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THE POLICY DIMENSIONS OF SCALING UP HEALTH INITIATIVES

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This publication was prepared by Karen Hardee, Lori Ashford (consultant), Elizabeth Rottach, Rima Jolivet, and Rachel Kiesel of the Health Policy Project.



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The Policy Dimensions of Scaling Up Health Initiatives

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This publication was prepared by Karen Hardee,¹ Lori Ashford (consultant), Elisabeth Rottach,¹ Rima Jolivet,² and Rachel Kiesel¹ of the Health Policy Project.

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Introduction

Adopting new practices in health on a large scale requires systematic approaches to planning, implementation, and follow-up; and often calls for profound and lasting changes in health systems. Any systematic approach must include addressing the policy dimensions of scaling up. Without attention to the policies that underlie health systems and health services, the scale-up of promising pilot projects is not likely to succeed and be sustained.

Interest in scale-up has grown in recent years because of an increased urgency to rapidly expand effective interventions to improve the health of mothers, children, and families, particularly the poor and underserved. This paper focuses on efforts to scale up interventions in family planning, reproductive health, and maternal, neonatal, and child health in developing countries. It defines “scale-up” and describes some of the frameworks and approaches to scaling up found in recent health literature and how they address policy. The paper also reviews the experience of selected organizations in scaling up best practices and how they have addressed policy issues.

Often, frameworks for scaling up mention policies only in passing, as if addressing policy were a single step. Few scale-up frameworks and methodologies offer systematic guidance on identifying and addressing policy issues at each phase of scale-up, from planning through implementation, and on monitoring and evaluation for sustainability. Similarly, many programs tend to focus more on expansion than on institutionalization of new practices. As a result, program planners may fail to pay attention to policy throughout the health system, which is essential for programs to be successfully established and sustained.

“Policy” should be understood as more than a national law or health policy that supports a program or intervention. Operational policies are the rules, regulations, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services. The policy process encompasses decisions made at a national or decentralized level (including funding decisions) that affect whether and how services are delivered. Thus, attention must be paid to policies at multiple levels of the health system *and* over time to ensure sustainable scale-up. A supportive policy environment will facilitate the scale-up of health interventions.

This paper does not replace the valuable guides that are available for scaling up health innovations. Rather, it focuses on lessons learned related to policy implementation associated with scaling up and outlines key actions to ensure supportive policies, regardless of the scale-up model or approach used.

The Challenge of Scaling Up

Recent global initiatives in health have drawn attention to the need to use evidence-based practices to effectively make improvements in health. Much of the evidence about what works, however, comes from projects undertaken on a small scale in controlled environments where funding and technical assistance have been sufficient to support implementation and measure results. To be applied to larger and more diverse populations, the tested interventions need to be implemented on a larger scale, in complex health systems. This poses a challenge. Thus, interest in the topic of scale-up has grown tremendously in recent years, and a large body of publications on the science and practice of scaling up are now available.

Definition of Scale-Up

The term “scale-up” is used widely in the global health literature and generally means to expand an intervention or activity. A more comprehensive definition has been developed by ExpandNet, a global network of public health professionals that grew out of a World Health Organization (WHO) initiative to strengthen reproductive health programs in developing countries.¹ Writing for ExpandNet, Simmons and colleagues (2007, p. vii–xvii) defined **scale-up** as

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

“Deliberate efforts” refer to a planned and guided process, which is necessary because large-scale change in any system rarely happens automatically. The definition also refers to innovations or new practices that have been “successfully tested” (i.e., proved efficient in a controlled trial or a demonstration project). Interventions that have locally generated evidence of effectiveness and feasibility are more likely to be successfully scaled up than those that have not been tested. Finally, “on a lasting basis” means that institutional capacity building and sustainability are essential (Simmons et al., 2007).

“Going to scale” is often interpreted to mean increasing geographic coverage from a limited study area to an entire region or country. In practice, efforts to scale up health interventions can take on different forms and move in multiple directions. Although **spontaneous scale-up** is possible, scale-up models focus on planned expansion and institutionalization of health interventions. **Vertical scale-up**, according to ExpandNet, involves institutionalizing an innovation through policy, regulatory, budgetary, or other health system changes. Often, policies and norms adopted at the national or ministerial level must move through all of the levels of a decentralized system to become standard practice. **Horizontal scale-up**, sometimes also called “spread,” involves replicating an intervention in different geographic sites or extending it to a wider area. Moving in this direction also does not happen automatically, because health managers and providers in different settings are likely to have varying levels of skills and experience or because clients’ needs may differ. **Functional scale-up**, or “diversification,” involves testing or adding a new innovation to an existing one. Scaling up may be

An important aspect of scaling up includes institutionalizing an intervention through policy, regulatory, budgetary, or other health system changes.

¹ See www.expandnet.net.

best considered through the lens of viewing a health system as a complex adaptive system, best addressed through flexible planning and implementation (Paina and Peters, 2011).

Two important prerequisites of scale-up are that the health intervention has been proven effective and that important stakeholders generally agree that it is worthy of scaling up. Such an intervention may be referred to as a **best practice**, which the WHO defines as “a technique or methodology that, through experience and research, has proven reliably to lead to a desired result” (WHO, 2008). USAID has placed priority on scaling up **high-impact practices**, defined as those that “demonstrate correlation with improved health behaviors and/or outcomes” (USAID, 2011), and **high-impact interventions** in maternal health (USAID, nd). Examples of such practices in family planning and maternal health include providing family planning counseling and methods as part of postpartum and postabortion care; screening pregnant women for malaria and providing them with bed nets for malaria prevention; and providing active management of the third stage of labor to prevent postpartum hemorrhage. Scaling up even relatively simple practices can be a complex process. Some examples of scale-up efforts are described on pages 11–15 of this paper.

Frameworks and Approaches for Scale-Up

Many frameworks and approaches for scaling up health interventions have been developed and tested in recent years. Some of those used in family planning and maternal and child health are described here and summarized in Table 1 (page 4). A few frameworks, such as those used by ExpandNet and the Maternal and Child Health Integrated Project (MCHIP), deal explicitly with policy issues, while others focus on changing practices among service providers and their managers, with only a brief mention of policy. The following are examples:

WHO/ExpandNet (2007) has developed a framework that links five elements: (1) the innovation itself; (2) the individuals and institutions facilitating its wider use (the resource team); (3) the scale-up strategy (horizontal, vertical, and functional); (4) the users of the innovation; and (5) the environment in which scale-up is taking place. Typically, expansion alone is insufficient to ensure that an innovation is fully integrated into the user organization. To be sustainable, scale-up must address both horizontal and vertical dimensions of diffusion (WHO/ExpandNet, 2009). Vertical scale-up requires policy, legal, political regulatory, budgetary, and other health system changes to ensure an innovation will be institutionalized (Simmons et al., 2010). For each type of scale-up, choices must be made related to dissemination and advocacy, organizational processes, resource mobilization, and monitoring and evaluation. The Institute for Reproductive Health’s FAM Project is using the ExpandNet framework to pursue both horizontal and vertical scale-up of fertility awareness-based methods of family planning in five countries (IRH, 2011a). This effort is described in more detail on page 11.

MCHIP, the USAID Bureau for Global Health’s flagship maternal, neonatal, and child health program, has developed a framework illustrating the pathway to implementing proven interventions (e.g., postpartum hemorrhage and pre-eclampsia and eclampsia) at scale through global actions, national strategic choices, program implementation, and sustainability of the intervention within the health system (Fujioka and Smith, 2011). Implementation of scale-up, broken into introduction, early, and mature phases, is guided by a readiness assessment of: health system governance; policy; service delivery capacity; health working capacity/training; and drugs/equipment. These components are monitored (and addressed again, if necessary) during the various phases of implementation. Scale-up using this

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framework is planned or underway in more than 30 priority countries where maternal mortality is highest. Progress is summarized on page 12.

The **Implementing Best Practices Consortium** (2007) developed the *Guide for Fostering Change to Scale Up Effective Health Services*, which includes five phases: (1) forming a change-coordination team; (2) defining the need for change; (3) planning for demonstration and scale-up; (4) supporting the demonstration; and (5) going to scale. The guide focuses on bringing about change at the service delivery level—in clinical practices, health providers’ behaviors and practices, management practices, and management systems. The fifth phase, “going to scale,” includes expansion (horizontal) and political (vertical) scale-up but does not elaborate on the policy changes needed or how to bring them about. The USAID-funded Extending Service Delivery (ESD) Project introduced this methodology to six country teams in USAID’s Asia and Middle East region to help them develop action plans (Bitar, 2011a).

The **Improvement Collaborative Approach**, developed by the Institute for Healthcare Improvement in the United States and adapted by the University Research Co. for developing countries, involves teams of health professionals working together to improve certain components of the health system (Massoud et al., 2010). The approach focuses on a single technical area, develops a time-limited strategy (i.e., 1–2 years), and spreads existing knowledge to multiple settings by involving a large number of teams. It is based on the premise that teamwork and learning from others are central to creating the conditions for breakthrough improvements and spread. In Indonesia, for example, the ESD Project assisted the Ministry of Health with using this approach to scale up a supervision system for emergency obstetric and neonatal services (Bitar, 2011a).

No single approach to scale-up is the “right” approach; however, many different strategies could potentially be successful, depending on the intervention and the context (Massoud et al., 2010; Yamey, 2011). What the approaches have in common is phases that address planning, implementation, consolidation, and sustainability. The approaches also highlight the need to be systematic, involve a wide range of stakeholders, and adapt according to local needs (see lessons on page 16).

Table 1: Selected Frameworks and Approaches for Scaling Up Health Interventions

Names/Authors	Description	How policy is addressed
ExpandNet/ WHO Framework (Simmons et al., 2007, 2010)	Framework elements include the innovation, resource team, scale-up strategy, user organizations, and the environment. Scale-up strategies include vertical, horizontal, functional, and spontaneous.	Vertical scale-up requires policy, legal, regulatory, budgetary, and other health system changes to ensure an innovation will be institutionalized. The framework includes analysis and action related to policy advocacy and policy reforms.
Maternal and Child Health Improvement Program Framework (Fujioka and Smith, 2011)	A conceptual map of the pathway to scale-up that includes global actions, national strategic choices, program implementation, and sustainability (institutionalization). Monitoring and evaluation is an integral part of the scale-up process.	Addresses reforms in policies and health systems needed for scale-up to be sustainable. Policies are addressed first in the readiness assessment prior to scale-up and are monitored (and addressed again, if necessary) during the various phases of implementation.

Implementing Best Practices Consortium, Guide for Fostering Change (2007)	A phased approach to scale-up, including forming the change coordination team; defining the need for change; planning for demonstration and scale-up; supporting the demonstration; and going to scale.	Limited attention to policy; focused on service providers and managers.
From Vision to Large-Scale Change: A Management Framework (Cooley and Kohl, 2006).	Framework with 10 tasks under the categories of developing a plan; establishing the preconditions for scale-up; and scaling up. Includes such tasks as legitimizing change, building a constituency, mobilizing resources, and modifying organizational structures.	Defines policy adoption as one type of scale-up. "Policy projects" focus explicitly on bringing about changes in public policy; they target policymakers and do not typically include direct provision of services.
Improvement Collaborative Approach (USAID, Healthcare Improvement Project)	An approach to improving healthcare that focuses on a single technical area and spreads existing knowledge or best practices to multiple settings through teams of professionals.	Calls on users to implement supportive policies and address policy barriers, as needed.
Options for Large-Scale Spread of High Impact Interventions (Massoud et al, 2010)	Presents the scientific basis for spreading healthcare innovations based on 20 years experience in quality improvement. Illustrates a range of approaches to promote change: affinity group approach; campaign approach; executive mandates; extension agents; emergency mobilization; improvement collaborative approach; leadership development; and natural diffusion.	Addresses operational policy issues.

Barriers to Scale-Up

Many barriers can inhibit the adoption of best practices even when there is widespread agreement about the merits of an intervention² (Mangham and Hanson, 2010; Koblinsky et al., 2006; McCannon et al., 2007; Kohl, 2010). The barriers may present themselves at many levels of the health system. Even in

Scale-up requires ensuring effective policies are in place at all levels of a health system.

countries in which the private sector is active in providing healthcare, governments maintain responsibility for health sector planning and programming. Officials and staff of central health ministries often struggle with managing an information overload, competing priorities, and large health budgets and external aid. Financial resources are extremely limited

in developing countries, and resources are often poorly or inequitably distributed among regions and urban/rural areas. Thus, the following obstacles to scaling up and adopting best practices can be formidable:

- **Resource mobilization challenges**, such as constrained budgets, weak or no insurance mechanisms, and inability to collect fees.

² Gender is an important factor in scale-up (see Rottach et al., 2012).

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- **Weaknesses in infrastructure and support systems**, including infrastructure and equipment; drugs, supplies, and logistics systems; transportation and vehicles; health information systems; and coordination and referral mechanisms.
- **Lack of qualified managers and staff** (too few and poorly distributed), low level of technical knowledge and inadequate supervision, inadequate pre-service education and in-service training, low motivation, and weak performance incentives.
- **Laws, policies, and regulations**, such as import restrictions, licensing, user fees, technical standards, and service protocols that conflict with or inhibit adoption of a new practice.
- **Lack of clear policies** guiding all levels of the health system related to program implementation.
- **Cultural sensitivity or resistance** to a new policy or practice (among policymakers, providers, and clients).

Many barriers listed above stem from the policy environment surrounding health services or specific policies governing how services are delivered. For example, management bottlenecks related to hiring, firing, and reassigning staff are sometimes rooted in personnel rules and regulations (see Box 1 on page 10). Even cultural barriers, such as opposition to certain methods of contraception or women's preference to give birth at home, can manifest themselves in policies, laws, and bias among decisionmakers and therefore need to be addressed at a policy level. The relevant decisionmakers at the national, regional, and local levels must be convinced of the benefits of the health intervention(s), and policy hurdles must be overcome before new practices can be adopted and sustained on a wide scale. Thus, policy plays a crucial role in scaling up and sustaining health interventions.

"Policies and plans are essential for supporting program scale-up and sustainability—by setting standards, outlining roles and responsibilities, establishing coordination and monitoring mechanisms, guiding resource decision making and fostering continuity" (Health Policy Initiative, Task Order 1, 2010, p. 34).

Yet, few of the scale-up frameworks and methodologies offer systematic guidance for how to ensure effective policies are in place *at all levels* of a health system. This entails assessing the policy environment, identifying policies that pose barriers or enable scale-up, and taking action to ensure enabling policies are in place at all levels of the health system.

Understanding the Policy Dimensions of Scale-Up

Any widespread change in health services requires changes in health policies and systems if the new practice is to be institutionalized and sustained. Too often, the word “policy” is equated with national declarations and laws adopted by central governments and passed by parliaments. These are only one facet of policy, however.

The policy framework in Figure 1 illustrates how the adoption of a new practice requires policy reforms at many levels—from macro-level policies (often referred to as “Big P” policies) to micro-level protocols, norms, and standards of care (the “little p” policies). Policies, ranging from national policies to rules, regulations, guidelines, operating procedures, and administrative norms (Cross et al., 2001) not only guide a health system to improve health outcomes but are also the mortar that bind the health systems building blocks (WHO, 2007) together. The building blocks include service delivery, the health workforce, information, medical products and technologies, financing, and leadership and governance.³ The system in Figure 1 is shown as linear for ease of illustration; in fact, the system could be considered a complex adaptive system (Paina and Peters, 2011) with many feedback loops.

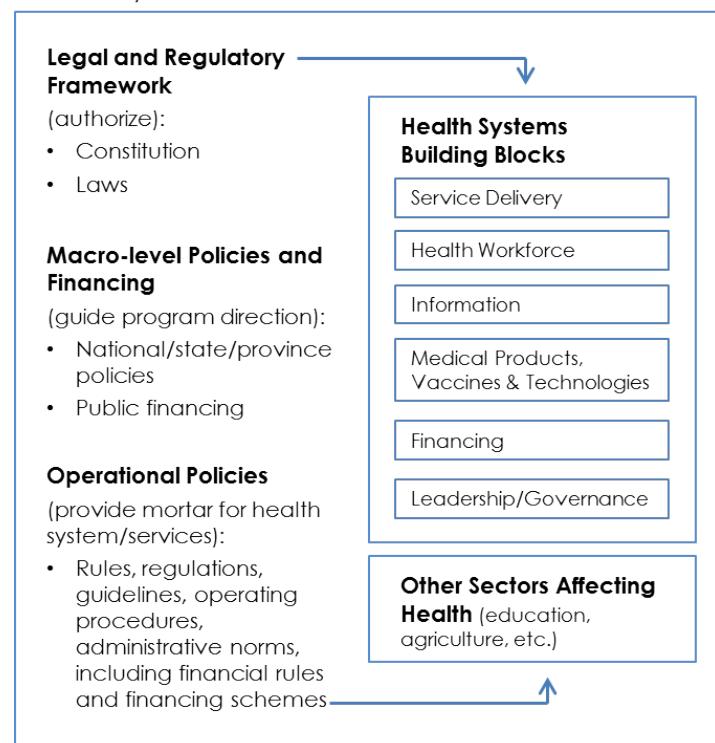
Macro-Level Policy

At the macro level, national laws and policies (or state/province laws in decentralized systems) provide overall guidance for the health system. The legal and regulatory level is important for authorizing macro policies. For example, constitutional provisions or other laws may establish healthcare as a right or mandate that certain health services be available (or prohibited). Macro-level (national/state/provincial) health policies usually define the goals, objectives, and desired outcomes of health services.

Macro-level health policies are often spelled out in multiyear strategic plans that set priorities and outline how health goals are to be achieved. In many developing countries, strategies for the health sector are guided by sector-wide approaches and related funding arrangements, such as poverty reduction strategy papers. These arrangements establish partnerships between the government and donors and tie streams of funding to a set of agreed-on outcomes. These macro-level plans usually do not delve into the implementation details of specific health services.

Figure 1: Policy and Health Systems

Policy Levels → Health and Other Sectors



³ It could also be argued that an important building block of the health system is demand for services among the population.

To put macro-level health policies into practice, action plans and regulations outline *what, how, who, when, and where* resources and efforts are needed. In each country, the names of the plans and who has authority over them may differ. One important step is to ensure that the health intervention to be scaled up is added to the national health action plan or that the problem it addresses is identified as a national priority in the strategy.

Macro-level financing encompasses the financial, human, material, and other resources needed to carry out plans. The processes for determining the budget and resource allocation for the health sector are central to health policymaking everywhere. National health budgets may contain specific line items or directives regarding how funds are meant to be used, or they may grant lump sums to regions or districts, devolving resource-allocation responsibility to lower levels of the system.

Operational Policies—the Mortar of the Health System

Many policy constraints that prevent the adoption of new practices occur in the vast arena between national policies and the point of service delivery—a domain that we call “operational policies.” These two facets of policies are sometimes informally referred to as the “Big P” and “little p” of policy.

Operational policies are the rules, regulations, codes, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services (Cross et al., 2001). These policies can be found at every level in the health system, and their consequences can be seen in every service delivery outlet because they govern how resources such as personnel, commodities, equipment, and transportation are deployed. Many constraints to scale-up occur at an operational level but have *roots* in policy and thus can be considered operational policy barriers.

Policies not only guide a health system to improve health outcomes but are also the mortar that bind the components of a health system together by translating national policies into rules, regulations, guidelines, operating procedures, and administrative norms.

Operational barriers can stem from policies that are presumed to exist but do not, as well as from policies that are misguided or poorly designed. These barriers create conditions that are burdensome, conflicting, outmoded, or difficult to change—adversely affecting the quality of services and efforts to improve them. While it may be possible to work around such barriers in the context of a pilot project, when programs go to scale, operational policies must be addressed.

The following are examples of **operational policy barriers** related to five of the health system building blocks:

- **Service delivery:** Restrictions regarding the age or marital status of young people seeking reproductive health services. Parity requirements for long-term or permanent contraceptive methods.
- **Health workforce:** Requirements that doctors perform services that nurses can be trained to perform.
- **Information:** Forms and registers that service providers are required to complete due to outdated regulations no longer provide useful information. Lack of regulations authorizing vertical health programs to share patient and service delivery information with other health facilities or specialty

areas (e.g., no requirement to collect data from or about clients related to gender-based violence, resulting in a lack of understanding of the scope of the problem).

- **Medical products:** Inability to obtain drugs and supplies because of import restrictions or procurement policies and processes. Contraceptives missing from essential drug lists or official procurement lists.
- **Financing:** Vehicles that are available but in disrepair because the budget for maintaining them falls under another authority.

The health system building blocks are all governed by laws, policies, and regulations. Human and material resources, health information systems, commodities and logistics, and monitoring and evaluation plans all have rules and requirements associated with them (see examples in Box 1).

At the service delivery level, service guidelines and protocols govern the care that is provided. These guidelines might contain new or revised elements of training and supervision or establish lines of accountability between staff and managers. Ideally, they are developed with input from the staff and disseminated widely.

The policy areas listed above and in Box 1 are illustrative. Laws, policies, and regulations differ from one country to another, and program planners will not necessarily need to address issues in all of these areas when going to scale. However, planners should carefully examine the policy environment to determine *which* policies need to be reformed before moving forward.

Box 1: Levels of Policies Governing Health Services

Legal and Regulatory Framework

- Constitution
- National laws concerning health and healthcare provision
- Constitutional provisions and human rights guarantees

Macro-Level Policies and Financing

- National/state/province health policies and sector-wide plans
- Public resources for health

Operational Policies

- *Health Financing*⁴
 - Budget—the amount of funds available and how they may be spent
 - Taxes and duties—excise, import, value-added tax, and exemptions
 - Insurance schemes and funding pools—public or private
- *Health Sector Regulations*
 - Licensing and accreditation and scope of practice regulation, standards of care for health facilities and pharmacies, and health personnel
 - Education and training standards—admissions, curricula, and standards in schools of medicine, nursing, midwives, and auxiliaries
 - Personnel—rules for hiring, firing, and transfer; and pay and incentives
- *Health Systems Management*⁵
 - Personnel—performance monitoring, supervision, lines of authority, task shifting
 - Transportation/vehicles—resources and rules for obtaining and maintaining them
 - Information systems—requirements for reporting, monitoring, and evaluation
 - Commodity procurement and logistics—ensuring of consistent supplies (including contraceptive security)
- *Service Delivery*
 - Guidelines, protocols, norms, and standards
 - Job descriptions and assignments
 - Operating procedures for health facilities
 - Collection of fees (and granting waivers)

Source: Adapted from Cross et al., 2001.

⁴ Health financing issues are relevant at all levels of policy; for example, public resources are required to ensure adherence to laws, as well as the implementation of national/state/provincial policies. Health financing is also relevant to operational policies; for example, there are rules and regulations associated with how health budgets are allocated, spent, and tracked and how fees are determined and collected; the costs of health taxes and duties can deter the procurement of commodities; and insurance and other financing schemes can influence how clients access and pay for services.

⁵ Operational policies related to health systems management and service delivery are linked to the WHO's health systems building blocks (service delivery; health workforce; information; medical products, vaccines, and technology; financing; and leadership/governance).

Examples of Scale-Up Efforts That Have Addressed Policy Issues

This section describes three scale-up initiatives and the policy challenges they addressed and/or currently face. The first and second examples highlight ongoing multi-country efforts to scale up evidence-based practices: integration of the Standard Days Method into family planning programs and prevention of postpartum hemorrhage and pre-eclampsia and eclampsia as part of maternity care. The third example is a case study on scaling up postabortion care in Bolivia and Mexico from the 1990s to the mid-2000s. It draws policy lessons by comparing achievements in the two countries. In each example, the program planners or the evaluators use a scale-up framework to guide or measure progress—and each addresses policy issues.

Scaling Up Fertility Awareness-based Methods of Family Planning

Georgetown University’s Institute for Reproductive Health (IRH) is conducting prospective studies of the scale-up of fertility awareness-based methods of family planning in five countries: Democratic Republic of Congo, Guatemala, India, Mali and Rwanda.⁶ Scale-up efforts are focused primarily on the Standard Days Method (SDM)—a family planning method that uses Cyclebeads® to help women track their cycle and know when they are fertile. Applying the ExpandNet framework, the studies are exploring both horizontal scale-up (expanding coverage) and vertical scale-up (institutionalization).

Vertical scale-up—which touches on many policy dimensions of scale-up—has involved integrating the method into family planning norms, policies, service and supervision guidelines, training curricula, reporting systems, procurement, and health-promotion activities. The process has required forming stakeholder groups to identify issues and advocate for reforms, and it has helped staff embrace their role as policy advocates (Lundgren, 2011).

At the heart of IRH’s current strategy for scale-up is a “systems-based” approach to monitoring and evaluation. The approach must be systems-based because the environment in which scale-up occurs goes well beyond the programs that directly serve clients. It includes the larger service delivery system and its many components (e.g., training, supervision, reporting, and procurement); the influence of the media; the role of opinion leaders; the policy climate on which financing and approvals depend; and cultural, economic, and other factors that influence clients and their families.

The hallmark of IRH’s monitoring and evaluation approach is the establishment of 10 critical indicators of scale-up, along with a semi-annual process to monitor benchmarks. Examples of horizontal scale-up

Standard Days Method Use (5 countries)

Vertical scale-up:

- Integration into family planning norms, policies, guidelines, curricula, reporting systems, procurement, and health promotion through participatory dialogue and advocacy for reform
- Development of monitoring and evaluation indicators and semi-annual process to monitor benchmarks

Horizontal scale-up:

- Expansion of service-delivery points
- Increase in number of counselors trained

Lessons learned to date:

- Monitor pace of scale-up
- Address both macro- and micro-level policies

⁶ See www.irh.org.

Examples of Scale-Up Efforts That Have Addressed Policy Issues

indicators include the proportion of service-delivery points offering SDM and number of individuals trained to counsel clients on the method. Vertical scale-up (institutionalization) is tracked with indicators such as the inclusion of SDM in key policies, norms, protocols, and guidelines; presence of the method in pre-service training and continuing education; and inclusion of CycleBeads in national procurement and logistic systems, reporting systems, and information, education, and communication activities (IRH, 2011b).

Mid-project results show that the institutionalization of SDM in national standards and guidelines is close to completion. The institute is still working to ensure that SDM appears in essential supply and procurement tables and that it is reported at all levels of health management information systems. Additional work is also needed to institutionalize SDM in the pre-service training curriculum for providers (IRH, 2011a). Project managers have found that monitoring the pace of scale-up and paying attention to both macro-level and micro-level policies are essential (Lundgren, 2011).

A Pathway to Implementing Maternal Health Interventions at Scale

The Maternal and Child Health Integrated Program (MCHIP) addresses the major causes of maternal, newborn, and child mortality by bringing high-impact interventions to scale in more than 30 countries with the highest mortality rates.⁷ The program has designed a framework depicted through conceptual maps for scaling up two interventions—postpartum hemorrhage (PPH) prevention and management and pre-eclampsia and eclampsia (PE/E) management—that address the most common causes of maternal deaths in developing countries.

Postpartum Hemorrhage and Pre-Eclampsia and Eclampsia Management (30+ countries)

Approach:

- Conceptual mapping of intervention scale-up, helping to monitor progress in addressing policy issues while passing through each phase of implementation

Lessons learned to date:

- Create a “rulebook” to document agreed-on objectives related to service scale-up
- Monitor operational policies throughout all the stages of scale-up/program implementation
- Conduct ongoing national advocacy to standardize approaches and increase financing to support scale-up

The conceptual maps describe the phases of implementation that programs pass through; they begin with global actions, national strategic choices, and the introduction of programs and move toward mature and sustainable programs (Smith et al., 2011). The program addresses health policy and management issues (operational policies) during each phase and collects data to measure progress. Using color-coding to indicate progress, managers can visually identify how far country programs have progressed and which issues, such as governance or finance, are posing problems (Smith, 2011). Managers have found it essential to have all stakeholders agree on common objectives—in this case, a “rulebook” for a basic package of maternal health services (Smith, 2011).

The MCHIP scale-up framework makes clear that policy work does not end once programs are introduced. Operational policy issues continue to be monitored and addressed during the introduction and early and mature phases of scale-up. After programs are piloted, in the early phase, national advocacy is needed to support expansion, standardize approaches, and

⁷ See www.mchip.net.

support financing for programmatic growth. To ensure that programs can be sustained in the mature phase, government budgets must support the training programs (pre-service and in-service curricula), and the government's procurement mechanism must include drugs and supplies.

MCHIP has used surveys to assess progress in scaling up. From January–March 2011, MCHIP conducted a survey in 31 countries to assess the national scale-up of PPH and PE/E reduction programs (Fujioka and Smith, 2011). Findings showed a disparity between nationally approved policies and guidelines to reduce PPH and PE/E and the actual services delivered. For example, all 31 countries reported that oxytocin, a critical drug for the active management of the third stage of labor (AMTSL), appeared on the Essential Drug List, and 97 percent of countries have incorporated AMTSL with a national policy for PPH prevention. But not all countries authorize midwives to perform AMTSL, and about one-fourth of countries reported inconsistent availability of oxytocin in facilities offering maternity care—although reasons for the inconsistent availability were not given. Survey questions also addressed education and training in AMTSL, the availability of misoprostol and magnesium sulfate, and education and training in PE/E management principles.

Surveys such as these, which MCHIP plans to repeat each year to monitor progress, are useful in providing a country-by-country assessment of progress in moving to scale. The results indicate areas where objectives have been achieved and those that remain to be addressed through additional work on policy, regulatory, or financing issues or on education and management at the clinic level.

Scaling Up Postabortion Care in Bolivia and Mexico

Researchers from Ipas, a reproductive health organization based in Chapel Hill, NC, conducted a comparative study on scaling up postabortion care (PAC) in Bolivia and Mexico. The study built on a conceptual framework developed by Cooley and Kohl of Management Systems International in 2006 (Billings et al., 2007). PAC is a package of interventions that helps reduce maternal mortality and morbidity by giving women prompt treatment after complications from abortion (using manual vacuum aspiration when indicated) and links to contraceptive services.

The Ipas study examines the process of policy change during three phases of scale-up (the start-up phase, expansion, and institutionalization) and also looks at the environmental context in each country. Similar to MCHIP's pathway to implementing at scale, the authors describe the policy interventions needed at each phase. In this case, however, because scale-up began over a decade ago, the study was able to look retrospectively at what worked and what did not.

In terms of the policy environment, both Bolivia and Mexico have restrictive abortion laws. PAC has been a politically acceptable way to address abortions—improving women's health by providing them humane and compassionate postabortion care.

During the start-up phase of scaling up in the early 1990s, both countries had *catalyzers*—strong and persuasive advocates who were well positioned to influence decisionmakers in the public health system. Collaboration between international nongovernmental organizations and the national governments in both countries was essential for start-up, as were resources provided by private foundations and USAID.

Examples of Scale-Up Efforts That Have Addressed Policy Issues

The expansion phase, from 1994–2005, included improving health system capacity (through training, supervision, and solidifying of policies and norms of care) and improving access to technologies and equipment. During this phase, partnerships among stakeholders and use of research results were key inputs to strengthening political commitment. In 1998, Bolivian stakeholders created the Inter-institutional Coordinating Committee for Postabortion Care, in which the Ministry of Health was among 29 members working on creating national norms and guidelines for PAC.

In contrast, in Mexico, a coordinated body of stakeholders was never formed to guide and sustain PAC implementation. Thus, communication among public sector institutions and nongovernmental organizations has been weak or nonexistent. Collaboration between nongovernmental organizations and the government in Mexico is complex because the health system is decentralized and multiple institutions manage and deliver services.

As a result of these and other factors, PAC has been institutionalized in a relatively short time in Bolivia, while Mexico still needs work in a number of areas. For example, while policies, norms, and guidelines for comprehensive PAC services have been developed and disseminated nationally in Bolivia, the services remain unique to each institution in Mexico. And while Bolivia has dedicated resources in the national health insurance plan to cover PAC services for poor women, insurance coverage in Mexico varies from one institution to another.

Institutionalizing PAC has faced challenges in both countries because it competes with hundreds of other health programs and priorities. Nevertheless, Bolivia successfully scaled up programs to a national level and at all levels of care. Including PAC from the outset as part of donor and government plans created a foundation for ongoing evaluation, training, updating of norms and guidelines, and acquisition of technology over time. The coordination of communication and strategy development among stakeholders from different sectors was also a key to success (Billings et al., 2007).

Postabortion Care (Bolivia and Mexico)

Vertical scale-up:

- Creation of the Inter-institutional Coordinating Committee for Postabortion Care (Bolivia)
- Inclusion of PAC in donor and government plans (Bolivia)
- Allocation of resources to PAC in the national health insurance plan (Bolivia)

Horizontal scale-up:

- Expansion of training and supervision (Bolivia and Mexico)
- Increase in access to technologies and equipment (Bolivia and Mexico)

Lessons learned to date:

- Identify catalysts (strong advocates) to influence decisionmakers throughout the public health system
- Closely coordinate communication and strategy development (among stakeholders of different sectors)
- Standardize policies, norms, guidelines, and services across decentralized institutions

Lessons from Scale-Up Experiences with Relevance for Policy

Many common lessons have emerged from the case studies above and from a range of other experiences in bringing health interventions to scale. The keys to success in scaling up are similar to those for implementing effective programs in general. The following lessons have particular relevance for policy approaches to scaling up best practices:

- **Scaling up usually requires extensive planning and long-term efforts** because of the large number of actors involved, the policies and systems to be reformed, and the capacity to be built. Adding to existing programs is generally easier than adopting entirely new programs (ESD, 2011). Specific technical improvements, such as enhancing supervision through improvement collaborative approaches or adding zinc to oral rehydration packages, would not necessarily entail extensive policy reforms (Bitar, 2011b)—though they could not likely be achieved in less than one year (ESD Project, 2011).

Much more time is needed for lasting changes to take hold nationwide. The programs examined for this paper required work for 5–10 years (or more) to see scale-up efforts come to fruition (Kohl, 2010). Regardless of the scope of the program to be scaled up, however, attention to policy barriers and plans to overcome them are essential.

- **All scale-up efforts should have a planning team** (ExpandNet calls it the “resource team”), and ideally, team members should have a strong understanding of how the public sector works, including governance issues and how laws and policies are developed, enacted, and implemented. An important function of the team should be to analyze the relevant national and operational policies to ensure that they create the right conditions for scale-up. The team should establish a process or collaborative system for analyzing existing policies, identifying potential barriers to scale-up in the policy landscape, and following through with recommendations to reform policies. The actions needed to develop and implement favorable policies for scale-up are described in the last section of this paper.
- **Stakeholders need to be involved before and during scale-up** to create a sense of ownership and ensure continuity (Bitar, 2011a; ESD Project, 2011; IBP Consortium, 2007; Nath, 2007; Simmons et al., 2010; and Yamey, 2011). It is important to involve a range of stakeholders in determining priorities to be addressed in scale-up and the policy dimensions associated with scaling up health practices. Stakeholders range from those who can identify needed best practices to scale-up, to those who articulate barriers to services, to those with authority to undertake policy reform. The latter group of stakeholders “can work on policy issues beyond the reach of the operational-level staff and, in collaboration with service delivery organizations, ensure sound problem analysis and appropriate, practical reforms” to ensure successful scale-up (Cross et al., 2001, p.15). Ideally, to ensure institutionalization and sustainability (vertical scale-up), key decisionmakers with the authority to undertake policy reform would be engaged during the research and testing phase and in the dissemination of evidence—long before scale-up begins. Similarly, before new practices can be scaled up horizontally—replicated in new service sites—the participation and involvement of local staff and managers is essential. Focusing on creating

ownership from the beginning will save time in the long run. As Kohl notes, it is “hard to overcome personalized politics and vested interest groups without time, commitment, and resources” (2010, p. 36).

- **Policy “champions” and advocacy efforts are essential** to support the change process (ESD Project, 2011; Simmons and Shiffman, 2007; Billings et al., 2007) because internal—and external—pressure by stakeholders in decision-making bodies is often needed to bring attention to an issue and push through reforms. Particularly in environments where a large number of problems must be addressed with limited resources, champions are needed to maintain focus and momentum. Policy champions are also needed to ensure not only that macro-level policies are enacted or changed to support the scale-up but also to ensure that macro-level policies are decentralized and that relevant operational policies are reformed throughout the program to ensure institutionalization and sustainability.
- **More resources are needed for scale-up** than for routine service provision because of the reforms and training needed at many levels of the health system for a new practice to be adopted (IRH, 2011a; Nath, 2007; Billings et al., 2007). Gaps in funding can be a fatal blow to scale-up efforts (IRH, 2011b). Thus, scale-up needs to be incorporated into the budget and planning cycles of external donors and the government. Budgeting for scale-up is an essential part of the planning process, including external and internal funding sources, and with attention to sustainability. Donors should be involved in the stakeholders’ meetings described above and should be informed about the time and resources necessary for scale-up.
- **Financial and human resources may need to be reallocated.** Often tertiary care can starve the health system of resources that might be more effectively used at lower levels of care. Or task shifting among service providers may be needed—and associated policies reformed—for new services to be added. For example, nurses/midwives can be trained (instead of doctors) to insert intrauterine devices or to manage certain complications during delivery.
- **Monitoring and evaluation are essential** so that adjustments can be made as scale-up progresses (IRH, 2011a; Smith et al., 2011). Also, monitoring and evaluation hold the implementing agencies accountable for outcomes. Having well-designed systems for gathering and disseminating evaluation data is central to good governance: institutions and staff must be committed to operating efficiently, identifying and addressing challenges, and being responsive to citizens’ and clients’ needs (Health Policy Initiative, Task Order 1, 2010). Both IRH and MCHIP have developed strong systems for monitoring scale-up, including tools to measure policy readiness and monitor policy change.

Research is crucial before scale-up can begin (to show global and local effectiveness), and it does not end with the approval of plans. New research findings, along with monitoring and evaluation data, should continue to inform plans related to scale-up, which should be seen as a dynamic and iterative process.

Key Actions to Ensure Supportive Policies

A well-designed strategy for scale-up should bear these lessons in mind and give attention to the policy dimensions of operating at scale. A number of guides, frameworks, and approaches can be studied and used to develop and implement a scale-up strategy. Whatever framework and approaches are adopted, program planners should be sure that policy issues are adequately addressed. The following actions are drawn from lessons learned in scaling up and from many years of policy experience in family planning and reproductive health programs (Health Policy Initiative, Task Order 1, 2010). Though each scale-up effort may confront a unique set of issues, policy work related to scale-up should include most or all of these actions:

- 1. Identify the relevant policy issues and the decisionmakers responsible for them** at each phase of implementation and at each level of the health system. To develop sound policies, program planners should examine the current policy situation and the feasibility—both financial and political—of any proposed policy changes. Furthermore, in addressing policy in scale-up, it is important to understand how scaling up best practices fits within government priorities, plans, and strategies; lines of authority and responsibility; and government, donor, and multilateral organization coordination. Assessments of what it would take to institutionalize best practices, including through policy reform, can complement pilot studies to show the effectiveness of best practices in improving health outcomes. Planners should also ensure that new policies are clear and comprehensive so as to avoid implementation problems. Whether working at a national, regional, or local level, the basic policy questions to ask are as follows:
 - What changes need to be made?
 - Who has the authority to make decisions regarding the change?
 - Who has the authority to implement the change?
 - Will the change require increased resources?
 - Who has the authority to decide on the increased resources?
 - How are the changes in policies being communicated to the providers, other health personnel, and to their managers and supervisors?
 - How will the policy change be monitored to ensure implementation?
- 2. Identify allies and champions** who will work to garner political and financial support for the scale-up initiative. These leaders—from parliamentarians to religious leaders to advocates for women and marginalized groups—and their networks should be strengthened so that they work to keep the issue on the national and local policy agendas.
- 3. Pay attention to timing and sequencing** in terms of the political context (e.g., elections) and budget cycles. Experience has shown that gaps in funding—often created by delays in disbursements—can stall or put a sudden end to expansion efforts. It is also important to be on the lookout for and seize windows of opportunity: a change in political parties, for example, could make way for new commitment and resources for health. Ideally, a roll-out strategy for any initiative should be linked to the country’s budget and planning cycles.

- 4. Communicate and coordinate among stakeholders on an ongoing basis**, not just during a one-time event such as a national conference. In most countries, both public and private sector stakeholders need to be involved: politicians; government officials and staff from the relevant ministries and departments (including finance); local government representatives; and representatives of international organizations, civil society groups, private medical organizations;, advocacy groups, and other nongovernmental organizations. Because such a large process can become unwieldy, a smaller group of committed stakeholders—a council or coordinating committee—might be formed to ensure that favorable policies are adopted and that commitments are followed through. (Such a committee was formed in Bolivia to support the scale-up of postabortion care—see page 14.) Also, because there can be frequent turnover among high-level policymakers, a standing committee can ensure that policy work continues and new decisionmakers are informed about the issues.
- 5. Build institutional capacity for policy work** as well as program implementation and service delivery. The staff members of health ministries and national health organizations need skills related to data analysis, planning, budgeting, monitoring and evaluation, and communication and advocacy—all essential processes that support health programs and services.
- 6. Feed monitoring and evaluation data back into the policy process** to determine what is working and what is not and to identify additional reforms in operational policies that are needed. Scale-up strategies should have monitoring and evaluation plans with clear indicators of progress, along with systems to track service delivery and agreed-on outcomes. These systems, in turn, should be linked with the group of stakeholders (described above) that is monitoring progress. Good monitoring and evaluation data promote accountability, transparency, and ownership of policy initiatives.

Policy reforms do not need to be complete for scale-up to start. Indeed, waiting for policy action could delay start-up unnecessarily in some cases. The relationship between policies and programs can be dynamic, in which one can influence the other (Simmons, 2011). The planning team can set up a timeline and set of priorities in which it identifies the policies to address in the short-term and long-term.

Scale-up and sustainability are achieved when the goals, principles, and operational guidelines contained in policy directives are normalized and consistently supported as part of the everyday practice of health service planning and provision. Reaching this endpoint cannot be accomplished through a “check-the-box” approach to policy, however. Policy work should be seen as a continuous process and an integral part of a long-term, scale-up strategy.

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