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Maternal and Child Survival Program

Supporting Country-Led Efforts to Systematically Scale-Up and Sustain Reproductive, Maternal, Newborn, Child and Adolescent Health Interventions

Scale-up Coordinator's Guide

www.mcsprogram.org

MCSP is a global, $560 million, 5-year cooperative agreement funded by USAID to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. Visit www.mcsprogram.org to learn more.

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Acronyms

CBNC	Community based newborn care
CHW	Community health worker
CHX	Chlorhexidine
CII	USAID's Center for Innovation and Impact
DHIS-2	District Health Information Software 2
DHS	Demographic and Household Survey
ENC	Essential Newborn Care
HBB	Helping Babies Breathe
HCD	Human centered design
HIV	Human immunodeficiency virus
HMIS	Health management information system
iCCM	Integrated community case management
LMICs	Low and middle income countries
LQAS	Lot quality assurance sampling
IMCI	Integrated management of childhood illness
M&E	Monitoring and evaluation
MCHIP	Maternal and Child Health Integrated Program
MCSP	Maternal and Child Survival Program
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MSI	Management Systems International
NGO	Non-governmental organization
PMP	Performance monitoring plan
PPFP	Postpartum family planning
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
RMNCH	Reproductive, maternal, newborn, and child health
SDGs	Sustainable Development Goals
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. Why this guide and who should use it?

1.1 Who is this guide written for?[1]

Scale-up Coordinator Lessons Learned

- A scale-up coordinator should have both management skills and political savvy to drive organizational partners through the inevitable ups and downs of a product introduction, as well as introduction and scale-up of a service or approach.
- Going from initial introductions to real scale requires considerable vigilance, and handover to country adoption is not a given without continued advocacy and planning. It can be worthwhile to invest in developing communication skills among the core team and key partners/ stakeholders.

This guide is for those supporting a systematic process of scale-up. Although the process can be managed successfully in various ways, we wrote this guide specifically with the perspective that there is a "scale-up coordinator" or scale-up manager. The concept for this figure is based on that used by the United States Agency for International Development's (USAID's) Center for Innovation and Impact (CII), who calls this person an "Uptake Coordinator" or "Product Manager." It is described in the text box. CII, in turn, adapted this idea from the successful experiences of the Chlorhexidine (CHX) Work Group and the US pharmaceutical industry which often employs product managers to facilitate the rollout of a new drug or vaccine and see it through to rapid and widespread use. We generalize the concept to include scale-up of a service or approach. In global health, we feel that having a specific person in charge of the various processes and tasks is critical, because there are needs for coordination that span across various roles and touch on multiple routine systems, multiple Ministry of Health (MOH) departments, other public sector institutions, various partner agencies, and private sector partners. Someone supporting scale-up needs the scope and authority to bridge these divides. In order to be effective, this person must juggle various types of activities including technical and management roles. In the experiences used illustratively in this guide, the scale-up coordinator was someone working in the country office of an agency giving technical support to country-led MOH scale-up efforts, but with the right terms of reference and level of authority, this person could also be someone within the government structure itself.

We also wrote this guide with the assumption we are entering the scale-up process after the initial stages of the innovation process have been completed (like initial development and pilot testing), even if those stages were done in another country. We imagine a landscape in which some or all of the country "scale readiness benchmarks" have been achieved (i.e., testing for small scale effectiveness, supportive policies developed, inclusion in health sector strategies). Some other guides and articles on scale-up treat completion of this stage as *the end point of the process of scale-up;* however, there are many examples of interventions that have failed to reach sustained and widespread impact *even after reaching this point.* We set out to write a guide for those managing the scale up process that specifically focuses on the scale-up process from this point forward — what we call the "advanced stages" of scale-up. We know that the process of scale-up is always messy and often protracted, and so many scale-up processes that have seemingly graduated beyond the initial stages of innovation may have important unfinished issues related to scale readiness, like lack of supportive policies, so this guide also deals with how those managing the scale up process should assess and address these gaps in scale readiness.

1.2 Framing the issue of scale-up

Scaling up proven interventions that are not currently in routine practice is a process that needs to occur constantly, as counties improve their health systems and respond to new challenges. In the current environment, many planners and donors in low and middle income countries (LMICs) feel great pressure to try to scale up new interventions as quickly as possible, to demonstrate that they are making rapid progress on their journeys to self-reliance and are being responsive to their people. But even in high resource settings with

[1] The text box is taken from USAID (2015). Center for Innovation and Impact (CII), *Idea to Impact: A guide to Introduction and Scale.* Accessed May 2019: http://www.usaid.gov/cii/guide-introduction-and-scale

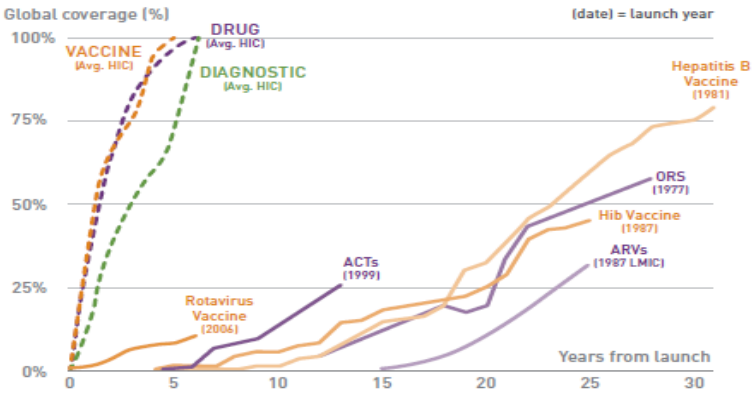
fewer constraints, the entire span of the scale-up process that starts with a good idea and ends with widespread implementation at scale occurs on a timeframe that almost always extends over many years.[2] This is not to say that the process is always slow or painstaking. There is, in fact, great variation across different scale-up experiences. This variation is not always appreciated because hard-and-fast metrics and data are difficult to come by that would facilitate comparisons. Figure 1 is an attempt to highlight this variation, using information extracted from many projects and sources.[3] We should note that this figure shows wide variation even among relatively simple product-centered interventions like vaccines or drugs, and we can imagine that the difficulty of effectively scaling up complex intervention packages is even more acute, like ones that need to engage other sectors outside of health or ones that include strong behavior change elements. Yet even some of the interventions in Figure 1 are complex and have important systems and behavioral components, but implementers have still successfully scaled them up relatively rapidly in some settings. This figure is stylized and leaves out a lot of relevant information, but we also hope that it starts us thinking about some important issues and questions that those involved in scale-up need to think about, like the following —

- What characteristics of an intervention, like its complexity, influence its scalability?
- How has financing and prioritization affected the scale-up process?
- What are the contextual factors that help or harm prospects for effective scale-up?

They should also think about the best practices they might learn and apply from product launches in high income countries that can be applied in low- and middle-income countries.

There is no doubt that in the complex and messy world where scale-up occurs, some factors critical to success will always be outside the control of those managing the scale-up process. But there is emerging programmatic evidence that a more systematic approach to actively and adaptively manage the process and guide the actions of various stakeholders is more likely to result in successful outcomes, and to do so at a faster pace. A good summary of the evidence comes from the Center for Global Development, which first published its monograph Millions Saved[4] over ten years ago and have continued to refine their analysis of the success factors for health programs that have achieved large scale and sustained impact.

Figure 1. Years to scale-up



While drugs, diagnostics, and vaccines typically scale within the first two years of launch in developed countries, they often take decades to scale in lower- and middle-income countries.

Source: Bill & Melinda Gates Foundation

The cases span various kinds of health programming and contexts. They have continued to refine the cases and the findings from this work. Their four key findings speak to the need not only to choose an effective intervention but to manage the process of scale up actively:

- Wise choices were made about the interventions or tactics to be deployed, based on the best available scientific evidence.

[2] Morris Z, Wooding S, Grant J (2011), The answer is 17 years, what is the question: understanding time lags in translational research, J R Soc Med, 104 (12): 510-520

[3] Idea to Impact (USAID, 2015), Figure 1 (page 5). Figure adapted from a report by the Bill and Melinda Gates Foundation.

[4] Available at http://millionssaved.cgdev.org/findings.

- Partnerships and coalitions were formed to mobilize needed technical, financial, and political resources, domestically and internationally.
- Not one, but many political leaders — sometimes across political cycles – sustained efforts over time.
- The programs used data, results, and evaluation in their particular settings and countries, and parlayed this information to improve health.

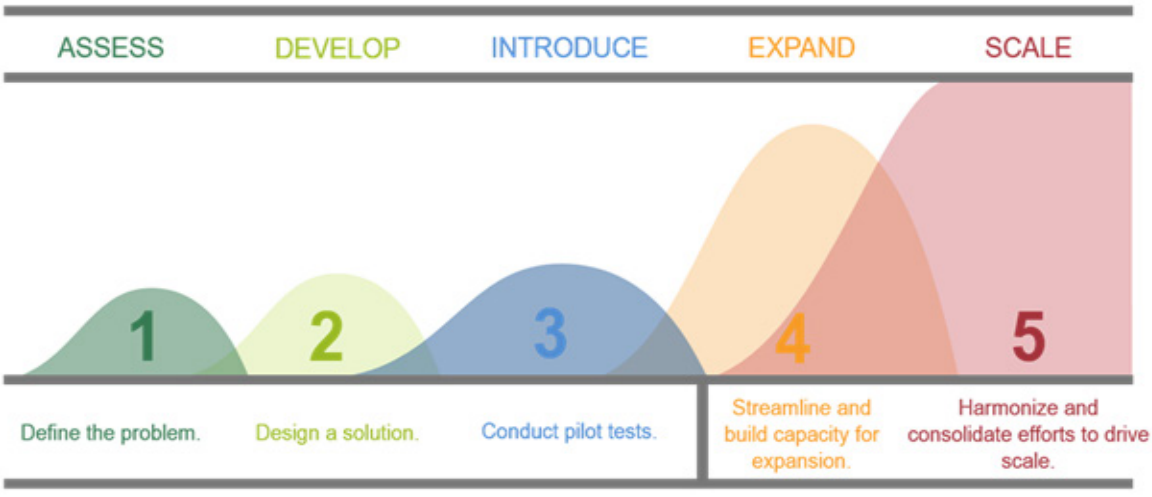
In this guide, we suggest some strategies and a minimum set of tools that can highlight critical issues, help those managing the scale up process to intervene effectively on issues under their control, try to positively influence at least some of those things outside their control, and mitigate the negative influence of yet other issues outside their scope of influence. In Annex 4, we also point those with more interest to additional resources.

The scale-up process should be informed by national policies and strategies and led by the government either alone or in partnership with others (i.e., other public sector institutions, critical private and non-governmental actors, and international technical agencies). But no matter who is involved in the process, one clear implication of Figure 1 is that scale-up takes place over a span of time and geography that is so large that support from a single project or organization is unlikely to be sufficient to see the process through from start to finish, especially within the five-year timeframe for most projects being implemented in LMICs.

1.3 Scale-up in its advanced stages: What this guide is meant to do (and not to do)

The end goal of the scale-up process is *sustained impact at scale* achieved through the combination of widespread effective coverage (i.e., utilization) of the population in need and institutionalization of key systems supports to sustain the expanded services. In the real world, this trajectory is not as smooth and continuous as what is depicted in Figure 1. To better show the evolving nature of the issues over the lifespan of a scale-up effort, in Figure 2 we break down the process into several stages. These stages are not usually followed in as orderly a fashion as shown, but we have found that thinking this way helps to guide discussions on how much progress has been made and what likely next steps are needed. The first three stages in Figure 2 are all at the level of innovation and piloting – that is, identifying a critical problem, designing an effective and viable solution, and then piloting or testing it. **This guide is focused on what happens after these initial stages, in Stages 4 and 5 of Figure 2.** That is, the stages of *expansion* and *full scale-up*.

Figure 2. The stages from innovation to full scale, leading to sustainable impact at scale



It is possible for these first three innovation stages to be done systematically over a single four to five year project or public sector strategic planning cycle. Once the testing and piloting are complete, if all goes well and the results are encouraging, decision makers will need to choose whether to expand and fully scale up the intervention. Increasingly, decision makers are willing to accept that the pilot experience may have taken place in another country, and they will often then be interested in taking the intervention to full scale immediately. Programmatic experience shows that even if there is strong will to scale up immediately, rolling out in waves that encompass larger and larger geographic areas is still best practice, as it provides opportunities for review and adaptation to keep the process on track. Each of these latter stages (expansion and full scale) is likely to take at least as long as the previous three innovation stages combined (in other words, at least two more four to five year project or strategic planning cycles). Assuming otherwise is likely to set up managers and implementers for failure and disappointment.

Key resources already exist that focus on guiding the initial design and testing process, including ExpandNet's Beginning with the End in Mind (and other resources) (2007, 2009, 2010, 2011) USAID CII's Idea to Impact: Guide to Introduction and Scale (2015) and Ready, Set, Launch: A Country-Level Launch Planning Guide (updated 2019), and Management Systems International's (MSI's) Scaling Up—From Vision to Large-Scale Change (2012). This guide will highlight a minimum set of suggested tools that are specifically focused on the latter stages. These tools draw from these and other guides. We also point to these and other in-depth resources for additional strategies and tools.

One of our favorite colleagues who has since retired from USAID used to show a slide of a housefly the size of a building and would say "not everything is meant to be scaled up!" Indeed, we agree with him. Some new interventions are not even effective at small scale and do not deserve the attention and resources needed to scale them up. Sometimes, for a variety of reasons, such an intervention has been scaled up anyway. One such intervention is the Drug Abuse Resistance Education (DARE) program in US schools that has repeatedly been shown to be ineffective for its stated objective of preventing drug use among youth, but nevertheless continued to be implemented at scale in many states.[5] Various writers have speculated about the reasons for this.[6] Conversely, even when we decide that an intervention successful at small scale deserves the resources and effort needed to scale it up, leaders may not have completed all the tasks we would expect of an intervention that has gone through the innovation stages (i.e., approved supportive policies; included in health sector strategies; secured sufficient financing for expansion over the next four to five year strategic planning cycle). This guide recommends we uncover such "readiness gaps" in the assessment stage and address them. Moving to the stages of expansion and full scale-up without first ensuring this "scale readiness" will almost certainly result in failure to achieve expansion and sustainable impact at scale. This has happened repeatedly in Kenya with integrated community case management (iCCM) of child illness, because despite numerous successful small and medium scale trials there over the last 15-20 years, there are not policies supportive of it. Finally, we feel that the systematic and system-oriented process of scale-up we present here is more likely to result in sustainable impact at scale, rather than "empty scale-up" (i.e., far-reaching nominal spread of an effective intervention but with little impact) as happened in a number of countries with the integrated management of childhood illness (IMCI) strategy 15 years ago when they relied mainly on training health personnel but without sufficient focus on other critical system supports. In several countries the IMCI Multi-Country Evaluation showed no impact at all because of weak implementation strength.[7]

[5] For a typical evaluation, see Ringwalt C, Ennett S, Holt K (1991), *An outcome evaluation of Project DARE (Drug Abuse Resistance Education)*, Health Education Research: 6 (3), 327–337, https://doi.org/10.1093/her/6.3.327

[6] This history is recounted in the Hodgins and Quissell reference in the accompanying Basic Toolkit for Systematic Scale-up.

[7] Bryce J, Victora C, Habicht JP, et al. (2004). The Multi-Country Evaluation of the Integrated Management of Childhood Illness Strategy: Lessons for the Evaluation of Public Health Interventions, Am J Pub Health, 94(3): 406–415

1.4 How this guide was developed

The Maternal and Child Survival Program (MCSP) has been USAID's global flagship program to support reproductive, maternal, newborn, and child health (RMNCH) programming globally from 2014 to 2019. The first of MCSP's three strategic objectives was to "Support countries to increase coverage and utilization of evidence-based, high-quality RMNCH interventions at the household, community, and health facility levels."[8] The interventions that fell under this objective were those for which there was already strong evidence of effectiveness and at least some positive operational experience. MCSP devoted effort to help stakeholders within and across the countries it supported to learn about how best to carry out the scale-up process. We tried to do so in a systematic but streamlined way with the least possible disruption to routine practice. In support of this objective, MCSP worked with the ExpandNet secretariat, as well as the Evidence to Action Scale-up Community of Practice, MSI, USAID CII, the CHX Work Group, and other scale-up experts to select and adapt a minimum set of tools and strategies from among those available that would be appropriate for health interventions that are relatively far down the pathway toward implementation at full scale. We did not develop full research protocols to support this process, but rather used embedded and streamlined implementation research that was more akin to "systematic practice," learning and sharing lessons among those involved in the process.

This guide started as a short set of materials and tools, evolved into a full draft guide for teams, and eventually into this final version. That means that no one country went through the process exactly as written nor used all the tools in exactly the form in which they appear here, as the teams were constantly sharing experiences and improving the processes and tools through learning visits, webinars, internal Scale-up Technical Work Group meetings, and external dissemination events. There was an initial test of some of the materials in Afghanistan in 2014 for the scale-up of misoprostol for the prevention of postpartum hemorrhage at home birth. Afterwards, the specific countries and interventions that contributed to some portion of this guide were the following (those with an asterisk used the process described here most fully):

- Bangladesh – CHX for prevention of newborn sepsis
- Democratic Republic of Congo – iCCM *
- Ethiopia – Community Based Newborn Care
- Mozambique – Misoprostol for the prevention of postpartum hemorrhage at home birth *
- Liberia – CHX for prevention of newborn sepsis
- Nigeria – CHX for prevention of newborn sepsis *
- Rwanda – Pre-discharge postpartum family planning (PPFP) *
- Rwanda – Newborn resuscitation using the Helping Babies Breathe (HBB) protocol integrated with Essential Newborn Care (ENC) *

[8] https://www.mcsprogram.org/

2. Putting the pieces of systematic scale-up together

2.1 Critical principles for systematic scale-up

For effective scale-up, there must be a plan that guides the actions of multiple stakeholders. In the complex, dynamic, and multi-partner environment of a scale-up process, even a perfectly designed intervention with a well-constructed plan for one place and time is unlikely to be perfect as efforts expand geographically and extend in time. In such a context, adaptation and adaptive management are not just luxuries but absolute necessities. This calls for real-time feedback and continuous learning about what is and is not working and why, with adaptations as needed. Another critical concept is that country actors must be in the driver's seat at all times, leading a multi-partner coalition to take advantage of the full spectrum of resources and competencies available. They are the ones that are implementing the intervention and need to sustain it. Table 1 summarizes these and other critical principles on which this guide is based.

Table 1. Ten Guiding Principles for a Systematic Process for Advanced Scale-up

The government should lead a multi-partner scale-up effort, following its national strategic priorities. For maximum effectiveness the group of partners managing the efforts should include other stakeholders critical to success, including private sector partners when relevant.
Leaders should **assess and build on previous scale readiness** (i.e., evidence of real-world effectiveness of the intervention package; supportive policies; inclusion in health sector strategies; and sufficient commitment of financing for several years of ongoing activity). Any gaps in scale readiness need to be addressed immediately; and large gaps should cause leaders to pause before moving to support advanced scale-up.
Although not completely necessary, a successful model is to **have a single scale-up coordinator whose role is to facilitate (but not lead) the actions related to the scale-up process**. In the experiences used illustratively in this guide, this was someone working in the country office of an agency giving technical support to the scale-up efforts, but with the right terms of reference and level of authority, this person could also be someone within the government structure.
There must be a realistic **scale-up plan that includes both strategic and operational aspects, including costs.** This plan ought to be based on an explicit **Theory of Change** and aligned with national strategic goals.
The scale-up plan must build on existing assets and **systematically address both demand-side and supply-side needs** so that progress is made in reaching a high proportion of people in need of the intervention, while maintaining the quality of the services they receive.
A scale-up plan should **specify activities to institutionalize (i.e., integrate) the intervention and key supports for it in country systems** in order to increase the chance of sustainability. For public institutions, the systems referred to are the World Health Organization (WHO) health system building blocks (i.e., governance, finance, personnel, etc.), with consideration of clients added. For private providers, the systems referred to are markets.
Implementation of the plan should **emphasize fidelity to outcomes rather than to processes, with systematic adaptation** through empowered local entities and moments for review and reflection on progress and challenges. An implication is that the activities that support the core intervention package will likely not be the same over time nor in different areas of the country.
The intervention package should be **expanded geographically in waves, with learning and adaptation based on operational scalable units** (i.e., usually districts or the equivalent).
To engage in continuous learning and adaptive management, **there must be valid and transparent real-time quantitative and qualitative information** about the scale-up outcomes and critical processes, occurring at several levels from local to national. In order for this to be feasible, the information gathering should be as simple and streamlined as possible.
There needs to be **stable and adequate funding** to support scale-up over a multi-year period. Otherwise, results will regress or even disappear. In order to mitigate the risk of a gap in funding, those actively managing the scale-up process must have a clear **accounting of the costs of scale-up and include activities to mobilize additional resources** as a fundamental component of their plans and activities. The funding should be flexible enough to address new needs as they are identified.

2.2 The framework for systematic scale-up in its advanced stages

Figure 3 shows the framework for the systematic scale-up process in its advanced stages of *expansion* and *full scale-up*:

- The left side shows the *key initial inputs* that should already be in place from the earlier piloting stages. In other words, these are the elements of "scale readiness." We need to check the assumption that these elements really are in place in the Assessment Phase that we will describe in the next section of this guide.

Scaling up is predominantly an organizational, managerial, policy, and political task and not primarily a technical one.

–ExpandNet

- The inner section of the middle circle in the diagram shows the critical *actors* (i.e., Leaders and Managers; Implementers and Clients) and *ongoing inputs* that "fuel" the adaptive cycle (i.e., timely information and ongoing funding).
- The outer section of the middle circle shows the phases of the iterative cycle – engagement and assessment; planning through co-creation; and implementation with learning and adaptation. We will deal with these phases in the next section of the guide.
- Finally, the right side of the framework shows the desired eventual impact of the process (i.e., "widespread and sustained improvements in health," or in other words, sustainable impact at scale). In order to attain this, the desired outcomes are "high effective coverage" (that is, utilization by the population in need) as well as institutionalization in order to sustain the gains.

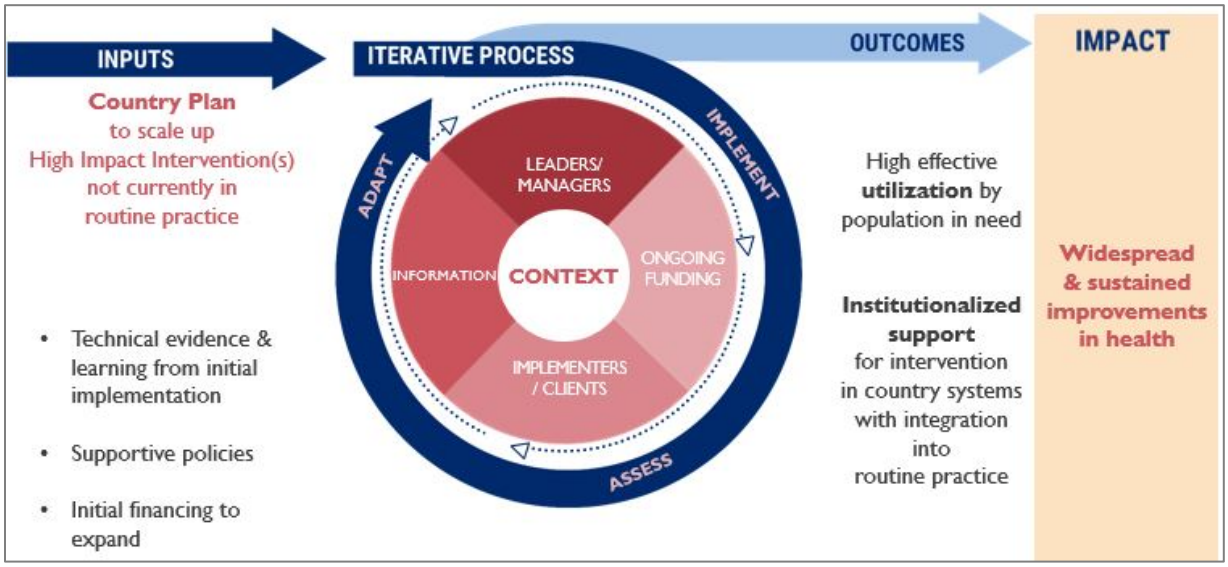
ExpandNet Scaling Up Definition

Deliberate efforts to increase the impact of innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and program development on a lasting basis.

2.3 What is the ultimate point of a scale-up process? Scale-up outcomes

In order for an effective intervention to contribute to progress on national health targets, the ultimate goal of any scale-up process is that it achieves *sustainable impact at scale*. That is, widespread and sustained improvements in health. Analyzing this a bit further, we can say that an effective scale-up process is one in which, ultimately, most of the people that need the intervention actually receive it – and with sufficient quality for it to be effective. We also desire that there is a continuation of the intervention, i.e., it is sustainable.

Figure 3: The general framework for driving the "advanced stages" of scale-up



Putting this together, that means there are twin objectives to the scale-up process, as shown in the framework:

- High **effective coverage** (i.e., utilization) by the population in need; and
- **Institutionalization** of key supports in country systems in order to *sustain* the effective coverage.

To be clear, no one is likely to be satisfied with a scale-up process that achieves impact but cannot be sustained without substantial ongoing outside support. After a single four to five year project cycle or government strategic planning cycle, it is not reasonable to expect a relatively new intervention to be completely financially and managerially sustainable—however, there should be progress in this direction. Lastly, we want to acknowledge that although the examples outlined in this guide are weighted toward public sector experiences, institutionalization of some or all of the supports for an intervention can be in private systems (i.e., **markets**) and not just in public systems. We invite the reader to think about opportunities in their context to engage the private sector in resource mobilization, governance, service delivery, etc.

2.4 Scale-up inputs ("Scale-up Readiness")

We are dealing with the more advanced stages of scale-up here. There should already be evidence that the intervention works (i.e., it is *effective*) and that it has been able to work in similar contexts and address an important need (i.e., it is *appropriate*). The issues of feasibility and acceptability are stickier. Even if shown to be feasible and acceptable in one area of a country, when expanding to other areas of the country with different cultures or organizational systems, there may be important new considerations to take into account. However, there should be at least some preliminary information with regard to these parameters.

There are some other critical components of scale readiness that should already be in place. That is, the MOH should signal their desire to scale up the intervention by **including it in their overall health sector strategy.** They should also have the needed **supportive policies.** For instance, the strategy of iCCM of childhood illness implies task shifting of the treatment of child pneumonia to community health workers (CHWs). If there is not a policy permitting the administration of antibiotics by CHWs, then no matter how successful a small scale experience is, it is unlikely that a scale-up effort will be successful in moving to the stages of *expansion* and *full scale-up*. On the other hand, having a policy is not an "all or nothing" issue, and we need to be constantly aware that a policy is likely to need to be refined and improved. Finally, there is the issue of financing. We do not expect financing to be secured for the overall scale-up process which may take many years, but sufficient financing needs to be secured at least to move forward over the next several years. Once the plan for scale-up is in motion, it will be important for leaders and managers to continue to think strategically about possible cost reduction as well as seeking ongoing financing – from both domestic and external sources. But without the initial financing there is not enough certainty to move forward at all. The Assessment Phase described in the next section is largely concerned with characterizing the situation with regards to these scale-up readiness benchmarks.

A note on sustainability

One of the two equal objectives of a systematic scale-up process is *institutionalized* support for the intervention(s) so that it becomes part of routine practice and therefore is more likely to be sustained. Sometimes we have noticed when speaking with stakeholders that someone will ask "But what about sustainability?" even though we consider sustainability to be an integral part of an effective scale-up process. After all, what country planner wants to make the effort to expand an intervention and then have it collapse after only a short time? But if it makes it any clearer for those you work with, then we suggest that you say that the process outlined in this guide is a process for "scale-up and sustainability." You should also emphasize that the ultimate goal of the \scale-up process is "sustainable impact at scale."

2.5 The people and organizations in the scale-up process

Implementers / Clients

The *implementers* are the health workers actually carrying out the intervention and the places in which they work. The *clients* are those receiving the intervention. We need to know about their experience of carrying out the intervention, as well as the experience of the clients expected to use or receive the intervention. The assessment materials from ExpandNet include interviews with clients and providers to understand the feasibility and acceptability of the intervention. Some of the materials on human centered design (HCD) can also be used to go into more depth about the lived experiences of clients and providers and help us think about adjustments that might make the intervention more effective and/or feasible, and therefore more scalable.[9]

Leaders / Managers

It is important to note that a scale management structure does not need to be separate and vertical; indeed, it is preferable that it is not. We think it is a best practice that the leadership and management structure is embedded in established structures with recognized authority, as is the case in the examples that informed this guide. For instance, if the intervention is for use of misoprostol for home delivery, at national level, the group may be an established multi-partner Safe Motherhood Work Group. We found that it was important to connect the scale-up process with such an established group because it already was led by the MOH, it included many or all partners critical to the scale-up process (e.g. organizations with great credibility like professional associations), and had recognized authority. At the same time, we found that such groups had wide mandates and busy schedules, so for the week to week management, in almost all cases that MCSP supported, the established authority recommended convening a sub-committee that dealt specifically with the scale-up issues. This sub-committee then had the time to deal with the many issues that arose, but also could report back to the larger group on a periodic basis and have them make important decisions when needed, such as updating a relevant policy.

The leadership and management team (also referred to here as a scale-up management team) is not only the structure or work group at the national level, but includes the entire structure supporting the scale-up process, such as district managers and focal people at the local level. In order to be effective, these levels must articulate with one another. Again, if the scale-up management process takes advantage of established structures, then there are already recognized entities at the district and local levels, with established communication channels. So District Health Management Teams and local health managers can and should be engaged in managing the scale-up process. As at the national level, they have a wide array of responsibilities so they will have limited time to devote to scale management issues. Sometimes, District Health Management Teams and local entities found it useful to create new committees, but more often, leaders added discussion of scale-up management as an agenda item on regularly scheduled meetings. It is critical that decision makers at all levels they have efficient mechanisms and tools to review data, discuss challenges, and take actions, since scale-up will be one of several issues discussed at these meetings.

2.6 The "fuel" to drive the iterative implementation cycle with learning and adaptive management

Timely information

Routine tracking is a critical part of the scale-up process, supplying information to managers and leaders to engage in learning and adaptive management, so they can make course corrections as needed. While MOHs monitor or track their progress, they do not engage in monitoring and evaluation (M&E) in the same way that projects do. While they track their performance and review it on a periodic basis – at local, district, and national levels – their processes are streamlined compared to singularly focused projects. We need to fit into

[9] BMGF and USAID have a partnership on human-centered design and have produced a useful resource: https://www.designforhealth.org/resources-overview

these streamlined processes and the structures already in use as much as possible, because they are doing this for many different routine interventions.

"Fitting in" is a delicate balance, though, and can be taken too far, because after all, we are talking about a new intervention that has not yet been incorporated into routine practice. So by definition it will not yet have all the supports and procedures that more established practices have. However, just as an innovation at its early stages needed a "proof of concept" to show that it was feasible and effective at small scale as an isolated set of activities, as we move to the stage of *expansion* it needs to go through a similar proof of concept that it can work when integrated with the rest of what a local health provider does, a district manager does, and a national leader does. In carrying out this "proof of concept for integration and institutionalization" we will need to call out the intervention for special attention just enough to see that it is working and make needed adjustments, but not so much that it is implemented in a non-routine way that does not inform its eventual full integration into routine systems.

How can we help managers? Keep it simple!

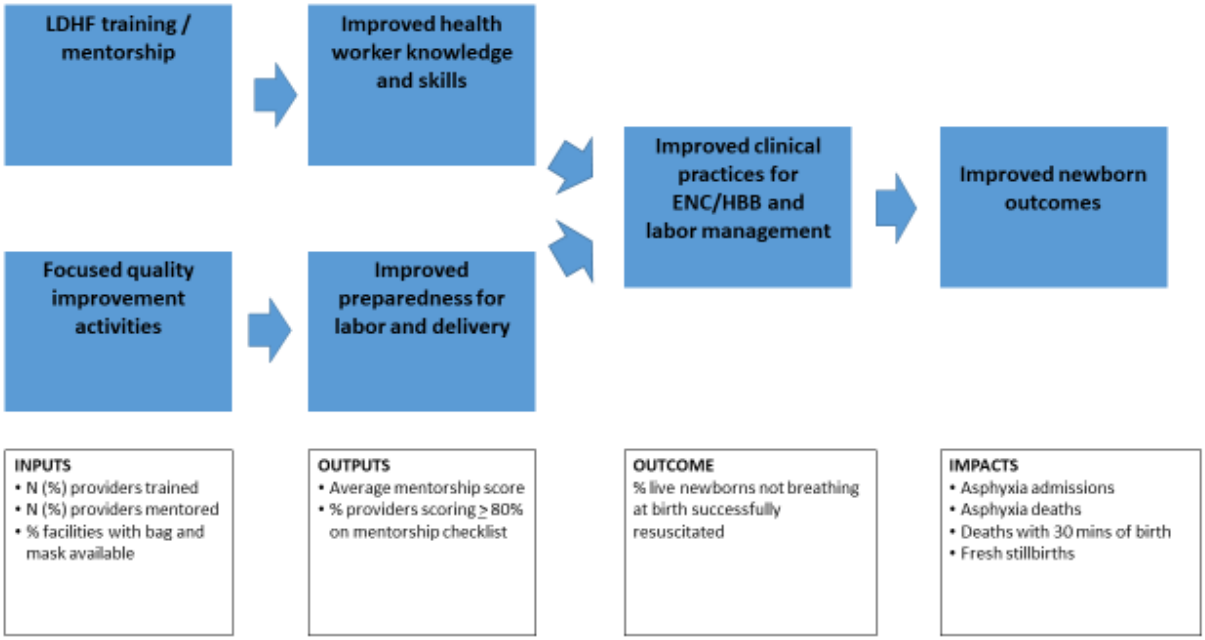
We once worked with a consultant's report that suggested a scale-up dashboard it called "streamlined" but that had almost 20 indicators. When one considers that a MOH has 30, 40, or 50 key interventions it is responsible for, it cannot have a dashboard for one of them that has 19 indicators. So we worked with stakeholder to reduce this dashboard to three indicators, all available through routine reporting mechanisms.

The tracking system should be based on a Theory of Change and have the following types of information:

- A short set of quantitative indicators to track key outcomes and critical outputs that should be visualized in a dashboard; and
- Structured qualitative information about:
    - Whether planned activities were carried out ("strength of implementation")
    - Any adaptations or adjustments made to initial implementation strategies to make them more feasible and/or effective.

The tracking system needs to produce information that can be used at several levels (i.e., locally, at district level, and nationally) and should be based on solid information from the local points of service. The adaptive management process starts there. It is critical that information is not only collected at the local level, but used there as well, because data that is collected but not used by the same data collectors is unlikely to have high data quality. On the other hand, not all information is needed at every level, so more information may be collected at the local level than gets reported to higher levels. For instance, consider the Theory of Change for Rwanda's scale-up of the protocol for the management of newborn asphyxia (known as Helping Babies Breathe or HBB) and essential newborn care (ENC) shown below. There were two streams of activity – one to improve health worker practices through improving knowledge and skills in initial results-based training as well as ongoing mentoring; and another to improve labor and delivery readiness and management through having a designated area for care of newborns, having sufficient equipment (specifically bags and mask for resuscitation), and having protocols to have the bag and mask clean, ready and assembled so it could be used immediately when needed. The information on the left side of the diagram, like trained and validated providers, is important at local levels. For the dashboard that leaders and managers tracked, the information on the right side is the most important – this has to do with quality implementation of the intervention, which should result in successfully resuscitated newborns and improvements in newborn mortality.

Figure 4. Illustrative Theory of Change for Rwanda Helping Babies Breathe (HBB)



The information in a scale-up dashboard should be as streamlined as possible. DHIS-2 (District Health Information Software 2) electronic information systems now in wide use in many countries make the construction of dashboards much more feasible and user-friendly. The dashboard indicators can be shown in a wall chart at the local level to inform frequent discussions, and then made into electronic dashboards at district and national levels. As a rough rule of thumb, there ought to only be one to five indicators in a typical scale-up dashboard. For instance, in the case of Nigeria chlorhexidine use in facilities, the dashboard included three indicators – one "practice" indicator and two output indicators (i.e., chlorhexidine application; stockouts of chlorhexidine; and presence of sufficient personnel trained in use of chlorhexidine).

In order to be most useful for adaptive management, the information in a dashboard should first be collected *and used* at the local level; managers at the district level should examine the data disaggregated by local implementing units (i.e., facility or community). This facilitates the adaptive management process, by making clear where there are positive outliers that may have developed possible replicable adaptations, as well as negative outliers in need of additional attention. The data presented at national level also ought to be disaggregated by district, again to identify both positive and negative outliers. For the scale-up cases presented here, progress on the scale-up plan was reviewed quarterly.

On a less frequent basis (in the cases here, this was done annually), the tracking also looked at contextual factors (the "scale-up environment") to see if there were any changes requiring modifications of plans. On an annual basis, the scale-up management team also analyzed and scored progress on institutionalization.
If funding is available, managers may also want information from additional non-routine studies such as:

- A small survey to confirm service statistics-derived data, perhaps using Lot Quality Assurance Sampling (LQAS)[10]
- A routine data quality assurance exercise to improve data collected for tracking key indicators
- A survey of clients to measure acceptability when expanding to a new area with a different profile of clients or exploration of demand-side barriers and facilitators to support behavior change strategies
- Exploratory inquiry on feasibility of implementing the strategy in new service areas

[10] See https://www.measureevaluation.org/resources/tools/fact-sheet-available-on-lot-quality-assurance-sampling for more information about LQAS

Fidelity to outcomes and not to processes

The *"core intervention"* should be defined as narrowly as possible, and is composed of those pieces that we are most sure cause the desired health effects. In the case of HBB, we defined the "core" as the clinical actions related to the protocol to manage a baby not breathing at birth. This had already been shown at small scale to reduce mortality. This is the part of the intervention around which we designed the quantitative *data dashboard*. We did not want to design the dashboard around the processes, but rather the consequences of those actions (i.e., the known health effects). In this case, the main indicator tracked in the dashboard was *"% of newborns not breathing at birth who were successfully resuscitated."* So we didn't have to guess if implementers were maintaining fidelity to the processes of the protocol. By tracking fidelity to the *outcome* desired – i.e., saving babies – we knew if they were maintaining quality.

Electronic DHIS-2 systems that many countries now use as their national health information systems allow MOHs to create electronic dashboards (e.g., run charts, bar graphs, maps, etc.) that can be integrated directly into routine management. If we can do so feasibly, we should also track a few key output indicators that help us pinpoint system bottlenecks in need of attention (e.g., presence of a trained provider, presence of needed equipment).

From previous work, we also had an idea of the "active ingredients" to make improvement of health providers' practice of neonatal resuscitation work well. We agreed on and described the initial parameters of these active ingredients (i.e., critical implementation strategies), like mentorship and focused quality improvement. Then the structured qualitative monitoring information (using Most Significant Change) could focus on the effectiveness and feasibility of these strategies and any adaptations made to improve them in one facility or district, so that they could be shared with others. *There should not be fidelity to the processes. Instead, there should be trial-and-error adaption to processes to maintain or even improve outcomes.*

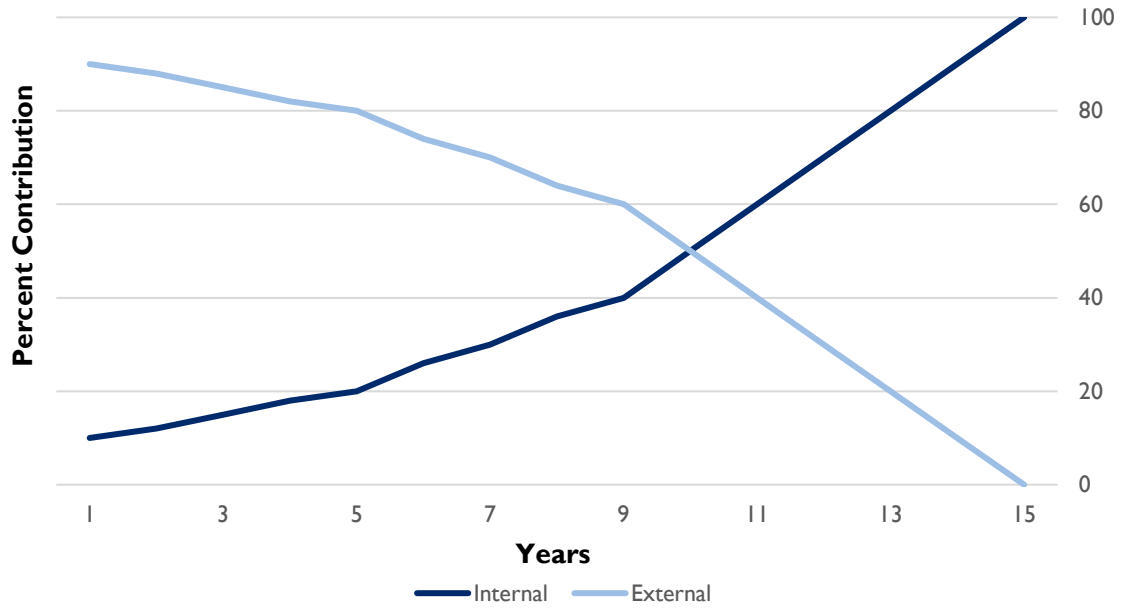
Ongoing Resources / Funding

One of the reasons why many initially successful experiences with scale-up eventually fail to reach sustainable impact at scale is that they run out of the needed resources. Much of the work on introducing and then scaling a new intervention is initially externally financed, and most of this is on a maximum four to five year cycle (and oftentimes on an even a shorter timescale). In all but the most exceptional cases, this simply is not enough time to move through the stages from innovation to expansion and full scale-up. Given the research from the US and England cited in the introduction that has shown that the average time to go from a good idea to widespread practice has been 17 years, we can think of this as taking three or four project cycles (and since many MOH strategic planning cycles are also five years, then we could also think of this as three or four strategic planning cycles). If we assume that the innovation stages of problem identification, solution development and initial testing/piloting will occupy one of these four to five year cycles, we could then reasonably assume that the expansion and full scale-up stages will take an additional two to three of these cycles.

When we are at the innovation stages, it is not necessarily in the interest of a MOH to take risks with their limited resources to fund an innovation effort completely on their own. It is reasonable that much of the effort will be externally financed. But if the experiences at these stages have been positive, then we hope that key decision makers will decide to move forward. It does not strike us as a reasonable expectation that MOHs would transition to fully funding the intervention at this point, given competing priorities, resource constraints, and the risk that the intervention still might not prove feasible and effective when implemented at larger scale. Of course, the host government should be willing to finance an increasing portion of the costs as an indicator of commitment on their part, with the eventual goal that the intervention needs to become fully integrated into systems, including budgeting and financing. The private sector can also be a significant source of funding and resources for training, service delivery, etc.[11] As a rule of thumb, we might approximate the time course for the funding mix as looking something like that in Figure 5 with progressively less dependence on outside sources of funding.

[11] See USAID's Private Sector Engagement policy: https://www.usaid.gov/sites/default/files/documents/1865/usaid_psepolicy_final.pdf

Figure 5. A hypothetical time course for increasing internal funding for an intervention being scaled up over years



The new sources of funding will not all necessarily be public. Perhaps the manufacture and supply of a critical product like chlorhexidine could be done in the private market. There could be other sources for domestic resource mobilization like philanthropy or in-kind donations by community based organizations. And if there is to be ongoing external support, even if decreased in importance, then it is important to immediately start thinking about the possible content of the next proposal and how to diversify the funding base, perhaps by including representatives from other potential funders in the scale-up management team.

No matter the varied sources of funding, a constant factor is the need to start planning for the next round of funding at the beginning of the current round. Otherwise, even successful scale-up experiences can run out of the fuel needed to keep going, and activity and results may well fall back to baseline levels. Quantifying the costs of interventions under realistic and routine conditions is a critical element to help decision makers in planning, domestic resource mobilization from both public and private sources, and advocacy to other donors. Some examples of such costing exercises are included on the MCSP Scale-up Legacy webpage https://legacy.mcsprogram.org/scaleforsuccess/

3. Scale-up activities and tools to use through the phases of the iterative cycle

3.1 Going through the phases of the iterative cycle

Phases of the iterative cycle for scale-up

- Phase 1. Engagement and assessment
- Phase 2. System-oriented co-creation (planning)
- Phase 3. Implementation with learning and adaptive management

This section describes the activities and minimum set of tools (available in the accompanying *Basic Toolkit for Systematic Scale-up*) that those managing scale up can use to help guide the process through the ***phases of the iterative cycle for systematic scale-up***. First, we need to know what has happened to date and how stakeholders have gotten to the point where they are now. Finding out this information is the purpose of the first phase of *engagement and assessment*, which feeds directly into the second phase of system-oriented *co-creation (planning)*. The third phase involves implementing the co-created plan with mechanisms for managers and leaders to get frequent feedback and engage in a process of continuous learning and adaptive management. This will then bring us back to the next cycle of engagement and assessment, and so forth.

The rhythm of the cycle should be timed to coincide with the rhythms of the MOH (i.e., the agency that is implementing the intervention). We have found that it makes the most sense for RMNCH interventions to go through one turn of the overall cycle in one year, to coincide with annual MOH planning cycle. In the first trip around the cycle, the phases of engagement and assessment, and then co-creation of the plan are likely to take four to six months, leaving six to eight months for initial implementation with learning and adaptation. But in subsequent trips around the cycle, those involved will need less time to consider adjustments to their engagement as well as assessing progress over the previous year. That means that these phases as well as the co-creation of the next annual plan can fit in a much shorter time span after the initial cycle. After the initial cycle, partners will spend the large bulk of their time on the phases of implementation with learning and adaptation.

These iterative cycles at the national level should be based on more frequent iterative cycles at the local and district levels. At the local level, it is usual for the health facilities to report monthly, so we found that it makes sense to include time during this monthly reporting cycle when a local scale-up focal point can do a data review tied to routine reporting. Then at the district level, district managers can include the quarterly reviews we envision here in their usual management processes. It is very helpful for having an efficient discussion that can be incorporated in usual management processes if district managers have systematic quantitative information visualized in the form of a dashboard, as well as a clear idea of the prioritized implementation strategies and some structured qualitative information on them to help them guide the discussion on what is working, the challenges, and the adaptations made locally that they want to share and disseminate to others.

It is best practice to roll out an intervention in a phased manner (we refer here not to the phases of the programming cycle, but to phased geographic expansion). We believe that the best way to think about the process of service expansion is again with reference to the usual ways of doing business of the MOH. That is, to think of the "scalable unit" [12] which should correspond to the units by which MOHs organizes itself. This is usually the district. In other words, the MOH does not think in terms of 10, 20, or 30 health facilities, but rather the number of districts implementing an initiative. So the task of expansion can be split into *growth within the district* and *replication in other districts* (of course, with adaptation!). To illustrate this concretely, given a choice on how to spend limited outside funding that would be sufficient to roll out an intervention in 100 facilities, the MOH could opt to implement initially in five facilities in each of 20 districts, but they would be much more likely to learn the lessons they need to effectively manage, expand, and sustain the intervention

[12] Barker P, Reid A, Schall M (2106). A framework for scaling up health interventions: Lessons from large-scale improvement initiatives in Africa. Implemetation Science. 11(1): 12

if they would pick three districts (let's assume that an average district in this country has 30-35 facilities) and fully saturate them. In these districts in the initial phase, they will learn how to manage all the processes and system components and develop a model for how to reach full coverage of all the health facilities, even those that need additional assistance and not just the "positive outliers." In this sense, the district managers are producing "prototypes" for other districts that join in the next phase of expansion that they can start with and adapt.[13] Then the expansion phase happens by adding new districts. There is some evidence that conducting the expansion this way facilitates learning and allows the expansion to happen more effectively and efficiently in the districts added in subsequent phases.[14]

Having this "scalable unit" or "scalable model" structure also allows facilitates systematic thinking on several distinct types of expansion (shown in Figure 6) and how partners can help with each. Within a single district the task is to reach all the eligible clients in need of the intervention. Partnerships may be needed to achieve this, e.g. with faith-based or private providers. The Rwanda MOH used this type of partnership with Catholic hospitals to help extend pre-discharge PPFP services to cover entire districts. In terms of replication in other districts, it is common for MOHs to have various external agencies supporting the same types of services in different geographic areas. This is how the respective MOHs partnered with various international NGOs to support the expansion of chlorhexidine in Liberia, and the expansion of iCCM in DRC. Finally, MOHs often collaborate with other agencies to support key components of an intervention – like logistics and supply chain management, or Health Management Information System (HMIS) improvement. This, of course, can be done across scalable units.

Figure 6. Mechanisms to Achieve Service Expansion

Approach	Method
Growth	• Growth within a district through public system • Franchising of private providers
Replication	• MOH implements without outside assistance in additional districts • Other partners assist implementation in additional districts
Collaboration	• Formal partnerships to implement full package • Networks or coalitions that divide responsibility for key components of package

Adapted from Cooley L. 2016. Scaling Up—From Vision to Large Scale Change, 3rd Ed., misworldwide.com

3.2 Phase 1: Engagement and Assessment

Goal	Key Activities	Estimated Timeframe
Engage critical partners and improve understanding of the scalability of the intervention in the particular context	• Conduct desk review and initial brainstorming • Conduct field observation • Consult with experts and key informants in the country • Develop a draft Theory of Change (if one has not already been developed)	2 – 3 months

[13] Ibid.

[14] Massoud MR, Mensah-Abrampah N (2014), *A promising approach to scale up health care improvements in low-and middle-income countries: the Wave-Sequence Spread Approach and the concept of the Slice of a System,* F1000Research https://f1000research.com/articles/3-100/v2

Engagement and Assessment involves gauging to what extent a scalable model within one or more "scalable units," like a district, has been tested and improved and is ready for replication (with needed adaptations) in additional units. The scalable unit is the smallest level of organization of the country health system that brings together all the system elements needed to sustainably support the intervention; it is usually the district.

This phase involves taking stock of past experiences, introducing and/or expanding the intervention package, and assessing the current scale-up environment, and the state of readiness to scale, through key questions:

- What is being scaled? Is there a clear consensus on the intervention package to be scaled up?
- Are key inputs in place (for example: initial financing, supportive policies, delineation in national strategic plans)? *If not, then further action might need to wait or we should move forward cautiously, with commitments about actions and decision points for filling the gaps in readiness.*
- Who is scaling the intervention? Who are the key stakeholders and are they already on a functioning team that can serve as the scale-up management team? Are there identified champions/focal people in current and expansion units? Consider stakeholders that could support the achievement of service expansion through any of the methods above (Figure 6).

Refer to the checklist in the ExpandNet's Beginning with the End in Mind guide for a more detailed discussion.

Phase 1: Engagement and Assessment	
Tasks	**Tools/Resources**
Initial steps for the Scale-up Coordinator • Identify key people within their organization to support scale-up activities • Review timeline and budget for scale support activities in their organization • Orient their staff on the concepts of scale-up and especially the steps of assessment and developing a scale-up plan	ExpandNet Practical Guidance for Scaling Up Health Service Innovations (ExpandNet and WHO, 2009)
Desk review of **previous experiences** with the intervention • Review previous experience for their activities and approaches, effectiveness, feasibility, and acceptability (what did/did not work and why/why not?) • Review the information used for tracking progress: indicators, sources of information and reporting chains, data collection techniques, data collection burden, and data quality • Review any available information on costs	Plans, budgets, evaluations from previous experiences
Review and adapt tools in this guide for use in this situation	All tools in referenced in this guide and the accompanying *Basic Toolkit for Systematic Scale-up*

Phase 1: Engagement and Assessment	
Tasks	**Tools/Resources**
Meet with key stakeholders • Review the **intervention package**; explore any variations in the way it has been implemented; and begin discussions about ideas for needed refinements/adaptations • Assess needs, capabilities, and challenges of implementers in supporting implementation	Nine steps for developing a scaling-up strategy (ExpandNet and WHO, 2010) Worksheets for developing a scaling-up strategy (ExpandNet and WHO, 2012) (*See MCSP Scale-up Legacy page for examples*) Tool 1: Definition of Intervention Tool 2: Scalability Tool 4: Assess Scale-Up Environment
Conduct field visits to sites that have implemented the intervention package and interview key informants	Tool 3: Assess Implementer Capacity to Integrate and Implement Intervention Package
Assist partners to identify or form the government-led scale-up management team at national level • Explore the right mix of personnel and their responsibilities, competencies, and availability • This is likely to be an existing work group, but they may need to form a sub-committee in order to give sufficient attention to the scale-up process	Tool 5: Identify Key Stakeholders and Describe Scale-Up Management Team
Begin formulating a draft Theory of Change for the intervention package based on stakeholder consultations	Theory of Change resources in References (Anderson, UNICEF)
Identify and prepare list of any key gaps in information in preparation for discussion at scale-up planning workshop	

Note: Tools 1-5 can be found in the accompanying *Basic Toolkit for Systematic Scale-up*

3.3 Phase 2: System-oriented co-creation (planning)

Goal	Key Activities	Estimated Timeframe
Co-create a finalized national scale-up plan with key stakeholders and formulate guidance for development of district operational plans, based on national plan	Prepare for scale-up planning workshop	1–2 months
	Conduct scale-up planning workshop	2 weeks
	Conduct immediate workshop follow-up	1–2 months

System-oriented scale-up co-creation (planning) involves the activities leading up to, including, and immediately following the development of a costed and benchmarked scale-up plan. Although there may be other ways to bring about consensus on a co-created plan, this is most efficiently and effectively done through convening a scale-up planning workshop. This workshop will ideally have the following activities leading to the critical elements of a co-created plan, the aim of which is to expand effective coverage as well as advance the institutionalization of the supports for the intervention in country systems (Figure 7):

1. Formulate the **Vision.** This should align with MOH strategy but to be most useful it should be more specific and time bound than likely was stated in the overall health sector strategy.
2. Analyze the **intervention package** within an overall Theory of Change; and analyze its scalability within the context/environment.
3. Analyze the **implementer and clients**: review strengths and challenges in integrating the new activities into existing processes; review what is known about client preferences and needs.
4. Analyze who is **leading and managing** the scale-up process at national and district level.
5. Develop a **plan** to address identified issues:
    - National-level strategic plan; and
    - Aligned district operational plans.
6. Include activities for **tracking** critical quantitative information (for a dashboard) and systematic qualitative information for continuous learning and adaptive management

Figure 7. Developing a Plan for Achieving Sustainable Impact at Scale

The information gathered during the Engagement and Assessment phase feeds directly into the preparations for the scale-up planning workshop. The purpose of the System-oriented scale-up co-creation (planning) phase is to help stakeholders shape a realistic and detailed plan for scaling up the intervention, building on previous experience and current assets. Preparations for the scale-up planning workshop involve further refinement of the key scale-up tools and documents, in accordance with the findings of the assessment, preparation of the sessions, and packaging of materials for the workshop.

The workshop ideally includes all members invited to participate in the scale-up management team that will eventually be responsible for overseeing and managing the scale-up plan. The workshop should deepen understanding of effective scale-up strategies and implementation; facilitate ongoing collaboration among the key stakeholders; identify any gaps or changes necessary in the scale-up planning; and assist stakeholders to agree on immediate next steps, timeline, and processes for finalizing a national scale-up plan and operational plans to roll out scale-up strategies at the "scalable unit" (i.e., district) level.

Phase 2: System Oriented Co Creation (Scale Up Planning)	
Tasks In PREPARATION For The Scale-Up Co-Creation Planning Workshop	**Tools/Resources**
Package the Engagement and Assessment phase findings for presentation at the workshop	Nine steps for developing a scaling-up strategy (ExpandNet and WHO, 2009)
Support the scale-up management team to prepare: • Identify and invite appropriate participants • Prepare workshop materials • Complete logistical preparations	See examples on *MCSP Scale-up Legacy page* of scale-up planning workshop materials (agendas, invitees)
Tasks DURING the scale up co creation planning workshop	

Hold two- or three-day scale-up workshop with key stakeholders
• During the workshop, the implementers and managers from the districts that have implemented the intervention package should make presentations about their experience to date
• Review results of assessments and consultative visits
• Make decisions about critical elements and activities for multi-year strategic plan for scale-up, using strategy development exercises
• Agree on process for developing operational plans at the district/subnational level
• Review initial operational costing estimates for scaling up
• Secure commitments for immediate and longer-term follow-up activities by key stakeholders
	• Examples on *MCSP Scale-up Legacy page* of scale-up planning workshop materials (agendas, presentations, small group discussion guides)
	• Examples on *MCSP Scale-up Legacy page* of costing analyses
	• During workshop
	  • Have participants review drafts of materials from Tools 1-5 to revise and validate
	  • Have participants fill in planning tools:
	  • Tool 6: Roles and Responsibilities for Leaders and Managers; and
	  • Tool 7: Plan Scale-Up Strategies for Institutionalization and Service Expansion

Tasks to FOLLOW UP after the scale up co creation planning workshop	
Circulate workshop proceedings document for stakeholders to review	Examples on *MCSP Scale-up Legacy page* of workshop reports
Draft national scale-up plan, based on the proceedings	Examples on *MCSP Scale-up Legacy page* of plans
Individual follow-up meetings with key stakeholders to review critical aspects of the scale-up plan, including costs and benchmarks	
Finalize matrix for tracking the implementation of the national and subnational scale-up plans	Tool 9: Matrix to Track Achievement of Activities in Plan (Strength of Implementation)
Finalize dashboard to visualize progress on key service expansion indicators and facilitate decision-making	Tool 10: Build Service Expansion Dashboard
Finalize complete national scale-up plan with costs and benchmarks	

Note: Tools 6-10 can be found in the accompanying *Basic Toolkit for Systematic Scale-up*

3.4 Phase 3: Implementation with learning and adaptive management

Goal	Key Activities	Estimated Timeframe
Support the government-led scale-up management team in implementing, tracking, and adaptively managing the scale-up process based on the national scale-up plan	• Conduct ongoing tracking of implementation of the scale-up plan • Review key outputs/outcomes in the scale-up dashboard • Build capacity of implementers and managers for continuous learning and adaptive management through ongoing mentoring	**Quarterly:** Meetings at national and sub-national levels for review, learning, and adaptations **Annually:** Begin cycle again with more in-depth annual partners' meeting to assess progress and adaptations and co-create next annual plan

The key issue in this phase is the concept of continuous learning and adaptive management. For the scale-up management team and others at district and local levels to engage in effective adaptive management, they need "good enough" information on key areas "in real time." That is, the information does not need to be of the level of rigor of a research study; rather, it needs to contain critical data on how the scale-up process is working.

The ultimate goal of the scale-up process is widespread and sustained impact to contribute to national health targets. The intervention will have to reach high levels of utilization to achieve impact and will need to be institutionalized in key health systems to be sustained.

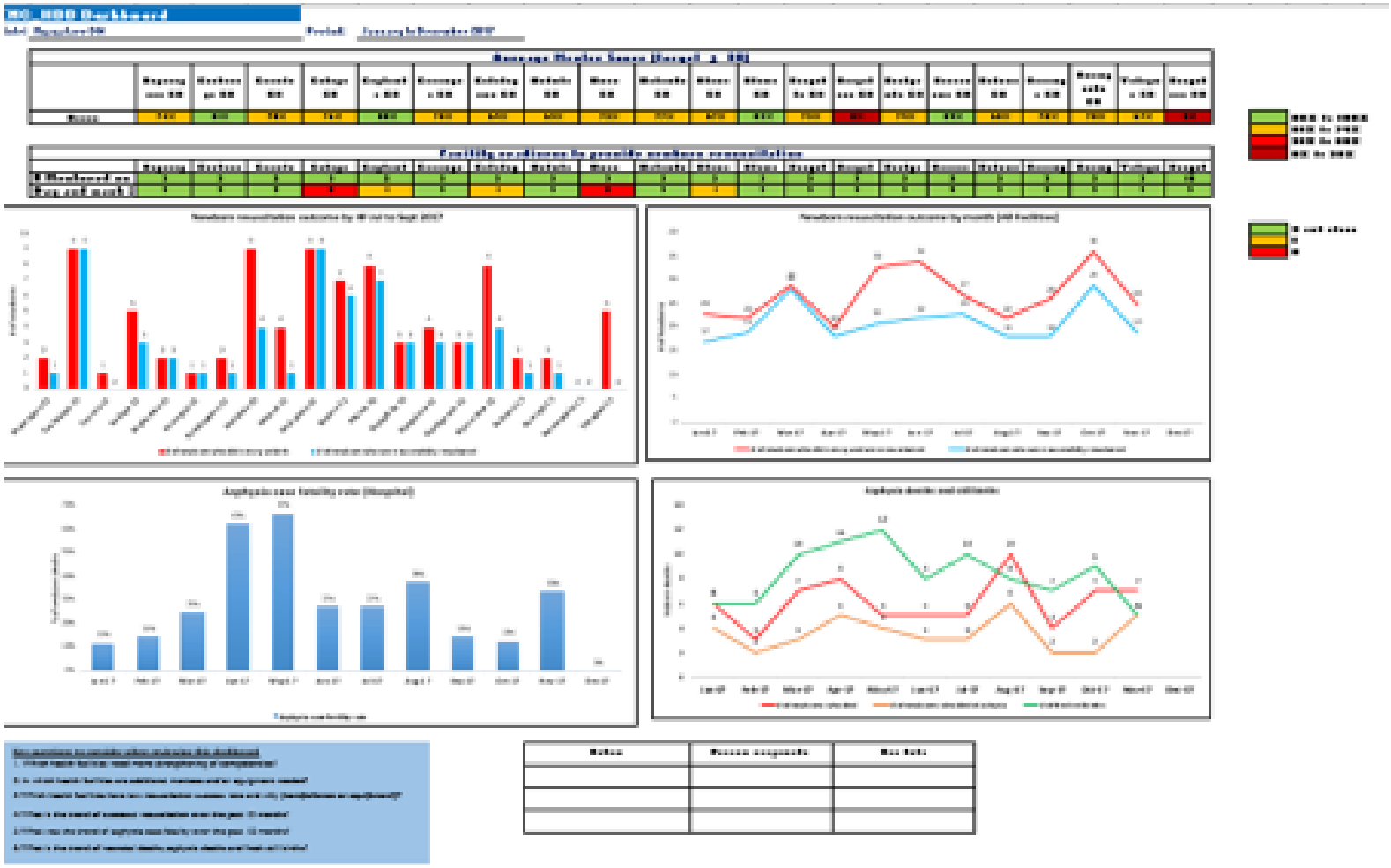
The scale-up management team should monitor progress on coverage expansion. Depending on data availability in the country, this information may prove challenging to obtain with accuracy and regularity. Approximations and estimates may be needed, but efforts should be made to build out local systems that will eventually track the right information in an efficient and routine manner. It is best if this information is kept disaggregated by district when reporting to national level, and by health unit when reporting to district level, in order to identify good performers as well as those experiencing challenges. This is similar to the way immunization data is reported—with a few key indicators reported quarterly by district.

In order to help pinpoint possible problems, the scale-up dashboard should also include a few key outputs (based on the Theory of Change) like presence of trained personnel and availability of key commodities. In Rwanda, for scale-up of HBB/ENC, the data for the indicators included in the dashboard was in the DHIS-2 national health information system. It was displayed in a graphical format and reviewed by staff on a regular basis to make sure that the process was on track, and if not, to help plan timely key corrective actions (Figure 8). The key items on the dashboard were:

- Resuscitation outcome (% successfully resuscitated)
- Average mentee score (target > 80%)
- Facility readiness: presence of clean bag and mask

Some dashboards might be more complex. Figure 9 shows a dashboard from Bangladesh for chlorhexidine application on the umbilical stump of the newborn to prevent sepsis. The top of the figure shows the matrix with the key indicators being tracked, and the bottom part of the figure shows the visualization of attainment of the indicator by district for three critical indicators in the dashboard.

Figure 8. Rwanda Dashboard for scale-up of newborn resuscitation and essential newborn care

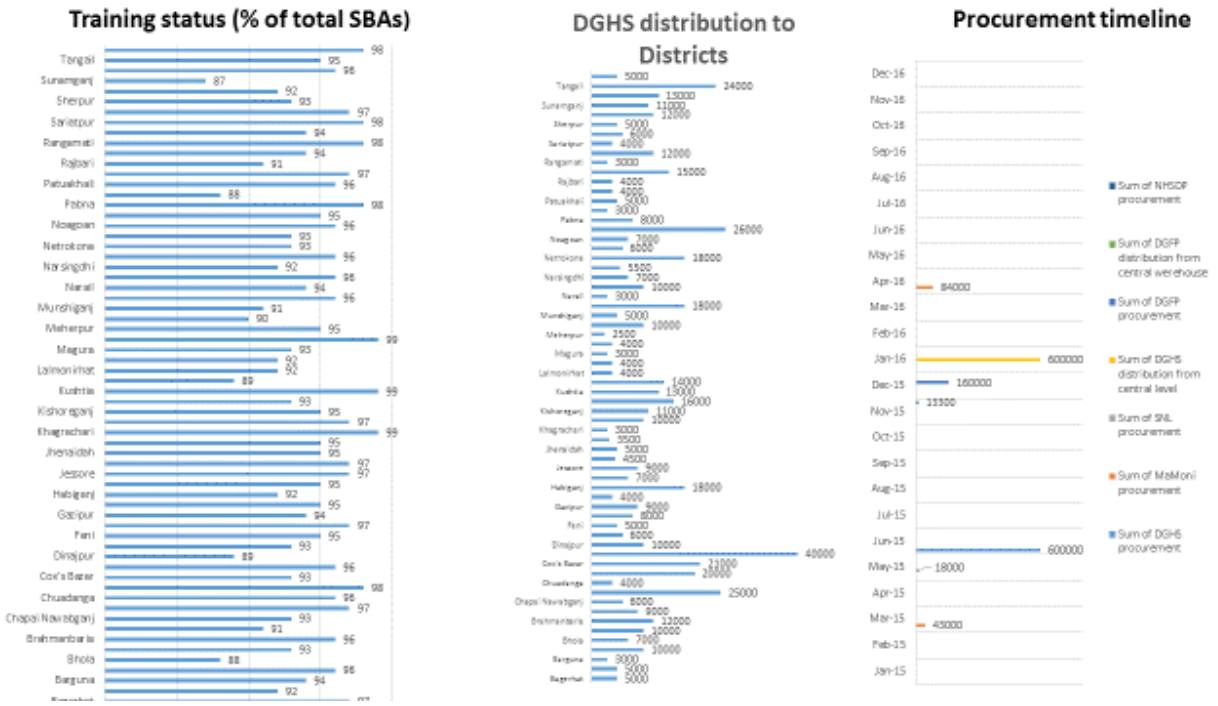


Key items on ENC/HBB Dashboard

- Average Mentee Score (target > 80)
- Facility readiness: Bag and mask
- Resuscitation outcome

Figure 9. Dashboard Indicators: Bangladesh Chlorhexidine (CHX) Scale-Up

Domain	Parameters	Level	Frequency	Data source
Capacity building	No. of staff trained on essential newborn care, including 7.1% CHX application	District	Not applicable	MaMoni national scale-up team
	Proportion of MOHFW staff trained on essential newborn care, including 7.1% CHX application	District	Half yearly	Mini survey/review meeting
	No. of non GoB staff trained on essential newborn care, including 7.1% CHX application	District	Not applicable	MaMoni national scale-up team
Procurement	Quantities of CHX procured by DGHS, DGFP and other private/NGO providers	National	Date of procurement	IMCI newborn cell and DGFP focal person/SIAPS
Stock and Supply	DGHS current stock status at DRS	District	Monthly	IMCI newborn cell
	DGHS last supply at DRS	District	Specific date	IMCI newborn cell
	DGFP current stock status at upazila store	District	Monthly	SIAPS
	DGFP last supply at upazila store	District	Specific date	SIAPS
Distribution	Distribution from DGFP SDP	District	Monthly	SIAPS
	Distribution from DGFP Warehouse	Regional WH	Monthly	SIAPS
Service utilization	Use of CHX by district	District	Monthly	MIS-4, CSBA report, EmOC report, NGOs report, ACI's agents sell report
Coverage	Source of CHX	MaMoni districts	6 monthly	Tracer Survey
	Use of CHX by wealth quintile	MaMoni districts	6 monthly	Tracer Survey
	Percentage of CHX users receiving counseling/information about CHX by source	MaMoni districts	6 monthly	Tracer Survey
	Proportion of CHX use by place of delivery	MaMoni districts	6 monthly	Tracer Survey



The scale-up coordinator's support during the implementation with learning and adaptive management phase primarily takes two forms. One is in ensuring that there is a plan in place to track strength of implementation, service expansion indicators, and institutionalization. The other is in supporting the scale-up management team to analyze, learn from, and adaptively manage the process based on reviewing the data on a quarterly basis. This process of "iterative learning and adaptive management" is facilitated by review of the scale-up dashboard during regular meetings of the scale-up management team to understand what is and is not working in the national scale-up plan, and what course corrections can be taken, by whom, and on what timetable. The scale-up coordinator also needs to help the members of the scale-up management team to coach district teams (i.e., those in the "scalable units") to incorporate similar review and adaptive management discussion about the intervention into their regular and routine (likely monthly or at least quarterly) meetings.

Phase 3: Implementation with Learning and Adaptation	
Tasks	**Tools/Resources**
Establish institutionalization baseline and update it annually	Tool 11: Assess Institutionalization of Intervention Package
Facilitate periodic (likely quarterly) review and learning meetings of the scale-up management team at national level and encourage the same for subnational meetings • Review progress on planned activities (planned vs. actual activities) • Review scale-up progress on scale-up dashboard across district ("scalable units") • Discuss challenges and any adaptations made locally • Circulate brief meeting report	Example of summary of learning meeting on *MCSP Scale-up Legacy page* Most Significant Change materials for example of qualitative monitoring: https://www.betterevaluation.org/en/plan/approach/most_significant_change Examples in Annex 4 of use of Tool 9 (activity tracker) and Tool 10 (service expansion dashboard)
Facilitate annual meeting • Review progress on planned activities (planned vs. actual activities) • Review scale-up progress on scale-up dashboard across district ("scalable units) • Discuss challenges and any adaptations made locally • Review progress on Institutionalization matrix • Circulate brief meeting report	Example of annual meeting summary on *MCSP Scale-up Legacy page* Examples in Annex 4 of use of Tool 9 (activity tracker); Tool 10 (service expansion dashboard); and Tool 11 (institutionalization matrix)

Note: Tools 9-11 can be found in the accompanying *Basic Toolkit for Systematic Scale-up*

Glossary of Important Terms Used in this Guide

Acceptability: The perception among stakeholders (e.g., clients, providers, managers, policymakers) that an intervention is agreeable. This is related to satisfaction but is specifically about the intervention itself and not the total experience that may be affected by operational aspects.

Effective Coverage: "A measure of health system performance that is intended to combine three aspects of health care service delivery into a single measure: need, use (often referred to in the literature as "utilization" [...]), and quality."[15]

Feasibility: The extent to which an intervention can be carried out in a particular setting or organization.

Implementer: The implementers are those carrying out the intervention. They "are the institutions or organizations that seek to or are expected to adopt and implement the innovation on a large scale. (Examples: the ministry of health, education or social welfare; several ministries working together; non-governmental organizations (NGOs) or other community-based organizations; a network of private providers; a combination of the above." (ExpandNet, which uses the term "user organization" for this)

Institutionalization: Incorporation of the intervention and its supports into routine local systems.

Intervention package: The "health interventions and/or other practices that are being scaled up. This is usually a package of interventions, often consisting of several components." (ExpandNet, which uses the term "innovation" for this. We do not use the term "innovation," to signal that we are discussing the advanced stages of scale-up). The intervention package can include one or several high-impact interventions.

Population coverage (or **utilization** by the population in need): The percent of the population in need of the intervention that actually receives it.

Scale-up coordinator: A person who facilitates the various processes related to systematic scale-up. In many of the experiences used illustratively in this guide, this was someone working in the country office of an agency giving technical support to the scale-up efforts, but with the right terms of reference and level of authority, this person could also be someone within the government structure.

Scale-up readiness: This refers to the set of conditions that need to be in place to support the advanced stages of scale-up. That is, some evidence of "real world" effectiveness of the intervention package, agreement on its appropriateness and inclusion in key policies and strategies by policymakers, and commitment of funding for the next strategic cycle (typically four to five years).

Scalable unit: The geographic or managerial unit for operational planning for scale-up. This unit should include those with some measure of control over all the health system components needed for effective implementation. In most countries this is the district or its equivalent. When doing operational planning we then aim to have the intervention *spread* within the district so as to cover it completely and to have it *replicated* (with needed adaptations) in other districts.

Scale-up: Scale-up involves "deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and program development on a lasting basis"

[15] J Colston J (2011), *The Use of Effective Coverage in the Evaluation of Maternal and Child Health*, Inter-American Development Bank, https://publications.iadb.org/en/bitstream/handle/11319/5231/The%20Use%20of%20Effective%20Coverage%20in%20the%20Evaluation%20of%20Maternal%20and%20Child%20Health%20Programs%20.pdf?sequence=1

(ExpandNet, 2009). This definition includes both the idea of reaching high effective coverage ("benefit more people") and the idea of sustainability/institutionalization ("on a lasting basis").
Scale-up management team: The scale-up management team refers to the government-led group of individuals and organizations facilitating the wider use of the intervention package. A scale-up management team may be a stand-alone group or, more often, part of a larger body within a government agency. It should include representatives from local implementers as well as stakeholders who have significant influence over key components of the intervention package (e.g., program managers, technical experts, trainers/educators, other relevant ministries, national and international NGOs, professional associations, researchers, relevant private sector institutions).

Service availability: The percent of geopolitical units (e.g., districts) and/or service delivery points fully implementing the intervention package.

Service expansion: The increase in the provision of the intervention package.

Waves of expansion: This refers to starting with a smaller group of entities ("scalable units") in which the intervention is implemented and going through at least one iterative cycle (typically annual) before adding additional units. This cycle can be repeated several times to reach larger and larger geographic coverage.

Other Materials

Other materials are also available on the *MCSP Scale-up Legacy page*:

- Basic Toolkit for Systematic Scale-up
- Examples of products produced by countries involved in systematic scale-up
  - National Scale-up Plans
    - Afghanistan postpartum hemorrhage prevention
    - Nigeria chlorhexidine
    - Liberia chlorhexidine
    - Rwanda pre-discharge postpartum family planning
    - Rwanda newborn asphyxia practice improvement
  - Costing tools and briefs
    - Liberia chlorhexidine
    - Rwanda pre-discharge postpartum family planning
    - Rwanda newborn asphyxia practice improvement
- MCSP Scale-up Technical Work Group materials on critical topics
  - Dashboards
  - Developing a National Plan
  - Costing
  - Operational Planning
  - Scale-up Management Team and Data Use
  - Scalable Model
  - Adaptive Management
- Briefers and presentations from event on Successful Country-Led Scale-Up of RMNCAH Interventions (May 2018)

Annex 1: Summary of Best Practices for Systematic Scale-up

	BEST practices for scale up	X TRADITIONAL POOR practices for scale up
	WHAT IS BEING SCALED UP?	
Definition of intervention package	Consensus on the core elements of the intervention package (e.g., "daily application of chlorohexidine gel to cord for 7 days, with first application within 24 hours of birth") and the key supporting components within the health systems – the "key ingredients" (e.g., key changes to current practice in terms of personnel, training and supervision; manufacture, procurement, and distribution of needed product(s); demand, etc.)	Often not clearly defined and communicated to stakeholders or if defined, usually only a national policy pertaining to the technical elements of the intervention package
	WHO IS MANAGING THE SCALE-UP?	
Leaders / managers	A leadership and management structure at national level that has contact/reach to the managerial level (i.e., this is usually the district or its equivalent) which in turn has contact to the operational level through focal points or organizational bodies	Often only a national coordinating and/or information sharing body (or no body at all); often with no scope or authority to make decisions and no reach to operational units (i.e., districts)
	HOW IS SCALE-UP HAPPENING?	
Plan	National plan with benchmarks; budget; clear strategies for both supply and demand that address key barriers to scale-up and build on current assets across key systems AND Aligned operational plans at "operational units" (i.e., districts or their equivalent)	Often only a vague plan stated within overall MOH strategy in the relevant health area; often only addressing one or a couple systems, like training or policy development; usually with no specific corresponding and aligned operational plans at district level
Vision/ goal	Clear statement of achievement of *sustained impact at scale* within an explicit timeframe, based on current national strategies	Sometimes no explicit scale-up goal; sometimes the goal is stated as "achievement of high coverage" or mere "presence" of the intervention without explicit mention of the quality of the service(s) delivered
Objectives	High *effective coverage* (i.e., a high proportion of the population in need is reached with quality services) AND *Institutionalization* in key country systems	Often only an implicit objective of reaching as many beneficiaries as possible or only reaching "scale-up readiness benchmarks." Sometimes neither of these objectives is clearly stated
Roll out / expansion	In phases, expanding to larger numbers of "operational units" (i.e., usually the district) included in each new phase	Often rapid expansion to as many operational units as quickly as possible, with no chance to correct problems encountered; often uncoordinated across multiple supporting partners

	BEST practices for scale up	X TRADITIONAL POOR practices for scale up
Tracking / monitoring	Small set of key quantitative indicators that measure: • population coverage for those in need of the intervention • outputs across key system components needed to support intervention Systematic process for collecting critical qualitative information focused on experience and adaptations related to the core intervention and its key ingredients (e.g., Most Significant Change or other streamlined tools like ExpandNet's Implementation Mapping Tool)	Often monitor only outputs and often without explicitly stated targets (e.g., numbers of providers trained, number of facilities equipped, numbers of facilities or districts involved); Often outcomes like population coverage are left for surveys, like Demographic and Health Surveys, that are done so infrequently they cannot serve management purposes
Learning and adaptive management	Provision for continuous collection of a small set of key quantitative and qualitative information to give managers feedback on what is working and what needs improvement, with commitment to adaptive management and possible further in-depth investigation and correction of problems identified based on this information	During the pilot phase there may be tightly controlled and rigorous learning. There may even be a randomized controlled trial at this stage. This proves that the intervention *can* be effective, but not necessarily under routine conditions. Often during expansion phase, there is no provision for continued learning to determine what is working and identify and act upon what needs improvement

Annex 2: Scale-up Coordinator's Checklist

This checklist summarizes the tasks that ought to happen at each phase as discussed in section three of this guide. Note: Tools 1-11 can be found in the accompanying *Basic Toolkit for Systematic Scale-up*.

Phase 1: Engagement and Assessment	
Tasks	**Tools/Resources**
Initial steps for the Scale-up Coordinator • Identify key people within your organization to support scale-up activities • Review timeline and budget for scale support activities in your organization • Orient staff on the concepts of scale-up and especially the phases of engagement, assessment and co-creation of a scale-up plan	Nine steps for developing a scaling-up strategy (ExpandNet and WHO, 2009)
Desk review of **previous experiences** with the intervention and completion of tasks of scale readiness • Review evidence of effectiveness, feasibility and acceptability at small scale • Review the state of policies supportive of key elements of the intervention package and inclusion in national strategies • Review indicators for tracking progress: proposed indicators, sources of information and reporting chains, data collection capabilities and data quality • Review any available information on costs	Plans, budgets, evaluations for previous experiences
Review and adapt tools in this guide	All tools in referenced in this guide and the accompanying *Basic Toolkit for Systematic Scale-up*
Review the **intervention package** and begin discussions about any ideas for needed refinements/adaptations	Tool 1: Definition of the Intervention Tool 2: Scalability Checklist
Meet with **key stakeholders** to assess needs, capabilities, red flags, and get input on composition of scale-up management team	Tool 3: Assess Implementer Capacity
Conduct field visits to sites that have implemented the intervention package and interview key informants	WHO/ExpandNet Scale-Up Assessment Worksheets Tool 4: Assess Scale-up Environment
Assist partners to identify or form the government-led scale-up management team at national level to ensure the right mix of competencies and personalities, and availability (this is likely to be an existing work group, but they may need to form a committee in order to give sufficient attention to the scale-up process)	Tool 5: Identify Key Stakeholders and Characterize Scale-up Management Team
Identify and prepare list of any key gaps in information and logistical preparations needed for national scale-up planning workshop	

Phase 2: Scale up co creation (planning)	
Tasks in PREPARATION FOR the scale-up co-creation planning workshop	**Tools/Resources**
Package results of the pilot (and any scale efforts to date) and the desk review and assessment of scale readiness, for presentation at the workshop	Nine steps for developing a scaling-up strategy (ExpandNet and WHO, 2009)
Support the scale-up management team to prepare for co-creation workshop • identify and invite appropriate participants • logistical preparation: • adapt workshop materials	Examples on *MCSP Scale-up Legacy page* of scale-up planning workshops (agendas, invitees)
Tasks DURING the scale-up co-creation planning workshop	

Hold two- or three-day scale-up workshop with key stakeholders
• During the workshop, the implementers and managers from the districts that have implemented the intervention package should make presentations about their experience to date.
• Produce national multi-year strategic plan for scale-up, using strategy development exercises
• Review initial operational costing estimates for scaling up
• Agree on process for developing operational plans at the district/subnational level
• Secure commitments for immediate and longer-term follow-up activities by key stakeholders
	• Examples on *MCSP Scale-up Legacy page* of scale-up planning workshop materials (agendas, presentations, small group discussion guides)
	• Examples on *MCSP Scale-up Legacy page* of costing analyses
	• During workshop
	  • Have participants review drafts of materials from Tools 1-5 to revise and validate
	  • Have participants fill in planning tools (Tool 6: Roles and Responsibilities for Leaders and Managers and
	  • Tool 7: Plan Scale-Up Strategies for Institutionalization and Service Expansion)

Tasks to FOLLOW UP after the scale-up co-creation planning workshop	
Circulate workshop proceedings document for stakeholders to review	Examples on *MCSP Scale-up Legacy page* of planning workshop materials
Draft national scale-up plan, based on the proceedings	Examples on *MCSP Scale-up Legacy page* of planning workshop reports
Individual follow-up meetings with key stakeholders to review critical aspects of the scale-up plan, including costs and benchmarks and complete any information gaps	
Finalize matrix for tracking the implementation of the national and district scale-up plans	Tool 9: Matrix to Track Achievement of Activities in Plan (Strength of Implementation)
Finalize dashboard to visualize progress on key service expansion indicators and facilitate decision-making	Tool 10: Build Service Expansion Dashboard
Finalize complete national scale-up plan with costs and benchmarks	Examples on *MCSP Scale-up Legacy page* of plans

Phase 3: Implementation with Learning and Adaptation	
Tasks	**Tools/Resources**
Establish institutionalization baseline and update it annually	Tool 11: Assess Institutionalization of the Intervention Package
Facilitate periodic (likely quarterly) review and learning meetings of the scale-up management team at national level and encourage subnational meetings to do the same Review progress on planned activities (planned vs. actual activities) Review scale-up progress on scale-up dashboard across district ("scalable units") Discuss challenges and any adaptations made locally Circulate brief meeting report	Example of summary of learning meeting on MCSP Scale Legacy website Most Significant Change materials for example of qualitative monitoring: https://www.betterevaluation.org/en/plan/approach/most_significant_change Examples in Annex 4 of use of Tool 9 (activity tracker) and Tool 10 (service expansion dashboard)
Facilitate annual meeting Review progress on planned activities (planned vs. actual activities) • Review scale-up progress on scale-up dashboard across district ("scalable units) • Discuss challenges and any adaptations made locally • Review progress on Institutionalization matrix • Circulate brief meeting report	Example of annual meeting summary on MCSP Scale Legacy website Examples in Annex 4 of use of Tool 9 (activity tracker); Tool 10 (service expansion dashboard); and Tool 11 (institutionalization matrix)

Annex 3: Illustrative questions for a Scale-up Learning Agenda

This list of questions is not meant to be exhaustive. We also do not mean to suggest that it is likely to have sufficient resources or appetite for answering *all* of these questions. Rather, this list is meant to stimulate discussion among stakeholders to help them think about one or several of these issues relevant to their context that they feel would be priority areas to explore during implementation. During adaptive management meetings, participants review the quantitative information for a small set of outcome-oriented quantitative indicators that can tell implementers and managers if the scale-up process is achieving the desired results. The facilitator should also reflect on experiences with the key implementation strategies and the adaptations made to improve effectiveness and/or feasibility and acceptability in their context. The scale-up management team may also want to direct teams to reflect on some of the questions below, if they feel like these will be active areas of exploration.

What are we scaling up?

- What are the characteristics of the intervention package that are facilitators and sticking points for achieving effectiveness and feasibility? Can they be modified to improve success? If so, how?
- What is needed to develop a feasible and effective "scalable model" at the district level (i.e., not just at the local level, but working within routine management systems)?
- What are the costs for implementing the intervention package in routine systems?

Who is managing the scale-up process?

- What form of national scale-up management team is most functional and fit to context (i.e., is it a committee under an existing work group, or a stand-alone organizational structure)?
- What partners should be included on the team? Who should the team coordinate with and advocate with?
- What is the most functional and effective structure for sub-national (i.e., district) managers and local managers and implementers? And how do they most feasibly and effectively articulate with the national scale-up leadership team?
- What is the role of champions and how can they best be supported?
- What is the right scope of authority and placement for the designated scale-up coordinator?

How are we scaling this up?

- What elements are most important to include in system-oriented scale-up plans?
- What are the best indicators and forms of dashboard to guide decision making?
- What other types of information, including systematic qualitative monitoring information, can we use to guide the scale-up process that are useful, valid, reliable, and feasible?
- How can iterative learning and adaptive management best be promoted and implemented? What capacities need to be improved, or what ways of doing business need to be modified?
- What system and demand side elements are most difficult to institutionalize and sustain?

Annex 4: Selected References for More In-depth Information on Key Topics in the Guide

This list of references is by no means comprehensive, but includes some of the most practical guidance on strategies and toolkits for those managing the scale-up process in general and for specific aspects of the phases mentioned in this guide. We have also included some references for aspects of Human Centered Design (especially for getting feedback from clients and providers), for developing a Theory of Change, for use of the Most Significant Change qualitative monitoring technique, and a short guide on implementation research methods that are relevant to learning and adaptive management for scale-up. This list of resources is skewed toward health interventions, but we think the lessons learned from other sectors like education and agriculture are also instructive, and we have included some resources that deal with these sectors.

Scale-up Strategies and Toolkits

ExpandNet (2007). *Scaling up health service delivery – from pilot innovations to policies and programmes.* Ruth Simmons, Peter Fajans, and Laura Ghiron, (eds). Geneva: World Health Organization. Accessed May 2019: https://www.who.int/reproductivehealth/publications/strategic_approach/9789241563512/en/

ExpandNet (2007). *20 questions for developing a scaling up case study,* prepared for Implementing Best Practices in Reproductive Health Initiative. Accessed May 2019: http://expandnet.net/PDFs/MSI-ExpandNet IBP%20Case%20Study%2020%20case%20study%20questions.pdf

ExpandNet (2009). *Practical Guidance for Scaling Up Health Service Innovations*. Geneva: World Health Organization. Accessed May 2019: http://www.who.int/reproductivehealth/publications/strategic_approach/9789241598521/en/

ExpandNet (2010). *Nine Steps for Developing a Scaling-Up Strategy*. Geneva: World Health Organization. Accessed May 2019: http://www.who.int/reproductivehealth/publications/strategic_approach/9789241500319/en/

ExpandNet (2011). *Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up*. Geneva: World Health Organization. Accessed April 2019: http://www.who.int/reproductivehealth/publications/strategic_approach/9789241502320/en/

Implementing Best Practices (IBP) Initiative (2007). *A Guide for Fostering Change to Scale up Effective Services.* Accessed May 2019: http://www.who.int/management/AGuideFosteringChangeScalingUpHealthServices.pdf

Institute for Reproductive Health (2013). *Monitoring and Evaluating Scale-Up of Health Systems Innovations.* Washington, Georgetown University and Fertility Awareness Methods (FAM) project. Accessed May 2019: http://irh.org/wp-content/uploads/2013/09/ME_Scale_Up_Briefing_Paper_Final.pdf

MSI Worldwide (2012). *Scaling Up - From Vision to Large-Scale Change: A Management Framework for Practitioners* (Guide and Toolkit). Second Edition, 2012. Accessed on K4Health, May 2019: https://www.k4health.org/toolkits/research-utilization/scaling-vision-large-scale-change-tools-and-techniques-practitioners

USAID (2019) Center for Innovation and Impact (CII), USAID CII's Ready, Set, Launch: A Country-Level Launch Planning Guide. https://www.usaid.gov/cii/ready-set-launch

USAID (2015). Center for Innovation and Impact (CII), *Idea to Impact: A guide to Introduction and Scale.* Accessed May 2019: http://www.usaid.gov/cii/guide-introduction-and-scale

Lessons on effective scale-up

Begovic M, Linn J, and Vrbesky R (2017). *Scaling up the Impact of Development Interventions: Lessons from a review of UNDP country programs,* Brookings Institution. Accessed May 2019: https://www.brookings.edu/wp-content/uploads/2017/03/global-20170315-undp.pdf

Center for Global Development (no date). *Millions Saved: a collection of success stories in global health—remarkable cases in which large-scale efforts to improve health in developing countries have succeeded.* Accessed May 2019: http://millionssaved.cgdev.org/

Cooley L and Papadapoulis L (Nov. 2017 blog post). *Scalable solutions in fragile states*. Brookings Institution. Accessed May 2019: https://www.brookings.edu/blog/future-development/2017/11/28/scalable-solutions-in-fragile-states/

Evidence to Action Project (2017). *Systematic Approaches for Scaling Up: Bibliography of the Community of Practice, volume 2.* Accessed May 2019: https://www.e2aproject.org/publication/systematic-approaches-for-scaling-up-bibliography-of-the-community-of-practice-v2/

Hodgins S and Quissell K, Saving Newborn Lives working paper (2016), *Scale-up as if Impact Mattered: Learning and Adaptation as the essential (often missing) ingredient.* Accessed May 2019: https://www.healthynewbornnetwork.org/hnn-content/uploads/Empty-Scale-Up-Working-Paper_Dec2016.pdf

Results for Development (2016). *Journeys to Scale: Accompanying the Finalists in the Innovations to Education Initiative.* Accessed May 2019: https://www.r4d.org/wp-content/uploads/Journeys-to-Scale-Full-Report.pdf

Human Centered Design resources

Bazzano A, Martin J, Hicks E, et al. (2017). *Human-centered design in global health: A scoping review of applications and contexts. PLOS ONE 12(1): e0186744.* https://doi.org/10.1371/journal.pone.0186744

Design for Health (no date). Website accessed May 2019: https://www.designforhealth.org/

IDEO, *The Field Guide to Human Centered Design.* (PDF is available for free download. Step 4 for client feedback is most relevant). Accessed May 2019: http://www.designkit.org/

Theory of Change resources

Anderson A (no date). *The Community Builder's Approach to Theory of Change,* Aspen Institute. Accessed May 2019: http://www.theoryofchange.org/pdf/TOC_fac_guide.pdf

UNICEF (2014, written by Patricia Rogers). *Theory of Change.* Accessed May 2019: https://www.betterevaluation.org/en/resources/guide/theory_of_change

Most Significant Change qualitative monitoring technique resources

Davies R and Dart J, *Most Significant Change Technique* (Guide and supporting materials on Better Evaluation website). Accessed May 2019: https://www.betterevaluation.org/en/plan/approach/most_significant_change

Adaptive Management resources

USAID Learning Lab (2018), *What is adaptive management?* Accessed May 2019: https://usaidlearninglab.org/lab-notes/what-adaptive-management-0

The Global Learning for Adaptive Management Initiative (GLAM). Website accessed May 2019: https://www.odi.org/projects/2918-global-learning-adaptive-management-initiative-glam

"Scalable Unit" – explanation of what it is and why it's important

Barker P, Reid A, Schall M (2106). A framework for scaling up healht interventions: Lessons from large-scale imporvement initiatives in Africa. Implemetation Scienc. 11(1): 12

Implementation Research guide relevant to studying scale-up

Peters D, et al. (2013). *Implementation Research in Health: A Practical Guide*. Geneva: World Health Organization. Accessed May 2019: https://www.who.int/alliance-hpsr/resources/implementationresearchguide/en/

Annex 5: Feedback from Users of Guide and Toolkit

At the end of the process of using, adapting, and refining the guide and toolkit over the five years of MCSP's support for country-led scale up in seven countries, we did an "exit interview" with three of the heaviest users, among the scale-up coordinators and their MoH counterparts. All respondents said that all of the tools were helpful, but some were especially helpful whereas others caused some difficulties depending on the context. The toolkit is the minimum needed and so all tools were used. Some also felt that the MoH counterparts were not always as well-oriented on the use of the tools as they ideally should have been. Below are some of the comments about specific tools in the toolkit.

- **Tool 1 - Defining the intervention package:** This tool helped key stakeholders to come to a consensus about what the components of the intervention package were, so that they all had a common understanding.
- **Tool 5 – Identify key stakeholders and describe scale-up management team:** Some felt this was a useful tool to review the membership on the designated scale-up management team (which, in all cases, was an existing coordination body). In some countries this was difficult to put into context at a national level because of decentralization. In these cases this tool and Tool 6 (Roles and responsibilities for leaders and managers) needed to be re-conceived as applying to a lower level of the system.
- **Tool 8 – Developing a vision:** Formulating a vision for a specific intervention package (rather than the overall direction of the MOH) was not the usual way that some stakeholders thought. But several people felt that filling it out helped to clarify some issues and get stakeholders to think about the issues that they needed to address to reach sustainable impact at scale.
- **Tool 10 – Build dashboard for key service expansion indicators:** Some felt that having such a data dashboard was a best practice. They felt that this tool was particularly useful for advocacy purposes and also for institutionalization of the intervention.