

Scaling up sexuality education in Nigeria: From national policy to nationwide application

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A thesis

submitted in partial fulfillment of the  
requirements for the degree of

Master of Public Health

University of Washington

2013

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Program authorized to Offer Degree:

Global Health

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Abstract

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Comprehensive sexuality education (CSE) is recommended for universal coverage as an effective tool to reduce unwanted pregnancies, maternal mortality and transmission of sexually transmitted infections including HIV and to increase. Nigeria is one of few countries that have translated national policies on school-based CSE into near-nationwide implementation. Using the World Health Organization-ExpandNet framework, which provides a systematic structure for planning and managing the scaling up of health innovations, we examine how Nigeria's nationwide program was designed and executed.

Crucial attributes that facilitated the scaling up included: technical consensus about the innovation and clarity about its components, dissection of a complex intervention into manageable components for implementation by organizations with complementary expertise, strong political leadership and championship in concert with advocacy and technical support from non-governmental organizations, proactive and energetic involvement of community stakeholders, effective program management to ensure adequate educational materials, and supervision and support. While initially insufficient, improvements were made to the information

management system to ensure on-track implementation and mid-course corrections and to keep all the stakeholders, including funders, informed and engaged. Challenges included resistance to sexuality education, competing priorities for available human resources, and a lack of predictable and adequate funding for installing and sustaining a rapid scale up effort.

Following the adoption of a national policy in 2002, Nigeria developed a well thought through strategy to scale up school-based CSE. Despite some weakness, implementation has largely proceeded according to plan. Nigeria's achievements and lessons learned are pertinent because, even in countries with national sexuality education policies, implementation remains patchy for the most part, especially in resource-limited settings.

## **Introduction**

Comprehensive sexuality education (CSE) is defined as “ a rights-based approach that seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality- physically and emotionally, individually and in relationships.”(IPPF, 2010) There is sound evidence about the benefits of CSE. It contributes to improved knowledge and attitudes about sexual and reproductive health (SRH). When used in combination with other actions, it can contribute to preventing early and unprotected sexual activity, rather than leading to them, as feared by some.(IPPF, 2009; UNESCO, 2009) It can be delivered effectively even in resource constrained settings.(UNFPA, 2008)

In 1994, the International Conference on Population and Development in Cairo called for universal coverage of sexuality education.(International Conference on Population and Development, 1995) In 2012, The 45<sup>th</sup> session of the Commission on Population and Development noted that despite the inclusion of sexuality education in global and regional health strategies and ministerial declarations, the call made in Cairo has only been partially acted upon.(International Conference on Population and Development, 2012) Furthermore, a 2012 UNESCO report concluded that only small pockets of adolescents aged 10-19 years in most developing countries are reached by such programs.(UNESCO, 2012) In developed countries too, the picture is mixed. CSE only reaches high coverage in countries where it is compulsory and where support for its application has not waned.(UNESCO, 2012)

Barriers at many levels contribute to patchy and low coverage of CSE. They can be broadly categorized as lack of real commitment on the one hand, and lack of delivery capacity – technical and financial – on the other. In some countries, CSE does not even figure in national policies and strategies while in others it is represented by a plan and budget line item and perfunctory implementation, if at all. The space left by governments is sometimes filled by international and local NGOs with small-scale and time-limited projects. Clearly, national-level applications of evidence-based approaches to deliver CSE programs are needed. In other words, CSE programs need to be scaled up.

The 2012 UNESCO report and an earlier one (UNESCO, 2010) identified five developing countries where such programs have been scaled up and sustained. Nigeria is one of those countries. Nigeria's CSE program is known as the Family Life HIV Education (FLHE) curriculum.

Nigeria is a large, diverse and complex country. Religious, cultural traditions and climatic conditions broadly divide the country into two parts – a mainly Muslim north and a mainly Christian south.(NDHS, 2009; Ola, Oyerinde, Amosu, Degun, & M Thomas, 2011) It has a federal structure with clearly defined roles and functions for its national and 36 powerful state governments. Despite enormous oil revenues, poverty is a prevalent problem and recent economic advancements have exacerbated socioeconomic inequities.(NDHS, 2009)

Nigeria has an estimated population of 140,431,790 (NDHS, 2009) 22% are adolescents.(UNICEF) In 2008 17.2% and 6.7% of adolescent girls and boys, respectively, were

sexually active before the age of 15 years, 95 % did not use contraceptives, 4.1% were HIV-infected, and 18% of adolescent girls were pregnant.(NDHS, 2009) In 2006 60% of the unsafe abortions were among young people.(F. M. o. H. Nigeria, 2007)

Nigerian government policy at the national level recognizes the pressing SRH needs of young people.(M. o. H. Nigeria, 2007) Furthermore, Nigeria has acted on its policy commitments, making it one of the few countries to implement near-nationwide CSE.(UNESCO, 2010, 2012) We aimed to identify and describe how Nigeria planned and executed its program, and more importantly, the key features of the scale-up strategy because the lessons learned from this experience can be applied widely.

## **Methods**

### Systematic Search:

We built upon the two UNESCO reports referred to above and conducted a comprehensive and systematic search to identify additional pertinent literature. We sought publications published after 2000 that reported on the following criteria specific to Nigeria:

Type 1. Pre-scale up of teacher-led CSE in secondary schools: The rationale for sexuality education

Type 2. Post-scale up of teacher-led CSE in secondary schools including regarding its:

- Policy or strategy,
- Implementation,

- Evaluation of coverage rates, or impact on adolescent and/or community (e.g. teachers, parents) knowledge, attitudes, and practices related to adolescent SRH, or adolescent clinical outcomes, or
- Lessons learned, successes, challenges

We excluded publications on general health education and sexuality education delivered by peers or outside of school settings.

We searched six online databases (PubMed, Ovid Medline, Cochrane Library, World Catalog Org, EBSCO and ERIC) using various combinations of the following terms and concepts: "Nigeria", "adolescents", "health knowledge, attitudes, practice", "reproductive health", "health education", "sexuality education", "school sex education", "school health services", "health planning", "program effectiveness", "program implementation", "program planning", "program evaluation", "scaling up", and "expanding". We also sought publications using the snowball sampling technique (i.e. by reviewing the bibliographies of references meeting our inclusion criteria). We further searched the Google search engine for documents produced by the Nigerian government or other organizations working in Nigeria on adolescent health policy or CSE.

An initial total of 460 references were retrieved from the searched databases. Titles and abstracts were initially assessed by one author (SH-Q), and 68 were identified as potentially relevant. Two authors (SH-Q and VC-M) then reviewed the publications to determine eligibility according to our inclusion/exclusion criteria. Twenty-six were identified, including 20 Type 1 and six Type 2 publications (See Table 1a and Table 1b). The latter were outcome evaluations of FLHE in Edo

and Lagos States; we did not find any publications about the nationwide scale up of this curriculum. The same two authors then extracted relevant data from these publications.

#### Analytic framework:

The WHO-ExpandNet framework for designing, carrying out and assessing the results of scaling up health innovations (WHO, 2010) provides a step-by-step process, beginning with the end in mind. It contains two complementary sections. First, the planning section guides consideration of four key elements – 1) the innovation to be scaled up, 2) the user organization, 3) the resource organization, and 4) the environment. Then the managing section guides strategic choices needed regarding: 1) information dissemination and advocacy, 2) organization and management, 3) mobilization of needed resources, and 4) monitoring and evaluation.

We planned to use the WHO-ExpandNet framework for this analysis because it is an important pillar of WHO's work in this area. In order to ensure that our analysis was informed by the latest thinking in the scaling up field, we searched for other available frameworks. We used UNESCO's brief review of the scaling up literature (UNESCO, 2012) as our starting point and searched for other papers on conceptual and operational frameworks on scaling up health and other innovations using PubMed. We identified 14 publications describing five frameworks. (See Table 2)

Based on this review, it became clear to us that the WHO-ExpandNet framework was best suited for our task because it broke down the process into pieces that could be examined closely. However, based on our examination of other frameworks and the related literature, particularly

two reviews published in 2011 (Subramanian, Naimoli, Matsubayashi, & Peters, 2011; Yamey, 2011) we strengthened the WHO-ExpandNet framework in one area - the need to evaluate the innovation as scaling up occurs followed with responsive modifications in an ongoing manner.

## **Results**

We present the results of our review within the WHO-ExpandNet framework. Boxes 1 and 2 contain definitions of the terms used in the framework as well as the related attributes (where applicable) for successful scale up.

### **1. Planning the scaling up strategy:**

#### **1.1. Innovation.** See Box 1

The innovation scaled in Nigeria was FLHE. According to the Nigerian Educational Research and Development Council, FLHE is a “planned process of education that fosters the acquisition of factual information, formation of positive attitudes, beliefs and values as well as development of skills to cope with the biological, psychological, socio-cultural and spiritual aspects of human living”. It provides a comprehensive approach to HIV prevention education and general sexual health at the secondary levels of education.

FLHE was relevant to the country. Its content was clear and it was seen as credible. However, it conflicted with prevailing values and norms in some quarters and was difficult to install.

a) Relevant: The pressing need to address the consequences of early and unprotected sexual activity had been widely identified by Nigerian health and education professionals; given this, CSE in schools was an extremely relevant response. (AHI, 2010; IDRC, 2012; UNESCO,

2010) The intervention responded to many adolescent SRH problems including: the increasing prevalence of HIV and other STIs,(UNESCO, 2012) the high prevalence of unwanted pregnancy and abortions,(Anochie & Ikpeme, 2001) the early initiation of sexual intercourse,(Anochie & Ikpeme, 2001; Nwaorgu, Onyeneho, Okolo, Obadike, & Enibe, 2008; Okonta, 2007; Otoide, Oronsaye, & Okonofua, 2001) the low frequency of condom use,(Bamidele, Abodunrin, & Adebimpe, 2009; Otoide, et al., 2001) the high prevalence of casual sex and sex with multiple partners,(Bamidele, et al., 2009; Okonta, 2007) the prevalent sexual stereotypes that encourage risky sexual behavior,(Popoola, 2011) and the lack of appropriate sources of information on sexuality education.(L. A. Briggs, 1998; Nwalo & Anasi, 2009; Omigbodun & Omigbodun, 2004) Finally, it responded to the need highlighted by various studies calling for sexual health education as a core subject in schools(Adeokun, Ricketts, Ajuwon, & Ladipo, 2009; Moronkola & Fakeye, 2007; Nwalo & Anasi, 2009; Nwaorgu, et al., 2008; Nwaorgu et al., 2009) and the call for a national CSE curriculum.(Ajuwon & Brieger, 2007; Esere, 2008; Mba, Obi, & Ozumba, 2007) (See Table 3)

- b) Credible: The innovation was strongly endorsed by the international scientific and development community. It is grounded on the evidence that sexuality education reduces the risk of early and unprotected sexuality activity, unsafe abortion, HIV and other STI transmission, and maternal mortality. (IPPF, 2009; UNESCO, 2009)

This was further supported specifically in Nigeria by a three-year study of the FLHE curriculum in Lagos State that showed higher levels of knowledge about SRH and HIV and improved gender equity attitudes among students exposed to the curriculum(Agency, 2012; AHI, 2010). (See Table 4) Among those exposed to the curriculum, boys reported that they

were less likely to pressure girls into sex and girls reported more confidence to say no to sex, and fewer of both gender reported being sexually active.(Esiet, Esiet, Philliber, & Philliber, 2009) A study of subsequent implementation in Edo State strengthened those findings.(Arnold et al., 2012)

- c) Clear: The innovation had two clearly articulated components. First, carrier-subject teachers (i.e. Integrated Science, Social Studies and English Language teachers) received pre- and in-service training on the FLHE curriculum and later used the FHLE teacher's manual, a week-by-week instruction scheme, and a student textbook to teach the curriculum to junior and senior secondary school students.(FMoE, 2011) The frequency and duration of training varies between states. For example, in Edo State selected teachers received in-service training once per calendar year, with a schedule of 6.5 hours/day for 10 consecutive days. (IDRC, 2012) This teaching was integrated into Social Studies, Integrated Science and English Language and incorporated into extracurricular activities as well. Second, the carrier-subject teachers attended workshops, based on the manual, to build comfort and expertise in delivering the content and using the interactive teaching methodology.(NERDC, 2003)
- d) Not compatible with the values of some segments of the population: Sexuality education is often perceived as incompatible with prevailing traditional societies' values and norms. In Nigeria, as in most countries, there are many groups, including those who are truly concerned about the wellbeing of adolescents, who strongly oppose sexuality education as not being in the best interest of adolescents.(I. L. Briggs, 2002; Orji & Esimai, 2003; Oshi, Nakalema, & Oshi, 2005)

Schools in all states were mandated to provide the FLHE curriculum. Even though states were provided with some flexibility in its naming and delivery, it has not been fully accepted

in all secondary schools. The nationwide coverage rate of FLHE by schools is not available; however in Lagos State all of the more than 300 public secondary schools had implemented the curriculum by mid-2007 (AHI, 2010) and in Edo State 84 schools implemented it by 2008. (Arnold, et al., 2012)

- e) Not easy to install: Sexuality education can be difficult to teach. Many Nigerian teachers, despite training, were not able to conduct education sessions effectively.(Asekun-Olarinmoye, Fawole, Dairo, & Amusan, 2007; Orji & Esimai, 2003) To address this challenge, efforts were made to standardize and simplify curriculum delivery. Further efforts were made to identify the most appropriate teachers for the topic and build their capacity to deliver it. The proportion of teachers who are in fact delivering the innovation is not available; however, in Lagos and Edo States a total of 12,000 secondary school teachers and 500 teachers in colleges of education had received training by the end of 2011. (IDRC, 2012)
- Nigeria also faced challenges of crowded curricula, teacher shortages and overburdening of existing teachers. (Ola, et al., 2011)Allocating the necessary human resources faced resistance from both federal and state education authorities as well as school administrators and teachers. (Asekun-Olarinmoye, et al., 2007; Dlamini et al., 2012)

## **1.2. User Organization**

See Box 1

In Nigeria three different categories of user organizations served different, but complementary, functions in the scaling up effort:

- Youth and reproductive health non-governmental organizations (YRH-NGOs) provided teacher in-service training on the FLHE curriculum and on-going support to schools.

- Secondary schools were responsible for classroom teaching and extracurricular activities.
- Teacher-training institutes delivered the student-teacher training.

The credibility of all three categories of organizations was an important element of success in the effort. Their ‘score’ on commitment and capacity was somewhat mixed and contributed to some of the challenges in the scale up.

- Credibility:** Because of their track record in advocating for CSE and national policy on the subject, and because of their related hands-on work, YRH-NGOs such as Action Health Incorporated (AHI), Girl Power Initiative, and Global Health and Awareness Research Foundation were viewed as highly credible in carrying out their assigned function. Schools are important social institutions in Nigeria. (UNESCO, 2012) The National Council of Education charged them with carrying out the FLHE curriculum. Teacher training institutes were mandated and supported by the National Commission for Colleges of Education and the Universal Basic Education Commission to provide pre-service training. (NERDC, 2003)
- Commitment:** The YRH-NGOs were generally highly committed to this effort. Some of them, such as AHI, were involved from very early stages while others were involved at a subsequent stage in supporting state level Ministries of Education to carry out FLHE. (AHI, 2010; IDRC, 2012) Many school administrators, teachers and teachers training institutes were strongly committed to this work, (UNESCO, 2010) but some of them were not, (Dlamini, et al., 2012) hindering the effort in their institutions.
- Implementation capacity:** Any one of the three categories of organizations would not have been able to scale up all of the various elements of the innovation alone, but together, they were able to do this. The capacity of the YRH-NGOs was built through their immersion in this work, their opportunities internal to their organizations, as well as external funding.

Human and financial constraints meant that the capacity of schools and teacher training institutes varied greatly.(AHI, 2010)

### **1.3 Resource team**

See Box 1

Resource teams at two levels contributed to the scale up effort:

- Federal level: The Federal Ministry of Education (FMoE) and AHI.
- State level: The various State Ministries of Education (SmoE) and various YRH- NGOs- e.g. AHI in Jigawa and Lagos States, Girl Power Initiative in Cross River and Endo States, Global Health and Awareness Research Foundation in Enugu State, and HIV Prevention For Rural Youth in Edo State.

The government/YRH-NGOs partnership and the way in which each partner contributed to the implementation of the initiative strengthened their leadership position. Schools and the communities they worked with viewed them as credible, committed and capable.(UNESCO, 2010)

Without the leadership and commitment of the FMoE, FLHE would have remained a patchwork of small-scale programs run by an NGO here and another there or supported by SMoE in some places but not in others. Clear policy directives, backed up by equally clear guidelines and tools, were the two pillars upon which the entire scale up effort could be built.(IDRC, 2012)

## 1.4 Environment

See Box 1

Understanding the challenges and opportunities in the environment during the design and application of the scale up occurred at two levels:

a. Political/policy: Nigeria's political and bureaucratic elites are knowledgeable and sophisticated. There was an understanding of the importance of CSE. They were also well aware that social and cultural norms did not permit open discussion of sexuality and that there was a constituency who opposed CSE.(Bryant, 2004; Oshi, et al., 2005) An enormous amount of time and effort was devoted to forging a common understanding among different stakeholders and articulating a national policy, as summarized in the timeline depicted in Table 5.

A major challenge was that people were often in positions of authority for short terms. There was no guarantee that newcomers would uphold the positions held by predecessors or follow up on prior decisions. Rapport building and support building needed to be done and redone.(UNESCO, 2010, 2012)

b. Sociocultural: Nigeria's strong religious and cultural beliefs sometimes conflicted with the application of the curriculum. In order to support the introduction of FLHE and to ensure that implementation was according to national guidelines, Advisory and Advocacy Committees consisting of key stakeholders - traditional and religious leaders, school administrators, and representatives of teachers unions and parents associations were formed.(UNESCO, 2010) Their participation was desired to facilitate dialogue; however, sometimes their strongly opposing views predominated.(Dlamini, et al., 2012) For example, Islamic schools were more resistant to sexuality education than Christian ones. Private schools supported it more

enthusiastically than public ones.(Ola, et al., 2011) Many parents considered talking about sexuality with their children a taboo. There was also a sentiment that providing sexuality education in schools could “give the wrong signal” to young people.(I. L. Briggs, 2002)

### **1.5 Making Strategic choices in scaling up**

The fifth (vertical scaling up), sixth (horizontal scaling up), seventh (diversification) and eighth (spontaneous scaling up) steps of the WHO-ExpandNet framework are about making strategic choices in selecting a scale up strategy.(WHO, 2010) Only steps five and six are relevant to this analysis. Nigeria put in place a strategy that had a mix of vertical and horizontal elements. See Box1

The vertical scaling up (i.e. policy formation) took considerable time and effort, but it was crucially important in providing both the political and the technical basis for the horizontal scale effort. Realizing that scaling up of good quality FLHE would not happen spontaneously, Nigeria deliberately chose to replicate the curriculum in all states (i.e. horizontal strategy). (FMoE, 2011)

## **2. Managing the scaling up effort**

### **2.1 Informing key stakeholders about the scale up effort and advocating for it**

See Box 2

The decision of the FMoE to scale up the FLHE curriculum was the central focus of the advocacy effort. The FLHE curriculum was distributed widely. The FMoE loudly communicated its full backing of the curriculum.

As depicted in Table 5, a sustained and sophisticated advocacy effort at the national level contributed to this policy decision. Furthermore, as mentioned above, proactive, energetic and on-going advocacy efforts were replicated in each state through the Advisory and Advocacy Committees.

## **2.2 Deciding on the managerial/organizational processes of scaling up**

See Box 2

In Nigeria, the FMoE decided to scale up in all 36 states over a five-year period starting in 2003. The scale up model that was envisaged was rapid and multiplicative (rather than a slow, phased, additive model). This was possibly because of the sense of urgency and because external resources available to support the scale up were often time-limited, for example, from the Global Fund for AIDS, Malaria and Tuberculosis.(UNESCO, 2012)

The model was adaptive to social and cultural characteristics, but preserved the essential core of the FLHE curriculum. For example, in Sokoto State, the name of the curriculum was changed to "School Health Education Program" instead of FLHE. (UNESCO, 2010)

The scaling up effort was decentralized. SMOEs were responsible for implementation, but their authority was limited by their need to turn to the FMoE and donors for funding. Donor influence sometimes drove priorities ahead of those of SMOEs. (see Section 2.3 below)

### **2.3 Mobilizing the resources needed for the scale up effort**

See Box 2

Financial resources came from two sources - external donor support and the contributions of federal and state governments. Resources provided by external donors were often tightly earmarked; for example for training of master trainers and for impact evaluation activities.(UNESCO, 2012) Some donors also earmarked funds to be used at specific sites; for example the Global Fund required the funds to be used in sites with high HIV prevalence.(UNESCO, 2012)

Both federal and state bodies provided funding for implementation. However, it was insufficient to support the rapid nationwide scale up effort. In many places resources were inadequate for printing and dissemination of materials.(AHI, 2010) Inadequate and uneven resource allocation resulted in patchy implementation.

### **2.4 Monitoring and evaluating the scale up effort**

See Box 2

Monitoring and evaluation indicators and the means of assessment were clearly built into the scale up strategy. This included on-going monitoring of pre-service training, teacher performance, and students' knowledge, attitudes and reported behaviors. (IDRC, 2012)

Monitoring, just like implementation, was well done in some places but not in others.

## **2.5 Drawing lessons from the scale up effort and taking remedial actions**

Not unexpectedly, the rapid scale up of the FLHE curricula resulted in uneven levels of implementation. As noted by UNESCO, there were “considerable variations between states and within schools in terms of methodology, content and quality of teaching.” (AHI, 2010; IDRC, 2012) The Nigerian FMoE responded to this by issuing national implementation guidelines in 2008.(UNESCO, 2010)

While monitoring and evaluation did not take place evenly in all states, there were studies that measured impact of the curriculum as shown in Table 4. For example, modest increases in SRH knowledge and gender attitudes were found in urban settings in Lagos State.(Esiet, et al., 2009) Improvements in knowledge, attitudes and practices were reported in rural Edo State.(Arnold, et al., 2012) Another study from Edo State found that teachers were generally willing to implement the curriculum. However, their strong beliefs about condom use were difficult to overcome—they largely omitted delivery of condom-related curriculum content. Furthermore, they reported feeling challenged by already overloaded schedules.(Dlamini, et al., 2012)

In Lagos State the following elements of good practice were identified: “Clarity and credibility of the program, high-level of political commitment since the beginning, partnership of organizations/institutions to deliver the package, effective acknowledgment of the cultural and religious contexts, and high-level of adaptation to local needs”. (AHI, 2010)

## **Discussion**

There are sound public health reasons for providing adolescents with CSE. There is convincing evidence that CSE leads to positive SRH outcomes and does not lead to negative ones.(IPPF, 2010) Studies of small-scale, time limited projects provide convincing evidence that it can be delivered effectively.(UNESCO, 2009)

CSE is strongly recommended by global and regional SRH programs of action and high-level declarations.(International Conference on Population and Development, 1995; UNAIDS, 2001) It is also part of almost every national SRH/HIV policy and strategy.(USAID)

Despite this strong call, large scale and sustained programs are under way to reach school-going adolescents in only a small number of countries. The two main reasons for this are ideological and practical. The ideological resistance emanates from the misconception that sexuality education teaches adolescents things that they do not need to know, to think about things they should not and to do things they should not. Furthermore, the practical challenge of delivering a sustainable complex intervention at scale is a formidable one.

Nigeria is one of a small number of low and middle-income countries that has scaled up CSE nationwide. We analyzed available information using the WHO-ExpandNet framework to dissect out and closely examine what Nigeria did to address and overcome the ideological and practical challenges that hampered efforts in so many countries. The WHO-ExpandNet framework is based on best practices. To the best of our knowledge, the framework has not been previously used to analyze scale up initiatives. We found it useful for two reasons – firstly, it breaks down

the scaling up 'journey' into a series of linear steps, while acknowledging that real programs are messy, and secondly, it provides clear criteria for good practice in each step.

Why was Nigeria able to scale up CSE when so many other countries have not been able to do so?

There are at least five clear answers to this.

Firstly, CSE met an expressed need in the country and it was endorsed by national and international experts based on strong evidence (including from within the country) and technical consensus.(CGD, 2007; Yamey, 2011) Nigeria developed its CSE curriculum with precise definitions of what was to be taught, who was to teach, and how the teaching was to be done.

The curriculum was simplified to the extent possible. Technical consensus, clarity and simplicity have also been identified as important attributes of scaling up success.(Yamey, 2011)

Secondly, YRH-NGOs, secondary schools and teacher training institutions, organizations with complementary areas of expertise, were engaged to lead different, but complementary components of a complex innovation. No single organizational type could have succeeded with the scale up without the other partners. Teasing out a complex innovation and clearly defining what is needed to install and sustain each element has been identified as crucial to scaling up success.(CGD, 2007; Yamey, 2011) Further, where appropriate, involving non-state players to contribute has been identified as a valuable approach.(CGD, 2007; Simmons, Fajans, & Ghiron, 2007; Yamey, 2011)

Thirdly, the FMoE set out a vision and pushed forward with determination and perseverance. Its leadership provided a solid foundation for the scale up effort. At the federal and state level, the MoE was stimulated and supported by a small group of YRH-NGOs with expertise that they had gained through their grassroots work and via their influential national and international connections. Thus, they played the twin roles of advocates and technical experts very effectively. These activities reflect best practice; political leadership and championship have been identified as important attributes of scaling up success.(CGD, 2007; Simmons, et al., 2007)

Fourthly, the proactive, energetic and on-going advocacy work of state-level Advisory and Advocacy Committees whose members included representatives of key stakeholder groups was crucial in creating public support and preventing backlash, as has happened in so many countries. Engaged and supportive communities have been identified as an important to the success of scale up efforts.(Simmons, et al., 2007)

Fifthly, once the scaling up strategy was decided upon, its management was well thought through. This included a managerial model, monitoring and evaluation system and business model for funding the effort. The decentralized managerial model meant that the effort was better managed, supervised, monitored and evaluated in some states than in others. A sound-funding model was put in place and although external donors and government bodies provided what was initially thought to be sufficient funding; the rapid scale up model made it difficult for resources to keep pace with actual implementation.

These three attributes have been identified as crucial to successful scale up effort.

- Managing implementation to ensure that competent and motivated people deliver the innovation, that they have the necessary supplies to do their work, and that they are supervised and supported;
- Gathering and using information effectively to ensure that implementation is on track, to make mid-course corrections that are needed, and to keep all the stakeholders (including funders) motivated and engaged; and
- Ensuring that there is predictable funding at adequate levels for installing and sustaining the innovation.(Gilson & Schneider, 2010; Oliveira-Cruz, Hanson, & Mills, 2003; Peters, El-Saharty, Siadat, Janovsky, & Vujicic, 2009; Simmons, et al., 2007)

Each of these attributes were met only in part in Nigeria. Given the size and complexity of the country and the decentralized scale up model used, areas of weakness and gaps are to be expected.

The challenge for Nigeria going forward is to protect the consensus that has been achieved through enormous effort and to hold together the complex coalition that has been forged. The real risk is that interest will wane with CSE moving from something new and exciting to routine and on-going. Nigeria needs to stay on the road and use a plan-do-check-act cycle to continually improve the quality of CSE while expanding coverage. It is also very important to champions of CSE, who see Nigeria as a model to emulate in Africa and beyond.

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## Annexes

### Tables and Boxes

## Tables

**Table 1a. Publications meeting inclusion criteria regarding sexuality education in Nigeria**

<b>Type 1. The Rationale for Sexuality Education</b>		
<b>Category</b>	<b>Author/ Publication Year</b>	<b>Title</b>
Unmet need for Sexuality Education	- Adeokun LA, Ricketts OL, Ajuwon AJ, Ladipo OA. 2009	Sexual and reproductive health knowledge, behaviour and education needs of in-school adolescents in Northern Nigeria
	- Anochie IC, Ikpe EE. 2001	Prevalence of sexual activity and outcome among female secondary school students in Port Harcourt, Nigeria
	- Bamidele JO, Abodunrin OL, Adebimpe WO. 2009	Sexual behavior and risk of HIV/AIDS among adolescents in public secondary schools in Osogbo, Osun State, Nigeria
	- Moronkola OA, Fakeye JA. 2007	Reproductive health knowledge, sexual partners, contraceptive use and motives for premarital sex among female sub-urban Nigerian secondary students
	- Nwalo KIN, Anasi SNI. 2009	Access to and Use of Reproductive Health Information among In- School Adolescent Girls in Lagos State, Nigeria
	- Nwaorgu OC, Onyeneho NG, Okolo M, Obadike E, Enibe G. 2008	Reproductive health knowledge and practices among junior secondary school grade one students in Enugu State: Threat to Achieving Millennium Development Goals in Nigeria
	- Nwaorgu OC, Onyeneho NG. 2009	Family life and HIV/AIDS education in schools in Enugu State: baseline study of reproductive health issues among in-school adolescents in Enugu State
	- Okonta PI. 2007	Adolescent sexual and reproductive health in the Niger Delta region of Nigeria-- issues and challenges
	- Omigbodun OO, Omigbodun AO. 2004	Unmet need for sexuality education among adolescent girls in southwest Nigeria
	- Otoide VO, Oronsaye F, Okonofua FE. 2011	Sexual behaviour and contraceptive use among secondary school adolescents in Benin City, Nigeria
- Popoola BI. 2011	Sex Stereotypes and School Adolescents' Sexual Behaviour in Osun State, Nigeria	
Impact of Sexuality Education	- Ajuwon AJ, Brieger WR. 2007	Evaluation of a school-based reproductive health education program in rural South Western, Nigeria
	- Esere MO. 2008	Effect of Sex Education Programme on at-risk sexual behaviour of school-going adolescents in Ilorin, Nigeria
	- Mba CI, Obi SN, Ozumba BC. 2007	The impact of health education on reproductive health knowledge among adolescents in a rural Nigerian community
Teachers and Parents Perspectives towards Sexuality Education	- Adegbenro C, Adeniyi JD, Oladepo O. 2006	Effect of training programme on secondary schools teachers' knowledge and attitude towards Reproductive health education in rural schools Ile-Ife, Nigeria
	- Asekun-Olarinmoye EO, Fawole OI, Dairo MD, Amusan OA. 2007	Knowledge, attitudes and perceptions of the teacher's role in sexuality education
	- Ola OO, Oyerinde OO, Amosu AM, Degun AM, M Thomas A. 2011	Methodological Approaches to Sexuality Education in Secondary Schools in Ilisan Remo, Ogun State, Nigeria
Cultural and Social Perspectives of Sexuality Education	- Briggs. 2002	Comparative analysis of parents' and teachers' view points on contraceptive
	- Orji EO, Esimai OA. 2003	Introduction of sex education into Nigerian schools: the parents', teachers' and students' perspectives
	- Oshi DC, Nakalema S, Oshi LL. 2005	Cultural and social aspects of HIV/AIDS sex education in secondary schools in Nigeria

**Table 1b. Publications meeting inclusion criteria regarding sexuality education in Nigeria**

<b>Type 2. The scale up of Family Life HIV Education curriculum in specific settings</b>		
<b>Category</b>	<b>Author/Publication Year</b>	<b>Title</b>
Peer Reviewed Journal Articles	- Arnold R, et al. 2012	Evaluation of school- and community-based HIV prevention interventions with junior secondary school students in Edo State, Nigeria
	- Dlamini N, et al . 2012	Empowering teachers to change youth practices: evaluating teacher delivery and responses to the FLHE programme in Edo State, Nigeria
	- Esiet AO, Esiet U, Philliber S, Philliber. 2009	Changes in knowledge and attitudes among junior secondary students exposed to the family life and HIV education curriculum in Lagos State, Nigeria
Reports	- Action Health Incorporated. 2010	Foundation for a healthy adulthood: lessons from school-based family life and HIV education curriculum implementation in Lagos State
	- Lagos State AIDS Control Agency. 2012	Family Life HIV Education Implementation. An assessment of the status of implementation of the Family Life HIV Education Curriculum in Lagos State
	- International Development Research Centre 2012	Family Life and HIV Education, Edo State. Implementation Report

**Table 2. Publications meeting inclusion criteria regarding scaling up frameworks**

<b>Category</b>	<b>Author/ Publication Year</b>	<b>Title</b>
Scaling up frameworks	- Centre for Global Development. 2007	Millions saved: Proven successes in global health
	- Mangham LJ, Hanson K. 2010	Scaling up in international health: what are the key issues?
	- Ranson K, Hanson K, Oliveira-Cruz V, Mills A. 2003	Constraints to expanding access to health interventions: An empirical analysis and country typology
	- Subramanian S, Naimoli J, Matsubayashi T, Peters DH. 2011	Do we have the right models for scaling up health services to achieve the Millennium Development Goals?
	- Yamey G. 2011	Scaling up global health interventions: a proposed framework for success.
Publications on scaling up health services regarding settings of implementation, barriers and overcoming barriers	- Catalano RF, Fagan AA, et al. 2012	Worldwide applications of prevention science in adolescent health
	- Gilson L, Schneider H. 2010	Commentary: Managing scaling up: what are the key issues?
	- K, Moto DD, Callewaert B. 2003	Constraints to scaling up health related interventions: the case of Chad, Central Africa
	- Milat AJ, King L, Bauman AE, Redman S. 2012	The concept of scalability: increasing the scale and potential adoption of health
	- Oliveira-Cruz V, Hanson K, Mills A. 2003	Approaches to overcoming health systems constraints at the peripheral level: a review of the evidence
	- Palna L, Peters D. 2012	Understanding pathways for scaling up health services through the lens of complex adaptive systems
	- Peters DH, El-Saharty S, Siadat B, Janovsky K. 2009	From Evidence to Learning and action; in Improving health service delivery in developing countries
	- Rao Seshadri S. 2003	Constraints to scaling up health programmes: a comparative study of two Indian states
- Travis P, Bennett S, et al. 2004	Overcoming health-systems constraints to achieve the Millennium Development	

**Table 3. Studies about the impact of Sexuality Education Initiatives in Nigeria preceding FLHE**

Findings	Location of the study
Increase in knowledge about STI, HIV/AIDS and family planning methods	- Ibarapa district, Oyo State (Ajuwon and Brieger, 2007)* - Ilorin, Metropolis, Kwara State (Esere, 2008)* - Item community, Abia State (Mba et al., 2007) *
Improved attitude towards use of contraceptives and pregnancy prevention practices	- Ibarapa, Oyo State (Ajuwon and Brieger, 2007) - Item, Abia State (Mba et al., 2007)
Increase in perceived self-efficacy for safe sex	- Ibarapa, Oyo State (Ajuwon and Brieger, 2007)
Increased reported consistent use of f condoms	- Ibarapa, Oyo State (Ajuwon and Brieger, 2007)
Reduced at-risk sexual behaviours following the intervention	- Ilorin, Kwara State (Esere, 2008) - Item, Abia State (Mba et al., 2007)
Positive and supportive attitude towards sexuality education	- Item, Abia State (Mba et al., 2007)

\* These studies were conducted before the implementation of FLHE

**Table 4. Impact of FLHE in Lagos and Edo States**

Authors/Year/ Study Objective	Population/ Location	Design/ Sample size	Results
Esiet et al., 2009  To reflect changes in the knowledge and attitudes among junior secondary school students one year after the introduction of FLHE	Students from first year junior secondary schools (JSS1)  Lagos State (Urban setting)	Comparison of pre- and post-intervention surveys, no control groups  - 1,563 students surveyed in 2004 and 1,366 re-surveyed in 2005 - 54% were male - Mean age of 12.1 years	- 8% increase in reproductive health knowledge scores (p<.001) - 7% increase in scores related to gender-equitable attitudes and rejection of sexual pressure (p<.001) - 13% increase in scores relating to attitudes supporting abstinence (p<.001)
Arnold et al., 2012  To evaluate the impact of FLHE delivered with and without a community intervention	Junior Secondary school students JSS1, JSS2, JSS3  Edo State (Rural setting)	Cluster randomized control trial with pre- and post-surveys at 18 months after initiation of intervention  Students assigned to three arms: A1. Received FLHE only A2. Received FLHE + C (community prevention programme) A3. Control	1. Coefficients for the program effect in both FLHE+C and FLHE only were significant for: - Rejection of cultural myths about HIV transmission in females (p<.01) - Abstinence among females (p<.05) 2. Coefficients for the program effect in FLHE only were significant for: - Rejection of cultural myths about HIV transmission in males (p<.01) 3. Coefficients for the program effect in FLHE+ C were significant for: - Attitudes related to abstinence and condom use among males (p<.05) 4. No significant change in reported condom use was found in any group
Dlamini et al., 2012  To evaluate teacher responses to the delivery of FLHE in Edo State	Teachers from 20 schools who received FLHE training from master trainers and peer educators, and teachers from 10 schools who served as the control group	Cluster randomized control trial with pre- and post-surveys at 18 months after initiation of intervention	- Teachers in FLHE schools were significantly more likely than those in control schools to feel they had enough training and were comfortable teaching FLHE subjects (Adjusted OR 9.17 and 5.94 respectively, p value <.05 for both)  - No significant increase among teachers in either factual knowledge about HIV or in recognition of myths as false information.

**Table 5. Timeline from Policy formation to Implementation of FLHE**

<b>Year</b>	<b>Activity</b>
1995	Formation of a nationwide Coalition on Sexuality Education
1996	Development of Guidelines on Comprehensive Sexuality Education by a task force emerging from the Coalition
1999	Decision by the National Council on Education to integrate sexuality education into the school curricula, at the First National Conference on Adolescent Reproductive Health
2000	Development of the National Comprehensive Sexuality Education Curricula by the National Education Research Council and AHI
2002	Name of curricula was changed to FLHE due to conservative political-religious pressure. The curricula was adopted by the FMoE with the decision to scale up.
2003	Initiation of scaling up at the state level

## Boxes

### Box 1. Planning Components of the WHO-ExpandNet Framework

Planning Elements	Definition	Attributes for successful scaling up
The Innovation	The interventions and/or practices to be scaled up.	<ul style="list-style-type: none"> <li>• Relevant</li> <li>• Credible</li> <li>• Clear</li> <li>• Compatible with prevailing values and norms</li> <li>• Easy to install</li> </ul>
User organization	The institution that adopts and implements the innovation at scale.	<ul style="list-style-type: none"> <li>• Credible</li> <li>• Commitment</li> <li>• Capacity</li> </ul>
Resource team	Individuals and organizations that have been involved in the development and testing of the innovation and/or seek to promote its wider use.	<ul style="list-style-type: none"> <li>• Leadership</li> <li>• Credibility</li> <li>• Commitment</li> <li>• Capacity</li> </ul>
Environment	The conditions and institutions, external to the user organization that substantially affect the prospects for scaling up.	<ul style="list-style-type: none"> <li>• Understanding the challenges and opportunities in the environment and taking them into account.</li> </ul>
Vertical scaling up strategy	The policy, political, legal, regulatory, budgetary or other health systems changes needed to institutionalize the innovation	It 'legitimizes' the innovation, integrates it in national and sub-national work plans and budgets and thus increases the likelihood of it being applied nationwide over a sustained period.
Horizontal scaling up strategy	The replication of the innovation in different geographic sites or its extension to larger or different population groups.	Wider application and reach out of the innovation

MWHO 2010. *Nine steps for developing a scaling-up strategy*. Geneva, Switzerland, World Health Organization

### Box 2. Managing the Scaling up Effort of the WHO-ExpandNet Framework

Managing Elements	Characteristics
Communication and advocacy	The ExpandNet framework stresses the importance of defining appropriate approaches and relationships for advocacy on, introduction of, and information about the innovation to reach key audiences.
Management and organization	The WHO-ExpandNet framework stresses the importance of charting out the management process its pace and scope, whether it is to be centralized or decentralized, whether it is to be adaptive or fixed and who would drive the process
Resources	The WHO-ExpandNet framework stresses the importance of integrating scaling up efforts into national and sub-national work plans and budgets, and of tapping into existing funding mechanisms.
Monitoring and evaluation	The WHO-ExpandNet framework stresses the critical importance of monitoring and evaluation using methods such as such as routinely gathered statistics, special surveys and formative and intervention-effectiveness research.

WHO 2010. *Nine steps for developing a scaling-up strategy*. Geneva, Switzerland, World Health Organization