Bibliography
Systematic Approaches for Scaling Up
Best Practices

A resource of the community of practice
“Systematic Approaches for Scale-Up of Family
Planning/Reproductive Health Best Practices”

April 2014
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 five-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International in partnership with the African Population and Health Research Center (APHRC), ExpandNet, Intrahealth International, Management Sciences for Health (MSH), and PATH.

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Systematic Approaches for Scaling Up: 
An Initial Bibliography of the Community of Practice

Introduction

The bibliography below is a selection of published articles and other reports that address systematic approaches to scaling up. It constitutes an initial set of particular relevance to the discussion 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 recent 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 the 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 produce literally thousands of articles with scaling up in the title or as a key word, but the majority of these articles do not address or describe a systematic process of scaling up or describe in detail the lessons being learned. At the same time we also 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 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

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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, are 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 are excluded at this initial stage. They will be considered for inclusion at a later date.

- **Broad range of health interventions:** Even though the community of practice for which the bibliography was developed is focused on family planning/reproductive health, this bibliography includes articles that deal with scaling up of other health interventions. Incorporating this broader literature is relevant because scaling up is predominantly an organizational, managerial, and policy task, and not primarily a narrowly technical one. Thus, 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.


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.


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.


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


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.
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.

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.


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

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.


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.


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.


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.


No abstract or executive summary available.


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.


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.


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.

Authors’ Abstract
As governments seek to meet the global health agendas of the past decade, new approaches to the training of health professionals are needed. Training must move away from an exclusive focus on technical skills and begin to incorporate educational strategies that empower providers, programme managers and community leaders to become agents of change. This chapter describes a methodology for in-service training that builds on Paulo Freire’s educational philosophy and explains how the capacity to provide innovative training was scaled up in public sector reproductive health services in Brazil, Bolivia and Chile. Statistics on the training sessions demonstrate the reach of this training initiative, and testimonials show its profound impact on newly trained trainers.


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.


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.


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.


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 to 21 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.

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 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.


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

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

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.


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.


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.


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.


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


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.

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.


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.


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.


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

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.


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.


Author’s 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.

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.


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.

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.


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.


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.


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.


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.

http://www.healthpolicyjrnl.com/article/S0168-8100-2900049-7/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.


Author’s 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.


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

Author’s 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.


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.


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.


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.


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).


A short commentary


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.


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 health programs used for scaling up, so that these examples may be of use to others implementing programs.


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.


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.


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 postoperative 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.

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.


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.


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.


No abstract; the executive summary is several pages long.


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.


**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.


**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.


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.


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.


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 a field 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.


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.


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 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.


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.

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.


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.

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.


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

Authors’ Abstract
This chapter describes two initiatives that have utilized research to guide the development and scaling up of community-based health and family planning programmes. In Bangladesh and Ghana, evidence was accumulated in stages, beginning with an exploratory investigation, followed by an experimental trial testing potential interventions and a replication phase for validating research results in a non-research programme setting. The process concluded with research-guided programme expansion. Each stage was associated with shifts in generations of questions, mechanisms and outcomes as the process unfolded. Large-scale health systems development was achieved in both countries, not because the scaling-up strategies were alike but because similar research approaches led to different strategies adapted to contrastingsocietal and institutional contexts.


No abstract available

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


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.


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.

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**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.


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.


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.


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) issues at hand. A more in-depth understanding of the situation informs development of strategies for how to increase reach and access to use 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.


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.


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.


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.


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.


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.


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.


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.

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.


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


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


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

Authors’ Abstract
This case-study explores the programmatic challenges of moving from pilot interventions to regional programmes. It documents the history of an initiative to scale up reproductive health interventions, developed and tested between 1996 and 2000 in Zambia’s Copperbelt Province. The interventions included an expansion of the range of contraceptive methods available at health facilities, the development of innovative training approaches for healthcare workers, and the testing of strategies to reach out to communities. This chapter
highlights the challenges facing programmers as they must decide which elements of a pilot study to scale up, the structures most appropriate for managing the process, and the pace and breadth of the expansion effort. Finally, it provides a conceptual framework to guide the scaling-up process and to weigh the potential trade-offs between increasing scale and maintaining quality, local values, local relevance and sustainability.

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.


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.


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.


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.


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


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.


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.

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.


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.


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.