

# TEN DIMENSIONS OF SCALING UP REPRODUCTIVE HEALTH PROGRAMS: AN INTRODUCTION

**This is the introduction to a series of issue papers for FP/RH program managers that consider the following questions on the subject of scaling up:**

- A question of change: How do we know when we have achieved scale?
- A question of capacity: What management, technological, and human competencies are necessary to bring programs to scale?
- A question of strategy: What strategies most effectively produce the desired leap?
- A question of impact: How should the desired impact be measured?
- A question of sustainability: How do we maintain the gains of an expanded and comprehensive program?
- A question of access: What kind of coverage is enough to qualify as “scaled up”?
- A question of supply and demand: What is being scaled up?
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- A question of timing: When is the right time to scale up?

## **Scaling Up Reproductive Health Programs : What’s New?**

“Scaling up” has entered the thinking of program managers as one of the important contemporary challenges for reproductive health programs. On the surface, achieving scale has always been a concern, whether the challenge was defined as increasing the number of users of modern methods, overcoming periods of stagnation, meeting unmet need, or improving program performance in areas of demand, access, and quality.

The complexity of reproductive health programs with their multiple client groups, priorities, and linkages to the HIV/AIDS epidemic further complicates the strategies and technologies which need to be brought together to expand programs and increase impact. Sociopolitical changes, health sector reforms, and the shifting sands of resource availability—from money to contraceptives—create additional hurdles for program managers.

What is new? It can be argued that the scaling up of reproductive health programs has been going on since they became a focus of health sector and social development. In some situations, programs scale up almost by default as they grow to accommodate population increase, even though indicators remain the same. However, the current term “scaling up” suggests a combination of strategies and technologies that are designed to be faster and of greater magnitude than the normal process of program expansion. It is no longer a question of waiting to see what happens and being surprised by changes, but to create purposeful change.

When leaders act to scale up programs, they must make the process of expansion more predictable, eliminate the cycles of growth and stagnation, and most important, transform embryonic programs (often comprised of scattered pilot projects with very limited capacity) into large systems offering a variety of services to entire populations. These are the new challenges that differentiate the challenges of today’s scaling up from the challenges of past program.

# TEN DIMENSIONS OF SCALING UP REPRODUCTIVE HEALTH PROGRAMS: AN INTRODUCTION

## Defining the Challenge of Scaling-Up Programs

How does one make the leap into large systems? Over the years and in many disciplines, experts have explored the concept of scaling up. Many see it as a process characterized by an explicit objective of providing services of national or regional scope. Others see it is the difference between planned expansion and natural program evolution. Still others see it as systematically overcoming limiting factors such as demand potential, resource availability, and technological barriers.

In general, most ideas about scaling up emphasize three dimensions: focus, process, and impact. The following table summarizes major documents addressing these dimensions.

## Scaling up: Summary of the literature

<b>Scaling up: Focus</b>	
<i>Source</i>	<i>Content</i>
All authors DeJong <sup>1</sup> , Kortzen DeJong, Kortzen Uvin, Miller <sup>2</sup>	Increasing access, increasing equity Increasing quality, increasing acceptability Increasing demand, satisfying new target groups Increasing institutional strength, size, sustainability
<b>Scaling up: Process</b>	
Myers <sup>3</sup> , Taylor Myers Uvin, Miller, DeJong Advance Africa/CAs <sup>4</sup> DeJong Myers, Taylor <sup>5</sup>  Taylor Uvin, Miller	Replication of successful pilot programs Association of complementary small programs Extension of geographical coverage Expansion of a new service throughout an existing system Vertical or horizontal integration of activities "Explosive" introduction of new policies, strategies on a national scale More rapid program expansion Paradigm shift to change underlying causes or environment
<b>Scaling up: Impact</b>	
Advance Africa/CAs  DeJong, Aylward <sup>6</sup>	Moving a program from one phase of development to a more mature phase Significant increase in key indicators of impact such as CPI, maternal mortality, HIV prevalence, IFR, EPI coverage

In practice, program managers need to address additional dimensions as well. There are at least ten areas that need to be addressed -- five strategic areas that include change, capacity, strategy, impact, and sustainability, and five operational areas that include access, supply and demand, cost, resources, and timing -- in order to initiate comprehensive efforts to scale up their programs. In this series of issue papers, we will address these dimensions individually to develop a clearer picture of the road to a scaled-up reproductive health program.

<sup>1</sup> Jocelyn DeJong. "A Question of Scale? The Challenges of Expanding the Impact of Nongovernmental Organizations' HIV/AIDS Efforts in Developing Countries" Washington, DC: Population Council, 2001.

<sup>2</sup> Peter Uvin and D. Miller "Scaling Up: Thinking through the Issues." Providence, RI: World Hunger Program Research Report, 1994.

<sup>3</sup> Ricardo Morán and R. Myers. "ECCD Guide: A Toolkit for Early Childhood Care and Development." Washington, DC: Inter-American Development Bank, 1999.

<sup>4</sup> Advance Africa and partner collaborating agency discussions on scaling-up. November–December 2001 and January 2002. Washington, DC.

<sup>5</sup> "Going to Scale: Can We Bring More Benefits to More People More Quickly?" NGO Committee, Consultative Group on International Agricultural Research of the World Bank. Workshop in Philippines. April 2000.

<sup>6</sup> B. Aylward et al. "When Is a Disease Eradicable? 100 Years of Lessons Learned," *American Journal of Public Health* 90: 1515–1520.

## SCALING-UP: A QUESTION OF CHANGE

This is the first in a series of issue papers for FP/RH program managers that consider the following questions on the subject of scaling up:

- **A question of change: How do we know when we have achieved scale?**
- A question of capacity: What management, technological, and human competencies are necessary to bring programs to scale?
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### **How do we know we have achieved “scale?”**

At what level of service delivery use can a program claim to have scaled up? Several general criteria as well as specific characteristics of programs can help signal when scale has been achieved. General criteria that can be used to distinguish “scale” from other kinds of program expansion follow.

**Some problems have been solved** Scaling up should produce permanent changes in unmet need for family planning services and long term reductions in rates of total fertility and population growth. Related problems such as infant and maternal mortality should be dramatically reduced. Other problems, such as availability of resources for educational and other social services, will be mitigated as a result of a smaller demographic burden.

**Priorities for population and reproductive health policy change.** In a scaled-up family planning program, dramatic decreases in the total fertility rate (TFR) can focus concern on aging rather than on young populations, and can enable programs to address the needs of special groups or concentrate on improving quality. In some countries, when contraceptive prevalence reaches high levels, family planning as an issue gives way to broader issues of reproductive and sexual health.

**Clients and client profiles change.** When a reproductive health program such as routine screening for cervical cancer is scaled up, the initial client profile differs from the long term client group. At first, screening tends to find clients with cancers at widely different stages of development, including a significant percentage of highly advanced and metastasized cancers for which treatment may not be possible or successful. However, over time, continued routine screening will find progressively younger patients with cervical cancer at earlier stages and precancerous cells, so that the probability of treatment success and survival will increase. Treatment of early-stage disease is less traumatic and often allows patients to have children and a normal reproductive life.

**New strategies for maintaining resources for scaled-up programs will emerge.** Although cost savings are generated by solving some problems, the debate about continued financing of scaled-up reproductive health programs may shift from allocating special funding to using regular revenue from local taxes or insurance schemes, or shifting financial responsibility from the public to the private sector. The debate will move from using resources to meet basic needs to using resources to promote choice and maximize efficiency, equity, and access in the distribution of high-quality services.

## SCALING-UP: A QUESTION OF CHANGE

Specific characteristics of scaled-up programs are illustrated the following table:

### Characteristics of scaled up reproductive health systems

Service	Scaled-up impact	Change in RH program needs
Family planning	<ul style="list-style-type: none"> <li>Contraceptive prevalence &gt; 70%</li> <li>Total fertility rate close to desired fertility rate according to the DHS and dropping toward replacement (IFR= 2.1)</li> </ul>	<ul style="list-style-type: none"> <li>Government maintains standards and quality guidance, drug authorization, but RH is entirely integrated into private, NGO, and public health systems</li> <li>Continue education in schools, media</li> </ul>
Maternal health services and general RH	<ul style="list-style-type: none"> <li>Maternal mortality rate has declined to a rate of &lt; 100/100,000 live births</li> <li>More than 95% of pregnant women receive prenatal care from skilled workers</li> <li>Age at first pregnancy has increased</li> </ul>	<ul style="list-style-type: none"> <li>Maintain norms and standards through professional regulatory bodies</li> <li>Finance and require services through national and private insurance schemes</li> <li>Continue IEC in schools, media</li> </ul>
Post-abortion care	<ul style="list-style-type: none"> <li>Repeat abortions are rare</li> <li>Maternal mortality due to incomplete abortion is almost entirely eliminated</li> <li>Patient profile has changed</li> </ul>	<ul style="list-style-type: none"> <li>Target IEC and FP efforts to youth to reduce incidence of abortion</li> <li>Maintain quality standards, defend legal status</li> </ul>
Youth, men, special target groups	<ul style="list-style-type: none"> <li>RH indicators for youth and men approach the results for the general population</li> <li>Special groups become smaller and even harder to serve (nomads, drug users, displaced persons, prison populations, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Re-definition of special targets groups and programs for them is ongoing through collaboration between public/private sectors</li> <li>Media, interest groups, NGOs active</li> </ul>
Sexually transmitted diseases	<ul style="list-style-type: none"> <li>Prevalence has declined, chronic cases are rare</li> <li>STI sufferers recognize problem and seek treatment rapidly</li> <li>Individuals protect themselves against STIs</li> </ul>	<ul style="list-style-type: none"> <li>Widespread access to a variety of service facilities, including anonymous services, providers must be maintained</li> <li>Dual protection must be encouraged</li> <li>Continue education in schools, media</li> </ul>
HIV/AIDS	<ul style="list-style-type: none"> <li>Incidence will stabilize and number of new cases decline due to prevention</li> <li>Prevalence will increase due to prolonged durations from diagnosis to death</li> <li>Quality of life of sick persons will increase due to treatment</li> <li>Maternal to child transmission will decline due to treatment and FP</li> </ul>	<ul style="list-style-type: none"> <li>HIV/AIDS will absorb major percentages of health resources and be dealt with as a multi-sectoral issue</li> <li>Financing for HIV/AIDS treatment through health insurance, national health plans</li> <li>Continue education in schools, media</li> <li>Continue to strengthen VCT, access to drugs, routine screening, dual protection</li> </ul>
Reproductive system cancers	<ul style="list-style-type: none"> <li>Due to routine screening, new cancers are less severe when found</li> <li>Cancer survival rates increase</li> <li>Confounding effects on incidence from higher rates of smoking, less breastfeeding among women</li> </ul>	<ul style="list-style-type: none"> <li>Create policies, norms, and standards for routine screening for breast, cervical, testicular, prostate cancers</li> <li>Finance screening through insurance and national health systems</li> <li>Encourage through media campaigns</li> </ul>
Infertility	<ul style="list-style-type: none"> <li>As FP succeeds in lowering the TFR, infertility becomes a major issue</li> <li>Couples seek and advocate for a variety of treatment options</li> </ul>	<ul style="list-style-type: none"> <li>Regulate, develop norms and standards for treatments for infertility</li> <li>Debate and seek solutions for financing infertility care</li> </ul>
Female genital mutilation (FGM)	<ul style="list-style-type: none"> <li>FGM is illegal</li> <li>Incidence has disappeared, if necessary, other culturally appropriate but non-dangerous practices have been found to mark transition to adulthood</li> </ul>	<ul style="list-style-type: none"> <li>Maintain vigilance and legal status</li> <li>Encourage development of appropriate but non-dangerous transition events</li> <li>Provide reparatory surgery to older women as needed</li> </ul>
Other agendas	<ul style="list-style-type: none"> <li>Other agendas for RH will emerge as some problems are solved.</li> <li>New agendas defined in Cairo and Beijing include domestic abuse and geriatric RH</li> </ul>	<ul style="list-style-type: none"> <li>Participate in the debate, move with the times, but do not sacrifice advances in the basic services</li> </ul>

\* Target rates in this table are adapted from "The PAI Report Card 2001 : A World of Difference, Sexual and Reproductive Health and Risks." Washington, DC: Population Action International, 2001.

## SCALING UP: A QUESTION OF CAPACITY

This is the second in a series of issue papers for FP/RH program managers that consider the following questions on the subject of scaling up:

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### **Is there enough capacity to scale up?**

Financing is not the only scarce capacity needed for scaling up. Other essential capacities—leadership, management, technical, community, logistical – are also essential requirements for scaling up. The level of these resources will affect the calendar and rhythm of a scaling-up plan. Planning to make needed resources available on schedule should begin at the same time as financial planning.

### **Leadership capacity**

Leadership is needed to create and maintain the vision of a scaled-up program, to rally staff, users, and supporters around that vision, and to mobilize and invest the resources needed. The leader must be able to persuade stakeholders that the additional work, disruption, and transitional uncertainties that scaling-up causes will produce a program that is better for the staff and the public. Emotional appeals will not be enough; the leader may also have to rethink job descriptions, contracts, pay scales, work schedules, and services.

### **Management capacity**

Secondly, management resources such as accounting, procurement, events organization and administration, secretarial support, car pools, logistical support, and even temporary housing and office space may be needed to manage the scaling-up process. And these resources will be needed *at the same time* as the institution carries out its normal schedule of health or community services. The leaders will need to evaluate whether this additional (unused) capacity is available within the institution or whether scaling up will require additional management support. Buying external technical assistance, recruiting temporary staff, or using skilled volunteers are options to consider.

Scaling up takes place within an already full calendar. Rainy season, the harvest, national vaccination days, official holidays, staff vacations, and national and regional elections all limit the availability and willingness of staff, contractors, external advisors, and the community to participate. In one African country, a newly appointed Health Minister changed national priorities from reproductive health to vaccination—the intensive training program for scaling up new reproductive health counselors had to be reprogrammed over an additional year to accommodate new targets and activities for vaccination coverage.

## **SCALING UP: A QUESTION OF CAPACITY**

Most of these time constraints will be known. The program manager who collaborates with experienced field staff to plan the scaling-up calendar will foresee most events and plan around them. If the program manager then reviews progress quarterly and revises the work plan rapidly and realistically, team members are less likely to be surprised either by the pace of events or the resources needed to realize them.

### **Technical capacity**

Are there enough trainers and training sites to provide the needed technical capacity? If the scaling-up activity requires extensive skills acquisition (such as the introduction of new counseling techniques or the creation of a village volunteer network for an entire region), hundreds of workers may need training. Instead of one specialized training team, multiple teams, each with its own materials, equipment, transport, and bookkeeper, will be needed. Yet skilled trainers may have other responsibilities that limit their availability, and training sites may be occupied with other groups or activities. The decision-maker needs to evaluate other ways of covering training needs, possibly by partnerships with public-sector or private-sector institutions with training capacity, by engaging first in extensive training of trainers, by prioritizing certain regions or groups for training, or by adopting a cascade method of training. If workers cannot leave their posts for long periods of time or if the new skills are limited, on-the-job training, distance learning, or monthly training sessions may suffice to impart the skills for scaling up.

### **Community capacity**

Scaling up often necessitates community participation. Are there enough community change agents? Scaling up community involvement is often a village-by-village, neighborhood-by-neighborhood undertaking. Special language skills, and ethnic, age, or gender balance have to be considered when recruiting appropriate change agents. The program manager may have to seek partners in agriculture, education, industry and environmental sectors to find the right community development teams and help the team members acquire the skills and information to make the community a vital part of the scaling up effort.

### **Logistical capacity**

Scaling up requires changes in logistical practices. Pilot projects and new programs often by-pass standard logistics systems by using special purchasing and distribution networks. Scaling up, on the other hand, requires institutionalizing the logistical capacity needed to maintain the supply chain. Institutionalization may require integrating new products into the national or central purchasing and distributing system. It may require coordinating distribution of reproductive health products with other supplies and medications. These changes will probably require integration with distribution networks controlled by managers outside the reproductive health group. If the task is sufficiently large, a major management division may have to be established. This will involve complex bidding processes and developing technical, financial, supervisory, and monitoring systems. The magnitude of the logistical support needed may actually require a change from doing everything “in-house” to engaging contractors or technical consultants for specialized support, including transport of people and materials. These engagements will require more formal definitions of tasks and norms and standards for performance. Whether through in-house expansion or through contracting, scaling up logistical capacity requires thorough analysis, planning and negotiation with potential partners.

## SCALING UP: A QUESTION OF STRATEGY

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### How does scaling up occur?

In scaling up a program, decisions makers need to consider strategies that will permit a rapid and accelerated expansion. There are four types of strategies to bring this about. Depending on the problem and program approach, one or more strategies may be appropriate.

### Replication by “blueprint”

Replication by “blueprint” means copying a successful program into other sites with little or no adaptation. Replication by “blueprint” of a successful pilot program or good practice is a straightforward but often expensive process. This strategy is useful when there is a particularly successful formula for reaching a specific client group. For example, worksite family planning programs have requirements with regard to policy, staffing, and service delivery approaches that can be reproduced in similar workplace settings. A rapid form of blueprint replication is called **explosive scaling up**, when a high-priority program or activity, such as an expanded program of immunization, is implemented uniformly within all health services, or throughout a region or nation.

Blueprint replication strategies are most applicable where client groups and service delivery environments are very similar, where most management systems operate adequately, and where there are few policy or regulatory constraints.

Few economies of scale are gained by replication. The cost of setting up a new site may be lowered because of efficiencies gained through experience, but the operating costs are likely to be similar for each new replication.

### Grafting on to existing programs

Grafting is the addition of a new practice or service to an existing program or site that is already functional. The grafting strategy is appropriate for interventions or practices that can be adapted to the circumstances of new environments, as long as basic principles and techniques are maintained. Grafting works best when the existing or “host” service is well run, and when the additional activities cause minimal disturbance. Grafting strategies are most useful for specific interventions that rely on technology and personnel that are similar to those already in place and when support systems such as supervision, logistics, or information are strong enough to accommodate additional requirements easily. Grafting strategies also work best when the new activities result in an increased number of clients for the existing service.

## **SCALING UP: A QUESTION OF STRATEGY**

Examples of grafting strategies include the introduction of new contraceptive methods in existing family planning programs or the introduction of post-abortion care with family planning counseling into all hospital OB/GYN services treating women for abortion complications. Integration of family planning and reproductive health activities frequently involves grafting. Program managers often recognize grafting possibilities as “unused opportunities,” such as providing IEC for HIV/AIDS voluntary counseling and testing while clients are waiting for family planning services.

### **Association of related programs or services**

Association is an approach to scaling up that links a variety of smaller projects and institutions that implement different components of the total service. Associational strategies can often scale up quality by increasing the depth of coverage within a program. For example, a program for promoting adolescent reproductive health can be improved by creating links between health, social, vocational and employment programs. Association is appropriate when problems are particularly complex, as with adolescent health and HIV/AIDS. In these cases, the client groups are very heterogeneous; each sub-group needs a specific, effective approach.

Another form of associational scaling up is through networking among similar organizations with similar client populations in order to mobilize resources for expanding coverage. Associational or network strategies need strong leadership. Often, new management structures are needed to provide guidance, information, and training, as well as to institute common monitoring and evaluation systems.

Maintaining common goals, shared visions, and service quality among all partners, and an effective referral and follow-up system so clients do not get lost as they move between partner organizations is one of the principal challenges of associational scaling up. Often one partner has to serve as the gateway to manage client referrals and follow-up.

### **Paradigm shift in norms**

Some programs can only be scaled up through fundamental normative changes in laws, policies, social practices, and attitudes. This is called scaling up through a paradigm shift. The enabling environment needs to change in order for the program to expand. Legalizing the importation of family planning products, eliminating professional barriers preventing nurses and midwives from prescribing or delivering contraceptives, or obtaining support from faith-based groups for family planning services have been important paradigm shifts in the past. Currently, paradigm shifts in social attitudes are needed in many countries to make reproductive health services available to youth and to overcome stigma and discrimination associated with HIV/AIDS.

Paradigm shifts depend on intensive local and international advocacy and strong champions from civil society to create broad popular support for new ways of thinking. Often coalitions or partnerships among groups with diverse agendas for change may be necessary to precipitate a paradigm shift.



## SCALING UP: A QUESTION OF IMPACT

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### **The impact of a scaled-up program**

The choice of which program, intervention, or practices could be scaled up and should take into consideration the magnitude of potential impact on major health indicators. Changes in major indicators should be proportional to scaled-up costs and to scaled-up access in order to justify the effort and resources needed. Because the decision will require the allocation of significant human and financial resources, it is wise to choose options that will produce the greatest impact. There are three kinds of impacts to consider: health, social, and financial.

### **Health impact**

Health impact indicators include standard epidemiological, demographic, and behavioral measures. However, in scaling up, attention should be paid to how quickly changes in these indicators can be expected to emerge. Some indicators, such as condom use, may change quickly, while others such as prevalence of STIs will change more slowly. Measuring and reporting on these indicators needs to be done at appropriate intervals and with great accuracy.

The pace of impact will depend on the way the scaling-up initiative is carried out and the responses of the affected population groups. Scenarios range from slow start-ups with slow responses to rapid start-ups and rapid responses. These variations depend on the state of demand and access when the scaling-up initiative is launched.

A set of milestones is helpful when measuring the intermediate stages of achieving desired impact of a scaling-up initiative. The Stages of Program Development Framework<sup>1</sup> provides a set of five milestones for the development of a family planning program as shown in the following table. This framework is helpful because it tells where the scaling-up initiative is and what conditions are necessary to get to a particular stage. Scaling up a practice or service should clearly contribute toward moving the national program from one stage of development to the next. If the program has not evolved in recent years, scaling up should focus on new target groups or untouched areas. In this framework, milestones are based on ranges of contraceptive prevalence. These rates can generally be linked to major qualitative differences in program characteristics. This framework would need to be adapted to other reproductive health initiatives, such as improvements in maternal health or prevention of new HIV/AIDS cases.

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<sup>1</sup> Destler, Harriett, et al. “Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties” Washington, DC: USAID, Office of Population, 1990.

## SCALING UP: A QUESTION OF IMPACT

### Family Planning Program Milestones

STAGE 1	STAGE 2	STAGE 3	STAGE 4	STAGE 5
CPR 0 – 7 %	CPR 8 – 15%	CPR 16 – 34%	CPR 35 – 49%	CPR 50% and higher
Build support and credibility for family planning	Broaden institutional base and client population  Provide information and services	Broaden service availability  Broaden FP information	Increase segmentation of the market	Build upon success achieved to date  Diversify the types of providers

### Social impact

A scaling-up initiative that consumes major resources should also show impact in other important areas. Demographic, epidemiological, and behavioral impact needs to be complemented by significant social benefits. Sustaining impact in these areas needs to be accompanied by impact in a number of other areas, including:

- **Gender relations.** Does the scaled-up program affect problems such as spousal abuse or rape, or other relations between men and women underlying the problems that the program aims to mitigate?
- **Unemployment, poverty and empowerment.** Will there be any significant changes in economic status as a result of the scaled-up program?
- **Equity.** Will scaling up affect access to health or services for underserved or vulnerable and hard to reach groups?
- **Educational opportunities.** Will scaling up affect schooling and school dropout rates in primary and secondary education for girls?
- **Stigma and discrimination.** Will scaling up affect attitudes toward vulnerable, marginalized population groups?

Social impact is often complex and difficult to measure. Program managers will have to collaborate with professionals in the social and other sciences to measure impact in these areas.

### Financial impact

All gains have costs. More spending on one program often means less spending on another program that may be equally important, or that may emerge as more important in the future. Thus, costs need to be acceptable to society at large and bearable both in the short and in the long term. The impact of costs needs to be measured and demonstrated by:

- long-term savings that are brought about by effectively scaled-up programs ;
- shifting of cost from one payer (such as the government) to another (such as health insurance or community financing schemes);
- changes in real terms of costs to the client or patient;
- a comparison of the consequences of diverting, as well as not diverting, resources to one problem rather than another.

## SCALING UP: A QUESTION OF SUSTAINABILITY

This is the fifth in a series of issue papers for FP/RH program managers that consider the following questions on the subject of scaling up:

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### What does sustainability mean in relation to scaling up?

Scaling up or accelerated expansion of a program to achieve greater access, quality and impact. The process of scaling-up can be lengthy and complex, so momentum must be sustained. Once the program has reached a new level of capacity, that level must be maintained and backsliding prevented. Most important, the health and population impacts brought about when the program operates at scale must be sustained for true progress.

### Sustaining the process

Even rapid, scaling-up takes time. Over several years, it is likely that new priorities will make competing demands on financial and human resources and jeopardize or undermine efforts already underway to scale up older programs. This is being felt in regard to family planning for example in the wake of the HIV/AIDS epidemic. Political will and resources that have taken so long to mobilize in regard to family planning and reproductive health run the risk of being sidelined as countries meet the continuing crisis of the HIV/AIDS epidemic. Sustaining the scaling-up process over time, as costs grow and impact is indeterminate, depends on three things:

First, it depends on **effective leadership**. Continued advocacy for reproductive health programs, advocacy that is founded on good data, is an essential element of leadership.

Second, sustaining the process means that the process itself has to be evaluated regularly and updated in light of new technology, and changes in the demographic, epidemiological, political and technological environment. Concepts of public health and public good will change over time, and a process that is likely to take several years needs to incorporate new ideas, new ways of explaining goals and objectives, and new strategies and practices that prove most economical and effective. An important element in sustaining the process of scaling up a program is the **constant search for and assimilation of best practices**.

Finally, sustaining the process requires **good management**. Maintaining high standards in planning, accounting, and monitoring and evaluation are important aspects of sustaining the process. This is often easier said than done, as over time, good people who were key to initiating the process of scaling up often leave and it takes time for the replacements to gain experience and show commitment.

## **SCALING UP: A QUESTION OF SUSTAINABILITY**

### **Sustaining the program**

Once programs have reached scale, keeping them running at desired levels of quality becomes a challenge. Leading and managing programs at scale requires different skills from those needed to bring the program to scale. The sense of emergency or crisis that generates the political will and the resources to bring a program to scale tends to slacken once the program has reached scale and is not necessarily replaced by the patient attentiveness required to maintain the program. This phenomenon has occurred many times in regard to immunization programs where the achievement of high coverage rates has been followed by periods of backsliding to “pre-campaigning” levels.

In other instances, routine programs at scale can be jeopardized by reform initiatives affecting the organization and financing of services. Decentralization, reorganization of drug logistics, cost recovery policies and renewed emphasis on primary health care can bring about changes in ways that resources are allocated and personnel used that can have unanticipated consequences on the implementation of a scaled up program. The program can start to come apart as priorities change from locale to locale, and as mechanisms for maintaining high standards such as systems for supervising personnel and financial management procedures are fragmented.

As programs begin to reach scale they become increasingly sensitive and vulnerable to major changes in public administration and management policies and procedures. Program managers will have to continually assess how economic, political and administrative changes being planned or underway in their countries can affect the way the scaled up programs will be carried out at the local level. As they go to scale, programs need to constantly reinforce their local roots at the village, municipal and district level. They have to be seen as local solutions to local problems. Commitment, advocacy and good management practice is as important at the local level as it is at the national level for programs operating at scale.

### **Sustaining the impact**

In some cases, once a program has reached scale and brought about significant changes in the behavior and health of the population, the program itself becomes less important than the need to maintain improved health status. The public may be able to access similar services through other means. When demand for reproductive health services becomes strong enough, it may be possible to shift the supply side of the program from the public to the private sector. With the development of contraceptive technologies, it may be possible to shift the distribution of many contraceptives from fixed health facilities to social marketing venues. Also as population characteristics change over time, certain programs that were once very effective may no longer produce results. This phenomenon often has been seen as addressing the rapid generational change among adolescents.

Maintaining health impact over time requires constant program evaluation and renewal. Sustaining impact of family planning means working within the framework of a long term vision of how women can continually be enabled to choose a method, stop the method to carry a desired pregnancy to term successfully and then resume contraception, as well as helping new generations of adolescents begin protection. A sustainable program means that demand for services is maintained and that sustained access and quality meet that demand.

# SCALING UP: A QUESTION OF ACCESS

This is the sixth in a series of issue papers for FP/RH program managers that consider the following questions on the subject of scaling up:

- A question of change: How do we know when we have achieved scale?
- A question of capacity: What management, technological, and human competencies are necessary to bring programs to scale?
- A question of strategy: What strategies most effectively produce the desired leap?
- A question of impact: How should the desired impact be measured?
- A question of sustainability: How do we maintain the gains of an expanded and comprehensive program?
- **A question of access: What kind of coverage is enough to qualify as “scaled up”?**
- A question of supply and demand: What is being scaled up?
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## A Question of Access

Scaled-up programs, interventions, or practices need to aim for *universal* access for the general population, special subpopulations, or special, vulnerable, or high-risk groups. Universal access means that services are available through a variety of different sectors and permeate entire regions or even nations, and that services operate in all institutions and combinations of institutions through the public, NGO, and private sectors. Expanding access also implies enabling services to reach more people through greater management efficiencies or by eliminating barriers to demand, for, example, by improving quality. Scaling up access has two dimensions: *breadth* and *depth*.

### Breadth

Reproductive health access is considered to be broad when geographic access to services is available throughout a given area and when different client groups can make use of the same services.

The geographic dimension of coverage is sometimes considered the simplest to assure. This type of scale has been described by some as “quantitative.”<sup>1</sup> Nevertheless, geographic access poses specific challenges. As services spread toward remote or difficult areas, it may become harder and harder to find health workers and staff willing to relocate there. Housing or other special benefits may have to be provided to induce staff to accept these posts. Communications, drug pipelines, supervision, and other components may require longer lead times or special arrangements to be functional. Scaling up geographic access requires careful evaluation of feasibility, potential client base, and financing.

Access is broad when there is programmatic diversity to meet the multiple needs of clients or to meet needs of different client groups that are unable or unwilling to use services made available to the general population. As target groups find services that are acceptable to them and as the population changes, the concept of unmet need changes. Maintaining breadth of this kind requires continual assessment of the population’s needs as the demographic and epidemiological situation evolves over time. Managers have to identify both the apparent needs and unmet needs.

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<sup>1</sup> Uvin, P. and D. Miller. *Scaling Up: Thinking through the issues*. Providence, RI: World Hunger Program Research Report, 1994.

# SCALING UP: A QUESTION OF ACCESS

## Depth

Access has depth when there is a wide variety of services which are of adequate levels of quality. In family planning, access has depth when the contraceptive method mix includes short-, medium-, and long-term methods. In maternal health, coverage has depth when there is a functional referral system so that normal births occur in multiple settings (for example, at home with a trained TBA or midwife or in a skilled care setting), difficult births are referred to higher levels of care, and emergency transport is available in a timely fashion to avoid maternal and infant deaths. Depth means that a client may choose from a variety of services and service settings, providers, and prices (e.g. as when a client may buy either male or female condoms in a pharmacy, bar, hotel, or shop, but also from a village health worker, a health facility, a youth center, or an HIV/AIDS center).

Breadth and depth of coverage are achieved not only by segmentation of the market, but also by multisectoral collaboration with institutions providing access to special groups or providing opportunities to serve target groups more efficiently or more effectively. The following table summarizes the main elements of universal access and ways to increase breadth and depth.

**Characteristics of scaled-up coverage for reproductive health systems**

Service	Characteristics of universal access	Increasing breadth and depth
Family planning	<ul style="list-style-type: none"> <li>• Services available at every health facility at all times of operation</li> <li>• Services provided by a variety of public, voluntary, and private-sector providers</li> <li>• Products, medications widely available, including de-medicalized sources</li> </ul>	<ul style="list-style-type: none"> <li>✓ Diversify logistical system with private sources, multiple products, as well as generic and public sources</li> <li>✓ Assure that there is a wide range of prices for services and products while meeting quality standards</li> <li>✓ Ensure multiple services/methods available</li> </ul>
Maternal health services and general RH	<ul style="list-style-type: none"> <li>• Quality of care institutionalized</li> <li>• Prenatal care, skilled assisted delivery, post natal care available everywhere from public and private providers</li> <li>• Referral system functions effectively</li> </ul>	<ul style="list-style-type: none"> <li>✓ Design special programs for young pregnant women, displaced persons, etc.</li> <li>✓ Campaign for earlier intake for prenatal care to reduce emergency deliveries</li> <li>✓ Ensure adequate knowledge of signs of complications for all involved</li> <li>✓ Ensure adequate referral and transport system</li> </ul>
Post-abortion care	<ul style="list-style-type: none"> <li>• All five key aspects of post-abortion care or referral available from all health providers</li> <li>• Strong links to family planning programs to prevent unintended pregnancies</li> </ul>	<ul style="list-style-type: none"> <li>✓ Obtain policy-level commitment, including budgets for PAC</li> <li>✓ Provide information to potential users through multi-sectoral channels</li> </ul>
Youth, men, special target groups	<ul style="list-style-type: none"> <li>• Special groups prioritized and targeted, interventions tested, revised, scaled up in an orderly fashion</li> </ul>	<ul style="list-style-type: none"> <li>✓ Continue demographic and client analysis in order to update and refine definition of special target groups</li> <li>✓ Make high-quality services available and accessible for special target groups</li> </ul>
Sexually transmitted diseases	<ul style="list-style-type: none"> <li>• Public and private health providers recognize and treat STIs, and routinely screen, treat pregnant women</li> <li>• STI treatment drugs available throughout the country</li> <li>• Public informed about STIs, how to prevent them, and where to get services</li> </ul>	<ul style="list-style-type: none"> <li>✓ Information campaigns should be multisectoral and involve schools, worksites</li> <li>✓ Target special needs groups like port workers, prostitutes, defense workers, transporters, miners</li> <li>✓ Design services appropriate for men</li> <li>✓ Work to reduce stigma, which is a barrier to care seeking</li> </ul>
HIV/AIDS	<ul style="list-style-type: none"> <li>• VCT widely available at low prices or free</li> <li>• Multisectoral prevention programs are</li> <li>• Blood safety maintained</li> <li>• Care and support extended to the home</li> <li>• Impact mitigation efforts underway</li> <li>• MTCT available</li> </ul>	<ul style="list-style-type: none"> <li>✓ National multisectoral policy guidance and leadership mobilizes resources, sets norms and standards, diffuses best practices, monitors introduction of new drugs and information</li> <li>✓ Both prevention and care services, including VCT and MTCT services, available and accessible</li> </ul>

# SCALING UP: A QUESTION OF SUPPLY AND DEMAND

**This is the seventh in a series of issue papers for FP/RH program managers that consider the following questions on the subject of scaling up:**

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## **What is being scaled up?**

At the most basic level, scaling-up aims to increase either the demand for reproductive health services or the supply of reproductive health services, or both. Significant unsatisfied demand for reproductive health services exists in many countries. Supply depends on the ability and willingness of the government, the voluntary sector and other provider institutions to make services available to potential clients.

## **Recognizing demand and supply constraints**

Demand constraints influence individual decisions on using services. These constraints generally include:

- clients’ knowledge, understanding, and appreciation of what reproductive health services are, their availability, and their potential benefits for the client and his/her family;
- clients’ willingness and ability to pay the social, time, and monetary costs;
- clients’ socio-demographic profile as defined by their habitat, education, and economic status, parity, and age and gender;
- clients’ needs for other services such as prevention and care for STIs and HIV/AIDS.

Supply constraints are limits on the provision of services. Six types of supply constraints or barriers operate:

- human resources—not enough providers, inappropriate training;
- infrastructure—inappropriate distribution of service delivery points and inappropriate service settings;
- management—stock-outs, inadequate delivery or ordering systems, poor use of information;
- quality—lack of confidentiality, inappropriate treatment of clients, inadequate clinical skills;
- legal—restriction on services or products, on access by client groups, or on provision by different categories of personnel;
- financial—impediments to funding, accessible pricing, or subsidized services.

# SCALING UP: A QUESTION OF SUPPLY AND DEMAND

## Typical demand and supply constraints and interventions to overcome them

	Constraints	Possible interventions to overcome constraints
Demand	<b>Policy</b> <ul style="list-style-type: none"> <li>No political will to publicly support RH services</li> <li>Legal restrictions on IEC, media use, message content for reproductive health</li> </ul>	<b>Policy</b> <ul style="list-style-type: none"> <li>✓ Advocate with political and institutional leaders</li> <li>✓ Identify and promote champions for RH and work with media to develop acceptable messages</li> <li>✓ Change laws or regulations</li> </ul>
	<b>Program</b> <ul style="list-style-type: none"> <li>Excessive user fees</li> </ul>	<b>Program</b> <ul style="list-style-type: none"> <li>✓ Work with worksite health, insurance, community fund schemes to include RH in package of financed services</li> <li>✓ Reduce costs and fees</li> </ul>
	<b>Community</b> <ul style="list-style-type: none"> <li>Cultural beliefs and practices</li> <li>Opposition, disinformation from religious leaders</li> </ul>	<b>Community</b> <ul style="list-style-type: none"> <li>✓ Change community attitudes through multimedia campaigns</li> <li>✓ Advocate with religious leaders, cultural leaders, and potential change agents</li> <li>Identify possible best practices</li> </ul>
	<b>Clients</b> <ul style="list-style-type: none"> <li>Physical access barriers</li> <li>Lack of knowledge about RH</li> <li>Resistance of spouse or family</li> <li>Cultural/psychosocial barriers</li> <li>Financial barriers</li> <li>Bad experience with RH</li> <li>Fear of diagnosis (pregnancy, STI, HIV/AIDS)</li> <li>Available services not seen as appropriate for them (adolescents, men, poor, other special groups)</li> </ul>	<b>Clients</b> <ul style="list-style-type: none"> <li>✓ Supply alternative such as community-based services</li> <li>✓ School RH information curriculum, behavior change communication, women's education programs, home visits by CBD, use of leaders for IEC, mass media</li> <li>✓ Provide suitable health financing mechanisms such as subsidized services, community health funds, lower user fees</li> <li>✓ Include client home visiting to find drop-outs, COPE, better quality</li> <li>✓ Include BCC, IEC about treatment, alternatives, VCT, confidentiality, improved counseling</li> <li>✓ Conduct focus group and other collaborative research to identify solutions, social marketing, targeting special services or hours to low-access groups</li> </ul>
Supply	<b>Policy</b> <ul style="list-style-type: none"> <li>Legislative barriers to methods or services</li> <li>Budgetary constraints</li> <li>Limitations on hiring, initial training of health workers</li> <li>Poor-quality standards</li> </ul>	<b>Policy</b> <ul style="list-style-type: none"> <li>✓ Advocate for deregulation or changes in the law</li> <li>✓ Advocate for prioritization of allocations to RH, find additional donors, prioritize services and focus on key issues</li> <li>✓ Advocate CBD, volunteers, training of nurses, aides</li> <li>✓ Create/Review national guidelines/clinical protocols</li> </ul>
	<b>Program</b> <ul style="list-style-type: none"> <li>Poor-quality services</li> <li>Poor logistics</li> <li>Inappropriate geographic placement of services</li> <li>No services for certain target groups</li> <li>Inconvenient, inappropriate opening times</li> <li>Poor mix of services</li> <li>Unpleasant, dirty, unsafe infrastructure</li> <li>Poor management of resources</li> <li>No supervision</li> </ul>	<b>Program</b> <ul style="list-style-type: none"> <li>✓ Implement RH service delivery guidelines through training, supervision, infrastructure/equipment improvements</li> <li>✓ Improve estimation of commodity needs and delivery channels</li> <li>✓ Consider replication or association to improve geographic coverage, transfer personnel if possible, use CBD or outreach</li> <li>✓ Decide if additional target groups can be accommodated,</li> <li>✓ Use focus group and other collaborative research to identify solutions</li> <li>✓ Identify possible best practices</li> </ul>
	<b>Sectors</b> <ul style="list-style-type: none"> <li>No collaboration between RH program and other health services</li> <li>No collaboration with non-health sectors</li> </ul>	<b>Sectors</b> <ul style="list-style-type: none"> <li>✓ Conduct strategic mapping of RH program.</li> <li>✓ Advocate for multisectoral approach to service delivery</li> <li>✓ Explore/develop partnerships with environmental, women's development, business, agricultural, education sectors</li> </ul>
	<b>Community</b> <ul style="list-style-type: none"> <li>Unwillingness to participate in CBD program or to allow RH activities in village</li> </ul>	<b>Community</b> <ul style="list-style-type: none"> <li>✓ Begin program elsewhere, allow village to join later</li> <li>✓ Provide leaders and others in BCC and sensitization activities</li> <li>✓ IEC</li> </ul>
	<b>Providers</b> <ul style="list-style-type: none"> <li>Inappropriate staff attitudes towards clients</li> <li>Unavailable during clinic hours</li> <li>Failure to respect clients' rights</li> <li>Failure to respect privacy and confidentiality</li> <li>Bias for or against specific services or methods</li> <li>Weak clinical or counseling skills</li> <li>Corruption</li> </ul>	<b>Providers</b> <ul style="list-style-type: none"> <li>✓ Institute quality focus tools such as COPE<sup>1</sup>, CQI<sup>2</sup></li> <li>✓ Reorganize weekly schedule and opening times</li> <li>✓ Train staff in interpersonal skills, supervision</li> <li>✓ Reorganize consultation rooms, waiting rooms</li> <li>✓ Introduce new methods</li> <li>✓ Integrate services</li> <li>✓ Review national guidelines and technical knowledge</li> <li>✓ Train staff in technical skills, norms, and standards</li> <li>✓ Provide supervision and leadership, auditing, involve village committee, do IEC on real prices, create new provider incentives</li> <li>✓ Identify strategies for financing renovation</li> </ul>

<sup>1</sup> Client Oriented Provider Efficiency

<sup>2</sup> Continuous Quality Improvement



## SCALING UP: A QUESTION OF COST

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### How much will scaling up cost?

Making the decision to scale up a program involves evaluating multiple choices: the choice of intensive scaling up versus the delayed impact of natural program growth; the choice between spending political capital on mobilizing support for this option versus some other option; and the choice of spending money on one program versus using the resources for another program. The financial costs of scaling up must take into account both the cost to **implement** the scaling-up activities and the cost to **maintain** the scaled-up program. Both types of costs have to be carefully estimated and realistic strategies for mobilizing resources need to be designed.

### Estimating start-up costs

Estimating start-up costs should begin with a thorough analysis of the costs of the pilot program or service to be scaled up and a choice of scaling-up strategies. On the basis of this analysis, a program manager can build a trial work plan defining the activities, acquisitions, and other actions to be completed in the scaling-up process. Using the work plan, the quantities of human, financial, and other resources needed can be estimated and costs attached to them. For programs of national scale, the manager may need the help of economists and national planners, as well as technical and program experts.

The costs of scaling up can be startling. Although unit costs (such as the cost of training one village health agent or buying one sterilizer) may be reasonable, multiplying the unit cost by the number of units needed to achieve universal coverage may produce results that the available budget cannot accommodate. These costs are even greater if capital investments such as renovation or construction are required or if support systems, such as MIS, must also be scaled up. It is important to experiment on paper with rapid and slow start-up plans, each having different annual cost implications, or to experiment with alternative strategies that may cost less.

### Estimating long-term running costs

Estimating long-term running costs requires predictions about the expected demand for services as well as the expected evolution of key cost elements such as salaries and commodities. Multiple scenarios of projected demand should be used to understand how costs would vary according to the pace of demand evolution. Similarly, factors like inflation, exchange rates, government salary reforms, utilities rates, and fluctuating drug prices should be considered in these estimates. Creating an estimate for a five-year period is probably sufficiently ambitious. Cost estimates need to be periodically evaluated. Projected costs will be affected not only by

## SCALING UP: A QUESTION OF COST

inflation or deflation but by the introduction of new strategies and technologies in reproductive health during the scaling-up period.

### **Economies of scale**

Economies of scale result when the cost of producing each unit of service drops as a program grows. These economies depend in part on the capacity of a system to produce. For example, the additional cost of treating one more client in a family planning center may be limited to the supplies used during the consultation. Increasing clientele in a homogeneous population by improving the quality of care may actually reduce average unit costs because the service is using human resources that were wasted before. However, if the aim of scaling up is to serve hard-to-reach populations, the prospect of falling marginal costs as volume is increased may not be realistic in the short term.

Depending on the scaling-up strategy chosen, some economies of scale may be found even during the start-up phase. Bulk purchasing of equipment, drugs, or supplies may produce a lower price per unit. Standardized training sessions may allow full use of trainers and training sites. Rational geographic planning of the scaling-up activities may allow better use of transport and other facilities. These “marginal” economies may add up even though the total costs are higher.

In general, economies of scale are achieved by programs with efficient and thoughtful management. Investment in improving financial management skills may save money in the long run.

### **The cost of alternatives**

Because the budget for scaling-up is large, decision-makers will usually want to know what else could be done with the same amount of money and compare different strategies. Decision-makers should be prepared to compare the scaling-up proposal to other proposals for different strategies or for rival programs both in terms of cost and impact.

### **Cost information for decision-making**

Costing should produce the following estimates for decision-makers:

- start-up costs for each of the scaling-up strategies, including supplies, human resources, management support, and capital investments;
- running costs to maintain high-quality services and meet expected demand;
- unit costs of each service in the scaled-up program over time;
- projected savings through efficiencies and improved management;
- projected income and revenue from user fees (if any);
- costs of alternative programs or alternative uses for needed resources.

Decision-makers should compare costs with expected outcomes, revenues, and savings to be able to justify expenditures for scaling-up to the public, to political leaders, and to financing institutions. They can also use cost information to seek resources for the scaling-up plan.

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### **Financing scaling up: How much for how long?**

The total magnitude of the cost of scaling up a health program is often a decisive factor in decision-making. Although costs per patient or per client may be reasonable, the total cost of scaling up may exceed available program budgets or revenues. Therefore, every scaling-up program must be accompanied by a financial support package. Mobilizing the resources to support the program will require significant effort from the decision-makers.

Unless the scaling-up activity can be achieved through a low-cost grafting process, scaling up will require major funding over several years. Leaders should be ready to tackle resource mobilization from two directions: by dividing the scaling-up plan into phases or stages that can be accelerated or delayed as funding becomes available, and by seeking multiple sources of funding and other resources, including nontraditional sources and income generation.

### **Mobilizing financial resources**

Governments and international bilateral, multilateral, and private donors have been the traditional funders of reproductive health services and large-scale health infrastructure projects. Government decision-makers must allocate very limited resources among a host of rival programs. They need to be convinced that positive benefits will come from the societal and political support for scaling up a particular program, compared to support for other uses of the funds. International donors, on the other hand, must be convinced that the scaling-up effort is aligned with their priorities and consistent with their existing commitments.

The wise leader should present to each type of funder the entire program of scaling up as well as that part of the program for which funds are sought from that donor. Increasingly, governments and international donors expect and even require multiple sources of funding for large-scale programs. Clear plans for coordinating various funding sources around a single work plan make donors more confident that the recipient institution is prepared for the long-term multi-donor effort required to implement it. Transparency and good accounting practices in the use of funding for large programs is crucial for building confidence with donors. They are also essential for maintaining public-private partnerships, which may be critical part of a scaling up strategy.

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### Mobilizing nontraditional resources

Scaling up may well require more than government or donor program support. The following table shows some other potential sources of support and the types of efforts needed to mobilize them. While a single source will not be sufficient to finance scaling-up alone, using a combination of these non-traditional mechanisms could reduce the amount required from donors.

### Types of support and needs for mobilization

Source	Type of resources	Mobilization efforts
Local communities, local businesses	Raw materials, labor, transport, financial contributions, ongoing volunteer participation	Classic community mobilization efforts may lead to significant contributions, may require technical supervision and/or training
Self-imposed household or hearth tax	Financial support from payments of the all potential beneficiary residents	Community or local government vote to raise funds for the program through self-imposed tax
Value-added tax or sales surcharge	Financial support from sales of specific types of goods	National or regional government vote or by-law to raise funds by a standard tax
Corporations, large businesses	Financial or material support from corporate philanthropy Human resources, technical assistance	Formal proposal to directors, publicity or formal recognition of contributions can be used, Inclusion on the program oversight committee also possible
Lotteries, charity events, walkathons	Financial support	Efforts to raise large amounts can be costly and time-consuming; Small sums can be effectively raised if major prizes are acquired through contributions
Cross-subsidization through user fees	Financial support from other health activities' revenues	Clear explanations to the client population in order to avoid reduced demand are needed
Rental/sales of unused resources	Fees from exploitation of excess capacity (such as empty buildings or partially used machines)	Identify excess capacity and potential purchasers or users who would be willing to pay for using them
Health insurance or community funds	Coverage of new services by the benefits package	Convince directors of cost-effectiveness of the service and potential demand, long-term benefits to members
User fees	Fees for services	Study feasibility of user fees Use mass media and clinic brochures explaining why user fees are needed

In Tanzania, regional health officials working with local business leaders and hospital staff managed to “scale up” the renovation of Mount Meru Regional Hospital from one wing to the entire hospital complex by combining four of these approaches over a three-year period. Transparent management of resources by a multisectoral committee (who paid for their own tea breaks and eschewed sitting fees) raised confidence among community, international, and corporate donors.

### Is partial funding better than none?

It is a rare and lucky program that secures guaranteed funding from start to finish. To convince funding organizations that their additional contribution will “build on success,” the decision-maker must show that the use of partial funds followed a logical plan, either through accomplishing essential first steps common to all phases of the program or by completing the scaling-up of one or more elements of the complete program. However, if the promised funds are not sufficient even for a phase or step, then the decision-maker should re-evaluate the feasibility of implementing the plan or the timing and process that have been chosen.

### The cost of mobilizing resources

Raising money costs money! The human effort, phone calls, travel, postage, photocopies, meetings, and plain hard work required to produce a proposal may add up to hundreds if not thousands of dollars and hours. Before selecting one or more financing targets, the program manager would be wise to evaluate the cost of a creditable mobilization effort and weigh those costs against the benefit of efforts in other areas and the likelihood of success.

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### **When is the right time to scale up?**

Scaling up is often thought of in terms of needed resources. It is also a question of timing. The time for scaling up is right when essential conditions for success are present or have been created. In discussing disease eradication activities, which by their very nature require implementation at scale, Bruce Aylward, et al.<sup>1</sup> have identified three conditions for testing the feasibility of mounting a successful large-scale effort. Adapted to reproductive health, these conditions are: 1) technical feasibility, 2) positive costs and benefits, and 3) societal and political support.

### **Is the technology compatible with current and future needs?**

The challenge of technical feasibility for scaling up lies in the very diversity of reproductive health services. These include contraception and family planning, sexually transmitted infections, sexuality, pregnancy and birth, counseling, and maternal health. All of these must be shown to work, produce results, and be replicable and sustainable without requiring too many additional environmental changes.

Timing is strongly affected by the availability of an appropriate technology. For example, we know that methods offering both contraception and HIV/AIDS prevention are key to successful protection for women. The female condom falls in this category but there are no other available technologies completely controllable by the woman user. Work is proceeding on appropriate microbicides, and when these are available, timing will be right to scale up female-focused prevention efforts.

A combination of local, national, and international information on the results of clinical studies, operations research projects, and pilot projects is needed to make decisions on technical feasibility. The current movement to document and disseminate “best” or “better” practices can facilitate the acquisition of information regarding technical feasibility and help answer whether the technology works, whether it is acceptable, and whether it is free of negative consequences.

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<sup>1</sup> Aylward, B. et al. “When is a Disease Eradicable? 100 Years of Lessons Learned.” *American Journal of Public Health* 90: 1515–1520.

## **SCALING UP: A QUESTION OF TIMING**

### **Are there long term savings and benefits?**

The timing for scaling up may be right if the service, strategy, tool, or specific intervention shows that it benefits both individuals and society as a whole. These benefits can be measured by indicators such as maternal mortality and morbidity, decreasing TFR, or reduced incidence of STIs, as well as by broader societal economic measures.

For a service, strategy, tool, or specific intervention to produce “positive costs”, it should provide net savings. These savings show up in two ways: 1) averted long-term expenses, or 2) cost-effectiveness savings in the short term. For example, if post-abortion care services are introduced, over the long term there will be fewer cases of abortion and lower hospital costs, particularly in countries where over 50% of OB-GYN ward beds are filled by women with incomplete abortions. In the short term, by reducing the length of hospital stay, manual vacuum aspiration (MVA) has proven more cost-effective than dilation and curettage (D&C) for treatment of medical postabortion complications.

In the past, the main arguments for family planning were both the long-term savings in resources to most development sectors and reduced costs due to lower maternal and child mortality and morbidity. Instituting family planning programs also resulted in healthier mothers and children, a higher quality of life, and increased per capita GNP.

### **Is there societal and political support?**

Societal support exists if the potential client population is ready for the product or service. Readiness is a combination of low resistance, high acceptance, and strong perceptions of social, economic, and personal benefit and need. If a program meets these conditions, it is likely to be in high demand. In many countries, according to DHS studies, men and women show little resistance to and high acceptance of family planning services. Perceived need in terms of intent to limit the number or space the birth of children is high.

Demand needs to be given voice by leaders or champions. The question of political support asks whether the service or product matches the agendas of the broadest spectrum of political decision-makers, or serves the interests of leaders who are most likely to act as champions. Advocacy is needed to overcome decision-makers' perception that there are no or limited positive benefits to supporting RH. Fear of political risk keeps decision-makers from supporting reproductive health for adolescents. Developing constituencies for controversial issues will make assuming that risk possible and even desirable.

### **When is the time right? How many conditions need to be met to move ahead?**

There is insufficient evidence about how many conditions (technical feasibility, positive costs and benefits, and societal and political support) must be present in order for scaling up to be successfully launched. Is the time right when only two out of three of these conditions are present or must all three conditions be present? It is probable that scaling up must always wait for technically feasible solutions to be found, because scaling up technically weak options has proven to be wasteful and detrimental. However, can scaling up be attempted when only one of the other two conditions—consensus on positive costs and benefits or societal and political support—is present? Or are both these conditions necessary? Analysis of successful scaling-up initiatives may help to provide these answers. Meanwhile, careful evaluation of all three conditions for successful timing of scaling up must be a part of the decision-making process.