% performance, even though two-thirds had a baseline performance below 50%. Teams achieved average increases of 51.9 percentage points (SE=28.0) per chart, with baseline value being the main determinant of absolute increase. Teams consistently maintained this level of performance for an average of 13 months (69% of months of observation). The average time to reach 80% performance was 9.2 months (SE 8.5), and to reach 90% performance, 14.4 months (SE=12.0).

Conclusion Collaborative improvement can produce significant, sustained gains in compliance with standards and outcomes in less-developed settings and merits wider application as a strategy for health systems strengthening.

Gasco M, Hedgecock D, Wright C. 2007."Romania: Reaching the poor - scaling up integrated family planning services." Boston, MA, John Snow Inc.

http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10157&lid=3

Authors' Abstract
This case study, developed as part of JSI's Best Practices in Scaling Up series, maps out how the Romanian Family Health Initiative (RFHI) has expanded family planning coverage nationwide to over 2000 rural communities. This case study highlights the process JSI's project used to integrate family planning into existing primary health services, including creating a favorable policy environment, training health care professionals, and implementing an effective logistics management system. Also included are highlights of what JSI staff learned along the way as scale-up processes were implemented.

George A, Menotti EP, Rivera D et al. 2011. "Community case management in Nicaragua: Lessons in fostering adoption and expanding implementation," *Health Policy and Planning*, 26: 327-337.

http://heapol.oxfordjournals.org/content/26/4/327.full.pdf+html

Authors' Abstract
Community case management (CCM) as applied to child survival is a strategy that enables trained community health workers or volunteers to assess, classify, treat and refer sick children who reside beyond the reach of fixed health facilities. The Nicaraguan Ministry of Health (MOH) and Save the Children trained and supported brigadistas (community health volunteers) in CCM to improve equitable access to treatment for pneumonia, diarrhoea and dysentery for children in remote areas. In this article, we examine the policy landscape and processes that

influenced the adoption and implementation of CCM in Nicaragua.

Contextual factors in the policy landscape that facilitated CCM included an international technical consensus supporting the strategy; the role of government in health care provision and commitment to reaching the poor; a history of community participation; the existence of community-based child survival strategies; the decentralization of implementation authority; internal MOH champions; and a credible catalyst organization. Challenges included scepticism about community-level cadres; resistance from health personnel; operational gaps in treatment norms and materials to support the strategy; resource constraints affecting service delivery; tensions around decentralization; and changes in administration.

In order to capitalize on the opportunities and overcome the challenges that characterized the policy landscape, stakeholders pursued various efforts to support CCM including sparking interest, framing issues, monitoring and communicating results, ensuring support and cohesion among health personnel, supporting local adaptation, assuring credibility and ownership, joint problem solving, addressing sustainability and fostering learning. While delineated as separate efforts, these policy and implementation processes were dynamic and interactive in nature, balancing various tensions. Our qualitative analysis highlights the importance of supporting routine monitoring and documentation of these strategic operational policy and management issues vital for CCM success. We also demonstrate that while challenges to CCM adoption and implementation exist, they are not insurmountable.

Gericke CA, Kurowski C, Ranson MK et al. 2003, "Feasibility of scaling-up interventions: The role of intervention design," Berlin University of Technology, Germany, and London School of Hygiene and Tropical Medicine, U.K.

http://www.dcp2.org/file/28/

Authors' Abstract

Different health interventions have very different implications for the degree of effort required to implement them. To some extent this is apparent in their cost, but in general cost is not a very effective proxy for the degree of effort or the characteristics of the resources required. The nature and availability of non-financial resources required to implement and sustain an intervention can be defined as intervention complexity. In this paper, a conceptual framework is proposed to analyse the importance of intervention design in expanding access to and utilisation of health services. The proposed framework categorises interventions along four dimensions: characteristics of the basic intervention; characteristics of delivery; the requirements the intervention imposes on government capacity; usage characteristics. Potential for simplification is separately assessed along these dimensions. Existing evidence and experiences of simplifying interventions in ways that place least burden on scarce capacity in very low resource settings are reviewed for a number of low-technology interventions. The overall purpose is to analyse interventions in a way that is useful for thinking about the feasibility of scaling up health services to meet the Millennium Goal targets. Analysing key health interventions using the conceptual framework proved useful in categorising interventions on their degree of complexity, identifying

supply and demand side constraints, and pointing to potential areas for improvement of specific aspects of each intervention. The framework could be used as a tool for policymakers, planners, and programme managers when considering the expansion of existing projects or the introduction of new interventions. The proposed systematic approach also allows for comparison with national benchmarks or with other regions, programmes or countries. Intervention complexity thus complements burden of disease, cost, cost-effectiveness, and political feasibility considerations in health policy decision making on scaling up.

Gericke CA, Kurowski C, Ranson MK et al. 2005, "Intervention complexity–a conceptual framework to inform priority-setting in health," *Bulletin of the World Health Organization*, 83:285–293.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2626218/pdf/15868020.pdf

Authors' Abstract

Health interventions vary substantially in the degree of effort required to implement them. To some extent this is apparent in their financial cost, but the nature and availability of non-financial resources is often of similar importance. In particular, human resource requirements are frequently a major constraint. We propose a conceptual framework for the analysis of interventions according to their degree of technical complexity; this complements the notion of institutional capacity in considering the feasibility of implementing an intervention. Interventions are categorized into four dimensions: characteristics of the basic intervention; characteristics of delivery; requirements on government capacity; and usage characteristics. The analysis of intervention complexity should lead to a better understanding of supply- and demand-side constraints to scaling up, indicate priorities for further research and development, and can point to potential areas for improvement of specific aspects of each intervention to close the gap between the complexity of an intervention and the capacity to implement it. The framework is illustrated using the examples of scaling up condom social marketing programmes, and the DOTS strategy for tuberculosis control in highly resource-constrained countries. The framework could be used as a tool for policy-makers, planners and programme managers when considering the expansion of existing projects or the introduction of new interventions. Intervention complexity thus complements the considerations of burden of disease, cost-effectiveness, affordability and political feasibility in health policy decision-making. Reducing the technical complexity of interventions will be crucial to meeting the health-related Millennium Development Goals.

*** Ghiron L, Shilingi L. Kabiswa C. 2014. "Beginning with sustainable scale up in mind: initial results from a population, health and environment project in East Africa."** ***RH Health Matters,*** **2(432)8492**

http://www.rhm-elsevier.com/article/S0968-8080%2814%2943761-3/fulltext

Authors' Abstract

Small-scale pilot projects have demonstrated that integrated population, health and environment approaches can address the needs and rights of vulnerable communities. However, these and other types of health and development projects have rarely gone on to influence larger policy and programme development. ExpandNet, a network of health professionals working on scaling up, argues this is because projects are often not designed with future sustainability and scaling up in mind. Developing and implementing sustainable interventions that can be applied on a larger scale requires a different mindset and new approaches to small-scale/pilot testing. This paper shows how this new approach is being applied and the initial lessons from its use in the Health of People and Environment in the Lake Victoria Basin Project currently underway in Uganda and Kenya. Specific lessons that are emerging are: 1) ongoing, meaningful stakeholder engagement has significantly shaped the design and implementation, 2) multi-sectoral projects are complex and striving for simplicity in the interventions is challenging, and 3) projects that address a sharply felt need experience substantial pressure for scale up, even before their effectiveness is established. Implicit in this paper is the recommendation that other projects would also benefit from applying a scale-up perspective from the outset.

Gillespie, S. 2004. "Scaling-up community-driven development: A synthesis of experience," Food Consumption and Nutrition Drive (FCND), International Food Policy Research Institute, Washington, DC.
http://www.ifpri.org/sites/default/files/pubs/divs/fcnd/dp/papers/fcndp181.pdf

Author's Abstract

While many community-driven development (CDD) initiatives may be successful, their impact is often limited by their small scale. Building on past and ongoing work on CDD, this study addresses the fundamental question: how can CDD initiatives motivate and empower the greatest number of communities to take control of their own development? What are the key contextual factors, institutional arrangements, capacity elements, and processes related to successful scaling-up of CDD, and, conversely, what are the main constraints or limiting factors, in different contexts? Drawing upon recent literature and the findings from five case studies, key lessons on how best to stimulate, facilitate, and support the scaling-up of CDD in different situations, along with some major challenges, are highlighted.

Lessons include the need for donors and supporters of CDD, including governments, to think of the *process* beyond the project, and of transformation or transition rather than exit. Donor push and community pull factors need to be balanced to prevent .supply-driven, demand-driven

development. Overall, capacity is pivotal to successful CDD and its successful scaling-up over time. Capacity is more than simply resources, however; it also includes motivation and commitment, which, in turn, requires appropriate incentives at all levels. Capacity development takes time and resources, but it is an essential upfront and ongoing investment, with the capacity and commitment of facilitators and local leaders being particularly important. A learning by doing culture, one that values adaptation, flexibility, and openness to change needs to be fostered at all levels, with time horizons adjusted accordingly. The building of a library of well documented, context-specific experiences through good monitoring, evaluation, and operational research will be useful in advocating for improvements in the contextual environment. Ultimately, for CDD to be sustained, it should be anchored within existing contextual systems (government), frameworks (e.g., PRSP), and processes (decentralization), even where these are imperfect.

Gilson L, Schneider H. 2010. "Managing scaling up: what are the key issues?" *Health Policy and Planning*, 25:97–98.

http://heapol.oxfordjournals.org/content/25/2/97.full.pdf+html
Short commentary without abstract.

*** Global Health: Science and Practice. Editorial. 2016. "Birthing centers staffed by skilled birth attendants: can they be effective…at scale?" *Global Health Science and Practice*, 4(1):1-3.**

http://www.ghspjournal.org/content/4/1/1.full.pdf+html

Editorial Summary
Peripheral-level birthing centers may be appropriate and effective in some circumstances if crucial systems requirements can be met. But promising models don't necessarily scale well, so policy makers and program managers need to consider what requirements can and cannot be met feasibly at scale. Apparently successful components of the birthing center model, such as engagement of traditional birth attendants and use of frontline staff who speak the local language, appear conducive to use in other similar settings.

Gonzales F, Arteaga E, Howard-Grabman, L. 1998. "Scaling up the Warmi Project: Lessons learned, mobilizing Bolivian communities around reproductive health," Save the Children Fund; 98:11. In: *"High impact PVO child survival programs. Volume 2. Proceedings of an Expert Consultation,"* Gallaudet University, Washington, DC, June 21-24, 1998, edited by Barton R. Burkhalter and Victoria L. Graham. Arlington, Virginia, Partnership for Child Health Care, Basic Support for Institutionalizing Child Survival [BASICS].

http://www.eldis.org/vfile/upload/1/document/0708/DOC15246.pdf

Authors' Abstract
This paper describes eight major steps in the process of scaling up from the experience of SCF/ Bolivia. From 1995 through 1997, SCF/Bolivia, working with the Ministry of Health, PROCOSI (a national PVO umbrella group), and other partners, expanded the Warmi Project from a pilot in three rural communities in one province to a national program affecting 513 communities in Bolivia. Their experience demonstrates how participatory approaches, specifically the community action cycle can be brought to national scale through flexibility, inter-institutional coordination and establishment of common goals. As the Warmi model expands to other countries in Latin America and Africa, health planners need to examine lessons learned from this seminal work in Bolivia.

*** Hadley, A., Chandra-Mouli, V., & Ingham, R. 2016. « Implementing the United Kingdom Government's 10-Year Teenage Pregnancy Strategy for England (1999–2010): Applicable Lessons for Other Countries." *Journal of Adolescent Health*.**

http://www.jahonline.org/article/S1054-139X(16)00102-6/pdf

Authors' Abstract
Purpose: Teenage pregnancy is an issue of inequality affecting the health, well-being, and life chances of young women, young men, and their children. Consequently, high levels of teenage pregnancy are of concern to an increasing number of developing and developed countries. The UK Labour Government's Teenage Pregnancy Strategy for England was one of the very few examples of a nationally led, locally implemented evidence-based strategy, resourced over a long duration, with an associated reduction of 51% in the under-18 conception rate. This article seeks to identify the lessons applicable to other countries.

Methods: The article focuses on the prevention program. Drawing on the detailed documentation of the 10-year strategy, it analyzes the factors that helped and hindered implementation against the World Health Organization (WHO) ExpandNet Framework. The Framework strives to improve the planning and management of the process of scaling-up of successful pilot programs with a focus on sexual and reproductive health, making it particularly suited for an analysis of England's teenage pregnancy strategy.

Results: The development and implementation of the strategy matches the Framework's key at- tributes for successful planning and scaling up of sexual and reproductive health programs. It also matched the attributes identified by the Centre for Global Development for scaled up approaches to complex public health issues.

Conclusions: Although the strategy was implemented in a high-income country, analysis against the WHO-ExpandNet Framework identifies many lessons which are transferable to low- and medium-income countries seeking to address high teenage pregnancy rates.

*** Hainsworth G Dr., Engel DMC. 2014. "Scale- up of adolescent contraceptive services: lessons from a 5-country comparative analysis". *JAIDS,* S200-S208**

http://journals.lww.com/jaids/Fulltext/2014/07011/Scale_up_of_Adolescent_Contraceptive_Services__.8.aspx

Authors' Abstract

Background: Poor sexual and reproductive health outcomes among adolescents aged 10–19 years are indicative of the barriers this group faces in accessing health services and highlights a gap in the availability of appropriate services, including adolescent-friendly contraceptive services (AFCS). The HIV Investment Framework identifies contraceptive services as an entry point for HIV counseling, testing, and treatment, and as a component of HIV prevention. To effectively meet the needs of adolescents, greater understanding of effective scale-up strategies for adolescent-friendly services is needed.

Methods: The authors conducted a retrospective analysis of AFCS scale-up experiences in Ethiopia, Ghana, Mozambique, Tanzania, and Vietnam using the ExpandNet/World Health Organization framework for systematic scale-up. The authors analyzed the type of scale (expansion or institutionalization), dissemination and advocacy, organizational process, costs and resource mobilization, and monitoring and evaluation.

Results: The analysis showed that all programs simultaneously pursued expansion and institutionalization, contributing to sustainable scale-up. Advocacy complemented by intensive capacity building at all levels of the health system contributed to adoption of AFCS in national and district work plans and budgets as well strengthening collection of age-disaggregated data.

Discussion: To achieve scale-up of AFCS, the authors identified the importance of institutionalization and expansion in tandem for synergy and reinforcement, empowering adolescents to be agents of change and hold government accountable to its commitments, and strengthening health systems to sustain AFCS.

Conclusions: This article contributes to a growing body of evidence around scale-up of AFCS, which can inform the implementation and sustainable scale-up of HIV and other services for adolescents.

Halperin DT. 2014. "Scaling up of family planning in low-income countries: lessons from Ethiopia," *Lancet*, 383(9924): 1264 – 1267.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2962032-2/fulltext?_eventId=login&rss=yes#

Author's Introductory Paragraph
Previous analyses have emphasized the crucial importance of family planning to achieve a range of health and other development objectives in developing countries. This viewpoint focuses on the successful implementation of services in Ethiopia, Africa's second most populous country. Ethiopia's encouraging experience could challenge the widely held assumption that a decline in fertility must be preceded by sweeping economic and educational advancement, and offers other useful policy and programmatic lessons for other low-income countries, especially in sub-Saharan Africa.

Hancock J, Proctor F, Csaki C. 2003. "Scaling-up the impact of good practices in rural development: A working paper to support implementation of the World Bank's Rural Development Strategy," Agriculture & Rural Development Department, World Bank, Washington, DC.

http://www.wds.worldbank.org/servlet/WDSContentServer/IW3P/IB/2004/01/30/000160016_20040130163125/Rendered/PDF/260310White0co1e1up1final1formatted.pdf

Authors' Abstract
A key thrust in the implementation of the Bank's new rural development strategy is identifying and "scaling-up good practice investments and innovations in rural development." Historically, successful World Bank projects have been one-time investments without strategies for leveraging projects to a larger scale or to broader coverage to increase efficiency and developmental impact in a country or region. The Bank believes that scaling-up good practices must become an integral part of national rural development strategies to reduce rural poverty and support broad-based rural development. This working paper, written in support of the Bank ' s rural development strategy, is intended to contribute to the development of a framework for thinking about scaling-up. The paper begins with a review of the literature on scaling-up in rural development and other contexts to develop an understanding of basic concepts and terms. Drawing from the literature review and interviews, the authors develop a working definition of the term scaling-up and a provisional framework for analyzing experiences of scaling-up in rural development. Then, to evaluate the provisional framework, the authors apply it to a few well-documented case studies of rapid scaling-up. The final sections of the paper draw lessons from the application of the framework to the case studies and identify key areas for moving forward to support scaling-up impacts in rural development.

Hanson K, Ranson MK, Oliviera-Cruz V et al. 2003. "Expanding access to priority health interventions: a framework for understanding the constraints to scaling-up," *Journal of International Development*, 15:1–14.

http://onlinelibrary.wiley.com/doi/10.1002/jid.963/abstract abstract only

Registration required for access through
http://onlinelibrary.wiley.com/doi/10.1002/jid.963/pdf

Authors' Abstract
The Commission on Macroeconomics and Health recommended a significant expansion in funding for health interventions in poor countries. However, there are a range of constraints to expanding access to health services: as well as an absolute lack of resources, access to health interventions is hindered by problems of demand, weak service delivery systems, policies at the health and cross-sectoral levels, and constraints related to governance, corruption and geography. This special issue is devoted to analysis of the nature and intensity of these constraints, and how they can best be overcome.

Hanson K, Cleary S, Schneider H et al. 2010. "Scaling up health policies and services in low- and middle-income settings," *BMC Health Services Research*, 10(Suppl 1): 11.

http://www.biomedcentral.com/content/pdf/1472-6963-10-S1-I1.pdf
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2895744/
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2895744/pdf/1472-6963-10-S1-I1.pdf

No abstract because this short paper is the introduction to a set of papers presented at a 2009 workshop and published in a special issue of BMC Health Services Research.

Hardee K. 2013. "Approach for addressing and measuring policy development and implementation in the scale-up of family planning and maternal, neonatal, and child health programs," Futures Group, Health Policy Project, Washington, DC.

http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=184

Author's Summary
This document presents a programming approach designed to help countries advance the integration and measurement of policy development and implementation into the scale-up of FP/MNCH interventions and best practices. The approach provides planners and implementers with initial guidance and suggestions on how to systematically address policy development and implementation as they scale up FP/MNCH programs.

Hardee K, Ashford L, Rottach E et al. 2012."The policy dimensions of scaling up health initiatives," Health Policy Project, Futures Group, Washington, DC.

http://www.healthpolicyproject.com/pubs/83_ScaleupPolicyJuly.pdf

Authors' Summary

Adopting new practices in health on a large scale requires systematic approaches to planning, implementation, and follow-up, and often calls for profound and lasting changes in health systems. Without attention to the policies that underlie health systems and health services, the scale-up of promising pilot projects is not likely to succeed and be sustained. Because of the urgency to rapidly expand effective interventions to improve the health of mothers, children, and families, particularly the poor and underserved, there exists a growing interest in scale-up among the international public health community and others involved in health policy and programs. To explore best practices and guide the scale-up of these practices, the Health Policy Project (HPP) reviewed the literature on scale-up, interviewed key experts involved in scaling up initiatives, and hosted a meeting on relevant policy and gender issues. This paper focuses on efforts to scale up interventions in family planning (FP) and reproductive health, and maternal, neonatal, and child health (MNCH) in developing countries. It defines "scale-up" and describes some of the frameworks and approaches to scale-up found in recent health literature and how such approaches address policy. The paper, developed with support from the U.S. Agency for International Development, also reviews the experience of selected organizations in scaling up best practices and how they have addressed policy issues. It identifies a number of lessons learned from scale-up initiatives and lists six recommendations for ensuring supportive policies to strengthen scale-up.

Harries AD, Makombe SD, Libamba E et al. 2011. "Why did the scale-up of HIV treatment work? A case example from Malawi," *Journal of Acquired Immune Deficiency Syndromes*: 57(Suppl.2): S64–7.

http://www.ncbi.nlm.nih.gov/pubmed/21857298

Authors' Abstract

The national scale-up of antiretroviral therapy (ART) in Malawi is based on a public health approach, with principles and practices borrowed from the successful DOTS (directly observed treatment short course-the system used to successfully deliver antituberculosis treatment to people in some of the poorest countries of the world) tuberculosis control framework. During the first 6 years, the number of patients registered on treatment increased from 3000 to >350,000 in both the public and private sectors. The most important reasons for this success have been strong international and national leadership combined with adequate funds, a standardized approach to ART with practical guidelines, an approved national scale-up plan with clear, time-bound milestones; investment in an intensive program of training and accreditation of ART sites, quarterly supervision and monitoring of ART and operational research, rational drug forecasting and no stock-outs of drugs during the first few years, and involvement of the private sector. The looming challenges of human resources, guaranteed financial support, better

but also more expensive ART regimens, use of electronic medical records to monitor response to therapy, and attention to HIV prevention need to be met head-on and solved if the momentum of the earlier years is to be maintained.

Hartmann A, and Linn J. 2008. "Scaling up: A framework and lessons for development effectiveness from literature and practice," Wolfensohn Center for Development, Working Paper 5, Brookings Institution, Washington DC.

http://www.brookings.edu/~/media/research/files/papers/2008/10/scaling%20up%20aid%20linn/10_scaling_up_aid_linn.pdf

Note that the Brookings Institution website has a number of other publications on the topic of scaling up development programs.

Authors' Abstract
Scaling up of development interventions is much debated today as a way to improve their impact and effectiveness. Based on a review of scaling up literature and practice, this paper develops a framework for the key dynamics that allow the scaling up process to happen. The authors explore the possible approaches and paths to scaling up, the drivers of expansion and of replication, the space that has to be created for interventions to grow, and the role of evaluation and of careful planning and implementation. They draw a number of lessons for the development analyst and practitioner. More than anything else, scaling up is about political and organizational leadership, about vision, values and mindset, and about incentives and accountability—all oriented to make scaling up a central element of individual, institutional, national and international development efforts. The paper concludes by highlighting some implications for aid and aid donors.

Hermida J, Robalino ME, Vaca L et al. 2005. "Scaling up and institutionalizing continuous quality improvement in the free maternity and child care program in Ecuador," LACHSR Report Number 65. Published for USAID by the Quality Assurance Project.

http://fkilp.iimb.ernet.in/pdf/Healthcare_Quality/Approaches%20to%20Improve%20Quality/Total_Quality_Management/Hermida_etal_Scaling_up_institutionalising_CQI_free_MCcare_prog_Ecuador.pdf

Authors' Abstract
The present document reports on an operations research study conducted by the Quality Assurance Project (QAP) to examine the process of institutionalizing a Continuous Quality Improvement (CQI) process within the context of the reforms introduced by the Law for the Provision of Free Maternity Services and Child Care. The objectives of the study were: a)

Describe and document the process , methods, and results of scaling-up and institutionalizing a quality assurance mechanism within the Free Maternity Program of the Ministry of Health of Ecuador; b) Explore associations between the degree of institutionalization achieved and the presence of reforms introduced by the Law, believed to be favorable to the QA institutionalization process; and c) Synthesize lessons learned that can be adapted and applied in other Latin American countries.

Hodgins S, McPherson R, Suvedi BK et al. 2010. "Testing a scalable community-based approach to improve maternal and neonatal health in rural Nepal," Journal of Perinatology, 30: 388-95.

http://www.ncbi.nlm.nih.gov/pubmed/19907428 abstract only

Authors' Abstract
Objective: The aim of the study was to determine the feasibility of improved maternal-neonatal care-seeking and household practices using an approach scalable under Nepal's primary health-care services.

Study design: Impact was assessed by pre- and post-intervention surveys of women delivering within the previous 12 months. Each district sample comprised 30 clusters, each with 30 respondents. The intervention consisted primarily of community-based antenatal counseling and dispensing and an early postnatal home visit; most activities were carried out by community-based health volunteers.

Result: There were notable improvements in most household practice and service utilization indicators, although results regarding care-seeking for danger signs were mixed.

Conclusion: It is feasible in a Nepal setting to significantly improve utilization of maternal-neonatal services and household practices, using the resources available under the government primary health-care system. This has the potential to significantly reduce neonatal mortality.

*** Horizons Program, YRG CARE, and the International HIV/AIDS Alliance. 2004. "Expanding Care and Support in South India: Scaling Up YRG CARE's Patient-Centered Approach," Horizons Final Report. Washington, D.C.: Population Council.**

http://www.hivpolicy.org/Library/HPP000954.pdf

Authors' Abstract

The number of new HIV infections in India is rapidly increasing and the health care system is already seeing a substantial increase in the demand for services. There are reports that people living with HIV and AIDS (PLHA) in India face severe discrimination and stigmatization and have limited access to appropriate care for HIV-related health problems. To prepare for increasing demands on health care resources due to HIV-related disease and to ensure that patients seeking care do not encounter stigma and discrimination, this study examines the experiences of Y.R. Gaitonde Centre for AIDS Research and Education (YRG CARE), a Chennai-based NGO, which provides an integrated continuum of prevention, care, and support services for PLHA in a country with an emerging HIV/AIDS epidemic.

In this report, the authors examine the process of scaling up YRG CARE's patient-centered approach and how this had led to the enhanced provision of care and support services at four selected sites in South India. The research employed a comparative case study approach using data collected at the four scale-up sites. Specifically, data were collected through situation assessments, process documentation, and in-depth interviews with scale-up partner staff and others at baseline (January 2000) and two years later (January 2002). At the end of the project, the scale-up partners participated in a data interpretation workshop, which resulted in the synthesis of key findings across the project sites.

The impetus for scaling up came from YRG CARE itself, realizing that the numbers of clients seeking their services would continue to grow rapidly, and that many travel long distances to reach YRG CARE. Discussions and strategic planning with the International HIV/AIDS Alliance resulted in the formulation of a plan to scale up services, and Horizons was invited to collaborate on research to study the process followed and resources required to introduce expanded care and support services in the other sites. The strategy that guided the scale-up process was concept replication. This means that the needs and opportunities of the local context, including existing and potential HIV/AIDS service providers determine how the underlying principles of integrated, patient-centered services are applied.

*** Huaynoca S, Chandra-Mouli V, Yaqub Jr. N, et al. 2014. "Scaling- Up comprehensive sexuality education in Nigeria: from national policy to nationwide application. *Sex Education: Sexuality, Society and Learning*, 14(2) 191-209**

http://www.tandfonline.com/doi/full/10.1080/14681811.2013.856292

Authors' Abstract

Nigeria is one of few countries that reports having translated national policies on school-based comprehensive sexuality education (CSE) into near-nationwide implementation. We analysed data using the World Health Organization-ExpandNet framework, which provides a systematic structure for planning and managing the scaling up of health innovations. We examined how Nigeria's nationwide programme was designed and executed. Since 2002, Nigeria has developed a well thought through strategy to scale up CSE. Crucial attributes that facilitated the scaling up

included technical consensus about the innovation and clarity about its components, dissection of a complex intervention into manageable components for implementation by organisations with complementary expertise, strong political leadership and championship in concert with advocacy and technical support from non-governmental organisations, proactive and energetic involvement of community stakeholders, effective programme management, and improvements to the information management system to ensure on-track implementation and mid-course corrections to keep stakeholders, including funders, informed and engaged. Challenges included programmatic values, competing priorities for available human resources and a lack of predictable funding for sustaining a rapid scale-up effort. Despite some weaknesses, implementation has largely proceeded according to plan. The lessons learned from Nigeria's experience can and should be used in other settings to achieve wide-scale coverage.

Huicho L, Davila M, Campos M et al. 2005. "Scaling up integrated management of childhood illness to the national level: achievements and challenges in Peru." ***Health Policy and Planning*****, 20: 14-24.**

http://heapol.oxfordjournals.org/content/20/1/14.full.pdf+html

Authors' Abstract

This paper presents the first published report of a national-level effort to implement the Integrated Management of Childhood Illness (IMCI) strategy at scale. IMCI was introduced in Peru in late 1996, the early implementation phase started in 1997, with the expansion phase starting in 1998. Here we report on a retrospective evaluation designed to describe and analyze the process of taking IMCI to scale in Peru, conducted as one of five studies within the Multi-Country Evaluation of IMCI Effectiveness, Cost and Impact (MCE) coordinated by the World Health Organization. Trained surveyors visited each of Peru's 34 districts, interviewed district health staff and reviewed district records. Findings show that IMCI was not institutionalized in Peru: it was implemented parallel to existing programmes to address acute respiratory infections and diarrhoea, sharing budget lines and management staff. The number of health workers trained in IMCI case management increased until 1999 and then decreased in 2000 and 2001, with overall coverage levels among doctors and nurses calculated to be 10.3%. Efforts to implement the community component of IMCI began with the training of community health workers in 2000, but expected synergies between health facility and community interventions were not realized because districts where clinical training was most intense were not those where community IMCI training was strongest. We summarize the constraints to scaling up IMCI, and examine both the methodological and policy implications of the findings. Few monitoring data were available to document IMCI implementation in Peru, limiting the potential of retrospective evaluations to contribute to programme improvement. Even basic indicators recommended for national monitoring could not be calculated at either district or national levels. The findings document weaknesses in the policy and programme supports for IMCI that would cripple any intervention delivered through the health service delivery system. The Ministry of Health in Peru is now working to address these weaknesses; other countries

working to achieve high and equitable coverage with essential child survival interventions can

learn from their experience.

*** Igras S, Sinai I, Mukabatsinda M. 2014. "Systems monitoring and evaluation guides scale up of the Standard Days Method of family planning in Rwanda."** ***Global Health Science and Practice,*** **2 (2) 234-244.**

http://irh.org/wp-content/uploads/2014/05/GHSP_Scale_Up_of_SDM_in_Rwanda.pdf.pdf
http://www.ghspjournal.org/content/2/2/234.full.pdf+html

Authors' Abstract
There is no guarantee that a successful pilot program introducing a reproductive health innovation can also be expanded successfully to the national or regional level, because the scaling-up process is complex and multilayered. This article describes how a successful pilot program to integrate the Standard Days Method (SDM) of family planning into existing Ministry of Health services was scaled up nationally in Rwanda. Much of the success of the scale-up effort was due to systematic use of monitoring and evaluation (M&E) data from several sources to make midcourse corrections. Four lessons learned illustrate this crucially important approach. First, ongoing M&E data showed that provider training protocols and client materials that worked in the pilot phase did not work at scale; therefore, we simplified these materials to support integration into the national program. Second, triangulation of ongoing monitoring data with national health facility and population-based surveys revealed serious problems in supply chain mechanisms that affected SDM (and the accompanying CycleBeads client tool) availability and use; new procedures for ordering supplies and monitoring stockouts were instituted at the facility level. Third, supervision reports and special studies revealed that providers were imposing unnecessary medical barriers to SDM use; refresher training and revised supervision protocols improved provider practices. Finally, informal environmental scans, stakeholder interviews, and key events timelines identified shifting political and health policy environments that influenced scale-up outcomes; ongoing advocacy efforts are addressing these issues. The SDM scale-up experience in Rwanda confirms the importance of monitoring and evaluating programmatic efforts continuously, using a variety of data sources, to improve program outcomes.

Implementing Best Practices Consortium. 2013. "Guide to fostering change to scale up effective health services: A K4H Toolkit". Geneva; Washington, DC.

http://www.k4health.org/toolkits/fostering-change

Author's Introduction
The IBP partners identified a key missing link between introducing and effectively implementing best practices: the ability to foster, lead and manage the change process required to implement effective practices and improve quality and performance. The IBP Fostering Change Task Team undertook a consultative and collaborative process to develop "A Guide for Fostering Change

to Scale Up Effective Health Services", published in 2007, that built on the large body of knowledge on change management.

In 2012, a task team surveyed users and non-users of the 2007 Guide and reviewed recently published guidelines and tools for effective change to produce the revised electronic guide/toolkit. The updated Guide provides a pathway that links proven change practices to "how to" steps for successful change. In addition, the Guide references key managerial tools produced by IBP partners. These tools can support the implementation of the change process.

Institute for Reproductive Health, Georgetown University. 2013. "Promising practices for scale-up: A prospective case study of Standard Days Method® integration," The FAM Project, Institute for Reproductive Health, Georgetown University.

http://irh.org/wp-content/uploads/2013/07/Promising_Practices_for_Scale-Up_FINAL.pdf

Authors' Summary
This summary document presents conclusions from a six-year, five-country initiative conducted by the Institute for Reproductive Health (IRH) and its many in-country partners to scale up Standard Days Method® (SDM) of family planning. SDM, briefly described in the text box, is itself not the topic of this document. Rather, the SDM scale-up experience is the source of the contributions that IRH makes to global knowledge of the *process of scaling up* tested health service innovations.

Institute for Reproductive Health, Georgetown University. 2012. "A systems approach to the M and E of scale up: A technical consultation report." Washington DC.

http://irh.org/resource-library/a-systems-approach-to-the-me-of-scale-up/

This meeting report was prepared following the *Monitoring and Evaluation of Scale-up Technical Consultation*, held December 2012.

Ir P, Bigdeli M, Meessen B et al. 2010. "Translating knowledge into policy and action to promote health equity: The Health Equity Fund policy process in Cambodia 2000-2008," *Health Policy*, 96: 200-209.

http://www.healthpolicyjrnl.com/article/S0168-8510%2810%2900049-7/abstract

Authors' Abstract
Objectives: To understand how knowledge is used to inform policy on Health Equity Funds (HEFs) in Cambodia; and to draw lessons for translating knowledge into health policies that promote equity.

Methods: We used a knowledge translation framework to analyse the HEF policy process between 2000 and 2008. The analysis was based on data from document analysis, key informant interviews and authors' observations. RESULTS: The HEF policy-making process in Cambodia was both innovative and incremental. Insights from pilot projects were gradually translated into national health policy. The uptake of HEF in health policy was determined by three important factors: a policy context conducive to the creation, dissemination and adoption of lessons gained in HEF pilots; the credibility and timeliness of HEF knowledge generated from pilot projects; and strong commitment, relationships and networks among actors.
Conclusions: Knowledge locally generated through pilot projects is crucial for innovative health policy. It can help adapt blueprints and best practices to a local context and creates ownership. While international organisations and donors can take a leading role in innovative interventions in low-income countries, the involvement of government policy makers is necessary for their scaling-up.

Janowitz B, Bratt J, Homan R et al. 2007. "How much will it cost to scale up a reproductive health pilot project?" *FRONTIERS Program Brief No. 8*, Population Council, Washington DC.

http://www.popcouncil.org/pdfs/frontiers/pbriefs/PB08.pdf

This brief explains how to adapt and modify cost information obtained from a pilot project to estimate scale-up costs. It is designed to help managers think critically about the factors that must be considered in estimating the costs of scaling up an effective intervention.

Johns B, Baltussen R. 2004. "Accounting for the cost of scaling-up health interventions," *Health Economics*, 13: 1117-24.
http://www.ncbi.nlm.nih.gov/pubmed/15386683

Authors' Abstract
Recent studies such as the Commission on Macroeconomics and Health have highlighted the need for expanding the coverage of services for HIV/AIDS, malaria, tuberculosis, immunisations and other diseases. In order for policy makers to plan for these changes, they need to analyse the change in costs when interventions are 'scaled-up' to cover greater percentages of the population. Previous studies suggest that applying current unit costs to an entire population can misconstrue the true costs of an intervention. This study presents the methodology used in

WHO- CHOICE's generalized cost effectiveness analysis, which includes non-linear cost functions for health centres, transportation and supervision costs, as well as the presence of fixed costs of establishing a health infrastructure. Results show changing marginal costs as predicted by economic theory.

Johns B, Tan Torres T. 2005."Costs of scaling up health interventions: a systematic review," *Health Policy and Planning*, 20:1-13. Oxford University Press.

http://heapol.oxfordjournals.org/content/20/1/1.long

Authors' Abstract

National governments and international agencies, including programmes like the Global Alliance for Vaccines and Immunizations and the Global Fund to Fight AIDS, Tuberculosis and Malaria, have committed to scaling up health interventions and to meeting the Millennium Development Goals (MDGs), and need information on costs of scaling up these interventions. However, there has been no systematic attempt across health interventions to determine the impact of scaling up on the costs of programmes. This paper presents a systematic review of the literature on the costs of scaling up health interventions. The objectives of this review are to identify factors affecting costs as coverage increases and to describe typical cost curves for different kinds of interventions. Thirty-seven studies were found, three containing cost data from programmes that had already been scaled up. The other studies provide either quantitative cost projections or qualitative descriptions of factors affecting costs when interventions are scaled up, and are used to determine important factors to consider when scaling up. Cost curves for the scaling up of different health interventions could not be derived with the available data. This review demonstrates that the costs of scaling up an intervention are specific to both the type of intervention and its particular setting. However, the literature indicates general principles that can guide the process: (1) calculate separate unit costs for urban and rural populations; (2) identify economies and diseconomies of scale, and separate the fixed and variable components of the costs; (3) assess availability and capacity of health human resources; and (4) include administrative costs, which can constitute a significant proportion of scale-up costs in the short run. This study is limited by the scarcity of real data reported in the public domain that address costs when scaling up health interventions. As coverage of health interventions increases in the process of meeting the MDGs and other health goals, it is recommended that costs of scaling up are reported alongside the impact on health of the scaled-up interventions.

*** Jordan K, Butrick E, Yamey G, Miller S (2016) Barriers and Facilitators to Scaling Up the Non-Pneumatic Anti-Shock Garment for Treating Obstetric Hemorrhage: A Qualitative Study. PLoS ONE 11(3): e0150739.**

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0150739

Authors' Abstract

Background: Obstetric hemorrhage (OH), which includes hemorrhage from multiple etiologies during pregnancy, childbirth, or postpartum, is the leading cause of maternal mortality and accounts for one-quarter of global maternal deaths. The Non-pneumatic Anti-Shock Garment (NASG) is a first-aid device for obstetric hemorrhage that can be applied for post-partum/post miscarriage and for ectopic pregnancies to buy time for a woman to reach a health care facility for definitive treatment. Despite successful field trials, and endorsement by safe motherhood organizations and the World Health Organization (WHO), scale-up has been slow in some countries. This qualitative study explores contextual factors affecting uptake.

Methods: From March 2013 to April 2013, we conducted 13 key informant interviews across four countries with a large burden of maternal mortality that had achieved varying success in scaling up the NASG: Ethiopia, India, Nigeria, and Zimbabwe. These key informants were health providers or program specialists working with the NASG. We applied a health policy analysis framework to organize the results. The framework has five domains: attributes of the intervention, attributes of the implementers, delivery strategy, attributes of the adopting community, the socio-political context, and the research context.

Results: The interviews from our study found that relevant facilitators for scale-up are the simplicity of the device, local and international champions, well-developed training sessions, recommendations by WHO and the International Federation of Gynecology and Obstetrics, and dissemination of NASG clinical trial results. Barriers to scaling up the NASG included limited health infrastructure, relatively high upfront cost of the NASG, initial resistance by providers and policy makers, lack of in-country champions or policy makers advocating for NASG implementation, inadequate return and exchange programs, and lack of political will.

Conclusions: There was a continuum of uptake ranging in both speed and scale. Ethiopia while not the first country to use the NASG has the most rapid scale-up, followed by Nigeria, then India, and finally Zimbabwe. Increasing the coverage of the NASG will require collaboration with local NASG champions, greater NASG awareness among clinicians and policymakers, as well as stronger political will and advocacy.

*** Joyce S, Askew I, Diagne AF et al. 2008. Multisectoral youth RH interventions: The scale up process in Kenya and Senegal. Program Brief No. 13. Washington, D.C.: The Population Council.**

http://pdf.usaid.gov/pdf_docs/PNADN556.pdf

Introduction

As in many developing countries, young people in Kenya and Senegal—those between ages 10 and 20—account for about 25 percent of the population. To ensure their future contribution to their countries, it is thus of vital strategic importance to safeguard the welfare of these young people. Rapid social change in both countries exposes youth to sexual and reproductive health

risks, including unintended pregnancy, sexually transmitted infections (STIs) including HIV, and sexual violence. In Kenya, the greatest risks are from unplanned pregnancy and STIs, including HIV. In Senegal, family members and the health care system often are ill-equipped to provide youth with information on reproductive and sexual health or to advise them on how to sexual risks (Askew, Chege, Njue, and Radeny 2004; Diop et al. 2004).

Beginning in 1999, the Population Council's Frontiers in Reproductive Health Program (FRONTIERS) conducted operations research (OR) studies that tested the feasibility, acceptability, and cost of a public-sector, multisectoral intervention to enhance young people's reproductive health knowledge and behavior. Study findings showed improvement in young people's reproductive health behavior and knowledge, successful engagement of government ministries, and increased understanding of the reproductive health needs among communities.

Communities and the participating ministries in both Kenya and Senegal expressed interest in incorporating elements from these interventions into their routine operations. FRONTIERS and its local partners launched follow-on projects in both countries to adapt, expand, institutionalize, and scale up the activities. This *Program Brief* describes the processes involved in institutionalizing and scaling up the multisectoral interventions.

Kaufman J, Zhang E, Xie Z. 2007. "Quality of care in China: from pilot project to national programme." In: Simmons R, Fajans P, Ghiron L, eds. *Scaling up health service delivery: from pilot innovations to policies and programmes.* Geneva, World Health Organization, 53–70.

http://expandnet.net/PDFs/Scaling_Up_HS_Delivery_Chapter_3.pdf

Authors' Abstract
China's family planning programme ranks as history's most intensive effort to control national population growth. While some have lauded China's effort to limit births as a fundamental part of its sustainable development goals, the population policy has also generated much international criticism. A long-overdue reform has begun to focus the family planning programme on client needs, informed choice of contraceptives, and better quality services. Partly inspired by the International Conference on Population and Development in 1994, the reform began as a pilot project in six counties and is now a blueprint for reorienting the national family planning programme. This chapter reviews the process by which a small innovative pilot project was scaled up into a national reform effort and the lessons learned about scaling up sensitive but needed innovation in a difficult political environment. These lessons relate to the importance of local ownership, adapting concepts to make them locally meaningful, careful choice of pilot sites to ensure success, mobilizing political networks, cultivating and educating allies in senior leadership positions, strategic use of donor funding and technical assistance, and the willingness to transfer project management to the next generation of leaders.

*** Kempers J, Ketting E, Chandra-Mouli V, et al. 2015. « The success factors of scaling-up Estonian sexual and reproductive health youth clinic network-from a grassroots initiative to a national programme 1991–2013." *Reproductive Health*, 12(1), 1.**

http://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-12-2

Authors' Abstract:
Background: A growing number of middle-income countries are scaling up youth-friendly sexual and reproductive health pilot projects to national level programmes. Yet, there are few case studies on successful national level scale-up of such programmes. Estonia is an excellent example of scale-up of a small grassroots adolescent sexual and reproductive health initiative to a national programme, which most likely contributed to improved adolescent sexual and reproductive health outcomes. This study; 1) documents the scale-up process of the Estonian youth clinic network 1991–2013, and 2) analyses factors that contributed to the successful scale-up. This research provides policy makers and programme managers with new insights to success factors of the scale-up, that can be used to support planning, implementation and scale-up of adolescent sexual and reproductive health programmes in other countries.

Methods: Information on the scale-up process and success factors were collected by conducting a literature review and interviewing key stakeholders. The findings were analysed using the WHO-ExpandNet framework, which provides a step-by-step process approach for design, implementation and assessment of the results of scaling-up health innovations.

Results: The scale-up was divided into two main phases: 1) planning the scale-up strategy 1991–1995 and 2) managing the scaling-up 1996–2013. The planning phase analysed innovation, user organizations (youth clinics), environment and resource team (a national NGO and international assistance). The managing phase examines strategic choices, advocacy, organization, resource mobilization, monitoring and evaluation, strategic planning and management of the scale-up.

Conclusions: The main factors that contributed to the successful scale-up in Estonia were: 1) favourable social and political climate, 2) clear demonstrated need for the adolescent services, 3) a national professional organization that advocated, coordinated and represented the youth clinics, 4) enthusiasm and dedication of personnel, 5) acceptance by user organizations and 6) sustainable funding through the national health insurance system. Finally, the measurement and recognition of the remarkable improvement of adolescent SRH outcomes in Estonia would not have been possible without development of good reporting and monitoring systems, and many studies and international publications.

*** Keyonzo N, Nyachae P, Kagwe P, et al. 2015. "From project to program: Tupange's experience with scaling up family planning interventions in urban Kenya."** ***Reproductive Health Matters*****, 23(45):103-113.**

http://expandnet.net/PDFs/RH%20Matters,%20May%202015%20-%20Keyonzo%20et%20al.pdf

Authors' Abstract
This paper describes how the Urban Reproductive Health Initiative in Kenya, the Tupange Project (2010-2015), successfully applied the ExpandNet approach to sustainably scale up family planning interventions, first in Machakos and Kakamega, and subsequently also in its three core cities, Nairobi, Kisumu and Mombasa. This new focus meant shifting from a "project" to a "program" approach, which required paying attention to government leadership and ownership, limiting external inputs, institutionalizing interventions in existing structures and emphasizing sustainability. The paper also highlights the project's efforts to prepare for the future scale up of Tupange's interventions in other counties to support continuing and improved access to family planning services in the new context of devolution (decentralization) in Kenya.

*** Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S., & Stall, R. (2007). "Implementing evidence-based interventions in health care: application of the replicating effective programs framework."** ***Implementation Science*****, 2(1), 42.**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2248206/

Authors' Abstract
Background: We describe the use of a conceptual framework and implementation protocol to prepare effective health services interventions for implementation in community-based (i.e., non-academic-affiliated) settings.

Methods: The framework is based on the experiences of the U.S. Centers for Disease Control and Prevention (CDC) Replicating Effective Programs (REP) project, which has been at the forefront of developing systematic and effective strategies to prepare HIV interventions for dissemination. This article describes the REP framework, and how it can be applied to implement clinical and health services interventions in community-based organizations.

Results: REP consists of four phases: pre-conditions (e.g., identifying need, target population, and suitable intervention), pre-implementation (e.g., intervention packaging and community input), implementation (e.g., package dissemination, training, technical assistance, and evaluation), and maintenance and evolution (e.g., preparing the intervention for sustainability). Key components of REP, including intervention packaging, training, technical assistance, and fidelity assessment are crucial to the implementation of effective interventions in health care.

Conclusion: REP is a well-suited framework for implementing health care interventions, as it specifies steps needed to maximize fidelity while allowing opportunities for flexibility (i.e., local

customizing) to maximize transferability. Strategies that foster the sustainability of REP as a tool to implement effective health care interventions need to be developed and tested.

Knippenberg R, Lawn JE, Darmstadt GL et al. 2005. "Systematic scaling up of neonatal care in countries," *Lancet Neonatal Survival Steering Team*, 365(9464): 1087-1098.

http://www.who.int/management/district/SystematicScalingUpNeonatalCare.pdf

Authors' Abstract
Every year about 70% of neonatal deaths (almost 3 million) happen because effective yet simple interventions do not reach those most in need. Coverage of interventions is low, progress in scaling up is slow, and inequity is high, especially for skilled clinical interventions. Situations vary between and within countries, and there is no single solution to saving lives of newborn babies. To scale up neonatal care, two interlinked processes are required: a systematic, data-driven decision-making process, and a participatory, rights-based policy process. The first step is to assess the situation and create a policy environment conducive to neonatal health. The next step is to achieve optimum care of newborn infants within health system constraints; in the absence of strong clinical services, programmes can start with family and community care and outreach services. Addressing missed opportunities within the limitations of health systems, and integrating care of newborn children into existing programmes--eg, safe motherhood and integrated management of child survival initiatives--reduces deaths at a low marginal cost. Scaling up of clinical care is a challenge but necessary if maximum effect and equity are to be achieved in neonatal health, and maternal deaths are to be reduced. This step involves systematically strengthening supply of, and demand for, services. Such a phased programmatic implementation builds momentum by reaching achievable targets early on, while building stronger health systems over the longer term. Purposeful orientation towards the poor is vital. Monitoring progress and effect is essential to refining strategies. National aims to reduce neonatal deaths should be set, and interventions incorporated into national plans and existing programmes.

Krueger K, Akol A, Wamala P et al. 2011. "Scaling up community provision of injectables through the public sector in Uganda," *Studies in Family Planning*, 42:117-124.

http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2011.00271.x/abstract

Authors' Abstract
This case study presents service monitoring data and programmatic lessons from scaling up Uganda's community-based distribution of depot medroxy progesterone acetate (DMPA, marketed as Depo-Provera) to the public sector in two districts. We describe the process and identify implementation opportunities and challenges, including modifications to the service

model. Analysis of monitoring data indicates that the number of women initiating DMPA with a community health worker (CHW) was 56 percent higher than the number of new DMPA acceptors served by clinics. Including continuing DMPA users, about three of every four DMPA clients chose CHWs as their service delivery point. CHW provision appears to be the preferred method of delivery for new DMPA users in this study, and may appeal even more to continuing clients. Lessons from scaling up in Uganda's public sector include recognizing the needs for ongoing assessment of support, a process to gain community "ownership," and spontaneous innovations to supplement CHW supervision.

*** Krumholz AR, Stone AE, Dalaba MA et al. 2015. "Factors facilitating and constraining the scaling up of an evidence-based strategy of community-based primary care: Management perspectives from northern Ghana."** ***Global Public Health*****, 10(3), 366-378.**

https://www.researchgate.net/profile/Philip_Adongo/publication/269116016_Factors_facilitating_and_constraining_the_scaling_up_of_an_evidence-based_strategy_of_community-based_primary_care_Management_perspectives_from_northern_Ghana/links/5485d2980cf289302e2800d0.pdf

Authors' Abstract

From 1994 to 2003, the government of Ghana investigated the child survival and fertility impacts of community-based primary care nurses and volunteer mobilisation efforts. This study, known as the Navrongo Project, demonstrated improved health outcomes and was scaled-up as the Community-based Health Planning and Services (CHPS) Initiative. Studies suggest that scaled-up CHPS services have not fully replicated the impact of the Project. This study investigates implementation challenges that could explain this atrophy by assembling the perspectives of health care managers that have experience with both the Project and CHPS. Data from in-depth interviews of health managers are analysed using deductive content analysis. Respondents exhibited a consistent vision of doorstep services with regard to the Project and CHPS. They shared the perspective that while scale-up has progressed slowly, it has expanded the range of services provided. Respondents felt, however, that the original emphasis on community involvement has atrophied with scale-up and that current operations are managed less rigorously than during the Project. Thus, while the expanded scope of CHPS has increased access to health care, the original focus on community engagement has faded. The original Project leadership strategy merits review for ways to integrate leadership development into scale-up activities.

*** Larson A, Raney L and Ricca J. 2014. "Lessons Learned from a Preliminary Analysis of the Scale-Up Experience of Six High-Impact Reproductive, Maternal, Newborn, and Child Health (RMNCH) Interventions." Jhpiego: Baltimore, MD.**

http://www.mchip.net/mchipcloseout3/files/Scale%20Brief.pdf

Relevant Paragraph

Since 2008, the USAID Bureau for Global Health's flagship Maternal and Child Health Integrated Program (MCHIP) has worked in more than 50 developing countries in Africa, Asia, Latin America, and the Caribbean to improve the health of women and children. MCHIP has worked with USAID Missions, governments, nongovernmental organizations, local communities, and partner agencies in over 50 developing countries to assist in the scale up of high impact interventions in reproductive, maternal, newborn, and child health (RMNCH), one of MCHIP's objectives. This brief summarizes the results of this scale up experience and the lessons learned, mainly based on 18 case studies of six high-impact RMNCH interventions in 14 countries supported by MCHIP over the life of the project (Larson et al. 2014). It also includes preliminary learning from two in-depth country studies and several studies of the scaling-up experience done by MCHIP technical teams for individual interventions they supported. The review analyzes the elements and strategies of the country scale up experiences and shows outcomes in institutionalizing and expanding the coverage of the interventions. It draws conclusions on lessons learned that could be applicable to other programs.

Larson CP, Koehlmoos TP, Sack DA et al. 2012. "Scaling up zinc treatment of childhood diarrhoea in Bangladesh: theoretical and practical considerations guiding the SUZY Project," *Health Policy and Planning,* 27:102-14.

http://heapol.oxfordjournals.org/content/early/2011/02/21/heapol.czr015.full.pdf

Authors' Abstract

In 2003, the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), in partnership with the Bangladesh Ministry of Health and Family Welfare (MOHFW) and the private sector embarked on a national exercise to scale up zinc treatment of childhood diarrhoea as an adjunct to oral rehydration solution (ORS). Private sector participation included national associations representing licensed and unlicensed health care providers, a local pharmaceutical laboratory, a marketing agency and a technology transfer from the European patent holder of the dispersible zinc tablet formulation promoted in the scale-up campaign. This project was a response to several years of research in the preceding decade demonstrating that zinc supplementation during a diarrhoeal illness episode significantly reduces illness severity and duration as well as prevents subsequent morbidity and mortality. It has been estimated that zinc treatment has the potential to annually save nearly 400 000 under-5 lives, thus significantly impacting on Millennium Development Goal #4. This paper summarizes the primary coverage outcomes of the Scaling Up of Zinc in Early Childhood (SUZY) Project into its third year (December 2006 to October 2009). These results are assessed in relation to the Project's

theoretical foundations and the performance framework that was jointly planned and implemented through a public-private partnership. The scale-up campaign encountered numerous constraints, but also benefited from several facilitating factors which are summarized under an assessment framework developed to identify barriers and better promote the scaling up of key health interventions in low- and middle-income countries. The lessons learned are described with the intent that this will contribute to the more effective scale-up of life-saving interventions that will reach those in greatest need.

Linn JF. 2011. "It's time to scale up success in development assistance," *KFW-Development Research*, 7(21).

http://www.brookings.edu/~/media/research/files/opinions/2011/10/25%20development%20assistance%20linn/meinungsforumentwicklungspolitik_linn_eng.pdf
A short commentary

Linn JF, Hartmann A, Kharas H et al. 2010. "Scaling up the fight against rural poverty: an institutional review of IFAD's approach." Global Economy & Development Working Paper 43, Washington, DC: The Brookings Institution.

http://www.brookings.edu/~/media/research/files/papers/2010/10/ifad%20linn%20kharas/10_ifad_linn_kharas.pdf

Authors' Abstract
The International Fund for Agricultural Development (IFAD) has for many years stressed innovation, knowledge and scaling up as essential ingredients of its strategy to combat rural poverty in developing countries. This institutional review of IFAD's approach to scaling up is the first of its kind: A team of development experts were funded by a small grant from IFAD to assess IFAD's track record in scaling up successful interventions, its operational policies and processes, instruments, resources and incentives, and to provide recommendations to management for how to turn IFAD into a scaling-up institution. Beyond IFAD, this institutional scaling up review is a pilot exercise that can serve as an example for other development institutions.

*** Linn JF. 2014. "Scaling Up Development Impact, A summary of current research, advice and outreach" Brookings Institute, Short Paper.**

http://www.brookings.edu/~/media/research/files/papers/2012/2/development%20interventions%20linn/linn_tajikistan.pdf

Author's Introductory Paragraph
Scaled up development interventions are critical for the achievement of sustained and inclusive growth, for meeting the Millennium Development Goals and beyond, for combating food and energy insecurity and for addressing the challenges of climate change. Many examples of successful scaling up exist, but more commonly development initiatives are one-off, fragmented and short-lived. Governments and aid donors therefore need to focus more systematically on how to scale up successful development.

*** Linn JF. 2015. "Scaling-up in the country program strategies of international aid agencies: an assessment of the African Development Bank's country strategy papers."** ***Global Journal of Emerging Market Economies.***

http://eme.sagepub.com/content/7/3/236.abstract (abstract only)

Author's Abstract
Scaling up the impact of interventions for maximum sustained development results should be a primary objective of international aid organizations. This article reports on a review of the African Development Bank's (AfDB) country strategy papers (CSPs) from a scaling-up perspective. It concludes, based on a sample of strategy and supporting documents, that the AfDB's CSPs do not focus systematically on scaling up the impact of the projects and programs that this multilateral development bank supports. This is not surprising, since the AfDB's corporate strategy, policies, and processes do not explicitly focus on scaling up. However, the review also concludes that key elements of a scaling-up approach are found in the AfDB's CSPs. If they were systematically applied across the board, AfDB could readily turn its CSPs into effective scaling-up strategies.

Lippeveld T. 2007. "Scaling up key public health interventions." Boston, MA, John Snow, Inc.

http://www.popline.org/node/184010 (abstract only)

This document introduces a series of case studies on best practices in scaling up public health interventions in resource-poor settings. This series is designed to delineate the processes successful heath programs used for scaling up, so that these examples may be of use to others implementing programs.

Management Sciences for Health. 2010. "Lessons learned in mainstreaming and scale-up of leadership and management capacity." Cambridge, MA.

No abstract; the executive summary is several pages long.

http://projects.msh.org/projects/lms/Results/upload/2010-06-09-Strategic-Evaluation-Mainstreaming-and-Scale-Up.pdf

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Mangham LJ, Hanson K. 2010. "Scaling up in international health: what are the key issues?" *Health Policy and Planning*, 25:85–96.

http://heapol.oxfordjournals.org/content/25/2/85.full.pdf

Authors' Abstract

The term 'scaling up' is now widely used in the international health literature, though it lacks an agreed definition. We review what is meant by scaling up in the context of changes in international health and development over the last decade. We argue that the notion of scaling up is primarily used to describe the ambition or process of expanding the coverage of health interventions, though the term has also referred to increasing the financial, human and capital resources required to expand coverage. We discuss four pertinent issues in scaling up the coverage of health interventions: the costs of scaling up coverage; constraints to scaling up; equity and quality concerns; and key service delivery issues when scaling up.

We then review recent progress in scaling up the coverage of health interventions. This includes a considerable increase in the volume of aid, accompanied by numerous new health initiatives and financing mechanisms. There have also been improvements in health outcomes and some examples of successful large-scale programmes. Finally, we reflect on the importance of obtaining a better understanding of how to deliver priority health interventions at scale, the current emphasis on health system strengthening and the challenges of sustaining scaling up in the prevailing global economic environment.

Mansour M, Mansour JB, El Swesy AH. 2010. "Scaling up proven public health interventions through a locally owned and sustained leadership development programme in rural Upper Egypt," *Human Resources for Health*, 8:1.

http://www.human-resources-health.com/content/pdf/1478-4491-8-1.pdf

Authors' Abstract

Introduction: In 2002, the Egypt Ministry of Health and Population faced the challenge of improving access to and quality of services in rural Upper Egypt in the face of low morale among health workers and managers. From 1992 to 2000, the Ministry, with donor support, had succeeded in reducing the nationwide maternal mortality rate by 52%. Nevertheless, a gap remained between urban and rural areas.

Case description: In 2002, the Ministry, with funding from the United States Agency for International Development and assistance from Management Sciences for Health, introduced a Leadership Development Programme (LDP) in Aswan Governorate. The programme aimed to

improve health services in three districts by increasing managers' ability to create high performing teams and lead them to achieve results.The programme introduced leadership and management practices and a methodology for identifying and addressing service delivery challenges. Ten teams of health workers participated.

Discussion and evaluation: In 2003, after participation in the LDP, the districts of Aswan, Daraw and KomOmbo increased the number of new family planning visits by 36%, 68% and 20%, respectively. The number of prenatal and postpartum visits also rose. After the United States 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 Leadership Development Programme participants in Aswan Governorate focused on reducing the maternal mortality rate as their annual goal. They reduced it from 85.0 per 100,000 live births to 35.5 per 100,000. The reduction in maternal mortality rate was much greater than in similar governorates in Egypt. Managers and teams across Aswan demonstrated their ability to scale up effective public health interventions though their increased commitment and ownership of service challenges.

Conclusions: When teams learn and apply empowering leadership and management practices, they can transform the way they work together and develop their own solutions to complex public health challenges. Committed health teams can use local resources to scale up effective public health interventions.

Massoud MR, Nielsen GA, Nolan K et al. 2006. "A framework for spread: From local improvements to system-wide change." IHI Innovation Series white paper. Institute for Healthcare Improvement, Cambridge, MA.

http://www.ihi.org/IHI/Results/WhitePapers/AFrameworkforSpreadWhitePaper.htm

Authors' Summary
A key factor in closing the gap between *best* practice and *common* practice is the ability of health care providers and their organizations to rapidly spread innovations and new ideas. Pockets of excellence exist in our health care systems, but knowledge of these better ideas and practices often remains isolated and unknown to others. One clinic may develop a new way to ensure that all diabetics have their HbA1c levels checked on a regular basis, or one medical-surgical unit in a hospital may develop a consistent way to reduce pain for post-operative patients. But too often these improvements remain unknown and unused by others within the organization. Organizations face several challenges in spreading good ideas, including the characteristics of the innovation itself; the willingness or ability of those making the adoption to try the new ideas; and characteristics of the culture and infrastructure of the organization to support change.

In 1999, the Institute for Healthcare Improvement (IHI) chartered a team to develop a "Framework for Spread." The stated aim of the team was to "…develop, test, and implement a

system for accelerating improvement by spreading change ideas within and between organizations." The team conducted a review of organizational and health care literature on the diffusion of innovations, and interviewed organizations both within and outside of health care that had been successful in spreading new ideas and processes, including Luther Midelfort Health System, Mayo Health System, Virginia Mason Medical Center, and Dean Health System.

Since then, the Framework for Spread and our deeper understanding of its content have continued to evolve. This white paper provides a snapshot of IHI's latest thinking and work on spread. It is divided into two parts:

The first part of the white paper describes the major spread projects that IHI has supported through early 2006, and harvests the lessons we have learned about the most effective ways to:

- Prepare for spread;
- Establish an aim for spread; and
- Develop, execute, and refine a spread plan.

The second part of the white paper is a reprint of an article published in the June 2005 issue of the *Joint Commission Journal on Quality and Patient Safety*, describing how the Veterans Health Administration (VHA) used the Framework for Spread to spread improvements in access to care to more than 1,800 outpatient clinics.

Massoud MR, Donohue KL, McCannon CJ. 2010. "Options for large-scale spread of simple, high-impact interventions. Technical report". USAID Health Care Improvement Project. Bethesda, Maryland.

http://www.ihi.org/resources/Pages/Publications/OptionsforLargeScaleSpreadSimpleHighImpactInterventions.aspx

Authors' Introduction

This paper outlines what we know to be effective in the adoption and spread of high-impact interventions. The approaches described herein draw on the experience of the authors and reviewers in large-scale health care improvement work; other approaches successfully used in influencing behavior change and spread are also described. These approaches included "natural" spread (where an individual recommends an innovation to others) and the collaborative, wave sequence, and campaign approaches. These last three are the least familiar and most likely to be availed in the diffusion of the safety checklist, so they are presented in detail and with examples.

This report opens with the scientific and theoretical bases underpinning the spread of innovations. It goes on to describe key elements including leadership at the executive level, factors that influence spread, and understanding a social system and the interactions of its parts while learning to work within the appropriate communication channels.

The next section outlines effective spread approaches which rely first on the individual's adoption of the health care innovation and second on factors that may foster or hinder spread in the system. Previous large-scale spread experiences have shown that the appropriate

approach depends on the innovation and the system surrounding it. The final section addresses the selection of an approach to spread, offering options depending on the innovation and surrounding system.

This paper is not intended to be an extensive review of the literature on this subject. It is written for the purpose of guiding the large-scale spread of health care checklists, as requested by the World Health Organization Patient Safety Programme and the Harvard School of Public Health. The first of these checklists is the Surgical Safety Checklist, an intervention to help surgical teams improve patient safety worldwide.

*** May, M.A., Misiti, A.J., Hussain, I., & Saleh, A. 2014. What does it take to scale up social impact? Insights from South Asia.**

http://innovation.brac.net/images/what%20does%20it%20take%20to%20scale%20social%20impact.pdf

Authors' Relevant Paragraphs

Around the world, there are many people like Arbind who dream of scaling a movement to affect the lives of thousands, even millions. Yet most of them fail. What is it then that Nidan and other organisations that succeeded in taking their impact to scale do differently?
At the BRAC Social Innovation Lab based in Bangladesh, we have spent the last two years studying precisely this question. While development overall is brimming with pilots and small organisations, South Asia in particular has given rise to a number of large-scale organisations and movements that buck the trend. We worked closely with practitioners in five South Asian organisations, including BRAC, to understand how they conceptualised scale and ensured that their initiatives succeeded at scale.

McCannon C J, Berwick DM, Massoud MRI. 2007. "The science of large-scale change in global health." *JAMA,* 298: 1937-1939.

http://www.amddprogram.org/v1/resources/McCannon%20et%20al_2007_The%20science%20of%20large%20scale%20change%20in%20global%20health%20(2).pdf
http://jama.jamanetwork.com/article.aspx?articleid=209234

Authors' Abstract

Innovation in health care includes important challenges: to find or create technologies and practices that are better able than the prevailing ones to reduce morbidity and mortality and to make those improvements ubiquitous quickly. In many respects in the pursuit of global health, the second challenge—the rapid spread of effective changes—seems to be the greater. Many sound (even powerful) solutions exist, such as new medicines and innovations in health care delivery, but their adoption is unreliable and slow. Often, they remain hidden in pockets around

the globe, flourishing locally without reliably reaching those in need elsewhere. Some such solutions come from biomedical research, but even more take shape at the point of care, in settings where local problem solvers create effective new approaches to problems that others who live far away face as well.

McCannon C J, Schall MW, Perla RJ. 2008. "Planning for scale: A guide for designing large-scale improvement initiatives." IHI Innovation Series white paper. Institute for Healthcare Improvement, Cambridge, Massachusetts.

http://www.breastfeedingor.org/wp-content/uploads/2012/10/ihiplanningforscalewhitepaper2008.pdf

Authors' Summary
This white paper aims to support those that are planning to take effective health care practices from one setting or isolated environment and to make them ubiquitous across a health care system, region, state, or nation. It is a preparation tool which is meant to guide conversation and thinking prior to the launch of a large-scale improvement effort; it considers the motivations, foundations, aims, interventions, social systems, and methods for spreading change that coordinators of such. This white paper does not attempt to describe the rigorous process for executing a large-scale improvement initiative, which entails tight management of logistics and a great deal of focus on tactics for mobilizing involvement, measuring progress, and stimulating sustainable change within a target population. That content will be the subject for future papers and is described in some detail in publications and content on the IHI website.

*** Metz A, Naoom S, Halle T, Bartley L. 2015. An integrated stage-based framework for implementation of early childhood programs and systems (OPRE Research Brief OPRE 2015-48). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.**

http://www.acf.hhs.gov/sites/default/files/opre/es_cceepra_stage_based_framework_brief_508.pdf

Relevant Paragraphs
This research brief series seeks to provide early childhood researchers, program developers, and funders with an introduction to implementation frameworks and promising practices in implementation science, with the aim of facilitating their use in early care and education research and program evaluation.

- A brief by Allison Metz, Sandra Naoom, Tamara Halle, and Leah Bartley introduces key elements of effective implementation within an integrated, stage-based framework.

- A brief by Jason Downer and Noreen Yazejian defines two cross-cutting themes: the quality and quantity of implementation. A review of recent empirical work provides examples of how these constructs are assessed and examined in relation to early care and education program outcomes. The authors highlight implications for researchers, purveyors, and funders of early childhood programs.
- A brief by Barbara Wasik, Shira Kolnik Mattera, Chrishana Lloyd, and Kimberly Boller uses an implementation science lens to help readers understand the effects that dosage of interventions can have on outcomes, as well as on general implementation factors such as training and program administration.
- A brief by Diane Paulsell, Anne M. Berghout Austin, and Maegan Lokteff introduces the importance of measuring implementation at multiple system levels and proposes tools for doing so. The brief conveys the benefits of measuring implementation at multiple system levels for practitioners, researchers, and policymakers, and offers suggestions and practical considerations.
- A brief by Amy Susman-Stillman, Shannon B. Wanless, and Christina Weiland reviews theoretical frameworks of fidelity from the fields of prevention science, clinical psychology, and elementary education; highlights useful aspects of each framework; and offers early care and education researchers considerations for choosing a framework to use in their studies.

Using implementation science, we can create a shared understanding of what it takes to have effective, replicable, and sustainable early childhood programs and systems in community-based settings. This research brief series aims to provide a useful overview of the current state of the field of implementation science research and its applications to the early care and education field. We hope that researchers, program developers, funders, and other stakeholders will find this series helpful in facilitating the use of implementation science frameworks, methodologies, and analysis in early care and education research and program evaluation.

*** Milat, A. J., Bauman, A., & Redman, S. 2015. "Narrative review of models and success factors for scaling up public health interventions."** ***Implementation Science, 10*****(1), 1.**

https://implementationscience.biomedcentral.com/articles/10.1186/s13012-015-0301-6

Authors' Abstract
Background: To maximise the impact of public health research, research interventions found to be effective in improving health need to be scaled up and delivered on a population-wide basis. Theoretical frameworks and approaches are useful for describing and understanding how effective interventions are scaled up from small trials into broader policy and practice and can be used as a tool to facilitate effective scale-up. The purpose of this literature review was to synthesise evidence on scaling up public health interventions into population-wide policy and practice, with a focus on the defining and describing frameworks, processes and methods of scaling up public health initiatives.

Methods: The review involved keyword searches of electronic databases including MEDLINE, CINAHL, PsycINFO, EBM Reviews and Google Scholar between August and December 2013. Keywords included 'scaling up' and 'scalability', while the search terms 'intervention research', 'translational research', 'research dissemination', 'health promotion' and 'public health' were used to focus the search on public health approaches. Studies included in the review were published in English from January 1990 to December 2013 and described processes, theories or frameworks associated with scaling up public health and health promotion interventions.

Results: There is a growing body of literature describing frameworks for scaling health interventions, with the review identifying eight frameworks, the majority of which have an explicit focus on scaling up health action in low and middle income country contexts. Key success factors for scaling up included the importance of establishing monitoring and evaluation systems, costing and economic modelling of intervention approaches, active engagement of a range of implementers and the target community, tailoring the scaled-up approach to the local context, the use of participatory approaches, the systematic use of evidence, infrastructure to support implementation, strong leadership and champions, political will, well defined scale-up strategy and strong advocacy.

Conclusions: Effective scaling up requires the systematic use of evidence, and it is essential that data from implementation monitoring is linked to decision making throughout the scaling up process. Conceptual frameworks can assist both policy makers and researchers to determine the type of research that is most useful at different stages of scaling up processes.

*** Moran AC, Kerber K, Pfitzer A et al. 2012. "Benchmarks to measure readiness to integrate and scale up newborn survival interventions."** ***Health Policy and Planning*****, 27(suppl 3), iii29-iii39.**

http://heapol.oxfordjournals.org/content/27/suppl_3/iii29.full.pdf+html

Authors' Abstract

Neonatal mortality accounts for 40% of under-five child mortality. Evidence-based interventions exist, but attention to implementation is recent. Nationally representative coverage data for these neonatal interventions are limited; therefore proximal measures of progress toward scale would be valuable for tracking change among countries and over time. We describe the process of selecting a set of benchmarks to assess scale up readiness or the degree to which health systems and national programmes are prepared to deliver interventions for newborn survival. A prioritization and consensus-building process was co-ordinated by the Saving Newborn Lives programme of Save the Children, resulting in selection of 27 benchmarks. These benchmarks are categorized into agenda setting (e.g. having a national newborn survival needs assessment); policy formulation (e.g. the national essential drugs list includes injectable antibiotics at primary care level); and policy implementation (e.g. standards for care of sick newborns exist at district hospital level). Benchmark data were collected by in-country stakeholders teams who filled out a standard form and provided evidence to support each benchmark achieved. Results are presented for nine countries at three time points: 2000, 2005 and 2010. By 2010, substantial

improvement was documented in all selected countries, with three countries achieving over 75% of the benchmarks and an additional five countries achieving over 50% of the benchmarks. Progress on benchmark achievement was accelerated after 2005. The policy process was similar in all countries, but did not proceed in a linear fashion. These benchmarks are a novel method to assess readiness to scale up, an important construct along the pathway to scale for newborn care. Similar exercises may also be applicable to other global health issues.

Nahar T, Azad K, Aumon BH et al. 2012. "Scaling up community mobilisation through women's groups for maternal and neonatal health: experiences from rural Bangladesh," *BMC Pregnancy Childbirth*, 12:5.

http://www.biomedcentral.com/1471-2393/12/5

Authors' Abstract

Background: Program coverage is likely to be an important determinant of the effectiveness of community interventions to reduce neonatal mortality. Rigorous examination and documentation of methods to scale-up interventions and measure coverage are scarce, however. To address this knowledge gap, this paper describes the process and measurement of scaling-up coverage of a community mobilisation intervention for maternal, child and neonatal health in rural Bangladesh and critiques this real-life experience in relation to available literature on scaling-up.

Methods: Scale-up activities took place in nine unions in rural Bangladesh. Recruitment and training of those who deliver the intervention, communication and engagement with the community and other stakeholders and active dissemination of intervention activities are described. Process evaluation and population survey data are presented and used to measure coverage and the success of scale-up.

Results: The intervention was scaled-up from 162 women's groups to 810, representing a five-fold increase in population coverage. The proportion of women of reproductive age and pregnant women who were engaged in the intervention increased from 9% and 3%, respectively, to 23% and 29%.

Conclusions: Examination and documentation of how scaling-up was successfully initiated, led, managed and monitored in rural Bangladesh provide a deeper knowledge base and valuable lessons. Strong operational capabilities and institutional knowledge of the implementing organisation were critical to the success of scale-up. It was possible to increase community engagement with the intervention without financial incentives and without an increase in managerial staff. Monitoring and feedback systems that allow for periodic programme corrections and continued innovation are central to successful scale-up and require programmatic and operational flexibility.

Nair N, Tripathy P Costello A et al. 2012. "Mobilizing women's groups for improved maternal and newborn health: Evidence for impact, and challenges for sustainability and scale Up," *International Journal of Gynaecology and Obstetrics,* 119(Suppl 1): S22-25.

http://www.ncbi.nlm.nih.gov/pubmed/22883914

Authors' Abstract

Research conducted over the past decade has shown that community-based interventions can improve the survival and health of mothers and newborns in low- and middle-income countries. Interventions engaging women's groups in participatory learning and action meetings and other group activities, for example, have led to substantial increases in neonatal survival in high-mortality settings. Participatory interventions with women's groups work by providing a forum for communities to develop a common understanding of maternal and neonatal problems, as well as locally acceptable and sustainable strategies to address these. Potential partners for scaling up interventions with women's groups include government community health workers and volunteers, as well as organizations working with self-help groups. It is important to tailor scale-up efforts to local contexts, while retaining fidelity to the intervention, by ensuring that the mobilization of women's groups complements other local programs (e.g. home visits), and by providing capacity building for participatory learning and action methods across a range of nongovernmental organizations and government stakeholders. Research into scale-up mechanisms and effectiveness is needed to inform further implementation, and prospective surveillance of maternal and neonatal mortality in key scale-up sites can provide valuable data for measuring impact and for advocacy. There is a need for further research into the role of participatory interventions with women's groups to improve the quality of health services, health, and nutrition beyond the perinatal period, as well as the role of groups in influencing non-health issues, such as women's decision-making power.

*** Nair, S. & Howlett, M. Scaling up of Policy Experiments and Pilots: A Qualitative Comparative Analysis and Lessons for the Water Sector. 2015. *Water Resource Management*, 29: 4945. doi:10.1007/s11269-015-1081-0**

http://link.springer.com/article/10.1007/s11269-015-1081-0

Authors' Abstract

The use of experimentation by practitioners and resource managers as a policy instrument for effective policy design under complex and dynamic conditions has been well-acknowledged both in theory and practice. For issues such as water resource management, policy experimentation, especially pilot projects, can play an important role in exploring alternate courses of action when faced with long-term uncertainty. While the political aspects of experimentation design and outcomes have been alluded to by several policy scholars, there is lack of empirical evidence that explores their interplay with other factors that may also be critical for scaling up of policy experiments. This paper examines experiences with scaling up of different types of water policy experiments through a Qualitative Comparative Analysis of fifteen pilot initiatives

in multiple sectors. Presence of political support is found to be necessary for scaling up in 97 % of the cases studied, followed closely by the need for synergies with ongoing policies and programmes. When in combination with effective pilot planning and strong monitoring and evaluation, both these factors create a sufficient condition for successful scaling up in nearly 60 % of the cases studied.

Nakimuli-Mpungu E, Alderman S, Kinyanda E et al. 2013. "Implementation and scale-up of psycho-trauma centers in a post-conflict area: a case study of a private-public partnership in Northern Uganda," *PLoS Medicine,* 10 (4): e1001427.

http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001427

Summary points

- The Peter C. Alderman Foundation (PCAF) and Ugandan government institutions initiated a public–private partnership (PPP) demonstrating the feasibility of delivering low cost, evidence-based mental health care to massively traumatized populations in northern Uganda.
- The PPP employed a systems approach to mental health care, wherein clinics could deliver uniform treatment that was locally adapted to each tribal culture.
- The PPP leveraged its pooled resources, raising the value of patient care to a level that none of the partners could provide by working alone.
- The PPP established metrics to assess the impact of therapy on war-affected people remaining in their own country after the cessation of hostilities. The ongoing prospective evaluation of PCAF program participants offers valuable information on the potential benefits of treating depression, post-traumatic stress disorder, and other mental, neurological, and substance use disorders in post-conflict low- and middle-income countries.

Norton WE, McCannon CJ, Schall MW et al. 2012. "A stakeholder-driven agenda for advancing the science and practice of scale-up and spread in health," *Implementation Science*, 7:118.

http://www.implementationscience.com/content/7/1/118

Authors' Abstract

Background: Although significant advances have been made in implementation science, comparatively less attention has been paid to broader scale-up and spread of effective health programs at the regional, national, or international level. To address this gap in research, practice and policy attention, representatives from key stakeholder groups launched an initiative to identify gaps and stimulate additional interest and activity in scale-up and spread of effective health programs. We describe the background and motivation for this initiative and the content, process, and outcomes of two main phases comprising the core of the initiative: a

state-of-the-art conference to develop recommendations for advancing scale-up and spread and a follow-up activity to operationalize and prioritize the recommendations. The conference was held in Washington, D.C. during July 2010 and attended by 100 representatives from research, practice, policy, public health, healthcare, and international health communities; the follow-up activity was conducted remotely the following year.

Discussion: Conference attendees identified and prioritized five recommendations (and corresponding sub-recommendations) for advancing scale-up and spread in health: increase awareness, facilitate information exchange, develop new methods, apply new approaches for evaluation, and expand capacity. In the follow-up activity, 'develop new methods' was rated as most important recommendation; expanding capacity was rated as least important, although differences were relatively minor.

Summary: Based on the results of these efforts, we discuss priority activities that are needed to advance research, practice and policy to accelerate the scale-up and spread of effective health programs.

Nyonator FK, Awoonor-Williams JK, Phillips JF et al. 2005. "The Ghana community-based health planning and services initiative for scaling up service delivery innovation." ***Health Policy and Planning*****, 20(1):25-34.**

http://heapol.oxfordjournals.org/content/20/1/25.full.pdf+html

Authors' Abstract

Research projects demonstrating ways to improve health services often fail to have an impact on what national health programmes actually do. An approach to evidence-based policy development has been launched in Ghana which bridges the gap between research and programme implementation. After nearly two decades of national debate and investigation into appropriate strategies for service delivery at the periphery, the Community-based Health Planning and Services (CHPS) Initiative has employed strategies tested in the successful Navrongo experiment to guide national health reforms that mobilize volunteerism, resources and cultural institutions for supporting community-based primary health care. Over a 2-year period, 104 out of the 110 districts in Ghana started CHPS. This paper reviews the development of the CHPS initiative, describes the processes of implementation and relates the initiative to the principles of scaling up organizational change which it embraces. Evidence from the national monitoring and evaluation programme provides insights into CHPS' success and identifies constraints on future progress.

Nyonator FK, Akosa AB, Awooner-Williams JK et al. 2007. Scaling-up experimental project success with the Community-based Health Planning and Services initiative in Ghana. In: Simmons R, Fajans P, Ghiron L, eds. Scaling up health service delivery: from pilot innovations to policies and programmes. Geneva, World Health Organization, 89–111.

http://expandnet.net/PDFs/Scaling_Up_HS_Delivery_Chapter_5.pdf

Authors' Abstract
The Community-based Health Planning and Services (CHPS) initiative in Ghana is an example of a strategy for scaling up afield trial to become a national programme. Representing a response to the problem that research projects can inadvertently produce nonreplicable service delivery capabilities, CHPS develops mechanisms for expanding national understanding and use of research findings to serve the health service needs of all Ghanaian households. This chapter describes strategies for introducing and developing community health services that were successfully tested in a Navrongo Health Research Centre trial and validated in Nkwanta District for a national programme of reorienting primary health care from clinics to communities. Nurses, once confined to clinical duties, are relocated to community-constructed clinics where they live and work. Volunteers support their services by mobilizing traditional social institutions to foster community support. Strategies for decentralized planning ensure that operational details of the programme are adapted to local circumstances. Strengths and limitations of the programme are reviewed and discussed.

Paina L, Peters DH. 2011. "Understanding pathways for scaling up health services through the lens of complex adaptive systems," *Health Policy and Planning*, 1-9.

http://heapol.oxfordjournals.org/content/early/2011/08/05/heapol.czr054.full.pdf+html

Authors' Abstract
Despite increased prominence and funding of global health initiatives, efforts to scale up health services in developing countries are falling short of the expectations of the Millennium Development Goals. Arguing that the dominant assumptions for scaling up are inadequate, we propose that interpreting change in health systems through the lens of complex adaptive systems (CAS) provides better models of pathways for scaling up. Based on an understanding of CAS behaviours, we describe how phenomena such as path dependence, feedback loops, scale-free networks, emergent behaviour and phase transitions can uncover relevant lessons for the design and implementation of health policy and programmes in the context of scaling up health services. The implications include paying more attention to local context, incentives and institutions, as well as anticipating certain types of unintended consequences that can undermine scaling up efforts, and developing and implementing programmes that engage key actors through transparent use of data for ongoing problem-solving and adaptation. We propose that future efforts to scale up should adapt and apply the models and methodologies which have been used in other fields that study CAS, yet are underused in public health. This can help policy makers, planners, implementers and researchers to explore different and

innovative approaches for reaching populations in need with effective, equitable and efficient health services. The old assumptions have led to disappointed expectations about how to scale up health services, and offer little insight on how to scale up effective interventions in the future. The alternative perspectives offered by CAS may better reflect the complex and changing nature of health systems, and create new opportunities for understanding and scaling up health services.

Pallas SW, Minhas D, Perez-Escamilla R et al. 2013. "Community health workers in low- and middle-income countries: What do we know about scaling up and sustainability?" ***American Journal of Public Health,*** **103:e74-82.**

http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2012.301102

Authors' Abstract
Objectives: We sought to provide a systematic review of the determinants of success in scaling up and sustaining community health worker (CHW) programs in low- and middle-income countries (LMICs).

Methods: We searched 11 electronic databases for academic literature published through December 2010 (n = 603 articles). Two independent reviewers applied exclusion criteria to identify articles that provided empirical evidence about the scale-up or sustainability of CHW programs in LMICs, and then extracted data from each article by using a standardized form. We analyzed the resulting data for determinants and themes through iterated categorization.

Results: The final sample of articles (n = 19) present data on CHW programs in 16 countries. We identified 23 enabling factors and 15 barriers to scale-up and sustainability, which were grouped into 3 thematic categories: program design and management, community fit, and integration with the broader environment.

Conclusions: Scaling up and sustaining CHW programs in LMICs requires effective program design and management, including adequate training, supervision, motivation, and funding; acceptability of the program to the communities served; and securing support for the program from political leaders and other health care providers.

Pathfinder International. 2011. "Integrating family planning and HIV in Ethiopia: An analysis of Pathfinder's approach and scale-up," Technical brief.

http://www.pathfinder.org/publications-tools/pdfs/Integrating-Family-Planning-and-HIV-in-Ethiopia-An-Analysis-of-Pathfinders-Approach-and-Scale-Up.pdf

Pathfinder International Ethiopia has extensive experience implementing family planning (FP)/HIV integration through public health centers (HCs) and community networks. This brief describes our approach and its evolution and scale-up over time. It presents our experience in relation to the recommendations of World Health Organization (WHO) guidelines on FP/HIV integration and also outlines next steps and recommendations.

Pathfinder International. 2012 "Scale-up of task-shifting for community-based provision of Implanon. 2009-2011 technical summary."

http://www2.pathfinder.org/site/DocServer/Implanon_Pub_11.2.2011_Rev.pdf?docID=19681

Pérez D, Lefevre P, Castro M et al. 2011. "Process-oriented fidelity research assists in evaluation, adjustment and scaling-up of community-based interventions," *Health Policy and Planning*, 26: 413–422.

http://heapol.oxfordjournals.org/content/26/5/413.full.pdf

Authors' Abstract

Fidelity research can help to answer essential questions about the diffusion process of innovative health interventions and provide insights for further scaling-up and institutionalization. This study assessed fidelity and reinvention in the implementation of a community-based control strategy for Aedes Aegypti control. The intervention was implemented in 16 study areas in La Lisa, a municipality of Havana, Cuba. Its major components were: organization & management, capacity-building, community work and surveillance. A participatory assessment of process data was performed to determine whether the components and subcomponents were implemented, not-implemented or modified. Frequencies were tabulated over all circumscriptions (lowest level of local government) and the average was calculated for the four components. Spearman Rank correlation coefficients were calculated to explore the relationships between components. In addition, semi-structured interviews were conducted with co-ordinators of the strategy at different levels to identify difficulties encountered in the strategy's implementation. Surveillance was the most implemented component (72.9%) followed by capacity-building (54.7%). Community work and organization & management were less implemented or modified (50% and 45%, respectively). Apart from surveillance and capacity-building, all components are significantly and strongly correlated (Spearman Rank correlation coefficient > 0.70, $P < 0.01$). If one component is implemented in a circumscription, the other components are also likely to be implemented. It is noticeable that areas which did not undergo organizational changes commonly did not implement community work activities. Within the whole strategy, few activities were added. Scarcely implemented subcomponents were the most innovative. The difficulties encountered during implementation were related to appropriate training and skills, available time, lack of support and commitment to the strategy, lack of motivation of local leadership, and integration

of actors and resources. The study showed a wide variability of fidelity in the implementation of the intervention and highlighted challenges for scaling-up and institutionalization of the community-based intervention.

Perez-Escamilla R, Curry L, Minhas D et al. 2012. "Scaling up of breastfeeding promotion programs in low- and middle-income countries: the "breastfeeding gear" model," *Advances in Nutrition,* 3: 790-800.

http://advances.nutrition.org/content/3/6/790.abstract

Authors' Abstract
Breastfeeding (BF) promotion is one of the most cost-effective interventions to advance mother-child health. Evidence-based frameworks and models to promote the effective scale up and sustainability of BF programs are still lacking. A systematic review of peer-reviewed and gray literature reports was conducted to identify key barriers and facilitators for scale up of BF programs in low- and middle-income countries. The review identified BF programs located in 28 countries in Africa, Latin America and the Caribbean, and Asia. Study designs included case studies, qualitative studies, and observational quantitative studies. Only 1 randomized, controlled trial was identified. A total of 22 enabling factors and 15 barriers were mapped into a scale-up framework termed "AIDED" that was used to build the parsimonious breastfeeding gear model (BFGM). Analogous to a well-oiled engine, the BFGM indicates the need for several key "gears" to be working in synchrony and coordination. Evidence-based advocacy is needed to generate the necessary political will to enact legislation and policies to protect, promote, and support BF at the hospital and community levels. This political-policy axis in turn drives the resources needed to support workforce development, program delivery, and promotion. Research and evaluation are needed to sustain the decentralized program coordination "gear" required for goal setting and system feedback. The BFGM helps explain the different levels of performance in national BF outcomes in Mexico and Brazil. Empirical research is recommended to further test the usefulness of the AIDED framework and BFGM for global scaling up of BF programs.

Peters DH, Adam T, Alonge O et al. 2013. "Implementation research: what it is and how to do it," *BMJ,* 347:f6753.

http://www.bmj.com/content/347/bmj.f6753

Authors' Abstract
The field of implementation research is growing, but it is not well understood despite the need for better research to inform decisions about health policies, programmes, and practices. This article focuses on the context and factors affecting implementation, the key audiences for the research, implementation outcome variables that describe various aspects of how

implementation occurs, and the study of implementation strategies that support the delivery of health services, programmes, and policies. We provide a framework for using the research question as the basis for selecting among the wide range of qualitative, quantitative, and mixed methods that can be applied in implementation research, along with brief descriptions of methods specifically suitable for implementation research. Expanding the use of well-designed implementation research should contribute to more effective public health and clinical policies and programmes.

Peters DH, Tran NT, Adam T. 2013. "Implementation research in health: a practical guide," Alliance for Health Policy and Systems Research, World Health Organization, Geneva.

http://who.int/alliance-hpsr/alliancehpsr_irpguide.pdf

Authors' Executive Summary

Billions are spent on health innovations, but very little on how best to apply them in real-world settings. Despite the importance of implementation research, it continues to be a neglected field of study, partly because of a lack of understanding regarding what it is and what it offers. Intended for newcomers to the field, those already conducting implementation research, and those with responsibility for implementing programmes, this guide provides an introduction to basic implementation research concepts and briefly outlines what it involves, and describes the many exciting opportunities that it presents.

Phillips JF, Nyonator FK, Jones TC et al. 2007. Evidence-based scaling-up of health and family planning service innovations in Bangladesh and Ghana. In: Simmons R, Fajans P, Ghiron L, eds. *Scaling up health service delivery: from pilot innovations to policies and programmes.* Geneva, World Health Organization.

http://expandnet.net/PDFs/Scaling_Up_HS_Delivery_Chapter_6.pdf

Authors' Abstract

This chapter describes two initiatives that have utilized researchto guide the development and scaling up of community-basedhealth and family planning programmes. In Bangladesh andGhana, evidence was accumulated in stages, beginning with anexploratory investigation, followed by an experimental trial testingpotential interventions and a replication phase for validatingresearch results in a non-research programme setting. Theprocess concluded with research-guided programme expansion.Each stage was associated with shifts in generations of questions,mechanisms and outcomes as the process unfolded. Large-scalehealth systems development was achieved in both countries, notbecause the scaling-up strategies were alike but because similarresearch approaches led to different strategies adapted to contrastingsocietal and institutional contexts.

Progress Project, FHI360. 2011. "Scaling up community-based distribution of injectable contraception: Case studies from Madagascar and Uganda."
No abstract available

http://www.k4health.org/sites/default/files/Scaling%20Up%20Community-Based%20Distribution%20of%20Injectable%20Contraception_Madagascar%20and%20Uganda_0.pdf

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RamaRao S, Townsend JW, Diop N et al. 2011. "Postabortion care: going to scale". *International Perspectives on Sexual and Reproductive Health*, 37:40-4.

http://www.guttmacher.org/pubs/journals/3704011.pdf

Authors' Abstract
This commentary discusses the complementary efforts required to ensure that research findings associated with designing and delivering postabortion care services are utilized and scaled up. It describes the complementary efforts as ranging from identifying champions and advocates for postabortion care to providing technical assistance for replication and scale-up. It draws on specific country program experiences in sub-Saharan Africa, Latin America and Asia where postabortion care services have been, or have the potential to be, scaled up.

Rasschaert F, Philips M, Leemput V et al. 2011. "Tackling health workforce shortages during antiretroviral treatment scale-up—Experiences from Ethiopia and Malawi," Journal of Acquired Immune Deficiency Syndromes, 57(Suppl 2): S109–12.

http://www.ncbi.nlm.nih.gov/pubmed/21857292 (abstract only)

Authors' Abstract
In many sub-Saharan countries, the health workforce shortage has been a major constraint in the scale-up of antiretroviral treatment. This human resource crisis has led to profound adjustments of the antiretroviral treatment care delivery model in several countries in the region. It also inspired some governments to take swift measures to substantially increase human resources capacity. This article draws on the experience of Malawi and Ethiopia, which have been able to successfully increase their health workforce over a relatively short period, allowing scaling up of antiretroviral treatment. Additional international HIV funding and strong political commitment made possible this exceptional response. Both countries implemented a combination of measures to tackle the human resource crisis: the delegation of medical and administrative tasks to lower health cadres and lay workers, the introduction of new health cadres, the reinforcement of pre-service training, and improving health staff remuneration. In particular, the involvement of community and lay health workers in HIV-related service delivery substantially increased the health workforce. The involvement of lay cadres has important long-

term implications. To sustain results, continued political commitment, ongoing training and supervision to maintain quality of care, and strategies to avoid attrition among lay cadres will be essential. Although task shifting and involvement of lay cadres allowed bridging of the human resource gap in a short time, other strategies have to be considered simultaneously, and all interventions must be maintained over a longer period to yield results.

Renju J, Andrew B, Nyalali K et al. 2010. "A process evaluation of the scale up of a youth-friendly health services initiative in northern Tanzania." ***Journal of the International AIDS Society,*** **13:32.**

http://www.jiasociety.org/index.php/jias/article/view/17552

Authors' Abstract
Background: While there are a number of examples of successful small-scale, youth-friendly services interventions aimed at improving reproductive health service provision for young people, these projects are often short term and have low coverage. In order to have a significant, long-term impact, these initiatives must be implemented over a sustained period and on a large scale. We conducted a process evaluation of the 10-fold scale up of an evaluated youth-friendly services intervention in Mwanza Region, Tanzania, in order to identify key facilitating and inhibitory factors from both user and provider perspectives. **Methods**: The intervention was scaled up in two training rounds lasting six and 10 months. This process was evaluated through the triangulation of multiple methods: (i) a simulated patient study; (ii) focus group discussions and semi-structured interviews with health workers and trainers; (iii) training observations; and (iv) pre- and post-training questionnaires. These methods were used to compare pre- and post-intervention groups and assess differences between the two training rounds.

Results: Between 2004 and 2007, local government officials trained 429 health workers. The training was well implemented and over time, trainers' confidence and ability to lead sessions improved. The district-led training significantly improved knowledge relating to HIV/AIDS and puberty (RR ranged from 1.06 to 2.0), attitudes towards condoms, confidentiality and young people's right to treatment (RR range: 1.23-1.36). Intervention health units scored higher in the family planning and condom request simulated patient scenarios, but lower in the sexually transmitted infection scenario than the control health units. The scale up faced challenges in the selection and retention of trained health workers and was limited by various contextual factors and structural constraints.

Conclusions: Youth-friendly services interventions can remain well delivered, even after expansion through existing systems. The scaling-up process did affect some aspects of intervention quality, and our research supports others in emphasizing the need to train more staff (both clinical and non-clinical) per facility in order to ensure youth-friendly services delivery. Further research is needed to identify effective strategies to address structural constraints and broader social norms that hampered the scale up.

Renju J, Makokha M, Kato C et al. 2010. "Partnering to proceed: scaling up adolescent sexual reproductive health programmes in Tanzania. Operational research into the factors that influenced local government uptake and implementation." ***Health Research Policy and Systems*****, 8:12.**

http://www.health-policy-systems.com/content/pdf/1478-4505-8-12.pdf

Authors' Abstract
Background: Little is known about how to implement promising small-scale projects to reduce reproductive ill health and HIV vulnerability in young people on a large scale. This evaluation documents and explains how a partnership between a non-governmental organization (NGO) and local government authorities (LGAs) influenced the LGA-led scale-up of an innovative NGO programme in the wider context of a new national multisectoral AIDS strategy.

Methods: Four rounds of semi-structured interviews with 82 key informants, 8 group discussions with 49 district trainers and supervisors (DTS), 8 participatory workshops involving 52 DTS, and participant observations of 80% of LGA-led and 100% of NGO-led meetings were conducted, to ascertain views on project components, flow of communication and decision-making and amount of time DTS utilized undertaking project activities.

Results: Despite a successful ten-fold scale-up of intervention activities in three years, full integration into LGA systems did not materialize. LGAs contributed significant human resources but limited finances; the NGO retained control over finances and decision-making and LGAs largely continued to view activities as NGO driven. Embedding of technical assistants (TAs) in the LGAs contributed to capacity building among district implementers, but may paradoxically have hindered project integration, because TAs were unable to effectively transition from an implementing to a facilitating role. Operation of NGO administration and financial mechanisms also hindered integration into district systems.

Conclusions: Sustainable intervention scale-up requires operational, financial and psychological integration into local government mechanisms. This must include substantial time for district systems to try out implementation with only minimal NGO support and modest output targets. It must therefore go beyond the typical three- to four-year project cycles. Scale-up of NGO pilot projects of this nature also need NGOs to be flexible enough to adapt to local government planning cycles and ongoing evaluation is needed to ensure strategies employed to do so really do achieve full intervention integration.

Renju J, Nyalali K, Andrew B et al. 2010. "Scaling up a school-based sexual and reproductive health intervention in rural Tanzania: A process evaluation describing the implementation realities for the teachers," *Health Education Research*, 25(6): 903-916.

http://her.oxfordjournals.org/content/25/6/903.full

Authors' Abstract
Little is known about the nature and mechanisms of factors that facilitate or inhibit the scale-up and subsequent implementation of school-based adolescent sexual and reproductive health (ASRH) interventions. We present process evaluation findings examining the factors that affected the 10-fold scale-up of such an intervention, focusing on teachers ' attitudes and experiences. Qualitative interviews and focus group discussions with teachers, head teachers, ward education coordinators and school committees from eight schools took place before, during and after intervention implementation. The results were triangulated with observations of training sessions and training questionnaires. The training was well implemented and led to some key improvements in teachers' ASRH knowledge, attitudes and perceived self-efficacy, with substantial improvements in knowledge about reproductive biology and attitudes towards confidentiality. The trained teachers were more likely to consider ASRH a priority in schools and less likely to link teaching ASRH to the early initiation of sex than non-trained teachers. Facilitating factors included teacher enjoyment, their recognition of training benefits, the participatory teaching techniques, support from local government as well as the structured nature of the intervention. Challenges included differential participation by male and female teachers, limited availability of materials and high turnover of trained teachers.

Renju JR, Andrew B, Medard L et al. 2011. "Scaling up adolescent sexual and reproductive health interventions through existing government systems? A detailed process evaluation of a school-based intervention in Mwanza region in the northwest of Tanzania." *Journal of Adolescent Health,* 48(1)79-86.

http://www.jahonline.org/article/S1054-139X%2810%2900233-8/abstract

Authors' Abstract
Purpose: There is little evidence from the developing world of the effect of scale-up on model adolescent sexual and reproductive health (ASRH) programmes. In this article, we document the effect of scaling up a school-based intervention (MEMA kwa Vijana) from 62 to 649 schools on the coverage and quality of implementation
Methods: Observations of 1,111 students' exercise books, 11 ASRH sessions, and 19 peer-assistant role plays were supplemented with interviews with 47 ASRH-trained teachers, to assess the coverage and quality of ASRH sessions in schools.
Results: Despite various modifications, the 10-fold scale-up achieved high coverage. A total of 89% (989) of exercise books contained some MEMA kwa Vijana 2 notes. Teachers were enthusiastic and interacted well with students. Students enjoyed the sessions and scripted role plays strengthened participation. Coverage of the biological topics was higher than the psycho-

social sessions. The scale-up was facilitated by the structured nature of the intervention and the examined status of some topics. However, delays in the training, teacher turnover, and a lack of incentive for teaching additional activities were barriers to implementation.
Conclusions: High coverage of participatory school-based reproductive health interventions can be maintained during scale-up. However, this is likely to be associated with significant changes in programme content and delivery. A greater emphasis should be placed on improving teachers' capacity to teach more complex-skills–related activities. Future intervention scale-up should also include an increased level of supervision and may be strengthened by underpinning from national level directives and inclusion of behavioral topics in national examinations.

Rottach E, Hardee K, Jolivet R et al. 2012. "Integrating gender into the scale-up of family planning and maternal, neonatal, and child health programs." Working Paper No. 1. Futures Group, Health Policy Project, Washington, DC.

http://www.healthpolicyproject.com/pubs/51_ScaleupofGenderintoFPMCHprogramsJuly.pdf

Authors' Summary

Relevant literature indicates that the incorporation of strategies to address gender inequality can lead to improved health and program outcomes. Many donors and program implementers have begun to incorporate strategies and approaches that address gender barriers and constraints. However, it is not clear that regular attention is being paid to gender factors during program scale-up. Gender factors influence a range of scale-up processes, including the choice of which practices to bring to scale, methods of scale-up, and strategies for reaching target populations. Throughout the scale-up process greater awareness of underlying gender norms and factors could strengthen scale-up efforts through improved understanding of the family planning and maternal, neonatal, and child health (FP/MNCH) issuesat hand. A more in-depth understanding of the situation informs development of strategies for how to increase reach and access to anduse of the intervention. We conducted a literature review to identify and analyze whether systematic attention to gender factors during the planning and process of scaling up FP/MNCH programs improves the effectiveness of that process. Our hypothesis is that incorporating gender strategies during program scale-up would in fact achieve better programmatic outcomes (e.g., wider availability of health services, health interventions institutionalized and sustained) and health outcomes (e.g., increased contraceptive prevalence rate, decreased maternal mortality rate) among their clients.

Samandari G, Wolf M, Basnett I et al. 2012. "Implementation of legal abortion in Nepal: a model for rapid scale-up of high-quality care," *Reproductive Health*, 9:7 doi:10.1189/1742-4755-9-7.

http://www.reproductive-health-journal.com/content/9/1/7

Authors' Abstract

Unsafe abortion's significant contribution to maternal mortality and morbidity was a critical factor leading to liberalization of Nepal's restrictive abortion law in 2002. Careful, comprehensive planning among a range of multisectoral stakeholders, led by Nepal's Ministry of Health and Population, enabled the country subsequently to introduce and scale up safe abortion services in a remarkably short timeframe. This paper examines factors that contributed to rapid, successful implementation of legal abortion in this mountainous republic, including deliberate attention to the key areas of policy, health system capacity, equipment and supplies, and information dissemination. Important elements of this successful model of scaling up safe legal abortion include: the pre-existence of postabortion care services, through which health-care providers were already familiar with the main clinical technique for safe abortion; government leadership in coordinating complementary contributions from a wide range of public- and private-sector actors; reliance on public-health evidence in formulating policies governing abortion provision, which led to the embrace of medical abortion and authorization of midlevel providers as key strategies for decentralizing care; and integration of abortion care into existing Safe Motherhood and the broader health system. While challenges remain in ensuring that all Nepali women can readily exercise their legal right to early pregnancy termination, the national safe abortion program has already yielded strong positive results. Nepal's experience making high-quality abortion care widely accessible in a short period of time offers important lessons for other countries seeking to reduce maternal mortality and morbidity from unsafe abortion and to achieve Millennium Development Goals.

*** Sauerhaft B and Hope-Johnstone I. "Scaling up agricultural supply chains in the private sector." Focus 19. Brief 8. 2012. In "Scaling up in agriculture rural development, and nutrition." Edited by Johannes Linn. 2012. 2020 Vision for Food, Agriculture, and the Environment. International Food Policy Research Institute.**

http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/126977/filename/127188.pdf

No abstract

Schneider H, Coetzee D, Van Rensburg D et al. 2010. "Differences in antiretroviral scale up in three South African provinces: The role of implementation management." *BMC Health Services Research*, 10(Suppl 1):S4.

http://www.biomedcentral.com/content/pdf/1472-6963-10-S1-S4.pdf

Authors' Abstract
Background: South Africa's antiretroviral programme is governed by defined national plans, establishing treatment targets and providing funding through ring-fenced conditional grants. However, in terms of the country's quasi-federal constitution, provincial governments bear the main responsibility for provision of health care, and have a certain amount of autonomy and

therefore choice in the way their HIV/AIDS programmes are implemented.

Methods: The paper is a comparative case study of the early management of ART scale up in three South African provincial governments – Western Cape, Gauteng and Free State – focusing on both operational and strategic dimensions. Drawing on surveys of models of ART care and analyses of the policy process conducted in the three provinces between 2005 and 2007, as well as a considerable body of grey and indexed literature on ART scale up in South Africa, it draws links between implementation processes and variations in provincial ART coverage (low, medium and high) achieved in the three provinces.

Results: While they adopted similar chronic disease care approaches, the provinces differed with respect to political and managerial leadership of the programme, programme design, the balance between central standardisation and local flexibility, the effectiveness of monitoring and evaluation systems, and the nature and extent of external support and programme partnerships.

Conclusions: This case study points to the importance of sub-national programme processes and the influence of factors other than financing or human resource capacity, in understanding intervention scale up.

*** Schouten LMT, Hulscher MEJL, Everdingen JJE, Et al. 2008. "Evidence for the impact of quality improvement collaboratives: systematic review."** ***British Medical Journal,*** **336:1491-1499**

http://www.bmj.com/content/336/7659/1491

Authors' Abstract
Objective To evaluate the effectiveness of quality improvement collaboratives in improving the quality of care.

Data sources Relevant studies through Medline, Embase, PsycINFO, CINAHL, and Cochrane databases.

Study selection Two reviewers independently extracted data on topics, participants, setting, study design, and outcomes.

Data synthesis Of 1104 articles identified, 72 were included in the study. Twelve reports representing nine studies (including two randomised controlled trials) used a controlled design to measure the effects of the quality improvement collaborative intervention on care processes or outcomes of care. Systematic review of these nine studies showed moderate positive results. Seven studies (including one randomised controlled trial) reported an effect on some of the selected outcome measures. Two studies (including one randomised controlled trial) did not show any significant effect.

Conclusions The evidence underlying quality improvement collaboratives is positive but limited and the effects cannot be predicted with great certainty. Considering that quality improvement collaboratives seem to play a key part in current strategies focused on accelerating improvement, but may have only modest effects on outcomes at best, further knowledge of the basic components effectiveness, cost effectiveness, and success factors is crucial to determine the value of quality improvement collaboratives.

Scott VE, Chopra M, Conrad L et al. 2005. "How equitable is the scaling up of HIV service provision in South Africa?" ***South African Medical Journal,*** **95(2): 109-13.**

http://www.ncbi.nlm.nih.gov/pubmed/15751205
Access full text through the archives on the SAMJ website

Authors' Abstract
Objectives: To assess the extent of inequalities in availability and utilization of HIV services across South Africa.

Design: Cross-sectional descriptive study.

Setting: Three districts reflecting different socio- economic conditions, but with similar levels of HIV infection, were purposively sampled.

Outcome measures: Availability and utilization of HIV services and management and support structures for programmes were assessed through the collection of secondary data supplemented by site visits.

Results: There were marked inequalities in service delivery between the three sites. Compared with two poorer sites, clinics at the urban site had greater availability of HIV services, including voluntary counseling and testing (100% v. 52% and 24% respectively), better uptake of this service (59 v. 9 and 5.5 clients per 1000 adults respectively) and greater distribution of condoms (15.6 v. 8.2 condoms per adult male per year). Extra counselors had also been employed at the urban site in contrast to the other 2 sites. The urban site also had far more intensive management support and monitoring, with 1 manager per 12 health facilities compared with 1 manager per more than 90 health facilities at the other 2 sites.

Conclusion: The process of scaling up of HIV services seems to be accentuating inequalities. The urban site in this study was better able to utilize the extra resources. In contrast, the poorer sites have thus far been unable to scale up the response to HIV even with the availability of extra resources. Unless policy makers pay more attention to equity, efficacious interventions may prove to be of limited effectiveness.

*** Sgaier SK, Anthony J, Bhattacharjee P et al. 2014. "Strengthening government management capacity to scale up HIV prevention programs through the use of Technical Support Units: lessons from Karnataka state, India."** ***Advance Access in Global Health: Science and Practice.*** **November 25, 2014** ***p.1-15***

http://www.ghspjournal.org/content/early/2014/11/24/GHSP-D-14-00141.full.pdf+html

Authors' Abstract
Scaling up HIV prevention programming among key populations (female sex workers and men who have sex with men) has been a central strategy of the Government of India. However, state governments have lacked the technical and managerial capacity to oversee and scale up interventions or to absorb donor-funded programs. In response, the national government contracted Technical Support Units (TSUs), teams with expertise from the private and nongovernmental sectors, to collaborate with and assist state governments. In 2008, a TSU was established in Karnataka, one of 6 Indian states with the highest HIV prevalence in the country and where monitoring showed that its prevention programs were reaching only 5% of key populations. The TSU provided support to the state in 5 key areas: assisting in strategic planning, rolling out a comprehensive monitoring and evaluation system, providing supportive supervision to intervention units, facilitating training, and assisting with information, education, and communication activities. This collaborative management model helped to increase capacity of the state, enabling it to take over funding and oversight of HIV prevention programs previously funded through donors. With the combined efforts of the TSU and the state government, the number of intervention units statewide increased from 40 to 126 between 2009 and 2013. Monthly contacts with female sex workers increased from 5% in 2008 to 88% in 2012, and with men who have sex with men, from 36% in 2009 to 81% in 2012. There were also increases in the proportion of both populations who visited HIV testing and counseling centers (from 3% to 47% among female sex workers and from 6% to 33% among men who have sex with men) and sexually transmitted infection clinics (from 4% to 75% among female sex workers and from 7% to 67% among men who have sex with men). Changes in sexual behaviors among key populations were also documented. For example, between 2008 and 2010, the proportion of surveyed female sex workers in 9 districts reporting that they used a condom at last intercourse rose from 60% to 68%; in 6 districts, the proportion of surveyed men who have sex with men reporting that they used a condom at last anal sex increased from 89% to 97%. The Karnataka experience suggests that TSUs can help governments enhance managerial and technical resources and leverage funds more effectively. With careful management of the working and reporting relationships between the TSU and the state government, this additional capacity can pave the way for the government to improve and scale up programs and to absorb previously donor-funded programs.

Sgaier SK , Ramakrishnan A, Dhhingra N et al. 2013. "How the Avahan HIV Prevention Program transitioned from the Gates Foundation to the Government of India." *Health Affairs,* 32: 1265-73.

http://www.ncbi.nlm.nih.gov/pubmed/23836743 abstract only

Authors' Abstract

Developing countries face diminishing development aid and time-limited donor commitments that challenge the long-term sustainability of donor-funded programs to improve the health of local populations. Increasing country ownership of the programs is one solution. Transitioning managerial and financial responsibility for donor-funded programs to governments and local stakeholders represents a highly advanced form of country ownership, but there are few successful examples among large-scale programs. We present a transition framework and describe how it was used to transfer the Bill & Melinda Gates Foundation's HIV/AIDS prevention program, the Avahan program, to the Government of India. Essential features recommended for the transition of donor-funded programs to governments include early planning with the government, aligning donor program components with government structures and funding models prior to transition, building government capacity through active technical and management support, budgeting for adequate support during and after the transition, and dividing the transition into phases to allow time for adjustments and corrections. The transition of programs to governments is an important sustainability strategy for efforts to scale up HIV prevention programs to reach the populations most at risk.

*** Shelton JD. 2014. "Evidence-based public health: not only whether it works, but how it can be made to work practicably at scale." *Global Health Science and Practice,* 2(3) 253-257.**

http://www.ghspjournal.org/content/2/3/253.full.pdf

Author's Abstract

Because public health must operate at scale in widely diverse, complex situations, randomized controlled trials (RCTs) have limited utility for public health. Other methodologies are needed. A key conceptual backbone is a detailed "theory of change" to apply appropriate evidence for each operational component. Synthesizing patterns of findings across multiple methodologies provides key insights. Programs operating successfully across a variety of settings can provide some of the best evidence. Challenges include judging the quality of such evidence and assisting programs to apply it. WHO and others should shift emphasis from RCTs to more relevant evidence when assessing public health issues.

Simmons R, Ghiron L, Fajans P. 2012. "Scaling up the Standard Days Method® of family planning in five countries," Unpublished manuscript.

http://irh.org/wp-content/uploads/2013/07/Scaling_Up_the_Standard_Days_Method_ExpandNet_FINAL.pdf

Authors' Abstract
Background: This paper uses the ExpandNet framework to analyze the process of scaling up access to an innovative, natural, modern family planning method, the Standard Days Method® (SDM), in five countries: the Democratic Republic of the Congo (DRC), Guatemala, India, Mali and Rwanda.

Methods: Findings are assessed at the midpoint of a six-year scale-up project and are based on in-depth interviews about project implementation with headquarters and field staff of the Institute for Reproductive Health of Georgetown University, participant observation through field trips to two countries, and review of country-level monitoring data and project documents.

Results: SDM was substantially institutionalized in policies, norms and guidelines and was made available in numerous service delivery sites over the three-year period, although the extent of expansion varied significantly. Demand creation efforts were more limited. Results on the process of expansion showed that scaling up of SDM required 1) a considerable degree of change in the behavior of method users and in the service delivery system; 2) substantial simplification of the training process and materials; 3) adaptation of promotional strategies related to male involvement, condom use, gender issues and other socio-cultural characteristics of the country; 4) capacity building of the public sector in the provision of family planning, beyond a narrow focus on SDM; and 5) partnering with NGOs and the private sector. Government interest in the method in the five countries was an important factor in explaining the success attained; however, continued professional bias among health providers and decision makers remained a significant obstacle. The dedication and the level of effort of the IRH resource team supporting activities and their close coordination with the government were important factors in explaining the progress made.

Conclusion: The country studies identified three major conclusions that have implications for future scaling up of family planning and other health interventions. These relate to: 1) the importance of systems-based strategies rather than single-focused approaches such as training, 2) the need to strike a balance between working to increase the supply-side vs. strengthening the demand-side, and 3) the central role of the resource team working to expand and institutionalize the innovation.

Simmons R, Brown J, Díaz M. 2002. "Facilitating large-scale transitions to quality of care: An idea whose time has come". *Studies in Family Planning*, 33:61-75.

http://www.expandnet.net/PDFs/Facilitating%20Large%20Scale%20Transitions.pdf

Authors' Abstract
In the field of reproductive health, investigation of the transfer of knowledge gained from demonstration and pilot projects to large public- sector programs typically has not been considered a relevant domain for research or other investigation. This article draws on a range of research in the social sciences and presents two frameworks for understanding the critical attributes of successful expansion of small-scale innovations. Seven key lessons are developed using examples from family planning where scaling up was an explicit objective, including the early Taichung Study of Taiwan, the Chinese Experiment in Quality of Care, the Bangladesh MCH-FP Extension Project, the Navrongo Project in Ghana, and the Reprolatina Project in Brazil. Unless small, innovative projects concern themselves from the outset with determining how their innovations can be put to use on a larger scale, they risk remaining irrelevant for policy and program development.

Simmons R, Fajans P, Ghiron L, eds. 2007. Scaling up health service delivery: from pilot innovations to policies and programmes. World Health Organization, Geneva.

http://www.who.int/reproductivehealth/publications/strategic_approach/9789241563512/en/index.html

http://expandnet.net/volume.htm (individual chapters as well as the entire book are available for download at this address)

Authors' Abstract
This book addresses some of the issues involved in scaling up health service delivery. The focus is on ways to increase the impact of health service innovations that have been tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting, sustainable basis. The book addresses a major failure in the global health and development field: namely, the failure to expand the many successful small-scale pilot or demonstration projects that have been organized around the world so as to benefit larger populations than those initially served. It presents a conceptual framework for thinking about scaling up as well as case-studies from Africa, Asia and Latin America where the potential for expansion was a concern from the very inception of pilot or experimental projects. The case-studies discuss family planning and related sexual and reproductive health service interventions as well as other innovations in primary health care.

Simmons R, Shiffman J. 2007. "Scaling-up reproductive health service innovations: a framework for action". In: Simmons R, Fajans P, Ghiron L, eds. *Scaling up health service delivery: from pilot innovations to policies and programmes.* World Health Organization, Geneva.

http://expandnet.net/PDFs/Scaling-Up_Health_Service_Delivery-WHO-ExpandNet.pdf

Authors' Abstract
This chapter provides a conceptual framework for scaling up, with a focus on evidence-based reproductive health service innovations. It cites an extensive literature from several disciplines. The framework links an innovation to be scaled up with four other elements: a resource team that promotes it; a user organization expected to adopt the innovation; a strategy to transfer it; and an environment in which the transfer takes place. The authors discuss key attributes that have been found to facilitate the scaling-up process and identify strategic choices that must be made to ensure success. A final section identifies the diverse environments in which scaling up occurs, arguing that successful scale up requires tailoring strategies to the various dimensions of these settings.

Simmons R, Fajans P, Ghiron L. 2007. "Introduction". In: Simmons R, Fajans P, Ghiron L, eds. Scaling up health service delivery: from pilot innovations to policies and programmes. World Health Organization, Geneva.

http://expandnet.net/PDFs/Scaling-Up_Health_Service_Delivery-WHO-ExpandNet.pdf
No abstract available

Simmons R, Fajans P, Ghiron L. 2007. "Conclusions". In: Simmons R, Fajans P, Ghiron L, eds. *Scaling up health service delivery: from pilot innovations to policies and programmes.* World Health Organization, Geneva.

http://expandnet.net/PDFs/Scaling_Up_HS_Delivery_Conclusions.pdf
No abstract available

Skibiak J, Mijere P, Zama M. 2007. "Expanding contraceptive choice and improving quality of care in Zambia's Copperbelt: A case study in moving from pilot projects to regional programmes." In: Simmons R, Fajans P, Ghiron L, eds. *Scaling up health service delivery: from pilot innovations topolicies and programmes.* World Health Organization, Geneva.

http://expandnet.net/PDFs/Scaling_Up_HS_Delivery_Chapter_4.pdf

Authors' Abstract
This case-study explores the programmatic challenges of movingfrom pilot interventions to regional programmes. It documentsthe history of an initiative to scale up reproductive health interventions,developed and tested between 1996 and 2000 in Zambia'sCopperbelt Province. The interventions included an expansion ofthe range of contraceptive methods available at health facilities,the development of innovative training approaches for healthcareworkers, and

the testing of strategies to reach out to communities.This chapter highlights the challenges facing programmedesigners as they must decide which elements of a pilot study toscale up, the structures most appropriate for managing the process,and the pace and breadth of the expansion effort. Finally, itprovides a conceptual framework to guide the scaling-up processand to weigh the potential trade-offs between increasing scaleand the need to maintain quality, local values, local relevance andsustainability.

*** Smith JM, de Graft-Johnson J, Zyaee P, Ricca J, Fullerton J. "Scaling up high-impact interventions: How is it done?" *International Journal of Gynecology and Obstetrics,* 130 (2015) S4–S10**

http://www.ijgo.org/article/S0020-7292(15)00139-3/pdf

Authors' Abstract

Building upon the World Health Organization's ExpandNet framework, 12 key principles of scale-up have emerged from the implementation of maternal and newborn health interventions. These principles are illustrated by three case studies of scale up of high-impact interventions: the Helping Babies Breathe initiative; preservice midwifery education in Afghanistan; and advanced distribution of misoprostol for self-administration at home births to prevent postpartum hemorrhage. Program planners who seek to scale a maternal and/or newborn health intervention must ensure that: the necessary evidence and mechanisms for local ownership for the intervention are well-established; the intervention is as simple and cost-effective as possible; and the implementers and beneficiaries of the intervention are working in tandem to build institutional capacity at all levels and in consideration of all perspectives.

*** Spicer N, Bhattacharya D, Dimka R, Fanta F, Mangham-Jefferies L, Schellenberg J, Tamire-Woldemariam A et al. 2014. "'Scaling-up is a craft not a science': Catalysing scale-up of health innovations in Ethiopia, India and Nigeria." *Social Science & Medicine*, 121 30e38.**

http://www.sciencedirect.com/science/article/pii/S0277953614006133

Authors' Abstract

Donors and other development partners commonly introduce innovative practices and technologies to improve health in low and middle income countries. Yet many innovations that are effective in improving health and survival are slow to be translated into policy and implemented at scale. Understanding the factors influencing scale-up is important. We conducted a qualitative study involving 150 semi-structured interviews with government, development partners, civil society organisations and externally funded implementers, professional associations and academic institutions in 2012/13 to explore scale-up of innovative interventions targeting mothers and newborns in Ethiopia, the Indian state of Uttar Pradesh and the six states of northeast Nigeria, which are settings with high burdens of maternal and neonatal mortality. Interviews were analysed using a common analytic framework developed for

cross-country comparison and themes were coded using Nvivo. We found that programme implementers across the three settings require multiple steps to catalyse scale-up. Advocating for government to adopt and finance health innovations requires: designing scalable innovations; embedding scale-up in programme design and allocating time and resources; building implementer capacity to catalyse scale-up; adopting effective approaches to advocacy; presenting strong evidence to support government decision making; involving government in programme design; invoking policy champions and networks; strengthening harmonisation among external programmes; aligning innovations with health systems and priorities. Other steps include: supporting government to develop policies and programmes and strengthening health systems and staff; promoting community uptake by involving media, community leaders, mobilisation teams and role models. We conclude that scale-up has no magic bullet solution – implementers must embrace multiple activities, and require substantial support from donors and governments in doing so.

Subramanian S, Naimoli J, Matsubayashi T et al. 2011. "Do we have the right models for scaling up health services to achieve the Millennium Development Goals?" *BMC Health Services Research,* 11:336.

http://www.biomedcentral.com/content/pdf/1472-6963-11-336.pdf

Authors' Abstract
Background: There is widespread agreement on the need for scaling up in the health sector to achieve the Millennium Development Goals (MDGs). But many countries are not on track to reach the MDG targets. The dominant approach used by global health initiatives promotes uniform interventions and targets, assuming that specific technical interventions tested in one country can be replicated across countries to rapidly expand coverage. Yet countries scale up health services and progress against the MDGs at very different rates. Global health initiatives need to take advantage of what has been learned about scaling up.

Methods: A systematic literature review was conducted to identify conceptual models for scaling up health in developing countries, with the articles assessed according to the practical concerns of how to scale up, including the planning, monitoring and implementation approaches.

Results: We identified six conceptual models for scaling up in health based on experience with expanding pilot projects and diffusion of innovations. They place importance on paying attention to enhancing organizational, functional, and political capabilities through experimentation and adaptation of strategies in addition to increasing the coverage and range of health services. These scaling up approaches focus on fostering sustainable institutions and the constructive engagement between end users and the provider and financing organizations.

Conclusions: The current approaches to scaling up health services to reach the MDGs are overly simplistic and not working adequately. Rather than relying on blueprint planning and raising funds, an approach characteristic of current global health efforts, experience with

alternative models suggests that more promising pathways involve "learning by doing" in ways that engage key stakeholders, uses data to address constraints, and incorporates results from pilot projects. Such approaches should be applied to current strategies to achieve the MDGs.

Terris-Prestholt F, Kumaranayake L, Obasi AIN et al. 2006. "From trial intervention to scale-up: costs of an adolescent sexual health program in Mwanza, Tanzania," *Sexually Transmitted Diseases,* 33 (10 SUPPL): S133-S139.

http://journals.lww.com/stdjournal/Fulltext/2006/10001/From Trial Intervention to Scale Up Costs of an.9.aspx

Authors' Abstract
Objective: To estimate annual costs of a multifaceted adolescent sexual health intervention in Mwanza, Tanzania, by input (capital and recurrent), component (in-school, community activities, youth-friendly health services, condom distribution), and phase (development, startup, trial implementation, scale-up).

Study Design: Financial and economic providers' costs and intervention outputs were collected to estimate annual total and unit costs (1999-2001). The incremental financial budget projects funding requirements for scale-up within an integrated model.

Results: The 3-year economic costs of trial implementation were $879,032, of which ~70% were for the school-based component. Costs of initial development and startup were relatively substantial (~21% of total costs); however, annual costs per school child dropped from $16 in 1999 to $10 in 2001. The incremental scale-up cost is ~1/5 of ward trial implementation running costs.

Conclusions: Annual costs can reduce by almost 40% as project implementation matures. When scaled up, only an additional $1.54 is needed per pupil per year to continue the intervention.

*** USAID Health Care Improvement Project. 2008. The Improvement Collaborative: An Approach to Rapidly Improve Health Care and Scale Up Quality Services. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).**

https://www.usaidassist.org/sites/assist/files/the_improvement_collaborative.june08.pdf

Relevant paragraphs
Quality health care can be defined as accessible care that is delivered in compliance with evidence-based standards and that addresses clients' needs. High quality care is a function of the health system's ability to assure a continuum of care that addresses clients' needs in an

effective, responsive, and respectful manner. Underlying most definitions of health care quality are standards: explicit statements of how a health care activity should be performed in order to produce the desired outcomes (Ashton 2001). Standards are based on formal evidence that links specific care content or processes to a desired outcome. Performance according to standards is crucial for quality care because it is associated with improved health outcomes (Walker, Ashley, and Hayes 1988; Grimshaw and Russell 1993). Standards thus define for both health workers and clients alike what constitutes quality care.

Evidence-based standards and guidelines already exist or are rapidly emerging for most of the world's health priorities, particularly those embodied in the Millennium Development Goals. Yet, evidence from countries around the world suggests that the health care provided for much of the world's population is of very poor quality and does not meet evidence-based standards. Studies show that providers routinely comply with only a small proportion of guidelines, even after standards-based training (Nicholas, Heiby, and Hatzell 1991; Rowe at el. 2000; Rowe et al. 2001; Nolan et al. 2001; Harvey et al. 2004; Boonstra, Lindbaek, and Ngome 2005, Burkhalter et al. 2006; Osterholt et al. 2006; Edson, Burkhalter, and McCaw-Binns 2007).

Many factors contribute to poor quality care: lack of necessary supplies or equipment, lack of awareness of standards, low provider competence, poor organization of care, and lack of motivation or rewards for quality (Marquez 2001). Inefficient organization of care is common in many settings, resulting in poor health care quality and waste. Culturally inappropriate care or poor interpersonal treatment also contributes to poor quality care and negatively affects acceptance and utilization of health services, especially by disadvantaged and underserved groups.

Modern quality improvement (QI) approaches offer methods for overcoming common barriers to quality care, even in the context of weak health systems facing severe material and human resource constraints (Zeitz et al. 1993; Loevinsohn, Guerrero, and Gregorio 1995; Heiby 1998; Massoud et al. 2001; Kelley et al. 2001; Hermida and Robalino 2002; Berwick 2004; Rowe et al. 2005; Rennie et al. 2007; Dickson, Ashton, and Smith 2007). QI methods improve processes of care and are based on four principles: 1) understanding and focusing on client needs; 2) understanding how processes of care function within the system; 3) using data to measure result

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*** USAID. Idea to Impact: A Guide to Introduction and Scale of Global Health Innovations. 2015.**

https://www.usaid.gov/sites/default/files/documents/1864/Idea-to-Impact_Jan-2015-508.pdf

Relevant Paragraphs

Idea to Impact: A Guide to Introduction and Scale of Global Health Innovations consolidates and shares best practices and lessons learned from decades of scaling global health innovations and draws on best practices from the private sector, while offering a dynamic and flexible home for new thinking and advancements still to come. Many of the insights and examples are heavily

informed by the learnings and practices of private companies, non-governmental organizations, academia, USAID and other donors, and other public health experts.

With a focus on activities needed to support successful delivery, this Guide:

1. Introduces a framework that highlights priority introduction and scale activities.
2. Demonstrates the importance of priority activities through case studies and lessons learned.
3. Provides practitioners with a growing list of tools and an understanding of when and how to use them.

Frameworks that offer a structured process and clear accountability are not new to the private sector. BD (Becton, Dickinson and Company), an $8 billion medical device company, lays out years of development and launch activities in its "Global Product Development System." Medtronic calls their process the "Patient Access Acceleration Framework." GlaxoSmithKline applies a detailed "Marketing Framework" in preparation for all of its new product launches. In fact, while these companies may give different names to it, all major medical technology, pharmaceutical, and other product companies have defined processes with clear deliverables, timelines, and responsibility. They have learned that planning for scale must happen early, often years ahead of product approval. While scaling products in developing-country markets presents unique challenges, the rigor and principles behind these private-sector models can offer useful structure when developing, launching, and scaling up global health products.

This Guide was designed for the global health community, including USAID and other donors working at the global level who oversee grants and manage deliverables, and implementing partners who contribute to global development, introduction, and scale-up efforts of global health products. It can also inform social entrepreneurs and innovators, as well as commercial partners, such as medical device and pharmaceutical companies expanding into Southeast Asia and sub-Saharan Africa—home to some of the fastest growing health care markets in the world. Generally, the principles in this Guide can be applied to any global health product, whether a device, drug, diagnostic, vaccine, or consumer product.

*** Uvin P, Jain PS, and Brown LD. 2000. Think large and act small: Toward a new paradigm for NGO scaling up. *World Development, 28*(8), 1409-1419.**

http://www.sciencedirect.com/science/article/pii/S0305750X0000037I

Authors' Abstract

Scaling up is about "expanding impact" and not about "becoming large," the latter being only one possible way to achieve the former. The experiences of five Indian nongovernment organizations (NGOs) suggest the emergence of a new paradigm of scaling up, in which NGOs become catalysts of policy innovations and social capital, creators of programmatic knowledge that can be spun off and integrated into government and market institutions, and builders of

vibrant and diverse civil societies. We detail the mechanisms by which NGO impact can be scaled up without drastically increasing the size of the organization.

Uvin P and Miller D. 1994. "Scaling up: Thinking through the issues." The World Hunger Program, Watson Institute of International Studies, Brown University, Providence, RI.

http://www.globalpolicy.org/component/content/article/177/31630.html.

Authors' Abstract
Some important questions about scaling-up need to be answered. What role do the participants that expand the ranks of the scaled up organizations play within these organizations or within their funded projects? Is there a relationship between donor support of scaling-up and constituent participation? In what way will this new interest in scaling-up affect the rank and file of the participation movement? Has the redirection of development assistance toward scaling-up initiatives been effective? As Edwards and Hulme stated it: "how can [NGOs] increase their development impact without losing their traditional flexibility, value-base and effectiveness at the local level?" This article proposes a first scientific look at scaling up. It does not present any grand theory of scaling up, nor is it the result of detailed comparative field research. Rather, it represents what can be called a "pre-theory:" the development of some clear definitions and taxonomies, which can constitute the basis for scientific investigation and discussion. Indeed, only when there is an understanding of the dimensions of the concept of scaling up can donor and beneficiary, participant and observer, scholar and practitioner, begin to communicate in a way that can address the questions above. This article will also supply the interested reader with a foray into the existing literature, suggesting paths for further reading.

Van Damme W, Kober K, Kegels G. 2008. "Scaling-up antiretroviral treatment in Southern African countries with human resource shortage: how will health systems adapt?" *Social Science and Medicine*, 66:2108–21.

http://ac.els-cdn.com/S0277953608000555/1-s2.0-S0277953608000555-main.pdf?_tid=c13d80bc-091c-11e3-aab6-00000aab0f01&acdnat=1376950665_9f50528e2e207b450ab3ebbf18e960ad

http://www.sciencedirect.com/science/article/pii/S0277953608000555 abstract only

Authors' Abstract
Scaling-up antiretroviral treatment (ART) to socially meaningful levels in low-income countries with a high AIDS burden is constrained by (1) the continuously growing caseload of people to be maintained on long-term ART; (2) evident problems of shortage and skewed distribution in the health workforce; and (3) the heavy workload inherent to presently used ART delivery models. If we want to imagine how health systems can react to such challenges, we need to

understand better what needs to be done regarding the different types of functions ART requires, and how these can be distributed through the care supply system, knowing that different functions rely on different rationales (professional, bureaucratic, social) for which the human input need not necessarily be found in formal healthcare supply systems. Given the present realities of an increasingly pluralistic healthcare supply and highly eclectic demand, we advance three main generic requirements for ART interventions to be successful: trustworthiness, affordability and exclusiveness--and their constituting elements. We then apply this analytic model to the baseline situation (no fundamental changes) and different scenarios. In Scenario A there are no fundamental changes, but ART gets priority status and increased resources. In Scenario B the ART scale-up strengthens the overall health system: we detail a B1 technocratic variant scenario, with profoundly re-engineered ART service production, including significant task shifting, away from classical delivery models and aimed at maximum standardisation and control of all operations; while in the B2 community-based variant scenario the typology of ART functions is maximally exploited to distribute the tasks over a human potential pool that is as wide as possible, including patients and possible communities. The latter two scenarios would entail a high degree of de-medicalisation of ART.

*** Ved RR. 2009. Scaling - up ICDS: Can Universalisation Address Persistent Malnutrition? IDS Bulletin, 40(4), 53-59.**

https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/8094/IDSB_40_4_10.1111-j.1759-5436.2009.00059.x.pdf?sequence=1

A countrywide initiative, the ICDS programme is India's primary response to addressing child malnutrition, but has had mixed success on the state of malnutrition in India. This article reviews the ICDS from the perspective of a scaling-up management framework and analyses aspects of design, advocacy, implementation and monitoring in the scaling-up of ICDS. Universalisation of ICDS with quality is well within the means of government and recent advocacy has resulted in increased funding; the scaling-up of ICDS is challenging. Successful scaling-up of ICDS requires the implementation of a multicomponent model, demanding a high level of quality and performance, coordination and convergence in the face of varying and limited management and technical capacity, poor governance environments, and little experience of engaging communities. Success in addressing these constraints is possible but attention to detail is critical and lessons should be adapted to suit local context.

Victora CG, Barros FC, Assuncao MC et al. 2012. "Scaling up maternal nutrition programs to improve birth outcomes: a review of implementation issues," *Food & Nutrition Bulletin,* 33(Suppl 1): S6-26.

http://www.ingentaconnect.com/content/nsinf/fnb/2012/00000033/A00102s1/art00002?crawler=true

Authors' Abstract
Background: Maternal nutrition interventions are efficacious in improving birth outcomes. It is important to demonstrate that if delivered in field conditions they produce improvements in health and nutrition.

Objective: Analyses of scaling-up of five types of programs implemented in several countries. These include micronutrient supplementation, food fortification, food supplements, nutrition education and counseling, and conditional cash transfers (as a platform for delivering interventions). Evidence on impact and cost-effectiveness is assessed, especially on achieving high, equitable, and sustained coverage, and reasons for success or failure.

Methods: Systematic review of articles on large-scale programs in several databases. Two separate reviewers carried out independent searches. A separate review of the gray literature was carried out including websites of the most important organizations leading with these programs. With Google Scholar a detailed review of the 100 most frequently cited references on each of the five above topics was conducted.

Results: Food fortification programs: iron and folic acid fortification were less successful than salt iodization initiatives, as the latter attracted more advocacy. Micronutrient supplementation programs: Nicaragua and Nepal achieved good coverage. Key elements of success are antenatal care coverage, ensuring availability of tablets, and improving compliance. Integrated nutrition programs in India, Bangladesh, and Madagascar with food supplementation and/or behavioral change interventions report improved coverage and behaviors, but achievements are below targets. The Mexican conditional cash transfer program provides a good example of use of this platform to deliver maternal nutritional interventions.

Conclusions: Programs differ in complexity, and key elements for success vary with the type of program and the context in which they operate. Special attention must be given to equity, as even with improved overall coverage and impact inequalities may even be increased. Finally, much greater investments are needed in independent monitoring and evaluation.

*** Victora CG, Hanson K, Bryce J et al. 2004. Achieving universal coverage with health interventions. *Lancet*, 364(9444), 1541-1548.**

http://www.sciencedirect.com/science/article/pii/S0140673604172796

Authors' Abstract
Cost-effective public health interventions are not reaching developing country populations who need them. Programmes to deliver these interventions are too often patchy, low quality, inequitable, and short-lived. We review the challenges of going to scale—ie, building on known, effective interventions to achieve universal coverage. One challenge is to choose interventions consistent with the epidemiological profile of the population. A second is to plan for context-specific delivery mechanisms effective in going to scale, and to avoid uniform approaches. A third is to develop innovative delivery mechanisms that move incrementally along the vertical-

to-horizontal axis as health systems gain capacity in service delivery. The availability of sufficient funds is essential, but constraints to reaching universal coverage go well beyond financial issues. Accurate estimates of resource requirements need a full understanding of the factors that limit intervention delivery. Sound decisions need to be made about the choice of delivery mechanisms, the sequence of action, and the pace at which services can be expanded. Strong health systems are required, and the time frames and funding cycles of national and international agencies are often unrealistically short.

World Health Organization. 2004. "An approach to rapid scale-up using HIV/AIDS treatment and care as an example," World Health Organization, Geneva.

http://www.who.int/hiv/pub/prev_care/en/rapidscale_up.pdf

Author's Purpose

Scaling up – which is defined here as the activity of expanding an intervention or programme from initial facilities that serve a small proportion of the population to facilities that serve a significantly larger population (such as an entire region or country) – has several approaches. The World Health Organization (WHO) is in the process of exploring these approaches and of refining its recommendations, based on reviews and international experiences.

This document provides general guidance for policy-makers, health care managers and administrators, and health care providers on one general dynamic approach (process) to rapid scale up. The document uses human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) treatment and care as an example.

The scale-up method presented in this document includes the following elements:

The Breakthrough Series (BTS) collaborative: An improvement approach that relies on the spread and adaptation of existing knowledge to multiple settings simultaneously, to accomplish a common aim.

A Real-Time Interactive Operational Research (RTIOR) method: This method, which is linked to the BTS approach, allows providers of health care services at facilities to learn from their experiences and to share their knowledge with peers.

A multiplicative scale-up framework: To reach the full scale intended, this framework expands implementation from an initial number of pilot sites, using a sequence of phases each involving 5-10 times more facilities.

*** World Health Organization (2015). The MAPS Toolkit: mHealth Assessment and Planning for Scale.**

http://apps.who.int/iris/bitstream/10665/185238/1/9789241509510_eng.pdf

Executive Summary:

The mHealth Assessment and Planning for Scale (MAPS) Toolkit is a comprehensive se assessment and planning guide designed to improve the capacity of projects to pursue strategies

that increase their potential for scaling up and achieving long-term sustainability. MAPS is designed specially for project managers and project teams who are already deploying an mHealth product, and who are aiming to increase the scale of impact. External parties seeking to understand the maturity and value of mHealth projects may also find value in using the Toolkit jointly with projects.

The Toolkit covers six major areas (referred to as the "axes of scale") that influence the scaling up of mHealth: Groundwork, Partnerships, Financial health, Technology & architecture, Operations, and Monitoring & evaluation. The axes of scale reflect the key concerns, activities and decisions that relate to these six areas.

MAPS allows users to assess where projects stand in relation to each of the axes of scale, and to track progress as activities evolve and progress. The Toolkit will help project teams to identify areas that require further attention, and then to devise strategies to overcome any challenges or obstacles to progress. MAPS is designed to be used periodically at several time points throughout a project's trajectory, guiding projects through an iterative process of thorough assessment, careful planning and targeted improvements. These steps facilitate successful scaling up of mHealth products.

Yamey G. 2012. "What are the barriers to scaling up health interventions in low and middle income countries? A qualitative study of academic leaders in implementation science," *Globalization and Health,* 8:11.

http://www.globalizationandhealth.com/content/pdf/1744-8603-8-11.pdf

Author's Abstract
Background: Most low and middle income countries (LMICs) are currently not on track to reach the health-related Millennium Development Goals (MDGs). One way to accelerate progress would be through the large-scale implementation of evidence-based health tools and interventions. This study aimed to: (a) explore the barriers that have impeded such scale-up in LMICs, and (b) lay out an "implementation research agenda"--a series of key research questions that need to be addressed in order to help overcome such barriers.

Methods: Interviews were conducted with fourteen key informants, all of whom are academic leaders in the field of implementation science, who were purposively selected for their expertise in scaling up in LMICs. Interviews were transcribed by hand and manually coded to look for emerging themes related to the two study aims. Barriers to scaling up, and unanswered research questions, were organized into six categories, representing different components of the scaling up process: attributes of the intervention; attributes of the implementers; scale-up approach; attributes of the adopting community; socio-political, fiscal, and cultural context; and research context.

Results: Factors impeding the success of scale-up that emerged from the key informant interviews, and which are areas for future investigation, include: complexity of the intervention

and lack of technical consensus; limited human resource, leadership, management, and health systems capacity; poor application of proven diffusion techniques; lack of engagement of local implementers and of the adopting community; and inadequate integration of research into scale-up efforts.

Conclusions: Key steps in expanding the evidence base on implementation in LMICs include studying how to: simplify interventions; train "scale-up leaders" and health workers dedicated to scale-up; reach and engage communities; match the best delivery strategy to the specific health problem and context; and raise the low profile of implementation science.

Yamey G. 2011. "Scaling up global health interventions: A proposed framework for success." ***PLoS Med,*** **8:e1001049**

http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001049

Author's Abstract

The rise in international aid to fund large-scale global health programs over the last decade has catalyzed interest in improving the science of scale-up. This Essay draws upon key themes in the emerging science of large-scale change in global health to propose a framework for explaining successful scale-up. Success factors for scaling up were identified from interviews with implementation experts and from the published literature. These factors include the following: choosing a simple intervention widely agreed to be valuable, strong leadership and governance, active engagement of a range of implementers and of the target community, tailoring the scale-up approach to the local situation, and incorporating research into implementation.

Yothasamut J, Putchon C, Sirisamutr T et al. 2010. "Scaling up cervical cancer screening in the midst of human papillomavirus vaccination advocacy in Thailand." ***BMC Health Services Research*****, 10(Suppl 1):S5.**

http://www.biomedcentral.com/content/pdf/1472-6963-10-S1-S5.pdf

Authors' Abstract

Background: Screening tests for cervical cancer are effective in reducing the disease burden. In Thailand, a Pap smear program has been implemented throughout the country for 40 years. In 2008 the Ministry of Public Health (MoPH) unexpectedly decided to scale up the coverage of free cervical cancer screening services, to meet an ambitious target. This study analyzes the processes and factors that drove this policy innovation in the area of cervical cancer control in Thailand.

Methods: In-depth interviews with key policy actors and review of relevant documents were conducted in 2009. Data analysis was guided by a framework, developed on public policy models and existing literature on scaling-up health care interventions.

Results: Between 2006 and 2008 international organizations and the vaccine industry advocated the introduction of Human Papillomavirus (HPV) vaccine for the primary prevention of cervical cancer. Meanwhile, a local study suggested that the vaccine was considerably less cost-effective than cervical cancer screening in the Thai context. Then, from August to December 2008, the MoPH carried out a campaign to expand the coverage of its cervical cancer screening program, targeting one million women. The study reveals that several factors were influential in focusing the attention of policymakers on strengthening the screening services. These included the high burden of cervical cancer in Thailand, the launch of the HPV vaccine onto the global and domestic markets, the country's political instability, and the dissemination of scientific evidence regarding the appropriateness of different options for cervical cancer prevention. Influenced by the country's political crisis, the MoPH's campaign was devised in a very short time. In the view of the responsible health officials, the campaign was not successful and indeed, did not achieve its ambitious target.

Conclusion: The Thai case study suggests that the political crisis was a crucial factor that drew the attention of policymakers to the cervical cancer problem and led the government to adopt a policy of expanding coverage of screening services. At the same time, the instability in the political system impeded the scaling up process, as it constrained the formulation and implementation of the policy in the later phase.

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