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EXPERT MEETING ON POLICY IMPLEMENTATION AND GENDER INTEGRATION

in the Scale-Up of Family Planning and Maternal, Neonatal, and Child Health Best Practices

This publication was prepared by Karen Hardee, Elisabeth Rottach, and Rachel Kiesel of the Health Policy Project.

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Expert Meeting on Policy Implementation and Gender Integration

in the Scale-Up of Family Planning and Maternal, Neonatal, and Child Health Best Practices

Workshop Report
December 12, 2011

JULY 2012

This publication was prepared by Karen Hardee,[1] Elisabeth Rottach,[1] and Rachel Kiesel[1] of the Health Policy Project.

[1]Futures Group

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- Doris Bartel, CARE
- Salwa Bitar, Management Sciences for Health
- Rebecka Lundgren, Institute for Reproductive Health
- Mohammed Rashad Massoud, University Research Co.
- Suzanne Reier, World Health Organization
- Ruth Simmons, ExpandNet
- Jeffrey Smith, JHPIEGO
- Nhan Tran, World Health Organization

Finally, we would like to thank Shelah Bloom and Jessica Fehringer of MEASURE Evaluation, our implementation partner on the Gender, Policy, and Measurement activity.

Executive Summary

The Health Policy Project (HPP), in collaboration with MEASURE Evaluation, is working with the Asia and Middle East (AME) Bureaus of the United States Agency for International Development (USAID) to implement the scale-up of best practices in family planning and maternal, neonatal, and child health (FP/MNCH) through addressing two components in the scale-up process: gender and policy. Under this activity, called Gender, Policy, and Measurement (GPM), HPP hosted an expert meeting on experiences with scaling up best practices in FP/MNCH, with attention to gender integration and policy implementation. Held on December 12, 2011, at Futures Group in Washington, DC, the meeting included 42 representatives from bilateral and multilateral agencies, as well as individuals known for their contributions to scaling up best practices.

The meeting objectives were to

- Introduce the Gender, Policy, and Measurement activity;
- Share experiences and lessons learned regarding the role of gender integration and policy implementation in scaling up FP/MNCH best practices;
- Build consensus on priorities for gender integration and policy implementation in scaling up FP/MNCH best practices; and
- Strengthen partnerships for the effective design and implementation of FP/MNCH scale-up efforts with attention to gender and policy.

To frame the day's discussion, HPP's Deputy Director for Population and Reproductive Health, Karen Hardee, summarized the findings of the GPM literature review on policy and scale-up in a presentation titled "The Policy Dimensions of Scaling Up Family Planning and Maternal, Neonatal and Child Health Services." Subsequently, HPP's Gender Advisor, Elisabeth Rottach, summarized a review of gender and scale-up in a presentation titled "Integrating Gender into the Scale-Up of Family Planning and Maternal, Neonatal and Child Health Programs."[1] Following the presentations, eight experts on scale-up, policy, and gender provided feedback on the papers and discussed their own scale-up efforts.

During the afternoon, the participants broke into two working groups: one on gender and scale-up and one on policy and scale-up. The participants identified (1) gaps and challenges in addressing gender and policy in scale-up, (2) priorities for addressing gender and policy in scale-up, and (3) entry points for integrating gender and policy priorities into scale-up.

HPP greatly benefited from the active participation of esteemed experts on best practices, scale-up, gender, and policy, as well as from the lively discussion among all participants in the plenary sessions and small working groups. The information shared and the constructive feedback given will help HPP to revise the two papers presented and will inform the project's work under GPM.

Gender priorities for integrating gender into scale-up processes

- Conduct a gender assessment(s)
- Focus on coalition building
- Integrate gender into scale-up frameworks (i.e., do not develop a separate framework for gender-integration)
- Move toward gender equality

Key policy factors in scaling up a health innovation

- Big "P" or legislation/policies that affect issues such as access and commodity availability
- Little "p" or operational policies—including norms, standards, guidelines and protocols—that affect both service provision and clinical practices
- Management (e.g., task shifting)
- Financial resource allocation

[1] Both the papers and PowerPoint presenations are available at www.healthpolicyproject.com.

Abbreviations

AIDS	aquired immune deficiency syndrome
AME	Asia and Middle East
BP	best practice/s
E2A	Evidence to Action (project)
ESD	Extending Service Delivery (project)
FAM	Fertility Awareness-based Methods (project)
FHI	Family Health International
FP	family planning
GHI	Global Health Initiative
GPM	Gender, Policy, and Measurement (activity)
HIV	human immunodeficiency virus
HPP	Health Policy Project
IBP	Implementing Best Practices (initiative)
IRP	Implementation Research Platform
IRH	Institute for Reproductive Health
MCHIP	Maternal and Child Health Integrated Project
M&E	monitoring and evaluation
MNCH	maternal, neonatal, and child health
PEPFAR	President's Emergency Plan for AIDS Relief
RH	reproductive health
SBCC	social and behavior change communication
SBP	Scaling Up Best Practices
URC	University Research Co.
USAID	United States Agency for International Development
WHO	World Health Organization

Background

The Asia and Middle East (AME) Bureaus seek to stimulate risk taking, innovation, and learning among program efforts across the region. Over the last four years, the bureaus have seen great success with the AME Scaling Up Best Practices (SBP) activity, implemented by the Extending Service Delivery Project (ESD) of the Bureau for Global Health. The activity has helped countries implement and scale up best practices (BP) in family planning and maternal, neonatal, child health (FP/MNCH) throughout Asia and the Middle East. However, lessons and successes from the activity highlight that gender integration and policy implementation have not been adequately considered in the application and scale-up of these practices.

Gender integration is the process of taking into account gender norms and the differences and inequalities between men and women in program planning, implementation, and monitoring and evaluation.

Policy implementation in scale-up includes ensuring that national and operational policies and systems needed to prioritize the scale-up of best practices are identified and addressed. Policy implementation related to scale-up could include capacity building for policy machineries (including government ministries and civil society), development of new policies, barriers analysis, policy monitoring, revision of existing policies, and/or implementation of new, revised, or existing policies.

In response, the bureaus have enlisted the Health Policy Project (HPP) and MEASURE Evaluation to build on the successes of SBP by systematically (1) addressing and enhancing the integration of gender into the scale-up of FP/MNCH BP[2]; (2) building stronger policy responses and system strengthening approaches to scaling up FP/MNCH BP; and (3) rigorously monitoring, evaluating, and disseminating outcomes.

HPP, using a system strengthening approach, is providing technical expertise on the application of gender and policy in scaling up best practices. The project is holding a series of consultations, preparing several white papers, and providing technical assistance to bilateral projects. MEASURE Evaluation will design a rigorous evaluation to measure the impact of gender integration and policy implementation on scale-up, systems strengthening, and health outcomes.

This activity supports the agency's Global Health Initiative (GHI) goals of improving family planning and maternal health outcomes and adheres to several GHI principles.[3] The inclusion of MEASURE Evaluation addresses the U.S. Government's mandate for an independent, impact evaluation of the agency's work and the need for strong, unbiased evidence on how gender integration and policy implementation in the scale-up of BP affects health systems and outcomes. This work also supports the agency's Gender, Equality, and Female Empowerment Policy.

To date, HPP has undertaken literature reviews and in-depth interviews on the gender and policy dimensions of scaling up best practices. The literature reviews synthesize information and lessons learned from experience to date with scaling up BP in FP/MNCH, with a particular focus on gender and policy.

[2] This includes related areas such as nutrition.
[3] Women, girls, and gender equality (WGGE); encourage country ownership and invest in country-led plans; build sustainability through health systems strengthening; improve metrics, monitoring, and evaluation; and promote research and innovation.

In addition, HPP hosted an expert meeting on December 12, 2011, at Futures Group in Washington, DC. The meeting focused on experiences with scaling up BP and innovations in health and included discussions of policy, gender, and measurement. The objectives were to

- Introduce the Gender, Policy, and Measurement (GPM) activity;
- Share experiences and lessons learned regarding the role of gender integration and policy implementation in scaling up FP/MNCH best practices;
- Build consensus on priorities for gender integration and policy implementation in scaling up FP/MNCH best practices; and
- Strengthen partnerships for the effective design and implementation of FP/MNCH scale-up efforts with attention to gender and policy.

Agenda

HPP staff began the meeting by presenting two papers on gender and policy in scale-up. Subsequently, eight technical experts provided feedback on the papers and then spoke about their work on scaling up, particularly the gender- and policy-related barriers they identified and how they addressed them.

Following lunch, the participants broke into two working groups: one on gender and scale-up and one on policy and scale-up. All reported back in the plenary. The meeting closed with a summary of the working group discussions and plans for continued collaboration among the groups working on scaling up health interventions. See Annex 1 for the meeting agenda.

Participants

The participants included 42 representatives from bilateral and multilateral agencies, as well as individuals known for their contributions in scale-up and best practices. See Annexes 2 and 3 for a participant list and bios of the speakers and discussants.

Presentations and Discussion

Rima Jolivet, HPP Technical Director for MCH facilitated the meeting and opened it by welcoming participants and reviewing the agenda. Laura McPherson, HPP Deputy Director of Field Programs, welcomed participants on behalf of HPP; and Patty Alleman, Technical Advisor, Policy, Communication and Evaluation Division, Office of Population and Reproductive Health, welcomed participants on behalf of USAID. Katie Qutub, Health Advisor, AME Bureaus, summarized the GPM activity as a joint project under HPP and MEASURE Evaluation and as envisioned by the AME Bureaus.

To frame the day's discussion, HPP's Deputy Director for Population and Reproductive Health, Karen Hardee, summarized the findings of the GPM literature review on policy and scale-up in a presentation titled "The Policy Dimensions of Scaling Up Family Planning and Maternal, Neonatal and Child Health Services." Subsequently, HPP's Gender Advisor, Elisabeth Rottach, summarized a review of gender and scale-up in a presentation titled "Integrating Gender into the Scale-Up of Family Planning and Maternal, Neonatal and Child Health Programs."[4]

[4] Both the papers and PowerPoint presentations are available at www.healthpolicyproject.com.

The presentation on policy included the following key actions:

- Identify the policy issues and decisionmakers responsible for them
  - What changes need to be made?
  - Who has the authority to make decisions regarding the change?
  - Will the change require increased resources?
  - Who has the authority to decide on the increased resources?
  - How are the changes in policies being communicated to the providers, other health personnel, and to their managers and supervisors?
  - How will the policy change be monitored to ensure implementation?
- Identify allies and champions
- Pay attention to timing and sequencing
- Maintain ongoing communication and coordination among stakeholders
- Build institutional capacity for policy work
- Feed monitoring and evaluation data back into the policy process

The presentation on gender included the following key actions:

- Integrate gender into scale-up frameworks and approaches
- Carry out gender analyses to identify and address gender barriers and opportunities relevant to scale-up
- Develop approaches to address gender constraints and opportunities that can be brought to scale
- Engage a broad range of stakeholders representing women's and men's groups and vulnerable populations
- Mobilize resources for gender-integrated programs through advocacy to decisionmakers and policymakers
- Monitor and evaluate the scale-up process to better understand how gender factors influence the process, outcomes, and impacts

Following the HPP presentations, eight experts on scale-up, policy, and gender provided feedback on the papers/presentations and discussed their experiences. Summarized below, their presentations are available on request.

Ruth Simmons represented **ExpandNet** (www.expandnet.net) at the meeting and presented ExpandNet's scale-up model in addition to discussing the HPP paper on policy and scale up. She reinforced the importance of "beginning with the end in mind" when planning pilot projects. She noted that organizations often focus only on expansion, not on institutionalization of policies. She said that the HPP paper and presentation effectively show that both vertical and horizontal scale-up are necessary. Dr. Simmons highlighted sequencing and asked if all policies need to change before scale-up is possible. The answer is not necessarily. The relationship between policy change and expansion is dynamic; one can influence the other. She said that gender can be part of the environment in which scale-up takes place. For each type of scale-up (horizontal, vertical, etc.), one must determine approaches toward dissemination and advocacy. It is also important to recognize that some scale-up efforts require more than others. This is variable—some new practices can be adopted without a lot of systemic change. Scaling up often takes long-term efforts (5–10 years), which requires advocacy. Donor funding needs to take into account this longer time frame. Dr. Simmons noted that a gap often exists between policies and implementation; thus, it is good that the paper emphasizes operational policies.

Rebecca Lundgren, Institute for Reproductive Health (IRH), presented the experience of the Fertility Awareness-based Methods (FAM) Project with scaling up the Standard Days Method in five

countries (www.irh.org). IRH is using the ExpandNet model to guide the scale-up. Regarding policy, Ms. Lundgren noted that a focus on vertical scale-up helps staff embrace their role as policy advocates. The formation of stakeholder groups that identify issues and advocate is important for moving policy issues forward. Definition of the innovation and its operationalization are essential. Stakeholders must understand the innovation. Also, what is scale-up? What is enough? Monitoring of the pace of scale-up and sharing results are essential. It is also important to pay attention to both macro and micro policies. There is a need to integrate the new health innovation into norms and protocols; training; information, education, and communication efforts; procurement; and distribution—all under the realm of operational policies. Scale-up plans must pay attention to resources and systems, with phases tied to Ministry of Health plans.

In his presentation on the **Maternal and Child Health Integrated Project (MCHIP)** (www.mchip.net) and its mapping of scale-up, **Jeffrey Smith** noted that many programs are lacking coverage data and therefore cannot measure change over time. The MCHIP's framework map allows for shading so it is possible to track visually which programs are making more and less progress. Progress can be tracked in a rightward direction across the map. The map can also reveal, for example, that health governance and financing is not being addressed by anyone. The mapping is most useful when all stakeholders are involved in filling it out and deciding on next steps to ensure progress. Dr. Smith noted a key lesson—the importance of getting everyone to agree on a "rulebook" for a basic package of health services. Dr. Smith also noted that scale-up efforts should consider (1) gender barriers within and outside of the health sector and (2) the gendered effects of policies (e.g., civil service policies affect male and female employees in different ways).

Mohammed Rashad Massoud from the **University Research Co. (URC)** (www.urc-chs.com) noted that, in earlier years, program results could be produced among smaller teams and units. Today, change must occur at scale to be meaningful. Nevertheless, programs must be tested at a small scale first to provide a prototype. Dr. Massoud gave an example of a policy barrier in a child health scale-up activity in Russia. In that country, a directive did not permit the referral of neonates from one center to another for 10 days, which was a death sentence for some newborns. As a solution, an exemption was sought and results were demonstrated. That kind of work can lead to policy change. In another example, in Niger, coverage of active management of the third stage of labor was increased, and thus post-partum hemorrhage declined on a national scale. A team from Niger then helped Mali accomplish the same thing in two years (less time than it took in Niger). This example shows how champions in one country can support change in another. Dr. Massoud also described using champions who worked on the prototype or first wave of scale-up to also work on the second wave. Scale-up can be easier and faster with peer learning.

Salwa Bitar from the new **Evidence to Action (E2A) Project** and formerly of the **ESD Project**, which implemented scale-up activities with support from the AME Bureaus, described ESD's use of the Fostering Change, ExpandNet, and Improvement Collaborative frameworks to identify policy and service gaps and develop action plans for scale-up. The ESD website (www.esdproj.org) has reports and briefs on the project's scale-up activities. Successful country scale-up teams included high-level participants, deputies, and directors, as well as representatives of services. This composition was a key to success. The teams identified policy gaps, especially related to task shifting. A major challenge for policy change is turnover. Changes in leadership can add years to a timeline, especially in centralized systems where approval from the top is needed. Another constraint to scale-up is lack of evidence on global *and* local effectiveness. Dr. Bitar suggested that HPP clarify the health system building blocks in its paper on policy and scale up—what are these components and what are the policy aspects in each?

Suzanne Reier, from the **Implementing Best Practices Initiative (IBP)** (www.ibpinitiative.org), described IBP's Fostering Change methodology, noting that the different types of scale-up have similar objectives and are not in conflict with each other. IBP developed the Fostering Change framework to bring tools together to better assist teams in implementing scale-up. The project is updating the framework now, and the next version will include more on monitoring and evaluation (M&E). An important principle is that change must matter to those involved—whether it's a policymaker or the implementation team. Champions at the policy level are needed. For example, Ethiopia's recent expansion of its family planning program was spearheaded by national leaders and the coordination team, which was essential for maintaining consistency related to goals and messages. Regarding the policy and scale-up paper, Ms. Reier suggested that HPP be more specific about what it takes to bring about policy change (i.e., what does policy work consist of?). She noted that bigger changes take longer; smaller changes take less time. There is a need for advocacy and champions at national and local levels. On the gender paper, she asked about examples of programs that worked well because of integrating gender and about how programs can maintain a gendered perspective.

Nhan Tran described the **Implementation Research Platform (IRP)** under the Alliance for Health Policy and Health Systems Research (http://www.who.int/alliance-hpsr/projects/implementationresearch/en/index.html) at the World Health Organization (WHO). The IRP was launched in 2010 as a platform to unite, strengthen, and build on existing implementation research work within the WHO and its partnerships. The scope of IRP's work is to promote and support implementation research to accelerate progress toward Millennium Development Goals 4, 5, and 6, especially related to MNCH and sustainable strengthening of health systems. The research supported through IRP identifies common implementation problems and their main determinants; develops and tests practical solutions to these problems; and determines the best way of introducing the solutions into the health system and facilitates their full scale implementation, evaluation, and modification. Regarding the HPP papers, Dr. Tran recommended being more specific about what is meant by scale-up and who owns it, including defining the roles of all stakeholders. He also suggested being more specific about the role of research—where does it come in at each phase? How can research better inform scale-up?

Doris Bartel, from the Gender and Empowerment Unit at **CARE**, described CARE's approach to gender integration in its work, which includes staff training; gender analysis; strategic planning; intervention design; partnership building with rights-based nongovernmental organizations; monitoring, including reflection by staff; and evaluation. CARE uses an ecological model in its work on women's empowerment, with a focus on the individual level, in addition to the household, services, community, and society. Regarding HPP's gender and scale-up paper, Ms. Bartel noted that it is logical to integrate gender into the project cycle and that it will be important to provide practical examples of achievements related to gender integration. Will reducing child marriage leverage more results than improving women's mobility or household decision making? It will be important to disaggregate and analyze: "women and "men" are not homogeneous groups—there are broad differences in experiences of gender barriers to healthcare, depending on ethnicity, language, caste, class, race, or profession. Finally, she noted that "more than mobilizing resources, we will also need to mobilize political will" to address gender in scale-up.

Small Group Work

Objectives

- Establish priorities for integrating policy and gender into scale-up strategies
- Identify key entry points for integrating policy and gender into scale-up efforts
- Articulate policy and gender integrated scale-up strategies

Instructions

Each group was asked a series of questions related to integrating gender or policy into scale-up efforts. The groups were asked to summarize their discussions on a flip chart, which would be displayed and discussed during the gallery walk at the end of the group work.

Gender Working Group Discussion

Gender Group Questions

1. What are the priorities for integrating gender into components of scale-up (regardless of the scale-up framework or approach used)?
2. Of these priorities, which are currently being addressed in scale-up and which are not?
3. What are the challenges in operationalizing the identified priorities?
4. What are the entry points for integrating gender priorities into scale-up?
5. What advice would your group give a project that is seeking to integrate gender into its scale-up activity? Or, if your organization were asked to undertake an initiative to integrate gender into a scale-up activity, what would you want to know?

Output: Suggestions for a scale-up strategy that integrates gender priorities at the appropriate entry points.

The gender working group appointed Rebecka Lundgren and Debbie Caro the facilitator and notetaker/reporter, respectively. The group then discussed the audience for the activity (i.e., who would be the recipient of the gender-integrated scale-up strategy). Diana Santillan from USAID explained that the strategy will support missions in scaling up health interventions. Specifically, HPP will assist missions with the design, implementation, and monitoring of scale-up activities, while MEASURE Evaluation will design an impact evaluation for 1–2 scale-up initiatives.

The group first walked through the steps of scale-up[5] and then identified entry points for gender integration. The scale-up steps included pilot testing and scalability assessments, team formation and planning, monitoring and evaluation, scale-up strategy development, and implementation.[6] The group identified specific entry points for integrating gender into each step of scale-up. As an important preliminary first step, whoever is leading the scale-up process should be oriented on why it is important to address gender in scale-up. This may require outside consultation; for example, in the case of USAID missions, USAID/Washington gender advisors could help raise awareness of and dialogue on the importance of gender integration.

Entry Points for Integrating Gender into Scale-Up

Step 1: Pilot testing

During the pilot test, the intervention or best practice is tested for efficacy and scalability. There was a discussion on assessing cost, and it was pointed out that "value for money" may be a more appropriate term than "cost," as while an intervention may be costly, it may also reach large populations and create lasting change. ExpandNet has developed a checklist for assessing scalability of interventions. (Note: the checklist includes the following question: Has the project identified and taken into consideration

[5] The participants loosely followed the ExpandNet framework and steps for developing a scale-up strategy. In addition, they drew on their own knowledge and experience in scaling up health practices.

[6] For organizational reasons, the five steps are consolidated into four steps in the summary that follows. All the entry points discussed and recorded during the group session are included, although some may fall under a different heading.

community, cultural, and gender factors that might constrain or support implementation of the innovation?)

- ***Conduct a gender assessment***
  - The group agreed that, as part of scaling up a best practice, gender assessments should be undertaken to inform decisions about how to scale up and to help guide development of a roadmap for scale-up. Diana Santillan raised the following example questions for a gender assessment related to scale-up: What would be the impacts of the practice on gender? What, in terms of gender, would you want to monitor? The gender assessment was discussed in terms of "screening" the practice to see how it would influence gender. A third idea was to require the intervention to undergo a process like the Institutional Review Board, in terms of gender.
  - The group noted that gender assessments should be conducted in consultation with women's or gender groups and other stakeholders. Because women and men are not homogenous groups, the group also noted that women's and men's groups should be further disaggregated by age, ethnicity, and other relevant characteristics.
  - In conducting a gender assessment, questions remained about which methodologies, tools, and expertise are available and would be needed. USAID is currently supporting the development of a gender assessment guide for missions. A question was raised as to whether this tool would be applicable to scale-up.
  - An overarching question of the gender assessment should focus on to what extent the scale up of the practice contributes to gender equality (e.g., reducing differences in power and health outcomes).

Step 2: Planning and team formation

At this stage, the scale-up team is formed, stakeholders are identified, and planning for scale-up begins.

- ***Form a gender diverse resource team***
  - It will be important to ensure the representation of a range of individuals from women's, men's, and gender groups.

- ***Provide gender training, support, and team building***
  - The team will likely need training on rights and gender integration or gender mainstreaming. Data from the gender assessment can be used to inform the content of the training and tailor it to the gender context.
  - In addition to training, it will be important to create a shared vision of the practice to be scaled up and the gender dimensions and considerations connected with the practice.

- ***Develop gender objectives***
  - Using the results of the gender assessment, objectives for gender equality should be developed.

Step 3: Development of a scale-up strategy

At this stage, the team will prepare a strategy for the most effective scale-up of the intervention. This strategy could include horizontal approaches (i.e., expansion to other geographic areas or populations), vertical approaches (i.e., institutionalization of an intervention through policy or systems changes), or a combination of both horizontal and vertical approaches. The participants discussed two concrete examples for how to use the results of a gender analysis to inform development of the scale-up strategy.

- ***Map strategies to address gender-based constraints and opportunities***

  - In developing a scale-up strategy, both vertical and horizontal approaches can be used. A mapping exercise could be conducted to identify how and when to address gender-based constraints and opportunities and reduce gender equality gaps. For example, the MCHIP mapping tool could be adapted for gender, or gender could be integrated into the tool, and then applied to the development of scale-up strategies.

- ***Measure gender-based constraints and opportunities***
  - The results of the gender assessment should inform the development of the monitoring and evaluation plan. The M&E plan should monitor progress of the scale-up activity in terms of gender-based barriers and opportunities through using gender-specific indicators and benchmarks. Sex-disaggregated data should be collected. The team should also monitor the removal of gender barriers and extension of gender opportunities. The process of scale-up, as well as health and gender equality, should be measured. The relationship between the process indicators and outcomes should also be monitored for discrepancies in gender. Debbie Caro gave the example of a training program where 20 women and 20 men are trained (process) but only one woman successfully finds employment while all 20 men find employment.

Step 4: Implementation, monitoring, and evaluation

- ***Make implementation of scale-up a participatory and inclusive process***
  - The implementation of scale-up should be participatory and inclusive. Mechanisms for feedback should be established to enable proper monitoring and to ensure necessary adjustments are identified and made.

- ***Monitor discrimination and exercise of rights***
  - During implementation, scale-up programs should monitor discrimination and the ability to exercise rights.

- ***Conduct advocacy***
  - Data gathered from monitoring and evaluation can be used for advocacy and coalition building among stakeholders.

Challenges and Barriers

The following is a short list of challenges and barriers to carrying out gender integration in scale-up processes:

- Limited knowledge and experience on how to use gender analyses
- Lack of training and know-how about gender integration
- Lack of recognition of the need for gender skills and expertise
- Late arrival of technical assistance on gender integration

Recommendations

Recommendations for how to move the field forward regarding integrating gender into scale-up processes include the following:

- Develop cases/examples of different interventions and socio-cultural contexts
- Identify types of practices to scale up
- Develop guiding principles for a gender-integrated scale-up process
- Develop key gender-related questions to ask throughout the scale-up process
- Define entry points for integrating gender into scale-up processes
- Integrate gender into scale-up frameworks more explicitly

Priorities for Integrating Gender into Scale-Up

The following are the priorities identified by the group for integrating gender into scale-up processes.

- Conduct a gender assessment(s)
- Focus on coalition building
- Integrate gender into scale-up frameworks (i.e., do not develop a separate gender-integrated scale-up framework)
- Move toward gender equality

Policy Working Group Discussion

Policy Group Questions

1. What are the priorities for addressing policy in the components of scale-up?
2. Of these priorities, which are currently being addressed in scale-up and which are not?
3. What are the challenges in operationalizing the identified priorities?
4. What are the entry points for integrating policy priorities into scale-up?
5. What advice would your group give a project that is seeking to address policy in its scale-up activity? Or, if your organization were asked to undertake an initiative that addresses policy in a scale-up initiative, what would you want to know?

Output: Suggestions for a scale-up strategy that addresses policy priorities at the appropriate entry points.

The policy working group appointed Rima Jolivet and Nhan Tran as the facilitator and notetaker, respectively. Ruth Simmons reminded the group that potential scale-up issues should be identified early on in the process and that each intervention will require a different set of policy changes. Salwa Bitar asked whether horizontal scale-up can take place without macro-level changes and added that it could but not without operational policy change. She gave the example of adding zinc to oral rehydration salts and making it part of the Integrated Management of Childhood Illness package in one country and noted the need to only change the guidelines, which was a quick addition/change. Karen Hardee asked whether that was really the only operational policy change needed? How about procuring the zinc? Were resources/budget available? Was there any advocacy needed to convince the ministry or any other authorizing agency that zinc should be part of the package? Were any changes needed in the training curriculum and training for providers? This discussion helped stimulate thinking about of the complexities of addressing policy in scale-up.

The group noted the importance of evidence, money, and windows of opportunity, such as “deliberate dialogue” that puts policymakers in the room with researchers (evidence brokers). Experience shows that policymakers respond to local evidence that an innovation is effective and acceptable (for example, male circumcision was offered in one country but men did not come for services; the problem in that case was not policy or the scale-up process per se but that the innovation itself was not tested for local acceptability). Although in-country implementation research is needed, country resources are shrinking everywhere, so it is not possible to demonstrate everything everywhere and test everything rigorously. Small, targeted implementation studies may be sufficient. Technical advisory groups are useful and should include members with advocacy and communications expertise. During a pilot demonstration, a participatory policy assessment can help to create ownership, develop an advocacy plan, and get high-level buy in for the scale-up. Entry points for addressing policy in scale-up include little “p” or operational policies or big “P” policies or global directives to create pressure/advocacy. Suzanne Reier noted that the most critical policy issues everywhere are related to resources, particularly human

resources and related task shifting. There is poor resource allocation in favor of tertiary care. We need to analyze barriers (ideally beforehand), present evidence, and focus on policies that remove barriers.
The discussion generated numerous questions about policy and scale-up:

- Where to start? Barriers…
- Which barriers are a priority? Depends on the country and program context; any barriers could be policy-related.
- Where does policy begin and end? There is a fine line between policy and program operations.
- What is the magnitude of policy change needed? What is the best way to assess the policy changes needed? Clinical changes require narrower, technical changes compared with management changes. We must look at the levels of change required and prove the need through research.
- Policy work emphasizes the supply side; how can we bring in the demand side? Are there policy issues related to the demand side?
- How can gender be integrated into policy work?

The group identified the following key policy factors in the scale-up of a health innovation:

- Big "P" or legislation or policies (e.g., affecting access and commodity availability)
- Management (e.g., task shifting)
- Financial resource allocation
- Little "p" or operational policies, including norms, standards, guidelines, and protocols (e.g., affecting both provision of services and clinical practices)

Next Steps

HPP greatly benefited from the active participation of esteemed experts on best practices, scale-up, gender, and policy, as well as from the lively discussion among all participants in the plenary sessions and small working groups. The information shared and the constructive feedback given will help HPP to revise the two papers presented and will inform the project's work under GPM. HPP will send the revised papers and this meeting report to participants and will keep everyone apprised of GPM country and other related activities as they are implemented. While plans for future years of GPM are not clear, it would be beneficial to convene another expert meeting toward the end of the project to share technical lessons learned in addressing policy and gender in the scale-up of best practices.

Annex 1. Agenda

Time	Session	Description
8:30-9:00	Light breakfast	
9:00-9:15	Welcome and introductions	Patty Alleman, USAID and Laura McPherson, HPP
9:15-9:30	Background on AME GPM	Katie Qutub, USAID/AME
9:30-10:00	Presentations and brief comments/discussion	Presentation #1: The Policy Implementation Dimensions of Scaling Up Health Initiatives (draft white paper for discussion) Karen Hardee, HPP
10:00-10:30		Presentation #2: Gender Integration and Scale-up Efforts (draft white paper for discussion) Elisabeth Rottach, HPP
10:30-10:45	Break	
10:45-1:00	Panel discussion on how organizations/projects have addressed gender and policy in scale-up and challenges	Sharing of knowledge and experience and reaction to white papers Ruth Simmons, ExpandNet, Rebecka Lundgren, IRH/FAM Jeffrey Smith, MCHIP Rashad Massoud, Improvement Collaboratives, Spread Salwa Bitar, ESD/E2A projects Suzanne Reier, IBP Nahn Tran, WHO Implementing Research Platform Doris Bartel, CARE Questions/Discussion
1:00-2:00	Lunch	To be determined: working lunch or break
2:00-3:30	Small groups: Priorities for integrating policy and gender into scale-up efforts	Groups 1–2: Integrating gender into scale-up frameworks and implementation: Entry points and strategies
		Group 3–4: Strengthening policy approaches in scale-up frameworks and implementation: Entry points and strategies
3:30-3:45	Break	
3:45-4:30	Gallery walk	Participants report out from small groups
4:30	Closing	Bringing it all together and next steps

Annex 2. Participant List

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Annex 3. Bios of Speakers and Discussants

Patty Alleman

Patty Alleman is a public health professional and social anthropologist with extensive technical experience in governance, policy, and research. She is a senior technical advisor in the USAID Global Health Bureau/Washington, Office of Population and Reproductive Health. As a Global Health Fellow, she provides technical support to USAID missions in the areas of governance, policy, advocacy, financing, and gender. Her current scope of work also includes maintaining strong linkages with other donors and multilaterals in the aforementioned technical areas. She also provides technical and managerial oversight for the USAID-funded Health Policy Project. Prior to her fellowship, Patty was a senior project manager at Family Health International, where she provided technical input and management of socio-behavioral research studies in HIV/AIDS and family planning and managed activities in support of country-ownership and sustainability for research. She holds a Master in Public Health and MA in medical anthropology. She has numerous publications and often serves on task forces and related panels.

Doris Bartel

Doris Bartel is currently leading CARE's Gender and Empowerment Unit, which supports the organization's ongoing commitment to gender equality and women's and girls' empowerment. She is a public health specialist with more than 20 years of programming, clinical, and research experience in development and humanitarian contexts, specializing in guidance for gender integration into health and development programs. She is a certified Women's Health Nurse Practitioner, with a background in community development, conflict mitigation, and reproductive health and rights.

Salwa Bitar, MD

Dr. Bitar is the E2A Senior Advisor on Global Alliances. E2A is the global USAID flagship project for strengthening and scaling up FP/RH services and best practices. Before the project was awarded in September 2011, she was the ESD Project's MNCH/FP Regional Advisor for Asia and the Middle East. She is an expert in scaling up FP/MNCH best practices through her work with country teams and grantees. She is a medical doctor and a public health specialist with more than 20 years of experience in management, design, and implementation of population and family health programs. Prior to working for ESD, she spent 17 years managing family planning and reproductive health, healthcare reform, women's health, behavior change, and safe motherhood initiatives for USAID/Jordan. Earlier, Dr. Bitar was a medical provider of FP/RH services for Jordanian women from the low socio-economic class. She then joined Save the Children, where she designed and implemented a child survival program in Jordan. Dr. Bitar obtained her medical degree from Jordan University in 1978 and her MPH from Jordan University for Science and Technology in 1997.

Karen Hardee, PhD

Dr. Hardee is a social demographer with extensive global technical and leadership experience in family planning and reproductive health. She is a senior fellow and deputy director of population and reproductive health for the Health Policy Project at Futures Group and has been a visiting senior fellow at the Population Reference Bureau. She is also the president of Hardee Associates, LLC. She has been the vice president of Research at Population Action International, where she directed the population and climate change program; and a senior advisor at John Snow, Inc., where she worked on the MEASURE Evaluation project and

provided technical input to projects related to HIV/AIDS, family planning, and reproductive health. Dr. Hardee managed a project on the harmonization of M&E data quality tools for multiple donors, including the Global Fund, U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and WHO. Dr. Hardee has also worked at Family Health International as a deputy director and principal research scientist and at USAID and the U.S. Bureau of the Census as a presidential management fellow. She has worked as a consultant on policy, program design, research, and information dissemination projects. Dr. Hardee has published extensively and serves on expert panels and as a reviewer for a range of journals.

Rima Jolivet, DrPh

Rima Jolivet is a certified nurse-midwife with a doctorate in public health. She is the Maternal Health Technical Specialist at the White Ribbon Alliance. She leads the maternal health programs for HPP. Her current work focuses on advocacy to improve the status and working conditions of midwives and the promotion of respectful maternity care as a basic human right. Rima Jolivet has broad clinical experience in maternity care and women's health, having worked as a childbirth educator, a doula and an interpreter for non-English speaking women in labor, and a lactation consultant before becoming a midwife and then developing expertise in quality improvement and health systems. Previously, she was the Associate Director of Programs at Childbirth Connection and contributed to the organization's long-term national program to promote evidence-based maternity care through research, education, public policy, and advocacy. She was the Director of the Transforming Maternity Care initiative and author of a quarterly column, "Current Resources for Evidence-Based Practice," published simultaneously in two peer-reviewed journals. Rima has also worked at the American College of Nurse-Midwives and the Centering Healthcare Institute.

Rebecka Lundgren, MPH

Ms. Lundgren is the Deputy Director, Director of Operations and Behavioral Research of IRH and Research Instructor, Department of Obstetrics and Gynecology of Georgetown University Medical Center. Ms. Lundgren joined IRH in 1997. She has worked for more than 20 years in program implementation, research, and evaluation—including 12 years serving in Latin America. During this time, she worked in the areas of youth, reproductive health, HIV/AIDS, and child survival. Her current research focuses on expanding contraceptive choice by integrating FAM into family planning services. Ms. Lundgren has particular interest in diffusion of innovation and scale-up; addressing couple issues; and engaging men in reproductive health and family planning. She received an MPH from UCLA's School of Public Health in the Department of Population and Family Health in 1987. She is currently working on a doctorate in applied anthropology at the University of Maryland.

Mohammed Rashad Massoud, MD, MPH, FACP

Dr. Massoud is a physician and public health specialist internationally recognized for his leadership in global healthcare improvement. He is the Director of the USAID Health Care Improvement Project and Senior Vice President of the Quality and Performance Institute at URC, leading its quality improvement efforts. He has a proven record of strong leadership and management, Previously, he was Senior Vice President at the Institute for Healthcare Improvement in Cambridge, MA, responsible for its Strategic Partners—key customers working on innovation, transformation, and large-scale spread, such as the Health Resources and Services Administration's Health Disparities Collaborative, Kaiser Permanente, the National Health Service's Institute for Innovation and Improvement in the United Kingdon, and the Department of Health and Human Services' Indian Health Service. Dr. Massoud previousely served as the Associate Director of the USAID Quality Assurance and Workforce Development Project (QAP 2 and 3), responsible for the project's activities in Europe and Eurasia/Asia and the Middle East. Dr. Massoud pioneered the application of the improvement collaborative methodology in several middle- and low-

income countries. He helped developed the WHO strategy for the design and scale-up of antiretroviral therapy to meet the 3x5 target and has worked on large-scale health service improvement in the Russian Federation; improving rehabilitation care in Vietnam; developing the Policy and Regulatory Framework for the Agency for Accreditation and Quality Improvement in the Republic of Srpska; and developing plans for the rationalization of health services in Uzbekistan. He founded and for several years led the Palestinian healthcare quality improvement effort. He was a founding member of and Chairman of the Quality Management Program for Health Care Organizations in the Middle East and North Africa, which helped improve health care in five participating Middle East countries. He has worked on healthcare quality improvement for the Harvard Institute for International Development and the Palestine Council of Health. He also served as a Medical Officer with the United Nations Relief and Works Agency, and he has consulted for and collaborated with several nongovernmental organizations, KPMG, United Children's Fund, the World Bank, and WHO.

Laura McPherson

Laura McPherson is a development expert with 30 years of experience, mainly with USAID programs in Africa and Haiti. Much of her overseas experience was as a resident advisor—as a USAID direct hire employee in Nepal and Somalia; a personal services contractor in Niger, Burkina Faso, Haiti, and Barbados; and a dependent spouse and contractor in the Democratic Republic of Congo. She ran her own development consulting company for 16 years, based first in Haiti and then in Miami, during which she developed numerous program strategies, designs, and requests for proposals and applications for USAID health offices. She also worked with interagency U.S. government teams in Ethiopia, Zimbabwe, Botswana, and South Sudan to develop PEPFAR Country Operational Plans .

Suzanne Reier, MPH

Suzanne Reier has worked for 30 years in international development situations ranging from community-based health and social service programs to large-scale bilateral programs to improve quality of reproductive health services. The majority of her international experience has been in East, North, and West Africa. Suzanne has extensive experience as a manager, trainer, and facilitator. She currently works with the IBP Initiative, based at WHO/Geneva in the Reproductive Health Department to facilitate a coordinated effort of 35 major reproductive health organizations to collectively improve the quality and access of reproductive health programs. The key elements of this initiative are to foster change and scale up proven effective practices and programs by harmonizing efforts among partners. She has introduced and trained program managers at regional and country levels in Africa, the Middle East, and Southeast Asia to use the Fostering Change framework as well as facilitated scale-up efforts in countries using the ExpandNet model. Suzanne feels that we have a moral and ethical obligation to build on the work and progress being done worldwide for the past 40 years of development and, therefore, must now focus our attention on the process of scaling up what we know works.

Elisabeth Rottach, MA

Elisabeth Rottach holds an MA in International Development from the University of Pittsburgh and has more than five years of experience in international health projects, including family planning and reproductive health, social and behavior change communication (SBCC), and gender and women's empowerment. Currently, Ms. Rottach is a Gender Advisor at Futures Group, responsible for carrying out programs on gender integration and the scale-up of best practices in family planning and maternal and child health, gender-based violence, capacity strengthening, and programs for women and girls. Prior to joining Futures Group, she led and supported research activities in Africa and Asia in family planning, reproductive health, and gender. She also led SBCC capacity-strengthening work in Guatemala for the

USAID mission's Health and Education Office and its partners. She has written articles in peer-reviewed journals and co-authored a number of papers for international health conferences. Her language skills include Spanish and Portuguese.

Ruth Simmons, PhD

Ruth Simmons is Professor Emerita in the Department of Health Behavior and Health Education at the University of Michigan School of Public Health, with a PhD in Political Science from the University of California at Berkeley. Dr. Simmons has worked with the WHO and country programs in the development and implementation of the Strategic Approach to Strengthening Reproductive Health Policies and Programmes since 1991. She has more than three decades of experience in research and writing in the areas of institution building, international health systems, family planning and related reproductive health policy and program development, and quality of care and user perspectives. An expert in organization development and health services action research, Dr. Simmons has worked extensively in South and East Asia, Africa, and Latin America. Dr. Simmons' current work includes, together with WHO, convening ExpandNet, a global learning community of senior health professionals, policymakers, and scholars engaged in efforts to take health service innovations to scale.

Jeffrey Smith, MD

Dr. Smith currently provides technical assistance to MCHIP in reproductive health needs assessments and program design, standardization and strengthening of preservice education and inservice training systems, and clinical updating and standardization of providers in a variety of clinical reproductive health areas. An Obstetrician-Gynecologist and public health expert with extensive experience in developing countries and strong program management and clinical skills, Dr. Smith's background includes strategic field experience in program design, implementation, and management, as well as technical excellence in clinical service delivery and training for maternal and newborn health services. As the Assistant Professor in the Departments of Gynecology and Obstetrics at the Johns Hopkins University School of Medicine and Bloomberg School of Public Health, he participated in clinical, teaching, and research activities. For more than three years, he served as the Safe Motherhood Advisor and subsequently Country Director for Jhpiego programs in Afghanistan, focusing on rebuilding the reproductive health system in a post-conflict environment. His international experience also includes extensive experience in Asia (Nepal, Vietnam, Cambodia, Pakistan, and India); Latin America (Peru, Bolivia, Guatemala, and Paraguay); and Africa (Rwanda, Uganda, Ethiopia, and Malawi).

Nhan Tran, MHS, PhD

As the Manager of the IRP, Nhan oversees work carried out in the three focus areas of the program: stewardship, capacity strengthening, and programmatic research. Additionally, he is also responsible for the coordination of activities among the IRP partners within and outside the WHO. Before joining the Alliance, Nhan worked as a health systems researcher at Johns Hopkins University, where he led the development of an HIV surveillance system in Afghanistan as well as studies on the scale-up of road safety interventions in Russia, Cambodia, and Vietnam. In addition to his work at Hopkins, Nhan also brings 10 years of professional experience working with the U.S. Department of Health and Human Services, where he designed and managed implementation research studies to inform national strategies for the delivery of family planning services.

Katie Qutub, MPH

Katie Qutub is a Health Advisor in the Office of Technical Support, Bureaus for Asia and the Middle East at USAID. In this position, Katie provides technical support to the two regional bureaus and the missions in 25 countries in the areas of maternal and child health, family planning and reproductive health, HIV/AIDS, malaria, tuberculosis, infectious diseases, and health systems. Katie assists with technical analysis of health status indicators and demographic data in the Asia and Middle East regions; identifies priority concerns in the population, health, and nutrition sector; and makes recommendations for action as appropriate. Prior to her fellowship, Katie was a Senior Development Specialist in the Healthcare Practice at Cardno Emerging Markets, USA, Ltd., where she managed healthcare projects funded by USAID, the Global Fund, and the World Bank. She holds an MPH in Family and Child Health with an international focus from the University of Arizona and a BS in Public and Non-Profit Administration from Grand Valley State University.

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