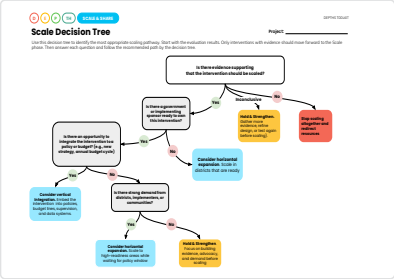
Scale

Welcome to *Scale*!

This phase explores how to expand a tested intervention, either by reaching larger populations, adapting to new regions, or becoming a part of policies and systems.

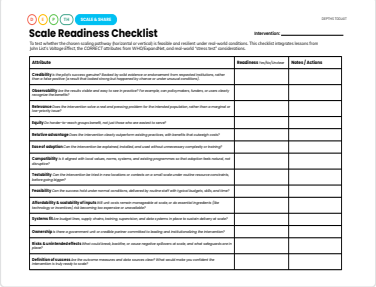
The goal of scaling an intervention is simple: **expand its reach and adapt to new contexts without losing effectiveness.** This is accomplished by identifying the essential components that drive an intervention's effectiveness, along with implementing supportive infrastructure and securing the resources necessary for sustained delivery.

Key activities in this phase include:



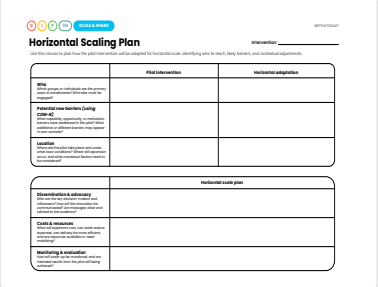
Scale Decision Tree

Deciding whether to expand the intervention horizontally (to new geographies or groups) and/ or vertically (by integrating it into policies and systems) using a **Scale Decision Tree**



Scale Readiness Checklist

Conducting a **Scale Readiness Checklist** to assess the intervention's readiness to scale



Scale Plan

Preparing a **Scale Plan** that outlines the steps, roles, responsibilities, and financials of scale

Steps in the *Scale* phase

1 → 2 → 3

Decide Pathway

Choose the best pathway for scaling the intervention and evaluate readiness to use that pathway to deliver the intervention at scale.

TOOLS:

Scale Decision Tree

Scale Readiness Checklist

Build Support

With the problem and outcomes defined, identify the constituent behaviours. Select one that has the highest potential impact and feasibility of being changed

TOOLS:

Stakeholder Support Matrix

Plan for Scale

Prepare the people and institutions who will drive the process. identify the most influential actors, define their roles, and mapping out when and how to engage them.

TOOLS:

Horizontal Scaling Plan

Vertical Scaling Plan

Why Scale?

Without careful planning, even the most promising interventions can stall, collapse, or cause harm when spread too widely or too quickly. This section highlights why scaling matters, the risks of scaling without adaptation, the challenge of sustainability and systems integration, and the potential when scaling is done well.

The importance of scaling

For UNICEF, scaling entails the deliberate effort to ensure proven solutions benefit children and communities at the population level, not just in pilot sites. As pilots often operate under special conditions that are not necessarily present at scale, scaling is not simple replication but a guided and strategic process that requires systematic planning, and the careful consideration of institutional capacity and sustainability.

Sharing is part of this process. Through the intentional dissemination of insights, evidence, and lessons, other communities, partners, or policymakers can adopt, adapt, and multiply the impact in their own contexts.[1] This process ensures that insights can influence real world practice and policy, even where the full replication of an intervention is not possible.

However, evidence of effectiveness during pilot testing does not guarantee success at scale. Consider the following factors:

- **Feasibility**: whether the intervention is affordable and possible to be integrated with routine processes
- **Strategy**: whether the intervention delivers clear value to key stakeholders, such as the government
- **Adaptability**: whether the intervention is flexible enough to fit into policies and organizational contexts
- **Acceptability**: whether the intervention is trusted and welcomed by the target population

Even when these criteria are met, many other factors are critical in whether an intervention succeeds at scale, including the ownership and expertise of implementing teams, delivery capacity, political commitment, financing models, and alignment with policy windows.

Ideally, scaling should be considered from the onset of the DEPTHS process, to ensure that interventions are designed for real-world systems and future adaptation. However, it's also essential to resist the pressure to scale too soon, before an intervention's feasibility and effectiveness have been established. Scaling depends as much on systems, relationships, and timing as it does on evidence. Recognizing both intervention and non-intervention factors that impact scalability from the outset increases the likelihood that innovations move beyond the pilot stage to become sustainable, institutionalized solutions.[2]

1 World Health Organization (2010). Nine steps for developing a scaling-up strategy. Geneva: World Health Organization. Available at: https://iris.who.int/bitstream/handle/10665/44432/9789241500319_eng.pdf?sequence=1 [Accessed 26 Aug. 2025].

2 World Health Organization (2010). Nine steps for developing a scaling-up strategy. Geneva: World Health Organization. Available at: https://iris.who.int/bitstream/handle/10665/44432/9789241500319_eng.pdf?sequence=1 [Accessed 26 Aug. 2025].

1. The risks of scaling without adaptation and support

Not every idea that succeeds in a pilot setting will produce impact elsewhere if differences in context, systems, or delivery capacity are ignored. Scaling requires both adaptation to new environments (**horizontal scale**) and support within existing systems (**vertical scale**).

Horizontal scale — ignoring contextual differences

Community-Led Total Sanitation (CLTS) is an approach that mobilizes entire communities to end open defecation through collective action, peer pressure, and local pride — rather than through subsidies or external enforcement. The model proved highly effective in Bangladesh, where strong community cohesion enabled rapid behaviour change and widespread adoption of household latrines.

Inspired by this success, governments and partners scaled CLTS across Africa and Asia. Yet results varied when introduced in settings with weaker social cohesion, limited access to materials, or less intensive facilitation. For example, large-scale evaluations in Mali[3] and Indonesia[4] found that sanitation gains were modest or diminished over time when local enabling conditions — such as collective motivation and follow-up support — were lacking. This example shows that when community-based models are scaled without adjusting to the social dynamics and resource conditions of new settings, their initial success can quickly fade.

Vertical scale — neglecting system support

One example comes from treating malaria: Artemisinin-based therapies, adopted in the early 2000s, revolutionized care, yet rapid scale-up without strong regulatory systems allowed substandard and counterfeit drugs to circulate widely, fueling drug resistance to Artemisinin and threatening global progress.[5,6] This example underscores that scaling biomedical innovations without investing in quality assurance, regulation, and institutional accountability can undermine both health outcomes and public trust.

Social and behaviour change programmes often face similar challenges. For example, community health workers (CHWs) played a pivotal role in raising demand for childhood vaccination through face-to-face outreach in Nepal, Senegal, and Zambia. Yet when many of these programmes expanded without sustained investments in ongoing CHW training, supervision, and/or specific adaptations tailored to the country, the impact of the programmes decreased — demonstrating that sustainable scale requires resilient, context-sensitive support systems, not just replication.[7]

Scaling without embedding interventions into systems of financing, maintenance, and accountability may produce short term impact, but it doesn't ensure sustainability in the long run. Success at scale is never about replication alone; this process requires an adaptation to context, investment in delivery systems, and integration into structures that can sustain results over time.

3 Pickering, A. J., Djebbari, H., Lopez, C., Coulibaly, M., & Alzua, M. L. (2015). Effect of a community-led sanitation intervention on child diarrhoea and child growth in rural Mali: A cluster-randomised controlled trial. The Lancet Global Health, 3(11), e701–e711. https://doi.org/10.1016/S2214-109X(15)00144-8

4 Cameron, L., Olivia, S., & Shah, M. (2019). Scaling up sanitation: Evidence from an RCT in Indonesia. Journal of Development Economics, 138, 1–16. https://doi.org/10.1016/j.jdeveco.2018.12.001

5 Karunamoorthi K. The counterfeit anti-malarial is a crime against humanity: a systematic review of the scientific evidence. Malar J. 2014 Jun 2;13:209. doi: 10.1186/1475-2875-13-209. PMID: 24888370; PMCID: PMC4064812.

6 Newton PN, McGready R, Fernandez F, Green MD, Sunjio M, Bruneton C, et al. (2006) Manslaughter by Fake Artesunate in Asia—Will Africa Be Next? PLoS Med 3(6): e197. https://doi.org/10.1371/journal.pmed.0030197

7 Ogutu, E. A., Ellis, A. S., Hester, K. A., Rodriguez, K., Sakas, Z., Jaishwal, C., Yang, C., Dixit, S., Bose, A. S., Sarr, M., Kilembe, W., Bednarczyk, R., & Freeman, M. C. (2024). Success in vaccination programming through community health workers: a qualitative analysis of interviews and focus group discussions from Nepal, Senegal and Zambia. BMJ open, 14(4), e079358. https://doi.org/10.1136/bmjopen-2023-079358

2. Why sharing is an integral part of scaling

Sharing allows others to adopt and adapt solutions in ways that take insights further, even when full-scale replication is challenging or impossible.

Water chlorination, recognized as one of the most effective ways to make drinking water safe, is another example. When piloted in the early 2000s through the distribution of small chlorine packets for household use, early results were encouraging: diarrhoeal disease declined, households reported fewer child illnesses, and many valued the convenience of a home-based solution.

But when these programmes attempted a rapid scale-up, uptake stalled. A systematic review of point-of-use chlorination interventions found that adoption rates typically hovered around 47%, with steep declines over time, and only improved when household engagement with health workers was frequent.[8] The taste of chlorinated water was off-putting, habits around water storage were deeply entrenched, and consistent use required behaviour changes that were not easily supported in daily life. Barriers in affordability and weak distribution systems further undermined its sustained use.

However, the evidence from these pilots proved invaluable. NGOs and governments shared their findings widely, not only on the product itself, but on the behavioural barriers households faced. These insights shifted strategies beyond the sachets toward a broader mix of solutions to meet community needs and behavioural patterns: bulk chlorination at community water points, integration of safe water messaging into health worker visits, and system-level treatment at municipal plants.[9] By sharing behavioural insights alongside technical lessons, the pilots sparked innovations that ultimately reached a greater number of households.

3. When scale succeeds

Scaling done well can transform public health, with one clear example being the global effort to eradicate polio. In the mid-20th century, polio was one of the most feared diseases worldwide, paralysing hundreds of thousands of children each year. Early vaccines proved highly effective in small-scale trials, but success at the population level required more than the product alone: it demanded coordinated systems, global partnerships, and community trust.

Scaling polio vaccination was a dual effort. On the systems side, the WHO, UNICEF, governments, and partners built vast delivery platforms, from cold-chain logistics and mass immunization campaigns to surveillance networks that could quickly detect and respond to outbreaks. On the behavioural side, trusted health workers and community leaders carried out house-to-house outreach, addressing fears, misinformation, and resistance. In many settings, sustained advocacy from religious leaders and local champions was crucial to achieving acceptance.

The results are historic. Polio cases have fallen by more than 99% since 1988, and the disease is now close to eradication. This success was not automatic: it came from pairing evidence-based tools with deliberate system integration, political commitment, and behavioural strategies that supported uptake.

8 Crider, Yoshika & Tsuchiya, Miki & Mukundwa, Magnifique & Ray, Isha & Pickering, Amy. (2023). Adoption of Point-of-Use Chlorination for Household Drinking Water Treatment: A Systematic Review. Environmental Health Perspectives. 131. 10.1289/EHP10839.-

9 Crider, Yoshika & Tsuchiya, Miki & Mukundwa, Magnifique & Ray, Isha & Pickering, Amy. (2023). Adoption of Point-of-Use Chlorination for Household Drinking Water Treatment: A Systematic Review. Environmental Health Perspectives. 131. 10.1289/EHP10839.

How can we Scale?

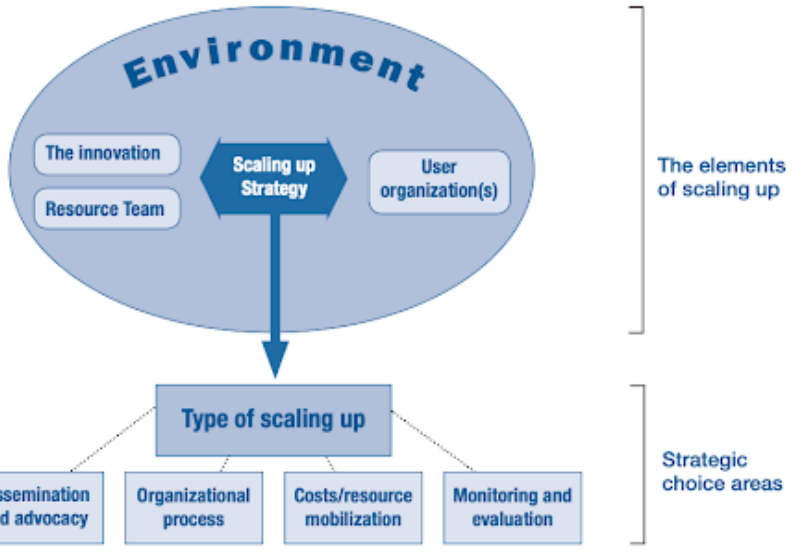
Just as designing and testing interventions requires structured methods, scaling their impact calls for dedicated strategies and tools. This chapter is based on the Nine Steps for Developing a Scaling-Up Strategy by ExpandNet/WHO (2010). The framework has been adapted to support behavioural interventions.

Common pitfalls

Throughout the Scale phase, keep these possible issues in mind:

- **Weak stakeholder engagement.** Scaling needs strong support from governments, partners, and staff delivering the intervention. Building coalitions, aligning incentives, and negotiating roles up front can mitigate the risk of failure.
- **Underestimating costs and resources needed.** Scaling often costs more than expected. Striving to serve communities adds time and effort, and beyond the pilot phase, both human and financial resources are often not budgeted for. If costs are underestimated, programmes cannot be sustained.
- **Growing complexity and short term funding.** As interventions scale, extra tools, training or technology are often added, particularly if new partners or funders add tools based on their own priorities — making programmes more difficult for both workers to deliver and systems to manage. Many scale efforts rely on project money or temporary donor support; as such, when this funding ends, programmes often shrink or come to a halt, even if they are succeeding. This unfortunately occurs when long term financing and government budgets are not built in from the start.

Figure 1. The ExpandNet/WHO framework for scaling up



ExpandNet. n.d. "Scaling-Up Framework and Principles." Accessed February 17, 2026. https://expandnet.net/scaling-up-framework-and-principles/

The case of increasing childhood vaccination uptake in Lebanon

In the previous chapter, *Test Hypotheses*, the project team ran a randomized controlled trial (RCT) of the reminder postcard and found it increased vaccination uptake by 6.7 percentage points compared to the control group. While the evidence of effectiveness was clear, the team still needed to confirm that the intervention was truly ready to scale.

The Ministry of Public Health (MoPH), a key partner, was ready to secure the intervention, and there was strong demand from other districts not included in the pilot. These factors pointed to a dual approach to scale: horizontal expansion (scaling the intervention to new regions) alongside vertical integration (embedding the postcard into the MoPH's national health systems). While the evaluation results were encouraging, the team was aware that scaling would require more than evidence of effectiveness.

To mitigate any risks during scale, the team worked through a checklist of good practices and signals to review before scaling. This helped them to identify several key considerations. For example, the RCT results and subgroup analysis gave the intervention credibility, demonstrating that the approach could improve equity by benefiting low income and refugee families at a lower cost than existing practices. However, they also identified a key risk: systems fit was only partial. While easy to use, the postcards were not yet integrated into routine procurement or supply chains, creating a risk of stockouts at scale.

To address this risk, the team returned to the Stakeholder Map created in the Define phase, adding new stakeholders that would be key to scaling success. With this updated list, they planned the engagement approach, mapped interests, and identified what each actor needed to know and do. For example, the MoPH required cost benefit data to approve a budget line, health centre supervisors needed simple training materials, and donors needed evidence of a sustainable exit strategy.

The team also ensured donors would fund the government during the transition, until systems were in place to integrate the postcard into routine supply chains within vaccination policy.

Finally, the team prepared plans for both geographical and population expansion (horizontal scale) and integration with the MoPH's system (vertical scale). The Horizontal Scaling Plan detailed a phased rollout to three new regions, leveraging existing vaccine supply chains for distribution and using a simple dashboard to monitor fidelity, equity, and cost effectiveness. In parallel, the Vertical Scaling Plan outlined steps for institutionalization: the MoPH issuing a circular (an official document formalizing the intervention's integration into health services), a permanent budget allocated for printing, and inclusion of the postcard in official supply order forms and training modules.

By systematically deciding on a pathway, checking readiness, building support, and creating detailed plans, the team could strategically scale the intervention, expanding its impact while embedding it into the systems that would sustain it for years to come.

***Note:** While this is a real project that closely followed a very similar process to DEPTHS, there were a few tools from the toolkit that the project team did not apply during implementation. In those cases, we've gone back and retrospectively applied the tools using real project data to illustrate how they might have looked if they had been used at the time.*

STEP 1:
Decide pathway

Associated Tools:

- Scale Decision Tree
- Scale Readiness Checklist

In this step:

Here, the focus is on two key tasks:

1. **Choosing the pathway for scaling.** Use the Scale Decision Tree to reflect on the most appropriate scaling approach for the intervention, including the following:
    - Horizontal expansion, where interventions are scaled to new geographies and/or groups.
    - Vertical integration, where the intervention is embedded into existing policies, budgets, and systems.

    If there is a lack of political and community demand, evidence is weak, or results consistently fail to show value or feasibility, stop the scaling process and strengthen the intervention.
2. **Checking readiness.** Once the decision on what type of scaling approach has been made, use the Scale Readiness Checklist to reflect on whether the intervention is likely to remain effective when delivered at larger scale and under routine system conditions.

Why it matters:

Jumping into scale without first reflecting on the most suitable approach can push teams down the wrong path and waste time and resources.

In addition to positive evaluation results, other strong predictors of success include financing, delivery capacity, and political support. For example, a mobile vaccination team may succeed in one city but struggle in remote areas, if fuel costs are high or staff cannot travel regularly.

How to do it:

1. Reflect on the best pathway for scaling

a. The first step is to decide whether scaling the intervention is worthwhile — if so, whether a horizontal or vertical pathway is most appropriate. Both may be desirable over time, but identifying a primary focus early on helps to concentrate effort for maximum impact.

- **Horizontal scaling** involves extending an intervention to new places or groups, while ensuring that it is suited to local conditions and continues to preserve the core behavioural elements that drive its impact. This can also be referred to as expansion or replication.
- **Vertical scaling** refers to embedding an intervention into higher-level systems — such as policies, regulations, and institutional frameworks — to ensure it becomes formally adopted and supported at scale. For example, an intervention that improves service delivery may be written into national guidelines or included in government budgets for it to continue without external support. Vertical scaling typically depends on government leadership and long-term commitment, as well as stable funding and policy alignment.

Most teams already have an idea of which path they want to pursue. The Scale Decision Tree helps to test this tentative direction for scale by posing clear questions about evidence, government backing, policy opportunities, and user demand.

Begin with reviewing findings from the Test Hypotheses phase. Scaling should be considered only when evaluation results demonstrate that the intervention has a significant positive impact on the outcomes outlined in the Theory of Change from the Prototype Designs phase. Three criteria are needed to assess whether the evidence supports scaling an intervention:

- **Effectiveness:** Evidence from the Test Hypotheses phase shows measurable improvements in the behaviour targeted by the intervention. This may come from different types of evidence: in some cases, rigorous trials such as RCTs or quasi-experimental designs provide statistically significant results; in others, strong observational evidence shows consistent patterns across sites, or large-scale monitoring data reveals improvements in coverage and demand.
- Effectiveness can also be established when different data sources converge to show meaningful impact, or when results are considered 'good enough' to justify adoption at scale given cost, feasibility, and demand. For example, a text message reminder for contraceptive use was tested across multiple clinics and consistently improved adherence, with results holding across different settings, not only one site.

- **Equity:** Building on effectiveness results, consider whether the intervention benefits vulnerable populations, not only those most easily reached. Sub-group analysis of pilot results can help to assess this – for example, by disaggregating outcomes across gender, age, geography, or socioeconomic status. In some cases, such analysis may not be feasible, and judgments about equity will rely on more subjective or contextual assessments — such as whether the intervention addresses known barriers faced by marginalized groups.

  For example, contraceptive reminder messages may be assessed not only for their impact among urban women with stable phone access, but also for their relevance and accessibility to adolescents and rural populations who face greater barriers.

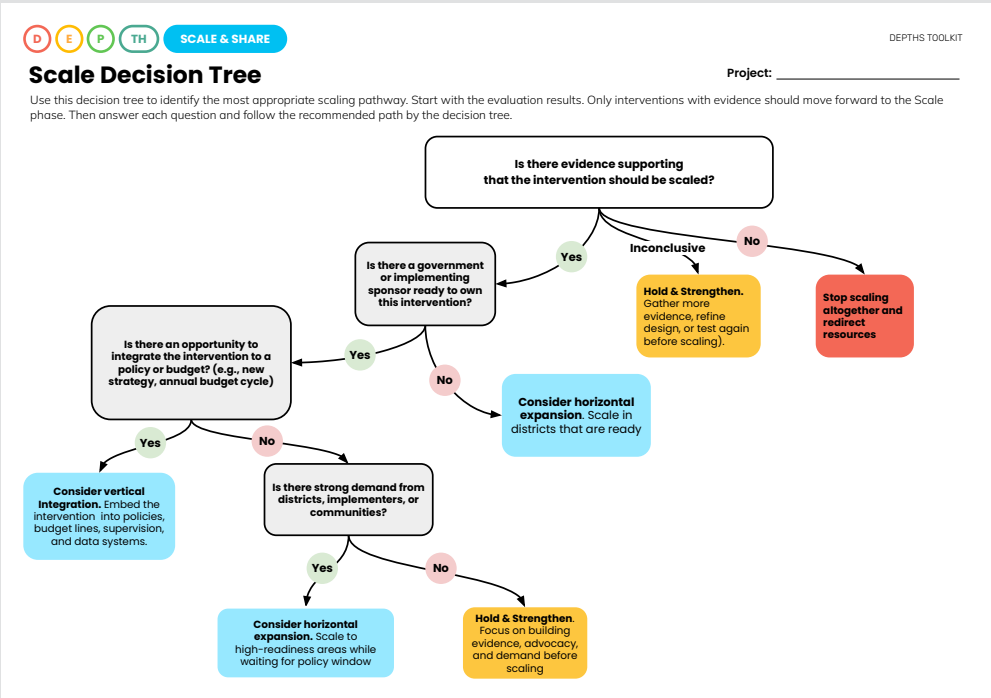
- **Affordability:** Cost–benefit analysis from the pilot should demonstrate that the intervention's costs are proportionate to its impact, and manageable within routine budgets. For example, bulk SMS reminders may cost only a few cents per user per month, making it realistic to integrate them into existing national communication platforms.

b. If the evaluation reveals no improvement in behavioural outcomes, benefits limited to the easiest-to-reach groups, or costs that exceed what systems can realistically sustain, scaling the intervention is not justified. In such cases, stop the scaling process and focus on assessing the lessons learned.

c. If the intervention does not meet all three criteria, the evidence is not strong enough to justify scaling. In these situations, scaling should be paused. Consider refining the intervention, gathering additional data, or conducting another round of testing before moving forward.

d. When pilot data indicates that an intervention is effective, equitable, and affordable, scaling is justified. The choice of scaling pathway, however, depends on the context and prevailing conditions. To decide which pathway to follow, consider the following three questions:

- **Is there a government or institutional sponsor ready to take ownership?** If yes, the next step is to look for opportunities to integrate the intervention into policy, budgets, or delivery systems.



This is the pathway to vertical scaling. For example, a contraceptive reminder service could be built into the national digital health platform or funded through government family planning budgets.

- **If no sponsor is ready, is there strong demand from districts, implementers, or communities?** If local demand is strong, horizontal expansion may be the best first step. The intervention can expand reach in high-readiness areas while continuing to advocate for government support. For example, clinics in certain districts may already have the staff and resources to roll out contraceptive reminder messages quickly.
- **If neither ownership nor demand is clear, what can be strengthened now?** In this case, it is better to pause and focus on building the enabling conditions. This may mean advocacy to create political will, further testing to adapt the design, or working with partners to build capacity and interest. For example, if contraceptive reminder messages have not yet attracted government sponsorship or community demand, consider pausing scaling while gathering more evidence, tailoring the design, and engaging stakeholders to build support.

The most appropriate scaling pathway will be identified by the end of the Scale Decision Tree, leading to the next step: reviewing the intervention's readiness for pursuing the chosen pathway.

2. Assess readiness

Once a pathway for scale is established, the next step is to rigorously assess the intervention's preparedness to move in that direction. Assessing readiness requires systematically testing the intervention against key conditions, identifying which are firmly in place, where critical gaps remain, and what investments or adaptations will be necessary to enable scale.

The Scale Readiness Checklist helps with this process. It draws on three complementary frameworks:

- **John List's Voltage Effect framework**[10]: This framework explores why promising pilots often fail at scale, such as dependence on special conditions or underestimating real-world costs.
- **CORRECT attributes** (WHO/ExpandNet[11]): This framework establishes practical criteria for scalability, including credibility, relevance, ease of adoption, and compatibility with existing systems.
- **Option C thinking**[12]: This framework stress-tests whether success can be maintained when budgets are tighter, systems are overstretched, or delivery conditions differ from the pilot.

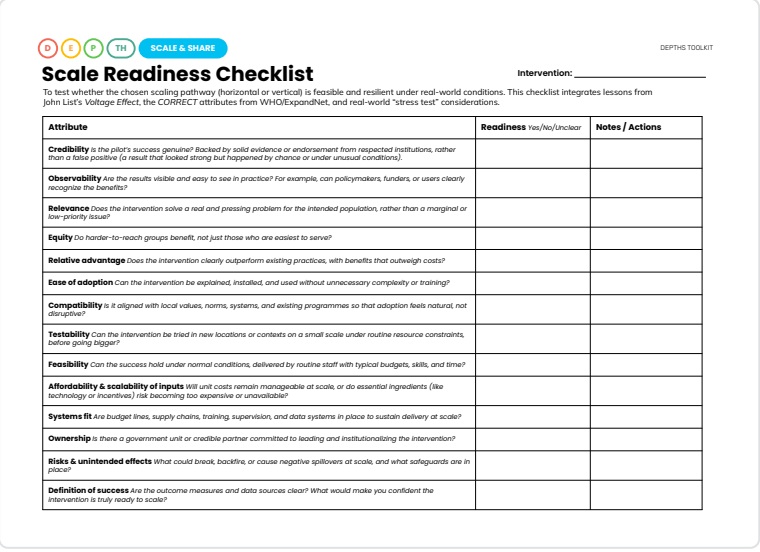
Before completing the checklist, review the operational dimensions that determine whether an intervention can succeed under routine conditions. Pilots often benefit from extra resources or ideal circumstances that cannot be assumed at scale. Appendix 2 outlines the areas most likely to falter during expansion, such as staffing and supervision, supply chains, financing, and community access. Considering these dimensions first will provide a more realistic foundation for completing the Scale Readiness Checklist, helping to spot hidden risks and identify elements that need adaptation or reinforcement.

To complete the Scale Readiness Checklist:

a. Start by reviewing Table 2 below, which details why each readiness attribute matters, the risks if it is not met, and possible actions to address gaps.

b. For each attribute listed in the Scale Readiness Checklist, decide whether the intervention currently meets the requirement for scale. Record your judgment as Yes (ready), No (not ready), or Unclear (evidence is mixed or missing).

c. In the Notes / Actions column, describe what is missing and what steps could strengthen the intervention before scaling.



D E P TH SCALE & SHARE

DEPTHS TOOLKIT

Scale Readiness Checklist

Intervention: _____

To test whether the chosen scaling pathway (horizontal or vertical) is feasible and resilient under real-world conditions. This checklist integrates lessons from John List's *Voltage Effect*, the *CORRECT* attributes from WHO/ExpandNet, and real-world "stress test" considerations.

Attribute	Readiness *Yes/No/Unclear*	Notes / Actions
Credibility *Is the pilot's success genuine? Backed by solid evidence or endorsement from respected institutions, rather than a false positive (a result that looked strong but happened by chance or under unusual conditions).*		
Observability *Are the results visible and easy to see in practice? For example, can policymakers, funders, or users clearly recognize the benefits?*		
Relevance *Does the intervention solve a real and pressing problem for the intended population, rather than a marginal or low-priority issue?*		
Equity *Do harder-to-reach groups benefit, not just those who are easiest to serve?*		
Relative advantage *Does the intervention clearly outperform existing practices, with benefits that outweigh costs?*		
Ease of adoption *Can the intervention be explained, installed, and used without unnecessary complexity or training?*		
Compatibility *Is it aligned with local values, norms, systems, and existing programmes so that adoption feels natural, not disruptive?*		
Testability *Can the intervention be tried in new locations or contexts on a small scale under routine resource constraints, before going bigger?*		
Feasibility *Can the success hold under normal conditions, delivered by routine staff with typical budgets, skills, and time?*		
Affordability & scalability of inputs *Will unit costs remain manageable at scale, or do essential ingredients (like technology or incentives) risk becoming too expensive or unavailable?*		
Systems fit *Are budget lines, supply chains, training, supervision, and data systems in place to sustain delivery at scale?*		
Ownership *Is there a government unit or credible partner committed to leading and institutionalizing the intervention?*		
Risks & unintended effects *What could break, backfire, or cause negative spillovers at scale, and what safeguards are in place?*		
Definition of success *Are the outcome measures and data sources clear? What would make you confident the intervention is truly ready to scale?*		

10 For more information on John List's Voltage Effect framework, see Appendix 1 at the end of the chapter.

11 World Health Organization & ExpandNet. Nine Steps for Developing a Scaling-Up Strategy. WHO, 2010.

12 Al-Ubaydli, Omar, and John A. List. "Will It Scale?" Issues in Science and Technology 41, no. 1 (Fall 2024): 34–36.

TABLE 2. ATTRIBUTES FOR THE SCALE READINESS CHECKLIST

ATTRIBUTE	DESCRIPTION	EXAMPLE	POTENTIAL MITIGATION ACTIONS
Credibility: Is the intervention's success genuine, backed by reliable evidence or respected endorsements?	John List's *Voltage Effect* warns that many pilots risk being "false positives" — appearing successful under special conditions but failing when scaled. As discussed in the Test Hypotheses chapter, a false positive occurs when an evaluation suggests an effect that is not truly there, much like a pregnancy test showing a positive result when the person is not pregnant.	The Climate Schools programme was an online school-based intervention using interactive lessons and cartoon scenarios to prevent depression and anxiety in adolescents. Small early studies showed promising results. But when tested in a large trial across 18 schools, it did not improve core mental health outcomes, and in some measures students in intervention schools did worse than controls. This highlights the credibility risk: early positive results may not hold up under routine conditions or larger, more diverse settings.[13]	Confirm pilot results are statistically robust and not dependent on exceptional circumstances (e.g., "impact observed only in one district with unusually high staff support"). If these checks were not already completed during the Test Hypotheses phase, they should include multiple-comparison adjustments, a review of effect sizes and confidence intervals, and analyses of sensitivity or robustness.
Observability: Can the benefits of the intervention be seen and recognized by others?	Observability, one of the CORRECT attributes identified by WHO/ExpandNet, refers to whether the benefits of an intervention can be seen and recognized by others. Interventions are more likely to scale when positive outcomes are visible.	In a programme with US college students, some participants saw their steps displayed on a public leaderboard, while others received only private feedback. Those in the public group walked more, showing that visible results (in this case, peers exercising) can motivate wider uptake.[14]	Assess whether the benefits of the intervention are noticeable to others. If not, make results more visible through strategies such as public demonstrations, recognition events, or presenting data in formats that communities, health workers, or leaders can easily see and understand.
Relevance: Does the intervention address a problem that feels urgent to the population?	Relevance emphasizes that scaling is most successful when the issue resonates as a clear priority for people and institutions. If the problem is not seen as important, motivation to adopt is weaker. Teams should therefore examine whether the issue is recognized as a priority and adjust framing if needed.	In Spain, the EIRA study aimed to change multiple unhealthy behaviours — smoking, physical activity, and diet — among adults aged 45–75 in primary health care centres. While the intervention improved diet, it had little impact on smoking or physical activity. One reason was that increasing physical activity was not perceived as urgent. This lack of resonance reduced motivation to engage, limiting broader uptake.[15]	Assess whether the issue is seen as a top priority by the target group and policymakers. If not, adapt how the intervention is framed. For example, connect it to existing concerns people already care about, such as protecting family health, saving money, or reducing stress.

Table continues on following page.

13 Andrews JL, Birrell L, Chapman C, Teesson M, Newton N, Allsop S, McBride N, Hides L, Andrews G, Olsen N, Mewton L, Slade T. Evaluating the effectiveness of a universal eHealth school-based prevention programme for depression and anxiety, and the moderating role of friendship network characteristics. Psychol Med. 2023 Aug;53(11):5042-5051. doi: 10.1017/S0033291722002033. Epub 2022 Jul 15. PMID: 35838377.

14 Lee JJ, Kim Y, Welk GJ, Hannon JC. The effect of using onymous and anonymous normative feedback on physical activity in college students: a randomized controlled trial. BMC Sports Sci Med Rehabil. 2020;12:27. doi:10.1186/s13102-020-00202-y.

15 Zabaleta-del-Olmo, E., Casajuana-Closas, M., López-Jiménez, T. et al. Multiple health behaviour change primary care intervention for smoking cessation, physical activity and healthy diet in adults 45 to 75 years old (EIRA study): a hybrid effectiveness-implementation cluster randomised trial. BMC Public Health 21, 2208 (2021). https://doi.org/10.1186/s12889-021-11982-4

ATTRIBUTE	DESCRIPTION	EXAMPLE	POTENTIAL MITIGATION ACTIONS
Equity: Does the intervention reach those who are underserved or at higher risk?	Scaling a solution that only works for well-resourced groups can widen gaps. Equity means ensuring that harder to reach populations also engage and benefit from an intervention, further ensuring that scaling does not deepen any inequalities.	A randomized trial of a mobile health programme for adults with type 2 diabetes in the United States showed uneven engagement. Non-white participants, those with lower health literacy, and older adults were significantly less likely to use the programme. As a result, the groups most in need were the least likely to benefit—an equity risk if the programme were scaled.[16]	Review pilot results by different groups such as age, gender, or literacy. If gaps appear, plan adaptations before scaling. This can include using simpler messages, voice calls, face-to-face support, or trusted community helpers.
Relative advantage: Does the intervention clearly outperform current practice?	People adopt innovations that save time, effort, or cost. If the benefit over current practice is weak or fades in routine use, uptake will stall. It is important to ensure that improvements are clear, lasting, and valuable to users.	In a large randomized trial in India, lab-validated improved cookstoves initially reduced smoke exposure, but the gains disappeared by year two. There were no improvements in health or fuel use because households used stoves irregularly, didn't maintain them, and usage declined over time. The stoves did not offer a compelling enough relative advantage over existing practices to sustain behaviour at scale.[17]	When reviewing relative advantage, record whether the intervention delivers clear, understandable improvements over current practice for users and institutions (e.g., fewer steps, less time, lower ongoing cost, better reliability). Note any signs that benefits fade without extra support, or that maintenance/ training burdens erode day-to-day value. If the relative advantage is weak, identify adaptations that could strengthen it.
Ease of adoption: Can the intervention be used without too much training, supervision, or effort?	Interventions that are simple and convenient spread more easily. If adoption requires specialist skills, ongoing support, or tolerance for negative side effects, uptake is limited. Simplifications may be needed.	A cluster-randomized trial in Bangladesh evaluated household point-of-use chlorination for drinking water. While chlorination effectively reduced diarrhoea in the short term, sustained adoption was very low. Many households reported that dosing was confusing, the process felt burdensome, and the taste of chlorinated water discouraged consistent use. Despite health benefits, the intervention's lack of ease of adoption made it difficult to scale without major modifications.[18]	Assess whether people can use the intervention quickly and consistently under normal conditions, without ongoing external support. Note if tasks require specialist skills, repeated reminders, or the tolerance of negative side effects. If adoption barriers are high, identify simplifications or supports needed before scaling—for example, automated dosing, integration with routine services, or redesigning delivery.

Table continues on following page.

16 Nelson LA, Mulvaney SA, Gebretsadik T, Ho Y-X, Johnson KB, Osborn CY. Disparities in the use of a mHealth medication adherence promotion intervention for low-income adults with type 2 diabetes. J Am Med Inform Assoc. 2016;23(1):12-18.

17 Hanna R, Duflo E, Greenstone M. Up in Smoke: The Influence of Household Behavior on the Long-Run Impact of Improved Cooking Stoves. American Economic Journal: Economic Policy. 2016;8(1):80–114. doi:10.1257/pol.20140008.

18 Pickering AJ, Crider Y, Sultana S, Swarthout J, Goddard FG, Anjerul Islam S, Sen S, Ayyagari R, Luby SP. Effect of in-line drinking water chlorination at the point of collection on child diarrhoea in urban Bangladesh: a double-blind, cluster-randomised controlled trial. Lancet Glob Health. 2019 Sep;7(9):e1247-e1256. doi: 10.1016/S2214-109X(19)30315-8. PMID: 31402005.

ATTRIBUTE	DESCRIPTION	EXAMPLE	POTENTIAL MITIGATION ACTIONS
Compatibility: Is the intervention aligned with community norms and institutional routines?	Even effective interventions could fail if they clash with cultural values or established systems. Compatibility increases when the intervention fits with everyday life and existing systems.	A randomized controlled trial of household latrine promotion in rural India (the MANTRA programme) found that even when latrines were constructed, use remained low. One key reason was cultural incompatibility: open defecation was widely perceived as healthier and more convenient, and latrines were not considered acceptable spaces within household compounds. Despite financial subsidies and infrastructure, low compatibility with community norms limited adoption and undermined the intervention's impact.[19]	When reviewing compatibility, assess whether the intervention fits with community norms and institutional practices. Consider whether values, traditions, or routines might conflict with the intervention's design. If compatibility is weak, note the adaptations required before attempting to scale. For example, modifying the intervention to align with cultural norms, reframing messages to match community values, or embedding the approach into existing service delivery systems.
Testability: Can the intervention be tried in new areas under routine conditions, before full rollout?	People and institutions are more likely to adopt an intervention if they can "try before they buy." Phased rollouts and pilot sites reduce risk and allow adaptation. If large upfront investment is needed, entry points should be smaller.	In rural Kenya, chlorine dispensers were installed at communal water sources. Unlike earlier household-based approaches, dispensers allowed families to test water treatment immediately, with little cost or burden. Uptake was higher and more sustained because people could experience the benefits under routine conditions before committing to long-term use.[20]	Assess whether the unit costs observed in the pilot can be maintained or reduced at scale, and whether essential inputs (e.g. commodities, technologies, staff, and infrastructure) can be supplied consistently. If costs escalate or supply chains are fragile, explore strategies such as alternative delivery channels, pooled procurement, or integration into existing logistics systems.
Feasibility: Can routine staff deliver the intervention within normal budgets and workloads?	Pilots often benefit from extra supervision, funding, or incentives that are not sustainable. Feasibility means the intervention can succeed under routine conditions with existing staff and resources.	A review of strategies to improve provider practices across low- and middle-income countries found that many interventions relying on intensive supervision, training, or large financial incentives produced strong results in pilots, but failed to sustain impact at scale. Health systems could not replicate the support provided during trials. Feasibility depends on whether improvements can be delivered under routine budgets and staffing constraints.[21]	Note whether the intervention can be delivered by frontline staff under normal conditions (e.g., typical work load, existing training, and routine budgets). If the pilot depended on extra supervision, incentives, or donor subsidies, record these gaps. Consider what adaptations could reduce resource intensity to make the model feasible at scale. For example, simplified protocols, digital tools, or integration into existing workflows.

Table continues on following page.

19 Clasen T, Boisson S, Routray P, Torondel B, Bell M, Cumming O, Ensink J, Freeman M, Jenkins M, Odagiri M, Ray S, Sinha A, Suar M, Schmidt WP. Effectiveness of a rural sanitation programme on diarrhoea, soil-transmitted helminth infection, and child malnutrition in Odisha, India: a cluster-randomised trial. Lancet Glob Health. 2014 Nov;2(11):e645-53. doi: 10.1016/S2214-109X(14)70307-9. Epub 2014 Oct 9. PMID: 25442689.

20 Kremer M, Miguel E, Mullainathan S, Null C, Zwane AP. Spring cleaning: Rural water impacts, valuation, and property rights institutions. Q J Econ. 2011;126(1):145–205. doi:10.1093/qje/qjq010.

21 Rowe AK, Rowe SY, Peters DH, Holloway KA, Chalker J, Ross-Degnan D. Effectiveness of strategies to improve health-care provider practices in low-income and middle-income countries: a systematic review. Lancet Glob Health. 2018;6(11):e1163–e1175. doi:10.1016/S2214-109X(18)30398-X.

ATTRIBUTE	DESCRIPTION	EXAMPLE	POTENTIAL MITIGATION ACTIONS
Affordability and scalability of inputs: Will costs and supplies remain manageable at scale?	Inputs that are affordable in pilots may not remain so when scaled. Ensure that unit costs and supply chains are sustainable and reliable at national level.	In a multi-country evidence synthesis, a randomized controlled trial in Nepal tested the use of micronutrient powders (MNPs) to reduce childhood anaemia. While effective in small pilots, evaluations of larger rollouts revealed that procurement and distribution costs, coupled with weak supply chains, made routine delivery difficult. Stock-outs were common, and sustained financing was a challenge for government systems. The scalability of MNP sachets became the primary barrier to scale.[22]	Record whether the unit costs observed in the pilot can be maintained or reduced when scaled, and whether key inputs (commodities, technologies, staff, and infrastructure) can be supplied reliably. If costs balloon or supply chains are fragile, note these risks explicitly. Consider whether alternative delivery channels, pooled procurement, or integration into existing logistics systems could make the intervention more affordable and scalable.
Systems fit: Are the supporting systems in place to sustain delivery?	Scale requires budgets, supply chains, training, supervision, and data systems. If these are weak, even strong interventions can collapse after expansion.	In India, the large-scale Janani Suraksha Yojana (JSY) conditional cash transfer programme increased facility births but strained health system capacity. Evaluations found that many facilities lacked sufficient staff, drugs, and supplies to handle the surge. While uptake was high, the absence of parallel investments in health system infrastructure and supervision undermined quality of care and limited the programme's overall impact.[23]	Record whether key systems (budgets, logistics, workforce training, supervision, and data monitoring) are strong enough to support delivery at scale. If gaps exist, note them clearly and identify what investments or partnerships are needed. Without alignment with supporting systems, scaling risks short-term expansion followed by breakdown.
Ownership: Is there strong commitment from governments, institutions, and communities?	Without ownership, interventions often collapse once external support ends. Ownership means leaders, staff, and communities view the intervention as theirs, and commit resources to sustaining it.	In Zambia, a randomized evaluation of a performance-based financing (PBF) scheme showed that while the pilot improved service delivery indicators, government ownership was limited. The programme was largely donor-driven, and when external funding and technical support ended, many gains were not sustained.[24]	Note whether governments and communities see the intervention as theirs, which can be reflected in political commitment, the allocation of domestic resources, and integration into existing institutions. If ownership is weak, note whether advocacy, alignment with national priorities, or participatory co-design processes are needed before scaling.

Table continues on following page.

22 Locks LM, Reerink I, Hedlund K, Peña-Rosas JP, Jefferds ME, Mclean MS, et al. Micronutrient powder programs: lessons learned for integrated infant and young child feeding. Am J Clin Nutr. 2017;105(5):1126–1136. doi:10.3945/ajcn.116.144055.

23 Lim SS, Dandona L, Hoisington JA, James SL, Hogan MC, Gakidou E. India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation. Lancet. 2010;375(9730):2009–2023. doi:10.1016/S0140-6736(10)60744-1.

24 Friedman J, Qamruddin J, Chansa C, Das AK, McMahon S, McPake B. Impact evaluation of Zambia's health results-based financing pilot project. Health Policy Plan. 2016;31(9):1117–1124. doi:10.1093/heapol/czw049.

ATTRIBUTE	DESCRIPTION	EXAMPLE	POTENTIAL MITIGATION ACTIONS
Risks and unintended effects: What could go wrong once scaled?	Scale can create problems such as system overload, inequities, or negative spillovers. Anticipating risks allows for the design of safeguards.	Analysis of seven scaled physical activity and nutrition interventions in Australia found that even when programmes achieved their intended outcomes, scale sometimes produced unintended consequences. These included increased workload for frontline staff, reduced sustainability in some settings, and shifting priorities that undermined programme value. The study concluded that mechanisms of scale can generate both positive and negative effects, and that anticipating risks is vital.[25]	Explore what could go wrong if the intervention is scaled—for example, service overload, inequities, or unintended spillovers. Examine evidence from the pilot, or from similar interventions where such risks have occurred, and record whether safeguards are in place, such as phased rollouts, monitoring systems, or equity tracking. If risks are likely, scaling plans should incorporate mitigation strategies, rather than assume that expansion will simply multiply benefits.
Definition of success: Are outcomes and data sources clear and measurable?	Without a clear definition of success, it's difficult to know if scale is working. Outcomes should be specific, credible, and meaningful to communities, governments, and funders.	In Kenya, the WelTel Kenya1 randomized controlled trial used weekly SMS check-ins to support antiretroviral therapy adherence. Unlike many mHealth pilots that track only engagement (e.g., number of messages sent), this trial defined success in terms of biologically verified adherence and viral suppression, measured through electronic monitoring and clinical outcomes. By using clear, rigorous outcome definitions, the trial gave funders and policymakers confidence that the intervention's effects were real and worth considering for broader investment.[26]	Record whether outcomes of interest are explicitly defined and tied to credible data sources. Ask: What would success look like at scale, and how will it be measured? If outcomes are vague (e.g., "improved awareness"), note the need to sharpen definitions. Where possible, ensure indicators are linked to behaviour change or health outcomes, not just process measures, so teams and funders can track whether scaling is truly delivering value.

25 Koorts H, Eakin E, Estabrooks P, Timperio A, Salmon J, Bauman A. Mechanisms of scaling up: combining a realist perspective and systems analysis to understand successfully scaled interventions. Int J Behav Nutr Phys Act. 2021;18:61. doi:10.1186/s12966-021-01103-0.

26 Lester RT, et al. Lancet. 2010;376(9755):1838-1845. doi:10.1016/S0140-6736(10)61997-6.

Case study: increasing childhood vaccination uptake in Lebanon

The tools mentioned in this step of the Scale phase were not used by the original project team. This case study is a recreated example based on real project data and context.

The decision

After reviewing the evaluation results, the team concluded that both horizontal and vertical scaling were possible, however, the immediate priority was horizontal expansion. Several districts outside of the pilot area had already expressed interest, and the postcard intervention was simple and low-cost to replicate. At the same time, the team decided to prepare for vertical integration into the Ministry of Public Health's Expanded Programme on immunization (EPI), which would require policy and budget adjustments. This dual approach balanced short-term expansion with longer-term sustainability.

Checking readiness

With the decision clear, the team applied the Scale Readiness Checklist to test whether the postcards could hold up under scale.

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Scale Readiness Checklist

Intervention: Appointment reminder card

Attribute	Readiness *Yes/No/Unclear*	Notes / Actions
Credibility	Yes	The RCT showed a significant 6.7 percentage point increase in timely vaccination. Results were statistically robust. Action: Package findings into briefs and presentations endorsed by trusted institutions (e.g., Ministry of Public Health, UNICEF) to strengthen credibility.
Observability	Yes	Caregivers bring postcards to clinics, which staff can see. Benefits are tangible and easy to demonstrate. Action: Encourage staff to share stories and examples with district managers to reinforce visibility.
Relevance	Yes	Childhood vaccination is a national health priority, especially given pockets of under-immunisation among vulnerable groups. Action: Frame postcards as a low-cost way to meet immunisation targets.
Equity	Yes	Analysis showed positive effects even among low-income families and refugee households. Action: Monitor distribution to ensure marginalised groups continue to receive cards equitably.
Relative advantage	Yes	Postcards provide a reliable reminder compared to informal word of mouth. They are inexpensive, physical, and hard to miss. Action: Collect testimonials from caregivers to highlight added value over existing practices.
Ease of adoption	Mostly yes	Health workers reported postcards were simple to distribute and fill in, though training was needed for consistency. Action: Create a pictorial job aid for health workers to reduce variation.
Compatibility	Yes	Postcards fit naturally into clinic workflows and community norms. Caregivers are familiar with keeping health documents at home. Action: Link postcards to existing vaccination cards for smoother integration.
Testability	Yes	Districts can adopt postcards with minimal investment and test under routine conditions. Action: Plan phased introduction in 3–4 districts before national rollout.
Feasibility	Mostly yes	Clinics can manage postcard distribution under current staffing, but supervision may be inconsistent. Action: Add a tick-box in supervisory checklists to monitor use.
Affordability & scalability of inputs	Yes	Printing costs are low (less than $0.20 per postcard). Cards can be bundled with vaccine shipments. Action: Secure framework agreements with local printers to keep costs stable.
Systems fit	Partly	Logistics and supply systems can handle postcard delivery, but budgets are not yet institutionalised. Action: Advocate for a dedicated budget line in the national immunisation plan.
Ownership	Unclear	Ministry of Public Health expressed interest but has not yet formalised commitment through policy or budgets. Action: Engage the EPI unit early, demonstrate results from district pilots, and prepare a circular for formal adoption.
Risks & unintended effects	Yes, some risks	Risks include stock-outs if printing is not managed well, novelty fade among caregivers, and inconsistent clinic use. Action: Plan design refreshes every 2 years and embed postcards into national supply chain codes.
Definition of success	Yes	Success is defined as increased on-time vaccination, measured through clinic records. Equity effects for vulnerable groups are tracked separately. Action: Maintain outcome measures linked to health impact, not only distribution numbers.

- **Credibility**: The randomized trial showed a 6.7 percentage point increase in on-time vaccination. The effect was consistent across sites, reducing the risk of a false positive.
- **Equity**: Sub-group analysis showed that low income and refugee families also benefited, not only higher income households. This strengthened the case for national adoption.
- **Observability and relative advantage**: The postcards were highly visible. Health workers saw caregivers bringing them to clinics, and caregivers found them easier to track than verbal reminders. This created a clear improvement over existing practice.
- **Feasibility and systems fit**: Printing and distribution were straightforward in the pilot but not yet built into national systems. Without a dedicated budget line or supply code, there was a risk of stock-outs if the programme expanded too quickly.
- **Ownership and timing**: The Ministry of Public Health expressed interest but had not formalized the intervention's adoption. The team noted the importance of aligning with the upcoming budget cycle to create an entry point for institutionalization.
- **Risks**: If the postcards were poorly managed, stock-outs could harm trust. Caregivers might also lose interest over time. The team flagged the need for design refreshes every two years and supply chain integration to mitigate these risks.
- **Definition of success**: Success was defined as not only the number of postcards distributed, but improved on-time vaccination rates, particularly among vulnerable groups.

STEP 2:

Build support

Associated Tools:

- Stakeholder Support Matrix

In this step:

Scaling depends not only on the strength of the intervention, but on the alignment, commitment, and readiness of key actors. After selecting the pathway for scale and assessing readiness, the next step is to prepare the people and institutions who will drive the process.

Begin by identifying the most influential actors, defining their roles, and mapping out when and how to engage them. Move beyond a simple stakeholder list by asking: What do they need to know? What decisions must they make? What actions must they take? This transforms a broad roster of stakeholders into a practical engagement plan.

Why it matters:

Even strong interventions can falter if key stakeholders are not aligned. Preparing for scale means bringing these actors in early, clarifying responsibilities, and ensuring they are coordinated, communicative, and moving in the same direction.

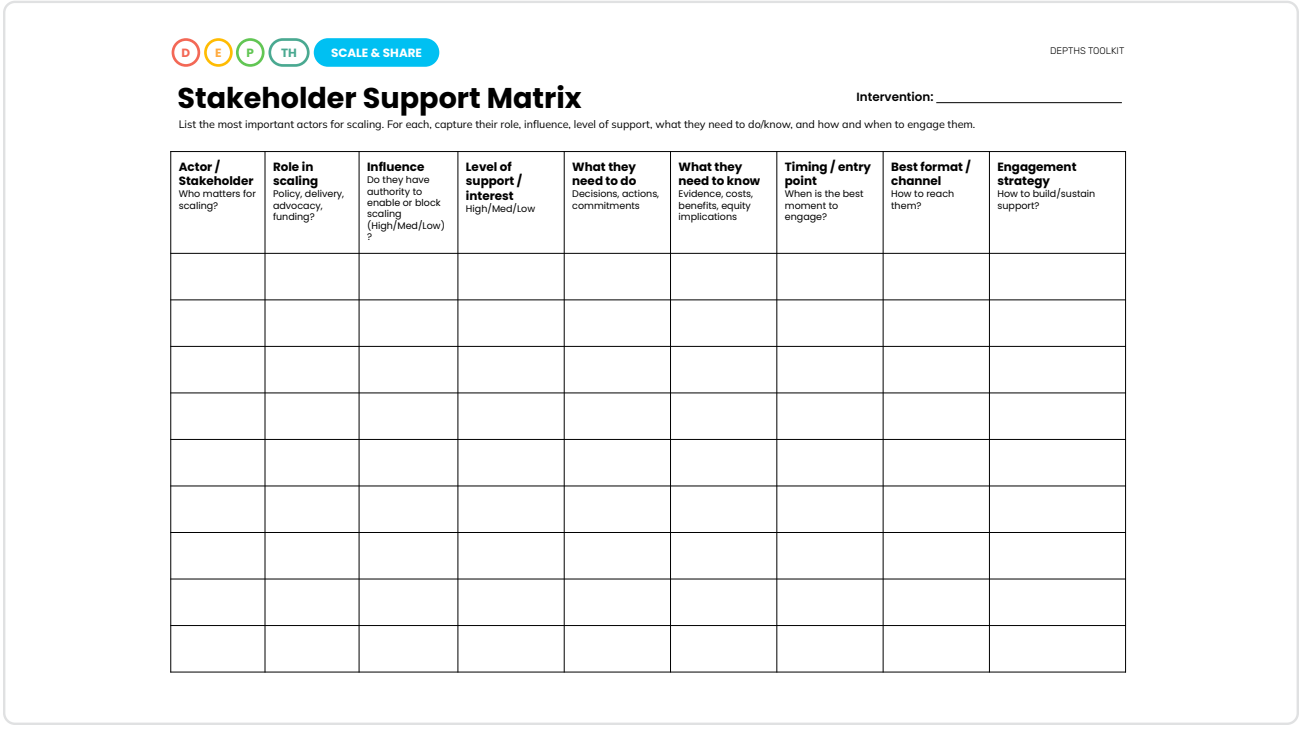
How to do it:

The Stakeholder Support Matrix is designed to help clarify the critical actors and the role each must play, with particular attention to their level of influence, the decisions they control, and the kind of engagement they will need to stay committed.

1. Outline the key actors and stakeholders involved in the scaling process

a. Building on the Stakeholder Map and Target Audiences tool created during the *Define* phase, begin by listing the actors and institutions whose decisions, resources, and actions will shape the scaling process. Scaling requires collaboration across different stakeholders groups. Some will deliver the intervention, others will provide resources, and others will guide or support the process. Scaling is more likely to succeed when each of these roles are defined from the start. Use Table 3 to identify all potential stakeholder groups.

***Note**: The examples provided in the "Why they matter" column draw from different UNICEF sectors — including child rights, protection, health and nutrition, education, WASH, and emergency response — to illustrate how scaling principles apply across diverse contexts.*



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Stakeholder Support Matrix

Intervention: _____

List the most important actors for scaling. For each, capture their role, influence, level of support, what they need to do/know, and how and when to engage them.

Actor / Stakeholder Who matters for scaling?	**Role in scaling** Policy, delivery, advocacy, funding?	**Influence** Do they have authority to enable or block scaling (High/Med/Low)?	**Level of support / interest** High/Med/Low	**What they need to do** Decisions, actions, commitments	**What they need to know** Evidence, costs, benefits, equity implications	**Timing / entry point** When is the best moment to engage?	**Best format / channel** How to reach them?	**Engagement strategy** How to build/sustain support?

TABLE 3: COMMON KEY STAKEHOLDER GROUPS AND ACTORS TO CONSIDER

STAKEHOLDER	WHO THEY ARE	WHAT THEY DO	WHY THEY MATTER
Lead organization	The organization that will eventually own and deliver the intervention. Examples include ministries of health, non-governmental organizations, or provider networks, such as groups of clinics or hospitals.	Put the intervention into practice at scale. They deliver services, manage staff, integrate the work into budgets, and reach communities.	Their capacity and willingness to take ownership determine whether scaling is possible and sustainable. For example, when a ministry of environment adopts a community-led flood-warning system and integrates it into its national disaster-preparedness framework, the intervention becomes part of long-term climate resilience planning, rather than a project-based activity.
Resource teams	Technical partners and individuals who developed or tested the intervention. Examples include project teams, research institutions, or technical agencies.	Provide expertise on design, evidence, and adaptation. They strengthen systems and support lead organizations and stakeholder groups to adopt and deliver at scale.	They link the pilot stage to the larger system, ensuring knowledge is transferred and quality is maintained during expansion. For example, a university research team that piloted a digital learning platform for remote classrooms may support a ministry of education in adapting its content for local languages and low-connectivity schools.
UNICEF team members	UNICEF staff at headquarters, regional, and country levels who are involved in programme management, advocacy, or technical support.	Coordinate efforts, align with government priorities, and connect with other UNICEF sectors and resources.	Their influence and ability to bring partners together can speed up adoption and ensure lessons are built into wider UNICEF work. For example, UNICEF country staff may help a national civil registration authority secure funding to digitize birth registration systems, ensuring every child's identity is recorded and linked to essential services.
Funders	Donors, development banks, philanthropic organizations, or government financing bodies.	Provide financial resources, shape funding priorities, and set reporting requirements.	Lasting scale depends on reliable financing that fits both government plans and funder priorities. For example, a donor might fund the first phase of expanding early learning centres, providing the government with time to include the programme in its regular education budget.
Multipliers	Actors who can increase influence and reach. Examples include professional associations, media, regional networks, or global initiatives.	Share evidence, shape messages, advocate for policy change, and encourage an intervention's adoption.	They can spread the impact beyond the pilot by influencing both policymakers and practitioners at national and global levels. For example, when a national teachers' union endorses new child-friendly classroom practices, it encourages schools across the country to adopt the approach and strengthens policy support for safer learning environments.

STAKEHOLDER	WHO THEY ARE	WHAT THEY DO	WHY THEY MATTER
Local stakeholders	Community leaders, frontline workers, civil society groups, or traditional authorities.	Mobilize demand, adapt interventions to local norms, and maintain community trust.	Without local support, interventions risk rejection or loss once external support ends. For example, when village councils and parent groups organize community clean-up days and manage shared water points, it strengthens local ownership of safe water and sanitation services.
Other stakeholders	Partners who bring additional expertise and resources. Examples include private sector actors, universities, or ministries such as education, finance, or information technology.	Provide skills, products, or infrastructure that help with delivery and adaptation.	They add strength and resilience by bringing in resources and innovations from outside the health sector. For example, during emergencies, logistics and supply companies partnering with the government can help to ensure that relief supplies—such as safe water, learning materials, or nutrition kits—reach affected communities quickly and efficiently.

b. Start by identifying the lead organization. Begin with the brainstormed list of stakeholders and determine which one has the mandate to lead the scaling process. The lead organization is the actor with formal responsibility for the issue — such as a ministry department, government agency, or other mandated institution. The organization should also demonstrate clear demand for the intervention and have the capacity to deliver at scale. This is distinct from supportive stakeholders, who may be highly interested but lack the mandate or authority to lead.

To identify the lead organization, review Table 4, which sets out four domains for assessment: demand, capacity, timing, and context, along with strengths and constraints. Once identified, record the lead organization in Column 1 of the worksheet.

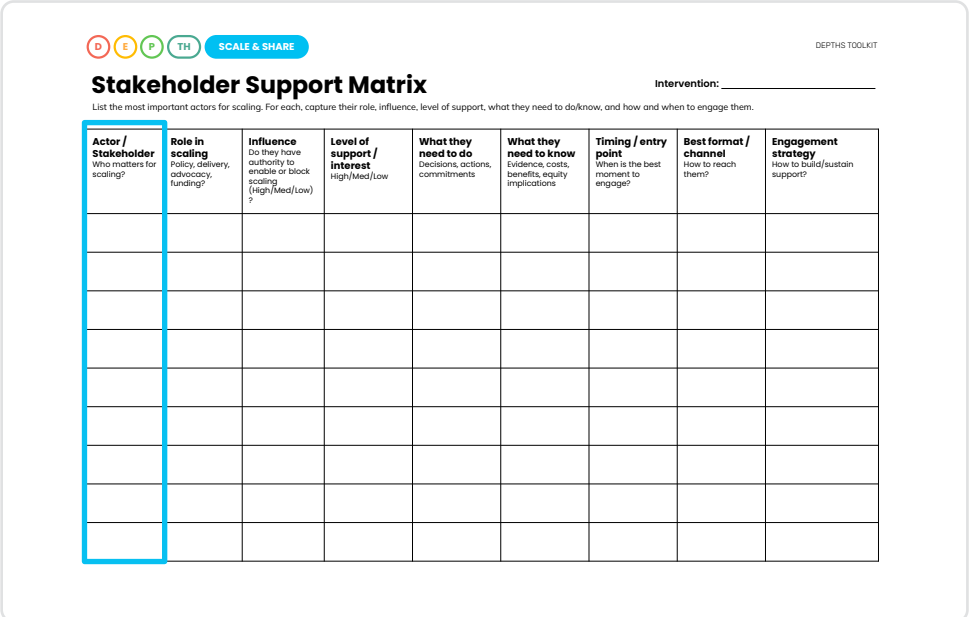
TABLE 4. GUIDE TO ASSESS THE LEAD ORGANIZATION

DOMAIN TO REVIEW	EXAMPLE: IMAGINE A COUNTRY CONSIDERING WHETHER TO SCALE UP COMMUNITY CASEWORKER HOME VISITS TO IDENTIFY AND SUPPORT GIRLS AT RISK OF CHILD MARRIAGE.
Demand: Does the intervention match the organization's priorities? Are there internal champions to push it forward? Do the benefits outweigh the costs or risks?	A ministry of social welfare may publicly commit to ending child marriage, creating strong policy demand. However, if attention and funding are focused on cash transfers or social assistance, there may be limited leadership energy to expand caseworker programmes.
Capacity: Are staff, supervisors, and supply systems ready to take on new tasks without weakening other services?	The ministry may already employ community caseworkers, but high caseloads and limited supervision could make it difficult to add new responsibilities. Additional mentoring, simplified reporting tools, or stronger links with local NGOs may be needed to sustain quality.
Timing and context: Are there opportunities such as budget cycles, new strategies, or political windows that can help? Or are there risks like elections, leadership changes, or public concerns that could slow progress?	Scaling may align with a new national strategy on child protection or a global spotlight on ending child marriage, but it could lose momentum if government restructuring shifts the programme oversight, or donor priorities change.
Strengths and constraints: Note both. Recording actions to fill these gaps creates a clear roadmap for building ownership and momentum.	The ministry may have strong coordination with local protection committees but weak digital data systems for case tracking. Identifying this gap points to the need to strengthen digital reporting tools and train staff before a national scale-up.

c. Next, identify the resource team, which supports the lead organization in moving from pilot to scale. This often includes those who designed or tested the intervention, but should also bring in capacities beyond technical expertise, such as management, financing, advocacy, and systems strengthening. To identify the resource team, review stakeholders across the relevant domains in Table 5. Record the resource team in Column 1 of the worksheet.

TABLE 5. GUIDE TO ASSESS THE RESOURCE TEAM

AREA TO REVIEW	EXAMPLE: IMAGINE A COUNTRY CONSIDERING WHETHER TO SCALE UP COMMUNITY HEALTH WORKER HOME VISITS TO INCREASE CHILDHOOD VACCINATION.
Composition: Who should be included in the resource team? Is there a mix of people with technical, managerial, and advocacy skills?	The pilot team was mainly researchers and NGO staff. For scale, the resource team now includes experts in behaviour change, supply chain management, and community engagement, alongside representatives from the Ministry of Health to ensure alignment.
Credibility and leadership: Does the team include trusted figures who can influence the lead organization and reassure communities?	A respected paediatrician known for championing immunization joins the team. Their voice gives confidence to ministry leaders and communities that home visits are credible and valuable.
Skills and experience: Does the team have the right balance of skills in supervision, financing, supply systems, monitoring, and communication? Has anyone led a scale-up before?	The NGO partner has run national training programmes, while the research team has experience in monitoring results. However, no one has led a large-scale expansion of community health worker programmes. This is flagged as a gap needing external support or mentorship.
Resources and stability: Does the team have enough staff, funding, and long-term commitment to provide ongoing support during scale?	Funding for technical support is secured only for two years. This creates a risk if scale-up requires longer accompaniment. The team records this as a gap and seeks to embed more responsibility within the Ministry of Health over time.



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Stakeholder Support Matrix

Intervention: _____

List the most important actors for scaling. For each, capture their role, influence, level of support, what they need to do/know, and how and when to engage them.

Actor / Stakeholder Who matters for scaling?	**Role in scaling** Policy, delivery, advocacy, funding?	**Influence** Do they have authority to enable or block scaling (High/Med/Low)?	**Level of support / interest** High/Med/Low	**What they need to do** Decisions, actions, commitments	**What they need to know** Evidence, costs, benefits, equity implications	**Timing / entry point** When is the best moment to engage?	**Best format / channel** How to reach them?	**Engagement strategy** How to build/sustain support?

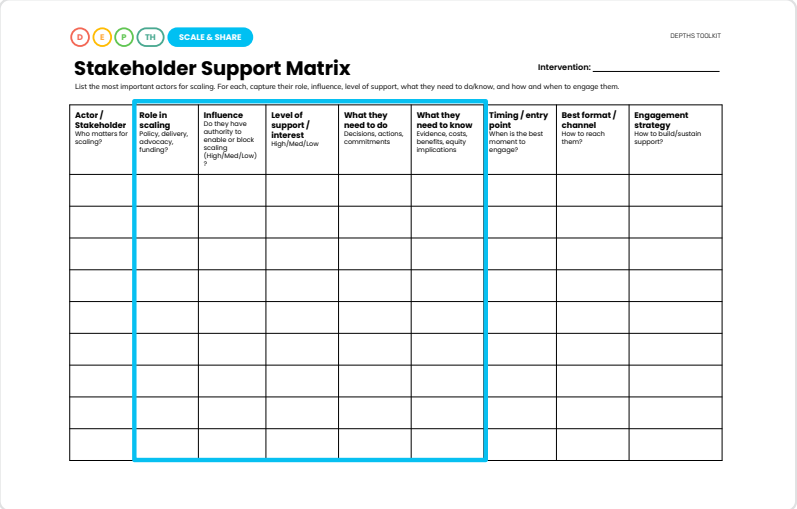
Outside of the lead organization and resource team, scaling also relies on a wider set of stakeholders who influence acceptance, resources, and long-term support. Successful scale depends on their alignment and the effective flow of knowledge and resources between them. Identify the key actors needed for scale, and record all stakeholder groups or actors in Column 1 of the worksheet.

2. Strategize roles, influence, and support

a. **Define the role** in scaling that each stakeholder group plays in moving an intervention from a small pilot to wider delivery. Roles can include:

- **Policymaking**: setting standards or adding an intervention to national guidelines
- **Financing**: securing budgets or donor support
- **Delivery**: managing staff and services
- **Supervision**: maintaining quality and accountability
- **Advocacy**: mobilizing champions or shaping public opinion

Roles of stakeholder groups can change over time. A project team may lead during the pilot, but later shift into a support role once a ministry or provider network takes ownership. Clarifying roles allows teams to coordinate efforts, manage handovers, and ensure that scaling responsibilities are clear, achievable, and sustainable.


D E P TH SCALE & SHARE

DEPTHS TOOLKIT

Stakeholder Support Matrix

Intervention: _____

List the most important actors for scaling. For each, capture their role, influence, level of support, what they need to do/know, and how and when to engage them.

Actor / Stakeholder Who matters for scaling?	Role in scaling Policy, delivery, advocacy, funding?	Influence Do they have authority to enable or block scaling (High/Med/Low)?	Level of support / interest High/Med/Low	What they need to do Decisions, actions, commitments	What they need to know Evidence, costs, benefits, equity implications	Timing / entry point When is the best moment to engage?	Best format / channel How to reach them?	Engagement strategy How to build/sustain support?

b. Next, capture the degree of **influence** each stakeholder group has to enable or block progress. Influence can be formal, such as approving budgets or passing regulations, or informal, such as trusted community leaders shaping public views. Mapping influence helps to highlight who the decision makers are, where alliances are needed, and where advocacy should be directed. For instance, a professional association might not control funds but can sway health workers' acceptance.

c. Assess the level of **support/interest** from each stakeholder group for the intervention. High support often comes when the intervention matches existing priorities or personal commitment. Low support may come from competing agendas or doubts about effectiveness. Recognizing these drivers helps to anticipate resistance and tailor engagement. For example, a district health office may be enthusiastic if the programme reduces their workload, but less interested if it adds extra reporting requirements.

Clarify what each stakeholder group **needs to do**. This avoids vague promises and links groups and people to concrete actions, such as approving policy changes, allocating resources, or delivering services. For instance, a ministry may be responsible for printing materials at national level, while local managers ensure they reach clinics on time.

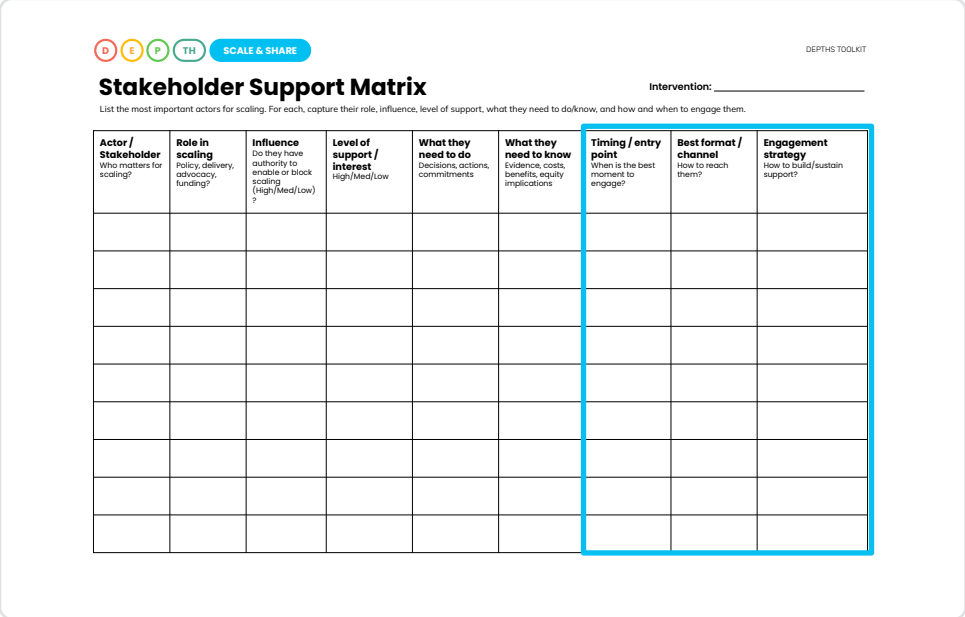
Identify what each stakeholder group **needs to know** in terms of evidence or information required to take action. Policymakers may need data on costs and equity, funders may need clear reporting frameworks, and community leaders may want proof that the intervention improves local wellbeing. Tailoring evidence to these needs ensures that information is both useful and motivating.

3. Plan stakeholder engagement

a. Determine the **timing and entry points** of engaging with each stakeholder group. Some groups work on fixed cycles such as budget approvals or policy reviews. Others may be most receptive during pilot demonstrations or community consultations. Planning around these windows prevents missed opportunities. For example, introducing results just before an annual budget cycle can increase the chance of funding.

b. Choose the best **format/channel** to communicate with stakeholder groups. For example, senior government leaders may prefer short policy briefs or direct meetings. Implementers may engage better through workshops, while communities may respond to radio messages or local events. Choosing the right format increases clarity, credibility, and uptake.

c. Plan the best **engagement strategy** for each stakeholder group, outlining how to build and maintain support over time. This can involve targeted advocacy, regular relationship management, or nurturing champions within institutions. The goal is to turn early interest into long-term commitment. For example, assigning a respected district officer as a champion can maintain momentum even when leadership changes.



D E P TH SCALE & SHARE

DEPTHS TOOLKIT

Stakeholder Support Matrix

Intervention: _____

List the most important actors for scaling. For each, capture their role, influence, level of support, what they need to do/know, and how and when to engage them.

Actor / Stakeholder Who matters for scaling?	**Role in scaling** Policy, delivery, advocacy, funding?	**Influence** Do they have authority to enable or block scaling (High/Med/Low) ?	**Level of support / interest** High/Med/Low	**What they need to do** Decisions, actions, commitments	**What they need to know** Evidence, costs, benefits, equity implications	**Timing / entry point** When is the best moment to engage?	**Best format / channel** How to reach them?	**Engagement strategy** How to build/sustain support?

CASE STUDY:

Increasing childhood vaccination uptake in Lebanon

The tools mentioned in this step of the Scale phase were not used by the original project team. This case study is a recreated example based on real project data and context.

Outlining the key stakeholders

The team began by revisiting the initial Stakeholder Map they had created at the beginning of the project, from the Define phase. They analysed and then built the list with new stakeholders they considered important for the scaling process. For example, some key stakeholder groups mapped were the Ministry of Public Health's Expanded Programme on immunization, primary health care centres (PHCCs), potential funders such as Gavi and the European Union, paediatric associations and local media, and local stakeholders such as community leaders, health workers, and NGOs.

Identifying the lead organization

The Ministry of Public Health was identified as the lead organization. This choice was based on its mandate and capacity to oversee national immunization services. The team assessed the ministry across four domains:

- Demand: Vaccination was a top health priority, and champions within the EPI unit signalled strong interest in the postcards.
- Capacity: Supply and distribution systems were relatively robust, but staff would need training to use the postcards consistently without extra supervision.
- Timing and context: Budget discussions were underway, creating an opportunity to propose a new budget line for printing. At the same time, leadership changes in the ministry posed some uncertainty, making advocacy at multiple levels essential.
- Strengths and constraints: The Ministry had strong procurement systems but weak community outreach. The team noted this, and noted that partnerships with NGOs could help to fill this gap.

Identifying the resource team

The resource team included UNICEF staff and the researchers who had led the trial. Together they brought technical evidence, credibility, and experience. The team assessed themselves using the four domains:

- Composition: While researchers brought technical knowledge, the team added UNICEF staff with experience in government engagement and supply chain management.
- Credibility and leadership: A respected paediatrician was invited as an advisor to increase trust among ministry leaders and communities.
- Skills and experience: The team had expertise in evaluation and communication, but limited experience in national scale-up. They flagged this as a gap and sought mentorship from UNICEF colleagues who had worked on other scaled health interventions.
- Resources and stability: External funding was secured for two years, enough to support initial expansion but not long-term scale. This made government budget allocation a critical goal.

Defining other stakeholders

Beyond the Ministry and the resource team, scaling depended on wider stakeholder groups. UNICEF staff at the country office provided policy alignment and convening power. Funders offered financial support and legitimacy. Multipliers such as professional associations helped to spread visibility and endorsement. Local stakeholders, community leaders, NGOs, and frontline staff ensured the intervention remained trusted and relevant in daily practice. Together, these groups formed an ecosystem where each stakeholder group's role was distinct but interconnected.

Determining roles, influence, and support

The Stakeholder Support Matrix helped to clarify each stakeholder group's role. The Ministry of Public Health held high authority and medium-to-high support, with responsibilities ranging from issuing circulars to financing. Funders had high influence through budget priorities. UNICEF played a bridging role, coordinating between

technical experts and the government. Multipliers and local stakeholders had lower formal authority but high informal influence, shaping public trust and acceptance.

What they needed to do and know

The team defined concrete responsibilities for each stakeholder. The Ministry needed to approve a budget line, update guidelines, and supervise delivery. Funders needed to commit short-term financing. PHCC staff had to distribute and explain postcards to caregivers. Local stakeholders needed to encourage families to keep and use the cards. To act, each group required tailored information: policymakers needed cost and equity data, funders needed evidence of effectiveness, and communities needed reassurance that the intervention was simple, safe, and useful.

Timing, channels, and engagement strategies

Engagement was planned around natural entry points. For the Ministry, the optimal moment was the annual budget cycle and the next meeting of the National Immunization Technical Advisory Group. For funders, the key window was the donor coordination forum. For local stakeholder groups, entry points were routine community meetings and PHCC consultations.

Communication formats were tailored: a short policy brief for the ministry, a costing slide deck for funders, and pictorial materials for communities. Strategies also varied: high-level advocacy with government, relationship management with funders, and participatory engagement with community leaders.

Putting it all together

By using the Stakeholder Support Matrix, the team turned a long list of potential stakeholder groups into a practical plan for engagement. Each stakeholder was matched with roles, responsibilities, and entry points. This ensured that when horizontal and vertical scaling plans were later developed, they were grounded in real commitments and aligned with the institutions that would sustain the intervention.

D E P TH SCALE & SHARE

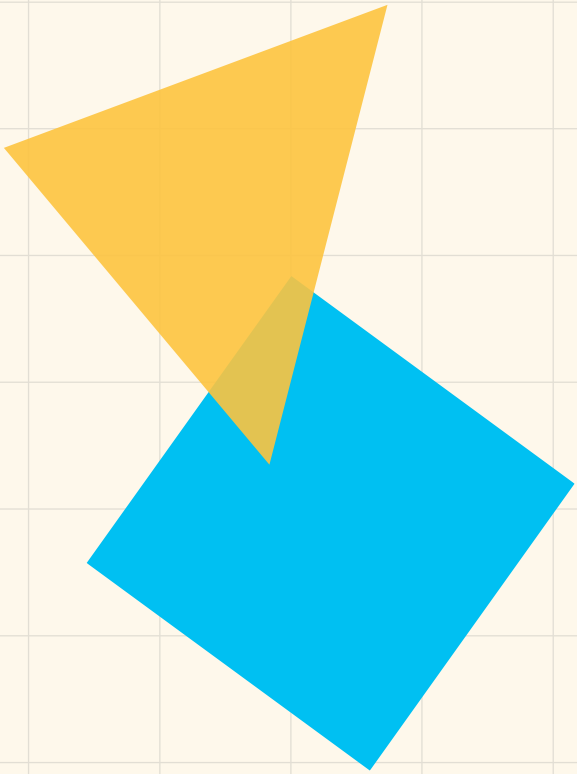
DEPTHS TOOLKIT

Stakeholder Support Matrix

Intervention: Appointment reminder card

List the most important actors for scaling. For each, capture their role, influence, level of support, what they need to do/know, and how and when to engage them.

Actor	Role in scaling	Influence	Level of support	What they need to do	What they need to know	Timing / entry point	Best format / channel	Engagement strategy
Ministry of Public Health (MoPH)	Policy, financing, supervision	High	High	Endorse reminder postcards as part of national immunisation strategy, include in guidelines, allocate budget for printing and distribution	Evidence of improved vaccination uptake, affordability data (low per-child cost), potential for equity gains in underserved areas	Annual immunisation programme review, budget cycle	Policy briefs, technical presentations, high-level meetings	Position postcards as a cost-effective, scalable intervention that strengthens routine immunisation. Link to national child health priorities.
Primary Health Care Centres (PHCCs)	Delivery, supervision	Medium	Medium to High	Distribute postcards, train staff on filling and explaining them, track use through supervision	Evidence on simplicity of process, minimal additional workload, improved caregiver return rates	During staff training sessions and supervision cycles	Practical training sessions, illustrated job aids	Emphasise how postcards reduce missed appointments and ease follow-up work. Provide supportive supervision to reinforce use.
Community health workers (CHWs)	Delivery, advocacy	Low to Medium	Medium	Encourage caregivers to use and keep postcards, answer questions, follow up in the community	Benefits for caregivers (fewer missed vaccinations, healthier children), evidence of ease of use	Community meetings, monthly outreach cycles	Orientation sessions, simple pictorial materials	Position postcards as a tool that strengthens trust with families. Reinforce role as trusted messengers.
Caregivers / communities	End users, advocacy	Low individually, High collectively (through uptake and word of mouth)	Variable (High where trust in vaccination is strong, lower where hesitancy exists)	Bring postcards to visits, follow reminders, encourage peers	Evidence that postcards help protect children, stories of other caregivers benefitting, reassurance on confidentiality	Community gatherings, vaccination sessions	Posters in clinics, community radio, peer mothers' groups	Build demand through visible use of postcards, testimonials, and community endorsement.
UNICEF Lebanon	Technical support, advocacy, funding leverage	High	High	Advocate with government, align with broader child health strategies, provide initial funding and technical assistance	Evidence of effectiveness from the RCT, costs, and relevance to UNICEF's child health agenda	Policy discussions with MoPH, donor meetings	Policy briefs, technical reports, joint MoPH–UNICEF presentations	Use UNICEF credibility to reinforce government ownership, ensure alignment with global immunisation initiatives.
Donors (e.g., Gavi, EU, WHO, local donors)	Funding, advocacy	High	Medium to High	Provide financing for early scale-up, integrate into grants or projects	Cost-effectiveness data, sustainability pathway, potential impact at national level	Donor funding cycles, proposal windows	Funding proposals, results briefs, donor roundtables	Frame postcards as a "quick win" intervention with strong evidence and low cost, while highlighting integration into MoPH systems for sustainability.
Local NGOs / CSOs	Advocacy, community engagement	Medium	Medium	Help raise awareness, integrate postcards into outreach, provide feedback from the ground	Local impact stories, evidence of caregiver acceptance, role in reducing dropouts	During project rollouts, community mobilisation activities	Community meetings, joint workshops with MoPH/UNICEF	Strengthen trust and local ownership by involving them in adaptation and feedback loops.



STEP 3:

Plan for Scale

Associated Tools:

- Horizontal Scaling Plan
- Vertical Scaling Plan

In this step:

The final step is to develop a scaling plan for the pathway identified in Step 1. Scaling requires deliberate choices about whether to grow outwardly to new settings, districts, or communities (horizontal scaling) or embedding the intervention into policies, budgets, and institutions (vertical scaling). Both can support long-term sustainability, but each has distinct considerations.

Horizontal scaling builds sustainability by showing that an intervention works across diverse contexts, and by spreading demand and ownership amongst diverse communities. The challenge is to preserve the core elements that make it effective while adapting to new conditions.

Vertical scaling secures resources and long-term commitment by institutionalizing the intervention within government systems. Its success, however, depends on political will and institutional capacity.

Whichever pathway is chosen, success depends on protecting the intervention's core elements and building the partnerships, systems, and resources needed for them to endure at scale.

Why it matters:

Evidence from a pilot may show that an intervention works, but without a strategy for growth it can remain an isolated success. Scaling is shaped not only by design, but also by politics, resources, and institutions. A clear plan makes these forces visible, helps teams to anticipate challenges, and guides trade-offs. It clarifies the roles of different actors and ensures systems and resources are in place to carry the impact forward.

How to do it:

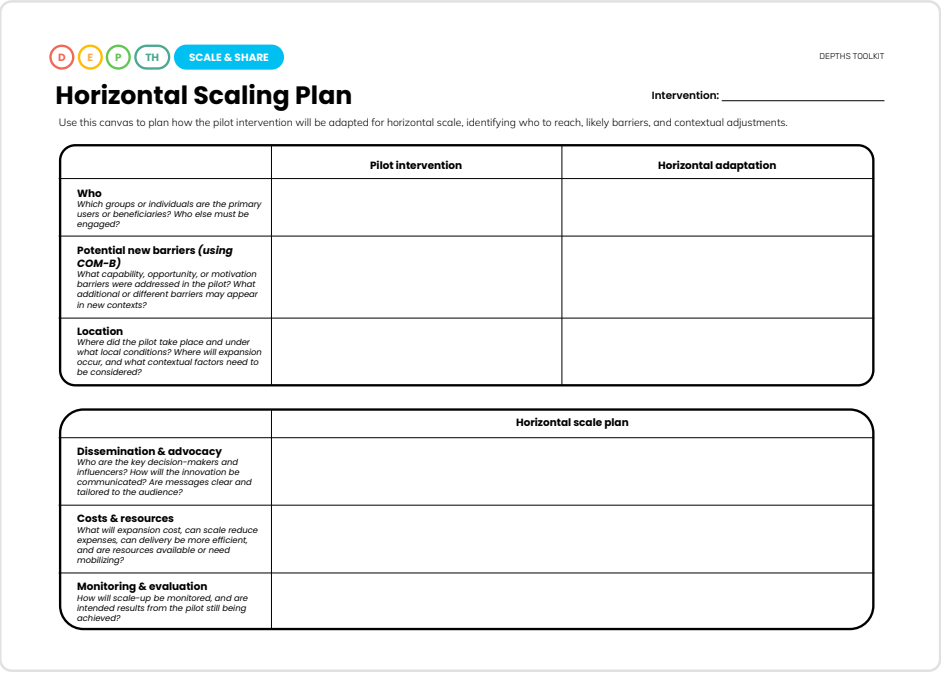
The tools in this step help to identify the core elements that must be preserved, the adaptations required, and the new barriers or demands that may emerge. The result is a concrete roadmap for scaling.

1. Horizontal Scaling: Expanding reach

Using part I of the Horizontal Scaling Plan, compare the realities of the pilot with the adaptations needed for expansion across key dimensions: where the intervention will be implemented, who it is intended to reach, and how behavioural barriers may shift during scale.

a. Starting with "**Who**" in the top box of the worksheet, record the primary users or beneficiaries from the pilot, along with the actors who supported delivery. Then consider expansion: as the intervention reaches new geographies or populations, will these same groups remain central, or will additional ones need to be engaged?

- **Expanding to new geographies:** A pilot in one district may have relied on a small group of dedicated teachers and community youth volunteers. Scaling to several districts may require mobilizing additional stakeholders such as faith leaders, local councils, or parent associations who hold influence in those new contexts.
- **Expanding to new population groups:** When scaled, a pilot designed for out-of-school adolescents may also need to engage parents, teachers, and community mentors to support enrolment and sustained participation.



D E P TH SCALE & SHARE

DEPTHS TOOLKIT

Horizontal Scaling Plan

Intervention: _____

Use this canvas to plan how the pilot intervention will be adapted for horizontal scale, identifying who to reach, likely barriers, and contextual adjustments.

	Pilot intervention	Horizontal adaptation
Who *Which groups or individuals are the primary users or beneficiaries? Who else must be engaged?*		
Potential new barriers *(using COM-B)* *What capability, opportunity, or motivation barriers were addressed in the pilot? What additional or different barriers may appear in new contexts?*		
Location *Where did the pilot take place and under what local conditions? Where will expansion occur, and what contextual factors need to be considered?*		

	Horizontal scale plan
Dissemination & advocacy *Who are the key decision-makers and influencers? How will the innovation be communicated? Are messages clear and tailored to the audience?*	
Costs & resources *What will expansion cost, can scale reduce expenses, can delivery be more efficient, and are resources available or need mobilizing?*	
Monitoring & evaluation *How will scale-up be monitored, and are intended results from the pilot still being achieved?*	

In both cases — whether expanding to new geographies or to new population groups — horizontal scaling requires clarifying how the who changes from pilot to scale. This includes not only those directly reached by the intervention, but also the intermediaries and influencers whose involvement is essential to sustain and expand impact. Mapping these shifts sets the stage for the next step: identifying how new groups may introduce new barriers that must be anticipated for the intervention to succeed at scale.

b. The next step is to examine how the **behavioural drivers** of these new groups may differ from those in the pilot. Applying the COM-B framework provides a structured way to identify potential barriers to capability, opportunity, or motivation at scale, and to compare them with the barriers already addressed during the pilot.

- **Expanding to new geographies:** In one setting, reminders may reduce a capability barrier by helping people to remember contraceptive refills or follow-up visits. But when the same intervention is introduced in rural areas, new barriers can appear. Longer distances to social service offices may prevent families from accessing legal or child-protection support (opportunity barrier), and in some areas caseworkers may have limited training to identify and respond to child-safety concerns (capability barrier).
- **Expanding to new population groups:** A school attendance reminder system originally designed for parents may need to be adapted for older students themselves. This can introduce new barriers — for example, some adolescents may see attendance reminders as unnecessary or intrusive (motivation barrier), or may not know how to update or respond to messages in the platform (capability barrier).

  By comparing the behavioural barriers addressed in the pilot with those likely to emerge in new geographies or population groups, teams can pinpoint the adaptations needed to keep the intervention effective.

c. Scaling requires carefully comparing the **conditions** of the pilot with those in the locations where scale will occur. Geography, infrastructure, service delivery systems, and local dynamics can all help or hinder effectiveness. What factors supported success in the pilot, and what will differ in the new context? Documenting these differences prevents the assumption that what worked in one place will automatically succeed elsewhere.

- **Expanding to new geographies:** A programme that thrived in an urban district with reliable transport, well-equipped schools, and steady teacher staffing may struggle in rural areas where schools are far apart, transport is costly and irregular, and resources arrive inconsistently. These differences can make it harder for children to attend regularly and for teachers to deliver lessons effectively.
- **Expanding to new populations**: A pilot tested in one linguistic or cultural setting may need significant adaptation when introduced into areas with different languages, social norms, or behaviours. For example, messages designed for communities where mothers make health decisions may not resonate in places where fathers or elders play a stronger role, or where translation into local languages changes the clarity or tone of the message.

The second part of the Horizontal Scaling Plan moves to planning the additional elements needed for success at scale. Teams must consider how to communicate and advocate for the intervention, how to secure and allocate resources, and how to monitor and evaluate progress so that results are sustained as the intervention's reach expands.

d. Begin with **dissemination and advocacy**. Scaling to new regions or populations depends on building support from the people and institutions who can enable or block progress. This section draws directly on the Stakeholder Support Map from Step 2 and translates that analysis into a clear plan for action.

Use the worksheet to produce a single, coherent, and accessible paragraph that answers three core questions:

- Who are the key decision-makers and influencers?
- How will the intervention be communicated to them?
- Are the messages tailored to their priorities?

e. Next, reflect on **costs and resources**. Expansion requires deliberate decisions about how costs will shift across settings and whether resources can be sustainably mobilized at scale. This part of the Horizontal Scaling Plan focuses on assessing both affordability and long-term sustainability, anticipating uneven cost patterns across contexts rather than assuming uniformity.

Horizontal scaling often reveals hidden variations. For example, rural areas may demand additional transport, supervision, or incentives to reach dispersed populations, while urban areas may require greater investment in communication channels and community outreach. Some helpful guiding questions to better plan for costs and resources needed during horizontal scaling are:

- **What will expansion cost across different settings?** Estimate the financial requirements for training, supplies, transport, supervision, and communication in new geographies or populations. Consider where costs may rise and where efficiencies of scale may offset them. For example, rural districts may require extra fuel and allowances for outreach teams, while in dense urban areas, it's common to spend more on community outreach.
- **What existing resources can be leveraged?** Review which resources supported the pilot, such as staff time, infrastructure, or volunteer contributions, and assess whether these can stretch to support scale. Identify gaps that must be filled. For example, school committees and local water-user groups can organize hygiene activities during community meetings, and existing maintenance logs or mobile apps can help to track when repairs are due.
- **How will new resources be mobilized?** Determine whether expansion will be funded through district or national budgets, donor partnerships, or integration into sector-wide financing mechanisms. Plan strategies to secure and sustain resources so that costs do not become a barrier to scale. For example, UNICEF can help the Ministry of Education include training materials and teacher stipends in the annual education budget and partner with local radio stations to provide learning content at a reduced cost.

f. Finally, plan for **monitoring and evaluation (M&E)**. As interventions expand into new geographies or populations, monitoring systems must balance comparability with adaptability: indicators should be consistent enough to track performance across sites, yet flexible enough to capture local adaptations. For example, a national child helpline might track a core indicator such as "number of calls responded to within 24 hours," while allowing country-specific measures — like "calls received in local languages" or "percentage of referrals successfully completed" — to reflect context-specific priorities.

M&E should also assess whether scale is reaching all intended groups, whether outcomes are sustained across diverse populations, and whether the core behavioural mechanisms that drove the pilot's success remain intact. Comparisons between pilot and scale sites are especially important for spotting where results weaken and why.

For example, if a pilot reading campaign improved attendance and literacy outcomes in urban schools, M&E at scale should include measures of lesson delivery and student engagement, to ensure that children in rural or resource-constrained schools are equally reached and benefiting.

Below are some helpful guiding questions to consider when building an M&E plan.

- **How will success be measured?** M&E plans should be designed to measure more than reach. Data should be collected to capture whether the intervention is being delivered as intended (process), whether it continues to generate the desired changes (outcomes), and whether it contributes to longer-term shifts (impacts). Select a small set of indicators that balance feasibility (data that can realistically be collected across multiple sites) with meaningfulness (data that confirms the intervention is generating impact as intended, and that behavioural mechanisms are holding).
- **What systems and tools will be used?** Sustainability depends on embedding monitoring into existing structures wherever possible. Explore how to integrate new indicators into government systems or existing service statistics. Where routine systems are weak, consider lighter supplemental tools, like simple reporting forms or mobile-based tracking, that can provide timely data without overburdening staff.

- **What additional assessments are needed?** Routine monitoring rarely captures the full picture. Rapid qualitative studies, focus group discussions, or community feedback tools can help to explain why outcomes differ across sites, while special evaluations may be needed to test outcomes or impacts more rigorously. These complementary assessments ensure that scale-up is not only tracked but also understood.
- **How will findings inform strategy?** Data is only valuable if it is used. Build in regular review mechanisms (monthly dashboards, quarterly reflection meetings, or joint reviews with stakeholders) to ensure that results feed directly into decision-making. Findings should guide any adjustments to implementation, refine delivery strategies, and hold partners accountable for supporting scale.

2. Vertical scaling: Institutionalization and systems change

While horizontal scaling is a more common pathway, vertical scaling is just as important. When an activity is built into systems, policies, and budgets, it becomes part of routine delivery and delivers lasting results. Vertical scaling depends on alignment with policy makers, funders, civil servants, and the parts of government that can formalize and sustain actions. In short, success depends on the extent to which activities can fit within existing institutions and systems.

For example, a school nutrition activity might work well in a pilot, but it will only last if it is written into teacher training, included in education budgets, and monitored through school inspections.

The Vertical Scaling Plan helps to identify categories of change, specify the necessary adjustments, and outline how the change will be communicated, funded, and monitored.

a. The first step is to clarify the type of vertical scale-up in the left-hand column of the worksheet. Ask: What form of scale-up is the goal? The table below summarizes common types of vertical scale-up and offers guidance on when each type can be most useful.

D E P TH SCALE & SHARE

DEPTHS TOOLKIT

Vertical Scaling Plan

Intervention: _____

Use this canvas to plan how the pilot intervention will be adapted for vertical scale.

Type of Scale-Up
Choose all that apply

[ ] New programme or policy rollout – Create and launch a completely new programme or policy based on the intervention.

[ ] Policy integration into an existing programme – Embed the intervention into an established programme, service, or policy framework.

[ ] Service-level integration – Incorporate the intervention into routine service delivery platforms (e.g., adding to health worker protocols, school curricula).

[ ] Institutionalisation – Make the intervention part of standard operating procedures, guidelines, or job descriptions, with dedicated budget lines.

[ ] Legislative or regulatory adoption – Codify the intervention through laws, regulations, or formal government mandates.

Category of change	Change needed *(yes/no/unknown)*	Describe specific changes needed *or how needs should be assessed*
Policy		
Political commitment		
Legal change		
Regulations, norms, guidelines		
Financing and budgets		
Logistics		
Management information systems		
Supervision		
Staff evaluation, performance incentives		
Training curricula and approaches		
Health workforce changes		
IEC materials		
Other		

Dissemination
Who are the key decision-makers and influencers? How will the innovation be communicated (training, peers, media, briefs)? Are messages clear and tailored to the audience?

Costs & resources
What will expansion cost, can scale reduce expenses, can delivery be more efficient, and are resources available or need mobilizing?

Monitoring & evaluation
How will scale-up be monitored, and are intended results from the pilot still being achieved?

TABLE 7. TYPES OF VERTICAL SCALE-UP

TYPE OF SCALE-UP	MOST USEFUL WHEN	EXAMPLE
New programme or policy rollout: Create and launch a brand-new national or sub-national programme built around the intervention.	There's no obvious home for the intervention; high visibility and coordinated roll-out are needed.	The Ministry of Health launches a National Follow-Up Calling Programme, mandating a weekly two-hour calling block in all clinics, funded by the government.
Integration into existing policies or programmes: Embed the intervention within an established programme so it becomes a standard component.	An existing programme can absorb the work with minor adjustments.	The national immunization programme updates its policy to include weekly defaulter calls, adds it to annual plans, and aligns it with supervision and reporting.
Service-level integration: Incorporate the intervention into routine workflows and supervision.	The main change is frontline practice rather than high-level policy; quick adoption is feasible.	Clinics add a two hour weekly calling slot to timetables, nurses use a 60 second script, and supervisors check a one page call log during regular visits.
Institutionalization (SOPs, roles, budgets): Make the intervention part of standard procedures, job descriptions, supervision tools, indicators, and give it a dedicated budget line.	Long-term durability and funding protection are needed; shifting from project to "business as usual."	Nurse job descriptions include calling caregivers of missed appointments, supervision forms add a tick-box, a small monthly airtime line is in clinic budgets, and a simple calling indicator is included in routine reports.
Legislative or regulatory adoption: Codify the intervention through regulations or laws to set authority, privacy standards, and minimum practice.	Legal clarity is needed (e.g., privacy/consent), leadership turnover is likely, or standards must be protected across administrations.	A health regulation authorizes brief clinic calls to caregivers using an approved privacy script, sets data-handling rules, and requires basic call records.

b. The next step is to check which parts of the system must change so the activity can move from a pilot into a policy or routine delivery. The middle column of the Vertical Scaling Plan lists areas to review: policy, political commitment, financing, supervision, training, and information systems. For each area, note if a change is needed and describe the specific adjustment. This comparison shows where institutional change is required to move beyond short term projects.

- **Policy**: Does scaling require a new policy directive or inclusion in an existing policy framework? For example, adding community caseworker roles and reporting protocols to the national child protection policy so that outreach becomes part of routine government service delivery.
- **Political commitment**: Are champions at higher levels of government needed to support institutionalization? Political leadership may be critical to secure approval or drive adoption.
- **Financing and budgets**: Will new budget lines be needed, or can financing be absorbed into existing sector allocations? For instance, including teacher training

costs for a new reading initiative within the national education budget rather than relying on external project grants.

- **Supervision and performance management:** Does institutionalization demand new supervisory structures, evaluation criteria, or reporting lines? For example, ensuring district managers include the intervention in their regular oversight.
- **Training and curricula**: Are pre-service or in-service training materials required to institutionalize practices for health workers, teachers, or other frontline staff?
- **Information systems**: Should new indicators be added to administrative datasets, school records, or other reporting platforms to ensure sustainability and accountability?

c. Next, reflect on **dissemination needs**. Vertical scale depends on visibility, legitimacy, and shared ownership among institutions that set policy and control finance. At this stage, the focus shifts from sharing results to advocating for system change, using channels that influence decision makers, budget holders, and institutional leaders.

Advocacy can include short policy briefs with clear recommendations, meetings with key ministries and partners, identifying internal champions, and site visits where leaders see the activity in practice. Input into national or subnational processes, such as budget reviews and sector plans, is often the moment when routine adoption can be secured.

A core aim is broad ownership. Present the activity as part of routine delivery, not an add-on. Tailor messages for senior officials, programme managers, frontline staff, and community representatives for each to understand their role in sustaining the work.

By matching formal and informal channels to upcoming policy moments and institutional priorities, the activity can be seen as credible and essential for routine practice.

This section of the worksheet should distil insights from the Scaling Support Matrix in Step 2 into a focused plan. It should identify priority actors, outline how to reach them, and confirm that messages are simple, tailored, and aligned with institutional priorities.

d. Vertical scale requires dedicated **resources**. Pilots often rely on external or short term funds, but institutionalization depends on fitting costs into government and partner budgets. The key task is to show how ongoing costs for training, supervision, logistics, and supplies will sit within existing budgets for health, education, or social welfare. The aim is to move from temporary funding to stable investment, so the activity is not exposed to any project cycles or donor changes.

This section should produce one clear paragraph that answers the following four questions:

- What will vertical expansion cost?
- Can scale reduce costs or make delivery more efficient?
- Which resources are already available?
- Which new resources are needed, and through which budgets or partnerships will they be raised?

e. Finally, plan for **monitoring and evaluation (M&E)**. Vertical scale should track both results and progress in institutionalization. Pilots focus on behaviour change and service use. At scale, monitoring must also show whether the activity is being built into systems, policies, and budgets, and whether it continues to deliver results once embedded. For example, track whether dedicated budget lines exist for printing reminders, and whether supervisors record that reminders were given during routine visits.

Begin by asking: How will vertical scaling be monitored and evaluated, and what indicators are appropriate? This may involve:

- **Tracking institutionalization milestones:** New policies, budget lines, updates to training, or simple indicators added to routine records.
- **Monitoring outcomes at scale:** Ensuring that the behavioural results demonstrated in the pilot are still being achieved.

- **Using existing service statistics:** Integrating indicators into routine reporting systems, so that monitoring is sustainable and aligned with sector priorities.
- **Supplementing with additional studies:** Rapid qualitative research to identify barriers as the activity becomes routine, and simple checks to see if it is being delivered as planned and still achieving results.
- **Realizing course corrections:** Regular reviews that use findings to adjust plans when political, financial, or system bottlenecks appear.

Combining institutional indicators with outcome data helps to confirm that an activity is anchored in systems that can sustain it over time. For example, if a school-based handwashing initiative improved attendance and hygiene outcomes during the pilot, national scale-up should also track whether the Ministry of Education has included hygiene promotion in school supervision checklists, teacher training plans, and annual budgets — signs that the practice is becoming part of routine delivery.

This section of the worksheet should produce one clear paragraph that sets out the monitoring approach. It should name the key institutionalization indicators to measure, state how outcomes will be checked at scale, and explain how findings will feed into decisions, so strategies can be adjusted in real time. The aim is a concise plan that shows both how institutionalization will be measured, and how effectiveness will be maintained.

The Vertical Scale Plan helps ministries, partners, and funders align on priorities, set a realistic order of actions, and track progress over time. It also clarifies who is responsible for policy changes, budgets, and monitoring, so commitments turn into routine practice. The plan should be treated as a living document and reviewed at set intervals, with clear triggers for course correction if risks or delays appear.

The tools in this phase help to test readiness, ground scaling efforts in evidence and alignment, and set clear paths for horizontal adaptation and vertical institutionalization — turning promising pilot results into lasting change.

CASE STUDY:

Increasing childhood vaccination uptake in Lebanon

The tools mentioned in this step of the Scale phase were not used by the original project team.
This case study is a recreated example based on real project data and context.

Choosing the pathways

With intervention scale readiness established in Step 1 and the ground prepared in Step 2, the project team faced the core choice of how to scale: expand across settings (horizontal) while also embedding within systems (vertical). The Stakeholder Support Map suggested both routes were viable: district managers and community actors were ready for expansion, and the Ministry of Health's Expanded Programme on Immunization signalled intent to institutionalize the approach, pending a short phased roll-out.

The team planned a two track scale: a controlled horizontal expansion to three new regions with different geographic and population characteristics, alongside a vertical integration process to embed the intervention in national policy, budgets, and supervision systems.

Horizontal Scaling Plan — Part I:

Pilot to scale comparison. The team confirmed who remained central: caregivers as primary users, outreach workers and supervisors as implementers, and EPI/UNICEF as enablers. They listed anticipated COM-B shifts at scale:

- **Capability**: A higher share of low-literacy caregivers in rural areas, requiring pictorial and multi-language card versions.
- **Opportunity**: The risk of inconsistent distribution in districts without established outreach channels, and reliance on standard (not project-specific) supervision.
- **Motivation**: Novelty could fade if the card design remained unchanged.

They also noted contextual differences between the pilot and new sites. The original pilot operated in one urban

D E P TH SCALE & SHARE

DEPTHS TOOLKIT

Horizontal Scaling Plan

Intervention: Appointment reminder card

Use this canvas to plan how the pilot intervention will be adapted for horizontal scale, identifying who to reach, likely barriers, and contextual adjustments.

	Pilot intervention	Horizontal adaptation
Who *Which groups or individuals are the primary users or beneficiaries? Who else must be engaged?*	Primary users/beneficiaries: Caregivers of un- or under-vaccinated children, mainly in vulnerable households.	Other engaged actors: Outreach workers delivering postcards, supervisors overseeing fidelity, Ministry of Health approving design, UNICEF providing technical support.
Potential new barriers *(using COM-B)* *What capability, opportunity, or motivation barriers were addressed in the pilot? What additional or different barriers may appear in new contexts?*	• **Capability**: Caregivers lacked planning capability (forgetting dates) • **Motivation**: Low salience • **Opportunity**: Weak prompts to attend clinics.	• **Capability**: higher-literacy groups may ignore visuals, while low-literacy groups may need more pictorial adaptation. • **Opportunity**: Distribution may be inconsistent if supply chain is weak. • **Motivation**: Novelty may fade if postcards are not refreshed; competing priorities in households may reduce motivation to act.
Location *Where did the pilot take place and under what local conditions? Where will expansion occur, and what contextual factors need to be considered?*	Implemented in select low-resource communities with strong outreach presence, during a short-term vaccination campaign.	Planned for routine immunisation in urban, peri-urban, and rural areas. Contextual factors include varying literacy rates, mobile/migrant populations, and different levels of trust in government health services.

	Horizontal scale plan	
Dissemination & advocacy *Who are the key decision-makers and influencers? How will the innovation be communicated? Are messages clear and tailored to the audience?*	**Key decision-makers and influencers:** Ministry of Health leadership, donor agencies, district health directors, outreach supervisors. **Tailoring:** Use multi-language and pictorial formats for caregivers; emphasise cost-effectiveness and equity for policymakers/donors.	**Communication approach:** • **Policymakers**: policy briefs with cost-benefit results. • **Donors**: slide decks showing equity and cost-effectiveness. • **Outreach workers:** simple training/job aids. • **Communities**: human-interest stories and local demonstrations.
Costs & resources *What will expansion cost, can scale reduce expenses, can delivery be more efficient, and are resources available?*	**Pilot costs:** $0.20 per postcard, less than $10,000 total for 10,000 households. **Scaling estimate:** Printing 500,000 postcards annually (= $100,000 -with potential bulk printing discounts-) **Resources needed:** Funding for printing and replenishment, integration with vaccine supply logistics, and small training modules. **Efficiency:** Economies of scale likely, especially if bundled with vaccine shipments and procured nationally.	
Monitoring & evaluation *How will scale-up be monitored, and are intended results from the pilot still being achieved?*	**Monitoring methods:** Supervisors check postcard distribution during outreach visits. Routine immunisation registers track uptake and completion. Household caregiver surveys capture recall and usefulness. Cost-tracking templates for procurement and logistics.	**Success criteria:** (1) More than 5 percentage point increase in timely vaccine completion across diverse contexts; (2) Fidelity of 80% (postcards correctly filled and delivered); (3) equity gap reduction between vulnerable and non-vulnerable populations; (4) stable cost per additional vaccinated child (less than $10).

district during an intensive campaign period, whereas scale-up involved year-round routine delivery across three new regions, including remote and peri-urban areas with more limited transport and staff coverage.

Horizontal Scaling Plan — Part II: Dissemination, resources, and monitoring

The plan translated comparison into action. District managers were slated to receive a concise "why this, why now" brief, supervisors would run a short practice during the monthly meeting, and clinics would use a simple pictorial job aid to demonstrate the postcard to caregivers. Costs and resources were written directly into the plan, including a printing contract to keep the unit cost below twenty cents and an initial requirement of roughly 150,000 cards for the first three regions. Distribution was riding on existing vaccine consignments across three regions with differing outreach structures, and practice was absorbed into routine two-hour refresher sessions.

Monitoring was kept deliberately simple and tied to routine systems, with four dials specified and thresholded to compare performance across the three regions and identify where adaptation might be needed. (This was noted as fidelity at or above 80% correct completion, on-time doses gaining at least five percentage points relative to matched districts, equity gaps narrowing for marginalized families, and cost per additional fully vaccinated child remaining below ten dollars). A single decision gate was recorded in plain language: expand no further unless at least two of the three regions meet all thresholds after two quarters – otherwise, pause, fix, and retest.

Vertical Scaling Plan — Pathway selection

In parallel, the team selected the vertical routes on the plan: policy integration into EPI, service-level integration through SOPs, supervision forms, and ordering, along with institutionalization via a ministry circular, an EPI budget line, and a training module. Legislative change was noted as not required for immediate adoption.

Vertical Scaling Plan — Categories of change

Each category of change refers to a specific part of the system that must adjust for the intervention to become routine—such as policy, financing, logistics, training, supervision, or information systems. Each was assigned an owner and a corresponding document or process to update.

D E P TH SCALE & SHARE

DEPTHS TOOLKIT

Vertical Scaling Plan

Intervention: **Appointment reminder card**

Type of Scale-Up

[X] Policy integration into an existing programme – Embed the intervention into an established programme, service, or policy framework.

[X] Service-level integration – Incorporate the intervention into routine service delivery platforms (e.g., adding to health worker protocols, school curricula).

[X] Institutionalisation – Make the intervention part of standard operating procedures, guidelines, or job descriptions, with dedicated budget lines.

Category of change	Change needed	Describe specific changes needed
Policy	Yes	Postcards must be included in MoH vaccination operational guidelines and demand-generation policies.
Political commitment	Yes	Ministers and senior officials must endorse and champion postcards as a national priority.
Legal change	No	Not required.
Regulations, norms, guidelines	Yes	Add postcards to immunisation SOPs, supervision checklists, and reporting templates.
Financing and budgets	Yes	Secure a dedicated budget line for postcard design, printing, and distribution.
Logistics	Yes	Integrate postcard supply with existing vaccine distribution chains.
Management information systems	To be defined	May need small adjustments to record postcard distribution and track fidelity.
Supervision	Yes	Supervisors must include postcard use in standard monitoring visits.
Staff evaluation, performance incentives	To be defined	Postcard delivery may be linked to outreach performance, but this needs assessment.
Training curricula and approaches	Yes	Add postcards to outreach worker training modules and refresher sessions.
Health workforce changes	No	No new staff needed; uses existing staff.
IEC materials	Yes	Postcards must be co-branded with MoH/UNICEF logos, translated into multiple languages, and pictorially adapted for low-literacy groups.
Other	Yes	Mechanism for periodic redesign (to prevent message fatigue) should be established.

Dissemination

- **Decision-makers:** MoH, UNICEF, WHO, district directors.
- **Approach:** Policy briefs and cost summaries for MoH/donors; peer learning for managers; job aids for workers; evidence briefs/webinars for multipliers.
- **Message:** Low-cost, equity-enhancing, easy to integrate.

Costs & resources

- **Costs:** At scale, $0.20 per postcard; 500,000 postcards annually (=$100,000.)
- **Efficiency:** Economies of scale achievable with bulk printing and bundling with vaccine shipments.
- **Resources needed:** Donor co-financing in early phases; eventual transition to MoH budget line. Communications experts for design adaptation.

Monitoring & evaluation

- **Monitoring:** Supervisors check postcard use; immunisation data track uptake/timeliness; spot surveys assess caregiver recall.
- **Key indicators:** % postcards distributed correctly; % increase in on-time vaccination; equity gap reduction; cost per additional child vaccinated.
- **Evaluation:** Quasi-experiment to assess impact on vaccination uptake

Policy and guidelines required a ministry circular and revisions to EPI operational guidance to formalize the postcard use in routine immunization. **Financing** called for creating a dedicated EPI budget line, initially supported by donor funds and later absorbed into domestic financing. **Logistics** required an ordering code for reminder cards, bundling with vaccine shipments, and quarterly district stock counts. **Training** added a short module on postcard use to in-service refreshers and pre-service materials. **Supervision** integrated a tick-box for correct postcard completion on monthly visit forms, and recognition for high-performing teams. **Information systems** remained light, using existing immunization indicators to track progress, while a simple schedule for periodic postcard redesigns was added to sustain user interest over time.

Vertical Scaling Plan — Decision-making and dissemination

Dissemination for vertical decisions followed the plan precisely. EPI leadership received a two page brief and a short decision deck, while a low-key site visit preceded tabling at the National Immunization Technical Advisory Group. Nothing was staged: a caregiver showed the postcard at home and a nurse read out the next date already written. Requests to the Ministry were narrow and concrete — issue the circular, activate the budget line, add the supervision tick-box, and switch on the ordering code. NITAG endorsed, and the circular was signed the following week.

Learn more

This field guide introduces practical tools to help teams assess readiness, build support, and plan for scale. Scaling, however, is a complex field in its own right, drawing on insights from implementation science, systems change, political economy, and organizational management. No single guide can capture all of the perspectives, lessons, or strategies available. For that reason, this section points to additional resources for those who want to go deeper — whether to explore the frameworks introduced here in further detail, or to broaden their understanding of scaling challenges and approaches.

"I want to understand more about John List's *Voltage Effect.*"

"Voltage Effect" details potential 'voltage drops' that occur when interventions that look strong in a pilot lose effectiveness or cost-efficiency as they scale (see Appendix 1 for more detail).

"I want a quick, structured check of scalability before investing."

The Intervention Scalability Assessment Tool (ISAT) by Milat et al. gives policymakers and implementers a practical checklist to judge readiness for scale across domains like evidence strength, costs, fidelity, and context.

"I want to complement the Scale phase of the DEPTHS process with another scaling alternative."

WHO/ExpandNet: Nine Steps for Developing a Scaling-Up Strategy is a field-tested roadmap covering what to scale, who will adopt it, resource needs, partnerships, and monitoring. Pair it with ExpandNet: Beginning with the End in Mind to design pilots that keep future scale (budgets, roles, and data systems) in view from day one.

Another option is the BehaviourWorks Scale-up Toolkit, which helps teams to map core vs. adaptable elements, plan adoption pathways, anticipate voltage drops, and choose scale tactics (e.g., staged rollout, new channels). It's a good operational bridge between Horizontal and Vertical Scaling Plans.

"I want robust implementation frameworks to understand the context before implementation."

Teams can use the CFIR (Consolidated Framework for Implementation Research), which helps to identify barriers and enablers across the intervention, along with the setting, people, and processes involved. EPIS (Exploration, Preparation, Implementation, Sustainment) adds a phased view and "bridging factors" between systems and services. For busy teams, use CFIR to structure your risks/assumptions log, and EPIS to plan when and how adaptations will happen.

"I need to design adaptations without losing the core."

The Dynamic Adaptation Process (DAP) shows how to plan and document adaptations while protecting core functions. It's useful when your Horizontal Adaptation Plan calls for changes across languages, channels, or staffing models.

"I want to plan for long-term fit, not just launch."

The Dynamic Sustainability Framework (DSF) argues that context changes, and so must interventions. Use it to set up light, continuous improvement loops (e.g., quarterly fidelity + outcome reviews) during scale so the intervention stays effective as conditions shift.

"I need to monitor reach, fidelity, and maintenance during scale."

RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) gives five plain-English outcomes you can track with routine data. Combine it with PRISM if you need extra prompts on context (workflows, leadership, data systems) that shape those outcomes. Use these to choose a small set of indicators for your scale dashboards.

"I want to track and communicate broader public value."

The Translational Science Benefits Model helps to document community, clinical, economic, and policy benefits beyond the main effect size. It's useful for donor updates, budget justifications, and policy briefs during vertical scale-up.

“I need to turn evidence into decisions and products.”

FHI 360’s Research Utilization Framework maps a practical route from evidence to action—stakeholder mapping, product design, and institutionalization. For writing and planning, the PRB Research Translation Toolkit offers templates for policy briefs, stakeholder plans, and research-to-action roadmaps. The Value-Added Research Dissemination Framework gives a simple, end-to-end view of how to package and share findings so they are used.

UNICEF also offers a strong base of internal expertise and resources to support scaling. Staff with direct experience, along with internal documents and guidance, are available to help teams navigate this stage. Drawing on these assets can make scaling more achievable, especially considering that it is often the most complex part of applying behavioural science in practice.

RESOURCE	WHAT IT OFFERS & HOW IT’S USEFUL FOR SCALING
Social & Behaviour Change Programme Guidance: All Tools (UNICEF SBC Guidance)	A set of internal guidance, framing documents, and tools for SBC. Helps with designing, implementing, and iterating behaviour change programmes — useful when scaling to ensure consistent approach and quality.
Implementation Research Resources (UNICEF)	Practical guidance and case studies on how to use implementation research (IR) to adapt and scale interventions in real-world settings. Useful for identifying barriers, testing adaptations, and informing sustainable scale-up.
Scaling Up Child Protection: A Framework (Vol. 1, Vol. 2)	Provides a conceptual and practical roadmap for scaling programmes, policies, and services in child protection. Steps include building consensus, assessing scalability, scaling strategy, implementation, monitoring, and adaptation.
Implementation Research Compendium (UNICEF)	A collection of case studies from nine countries showing how implementation research (IR) helps in real-world settings, especially for adaptation and scale.
Scaling innovation for every child (UNICEF)	The UNICEF Innovation Group’s principles and guidance for scaling innovations, particularly digital, within UNICEF’s ecosystem.
Tools and ethics for applied behavioural insights: Basic toolkit (UNICEF Knowledge Summit)	Ethics and tools in applying behavioural insights. Useful for ensuring scaling is done responsibly, and that as reach increases, any risk of harm, unintended outcomes, or mis-application is managed.

Appendices

Appendix 1: Five Voltage Drops according to John List[27]

VITAL SIGN	WHAT IT MEANS	EXAMPLE
False positives	The pilot appeared effective, but the result was not real or replicable in the first place.	With DARE (Drug Abuse Resistance Education), early school pilots reported encouraging shifts in attitudes and intentions, with the programme spreading to thousands of schools. Later independent studies that tracked actual behaviour found little to no reduction in drug use, and in some cases, small backfire effects. The early "success" came from short term, self reported measures that did not hold up when larger groups and longer follow-ups were tested. The lesson is to confirm results with real outcomes and replication before wide rollout.
Population representativeness	The pilot worked for a sampled population, which is vastly different from the population at scale.	A preschool curriculum in a Chicago suburb raised test scores more for Hispanic families than for white or Black families, partly because Hispanic households in the setting were more often multigenerational, with grandparents able to help when parents were unavailable. If the team had scaled indiscriminately, it would have over-invested for groups that benefited less – as such, knowing who the intervention worked for would have guided targeting and adaptation.
Spillovers	If an intervention affects groups other than those sampled, then the impact at scale will not be like the impact in the initial test.	Positive spillovers had appeared in a preschool case, where children who were not enrolled still improved by playing with classmates who were – scaling would have amplified impact.
Supply side	Even if benefits persist at scale, 'diseconomies of scale' can cause a voltage drop if expansion of the programme causes costs to rise disproportionately.	A team planned for costs and delivery capacity as the intervention developed, deliberately designing the Chicago Heights curriculum so that ordinary communities relying on "average" teachers could deliver the intervention. This made the model more financially and operationally scalable.
Context representativeness	The intervention worked in a particular situation that was too different from the world at scale.	The early childhood programme succeeded with a limited number of excellent teachers, but hiring 30,000 such teachers would not have been feasible. Similarly, Early Head Start struggled when parents with spare time, their key ingredient, were no longer available. In short, the situation that enabled the pilot's success would not have scaled.

27 List, J.A. Optimally generate policy-based evidence before scaling. Nature 626, 491–499 (2024). https://doi.org/10.1038/s41586-023-06972-y

Appendix 2: Operational dimensions that most often break at scale.

Pilots often work because they benefit from extra funding, supervision, or ideal conditions that no longer exist when scaled up. The table below lists the operational areas that most often break under routine conditions — from staffing and training to supplies, data, and community access. Reviewing these areas helps to spot where a pilot's advantages can't be assumed, and where adjustments will be needed to make scale possible.

OPERATIONAL DIMENSION	CONSIDERATIONS
People and workload	• How many staff are on duty per session • Who accomplishes which tasks (nurses, clerks, outreach workers) • Usual sick leave or staff leaving, and how gaps are covered • Protected time versus competing duties • Time required for each task • Shift patterns and overtime rules • Reliability of volunteers • Any limits on what each role is permitted to do • How quickly replacements can be hired
Training and onboarding	• Length and style of training (classroom, or on the job) • Practice time and what counts as a pass • Number of trainers per group • Languages used, and whether materials are easy to read • Who trains whom (central team or local supervisors) • How often refreshers occur • Job aids provided • How new or rotating staff are brought up to speed • Whether training fits into regular staff meetings and budgets

Table continues on following page.

OPERATIONAL DIMENSION	CONSIDERATIONS
Supervision and QA	• How often supervisors visit, and for how long • How many staff each supervisor supports • Tools used by staff (simple checklists, observation forms) and how feedback is given • How problems are raised, by whom, and how quickly they are fixed • How many sessions are observed • Whether mentoring or peer support is available • Whether supervision actually occurs, given travel time and workload
Service delivery pattern	• Days and hours clinics are open • How often outreach occurs, and how it is planned • How long a typical session runs, and whether it starts on time • Client flow (busy times, queues, fast track for very young children) • Appointment and no-show rates • Which services are offered together (e.g., child growth checks with vaccines) • Clashes with other events, like campaigns or market days • Seasonal changes in demand
Caseload and coverage	• Average number of clients per day or session • Share of new vs. return visits • Size and spread of the catchment area • Busy seasons • Drop-off between doses • Number of individuals requiring follow-up each week • Coverage targets and recent trends • Gaps between neighbourhoods or groups • How often target lists are updated, and how accurate they are

Table continues on following page.

OPERATIONAL DIMENSION	CONSIDERATIONS
Supplies and logistics	• Who forecasts needs, and how • How often deliveries arrive, and typical waiting times • Storage space in rooms and in fridges or freezers • How temperatures are tracked • Agreed buffer stock levels • How often items run out, and for how long • Wastage and whether the soonest-expiring stock is used first • Whether items come in complete sets (syringes, safety boxes, cotton, gloves) • Storage security and tidiness • How accurate stock records are
Transport and access	• Travel time to outreach sites • Whether vehicles are available, and how they are booked • Fuel rules and budgets • Breakdowns and maintenance • Road and weather issues • Reliability of public transport • Checkpoints or security stops • Back-up options, like motorbikes or hired cars • Cost and approvals needed for trips

Table continues on following page.

OPERATIONAL DIMENSION	CONSIDERATIONS
Data and IT	• Main source of data (paper register, simple tally, electronic register) and how it advances through the system • How often reports are sent, and whether they arrive on time and complete • How many people share a device • Network coverage and any offline options • Charging and battery issues • Who helps when devices or software fail, and how quickly • Common errors (name mix-ups, duplicate records) • How permission and privacy rules are followed • Who accesses dashboards and how they are used in meetings
Payments and incentives	• Rules and rates for daily allowances, meals, or travel • Airtime or data support for phone calls or messaging • Any performance bonuses, what they are based on, and how quickly they are paid • Volunteer stipends or other recognition • Whether staff feel payments are fair • The length of paperwork processing, from claim to payment • How secure the funding source is
Communication channels	• Official methods of sharing decisions (memos, circulars, regular meetings) and how long it takes for front-line staff to hear about changes • Informal channels (WhatsApp groups) and who moderates them • Community channels (local radio, town announcements, faith groups) • Whether messages are easy to read and written in the correct languagesHow feedback from front-line staff reaches managers • How rumours are spotted and addressed

Table continues on following page.

OPERATIONAL DIMENSION	CONSIDERATIONS
Procurement and finance	• How long it takes to buy printing, protective equipment, stationery, or fridge parts • Whether there are standing agreements with suppliers or one-off purchases • Who signs off at each amount, and how long it takes • Limits on small cash • Spending bans at the end of a quarter or year • Supplier reliability and late payments • Exchange-rate or inflation risks • Tax or duty exemptions • Paperwork needed for financial checks
Policy and governance	• What approvals are needed (ministry notice, technical group sign-off, ethics if required) • Whether plans match current guidelines and written procedures • Any rules that limit data sharing or consent • Who decides at national, district, and facility levels • How accountability works • How often inspections or checks occur • Alignment with partner rules (UN/NGO)
Environment and security (if relevant)	• Curfews or movement limits • Patterns of conflict or violence • Disaster seasons (floods, storms, extreme heat) and back-up plans • Safe routes for outreach • Insurance or risk cover • Community acceptance and possible backlash • Staff stress and support • Contingency stock and mobile cold-storage options

Table continues on following page.

OPERATIONAL DIMENSION	CONSIDERATIONS
Equity or access constraints	• Languages and literacy levels • Disability access (ramps, signs, communication aids) • Gender norms that affect attendance or decision-making • Time and travel costs for caregivers • Need for identity documents and who lacks them • Status of refugees or migrants, and their entitlements • Cultural or religious calendars • Risks of stigma or discrimination • Tailored solutions, such as interpreters, flexible hours, or privacy during visits

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