

“SCALE” and “SCALING-UP”
A CORE Group Background Paper on “Scaling-Up” Maternal, Newborn and Child Health Services
July 11, 2005

This paper briefly summarizes definitions, approaches, and challenges to achieving “scale” in community-focused health programs as discussed at the 2005 CORE spring meeting and the USAID child survival and health grants program mini-university. This paper is meant to harmonize a vocabulary for use by NGOs and their partners as they further discuss, debate, and analyze how NGOs and their partners can reach more people with high quality maternal, child and neonatal health interventions. Case studies and further documentation of discussions on scale can be found in the proceedings from the CORE Spring 2005 Meeting available on the CORE website: <http://www.coregroup.org>.

1. GLOBAL BACKGROUND

If the child survival community is to achieve the Millennium Development Goals for health of reducing child mortality worldwide by two-thirds, reducing maternal mortality by three quarters, and reversing the incidence of malaria and other infectious diseases, all by 2015, successful programs need to be taken “to scale” quickly. A major issue for many governments is how to reduce mortality “at scale” and ensure that interventions to reduce mortality also reach the marginalized and poor. The 2003 *Lancet* Series on Child Survival made the challenge clear:

Too few children are receiving the known and effective interventions that could save their lives. A major research priority is how to effectively scale-up the successful experiences of many local projects; this area of research has unfortunately received much less attention than the development or small-scale implementation of new interventions ... We must also question current assumptions about how interventions should be delivered--where, when, and by whom--as the basis for development of new strategies that make sense within local epidemiological, health-system, and cultural contexts.

We know that cost-effective interventions exist which could save the lives of children and newborns, but they are not reaching those most in need. Many deaths could be prevented if proven interventions were implemented effectively and at high coverage where they are needed most. Community mobilization combined with household / caregiver mobilization to adopt healthy home practices and care seeking for illness are cornerstones of effective programs. A number of global initiatives – including the RBM Partnership, the new Maternal, Neonatal, and Child Health Partnership, the Stop TB Partnership – have shown success in coordinating efforts from a broad range of partners to maximize the use of available resources toward common goals. At the country level, efforts such as the Country Coordinating Mechanisms for the Global Fund to Fight AIDS, TB and Malaria, are doing their part as well. PVOs/NGOs are critical partners in all these efforts.

With the establishment of the Millennium Challenge Account and similar mechanisms, the U.S. government has made “accountability” the watchword of global development programming. NGOs and PVOs are under increasing pressure to show results; “scaling-up” may offer a way forward.

2. DEFINITION of “SCALE”

Several groups have tried to define “scale” in the past few years. A compilation of the many definitions can be found in “Achieving Impact on Child Health at Scale” produced by Mary Taylor for the BASICS II project (2002) and which resulted in the project’s adoption of a central definition.

The definition of “scale” is widespread achievement of impact at affordable cost.

Increased impact is a function of the COVERAGE of a population, program EFFECTIVENESS (*quality of implementation and efficacy of interventions employed*), EFFICIENCY (*cost per beneficiary*), SUSTAINABILITY (*continuity, ownership*), and EQUITY (*reaching the hardest to reach, usually the poor*).

When the term “scale” is used in common parlance, most people mean that a large number of beneficiaries are covered by some package of interventions. This increased coverage can cause impact to increase; however, we can see that impact is also related to and affected by a number of other variables such as program quality, affordability, and local ownership that contribute to sustainability. Equity is of particular concern to the NGO community. NGO programs typically try to increase preventive, promotive and curative health services to people farthest from health facilities, people living in cash-poor environments, and/or people not predisposed to adopt new health behaviors. We therefore propose that increased coverage alone is insufficient to create the widespread impact at scale that we are attempting to achieve without consideration of these other variables.

Policy makers discussing the issue of “scale” consider how a package of services or interventions can reach and be utilized by all people in a country or a region. Worldwide goals, such as the Millenium Development Goals, are set with ambitious goals and targets that countries commit to achieve on a national “scale”. For example, many countries have set a national goal of 85% coverage of all children with a completed series of life-saving vaccinations before their first birthday. Governments and donors then expect the NGO community to help contribute to the achievement of these national level targets, and are increasingly challenging NGOs to think more broadly about how NGO efforts can positively affect processes and systems that can efficiently lead to this desired national scale.

Many NGOs have typically set up programs in remote districts and focus on improving health outcomes in selected communities or sub-districts or at the district level. NGO programs can focus solely on one health intervention (for example, delivery of immunizations or Vitamin A) but the majority of NGO programs seek to achieve scale with multiple health or multiple health and development interventions that respond to a broad range of community needs and involve the community in local decision making. NGOs typically define “scale” based on the local context taking into consideration determinants or factors that affect a program’s ability to achieve “scale” over a period of time. The definition of what is possible to be done at “scale” will naturally differ for one intervention versus multiple interventions, or in a fragile region or district versus one with a more developed health infrastructure. Many NGOs have chosen to work with the district level government as the important entity for local planning and implementation. While many of these efforts have been very successful, governments and donors are asking NGOs to think about how other districts or parts of the health system can benefit from these efforts and achieve a greater “scale”. Can some of these innovations tested by NGOs be more efficiently mainstreamed into existing government and private health systems? If NGOs were to work more in tandem with other government, donor and implementing agencies at the onset of a program, could the potential vision and targets for “scale” be increased? Each NGO project needs to consider how it can best contribute to national “scale” by setting a “scale” vision that reflects the package of interventions, partners, geography, epidemiology, culture and state of the existing health and political system.

3. DEFINITION OF “SCALING-UP”

In order to achieve its vision of “scale”, each project must develop a strategy to influence or change the prevailing health and development system. We refer to this strategy as “scaling-up”, and offer the definition proposed by the International Institute for Rural Reconstruction that is referred to in several United Nations documents.

“Scaling-up” refers to efforts to bring more quality benefits to more people over a wider geographical area more quickly, more equitably, and more lastingly.

These efforts can be accomplished by an individual organization or by multiple organizations working together. In all cases, the organization(s) needs to work in tandem with their ministry of health counterparts and other key stakeholders within the local context.

4. “SCALING-UP: STRATEGIES FOR ACHIEVING SCALE”

Peter Uvin and David Miller developed a “taxonomy of scale-up,” that has been used by UNDP, JHPIEGO and several USAID cooperating agencies in health to describe scaling-up strategies. The four strategies they cite are often referred to in health literature and are frequently used by the NGO community. These strategies are not mutually exclusive, and in fact, an organization wanting to “scale-up” ought to consider using a combination of these various strategies.

- 1) **Quantitative “Scale-Up” Strategy**: Increasing the number of beneficiaries reached. Quantitative “scale-up” can be accomplished by adding on or expanding to new areas through *geographical expansion*. This was the most common type of “scaling-up” effort presented by NGOs at the 2005 CORE spring meeting.

Geographical expansion can take place through several different sub-strategies, referred to in the literature as “additive strategies, associative strategies, diffusive strategies, or multiplicative strategies”. Different actors can define the package of interventions that is to be replicated no matter what sub-strategy is utilized. In some countries the NGO, in coordination with the government and the donor, will determine the package of interventions to be replicated, based on their evidence-based experience. For example, CRS, in the Philippines, demonstrated the effectiveness of a modified IMCI algorithm for use by Community Health Workers (CHWs) to manage childhood illnesses before “scaling-up” the intervention to new areas. Save the Children in Vietnam, demonstrated the effectiveness of the Positive Deviance / Hearth approach before scaling it up to new areas. In other countries, the Ministry of Health defines an essential package of services and requests that NGOs replicate this package. For example, in Nicaragua, Project HOPE is helping the MOH to roll out their Community IMCI / Growth Promotion (AIN/AEIP) package with other NGOs in selected geographic areas. In Guatemala, URC, the lead USAID-bilateral agency, with the MOH, the donor, and the NGO community defined a set of interventions for scale up of AIN/AEIP based on an analysis of various experiences. In many of the hard to reach populations where NGOs work, though, “scale-up” cannot happen without the community’s ownership of the package of interventions. For example, for a Positive Deviance / Hearth project to be successful, each community must conduct a positive deviance inquiry to discover those local child caring and feeding practices based on local wisdom that are doable for even the poorest. It is this process of discovery and problem-solving that leads to the commitment for social and behavioral change.

This and other examples presented in this paper emphasize the fact that *processes and structures* (e.g., positive deviance inquiries, care groups) can be “scaled up” as well as defined *technical interventions* like immunization. Scaling up these sorts of programs may give more inherent flexibility, as the final intervention package may differ from place to place depending on local circumstances encountered. It also can be a way to preserve community participation and input, which is always a challenge as projects are “scaled up.”

NGOs frequently use “*additive strategies*” for quantitative “scale-up”. This implies an increase in the size of the overall program area of one or more agencies, or through use or duplication of a program by other agencies. NGOs have employed this type of “scale-up” strategy in several different ways.

One project strategy often used by NGOs is to start with a small pilot effort or model program that demonstrates effective results, and over time, with additional resources, continue to add or phase in adjacent population areas that will receive the same or a more limited set of interventions. In new areas where the NGO has little experience, or where there is a problem that requires an innovation, the NGO may initiate work in a limited number of communities or sub-districts and then expand outward to the district level. Where NGOs have more experience working within the local culture and with a set of known interventions, an NGO may conduct a pilot effort at the district level and then expand outward into adjacent districts. Costs per beneficiary may decrease with the expansion once the NGO has developed local community infrastructure or better defined the set of interventions that can be “scaled-up”.

Projects that demonstrated the greatest “scale-up” worked in tandem with various partners, although the direct replication of a package of interventions into new areas can be carried out by the NGO’s own staff. More often, especially in fragile states or conflict areas, the NGO will identify, support and mentor local NGOs or CBOs or local government or ministry of health staff to deliver these interventions. An increasingly common approach to replicate over a wider coverage area is through sub-granting of funds to other NGOs or organizations to deliver the package of interventions. The organization that manages the sub-granting of funds can be a lead NGO, a network, a bilateral, the government, or multi-lateral organizations such as the World Bank. In the Polio Eradication Partners Project, a unique sub-granting process was used that ensured more partner equity and coordination with each other and the MOH. NGOs developed bundled proposals (each agency having an individual workplan and budget for a common set of focused and complementary interventions) with funding for a small secretariat to coordinate the activities and represent the combined “scale-up” effort of multiple NGOs to government and donors. In Nepal, the USAID bilateral project managed through JSI was the lead organization selected to “scale-up” a community-based ARI program for children under five. JSI with the MOH and other partners developed a community-based delivery package of ARI services through female community health workers and then provided sub-grants to NGOs to deliver that package of health services in prioritized districts. Other times, NGOs have formed networks (such as Nicasalud in Nicaragua) to simultaneously deliver services or an approach.

Another type of quantitative “scaling-up” strategy used when multiple organizations are working in overlapping geographic areas involves each organization providing a different set of services to the same population based on their own programmatic competency. In some cases, the health services may be related, while in other cases, a cross-sectoral partnership may serve as a vehicle for health delivery. For example, there may be pockets of severe malnutrition across a few districts where a PD/Hearth intervention may be applicable. One organization may focus on PD/Hearth efforts in limited areas while another organization may be working with the MOH to implement a general nutrition program that combines micronutrients, growth monitoring and promotion, and counseling support for infant feeding. Together, while only loosely coordinated, they have the potential to achieve widespread reduction in malnutrition. One organization may utilize the services of another organization to deliver its services. For example, PSI added the delivery of insecticide treated bednets onto the local “coca-cola” distribution system in several African countries. These types of “*Associative strategies*” piece together coverage though they are not necessarily coordinated projects and programs. Each project effort responds to the needs of a distinct part of the total population served.

Geographical expansion can also take place informally or spontaneously. For example, many communities that witnessed the positive effects of a Positive Deviance / Hearth program to improve children’s health, started the program in their communities on their own with assistance from neighboring community volunteers. A mother who successfully went through a La Leche League peer group session may wish to start a peer group for breastfeeding support in her village. These

types of expansion strategies are referred to as “*Diffusive strategies*”, where spread is gradually extended through good practice, learning and influence.

An increasingly popular strategy for quantitative scaling-up is the use of “learning centers” or “centers of excellence” or “living universities” to influence the replication of interventions in new project areas by new partners. These types of efforts are called “*Multiplicative strategies*”, which imply a deliberate use of a learning strategy to influence multiple organizations to replicate a program. This type of approach has the potential to achieve widespread coverage at reduced cost.

✓ One type of multiplicative strategy is the SEED-SCALE model developed by Carl Taylor. This model has been used to enable leaders and other communities to systematically learn from one or several specific successful community-based projects, and apply the learnings to new areas. The model combines a step-wise process called SEED (Self-Evaluation for Effective Decision-making) for building the capacity of a community to take and evaluate action. The second process called SCALE (System for Communities to Adapt Learning and Expand) is a series of steps to transform these experiences into teaching centers where people can witness positive changes and replicate the approach in new areas. The model clusters the development process into three stages that do not have to follow sequentially.

SEED One: This is similar to a model project approach where an NGO will select, learn from and promote a successful community-based project in a defined geographical location.

SEED Squared: The NGO can transform a demonstration project or set of communities into a learning center for others.

SEED Cubed: The government creates an enabling environment for rapid up-take and the NGO promotes systematic extension throughout regions.

World Relief is using this model in Mozambique to replicate the “Care Group” approach of working with and supporting CHWs to deliver a wide range of integrated preventive and promotive services for children. World Relief demonstrated and measured the positive effect of this approach in Gaza Province, Mozambique from 1995-1999 to reach a total population of 107,000. They then expanded the project to a neighboring district to reach an additional population of 130,000 from 1999-2003, used the initial districts at learning centers, and have begun to reach an additional population of 228,000 people in 5 new districts in Gaza Province at a significantly reduced cost through a learning center approach. They have also used the learning center to train other WR project staff in Cambodia, Rwanda and Malawi to replicate the approach as well as additional organizations. Notice here that a “platform” or structure for community-based service delivery has been “scaled-up”. Various health (and/or non-health) interventions can use this structure, giving great flexibility.

Several NGOs emphasized that an intentional effort was critical to the achievement of “scale”, even if that effort was directed at nurturing and maintaining quality of a more spontaneous diffusive strategy. Several NGOs have built the “SEED” model into their ongoing program efforts. Systematic evaluations to evaluate the success of the approach in the next few years should provide us with greater understanding on the success of this strategy.

- 2) **Functional “Scale-Up” Strategy:** Expanding the number and types of technical intervention areas included within a program (increasing program breadth or depth). Many NGOs have used

this strategy in a second-phase of a project or as part of their extension funding requests for the Child Survival and Health Grants Program.

Functional “scale-up” can also be divided into different sub-strategies to increase program breadth or depth. Once an NGO has established trust within an area, strengthened the community health infrastructure, and delivered a package of successful interventions they will often add on additional sectoral activities to these existing programs through integration. This is referred to as “*horizontal*” layering. For example, an NGO will often mobilize a community to act upon health issues, train CHWs, form or strengthen Village Health Committees, and build the capacity of government owned health posts or referral facilities to monitor growth promotion and treat malnutrition. After a period of time, the NGO may then add on new efforts such as diarrheal disease and acute respiratory infection management interventions that build on the same community infrastructure.

Another type of functional “scale-up” strategy is known as “*vertical*” layering that refers to the addition of similar types of activities to an existing program. For example, an NGO may add actual immunization delivery to a program that does awareness raising and promotion of National Immunization Days.

A functional “scaling-up” strategy is very common with community-based NGO programs that attempt to address community felt needs. NGOs most often used a phased approach to build new interventions onto a strengthened delivery system. A key is to maximize the potential impact of a system or health worker without overburdening the people involved.

- 3) **Political “Scale-Up” Strategy**: Addressing national-level barriers to effective programs and services. This type of “scale-up” achieves expanded impact through deliberate influence, networking, policy change, legal reform or capacity building. Several recent articles have called for more attention to this type of “scale-up” effort.

NGOs cited a few examples of political “scale-up” efforts that were able to affect a large systems change, generally by strengthening government systems. This type of “scale-up” implies an NGO working to directly influence the MOH or other large health service provider. Addressing constraints that limit a system from functioning effectively may enable multiple organizations to then more efficiently implement a “scaled-up” response. For example, the Saving Newborn Lives project in Pakistan was able to increase coverage of tetanus toxoid vaccinations and overall health impact to marginalized populations by working with the MOH to change from using male to female vaccinators for women of reproductive age. This type of effort came about through a partnership with the MOH to analyze systems barriers to use of services through use of qualitative formative research combined with quantitative evaluation. Advocacy activities are often important in this approach, such as working with the “First Lady” or other influentials or health professionals to gain the political will and credibility needed to “scale-up” health programs. Concern Worldwide, IRC, and World Relief in Rwanda worked together to test the effectiveness of delivery of anti-malarials by community-based agents leading to new MOH policies on use of community-based agents for curative care. They were able to secure Global Fund resources to implement and “scale-up” the training and service delivery. In general, this is a new way of looking at “scaling- up” efforts for NGOs. NGOs recommended that further guidance and support be provided on tools that would enable them to understand constraints that could be addressed to leverage expanded access to and use of health services. This approach may be a preliminary step to efficiently achieve quantitative “scaling-up” by preparing for the development of a systems-wide approach, or may enable “scale-up” to occur directly with current implementing partners.

- 4) **Organizational “Scale-Up” Strategy:** Improving its own or another organization’s ability to support an initiative or program in an effective and sustainable manner. Includes building of alliances, and requires organizational capacity building. NGOs employ this strategy for both “scaling-up” and for maintaining sustainability of an intervention or approach.

There are several examples of how NGOs have used this strategy. Many NGOs have been able to build the capacity of several of their country and technical staff to utilize successful strategies that were originally implemented and evaluated through a Child Survival and Health Grants Program (CSHGP) project in one country. For example, World Vision has been able to mainstream successful maternal and child survival interventions learned through the CSHGP throughout their worldwide Area Development Programs, thereby increasing the widespread impact of their health programs. In Nepal, several NGOs trained each other in key methodologies and competencies so that each NGO could strengthen government and community health services in several districts simultaneously, thereby increasing immediate impact. World Relief has trained several NGOs on the use of the Care Group approach. The American Red Cross re-trained its Red Cross volunteers to deliver essential services for children under five years in addition to its basic emphasis on first-aid training. Other NGOs have “scaled-up” strategies to strengthen ministry of health services. For example, in Indonesia, the Positive Deviance Network is training MOH to employ PD as a behavioral change strategy.

In all examples presented of programs achieving some new level of “scale”, multiple types of “scaling-up” efforts were used. NGOs most commonly employed a combination of quantitative and functional approaches, although other combinations (quantitative and political or quantitative and organizational) were also cited.

Field Example Using Multiple “Scaling-Up” Strategies

CARE India’s RACHNA program (Reproductive and Child Health, Nutrition and AIDS) which is reaching one hundred million population employed all four types of “scaling-up” efforts in phased approaches over a few decades. First starting as a food distribution project in a fixed location in the late 1980s, CARE expanded the food program to new areas (*additive quantitative “scale-up”*). In 1996, CARE added on new complementary nutrition and child survival interventions and strengthened collaboration with the government by adding food as an incentive to the government’s Integrated Child Development Services (ICDS) which ran a system of community outreach centers (Anganwadi Centers) (*functional “scale-up”*). In 2001, CARE again added on a set of newborn care interventions, and in 2003 they layered reproductive health and HIV prevention interventions in four out of nine states of India where the government’s Reproductive and Child Health Program (RCH) was active along with the ICDS. CARE’s plan was to “scale-up” through strengthening government systems to seek and solve problems using lessons learned from demonstration projects that showed feasible ways of solving operational problems at community and systems levels (*multiplicative quantitative “scale-up”*). CARE used a systems approach to influence the government to have its Anganwadi Centers deliver the package of interventions, including food on a fixed day, fixed site system. CARE influenced the ICDS to focus on prevention of malnutrition rather than treatment of malnutrition; and to focus the immunization strategy on left outs and drop-outs (*political “scale-up”*). They worked with the government to streamline tasks and supervision of all volunteers, whether nominated by ICDS or RCH. CARE increased the organizational capacity of the Anganwadi Centers to provide essential newborn care in addition to other tasks by developing a curriculum and training government Anganwadi workers to understand the basic technical elements for an essential newborn care package (*organizational “scale-up”*).

5. STEPS TO SCALING UP

Several organizations have analyzed how various projects have “scaled-up” and have developed recommendations for “scaling-up”. One germane resource for the NGO community is from Save the Children / JHUCCP: “How to Mobilize Communities for Health and Social Change” written by Lisa Howard-Grabman and Gail Snetro. These steps were applicable to many of the NGO projects discussed and represented the need to systematically plan for “scale-up” during the project design and early implementation stages, as well as during the “scale-up” stage.

Before Scale-Up

1. Have a vision to “scale up” from the beginning
2. Determine the effectiveness of the approach
3. Assess the potential to scale up
4. Consolidate, define and refine the approach
5. Build a consensus for “scale-up”
6. Advocate for supportive policies

As you Scale-Up

7. Define roles, relationships and responsibilities of implementing partners
8. Secure funding and other resources
9. Develop partners capacity to implement the program
10. Establish and maintain an M&E system
11. Support institutional development for scale.

6. FACTORS INFLUENCING SUCCESS OF “SCALING-UP” STRATEGIES

Several factors have been identified that significantly contribute to successful “scaling-up” project efforts. The Center for Global Development, in its review of 17 cases of large-scale health efforts, lists six key factors. Project challenges and successes presented by NGOs validated this list and provided specific information related to each factor.

◆ ***Predictable, adequate funding comes from both international and local sources (up to or more than 20 years).***

NGO programs that achieved some new level of “scale” required a consistent source of funding of at least ten years. Those programs that diversified their funding sources at international and local levels seemed to have the most predictable funding with concomitant ownership by multiple stakeholders. The more complex the set of interventions, the longer period of funding needed.

◆ ***Political leadership and champions ensure visible high-level commitment and maintain vision of “scale”.***

A favorable policy environment with policy support for community-based programs (such as support of a Community Health Worker approach) was a necessary element of NGO programs that achieved some level of “scale”. Political will and local ownership by the MOH were cited as critical components. While national-level champions were critical to success, NGOs cited the importance of district-level champions especially in decentralized systems. Community champions that valued the health services, participated in program design and implementation, and advocated for their spread or diffused these services or approaches to neighboring communities were vital for mainstreaming the quality, sustainability and integrity of the “scale-up” work.

- ◆ ***Existing systems are used / adapted to introduce project technologies at a sustainable price.***
Those NGOs that had success in “scaling-up” community-focused interventions worked with community structures that were already in place. The Care Group model used in Mozambique capitalized on an existing “block” structure of ten families/block with an elected block leader, and worked within the existing MOH system. World Relief improved the weak links between communities and health facilities in coordination with government and other stakeholders.

NGOs that started out with a pilot model or activity needed to ensure that the complexity, depth and breadth of project technologies / approaches that were “scaled-up” did not overburden the health or community infrastructure or resources. This often meant that project interventions had to be “scaled-down” or simplified to be “scaled-up”. Successful NGOs refined a selective intervention package for “scale”, not the entire project approach / package. For example, in Vietnam, Save the Children simplified a number of integrated interventions in their “Poverty Alleviation and Nutrition Program” to a set of core interventions for “scale-up” of the “Positive Deviance / Hearth” approach. To keep the intervention at a sustainable price, a multi-sectoral approach also proved useful in many projects, both to deliver services and communicate messages, and also to reinforce behaviors through many channels.

- ◆ ***Technical consensus about the appropriate biomedical or public health approach exists.***
Sufficient biomedical evidence exists regarding the effectiveness of key life-saving interventions such as immunizations, Vitamin A, zinc, ORS, anti-malarials and antibiotics. NGOs need to ensure that the planned package of interventions respond to a major epidemiological need, and is consistent and well-defined regarding current state-of-the-art knowledge. While the appropriate interventions are known, the best approach to their delivery in different types of locations, especially to remote or difficult to reach populations is less known.

Successfully “scaled-up” programs had sufficient coordination between partners for standardization of a project delivery approach while allowing for local adaptation. NGOs working in the same country using different delivery strategies based on different principles for the same set of interventions found themselves impeding scale-up, since the MOH could not support at a national-level several different strategies. Successful “scale-up” efforts had partners that agreed on mutually defined goals, but ensured that a critical thinking process for evidence-based prioritization, planning, implementation and monitoring was built into the project at all levels.

- ◆ ***Good management on the ground is in place to maintain quality of the project.***
Internal capacity and commitment are essential to maintain the leadership and vision for “scale” over time. The need for supportive supervision was emphasized to ensure program quality exists as “scale-up” occurs. Several NGOs also referred to the importance of building capacity of partner staff in problem solving skills so that they would be able to adapt delivery interventions for the local population. Several projects ensured that an adequate number of capable partners were supporting and implementing the program interventions, and as necessary, built the capacity of new partners.
- ◆ ***Effective use of information for action.***
NGOs stressed the need for collecting, analyzing and sharing quality information in order to design and manage the project as it scales up. Both qualitative and quantitative data is critical for the advocacy work needed to maintain support for the project at “scale”. Outcome data was also used to shift the focus of the project to the most critical interventions over time.

7. DEFINING THE CHALLENGE

NGOs work in those rural and peri-urban areas hard hit by poverty, inaccessibility, HIV/AIDS, malnutrition and infectious diseases. “Scaling-up” health interventions or programs that effectively engage people in these marginalized areas will, of necessity, be complex, because program challenges are greater than in other areas. Transport and communication systems are less developed, health workers have less training, communities have lower literacy levels, and overall economic resources are minimal. NGOs often attempt to build the capacity of government systems to focus, target and reach these most vulnerable groups, while they are empowering communities for behavior change. Many NGOs are including action research as part of their programs so they can use evidence-based experience to influence national program policies and practices to be more community responsive. Peter Uvin and David Miller stressed the challenge for NGO programs that choose to remain focused on community participation and empowerment in marginalized areas as the vision for “scale” is set.

“How can a development initiative move beyond the local level and make a larger impact while continuing to foster participation? Can a participatory, bottom-up program, or the organization managing it, scale-up while avoiding the problems of cumbersome and overstuffed organizations, detached from their grassroots bases, becoming mere sub-contractors of the foreign aid system or of the state, unaccountable to the communities who they claim to represent?”

NGOs have experience in working at increasing the “scale” of their health project efforts in these under-resourced areas, using a wide range of quantitative, functional, political and organizational approaches. CORE member organizations have reached increased numbers of people with high quality programs in under-served locations throughout the world, especially in the last decade. Some of these more complex participatory health and development efforts were shown to be time intensive and will need to “scale-up” slowly, in phased approaches, over time. NGOs demonstrated that other health efforts, focused on a complementary set of limited interventions, could be “scaled-up” more quickly. These “scale-up” approaches need to be more widely discussed, catalogued and analyzed in order to understand more systematically how coverage, quality, equity, efficiency, and sustainability are addressed in the search for greater impact.

A recent Lancet article states that achieving the millennium development goal for child survival is affordable but that “scaling-up” policy choices will need to be made. To increase coverage, delivery of interventions at the community-level must be expanded to complement facility-based services. To increase quality of interventions at the community-level, communities must become partners of the health system. To increase equity, governments need to prioritize investments for known life-saving interventions for the poor and disadvantaged. To increase efficiency, a better understanding and use of integrated delivery strategies within comprehensive child survival programs need to be implemented rather than narrow vertical delivery systems to avoid redundancy. To increase sustainability, more effort needs to be made on improving preventive and promotive practices so that treatment costs and the burden on health facilities are reduced. NGOs are playing a critical role in the “scale-up” of maternal, child and newborn health services and can play a greater role by planning for “scale” at the beginning of project efforts. To affect national “scale”, NGOs will need to consider how to strengthen partnerships early on in their efforts and work with other organizations also attempting to “scale-up” a similar set of interventions. Rather than asking the question “how can my NGO “scale-up” our project efforts?”, NGOs may need to consider asking a question during program planning such as “what is the role my NGO can play in “scaling-up” this set of interventions in this country in this context?”. By using the steps for “scaling-up” and “factors for scaling-up” and then sharing experiential results on “scaling-up” efforts, NGOs can contribute to the understanding of the best “scale-up” approaches for achieving widespread impact.

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