# Scaling Up — From Vision to Large-Scale Change

Tools and Techniques for Practitioners

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## **Table of Contents**

Foreword	.iii
Chapter 1: Introduction	1
Chapter 2: Tools for Framework Step 1: Developing a Scaling Up Plan	3
1.1: Mapping the Model	3
Tool 1: Reverse LogFrame	6
Tool 2: Visual Mapping 7	
Tool 3: Model Profile 8	
Tool 3a Guide: Describing the Originating Organization	10
Tool 4: Evidence Standards	14
1.2: Assessing Feasibility	15
Tool 5: Methods Screen 15	
Tool 6: Scalability Assessment Tool (SAT)	18
Chapter 3: Tools for Framework Step 2: Establishing the Pre-Conditions for Scaling Up	25
2.1: Mobilizing Support	25
Tool 7: Stakeholder Analysis	26
Tool 8: Network Mapping	30
Tool 9: Force Field Analysis	32
Tool 10: Advocacy Strategy Profile – Part I	33
Tool 11: Advocacy Strategy Profile - Part II	36
2.2 Mobilizing Resources	38
Tool 12: Cost Analysis Manual	38
Chapter 4: Tools for Framework Step 3: Managing the Scaling Up Process	40
Tool 13: Institutional Development Framework	40
Tool 14: Organizational Responsibility Chart (ORC)	44
Tool 15: Monitoring and Evaluation Guidelines	47
Chapter 5: Conclusion	50
Annex A: Types of Evaluations	51
Annex B: Scalability Assessment Tool, Terms, and Concepts	55
Annex C: Field Applications of SUM Framework	64





## Tables

Tuble 1. 10015 and Guides
Table 2: Example, Home-Based Newborn Care LogFrame
Table 3. Tool 3 Elements of the Model, Home-Based Newborn Care Project Example10
Table 4. Alternative Approaches and Methods of Scaling Up12
Table 5. Tool 7 Stakeholder Analysis Table    27
Table 6. Stakeholder Analysis: Policy on Expanded Insurance Coverage for
HIV/AIDS
Table 7. Tool 11 Advocacy Strategy Profile, Part I    35
Table 8. Tool 11 Advocacy Strategy Profile, Part II    36
Table 9. Guidelines for Estimating Effect of Scaling Up on Unit Costs
Table 10. Institutional Development Framework    42
Table 11. Tool 13 Criteria for Progressive Stages in the IDF
Table 13. Illustrative ORC for Scaling Up a Code of Conduct for HIV Anti-
Discrimination Efforts
Table 14. GuidING Questions FOR Process Monitoring

## **Figures**

Figure 1. Critical Questions to Ask in Scaling Up	1
Figure 2. Linkages	7
Figure 3. Path Diagram for Home-Based Newborn Care Model	8
Figure 4. Tool 5 Methods Screen	16
Figure 5. Power/Interest Matrix	
Figure 6. Network Map, Health Sector of Boliguay	
Figure 7. Advocacy Strategy Continuum	



## Foreword

In response to increasing interest across the international development community in scaling up fieldtested models and approaches for addressing widespread and persistent problems, Management Systems International (MSI), with support from the John D. and Catherine T. MacArthur Foundation, published "*Scaling Up – From Vision to Large-scale Change, A Management Framework for Practitioners*" (the "FRAMEWORK") in March 2006<sup>1</sup> The impetus was to address the gap between the numerous successful projects and innovations to be found in the development field, and those precious few that were actually taken to scale.

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

**This document is intended to be a companion document to the FRAMEWORK** and includes 15 tools for use with selected tasks outlined in that report. The materials in this document were developed, refined, and applied over a nine year period in 22 projects in India, Mexico, and Nigeria. It integrates several case studies, mostly drawn from the health sector, , to demonstrate how the tools are used. The Toolkit is designed as a practical resource for field practitioners.

#### Acknowledgements

This work has many forerunners including MSI products such as the Institutional Development Framework, the Implementing Policy Change model, and the Logical Framework. It also draws on numerous valuable products from other members of the scaling up community of practice including ExpandNet, the World Bank, IFAD, the Population Fund of India, IFPRI, and the Brookings Institution. Special thanks go out to the MacArthur Foundation for its generous sponsorship of much of the fieldwork on which this product is based, and personal thanks go to Judith Helzner, Poonam Muttreja, and Dipa Nag Chowdhury who believed in and supported this work for over almost a decade.

The principal authors of this document are Larry Cooley, Rajani Ved, and Kate Fehlenberg.

<sup>&</sup>lt;sup>1</sup> This FRAMEWORK, revised in December of 2012, is available on line at: <u>http://www.msiworldwide.com/files/scalingup-framework.pdf</u>



## **Chapter 1: Introduction**

The **PURPOSE** of this companion volume is to provide a set of tools, guides, and techniques developed and refined through field experience to provide practical help in applying the FRAMEWORK's conceptual steps and broad tasks. The Toolkit attempts to answer the Critical Questions in Figure 1 and is intended for use by:

- Field managers working in development implementing agencies (government or non);
- Staff and managers at funding agencies (governments, international donors, and private foundations) interested in scaling up their programs or integrating scaling up into the design of new programs;
- Academics in professional fields like public health, public policy, social welfare, international affairs, and international development;
- Monitoring and evaluation practitioners interested in integrating scaling up into the design and implementation of their monitoring and evaluation work or in managing the quality of the scaling up process.



#### **Figure 1. Critical Questions to Ask in Scaling Up**

The **STRUCTURE** of this volume follows the three steps of the FRAMEWORK, and offers tools associated with the 10 tasks referenced in that document. Table 1 below lays out the tools and guides in presented in this volume. Like the FRAMEWORK tasks they support, these tools can be **undertaken in parallel** rather than in a strict linear **sequence**.





SCALING UP STEPS	SUB-TASKS	ASSOCIATED TOOLS AND GUIDES
Step 1: Develop a	<ul> <li>Create a Vision</li> </ul>	Model Mapping
Scaling Up Plan	✤ Assess Scalability	Tool 1: Reverse LogFrame
	<ul> <li>Fill Information Gaps</li> </ul>	Tool 2: Visual Mapping
	<ul> <li>Prepare Scaling Up Plan</li> </ul>	Tool 3: Model Profile
		Tool 4: Evidence Standards
		Assessing Feasibility
		Tool 5: Methods Screen
		Tool 6: Scalability Assessment
Step 2: Establish	<ul> <li>Legitimize Change</li> </ul>	Mobilizing Support
Pre-Conditions	<ul> <li>Build a Constituency</li> </ul>	Tool 7: Stakeholder Analysis
for Scaling Up	✤ Mobilize Resources	Tool 8: Network Mapping
		Tool 9: Force Field Analysis
		Tool 10: Advocacy Strategy Profile:
		Part I
		Tool 11: Advocacy Strategy Profile:
		Part II
		Mobilizing Resources
		Tool 12: Cost Analysis Manual
Step 3: Manage the	<ul> <li>Modify and Strengthen</li> </ul>	<ul> <li>Strengthen Organizations</li> </ul>
Scaling Up Process	Organization(s)	Tool 13: Institutional Development
	<ul> <li>Coordinate Action</li> </ul>	Framework
	<ul> <li>Track Performance and</li> </ul>	<ul> <li>Coordinate Key Actors</li> </ul>
	Maintain Momentum	Tool 14: Organizational
		Responsibility Chart
		Information Procedures and Protocols
		Tool 15: Monitoring & Evaluation
		Guidelines

## TABLE 1: TOOLS AND GUIDES



## **Chapter 2: Tools for Framework Step 1: Developing a Scaling Up Plan**

#### Introduction

Figuring out **what** to scale up often involves tracing backwards from the desirable results we observe to what the project did and **how** it produced those successful results. Technically, what the project did is called an "intervention"; the term "**model**" as used here refers to **both the intervention and the contextual and operational keys to its success**, which are often unarticulated in the original design. Identifying these factors and assessing those which were critical to the success of the intervention is at the heart of identifying the model.

Once availablea, this information is fed into a *Scalability Assessment Tool*, which enables a rapid diagnosis of the scalability of the pilot (assessing how easy/difficult scale up may be) and a preliminary identification of the key challenges for getting to scale. Another important partof Step 1 is determining which of ten scaling methods will be used. Last but not least, Step 1 requires determining **who will manage the scale up process, and who will run the scaled up model**.

The following tools for Step 1 are to be used primarily with key staff members of the organization that carried out the original "pilot project," including field staff, and any key external actors with intimate knowledge of the model (e.g., researchers, external consultants involved in the original intervention, members of advisory or steering committees, etc.). The facilitation of this process is best carried out by a third party. As soon as preliminary decisions are taken about the agency expected to implement the model at scale, representatives from that organization should be engaged as well.

## 1.1: Mapping the Model

These tools help to elucidate **key components** of the model, the **context** within which the model was developed, and any **evidence** of impact, as well as to organize that information. This enables a clearer understanding of the key elements of the model in preparation for subsequent steps, including scalability assessment tasks, the reaching of consensus on which components were critical to the outcomes (and which not), and understanding how best to refine or simplify the model to suit the context of the adopting agency.

Projects that will benefit most from the *Mapping the Model* tools include those that were not designed with scaling up in mind, but which were nonetheless successful enough to be considered for scale up.





These may include elements of established programs and projects as well as stand-alone pilot projects.

The mapping process makes use of four tools:

Tool 1:	Reverse LogFrame
Tool 2:	Visual Mapping
Tool 3:	<b>Model Profile</b>
Tool 4:	<b>Evidence Standards</b>

This section uses the example of a model for the Home-Based Newborn Care pilot to illustrate the first three of these four tools. While this case study is unusual in its level of research and evidence (comparison study design and *Lancet* publication), the process tools can be applied widely.

#### Example: Home-Based Newborn Care<sup>2</sup> in India

#### Context

Society for Education, Action, and Research on Community Health (SEARCH) was set up by Drs. Abhay and Rani Bang in Gadchiroli, one of the poorest and most rural parts of Maharashtra State in India in 1985. Their objective was to address the health needs of remote, underserved populations using community-based solutions. SEARCH set up a hospital and campus whose designs closely resembled the local village structure. SEARCH began to implement a model of community-based research to identify local health needs. One major finding was high rates of neonatal mortality. At the time, nearly 83 percent of newborns in India were born at home and sick newborns were referred to health facilities as standard practice; however, costs and social customs prevented the treatment of newborns in these facilities. During this same time, neonatal mortality was gaining global attention.

#### The Model: Home-Based Newborn Care

The community campus model was implemented as a pilot from 1995-1998 in 100 villages, comprised of 53 intervention and 47 control villages. After obtaining community consent, the initial intervention began to recruit village women with at least a primary education to be trained as Village Health

Mavalankar, V., Raman, Parvathy, Centre for Management Health Services, Indian Institute of Management Ahmedabad, ANKUR Project: A Case Study of Replication of Home Based Newborn Care. Accessed January 13, 2012 at *nipccd.nic.in/mch/fr/nbc/erl25.pdf* 



<sup>&</sup>lt;sup>2</sup> This example was developed using the references cited below. The case combines features of the original pilot implemented by SEARCH and the Ankur study with the goal of reducing neonatal mortality using the same methodology, but implemented through seven NGOs in the state of Maharashtra.

Bang, A., Bang, RA., Baitule, SB., Reddy, MH., Deshmukh, MD., "Effect of home-based neonatal care and management of sepsis on neonatal mortality: field trial in rural India," *Lancet*, 354 (1999):1955-61.

Bang, A. Feasibility and effectiveness of replicating the home-based newborn care: the ANKUR project (2008). Available from: <u>http://www.globalhealth.org/conference\_2008/presentations/f4\_a\_bang.pdf</u>

Bang, AT., Bang, RA., Reddy, HM, "Home-based neonatal care: summary and applications of the field trial in rural Gadchiroli, India (1993-2003)," *Journal of Perinatology*, 25 (2005):S108-S22.

Bang, A., Baitule, SB., Reddy, HM., Deshmukh, MD., Bang, RA., "Low birth weight and preterm neonates: can they be managed at home by mother and a trained village health worker?" *Journal of Perinatology*, 25 (2005):S72-S81.

Workers (VHWs). VHW supervisors were identified (requiring some background in health) and trained in advance of the VHW training. The VHWs were trained for one year using a "step-ladder approach": classroom training followed by field practice, classroom review, and further training in a new topic. In total, the training consisted of 17 modules delivered through seven training workshops spread over 31 days. The VHWs were trained in home-based neonatal care modules (for common problems such as birth asphyxia, hypothermia, and sepsis). The model expanded in Year 3 to include direct health education interventions for beneficiaries, including pregnant women and mothers-in-law, on pre-natal and neonatal care and danger signs.

The project also developed efficient and extensive patient data systems, which greatly improved data for referrals and health care providers, as well as the documentation of health outcomes. Intensive supervision was a vital component of the pilot: physicians supervised the VHWs, and the study was supported by an external group of neonatologists and practitioners who met once a year at the SEARCH headquarters.

#### **Evidence: Results from the Pilot**

By the third year of the intervention, about 93 percent of neonates in the intervention area received home-based neonatal care, and neonatal and perinatal mortality rates fell by 62 percent and 71 percent respectively, compared with control villages. The findings of this pilot were published in the *Lancet* and gained wide recognition as a feasible way of reducing infant and child mortality in resource-poor settings across the world.





### Tool 1: Reverse LogFrame<sup>3</sup>

#### Purpose

This tool provides a simple and logical description of the results the model is intended to accomplish and how.

#### How to Use the Tool

This tool reverse engineers the traditional LogFrame to map out the key goals, outputs, outcomes, and activities of a particular intervention. Based on what the program did, describe its goals and work backwards with the following *Guiding Questions*:

- What Outcomes were necessary to produce the Goals?
- What Outputs were necessary to produce the Outcomes?
- What Activities were necessary to produce the Outputs?

GOAL	(←(	DUTCOMES	<b>~</b> (	DUTPUTS	<b>←</b> A	ACTIVITIES
Reduce	-	Home deliveries attended		Home-based care by VHWs	-	Obtaining community
Neonatal		by a VHW (skilled		VHW can identify and		consent
Mortality		attendance)		manage neonatal risk		Identifying VHWs
		Newborns delivered at		factors		Developing standardized
		home examined by a VHW		Bi-weekly supervisor visits		technical guidelines and
		within 24 hours after birth		Development of MIS and		protocols
		Newborns in program are		performance indicators		Standard training methods
		exclusively breastfed within		Semi-annual population		and materials
		24 hours after delivery		census in program villages		Logistics systems,
	*	Newborns received at least		to record births and deaths		uninterrupted supply
		four visits by a VHW		Health education sessions		Develop reporting formats
		during neonatal period		conducted at community		Record vital stats
	*	Newborns received at least		and household levels	*	Health education
		one supervisory visit by a				Home visits
		supervisor during the			*	Fortnightly visits by
		neonatal period				supervisors for quality
		Babies with danger signs				control
		diagnosed and received				Referral advice, but initial
		treatment from a VHW or				management at home
		referral to a clinic				Step-ladder training
	*	Mothers received health			*	Performance based
		education in pregnancy and				payment, annual incentives
		the postpartum period				

#### TABLE 2: EXAMPLE, HOME-BASED NEWBORN CARE LOGFRAME

VHW: village health worker; MIS: Management Information Systems



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<sup>&</sup>lt;sup>3</sup> For a full treatment of the Logical Framework and its use, please see: Cooley, Lawrence, "The Logical Framework," *The Entrepreneurial Economy Review*, Vol. 8 (July/August 1989): 8-15.

In addition to this "hierarchy of objectives," the LogFrame calls for identification of the most important assumptions implicit in the link between activities and outputs, outputs and outcomes, and outcomes and the overall goal, as reflected in the following graphic.



#### **Figure 2. Linkages**

Identifying and testing these assumptions (often unstated in project descriptions and implicit in the minds of those carrying out the pilot program) is an essential first step in validating a model's applicability to new contexts.

## **Tool 2: Visual Mapping**

#### Purpose

The visual mapping of the sequence of steps in an intervention—including steps that are contingent on specific conditions—helps to ensure that all key steps are identified and their elements and norms specified.





#### How to Use This Tool

These graphics, called **path diagrams**, help to grasp a model's essence before delving into the detailed requirements associated with each process step in an intervention. There are several sequences that are important in the Home-Based Newborn Care case; one of these, the preparatory or training sequence, is illustrated in Figure 3 below. Visual mapping is a useful exercise to ensure that no component is missed and to better understand issues of sequencing.



#### Figure 3. Path Diagram for Home-Based Newborn Care Model

### **Tool 3: Model Profile**

#### Purpose

Now that the key objectives and sequences are understood, the elements of the model can be teased out. This mapping exercise includes the identification of the less tangible parts of the model and therefore relies on tapping the tacit knowledge of those involved in implementation. This tool enables the categorizing of key components of the model into its technical and process elements, and also collates information into organizational or social elements. The information in this tool helps participants to reach consensus on the scope—the **who** and **where**—of scaling up. It also provides information on which elements could be dropped or modified to simplify or refine the model. Finally, it clarifies the organizational profile and the particular social context in which the model was embedded (the how), as all of these are important in assessing scalability.



#### How to Use This Tool

Participants in the original project or pilot should be able to provide information on the organization's vision, mission, values, staffing, funding, human resources, and core competencies. The idea here is not so much an accurate classification of every activity in the correct column, but ensuring that when scaling up decisions are made that decision makers are aware of the multiple components of the model.

The following guide is used to fill in each column:

- Technical Elements: This includes technology, human resources, supplies, training modules, salaries, and incentives, etc.
- Process Elements: These include program management and strategic design elements such as stakeholder dialogues, community sensitization, training supervision, monitoring, etc.
- Organizational Profile: These elements include organizations' visions and missions, values and culture (rights-based approach, gender equity, or community engagement), levels of collaboration, transparency in decision-making, and governance structures. (Tool 4 can be used as a guide to collecting organizational data.)
- Context: This information relates to the physical, economic, cultural, and political environment in which the original model took place. Contextual information is needed to compare the original context to the one being considered for scale-up. This is not to say that a model cannot be scaled to contexts different from the original/pilot context—on the contrary, scaling is often that—but these differences must be understood and managed, especially since some projects' success may be more a result of contextual rather than technical factors. Two primary types of contextual information are:
  - Target Population: Information in this category would include standard demographic data, which is most often available from secondary sources. Examples include: age, gender, education levels, ethnicity, socioeconomic status, and any special characteristics, such as refugee status, religious affiliation, or other salient differentiators should be included here.
  - Environment: This refers to both human and physical elements that may have significant influence on the model such as: rural versus urban environments (employment rates, ethnic diversity, family size, etc.); major economic activities (diverse or not, requiring higher levels of education or not, etc.); conflict versus stable environments; local political systems (democratic or authoritarian); and status of infrastructure such as transport and communications systems, etc.





#### TABLE 3. TOOL 3 ELEMENTS OF THE MODEL, HOME-BASED NEWBORN CARE PROJECT EXAMPLE

TECHNICAL ELEMENTS PROCESS ELEMENTS		ORGANIZATIONAL		CONTEXTUAL			
				PRC	OFILE	ELE	MENTS
*	Developing	*	Obtaining community	*	Priorities driven by	*	High infant
	standardized		consent		community needs, not		mortality rates
	technical guidelines,	*	Community-led		donor or government	*	Low rates of birth
	protocols, training		selection of VHWs		priorities		in facilities
	methods/materials	*	Mandatory home visits	*	Strong credibility in	*	Poor referral
*	Logistics systems		Frequent supervisory		community		services
*	Management		visits for mentoring and	*	Ability to secure	*	Social barriers to
	Information System		quality checking		external funding		care-seeking
*	Semi-annual	*	Health education for	*	Strong collaboration	*	High population
	population census		mothers and families on		with community to		density
*	Development of		importance of care		identify needs	*	Community
	reporting formats	*	Step-ladder training	*	Strong emphasis on		acceptance of
*	Development of		curriculum		training		VHWs
	communication	*	Field data validation	*	Existing staff in pilot	*	VHWs recruited
	materials	*	Monthly supervisor		areas		from the
*	Task shifting: VHW		reviews and feedback to	*	Respect for mothers		community (no
	identifies and		VHWs		and VHWs		issues with security
	manages neonatal	*	Community	***	Subscribes to gender		or home visits)
	health problems in		engagement throughout		and social equity,		
	the home				women's		
*	Referral to clinics				empowerment		
	when needed			**	Inbuilt equity:		
					universal coverage		
					design		

### Tool 3a Guide: Describing the Originating Organization

#### How to Use this Guide

This guide can be used to describe the originating agency (the one that implemented the original model), and then again for the adopting agency/agencies that will run the scaled up model. For the adopting agency, the questions in this guide will identify what is **intended** to be done. Comparisons between the two descriptions will help highlight differences that may need to be accounted for.

It normally takes several rounds of interviews with various key informants (technical and administrative staff, and leadership) to collect all this information. Questions 1-7 can be answered by technical staff with basic monitoring data and can sometimes be done remotely, while questions 8-13 are more qualitative in nature and require more in-depth discussions with all types of staff, but particularly with the leadership. It is recommended that sufficient time and resources be allocated for



the collection of this data, and that questions 8-13 be sent in advance to key informants to allow time to prepare for the interview, which should be conducted by a trained interviewer thoroughly versed in scaling up concepts and competent in skilled probing and the elucidation of needed information.

In eliciting and interpreting this information, special attention should be focused on incentives. For sustainable change to occur, it is essential to understand and replicate incentives from the original model or to create an alternative incentive system to reinforce needed actions and desired results. Changes in rules, regulations, and procedures are often necessary and require detailed knowledge of both the originating and adopting organization. For example, many Home-Based Newborn Care programs pay for all transportation and hospital stay costs to encourage mothers to deliver at a clinic. Staff incentives are also critical to ensure the sustainability of new activities post-training.

1. Type of	agenc	y/organi	zation (check or	ne box)							
Government					Priv	ate Sector					
National Min	istry		State Age	ency	Not	for Profit	F	For Profit			
2. Number	of ye	ars mode	el has been in o	peration (ch	eck (	one box)					
Less than 3		3-5			6-10		Ν	lore t	han 10		
3. Budget	used i	mplemer	nting the model								
Year 1 budget of model (\$USD) Percent of total originating											
agency budget, Year 1											
Latest full an	nual b	udget				Percent of total of	riginating				
(if different f	rom Y	(ear 1)				agency budget, la	ast year				
4. Location	n of ac	ctivities o	of model (check	one box)							
All in one		In mu	ltiple districts, b	ut in	In	multiple states/		Nati	on-wide (all		
district		same/s	single state/prov	ince	pro	ovinces, but not all		state	s/provinces)		
5. Which o and use	of the : of the	following model?	g best describes (Check all that a	the sources apply):	of fu	inding the organiz	zation used	l to fi	nance the intr	oductio	n
a. Financed internally from general revenues or budget allocation of the organization											
b. Self-financ	ced on	a fee for	service basis								
c. Special res	ource	s provide	d to the organiza	ation from na	ationa	al or local governm	ent sources	for the	his purpose		
d. Foreign as	sistan	ce donor	resources provid	led by one or	mor	e foreign governme	ent, founda	tion, d	or corporation	for	
this purpose			-	-					-		
e. National d	lonor	resources	provided by one	e or more loc	cal fo	undation or corpora	ation for th	is pur	pose		
Provide any	impor	tant addi	tional informati	ion on the m	etho	d used to finance th	he model l	elow.	:	•	
	0	1 00			( ) 0						
6. Number	• of pe	ople affe	cted by or rece	iving service	e(s) f	rom the model du	ring the la	st 12	months		
(total nu	mber	rom AL	L service sites co	ombined)		71+11 days and an			Tatal		
# Men			#women			12			Total		
ба. <b>Average</b>	6a Average number of people served or affected per service site/area										
(only for mod	lels in	plemente	ed in multiple sit	es)							
# Men			#Women		(	Children under		Ave	erage of <b>all</b>		
			1	12		peo	ple served				
7. Staff hor	urs pe	er day re	quired to imple	ment model	l at oi	riginal site (for mul	ltiple delive	ery sit	es, use an aver	age)	
Total number	r		Average			Average		Ave	erage number		
of staff			number of			number of		of full-time <b>staff</b>			
implementing	g		hours worked			staff per		req	uired per		





					r r			
model in <b>all</b>		per staff		location		location		
locations		member						
7a. Superviso	ry staff (tecl	nnical) hours requ	ired to implen	nent model (for	multiple delive	ery sites, u	ise an ave	erage)
Total number		Average		Average		Average	•	
of		number of		number of		number of	of <b>full-</b>	
supervisors		hours worked		supervisors		time		
implementing		per supervisor		per location		supervis	ors	
model in all		person		-		required	per	
locations		1				location	1	
7b. Administr	ative staff h	ours required to i	mplement mo	<b>lel</b> (for multiple	delivery sites.	use an av	erage)	
Total number		Average	1	Average	<b>,</b>	Averag	e	
of admin		number of		number of		number	of	
staff		hours worked		admin staff		full_tim	<b>6</b>	
implementing		nor admin		nor location		odmin a	toff	
model in all		stoff parson		per location			nor	
		stan person				legation	i per	
locations	TT 4 66 1				6 11 4	location	1	
7c. Total of A	LL staff hou	irs required to im	plement mode	(totals and aver	rages of all thre	e above):	r	
Total number		Total full-time		Average		Average	e	
of staff		equivalent		number of		number	of full-	
implementing		required from		all staff per		time		
model		all staff (total		location		staff per		
		number of 8				location		
		hour days)						
If there are mor	e types of sta	aff required to impl	ement the mode	el. add additiona	l lines and rep	eat the ex	ercise.	
8. Which of th	e following	best describes the	originating or	ganization's mo	nitoring and a	valuatio	n of its m	odel?
o. which of th	e lono wing		ntions		mitoring and v	varuatio	Check all	that Apply
a The organizat	tion did not	monitor or ovaluat	o implementati	on of the model	in any structure	ad way		indi Appiy
h The organizat	tion monitor	ad the introduction	of the model of	on of the model	and set of n	a way.		
b. The organiza			of the model as	gainst <b>a timenn</b> o	e and set of pro	ogress/		
results benchm	arks it estat	blished before imple	ementation beg	an.	1	.1 1.		
c. The organizat	tion evaluate	d the introduction of	of the model for	r the purpose of	determining wi	nether it		
was as effective	as or more	effective than prev	ious practices.					
d. The organizat	tion evaluate	d the introduction of	of the model for	r the purpose of	determining wl	nether it		
was as cost-effe	ective as or 1	nore cost-effective	than previous	practices.				
Provide any add	ditional com	ments on the moni	toring and eva	luation of the in	troduction of t	he model	in the sp	ace below.
9. In the view of	of the origina	ating organization	's leadership, i	n what wavs is	the model a si	gnificant	improve	ment over
past practices?			· · · · · · · · · · · · · · · · · · ·				1	
0. In the view	of the origin	nating auganizatio	n'a landanahin	what agreets a	f their vision	voluos or	. aulture	if any
9a. In the view	of the origin	nating organizatio	n's leadersnip,	what aspects of	a their vision,	values, of	culture,	iii aliy,
contributed to	the successi	ui development an	a implementa	tion of the mod				
10. In the view	of the origin	nating organizatio	n's technical/s	upervisory staff	, in what ways	is the mo	odel a sig	nificant
improvement o	over past pra	actices?						



10a. In the view of the originating organization's *technical/supervisory staff*, what aspects of the organization's vision, values, or culture, if any, contributed to the successful development and implementation of the model?

11. In the view of the originating organization's *front-line service/delivery staff*, in what ways is the model a significant improvement over past practices?

11a. In the view of the originating organization's *front-line service/delivery staff*, what aspects of the organization's vision, values, or culture, if any, contributed to the successful development and implementation of the model?

12. Which of the following best describes the *interest/commitment* of the originating organization's leadership to *scaling up* the model? (Check only one response)

a. Views scaling up positively, but is not committed to playing an active role

b. Committed to scaling up, but does not perceive itself as capable of leading that process

c. Committed to scaling up and leading the effort to do so

Provide any important additional comments below.

**13.** Which of the following best describes the originating organization's *view* of its *capacity* for scaling up the model? (Check only response per column)

a. Capacity to scale up model themselves	Select	b. Capacity to advise/ supervise others in how to	Select one		
	one	scale up the model			
Very limited capacity		Very limited capacity			
Some capacity		Some capacity			
Strong capacity		Strong capacity			
Provide any important additional comments in the space below					

Briefly describe the decision-making process (i.e., on whose authority) that enables the scale up of the model or allows others to scale it up (e.g., the CEO, board of directors, management team, donor, etc.). Include any conditions the decision makers may place on allowing others to scale up the model.





### **Tool 4: Evidence Standards**

#### Purpose

When defining **what is the model** in Step 1, part of the definition includes an assessment of the evidence of impact, i.e., **do we have proof the original model worked**? The more credible the evidence, the easier it is to convince policy and decision makers and other stakeholders of the value of the model. This section does not suggest the use of a particular tool, since evaluation methodologies differ significantly and depend on the model being assessed. Rather, the following paragraphs offer a guide to determining the right type of evaluation and considerations for gathering evidence to support the case for scaling up.

#### **Types of Evaluation**

It is often the case in scaling up that decision makers in potential adopting organizations are persuaded to adopt a model with less rigorous data if the logic is clear and confirmed by other studies or international evidence. However, experience shows that this strategy can be risky in terms of successful scaling up if assumptions about the external environment are not made explicit, understood, and verified. Also, the process of gathering evidence often reveals previously unknown factors that contributed to the success (or not) of the pilot project.

In order to generate credible evidence and understand the underlying dynamics of a pilot's success, a range of evaluation methods are possible (see Annex A for Evaluation Method descriptions). While there is a current bias in favor of Randomized Control Trials (RCTs) as being the most rigorous, RCTs are most appropriate for simple interventions with clear and quantifiable results, relatively few components, and a modest number of contextual variables. In addition to generating evidence for the impact of the model itself, a mix of qualitative as well as quantitative data collection and analysis can yield a more comprehensive picture of the economic, political, institutional, and social aspects of the environment in which the model was implemented, and the effects of these various factors on its effectiveness.

Often pilots rely on data collected or analyzed by the organization itself which, even if high-quality, can be perceived as biased. For scaling up purposes, there is a strong preference for a formal external evaluation of the model. A second best alternative is a rigorous external review of internal evaluations.

#### **Types of Data**

Statistically significant impact data is preferable, though often not possible. Other types of data (listed below) are more common, though credibility tends to be lower the further down you go on the list, with activity data being the least compelling. In the case of the Home-Based Newborn Care example, this would include:



- Impact data: rates of maternal mortality or morbidity, total fertility rates, rate of population growth
- Outcome data: percent of institutional deliveries, percent of pregnant women receiving antenatal care
- Output data: number of service providers competent to provide emergency obstetric care (EmOC), number of community members with basic knowledge of high risk pregnancies
- \* Activity data: number of service providers trained, community sensitization meetings held

Data from pilot projects are rarely tailored to the information needs, jurisdictions, or decision-making styles of policy makers. Data on effectiveness is often necessary, but usually insufficient. It is critical to make sure the priorities and mandate of the audience you are trying to convince are addressed. For example, giving evidence to the District Health Officer on the success of new training modules is of little use when the training curriculums are set by the Regional Health Board.

## **1.2: Assessing Feasibility**

These tools help to chart the pathway to scale, role of key actors, and likelihood of success. As such, they provide the basis for a detailed scaling up plan.

The assessment process makes use of two tools:

Tool 5:Methods ScreenTool 6:Scalability Assessment Tool

### **Tool 5: Methods Screen**

#### Purpose

This tool aids in the identification of an overall scaling up strategy by helping organizations to choose among alternative scaling up methods.

#### How to Use This Tool

The FRAMEWORK groups scaling up strategies into three approaches—expansion, replication, and collaboration—distinguished from one another by the degree to which the originating organization maintains control over implementation as the model goes to scale.

**Expansion** here refers to taking a model to scale by increasing the scope of operations of the organization that originally developed and piloted it. This means the model remains with the original implementers, so it is simpler in that administrative and management processes do not need to be reconfigured for new adopting agencies. Expansion can take place geographically or in new markets,





such as new target populations (for example, marketing to teens as well as adults) or by product or service (for example, offering a new service within an existing health program).

**Replication** differs from expansion in that the model is taken on by new adopters. This almost always involves significant modifications to the original model to suit the various organizational cultures and capacities of the new adopters, and therefore will require much more attention to identify the salient components of the original model and ensure its integrity (and therefore, effectiveness) is maintained in the transfer. In these cases, an arms-length relationship between the originating and adopting organizations (defined below) usually exists after the transfer.

**Collaboration** falls somewhere between the expansion and replication approaches. Collaboration mechanisms run the gamut from formal partnerships to informal networks and include a number of innovative structures and governance arrangements. Formal partnerships, joint ventures, and strategic alliances are increasingly common methods for organizing collaborative efforts, as are less formal networks and coalitions based on a memorandum of understanding or merely a handshake. Typically, these arrangements include some division of responsibility among the collaborating organizations.

The Methods Screen aids in the selection of the most appropriate scaling up method by comparing the characteristics of the pilot project or model with the pros and cons of each scaling up method.

FACTORS AFFECTING CHOICE OF SCALING-UP METHOD	PREFERRED METHODS
Type of Model	
Technology Intensive	Any
Process Intensive	Expansion or Collaboration
Comprehensiveness of Model	
Specific Practice	Any
Complete Model	Expansion
Capacity of Originating Organization	
Strong	Expansion or Collaboration
Weak	Replication
Source of Financing	
Internal	Any
External	Replication or Collaboration
Availability of Formal Evaluation and Documentation of the I	Model
Yes	Any
No	Expansion
Observability of Results	
High	Any
Low	Expansion
Ease of Transfer to Other Organizations	
High	Replication or Collaboration
Low	Expansion
Quality of Governance	
High	Replication
Low	Expansion or Collaboration
Presence of NGO Networks	
Strong	Replication
Weak	Expansion or Collaboration
social Homogeneity	
High	Any
Low	Replication/ Collaboration
LOW	Replication / Collaboration

#### Figure 4. Tool 5 Methods Screen



Each of the three broad approaches to scaling up—expansion, replication, and collaboration— include several alternatives methods. The following table summarizes ten of these methods based on the literature and MSI's field experience:

Approach	Method
Expansion	• Growth
	Restructuring
	• Franchising
	• Spin-Off
Replication	Policy Adoption
	• Diffusion
	• Grafting
	Commercialization
Collaboration	Formal Partnerships and Strategic Alliances
	Networks and Coalitions

#### TABLE 4. ALTERNATIVE APPROACHES AND METHODS OF SCALING UP

Each of these methods has pros, cons, and implications. There are considerations that have yet to be comprehensively catalogued or analyzed, but there is a growing body of case experiences that practitioners can use in choosing among alternative scaling up methods and designing effective strategies.





## **Tool 6: Scalability Assessment Tool (SAT)**

#### Purpose

The Scalability Assessment Tool (SAT) enables the recognition and differentiation of contextual factors affecting the scalability of a model and the key features that are intrinsic to the model itself. The tool has multiple purposes:

- Helping to decide whether scaling up is a **viable** option;
- Assessing how relatively **hard or easy** that process will be; and
- Identifying ways to improve its scalability.

The SAT was originally developed by MSI based on a review of the literature on the diffusion of innovation and scaling up. It subsequently evolved into the present tool of seven sections and 28 questions based on field experience with scaling up in Mexico, Nigeria, and India.

The SAT is divided into the following seven sections and an accompanying score sheet:

- 1) **Credibility:** The extent to which the model is credible in the eyes of potential adopters, funders, implementers, and other stakeholders, including beneficiaries or end-users. The sources of credibility can take many forms from qualitative, quantitative, and anecdotal evidence to the recommendations of experts or endorsements by prominent people.
- 2) **Observable:** The extent to which the results (impact or effectiveness) of the model are observable. This is especially significant because most relevant stakeholders and decision makers in the context of scaling up will not be technical experts in the field; for them, seeing is believing.
- 3) **Relevance:** The extent to which the model is relevant to the concerns of potential adopters, funders, implementers, beneficiaries, and other stakeholders. It is hard to "sell" a new solution when the problem or issue is not considered important. From a scalability perspective, relevance has three dimensions:
  - a. There is an objective problem (not just someone's opinion);
  - b. There is a problem from the perception of policy makers or other relevant decision makers; and
  - c. There is a problem in the eyes of potential beneficiaries.
- 4) **Relative Advantage:** The extent to which the model has relative advantages over existing practices. Sometimes this means there are no alternative solutions or responses.
- 5) **Easy to Adopt:** This refers to the adoption of the model by other organizations as well as its transfer to other social contexts. Scaling up through other organizations depends on the characteristics of the model itself, such as how complex or resource consuming a model is and the capacity of the adopting agency to manage these difficulties. It also involves how the



requirements of the model match up with the culture, capabilities, and incentives of potential large-scale implementers.

- 6) **Testable and Adaptable**: The first part of this refers to the ease with which the model can be tried on a small scale by potential adopters without a large commitment of resources. The second part is whether the model can be adapted to new contexts and still retain its effectiveness, even with modifications.
- 7) **Affordable:** This criterion refers to the extent to which the model is more cost-effective than existing and competing models. It also includes the extent to which the total cost at scale fits realistically within the resources or financial envelope of possible adopters and funders and the non-financial capacities, especially human resources and infrastructure, available to implement it. This is especially important when considering the scaling of a program that has been largely donor-funded.

The primary purpose of the assessment is not to give a **yes or no** regarding scaling up but to provide a very rough indication of the scalability of a model and a basis for anticipating the most likely challenges that will be faced.

The SAT is applicable to all three methods of scaling up (expansion, replication, and collaboration); however, specific criteria take on different meanings depending upon which method is being used. A good example is Criteria 8 in the SAT: "[Does the model] address an issue that is currently a high policy priority?" In the case of expansion, the priority would be that of concern to senior decision makers in the piloting organization, most likely the Executive Director or a board of directors. In the case of replication, the priority would be that of key decision makers in the adopting organizations; and in the case of collaboration, it would be key decision makers in each of the collaborating organizations.

#### How to Use This Tool

#### What is Needed Before You Get Started?

Using the scalability tool requires:

- An understanding of the model itself and the context in which it has been effective
- An understanding of any evidence of efficacy, efficiency, or both
- A basic understanding of the potential adopting institutions and infrastructures in place, and their capacities and capabilities
- An understanding of relevant policy, budget, and resource issues in that sector

#### Scoring

Once the SAT has been reviewed and the explanation of all the indictors is clear (see Annex for *Scalability Assessment Tool Terms*), the checklist is scored by simply putting a check mark or X in the appropriate column for each criterion. The scores in each of the three columns are added to provide a crude assessment of scalability. The user(s) can then look at criteria where the intervention was scored as making scaling up more difficult and assess how critical this complicating factor is to scaling up,





and what can be done to address it. For example, if the model lacks cost data, what can be done to generate cost data? If the model appears to be expensive relative to resources available, what can be done to make it less expensive to implement? In areas where information is not available, such as on the cost envelope, flagging the need to do research on this issue should be added to the list of actions to take.

#### Case Study: SAT and the PRACHAR Project, India

The Packard Foundation funded Pathfinder International/India to design and field test a pilot model at small scale titled PRACHAR (Promoting Change in Reproductive Behavior) whose goal was to increase the age of women at first conception and promote child spacing. The design was a combination of training, behavioral change communications, and service delivery activities designed to bring about significant changes in the knowledge, attitudes, and behavior regarding these issues.

PRACHAR was implemented in two phases in five districts in Bihar: PRACHAR I was implemented from July 2001 to May 2005 and was designed to see if the basic approach—a comprehensive, community-based education program—would produce the expected results, increasing the age of first conception and child spacing. PRACHAR II (2005-2009) was designed as an operations research model to answer the following scaling up questions: (a) whether a simplified model would be as effective as PRACHAR I; (b) how the length of implementation affected results; and (c) whether the results would persist after active intervention had ended. Following these two phases, MSI was asked by the Packard Foundation to assess the scalability of the PRACHAR model.

MSI applied the SAT to the original PRACHAR model as tested in Phase I, and then revised its assessment based on the Phase II results. For the 28 items contained in the tool, eight scored as making scaling up easier, 9 scored as making scaling up more difficult, and eleven were neutral. MSI found that the models (the original in Phase I and the refined one in Phase II) had a number of notable strengths, especially the strong evidence for success and the fact that it presented a solution to an objectively important public health problem in the absence of existing alternatives. MSI found that the Phase I model also had a number of characteristics that would likely make scaling up challenging, the most important of which was that the original model was complex and process intensive.



Model Categories		A ©√	←Scaling Up is easier	B ⊜√	Scaling Up is harder $\rightarrow$	C ⊗√
	1	✓	Based on sound evidence		Little or no solid evidence	
A T. d.	2		Independent external evaluation	✓	No independent external evaluation	
A. Is the model	3		There is evidence that the model	✓	There is no evidence that the model	
credible?	4		The model is supported by eminent		The model is supported by few or po	
	4		individuals and institutions		eminent individuals and institutions	~
	5		The impact is very visible to casual	~	The impact is not very visible; not	
B. How			observation; tangible	•	easily communicated to public	
observable are	6	1	Clearly associated with the		Not clearly associated with the	
the model's		•	intervention		intervention	
results?	7		Evidence and documentation exists		Currently little or no evidence with	
			with clear emotional appeal	•	clear emotional appeal	
	8	1	Addresses an objectively significant,		Addresses a problem which affects	
		×	persistent problem		few people or has limited impact	
C. How	9		Addresses an issue which is		Addresses an issue which is low or	
relevant is the			currently high on the policy agenda	<b>*</b>	invisible on the policy agenda	
model?	10		Addresses a need which is sharply		Addresses a need which is not	
			felt by potential beneficiaries		sharply felt by potential beneficiaries	~
D Does the	11		Current solutions for this issue are		Current solutions are considered	
model have		~	considered inadequate		adequate	
relative	12		Superior effectiveness to current		Little or no objective evidence of	
advantage		~	solutions is clearly established		superiority to current solutions	
over existing	13		Superior effectiveness to other		Superior effectiveness to other	
practices?			innovative models established		innovative models not established	~
	14		Implementable within existing			
			systems, infrastructure, and human	✓	Requires new or additional systems,	
			resources		infrastructure, or human resources	
	15		Contains a few components easily		Is a complete or comprehensive	
			added onto existing systems	~	package of multiple components	
	16		Small departure from current		Large departure from current	
			practices and behaviors of <i>target</i>	✓	practices and behaviors for target	
			population		population	
	17		Small departure from current		Large departure from current	
г н			practices and culture of <i>adopting</i>	✓	practices and culture of <i>adopting</i>	
E. How easy is			organization(s)		organization(s)	
the model to	18		Few decision makers are involved in	1	Many decision makers are involved in	
adopt?			agreeing to adoption of the model	ľ	agreeing to adoption	
	19		Demonstrated effectiveness in		Demonstrated effectiveness in only	
			diverse organizational settings		one/pilot organizational setting	✓
			uiverse organizational settings		one/phot organizational setting	
	20		The model is not particularly value		Process and/or values are an	1
			or process intensive		important component of the model	
	21		Low technical sophistication of the		High technical sophistication of the	
		~	components and activities of the		components and activities of the	
			model		model	
	22		Key innovation is a clear and easily		Focus of the model is not a <i>technology</i> ,	1
			$\mathbf{r}$		or one which is not easily replicated	

#### Tool 6. Scalability Assessment Tool (SAT)





	23		Low complexity; simple with few components and easily added on to existing systems	*	High complexity with many components; integrated package	
	24		Includes little supervision and monitoring		Includes substantial supervision and monitoring for implementation	~
F. How testable is the model?	Able to be tested by users on a Unable to be tested we adoption at a large-scenario adoption adoption at a large-scenario adoption adoption at a large-scenario adoption a		Unable to be tested without complete adoption at a large-scale			
C. Lathana	26		Superior <i>cost-effectiveness</i> to existing or other solutions clearly established		Little evidence of superiority in terms of <i>cost-effectiveness</i>	~
G. Is there a sustainable	27	~	Requires a large commitment of funds at scale		Requires a small absolute commitment of funds at scale	
funding?	28		The model itself has its own internal funding (e.g., user fees) or endowment		No internal funding; the model is dependent on external funding source	~
Total number of checks		8		11		9



#### Analysis of Results and Recommendations

The major findings and recommendations from the scalability assessment exercise done with the PRACHAR project are organized in the table below, grouped by the 7 SAT scalability criteria.

SAT Categories A			
and B	Credibility and Observability		
	Strong, robust evidence that model achieves its stated goals and key		
Positive Results	outcome indicators		
	Results are clearly associated with the intervention		
	<ul> <li>Evidence that a model works in diverse social contexts is mixed</li> </ul>		
Challenges	(good across pilot state; unproven outside of Bihar State)		
	Have not (yet) received the support of influential individuals or		
	institutions		
D 1.0	<ul> <li>Conduct a two-pronged advocacy campaign:</li> <li>1 To a state of the device of the</li></ul>		
Recommendation	I. Larget influential individuals or institutions with strong evaluation		
	data as the core of the message to gain their support and add status		
	• 2 Add to qualitative evidence with the additional of personal		
	testimonies and anecdotes in a media campaign to the general public		
	$(e_{\sigma} a_{r})$ video of providers and families testifying to benefits) to		
	garner widespread support		
	To make a plausible argument that it may work outside Bihar		
	without evidence, add a description of the social diversity of the pilot		
	areas and provide analysis of how the model is affected by		
	differences in socioeconomic status that may be applied to other		
	similar settings		
SAT Categories C	Relevance of the Model and Comparison to Alternatives		
and D	Relevance of the woder and Comparison to Alternatives		
	Model moderately relevant: Of the three factors, it did well on (1)		
<b>Positive Results</b>	addressing an objective problem, and moderately well on (2) issues		
	perceived as problem by policy and decision makers		
	<ul> <li>No other solutions being implemented at scale</li> </ul>		
Challenges	Project ranked poorly on a third factor: (3) issue is seen as a problem		
	by beneficiaries (early marriage and births were the cultural norm)		
Recommendation	Greater advocacy for the <i>issues</i> (not just solutions) of adolescent		
	reproductive and sexual health, age of first births, and child spacing		
	generally would help		
SAT Category E	Ease of Transfer and Adoption		
Positive Results	PRACHAR II Model:		
	<ul> <li>Evidence showed that a simpler model could be effective</li> </ul>		
	<ul> <li>Small departure from current practices for NGO adopters and</li> </ul>		
	beneficiaries		
	<ul> <li>Implementable within existing systems and resources</li> </ul>		





Challenges	PRACHAR I Model:
	✤ Complex
	<ul> <li>Comprehensive</li> </ul>
	<ul> <li>Process and resource-heavy (intense training, supervision, and monitoring activities)</li> </ul>
	Model is a substantial departure from current practice for the Bihari government and Ministry of Health and Family Welfare, making long-term government support and project sustainability difficult
	To provide the training, monitoring, and coordination of the NGO implementers themselves, i.e., the role that Pathfinder played in pilot phase
Recommendation	<ul> <li>Four different options developed (one per scale up method), but expansion of the existing pilot seems most promising</li> </ul>
	Alternative: test effectiveness of model under conditions of average implementation, i.e., by another organization less capable than the high-performing Pathfinder
SAT Categories F and G	Ease of Further Testing and Funding
Positive Results	Model does not have obvious economies of scale or scope so that potential adopting organizations, such as Bihar State, should be able to test or roll it out gradually
Challenges	<ul> <li>No data on either absolute cost or relative cost-effectiveness, so it is impossible to assess these criteria or state-wide implementation</li> <li>The model itself does not generate any funding</li> </ul>
Recommendation	Develop cost data on the PRACHAR model and different versions tested under PRACHAR II, and cost-benefits of simpler versus more complex models



## Chapter 3:Tools for Framework Step 2: Establishing the Pre-Conditions for Scaling Up

#### Introduction

The tools in this section involve the most neglected yet critical part of the scaling up process: securing the support needed to **go** to scale, and to **stay** at scale. This set of tools is most useful in supporting Step 2 of the FRAMEWORK. The result of Step 2 is that decisions for scaling up are taken and resources (financial and human) for scaling up are allocated.

## 2.1: Mobilizing Support

The tasks of **legitimizing change** and **building a constituency** require an understanding of the policy milieu and the key stakeholders involved in the (potential) scaling up process. Legitimation implies placing the need for change high on the agenda of decision makers. It involves the emergence or designation of one or more policy "champions" with credibility, and the willingness to use that political capital in support of the model. Constituency building is the identification, assembly, and mobilization of coalitions necessary to ensure the adoption and implementation of needed changes.

All of this requires analyses of potential supporters and opponents and their interests, resources, and willingness to be involved. Conducting such analysis is facilitated by the use of four tools:

Tool 7:	Stakeholder Analysis enables a listing and analysis of stakeholders and an
	understanding of their positions and resources
Tool 8:	Network Mapping enables the charting of decision-making processes and the
	people and groups who can influence each of these processes





- Tool 9: **Force Field Analysis** helps to array and assess the forces supporting or opposing a certain change
- Tools 10 & 11: Advocacy Strategy Profile (Parts I and II) enables proponents to assess how best to engage government agencies in support of the scaling up effort

While these tools can be used in conjunction with one another to provide a fuller picture of scaling up prospects and strategies, it is more common for organizations to select one or two of these tools based on their skills and circumstances.

## **Tool 7: Stakeholder Analysis**

#### Purpose

The purpose of a stakeholder analysis is to inform the process of constituency building by identifying and examining potential sources of support and opposition for the scaling up of a particular model. It is a tabular presentation of key stakeholders in relation to their interests, positions, and resources relevant to that policy. Stakeholder analysis is useful during the formulation of the scaling up strategy and when the model is being implemented at scale. At the formulation stage, it helps to ensure that policies are shaped in ways that support the adoption and scaling of the model. During the implementation stage, the tool helps to build an appreciation of the relative importance of different groups and the roles each may play in the implementation process, allowing for early engagement and wider ownership around the model and enhancing its chances of success and sustainability at scale.

The definition of stakeholder is an individual, group, or organization

- Whose interests are affected by the model/issue/policy
- Who has an ability to impact the model/issue/policy
- Who has an interest (stated/unstated) or stake in the model/issue/policy
- Who will "win" or "lose" when the status quo changes

The key uses of the stakeholder analysis are to:

- Enable an assessment of the sources of influence, positive or negative, these groups will have
- Identify critical issues around which conflict and compromise are possible
- Help develop strategies for legitimation and advocacy for scaling up
- Identify resources for advocacy and for implementing at scale. This involves strategies for activating constituencies located in cell 1 in Figure 5 below; strategies for enhancing the influence of constituencies in cell 2; and strategies for appealing to stakeholders in cell 3.







#### How to Use the Tool

The stakeholder analysis is presented in a tabular format with five columns and as many rows as there are relevant stakeholders.

GROUP	<b>GROUP'S</b>	RESOURCES	RESOURCE	POSITION
	INTEREST	AVAILABLE	MOBILIZATION	ON
	<b>IN ISSUE</b>		CAPACITY	ISSUE
Name of	- Estimate the level	- Summary of resources	- Estimate of how	- Estimate of the group's
group	of group interest in	held by the group or to	easily the group can	position on the issue (e.g.,
	the issue (e.g., high	which it has access	mobilize resources	pro or con or positive to
	to low)	(may include economic,	in pursuit of	negative, as ranked on a
	- Indicate what	information, status,	objectives	scale of +3 (very supportive)
	those interests are	legitimacy, power)	(high or low)	to -3 (very opposed); 0 is
	(political, financial,			neutral
	etc.)			

#### TABLE 5. TOOL 7 STAKEHOLDER ANALYSIS TABLE





**Column 1** (*Group*) presents a list of relevant stakeholders. Although a full listing of stakeholders would include any person or group affected by or able to affect the scaling up of the model, for purposes of this analysis, stakeholders are considered relevant if and only if the group or actor has significant mobilizable resources that can be applied for or against the scaling up of the model. The best way to develop a first draft of this list is usually in a brainstorming session with six to ten knowledgeable practitioners. This is often referred to as a stakeholder consultation. It is not unusual for such brainstorming sessions to identify 20 or 30 significant stakeholders. This preliminary list should be edited and used as a point of departure for the analysis.

**Column 2** (*Group's Interest in Issue*) lists those interests that will be affected by the scaling up of the model. What are the group's specific interests that would be affected positively or negatively? These questions are best answered by either engaging these groups in a dialogue or by putting yourself in their shoes.

**Column 3** (*Resources*) identifies resources that the group possesses that could be brought to bear in the decision-making or scaling up of the model. Can the group offer some special knowledge or information? Would the group's status or presence on one side of the issue heavily influence its implementation or blockage?

Types of resources can be classified as follows:

- Economic: financial, human (expertise), or in-kind resources such as media time.
- Information: knowledge gained through study, communication, research, or instructions; or facts, data, analyses, and studies.
- Status: a position or rank in relation to others, personal renown, or reputation that can influence decision-making.
- Power: the ability to compel behavior from persons or organizations.

**Column 4** (*Resource Mobilization Capacity*) describes the ease and speed with which the group can mobilize and deploy its resources. If the group cannot mobilize or make effective use of its resources, then they are not really resources in any meaningful sense of the word.

**Column 5** (*Position on Issue*) characterizes the group's position regarding the issue. It should give an indication of the strength of the group's opposition or support (for example, using a –3 to +3 scale).

The example below provides a summary of a completed stakeholder analysis and the strategic implications drawn from it.

#### TABLE 6. STAKEHOLDER ANALYSIS: POLICY ON EXPANDED INSURANCE COVERAGE FOR HIV/AIDS

List of Stakeholders	Resource Mobilization	Position (-3 to + 3)
	Potential	



Insurance Companies	Н	0
Commissioner of Insurance	Н	+1
Underwriters	М	0
HIV Negative Policy Holders	L	-2
National Health Insurance Fund	L	+2
Ministry of Health	М	0
Medical Practitioners' Association	Н	+3
Hospitals	М	+2
Drug Manufacturers	Н	+3
Vendors of Drugs and Medical	L	+3
Supplies		
People with HIV/AIDS	М	+3
AIDS Networks	М	+3
National AIDS Control Council	Н	0
Private Employers	Н	-3
Banks and Mortgage Companies	М	+1
Trade Unions	Н	+3
Ministry of Finance	Н	-2
President	Н	0
Parliament	М	+1
Human Rights NGOs	L	+1
NGO Council	М	0
Churches	Н	+1
Media	Н	0
Donors	Н	+1

#### Alternative Strategies Suggested:

- Begin with stakeholders possessing the strongest support (+3), then move to engage the next concentric circle of supporters, etc.
- Bring in the insurance companies early as they will be the ultimate owners and managers of this effort
- Begin at the top: Presidential Initiatives or big tent efforts with high visibility and high-level political support
- Look for people who are able to bridge with other groups and concentric circles based on the nature of the group (i.e., in both camps) and/or personal/collateral relationships
- Work with or involve like-minded legislators or legislative staff
- Divide stakeholders into those with high support (but minimal resources) and those with high resources (but minimal support); use the first group to articulate strategies and then strategize about how to reach out to the second group in terms of interests





## **Tool 8: Network Mapping**

#### Purpose

A network map is an analytical tool used to mobilize support for and against specific decisions. Its key uses are:

- Mapping the decision-making process or flow and identifying who the decision makers at each step
- Identifying entry points and potential ways of gaining access to the decision-making process
- Augmenting a stakeholder analysis

#### How to Use This Tool

There are several steps in developing a policy network map. Below are some guiding questions and considerations:

- What are the different points through which a funding decision or policy passes?
- Precisely what formal decisions need to be made for scaling up of the model (policy, regulation, law, legislation, etc.)?
- Who are the decision makers (policy makers, political leaders)? Who are the actor(s) in charge of each step?
- In what ways can officials exercise influence over this process? Do they have any particular skills or contacts that might help in this process?
- Are there other actors, though not officially part of the processes, who have substantial influence over key decision makers?


This information is then displayed graphically, as in the following example, as a basis for serious discussions of advocacy strategies and messages.

Figure 6 below presents a network map for a fictional country seeking to scale up new methods of extending health care services to poor, rural workers and their families. The map suggests that important constituents of the president include the health workers union and the medical association. Perhaps these groups could be brought into some kind of alliance that could bring pressure to bear on the president? Within Congress, it seems that the committees on budget and finance are in charge of approving the budget submitted by the president. Might there be some mechanism to influence the committee or the committee staff charged with the preparation of authorization bills for the budget? Does a certain member of the committee have a keen interest in the problems of rural health? Perhaps the minister could bolster member interest with pertinent and timely information that could be used to defend the policy in committee debates or hearings. Perhaps pressure from diverse groups like the Mayors' Association, the National Cooperative Association, and the Agricultural Workers Union might be brought to bear because while these groups are not direct players in the policy process, they are the eventual stakeholders and could be important sources of influence.



## Figure 6. Network Map, Health Sector of Boliguay





## **Tool 9: Force Field Analysis**

## Purpose

Force Field Analysis is another convenient method to illustrate the forces that oppose or support scaling up a particular model. Force Field Analysis enables critical assessment of which force(s) hold the key to changing the status quo. The network map and the Force Field Analysis are usually developed independently and often only one or the other is needed.

## How to Use This Tool

On one side of the chart are arrayed the forces supporting the decision to scale up the model. These are called "driving forces" and can be economic, political, cultural, environmental, or technological (e.g., the upcoming election, recent protests, rising disposable income, support from the medical association, etc.). The forces opposing change are called "restraining forces" and can likewise be economic, political, cultural, environmental or technological (e.g., competing budget priorities, opposition from competing service providers, lack of convincing evidence, bureaucratic inertia, etc.).

Another way to think of these forces is in terms of incentives and disincentives. By definition, things are the way they are because driving and restraining forces balance each other. To advance a model, the forces favoring change need to be stronger than those that oppose it; this can happen either by adding new driving forces or by disabling current restraining forces. Extensive experience and strong theory demonstrate that the better strategy is usually to find ways of disabling or reducing current restraining forces because new driving forces tend to create new opposition.

Given below is the application of Force Field Analysis for a model to train primary care physicians in emergency obstetric care (EmOC) where specialist Ob-Gyns physicians are not available.

## Case Study: FOGSI (Federation of Obstetric and Gynecological Societies of India)

Maternal mortality in India remains high partly because of limited access to EmOC. In most parts of rural India, EmOC is not available due to the shortage of trained medical and paramedical staff, with few obstetricians and gynecologists in most districts. Most general practitioners in India do not provide even basic EmOC. Baseline assessments conducted by the Averting Maternal Death and Disability Program of the Mailman School of Public Health of Columbia University in rural Rajasthan and Maharashtra showed that EmOC was only available 10-15 percent of the time in some districts.

## **Model Description**

In 2003, the MacArthur Foundation supported the FOGSI Societies of India4 through technical assistance from the Johns Hopkins Institute for Gynecology and Obstetrics (JHPIEGO) to develop the capacity of general practitioners and non-specialist doctors to provide quality EmOC services.

<sup>&</sup>lt;sup>4</sup> Established in 1950, FOGSI is a federation of more than 184 individual city and state-based societies of obstetricians and gynecologists throughout India.



Although there were no outcome data for the success of the model, it was widely acclaimed in policy circles as an effective approach to reducing maternal mortality. In 2006, the Government of India, impressed by the potential of the model and seeking to expand its human resources to manage obstetric complications, particularly in the rural areas, committed Rs. 20,000,000 (USD 5 million) to establish training sites in 25 centers across the country. However, since obstetricians and gynecologists have traditionally blocked the shifting of EmOC skills to non-specialist physicians, legitimizing this key component of the model was a significant challenge.

A Force Field Analysis helped to identify the factors that supported and restrained the scaling up of this change and aided in developing an effective scaling up strategy. A portion of that analysis is shown below:

MULTI-TASKING FOR THE PROVISION OF EMERGENCY OBSTETRIC CARE				
Restraining Forces				
Large capacity for skill based training				
Professional privilege/FOGSI resistance				
Lack of regulation				
Intensive supervision required for non-specialists				

## **Tool 10: Advocacy Strategy Profile – Part I**

A major element of taking any intervention to scale is advocacy. A wide range of stakeholders need to be persuaded that the model proposed for scaling up is sufficiently better than the status quo and other available alternatives to justify the time, costs, and efforts needed to make the change.

If new resources are required, those in charge of funding decisions need to be persuaded to mobilize the necessary resources and perhaps to re-direct them from another use. If organizations need to repurpose, take on new responsibilities, or to discontinue old ones, the leaders of those organizations need to be convinced that these difficult and taxing changes will be worthwhile.

Who performs these advocacy functions and what guidelines can we offer them? In some countries and sectors, there are a host of organizations whose explicit purpose is advocacy. Often, however, these advocacy functions are performed by organizations that play other roles as well—service delivery organizations, professional associations, foundations, civic organizations, think tanks, private companies, and government policy units. In addition to these third party institutions, advocacy functions are often performed by the originating organization (i.e., the organization that developed the model), adopting organization (i.e., an organization that hopes to apply it at scale), or intermediary organization (i.e., an organization helping to facilitate the scaling up process). The following tools and guidelines are intended for people within any of these organizations charged with advocating for the scaling up of innovative models.

## Purpose

The Advocacy Strategy Profile is a decision-support tool that helps advocates choose the best



approach for constructively engaging with the government based on the realities of the political and administrative environment, the resources available to them, and their core competencies.

## How to Use This Tool

The profile distinguishes five different advocacy approaches that make up an advocacy strategy continuum (see below). At one end of the continuum are approaches based on full collaboration with the government and limited to a specific initiative. At the other end of the continuum are permanent advocacy groups dedicated entirely to lobbying government on behalf of members' concerns and interests.

One-time		Ongoing		Sporadic		Lobbying		Permanent
Collaboration		Collaboration		Lobbying		Structure		Advocacy Group
- Least		- Proven		- Can develop		- Adoption of		- Created
demanding		credibility		positions		"strategic		specifically for
- Focused on		yields subtle		independent		approach"		advocacy
specific issue		influence		of		- Development		- Sectorally
- Group		- Joint problem		government	_→	of improved		based
influence only	•	solving	←	- Not a core	<b>↓</b>	advocacy	•	- constituency –
needed for		- Government		function of		capacity		not single
issue		continues to		organization		- Permanent		organization
- May provide		set rules		- Influence		resources		- Research based
opportunity		- Risks of		dependent		assigned to		policy
to raise other		ongoing		on stature		lobbying		positions,
issues		association		connections		- Development		technical
- Opportunity		with		of		of more		credibility
to build		government		individuals		permanent		- Use of multiple
legitimacy		that may not				relationships		tactics
and/or		be popular				with policy		
credibility						makers		

## Figure 7. Advocacy Strategy Continuum

To determine the advocacy approach most appropriate for a given organization, the leadership of the (potential) advocacy group begins by completing the Advocacy Strategy Profile: Part I below, characterizing the prevailing situation with regard to each of the 11 factors on the grid and placing an "X" in the appropriate box on the grid. The numbers 1 and 5 are defined by the narrative statements at either side of the grid. Numbers 2, 3 and 4 reflect a range of intermediate positions. If those preparing the profile differ in their views regarding the proper rating of a given factor, they should discuss the issue until they reach agreement or, if that fails, combine their ratings into an average.



		1	2	3	4	5	
	Highly centralized						Decentralized decision-making
ironment	Undifferentiated decision-making						Alternative decision makers
al Envi	Little public accountability						Effective public accountability
Politic	Hostile to reform initiatives						Receptive to reform initiatives
	Little tradition of participation						Tradition of participation
es to	Limited human resources						Extensive human resources
source ailable Group	Limited technical resources						Extensive technical resources
Re Avi	Limited/unsustainable financial resources						Extensive/sustainable financial resources
roup's anization ructure	Exclusively non- governmental						Mixed public, NGO, and private sector participation
	Temporary organization						Permanent organization
Org St	Policy influence as only activity						Many activities in addition to policy influence

#### TABLE 7. TOOL 11 ADVOCACY STRATEGY PROFILE, PART I

After scores have been agreed upon for each factor, a line is drawn connecting the "X's." In general, the placement of the line from left to right corresponds with the five advocacy approaches indicated in the advocacy strategy continuum figure on page 44 above. For example, if the line is to the far left, the suggested approach would be collaborative. Often, however, the line connecting the "X's" is not a straight one. Under these conditions, the profile should be used as the basis for an active discussion within the organization about the opportunities and risks associated with different advocacy models and whether it is possible to move some factors from the left to the right on the profile.





## **Tool 11: Advocacy Strategy Profile - Part II**

## Purpose

Regardless of structure and approach, effective advocacy organizations need to perform certain functions. Part II of the Advocacy Strategy Profile helps members of those organizations and third parties to determine where specifically organizations are most in need of strengthening. This can be done in the form of a list of strategic actions (see figure below), each of which can be scored from 1 (no action yet taken) to 5 (fully effective). Intermediate ratings necessarily involve subjectivity on the part of those doing the ratings. Items scoring 2 or less are candidates for attention as the organization seeks to deepen the effectiveness of its lobbying and advocacy efforts.

				Priority?			
Action Level		el	Advocacy Activities	Y/N			
1	2	3	4	5			
	Advocacy group becomes more informed about policy issues and its						
					impact on their interests and constituents:		
					Group collects information on policy issue from relevant sources.		
					Group analyzes policy and related issues and examines impact of policy		
					elements on group interests. Impacts should be quantified where		
					appropriate.		
					Group analyzes positions and interests of other stakeholders on the		
					issue.		
					Group analyzes and understands decisions making process for this		
					particular issue.		
		Group analyzes and understands political environment for policy issue –					
	understands the nature of support and opposition for the issue.						
					Advocacy group formulates a position and strategy for advocacy on the		
	1				issue:		
					Group formulates position on the issue in a participatory manner.		
					Group develops a written statement of its position on the issue (clearly		
					stating policy interests and action required for implementation of the		
					policy).		
					Presentation materials are developed using attractive, attention getting		
					techniques (short, punchy, and to the point).		
					Strategy is developed for lobbying and advocacy on the issue (strategy		
					should outline where resources for the lobbying effort will come from		
					and indicate who will do what, when, and how).		
					Advocacy group develops strategic alliances or develops/participates in		
	r				coalition supporting policy change:		
					Group examines needs for participation in coalition or alliance on policy		
					issue, and clearly understands cost and benefits.		

#### TABLE 8. TOOL 11 ADVOCACY STRATEGY PROFILE, PART II



	Joint meetings held to examine mutual interests and negotiate terms of				
	joint actions, responsibilities of each partner and to examine needs for				
	acquiring other resources (e.g., collaboration of think tanks, international				
	organizations).				
	Coalition, alliance, network formed with clear understanding of each				
	partner's role. Position statements and supporting presentation				
	materials developed. Strategy for coalition activity developed and				
resources identified for carrying out actions.					
Joint actions planned and executed, including the development of public					
	forums, lobbying, media campaigns, etc.				
Advocacy group implements strategy for issue advocacy:					
	Press releases, public forums held, participation on local talk shows, etc.				
	Policy papers disseminated.				
	Members initiate direct action to become "opinion leaders" on issue.				
	Lobbying campaign initiated and sustained.				
	Group develops scorecard on actions taken and results achieved.				





## **2.2 Mobilizing Resources**

The task of **realigning and mobilizing resources** requires a nuanced understanding of the one-time costs associated with the scaling up process and the unit costs of operating the model at scale. These costs needs to be disaggregated by source (i.e., who is expected to incur what costs) and linked where appropriate to offsetting revenues; or new revenues need to be identified for each cost. The model's costs also need to be compared with that of competing models, and the one-time start-up costs of transferring the pilot to a new organization need to be estimated provided for. A tool to aid in the identification, analysis, and presentation of this cost information is the *Scaling Up Cost Analysis Manual* developed by Population Foundation of India, MSI's collaborating partner in India.<sup>5</sup>

## **Tool 12: Cost Analysis Manual**

The cost analysis manual, which does not presume previous training in economics or accounting, provides guidance to program managers on (1) how to apply costing techniques to estimate resource needs for an intervention, and (2) how to do a simple analysis of cost-effectiveness to assess the value for money invested in a particular intervention. The concepts and techniques presented in this manual are explicitly linked to the decisions, steps, and tasks associated with scaling up.

The manual presents the basic concepts and classifications related to costs and cost estimation before proceeding to lay out a step-by-step process for cost analysis. It then details a means for assessing and analyzing incremental costs or changes to unit costs associated with scaling up particular initiatives, including guidelines (summarized below) for estimating these costs. The manual also presents a simple procedure for cost-effectiveness analysis.

Scale Factors	Specific Points of Interest	Selected Key Additional Areas in the Costing Process
Geography and Infrastructure	<ul> <li>Higher cost of transportation, training, and supervision</li> <li>Some topographies are more costly to build in/maintain/travel</li> </ul>	• "Difficulty" weights in the estimation of unit cost
Human Resources	<ul> <li>Not enough trained professionals to implement scale up</li> <li>Staff may need incentives/pay to relocate to rural areas</li> </ul>	<ul> <li>Additional cost for recruitment, training of new staff</li> <li>Retention incentives</li> </ul>

### TABLE 9. GUIDELINES FOR ESTIMATING EFFECT OF SCALING UP ON UNIT COSTS



<sup>&</sup>lt;sup>5</sup> For complete information, see *Cost Analysis for Scaling Up Initiatives: Training Manual*, PFI, 2012.

Scale Factors	Specific Points of Interest	Selected Key Additional Areas in the Costing Process
Fixed Costs	<ul> <li>Programs with high fixed costs/centralization will show declining unit costs</li> <li>May need different technologies in rural and low-demand areas (e.g., mobile health)</li> </ul>	<ul> <li>Additional fixed costs</li> <li>Costs of alternative technology</li> </ul>
Management and Support System	<ul> <li>Increased need for system support</li> <li>Lack of management infrastructure</li> <li>Need for expansion of technical support</li> <li>Increased need for demand generation and communication</li> </ul>	<ul> <li>Additional costs for:</li> <li>New infrastructure for capacity-building or leveraging existing infrastructures</li> <li>Technical support team</li> <li>Coordination team (Project management unit)</li> <li>Demand generation through mass communication</li> <li>MIS infrastructure</li> <li>Logistic hubs (e.g., distribution centers, etc.)</li> </ul>
Changes in the Intervention	• The composition of components in the pilot stage may change in the scale-up stage	Change in the proportion of cost components





# **Chapter 4: Tools for Framework Step 3: Managing the Scaling Up Process**

## Introduction

This set of tools is most useful in supporting Step 3 of the FRAMEWORK. The desired result of Step 3 is the sustainable application of the new model at scale. The three tasks of Step 3 are:

- Modifying and Strengthening Organizations
- Coordinating Action
- Tracking Performance and Maintaining Momentum

The section presents one tool to assist with each of these tasks. These tools are:

Tool 13:	Institutional Development Framework: Provides a basis for planning and
	tracking needed changes in the adopting organization(s)
Tool 14:	Organizational Responsibility Chart: Helps to coordinate the actions of all
	parties involved in the scaling up process
Tool 15:	Monitoring and Evaluation Guidelines: Provides a basis for keeping the
	scaling up process on track and to assess performance at scale

## Tool 13: Institutional Development Framework<sup>6</sup>

## Purpose

The purpose of the Institutional Development Framework (IDF) and its associated tools is to help an organization scale up its operations, align with new policy directions, increase efficiency, and chart its own path to institutional development. One of the most appealing features of the IDF is its ability to



<sup>&</sup>lt;sup>6</sup> For complete information on the IDF, see: Renzi, Mark," An Integrated TOOLKIT for Institutional Development," *Public Administration and Development*, Vol. 16 (1996): 469–483

track progress over time and illustrate graphically to all concerned how effectively the organization is implementing its proposed changes. The IDF can be used to assess an organization before or during scaling up to plan and track necessary changes in the adopting organization. It does this by helping an organization to: (1) consider what it will take to make it successful; (2) assess its own strengths and weaknesses in light of those factors, (3) map a prioritized plan for improvement; and (4) measure progress against the goals it sets. The framework is based on empirical studies in several countries and is reasonably free of a regional or cultural bias.

## How to Use the Tool

The most effective way to use this tool is to develop it in a workshop setting with representatives from the originating organization, adopting organization, and other key stakeholders. While there is no one "right" answer, the interplay between these individuals is virtually assured to generate important insights about the changes needed in the adopting organization and the best way to encourage these changes.

The IDF is organized in a matrix format. In the first column are listed the institutional "resources" critical to an organization's effectiveness. The untailored (generic) version of the framework includes five such resources, each of which has several components (see table below). Listed across the top of the matrix are the four stages through which organizations mature.





	Criteria for E	Each Progressi	ve Stage	
	Start-up	Development	Expansion/ Consolidation	Sustainability
Resources	1	2	3	4
Oversight/Vision				
- board				
- mission				
- autonomy				
Management Resources				
- leadership style				
- participatory management				
- management systems				
- planning				
- service delivery, etc.				
Human Resources				
- staff skills				
- staff development				
- organizational diversity				
Financial Resources				
- financial management				
- financial vulnerability				
- financial viability				
External Resources				
- public relations				
- ability to work with local communities				
and governments, etc.				

### TABLE 10. INSTITUTIONAL DEVELOPMENT FRAMEWORK

## Step 1: Adapt Generic IDF

The organization reviews the generic framework (ideally, with a facilitator) first to modify the categories and components to reflect their particular circumstances and second to identify, for each cell of the matrix, one or more performance criteria. The questions driving this process should probe what it will take, organizationally, for the institution to effectively implement the new model as scale. A sample truncated IDF is presented below:



	Criteria for Each Progressive Stage			
Resources	Start-up 1	Development 2	Expansion/ Consolidation 3	Sustainability 4
Management Resources				
Leadership Style	Leadership emanates from the founder	Leadership comes from founder and one or two board members	Vision increasingly comes from board as board members improve involvement	All Board members contribute to leadership and development of the organization
	Staff provide technical input only	1-2 staff provide organizational impetus, in addition to director	Staff increasingly provide vital drive to organization	Organization would survive without current director
Management Systems	No formal file system exists	Files are maintained, but are not comprehensive or systematic	Files are systematic and accessible, but significant gaps remain	Files are comprehensive, systematic, and accessible
	Few administrative procedures formalized	Administrative procedures increasingly formalized but no operating manual	Administrative manual in place, although not up-to- date or considered "the Bible"	Administrative manual updated as needed. Considered the arbiter of procedures

### TABLE 11. TOOL 13 CRITERIA FOR PROGRESSIVE STAGES IN THE IDF

## Step 2: Plot the Organization on the IDF

The IDF is based on "Progress Cells" which correspond to the following four stages through which organizations generally change or evolve:

Start-up  $\rightarrow$  Development  $\rightarrow$  Expansion/Consolidation  $\rightarrow$ Sustainability

The next step is for the organization to examine the IDF, row by row, and determine where along the continuum it is currently situated. The simplest approach is to mark an "X" in the spot that describes the organization at the time of the assessment (see matrix below).

Although the cells of the IDF reflect benchmarked best practices and progression sequences, users of the tool are encouraged to amend the "Progress Cells" to ensure they capture where the organization is currently "located," and where it needs to be to operate the new model effectively at scale.





## Step 3: Set Institutional Development Priorities, Goals, and Improvement Strategy

The next step for the organization is to determine which components are most important for the successful implementation of the scaling up effort. Having identified the areas that need change or improvement, the organization can set goals (e.g., moving from a "1" to a "3" in its financial management systems) and a timeframe (e.g., three months, six months, or one year) to accomplish each goal. In most cases, organizations will select only a few areas (rows) on which to concentrate their efforts as resources allow. It should be noted that timeframes will depend on both the sequencing of the changes associated with the scaling up the model and the demands and resources of other actors in the scaling effort.

## Tool 14: Organizational Responsibility Chart (ORC)

## Purpose

The purpose of the Organizational Responsibility Chart (ORC) is to disentangle the respective roles of the individuals and groups responsible for scaling up the model. It is particularly useful when activities depend on a number of different organizations or organizational units (e.g., different departments/divisions or levels, such as national, regional, local, etc.). In a simple matrix, the ORC displays the responsibilities of each major actor with regard to each significant task. It can and should be used not only to describe current practices, but also to guide streamlining and other organizational improvements required for implementing the new model. It can be used in conjunction with the IDF– once key capacities or improvements have been identified, the ORC can help facilitate their achievement—or as a separate tool for multiple organizations that are involved in taking a model to scale.

The rows of the matrix correspond to the major activities needed in the scaling up effort. These activities should be listed in the first column of the matrix, grouped by major output or category of activity. Normally, a participatory planning workshop (ideally facilitated by the intermediary organization) is the best way to develop this list and to ensure that all key actors agree on it. In some cases, it is also appropriate to use this same list as a starting point for developing a bar chart, PERT chart, or schedule of deliverables.<sup>7</sup>

<sup>&</sup>lt;sup>7</sup> A PERT chart is a project management tool used to schedule, organize, and coordinate tasks within a project. PERT stands for Program Evaluation Review Technique. A similar methodology, the Critical Path Method (CPM), has become synonymous with PERT so that the technique is known by any variation on the names: PERT, CPM, or PERT/CPM. For additional information search for PERT in <u>www.whatis.com</u>.



The other columns of the matrix correspond to the full range of actors (individuals, organizations, and/or organizational units) involved in scaling up the model. By excluding minor players, it is usually possible to limit this list to somewhere between 10 and 20 major actors.

For each of the listed activities, four questions are asked:

- **1.** Who (if anyone) must agree to or approve this activity?
- 2. Who is responsible for executing this activity?
- **3.** Who should provide tangible support for this activity?
- 4. Who needs to be kept informed about this activity?

If someone or some group has approval authority for a given activity, the letter "A" should be written in the corresponding box in the matrix. For those responsible for executing the activity (i.e., those that could be held responsible for its successful completion), write an "R." Those providing support receive an "S," and those to be informed receive an "I."

While an ORC may be completed by one or more analysts, it is most effective when used interactively by directly affected parties to clarify and streamline working relationships. One very useful technique is to have the key actors complete the chart separately and then compare their versions as a starting point to negotiate an agreed version. The following questions and guidelines can be used to inform that discussion:

- Are there major disagreements or differences of opinion about the list of key activities or allocation of responsibilities?
- Are there important activities with too many people (or no one) in change?
- Are there apparent bottlenecks (i.e., do the same people have too many things to do)?
- Do agreed procedures exist for making decisions when there is more than one decisionmaker? For supervising activities that cross organizational lines, and for sharing information with those who need it?

The first rule of coordination should be to eliminate the need for coordination wherever possible and, where needed, to opt for the simplest approaches possible. For this purpose, it is worth noting that sharing information is normally easier than sharing resources, and sharing resources is normally easier than joint action. Seen in the context of the ORC, this suggests that it is usually more efficient for cells of the matrix to be empty than to be filled. This needs to be balanced, however, by the dictates of the particular task and by the requirements for transparency and democratic decision-making.





## TABLE 13. ILLUSTRATIVE ORC FOR SCALING UP A CODE OF CONDUCT FOR HIV ANTI-DISCRIMINATION EFFORTS

	Actors						
Activity	Minis- try of Justice	Gover- ning Body	Ministry of Health	Legal Assistance Center	National Network of Service Organi- zations	People Living Positively	
Establish governing body	Ι	Ι		R	S	S	
Draft code of conduct	Ι	А	Ι	R	S	S	
Establish criteria for monitoring compliance	Ι	А		S	R	R	
Determine appropriate sanctions	R			R	S	S	
Establish system through which complaints can be processed	Ι		Ι	S	R	R	
Develop and maintain a registry of counselors			Ι		R	Ι	
Monitor compliance		R					
Advocate compliance and publicize performance	S	S	S	R	R		
A=Ap	A=Approves R=Responsible S=Supports I=To Be Informed						

One of the most attractive features of ORCs is the speed with which an individual or group can learn the tool and put it to practical use. Although this can be done using written guidance alone, it is helpful to have someone experienced in the use of the tool spend time (usually 30 minutes is sufficient) introducing it and answering questions. When used in a workshop setting, it is very helpful to have the benefit of a trained facilitator who can help the group see potential coordination problems and resolve any conflicts that may arise with regard to roles and responsibilities.



## **Tool 15: Monitoring and Evaluation Guidelines**

## Purpose

It is essential to monitor and report on **both** the scaling up **process** (getting there) and **implementation** at scale (once you are there). The monitoring and reporting process can and should be used as part of an ongoing strategy to maintain political and popular support and funding. While ongoing monitoring is integral across each step, it is particularly important to track the effects of introducing a new model and to make adjustments if results differ from what was intended. Such monitoring and evaluation ideally begins early in the process, with assessments during Step 1 to determine the effectiveness of the pilot project (Tool 4). In addition to the usual requirements for sound project management and donor reporting, such studies need to anticipate the questions and concerns of the broader audience involved in approving, funding, and implementing the scaling up process. This puts a particular premium on monitoring and evaluation being done in a credible, public, and transparent manner, and there is considerable value to involving independent third parties in this effort.

In sum, there are three main ways in which monitoring and evaluation tools are used to support a scaling up process:

- 1. Evaluation of the Model (see Tool 4, Evidence Standards)
- 2. Monitoring the Scaling up Process
- 3. Monitoring and Evaluating Performance and Impact at Scale

## How to Use This Tool

## Guide: Monitoring the Scaling Up Process

In contrast to rigorous evaluations on the impact of a model, monitoring the progress of a scaling up plan relies more on setting concrete performance indicators and milestones, and using wellestablished but useful tools such as work-plans, GANTT charts, performance monitoring plans, and Microsoft Project Manager to track and report progress against schedules, milestones, and products associated with each task. Numerous published guidelines exist for the application of these tools. The reverse LogFrame (Tool 1) is an excellent place to begin developing these indicators and monitoring systems.

In addition to efforts to track the roll-out of the model, it is important during the scaling up period to monitor the continual commitment of those who fund and implement interventions at scale; this may also be thought of as "sustainability" or an "end game." Monitoring of this type is often closely linked to advocacy activities and is meant to take place in the public eye. This aspect of monitoring is sometimes carried out by a "watchdog" or citizen committee and can often be integrated into oversight and ongoing efforts to build a constituency for change. For this type of monitoring, specific tools are less important than consistency of attention and willingness of the monitor(s) to sound an





alarm when progress stalls, the attention of implementers begins to drift, or the intended change is watered down.

Also of critical importance is the creation of avenues for feeding this information back to the public and to decision makers, and ensuring that it is widely discussed. The press, academia, and nonpartisan monitoring organizations can play important roles in this process. Among other things, this monitoring is a catalyst for maintaining momentum and accountability, following the adage "what gets monitored gets done."

Suggested mechanisms for this kind of oversight include:

- Citizen oversight panels
- Public hearings
- Blue-ribbon panels
- International monitoring groups
- Listserves and other web-based, open-access dissemination
- Comparative scorecards
- Sustained media coverage

## Guide: Monitoring and Evaluating Performance and Impact at Scale

Evaluation at scale can serve two purposes: (1) to reconfirm expectations about differences in the effectiveness of a model in diverse cultural settings; and (2) to examine situations in which the model at scale is over- or under-performing, and to determine why. As this suggests, the types of evaluations that will be appropriate when an intervention has been taken to scale will likely vary widely depending on the intervention. Monitoring the fidelity to the original model (or a simplified version of it) will likely be needed with most scaling up initiatives.

Once the scaled up model begins to produce results, both monitoring of outcomes and evaluation of impact will be required as with any other program. If the adopting agency is part of the government or is cooperating with the government, monitoring data should be captured by, or delivered to, a management information system that is congruent with existing national systems. The indicators for this phase of the process should include parameters for monitoring quality as well as quantity.

The term **implementation fidelity** is used to capture the notion of compliance guidelines for delivering an intervention at scale. Useful products are emerging to help those involved in scaling up efforts conceptualize and measure implementation fidelity (for example, see <u>http://www.nrcld.org/rti\_manual/pages/RTIManualSection4.pdf</u>), and a set of helpful process questions is provided below.



TABLE 14. GUIDING QUESTIONS FOR PROCESS MONITORING						
Areas for Process Monitoring	What to Track	WHAT TO LOOK FOR				
Organization Analysis	<i>Vision</i> : Does it need any adjustment? <i>Goals</i> : Should we add a new goal or eliminate any? <i>Strategy</i> : What modification can give us a better edge?	<ul> <li>Does our staff refer often to our vision and goal in their work?</li> <li>Are they passionate about scaling up targets and strategy?</li> <li>Have there been significant social, political, or cultural changes?</li> </ul>				
Stakeholder Analysis	<i>Beneficiaries</i> : Are we doing for them what we set out to do? <i>Partners</i> : Are they fully aligned with our goals and strategy? <i>Community</i> : Is the community, local and national, on our side?	<ul> <li>Do the beneficiaries understand and accept the project goals fully?</li> <li>Do we have too many disagreements with partners on key points?</li> <li>Are local leaders supportive? Is the local media sympathetic?</li> </ul>				
Project Analysis	<i>Policies</i> : Are our policies serving us well and fully? <i>Processes</i> : Are our processes both efficient and effective? <i>Tools</i> : Are our facilities, equipment, and supplies still right?	<ul> <li>Are there frequent disputes about the meaning of existing policies?</li> <li>Do key participants complain that current processes are in their way?</li> <li>Is the staff satisfied that they have what they need to operate well?</li> </ul>				
Resources Analysis	<i>Sources</i> : Are our funding sources solidly with us? <i>Usage</i> : Are the use of our resources prudent and timely? <i>Continuity</i> : Can our needs be fully met in the foreseeable future?	<ul> <li>Have funding authorities express satisfaction with project progress?</li> <li>Are the allocated resources used reasonably close to plans?</li> <li>Do we have sound indications about future funding?</li> </ul>				
Staff Analysis	<i>Skills</i> : Do our people have key skills at the desired levels? <i>Motivation</i> : Are they fully committed and enthusiastic? <i>Capacity</i> : Are we developing our capacity with emerging needs?	<ul> <li>Are there frequent cases of staff not doing what it is expected to do?</li> <li>Are there frequent cases of staff work that is below the quality desired?</li> <li>Are our trainings just enough to meet immediate needs?</li> </ul>				





## **Chapter 5: Conclusion**

This Toolkit is intended as a living document. As experience grows, we expect the number of tools, and the tools themselves, to evolve and deepen. We plan to update in real time the FRAMEWORK document, Toolkit, and the cases on which they draw and to re-issue revised versions of these documents periodically. If you make yourselves known to us, we will make sure this information finds its way to you.

For the sake of clarity, the cases on which this document is based are drawn from the health sector. The FRAMEWORK and various tools have also been applied in fields as diverse as food security, livelihoods, local government, early childhood education, judicial sector reform, and community policing. We hope the variety of these applications will continue, and we are committed to doing whatever we can to document and support that expansion.

There is a vibrant and growing community of practice around issues associated with scaling up, and we expect the continual growth of that group and its insights. To that end, we invite interested practitioners and researchers to contribute their experiences, and their reactions to this document, to: www.scalingup@msi-inc.com.



## Annex A: Types of Evaluations

The impact of a program is essentially the difference between beneficiary outcomes after program implementation (treated outcomes) and what the outcomes would have been had the program not happened (counterfactual outcomes). The main impact evaluation problem is that while treated outcomes are observed, counterfactual outcomes are not. To measure program impacts, researchers use a variety of rigorous techniques to determine counterfactual outcomes. The methods fall into two general categories, which are discussed below: randomized control trial (RCT) evaluations and quasi-experimental evaluations.

### **Randomized Control Trials (RCTs)**

RCT evaluations employ the most rigorous logic, structure, and procedures available for detecting and quantifying program impacts. They are distinguished by two key features: (1) the evaluation design and methodology are developed prior to program implementation, and (2) the design includes a formal counterfactual that permits a valid comparison of program results for beneficiaries to outcomes experienced by comparable groups not affected by the program.

Planning an impact evaluation during the program's development stage makes it possible to arrange for the collection of baseline measures for key data elements prior to the program's initiation. These efforts may include new surveys or other data collection specifically aimed at establishing the baseline for measures of interest. To establish credible counterfactual conditions, RCT evaluations employ rigorous experimental designs—including random assignment of individuals, families, communities, or other aggregates—to treatment and control groups to ensure comparability of the populations.

The solution to an impact evaluation challenge is straightforward under a RCT design, where random assignment is used to determine which units (households, geographic areas, etc.) will receive the treatment.

To estimate program impacts in an RCT design, two sources of data are required:

Baseline participant information: The evaluator must collect information about the units (households, individuals, etc.) assigned to the treatment or control group at the time as the random assignment (that is, before the implementation of the program). This information may include participant contact information; key socioeconomic characteristics; employment, health, and nutrition status; and household information. This information may be available from data already collected by the country's statistical agencies. Otherwise, data must be collected through a population-based survey.





Follow-up data: The evaluator must collect information on participant outcomes (e.g., employment, wages, nutrition, health, etc.) following implementation of the program. This information may be collected from existing data sources or through follow-up surveys.

Random assignment ensures that treatment units are equivalent to control group units in their observed and unobserved characteristics; thus, any subsequent differences between treatment and control outcomes can be attributed to the program. This explains why RCT designs are preferable for rigorously assessing program impacts relative to other methods that rely on statistical methods to identify appropriate comparison groups.

Since random assignment is used to determine program participation, we can estimate program impacts through treatment/control group comparisons of mean outcomes. To estimate program impacts with increased statistical efficiency, regression models should be used. These models serve two goals: (1) they eliminate differences in outcomes between the treatment and control groups that may have occurred by chance as a result of differences in observed characteristics; and (2) they remove variation in outcomes due to observed characteristics, enabling us to detect statistically significant impact estimates with higher statistical efficiency. Successfully implementing an RCT design requires significant planning before implementation.

### **Quasi-Experimental Evaluations**

When an RCT design is not feasible, quasi-experimental designs may be used to establish comparison groups to assess project impacts. In contrast to RCT evaluations, quasi-experimental evaluations are typically designed after the model has been initiated or, in some cases, once it has already been completed. Consequently, many quasi-experimental evaluations rely on baseline data collected by the agency that were designed for monitoring purposes, or as a proxy for measuring impact.

Depending on the data available it may be possible to conduct quasi-experimental evaluations using advanced statistical models to create credible comparisons that can detect and quantify program effects. In addition, using multiple methodologies to triangulate findings and document program impact may overcome the weaknesses of a single approach. In other cases, projects requiring quasi-experimental evaluation designs may lack baseline data to support impact evaluation goals. In such cases, a range of quantitative and qualitative designs should be considered based on available resources. Quasi-experimental designs rely on statistical methods.

### **Qualitative Research and Analysis**

Qualitative research allows for the collection and analysis of in-depth information on individuals, groups, and communities—including social, political, organizational, and cultural factors that might not otherwise be captured. The following qualitative methodologies can be used as appropriate: in-depth interviews focus groups, ethnographies, and direct observation.

In-depth interviews are most appropriate when speaking with community and project leaders, and allow us to gain a detailed understanding of an individual's thoughts and experiences. Focus groups are advantageous to interpret behavior as well as to learn about less understood topics and groups of



people. Ethnographies are another methodology that is useful to investigate behavior through realworld observations. Using this methodology, we are able to observe and understand the effects of a program on a community. Lastly, we can conduct direct observations of the community. This method is ideal for gaining a rapid assessment of behavior and the environmental factors or potential problems that need to be addressed immediately in an impact evaluation design. These data collection methods can be made more rigorous by the random selection of informants, for example, when using direct observation to collect data on health service provision. Qualitative analysis techniques include content, domain, and schema analysis.

**Content analysis** involves the systematic review and interpretation of qualitative data with the goal of identifying patterns, themes, biases, and meanings. Content analysis is most often applied to data collected through focus groups, interviews, and direct observation. In this method, themes are developed based on the topics the participants discuss as well as observations of environmental factors.

**Domain analysis** is a method of discovering semantic relationships between concepts in qualitative data, as well as discerning the social and cultural meanings that participants ascribe to those concepts. This approach is well-suited for unstructured data capturing where participants can assign their own importance to the concepts being discussed. Participants indicate the relationships that they believe exist between concepts; these relationships can be causal, rational, functional, or means-end.

**Schema analysis** examines patterns or themes in the language used by participants (especially in analogies and metaphors) to develop a mental model of the participants' understanding of concepts. The relationships between concepts are mapped based on the choice of language that participants use in talking about those concepts. Similar word choices (such as similar analogies or metaphors) would indicate a similar understanding. This analytical technique could be applied to focus group data.

**Internal validity** is an original or single site test of a hypothesis that, using the best available methods, determines whether effects/impacts (final results) appeared in response to causes (activities, equipment, other interventions). Sometimes the original intervention is planned in advance as a test, often called a pilot. At other times, interest in replication and scaling up emerges when a project or program that was not set up as a test unexpectedly turns out to be more effective or successful than anticipated. Technically, what these two types of original interventions establish (or claims to have established) is called internal validity. Simply put, it means that the project/program intervention worked and produced the desired results.





#### Demonstrations

The ability to prove that a project works in one site does not mean that it will work everywhere. At the original site, there are an enormous number of situational characteristics, e.g., poverty levels, transportation system, political system, etc., as well as the organizational characteristics of the group that ran the project and the characteristics of the program/project beneficiaries. Altogether, this particular set of conditions will never exist in quite the same way elsewhere. In order to have confidence that a cause-and-effect model will work just as well in other localities or for other populations, researchers often conduct a second round of tests before trying to broadly scale up a project.

This second stage of testing is called a demonstration, and demonstrations of what worked at the original site are often carried out in several different sites at once, i.e., sites that differ from each other in ways that are important as determined by those associated with the original program/project. What second stage demonstrations test is external validity, i.e., does the model work effectively in a variety of circumstances. This second test is important. Even if the demonstration stage is only carried out in a few sites, it provides extremely important information, provided that demonstration sites differed from the original site in ways that may be important, i.e., that may interfere with success in the demonstration environments. For example, differences in literacy or poverty ranges between the pilot and demonstration sites could mean that fewer potential service users would be able to afford the program/project's services or be able to reach labels and other critical materials.



# Annex B: Scalability Assessment Tool, Terms, and Concepts

#### Terms:

**Model**: This refers to what is to be scaled up; however, it is **not** simply the original technical intervention. It is the slimmed down collection of all the inputs and processes both necessary and sufficient to achieve desired results in a variety of settings. Inputs include personnel, funding, and external support (popular and political). Processes include not only technical activities but administrative processes such as human resources, financial systems, and incentives to implement change.

#### **Concepts**

- **1.** *Based on statistically significant, sound evidence of sizable impact.* This refers to scientific evidence. The more credible the evidence, the easier it is to convince policy and decision makers and other stakeholders of the value of the model. Statistically significant quantitative or qualitative evidence of impact is preferable. It is important to note that while impact data is more desirable than outcomes, and outcomes more desirable than outputs, etc., it is often the case that while pilots are constrained in proving impact so that "lower" levels of evidence are accepted, it is only acceptable if the logic connecting lower (outcomes) and higher (impact) levels is clear and confirmed by other studies or international evidence.
- 2. Independent evaluation by respected and reliable sources. Evidence from independent sources, such as an independent external evaluation, increases credibility. Often pilots rely on data conducted, collected, or analyzed by the organization itself, which even when of high-quality and good design, can be perceived as biased. For scaling up purposes, there is a strong preference for a formal external evaluation of the model. A second best alternative is the rigorous external review of internal evaluations combined with an external advisory panel in the design and implementation of the research design and monitoring and evaluation framework. Publication in a well-regarded peer-reviewed journal can usually be considered equivalent to an external evaluation or review.
- **3.** *Model works in diverse social contexts.* A model works in diverse social contexts because it has been successfully implemented in multiple and diverse settings, or within a wider institutional context, such as access to and quality of services or commodities. Examples of relevant social variables might include population density, attitudes on family planning and





size, degree of poverty, and access to services, etc. Examples of relevant institutional variables are: availability of transportation, availability and cost of family planning commodities, and quality of care.

For the purposes of scaling up, there is a strong preference for projects that have been piloted in multiple sites and settings, i.e., that have both internal and external validity. This is particularly true in countries like India or Nigeria where even within national boundaries there is huge diversity in social norms, infrastructure, governance, incomes, etc. The following list combines measures of internal and external validity. The further up the ladder of success listed below, the stronger the candidate.

- Innovation (minimal objective evidence)
- Promising Practice (anecdotal reports)
- Model (positive evidence in a few cases)
- Good Practice (clear evidence from several cases)
- Best Practice (evidence of impact from multiple settings and meta-analyses)
- Policy Principle (proven, a "truism" essential for success)
- **4.** *The model is supported by eminent or credible individuals and institutions*. Support or endorsements from eminent individuals or institutions help in advocacy efforts. These can be either recognized experts who confer *legitimacy*, e.g., the Indian College of Medical Research or the World Health Organization, or well-known and famous personalities who confer *status*, whether from the media, sports, politics, or other fields, e.g., first ladies, or the Indian actor/model Amitabh Bacchan's support for polio vaccine.
- **5.** *The results are visible to casual observation; tangible.* It is easier to convince people of the impact of things that they can easily see and experience for themselves then those they cannot. Experience has shown that it is easier to scale up interventions like bednets or treatments that stop maternal hemorrhage than those where the results are less visible or tangible, such as the empowerment of women or communities.
- 6. *Results are clearly associated with the intervention.* It is easier to convince people if the impact is not just a byproduct of an intervention, but easily attributable to the model itself. This criterion emphasizes the fact that decisions to adopt and implement models are often not made, or are only made, on the basis of objective, statistical evidence despite an increased emphasis on high-quality evidence and evidence-based policy making. Outcomes in health, education, or other fields are often driven by multiple factors. Skeptics may claim that the results observed were not due to the intervention but to other factors. While a good experimental or quasi-experimental design can address this for a technical audience, the ability to literally see the causal relationship can be an important factor for a non-technical audience. Models that are difficult to scale up are those in which impact is lagging or delayed or the causal mechanisms are not straightforward, e.g., the effects of psychosocial development on childhood performance. Counterexamples are Oral Rehydration Therapy



(salts) to reduce childhood diarrhea, an intervention with a direct, immediate, and simple causality. Sometimes models are able to go to scale, or at least convince key decision makers to approve adoption and funding, without strong evidence because their internal logic is inherently compelling; this is often true of models that involve training or have evidence from the literature. However it is often the case that there are several other assumptions which need to hold true for the causal chain to achieve desired outcomes, and it is important to test the validity of these assumptions.

- 7. Evidence and documentation that have a strong emotional appeal exist. This criterion emphasizes the fact that decisions to adopt and implement models are often not made on the basis of objective, statistical evidence but on emotions (despite the increased emphasis on high-quality evidence and evidence-based policy making). Seeing a sick baby healed or a woman who is bleeding to death revive and recover could be more important than dry statistical evidence to many policy and decision makers. Successful advocacy uses both scientific and other evidence to advance change, especially through stories, photos, video/film, and other media that are able to convey a message with an emotional appeal.
- 8. Addresses an objectively significant, persistent issue. It is easier to successfully advocate for social problems and issues when those issues affect large numbers of people in a significant way. In other words, it is easier to scale up models that an objective outside observer would rank as one of the major challenges in health, education, etc., for a country, population, or subregion. In health, for example, this may be an issue that is a leading cause of death or recognized as an easily preventable or treatable cause of death or disease with permanent debilitating effects. That is why tuberculosis, malaria, and polio have all become major health priorities. In education, this may be levels of malnutrition and stunting in young children with the effect of permanent and destabilizing mental abilities. It is important to point out that just because an issue is objectively important, it does not mean that it is a major policy priority. One of the actions that can come out of a scalability assessment is precisely what needs to be done to move an objectively important issue higher up on the policy and social priority list. Early childhood education is a good example of an objectively important issue which, in many cases, has not received adequate attention.
- **9.** Addresses an issue that is currently a high (policy) priority of potential adopters and is aligned with organizational goals, mission, and vision. This item is particularly relevant when scaling up is being considered by the government, where government approval, funding, or other roles may be important. When an issue is high on the policy agenda, it means that the government is actively looking for solutions and willing to provide funding. It is easier to scale up something which is already an important priority than to move something up the agenda. For example, a current environmental intervention that addresses maternal mortality is also a Millennium Development Goal; therefore, it is easier to scale up than interventions that address the health of gay, lesbian, bisexual, and transgender populations. It is a plus when organizations and their constituencies already consider the issue a high priority and when it is already aligned with the organization's mission and vision; thus, expansion is facilitated when an organization's funders or board of directors think the issue is important.





- **10.** *Addresses a need sharply felt by potential beneficiaries or participants in the target area.* A felt need means that if survey research, focus groups, or other forms of interviews were conducted, the issue that the model addresses would emerge from participants as a major priority. It is easier to mobilize popular and grassroots support for interventions that address felt needs to achieve acceptance of new programs and interventions. Felt needs tend to be tangible and immediate like poverty and livelihoods, safe drinking water, and curative care as opposed to issues where benefits are captured in the future, e.g., preventive care, or where there lacks the perception that the status quo could or should be different, e.g., levels of infant or maternal mortality, or number of births per family.
- **11.** *Current solutions for this issue are considered inadequate*. Current solutions refer to programs or policies already in place to address the issue. It is easier to advocate for the model if people and decision makers assess that the current solution is not working, or if there are no solutions at all. If there are no current solutions in place, this concept refers to whether people think the lack of a solution is a problem at all, e.g., providing child health interventions solely through facility based approaches.
- **12.** *Superior effectiveness to current solutions is clearly established.* This criterion should be selfevident. If the model being proposed for scale up has evidence of greater impact or effectiveness than existing solutions, it is easier to scale up.
- **13.** Superior effectiveness to other innovative models established. Advocacy of a particular model or solution must compete with other approaches for the attention of policy makers. The model should be able to demonstrate success in achieving results, but also superiority over alternative approaches. It is also important to assess if there are any foreseeable potential opposition from vested interests or social/cultural groups. Some issues or solutions (the intervention) can threaten vested interests or become controversial for certain elements of the population. In public health, interventions which shift tasks from skilled to less-skilled professionals can threaten the former's authority, prestige, and perhaps most importantly, livelihoods, even when they are already overburdened. For example, having VHWs in rural areas give injections of antibiotics to newborns with sepsis was opposed to by neonatologists, even though there was no evidence of complications in the administering of injections nor were there any neonatologists who actually served those populations. Similarly, (unqualified) rural medical practitioners have opposed the management of public primary health clinics by NGOs because they fear the loss of business if the quality of care, and therefore competition, improves. In many areas, adolescent sexuality and health education can be opposed by conservative social or religious groups on ethical or religious grounds. The lack of opposition can increase the prospects for scaling up. It is important to establish some clear standardized criteria for comparison with a common denominator, preferably in terms of outcomes and impacts.



- **14.** *Implementable within existing organizational systems, infrastructure, and human resources.* It is easier to implement a model at scale if it can use existing systems, i.e., if they can be grafted on, then if they require the creation of a whole new infrastructure, organization, management, and systems. This is because investing in new systems and infrastructure is usually expensive and can be politically threatening to existing bureaucracies and organizations. However, on some occasions, creating a new system may have advantages in terms of circumventing political and bureaucratic obstacles and weak capabilities. Models which require long and intensive training periods for staff are more difficult to scale up and face opposition from potential adopters due to the costs and time involved.
- **15.** *Contains a few components easily added on to existing systems.* The fewer the elements of a model, the simpler it is to scale up. The Home-Based Newborn Care model that was originally implemented had several distinct components which made large-scale implementers wary of scaling it up. Thus, while designing a scaling up strategy, it was important to simplify the model so that implementation on a larger scale was easier.
- **16.** *Small departure from current practices and behaviors of the <u>target population</u>. It is easier to implement a model if does not require significant changes from the existing behaviors, beliefs, and practices of the target population, clientele, or beneficiaries of the model, e.g., counseling mothers on using food cooked for the family as supplementary feeding for children, versus advocating the cooking of meals separately.*
- **17.** *Small departure from current practices and culture of the <u>adopting organization</u>(s). This concerns the intervention's compatibility with the culture, practices, physical infrastructure, and resources of the adopting organization(s). It is easier to implement a model if does not require significant changes from the existing behaviors, beliefs, and practices of the organization that will implement the model at scale. For example, in a government system that emphasizes delivery of curative medical services, the introduction of community mobilization, treating clients with respect and dignity, preventive services, or working with and through non-professional VHWs may require a substantial changes in culture or norms. It is important to note that even in the case of Expansion, where the implementing organization remains the same, a major challenge may be in maintaining its organizational culture, practices, and roles as the organization grows. This criterion also assesses the extent to which adoption/scaling of the model is likely to meet internal opposition, resistance, or support within the adopting or expanding organization.*
- **18.** *Few decision makers are involved in agreeing to the adoption of the model.* This criterion addresses the number and hierarchy of decision makers required to approve scaling up. For example, the Home-Based Newborn Care model required not just the approval and buy-in of policy makers and programme implementers in the public health system, it also needed the approval of the Indian Academy of Paediatrics and the National Neonatology Forum. This process of engagement and negotiation with multiple decision makers can be tedious and slow the scaling up process.





- **19.** *Demonstrated effectiveness in diverse organizational settings.* Compatibility with systems and infrastructure within diverse organizational settings is best demonstrated by actual evidence in those types of settings. This can help convince organizations and skeptics in general that the intervention will work, and serves as a strong counterweight to the "not invented here" argument—indicating that there is evidence that the model has had similar impact when implemented in multiple and diverse organizational settings whether it be a NGO, government, or private sector actor; or a tertiary, secondary, or primary facility in health. Diversity can refer to variances in quality in terms of infrastructure, equipment, supplies, and the effectiveness of the organization that is implementing the model. The more evidence available on the robustness and resilience of the model in different organizational settings, the easier it is to scale up.
- **20.** *The model is not particularly value or process intensive.* Here, value or process are defined as models that focus on tacit knowledge, i.e., how things are done or delivered versus the technical content (which focuses on drugs, equipment, procedures, and information such as changing attitudes, knowledge, and practices). Value or process intensive models are much more difficult to implement at large-scale because: (a) quality is usually important, (b) they tend to be time and resource-intensive to transfer to others, and (c) are often a substantial departure from existing practices in organizations with large-scale capacity because they are difficult to systematize, relying heavily on organizational culture. Examples of values or process intensive components include: community participation, community mobilization, teaching service providers to treat beneficiaries with dignity or respect, and free play in early childhood education versus lectures and rote learning.
- **21.** *Low technical sophistication of the components and activities of the model.* Models can be sophisticated or not whether they are technology/content-intensive or process intensive. The more sophisticated they are, the more they require either higher skilled and trained implementers or greater investments in the training and capacity building of personnel to implement them successfully. Thus, less sophisticated models are easier to scale. For example, standardized doses of drugs that require only one dose, do not require cold chains, are the same dosage regardless of body weight, and do not need monitoring of potential negative after effects are easier to scale up than those where multiple elements require a number of complex decision points.
- **22.** *Key innovation is a clear and easily replicated technology.* A model which has a single element such as delivering a vaccine through an existing service delivery mechanism stands a much better chance of approval for scaling up. For instance, a childhood pentavalent vaccine was introduced only in states that had robust immunization programs, where it was perfected over several decades and easily scaled up with minimal modifications to the infrastructure and reporting mechanisms.



- **23.** *Low complexity model, simple with few components added onto existing systems.* Models that are complex, have multiple elements, and need updated delivery mechanisms often require long lead-in times during which permission is obtained from gatekeepers and leaders, and acceptance and buy-in has to be created among participants, beneficiaries, and community leaders. In some cases, this can take a year or more; in other cases, it is not necessary because piloting organizations have already established trust and credibility based on their long-term relationships and presence in the localities in which they work. Regardless, models which require the building of trust, relationships, and permission from gatekeepers are harder to scale up or at least, take much longer. Models vary widely in terms not only of the pre-conditions necessary before a model is implemented, but the training, skills building, and general capacity required of front-line implementers, supervisors, and other staff. Capacity building is time, effort, and resource-intensive and often difficult to replicate at scale when all three of these elements are scarce.
- **24.** *Model requires little supervision or monitoring.* Models which require intensive monitoring and supervision are harder to scale up. Many organizations with large capacity are weak in these areas, and it can be difficult to enforce monitoring and supervision at large-scale. Models in which implementers are either self-motivate or where they can work effectively independently are easier to scale up. Monitoring intensive models can be made simpler by the use of monetary and non-monetary incentives, and by using electronic data collection systems supported by on site supervision as required.
- **25.** *Able to be tested by users on a limited scale.* This means that organizations that are interested in adopting the model should be able to run their own pilots without having to commit substantial resources or undergo significant organizational changes to see if it works.
- **26.** *Superior cost-effectiveness to existing and competing solutions clearly established.* Models not only need to be more effective than existing or competing solutions to have a chance of being scaled up, they need to be more cost-effective. This requires getting comparable measures of cost-effectiveness, which can be hard to come by in low-resource situations.
- **27.** *Requires a large commitment of funds at scale.* Models that require substantial upfront commitments are generally complex and require changes in existing systems. Advocacy for this is facilitated by demonstrating high impact, extensive stakeholder support, and importantly, a good understanding of the unit cost (or some other measure of impact) per resources spent. This needs to go beyond simple calculations such as the total project budget divided by the number of beneficiaries, communities, etc., which often underestimates costs by ignoring the contributions of management and technical assistance or which overestimates them by including evaluation costs which will not be replicated at scale. Having solid cost data is necessary for successful advocacy, and knowing whether or not an intervention is affordable given the available resources and objective need can make or break an intervention in terms of scalability.





**28.** *The model has its own internal funding (e.g., user fees), corpus or endowment, or some other long-term sustainable funding source, or overall funding for this sector is a priority.* Funding here refers to the funding of the model and not the project which piloted the model. It means that the model includes an internal mechanism of recovering costs whether they are user fees, profit margins on goods or services provided, etc. Overall funding for this sector is a priority and growing, to the extent that there are unspent funds. Funding refers to public sector support for the general sector in which the model works, e.g., health, education, livelihoods, poverty, or women and children. When thinking about this issue, it is worth considering if there are alternative sources of funding.

Model Categories		A ©√	←Scaling Up is easier	B ⊜√	Scaling Up is harder <del>&gt;</del>	C ®
A. Is the model credible?	1		Based on sound evidence		Little or no solid evidence	
	2		Independent external evaluation		No independent external evaluation	
	3		There is evidence that the model works in diverse social contexts		There is no evidence that the model works in diverse social contexts	
	4		The model is supported by eminent individuals and institutions		The model is supported by few or no eminent individuals and institutions	
B. How observable are the model's results?	5		The impact is very visible to casual observation; tangible		The impact is not very visible; not easily communicated to public	
	6		Clearly associated with the intervention		Not clearly associated with the intervention	
	7		Evidence and documentation exists with clear emotional appeal		Currently little or no evidence with clear emotional appeal	
C. How relevant is the model?	8		Addresses an objectively significant, persistent problem		Addresses a problem which affects few people or has limited impact	
	9		Addresses an issue which is currently high on the policy agenda		Addresses an issue which is low or invisible on the policy agenda	
	10		Addresses a need which is sharply felt by potential beneficiaries		Addresses a need which is not sharply felt by potential beneficiaries	
D. Does the model have relative advantage over existing practices?	11		Current solutions for this issue are considered inadequate		Current solutions are considered adequate	
	12		Superior effectiveness to current solutions is clearly established		Little or no objective evidence of superiority to current solutions	
	13		Superior effectiveness to other innovative models established		Superior effectiveness to other innovative models not established	
E. How easy is the model to transfer and adopt?	14		Implementable within existing systems, infrastructure, and human resources		Requires new or additional systems, infrastructure, or human resources	
	15		Contains a few components easily added onto existing systems		Is a complete or comprehensive package of multiple components	
	16		Small departure from current practices and behaviors of <i>target population</i>		Large departure from current practices and behaviors for target population	
	17		Small departure from current practices and culture of <i>adopting</i> organization(s)		Large departure from current practices and culture of <i>adopting</i> organization(s)	
	18		Few decision makers are involved in agreeing to adoption of the model		Many decision makers are involved in agreeing to adoption	

## Table 3. Scalability Assessment Tool (SAT) Checklist



Model Categories		A ©√	←Scaling Up is easier	B ⊜√	Scaling Up is harder→	C 8
	19		Demonstrated effectiveness in <b>diverse</b> organizational settings		Demonstrated effectiveness in only one/pilot organizational setting	
	20		The model is not particularly value or process intensive		Process and/or values are an important component of the model	
	21		Low technical sophistication of the components and activities of the model		High technical sophistication of the components and activities of the model	
	22		Key innovation is a clear and easily replicated <i>technology</i> e.g. vaccine		Focus of the model is not a <i>technology</i> , or one which is not easily replicated	
	23		Low complexity; simple with few components and easily added on to existing systems		High complexity with many components; integrated package	
	24		Includes little supervision and monitoring		Includes substantial supervision and monitoring for implementation	
F. How testable is the model?	25		Able to be tested by users on a limited scale		Unable to be tested without complete adoption at a large-scale	
G. Is there a sustainable source of funding?	26		Superior <i>cost-effectiveness</i> to existing or other solutions clearly established		Little evidence of superiority in terms of <b>cost-effectiveness</b>	
	27		Requires a large commitment of funds at scale		Requires a small absolute commitment of funds at scale	
	28		The model itself has its own internal funding (e.g., user fees) or endowment		No internal funding; the model is dependent on external funding source	
Total number of checks						





## Annex C: Field Applications of SUM Framework

## India

- 1. Home-based neonatal care (Society for Action and Research in Health)
- 2. Improving immunization coverage through incentives (Seva Mandir)
- 3. Training of primary medical officers in emergency obstetric care (Federation of Obstetrics and Gynecology)
- 4. Using community networks and local governments for improved health and nutrition (Community Health Care Management Initiative)
- 5. Management of public health facilities by NGOs (Karuna Trust)
- 6. Cashless hospital services through micro insurance (Self-Employed Women's Association)
- 7. Promoting adolescent friendly health services through schools and communities in an urban setting (Sangath)
- 8. Reproductive health of married adolescent girls in rural settings (Institute of Health Management, Pachod)
- 9. Provision of family planning services using social franchisee clinics (Janani)
- 10. Increasing contraceptive use among newly married couples (Pathfinder)
- 11. Promoting reproductive health awareness among tribal youth (RISHTA, Tata Steel Rural Development Services)
- 12. Involving elected women's representatives in improving adolescent reproductive and sexual health services (CEDPA)
- 13. School-based delivery of adolescent reproductive and sexual health services (CEDPA)
- 14. Early childhood development through integrated child development services (ICDS)
- 15. Comprehensive abortion care in government health facilities (IPAS)
- 16. Community health workers as social mobilizers and service providers (The Mitanin Programme)

### Nigeria

- 17. Holistic, community-based approach to health education (Community Life Project)
- 18. Maternal mortality and morbidity (Pathfinder)
- 19. Non-pneumatic anti-shock garment (University of Ibadan/U.C. San Francisco)

## Mexico

- 20. Community-based maternal and childcare services (MexFam)
- 21. Public-private partnership for improved policies, training materials, and training of trainers in sexual education (Government of Mexico/NGO consortium)



22. Targeted sexual education curriculum for Indian populations (University, Government, NGO consortium)


Founded in 1981, MS1 is an 800-person international development consulting firm located in Washington, DC, and serving clients worldwide. MSI provides management consulting services to governments, local organizations, foundations, corporations and international donor agencies in more than 50 countries. In 2008, MSI was acquired by Coffey International and now forms part of the Coffey family with offices in 14 countries around the world.