The IDEAS Model for Demonstration & Replication:
An Experience from CARE India
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A: The Challenge of Scale

Successful efforts in reproductive and child health often depend on innovations that help change behavior, leverage improved systems or expand availability of and access to services. Once an innovation is proven to work, expectations shift to increasing its scope – also known as “scaling up.” Often, non-governmental organizations (NGOs) and government agencies alike are accused of focusing too much on creating new projects and not scaling up proven innovations.

How can an organization with scarce resources expand proven pilot programs and/or creative interventions? How can an innovation be linked to potential users, clients or beneficiaries? Scaling up means more than simply expanding a pilot project; it requires an explicit, institutionally grounded strategy for replicating a tested, validated innovation. Replicating a best practice gives individuals and organizations a chance to learn from shared experiences and develop together into a collective platform for sustainable impact.

B: CARE India and the Integrated Nutrition and Health Project (INHP)

To understand how CARE India developed the demonstration and replication model it uses in nutrition and health programs, it helps to know the context in which INHP was designed and launched. In 1994, CARE India and USAID began an impact evaluation of their PL-480-supported programs, also known as Food for Peace. After four decades, funding for these programs was in jeopardy for several reasons: (1) Congress was skeptical of funding more food aid in India; (2) USAID was increasing its emphasis on impact and results; and (3) there was growing pressure, especially in India, to take successful interventions to scale. Based on the evaluation, CARE India began searching for funding beyond USAID and other food-aid sources. It also began to broaden CARE’s technical staff and programs beyond logistics and commodity management. One new series of program and staff initiatives culminated in the design and implementation of INHP.

CARE India began INHP in 1996 to create “sustainable improvement in the nutrition and health status of women and children.” The project was implemented in partnership with the Women and Child Development and Health and Family Welfare departments of the government of India as well as various NGOs and community-based organizations (CBOs). The 10-year project has two phases: INHP-I (ended in 2001) and INHP-II.

The project reaches approximately 100,000 anganwadi centers (AWC) in eight states: Andhra Pradesh, Chattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. Established by India’s Integrated Child Development Services (ICDS) program, these centers provide the following community-level assistance to families with pregnant women and children under age two: antenatal care, with a focus on nutrition counseling and birth preparedness; maternal and child immunization; infant feeding; supplementary feeding; Vitamin A supplements; and newborn care. Final results are measured through population-based surveys.
INHP was designed to use six key strategies:

- Innovate and demonstrate behavior change with NGOs and other partners.
- Replicate best practices through government partnership and capacity building.
- Use food as a nutrition and development resource.
- Build strategic alliances for organizational learning and advocacy.
- Promote gender equity.
- Create synergy with other projects.

In 1999, the operational strategy for INHP-I was significantly changed after its midterm review. Originally, the blocks (government administrative units) in which INHP worked had one of the following designations:

- **Basic Nutrition**: Improved food programs were used as incentives for women and children to visit AWCs.
- **Capacity Building**: Government counterparts received support as they built their capacity to deliver key nutrition and health services.
- **High Impact**: All the above interventions were used along with other strategies to better reach out to women and children and empower communities to support healthy practices.

The midterm review found that while High Impact blocks had shown more results and created the potential for significant impact, the scale of that impact would be limited. Why? The implicit expectation that best practices and improved capacity from High Impact blocks would naturally spread to Basic Nutrition and Capacity Building blocks (“automatic diffusion”) was flawed. Because the government treated each block as a single operational unit, ideas could move easily within a block but not necessarily between blocks. To get the results it expected and deliver them at scale, the project would need a more explicit and intentional strategy for replication. Ideally, a strategy that acknowledged the underlying dynamics of institutional systems and structures, and that built upon those dynamics to foster an exchange of information and dissemination of practices.

### C: The IDEAS Model of Demonstration and Replication

The INHP-II replication strategy began with four skeleton components:

- Demonstrate successful strategies/practices at a convincing scale and in various contexts.
- In a user-friendly way, document and share information on successful practices with strategic audiences.
- Advocate for supportive policies and translation of those policies into practice.
- Build capacity, as needed, to support desired changes.

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1These strategies for INHP-II are listed in section B-4 of the INHP-II Development Activity Proposal (DAP).
In the first year of INHP-II, the project team worked with a facilitator to (1) create broad principles based on implementation experiences in INHP-I and (2) begin developing a replication strategy to scale up innovations in INHP-II. The team began fleshing out the skeleton replication strategy from the Development Activity Proposal (DAP) by identifying and defining key concepts:

- **Innovation**: A new practice, technology, tool or approach that produces desired results e.g., changed behavior, improved outcomes. An innovation can evolve from project design, implementation experiences or observations of culturally appropriate and community-specific efforts in the field.
- **Demonstration (Pilot)**: A planned reproduction of an innovation in multiple sites, with rigorous monitoring and evaluation/documentation of results.
- **Diffusion**: The spread of ideas, concepts and practices from the pilot.
- **Scale up**: To increase a program’s scope and coverage, including a larger number of beneficiaries.
- **Replication**: To reproduce a proven core program, with or without variations, on a larger scale for greater coverage.

The steps to replicating a best practice were then described, sequenced and linked to form the IDEAS Model for Demonstration and Replication. The diagram on the next page shows how elements of this model are related and identifies some of the people and processes involved.¹

¹The chart is read diagonally from bottom left to top right. The five core elements are highlighted in orange; above and below each are descriptions particular to that element.
The IDEAS Framework for Replication in INHP-II

The framework is a tool to empower people and institutions and create an enabling environment to own, perform, sustain and make a difference.

**People**

**Government & Partners**

The government systems (people and institutions) are the key replicators. The district collector as well as the entire ICDS and health functionary chain must be energized and supported. This requires systemic commitment, zeal and support.

**CARE’s Role**

Continue to innovate and demonstrate behavior change. District teams and a project management team proactively document, disseminate and advocate the best practices and models to the government system and institutions through capacity building, monitoring, motivating and rewarding.

**Innovate and demonstrate, evaluate and validate best practices and models to the government system and institutions through capacity building, monitoring, motivating and rewarding.**

**Processes**

**ASSESSMENT & CAPACITY-BUILDING**

- Assess capacity and preparedness of replicators
- Build targeted capacity while monitoring training and practice

**EXTERNAL MARKETING**

- Sell the idea
- Advocate for policy and regulation changes
- Identify replicators and define roles

**DOCUMENTATION**

- Describe best practices (steps, channels, inputs, problems)
- Document both descriptively and instructively

**SUPPORT**

- Motivate potential replicators
- Support active replicators
- Monitor rate and quality of replication
- Reward successful replicators

**Motivate potential replicators. Support those who show interest and take initiative to replicate. Periodically monitor the rate and quality of replication and the sustainability of replicators. Reward successful replicators to reinforce them.**

**Government & Partners**

Government actors, partner NGOs and communities take an increasing and proactive role in adopting best practices from INHP interventions and strategies. Effective implementation builds leadership, creates policy changes and improves performance.

**CARE’s Role**

Facilitator and catalyst: transforming learning and innovation into systems.

This could be done by sparking healthy competition by visibly thanking and rewarding replicators. Follow up beyond cross visits. Build connections between replicators in one geographical area. See replication both in and outside INHP areas. Identify indicators that reflect self-management by communities and CARE’s implementing partners.

**TRAINING AND RESEARCH INSTITUTIONS**

Training and research institutions as well as government partners will play a critical role in this effort. Assess whether they have resources to sustain activities over time and without financial support from CARE.

**Processes**

**The IDEAS Model for Demonstration and Replication**

- Market and sell the program as a whole and advocate for necessary policy changes and directives that facilitate adoption of best practices. Share advocacy materials and success stories. Identify all levels at which replication must take place (from policy to community). Define individual and institutional roles and know necessary skills.

- Assess capacity, preparedness and potential sustainability of replicators - groups, individuals and institutions. Rank the skills and capacities needed, compare the existing capacity and identify gaps. Assess the needed support. Build the necessary capacity, target capacity-building inputs, track the link between capacity building and replication outcome.

- The cross visit is an advocacy and learning tool for engaging government partners and implementers. Presentations to key audiences are critical. Media visibility, participation in key committees and providing support data, stories and policy papers are all helpful.

- Training and research institutions reinforce them.

- Motivate potential replicators. Support those who show interest and take initiative to replicate. Periodically monitor the rate and quality of replication and the sustainability of replicators. Reward successful replicators to reinforce them.

- Government & Partners follow up beyond cross visits. Build connections between replicators in one geographical area. See replication both in and outside INHP areas. Identify indicators that reflect self-management by communities and CARE’s implementing partners.

- Motivate potential replicators. Support those who show interest and take initiative to replicate. Periodically monitor the rate and quality of replication and the sustainability of replicators. Reward successful replicators to reinforce them.

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IDEAS: Key Elements of a Dynamic Process

- **Innovation** – innovate and then demonstrate those innovations in the project; evaluate the results of the innovation and repeat it in multiple contexts and sites to validate it as a best practice.
- **Documentation** – describe best practices e.g., steps, channels, inputs, problems, and document them in both descriptive (“what it is”) and instructive (“how and why”) terms.
- **External Marketing** – “sell” best practices to key participants and other stakeholders, and advocate with them for needed policy and regulatory changes; identify replicators and define their roles.
- **Assessment & Capacity Building** – assess capacity and preparedness of replicators; build targeted capacity while monitoring training and practice.
- **Support** – motivate potential replicators and support active ones; monitor the rate and quality of replication; reward successful replicators.

While each of the five IDEAS elements is presented in sequence, activities such as assessing capacity are best done on a recurring basis. This is a critical aspect of the IDEAS model: Elements are not steps in a strictly linear progression of events and actions. They can be deployed in iterations, with some elements occurring simultaneously and/or looping back to feed into the process repeatedly during replication.

**Innovation**
- Innovate and demonstrate innovations:
  > Repeat innovations in more than one location/context.
  > Explicitly link innovations to core INHP components or desired behavior changes.
- Evaluate and validate innovations systematically:
  > Capture proven experiences.
  > Use retrospective analyses of quantitative data.
  > Group relevant “success stories” or anecdotes about one particular innovation; create one document identifying common aspects and qualitative evidence supporting an emerging best practice.
  > Plan small, “nimble” reviews of newer innovations to validate them before adding to a best-practices list.

**Documentation**
- Describe the best practice e.g., its basic elements, what it looks like at different stages:
  > Make a checklist of what are “core” components, what are “frills,” what is the best practice, what it is not.
  > Show how a best practice may vary across states but have a common base. For example, a self-monitoring tool to measure IFA (Iron Folic Acid) consumption or TT (Tetanus Toxoid) vaccinations can be an AWC wall painting, poster or house decoration but still have common characteristics and purpose.
  > Describe results of the best practice and how these results benefit the target population and other stakeholders.
The IDEAS Model for Demonstration and Replication

• Instruct how to replicate best practices:
  > List steps, processes e.g., clusters, and inputs e.g., time, costs.
  > Describe program sequencing (or evolution) – how it moves from one stage to the next.
  > Explain common problems and proven solutions.
  > Describe capacities required to implement the best practice at the community, service-provider and policy-maker levels.
  > List frequently asked questions and answers.

• Document both descriptive and instructional aspects of the innovation and its demonstration:
  > Create a replication manual with narrative description and operational instructions.
  > Provide materials to help replicators sustain their efforts after cross visits.

External Marketing
• Market and sell the program as a whole; advocate for necessary policies and regulatory changes:
  > Share advocacy materials and successful advocacy stories within CARE.
  > Create strategies for and discuss the use of district-level decision makers such as district collectors (each of whom is the top official in a district), magistrates or administrators.
• Identify capacity needed at each level to begin replication.
• Define institutional roles clearly:
  > Identify all levels of society at which action must be taken for replication to happen, then define the capacity needed for each person, group, institution, etc. to replicate best practices.
  > Make a checklist of necessary skills and capacity for states to refine and use in assessing specific counterparts.

Assessment & Capacity Building
• Assess capacity, preparedness and potential sustainability of replicators:
  > Rank the skills and capacity elements e.g., what is important, essential or optional.
  > Compare replicators’ capacity to the list and identify gaps.
  > Examine the preparedness and potential sustainability of groups and institutions expected to replicate. If they are not ready, what support do they need? Do they have resources to sustain activities without CARE financial support?
• Build the targeted capacity necessary while monitoring the link between training and practice:
  > Target capacity-building inputs. Are there enough of the right capacity-building activities planned?
  > Brainstorm non-training, capacity-building activities to support replication e.g., on-the-job coaching, “supportive supervision” visits and innovative mechanisms in an ICDS district or block, to reward innovation despite limited resources.
  > Decide how to monitor the link between capacity building and replication. What specific outcomes and targets e.g., number of sites replicated, scale of independence or functionality, should be set?
Support

- Motivate potential replicators:
  > Create healthy competition by visibly thanking and rewarding them.
- Support those who want to replicate:
  > Plan to follow up and move beyond cross visits. Give project visitors written materials that help them take the techniques or activities they observed and use them in their own villages or blocks.
  > Create sustainable support networks by building connections between replicators who live near one another.
- Periodically monitor the rate and quality of replication and the ability of replicators to sustain their efforts:
  > Choose 2-3 indicators of rate e.g., number of replicated sites, increase in coverage of best replicated practices within INHP blocks, number of sites outside of INHP blocks that are replicating INHP best practices.
  > Measure quality by defining stages or levels of functionality of replicated sites, then monitor how many replicated sites are at each level/stage.
  > Gauge sustainability by identifying indicators that reflect independence and self-management by ICDS, health institutions and communities/NGOs.
- Reward successful replicators e.g., policy makers, service providers and community-level stakeholders, to reinforce them:
  > Recognize their achievements with certificates, ceremonies or letters to their supervisor.
  > Reward them with, for example, further training or letting them lead and/or host cross visits.

D: Replication in the Field

This section describes how the IDEAS model was implemented. It draws on field visits and consultations with CARE staff and counterpart replicators in March 2004. It also reviews challenges the project team faced and how they overcame them.

The first step in the replication strategy was defining best practices from INHP-I. This was done during a two-day workshop in late 2001 with CARE field and headquarters staff. In this session, participants:

- Created a list of 30 innovations emerging from INHP-I.
- Reviewed innovations using the IDEAS framework to see if they met best-practice criteria; demonstrated in several contexts and validated for its direct link to intended project results.
- Selected four innovations as best practices to be replicated at demonstration sites. They were:
  > Nutrition and Health Day: A single event, held at least once per month, in which supplementary food is given as take-home rations. Nutrition and health education is also

Workshop participants agreed that not all innovations had systematic, quantitative data that would allow validation, but they felt enough strong, anecdotal evidence existed for some of them, and agreed to proceed on that basis.
provided, and an auxiliary nurse midwife provides antenatal care and immunizations.

> **Change Agents:** Individuals and/or organizations that provide information, support healthy choices and help solve major problems in maternal and child health and nutrition.

> **Community-based Monitoring Systems:** Whether individual e.g., self-monitoring tool, or collective e.g., village mothers’ monitoring map, these systems promote, track and value healthy behaviors and critical inputs e.g., TT, IFA.

> **Block-level Resource Mapping and Planning:** Created in a coordinated forum where ICDS, health and community stakeholders come together.

These best practices, part of the INHP-II package of technical interventions, were to be replicated throughout INHP’s program area in replication sites – AWCs selected by government counterparts as ready for the expansion of INHP program interventions. Counterparts in government service providers, and in communities themselves, were identified as replicators.

Innovations not selected as best practices were ruled out either because they were: (1) not linked to the INHP core goals and objectives; (2) not yet adequately validated; or (3) not yet demonstrated in multiple contexts. Team members were encouraged to continue working on validating innovations that they felt strongly about, so long as those innovations aimed to deliver results that contributed to the program’s core goals.

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Considerable debate was generated by the facilitator team’s insistence on establishing a direct link between the innovation being considered and INHP core goals. Everyone agreed in principle that all creative ideas might not necessarily be innovations, and that not all good innovations will necessarily be adopted as best practices and replicated, but it was difficult for individuals advocating a particular innovation to see that some ideas might have merit but would not contribute substantially to reaching INHP goals.

Participants in the same workshop developed the IDEAS framework and, immediately afterward, identified and selected best practices. Using the framework allowed a systematic assessment using standard criteria for a best practice. The identification of best practices would have been even stronger if a structure for the validation (evaluating the technical validity or robustness of each innovation) had been agreed on earlier.
To introduce and then replicate best practices, INHP staff worked through two channels:

- **NGO partners**: Local NGOs worked with CARE and government service providers to ensure that best practices were implemented in the demonstration sites. The sites serve as practical examples of how to implement best practices as well as use local resources to achieve health and nutrition results through INHP strategies.

- **District Level Advisory Committees (DLACs) and Block Level Advisory Committees (BLACs)**: These committees enabled the planning, decision making and action required for large-scale replication. Key committee members were familiarized with processes and results expected in the demonstration sites, giving them information, examples and motivation for implementing best practices.

As the role of the demonstration sites evolved, differing visions of their purpose among blocks, districts, states and even CARE staff persisted through the project’s first two years:

- **A model anganwadi**, where interventions are numerous and high-quality.
- **An incubator of innovations**, where creative efforts are piloted.
- **A demonstration** of how designated activities and processes, including best practices, are clearly linked to desired health and nutrition results.

One premise of the IDEAS Model was that government counterparts would not nurture and launch demonstration efforts because of the time, resources and specialized technical inputs required. There are a few examples of government counterparts launching demonstration sites themselves. When these sites were successful, replication began sooner and developed more quickly. In the most common situation, in which demonstration efforts were led by NGO partners, a higher level of involvement and ownership by government counterparts usually meant a smoother replication process. Quicker development reduced the loss of quality or technical focus.

DLACs and BLACs were expected to play a key role as stakeholders, including service providers, implementers and/or community leaders.

The INHP-II operational strategy emphasized (1) responsive systems and service providers and (2) empowered communities demanding services and inputs, but did not anticipate the need to help link them. As the replication process moved into the third year of the project and was more clearly tied to the effort to “graduate” blocks that created and sustained desired processes and results, the need for links between systems and communities arose. That led to the recent proposal that BLACs and DLACs include

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*The INHP-II Operational Strategy specifically links best-practice replication to the achievement of a level of capacity and practice that allows a community to “graduate” from the program. In INHP, graduation is defined as “sustainable, independent functioning of the health and nutrition activities without CARE’s oversight, where inputs and resources can be managed, quality and timeliness of activities can be maintained, and desired outcome and objectives can be met.”*
a seat for community representatives – for example, members of the health and nutrition commit-tee of the Panchayati Raj Institution (locally elected representative body) or representatives from community-based mothers’ groups.

Replication speed has varied across project areas. It took the first full year of INHP-II to fully develop and share the replication strategy with field teams and stakeholders. One reason was the quality and extent of demonstration efforts, especially with regard to how well the innovation was documented, how well it was known to implementers and policy makers, and how clearly the demonstration site had linked best-practice processes and desired results.

Though demonstration sites existed at the end of INHP-I, they had evolved from the original High Impact blocks, where a wide range of innovations were being piloted. They were not distributed evenly across all program areas, and the maturity and quality of their activities varied. Thus, when the four best practices were selected in the first year of INHP-II, most existing sites had to launch at least two of them from scratch, which took 12-15 months.

The timetable to scale up best practices from demonstration to replication sites was ambitious enough that replication was begun before the demonstration sites were fully consolidated. That is, before they had fully reproduced the best-practices activities and demonstrated the results.

The IDEAS framework identifies the need to externally market best practices to key stakeholders. This includes advocating for their support of key concepts and leveraging their leadership to improve the institutional and policy environment. Measuring the success of these efforts was sometimes difficult because the monitoring indicator was based only on the issuance of government orders. While certainly important in the context of Indian bureaucracy – by issuing a policy circular or written directive, a district or state official authorizes field officials to act and thus helps CARE spread desired best practices – the mere existence of an order only partially reflects the constituency building and marketing efforts required for replication.

Capacity building is critical to replication and will be a major factor in sustaining efforts after INHP-II. Specifically, building the capacity of: (1) key leaders to communicate the benefits of best practices; (2) service providers to work together to channel supplies, resources and staff to deliver specific services and; (3) change agents and community organizations to

In retrospect, the replication strategy erred by committing to a “straight line” timetable for replication, where 25% of the target number of replication sites would be created in the second year, another 25% in the third, and so on. A more realistic distribution might have been 15% and 30%, considering the momentum that would need to be built among replicators during the first phase, and the trade-off that has emerged between quantity of sites and quality of processes replicated – a trade-off that could have been easily predicted.

This overambitious targeting, combined with a selection of indicators that overemphasized rate of replication and neglected quality, produced an environment in which attention was paid to the number of change agents identified and the number of training courses they attended, rather than the activities they engaged in and results they generated.

External marketing was most successful when it showed a specific link between interventions and results, and how those results solve problems that are a concern of government leaders and their constituencies.
deliver key messages, solve problems and support healthy behaviors. During the documentation phase of replication (the “D” in IDEAS), considerable attention was given to the necessary addition, or “layering,” of training, which addresses gaps in both knowledge and skills. This is followed by practice and coaching on the application of skills, with supportive supervision and occasional refresher training.

Though the operational strategy rests on responsive systems and service providers as well as empowered communities demanding services and inputs, most capacity building in INHP-II has built on INHP-I and focused on service providers, with demonstrated success (albeit with the shift in focus described above).

Identifying and building the capacity of change agents, one of the four identified best practices, is the core of the project’s community capacity-building efforts. INHP-II must evolve a more intensive and multi-faceted capacity-building program that focuses on the community.

CBO capacity building has mostly focused on (1) delivering messages and (2) building awareness and knowledge of nutrition and health issues. To truly empower communities, CBOs must learn to work together to identify problems in the community; mobilize resources and take action to solve those problems; and act as the voice for the most marginalized community members. Building this broader, group-based capacity in communities is essential to supporting the individual work of change agents and to sustaining gains made during interventions.

By March 2004, halfway through INHP-II, it was increasingly clear that the original plan to add more best practices throughout the life of the project could actually hinder its ability to deliver health and nutrition results as well as change behaviors.

Documentation of best practices usually provided enough guidance and detail on the full range of anticipated capacity-building activities. But indicators like “the number of change agents having completed three rounds of training” moved the focus from the multi-dimensional layered approach to capacity building and back to training inputs and outputs. This weakness was identified early in the first year of INHP-II.

The effectiveness of change agents and the sustainability of their role in communities are strengthened by CBOs that provide broader validation of change agents’ work and counterbalance traditional practices and pressures that may inhibit behavior change.

The designation of change agents as a best practice could have marginalized the CBO as a primary focus of INHP-II.

In INHP-II, some focused pilot work on CBO capacity building has found a weakness in the previously prioritized use of participatory rapid appraisal (PRA) as the primary way to build capacity of community groups like PRI committees or mothers’ groups. It becomes event-specific and product-centric rather than process-focused.

The proposed alternative is to retool CBO capacity building with participatory action research (PAR), focusing more on process and group skills, and leveraging ownership by linking health and nutrition issues to shared community values.
### E: Lessons Learned: Challenges and Opportunities

Throughout section D, specific lessons learned were highlighted in text boxes that described obstacles or successes during replication. The table below summarizes key lessons from this experience.

| I innovate | • Develop an agreed-upon process for identifying and reviewing innovations, with a clear timetable for the innovation-evaluation/validation-demonstration process; avoid an aggressive timetable.  
| eval, validate | • Make clear the criteria and standards for validating innovations and selecting them for replication or scaling-up; avoid an ad-hoc process that may undermine confidence in the results.  
| demonstrate in multiple contexts | • Build consensus for the criteria and the process, ideally including stakeholders and replicators to make explicit links between best practices and expected results. |
| D describe best practices | • Go beyond documentation that describes the innovation (“what”) and also communicate operational instructions (“how”).  
| instrut how they are undertaken | • Develop detailed descriptions of the innovation in order to build a common vision; avoid generalities that can confuse or, worse, support competing visions of the desired operational results of scaling up.  
| share documentation, both descriptive and instructive | • Refine and revise documentation (descriptive and instructive) as replication unfolds, incorporating evolving changes. |
| E external marketing | • Expand early consensus on best practices selected for replication by including potential leaders, or “champions,” among stakeholders; build commitment to the process by linking the expected results of best practices to their goals.  
| advocate for policy choices and regulations | • Define roles for all replicators; this helps reduce risks and fear of failure.  
| identify replicators and define roles | • Develop links between replicators (horizontal, at the operational field level, and vertical, between champions and field staff) that will support future capacity-building efforts. |
| A assess capacity and preparedness of replicators | • Involve potential replicators in identifying capacity gaps (through self-assessment) and incorporate their experiences in designing/refining training activities.  
| build targeted capacity | • Implement a capacity-building strategy that uses all these elements: skills training, knowledge transfer, on-the-job mentoring/twinning (linking organizations and/or communities) and coaching/supportive supervision.  
| monitor training and practice | • Select indicators for monitoring both outputs and outcomes of capacity building; avoid a skewed focus on numbers of persons trained and strive instead for indicators to monitor quality. |
| S support active replicators | • Plan a realistic yet vigorous timetable for replication; avoid a straight-line in favor of schedules that recognize the learning curve for the first round of replications.  
| motivate potential replicators | • Develop indicators and mechanisms to monitor both the pace and quality of replication, ideally involving replicators and stakeholders in the process; avoid overemphasis on easily collected data on pace, which moves the focus away from quality.  
| monitor rate and quality of replication | • Articulate in advance the replication process, or model, that will be used to scale up program innovations or best practices, and build consensus for it.  
| reward successful replicators | • Assess the risks associated with adding innovations/best practices in multiple “rounds” over time. (This is different from a phased plan for scaling up, in which areas are taken up in succession. The phased plan is highly desirable.) |

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**The IDEAS Model for Demonstration and Replication**

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- Make clear the criteria and standards for validating innovations and selecting them for replication or scaling-up; avoid an ad-hoc process that may undermine confidence in the results.
- Build consensus for the criteria and the process, ideally including stakeholders and replicators to make explicit links between best practices and expected results.
- Go beyond documentation that describes the innovation (“what”) and also communicate operational instructions (“how”).
- Develop detailed descriptions of the innovation in order to build a common vision; avoid generalities that can confuse or, worse, support competing visions of the desired operational results of scaling up.
- Refine and revise documentation (descriptive and instructive) as replication unfolds, incorporating evolving changes.
- Expand early consensus on best practices selected for replication by including potential leaders, or “champions,” among stakeholders; build commitment to the process by linking the expected results of best practices to their goals.
- Define roles for all replicators; this helps reduce risks and fear of failure.
- Develop links between replicators (horizontal, at the operational field level, and vertical, between champions and field staff) that will support future capacity-building efforts.
- Involve potential replicators in identifying capacity gaps (through self-assessment) and incorporate their experiences in designing/refining training activities.
- Implement a capacity-building strategy that uses all these elements: skills training, knowledge transfer, on-the-job mentoring/twinning (linking organizations and/or communities) and coaching/supportive supervision.
- Select indicators for monitoring both outputs and outcomes of capacity building; avoid a skewed focus on numbers of persons trained and strive instead for indicators to monitor quality.
- Plan a realistic yet vigorous timetable for replication; avoid a straight-line in favor of schedules that recognize the learning curve for the first round of replications.
- Develop indicators and mechanisms to monitor both the pace and quality of replication, ideally involving replicators and stakeholders in the process; avoid overemphasis on easily collected data on pace, which moves the focus away from quality.
- Articulate in advance the replication process, or model, that will be used to scale up program innovations or best practices, and build consensus for it.
- Assess the risks associated with adding innovations/best practices in multiple “rounds” over time. (This is different from a phased plan for scaling up, in which areas are taken up in succession. The phased plan is highly desirable.)