Chapter 3
The Scaling-Up Process and Health MDGs in the Philippines

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Introduction and Background

The Philippine record in health-related Millennium Development Goals is perhaps best described as stable but critical, to borrow from medical parlance. Thus far, the Philippines has achieved major gains in key battleground areas such as under-5 and infant mortality reduction, public health (esp. control of malaria and tuberculosis), and water supply and sanitation and is statistically on track to meet most of the 2015 health targets. These successes, taken as a whole, represent a steady stride toward an upturn in health outcomes, but at the same time they signify major vulnerabilities: on the demand side, large divergences in health care across the geographic expanse of the country, with scores of far-off areas remaining underserved, and on the supply side, continued underfunding, shortages of medical staff with expert skills, and lapses in monitoring, accountability, and quality control procedures. Such weaknesses, plus the sluggish pace in another crucial health MDG, maternal mortality rate reduction (along with the subgoal of improved access to reproductive health), suggest that the country's 2015 MDG health target is unlikely to be fully met. As Social Watch Philippines (2010) indicates, the Philippines is at risk of "winning the numbers but losing the war" (against ill-health and disease).

The unanswered need therefore is how to *broaden the MDG reach* to expand access and enhance quality for more Filipinos over a wider geographical area to cover more impoverished areas and to do so in ways that are efficient, equitable, and sustainable. Huge challenges confront the health establishment in delivering culturally appropriate outreach services to nonmainstream constituencies having varying social and cultural experiences. To avoid bureaucratic exhaustion and piloting dead ends, the key is *a scaling up that is at the same time a localizing down*. On the one

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hand, scaling up must address the necessity of building a strong sense of national ownership in the articulation of priority health needs. The national coherence of the Philippine health system is still unquestionably a reasonable objective. On the other hand, localizing must highlight the development and testing of local solutions in an environment of empowerment and sustainable change. Instead of just relying on a centrally directed expansion, scaling up must reclaim the formulation of context-specific strategies for spreading out small-scale successes across wider terrains, until they reach a tipping point for national acceptance. Localizing allows it to retrieve vibrant local social networks and rely on them as resources for enlarging the reach of health programs. Health is at its core contextual—the result of *localized* interactions, responses, and shared experiences, not clinical aloofness.

A *focused-down scaling up* is made more urgent by the Philippines' experience *under a decentralized system,* in which local jurisdictions have been cut off from the central health bureaucracy and its regional health units. This requires a holistic approach and a coordination strategy that resolves the many contested issues of MDG execution in the health sector. It is important to recognize that without a reinvented scaling up, many of the needy health constituencies, the urban and rural poor (especially women) and indigenous communities, will continue to be underserved by the health-care programs of the government. *In the process of reaching out, centrally directed national activities should be focused down without loss of coherence, and local activities should be scaled up without loss of context.* Equivalently, current reform is unlikely to lead to large-scale improvement unless it combines a localized *top-down governance structure* with an expanded *bottom-up governance framework.*

Recent studies provide ample proof of the need to reach out by localizing the scaling-up process. Samoff et al. (2003) argue *against* the standard evaluation model (which is based on a linear sequencing from premises to goals and objectives to measures, to observations, to findings, to recommendations) and *for* contextual and experiential adaptation to modify structure, content, and practice. Likewise, both Simmons and Schiffman (2007) and Gilson and Schneider (2010) suggest that scaling up is not just about technology transfer, but is a learning process that involves building local capacities for innovation and undertaking the needed adaptation of tested innovations to local realities. Dede (2005) refers to previous lessons about the need to avoid the "replica trap" (duplicating everywhere what worked locally, without considering local variations) by fixing problems of magnitude (fostering the basic conditions for change in large numbers of geographically scattered settings) and variation (diverse and often unfavorable conditions across settings). Lee and Luykx (2005) emphasize the compromises in conceptual rigor and fidelity of implementation of an innovation as it is subjected to the realities of varied multilingual, multicultural, or urban contexts.

Framework of Analysis

Taking our cue from Bossert and Beauvais (2002) and Bossert (1998), a modified *principal-agent approach* supplies a promising way to examine how a localized scaling up might smoothen the progress of the Philippine health MDGs. In this

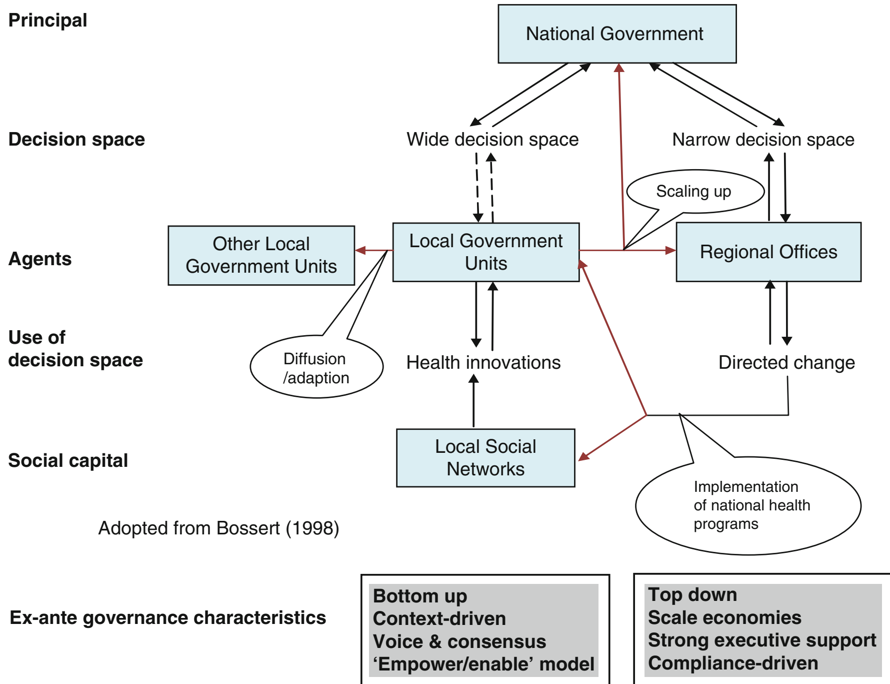
approach, decision-making is considered often hampered by the so-called agency problem, which assumes that agents, or the implementers, are likely to have other motives (usually driven by self-interest, such as increasing their own income) and better information about local conditions than do the principals, or central authorities. This gives them undue advantage that permits them to evade the mandates established by central authorities and instead use the agency's resources for their own benefit (a situation often labeled in the literature as moral hazard).

In the context of health care, several quandaries are inherent in the principal-agent problem: local health operations may be quite remote from the principal's direct oversight, making the actions of the agents unobservable; the principal may not possess the technical expertise needed to watch over complex health programs yet gaining more information may have prohibitive costs; and errors may be costly when agents are stewards of large amounts of resources and are responsible for projects affecting citizens' health.

To overcome this information asymmetry (i.e., offset the divergent interests between principals and agents), principals have to use incentives and sanctions to persuade agents to attain the agency's goals. The Philippine Department of Health (DOH), for instance, has to use alternatives like monitoring local health officials, conducting performance reviews, doing inspections, using inducements for proper behavior, providing grants and aid, and applying selective penalties in order to shape local decisions (Bossert and Beauvais 2002).

Following Bossert (1998), this principal-agent framework is extended by introducing the idea of *decision space*, which is a map of the range of choices observed by local government units and regionally based DOH offices (the agents) in order to achieve national health goals overseen by central DOH authorities (the principal). This decision space lays down the specific "rules of the game" for both field health offices (of the DOH) and local governments. A wide decision space connects central authorities to autonomous local governments within the context of decentralization mandated by a devolution law (the Local Government Code, or LGC), while a narrow decision space links them to their own field (i.e., regional) health offices. The DOH, as the principal, sets the targets and parameters for health policy and programs. This principal then grants resources to autonomous local agents—local government units, or LGUs—and authority to non-decentralized field offices, to carry out its objectives. That situates central government as a coordinating outfit, responsible for creating a supportive environment for community initiatives. Local authorities may make "wide" *innovative* choices that are different from a "narrow" *directed change* that the central authorities impose on their own regional units. By definition, autonomous authorities have a wider selection of decision choices than regional offices with a more constricted decision space.

An important part of this modified framework, shown graphically below, is the utilization of local health networks, which are at the bottom of the vertical chain of agents. Bossert (1998), taking off from Putnam's analysis of social capital, argues that communities with denser networks of civic and nongovernmental organizations will have greater *social capital* which will strengthen their capacity to decide which health innovations to pilot test and implement effectively. At a time when the Philippines is undertaking a far-reaching process of decentralization,



this situation offers opportunities in dealing with demanding health-care challenges. The presence of social networks allows for a quicker flow of information and interaction between local health service providers and consumers and should pave the way for a more organized involvement of citizens in reaching consensus regarding health goals, design, and financing and in monitoring service provision. The use of decision space creates a *community of practice* that evolves local health initiatives.

This expanded approach recognizes that local agents often have their own preferences for the assortment of health activities and expenditures to be carried out; they need to be responsive to local stakeholders and constituents who may have priorities that clash with those of the national level principal (Bossert and Beauvais 2002). The decision space outlook allows lower level officials to enhance flexibility at the ground level. To be sure, local agents with substantial local financial resources are likely to have greater leeway in generating locally directed innovations (Bossert 1998) that are not available to centrally directed field offices. The use of the decision space, either through the introduction of local health innovations or the enforcement of directed change, is thus critical in generating a two-way process: shaping choices at the periphery and providing advice to central authorities. It allows for a refocusing on what the national level can do to encourage local authorities to achieve the broad goals of health through the establishment of incentives and sanctions that effectively guide agent behavior without imposing unacceptable losses in efficiency and innovation (Bossert and Beauvais 2002). At the same time, it lets local authorities to

have a channel of power over which to influence central decisions, leading to health services that are more differentiated and better targeted to varying local needs. These local health providers need to have access to the discretionary authority needed to offer high-quality services (Lieberman 2002).

Rounding out this modified structure is a reminder of the ex ante governance characteristics of the two decision spaces. Most governance efforts commence as top-down initiatives with strong executive support (Earls 2011). Top-down governance is quite effective for setting standards, driving concurrence, and keeping general schemes intact. However, such structure emphasizes control in the governance process and requires role players to stick to process above all else (Andrews and Shah 2003). Top-down governance and decision models are based upon authority patterns and the power to enforce change. Once made, decisions are generally not open to debate, and compliance is not optional. Workers are expected to do as they are told (Thomas 2011).

Ultimately, health programs need to obtain greater local context and involvement from different stakeholders—and empower them to take more ownership of local governance initiatives (Earls 2011). Such an "empower and enable" model, within a bottom-up governance structure, must demonstrate *legitimacy and voice*: local stakeholders should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their intention, as well as capacities to participate constructively. Good governance likewise mediates differing interests to reach a broad *consensus* on what is in the best interest of the group and, where possible, on policies and procedures (Institute on Governance 2011). In short, bottom-up governance offers more *access, representation,* and *power* (Mediratta and Fruchter 2003).

This study relies on a critical assessment of a few significant cases of scaling up in public sector health service delivery systems in the Philippines. This chapter attempts to draw lessons, from the observations from the cases reviewed, regarding the links between local health contexts and a reinvented scaling-up process, utilizing the modified principal-agent approach.

Philippines MDG: Scale by Administration

To pick up the pace in complying with the MDGs, the Philippines made use of an existing model—bureaucratic mobilization and deployment. It is known in the literature as explosive scaling up due to desire for rapid implementation. According to Samoff et al. (2003), underlying this approach is the idea that it is best to mobilize the country's resources and leadership through high-profile national programs. When demand is kindled, it will fuel the ensuing expansion. As the momentum builds, the building blocks of the health initiatives are institutionalized, thus making it likely that they will be sustained.

Generally, health programs were organized in this way. The Philippine government has pursued this strategy in mounting national health campaigns. To combat infant and under-5 mortality, the National Policy and Plan of Action on Infant and Young Child Feeding (IYCF) has required (a) all hospitals and health facilities to

promote breastfeeding and rooming-in practices, while prohibiting the provision of breast milk substitutes, and (b) firms and shopping malls to establish breastfeeding facilities (Fabros 2010). They typify initiatives that carry features such as regulating behavior. Likewise, the Expanded Program on Immunization (EPI), the Maternal, Neonatal and Child Health and Nutrition (MNCHN) program that institutes child survival strategies and delivery service packages, the Essential Newborn Care (ENC) protocol that seeks to improve the health of the newborn through pre- and postdelivery interventions, and the Ensuring Food Security and Nutrition of Children 0–24 months all carry strong centrally directed mandates for implementation. A similar pattern can be observed in the field of public health, exemplified in the adoption of the DOTS strategy in the National Tuberculosis Control Program. The Philippine Development Plan (PDP) for 2011–2016, the country's development blueprint, itself carries national MDG targets from 2011 to 2016, thus allowing the government to direct health strategies, policies, and action plans (Pastrana 2011).

The benefit from centrally based efforts is clear: substantial energy and cost are spared in organizing and guiding scaling-up initiatives. It is also often the case that expanded central programs are associated with economies of scale. Likewise, cooperative strategies that piece together coverage distribute the burden across government entities (Simmons and Schiffman 2007). As Kirk and Standing (2006) point out, enabling institutional environments is best created within existing structures, however imperfect they are.

In a centrally directed setup, modifications and adaptations to accommodate diverse local settings generally come *after* rather than *before* the nationwide implementation (Samoff et al. 2003). Indeed, local governments quickly understand that their support of MDGs is contingent on instructions coming from principals at the center, such as the "Guide to Local Government Units in the Localization of the MDGs" issued by the Department of Interior and Local Government, policy guidelines and procedures in preparation of local budget proposals (which are required to include programs, projects, and activities in support of the MDGs), issued by the Department of Budget and Management, and the formulation of subnational MDG progress reports for the country's 17 regions (UNDP 2010).

Yet scale by administration has its downside. Centralized scaling-up initiatives, though authoritative, may be constrained by the tendency of central authorities to compel stiff implementation of a new health service model, making it hard to guarantee that innovations are fittingly tailored to local contexts (Simmons and Shiffman 2007). For instance, the MNCHN generally tends to be a top-down process, dependent on a hierarchical pool of health workers and for the most part driven by centrally directed agents rather than by those who are final consumers of the health delivery innovations.

Designing instruments at the national level and "cascading" them down to field levels, which is typical in bureaucratized settings, downplay the need to solicit inputs from the beneficiaries of central initiatives. Quickness of implementation of these programs may yield some encouraging results within a narrow decision space, but in the end it merely leads to waste in initiating the change, since the new approach is not likely to have taken root (Samoff et al. 2003). For example, when the DOH introduced

the risk approach to reduce maternal mortality, it was based on the untested premise that high-risk pregnant women could be identified during prenatal visits. Yet local experience (backed up afterward by research) would have clarified that most maternal deaths were due to life-threatening complications for which no antenatal screening was possible: puerperal sepsis, postpartum hemorrhage, and shock. These complications could neither be predicted nor prevented. It was only later that the DOH switched to an Emergency Obstetric Care (EmOC) approach, which requires a skilled attendant at delivery, 24-h access to emergency obstetric care, and a functioning referral system to allow the unimpeded flow of services to any pregnant woman who needs them at any place and at any time (May-I Fabros 2010).

Initial economies of scale in centrally managed programs may be offset by increasing unit costs (with respect to communicable disease control, regulation, financing, health education, personnel, procurement, and training activities) as the process of spreading out tries to touch base with those who are harder to reach. These include some 70 % of the population of the Autonomous Region of Muslim Mindanao having no access to potable water supply and almost all inhabitants of Tawi-Tawi, Lanao del Sur, and Sulu which have very low access to reproductive health services (Lais 2010).

Directives from the center's multiple principals often come out in an uncoordinated way, resulting in inconsistent policies and poor overall synergy. Health-related administrative orders, for instance, were issued without rhyme or reason, giving rise to a strong sense of incoherence. As Mai-I Fabros (2010) points out, the policy on natural family planning is separate from an overall policy on planned parenthood; a safe motherhood policy is disconnected from the reproductive health policy; a policy on the prevention and management of complications arising from abortion is detached from all other maternal care policies.

Local Initiatives: Scale by Expansion

Start small, step up steadily, and build on success: frequently termed *replication,* this is the universal model for enlarging scale. It is basically a stepwise learning process which starts with learning to be effective (start-up efficiency and coverage are low and mistakes are high), proceeds to learning to be efficient (reducing the input requirements per unit of output), and then progresses to learning to expand (recognizing the importance of local fit and pacing the expansion to match organizational capabilities) (Samoff et al. 2003).

The wave of momentum on small-scale, but open and user-driven, local innovations began to reach the health sector in the Philippines when it embarked on a wide-ranging decentralization that saw primary health-care services, more than 600 hospitals, other health facilities, and some 46,000 health personnel devolved to local jurisdictions. The decentralized service delivery model severed the hierarchical ties between local agents (cities, municipalities, and provinces) and central/regional health principals, but engendered local initiative, autonomy, and spontaneity in

addressing health challenges within a wide decision space. In fact, decentralization allowed subnational government units to resolve, in particular local contexts, stalemates in national health decision-making. The clearest example is reproductive health policy. While the national course of action on reproductive health has languished in legislative debates, mainly the outcome of Catholic Church resistance, to date there are 51 municipal ordinances and four provincial laws in support of reproductive health service provision (Mai-I Fabros 2010). When the national government stopped spending for modern contraceptives, many LGUs took up the slack, despite opposition from the Catholic hierarchy. In all these, local coalitions and focal groups (especially women) were consulted about the design of health and family planning services. As well, senior community leaders were asked to participate in program management, thus subsuming modern health leadership under the more customary system of local governance (UNDP 2010).

Within the narrower decision space, the decentralized structure requires that implementation of some pilot programs be vetted through the government bureaucratic machinery. These include the pay-for-performance scheme for field health workers who successfully persuade women to avail of facility-based (in lieu of home) deliveries, the PhilHealth Maternity Care Package (which accelerates access to facility-based services, including prenatal care, delivery, and newborn care), and lately, the Conditional Cash Transfer Program (or *Pantawid Pamilyang Pilipino Program*, which provides a monthly stipend to the poorest families but requires them to send their children to school and pregnant mothers to maternal care clinics). All these address the demand-side barriers to the use of maternal and child health services. Not surprisingly, as Mai-I Fabros (2010) reports, these centrally initiated pilots are not being widely applied in a synergistic manner. Their track record of success varies randomly from local government to local government, and their overall impact has tended to stay restricted to the original target areas, with few spillovers, signifying a letdown in meeting the needs of the underserved on the scale that is necessary in an uneven playing field.

With MDG donor pressures comes the demand to widen the reach of these programs, often in a short-term, quick-fix bureaucratic way. Deadline pressures to meet targets likewise tempt central authorities to hastily move toward completing projects while glossing over the need to accustom them to local circumstances. Yet, as Samoff et al. (2003) suggest, scaling-up success stories precisely rests on both systemic and specifically local elements. They address a well-understood "neighborhood" need and respond to substantive local demand. Finding out "what works" and what is "successful" is contextual and contingent, they argue, and depends on several factors:

- Promising local initiatives are doable precisely because they are small, the testing ground for trials and assessment is controlled, and the risks, should an initiative prove unviable, are limited. Efforts to scale up must recognize these constraints.
- Each initiative itself is largely locally derived and is nurtured by community stakeholders who are inventive and are able to build political coalitions to support

and shelter the innovation. Scaling up typically requires active sponsorship and concerted efforts from local networks of multiple stakeholders.
- Initiatives may not have an institutional base, particularly those introduced from above. Most good programs do not spread with ease, especially when no follow-up efforts at the local level occur. Scaling up must move beyond service delivery toward empowerment and change management.
- The programs are adequately financed locally. The scaling-up process must ensure significant local ownership, which is in part achieved if the community chips in its own resources.

The importance of "local content" becomes quite visible when scaling up fails, as manifested in the following[1]:

- The perceived local need that mobilized and energized participation in the pilots did not materialize in the new sites. That suggests that the program components of locally effective initiatives are often not universally reproducible, mainly because implementers have to deal not just with explicit, codifiable knowledge (which is easily documented and disseminated) but also with *tacit* knowledge, which is embedded in the community and does not move easily from place to place (Cortright 2001). Ethnographic studies in the Philippines, for instance, underline the important role of health practices located within the social, political, and historical milieu of indigenous peoples. Although the human experience of health care is universal, it is the cultural expressions that vary. Being able to understand the location-specific indigenous worldview around birth, healing, illness, and death is important for health practitioners in identifying and using "native" practices and models of care (Mai-I Fabros 2010). In general, communities with thriving pilots usually have high degrees of place-specific social capital (trust, *elan*, creativity) which are invested and generated by program processes. An unintended consequence of scaling up is the loss of the implicit features of the tested innovations.
- Managerial and administrative systems appropriate to a province or a country are not simply outsized versions of community-level oversight. In this case, organizational troubleshooting may overwhelm current managerial and administrative capacities. Moreover, expectations of how the innovation should work in the new project sites that commonly underlie citizens' own experiences become enormous challenges to expansion that envisages dramatic changes. For example, field demonstrations in the Philippines suggest that the accessibility, efficiency, and sustainability of essential health services pick up steam when based on community-focused operations. However, shifting to community-based services requires an intricate undertaking for evolving more complicated governance structures and policies. Hence, the clinic-based focus has unfortunately stayed as the foundation of most DOH health-care systems.

[1] The reasons are drawn mostly from Samoff et al. (2003); the examples are separately supplied.

- Programs may be hijacked or redirected by local or national governments or other institutions, exposing them to new political controls and unequal bargaining power. Rent-seeking local elites can invoke a horde of sharing norms and other redistributive instruments to make certain that their privileged status is not diminished. Efforts to enlarge programs that are oriented toward distributive politics may instead destroy them. A good example is provided by the *Medicare para sa Masa* (MpM) program of the Philippine Health Insurance Corporation, or PhilHealth. PhilHealth partners with local government units to enroll their indigent populations in MpM, with premiums partially subsidized by both LGUs and the national government. However, these steps have not improved the coverage of poor households (Lieberman 2002), mainly because the targeting and selection of poor beneficiaries have been left to local politicians, whose tendency is to choose their own followers among the poor. While resources may reach the poorest, clients of the elites dispensing resources gain disproportionately to the exclusion of certain sections of the poorest (Kirk and Standing 2006).
- There is poor documentation of the local conditions governing effective initiatives and successful attempts at scaling up. Likewise, not enough result-based monitoring is done, nor is there identifiable accountability for outcomes. Although the Community-Based Monitoring System (CBMS) for MDGs is in place in 59 Philippine provinces, collecting and assuring the quality of information, especially from far-off provinces, municipalities, and cities in the country, has been extremely difficult (UNDP 2010). Because empirical findings are poorly recorded, there is the risk of little productive connection between lessons drawn from research and scaling-up policy. The need for empirically detailed accounts of the institutional arrangements and delivery mechanisms for scaling up and better scientific understanding of the determinants of successful expansion provides added essential grounds for researching the process (Simmons and Schiffman 2007; Kirk and Standing 2006).

Implications and Lessons Learned

Convergence by Focusing Down: "Embedding" Initiatives in Decentralized Structures

Good practices do not exist *everywhere*. Practice is lived out differently from place to place and even from time to time in the same place. It is a false-positive to say that changes begun in a community can have an impact throughout the outlying areas. Local initiatives are "experimental" precisely because of time and place variations and are more of an interactive process among field practitioners and beneficiaries. On the other hand, enclaves of good practice are found just about *anywhere*, often amidst poverty and other very trying circumstances, indicating that *anyone*, from an enterprising field worker to an initiative-taking and politically influential local leader, from a risk-taking and nonconformist local

stakeholder to a progressive community, can be a source of effective innovations (Samoff et al. 2003).

This tug-of-war between presence (of pockets of small-scale initiatives) and absence (in areas where they are to be expanded) is bridged by *integration*: small pilots are built into existing decentralized structures and systems. Local governments assume responsibility for successful community initiatives. This pathway is especially appealing to both government and donors because it promises both rapid expansion and sustainability under a decentralized framework (Samoff et al. 2003). Devolution has generated organizational ambiguities between disconnected central offices and local jurisdictions. Integration restores coherence. Central health authorities could stimulate expansion by using incentives and rewards for LGUs to *nurture* promising initiatives on an increasingly large scale. Paradoxically, scaling up requires shifting power to the local level and applying the principle of subsidiarity. Along these lines, a priority for action will be to integrate the new Maternal, Neonatal and Child Health and Nutrition (MNCHN) service delivery into the Municipal Investment Plan for Health (MIPH) as well as the Provincial Investment Plan for Health (PIPH). This involves shifting from centrally controlled national programs operating separately and governed independently at various levels of the health system to an LGU-governed health system that is more responsive to the local situation (UNDP 2010).

Part of the power shift is the activation of local networks, a key convergence factor. A downward-focused scaling up requires *developing and nurturing* effective local *networks of interconnections that link organizations, people, and activities* around a collaborative culture (Samoff et al. 2003) and supply a supportive framework within a decentralized system. Such social capital is particularly helpful to LGUs that are under-resourced or overtaxed with other goings-on. Scaling up is most effective when these networks are preserved and used as rollout occurs. A decentralized set of connections has a dual edge, however. On the one hand, it is critical in ensuring that the health intervention sets in. On the other hand, it may contribute to over-localizing tendencies, so much so that the innovation diverges widely with average norms; it is no longer adaptable in other settings. In the final analysis, as Samoff et al. put it positively, the right equilibrium between central direction and local autonomy is specific to particular places and times and is likely to adjust as circumstances change. Hence, effective decentralization always reflects ongoing *negotiations*, among a variety of players, about where authority and responsibility for scalable innovations should lie.

Since decentralization has been institutionalized in the legal and policy structures of the country, it consequentially legitimates public sector-NGO partnership and teamwork. A good case in point is the Davao City government-NGO collaboration in combating HIV/AIDS. The Alliance Against AIDS in Mindanao (or *Alagad* Mindanao) entered into a partnership with the Davao Medical Center and the Reproductive Health and Wellness Center of the Davao City Health Office, the DOH Regional Health Office, and private laboratories and clinics to turn the corner in the delivery of treatment, psychosocial care, and support services to persons living with HIV (UNDP 2010).

Convergence by Replicating Conditions for Change, Not Elements of Health Program

That the scaling-up process breaks ground in *specific* locales implies that replicating *specific* elements of the initiative in other settings will hardly ever lead to a workable and enduring outcome. For that reason, instead of reproducing the specific components of the intervention, it would be more lasting to scale up *the conditions that allowed the initiative to do well* and the local wellspring that sustains it. In short, local stakeholders should nurture the spread of the *enabling conditions* for those local measures and the social landscape in which they are anchored (Samoff et al. 2003). Extending the coverage and reach of a new public health intervention will require adaptation of the wider system in which it is implemented (Gilson and Schneider 2010).

That challenge involves discovering ways to create congruence among key elements of the scaling-up process, generate widespread and locally rooted demand for the initiative, and encourage an inclusive locally based discussion over content and design. The key is to carve out political space for the scaling-up process and to shield it from local-vested interests who consider it as a threat and a public sector bureaucracy whose attempts at routinizing change often stifle it. Simultaneously, those managing the change must understand each intervention as a continuing process rather than as a definite outcome and must structure it to entrench learning at its core (Samoff et al. 2003).

The constructs “lessons learned” and “best practices” must be treated with caution. Lessons disengaged from their context are not useful at all. Best practices drawn from experiences in disparate settings may not be adaptable at all. Both must be sensitive to the innovation’s deeply contextual nature and its situational specificity. What makes a particular practice successful in one setting is a function of both the practice and the setting (Samoff et al. 2003). Packages of interventions incorporate not only new service components but also the managerial processes necessary for successful execution (Simmons and Shiffman 2007).

But is not health practice easily dissected from its context in order to study and evaluate it? Conceivably, of course it is possible to study health care by isolating it from confounding influences, exploring principal inputs and outputs, and testing hypothesized relationships. A scientific outlook would regard congruence and complex interaction as a source of confusion rather than as the appropriate focus for analytic attention (Samoff et al. 2003). Yet context does not lend itself to itemization. Consider maternal and child care in the Philippines. A good MCH program is never free of the context in which it is practiced. MCH evolves constantly as it is implemented and broadened. The Philippine MCH emerged from an interactive process that involved stakeholders with different know-hows and experiences (from specialized DOH doctors to Filipino mothers and children) who molded and modified it. The insight embedded in the program was generated by the clash of central perspectives (clinic focused, attendant based, standard driven) and local preferences (community focused, culturally founded). It was not scientific consensus

as much as effective local/central engagement in resolving issues of program design and the appropriate roles for health workers, mothers, and the community that mattered. As Samoff et al. contend, when scaling up sidesteps the technical process—assemble pertinent expertise, spell out the necessary activities and sequences, and then take each step in its turn, with little room for deliberation, reflection, and revision—it is likely to advance to the next level.

Going to Scale: The Critical Requisites

How can a participatory health initiative progress beyond the local level and make a bigger impact while avoiding the problem of cumbersome bureaucracy and be constantly accountable to the communities it represents? In this regard, several factors are critical:

- Credible local commitment, expressed in a multi-sectoral local leadership spearheaded by the local government, to the health program and its expansion. This kind of leadership spreads the ownership of the initiative but also demands challenging coordination structures (Senderowitz 2007), deep community involvement, firmness to proceed against odds (such as inadequate resources), and clear accountability for results. It must have the ability to promote efforts to encourage health providers to open up their innovation models and techniques for use by development organizations and social entrepreneurs. In Pasay City, a crowded urban center in Metro Manila, with the worst problems associated with urban poverty (a huge chunk, 41 %, of households lives below the poverty line), the city government inspired health workers and local organizations to make use of a novel innovation platform: localizing the MDGs in every family in order to nurture a "readiness for change." The eight goals were rephrased in the local language as positive, "can do" family-based statements:
    - MDG 1 My family has job and savings.
    - MDG 2 All our children go to school.
    - MDG 3 Men and women have equal rights.
    - MDG 4 All our children are healthy.
    - MDG 5 We keep pregnancy safe and healthy.
    - MDG 6 We avoid HIV/AIDS, malaria, and other diseases.
    - MDG 7 We keep our homes and the environment clean.
    - MDG 8 We get involved in community development.
- For technical assistance, the local authorities partnered with UN-Habitat, but assumed responsibility for financially sustaining the program. Because it has been implementing CBMS—in this case, a 100 % household saturation survey that keeps track of 14 poverty indicators—the city government can easily identify which households need assistance. The city's CBMS generates village maps and flags households with undernourished children, among others. Eventually, the family-oriented MDGs were further translated into child-focused MDGs

with detailed indicators tracking children's monthly progress on a report card maintained by each family. The data on the report cards feed into a participatory monitoring system at the neighborhood level (UNDP 2010).

- Strong demand and keen interest in the communities at the sites targeted for expansion. Here, strong direct, small-scale involvement progressively translates into collective innovative behavior, which, to borrow from Simmons and Shiffman (2007), becomes so contagious that it spreads like outbreaks of infectious disease, generating a "tipping point" for dramatic change. In three expansion sites of the reproductive health program in the Philippines—Talibon, Ubay, and Carmen in Bohol Province—out of the strong local demand emerged several birthing centers, maternal and newborn care facilities, and provision of family planning and adolescent and sexual reproductive health services. The large number of poor families overburdened by an unmanageably large number of children created a clearly perceived need for the innovation. The timing and circumstances were right: the provincial government had the appropriate implementation capacity (e.g., training facilities for health service providers), multi-sectoral agencies pitched in through aggressive advocacy initiatives, and local legislators backstopped the effort by passing reproductive health ordinances with sustainable budget provisions. Reproductive health champions from DOH lent evidence-based credibility to the program (using success stories from pilot areas, explaining the relative advantage of modern methods over traditional practices). It was also obvious that the ensuing widespread adoption of the program indicated that it was quite compatible with the users' evolving values and norms (which required defying Catholic Church injunctions). This led to a rising utilization of comprehensive, high-quality health services in these localities by women (facility-based deliveries, pre- and postnatal care, and contraceptive use) as well as by men (non-scalpel vasectomy). The outcome was dramatic: zero maternal deaths, particularly in Carmen and Talibon.
- Sustainable funding, which in practice means greater reliance on locally generated funds. Local government units must be encouraged to improve local taxation and make use of user fees to support their health platforms. If they avail of external aid at all, it should be in the form of competitive funding to increase the likelihood that only the most promising initiatives are nurtured and maintained. Almeria, a poor municipality in the province of Biliran, offers a praiseworthy model of wise use of meager resources. The Maternity Care Package (MCP) takes a huge toll on the LGU's limited manpower and budget. Yet, it successfully implemented the provincial directive to limit home deliveries, doing so by charging user fees for delivery in its health facilities. A portion of the proceeds goes to its expenditure for health (purchase of medicines and supplies), while the rest goes to a trust fund. The user charges have contributed to the sustainability of local health programs and generated funds for subsidizing the maternal and child care needs of the poor. Almeria's rural health unit is also accredited as MCP facility and outpatient benefit (OBP) facility under PhilHealth. As such, it has access to PhilHealth's capitation fund and reimbursement fund for services rendered. The money supports the operations of the rural health facility and pays for the health workers' incentives (UNDP 2010).

- A functioning result-based monitoring system. Health initiatives take time to unfold and spread out. An aggressive and forcible campaign runs the risk of an early breakdown. For instance, partly under international pressure, the TB DOTS program adopted an inflexible package and forced pace of scaling up—ignoring the considerable on-the-ground experience and knowledge within the country—which resulted in program resistance in several provinces (Schneider et al. 2006). To avoid any premature malfunction of innovative strategies, it is necessary to maintain unequivocal standards of practice and performance, backed up by an appropriate and reliable monitoring system. Keeping an eye on the progress of health programs and taking stock afterward offer clues on what works best under trying circumstances. CBMS is an example of a good monitoring system that has paved the way for the effective targeting of MDG beneficiaries, a process that entails an extensive data source which indicates where scarce resources are to be allocated (UNDP 2010). In turn, the lessons learned from stocktaking would be useful in laying the groundwork of a scaling-up process. But it is also important to begin with the end in mind: scaling up should be taken up at the first instance when a pilot project is designed—taking into account the resource environment in which expansion is to take place—and not relegated as a second-generation issue halfway into the experiment (Simmons and Schiffman 2007).

Summing Up

Going to scale is not necessarily incompatible with decentralized participation. There is ample room for both top-down governance, with its emphasis on coherence and discipline, and bottom-up governance, with its stress on autonomy, local voice, and flexibility. The appropriate *balance between central direction and local autonomy* is likely to vary over time and circumstances, perhaps even within the same setting. This equilibrium is not necessarily dependent on laws and institutions, but on a *negotiated arrangement* on where authority and responsibility for specific activities between principal at the center and local agents should lie. This is quite different from a traditional setting where a fixed adherence to a prior formal plan is required.

But what must be scaled up are the *conditions* that permitted the initiative to flourish and the underlying sources of strength that keep it going. That challenge involves finding ways to (1) shore up demand for the innovation and to sustain an informed and inclusive locally based debate over content and form order to increase the probability that local needs are appropriately reflected upon and taken into account, (2) carve out political space for the initiative and defend it from rent-seeking vested interests, and (3) make those directly involved understand change as a continuing, managed process rather than a specific outcome and to structure it to embed learning at its core.

While context-specific adaptation is indispensable, universal values have their place as well. For example, normative principles as free and informed consent and reproductive rights must be regarded as universal and nonnegotiable rather than as

open to self-dealing domestic versions (Simmons and Schiffman 2007). This has not happened as there is an ongoing confrontation between the central government (which favors informed choice) and religious authorities (which resist the use of artificial family planning methods).

Moreover, key challenges will remain that often require “trade-off” decisions between standardization and adaptation. Standardizing streamlines the implementation process but may not fit as well with local circumstances in expansion areas. Adapting improves the fit and increases ownership (Senderowitz 2007; Kirk and Standing 2006); CBMC should monitor the extent to which local adaptation maintains minimum established standards.

Over the last few decades, health interventions have been shifting to a more unlocked and networked process: stakeholders from within and outside established institutions—from health customers and end users to enthusiasts from other fields (e.g., basic education, which is correlated with health)—and epistemic communities from abroad have weighed in. Since innovative knowledge is broadly scattered, it has to be tapped by credibly committed individuals and organizations that can design and carry out strategies for expansion that are watchfully dovetailed to the realities of assorted settings. Indeed, for national and local initiatives to thrive in the Philippines, they must rely on a broad set of advocates and supporting constituencies.

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