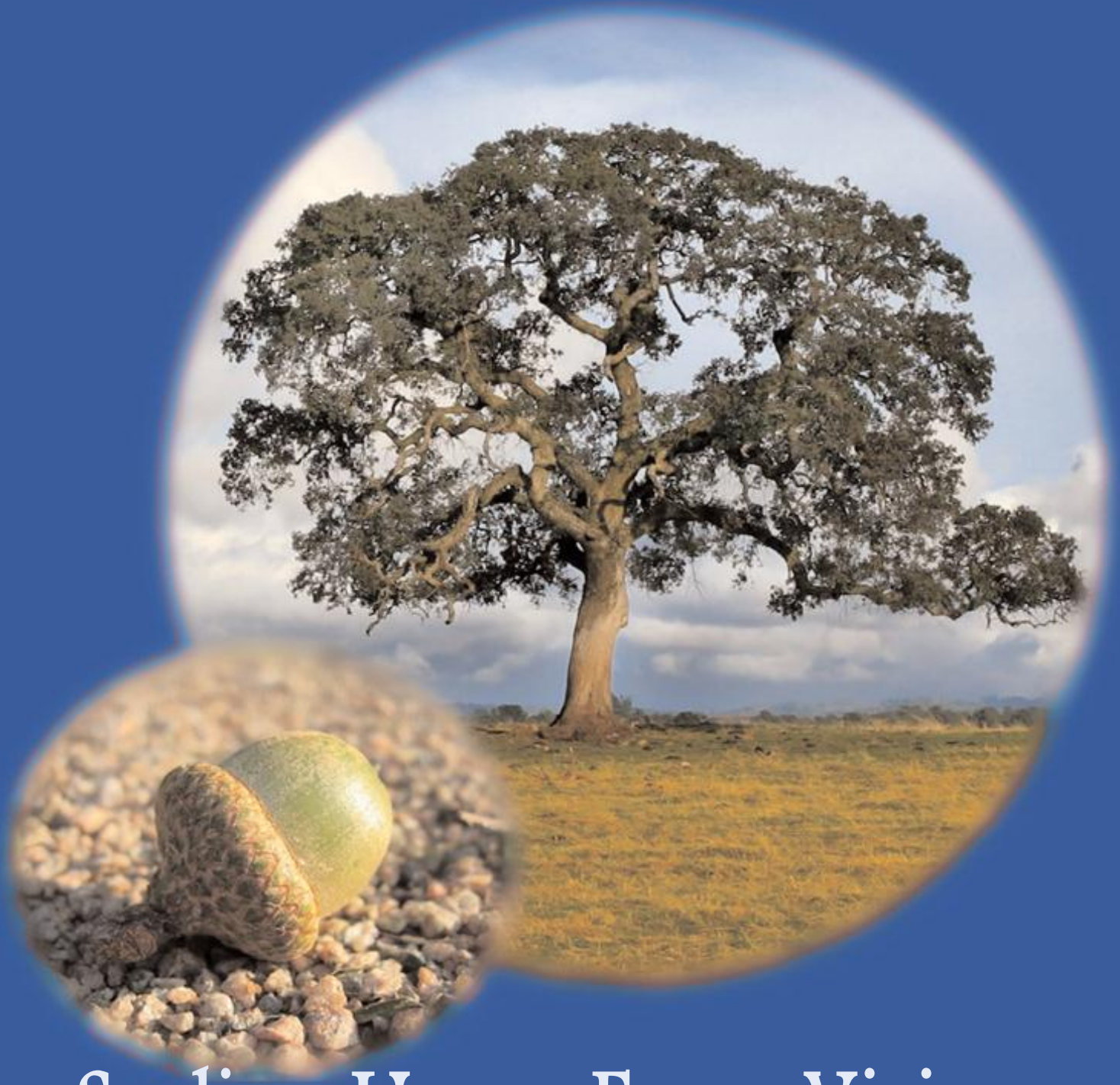

Scaling Up — From Vision to Large-scale Change

Tools and Techniques for Practitioners

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Forward

In this document, scaling-up is treated as a process through which approaches or models for delivering goods and services that seem to be effective in the situation—meaning a particular organizational context in a particular environment—in which they were originally used are transferred to new contexts and, sometimes, new organizations to implement on a larger scale. Steps for managing this transition effectively are outlined a Management Systems International (MSI) report entitled *Scaling Up—From Vision to Large-Scale Change* (2006). This document includes a number of supporting techniques, guides and tools for use with selected tasks outlined in that report. The presumption of this paper is approaches or models that are eventually be scaled up may not have been designed with scaling up in mind. Instead of planning for scalable successes, we may instead stumble on them. Often, thinking about scaling up starts when we notice that a project run by a non-governmental organization is making a difference; or when some aspect of a government program seems to be particularly effective. This document is constructed with this kind of experience in mind.

Introduction

Responding to increasing interest across the international development community in strategies for scaling up field tested models and approaches for addressing critical needs and persistent problems in developing countries, 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*" in March 2006.[1]

This volume is a companion to that publication. Its purpose is to provide scaling-up practitioners access to a range of tools, guides and techniques that will help them apply the ten step framework for scaling up pilot projects or models and approaches described in MSI's earlier publication. Tools and techniques referenced in the earlier volume are more fully described, and where appropriate, summaries of case studies that document scaling up experiences around the world are included along with links to fuller version of these case studies.

The structure of this volume follows the three steps of the framework described in MSI's earlier scaling up publication. These ten tasks, which the earlier volume groups into three major steps, are presented in the form of a flow diagram in Figure 1. As appropriate, this document indicates where tasks included in the framework can be undertaken in parallel rather than in a strict sequence. Further, where tools and techniques closely associated with one task in the framework might be useful for other task as well, those opportunities are pointed out. It should always be kept in mind that tailoring and modification is not only recommended, but often required to make scaling up successful for each individual effort.

SCALING-UP STEPS	ASSOCIATED TOOLS AND GUIDES
Step 1: Develop a Scaling Up Plan	❖ Identifying the Model ❖ Scalability Assessment Tool
Step 2: Establish Preconditions for Scaling-Up	❖ Stakeholder Analysis ❖ Policy Network Map ❖ Force Field Analysis ❖ Advocacy Strategy Profile
Step 3: Manage the Scaling Up Process	❖ Institutional Development Framework ❖ Techniques to Monitor the Process

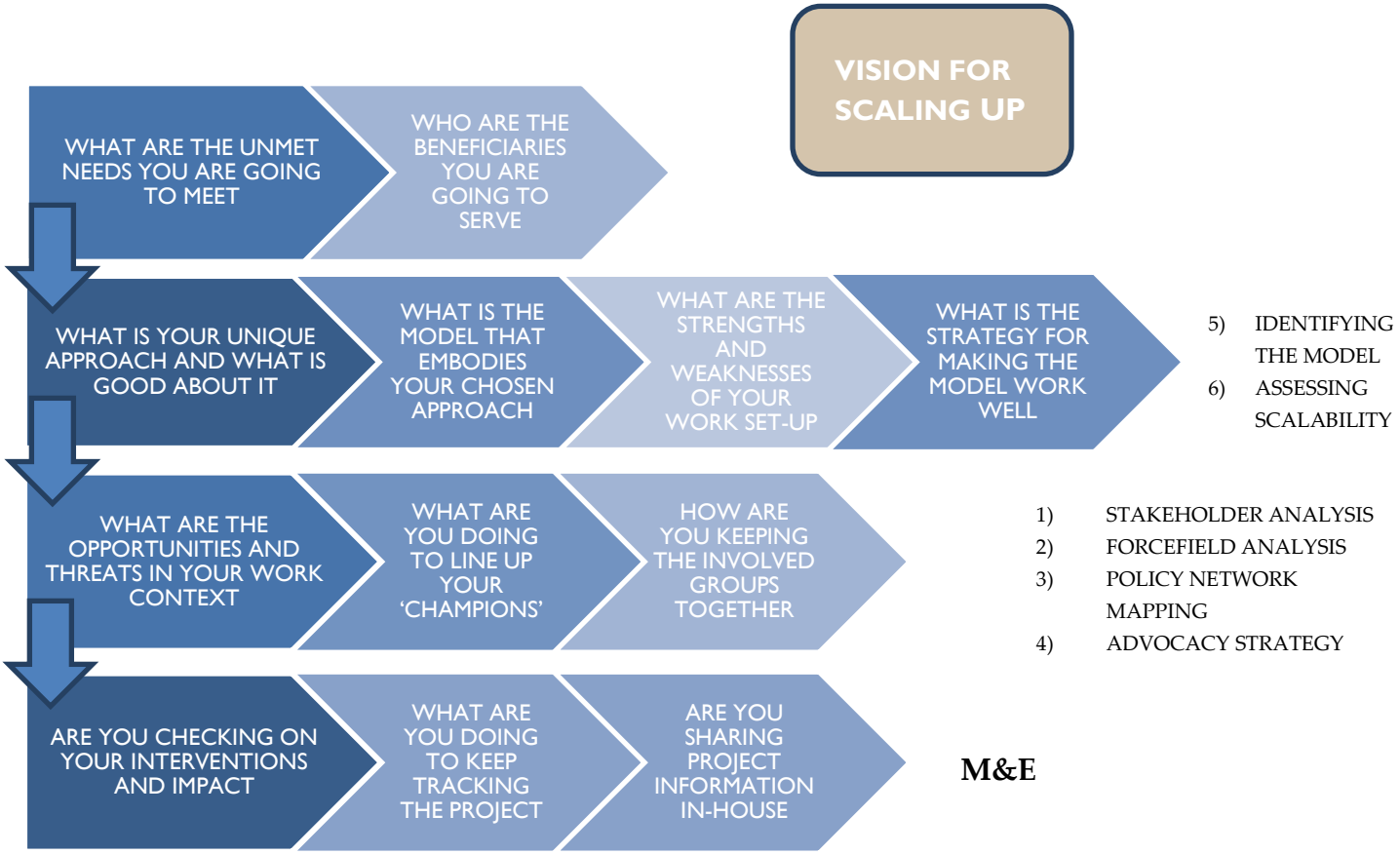
[1] This volume is available on line at: http://www.msiworldwide.com/files/scalingup-framework.pdf

Who Is the Audience?

This book is intended for practitioners who plan to be involved in public health work and want to take that work to scale. The book is also intended for anyone who has the need or desire to know how to take currently operating small scale programs or projects to large scale. This includes:

- **field managers** working in social change in implementing agencies like NGOs or government;
- **staff and managers at funding** agencies (bilateral, multi-lateral or private foundations) interested in scaling up their programs or in integrating scaling up into the design phase of new programs
- **academics** in professional fields like public health, public policy, social welfare, international affairs, international development, etc.
- **monitoring and evaluation practitioners** interested in integrating scaling up into the design and implementation of their M&E work or in managing the quality of the scaling up process

FIGURE 1: IMPORTANT THINGS TO REMEMBER IN SCALING UP



1)Step 1: Developing a Scaling-Up Plan

Introduction

This step of the Framework includes the three tasks required to develop a scaling up plan (the fourth task). The **tools** that are included in this chapter relate to steps of Tasks 1-3; they are:

1. **Creating a Vision**
   - **1.1. Identifying the Model**
     - **1.1.1. Modified Log Frame**
     - **1.1.2. Model Elements**
     - **1.1.3. A Guide to Assessing the Evidence**
   - **1.2. Selecting a scaling up method**
   - **1.3. Determining who will implement scale up**
   - **1.4. Scope of scale up**
2. **Assessing Scalability**
     - **2.1.1. Scalability Assessment Tool**
3. **Filling Information Gaps**

Scaling-up ideas are often based on what appears to be successful experience. When a particular program or project appears to yield positive results, we often think of expanding it to benefit others. Figuring out exactly what we want to scale up often involves tracing backwards from the desirable results we observed to exactly what the project did to produce those results. Technically, what the project did is called an "intervention;" the term "model", in turn, refers to **both the intervention** that is being considering for scaling-up **and the results,** or outcomes, the intervention is expected to (or has) produced. Often, only the technical aspects of a model are considered, but as we shall see, the context and culture in which the original intervention performed are as much a part of its success as the technical aspects.

The first action is to identify the key components of the model, including an assessment of the organizational profile of the original implementers and the social context, as well as evidence of effective health outcomes. The tool that is used to obtain this information is called *Mapping the Model*. Once this is accomplished, the second tool that is used is the *Scalability Assessment Tool*, which enables a rapid diagnosis of the scalability of the pilot (assessing how easy/difficult scale up may be). However, before applying the Scalability Assessment Tool, it is important to determine in advance which method will be used for going to scale (e.g., Replication, Expansion, etc.), and who will scale up the intervention and where the model will be scaled up (the Originating or Adopting agency, or an Intermediary)[2].

The following tools are used with key staff of the originating agency, including field staff, and a selected group of external stakeholders with intimate knowledge of the model. This could include academicians, researchers familiar with the intervention, external resource person engaged as consultants for specific tasks related to the intervention, and members of any advisory or steering committees that were set up. The facilitation process is best carried out by the intermediary agency.

[2] For details, refer Page 5 of the *Scaling Up Management Framework for Practitioners*, MSI, March 2006

1.1: Identifying the Model

Purpose

This tool helps elucidate the key components of the model, the context within which the model was developed, and the evidence of impact, and to organize that information. This enables a clearer understanding of the key elements of the model in preparation the tasks of the scalability assessment, reaching 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 organization.

Lesson 6: Plan Backwards

-Begin with an eye on scale and a strategy for achieving it
-Be strategic in the design/selection of the model and its testing
-Identify and involve the large scale implementer(s)
-Focus early on unit cost and implications for current service providers
-Identify **who** will do the scaling up (advocacy; capacity building) and scale-up **resources**

Projects that are more likely to benefit from using the *Mapping the Model* tool include projects that were not designed with scaling up in mind, but are nonetheless successful enough to be under review from a scaling up perspective. These may include elements of larger development projects that have gained attention or "projectized" aspects of longer-term programs which are being used to achieve results on a fast track basis or under otherwise difficult circumstances. In all these instances, a well-defined model would facilitate a scaling up effort.

This tool has three parts:

Tool 1.1.1: A modified Log frame
Tool 1.1.2: Visual Mapping
Tool 1.1.3: Model Elements
Tool 1.1.4: Evidence on the Original Model

This section uses the Home Based Newborn Care pilot to illustrate the three steps of this tool.

Case Study: Reducing Neonatal Mortality through a Community Based intervention[3]

Context

Society for Education, Action, 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 health problems of remote, poorly served populations using community based solutions, through a process of people's participation and empowerment.

The project site was an extremely underdeveloped district, where roads, communications, education, and health services are poor. Secondary care hospitals are located within 30 km of the most remote village in the district but specialized neonatal care is not available. Private rural medical practitioners, herbalists, and magic healers form the main sources of curative care. In this context SEARCH set up a hospital and campus whose design closely resembles local village structure. SEARCH began implementing a model of community-based research, which focused on the needs of the community; through this research, several health needs were identified, including the high rates of neonatal mortality. At the time, nearly 83% of newborns in India were born at home, and the standard practice for sick neonates was facility referral; however, the issues of access, costs and social barriers prevented referral of newborns to facilities in time. About the same time, neonatal mortality was gaining globally attention.

The Model: Home-Based Newborn Care

The model was implemented as a field research trial (pilot) from 1995-98 in 100 village: 53 intervention villages and 47 control villages. The initial intervention, after obtaining community consent, began recruiting village women with 5-10 years of education to be trained as Village Health Workers (VHW). Trainers were identified and trained for 25 days before the VHW training. Supervisors had to have some health/ medical background. The VHWs were trained for one year in using a "step-ladder approach"—classroom training followed by field practice, classroom review, and then training in a new topic. In total, the training consisted of 17 modules delivered through seven training workshops spread over 31 days. The health workers were trained in the following modules: birth asphyxia management; low birth weight management; managing hypothermia and sepsis (with antibiotics, both injection and oral); early and exclusive breastfeeding; cord, skin and eye care; and injection of Vitamin K. Health education of pregnant

[3] This case study was developed using the references cited below. The case combines features of the original pilot and 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. 1999. Effect of home-based neonatal care and management of sepsis on neonatal mortality: field trial in rural India. **Lancet** 354:1955-61.

Bang A. 2008. Feasibility and effectiveness of replicating the home-based newborn care: the ANKUR project. Available from: http://www.globalhealth.org/conference_2008/presentations/f4_a_bang.pdf

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

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

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, nipccd.nic.in/mch/fr/nbc/erl25.pdf

women and grandmothers was introduced in the third year of the intervention, and included care during pregnancy, care of the newborn, recognizing danger signs (delivery and neonatal) and prompt care seeking.

The project developed efficient and extensive patient data systems, which greatly improved data for referrals and health care providers, as well as documenting health outcomes. Intensive supervision is a vital component of 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

Baseline (1993-1995) neonatal mortality rates in the intervention and control areas were 62 and 58 per 1000 births, respectively. By the third year of intervention when about 93% of neonates in the intervention area received home based neonatal care, and the neonatal, infant and perinatal mortality rates in the intervention area fell to 25.5, 38.8 and 47.8, respectively. The net percentage reduction compared to the control area was 62.2% for neonatal mortality and 71% for perinatal mortality. The fatality rate among babies (with sepsis) treated by VHW declined to 2.8%, compared to 16.6% before treatment. The findings of the home-based neonatal care model were published in the Lancet (a medical journal of international repute) and quoted widely as a feasible way of reducing infant and child mortality across the world.

General Description of the SEARCH Model

Intervention	Actual Outcomes
❖ Expanded, well-supervised antenatal care for pregnant mothers in the intervention area by specifically trained VHWs ❖ Expanded, well-supervised range of home-based neonatal care provided for 93% of infants in the intervention area by specifically trained VHWs. ❖ Cost-effective delivery of expanded care ($5.3, of which $3.8 is for recurring costs)	❖ Reduced neonatal mortality (62.2% decline) ❖ Reduced perinatal mortality (71% decline) ❖ Lowered fatality rate for babies with sepsis (13.8% decline)

Tool 1.1.1 Log Frame

How to Use the Tool

This tool reverse engineers the traditional log frame to map out the key goals, outputs, outcomes and activities of a particular intervention. Start with the goals that the Model is designed to produce and work backwards with the following *Guiding Questions*:

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

Home-Based Neonatal Care Log Frame

GOAL	←OUTPUTS	←OUTCOMES	←ACTIVITIES
Reduce Neonatal Mortality	❖ Home deliveries attended by a VHW ❖ Newborns delivered at home examined by a VHW within 24 hours after birth ❖ Newborns exclusively breastfed within 24 hours after delivery ❖ Newborns who received at least four visits by a VHW during neonatal period ❖ Newborns who received at least one supervisory visit during neonatal period ❖ Babies with sepsis diagnosed and received treatment from a CHW or referred. ❖ Mothers who received health education in pregnancy in postpartum period	❖ Home based care through VHW ❖ VHW identifies and manages- High risk baby, LBW, BF, hypothermia, sepsis, birth asphyxia ❖ Bi-weekly supervisor visits ❖ Development of MIS and performance indicators ❖ Semi-annual population census ❖ Health education sessions conducted in community and household	❖ Obtaining community consent ❖ Identifying VHWs ❖ Developing Standardized technical guidelines and protocols ❖ Standard training methods and materials ❖ Logistics systems- uninterrupted supply ❖ Develop Reporting formats ❖ Record vital stats ❖ Health education ❖ Home visits ❖ Fortnightly visits by supervisors for QA/QC ❖ Referral advice, but initial management at home ❖ Step ladder training ❖ Performance based payment, annual incentives

Tool 1.1.2 Visual Mapping

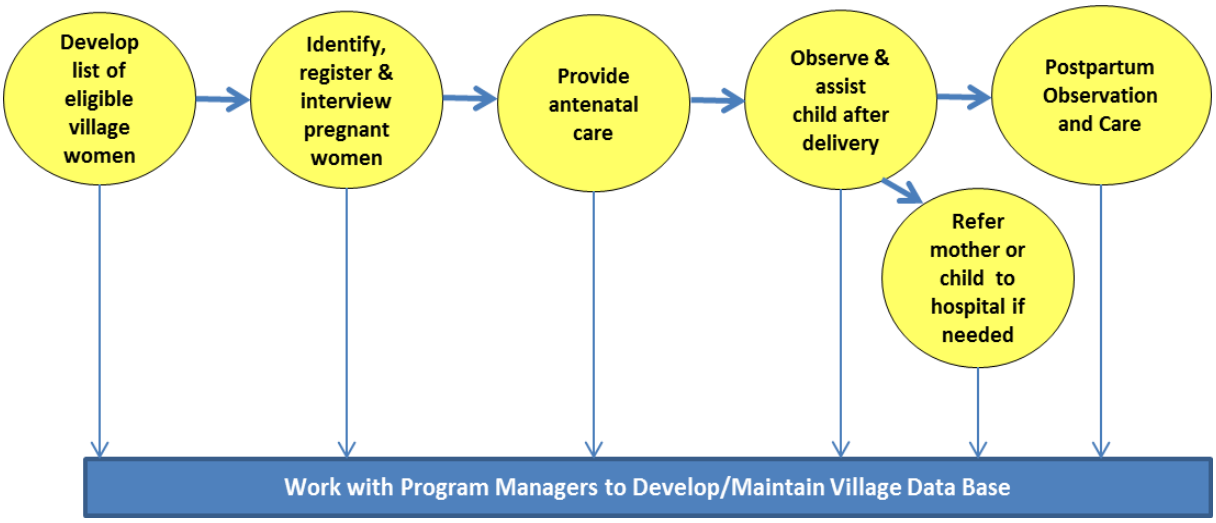
Purpose

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.

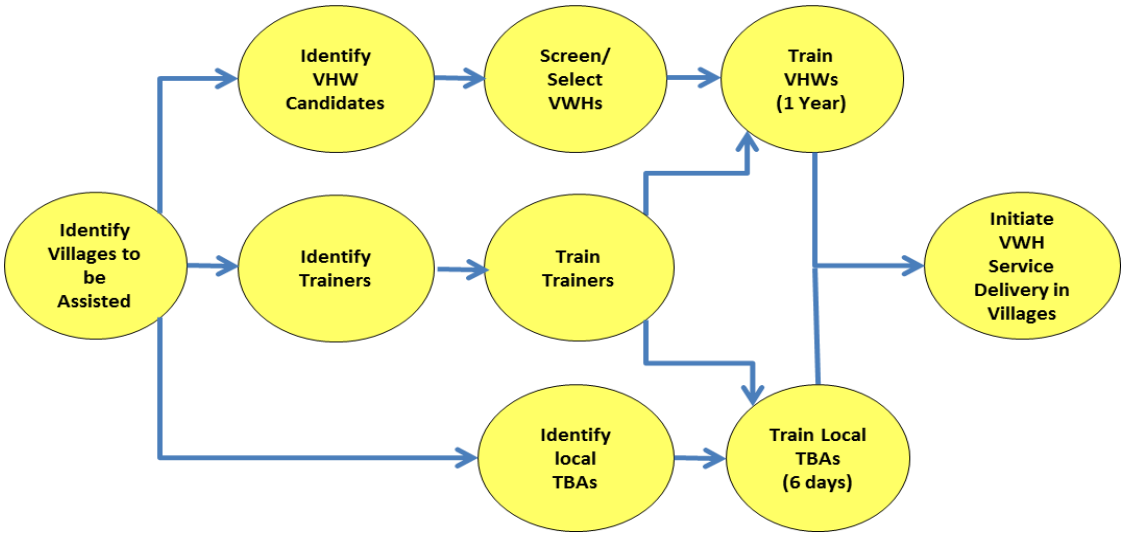
How to use this tool

These graphics, called *path diagrams*, help grasp a model's essence before delving into the detailed requirements associated with each process step in an intervention. In the SEARCH case, there are two sequences that are important. The primary intervention sequence–the one that directly feeds into the outcomes the model is expected to yield—is the VHW intervention sequence in villages. A secondary sequence in this model is the preparatory or training sequence. Both of these intervention sequences are shown below as an illustration. This is a useful exercise to ensure that no component is missed.

The VHW Intervention Sequence



Preparatory or Training Sequence



Tool 1.1.3 Elements of the Model

Purpose

Now that key sequences are understood, elements of the model can be teased out. This tool enables the categorization of the key components of the model into its Technical and Process elements and also collates information on the Organizational profile and the Social Context. The information in this tool helps participants 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, as all of these are all important in assessing scalability.

How to use this tool

Participants of the originating or pilot organization 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 all activities are listed so that when scaling up decisions are made, decision makers are aware of the multiple components of the model when considering scalability and modification of the model. Use the following guide to fill in each column:

- **Technical Elements*:*** This includes the traditional Project Planning elements: human resources, supplies, training modules, salaries and incentives, etc.
- **Process Elements*:*** These include typical program management elements, such as multi-stakeholder dialogues, community sensitization, supervision, monitoring, etc.
- **Organizational Profile*:*** These include elements of organizational culture, including the values of the agency, such as a rights-based approach, gender equity, community participation, etc.
- **Social Context*:*** These relate to the larger context in which the original model took place: socio-economic factors, local governance, status of service access, and other factors that could influence the model.

Lesson 9: Focus on Systems and Incentives

For sustainable change to occur, it's essential to understand and replicate the incentives from the model or make sure that an alternative incentive system reinforces needed actions. Changes in rules, regulations and procedures are often necessary which requires detailed knowledge of the adopting organization.

Guide: Context Information

The following are some aspects to consider when gathering information on the context in which the original model or pilot was implemented in. Information is needed to establish how unique these characteristics are, or to learn how different the original target population or area are from the population or social context in which replication or scaling up is to be done.

Target Population or Area: Information in this category would include standard demographic data, which most often is readily available from secondary sources, like the local DHS or census. Examples include: age; gender; education level; ethnicity; socioeconomic status and any special characteristics, such as refugee status.

Context: Context here refers to both human and infrastructure elements that may have salient influences on the model, such as: rural vs. urban area; political system (democratic or authoritarian regime); status of transport and communications systems; etc.

Other notable context information include characteristics of the originating organization and should also be noted, e.g., government or private sector—these data can be detailed in the three-page form, ***Organizational Type and Scale***, found in **Annex E**. (the form is not added here because a sample form filled from a health agency scaling up was not available at this time). This contextual information, often numeric, can be then captured in a narrative as other organizations that replicate the model need to be aware of these aspects as they plan to adopt the model.

Tool 1.1.3 Elements of the Model *Home-Based Neonatal Care Project*

TECHNICAL ELEMENTS	PROCESS ELEMENTS	ORGANIZATIONAL PROFILE (+ VALUES)	SOCIAL CONTEXT
❖ Developing Standardized technical guidelines and protocols ❖ Standard training methods and material ❖ Logistics systems ❖ Management Information System ❖ Semi-annual population census ❖ Development of reporting formats ❖ Development of communication material ❖ Supervisor visits ❖ CHW identifies and manages neonatal health problems ❖ Referral advice, but initial mgmt. at home	❖ Obtaining Community consent ❖ Identifying VHWs ❖ Home Visits ❖ Supervisory visits ❖ Health education ❖ Step ladder training ❖ Field for data validation ❖ Monthly review and feedback ❖ Community engagement throughout implementation	❖ Organization driven by community needs ❖ Has strong credibility in community ❖ Ability to attract external funding ❖ Strong research element responsive to community needs ❖ High focus and emphasis on training ❖ Has staff in place to implement pilot ❖ Good relations with external stakeholders in implementation ❖ Community engagement ❖ Respect for mother and VHW ❖ Empowerment of women ❖ Inbuilt equity: universal coverage	❖ High Infant Mortality Rate ❖ Low Institutional Delivery ❖ Poor referral services ❖ Barriers to care seeking in population ❖ High population density ❖ Acceptance of community of VHW regardless of caste/religion ❖ VHW from the community so no issues of security or threats, can conduct home visits.

End Case Study

Guide: Costing the Model

A full costing tool is not available in this edition; however, it should be noted that MSI partners PFI are currently developing such a tool to health model scale-ups, and will be added when ready. That said, below are some guiding cost categories, and the ***Organizational Type and Scale*** form also has several detailed costing sections that should prove useful.

- **Provider Costs:** Cost of the time of each type of provider that plays a direct role in the delivery of the intervention.
- **Management Costs:** Cost of the time of project management team who oversee the intervention and what portion of their time they charge.
- **Direct Costs:** Cost of all resources directly used in delivering the intervention in the model under examination, including training costs, medicines, supplies, etc.
- **Indirect Costs:** Cost of other resources which constitute an indirect cost for the intervention, such as supplies, office space, transport, etc. and how much of the total cost of such indirect expenses are (e.g., 15% overhead)

Lesson 8: Educate Funders on Scaling Up Reality

Going to Scale takes time, money, resources, and capacity/skills that are often larger and longer than the pilot! **Funding for transition and intermediation are critical and scarce.** The average time for scaling up to national application is **15 years.** There are distinct financing challenges for each of the three Steps: [1] preparation and planning; [2] legitimation and advocacy; and [3] implementation.

1.1.4: Evidence of the Model

Purpose

In Step 1, when defining *what is the model*, part of the definition included a look for evidence of impact; e.g., 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, while not providing a single tool, as evaluation types differ significantly and will depend on the model being assessed, offers a guide to determining the type of and considerations for gathering evidence to support your case to scale up.

Types of Evaluation

In order to generate credible evidence and understand underlying dynamics, a range of evaluation methods are possible (see Annex C for Evaluation Method descriptions). While there is a general bias in favor of Random Control Trials as being the most rigorous, we have found that RCTs are more appropriate for simple interventions with have at most 2-3 components rather than comprehensive interventions with multiple components, especially where changing social norms is part of the model, hence, quasi-experimental designs are generally accepted. In addition to generating the 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.

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 for a rigorous external review of internal evaluations. Publication in a well-regarded peer reviewed journal can usually be considered as equivalent to an external evaluation or review.

Types of Data

Statistically significant quantitative or qualitative evidence of impact is preferable, if possible. Sound evidence has multiple dimensions to it, which include kinds of information gathered. In a logical framework, data can be gathered confirming each step in a Log Frame. For example, in a mortality model, evidence could be collected on:

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

Tip: It is important to note that while impact data is more desirable than outcomes, and outcomes than outputs, etc., it is often the case in scaling up that decision makers in potential adopting organizations are persuaded to adopt a model with lower level of data if the logic connecting lower to higher levels 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 the assumptions necessary about the external environment for the logical chain to hold are not made explicit or verified that these hold in new locations and circumstance.

The data obtained in these efforts not only validates the model's past results, but is also used in subsequent steps to develop a scaling up strategy, including determining the Method of Scaling Up to be used. In principle, these tools for *Mapping the Model* are applicable for all types of scaling up situations--**Expansion; Replication, or Collaboration.** There may, however, be important differences in the degree to which the model is formally defined and specified depending on the type of scale up method. Tools may also vary by type of model—pilot projects vs. demonstration vs. capacity-building vs. policy vs. service-delivery.

Lesson 5. Tailor Evidence to the Audience

Data from pilot projects is rarely tailored to the decision-criteria or decision-making styles of policy-makers. Data on effectiveness is often necessary, but usually not sufficient; make sure you address the priorities and power (decisions within their jurisdiction) of the audience you are trying to convince.

Example of Scale-Up Method Assessment[4]

	Approval	Adoption	Funding	Implementation
Replication (Government)	State Government	State Government	State Government	State, District and Local Government
Collaboration (Public-Private Partnership)	State Government	State Government	State Government and Donors	NGOs
Replication (NGO)	State and District Government	Individual NGOs	External Donors (State government)	NGOs
Expansion	State and District Government	Pathfinder	External Donors	Pathfinder and Network of NGOs

Tool 1.2 Scalability Assessment Tool (SAT)

Purpose

The Scalability Assessment Tool enables the recognition and differentiation between the contextual factors affecting the *scalability* of a model and the key features that are intrinsic to the *model itself*. The SAT was developed in 2005 as part of MSI's overall *Scaling Up Management Framework*. It was originally conceived as a Scaling Up Checklist derived from a review of the literature on the economics of innovation and scaling up, and has since evolved into the present tool of seven sections and 28 questions based on field experience with scaling up in Mexico, Nigeria, and India[5].

The SAT is a tool that has multiple purposes: first, it can help decide whether scaling-up is a viable option; second, if scalable, assess how relatively hard or easy that process will be; and third, it can help identify actions to improve its scalability (where scores are low). It should also be remembered that organizations should not be afraid that it will generate a negative assessment of their work; rather the primary purpose of the Checklist is to help assess and improve *scalability*, not their performance.

The scalability tool comprises of a checklist with seven sections and an accompanying score sheet. The essential elements of scalability fall into seven categories (found in section 2A of the 2006 Framework); further implementation notes on each of these follow:

1) **Credibility:** The model is credible in the eyes of potential adopters, funders, implementers, beneficiaries and other stakeholders. Credibility can take many forms, from qualitative to quantitative to anecdotal evidence, to recommendations of experts or endorsements by prominent people.
2) **Observable:** 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.

[4] From the *Scalability Analysis of the PRACHAR Project* (Pathfinder/ Packard) by R. Kohl and R. Ved, MSI, June 2009
[5] These insights have been culled from the work of Management Systems International, the Population Foundation of India, and Learning and Leading for Large Scale Change.

3) **Relevance:** 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 is broken down to three factors:
    a. There is an objectively a problem (not just someone's opinon);
    b. There a problem in the perception of policy makers or other relevant decision makers; and
    c. There a problem in the eyes of potential beneficiaries. If adoption by the public sector is being considered, this means alignment with policy institutional priorities of the government or its agencies.

Relevance also differs by the type of model being considered:

    d. Pilot and demonstration projects that systematically test a clearly-specified intervention to address a well-defined problem normally specify the model they are testing, designating the intervention they are studying as the independent variable for their research and the results and outcomes the intervention is hypothesized to affect as their dependent variables.
    e. Projects that test several different approaches to determine how they affect a common set of dependent variables also tend to fully specify all aspects of their model in advance.[6] Policy projects are another type of intervention in which both the intervention that will be delivered, e.g., a change in the speed limit on highways, and the anticipated results, or dependent variables, are clearly enough defined to suggest that use of the Model Definition and Specification tool to extract these elements may not be necessary.

4) **Relative Advantage:** The model has relative advantages over existing practices; sometimes this means the advantage is simply that your model's solution is better because there is no alternative solution or response, and your project is the only one addressing it.
5) **Easy to Adopt:** This refers to both adoption by other organizations but also to other social contexts (and preferably both). 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 that. It also involves how the requirements of the model itself match up with the culture and capabilities of potential large-scale implementers. The potential threat to organizational culture and hierarchies can be another obstacle to scaling up; conversely, it can be a favorable factor where the model aligns with pre-existing culture and incentives.
6) **Testable and Adaptable**: The first part of this refers to the model being easy for potential adopters to try it at small scale without a large commitment of resources and see whether it works in the contexts that are relevant for them. The second is whether the model can be adapted to new contexts and still retain its effectiveness, even with modifications.
7) **Affordable:** The first part of this criteria means that it is more cost effective at producing the desired results then existing and competing models. It also means that its total cost given the

[6] A South African project that tested three different intervention models for promoting exclusive breast feeding to determine which model would be most cost-effective to scale up is a good example in this regard. Desmond, Chris, Ruth M. Bland, Gerard Boyce, Hoosen M. Coovadia, Anna Coutsoudis, Negel Rollins and Marie-Louise Newell. "Scaling-Up Exclusive Breastfeeding Support Programmes: The Example of KwaZulu-Natal" available at: http://www.plosone.org/article/info:doi/10.1371/journal.pone.0002454#pone-0002454-t001

desired scale will fit realistically within the resources or financial envelope of possible adopters and funders, and that non-financial capacity, especially human resources and infrastructure, are available to implement it.

How to Use This Tool

We recall for the reader that the primary purpose of the assessment is not to give a *yes or no* regarding scaling up but only a very rough indicator of the scalability of a model because all items are not equal. What are the most important criteria is usually a judgment call, so that applying a scalability assessment is as much an art as a science. In some cases the politics of scaling up can prove the most challenging, in others the persuasiveness of the evidence and the model itself. Experience has shown the most important criteria are usually those of transfer and adoption. It is important to note that scalability is not a fixed assessment, it can be changed by changing the model itself. This is especially true of contextual criteria: changing the goals of scaling up in terms of reach, target area or population can affect scalability.

A model that may not be scalable in one social context can be easily scalable in another. Similarly, certain models may be difficult to scale up using certain methods, while much more easily scaled up by others. For example, community-based models often pose a challenge for scaling up by governments, as they are often hierarchical and top-down, while it may be easier to scale those up through a network of NGOs well-versed in community work. Conversely, governments may be more effective in achieving national scale than NGOs because of their greater institutional capacity and national scope, though the presence of Grameen and BRAC in Bangladesh show that this is indeed contextual.

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 from criteria 8 in the SAT: "[does the model] address an issue currently a high policy priority?" In the case of Expansion, the priority would be that of senior decision makers in the piloting organization, most likely the Executive Director or Board of Directors or Board of Directors. In the case of Replication, it would be that of key decision makers in the adopting organizations. In the case of Collaboration, it would be key decision makers in each of the collaborating organizations.

What is needed before you get started?

Using the scalability tool requires an understanding of:

- An understanding of the model itself, its originating and transfer context, and scope (Task 1)
- A cursory review of any evidence of efficacy, efficiency or both
- A basic understanding of which potential adopting institutions and infrastructure are in place, their capacity and capabilities
- An understanding of relevant policy, budget and resource issues in that sector

Scoring

Once the tool has been reviewed and the explanation of all the indictors are clear (see Annex for *Scalability Assessment Tool Terms*), the Checklist is scored by simply putting a check mark or X in the most fitting column for that criteria. The scores in each of the three columns are added. If the aggregate scores

are heavily weighted towards the A, this is a good sign; the converse is not. The user(s) can then look at those criteria where the intervention was scored C, 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 the information is not available, such as on the cost envelope, then flagging the need to do research on this issue should be added to the list of actions to take.

Case Study: SAT and PRACHAR Project, India

The Packard Foundation has been funding Pathfinder International/ India to design and field test at small scale a pilot model named PRACHAR (promoting change in reproductive behavior) whose goal is to increase the age of first conception and child spacing since 2001. The goal has been to improve adolescent reproductive and sexual health (ARSH) outcomes, especially maternal mortality and morbidity. The design was a combination of training, behavioral change communications (BCC) and service delivery activities designed to bring 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 ARSH education program—would produce the expected results, increasing the age of first conception and of child spacing. PRACHAR II (2005-09) was designed as an operations research model to answer the following scaling-up questions: (a) whether a simpler model could be as effective PRACHAR I; (b) see how length of implementation affected the results; (c) whether the results would persist after active intervention had ended. MSI asked by the Packard Foundation to assess the scalability of the PRACHAR model using a Scalability Assessment Tool (SAT) in 2008-09. Of the three questions on scalability that the SAT helps answer (how easy or difficult it may be to scale up a particular innovation; to indicate areas for action that may improve the prospects for scaling up; and to help formulate a scaling up strategy given the SAT results), MSI focused on the latter two questions—areas for improvement and implications for strategy.

USAID TIPS: **Measuring Institutional Capacity: pdf.usaid.gov/pdf_docs/pnadw115.pdf**

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, 8 scored as making scaling up easier, 11 scored as making scaling up more difficult, and 9 in between the two. MSI found that the both models had a number of notable strengths, especially the strong evidence for success and the fact that it presents a solution to an objectively important public health problem in the absence of existing alternatives. MSI found that the Phase I model had a number of characteristics that were likely to make scaling up challenging: most importantly was that the original model was comprehensive, and process and supervision/ monitoring intensive, the latter of which is critical to the model's high quality implementation. Such human-resource intensive inputs would prove especially challenging in low-resource, low governance environment.

Tool 1.2 Scalability Assessment Tool example: *PRACHAR 2009*

Characteristics of the Model		A		B		C
		☺✓	**Scaling Up is easier**	😐✓	**Scaling Up is harder**	☹✓
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 not supported by few or no eminent individuals and institutions	✓
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	
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	✓

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	✓
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 target population	✓	Large departure from current practices and behaviors for target population	
	17		Small departure from current practices and culture of adopting organization(s)	✓	Large departure from current practices and culture of adopting organization(s)	
	18		Few decision makers are involved in agreeing to adoption of the model	✓	Many decision makers are involved in agreeing to adoption	
	19		Demonstrated effectiveness in diverse organizational settings		Demonstrated effectiveness in only one organizational setting	✓
	20		The model is not particularly value or process intensive		Process and/or values are an important component of the model	✓

How easy is the model to transfer and adopt?	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 technology e.g. vaccine		Focus of the model is not a technology, or one which is not easily replicated	✓
	23		Low complexity; simple with few components; 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	✓
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	
Is funding likely to be available or resources saved?	**26**		Superior **cost**-effectiveness to existing or other solutions clearly established		Little evidence of superiority in terms of **cost-effectiveness**	✓
	27	✓	Requires a large absolute 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 has dependent on external funding source	✓
Total number of Checks		**8**		**11**		**9**

PRACHAR SAT Results and Recommendations

The major findings and recommendations from the Scalability Assessment exercise done with the PRACHAR Project are organized in the table below by scalability issue category for easy reference.

SAT Category	**Credibility and Observability**
Positive Results	❖ Strong, robust evidence that model achieves its stated goals and key outcome indicators ❖ Results are clearly associated with the intervention
Challenges	❖ Evidence that a model works on diverse social contexts is mixed (good across Bihar; unproven outside Bihar) ❖ Not (yet) received the support of eminent individuals or institutions
Recommendation	❖ Try and leverage the strong evaluation data (e.g., perhaps a comparison of effectiveness with other models targeting the same outcomes) ❖ An advocacy campaign: begin by identifying and targeting eminent individuals or organizations to add status and legitimacy ❖ Add some description of social diversity of implementation areas and provide analysis of how the model is affected by differences in socio-economic status ❖ Add to qualitative evidence with additional personal testimony, anecdotes, in a media and advocacy campaign to lay audiences (e.g., a video of providers and families testifying to benefits)
SAT Category	**Relevance of the Model and Comparison to Alternatives**
Positive Results	❖ Model moderately relevant: On three factors, does well on (i) addressing objective problem; does moderately well on (ii) issues perceived as problem by policy and decision makers ❖ No other solutions being implemented at scale
Challenges	Project ranked poorly on (iii) issue is seen as problem by beneficiaries (early marriage and birth were the cultural norm)
Recommendation	Greater advocacy for the issues (not just solutions) of ARSH and age of first births and child spacing generally would help
SAT Category	**Ease of Transfer and Adoption**
Positive Results	PRACHAR II Model: ❖ Evidence showed that a simpler model could be effective ❖ Small departure from current practices for NGO adopters and beneficiaries ❖ Implementable within existing systems and resources
Challenges	PRACHAR I Model: ❖ Complex ❖ Comprehensive ❖ Process and Resource-heavy (intense Training, Supervision and Monitoring activities) ❖ Model is substantial departure from current practice for 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	❖ Four different options developed (1 per scale-up method), but Expansion of the existing pilot seems most promising ❖ Alternative: test effectiveness of model under conditions of average implementation, i.e. by another organization less capable than the high-performing Pathfinder
SAT Category	**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 the state of Bihar, should be able to test it or roll it out gradually
Challenges	❖ No data on either absolute cost or relative cost-effectiveness, so impossible to assess these criteria or state-wide implementation ❖ The model itself does not generate any funding
Recommendation	Develop cost data on the PRACHAR model and different versions tested under PRACHAR II, are cost-benefits of simpler vs. more complex models

Lesson 4: Avoid Common Pitfalls

Going to Scale is particularly difficult when:
-Models lack credible documentation of impact
-Do not include a technological innovation
-Are value-laden or process-intensive
-Are replacements or substitutes for government services rather than innovations in service delivery
-Are not easily grafted onto existing services
-Do not have a dedicated funding source or some other means of generating revenue

Step 2: Establishing the Pre-conditions for Scaling-Up

Introduction

This set of tools is most useful in enabling Step 2 of the SUM Framework. The result of Step 2 of the SUM framework is that decisions for scaling up (such as a policy articulation) and resources (financial and human) for scaling up are allocated. The three tasks of Step 2 are:

1. Legitimizing Change
2. Build a Constituency
3. Realign and Mobilize Resources

The first step in **legitimizing change** involves an understanding of the policy milieu and the key stakeholders that would be affected by the scaling up process. Beyond the identification of stakeholders and policy assessments it is important to understand the position and the power of stakeholders, the influencers of key decision makers and the forces that affect policies and stakeholders. Conducting such analyses can be facilitated through the use of three tools:

2.1 **Stakeholder Analysis:** Enables a listing and analysis of stakeholders and an understanding of their positions and resources
2.2 **Policy Network Mapping:** Enables charting of the decision making processes and the people and groups who can influence each of these processes
2.3 **Force Field Analysis:** Arraying and assessing the forces supporting or opposing a certain change.
2.4 **Advocacy Strategy Profile:** Enables those outside the government to decide how best to engage appropriate government agencies on supporting or adopting the model

A second function of these tools is to enable legitimation of the model. Legitimation implies placing the need for change and the outlines of that change high on the agenda, so as to create legitimacy of a particular model or issue. It involves the emergence or designation of one or more policy "champions" with credibility, political resources, and the willingness to risk that political capital in support of the model for key constituencies to develop ownership.

The more that scaling up entails a significant break from tradition, the more important it is that influential people and thought leaders support the model through public statements that the model is important, valid and desirable. These are known as “champions” or “allies” and must enjoy credibility and respect in that particular issue or domain. While champions can come from either the public or the private sector, it is important that those models that originate outside of government attract high-level government support. The task of legitimation is critical not only for getting new models integrated into the appropriate policy, but also necessary for developing a broader and deeper base of support needed for implementation.

Tool 2.1: Stakeholder Analysis Table

Purpose

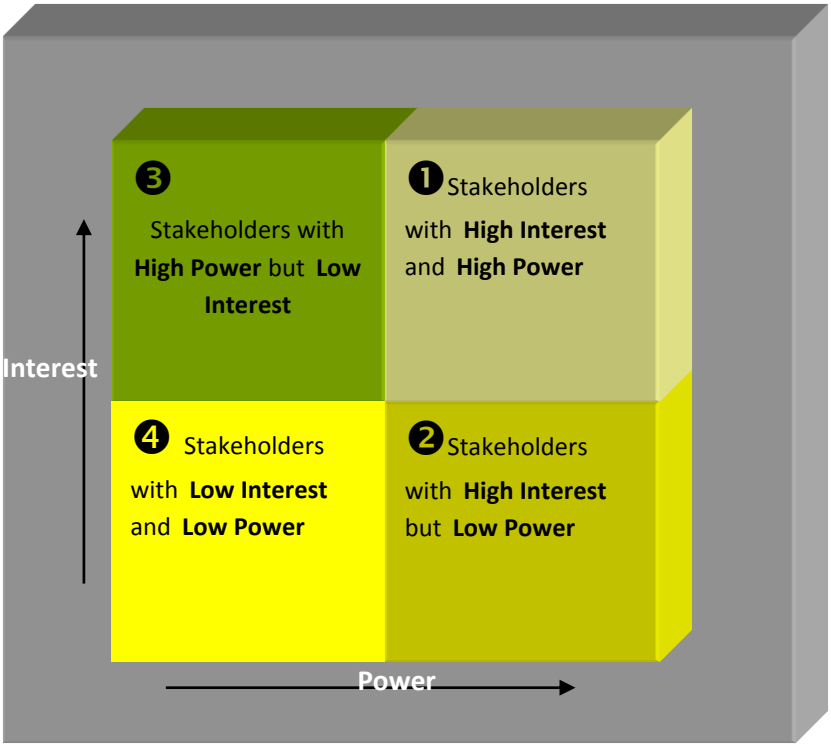
The purpose of stakeholder analysis is to inform the process of constituency building by identifying and examining potential sources of support and opposition for scaling up a particular model. It is a graphic presentation of key stakeholders in relation to their interests, positions, and resources relevant to that policy. Stakeholder analysis is useful at the time of formulating the scaling up strategy and during the period when the model is being implemented at scale. At the formulation stage, it helps to ensure that policies are shaped in ways to support the adoption and implementation of the model. During the implementation stage, the tool helps build an appreciation of the relative importance of different groups and the role each might play in the implementation process.

The definition of Stakeholder is: an individual or group or organization

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

The key uses of the stakeholder analysis are:

- Enables an assessment of the sources of influence, positive or negative, these groups will have
- Identifies critical issues
  - Compare perceptions based on input from diverse viewpoints
  - Where are the points of agreement and disagreement among stakeholders?
- Helps to develop strategies for legitimation and advocacy for scaling up
  - Mobilize proponents and `neutral' parties
  - Addressing potential sources of opposition
  - Target information/persuasion campaign based on stakeholders interests to address their positions
- Identifying resources for advocacy and for implementing at scale (Step 2 Task 8 and Step 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.

Tool 2.1: Stakeholder Analysis Table

GROUP	GROUP'S INTEREST IN ISSUE	RESOURCES AVAILABLE	RESOURCE MOBILIZATION CAPACITY	POSITION ON ISSUE
Name of group	- Estimate of the level of interest of the group in the issue (e.g., high to low). - Indicate what those interests are	Summary of resources held by group or to which it has access. (These may include economic, information, status, legitimacy, power). - Include Specifics	Estimate of how easily group can mobilize resources in pursuit of objectives. (High or Low)	Estimate of the group's position on the issue (e.g., pro or con or positive to negative, can be rated on a +3 to -3 scale)

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, a given policy, 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 implementation of the policy. 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.

There are various ways in which the information needed to complete a stakeholder analysis may be collected. The most common approach is a series of key informant interviews with journalists, heads and key members of civil society movements, religious leaders, business leaders, heads of political parties, university professors, government bureaucrats at senior and mid-levels, local think tanks, community activists, other opinion leaders and representatives of donor agencies. Other information collection techniques can also be used – particularly focus groups and workshops. 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.

Guiding Questions for selecting stakeholders:

- Will the interests be affected by the scaling up of this model? E.g. Local taxi drivers association when the model involves a centralized ambulance scheme
- Does the group have the resources to impact or block adoption? E.g Medical or Paediatric Associations when the model involves task shifting
- Can the group's support provide a net benefit to adoption, E.g., Parliamentarians for a model that could potentially have a high coverage and impact
- Can the group influence or block the success of implementation, E.g District health officials

The second column (*Group's Interest in Issue*) lists those interests that will be affected by the policy or decision to be taken for each stakeholder. What are the group's specific interests in the policy? The analyst should be careful to select only those two or three interests and/or expectations that are most important. For example, if the policy was to require that certain policies for health insurance cover HIV/AIDS, insurance companies' interests would include what services would be covered and how the new requirements would be regulated. The interest of people living with HIV/AIDS' might be related to qualifications to receive insurance and how expenses would be reimbursed.

The third column (*Resources*) identifies those resources that the group possesses that could be brought to bear in the decision making or implementation of the policy. Can the group offer some special knowledge or information? Would the group's status and presence on one side of the issue be key to its implementation or blockage? Multilateral donors often bring global pressure and funding to bear on policy adoption of member states. Thus for instance UNICEF and WHO champion the introduction of the Integrated Management for Childhood Illness, despite little evidence of success in reducing infant mortality. Thus they have both the status and presence (large state and district level offices to engage in ongoing advocacy through meetings workshops and exposure visits).

Types of resources can be classified as follow:

- Economic: financial, human (expertise) or in-kind resources such as media time.
  Information: knowledge gained through study, communication, research or instructions; facts, data, analyses, studies.
- Status: a position, rank, in relation to others or personal renown, celebrity, fame or reputation whose support can help influence decision making.
- Legitimacy: making something acceptable and normative to a group or audience. Often a person or group conveys legitimacy by their affiliation in an organization or position in it,
- Power: ability to compel behavior from person or organizations by use of power.

Column 4 (*Resource Mobilization Capacity*) describes the ease and speed with which the group can mobilize and deploy its resources. Quickly mobilizable resources are advantageous if the model's results are immediate, but less so if the impact of the model is further out into the future. 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. The analysts' judgment regarding mobilization capacity should be noted.

Column 5 (*Position on Issue*) the group's position regarding the issue should be examined and noted. Judgment should be more discrete than a simple for or against. It should give an indication of the strength of the group's opposition or support (using, for example, a –3 to +3 scale). If a group is barely in favor of an issue, a convincing argument could be enough to change its position.

While stakeholder analysis is helpful in gaining a better understanding of the interests and resources of the important players for policy decision-making and implementation, it is even more valuable when used in conjunction with other strategic management tools such as political mapping or Force Field Analysis. With political mapping, stakeholder analysis can help to refine the placement of political groups on the map. In the case of Force Field Analysis, it helps clarify a group's position as well as the comparative importance or salience of the group.

Tool 2.2: Policy Network Mapping

Purpose

A Policy Network Map is an analytical tool used to assess the support for and against specific policy changes. The purpose of the political map is to organize information about policy making or modification so that it relates to the key issues a decision maker faces. It enables the identification of key decision makers and the flow of the decision process within the government or other adopting organizations. It also helps the organization and identification of the most important political actors and spatially illustrates their relationships to one another. The construction of a policy network map can be extremely helpful in creating maps for specific policies and to understand who the key players are in the policy making area that will need to be accessed to enable scaling up.

How to Use This Tool

Key uses are:

- Mapping the policy making process or flow
  - Identifies the points through which a project or policy passes to become approved and implemented

    - Identifies who are the decision makers at each step
- Identifies potential ways of gaining access to the decision making process:
    - Who influences the decision makers?
    - Are there other actors, though not officially part of the process, that have substantial influence over those who decide
    - Identifies key entry points
- Augments Stakeholder Analysis

A full example of this tool can be found in the 2006 *Scaling Up Management Framework* under Step 2 Task 6, pages 31-34.

Guiding Questions: Network Mapping

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

- Understand the different points through which a project or policy passes to become approved and implemented
- Identify precisely what formal decisions need to be made for scaling up of the model (policy, regulation, law, legislation, MOU)
- Who are the decision makers: policy makers, political leadership? Who are the actor(s) in charge of each step?
- Are there other actors, though not officially part of the processes who have substantial influence over key decision makers? Who are the influencers? (NGOs, Medical lobby, Pharmaceutical lobby, etc.)
- Ways can officials exercise influence over this process? Do they have any particular skills or contracts that might help in this process?
- Noting the position of instrumental actors such as the bureaucracy
- Detect the existence of opposing alliances and potential support coalitions.
- What funding and resources are required

Guiding Questions: Validation

Once drawn, the map should answer the following questions:

- Who are the key decision makers in the process?
- What is known about their position on this model? For, Against, Neutral? (mark them on the map)
- Who are the key influencers?
- What is known about their position on this model? For, Against, Neutral? (mark them on the map)
- What does this analysis suggest as a "way in" to the key decision makers? (may be more than one) Where are the key supporters with access?
- Who are the key opponents and what can be done to neutralize or flip them or circumvent them?

Tool 2.3: Force Field Analysis

Purpose

Force field analysis[7] is another convenient method to illustrate support and opposition (i.e., the field of forces) to a particular policy, and for analyzing the forces that oppose or support the model. Force Field Analysis is helpful in a first cut and enables analysis of forces that are likely to oppose or obstruct the model and those that would support the scaling up of a model. It also enables the identification of which force(s) hold the key to changing the status quo and those that can be changed. For change to be possible, the driving forces must overcome the restraining forces.

→*Tip*: Usually, the most effective way to do this it to diminish or remove restraining forces, rather than try to strengthen the driving forces, as this tends to intensify the opposition.

Force field analysis is also a powerful decision-making tool: in evaluating the forces supporting and opposing a specific decision, managers can assess the likelihood of acceptance and manage the influencing forces to maximize the potential for acceptance and success. It is particularly useful for giving the scaling up team a quick impression of where major opposition and support lie. It is important that those applying this tool be knowledgeable about political institutions and actors in their country. It can be useful for examining how feasible a strategic objective is and what areas need to be focused on in any associated action plan.

How to Use This Tool

1. Identify and list all the forces which support scaling up of the model on the left.
2. Identify and list all the forces which act against the change on the right

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

Given below is the application of Force Field Analysis for a model to train primary care physicians in Emergency Obstetric Care (EmOC) to enable reductions in maternal mortality where specialist Ob-Gyns are not available.

Background

Maternal mortality in India continues to remain high partly because of limited access to Emergency Obstetric Care (EmOC). In most parts of rural India, EmOC is not available due to shortage of trained medical and paramedical staff, with only two to four 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 (AMDD) of the Mailman School of Public Health, Columbia University in some districts in rural Rajasthan and Maharashtra showed that the met need for EmOC was as low as 10-15%.

Model Description

[7] Using Lewin's Force Field Analysis in Implementing a Nursing Information System.Authors:MARILYNN G. BOZAKSource:CIN: Computers, Informatics, Nursing; Mar/Apr2003, Vol. 21 Issue 2, p80-85, 6p

In 2003, the MacArthur Foundation supported the FOGSI Societies of India[8] through technical assistance from the Johns Hopkins Institute for Gynaecology and Obstetrics (JHPIEGO) to develop the capacity of general practitioners and non-specialist doctors to provide quality emergency obstetric care services. The key interventions of the model were:

- Establishing one Center of Excellence in Christian Medical College, Vellore (CMC) to produce high quality trainers
- Developing the quality standards for infrastructure, equipment and training required in sites meant to serve as training centers.
- Up gradation of five medical colleges (located within teaching hospitals) with infrastructure and training facilities to serve as training sites for health providers. This requires the following steps:
    - Site assessment of tertiary centers to determine capacities and needs of each center - Site assessment is conducted to identify current practices and site strengthening. It requires examination of clinical facilities, obstetric and midwifery practices, infection prevention standards and teaching areas.
    - Technical Update of tertiary care center staff
    - Mentoring of trainers previously trained for clinical skills standardization course
    - Clinical teaching skill course
- Development of curriculum for Basic and Comprehensive EmOC
- Development of training modules and manuals
- Procurement of training aids
- Development of an evaluation and certification process for trainees
- Designing a post training follow up and support plan for trainees.

Since Obstetricians and Gynecologists have traditionally blocked the multi-skilling of non-specialist physicians to provide EmOC, enabling the legitimization of obstetric skills for such providers was a significant breakthrough. 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, based on its policy for the National Rural Health Mission (NRHM) of expanding the human resource cadre to manage obstetric complications, particularly in rural areas of the EAG states, and impressed by the potential of the model, committed an amount of Rs. 20,000,000, (USD 5 million) to establish training sites in 25 centers across the country.

Tool 2.3: Force Field Analysis example – *FOGSI*

MULTI-TASKING FOR THE PROVISION OF EMERGENCY OBSTETRIC CARE	
Driving Forces	**Restraining Forces**
High maternal mortality	Large capacity for skill based training is needed
Reaching underserved areas	Professional Privilege/ FOGSI resistance
Creating private enterprise	Lack of regulation
Access to large rural markets	Intensive monitoring

[8] Established in 1950, FOGSI is a federation of more than 184 individual city and state-based societies of obstetricians and gynecologists spread throughout India.

Tool 2.4: Advocacy Strategy Profile

Purpose

The Advocacy Strategy Profile (ASP) is a decision support tool that helps policy advocates outside of government choose the best approach for constructively engaging with the government. It is based on the premise that advocates need to adopt very different approaches when operating in a highly centralized decision-making environment than they do when dealing with multiple or decentralized decision-making regimes. Among the other relevant factors that should influence advocacy strategy are the resources available to the advocacy organization and the group's structure.

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

Advocacy Styles Continuum

Advocacy Styles

Collaboration ← → **Confrontation**

One-time Collaboration	Ongoing Collaboration	Sporadic Lobbying	Lobbying Structure	Permanent Advocacy Group
- Least demanding - Specific issue focused - Group influence limited to issue - May provide opportunity to raise other issues - Opportunity to build legitimacy and/or credibility	- Proven credibility yields subtle influence - Joint problem solving - Government continues to set rules - Risks of ongoing association with government	- Development of positions independent of government - Not a core function of the organization - Influence dependent on stature and connections of individual members	- Adoption of "strategic approach" - Development of improved technical capacity - Permanent resources assigned to lobbying - Development of more permanent relationships policy-makers	- Created specifically for lobbying/ advocacy - Sectorally based constituency – not single organization - Research based policy positions, technical credibility - Use of multiple tactics

Government Context

Highly Centralized Decision-Making ← → **Multiple/ Alternative Decision Centers**

Lesson 7: Begin Advocacy and Ownership Early

-Start advocacy from the beginning
-Create a multi-stakeholder team if possible
-Create an advisory board or some sort of mechanism to develop buy-in from key decision makers/adopters
-Create partnerships or collaborative mechanisms with potential alternative, competing models
-Address ownership of the scaling-up process
-Whose model is it – funder, manager, implementer, adopter, intermediary?
-Who will make decisions on whether and how to scale up? What and where?

Tool 2.4.1Advocacy Strategy Profile: Part I

ADVOCACY STRATEGY PROFILE: PART I

		1	2	3	4	5	
Political Environment	Highly centralized decision-making						Decentralized decision making
	Undifferentiated decision-making (Executive Branch)						Alternative decision makers (legislatures, local government, courts, etc.)
	Ineffective means for accountability						Effective public accountability
	Hostile to reform initiatives						Receptive to reform initiatives
	Little tradition of participation						Tradition of participation
Resources Available to Group	Limited human resources						Extensive human resources
	Limited technical resources						Extensive technical resources
	Limited/unsustainable financial resources						Extensive/sustainable financial resources
Group's Organization Structure	Exclusively non-governmental						Mixed public, NGO and private sector participation
	Temporary organization						Permanent organization
	Policy influence as only activity						Many activities in addition to policy influence

How to Use This Tool

To complete the Profile, an analyst or the leadership of the (potential) advocacy group identifies the prevailing situation, as they see it, with regard to each of 11 factors (see below). Each is scored subjectively from 1 to 5 and an "X" placed in the appropriate box on the grid. 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, should combine their ratings into an average.

After scores have been agreed upon for each factor, a line is drawn connecting the "Xs." In general, the placement of the line from left to right corresponds with the five advocacy approaches indicated in the figure above. For example, if the line is often to the far left, the suggested approach would be collaborative. Often, however, the line connecting the "Xs" 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 left to right on the Profile. In the case illustrated below for example, it would probably make the most sense for an Advocacy Group to begin working with the Government in a collaborative and informal way.

Tool 2.4.2 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 the members of those organizations and third parties determine where specific organizations are most in need of strengthening. It is in the form of a list of strategic actions (see figure below) each of which is to 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.

Tool 2.4.2 Advocacy Strategy Profile: Part II

Action Taken?					Advocacy Activities	Imminent Priority? Y/N
1	2	3	4	5		
					Advocacy group becomes more informed about policy issue and its impact on their interests and constituents:	
					Group collect s 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 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 lobby effort will come from and indicate who will do what, when, and how).	
					Advocacy group develops strategic alliances or develops/participates in coalition supporting policy change:	
					Group examines needs for participation in coalition or alliance on policy issue, and clearly understands cost and benefits.	
					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.	

Step 3: Managing the Scaling-Up Process

Introduction

Once there is policy and financial commitment to scaling up the intervention, planning and implementation into a large scale system is required. Implementing the large scale intervention requires organizational change that spans structures, systems, procedures, management styles and staff numbers and skills. The change also requires leadership and a commitment to the vision for scaling up. An important component of implementing scaling up is the need to effectively transfer the technology and the know-how. This is critical in the case of collaboration or replication where the originating agency itself is either only partially or not involved with the scaling up process. One tool to enable organization effectiveness for scaling up is the Institutional Development Framework.

Lesson 2: Beware of Path Dependency

Transferring responsibility to and from government from an NGO is very dependent on the details of governance in particular localities, states and countries. Transfer is made more difficult when there is a level of distrust between NGOs and governments.

Tool 3.1: Institutional Development Framework

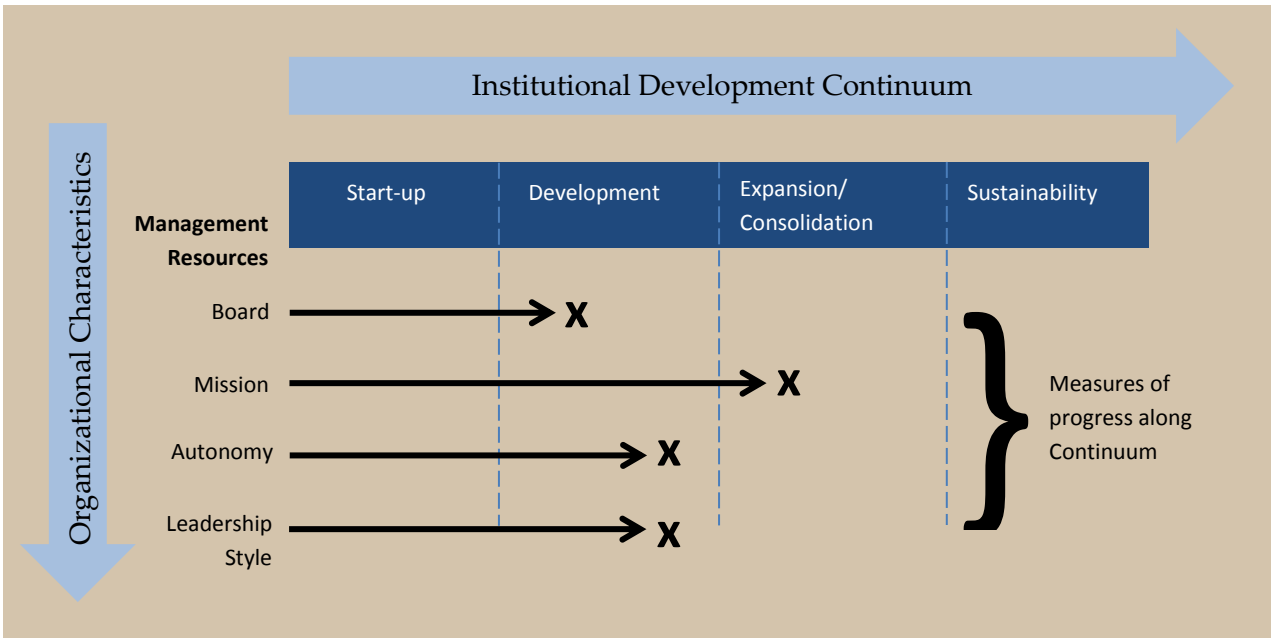
Purpose

An integrated Toolkit for institutional development is presented. It is intended to be used by the non-profits themselves to address current shortcomings in the field of institutional development of non-profit organizations, including: inadequate measures of institutional capacity; difficulty diagnosing priority areas within an organization for improvement; lack of simple mechanisms to improve understanding by non-profit staff of the interrelated components of their organization; and inadequate mechanisms to compare institutional development across organizations. The Toolkit emphasizes participation, use of management systems, and the independence of the organization. The Toolkit provides both an analytic (table) and visual (graphic) presentation of results. The system is now fully automated. Utilization of the Toolkit can address many of the shortcomings listed above as well as help provide a useful way to develop consensus and unite energies among the Board, staff, beneficiaries, and donors.

The framework provides a ***dynamic*** tool. We can use it to assess a development organization in various stages: before it undertakes a project or during a scaling up, especially if the scaling up is a multi-year, multi-phase enterprise. It is also a ***versatile*** tool. It can not only assess the organizational capability of an NGO, but also of a government agency, municipality or a private firm that may be partnering in a scaling up coalition. The organization can use it to assess its own capability or of a potential partner and, in the latter case, furnish the basis of objective negotiation. The framework is based on empirical studies in several countries and is reasonably free of a regional or cultural 'tilt.' However, for special situations or organizations, it allows us to modify some of the aspects or their components to make these more subject-specific. In that sense, it is also a very ***adaptable*** tool.

Due to its length, the full IDF is not presented in this paper. The remaining rows include Management Resources: leadership style, participatory management; management systems, planning, community participation, monitoring and evaluation; Human Resources: staff skills, staff development, organizational diversity; Financial Resources: financial management, financial vulnerability, financial solvency; External Resources: public relations, ability to work with local communities, ability to work with government bodies, ability to access local resources, ability to work with local NGOs. A short excerpt is presented in the Figure below.

Schematic View of Institutional Development Framework



These distinctions are somewhat arbitrary, and one might quibble with any particular entry. Taken as a whole, however, it paints a reasonable portrait of an organization's development. Although it is described as a continuum, an organization can regress, and the Expansion/Consolidation phase could also represent a restructuring.

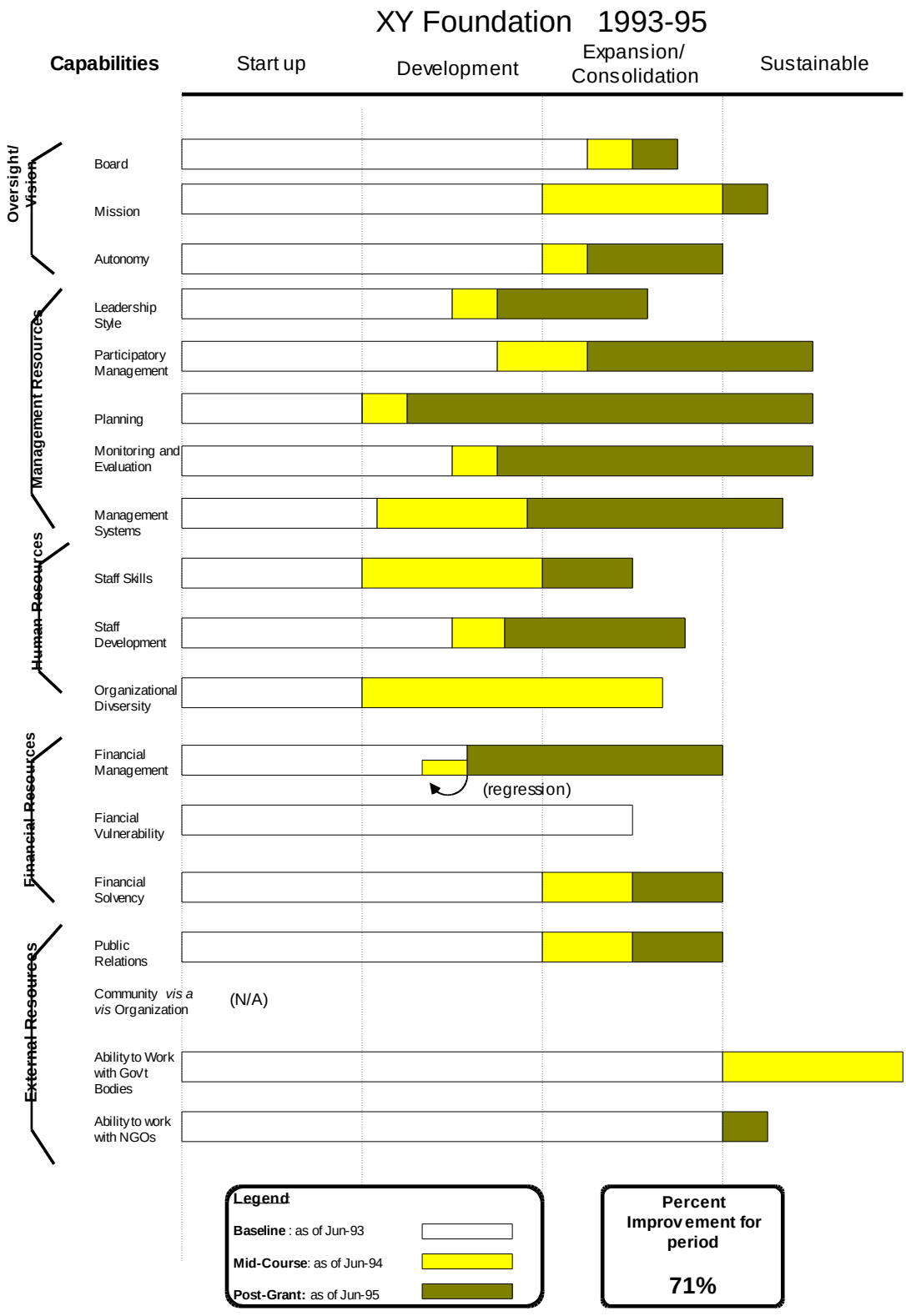
Lesson 3: Prioritize Intermediation

The tasks involved in going to scale are distinct from those involved in operating a successful pilot and from operating at scale. In many cases, there is a conspicuous lack of intermediary organizations with the skills, mandate and motivation to help organizations scale-up successfully, and a shortage of donors willing to fund the scaling up process; identifying such organizations to manage and fund scaling up will greatly enhance the chances for success.

The challenge of the Framework is first to fill in the "Progress Cells" with descriptions that help an organization consider where it may be located along the continuum at any given time. The "X marks the spot" (arrows in the Figure convey that concept). We have made a first effort at this for the framework, several rows of which are excerpted below.

	Criteria for Each Progressive Stage			
Resources	Start up	Development	Expansion/ Consolidation	Sustainability
	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.	One or two 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.

Example of Institutional Development Profile for XY Foundation



Tool 3.2: Monitoring and Evaluation – Steps and Guides

Introduction

Monitoring and evaluation are critical to a scaling up process. While ongoing monitoring is integral across each step, it is important to track the effects of introducing the new model and to make adjustments if the results differ from what was intended. Such monitoring and evaluation ideally begins early in the process, with assessments during Step 1 of the effectiveness of the pilot project (Tool 1.1.4). 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 any such 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.

Lesson 10: Provide for Multi-Stage Monitoring

It is essential to monitor and report on **both** the scaling up process (getting there) and *implementation* at scale (once you're 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.

There are four main ways in which monitoring and evaluation tools are used to support a scaling up process:

1. Evaluation of the Model (see Tool 1.1.4)
2. Monitoring the Scaling-up Process (under Task 9)
3. Monitoring and Evaluating Performance and Impact at Scale (under Task 10)
4. Monitoring Commitment: Follow through on Scaling Up and Sustainability (under Task 10)

Since 3.2.1 is also discussed as Tool 1.1.4, it will not be repeated here.

Tool 3.2.2: Monitoring the Scaling-up Process

Purpose

In contrast to rigorous evaluations on the impact of a model, monitoring the progress of a scaling up plan relies on more routine but useful tools such as work-plans linked to detailed schedules and well-defined milestones and products associated with each task. As indicated in the *Scaling Up Framework*, steps in the scaling up process are interactive in the sense that they inform each other, but these steps also have a logical sequence and flow that can be monitored using GANTT charts and other basic project management tools.

To illustrate this point, a sample GANTT chart is provided below laying out a schedule for completing a scaling up process over an 18 month period. In principle, a milestone or product could be defined for each "X" on this chart that would allow the manager of a scaling up effort (of either the Intermediary or Adopting Agency) to monitor the project's progress in qualitative as well as time terms. As for any project, expenditure targets can be associated with either time periods, or tasks, or both.

Sample GANTT Chart

Scaling-up Tasks	Months																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Step One: Develop a Scaling-up Plan																		
Task 1: Create a Vision	X																	
Task 2: Assess Scalability		X	X															
Task 3: Fill Information Gaps		X	X															
Task 4: Prepare a Scaling-up Plan				X														
Step 2: Establish the Preconditions for Scaling Up																		
Task 5: Legitimize Change					X	X	X		X									
Task 6: Build a Constituency			X	X	X	X	X		X		X		X		X			
Task 7: Realign and Mobilize Resources						X	X	X	X	X	X	X	X		X			
Step 3: Implement the Scaling-Up Process																		
Task 8: Modify And Strengthen Organizations					X	X	X	X	X	X		X		X		X		
Task 9: Coordinate Action					X	X	X	X	X	X		X		X		X		
Task 10: Track Performance and Maintain Momentum	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

How to Use This Tool

While Scaling Up Tasks 1-4 have a number of standard characteristics and products no matter what type of model is being considered, steps 5-9 will differ significantly depending on the country, sector and even specific locations in which a scaling up effort takes place. Of steps 5-9, the one for which some fairly standard milestones can be developed is Task 8, for the Institutional Development Framework should identify some of the kinds of practice standards that could be used in developing a set of institutional change and improvement markers that would help a scaling-up manager stay informed of progress in quality terms. Even these, however, are likely to require significant customization as they are put to use in scaling up efforts in different sectors and cultural environments.

Guide: Monitoring and Evaluating Performance and Impact at Scale

Evaluation at scale can serve two purposes: [1] it can be used to reconfirm expectations about the differences in the effectiveness of a model in diverse cultural settings; and [2] it can also be used on an "on call" basis to examine situations in which the model at scale is over- or under-performing, and why. As this suggests, needs for and the types of evaluations that will be appropriate when an intervention has been taken to scale will likely vary widely depending on the intervention. At scale, it is much more likely to be implementation fidelity monitoring that is needed with most scaling up initiatives.

At this stage, it should be noted that once the scale-up model begins to produce results, both monitoring of outcomes and evaluation of the impact will be required as with any other project. If the Adopting Agency is cooperating with local government (and it should), monitoring data should be captured by or delivered to a management information system that is congruent with existing national systems (likely, the NHMIS). **The indicators for this phase of the process should include monitoring quality parameters as well as quantity.** These indicators should be based on the salient elements decided in Step 1 Identifying the Model.

The term implementation fidelity is used to capture the notion of quality compliance guidelines for delivering an intervention at scale. Monitoring of implementation fidelity is common with programs that roll out government initiatives on a national basis, and in some technical fields. Useful products for helping those involved in scaling up efforts conceptualize and measure implementation fidelity are emerging. A 2006 chapter on implementation fidelity produced by the U.S. National Center for Research on Learning Disabilities is noteworthy in this regard. Also helpful is a Question Guide on the next page: (http://www.nrcld.org/rti_manual/pages/RTIManualSection4.pdf).

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

Guide: Monitoring Commitment

A final type of monitoring focuses on the continued commitment of those who fund and implement interventions at scale to persist; 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 is sometimes carried out by "watchdog" or citizen committees. This type of oversight is

something that can be integrated into scaling up efforts to build a constituency for an intervention and the problem it addresses to keep a spotlight on the issue and (hopefully) the model that was just scaled-up to address it. For this type of monitoring, specific tools are less important than consistency of attention and the willingness and skills of the kind of monitor(s) in sounding an alarm when the focus of attention starts to move away from an innovation that has been taken to scale and is producing results.

Also of critical importance is the creation of avenues for feeding this information back to the public and to decision makers, and for ensuring that it is widely discussed. The press, academia, and non-partisan 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 oversight of commitment 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

Annex A. Lessons Learned

Lesson 1 - Simplify

The more one can simplify a model–without compromising quality or effectiveness–the more feasible it is to scale it up. However, there is a strong reluctance on the part of most organizations to simplify, repackage, or relinquish control over their models for purposes of scaling them up; this will have to be negotiated as part of Step 2 of the process.

Lesson 2: Beware of Path Dependency

Transferring responsibility to and from government from an NGO is very dependent on the details of governance in particular localities, states and countries. Transfer is made more difficult when there is a level of distrust between NGOs and governments.

Lesson 3: Prioritize Intermediation

The tasks involved in going to scale are distinct from those involved in operating a successful pilot and from operating at scale. In many cases, there is a conspicuous lack of **intermediary organizations** with the skills, mandate and motivation to help organizations scale-up successfully, and a shortage of donors willing to fund the scaling up process; identifying such organizations to manage and fund scaling up will greatly enhance the chances for success.

Lesson 4: Avoid Common Pitfalls

Going to Scale is particularly difficult when:

- Models lack credible documentation of impact
- Do not include a technological innovation
- Are value-laden or process-intensive
- Are replacements or substitutes for government services rather than innovations in service delivery
- Are not easily grafted onto existing services
- Do not have a dedicated funding source or some other means of generating revenue

Lesson 5: Tailor Evidence to the Audience

Data from pilot projects is rarely tailored to the decision-criteria or decision-making styles of policy-makers. Data on effectiveness is often necessary, but usually not sufficient; make sure you address the priorities and power (decisions within their jurisdiction) of the audience you are trying to convince.

Lesson 6: Plan Backwards

- Begin with an eye on scale and a strategy for achieving it
- Be strategic in the design/selection of the model and its testing
- Identify and involve the large scale implementer(s)
- Focus early on unit cost and implications for current service providers
- Identify **who** will do the scaling up (advocacy; capacity building) and scale-up **resources**

Lesson 7: Begin Advocacy and Ownership Early

- Start advocacy from the beginning
- Create a multi-stakeholder team if possible
- Create an advisory board or some sort of mechanism to develop buy-in from key decision makers/adopters
- Create partnerships or collaborative mechanisms with potential alternative, competing models
- Address ownership of the scaling-up process
- Whose model is it – funder, manager, implementer, adopter, intermediary?
- Who will make decisions on whether and how to scale up? What and where?

Lesson 8: Educate Funders on Scaling Up Reality

Going to Scale takes time, money, resources, and capacity/skills that are often larger and longer than the pilot! **Funding for transition and intermediation are critical and scarce.** The average time for scaling up to national application is **15 years.** There are distinct financing challenges for each of the three Steps: [1] preparation and planning; [2] legitimation and advocacy; and [3] implementation.

Lesson 9: Focus on Systems and Incentives

For sustainable change to occur, it's essential to understand and replicate the incentives from the model or make sure that an alternative incentive system reinforces needed actions. Changes in rules, regulations and procedures are often necessary which requires detailed knowledge of the adopting organization.

Lesson 10: Provide for Multi-Stage Monitoring

It is essential to monitor and report on **both** the scaling up process (getting there) and *implementation* at scale (once you're 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.

Annex B: Glossary of Terms

Components (of the intervention or model)

Components are the basic activities that comprise an intervention and, more generally, a model. This book divides components into two taxonomies shown in the matrices under Task 1. *Example*: a component of the CNBC model is the payment of village health workers based on a monthly fixed stipend plus additional amounts based on performance.

(Organizational) Context

Interventions are implemented by organizations or institutions, which have systems, structures and capabilities. Complementing the components of the intervention are the components of the organizational context which are necessary for the intervention to be effectively implemented. These include logistics, human resources, equipment, financial resources, supplies, materials, management, supervision, accountability mechanisms, feedback mechanisms, and organizational culture. Taken together, the organizational context and the intervention define the model. A major challenge in scaling up is to identify from the specifics of the pilot project the generic organizational context necessary of the model.

Example: The organizational context of the CBNC model included how the VHWs receive supplies for their kits, how they were supervised, who supervised them, and what the training and capabilities of the supervisors were, who did the training, and the infrastructure and process that had to be created to deliver VHW training – trainers, training materials, training locations.

Social and Institutional Factors

The factors from the surrounding environment which affect the model's effectiveness and impact and are external to the model, i.e. are not components or activities of the model. In terms of a logical framework, these are equivalent to assumptions; factors, whether positive or negative, that have to be present for the causal relationship between components, outputs, outcomes and goals to hold. These can be cultural, social, geographic, and economic factors deriving from tribe, ethnicity, religion, caste, livelihoods, gender and other social distinctions. These factors may not be present.

Example: An external factor important for the CNBC model at the pilot stage was caste relationships in the surrounding community. Caste differences were not so rigid as to prevent low-caste VHWs from going into the homes of high-caste pregnant women, and vice-versa. If this model were to be scaled up throughout Northern India, this factor might become an issue in areas with rigid and conservative caste distinctions.

Implementing Organization

The organization(s) responsible for implementing the model at small or large scale. At small scale, this is often the same organization that manages the project. However, it is quite common for a large

organization to manage a project while actual implementation of the model will be done by a smaller, local organization, such as a local NGO. In such a case, the local NGO is the implementing organization. Situations like this often develop when the large organization is an international contractor or NGO funded by bilateral donors In cases where a model begins at small scale and then goes to scale (as opposed to being implemented directly at large scale), there is both a small scale implementing organization (SSIO) and a large scale implementing organization (LSIO). Depending on the method of scaling up chosen, these may be the same organization (expansion), or different organizations (replication), or multiple organizations (replication or collaboration).

Example: CNBC was implemented at small scale by a public health research NGO based in a remote rural area in the state of Maharastra, in central India. At small scale this NGO was both the managing and implementing organization. A second stage pilot was run using seven NGOs in a variety of diverse locations throughout the state of Maharastra, with a goal of testing external validity, i.e. that the model would prove effective in diverse contexts. In the second stage pilot, the original NGO served as the managing organization (see below) but not the implementing organization.

Managing Organization

In cases where management and implementation functions are separated, a separate organization undertakes the management and coordination of the overall effort, and often includes providing oversight, supervision, training and technical assistance to the implementing organizations. This does exist at small scale, but is more common at large scale.

Adopting Organization

The organization that provides legitimacy for the model at whatever scale it is being implemented. The adopting organization may provide legal status, authorization, or sufficient respectability so that beneficiaries and other relevant stakeholders accept the model.

Example: The initial strategy for scaling up CBNC focused on getting adoption by the Government of India, and specifically the Planning Commission (India's most senior policy making body) and the Ministry of Health and Family Welfare. Adoption by the government was seen as essential for credibility and access on large scale.

Resource Organization

The organization(s) that provides the financial and other resources necessary for the effective implementation of the model at the given scale.

Example: The first phase of implementing at scaling of the CBNC model was to be in 10 districts in five Northern Indian states. While adoption was on the part of the Government of India, and specifically the Ministry of Health and Family Welfare (MoHFW), the initial implementation at large scale was to be done by the MoHFW and financed by a third party, the Norwegian government, through the creation of a joint mechanism called the Norwegian-India Partnership Initiative. However the MoHFW did not have the necessary on-the-ground resources for training of VHWs, and this training was done using facilities and staff of CARE, an international NGO, and UNICEF, an international organization. At this stage of

scaling up, the adopting and implementing organizations were the national and district level MOHFW, the managing organization was NIPI, and the resource organizations included the Norwegian government, CARE and UNICEF.

Intermediary Organization

The organization which is responsible for the process of going to scale. The intermediary organization may be the small-scale implementing organization, the large scale adopting or implementing organization, a resource organization (such as a third party funder of the small or large scale effort), or a third party such as a consulting firm or nodal NGO. Given that there are a number of steps and tasks involved in going to scale–advocacy, capacity and capability building, monitoring–these tasks may be done by different organizations, each partially fulfilling the scaling up role. An intermediary organization needs to have skills and capabilities in advocacy, boundary spanning, coalition building, budgeting, capacity and capability building, convening power, group process facilitation, monitoring and evaluation, multi-stakeholder dialogue, and strategic and operational planning.

Example: In scaling up of CNBC, MSI fulfilled one of the primary intermediary roles in facilitating creation of an overall scaling up and advocacy strategy. MSI possessed strong capabilities in group process facilitation, monitoring and evaluation, multi-stakeholder dialogue, and strategic and operational planning. Lacking local knowledge and reputation, MSI partnered with the Population Foundation of India (PFI), which took the lead role in creating and mobilizing a broad-based coalition and implementing the advocacy strategy. PFI had strong capabilities in terms of convening power and advocacy. MSI and PFI jointly provided technical assistance to NIPI in developing a budget and operational plan for large-scale implementation.

Capabilities

Implementing organizations must be able to have both the capabilities to implement the model and the capacity to implement it at the desired scale or reach. The appropriate analogy is to a cup, it has the capability to hold liquids and a capacity of perhaps eight ounces. Implementing organizations must have a set of capabilities that correspond to both the components of the intervention and the needed organizational context. Whether an implementing organization has them or not is independent of scale or capacity.

Example: The CBNC model use of village health workers in the context of a community-based delivery system required capabilities in training, community mobilization and sensitization, gender empowerment, and financial management, amongst others. By contrast, field research showed that the model could be effectively implemented by organizations lacking technical expertise in clinical medicine or public health.

Capacity

The scale at which the organization is able to adopt, resource, or implement the model. Capacity is commensurate to the desired reach and coverage to be achieved at large scale. This might mean the ability to service a given (large) number of people, physical presence in a given geographic or political/administrative areas covered, ability to reach the target demographic groups, or some combination of these. If there is more than one implementing organization, the combined capacity must be sufficient.

Example: The goals for scaling up CNBC model were to reach marginalized populations in all of India, principally the rural and urban poor in the northern states with the worst health indicators, known as the Empowered Action Group (EAG) states. Identifying a large scaling implementing organization proved to be a major challenge, as the MOHF primary health clinic system has difficulty in effectively reaching the rural and urban poor, but can otherwise deliver at the desired scale. By contrast, there exist a large number of local NGOs who serve those communities, but even collectively they would only reach a fraction of that population.

Replication

Replication involves taking a model or some subset of the components of a model to scale by through implementation of the model by other organizations or institutions. In these cases, an arm's-length relationship between the small and large scale implementing organizations exists. Many possible configurations of replication exist.Implementing organizations at either scale may be local NGOs, international NGOs, government agencies, private contractors, or other civil society actors. Replication is commonly used where the SSIO either lacks the capacity or interest, or both, to implement at large scale.

In one of the most common types of replication, policy adoption, a model is scaled up from a pilot run by an NGO to a program or practice mandated and often run by the public sector. While policy adoption can happen spontaneously, experience shows that it more often happens, and certainly happens more quickly and effectively, when it is the result of a planned effort and includes follow through to ensure the quality and fidelity of large-scale implementation.

Another common form of replication is grafting, where a model—or one component of a model—is incorporated into another organization's array of services or methods of service delivery. Policy adoption and grafting can occur together, as when a public sector agency incorporates a technique innovated by NGOs into its services. One example is the grafting of a participatory approach to HIV education onto an existing network of clinics.

Example: The initial form of scaling up in the CBNC strategy was replication, and specifically policy adoption, going from a small local NGO to large-scale implementation by the MOHFW's public health system. At the same time as the CBNC model was going to scale, the GOI had already decided to implement a national system of village or community health workers, called Ashas. Thus scaling up of CNBC was to be grafted onto the Asha program, with the CBNC training integrated into the Asha

training. Grafting in this case required dropping or modifying some of the original components to conform to the larger ASHA scheme.

Expansion (Growth or Internal Dissemination)

Expansion takes a model to scale within the context of the same organization that implemented the model at small scale. This is the polar opposite of the arms-length relationship in replication. Expansion often occurs in three cases: where the small scale implementing organization already itself possesses large scale capacity; where the model requires specific capabilities that the small scale organization possesses and that are difficult to reproduce in other organizations, or where the originating organization is unwilling to relinquish ownership and control of the model.

There are two types of expansion, depending on the organization's operating pre-existing delivery capacity. For organizations which enter the scaling up process with limited capacity, scaling up through expansion means that scaling up the model is equivalent to scaling up the organization, or at least that part of the organization responsible for that model. In other words, it requires substantial capacity building. If increased scale requires covering a greater percentage of the population or additional groups in an existing area, capacity building might mean increasing the number of staff, building logistical capabilities, improving systems, etc. If increased scale requires covering a greater geographic area, capacity building might require establishing a physical presence–new offices or clinics—in new locations as well as larger staff and improved systems.

Expansion through capacity building sometimes is accompanied by decentralization, restructuring, downsizing, or some combination of the three. Organizational restructuring is the most common. Organizations that have a functional internal organizational structure often have to shift to geographic structures or a matrix approach in order to support large scale implementation. Similarly, small organization, which commonly operate with informal internal systems (planning, financial management, human resource management, supply and logistics) may be required to establish formal systems. This can involve a major organizational change effort and presents serious challenges in terms of preserving elements of the organizational culture that made the model effective in the first place. Restructuring or downsizing the organization's mix of activities and services can sometimes accompany scaling up through expansion. For example, an organization might realize that in order to deliver certain activities at scale it needs to narrow or focus its efforts.

The second form of expansion is internal dissemination. In this case, the organization enters into the scaling up process with sufficient capacity or reach to implement the model at the desired scale, but lacks the necessary capabilities organization-wide. The model in this case has most likely been developed, piloted or tested in one part of the organization. The scaling up challenge is how to disseminate that knowledge and capability throughout the organization as a whole, or through the appropriate parts.

Collaboration

Collaboration falls somewhere between expansion and replication. In collaboration, the small scale implementing organization continues to stay actively involved with implementation at large scale. Collaboration can either be one of division of responsibilities in terms of combing different capabilities in covering the same scale, achieving scale by combining different capacities, or both. Collaboration is particularly useful when no one organization has both the capabilities and capacities to implement the model at the desired scale. For example, if there is no one organization that can deliver at the desired scale, a network of NGOs might be created or organized that can collectively achieve delivery at scale.

In the case of capabilities, organizations might partner together to bring each organization's particular expertise to the scaling up effort. One organization might implement certain components of the model, such as community mobilization, another might implement training, and a third might provide actual services such as curative health care. While we have confined our distinctions on the different methods of scaling up along the single dimension of implementation, collaboration is often employed when capabilities for adoption, funding, and implementation lie with different organizations. Thus, contracting out is an example of collaboration as a means of scaling up.

Collaborations include a number of innovative structures and governance arrangements, from formal partnerships to informal networks. Formal partnerships, joint ventures and strategic alliances are increasingly common methods for organizing collaborative efforts, as are less formal networks and coalitions based on memoranda of understanding or merely a handshake. Some of these arrangements include the public sector as a key partner. Others are agreements among civil society groups and/or partnerships with private firms, such as an NGO involved in education and awareness that partnering with media organizations to co-create new methods of delivering products and services to an expanded audience. Recognition by private firms of commercial opportunities among the poor and a growing emphasis on corporate social responsibility have greatly expanded the opportunities for these types of partnerships. Consequently, public-private partnerships have become a more common way of scaling up and creating sustainability.

Virtual

Virtual scaling up can be used with all of the other methods of scaling up. In virtual scaling up, information and communication technologies, mass media or other technologies are used to reach a larger audience. Virtual scaling up is commonly used in education, training and teaching generally, through tools like webinars, E-learning and distance learning. In health, diagnosis and treatment from a distance using remote technologies are now being used to scale up, indeed in some cases this is the key component in the model which focuses on new delivery systems.

Virtual scaling up has the distinct advantage of requiring less capacity building to achieve greater reach, and is proving a valuable way of extending the reach of scarce human resources, such as medical expertise. It does have the drawback of losing the advantages of face-to-face communication, so that its net benefits have to be judged on a case-by-case basis; in models where tacit knowledge and intangibles

are important. Current limitations on reach to marginalized populations by technologies using the internet are coming down with innovative uses of cell phone technologies, which have wider coverage and users.

Monitoring can be used to track whether a project proceeding on schedule and within budget. It can also be used to track changes in the status of a target population on status measures or indicators of interest, including whether periodic performance targets are being met. A third use of monitoring in support of scaling up involves tracking whether an intervention is being delivered in line with plans for its delivery, or in the same way as it was delivered at the original site where its effectiveness triggered a scaling up effort. Monitoring is often described as a tool for determining "what" has occurred, including whether status measures for a population have changed. While monitoring tools are often good at detecting whether change occurred, monitoring data alone is usually insufficient for determining exactly what caused the changes that monitoring tools detect.

Evaluations are often distinguished from monitoring by their ability to answer "why" question and to otherwise establish the merit or worth of a project, or a narrower defined intervention. To this end, they utilize monitoring data, where it exists and is viewed as being credible, to describe changes that occurred over the period during which an intervention was delivered. Evaluations may examine why targets were not met or were exceeded, examining their realism as well as how project processes or external variables may have facilitated or impeded project efforts to achieve results. Evaluations can also go beyond well beyond evidence provided by a monitoring system about whether a population's status on outcome measures changed to test whether or to what degree the project intervention, rather than something else, "caused" those changes.

Annex C: 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 the treated outcomes are observed, the counterfactual outcomes are not observed. To measure program impacts, researchers use a variety of rigorous techniques to determine counterfactuals. The methods fall into two general categories, which are discussed below: randomized control trial 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 IE during the program's development stage makes it possible to arrange for the collection of baseline measures for key data elements prior the program's initiation. These efforts may include new surveys or other data collections 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 the 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 to the control group at the time of 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 (PBS).
- **Follow-up data:** The evaluator must collect information on participant outcomes (e.g., employment, wages, nutrition, health outcomes, 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 observed and

unobserved characteristics; thus any subsequent differences between the treatment outcomes and the 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 the control group 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 the start of FtF 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 the 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 be otherwise 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 will 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 real-world observation. Using this methodology, we will be able to observe and understand community effects of the FtF program. Lastly, we will conduct direct observations of the community. This method is ideal for

gaining a rapid assessment of behavior and environmental factors or potential problems that need to be addressed immediately in an IE design. These methods of data collection can also be made more rigorous by random selection of informants, for example when using direct observation to collect data on health service provision. Qualitative analysis techniques including content analysis, domain analysis, 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 meaning that participants ascribe to those concepts. This approach is well-suited for unstructured data capturing communication where participants can assign their own importance to the concepts being discussed. Participants indicate the relationships that they believe exist between concepts; these can be relationships such as causal, rationale, function, 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

An original or single site test of a hypothesis that determines, using the best available methods , 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 wasn't set up as a test unexpectedly turns out to be more effective or successful than anticipated. Technically what these two types of original intervention establish (or claims to have established) is called internal validity. Simply put, that means the project/program intervention worked, it produced the desired results.

Demonstrations

Proving that a project works in one site does not mean that it will work everywhere. At the original site, there were an enormous number of situational characteristics, e.g., poverty level, transportation system, political system, etc., as well as the organizational characteristics of the group that ran the project and characteristics of the program/project beneficiaries. As a group, that 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 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 people associated with the original program/project say were important. What second stage demonstrations test is called 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, providing the demonstration sites differ from the original site in ways that might be important, i.e., interfere with success in the demonstration environments. For example, differences in literacy or poverty rages between the pilot site 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 D: Scalability Assessment Tool Terms

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 than outputs, etc. it is often the case while pilots often are constrained to prove impact so "lower" levels of evidence are accepted, it is only if the logic connecting lower (outcomes) to 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 for a 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 as equivalent to an external evaluation or review.

3. The model is supported by eminent or credible individuals and institutions: Support or endorsements from eminent individuals or institutions help with advocacy efforts. These can be either recognized experts who confer legitimacy e.g. the Indian College of Medical Research or WHO, or well known, famous personalities who confer status, whether from the media, sports, politics or other fields, e.g. first ladies, the Indian actor/model Amitabh Bacchan's support for polio vaccine.

4. Model works in diverse social contexts or local conditions are irrelevant: By this we mean that the model works in diverse social contexts; in other words, the model has been successfully implemented in multiple and diverse settings. Institution in this case refers NOT to the organizations implementing the model, but to the 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; 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 validity and external validity. This 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)

5. Results are very 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 can't. Thus 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 empowerment of women or communities.

6. Results are clearly associated with the intervention: Easier to convince people if the impact is not just a byproduct but easily attributable to the model itself. This criteria emphasizes the fact that decisions to adopt and implement models are often not made, or only made, on the basis of objective, statistical evidence despite the 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 were not due to the intervention but other factors. While a good experimental or quasi-experimental design can address this for a technical audience, once again for a non-technical audience the ability to literally see the causal relationship can plan an important role. Examples of models which are difficult to scale up are those where there is impact with a lag or delay or the causal mechanisms is not straightforward e.g. effects of psychosocial development on childhood performance. Counterexamples are Oral Rehydration Therapy (salts) to reduce childhood diarrhea – direct, immediate, and simple causality.

7. **Logic of cause and effect is clear and easily accepted**. 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. Thus in India a model whose essence was to provide training in emergency obstetric care (EMOC) to district medical officers to lower maternal mortality and morbidity was approved by the Government of India to scale up without any evidence of impact. This was at least in part because the logic seemed compelling – there is a lack of EMOC in rural areas, so that if we train rural doctors in EMOC the supply of EMOC services will increase, more women will receive care, and MMR will decrease. As it turned out, there were several other assumptions that had to hold true in this case for this causal chain to achieve the desired outcomes, and in the event in many cases the assumptions were not valid.

8. **Operation and/or results of the model have a strong emotional appeal**. This criteria 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, a women who is bleeding to death revive and recover, can be more important than dry statistical evidence to many policy makers and other decision makers. Successful advocacy uses both scientific and other evidence, especially stories, photos, video/film and other media that are able to convey a clear emotional appeal.

9. 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 and affect them 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 sub-region. In health, for example, this would be something which is a leading cause of death or recognized as an easily preventable or treatable cause of death or disease with permanent debilitating affect. That is why tuberculosis, malaria and polio have all become major health priorities. In education, this might be levels of malnutrition and stunting in young children with permanent income on mental abilities. It is important to point out that just because an issue is objectively important does not mean that it already is a major priority. One of the actions that can come out of 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.

10. Addresses an issue 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 by the government is being considered, when government approval, funding or other role would 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 – in the current environment interventions which address maternal mortality – one of the MDGs – are easier to scale up than interventions which address the health of gay, lesbian, bisexual and transgender populations. Even when other methods of scaling up are being, it is a plus when those organizations and their constituencies already consider the issue a high priority and it is 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.

11. 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 grass roots support for interventions that address felt needs and 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 versus issues where the benefits are in the future e.g. preventive care, or there is no perception that the status quo could or should be different e.g. levels of infant or maternal mortality, number of births per family.

12. There is no foreseeable potential opposition from vested interests or social/cultural groups. Some issues or their solution–the intervention–can threaten vested interests or are 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 livelihood, even when they are already overburdened. In one example, having village health workers in rural areas give injections of antibiotics to newborns with sepsis was opposed by neonatologists even though there was no evidence of complications nor were there any neonatologists actually serving 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. Lack of opposition can increase the prospects for scaling up.

13. Current solutions for this issue are considered inadequate: Current solutions mean whatever programs or policies are already currently in place to address this 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 is no solution at all. If there are no current solutions in place, this refers to whether or not people think the lack of a solution is a problem e.g: providing child health interventions solely through facility based approaches.

14. Superior effectiveness to current solutions is clearly established: This criteria should be self-evident. If the model being proposed for scale up have evidence of greater impact or effectiveness than existing solutions, it is easier to scale up.

15. Superior effectiveness to other innovative models established: Advocacy of a particular model or solution must compete with other approaches for the same solution for the attention of policy makers. The model should be able to demonstrated success in achieving results, but also superiority over alternative approaches. It is important to establish some clear standardized criteria for comparison with a common denominator, which is preferably in terms of outcomes and impact.

16. Systems, infrastructure, transportation and access to services in target areas exist or are internal to the model itself. Interventions usually require certain external factors to be in place in order from them to be effective, especially if they are not comprehensive models. Thus in public health, interventions designed to increased demand for and utilization of services presume such services exist and are accessible or affordable. The same is true, with the converse logic, for interventions designed to increase the supply, access or affordability of services i.e. that there is latent unmet demand. In many cases these external conditions may have existed at small scale; it is important to verify that they exist at the targeted large scale location or demographic as well. Some models address this issue by being comprehensive in nature, creating or strengthening both the supply of and demand for services, and if necessary delivery mechanisms to connect the two.

17. Small departure from current practices and behaviors of target population: It is easier to implement a model if does not require significant changes from existing behaviors, beliefs and practices of the target population, clientele or beneficiaries of the model. E.g: counseling mothers on using food cooked for family to use as supplementary feeding for children, versus advocating meals cooked separately.

18. Front line implementers are willing and able to implement without additional incentives, motivation and capacity exist. The role and motivation of front-line implementers is a key issue in

scaling up that is often overlooked in the scaling up process. Many small scale interventions are successful because they either pay extra; hire highly motivated, mission driven staff; provide gifts, status or other non-financial means of reward or recognition. They also often use their own implementing staff whom are not burdened with multiple other tasks and competing demands on their time. For scaling up to be successful, these same conditions need to be replicated at scale or other ways of dealing with the motivation and workload issue need to be addressed.

19. Easily 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. can be grafted on to them, then if they require the creation of a whole new infrastructure, organizations, management and systems. This is because investing in new systems and infrastructure is usually expensive and potentially 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.

20. Small departure from current practices and culture of adopting organization(s) and is supported by key internal players: This differs from criteria #1'9 in that it concerns the intervention's compatibility with the adopting organizations culture and practice, as opposed to physical infrastructure and resources. These refer to the norms, values, and organizational culture of an organization, the way they do business normally. It is easier to implement a model if does not require significant changes from existing behaviors, beliefs and practices of the organization that will implement the model at scale. Examples: in a government system that emphasizes delivery of curative medical services, introducing community mobilization, treating clients with respect and dignity, preventive services, or working with and through non-professional village health workers might require a substantial change in culture or norms. It is important to note that even in the case of expansion, where the organization is the same, a major challenge may be in maintaining the organizational culture, practices and roles as the organization grows. This criteria also assess the extent to which adoption/scaling of the model is likely to meet internal opposition or resistance, or support, within the adopting or expanding organization.

21. Demonstrated effectiveness in organizational settings similar to intended adopting organizations. Compatibility with existing systems and infrastructure and with existing organizational culture is best demonstrated by actual evidence in those types of settings. This can help convince those organizations and skeptics in general that the intervention will work, and serves as a strong counterweight to the "not invented here" argument. This means there is evidence that the model has had similar impact when implemented in multiple and diverse organizational settings, whether NGO, govt. or private sector, or a tertiary, secondary or primary facility in health. It is targeting the fact that those diverse settings often have very different organizational cultures and objective organizational capabilities. Capabilities refers to the variance in quality in terms of infrastructure, equipment, supplies, and effectiveness of the organization that is implementing the model. Both include the variance of culture and capabilities within an organization, such as the quality of health care services offered across the public health system. The more robust and resilient the model is, and the impact it can achieve across large scale implementing

organizations the easier it is to scale up.

22. Intervention is largely content intensive, little emphasis on process or values, few process components. Value or process are defined as models that focus on tacit knowledge i.e. how things are done or delivered versus technical content (which focuses on drugs, equipment, procedures, information such as in changing attitudes knowledge, attitudes 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 or teach others to do; and (c) are often a substantial departure from existing practice 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; free play in early childhood education vs. lectures and rote learning.

23. Low 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 investment in 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, don't require cold chains, are the same dosage regardless of body weight, and don't need monitoring of potential negative after effects are easier to scale up than those where all of these things require a number of complex decision points.

24. Model requires little or no monitoring, supervision or follow-up to achieve impact. This is complementary to the criteria of motivation and incentives. An alternative to motivated an incentivized staff is a lot of monitoring and supervision. 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.

25. Low complexity; simple with few components. This means both the number of parts (many) and the ease with which someone can understand individual parts and how they relate to each other. The fewer and simpler the model, the easier it is to scale up. A new drug (assuming it can be delivered by existing systems, is simpler to scale up than an expanded essential drug list, even though both are largely technology intensive.

26. Model requires little up-front preparation both in terms of time and effort. Many models require long lead in times in which permission is obtained from gatekeepers and leaders, and acceptance and buy-in has to be created with participants, beneficiaries and community leaders. In some cases this can take a year or more, in other cases it is invisible because piloting organizations have already established trust and credibility based on long-term relationships and presence in the localities in which they work.

Regardless, models which require building of trust, relationship, permission from gatekeepers are harder to scale up or at least take much longer.

27. Skill building and training necessary for implementation is quick and easily done. Models vary widely in terms of not only the pre-conditions necessary before a model is implemented, but the training, skill building and general capability building required of front-line implementers, supervisors and other staff. Capacity building is time, effort and resource-intensive and often difficult to replicate at scale where all three of these elements are scarce. Models which require long and intensive training periods for staff are more difficult to scale up and also face opposition from potential adopters because of the costs, broadly defined, involved.

28. Able to be tested by users on a limited scale: This means that organizations that are interested in adopting the model could run their own pilots without having to commit substantial resources to see if it works or to change their entire organization to try it. Models that are not testable at small scale tend to be ones that benefit from economies of scale or scope, such as insurance.

29. Intervention will retain impact even if implemented with lesser quality, lack of fidelity. This is a measure of how sensitive the results of the model are to fidelity or to implementing the model exactly as it is designed. For some models, perfect adherence to procedures, processes and protocols are necessary, for others there is more flexibility. Since at scale in most cases quality and fidelity deteriorate somewhat, models that require fidelity are less scalable, and either require being less ambitious about the impact to be achieved at scale or more effort to ensure quality and fidelity, which can be costly in multiple dimensions.

30. Unit cost or cost per participant, beneficiary or location has been calculated and is within feasible budgetary envelopes of potential funders. Many interventions do not calculate the unit cost or some other measure of impact per resources spent. At best, they do simple calculations such as the total project budget divided by number of beneficiaries, communities, etc. which often underestimates costs by ignoring contributions of management and technical assistance or 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 available resources and the objective need can make or break an intervention in terms of scalability.

31. Superior cost-effectiveness to existing and competing solutions clearly established. Models need not only be more effective than existing or competing solutions to have a good 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.

32. The model itself 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 funding in the model and not the project which piloted the model. It means that the model includes some way internal to the model of recovering its costs –user fees, profit margins on goods or services provided, etc. Overall funding for this sector is a priority and growing, even to the extent of unspent funds: Funding refers to public sector funding for the general sector in which the model works, e.g. health, education, livelihoods, poverty, women and children. When thinking about this issue, it is worth considering if there are alternative sources of funding.

Annex E: Blank Tools and Forms

Tool 1.1.1 Modified Log Frame

Goals	Outcomes	Outputs	Activities

Tool 1.1.2 Model Elements

Technical Elements	Process Elements	Context Elements	Values Elements

Organizational Type and Scale Form

Original Organization Type and Scale							
Government				Private Sector			
National Ministry		State Agency		Not for Profit		For Profit	
Years of Operation (Total)							
Less than 3		3-5		6-10		More than 10	
Annual Budget of Original Organization							
Prior Year (in U.S. $)				Average Annual Budget – Past Three Years			
Location of Outlets (Total)							
All in one District		In Multiple Districts, One State/Province		In Multiple States/Provinces, but not All		In All States/Provinces, National	
Duration of Model or Innovation (in years)							
Less than 2		2-5		6-10		More than 10	
Budget Dedicated to Applying/Implementing the Model or Innovation							
Budget in Year Model or Innovation was Introduced (in U.S. $)				Percent of Total Budget that Year			
Latest Full Year Budget if different from Introductory Year (in U.S. $)				Percent of Total Budget in Latest Full Year			

Which of the following best describes the sources of funding the organization used to finance the introduction and use of the Model or Innovation?	
Options	*Mark All Relevant Options*
a. Financed internally from an allocation from the general revenues or budget allocation of the organization	
b. Self-financed on a fee for service basis	
c. Special resources for this purpose provided to the organization from national or local government sources	
d. Foreign assistance donor resources provided for this purpose provided by one or more foreign government, foundation or corporation	
e. National donor resources provided for this purpose provided by one or more local foundation or corporation.	
Provide any important additional comments on the method used to finance the introduction and use of the model or innovation in the space below.	

Number of People Affected by or Receiving Service Delivered via the Model or Innovation During the Previous 12 months (Total, all service sites)							
Men		Women		Children under Age 12		Total	
Average Number Served Per Service Organization Unit/Location during previous 12 months (total population served divided by number of service sites delivering services via "Model under review -- complete only if multiple sites provided services via the "Model" under review)							
Men		Women		Children under Age 12		Total	
Professional Staff Hours per Day Applying or Delivering Services using Model or Innovation (at original site or for average site if multiple delivery sites deliver services using the Model or Innovation)							
Total number Providing Service via "Model" in any week, all locations		FTE days per week at all locations, i.e., sum of hours of FT + PT ÷ by number of staff[9]		Average number working in each location		FTE equivalent average for one location	
Cross check total staff hours cited by original organization against four previous times of staff time. If there is a difference, i.e., more that the total of the four previous types of staff time, identify the additional types of staff time included in the total on the line below.							
Which of the following best describes the organization's monitoring and evaluation of its introduction of the Model or Innovation							
Options						*Mark All Relevant Options*	
a. The organization did not monitor or evaluate the introduction of the Model or Innovation in any structured way.							
b. The organization monitored the introduction of the Model or Innovation against a timeline and set of implementation benchmarks it established before implementation began.							
c. The organization evaluated the introduction of the Model or Innovation for the purpose of determining whether it was as effective or more effective than previous practices.							
d. The organization evaluated the introduction of the Model or Innovation for the purpose of determining whether it was as cost-effective or more cost-effective than previous practices.							
Provide any important additional comments on the monitoring and evaluation of introduction of the model or innovation in the space below.							

[9] Example: Ten professionals, of whom four work 8 hour days and six work 4 hour days (half time) on services involved in the "Model" under review: Total hours per day for all ten = 56, divided by 10 = 7 FTE per day.

In the view of the organization's leadership, in what ways is the Model or Innovation a significant improvement over past practice?
In the view of the organization's leadership, what aspects of the organization's vision, values or culture, if any, contributed to the successful development and implementation of the Model or Innovation?
In the view of the organization's technical/supervisory staff, in what ways is the Model or Innovation a significant improvement over past practice?
In the view of the 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 or Innovation?
In the view of the organization's front line service/delivery staff, in what ways is the Model or Innovation a significant improvement over past practice?
In the view of the 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 or Innovation?
Which of the following best describes the interest/commitment of the organization's leadership to scaling up the Model or Innovation *(check one)*

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

Provide any important additional comments on the interest and commitment of the organization's leadership to scaling up in the space below.

Which of the following best describes the original organization's view of its capacity of for scaling up the Model or Innovation *(check one)*	
a. Very limited capacity to scale up or teach others how to do so	
b. Some capacity for teaching others how to scale up the Model or Innovation, but little if any organization capacity to actually do it	
c. Limited capacity to scale up the Model or Innovation and an ability to support that process with training.	
d. Strong capacity for scaling up the Model or Innovation and conducting necessary training along the way.	
Provide any important additional comments on the organization's ability to scale up the Model or Innovation in the space below.	
What is the decision-making process, or on whose authority would a decision to scale up the Model or Innovation or allow others to scale it up depend? *(e.g., the CEO; a board of directors if one exists; a broad group of technical and leadership personnel in the organization, etc.)*	
What if any conditions has the original organization place on scaling up its Model or Innovation, e.g., payment for ownership rights, will only authorize scaling up through private sector or non-profit channels, etc.?	

Tool 1.2 Scalability Assessment Tool (SAT)

Characteristics of the Model	A		B		C
	☺		😐		☹
		Simplifying Factor		**Complicating Factor**	
I. Is the model credible? (1-4)		• Based on statistically significant evidence of substantial impact		Little or no convincing statistically significant evidence of impact, or impact is not substantial	
		• Evaluated by independent, respected and reliable sources		Not evaluated by independent sources	
		• Supported by individuals and institutions who have status or confer legitimacy		Not supported by respected individuals and institutions who have status or confer legitimacy	
		• Evidence that the model works in diverse social contexts or strong case that local social conditions are irrelevant		Little or no evidence that the model works in diverse social contexts, model appears sensitive to local conditions	
II. How observable are the model's results? (5-8)		• Results are very visible to casual observation; tangible and easily communicated		Not very visible; not easily communicated, little emotional appeal.	
		• Results are clearly associated (causally) with the intervention		Only indirectly or speculatively associated with the intervention	
		• Logic of cause-effect of actions-results is clear and commonly accepted		Underling logic is not transparent or not commonly accepted	
		• Operation and/or results of the model have a strong emotional appeal		Results have little emotional appeal or evidence demonstrating that appeal hasn't been collected	
III.How relevant is the model? (9-12)		• Addresses a significant objective, persistent issue		Addresses a temporary or minor problem with little evidence	

		• Addresses an issue currently a high priority to potential adopters and is aligned with organizational goals, mission and vision; socially important		The issue the model addresses is a low organizational priority or not aligned with mission, vision or the policy agenda; low social importance	
		• Addresses a need sharply felt by potential beneficiaries or participants in the target area		Addresses an issue not perceived to be important by beneficiaries or participants	
		• There is no foreseeable potential opposition from vested interests, social/cultural groups		Scaling up of the model is likely to threaten existing vested interests or identifiable social or cultural groups	
IV.Does the model have clear advantage over existing practices? (13-15)		• Current solutions are considered inadequate		Current solutions are considered adequate and effective	
		• Superior effectiveness to current solutions established		Little or no objective evidence of superiority to current solutions	
		• Superior effectiveness to alternative or competing solutions has been established		Little or no objective evidence of superior effectiveness to competing solutions	
V. How easy is the model to transfer and adopt? (16- 27)		• Systems, infrastructure, transportation and access to services in target areas are compatible with the needs of the model or internal to it		Systems, infrastructure, transportation and access to services in target areas are weak, lacking or incompatible with the needs of the intervention	
		• The model represents a small departure from current culture, practices and behaviors for target beneficiaries or participants		The model represents a large departure from the current culture, practices and behaviors of target beneficiaries or participants	
		• Front line implementers are willing and able to implement the model without additional incentives or motivation		The model requires the use of additional incentives or other types of motivation for front line implementers	

		• Easily implementable within the existing organizational capabilities, systems, infrastructure and human resources		Requires a new delivery system or substantial strengthening of existing capabilities, systems, infrastructure and human resources	
		• Small departure from current culture, practices and roles of intended adopting organizations. Aligns with self-interest of key organizational players.		Large departure from current culture, practices and roles of intended adopting organizations. Threatens internal vested interests and methods.	
		• Demonstrated effectiveness in organizational settings similar to intended adopting organizations		The intended adopting organizations appear to be significantly different in important ways, Effectiveness not demonstrated in those kinds of settings	
		• Intervention is largely content intensive, little emphasis on process or values, few process components		Process and/or values component are important to successful impact	
		• Low technical sophistication of the model and its components		High technical sophistication of the model itself	
		• Model requires little or no monitoring, supervision or follow-up to achieve impact		Model requires extensive monitoring supervision or follow-up to achieve impact	
		• Low complexity; simple with few components		High complexity with many components; comprehensive, integrated package	
		• Model requires little up-front preparation both in terms of time and effort		Model requires extensive preparation phase, including generating acceptance and buy-in by local leadership, participants and implementers	
		• Skill building and training necessary for implementation is quickly and easily done		Skill building and training necessary for implementation is time-consuming, effort-intensive, or both	

VI.How Testable is the Model?(28-29)		• The model can be tried by potential adopters at small scale without incurring substantial costs.		The model requires large scale (economies of scale) to be effective.	
VII. How affordable is the model? (29-32)		• Intervention will retain significant impact even if implemented with fewer components, lower quality, or lack of full fidelity		Components are interdependent; Impact will decline substantially if the entire model is not implemented or implemented with quality and fidelity	
		• Unit cost or cost per participant, beneficiary or location has been calculated and is within feasible budget envelopes of potential funders		Unit cost or cost per participant, beneficiary or location has NOT been calculated or calculation is rudimentary. Cost at scale is significantly greater than available resources.	
		• Superior cost-effectiveness to existing and competing solutions clearly established		Little or no objective evidence of superiority to existing or competing solutions in cost- effectiveness	
		• Fully funded by internal cost recovery or a dedicated long-term sustainable funding source, or overall funding for this sector is a priority		No internal cost recovery, relies 100% on short-term external (donor) funds	
Total # of Checks:					

Tool 2.1: Stakeholder Analysis Table

GROUP	GROUP'S INTEREST IN ISSUE	RESOURCES AVAILABLE	RESOURCE MOBILIZATION CAPACITY	POSITION ON ISSUE