Sample Monitoring and Evaluation of Scale-up Strategy for a Gender-Integrated Health Governance Project

Strategy Based on the Implementation and Evaluation of an Intervention to Strengthen Health Facility Operation and Management Committees in Nepal

Gender, **Policy**, and **Measurement Program**
MEASURE Evaluation, Health Policy Project, Suaahara Project

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Cover photograph courtesy of Bindu Gautam.

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ABBREVIATIONS

CEA	community engagement approach
DAG	disadvantaged group
DDC	District Development Committee
DPHO	district public health officer
FGD	focus group discussion
GESI	gender equality and social inclusion
GPM	gender, policy and measurement
HFOMC	Health Facility Operation and Management Committee
IDI	in-depth interview
KII	key informant interviews
M&E	monitoring and evaluation
MNCH	maternal, neonatal, and child health
NHTC	National Health Training Center
PNC	postnatal care
RHTC	Regional Health Training Center
USAID	U.S. Agency for International Development
VDC	village development committee
WHO	World Health Organization

INTRODUCTION

Sample Strategy to Monitor and Evaluate Scale-up: Value and Application

This document sets out the strategy for monitoring and evaluation of scale-up of a gender-integrated health governance project in Nepal. The Gender, Policy, and Measurement (GPM) Program (jointly implemented by the Health Policy Project and MEASURE Evaluation) has partnered with the Suaahara Project, a community-focused program dedicated to improving the health of pregnant and lactating women and children under two years of age. The partnership's aim is to design, implement, and evaluate a scalable capacity strengthening intervention for health facility operation and management committees (HFOMCs) in Nepal, to ensure that issues related to gender and social inclusion (GESI) are addressed as part of the delivery of quality health services. As part of this endeavor, GPM and Suaahara have created a strategy to prospectively monitor and evaluate the scale-up of this intervention.

Despite a growing interest in the monitoring and evaluation (M&E) of scale-up, the complexities associated with scale-up combined with the perceived M&E challenges have contributed to a dearth of resources on this topic. A shortage of appropriate resources may also perpetuate the belief that an M&E approach to scale-up is completely disparate from the M&E of other program indicators. In fact, however, these processes are often complementary and leverage similar study materials. This sample M&E of scale-up strategy was therefore written to provide program implementers, evaluators, and other stakeholders with a real example of a method to prospectively monitor and evaluate progress toward the achievement of scale-up goals. The strategy defines key domains of scale-up and develops methods and tools to monitor and evaluate each domain. As part of this sample strategy, we provide background on the intervention as well as the program implementation and evaluation plans, to give readers the appropriate context for the scale-up approach.

This document does not presume to be a how-to guide for monitoring and evaluating scale up[1]; instead, it is an example of how M&E of scale-up can be approached and applied to current and future global public health programs. These domains, indicators, and benchmarks could reasonably be applied to interventions covering a range of health-related topics.

Understanding Scale-up and the Need for M&E

A comprehensive definition of scale-up has been developed by ExpandNet, a global network of public health professionals that grew out of a World Health Organization (WHO) initiative to strengthen reproductive health programs in developing countries: "deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to

[1] For guidance on how to monitor scale-up, see *Guide for Monitoring Scale-up of Health Practices and Interventions* at: http://www.cpc.unc.edu/measure/prh/resources/guide-for-monitoring-scale-up-of-health-practices-and-interventions.

benefit more people and to foster policy and program development on a lasting basis."[2] This definition refers to two fundamental elements of scale-up:

- Scale-up is a deliberate and guided process; large-scale change in any health system rarely happens spontaneously.
- Interventions must be institutionalized—incorporated in policies and programs—so that they are sustainable and yield desired outcomes "on a lasting basis."

As evident from this definition, scale-up is a multi-faceted process that requires close attention and long-term commitment. A rigorous approach to M&E of scale-up is therefore paramount to achieving success in the expansion and institutionalization of program activities. Monitoring is important in order to identify implementation challenges that may prevent achievement of scale-up goals and to inform course corrections to account for implementation gaps. Evaluation is necessary in order to determine whether scale-up initiatives are having the intended impacts on health outcomes.

STRENGTHENING HFOMCs: PROGRAM AND EVALUATION DESCRIPTION

This section provides important contextual details on the intervention for which the strategy for the M&E of scale-up was created: *Strengthening HFOMCs through a Community Engagement Approach*. Information on program implementation and evaluation will facilitate understanding of the approach to the M&E scale-up approach.

Background

Nepal's rugged geography isolates many communities and can mean lengthy travel to health facilities. Access to high-quality health services is also restricted by such demand-side barriers as inadequate infrastructure, lack of transport, high cost of care, and poorly trained staff.[3,4]

The country's ethnic, religious, and caste diversity also presents significant barriers to delivering equitable and high-quality health services, as does gender inequality. Women and girls suffer low status and discrimination, as well as low educational attainment and household wealth status, which impede their access to information and ability to participate in household decision making, including decisions about their own health and well-being. Excluded groups, including Dalits, disadvantaged

[2] World Health Organization (WHO)/ExpandNet. *Practical Guidance for Scaling Up Health Service Innovations*. Geneva, Switzerland: WHO/ExpandNet; 2009.
[3] Asian Development Bank (ADB); Department for International Development (DFID), United Kingdom; World Bank. *Sectoral Perspectives on Gender and Social Inclusion* [volume II, Sectoral Series: Monograph 4]. Kathmandu, Nepal: ADB, DFID, World Bank; 2011.
[4] Namasivayam A, Osuorah DC, Syed R, and Antai D. "The Role of Gender Inequities in Women's Access to Reproductive Health Care: A Population-level Study of Namibia, Kenya, Nepal, and India." *International Journal of Women's Health.* 2012. 4:351–364.

Janajatis and Madhesis, and Muslims consistently have disproportionally poor health indicators[5] and experience inequality in access to healthcare.

Since 1999, Nepal has moved toward decentralization of its health sector, with the primary objective of involving local communities in planning for provision of high-quality health services. As part of its decentralization strategy, in 2002 Nepal's Ministry of Health and Population initiated a process for handing over management of local health facilities to HFOMCs. The multidisciplinary team that creates each HFOMC should draw its members from female community health volunteers (FCHVs), social workers, teachers, health facility staff, and village development committee officials. HFOMCs are responsible for overall oversight, management, and operations of the health facilities. They manage health facility staff, maintain physical infrastructure of the health facilities, ensure a proper supply of medicine and equipment, mobilize resources, plan and implement health programs, communicate and coordinate with other actors in the health system, and promote good governance. In addition to their operational and management functions, HFOMCs bridge the gap between communities and health providers, ensuring that health providers are responsive to community needs and offering a mechanism for communities to hold health providers accountable.

To strengthen the capacity of HFOMCs to reach marginalized communities and make health services more inclusive, the Suaahara Project—funded by the U.S. Agency for International Development (USAID) and led by Save the Children—and the GPM Program are collaborating to design, implement, and evaluate a scalable intervention to overcome barriers to HFOMC participation for women and disadvantaged groups (DAGs). The intervention, *Strengthening HFOMCs through a Community Engagement Approach* (hereafter *Strengthening HFOMCs*) will also strengthen the capacity of HFOMCs to engage externally with the broader community to improve health services. The project will be implemented through Suaahara in collaboration with the Nepalese government and will be evaluated independently by MEASURE Evaluation.

Goal of Strengthening HFOMCs

The goal of improving HFOMC responsiveness to the needs of women and other marginalized groups is to increase the use of health services by women and disadvantaged groups.

Objectives of Strengthening HFOMCs

By the end of the intervention, we will:

- Make HFOMCs inclusive and ensure that women and representatives of disadvantaged groups are empowered to participate meaningfully in committee meetings and decision-making processes
- Strengthen the capacity of HFOMCs to lead inclusive and collaborative quality improvement processes for community health services and programs

[5] Bennett L, Dahal DR, Govindasamy P. *Caste, Ethnic and Regional Identity in Nepal: Further Analysis of the 2006 Nepal Demographic and Health Survey*. Calverton, MD: Macro International Inc.; 2008.

- Create momentum for women and DAGs in HFOMCs to voice their health concerns and preferences to address local health issues

Intervention Components

The *Strengthening HFOMCs* intervention will consist of a package of strategies to build individual-level knowledge and skills in managing and operating local health facilities; strengthen the organizational-level processes that make committees more responsive to the needs of women and other marginalized groups; and mobilize communities to influence the delivery of health services and programs. The intervention will include capacity self-assessments, trainings, monitoring visits, coaching and accompaniment, and promotional activities. (See Appendix A.)

Gender equality is the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. To promote gender equality, measures must be taken to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field (Interagency Gender Working Group, 2013).

Social inclusion is the removal of institutional barriers and the enhancement of incentives to increase access of diverse individuals and groups to development opportunities (World Bank Sectoral Analysis Sourcebook, 2003).

The intervention will comprise two components. The first component will consist of training and technical support visits for HFOMC members on the foundational basics of managing and operating a health facility, through the lens of promoting GESI. The second component will consist of training, orientation, and accompaniment to reinforce the knowledge, skills, and processes related to community engagement and GESI learned during the HFOMC training. Table 1 provides details on the two components.

Table 1. Strengthening HFOMCs Intervention Components

Component A: GESI HFOMC Training and Technical Support
1. HFOMC reformulation
2. Three-day training for HFOMCs on operating and managing health facilities
3. Two review meetings for HFOMC members conducted six and 11 months after the initial training
4. Technical support visits (bimonthly)
Component B: Community Engagement Approach
1. Three-day training for HFOMCs
a. Subactivity: One day to build community engagement skills of HFOMC members
b. Subactivity: One day of community discussions with disadvantaged groups, analysis of results, and preparation for a participatory planning meeting
c. Subactivity: One-day meeting to develop a work plan that incorporates feedback from community and disadvantaged groups and a strategy for implementation
2. Technical support to implement work plan (bimonthly)
3. One-day orientation for community mobilizers on raising awareness of health services and the roles and responsibilities of HFOMCs, collecting the voices of communities, and representing the community at HFOMC monthly meetings
4. Periodic interaction between community mobilizers and the HFOMC (quarterly)

Key. HFOMC: Health Facility Operation and Management Committee; GESI: gender equality and social inclusion

Scale-up Phase for Strengthening HFOMCs

Following a six-month pilot study, which was conducted from February 2014 to July 2014, the HFOMC intervention was being scaled up and evaluated in two of Suaahara's program districts. The interventions were being rolled out simultaneously in the two districts, beginning in November 2014. The project will cover all village development committees (VDCs) in each district and will be implemented for a period of one-and-a-half years. In Baglung District, Components A and B will be implemented, covering a total of 53 VDCs.[6] In Syangja District, only Component A will be implemented, covering a total of 68 VDCs.

Evaluation for Strengthening HFOMCs

The GPM Program designed an impact evaluation in order to understand the value-added of the intervention components on household- and community-level health outcomes, as well as healthcare use by women and by children under two years old. The evaluation will compare the effectiveness of Component A with the effectiveness of Components A and B. A third arm, in Parbat District, will serve as the control, and there no intervention activities will be implemented. Table 2 shows the study districts and the assigned intervention components. The program conducted baseline data collection in 2014; end line data collection will be conducted in 2016. The results of the evaluation will be available late in 2016 and will inform plans by the Government of Nepal to scale up the local health governance capacity strengthening program.

Table 2. Evaluation Design

District	**Baseline** (July 2014)	**Intervention**	**End line** (2016)
Parbat (Control)	✓	Regular Suaahara activities	✓
Syangja (Component A)	✓	PLUS: HFOMC standard capacity strengthening activities	✓
Baglung (Component A+B)	✓	PLUS: CEA capacity strengthening activities for HFOMC and community mobilizers	✓

Key. HFOMC: Health Facility Operation and Management Committee; CEA: community engagement approach

[6] There are 59 VDCs in Baglung District. Because six VDCs participated in the pilot phase, 53 VDCs remain to participate in the large-scale implementation phase.

STRATEGY FOR MONITORING AND EVALUATING SCALE-UP

This sample M&E of scale-up strategy is based on WHO's ExpandNet[7] framework, as well as on a report by the Institute of Reproductive Health, at Georgetown University, on good practices for scale-up.[8] These sources highlight scale-up as a dynamic, iterative process that should be monitored across several key domains in order to achieve wide-reaching and lasting results. Below, we describe how our strategy will monitor scale-up of the HFOMC across seven key domains.

Domains of Scale-up

Coverage: In this domain, we will seek to measure the extent to which the intervention is being rolled out to new sites. For example, coverage measurement will be concerned with the number of HFOMCs receiving GESI-integrated and community engagement trainings, women and DAG involved in HFOMC meetings, and community members being reached by HFOMC activities.

Sustainability: Nepal's National Health Training Center (NHTC) endorsed the gender-integrated curriculum and incorporated it in existing HFOMC training modules, which will be rolled out to HFOMCs in study districts. Several monitoring tools will help capture acceptance and support of this intervention among HFOMCs and other stakeholders over time. Specifically, sustainability will be measured through the type and intensity of mentoring, training, and supervision of HFOMC members and processes. It will also look at budgets and work plans for HFOMC training by the NHTC and supervision by district public health officers (DPHO) and other mechanisms that will be integrated in norms at the local or national level.

Process: Feedback from government officials and HFOMC members, as well as community members

The HFOMC Domains

Coverage captures the replication and expansion of the intervention, which is often referred to as *horizontal scale-up*.

Sustainability is concerned with the institutionalization or *vertical scale-up* of the intervention. Sustainability also refers to the processes and inputs that ensure the intervention is accepted and implemented long-term by stakeholders at all levels.

While coverage and sustainability monitor what is being achieved as a result of scaling up, **process** is concerned with *how* scale-up is achieved. Process monitors all inputs and procedures that facilitate or act as barriers to horizontal or vertical scale-up.

Related to process is the **quality** of implementation and scale-up. While quality of scale-up could be measured in several ways, this domain is primarily concerned with fidelity to the original design as the intervention is rolled out to new sites.

Health outcomes may be an important domain to monitor, as key health outcomes should continue to improve or at least be maintained as the intervention is taken to scale.

Cost is another important factor that should be considered as the intervention is rolled out. Costs should be managed and supported by local organizations and government agencies in order to ensure that a program is replicable and sustainable.

The ExpandNet framework asserts that interventions taken to scale should emphasize the **values** of human rights, gender equality, and equity.

[7] WHO/ExpandNet. *Practical Guidance for Scaling Up Health Service Innovations*. Geneva, Switzerland: WHO/ExpandNet; 2009.

[8] Institute for Reproductive Health. *Promising Practices for Scale-up: A Prospective Case Study of Standard Days Method Integration*. Washington, DC: Institute for Reproductive Health, Georgetown University; 2013.

and leaders, will provide valuable information as to how *Strengthening HFOMCs* is actually implemented and the factors that contribute or pose barriers to its success.

Quality: By monitoring quality, we will ensure that the intervention is expanded in the same way to new VDCs. Quality monitoring will also provide an opportunity to assess whether or not materials and procedures work just as well at scale as they did during the pilot. If procedures need to be modified, changes will be made so as to ensure that *Strengthening HFOMCs* is effectively taken to scale.

Health outcomes: A key component of *Strengthening HFOMCs* is its impact on health-seeking behavior and health outcomes for women and DAGs. As the intervention is rolled out to new VDCs, more women and DAGs should access services that lead to improved health outcomes. Therefore, health outcomes are included as a domain in this M&E of scale-up framework. Health outcomes will primarily be measured in the household survey, which tracks women's use of antenatal care, postnatal care, and delivery services at health facilities, among other services.

Cost: By systematically collecting data on costs incurred under both program approaches, implementers will have a more realistic strategy for financial management and resource mobilization as the intervention is taken to scale.

GESI Values: Strengthening HFOMCs has a clear focus on GESI values and community engagement**.** Although GESI values are interwoven throughout all other domains, we will also monitor more explicitly that these values are maintained as the intervention is taken to scale.

Tools for Tracking the Domains of Scale-Up

It may be challenging for program managers and implementers to identify the types of tools that would be appropriate for monitoring and evaluating scale-up. This sample strategy shows that M&E of scale-up tools can encompass quantitative and qualitative data; furthermore, a single tool can be leveraged to assess scale-up across multiple domains. As shown in Table 3, we will use a variety of qualitative methods, including focus group discussions and in-depth interviews. Qualitative methods, in particular, are useful in monitoring several domains at once, since they are typically more flexible and allow for in-depth exploration of various topics. We will also collect quantitative data through large-scale household surveys and a variety of monitoring tools. Quantitative methods used here tend to be more targeted, capturing data on key indicators for two or more time points. Descriptions of qualitative and quantitative tools provide deeper insight into how a variety of methods track scale-up across all seven domains.

Qualitative tools: We will develop several qualitative tools to assess scale-up across the seven domains. Focus group discussion guides will be used as monitoring and evaluation tools to track coverage, sustainability, process, quality, and GESI values. Key informant interviews will also be used to evaluate scale-up across those five key domains. In-depth interviews will explore coverage, process, quality, and GESI values. In addition, observations at health facilities and HFOMC meetings will allow us to assess scale-up in a sixth domain, health outcomes, which will also be captured by exit interviews with maternal, neonatal, and child health clients.

Quantitative tools: We will develop large household and community surveys as key evaluation tools. They will provide information on scale-up in the coverage, quality, process, and health outcome domains. The monitoring tools that we will create for this intervention will be largely quantitative. The quarterly monitoring tools will capture information on key indicators in the coverage, sustainability, process, and GESI values domains that allow for performance assessments over time. Pre- and post-tests for various components will track coverage, quality, and GESI values. Capacity self-assessments conducted at trainings will monitor HFOMC progress, by assessing coverage, sustainability, and GESI values. Finally, just two tools will be targeted at one distinct domain. The quality standards monitoring tool will address quality of scale-up over time, while the cost monitoring tool will track the costs associated with the intervention.

Table 3: Tools to Track Scale-up Domains in Nepal

Tools/Approaches	Domains of Scale-up						
	Coverage	*Sustainability*	*Process*	*Quality*	*Health Outcomes*	*Cost*	*GESI Values*
			Monitoring Tools				
Monthly HFOMC monitoring tool	✔	✔	✔	✔			✔
Bimonthly HFOMC monitoring tool	✔	✔	✔	✔			✔
Capacity self-assessments	✔	✔					✔
Pre-/post-test for HFOMC trainings	✔			✔			✔
Quality standards				✔			
Institutionalization monitoring sheet		✔					
Cost monitoring tool						✔	
			Evaluation Tools				
Household survey	✔			✔	✔		
Community survey	✔		✔				
Exit interviews with MNCH clients				✔	✔		✔
Waiting room observations			✔	✔			✔
Observations of HFOMC meetings	✔	✔	✔	✔			✔
IDIs with DAG HFOMC members	✔		✔	✔			✔
KIIs with HF staff	✔	✔	✔	✔			✔
KIIs with district-level stakeholders		✔	✔	✔			✔
FGDs with 1,000 days mothers and fathers	✔						✔
KIIs with community leaders and implementers		✔	✔	✔			✔
FGDs with HFOMC members	✔	✔	✔	✔			✔

Key. HFOMC: Health Facility Operation and Management Committee; MNCH: maternal, newborn, and child health; IDI: in-depth interview; DAG: disadvantaged group; KII: key informant interview; FGD: focus group discussion

Benchmarks

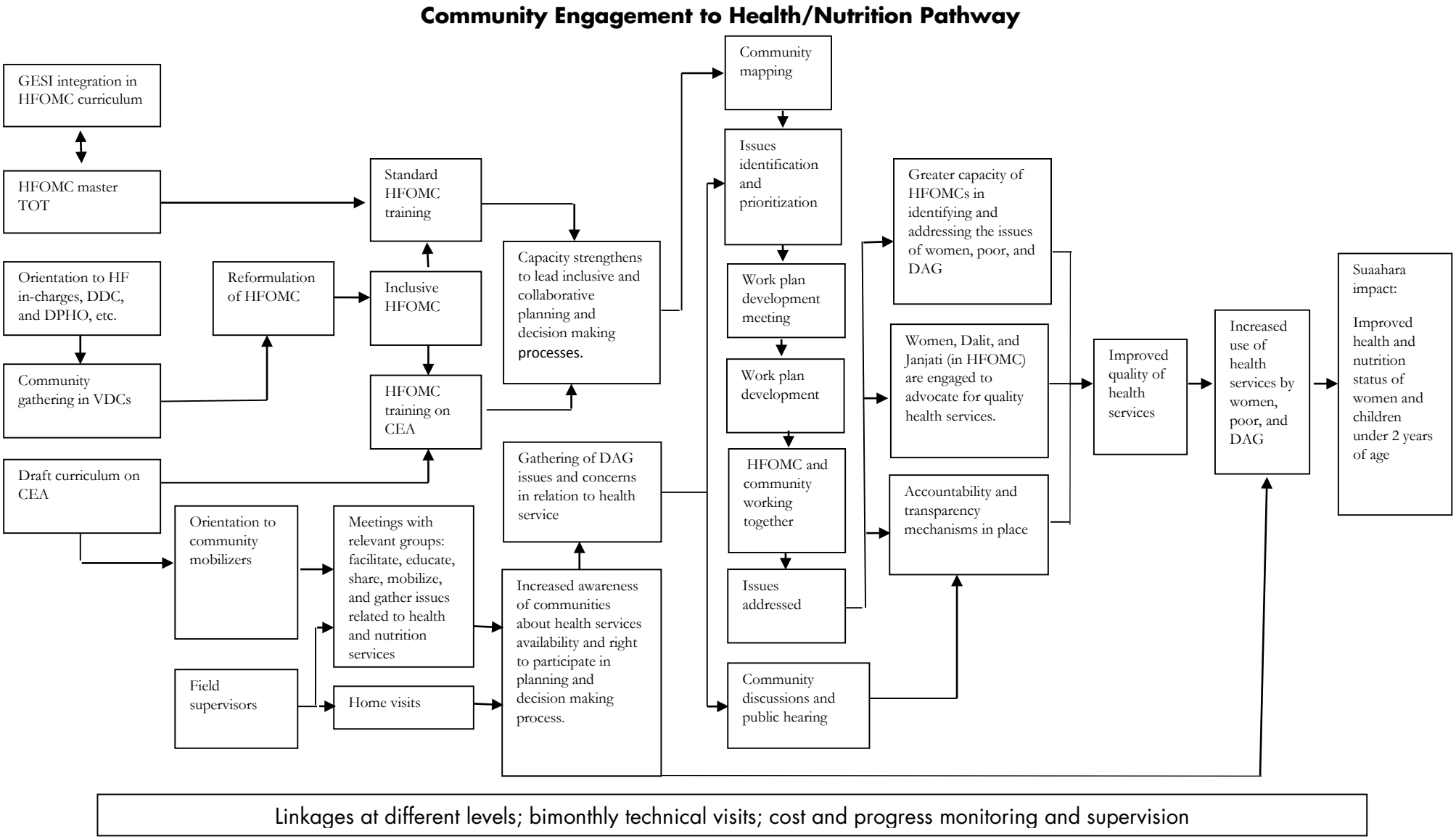
Two fundamental elements of scale-up are expansion and institutionalization. Expansion—or horizontal scale-up—refers to the spread of the intervention to other geographic areas or population groups. Institutionalization—or vertical scale-up—refers to the incorporation of the intervention in health policies or systems. We identified indicators to track progress toward the achievement of key benchmarks in vertical and horizontal scale-up (table 4). We will track these benchmarks in order to help the project team identify implementation gaps and necessary adjustments that will need to be made in order to achieve scale-up goals.

Table 4. Benchmarks by Type of Scale-up

Type of Scale-up	Benchmark
Vertical	• NHTC endorses GESI-integrated HFOMC curricula • NHTC endorses CEA curricula • NHTC or RHTC includes the conduct of HFOMC trainings in its annual work plan • NHTC or RHTC includes the conduct of HFOMC trainings in its annual budget • Supportive supervision visits included in government activity plans (DPHO, DPHO supervisors, or NHTC/RHTC) • Supportive supervision visits included in relevant job descriptions (DPHO, DPHO supervisors, or NHTC/RHTC staff) • Portion of DDC or VDC budget allocated to support HFOMC monthly meetings
Horizontal	Number of: • Master trainers trained • Reformulated HFOMCs • Health facilities receiving HFOMC training • Health facilities receiving CEA training • Bimonthly HFOMC supportive supervision visits • Quarterly HFOMC interactions with community mobilizers

Key. NHTC: National Health Training Center; GESI: gender equality and social inclusion; HFOMC: Health Facility Operation and Management Committee; CEA: community engagement approach; RHTC: Regional Health Training Center; DPHO: district public health officer; DDC: district development committee; VDC: village development committee

APPENDIX A: PROJECT IMPACT PATHWAY



Key. GESI: gender equality and social inclusion; HFOMC: Health Facility Operation and Management Committee; TOT: training of trainers; DAG: disadvantaged groups; HF: health facility; DDC: district development committee; DPHO: district public health officer; VDC: village development committee; CEA: CEA: community engagement approach

Appendix B: DESCRIPTIONS OF MONITORING AND EVALUATION TOOLS

Tool	Description
Monitoring	
Monthly HFOMC monitoring tool	Monitors the processes for conducting the monthly HFOMC meetings
Bimonthly HFOMC monitoring tool	Monitors general functionality of HFOMCs and their responsiveness to community needs
Capacity self-assessments	Assesses capacity of HFOMC's through the first year of the capacity-strengthening program; implemented at initial training and in 2-day and 1-day review sessions
Pre-/post-test for HFOMC trainings	Assesses HFOMC members' knowledge and skills pre- and post-training related to their roles and responsibilities
Quality standards	Observation checklist that monitors basic quality standards of trainers at each CEA training event
Institutionalization monitoring sheet	Captures achievement of key benchmarks for institutionalization (incorporation in annual work plans, budgets, etc.)
Cost monitoring tool	Captures and projects costs from all components of the intervention, including programmatic and government costs
Evaluation	
Household survey	Cross-sectional surveys pre- and post-intervention with women who have children under 2 measuring key outcomes: facility births, ANC, PNC, family planning, child health and feeding practices; also explore exposure to the HFOMC intervention, women's decision making, social inclusion, access to information, economic shocks, and household health expenditures
Community survey	Measures the type and availability of services at public and private health facilities in sampled communities pre- and post-intervention
Exit interviews with MNCH clients	Assess service quality and satisfaction pre- and post-intervention
Waiting room observations	Assess service quality and HFOMC accountability (e.g., through posting of meeting minutes and HFOMC member information in waiting rooms) pre- and post-intervention
Observations of HFOMC meetings	Examine HFOMC functioning, capacity, and GESI integration pre- and post-intervention
IDIs with DAG HFOMC members	Explore individual HFOMC members' experience of the interventions and develop a comprehensive view of the

Tool	Description
	behavior, attitudes, and motivations of female and DAG HFOMC members pre- and post-intervention
KIIs with health facility staff	Examine HFOMC functionality, accountability, and interactions as well as GESI integration in health services from the HF staff's perspective pre- and post-intervention
KIIs with district-level stakeholders	Gauge district-level support for and engagement with HFOMCs pre- and post-intervention
FGDs with 1,000 days mothers and fathers	Explore community knowledge of and attitudes toward HFOMCs as well as exposure to community organizations that seek to improve community participation in health services pre- and post-intervention
KIIs with community leaders and implementers	Assess potential changes outside the program implementation sphere over the intervention period that could influence service delivery provision or demand for and access to services; also, assess community perceptions of HFOMCs and exposure to participatory planning activities pre- and post-intervention
FGDs with HFOMC members using most significant change method	Explore perceived impact (intended and unintended) of intervention and understand how and when changes related to intervention occur

Key. HFOMC: Health Facility Operation and Management Committee; CEA: CEA: community engagement approach; ANC: antenatal care: PNC: postnatal care; MNCH: maternal, newborn, and child health; GESI: gender equality and social inclusion; IDI: in-depth interview; DAG: disadvantaged groups; KII: key informant interview; FGD: focus group discussion