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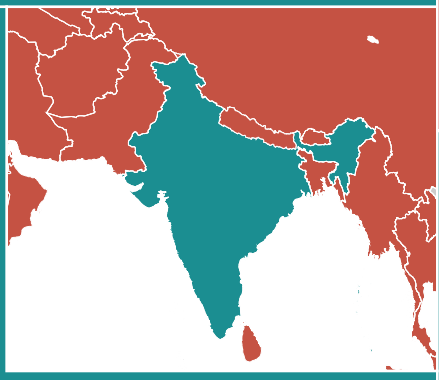
PROMOTING GENDER EQUALITY IN INDIA



Three Approaches to Scale-up

This publication was prepared by Sara Pappa, Arundati Muralidharan, Radhika Dayal, and Madhumita Das.

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Promoting Gender Equality in India

Three Approaches to Scale-up

AUGUST 2015

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CONTENTS

Acknowledgments iv

Abbreviations v

Introduction 1
- Background 1
- Context 1
- Rationale 3
- Aim 3

Methodology 5

Findings: Gender Equity Movement In Schools (GEMS) 6
- Background 6
- Key Intervention Components 6
- Scale-up Process 6
- Outcomes of Scale-up 8

Findings: PRACHAR 9
- Background 9
- Key Intervention Components and Results 9
- Scale-up Process 10
- Outcomes of Scale-up 12

Findings: Avahan 13
- Background 13
- Key Intervention Components 13
- Scale-up Process 14
- Outcomes of Scale-up 16

Comparative Analysis 17
- Scalability 17
- Partnerships and Resource Mobilization 18
- Adaptation and Expansion 20
- Institutionalization 21
- Monitoring and Evaluation 22
- Sustainability 23

Conclusion 24

References 25

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ABBREVIATIONS

ASHA	Accredited Social Health Activist
BMGF	Bill & Melinda Gates Foundation
CBO	community-based organization
CERT	Council of Education, Research and Training
CORO	Committee of Resource Organizations for Literacy
DoHFW	Department of Health and Family Welfare
FP	family planning
FP/MNCH	family planning and maternal, neonatal, and child health
FSW	female sex worker
GBV	gender-based violence
GEMS	Gender Equity Movement in Schools
GOB	Government of Bihar
GOH	Government of Haryana
GOI	Government of India
GPM	Gender, Policy and Measurement Program
HPP	Health Policy Project
ICRW	International Center for Research on Women
IDU	injecting drug user
IEC	information, education, communication
IRB	Institutional Review Board
KII	key informant interview
LMIC	low- and middle-income country
MDG	Millennium Development Goal
MNCH	maternal, neonatal and child health
MOWCD	Ministry of Women and Child Development
MPSP	Maharashtra Prathamik Shikshan Parishad
MSI	Management Systems International
MSM	men who have sex with men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NGO	nongovernmental organization
NRHM	National Rural Health Mission
PHFI	Public Health Foundation of India
RMNCH+A	reproductive, maternal, neonatal, child and adolescent health
SBCC	social and behavior change communication
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
STI	sexually transmitted infection
TI	Targeted Intervention
TISS	Tata Institute for Social Sciences
TSU	Technical Support Unit
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

INTRODUCTION

Background

The Gender, Policy and Measurement (GPM) program, funded by the Asia bureau of the United States Agency for International Development (USAID), is collaborating with USAID and other partners in the Asia region to strengthen programs for scale-up in Family Planning and Maternal, Neonatal, and Child Health (FP/MNCH). GPM works to address gender inequality and implement supportive policies and systems that augment the sustainability and foster the scale-up of effective programs.

As a part of this effort, the GPM program, under the USAID-funded Health Policy Project (HPP), along with partner institutions in India—the International Center for Research on Women (ICRW) and the Public Health Foundation of India (PHFI)—sought to examine how successful gender-integrated health programs (identified through a systematic review of gender-integrated health programs in low- and middle-income countries [LMICs])[1] have been scaled up, with a focus on programs that were scaled up through government structures in India.

This report assesses the processes, challenges, successes, and lessons learned from scaling up gender-integrated programs through government systems in India; it provides an in-depth, comparative analysis of the scale-up experiences of three programs: Gender Equity Movement in Schools (GEMS), PRACHAR, and Avahan. It identifies wide variations in government motivations for adoption and scale-up, approaches to scale-up, partnerships and engagement with key stakeholders, resource mobilization, and the modification or lack of attention to important gender components or aspects of the original pilot program(s). Finally, the study offers distinct and critical snapshots of gender integration in scale-up, contributing to the evidence base on the sustainability of gender throughout scale-up.

Context

The influence of gender on health service access and use, particularly in resource-constrained settings, is increasingly recognized by the global health community as a critical consideration when seeking to achieve positive health outcomes. Unequal gender norms restrict access to resources, such as education, information, employment, and income, which can significantly impact health knowledge, behaviors, and outcomes. Education, for example, is linked to higher utilization of maternal health services and subsequent reduction in risk of maternal mortality and morbidity (Adhikari, 2010; Ochako, 2011; Ribeiro, 2009; Paredes, 2005), increased contraceptive use (Yesuf, 2013), improved reproductive health knowledge, and lower likelihood of risky sexual debut among adolescents (Ibnouf, 2007). Social constructs of gender, such as those surrounding masculinity, may place men at an increased risk for HIV infection (Brown, 2005) and prevent them from seeking HIV treatment, as they may view treatment-seeking behavior as weak or a threat to one's manhood (Nyamhanga, 2013; Skovdal, 2011). Power dynamics within the household or community often dictate health decisions among men and women and globally; studies link husband approval to contraceptive use (Mohammed, 2014; Rahnama, 2010) or use of maternal and child health services (Allendorf, 2007; Haque, 2012; Shroff, 2011). Surpassing power dynamics, gender-based violence (GBV) is rooted in entrenched gender inequalities in a given society (Population Reference Bureau [PRB], 2010), and can be responsible for poor use of reproductive and maternal health services (Rahman, 2012), adverse child health outcomes (Rahman, 2012; Silverman,

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[1] For full systematic review, see: Muralidharan, A., J. Fehringer, S. Pappa, E. Rottach, M. Das and M. Mandal. 2014. *Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries*. Washington DC: Futures Group, Health Policy Project; and Chapel Hill, North Carolina: MEASURE Evaluation.

2011), and increased risk for STIs and HIV (Population Reference Bureau [PRB], 2010; Jewkes, 2010; Silverman, 2008).

Gender inequalities remain prevalent in many parts of the world and continue to undermine the achievement of positive health outcomes. According to the Global Gender Gap Report, while no country has fully closed the gender gap, India fares particularly poorly. Out of 142 countries, India is ranked 114 overall; looking specifically at health and survival, India ranks even lower at 141 (Beckhouche, 2014). In recognizing the need to focus on gender, donors and program implementers have begun to identify and incorporate strategies and approaches for addressing gender barriers and constraints in health programs. A considerable body of literature on gender-integrated health programs demonstrates how gender inequalities can be mitigated by identifying and actively challenging inequitable gender norms, roles, and interactions (Muralidharan, 2014; Rottach, 2009; Boender, 2004). Despite this, an enduring and persistent limitation is the lack of evidence on gender-integrated programs that have been scaled up. Existing frameworks and methodologies for scale-up do not offer systematic guidance on how to integrate and sustain a gender focus. Moreover, because there is a lack of evidence on how programs have incorporated a gender focus or how gender-integrated programs have been scaled-up, it is challenging to determine the actual impact of gender integration on scale-up (Rottach, 2013).

The past decade has witnessed a heightened interest in scaling up health programs (Yamey, 2012). The Millennium Development Goals (MDGs) and post-2015 Sustainable Development Goals (SDGs) provide impetus for the implementation of large-scale programs to bring about development progress; a focus on the scale-up of health services has been at the crux of the MDGs (Paina, 2012). Among program implementers, scale-up is in many ways a natural progression. Once a program or pilot project is shown to be effective, program beneficiaries, donors, or other interested parties will request more—typically an expansion, with a wider impact (Uvin, 2000). Scale-up, however, is a complex process; it cannot simply be a replication of efforts. Successful scale-up must occur through a system that is adaptive and flexible; overly simplistic approaches will not work (Renju, 2010; Bradley, 2012; Subramanian, 2011).

There is a general lack of consensus on one main scale-up framework or process for health programs. After examining various frameworks and processes, three salient features of scale-up emerge: evidence that the intervention is effective, a (strategic) plan for scaling up the effective intervention, and the readiness to scale-up. Gender inequality, however, is rarely addressed (Rottach, 2013). The only exception is the ExpandNet/World Health Organisation (WHO) framework, which proposes "respect for human rights, equity, and gender perspectives" as an underlying principle and further states that, "…scaling up should ensure attention to human dignity, the needs and rights of vulnerable groups and gender perspectives, as well as promote equitable access for all to quality services" (Simmons, 2007; ExpandNet/WHO, 2010). Despite mentioning the need to employ a gender focus, it offers little guidance on how to systematically attend to gender throughout the scale-up process.

In response to the apparent gap in guidance for addressing gender during scale-up, the GPM program conceptualized a programming approach to direct the systematic integration of gender into the scale-up of health interventions. Focused specifically on FP/MNCH outcomes, yet applicable to a wide range of health areas, the approach increases awareness of the need to address gender and achieve gender equality and female empowerment as outcomes of FP/MNCH programs taken to scale. Furthermore, the approach outlines four "priority global-level actions" that enable the systematic integration of gender during program scale-up (Rottach, 2013). The GPM approach, in many ways, mirrors the salient features mentioned above. The four key actions include

- Incorporating concrete guidance on addressing gender inequality into existing and new scale-up frameworks and approaches
- Mobilizing commitment and financial resources for scale-up

- Building the evidence base to demonstrate the impact of addressing gender equality in scale-up efforts
- Developing approaches to addressing gender equality that can be brought to scale (Rottach, 2013)

The approach goes on to elucidate five steps for integrating gender equality into the scale-up of FP/MNCH programs, or more widely, other health area programs. These steps include conducting a gender assessment to identify the gender-related barriers and opportunities relevant to program scale-up; preparing for scale-up by forming a diverse resource team with the skills required for successful scale-up and gender integration; developing a scale-up strategy that includes gender equality objectives for scale-up, a mapping of strategies and identification of best practice adaptations to effectively address gender-based constraints and opportunities, and plans for mobilizing political commitment and financial resources; preparing implementation and monitoring plans to ensure the scale-up process is participatory, inclusive, and diverse; and evaluating the process to measure gender equality and female empowerment outcomes (Rottach, 2013).

Rationale

Based on earlier evidence documenting the impact of gender-integrated programs on health outcomes, it is clear that gender-integrated programs can be effective in achieving a wide array of health outcomes, including gender outcomes (Muralidharan, 2014; Rottach, 2009; Boender, 2004). Gender-integrated programs recognize the critical influence of gender roles, norms, and behaviors on health access and use and health outcomes. Health programs that are gender-aware actively promote gender equity by addressing or challenging and transforming these roles, norms, and behaviors through their design, implementation, and monitoring and evaluation strategies.

Despite the breadth of evidence on gender-integrated programs, there is a lack of evidence about the scale-up of such programs through the original implementing organization or a government system and its existing programs or mechanisms (Muralidharan, 2014). Thus, two interrelated processes emerge as critical in this context; one relates to the implementation of gender-integrated programs and the other to scaling up such programs. This study attempts to document the experiences and lessons learned from scaling up three gender-integrated programs in India and, ultimately, contribute to a body of evidence on gender in scale-up.

Aim

This study is a comparative analysis of three case studies, examining gender-integrated health programs in India that have been adopted and scaled up by the government of India (GOI): Avahan (Bill & Melinda Gates Foundation), GEMS (ICRW), and PRACHAR (Pathfinder International). The study seeks to better understand the motivations behind government adoption and integration; the processes involved; and the successes, failures and lessons learned during the scale-up process. Most importantly, it examines in-depth the process by which a gender-integrated program is scaled up; specifically, how the gender components are sustained and valued during scale-up and whether or not the focus on gender is altered or compromised during the scale-up process.

Based on the systematic review, *Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries*, which looked at the evidence of how gender-integrated programming influences health outcomes across LMICs, the findings revealed a paucity of evidence on gender-integrated programs that had been successfully integrated into government health systems and scaled up. Despite being global in scope, because the systematic review was commissioned by USAID/India and intended to inform policymakers and program planners in India, the systematic review team decided to look more closely at the gender-integrated programs in India that had been adopted and scaled up by the government.

The main objectives of this study are as follows:

1. Identify the motivating and enabling factors that led the GOI to adopt each of the gender-integrated programs (Avahan, PRACHAR, or GEMS);
2. Examine the specific components of each program that have been adopted by the GOI and explore the motivations behind this, focusing specifically on the gender components; and
3. Understand how the GOI is scaling up each program (i.e., which model of scale-up is being considered most feasible in the Indian context) and determine the challenges, successes and lessons learned throughout the process.

METHODOLOGY

The case studies were carried out in July and August 2014 in India. Key informant interviews (KIIs) were conducted with government representatives at the state level and NGO and donor representatives affiliated with each program (for interview count by program, see Table 1). For the Avahan program, KIIs were conducted with one donor representative from the Bill & Melinda Gates Foundation (BMGF) and representatives from implementing NGOs; the case study team was unable to schedule any KIIs with government representatives affiliated with Avahan. For the GEMS program, KIIs were conducted with local government and NGO representatives and for PRACHAR, one KII was conducted with a representative of the government of Bihar (GOB) (via phone) and another with an NGO representative.

Most KIIs were conducted in person; however, three were conducted via Skype or phone. Institutional Review Board (IRB) approval, or other internal review and approval, was sought and achieved for each organization from the case study team (HPP, PHFI, and ICRW). All key informants received an informed consent form, which provided information on interview structure and required a signature by the informant. Interviews were no longer than one hour and all interviews were recorded if informants gave consent to do so. All informants have been left anonymous in this analysis; interview recordings were only used to check on interview information and content.

Analysis of interview content, along with background literature reviews on each program informed the findings of this report, which include a brief snapshot of each program, followed by an in-depth comparative analysis of all three programs. The structure of the comparative analysis is grounded in five criteria, based on the ExpandNet/WHO framework:

1. **Scalability:** Assess the level of scalability of each program (i.e., what specific attributes of each were appealing to the government for scale-up?); what aspects were *not* scalable?
2. **Partnerships and resource mobilization:** What key partnerships were formed to expand each program for scale-up and how was funding mobilized for scale-up?
3. **Institutionalization:** What changes were made to institutionalize each program within the government health system (i.e., level of political commitment, champions within the government, advocacy on behalf of donors/NGOs)?
4. **Monitoring and evaluation:** What are the strategies for monitoring and evaluation of the scale-up process and overall effectiveness of the program during and following scale-up?
5. **Sustainability:** How sustainable are the gender aspects of each program, following scale-up?

As detailed earlier, with the GPM approach offering a comprehensive look at the gender aspects of scale-up, the comparative analysis draws on the five steps of the approach (assess, prepare for scale-up, develop a scale-up strategy, implement and monitor, evaluate), within which important considerations and questions related to gender are touched on.

Table 1. Key Informant Interviews by Program

	NGO	Government	TOTAL
Avahan	4	0	**4**
PRACHAR	1	1	**2**
GEMS	5	3	**8**

FINDINGS: GENDER EQUITY MOVEMENT IN SCHOOLS (GEMS)

Background

Initiated in Maharashtra, India, in 2008 through a partnership between the International Center for Research on Women (ICRW), the Committee of Resource Organizations for Literacy (CORO), and the Tata Institute for Social Sciences (TISS), the GEMS program is a school-based intervention that works with adolescent girls and boys, ages 12 to 14, to promote gender equality by encouraging equal relationships, critical examination of social norms defining gender roles and responsibilities, and questioning the perpetuation of gender-based violence (GBV).

The GEMS program is based on the premise that gender norms, attitudes, and roles inculcated at a young age have lasting effects. Early adolescence, therefore, presents an opportunity to shape gender-equitable attitudes and behaviors. Institutions such as schools, where young adolescents spend much of their time, can potentially play an important role in instituting equitable gender norms and redressing negative attitudes that perpetuate GBV. Four main principles guide the implementation of GEMS: 1) starting young—reaching out to young adolescents to foster gender equitable norms; 2) working with both girls and boys to instill gender-equitable norms in both sexes; 3) implementing the program in institutional settings like schools to enable outreach to young adolescents; and 4) using a gender-transformative approach to bring about favorable changes in attitudes and behaviors.

Key Intervention Components

The GEMS curriculum includes sessions with both male and female students in grades 6 and 7 (implemented over a two-year period). The sessions cover three broad areas: 1) understanding gender (including gender discrimination, and gender roles and responsibilities); 2) physiological changes during adolescence and enhancing comfort with these bodily changes; and 3) GBV. The program begins by introducing key gender-related concepts and adolescent reproductive health. In the second year, sessions covered these concepts in greater depth and included a life skills component. To reinforce key messages, school-wide campaigns were conducted using social and behavior change communication (SBCC) strategies. Sessions were initially conducted by facilitators recruited and trained by CORO and TISS. In the third year of the intervention, the GEMS team conducted gender sensitization workshops with teachers and other school staff, as well as officials from the Department of Education in Maharashtra, to enhance their support and buy-in for the program. The involvement of these stakeholders laid the foundation for the scale-up of GEMS in schools across the state.

GEMS Intervention Approach

- Work with young adolescents of both sexes
- Reach out to school-going adolescents
- Deploy a gender-transformative approach

Gender Strategies

- Promoting critical reflection
- Sustaining results through social and behavior change communication (SBCC)

Results of the pilot found a reduction in physical violence by adolescent boys in schools, an increase in reports by girls and boys that they would take action against violence in schools, and a shift in attitudes about violence, with boys and girls more likely to oppose it.

Scale-up Process

Following the evaluation of the GEMS pilot, ICRW, CORO and TISS disseminated key findings to various governmental and nongovernmental stakeholders, including representatives from the Maharashtra Prathamik Shikshan Parishad (MPSP), experts from the education sector (such as former members of

MPSP), Education Department of Maharashtra, heads of schools, teachers, and representatives from nongovernmental organizations (NGOs), community-based organizations (CBOs), the United Nations, and donor organizations. Both government and nongovernmental representatives were impressed by the success of the GEMS pilot and expressed the need for such a program to be scaled up across the state, thus initiating a partnership for scale-up between the Department of Education and the original implementing NGOs in 2012.

Simultaneously, Meena Manch, a life skills education program for girls developed by the United Nations Children's Fund (UNICEF), was being implemented across government schools in Maharashtra. This program included some sessions on gender, but it was more of a stand-alone component than an integrated aspect of the sessions. Furthermore, the sessions did not focus as heavily on critical reflection and critical thinking, as compared to the GEMS program.

After learning about the approach and success of GEMS, representatives from the Department of Education felt that Meena Manch could be significantly strengthened by integrating two features of GEMS: the inclusion of gender considerations through critical reflection in each session, and the involvement of boys, in addition to girls, in the program. The merged program, Meena Raju Manch, was launched across 25,000 schools in 2011. Eliminating gender disparities in education was a salient feature of the new program, involving both male and female students, and eliciting teachers' support in ensuring a gender-equitable school environment. While the mainstay of Meena Raju Manch continued to be adolescents' life skills, students were encouraged to reflect upon gender norms, roles, and responsibilities during these sessions. The modified curriculum also included sessions on risk-taking among boys.

During the scale-up phase, the training of school-based facilitators, which took place in the third year of implementation during the pilot, was further strengthened. Staff from CORO trained gender facilitators, or *Sugam Kartas*, as well as 600 master trainers from education departments across the state, to enhance their skills in implementing the gender-integrated Meena Raju Manch. These master trainers trained school teachers to be facilitators in their own schools, serving to increase their buy-in and ownership, and increasing the sustainability of the program. A senior State Education Department official highlighted the flexibility and involvement that teachers have in the curriculum, in particular, the full freedom to develop it creatively. This freedom helped teachers increase their self-confidence, relate to the curriculum in a more personal manner, and reach and connect with their students.

The State Education Department finalized the Meena Raju Manch curriculum after review by the State Council of Education Research and Training (SCERT), UNICEF, and other organizations working on education/pedagogy. Key strengths of Meena Raju Manch were its adaptability and flexibility, while retaining the core of gender equity. Partner organizations, government and nongovernmental, may have had different mandates and motivations to participate in and support the program, but the focus on addressing gender disparities and inequalities through the education system has been the mainstay of implementation. The program's flexibility allows it to be implemented in accordance with the partner organization in charge of each school.

Implementing a gender-integrated program for young, school-going adolescents is fraught with challenges, because the attitudes of teachers and other school staff may reinforce and perpetuate the same societal prejudices and gender-inequitable norms a program is attempting to change. This program sensitizes various stakeholders in the education system to the importance of a gender-integrated curriculum, and simultaneously creates a sense of ownership to counter issues related to additional responsibilities or burdens on their time and limited school resources. CORO and TISS played key roles in building the capacity of teachers and other key stakeholders in the education network to both adopt and implement the newly converged program.

Meena Raju Manch is supported and monitored by Cluster Resource Persons or *Kendriya Pramukhs*, who liaise between the schools and the education department to facilitate integration of the program within the

government machinery, while simultaneously working to enhance the accountability of various stakeholders. School principals/headmasters report directly to the *Kendriya Pramukhs*, who in turn offer supportive supervision. *Kendriya Pramukhs* undergo training to work more effectively with teachers and students exposed to Meena Raju Manch. These capacity-building workshops also elicit their buy-in for the program.

The State Education Department, in recognition of the potential of the program, allocates Rs. 2,000 per year to each participating school to support program activities, including campaigns and competitions. A representative from CORO expressed a belief that this builds accountability.

Outcomes of Scale-up

While an evaluation of Meena Raju Manch is yet to happen, monitoring efforts by MPSP, CORO, and UNICEF in 12 districts across Maharashtra indicate that the program is functioning smoothly in those schools.

FINDINGS: PRACHAR

Background

In 2001, Pathfinder International launched the PRACHAR program in the north Indian state of Bihar to promote the health and well-being of mothers and children, and improve the economic well-being of families. Bihar exhibits some of the worst maternal and child health indicators in India, including high fertility rates and high unmet need for family planning, poor use of antenatal and skilled delivery care, high percentage of low-birth-weight babies and high rates of infant and child mortality (International Institute for Population Sciences [IIPS], 2007). Contributing to these indicators, early marriage plagues Bihar (63.7 percent of women are married before the legal age [Nirantar Trust, 2015]), as it does the rest of the country, where over 25 percent of women are married before age 15, accounting for one-third of child brides worldwide (United Nations Children's Fund, 2014). Early marriage often means immediate childbearing, which affects the health of both the mother and baby, and is associated with a number of health, social, economic, and emotional problems (Plan International, 2013). Further compounding the poor health indicators and high rates of early marriage in the state, young couples face several sociocultural barriers at the household and community levels, which in turn prevent them from talking about family planning and making joint decisions about when and how many children they want to have (Pathfinder International, 2013).

Aiming to improve maternal and child health in Bihar, PRACHAR sought to challenge and alter sociocultural norms related to early marriage and subsequent early childbearing among youth and other key community members (Pathfinder International, 2013; Daniel, 2008). Unmarried adolescents and young and newly married couples (ages 12–24) were the target beneficiaries, because they were identified as vulnerable groups with the potential to adopt and practice healthy behaviors. PRACHAR was designed to improve the sexual and reproductive health (SRH) behaviors of young and newly married couples, with a focus on contraceptive use, while simultaneously seeking to create an enabling environment and increase demand for and consistent use of contraceptives.

Key Intervention Components and Results

PRACHAR was piloted in two phases implemented through local NGO partners. In the first phase, implemented over a nearly four-year period (2001–2005), female and male change agents worked closely with unmarried adolescent girls and boys (ages 12–19), young married women and men, and community gatekeepers, such as parents and parents-in-law. The change agents provided essential SRH information and transformed social norms related to early marriage and childbearing through interpersonal communication for behavior change. PRACHAR also worked with government health facilities, social marketing agencies and local businesses to improve the quality of care and access to health services and contraceptives (Pathfinder International, 2013; Wilder, 2005).

PRACHAR Intervention Approach

- Life stage approach using communication messages relevant for adolescents and newly married couples, based on their life stage and SRH needs
- Creating an enabling environment by working with various stakeholders at the individual, family, and community levels

Gender Strategies

- Strengthening communication and negotiation skills of men, women, and couples
- Empowering disadvantaged or at-risk groups
- Sustaining results through social and behavior change communication

PRACHAR's second phase (2006–2008) focused on key outcomes related to family planning and adolescent health, refined and intensified the most effective interventions for adolescent health and family planning, and evaluated how programmatic inputs over a two-, three-, and five-year period affected the outcomes of interest.

PRACHAR's strength lay in its life-stage approach, employing varied communication strategies aimed at different levels (individual, household/family, group, and community) and stakeholders (youth, parents, community leaders, healthcare providers). Another strength was the role of female and male change agents, who were responsible for conducting interactive group activities/training workshops using developmentally appropriate content and exercises to identify and address barriers (including gender barriers), to healthy reproductive behaviors (e.g., parental and societal norms and pressures that encourage early marriage and childbearing; myths, fears, and misconceptions about pregnancy and contraception; negotiation skills with spouse, in-laws, and parents). Simultaneously, PRACHAR created an enabling environment for promoting and supporting healthy timing and spacing of pregnancies through the use of SBCC efforts with key community stakeholders (parents, mothers-in-law, community leaders) and by training healthcare providers, specifically *dais* and rural medical practitioners, to deliver health services and address misconceptions about timing and spacing of births. Furthermore, PRACHAR focused on improving couples' communication and joint decision making, while encouraging increased male involvement in family planning; one tactic for doing so was a newlywed ceremony called *Nav Dampati Swagath Samaroh*, which brought together 8–10 couples and was intended to draw attention to the project, as a whole, and its main goals.

Evaluations of PRACHAR reported a wide range of positive health outcomes, including increased contraceptive use to delay first birth among young married couples, increased age at marriage in intervention communities, and increased communication between parents and children regarding early marriage. Furthermore, provider clinical skills and knowledge related to antenatal care, delivery, and postnatal care improved, and overall, knowledge and awareness of health reproductive behaviors increased among young married women who participated in the program.

PRACHAR evaluations also reported a number of gender outcomes, such as increased decision-making power among women and joint decision making among couples, decision making related to sex and condom use, increased positive attitudes toward girls' education, increased gender-equitable attitudes and beliefs, increased partner communication, and increased positive attitudes toward healthy sexuality.

Scale-up Process

PRACHAR was scaled up in two states: Bihar (in 2011–2012) and Haryana (in 2014). In each state, the Department of Health and Family Welfare adapted and incorporated select intervention components or strategies of the PRACHAR program into its ongoing reproductive, maternal, neonatal, child, and adolescent health (RMNCH+A) program. Scale-up of these program components was undertaken with the goal of improving poor health indicators in the implementation areas.

Bihar (2011–2012)

The GOB was encouraged by PRACHAR's success in improving contraceptive use in pilot intervention areas (PRACHAR Phase I & II). During the third and final phase, PRACHAR employed a public-private partnership (PPP) model with the GOB in the scale-up of essential program components. As PRACHAR moved into its third phase and key intervention components were adopted and scaled up by the GOB, emphasis on strategies to create a more enabling environment declined. Activities such as facilitating greater couple communication and garnering support from key community stakeholders were "not within the purview of the government public health approaches" (Pathfinder International, 2011, p. 11).

Instead of using the female change agents who had been recruited and trained in the first two phases of PRACHAR, the GOB employed front line government health workers—Accredited Social Health

Activists (ASHAs). ASHAs were trained as change agents to conduct home visits with young, newly married women and provide targeted messages regarding timing and spacing of births to young couples with or without children. Unlike the first two phases of PRACHAR, the GOB did not recruit male change agents to work with adolescent boys and young men. However, some of the NGO-supported trainers and male change agents continued to conduct sessions with unmarried adolescents and young married men in the community.

Under the GOB, PRACHAR was scaled-up in another district in the state. To initiate the process, the PRACHAR team held several consultations with key government stakeholders, such as the Mission Director of the National Rural Health Mission (NRHM) in Bihar, family planning officer, child health officer, NGO coordinator and the M&E officer. A rapid situational assessment (RSA) was undertaken in eight districts to evaluate service provision gaps related to family planning and availability of ASHAs to implement components of PRACHAR.

Haryana (2014–present)

The government of Haryana (GOH) was looking to strengthen the family planning component of the state's ongoing RMNCH+A program. Specifically, the Department of Health and Family Welfare (DOHFW) had identified two poverty-stricken districts, Mewat and Palwal, characterized by high rates of maternal mortality, infant mortality, and early marriage, coupled with low levels of female literacy and low women's status. The conservative Muslim society in these districts required health interventions to address entrenched sociocultural and religious norms regarding family planning.

The DOHFW learned of PRACHAR's success in Bihar while looking for innovative community mobilization strategies to help overcome sociocultural barriers in Mewat and Palwal. The DOHFW sought technical assistance from Pathfinder International to implement relevant PRACHAR components in Mewat and Palwal. Subsequently, Pathfinder conducted an RSA in Mewat and Palwal, visiting health facilities and meeting various stakeholders to identify service provision needs and availability of ASHAs. The results of the RSA were used to frame an intervention and to develop a budget to support implementation. In line with PRACHAR's approach of creating an enabling environment by involving key community stakeholders, the program in Haryana, *Salamati PRACHAR*, identified religious leaders as a critical group to engage in promulgating gender equality and healthy timing and spacing of pregnancy. To elicit the support of religious leaders, Pathfinder International organized a sensitization workshop with Islamic scholars from Jamia Milia Islamia University that laid the foundation for intervention strategies that responded to and challenged the conservative norms surrounding family planning. Following the workshop, a core committee of scholars developed two modules: one that identified how Islamic holy texts (e.g., the Quran, Shariat) approached family planning, and a second that addressed questions about family planning and religion that were collated from community members and service providers. The modules used excerpts from the holy books to highlight how family planning messages were in line with what these religious texts advocated for maternal and child health.

Representatives from the GOH and Pathfinder met with religious leaders to present them with health indicators demonstrating poor maternal and child health outcomes in their districts. They discussed (using the two newly developed modules) how religion can help promote healthy practices related to maternal and child health and family planning. Through these meetings, the team enlisted the support of religious leaders to serve as change agents in mobilizing the larger community to adopt healthy behaviors.

In scaling up PRACHAR intervention components in Haryana, the GOH employed existing ASHAs to work as female change agents in select communities. ASHAs received additional training on how to deliver family planning messages tailored to women's specific family situations. Unlike Bihar, the GOH decided adopt the PRACHAR strategy of recruiting and utilizing community-based male change agents to work with men in the community. This decision was based on the recognition of the role of men as the primary decisionmakers in households and reluctance to have outsiders deliver health messages to

community members. The GOH recruited 160 male communicators, or *Rehber-e- Salamati,* from the intervention communities, appointing one male communicator per 5,000 people. The government decided on an incentive of Rs. 200 per meeting and required the male communicators to maintain and submit records of their meetings.

Pathfinder International conducted a training-of-trainers with state- and district-level officials to equip ASHAs and the *Rehber-e-Salamati* with the necessary skills to deliver key family planning and maternal and child health messages. Under the RMNCH+A program,[2] ASHAs were already reaching out to women in the community. Under *Salamati PRACHAR*, ASHAs' skills were further enhanced in implementing a life-stage approach (i.e., delivering messages according to the woman's life stage and family planning needs), and encouraging couple communication and joint decision making about family planning.

Outcomes of Scale-up

No evaluations of the scale-up process in Bihar or Haryana have been conducted. However, in Haryana, the government emphasizes the importance of monitoring and evaluation in program implementation and is working with a local medical research and education institute to monitor the scale-up process and conduct periodic surveys. In addition, KIIs in Haryana revealed that the government is exploring the possibility of engaging outside donors to support further expansion and scale-up to other districts with poor health indicators in the state.

[2] The Reproductive, Maternal, Newborn, Child and Adolescent Health Program (RMNCH+A) was launched by the government of India in 2013 to address the leading causes of mortality among women and children in India, as well as the key barriers they face in accessing and utilizing essential health services. More information about the RMNCH+A strategy can be found here.

FINDINGS: AVAHAN

Background

The Bill & Melinda Gates Foundation (BMGF) launched the Avahan program in 2003 to curb the spread of HIV in India. At the time of implementation, India was home to the largest number of people living with HIV (outside of South Africa), with 4.6 million individuals infected (UNAIDS, 2004). While general prevalence was low, serious epidemics among key populations were growing in individual states and districts in the country (UNAIDS, 2004). The program operated in those select states (Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Nagaland, and Manipur), which accounted for 83 percent of the country's HIV infections. It offered HIV prevention services to key populations, including female sex workers (FSWs); high-risk men who have sex with men (MSM); transgender people, or *hijra*; injecting drug users (IDUs); and clients of sex workers (Bill & Melinda Gates Foundation, 2008).

Key Intervention Components

Avahan Intervention Approach

- HIV prevention and service provision
- Community mobilization

Gender Strategies

- Community mobilization

Avahan pursued three main goals: to build an HIV prevention model at scale in India; to encourage others to take ownership and replicate the model; and to disseminate lessons learned within India and globally (Bill & Melinda Gates Foundation, 2008). To build an HIV-prevention model at scale, BMGF undertook extensive mapping exercises to identify locations, numbers, and characteristics of key populations in an effort to better tailor the program to meet their complex and differential needs, and to ensure interventions achieved maximum impact. BMGF worked with GOI representatives, NGOs, and other key stakeholders to include an advisory board of Indian public health officials and business leaders to further ensure effectiveness and scalability of the program (Bill & Melinda Gates Foundation, 2009). In pursuit of its second goal, from the very beginning, Avahan was designed and implemented to largely mirror the government's own structure for service delivery (Sgaier, 2013) and account for the eventual transition to the "natural owners" (the GOI), as well as the communities (Bill & Melinda Gates Foundation, 2008). By working with government stakeholders (i.e., national- and state-level AIDS control authorities) and structuring the overall Avahan model to emulate current government structures, BMGF was able to avoid duplication of service delivery in priority states and districts, and ensure complementary service coverage for key populations (Bill & Melinda Gates Foundation, 2008).

Avahan focused mainly on prevention and service provision, with a community mobilization component. Key interventions included peer-to-peer outreach, where high-risk individuals identified and reached out to others in their social network to provide support and information, in an effort to encourage condom use. Under the Targeted Interventions (TIs), key populations were provided condoms, risk-reduction counseling, testing, and treatment for STIs and HIV, and needle and syringe exchange. The community mobilization component aimed to reduce stigma and violence by working with key populations to address determinants of HIV risk and strengthen their individual and collective agency to encourage the adoption of healthy and safe behavior. Furthermore, the community component worked to ensure high-risk individuals had access to social services from welfare programs. By building the collective agency of key populations, BMGF sought to encourage ownership of the community component of the program to help ensure the sustainability of interventions and efforts beyond the life of Avahan (Bill & Melinda Gates Foundation, 2008; 2009).

Community-led crisis response systems, another aspect of the community mobilization component, were established across the program to address violence, harassment, abuse and discrimination. Specific

activities included responding to incidents of violence right away, counseling crisis victims to ensure access to adequate support and care, resolving family or community issues affecting high-risk individuals, providing legal support and training communities on their legal rights, undertaking advocacy efforts with key stakeholders and sensitizing the police and other stakeholders, and building relationships with the media to further target stigma against key populations (Bill & Melinda Gates Foundation, 2009).

Studies assessing the achievements and outcomes of the Avahan program revealed many positive findings, including an increase in safer sex practices among sex workers (Biradavolu et al., 2009), increased use of STI testing and treatment services among sex workers (Punyam et al., 2012), and decreased STI and HIV prevalence (Bhattacharjee et al., 2013; Rachakulla et al., 2011). On a much larger scale, another study found a significant association between the intensity of Avahan interventions during the first phase (2003–2008), a lower HIV prevalence in three south Indian states, and the prevention of 100,000 new HIV infections (Ng et al., 2011). Other studies found decreases in reports of violence against sex workers (Beattie et al., 2010) and increased self-advocacy among sex workers toward police, meaning sex workers felt more empowered and less fearful of the police and in the event of arrest, and were more likely to question police (Biradavolu et al., 2009).

Scale-up Process

Avahan was designed and implemented to account for a gradual handover to the Indian government. As it was implemented across the six target states from the very beginning, government adoption was a transition or vertical scale-up, whereby an intervention or intervention component is institutionalized through policy, regulatory, budgetary or other health systems changes (Hardee, 2012). The transition strategy under Avahan focused on three main activities—to build the capacity of communities, NGOs, and government entities to fall in line with the national AIDS control strategy (at the time of transition, NACP III); align the technical and managerial structures and mechanisms of Avahan with GOI norms and standards; and promote and sustain commitment to services for key populations (Bennett, 2011).

In each of the six states where Avahan was implemented, a lead agency worked with local organizations to deliver Targeted Interventions (TIs). The lead agencies (referred to as State Lead Partners) also provided technical and managerial support to those organizations (Sgaier, 2013) and were responsible for contracting with the smaller organizations, creating a structure of cascading contracts across the states (Bennett, 2011). During the actual phases of the transition, funding, ownership, and responsibilities shifted. The GOI, through the National AIDS Control Organization (NACO), took ownership of the TIs, directly funding the local organizations to carry them out under the oversight of State AIDS Control Societies (SACS) in each state. The government also provided additional funding to the original State Lead Partners to offer technical assistance (Sgaier, 2013). According to official memos between BMGF and the National AIDS Control Organization (NACO), 10 percent of the Targeted Interventions (TIs) would be transferred to the government by April 2009, a further 20 percent by April 2011, and the remaining 70 percent by April 2012 (Bennett, 2011). Condom distribution interventions were transitioned slightly differently, with 75 percent transferred in 2009 and 2010 and 25 percent in 2011; similarly, interventions under the truckers program were transitioned at different times, with 20 percent in 2010 and the remaining 80 percent in 2011 (Sgaier, 2013). According to several key informants, while the official transition was completed in 2013, BMGF worked with partner NGOs and local CBOs for one additional year to ensure a complete and smooth transition.

The community mobilization component of Avahan was the only gender-aware element of the program. It also proved to be the most difficult aspect to transition to the government. A study by Bennett et al. (2015) found that one year after transition, 64 percent of the community groups supported by the TIs that transitioned in 2011 and 45 percent of those supported by TIs that transitioned in 2012 had found additional sources of income. BMGF worked with these organizations to identify alternative funding

sources, such as underperforming grants or available savings (Jayaram, 2015). BMGF also continued to provide technical support to Swasti, a local NGO, to lead the community mobilization and collectivization work and build on the community components, such as ensuring access to loans and financing, social entitlements, and crisis response.

The community mobilization component is now funded and supported primarily through outside sources. Dual streams propel Avahan, post-transition: NACO has taken over all TIs and funds NGOs in each state to lead implementation, and the local community organizations mobilize key populations and implement crisis response systems, with limited support from NACO. According to one NGO representative, limited support includes only select staff salaries.

In a scaled HIV program of any kind, it is incredibly challenging to address violence, as it is manifested in ways that can be extremely specific to local contexts (Bill & Melinda Gates Foundation, 2009). As one NGO representative explained, in one community where Avahan was operating, it took nearly two years to reach and mobilize female sex workers. Differences in where FSWs worked—whether street-based or home-based—made it challenging to reach the women, as risks, challenges, and barriers were different. Because CBOs often drive health-seeking behavior among key populations for HIV and STI testing and treatment, thus supporting the TIs that are now run by the GOI, it is critical that the CBOs continue running and are fully supported. Another NGO representative commented that, unlike BMGF, the GOI—more specifically, NACO—does not have the capacity to simultaneously provide key HIV and STI services, collectivize key populations at the community level, and help lead the development and implementation of crisis response systems and advocacy efforts.

Avahan's was structure and implementation clearly aligned with the shifting goals of the national AIDS policies in India, particularly the shift from National AIDS Control Program (NACP) II to NACP III. While NACP II focused on reducing the spread of HIV in India and increasing the country's capacity to respond to HIV and AIDS on a longer-term basis, NACP III pursued the ultimate goal of halting and reversing the epidemic by scaling up prevention and treatment efforts for high-risk groups (Department of AIDS Control [NACO], 2012). During NACP III development, there was recognition that India's HIV policy required revision, and that the HIV response be more targeted to key populations. Avahan's TIs for specific key populations and its emphasis on differential strategies for different groups were particularly appealing and influential to the GOI (Tran, 2013). At the time of NACP III planning, Avahan had only been running for two years. The program's credibility and methods helped build support and influence the government planning process—according to one key informant, that particular "policy window" made way for Avahan's influence and facilitated the eventual transition. Furthermore, the flexibility of Avahan programming appealed to NACO as it ensured quick responsiveness to NACO's technical needs during periods of transition (Tran, 2013).

The success of Avahan demonstrated the feasibility of implementing targeted interventions for key populations at scale (Tran, 2013), which was a main focus of NACP III—to carry out targeted interventions using differential strategies for various groups and to do so at scale (Department of AIDS Control [NACO], 2012). As mentioned earlier, Avahan was already using a structure similar to that of the government service delivery structure, and by doing so at scale, Avahan programming appeared to be easily transferrable and achievable.

BMGF and Avahan partners generated lessons learned to share through peer-reviewed and grey literature, in addition to field visits for NACO staff and other key stakeholders, which provided a firsthand look at how the program was operating. Avahan and BMGF staff were also able to engage in informal communication, participate in executive meetings, contribute to various working groups (such as those established by NACO to help inform NACP III and address various programmatic areas), and participate in dialogue with other key development partners, such as the World Bank and USAID.

Other factors influencing the transition of Avahan to the GOI were the data management techniques employed under Avahan, which allowed for more rigorous tracking systems for different high-risk groups, and the overall management approach of Avahan (Tran, 2013).

At this point, it is unclear whether or not the GOI will expand the TIs to other states and districts, or how the transition of Avahan to the GOI will play out under NACP IV, which was officially launched in February 2014. The primary aim of NACP IV is to consolidate and accelerate the gains made under NACP III to effectively reverse the epidemic and further strengthen the response. Key strategies include: intensifying prevention services, with a sustained focus on reaching key populations and other vulnerable groups; increasing access to care, support and treatment; increasing information, education, and communication (IEC) services focused on behavior change and demand generation for key populations, as well as the general population; and building capacity at the national, state, district, and facility levels (Department of AIDS Control [NACO], 2012).

There is limited information about what will happen to the TIs under NACP IV. NACO has been absorbed under the Ministry of Health and Family Welfare (MoHFW), which has undergone an overall budget cut. Furthermore, funding for HIV programs was central under NACP III, but is now split between the central and state governments, with 60 percent of funding coming from the central government and 40 percent from state governments. The ultimate impact of this is unknown; however, it could be detrimental to the success and sustainability of Avahan, post-transition. With part of the funding left to the discretion of individual states, changes in leadership could affect priorities regarding the need to provide services for key populations (Jayaram, 2015), or to ensure the survival and sustainability of CBOs—the critical element for mobilizing and empowering key populations to seek HIV testing and treatment services and work together to overcome stigma and discrimination and violence.

Outcomes of Scale-up

No official evaluation looking at outcomes of scale-up took place; however, an evaluation study of the transition process did take place, highlighting some of the key lessons learned. These include the need to develop a strong and shared vision for transition between key partners, and the necessity of management plans that outline clear goals for implementation, budgets, and staffing structures to oversee transition (Bennett et al., 2015). While the evaluation offered valuable information and recommendations on the transition process, it focused solely on the TIs, not the gender-integrated community component.

COMPARATIVE ANALYSIS

HPP conducted a comparative analysis to examine the successes, challenges, and lessons learned in scale-up across the three programs. Pulling from the WHO/ExpandNet framework, we identified five areas for analysis: sustainability, partnerships and resource mobilization, adaptation and expansion, institutionalization, monitoring and evaluation, and sustainability. To employ a consistent gender lens to this analysis, we also used the GPM approach for integrating gender into scale-up as an additional guiding framework.

Scalability

The first step of the scale-up process is to assess the scalability of a program or program component(s). According to the WHO/ExpandNet framework, attributes of a particular program that are most likely to be scalable are: the program is credible and evidence-based; the results are observable to potential users and relevant to the issue at hand; the program has a relative advantage over existing programs or practices, thus making the case for taking on the costs of implementation; the program is easy to understand and implement and is compatible with the values, norms and facilities of the potential user; and the program is testable, allowing potential users to see it on a small scale prior to scale-up (ExpandNet/WHO, 2010). In the case of government scale-up, officials' perceptions of these features influence their motivations to take a program to scale. Similarly, the GPM approach highlights the importance of assessing the scalability of a particular program, specifically how the program addresses gender (Rottach, 2013).

In the case of Avahan, before the transition to GOI ownership, there was a critical need to reach key populations with HIV testing and treatment services to curb the spread of HIV. In response, NACO focused NACP III on the implementation of targeted interventions at scale. Avahan was already doing this; the program was initially designed and implemented to account for an eventual handover to the government, thus making an easier case for adoption. While the motivating factors behind NACO adoption were not particularly gender aware, there was a level of recognition that the gender-aware community component of Avahan added value.

Under GEMS, government officials in Maharashtra were motivated by the success of the pilot project. More importantly, they recognized the potential added value of the GEMS curriculum, if it were to be integrated into the existing Meena Manch program. While the program included some sessions on gender, gender was more of a standalone component, rather than fully integrated throughout. The State Education Department felt that two features of GEMS provided a relative advantage over Meena Manch: the inclusion of gender in each session through critical reflection, and the involvement of boys in the program. In comparison, in the case of PRACHAR, the pilot program was successful in improving contraceptive uptake, which was appealing to the Government of Bihar, as they were seeking to improve extremely poor maternal and child health indicators in state; similarly, in Haryana, the government sought to improve health indicators in two select districts. In Haryana, the government was also pursuing innovative community mobilization strategies and was motivated by PRACHAR's example. The community mobilization strategies employed under PRACHAR would eventually drive efforts to engage men, particularly community religious leaders, for support and buy-in.

In assessing scalability, it is also important to identify which components of a program are scalable and which are not. For Avahan, NACO adopted the TIs but was unable to maintain the community component. NACO recognized the value of the CBOs, but their activities fell outside of NACO's purview. Key informants reported that crisis response services and collectivization and empowerment of key populations, primarily female sex workers, fell within the scope of the Ministry of Women & Child

Development, rather than NACO. Furthermore, the financial cost of implementing the TIs alone under BMGF far exceeded NACO's budget. Fortunately, with the continued (non-financial) assistance of BMGF, the CBOs continue their work to support and empower key populations to utilize the HIV testing and treatment services now provided by NACO. While NACO could not support the CBOs, the decision not to do so may have been easier because the CBOs were already in place and received continued (non-financial) support from BMGF. The critical question is, if NACO expands the geographic reach of the TIs in the future, will the community component be scalable?

The government officials in Maharashtra felt that components of the GEMS curriculum, particularly the focus on critical reflection and inclusion of boys, was scalable and integrated it into the Meena Manch program. The government in Maharashtra was fully aware and supportive of gender in the case of GEMS. PRACHAR was a different case. The engagement of men through the use of male change agents in the community was the key gender component in the pilot program; however, the government in Bihar was not supportive of using male change agents—officials did not think it was appropriate to include men. Instead, they worked through existing ASHAs in scale-up areas. The scale-up experience in Haryana was quite different. With the influence and help of Pathfinder, the government felt it was critical to engage local male religious leaders in the two districts where the program would be scaled up. Before doing this, Pathfinder and the government also engaged Islamic scholars from Jamia Milia Islamia University to better tailor the intervention components to the local context. Also unlike Bihar, the government in Haryana used male change agents, *Rehber-e- Salamati*, as this was deemed critical to community mobilization.

Attention to gender in scale-up can play out in a number of ways. Motivations alone speak to the level of gender awareness of individuals interested in scaling up a program and the sustainability of gender components throughout the scale-up process. In some instances, motivations may be fueled by a focus on achieving positive health outcomes; the gender components may either be left out or perceived as critical to achieve positive health outcomes. In other instances, the gender components of a program may be the sole reason for government adoption and scale-up, so they will be sustained throughout the scale-up process. The components that government officials perceive to be scalable are illustrative of their attention and commitment to gender. To increase motivation, however, it is critical to demonstrate observable results of the gender components. If a pilot test is unable to isolate the influence of a gender component on health outcomes, or provide evidence for why the gender component matters for health, it will be difficult to motivate governments to invest in the gender components of an intervention.

Partnerships and Resource Mobilization

Scale-up is a complex process, requiring a diverse resource team equipped with a variety of skills. A resource team typically includes individuals who have been involved in the initial development and implementation of the program. In addition, because scale-up brings with it new requirements and challenges, the resource team must include individuals with a broad set of technical, managerial, and/or advocacy skills (ExpandNet/WHO, 2010). GPM staff also recommends that a diverse resource team should include wide representation and meaningful participation of women's and men's groups and vulnerable populations. Incorporating multiple perspectives and viewpoints lends itself to greater cultural sensitivity, awareness of underlying gender-related barriers and constraints, and ultimately, community ownership (Rottach, 2013).

Throughout the scale-up process, partnerships varied across the three programs. In expanding the GEMS curriculum to 25,000 schools across the state, the groups that implemented the pilot study (ICRW, CORO, TISS) worked closely with the Education Department of Maharashtra. Integrating GEMS components into Meena Manch also required extensive collaboration and curriculum review with various stakeholders, including UNICEF, SCERT, and other key organizations working on education in the state.

Despite different mandates and motivations to participate in the scale-up process, all the stakeholders remained focused on the main goal of addressing gender disparities and inequalities through the education system; these broad but focused partnerships propelled a successful and gender-focused scale-up of GEMS.

PRACHAR scale-up in Bihar involved fewer stakeholders; Pathfinder worked with the DOHFW to scale up in additional districts. In Haryana, Pathfinder also worked with the DOHFW; however, the resource team involved influential local community members. Due to the conservative Muslim culture in Haryana, Pathfinder and GOH representatives also engaged with Islamic scholars from Jamia Milia Islamia University to aid in the development of intervention strategies that were specific and responsive to the sociocultural environment. Just as it is important to identify and address local gender-related barriers and opportunities during the implementation of a pilot project, it is equally as important to do so during scale-up. Moreover, awareness of the ways gender-related barriers and opportunities shift and change by location is critical to the success of scale-up. The scale-up resource team and resulting partnerships should be created to account for these differing situations and circumstances. Unlike Haryana, the GOB did not account for any possible changes in the local sociocultural environment, despite expanding to additional districts in Bihar.

Similar to the scale-up experiences of PRACHAR and GEMS, the Avahan transition centered on a partnership between BMGF and NACO. Because the Avahan program involved a vast network of NGOs and CBOs that were to provide TIs under government funding, the transition partnerships were expansive. BMGF worked with the NGOs and CBOs to prepare them for transition, which included aligning budgets, staffing structures, and reporting mechanisms. State Lead Partners, the original lead agencies tasked with coordinating the local NGOs and CBOs in each state, received NACO funding to provide technical assistance to these organizations during transition. BMGF also set up and funded Technical Support Units (TSUs) to work with NACO and ensure a smooth transition. Moreover, BMGF now has a partnership with a local NGO, Swasti, which is tasked with managing the community component of Avahan. While it did not transition to NACO, BMGF felt it needed to be sustained but did not think the local community groups were ready to lead this on their own.

BMGF is still very committed to the gender component of the program: community collectivization of key populations. While consistent advocacy efforts on behalf of a scale-up resource team are critical to securing and sustaining political commitment and financial resources for gender (Rottach, 2013), in the case of Avahan, BMGF felt it necessarily to remain involved, because NACO did not fund this component of the program. Whether or not BMGF's support of Swasti and the community component will ultimately lead to NACO adoption, or transition under another government ministry, is an important consideration, especially in the event NACO expands TI implementation beyond original Avahan areas.

Avahan is also an important example of the financial challenges of transitioning or scaling up an NGO or donor-funded program through the government. Despite initial attempts to create and implement a program that mimicked GOI service delivery structures, Avahan was very expensive by NACO standards, which made transitioning implementation of the TIs to the government difficult. Since transition of the TIs alone proved to be a challenging task, NACO adoption of the community component, in any capacity, seems highly unlikely. Under NACP IV, funding structures have changed drastically; NACO now falls entirely under the MOHFW, and HIV funding decisions, which used to be entirely central, are now partly relegated to the states. This could affect funding of programs for key populations because state governments may not be as supportive of them as the central government or NACO. The drastic differences in what BMGF can afford to implement versus NACO, coupled with funding changes under NACP IV, may make it especially challenging for Avahan to achieve sustainability, let alone any further consideration or support of the community component.

Comparing the three programs, partnerships and the building of resource teams look largely similar; however, the continued involvement of the original donor or NGO could challenge the long-term sustainability of each program, especially any of the gender components. The key question is, when is it appropriate or feasible for donors or NGOs to pull out completely? With the gender components of each program in varied states, some firmly embedded, some receiving attention, and others more of a stand-alone aspect, it will be interesting to observe future sustainability, especially given the threat of changes in political commitment or financial support.

Adaptation and Expansion

The next step for effective scale-up is to make any necessary adjustments to the original program or program component (ExpandNet/WHO, 2010). When thinking about expansion, replicating an intervention in different geographic sites, or extending its reach to a wider area (Hardee, 2012)—as with GEMS and PRACHAR—it is critical to identify and address any gender-related barriers or constraints in the new locations and make necessary adaptations (Rottach, 2013).

PRACHAR was particularly skillful in doing this, as it expanded to an entirely new state. Upon initiating scale-up in two districts in Haryana, Pathfinder and the DOHFW together recognized the potential negative impact of the districts' deeply conservative Muslim culture on the acceptance and support of PRACHAR interventions. As discussed, Pathfinder and government representatives engaged local religious leaders and Islamic scholars to garner support and community buy-in. The scholars underwent a gender sensitization workshop and, afterward, worked to evaluate religious texts for their relevance in support of family planning and maternal and child health, and to inform program modules.

Recognizing the value of sensitization, the GEMS scale-up process involved an extensive series of trainings and sensitization workshops to serve the same purpose, plus the goal of ensuring sustainability and ownership of the program. During the third year of GEMS, before scale-up had even begun, sensitization workshops were conducted with government representatives from the Department of Education in Maharashtra to gain early support and buy-in. Later, during the scale-up phase, 600 *Sugam Kartas*, or gender facilitators, were trained as master trainers to improve teachers' skills in implementing Meena-Raju Manch, gain their buy-in, and create ownership to ensure sustainability of the program.

The use of gender sensitization workshops during the scale-up of GEMS and PRACHAR also draws from the GPM approach and its emphasis on providing gender integration training, support, and team building within the resource team and among key partners, further highlighting the importance of building a strong and diverse scale-up team. The approach goes a bit further in stressing how limited or differential the level of gender skills and knowledge can be and how critical training or workshops are; while systematic training within the resource teams of GEMS and PRACHAR did not occur, each program's efforts at gender sensitization are noteworthy.

Avahan also provided sensitization training to staff at government clinics to reduce stigma and discrimination against high-risk groups (Bennett et al., 2015). BMGF staff served on various NACP III planning and development working groups, one of which was a gender working group. BMGF's persistent support of the community component speaks to its commitment to sustaining the gender component of the program overall. However, should NACO expand implementation of the TIs to new locations, a certain level of gender awareness, particularly understanding the impact of violence against FSWs on HIV testing and treatment adherence, will be critical and, ultimately, a determinant of the sustainability of the community component.

In the case of Avahan, it is also important to note the considerable challenges the program faced in identifying and collectivizing FSWs to participate in the community-based groups and crisis response efforts. If NACO were to expand implementation of the TIs to additional locations, where community-

based groups are not in place, creating such groups will be very difficult. Key informant interviews spoke to these difficulties, as many FSWs were home-based and thus hard to identify and reach. A recent study reiterated this point; sex work in India has become more hidden as FSWs have shifted from brothel- or street-based to phone- or home-based, as stigmatization of brothels has increased, fueling changing client preferences (i.e., clients increasingly prefer home-based sex workers, as a disassociation from brothels creates more of an image of being with a "good woman"). In addition, increased awareness of HIV has made it more difficult to reach FSWs, especially in cases where TIs draw a link between FSWs and HIV risk, as FSWs are more hidden over fears of exposure and subsequent lost clients and greater financial insecurity (Kongelf, 2015).

If NACO expands coverage of TIs to additional states or districts, reaching out to key populations will be necessary, just as sensitizing community religious leaders or school teams was for PRACHAR and GEMS. While the community component of Avahan is not funded by NACO and does not necessarily have to operate in tandem with the TIs, implementation of the TIs and the community collectivization efforts are mutually beneficial. Collectivizing key populations helps ensure utilization of the services the TIs offer, and offering the TIs helps key populations, as it provides access to lifesaving HIV testing and treatment. Expansion will require finding financial and technical support for the community component, should NACO deem it necessary, and it will be challenging to find and collectivize an entirely new group of people.

Institutionalization

Institutionalizing the program or program component(s) requires various policy, political, legal, regulatory, or budgetary changes within the health system. In the case of government scale-up, integrating the program into certain policies, structures, or program procedures or mechanisms can be difficult (ExpandNet/WHO, 2010). As a program or program component(s) is institutionalized, ignoring existing gender constraints or opportunities can lead to resistance to a new policy or practice within the government system (Rottach, 2012); it is evident, therefore, that gender considerations are vital at each step in the scale-up process.

Institutionalization under PRACHAR and GEMS involved integrating original intervention components with existing government mechanisms and programs. In the case of PRACHAR in Haryana and Bihar, both states utilized ASHAs, local community health workers supported under the National Rural Health Mission (NRHM); ASHAs received additional training to deliver enhanced services that were delivered under PRACHAR. In Bihar, the government did not agree to include male change agents and only used the ASHAs; whereas in Haryana, the government was more interested in the community components and decided to use male change agents, in addition to ASHAs. Not only is this an example of government scale-up through existing structures or programs, it also points to the influence of government representatives involved in the process. In Bihar, there was a lack of political commitment to some aspects of the gender-aware features of PRACHAR (i.e., use of male change agents) and as a result, that component was left out, leaving the scaled up version of the program less able to address existing gender constraints and opportunities. In Haryana, not only was the government more supportive of involving men in the process, it was also more in tune with the local gender-related constraints and barriers, and recognized the need to engage and mobilize male religious leaders.

Similar to PRACHAR, the process for GEMS involved integrating specific components from the original curriculum into an existing government program, Meena Manch. The Department of Education in Maharasthra was interested in strengthening the Meena Manch program by including two features of GEMS: the emphasis on critical reflection and including boys. Finalizing the scaled up version of the program, Meena-Raju Manch, required inputs from multiple stakeholders, including the original organizations involved in GEMS; however, a consistent commitment to gender and tackling gender

barriers and constraints in schools maintained the focus on gender throughout the scale-up process. The GEMS and PRACHAR examples illustrate that if scale-up occurs through an existing government structure or program, the overall process is much smoother and more streamlined. Additionally, political commitment to gender helps ensure a consistent focus and priority for gender integration throughout scale-up.

The Avahan transition process was more challenging than GEMS and PRACHAR. Despite strides to create a program that largely reflected GOI service delivery mechanisms and structures, Avahan encountered difficulties aligning budgets, staffing structures, and reporting mechanisms. In particular, trouble aligning budgets resulted in stockouts at the clinics providing the TIs. While NACO only took over the TIs, leaving the gender-aware community components to outside support and funding, the transition experience highlights the difficulties and challenges faced during government scale-up.

Similar to PRACHAR and GEMS, BMGF was very involved in the transition process. Unlike PRACHAR and GEMS, however, BMGF worked closely with NACO from the very beginning of Avahan. Staff from BMGF served on technical working groups under NACO, and BMGF took on various informal and formal meetings and interactions with NACO staff, including inviting NACO representatives on site visits to see the workings of the program, even in its early stages. During transition and now post-transition, BMGF formed and funded, together with the World Bank and USAID, the Technical Support Units (TSUs) to ensure NACO stayed on track with the implementation of the TIs. Moreover, BMGF continues to support (non-financially) the CBOs in charge of collectivizing key populations in the communities. While donor involvement and advocacy is critical to the institutionalization process, the level of BMGF involvement may make it difficult to achieve the ultimate goal of full country ownership of the TI component of Avahan. More specifically, the fact that BMGF is still very supportive of the community component, even though NACO did not choose to adopt it, speaks to the challenges of transferring a program to full government ownership.

Monitoring and Evaluation

Throughout scale-up, it is critical to consistently monitor the process and track whether planned activities are being carried out, while also assessing progress toward overall program objectives. Gender should be integrated into the monitoring process to ensure that it is addressed throughout the scale-up process. In instances where a monitoring plan is developed, gender-responsive monitoring data, beyond sex-disaggregation, should be included to better monitor the impact on transforming gender norms (Rottach, 2013).

Looking across GEMS, PRACHAR, and Avahan, each program established a structure or mechanism to supervise or guide the scale-up process; however, only Avahan employed systematic monitoring. Similar to the technical support units under Avahan, which work within NACO to ensure transition stays on track, GEMS scale-up is supported and monitored by Cluster Resource Persons, or *Kendriya Pramukhs*, who liaise between the schools and the government to facilitate integration and ensure accountability of all stakeholders involved. Guiding PRACHAR scale-up in Haryana, efforts are underway to monitor scale-up and gather additional feedback on the process.

An evaluation of the actual transition process of Avahan took place. The evaluation looked at factors such as the extent of preparedness for transition and institutionalization, adoption and application of Avahan learning and processes within NACO, and the overall sustainability of services and program outcomes during and following transition (Bennett, 2011). This evaluation examined the challenges of and lessons learned from scale-up, in terms of transferring ownership of the TIs to NACO. However, it did not address the gender component of Avahan.

Sustainability

One of the strongest indicators of whether the scale-up of a particular gender component will be sustained is the initial motivation for government adoption and whether or not that motivation is gender aware; the analysis of GEMS, PRACHAR, and Avahan make this clear. The GEMS experience was straightforward and simple because the key motivating factor was the emphasis on the gender components: critical reflection and involvement of boys. Avahan was less straightforward; NACO was motivated by the success and flexibility of the program's TIs for key populations and the fact that BMGF was already doing this at scale. The gender-integrated community component was not feasible for NACO to adopt. Lastly, for PRACHAR in Bihar and Haryana, motivations were based on improving poor maternal and child health indicators and the program's success in increasing contraceptive uptake. In Haryana, the community mobilization component, which lent itself to more gender-aware activities and focus, also motivated the government to adopt. There is wide variation among the three programs in terms of maintaining a gender focus, with GEMS looking the most sustainable, Avahan unknown, and PRACHAR looking more sustainable in Haryana than Bihar.

After motivations, the makeup and diversity of partnerships and a resource team for scale-up are also critical for ensuring a gender focus. Across all three programs, there is the obvious partnership between the government and the implementing organization or donor. In the case of GEMS, a large and diverse resource team led the scale-up process and maintained a shared focus on the need to address gender inequality in schools. The Avahan transition included a large resource team and strong partnership between NACO and BMGF. A partnership between Pathfinder and the government led the process for PRACHAR, though in Haryana local religious leaders and Islamic scholars contributed to the planning process for scale-up.

Ensuring adaptability and expandability is also critical in scale-up, especially for a gender-integrated program, as gender barriers and opportunities differ by location or may be compromised when a program is implemented on a much larger scale. In Haryana, the government and Pathfinder understood the influence of men, particularly male religious leaders, in the districts where the program would be scaled up. In response, they worked with Islamic scholars to adapt program elements to the local context, while also sensitizing community leaders to the goals and objectives of the program. Similarly under GEMS, gender sensitization workshops with teachers were used to gain support and buy-in for the program. Avahan, however, was a different case. Because the scale-up was a transition, the Tis were not implemented in any new areas; however, adapting the TIs to the government structure and funding streams proved incredibly difficult and required deep involvement by BMGF.

Institutionalization under GEMS was fairly simple, as certain components from the pilot program were integrated into an existing government-run program, Meena Manch. This was also the case under PRAHCAR, as the government in Bihar trained ASHAs to take on additional responsibilities from the pilot project, and in Haryana, the government also instituted the male change agent component. Comparing Bihar and Haryana, government officials in Bihar excluded the use of male change agents due to lack of support, yet in Haryana, officials were more gender aware and cognizant of the positive impact of male involvement in family planning and maternal and child health. Under Avahan, the government adopted the TIs, but not the gender-aware community component. According to key informants, NACO could not adopt the community component because it was technically outside the agency's purview and more appropriate for the Ministry of Women and Child Development, given the focus on crisis response and violence. This scenario highlights the importance of multisectoral collaboration in scale-up.

CONCLUSION

This report assessed the processes, challenges, successes, and lessons learned of scaling up gender-integrated programs through government systems in India. In comparing the three programs, this study found wide variation in motivations and approaches to scale-up. Motivations ranged from the need to improve health indicators to the recognized advantages of a particular program component or characteristic. Approaches ranged from integration into existing government structures or mechanisms to transitioning interventions to full government ownership. In some cases, partnerships and the building of resource teams recognized the importance of involving a wide range of key stakeholders; others recognized the need to involve communities, while also highlighting the challenge of doing so throughout scale-up. During scale-up, program components were often modified or left out completely, reflecting attention or inattention to gender. Limited information exists on how each of the scaled up programs will be evaluated, which undermines the case for scaling up future gender-integrated interventions, or ensuring a consistent focus on gender throughout the scale-up process.

The variations across programs provide snapshots of gender integration in scale-up and ultimately, the sustainability of gender throughout the scale-up process. Integrating and maintaining a gender focus in pilot programs is challenging; attempting to sustain gender integration throughout scale-up is even more difficult once other factors come into play.

REFERENCES

Adhikari, R. 2010. "Demographic, socio-economic, and cultural factors affecting fertility differentials in Nepal." *BMC Pregnancy Childbirth* 10: 19.

Allendorf, K. 2007. "Couples' Reports of Women's Autonomy and Health-Care Use in Nepal." *Studies in Family Planning* 38(1): 35-46.

Beattie, T.S., P. Bhattacharjee, B.M. Ramesh, V. Gurnani, J. Anthony, S. Isac, H.L. Mohan, A. Ramakrishnan, T. Wheeler, J. Bradley, J.F. Blanchard and S. Moses. 2010. "Violence against female sex workers in Karnataka state, south India: impact on health, and reductions in violence following an intervention program." *BMC Public Health* 10: 476.

Beckhouche, Y., R. Hausmann, L.D. Tyson and S. Zahidi. 2014. *The Global Gender Gap Report 2014*. Geneva: World Economic Forum.

Bennett, S., D. Rodriguez, S. Ozawa, K. Singh, M. Bohren, V. Chhabra and S. Singh. 2015. "Management practices to support donor transition: lessons from Avahan, the India AIDS Initiative." *BMC Health Serv Res* 15: 232.

Bennett, S., S. Singh, S. Ozawa, N. Tran and J.S. Kang. 2011. "Sustainability of donor programs: evaluating and informing the transition of a large HIV prevention program in India to local ownership." *Glob Health Action* 4.

Bhattacharjee, P., R. Prakesh, P. Pillai, S. Isac, M. Haranhalli, A. Blanchard, M. Shahmanesh, J. Blanchard and S. Moses. 2013. "Understanding the role of peer group membership in reducing HIV-related risk and vulnerability among female sex workers in Karnataka, India." *AIDS Care* 25(suppl 1): S46-54.

Bill & Melinda Gates Foundation. 2008. *The India AIDS Initiative: The business of HIV prevention at scale*. New Delhi, India: Bill & Melinda Gates Foundation.

Bill & Melinda Gates Foundation. 2008. *Off the Beaten Track: Avahan's Experience in the Business of Prevention among India's Long-Distance Truckers*. New Delhi, India: Bill & Melinda Gates Foundation.

Bill & Melinda Gates Foundation. 2009. *Avahan - The India AIDS Initiative, Fact Sheet*. Seattle, WA: Bill & Melinda Gates Foundation.

Bill & Melinda Gates Foundation. 2009. *The Power to Tackle Violence: Avahan's Experience with Community Led Crisis Response in India*. New Delhi, India: Bill & Melinda Gates Foundation.

Biradavolu, M.R., S. Burris, A. George, A. Jena and K.M. Blankenship. 2009. "Can sex workers regulate police? Learning from an HIV prevention project for sex workers in southern India." *Soc Sci Med* 68(8): 1541-1547.

Blankenship, K.M., B.S. West, T.S. Kershaw and M.R. Biradavolu. 2008. "Power, community mobilization, and condom use practices among female sex workers in Andhra Pradesh, India." *AIDS* 22 Suppl 5: S109-116.

Boender, C., D. Santana, D. Santillan, K. Hardee, M.E. Greene and S. Schuler. 2004. *The 'So What?' report: A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes*. Washington DC: Population Reference Bureau (PRB), Interagency Gender Working Group Task Force.

Bradley, E.H., L.A. Curry, L.A. Taylor, S.W. Pallas, K. Talbert-Slagle, C. Yuan, A. Fox, D. Minhas, D. K. Ciccone, D. Berg and R. Perez-Escamilla. 2012. "A model for scale up of family health innovations in low-income and middle-income settings: a mixed methods study." *BMJ Open* 2(4).

Brown, J., J. Sorrell and M. Raffaelli. 2005. "An exploratory study of constructions of masculinity, sexuality and HIV/AIDS in Namibia, Southern Africa." *Cult Health Sex* 7(6): 585-598.

Daniel, E. E. M., R.; Rahman, M. 2008. "The effect of community-based reproductive health communication interventions on contraceptive use among young married couples in Bihar, India." *International family planning perspectives* 34(4): 189-197.

Department of AIDS Control (NACO). 2012. *National AIDS Control Programme, Phase IV (2012-2017), Strategy Document.* New Delhi, India: Department of AIDS Control (NACO), Ministry of Health and Family Welfare, Government of India.

ExpandNet/WHO. 2010. *Nine Steps for Developing a Scaling-up Strategy.* Geneva: World Health Organization (WHO).

Haque, S.E., M. Rahman, M G. Mostofa and M.S. Zahan. 2012. "Reproductive Health Care Utilization among Young Mothers in Bangladesh: Does Autonomy Matter?" *Women's Health Issues* 22(2): e171-180.

Hardee, K., L. Ashford, E. Rottach, R. Jolivet and R. Kiesel. 2012. *The Policy Dimensions of Scaling Up Health Initiatives.* Washington DC: Futures Group, Health Policy Project.

Ibnouf, A.H., H.W. van den Borne and J.A. Maarse. 2007. "Utilization of family planning services by married Sudanese women of reproductive age." *East Mediterr Health J* 13(6): 1372-1381.

International Institute for Population Sciences [IIPS] and Macro International. 2007. *National Family Health Survey [NFHS-3], 2005-06: India: Volume I.* Mumbai, IIPS.

Jayaram, M. 2015. "Transitioning Programs from Donor Support to Government: the Avahan Experience in India." PowerPoint presentation presented at Transitioning Programs from Donor Support to Government: the Avahan Experience in India, Washington DC.

Jewkes, R.K., K. Dunkle, M. Nduna and N. Shai. 2010. "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study." *Lancet* 376(9734): 41-48.

Kongelf, A., S.V. Bandewar, S. Bharat and M. Collumbien. 2015. "Is scale-up of community mobilisation among sex workers really possible in complex urban environments? The case of Mumbai, India." *PLoS One* 10(3): e0121014.

Management Systems International (MSI). 2012. *Scaling Up-From Vision to Large-Scale Change, A Management Framework for Practitioners.* Washington DC: Management Systems International (MSI).

Mangham, L.J. and K. Hanson. 2010. "Scaling up in international health: what are the key issues?" *Health Policy Plan* 25(2): 85-96.

Mohammed, A., D. Woldeyohannes, A. Feleke and B. Megabiaw. 2014. "Determinants of modern contraceptive utilization among married women of reproductive age group in North Shoa Zone, Amhara Region, Ethiopia." *Reprod Health* 11(1): 13.

Muralidharan, A., J. Fehringer, S. Pappa, E. Rottach, M. Das and M. Mandal. 2014. *Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries*. Washington DC and Chapel Hill, NC: Futures Group, Health Policy Project and MEASURE Evaluation.

Ng, M., E. Gakidou, A. Levin-Rector, A. Khera, C.J. Murray and L. Dandona. 2011. "Assessment of population-level effect of Avahan, an HIV-prevention initiative in India." *Lancet* 378(9803): 1643-1652.

Nirantar Trust. 2015. *Early and Child Marriage in India: A Landscape Analysis*. New Delhi, India: Nirantar Trust.

Nyamhanga, T.M., E.P. Muhondwa and R. Shayo. 2013. "Masculine attitudes of superiority deter men from accessing antiretroviral therapy in Dar es Salaam, Tanzania." *Glob Health Action* 6: 21812.

Ochako, R., J.C. Fotso, L. Ikamari and A. Khasakhala. 2011. "Utilization of maternal health services among young women in Kenya: insights from the Kenya Demographic and Health Survey, 2003." *BMC Pregnancy Childbirth* 11: 1.

Paina, L. and D.H. Peters. 2012. "Understanding pathways for scaling up health services through the lens of complex adaptive systems." *Health Policy Plan* 27(5): 365-373.

Pandey, A., R.M. Mishra, D. Sahu, S.K. Benara, U. Sengupta, R.S. Paranjape, A. Gautam, S.R. Lenka and R. Adhikary. 2011. "Heading towards the Safer Highways: an assessment of the Avahan prevention programme among long distance truck drivers in India." *BMC Public Health* 11 Suppl 6: S15.

Paredes, I., L. Hidalgo, P. Chedraui, J. Palma and J. Eugenio. 2005. "Factors associated with inadequate prenatal care in Ecuadorian women." *Int J Gynaecol Obstet* 88(2): 168-172.

Pathfinder International. 2011. *PRAGYA-Multisectoral, Gendered Approach to Improve Family Planning and Sexual and Reproductive Health for Young People: A Research Study.* Watertown, MA: Pathfinder International.

Pathfinder International. 2013. *PRAGYA: Multisectoral, Gendered Approach to Improve Family Planning and Sexual and Reproductive Health for Young People.* Watertown, MA: Pathfinder International: 35pp.

Plan International and International Center for Research on Women [ICRW]. 2013. *Asia Child Marriage Initiative: Summary of Research in Bangladesh, India and Nepal.* Bangkok, Thailand: Plan International.

Population Reference Bureau [PRB]. 2010. *Gender-Based Violence: Impediment to Reproductive Health.* Washington DC: Population Reference Bureau [PRB] for the Interagency Gender Working Group [IGWG].

Punyam, S., R.S. Pullikalu, R.M. Mishra, P. Sandri, B.P. Mutupuru, S.B. Kokku and P. Parimi. 2012. "Community advocacy groups as a means to address the social environment of female sex workers: a case study in Andhra Pradesh, India." *J Epidemiol Community Health* 66(suppl 2): ii87-94.

Rachakulla, H.K., V. Kodavalla, H. Rajkumar, S.P. Prasad, S. Kallam, P. Goswami, J. Dale, R. Adhikary, R. Paranjape and G.N. Brahman. 2011. "Condom use and prevalence of syphilis and HIV among female sex workers in Andhra Pradesh, India – following a large-scale HIV prevention intervention." *BMC Public Health* 11(suppl 6): S1.

Rahman, M., K.C. Poudel, J. Yasuoka, K. Otsuka, K. Yoshikawa and M. Jimba. 2012. "Maternal Exposure to Intimate Partner Violence and The Risk of Undernutrition among Children Younger than 5 Years in Bangladesh." *American Journal of Public Health* 102(7): 1336-1345.

Rahnama, P., A. Hidarnia, F.A. Shokravi, A. Kazemnejad, D. Oakley and A. Montazeri. 2010. "Why Iranian married women use withdrawal instead of oral contraceptives? A qualitative study from Iran." *BMC Public Health* 10: 289.

Renju, J., M. Makokha, C. Kato, L. Medard, B. Andrew, P. Remes, J. Changalucha and A. Obasi. 2010. "Partnering to proceed: scaling up adolescent sexual reproductive health programmes in Tanzania. Operational research into the factors that influenced local government uptake and implementation." *Health Res Policy Syst* 8: 12.

Ribeiro, E.R., A.M. Guimaraes, H. Bettiol, D.D. Lima, M.L. Almeida, L. de Souza, A.A. Silva and R.Q. Gurgel. 2009. "Risk factors for inadequate prenatal care use in the metropolitan area of Aracaju, Northeast Brazil." *BMC Pregnancy Childbirth* 9: 31.

Rottach, E. 2013. *Approach for Promoting and Measuring Gender Equality in the Scale-Up of Family Planning and Maternal, Neonatal, and Child Health Programs.* Washington DC: Futures Group, Health Policy Project.

Rottach, E., K. Hardee, R. Jolivet and R. Kiesel. 2012. *Integrating Gender into the Scale-Up of Family Planning and Maternal, Neonatal, and Child Health Programs.* Washington DC: Futures Group, Health Policy Project.

Rottach, E., S. Schuler and K. Hardee. 2009. *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence.* Washington DC: Population Reference Bureau (PRB).

Sgaier, S.K., A. Ramakrishnan, N. Dhingra, A. Wadhwani, A. Alexander, S. Bennett, A. Bhalla, S. Kumta, M. Jayaram, P. Gupta, P.K. Piot, S.M. Bertozzi and J. Anthony. 2013. "How the Avahan HIV prevention program transitioned from the Gates Foundation to the government of India." *Health Aff (Millwood)* 32(7): 1265-1273.

Shroff, M.R., P.L. Griffiths, C. Suchindran, B. Nagalla, S. Vazir and M.E. Bentley. 2011. "Does Maternal Autonomy Influence Feeding Practices and Infant Growth in Rural India?" *Social Science and Medicine* 73(3): 447-455.

Silverman, J.G., M.R. Decker, D.M. Cheng, K. Wirth, N. Saggurti, H.L. McCauley, K.L. Falb, B. Donta and A. Raj. 2011. "Gender-based disparities in infant and child mortality based on maternal exposure to spousal violence: the heavy burden borne by Indian girls." *Arch Pediatr Adolesc Med* 165(1): 22-27.

Silverman, J.G., M.R. Decker, N. Saggurti, D. Balaiah and A. Raj. 2008. "Intimate partner violence and HIV infection among married Indian women." *JAMA* 300(6): 703-710.

Simmons, R., P. Fajans and L. Ghiron. 2007. *Scaling up health service delivery: from pilot innovations to policies and programmes.* Geneva: World Health Organization.

Simmons, R. and J. Shiffman. 2007. *Scaling Up Reproductive Health Service Innovations: A Framework for Action.* P. F. Ruth Simmons, and Laura Ghiron (eds). Geneva: WHO.

Skovdal, M., C. Campbell, C. Madanhire, Z. Mupambireyi, C. Nyamukapa and S. Gregson. 2011. "Masculinity as a barrier to men's use of HIV services in Zimbabwe." *Global Health* 7: 13.

Subramanian, S., J. Naimoli, T. Matsubayashi and D.H. Peters. 2011. "Do we have the right models for scaling up health services to achieve the Millennium Development Goals?" *BMC Health Serv Res* 11: 336.

Tran, N.T., S.C. Bennett, R. Bishnu and S. Singh. 2013. "Analyzing the sources and nature of influence: how the Avahan program used evidence to influence HIV/AIDS prevention policy in India." *Implement Sci* 8: 44.

UNAIDS. 2004. *Report on the global AIDS epidemic, 4th global report*. Geneva, Switzerland: UNAIDS.

United Nations Children's Fund. 2014. *Ending Child Marriage: Progress and prospects*. New York: UNICEF.

Uvin, P., P.S. Jain and L.D. Brown. 2000. "Think Large and Act Small: Toward a New Paradigm for NGO Scaling Up." *World Development* 28(8): 1409-1419.

Wheeler, T., U. Kiran, G. Dallabetta, M. Jayaram, P. Chandrasekaran, A. Tangri, H. Menon, S. Kumta, S. Sgaier, A. Ramakrishnan, J. Moore, A. Wadhwani and A. Alexander. 2012. "Learning about scale, measurement and community mobilisation: reflections on the implementation of the Avahan HIV/AIDS initiative in India." *J Epidemiol Community Health* 66 Suppl 2: ii16-25.

Wilder, J.M., R.; Daniel, E.E. 2005. *Promoting change in the reproductive behavior of youth. Pathfinder International's PRACHAR Project, Bihar, India.* New Delhi, India: Pathfinder International: 32pp.

Yamey, G. 2012. "What are the barriers to scaling up health interventions in low and middle income countries? A qualitative study of academic leaders in implementation science." *Globalization and Health* 8: 11.

Yesuf, E.A. and R. Calderon-Margalit. 2013. "Disparities in the use of antenatal care service in Ethiopia over a period of fifteen years." *BMC Pregnancy Childbirth* 13(1): 131.

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