

**Gender Integration Case Study:
A Policy Implementation Analysis of USAID Health Sector Programming**

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ABSTRACT

**MARY MULHERN KINCAID: Gender Integration Case Study:
A Policy Implementation Analysis of USAID Health Sector Programming
(Under the direction of Suzanne Havala-Hobbs)**

U.S. foreign assistance programs in the health sector do not adequately and consistently address gender norms, roles and inequities present in many developing countries, despite the growing body of evidence that suggests doing so makes for better health and development results. Seeking to determine whether current gender-related policy pertaining to U.S. foreign assistance is being implemented effectively in USAID's health sector, and if not, why, the study employed a conceptual framework developed by Sabatier and Mazmanian for top-down policy implementation analysis. The framework identifies six conditions for effective implementation of policy, equally divided between statutory variables (relating to the statute itself, such as language, rationale, and the structure of implementation) and non-statutory variables (leadership commitment, advocates, and vulnerability of the policy to changes in the political, social and economic environment).

Purposeful sampling was used to recruit key informants from among USAID senior staff and program officers within the Bureau for Global Health. Data from the semi-structured interviews were analyzed vis-à-vis the six conditions, to identify strengths and weaknesses associated with three policies.

Results of the analysis suggested that weaknesses in the statutes themselves diminished their impact in spite of high levels of support from senior leadership and active advocacy from gender champions and key sovereigns. The dampening effect is most notable on the Percy Amendment, which was vaguely worded, poorly structured and had minimal exposure in the last 10 years within the Bureau; and the ADS regulations, which, in spite of recent advances in the specificity of the language, lack a sufficiently sound causal theory and any consequences for non-compliance. PEPFAR rated higher than the other two policies on statutory conditions but could be further strengthened by giving more jurisdiction to implementing officials and better structuring the implementation process. Overall, implementation of the policies was vulnerable to changes in the political environment. Improving the statutory framework for gender-related policy will make it more resilient to external influences and ensure more consistent implementation over time. The study ends with a proposal for policy change, based on the research results, public policy theory and the principles of public health leadership.

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LIST OF ACRONYMS

ADS	Automated Directive System
BGH	Bureau for Global Health (of USAID)
CDC	Centers for Disease Control and Prevention
FAA	Foreign Assistance Act of 1961
FACTS	Foreign Assistance Coordination and Tracking System
GAD	Gender and Development
GAO	United States Government Accountability Office
GBA	Gender-Based Analysis
GHI	Global Health Initiative
H.R.	United States House of Representatives
HHS	Department of Health and Human Services
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
IGWG	Interagency Gender Working Group
JICA	Japan International Cooperation Agency
MDG	Millenium Development Goal
OECD DAC	Organisation for Economic Co-operation and Development - Development Assistance Committee
OGAC	Office of the Global AIDS Coordinator
OPRH	Office of Population and Reproductive Health (of USAID)
PAHO	Pan American Health Organization

PEPFAR	President's Emergency Plan For AIDS Relief
POA	Programme of Action
STI	Sexually Transmitted Disease
SWAp	Sector-Wide Approach
UNC	University of North Carolina
UNIFEM	United Nations Development Fund for Women
U.S.	United States
USAID	United States Agency for International Development
USC	United States Code
USG	United States Government
WGGE	Women, Girls and Gender Equity Principle
WHO	World Health Organization
WID	Women in Development

Chapter 1 – Introduction

U.S. foreign assistance programs in the health sector do not adequately and consistently address gender norms, roles and inequities present in many developing countries, despite the growing body of evidence that suggests doing so makes for better health and development results (Rottach, Schuler & Hardee, 2009, Payne, 2009, Sen, Ostlin & George, 2007, Greene & Levack, 2010, Kim, et al., 2007, Jewkes, et al., 2006, WHO, 2007, Temin & Levine, 2009). Years of research, training, technical assistance and advocacy to promote attention to gender issues in the U.S. Agency for International Development (USAID) – the largest agency charged with implementing U.S. Government foreign assistance programs -- have yielded some improvements. Nevertheless, USAID still is far from achieving widespread implementation of gender-equitable health programming, suggesting that a new approach to policy in this area may be in order.

This study proposed to determine whether current gender-related policy pertaining to U.S. foreign assistance is being implemented effectively in USAID's health sector, and if not, what factors are impeding its implementation. The research assessed what works well about current policy, what doesn't work and why, and what changes to current policy would lead to better outcomes.

Gender Equality and Health Outcomes in Developing Countries

Most economic development professionals will agree that women and men in developing countries, in general, do not play on a level field. Women and girls in many developing countries are subject to social norms that limit their ability to attend school, to delay or opt out of marriage and childbearing, and even to decide when to go to the doctor (Lloyd, 2009). Many more women than men are unpaid for their labor in the agricultural or household arena, or underpaid in the informal sector with no legal protections or benefits (Boserup, 1990). Similarly, women are less active than men in governance and politics at all levels of decision making and so less able to influence the allocation of resources and the drafting of laws and policies that affect their health, education and economic opportunities (Longwe, 2000, Inter-Parliamentary Union, 2010, Staudt, 1998, Schuler, 1986). Development interventions, and economic growth itself, often affect traditional gender roles, relations and norms, shifting them in ways that are hard to predict. These changes can worsen women's status relative to men's and require specific efforts to address this imbalance (Boserup, 1990, Benería 2003, Jaquette & Staudt, 2006, Cornwall, Harrison & Whitehead, 2007).

The women in development (WID) movement was born in the early 1970s, on the heels of the western feminist movement, to force donors to explicitly consider how development programs affect women differently than men. It successfully changed international development policies to address a serious problem: "That [development] programs affected women differently than men was not recognized, much less considered. Worse, because development projects were using Northern models, they were perpetuating the unequal gender relationships against which the women's

movement was rebelling” (Tinker, 2004). The new policies put in place, however, were not sufficient: early WID funds went principally to small, women-only pilot projects which further sidelined women from mainstream development (Staudt, 2004). Likewise, efforts to implement attention to women more broadly across all development interventions were stymied by a lack of knowledge among development practitioners about gender roles and norms; discriminatory attitudes among practitioners and country partners; resistance to what was perceived as a “women’s agenda”; and the lack of any enforcement mechanisms in donor policies (Staudt, 2004).

By the mid-1980s, frustrated by the slow pace of progress under the WID paradigm, and looking for a way to better understand how development interventions were affecting and affected by traditional roles and responsibilities of both men and women, many of the large donor agencies adopted the gender and development (GAD) approach. As opposed to one’s sex, which is biologically (or medically) determined, gender refers to the “economic, social, political, and cultural attributes and opportunities associated with being female and male. The social definitions of what it means to be female or male vary among cultures and change over time” (OECD DAC, 1998, Caro, 2009). The GAD approach, then, “offered a new way of tackling women’s subordination by examining socially and historically constructed gender relations between women and men, rather than treating women in isolation from men” (Bannon & Correia, 2006).

As the field evolved, development practitioners and researchers, in the health sector in particular, began a push to “understand the male side of gender and the concept of masculinity . . . particularly in relation to reproductive and sexual health programming and HIV/AIDS. The literature reflects a belated recognition that men are also gendered

beings and have gender identities” (Bannon & Correia, 2006). Researchers in Latin America, for example, have looked at how *machismo* influences men’s risk behaviors by encouraging men to have multiple partners, engage in unprotected sex, and abuse drugs and alcohol (Pantelides & López, 2005, Carillo, Fontdevila, Brown, & Gómez, 2008, Viveros, Rivera, & Rodríguez, 2006). Studies of Mexican men find that those who eschew traditionally proscribed patterns of sexuality, including gays, transgenders and some monogamous heterosexuals, often report feeling isolated or rejected by their peers for not being sufficiently *macho* (Carillo, 2002).

Box 1: Gender-related Definitions and Concepts

Gender Mainstreaming: “The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality” (available at <http://www.ilo.org/public/english/bureau/gender/newsite2002/about/defin.htm>). Mainstreaming involves addressing gender concerns in both organizational processes as well as in policies and programs, or the outputs of organizations (Prügl and Lustgarten, 2006).

Gender Integration: “Strategies applied in program assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities” (IGWG, 2004). Gender integration can be a subset of gender mainstreaming, as it focuses on addressing gender in technical programs and projects, usually without specific attention to the organizational or institutional policies of the implementing organization.

Gender Equity: “Fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but which is considered equivalent in terms of rights, benefits, obligations and opportunities” (ILO, 2000).

Gender Equality: “The concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles and prejudices. Gender equality means that the different behaviour, aspirations and needs of women and men are considered, valued and favoured equally. It does not mean that women and men have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female” (ILO, 2000).

Few development professionals would dispute that women and men, of all sexual identities, should benefit equally from economic development, including experiencing improved health outcomes over the course of their lifetime. To do so, however, requires development institutions (like USAID, World Bank, WHO and European donor agencies), and their country partner institutions, to adopt and implement strategies for gender integration and improving gender equality, as a means to achieve better health outcomes. While awareness of the need to address gender has become widespread in donor agencies, including USAID (Hirschmann, 2006), a gap remains between awareness and action (Molyneux, 2007).

In the health sector, gender roles and norms can mean the difference between life and death: whether a woman is allowed to go to the hospital to deliver or is forced to stay home because “good mothers” deliver their babies at home in the old way; or whether a man feels compelled to have multiple partners and high-risk sex because that is what society says makes him a “man.” A comprehensive review of 200 reproductive health programs in developing countries “suggests that incorporating gender strategies contributes to reducing unintended pregnancy, improving maternal health, reducing HIV/AIDS and other STIs, eliminating harmful practices, and meeting the needs of youth . . .” (Rottach et al., 2009). More broadly, a recent WHO assessment of gender equity and health systems pointed to the “increasing recognition that health policy may exacerbate gender inequalities when it fails to address the needs of either men or women, and that health systems must address gender equity” (Payne, 2009).

Current US Government Policy Environment

Much of the impetus for addressing gender explicitly and holistically in health programs comes from the *Programme of Action (POA)* signed by the U.S. and other countries at the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt. According to the Interagency Gender Working Group (IGWG) Task Force Report (2004),

The POA identifies gender-based inequities as barriers to reproductive health, and gender equality as critical to successful health and development work. It advocates a set of actions for governments and international collaborators to take toward women's social and economic empowerment and men's responsibility in population and reproductive health policies and programs

Building on the vision laid out in Cairo, the Millenium Declaration in 2000 established indicators that explicitly measure the extent to which countries are achieving gender equality and women's empowerment under the Millenium Development Goal (MDG) 3: Promote Gender Equality and Women's Empowerment. The declaration also requires signatory countries to address gender as a cross-cutting issue across the remaining seven MDGs (World Bank, 2003, Caro, 2009).

Current federal legislation, specified in section 113 of the Foreign Assistance Act (FAA) of 1961 and commonly referred to as the Percy Amendment, requires attention to *women in development* in all US Government (USG) foreign assistance programs.

In 1973, the Percy Amendment required that U.S. bilateral assistance be administered to give particular attention to programs, projects and activities that contribute to integrating women into the national economies of developing countries. In 1977, this section was restated to recognize women's role in "overall production, family support and the overall development process" (U.S. Agency for International Development, 1982).

The USAID policy referenced above, the *Policy Paper on Women in Development*, serves as the policy guidance for the Agency to implement the congressional mandate on

women in development, “emphasizing the integration of women into the mainstream of development assistance” (USAID, 1982). Neither the Percy Amendment nor the 1982 USAID Women in Development Policy Paper, however, addressed *gender and development*, which development practitioners now understand to be critical to the social and economic development of countries. In 1996, the USAID Administrator issued a Gender Plan of Action, a two-page statement of the agency’s commitment to improving gender equality through development programs. None of these policy statements, however, included any penalty for failure to comply, such that they in effect became voluntary guidance rather than required policy (Molyneux, 2007).

By 2000, the USAID Office of Women in Development succeeded in getting attention to gender included in the Agency-wide regulations, the Automated Directives System (ADS). The ADS is the operating policy for USAID, and the Agency’s contract officers are supposed to approve or disapprove contracts and related materials based on whether they comply with all of the regulations laid out in the ADS. From 2000 to 2009, the ADS included a requirement that program managers must consider gender in the design, implementation and evaluation of projects. Many project officers, however, were not aware of the gender requirements or disregarded them. Congressional leaders duly noted USAID’s lack of progress and lack of enforcement mechanism for gender integration in various House of Representatives Reports (House of Representatives Report No. 108-010, 2003, House of Representatives Report No. 109-486, 2007).

Box 2: Congressional oversight of Percy Amendment

Congressional committee reports and appropriations bills have from time to time included language related to implementation of the Percy Amendment but focused on the very narrow issue of the USAID Office of Women in Development (WID Office). The WID Office, for its part, historically has been sidelined within USAID with a very small budget, an insufficient number of technical staff, and a mandate that does not explicitly include health.

In 2003, House Report 108-010 stated: “The managers conclude that the office [of Women in Development at USAID] is currently an underutilized resource at the Agency, and are disappointed that USAID over many years has consistently failed to fully comply with Congressional direction to provide the WID office with adequate financial resources and skilled personnel. . . . The managers urge USAID to increase the capacity of the Bureau for Policy and Program Coordination, in collaboration with the WID office to provide agency-wide leadership to integrate concerns of women in development strategies” (House of Representatives Report No. 108-010, 2003).

By 2007, House Report 109-486 addressed the issue by stating: “The Committee continues to believe a Women in Development (WID) Office empowered to monitor, assess, and make recommendations regarding the quality of gender integration at USAID could be of great benefit to the agency.” (House of Representatives Report No. 109-486) They went on to recommend an increase in funding for that office.

In November 2009, USAID approved a revised version of the ADS regulations to strengthen the requirements for gender analysis. The new ADS regulations state that USAID must take gender roles and relationships into account in Assistance Objectives (goals), strategic plans, projects and activities, performance management systems and evaluations, and procurement processes (solicitations) (USAID, 2009). It requires that gender analysis results *be considered* in strategy and project approval documents. As with the previous versions, however, the 2009 ADS does not include an enforcement mechanism, and the language leaves significant room for interpretation as to whether gender analysis results were considered or not.

Also in 2009, the Obama Administration announced the new Global Health Initiative (GHI) as the overarching framework for all health sector foreign assistance

programs, with an explicit focus on improving women's health and quality of life. "The first principle of the Global Health Initiative is that women and girls must be at the center of any global health strategy" (U.S. Department of State, 2009). This women- and girl-centered approach to health and gender equality promises to increase funding for programs that specifically serve women and girls, such as maternal health and family planning programs, along with "wrap-around programming" that will seek to remove the underlying social, economic, cultural and legal barriers that prevent women and girls from fully accessing health services. The GHI represents a departure from recent policy guidance on gender, as it combines elements of both women in development and gender in development approaches.

For the health sector, an additional piece of legislation applies to US foreign assistance for HIV/AIDS programming only: Public Law 108-25, the 2003 enabling legislation for the President's Emergency Plan for AIDS Relief (PEPFAR). This law was surprisingly explicit in specifying attention to several, key gender issues that arise in HIV/AIDS programs funded by the US Government (Box 3), including men's sexuality and roles in the family, women's inheritance rights, and gender-based violence. The legislation applies exclusively to HIV/AIDS programs implemented by CDC, USAID, Department of Defense, Department of Health and Human Services, and any other US government agency. The reauthorization of the PEPFAR legislation in 2008 further strengthened the language on gender to require addressing the underlying gender norms and inequities that fuel the epidemic and intensify its social and economic impact. Implementing programs that respond effectively to the legislation, particularly in light of the multisectoral coordination necessary to work across several technical areas, requires a

challenging combination of high-level leadership, strong technical skills of program officers and implementing partners, and monitoring and enforcement mechanisms.

Box 3: Language on Gender in PEPFAR Legislation

Public Law 108–25
108th Congress

An Act

To provide assistance to foreign countries to combat HIV/AIDS, tuberculosis, and malaria, and for other purposes.

May 27, 2008
[H.R. 1298]

United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003

Sec. 101 Development of a comprehensive, five-year, global strategy, includes the following elements:

(E) “specific strategies developed to meet the unique needs of women, including the empowerment of women in interpersonal situations, young people and children, including those orphaned by HIV/AIDS and those who are victims of the sex trade, rape, sexual abuse, assault, and exploitation.”

(F) “specific strategies developed to encourage men to be responsible in their sexual behavior, child rearing and to respect women including the reduction of sexual violence and coercion.”

(G) “A description of the specific strategies developed to increase women’s access to employment opportunities, income, productive resources, and microfinance programs.”

Sec. 314 Pilot program of assistance for children and families affected by HIV/AIDS, specifies the program should

(4) “Ensure the importance of inheritance rights of women, particularly women in African countries, due to the exponential growth in the number of young widows, orphaned girls, and grandmothers becoming heads of households as a result of HIV/AIDS pandemic.”

The Policy Problem

In USAID’s Bureau for Global Health BGH over at least the last 15 years (1996-2011), individual policy champions and groups like the Interagency Gender Working Group (IGWG) and the PEPFAR Gender Technical Working Group have been diligently attempting to integrate gender into global health programs with the goal of improving gender equality in developing countries. Whether explicit or not in their actions, these champions were helping to implement three pieces of gender-related policy: the Percy Amendment, the ADS regulations and, for HIV programs, the PEPFAR legislation’s

gender language. In spite of their concerted efforts in advocacy, research, training and technical assistance on program design, the results have been mixed. What steps can USAID take to improve the degree to which gender is integrated in its development assistance programming, particularly in the health sector?

Two opportunities have arisen in 2011 with the potential to influence gender integration in the agency. In early 2011, USAID's Administrator appointed a senior gender advisor to the agency with orders to prepare an agency-wide gender policy, which would supersede the 1996 Gender Plan of Action and the 1982 Women in Development Policy. How can this policy be structured and implemented to maximize its chances of having the desired outcome? Are there lessons to be learned from the experience of implementing current gender-related policy in the agency? In September 2011, Congressman Howard Berman introduced a discussion draft of the Global Partnerships Act, proposed to replace the Foreign Assistance Act of 1961. Berman's draft includes strong language committing the US Government to address gender equality and improve the situation of women and girls. New foreign assistance legislation, if passed, or an updated Percy Amendment at a minimum, could force USAID (and other US government agencies now involved in foreign assistance) to develop an implementation plan on gender integration and monitor and enforce it. Each of these two policy initiatives presents a tremendous opportunity for USAID to improve its performance on gender integration. But even a well-written, well-structured and robust policy can be ineffective if its implementation is not well-supported by leadership at all levels. An examination of the factors that have facilitated and impeded implementation of current policy can inform new efforts going forward.

Box 4: Policy-related Definitions

Policy: A broad definition of policy is employed for this research, to encompass laws as well as written organizational policies and regulations. Policy is defined here as: a governing principle that embraces general goals and mandates or constrains actions; a set of organizational rules, including but not limited to laws. (adapted from www.thecommunityguide.org/about/glossary.html and www.webs.uidaho.edu/uipolicy/definitions.htm)

Effective Policy Implementation: A policy is effective if it achieves its legal objectives; that is, if it is being implemented by its intended target audience and with the intended effect. (Mazmanian and Sabatier, 1989)

Research Questions

The objective of this case study was to assess whether current gender-related policy is being implemented effectively in the USAID health sector, and if not, what is impeding its implementation. The three, specific research questions follow below. The questions were framed and examined in the context of policy implementation analysis, discussed further in Chapter 3. Each question is labeled to identify its relationship to the conceptual framework for the analysis: “statutory” (language of the statute/policy itself), “non-statutory” (environmental factors affecting the implementation of the statute) or both.

1. What works well about current gender policy (ADS and PEPFAR) in the health sector? In other words, is it being implemented by its intended target audience and with the intended effect?

- 1.1. Under what programmatic and organizational circumstances are program officers most likely to adhere to the ADS regulations with respect to gender? (E.g., strong leadership, particular content/type of activity, personal experience) Why?

1.2. How do the ADS regulations affect or influence the design and delivery of gender-equitable health programming?

1.3. Under what programmatic and organizational circumstances are program officers most likely to adhere to the PEPFAR legislation with regard to its gender mandate? (E.g., strong leadership, particular content/type of activity, personal experience) Why?

1.4. How does the PEPFAR legislation affect or influence the design and delivery of gender-equitable health programming in the HIV/AIDS sector?

2. What doesn't work about current gender-related policy (ADS and PEPFAR) in the health sector? What barriers are impeding the implementation of current policy?

3. Did changes to the ADS and to PEPFAR legislation introduced over time improve their effectiveness? Did these changes (in 2009 and 2008 respectively) adequately address the factors that impeded the effectiveness of earlier policy?

Chapter 2 - Review of the Literature

A review of peer-reviewed literature examined the current state of knowledge about the way in which gender integration has been implemented by USAID (and other USG agencies, as relevant) in response to the existing legislation, policy statements and regulations on Women in Development and Gender and Development (WID/GAD). In particular, the search focused on gender mainstreaming, the dominant strategy used by large donor agencies, including USAID, adopted at the 1995 Fourth World Conference on Women in Beijing, China. The review sought to uncover what has been published about the effectiveness and challenges of gender integration in USAID and other US foreign assistance programs. The Beijing Platform for Action's push for gender mainstreaming "symbolized a move away from conceptualizing women as a separate target group or 'vulnerable group' to a more far-reaching goal of gender equity" (Theobald, Tolhurst, Elsey & Standing, 2005). Theobald et al. (2005) operationally define gender mainstreaming for the health sector as follows:

Gender mainstreaming in health means that gender should be considered at every stage of health care planning and provision, rather than being considered as an afterthought or in separate "women-centred projects." Interventions need to take into account the degree to which men and women have access to and control of the resources needed to protect their own health and that of family and community members. Preventive and public health interventions must be placed within social and cultural contexts, and recognize and respond to the needs and priorities of women, girls, men and boys. Gender issues need to be factored into institutional change in areas such as human resources policy.

Methodology

This section follows the four basic steps of a narrative review method: article collection, article selection, article abstractions and literature review (Williams & Skinner 2003). For the article collection, I limited the search to the online database PubMed, using the key words “gender mainstreaming + health + developing countries” and extending the search to related articles in an effort to find the most relevant information, based on the following criteria:

Inclusion criteria

- Title or abstract included any of the following terms: lessons learned, health programs, gender policies, gender planning, engendered or engendering, gender analysis, gender equity, gender mainstreaming
- Content related to mainstreaming a gender approach within a large donor agency (US, other developed country, or multilateral institution) or in its programming

Exclusion criteria

- Published before 1995 – the date of the International Conference on Population and Development in Cairo, and the turning point for broad-based advocacy efforts to address gender issues in the health sector
- Focus was too broadly on human rights, only including gender or WID as one of several other themes
- Content was focused on program implementation, not on policies, referring to gender issues in medical care, service delivery or research, for instance.

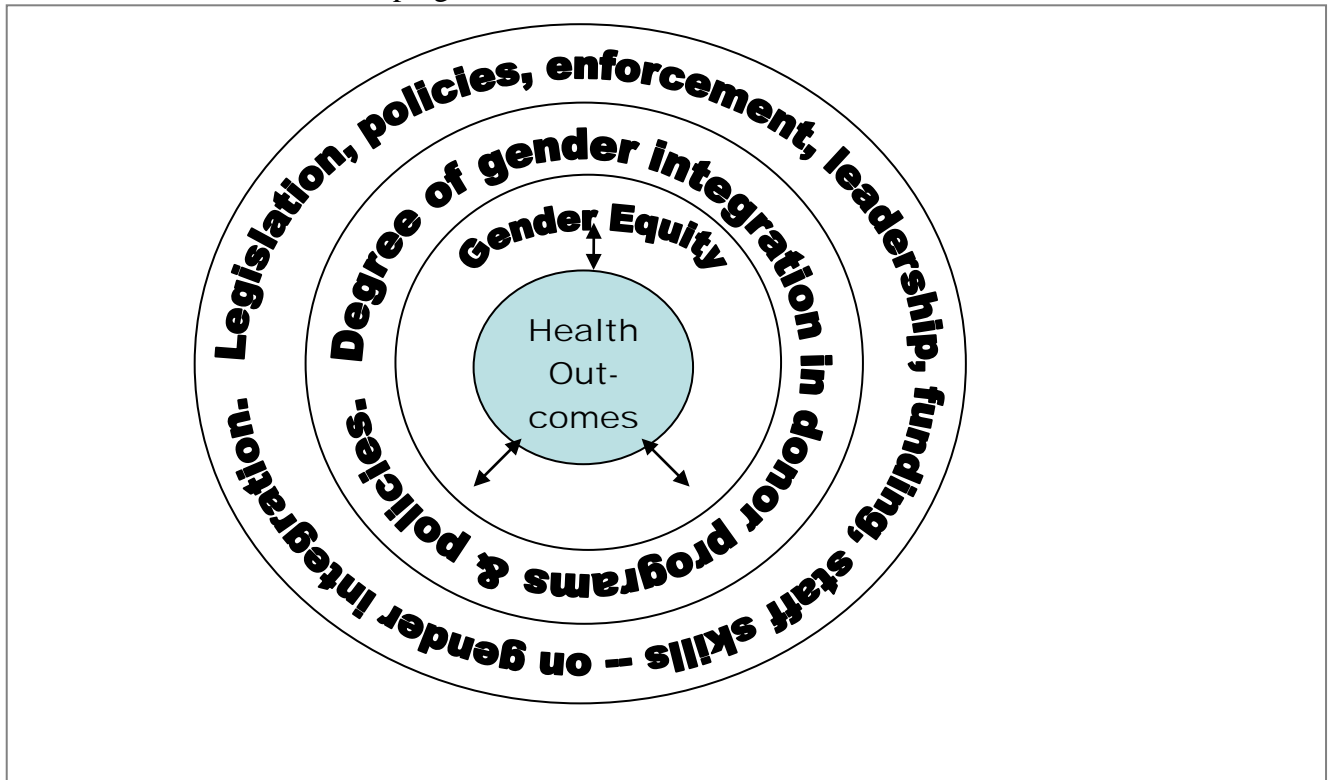
After an expanded search of PubMed to identify articles specific to USAID’s experience with gender mainstreaming (beyond health) yielded little, I turned to Google

for a search of “gender mainstreaming + USAID” and scanned the first 240 results, again using the criteria listed above. The search yielded several additional resources, drawn from both refereed journals and organizational/institutional websites (World Bank, United Nations Development Fund for Women/UNIFEM, Japan International Cooperation Agency/JICA). Newspaper articles, opinion pieces and articles/documents without references were excluded immediately. Material produced by USAID or one of its contractors was excluded, under the assumption of a positive bias in any evaluation or presentation of gender mainstreaming.

Results

The conceptual framework (Figure 1, below) for the review identified the factors considered relevant to the functioning of gender integration in foreign assistance programs in the health sector. In Figure 1, health outcomes are determined in part by gender equity. Gender equity in a given country, in turn, is influenced by, among other variables, the extent of gender integration in donor programs and policies, i.e., the extent to which interventions promote change in gender norms, directly or indirectly. And finally, the degree of gender integration in donor programs and policies is determined by a host of factors that can include legislative context, funding, and political leadership, mechanisms for enforcement of policies, and staff skills and capacity. There is a certain degree of fluidity and cross-influence between the spheres: the degree of integration is influenced by staff skills and vice versa. Articles reviewed were categorized according to which themes and/or relationships in Figure 1 they addressed, recognizing that many authors would touch on more than one sphere of the themes in their discussion. The results of the categorization are presented in Table 1.

Figure 1: Spheres of influence between gender integrated foreign assistance programs and health outcomes in developing countries



Of approximately 20 articles/documents reviewed for this study, only about half included information relevant to gender mainstreaming in development, and even fewer were specific to gender mainstreaming in the health sector. Notably, at least one of the articles included in the literature review results below (Theobald, et al., 2005) identified the lack of published information about gender mainstreaming experiences in the health sector, noting that much of this “exists in the grey literature, particularly consultancy and project reports.” The authors call for increased sharing of experiences and “further practitioner and academic reflection,” and present their findings in part, they note, to respond to the gap in the literature on gender mainstreaming in the health sector (and on sector-wide approaches in particular). The quality of the grey literature, however, varies

tremendously, and while it is referenced in other chapters of this dissertation, grey literature is not included in this formal review of the scholarly literature.

Table 1: Mapping the Literature to Conceptual Framework Categories

Author (year) + Journal	Geographic reference	Conceptual Framework Categories			
		Health outcomes and gender mainstreaming	Gender equity and/or equality and gender mainstreaming	Degree of gender mainstreaming in donor programs and policies	Policies, guidance and resources for gender mainstreaming
Beall (1998) <i>Social Policy & Administration</i>	Colombia, South Africa		X		X
Cornwall et al (2004) <i>IDS Bulletin</i>	Global		X		
El-Bushra (2000) <i>Gender and Development</i>	Global		X		
Elsay et al (2005) <i>AIDS Care</i>	Global	X		X	X
Hankivsky (2006) <i>Intl. Journal of Health Services</i>	Canada	X		X	X
Mansdotter et al (2004) <i>Health Policy</i>	global + Sweden	X	X		
Mukhopadhyay (2004) <i>IDS Bulletin</i>	global + Ethiopia		X		X
Theobald et al (2005) <i>Health Policy & Planning</i>	global + Africa	X	X		X
Vlassoff et al (2002) <i>Social Science & Medicine</i>	Global	X	X		X
Wilkins (2005) <i>Global Media Journal</i>	global + Japan			X	
PAHO (2006)* <i>Pan American Journal of Public Health</i>	Latin America	X			X
UNIFEM- United Nations Development Fund for Women (2006)*	Global			X	X
World Bank (2003)*	Global				X

* Not included in literature review section, as these are organization publications rather than peer-reviewed journal articles

The PubMed search using “Gender mainstreaming + health + developing countries” yielded only 3 articles, but almost 200 articles were listed in a related articles link, providing a broader range of thought on the subject. Using the inclusion/exclusion criteria, a total of 9 articles were identified for review. The articles included literature reviews and case studies, presenting qualitative research or conceptual discussions of gender and development. The questions they collectively respond to --all in the context of international development-- include:

- What do we know about gender mainstreaming in the health sector and impact on health outcomes?
- How have the concepts of gender equality and gender equity been dealt with in gender mainstreaming programs and related literature?
- To what degree has gender been mainstreamed in donor programs and policies? What problems have plagued gender mainstreaming efforts and with what effect?
- What policies, guidance and resources are most commonly associated with gender mainstreaming efforts?

Health Outcomes and Gender Mainstreaming: The studies reviewed unanimously agreed on the importance of addressing gender in programs aimed at improving health outcomes. Five articles discussed gender mainstreaming specifically in the context of health outcomes and/or health sector programs. This conclusion – that mainstreaming gender improved health outcomes -- was upheld across the range of programs studied: HIV/AIDS programming in developing countries (Elsey, Tolhurst & Theobald, 2005); health care policy, programs and services for women and girls in

Canada (Hankivsky, 2006); public health programs for men and women in Sweden (Mansdotter, Lindhom & Ohman., 2004); sector-wide approaches (host-country driven) to improving health in African countries (Theobald, et al., 2005); and health policies and programs globally (Vlassoff & Moreno, 2002).

Gender Equity/Equality and Gender Mainstreaming: The published research identifies ongoing disagreement about the language of and approaches to gender mainstreaming, and whether the end goal is gender equity or gender equality. Mansdotter et al. (2004) argue that the concept of “gender equity in health” is not consistently or clearly defined in public health discourse and is used alternatively to represent at least four different normative theories (welfare economics, health sector extra-welfarism, justice as fairness, and feminist justice). The authors suggest that a genderless society (the ultimate version of gender mainstreaming) would be a “very effective tool if society aims at health improvements.” Booth and Bennett (2002) describe gender mainstreaming as a “fuzzy concept.” While they characterize gender mainstreaming as “a strategy to promote gender equity,” they take issue with how it is variously defined (or not): “Key areas of fuzziness include whether it is a strategy or a set of tools, what its final goals are, how to evaluate it and what constitutes a successful example of gender mainstreaming in action.” (Theobald, et al., 2005).

Vlassoff and Moreno (2002) present a social justice approach to gender mainstreaming: “social justice may require that men and women be treated differently (e.g. in terms of the kinds of services provided for men and women) in order to achieve equality in the opportunity for an outcome such as health.” They argue that gender mainstreaming in health requires both gender equality and equity; that equity (of

opportunity) is not enough. El-Bushra (2000), in her call to “rethink gender and development practice for the 21st century,” criticizes development agencies for taking an overly economics-driven approach to development, which can marginalize efforts to promote gender equality. She states that “many development agencies adopt women’s economic empowerment as their main strategy for achieving gender equity, assuming that it will lead automatically to gender equality.” El-Bushra argues that many other factors affect power in social, political, economic and interpersonal relationships, all of which determine the degree to which gender equality is attainable.

Cornwall, Harrison and Whitehead (2004) take a slightly more controversial stance, discussing how the original feminist agenda to promote gender equality and gender justice was translated into the GAD movement and lost some of its focus and passion in the process of “political engagement.” They review the arguments that the “professionalism of gender and development has . . . become another technical fix with an ever looser link to feminism,” and that gender mainstreaming has “narrowed rather than widened the scope for [social] transformation.” Several other authors refer to the potential pitfalls of applying “technical solutions to political problems” (including Theobald et al. 2005 and Mukhopadhyay 2004), essentially warning that gender equality goals evaporate as technocrats take on the responsibility for gender mainstreaming. Beall, writing several years earlier in 1998, takes a more moderate approach to the debate, based on her case study research in Colombia and South Africa: “advancing gender equality demands striking a balance between the essentially political project of ensuring women’s social and economic participation and political representation, and the

more technical project of institutionalizing or mainstreaming a gender perspective in policy and practice.”

Degree of Gender Mainstreaming: The studies included in this review suggest that gender mainstreaming faces significant barriers to implementation that result in variation in the degree to which the strategy is effective in any given organization. Several articles in the group refer to the degree of gender mainstreaming in donor programs in general or specific organizational experiences. Elsey, Tolhurst and Theobald (2005) review the literature and collect supplemental qualitative data in Uganda to argue that the problems and approaches to mainstreaming HIV/AIDS issues in development programs overseas are quite similar to the experiences of mainstreaming gender in the same context. The authors conclude that in both cases --HIV and gender-- mainstreaming requires organizations to rethink how they do their business. They identify several problems associated with gender mainstreaming: confusion around what it means in practice; a tendency to reduce gender mainstreaming to simply “a gender balance in decision making positions and focusing on sexual, reproductive and maternal and child health”; and the lack of indicators and a solid evidence base.

Wilkins’ (2005) case study of the Japan International Cooperation Agency (JICA – the Japanese government equivalent of USAID) employs a critical realist approach to critique institutional discourse about women and gender within JICA. The assessment reveals that the constructs of women and gender – and the use of gender analyses – vary across regions of the world where JICA implements its programs. Wilkins concludes that although gender mainstreaming in JICA (as in USAID) has made some progress and has the potential to address gender dynamics in a positive way, it will not be sufficient unless

accompanied by organizational change - a “disengagement from the dominant development approaches” based on patriarchal assumptions that “reduce women to narrowly caricatured roles” and doom development strategies to failure.

The third article is a critical examination of the implementation of Canada’s *Women’s Health Strategy*, a gender mainstreaming policy for the health sector, introduced in 1999 as the Canadian government’s response to the Beijing Platform of Action. Hankivsky (2006) finds that the strategy failed by omission: “Specifically, there were no mechanisms for operationalizing gender-based analysis (GBA) within the provinces or territories or for coordinating and evaluating GBA efforts across all levels of government. Consequently ... progress to date is uneven, and in many instances, for most women and girls, health care policy and programs and services, and indeed the circumstances for healthy living, have not improved.”

Policies, Guidance and Resources for Gender Mainstreaming: The literature contained a relatively large amount of information (6 articles) on policies, guidance and/resources involved in gender mainstreaming either in donor agencies or developing country government ministries, from which best practices and shortcomings can be identified and used to inform future efforts. From the literature review and research by Elsey et al. (2005), we can extract the following key inputs for successful gender mainstreaming: focal points (persons) should be supported, funded, and given time and authority to carry out their mandate; training should build staff capacity to “ask the right questions” that get at the gender issues; gender policies and strategies must be informed by a strong evidence base; and stove piped funding streams must be made more flexible.

Theobald et al. (2005) review the experiences of gender mainstreaming in African Ministries of Health using sector-wide approaches (SWAps) to health programming. They conclude that to translate gender policies into action, gender advocates and policymakers must address the need for “a wider human resource structure for gender mainstreaming; capacity building strategies that are grounded in sectoral activities . . . ; disaggregated health information in priority areas . . . ; and sustainable strategies for funding gender mainstreaming activities under SWAps.”

Hankivsky’s 2006 review of the Canadian experience with gender mainstreaming via its *Women’s Health Strategy* found that structural shortcomings in effect neutralized the impact of a visionary strategy to improve women’s and girl’s health in Canada, as discussed above. Hankivsky concludes that to succeed, Canada will need to take several additional steps, including: put in place accountability mechanisms; increase funding for responsible government offices; update and renew the strategy and fully fund its implementation; integrate gender-based analysis into all parts of the strategy and provide funding for the implementation of this tool; and develop “an intersectoral approach that links social, economic and health policies and addresses the determinants of women’s lives in their communities” as a means of identifying and reducing health inequities.

Vlassoff and Moreno’s (2002) discussion of gender mainstreaming in health focuses principally on the fundamental nature of gender analysis in health sector programming and planning. They review the recent research on the benefits of using “gender analysis to improve health planning and programming,” as well as the challenges that continue to face proponents of gender mainstreaming. Among the challenges, they cite the shortage of “concrete examples of how to apply a gender analysis to health

programming and policy making,” gender integration tools specific to health systems, and operations research to validate and assess the impact of these tools. They further argue that strong leadership within organizations and funds are necessary to move gender mainstreaming from “rhetoric to reality.”

Drawing on her case study research in Colombia and South Africa, Beall (1998) concludes that gender mainstreaming efforts in developing countries must be locally driven, and not imposed by donor agendas. “The process of mainstreaming or institutionalizing gender cannot bypass the structures and mechanisms advancing gender equality in government, however weak; the political representatives of women, however inexperienced or fragile; or the organized constituencies and interest groups, which hold them to account.”

Mukhopadhyay (2004), in her evaluation of gender mainstreaming in government ministries in Ethiopia, arrives at the following conclusion: “Gender mainstreaming in the absence of accountability becomes merely a technical exercise without political outcomes.” Instead of the uphill battle implied by gender mainstreaming without accountability, Mukhopadhyay encourages adoption of best practices developed under a project of the Gender Unit of the Royal Tropical Institute in Amsterdam. These best practices are intended to promote “the political project [of pursuing gender equality] while not abandoning the present mode of engagement with development institutions.” The unifying concept is that promoting equality “requires engagement in politics – the messy business of creating voice, articulating demand, carving out rights, insisting on participation and mobilizing women’s constituencies to demand accountability.”

Discussion

The literature identified does not uncover anything specific about the effectiveness and challenges of gender mainstreaming in USAID and other US foreign assistance programs. As expected, that information is by and large confined to the grey literature and has not systematically appeared in peer-reviewed journals. The limited published material this search encountered, however, does address these issues in the context of other donor agencies and country-level government initiatives. It also discusses the conceptual issues around gender mainstreaming in health, the compatibility of gender equity or equality goals with a gender mainstreaming approach and the ongoing debate about whether the GAD and gender mainstreaming approaches “sell out” the *political* cause of feminism/gender equality in the name of *technically* sound development practice. Finally, the literature also presented information about the policies, guidance and resources commonly found in or recommended for successful gender mainstreaming initiatives.

The key findings from this review of the literature are summarized below.

- The evidence base on gender mainstreaming and health outcomes is still relatively limited. We do not have sufficient evidence of the direct effect on health outcomes of using gender-integrated approaches and/or gender analysis to improve programming. While there is widespread acceptance that gender issues help determine health outcomes, there is little consensus on how to most effectively address these issues, and to what extent programming should promote gender equity and/or gender equality goals concurrent with health objectives in USG-supported programming.

- The language of gender still is imprecise, even after twenty-five years of widespread use in the field of development. Consensus on operational definitions of gender mainstreaming, gender equity and gender equality, in particular, appears to be elusive, and definitions vary across the globe. This lack of clear language is an impediment: it is hard to promote a change in behavior in organizations without a well-defined and consistent message.
- Vision without structure and accountability will not yield the desired results. A well-crafted policy and tools on gender mainstreaming will be ineffective in the long run if they are not supported by human and financial resources to implement the policy and a credible monitoring and evaluation system to track both degree of implementation and the impact on program outcomes of addressing gender in this way.
- The target population for gender mainstreaming must “own” the process and the goals: a donor-driven push for gender mainstreaming in developing country programs will not succeed if it doesn’t have the support of the host country; and a donor agency looking to promote gender integration in its own organization likewise will need to take a participatory approach to policy change to make it effective. Rather than divorce the political stakeholders from the technocrats, a successful approach will involve both sides to design development assistance programs that promote the mutual goals of gender equity and gender equality.

The limitations of the review include restricting the search to PubMed and, to a limited extent, Google, and excluding grey literature and non-peer-reviewed materials. Tapping consultant reports and internal evaluations is likely to yield a number of significant documents that address the issue of gender mainstreaming in US government

foreign assistance programs in health (USAID principally, and to a limited extent, CDC and HHS). Nevertheless, by limiting the review to peer-reviewed journals, the studies included here were of a higher quality than what is often encountered in the grey literature and so provided relatively objective material on a subject too often laden with opinions and biases.

The review suggests a major **gap in the literature** related to the conceptual framework presented in Figure 1: there is relatively little published literature that assesses the degree and impact of gender mainstreaming in donor programs and policies. Since many donor agencies in fact have commissioned such assessments, it appears that the results are not being disseminated widely and/or not being submitted to peer-reviewed journals.

Chapter 3 - Research Methods

Summary of Research Question

This study proposed to determine whether current gender-related policy applying to US foreign assistance is being implemented efficiently in the USAID health sector, and if not, what are the key factors impeding its implementation. The research assessed, within the context of policy implementation analysis, what works well about current policy, what doesn't work and why, and what would improve the outcome. While several policy and white papers were released recently arguing for a stronger political commitment and increased funding for women's health (Payne, 2009), gender as a global health priority (Fleishman, 2009, Sen, et al. 2007), and gender within the context of HIV/AIDS (Ashburn, Oomman, Wendt & Rosenzweig 2009), the research described here took an analytical approach to the specific question of whether the current policy is being implemented effectively, using the data collected to inform subsequent policy recommendations.

The research was guided by a set of six conditions for effective policy implementation, asking stakeholders within USAID to assess gender-related policy vis á vis these conditions. The six conditions (Box 3), originally proposed by Mazmanian and Sabatier (1989) and widely tested over the last twenty-five years, are based on a conceptual framework for policy implementation analysis by the same authors.

Box 5: Six Conditions of Effective Implementation

1. Enabling legislation or other legal directive mandates policy objectives which are clear and consistent or at least provides substantive criteria for resolving goal conflicts.
2. Enabling legislation incorporates a sound theory identifying the principal factors and causal linkages affecting policy objectives and gives implementing officials sufficient jurisdiction over target groups and other points of leverage to attain, at least potentially, the desired goals.
3. Enabling legislation structures the implementation process so as to maximize the probability that implementing officials and target groups will perform as desired.
4. The leaders of the implementing agency possess substantial managerial and political skill and are committed to statutory goals.
5. Program is actively supported by organized constituency groups and by a few key legislators (or a chief executive) throughout the implementation process, with the courts being neutral or supportive.
6. Relative priority of statutory objectives is not undermined over time by the emergence of conflicting public policies or by changes in relevant socioeconomic conditions which weaken the statute's causal theory or political support.

From: Mazmanian & Sabatier (1989), pp. 41-2.

Study Design

Because the intent of the research was to understand a particular process within one specific organization, the investigator used the case study strategy, a qualitative research method, to investigate the research question and interpret the data. This strategy recognizes that the research is bounded by time and activity and actors (Creswell, 2003). Specifically, the research employed policy implementation analysis to assess the effectiveness of current gender-related policy applying to USAID's health sector programming. Having reviewed several, alternate methods of implementation analysis from the public policy field (Pressman & Wildavsky, 1984, Elmore, 1983, Spratt, 2009, Sabatier, 2007, Fiorino, 1997), a top-down (as opposed to a bottom-up) approach to implementation analysis was used. Mazmanian and Sabatier (1989) suggest that the top-down approach is the appropriate choice of method when "(1) there is a dominant piece of legislation structuring the situation or in which (2) research funds are very limited, one is primarily interested in mean responses, and the situation is structured at least

moderately well” (p.302). In the present case, the applicable gender-related policy included a short list of administrative regulations applying to all USAID programs (Automated Directives System, or ADS), a law that applies to HIV programs only (P.L. 108-25 –PEPFAR), and the Percy Amendment to the US Foreign Assistance Act (32 USC § 2151K); and the question of interest is what constrains the system (USAID health sector overall) in general, rather than local variations (USAID field missions), in responding to the regulation/law.

The top-down approach involves examining a policy and asking whether its objectives were met over a period of time and why, using four key questions:

1. To what extent were the actions of implementing officials and target groups consistent with (the objectives and procedures outlined in) that policy decision?
2. To what extent were the objectives attained over time, i.e., to what extent were the impacts consistent with the objectives?
3. What were the principal factors affecting policy outputs and impacts, both those relevant to the official policy as well as other politically significant ones?
4. How was the policy reformulated over time on the basis of experience? (Mazmanian & Sabatier, 1989, p.298-9)

The six conditions (Box 5) and the four key questions from the Sabatier/Mazmanian framework informed the interview guide as the basis for discussion with key informants. The design allowed an objective assessment of whether the inconsistent presence of gender-equitable health programming in USAID reflects ineffective policy implementation, and if so, whether it can be attributed to weaknesses in the policy itself (statutory variables), the complexity of the problem (tractability), less tangible, environmental variables like political support (nonstatutory variables), or a combination of several of these. The same data also provided information for

advocating how to move more effectively toward a norm of gender-equitable health programming in USAID.

Bounding the Study

Setting

The research was limited to USAID's Bureau for Global Health, for practical purposes (time and money constraints, plus inside knowledge of the organization) and given that it is the largest U.S. government agency carrying out health sector programming overseas.

Actors

The informants for the study were drawn from USAID senior leadership and program officers in the health sector, as these individuals either make or influence policy related to gender integration or are responsible for implementing it. Only the subset of key informants (approximately 7 of 15) who were knowledgeable about both the ADS and PEPFAR legislation were asked to respond to questions about PEPFAR (in addition to the ADS). Respondents were selected by reviewing the list of program officers and senior leadership in the Bureau for Global Health to identify a subset of gender advocates and non-advocates across the various technical offices (approximately four names per office). Those persons with less than five years of experience at USAID were dropped from the list, in order to obtain informants with a long-term perspective on the implementation of gender-related policy over time. To get a range of opinions from advocates and non-advocates, and cognizant of the need for balanced representation from the offices in the bureau as well as from males/females, foreign service/civil service and leadership/program officers, requests for interviews were sent out in a rolling process,

based on responses: when gender advocates had a higher response rate than non-advocates, for example, additional interview requests were sent to non-advocates on the list, to increase their participation rate. Chapter 4 describes the selection process in more detail and the characteristics of the final set of key informants.

Policies under review

Respondents were asked to comment on the effectiveness, in the context of USAID's health sector programming, of the following policies (1) the ADS as the institutional regulations corresponding to the Percy Amendment, and (2) the PEPFAR legislation as it applies to HIV/AIDS programming. A secondary emphasis was on the effectiveness of the Percy Amendment, to the extent that informants were knowledgeable about that law.

Ethical Considerations

Participants were recruited by email to request the interview and arrange the time, as well as to request that they sign an informed consent form. The research protocol, interview guide (Appendix A) and consent form (Appendix B) were submitted for review by the Public Health-Nursing Institutional Review Board at UNC in November 2010. The research was exempted from further review by the IRB on November 12, 2010. The interviews did not deal with sensitive issues or individual data, and all informants were public officials/civil servants speaking in their official capacity. All informants signed a consent form and faxed it to the primary investigator. Several respondents declined to be tape recorded; in those cases, the interviewer took comprehensive field notes to document the responses and transcribed them immediately

upon finishing the interview so to maximize recall of the material. The confidentiality of interview data was maintained by assigning a number to each interviewee and using this number only to identify the interview tape and subsequent Atlas.ti entries. The key (list of numbers/names) was stored in a locked filing cabinet in the investigator's office during the study, and destroyed after the analysis was completed. The interviews were recorded, transcribed and kept in electronic Word files on a memory stick, which has been stored in a locked filing cabinet in the office of the primary investigator.

Data Collection

A total of fifteen interviews averaging 25 minutes and ranging from 15-45 minutes were conducted between December 2010 and March 2011. All interviews were conducted in English. The interviews were conducted by telephone; used a standard interview protocol; were tape recorded (unless otherwise requested) and transcribed to avoid unintentional errors or omissions in note-taking during the interviews; and used the "six conditions" to stay carefully on track during the interviews and to guide the analysis.

Data Analysis Procedures

The interviews were transcribed by a third party and uploaded to Atlas.ti, a qualitative data analysis software program. Following the norm for qualitative data analysis (Creswell, 2003), the data was reviewed and classified to sort it according to relevance to the various research questions and subquestions. Using Atlas.ti, key response phrases in the transcriptions were identified, categorized and tabulated. The text excerpts for each condition were assigned ratings (low/medium/high) based on their content; respondents were not asked explicitly to rate the six conditions. Data labels

were drawn from Mazmanian and Sabatier's (1989, p. 22) conceptual framework: statutory variables (e.g., clear objectives, adequate causal theory, decision rules, financial resources), non-statutory variables (e.g., socioeconomic or sociocultural conditions, attitudes and resources of constituent groups, leadership commitment and skill), and tractability of the problem (e.g., technical difficulties or complexity, variation in target group behavior, extent of behavioral change required).

Study Limitations

The research was limited by the small number of interviews (15) and its reliance on respondents based in the Washington office of USAID at the time of the interview (14 of 15). With more resources to expand the number of interviews, the research could have reached a wider variety of USAID health officers and leadership. Similarly, additional resources would have allowed for a review of the USAID FACTS database to review USAID annual country reports on what missions have done to promote gender equity and to address gender-based violence within the health sector, what the trends in programming are and any gaps in either reporting or programming.

Other methodological limitations include the possibility of participant-observer bias, given the researcher's role as a contractor for USAID implementing global health policy projects. This bias included the potential for influencing respondents during the interviews to reinforce preconceived expectations; the use of the interview guide helped to minimize but not eliminate that risk. A further limitation arises from selection bias: it is impossible to know from the data collected whether respondents were more or less supportive of gender policies than those people who did not respond to the request for interviews or who declined to participate. No attempt was made to determine reasons for

non-response, which could include overseas travel, already-overloaded work schedule, reassignment to another bureau within or external to the agency, email transmission errors, or lack of interest in the subject.

Chapter 4 – Policy Implementation Analysis

In USAID's Bureau for Global Health over at least the last 15 years (1996-2011), individual policy champions and groups like the Interagency Gender Working Group (IGWG) and the PEPFAR Gender Technical Working Group have been diligently attempting to integrate gender into global health programs with the goal of improving gender equality in developing countries. Whether explicit or not in their actions, these champions were helping to implement three pieces of gender-related policy: the Percy Amendment, the ADS regulations and, for HIV programs, the PEPFAR legislation's gender language. In spite of their concerted efforts in advocacy, research, training and technical assistance on program design, the results were mixed, as key informants reported in this study.

To better understand why their efforts did not result in full implementation of these policies in the USAID Bureau for Global Health, the study employed a conceptual framework developed and tested extensively by two public policy experts, Paul Sabatier and Daniel Mazmanian. The framework identifies six conditions for effective implementation of policy, equally divided between statutory variables (relating to the statute itself, such as language, rationale, and the structure of implementation) and non-statutory variables (leadership commitment, advocates, and vulnerability of the policy to changes in the political, social and economic environment). The framework was tested in over 20 case studies during a period of ten years to measure the extent to which

conditions were met in various policy settings. Two conditions emerged as more essential than the others, depending on the degree of behavior change the policy was seeking. To effectively implement a policy, the first two conditions – clear, consistent policy objectives and a sound causal theory – need to be met at least moderately well (Mazmanian and Sabatier, 1989). For policies intended to change entrenched behaviors in a group of people against their will, all six conditions need a rating of “moderate” or “high”; however, “fairly low ratings on one or two of the last four conditions may not threaten programs involving less widespread change” (Mazmanian and Sabatier, 1989, p.42). In other words, if a policy is not clearly worded and supported by a logical justification, no amount of advocacy or leadership support will be able to achieve full implementation.

Characteristics of Key Informants

In a series of 15 telephone interviews, key informants (described below) from USAID’s health sector provided their observations and opinions about how three gender-related policies have been implemented in the health sector between the years 2000 and 2010, under what conditions they were most likely to be implemented, what barriers impeded their implementation, and what changes to the policies occurred over time and why. Potential respondents were identified using maximum variation sampling to obtain a cross-section of BGH personnel representing gender advocates and non-advocates (those viewed by their peers either as neutral or negative toward gender integration efforts). Of a total of 31 people contacted by email for an interview, 15 accepted the invitation (48%), of which ten were female and five were male. The response rate was

higher among advocates than non-advocates: 10 of 10 advocates who were contacted agreed to be interviewed, compared to 5 of the 21 non-advocates contacted (Table 2).

Table 2: Distribution of Respondents by Sex and Gender Advocate Status

	Gender Advocate	Non-Advocate	Total
Female	7	3	10
Male	3	2	5
Total	10	5	15

The key informants were drawn from the technical offices within the Bureau for Global Health as well as health officers within the Regional Bureaus. The sample included five Foreign Service officers (33%) and ten civil servants/personal service contractors (66%); all but one of the respondents was stationed in the Washington headquarters at the time of the interview. For comparison purposes, during 2007 in the Washington headquarters, 20% of employees were Foreign Service, 62% civil service and 18% other. USAID’s global workforce of 7500 persons in 2009 was comprised of 15% civil service personnel based in the US, 20% Foreign Service officers serving overseas and in the US, 57% Foreign Service nationals/foreign direct hires based overseas and 8% personal service contractors based in the US (GAO 2010).

As shown in Table 3 below, respondents were equally divided among senior staff members and senior technical advisors/program officers with an average tenure of 15 years at USAID; two-thirds had worked for 10 or more years at USAID. The study intentionally oversampled senior level leadership and technical staff, who generally have long tenure, in order to capture information on changes over time in the implementation

of gender policy. In this respect, the sample is not unrepresentative of the underlying population: the USAID workforce has a heavy proportion of seasoned professionals, with an estimated one of every three civil service and Foreign Service officers eligible for retirement (USAID 2008).

Table 3: Key Characteristics of Respondents

Average Tenure at USAID	15 years
Member of Senior Staff	8 of 15 respondents
Senior Technical Advisor/Program Officer	7 of 15 respondents
Foreign Service Officer	5 of 15 respondents

The sample also disproportionately represented gender advocates (10 of 15 respondents) compared with a “typical” office or field Mission. In the Bureau for Global Health in Washington, a typical technical office of eight to ten persons might include one to two people recognized by their peers as gender advocates, while a typical Mission’s health office, with five to six people, for example, might include one gender advocate or none at all.

Respondents were asked several questions to categorize their familiarity with gender policy and their involvement in its implementation. All respondents had heard of the ADS regulations and the PEPFAR legislation gender language (100% on both). Only half (7 of 15), however, had heard of the Percy Amendment, with no correlation between extent of involvement with gender integration and knowledge of the amendment that underlies all of USAID’s work in this area. Of those who had heard of the Percy Amendment, two were extensively involved with gender, three were involved to some degree and two reported being only minimally involved. Table 4 below shows the

distribution by sex of self-reported extent of involvement with gender integration.

Approximately one-fourth of respondents reported “extensive” involvement with gender integration; one-half reported “some” involvement and one-fourth reported “minimal” involvement. There was no differential pattern in the distribution of responses between male and female respondents.

Table 4: Distribution of Respondents by Sex & Extent of Involvement with Gender Integration

	Extensively Involved	Some Involvement	Minimal Involvement	Total
Female	3	5	2	10
Male	1	3	1	5
Total	4	8	3	15

The qualitative data collected during the interviews were analyzed using Atlas.ti analytic software. Codes representing the six conditions of the Sabatier/Mazmanian framework and related subtopics were assigned to text excerpts. The coded data were sorted and assigned a rating (low/medium/high), based on content analysis, for each of the six conditions vis á vis the three policies under consideration. The summary response for each condition and each policy is shown in Table 5 below; the number and distribution of responses is noted in each box in order to show the degree of consensus (or lack thereof) among respondents.

Table 5: Summary of Respondent Ratings on Extent to Which Conditions for Effective Implementation Were Met

<u>Condition</u>	<u>Assessment</u> Percy Amendment	<u>Assessment</u> ADS Regulations	<u>Assessment</u> PEPFAR Legislation
1. Regulation/legislation has clear & consistent policy objectives	-- (0 responses)	Low/Moderate (2 low, 1 low/moderate, 1 moderate)	Moderate (1 low/moderate, 3 moderate)
2. Regulation/legislation has sound causal theory & gives implementing officials sufficient jurisdiction to attain policy objectives	Low (4 low)	Low (5 low, 1 low/moderate)	Low/Moderate (2 low, 3 moderate)
3. Regulation/legislation structures implementation to maximize compliance from implementing agents	Low (1 low)	Low (8 low, 1 moderate)	Low/Moderate (2 low, 2 moderate)
4. Top implementing officials are strongly committed to attaining objectives and have skills necessary to ensure it happens	-- (0 responses)	Moderate/High (2 low/moderate, 5 moderate, 6 high)	Moderate/High (2 moderate, 2 high)
5. Program is actively supported by organized constituency groups and few key sovereigns throughout the implementation process	Low (1 low)	Moderate/High (3 moderate, 1 moderate/high, 7 high)	Moderate/High (1 moderate, 2 high)
6. Changing socioeconomic or sociocultural conditions do not weaken the causal theory or political support for attaining the stated objectives	-- (0 responses)	Low (6 low)	Low (1 low)

Summary of Results

When the interview data are arrayed across the six conditions for effective implementation, they highlight both strengths and weaknesses and suggest some clear action steps for improving gender policy implementation. Respondents identified two non-statutory variables, leadership commitment and support of constituency groups during implementation, as the strongest variables, even while recognizing the effect over time of changes in the political environment. Comments related to the nature of the policies themselves (the statutory variables) suggested these conditions were met to a lesser extent, with low to moderate ratings. The findings indicate that the policy framework for gender integration at USAID is weak overall (ADS and Percy), but slightly stronger for HIV programming (PEPFAR).

Respondents most often referred to the ADS regulations in their comments, with about half commenting on both ADS and PEPFAR. Given that only seven of fifteen respondents had heard of the Percy Amendment, and of those, only one reported knowing the content of the policy in detail, it follows that only a few people included the Percy Amendment in their remarks. Therefore, the discussion below focuses heavily on the ADS and PEPFAR.

Results: Statutory Variables

In the Sabatier/Mazmanian framework, the first three conditions are called statutory variables, as they refer to the statute (or policy) itself – how it is worded, the logic supporting it, and the way it structures implementation – rather than the environment in which it is implemented. Box 6 describes the statutory variables and their importance to policy implementation. Two of these statutory variables (or

conditions) are considered essential: to be successful, a policy needs at least “moderate” rankings on (1) clear and consistent policy objectives and (2) sound causal theory with sufficient jurisdiction for implementing officials. Relatively low ratings on the other variables can be tolerated if these first two conditions are met reasonably well.

(Mazmanian & Sabatier, 1989) Results from the interviews are presented below for each variable, with illustrative quotes from respondents shown in the figures. Findings suggest that the ADS and Percy Amendment rate “low” or “low/moderate” on the statutory variables, while PEPFAR is slightly stronger, rating “moderate” or “low/moderate.”

Box 6: Importance of the Statutory Variables to Implementation

1. Incorporating **clear and consistent objectives in the policy** improves implementation (the target audience knows exactly what is expected of them), evaluation (evaluators know what to measure), and advocacy (advocates can refer to the policy language with no ambiguity hampering their efforts).
2. **Understanding the causal pathways** between the government intervention and the policy objectives, and ensuring that implementing officials have jurisdiction over enough of those linkages to affect them, is essential for success. To change behaviors or outcomes, program officials must know the factors affecting the objectives and how they interact and be able to influence them through interventions.
3. **Structuring the implementation process** well-- by assigning responsibility for the policy to an organization/agency that is sympathetic to the issues, providing sufficient funds, minimizing the number of veto points (opportunities to impede implementation), and including sanctions and inducements to change behavior -- increases the probability that the target audience will do what the policy intends them to do.

Condition 1- Regulation/legislation has clear and consistent policy objectives.

Comments from respondents suggested a rating of “low/moderate” for ADS and “moderate” for PEPFAR on Condition 1 (Figure 2). Several respondents observed that program/technical officers are not clear on what they are required to do to comply with the ADS or PEPFAR. Some noted that PEPFAR is more specific than the ADS and attributed the heightened degree of attention to gender in HIV programs (compared to other health areas) to the relative strength of the legislative language. There were no comments related to the Percy Amendment for this variable, reflecting the very low levels of awareness and dissemination of that policy.

Figure 2: Illustrative Quotes on Extent to Which Condition 1 Was Met

Condition	ADS Regulations	PEPFAR Legislation
<p>1. Regulation/legislation has clear & consistent policy objectives</p>	<p>Rating: Low/Moderate</p> <p><u>Low</u> – “They don’t really understand what is expected out of the ADS or PEPFAR. They don’t really understand what is being asked of them [T]he greater implication of what gender programming would mean – they’re not clear on that.”</p> <p><u>Low</u> – “It’s not always so explicit and clear what it is they need to do and to what extent they need to integrate gender.”</p> <p><u>Low/Moderate</u> – “There are several places [in the 2009 ADS] where there is an attempt to articulate what it should mean to interpret these two basic questions [for gender analysis]. But they don’t seem all that different to me, they ask basically the same thing.”</p> <p><u>Moderate</u> – “It is not so much that the policies themselves are lacking or poorly written, but that we haven’t had any way to measure whether we are implementing them.”</p>	<p>Rating: Moderate</p> <p><u>Moderate</u> – “under PEPFAR, there has been a level of specificity, both in terms of requirements and measurement and in terms of funding ... that has allowed for much more implementation”</p> <p><u>Low/Moderate</u> – “some of the gender strategies in the PEPFAR policy seem to be making more progress because they are more programmable, more actionable. ... It’s an ongoing challenge, it’s a little uneven.”</p> <p><u>Moderate</u> – “Under PEPFAR, there’s a strong focus on making sure we promote gender equity and look at the implications of how HIV impacts women and men differently. ... It’s certainly required in writing, but I’m not sure the follow-through is there.”</p>

Condition 2- Regulation/legislation has sound causal theory and gives implementing officials sufficient jurisdiction to attain policy objectives. Across the policies, respondents pointed out problems related to weaknesses in the underlying causal theories and/or lack of jurisdiction to fully implement the policies (Figure 3). The comments suggested a rating of “low” for the ADS and Percy, while comments about PEPFAR were mixed, resulting in a rating of “low/moderate.” The sum of the comments indicated that the causal pathways between the actions specified by the policy and the desired outcome are not well defined or well thought out: for example, in Percy, how “giving particular attention to projects that integrate women” will lead to improved women’s status, or in the ADS, how “conducting a gender analysis during program design” will result in increased gender equality. Particularly for the ADS and Percy, the linkages -- or pathways -- needed to move the policy into practice are insufficiently specified. The mandatory reporting requirement for PEPFAR, however, was identified as important by several respondents. They noted that it helps to raise awareness of the policy and closes the loop by requiring program officers to report back annually on how their programs are addressing gender during project implementation and not just during program design.

Figure 3: Illustrative Quotes on Extent to Which Condition 2 Was Met

Condition	Percy Amendment	ADS Regulations	PEPFAR Legislation
<p>2. Regulation/ legislation has sound causal theory and gives implementing officials sufficient jurisdiction to attain policy objectives</p>	<p>Rating: Low</p> <p><u>Low</u> – “So the Percy Amendment, in terms of achieving greater attention to integrating women into national economies – while the attention may be there, the effect of it is still far below what I would expect it to be after all these years. Which goes back to ...the operationalization or application [of the policy]?”</p> <p><u>Low</u> – “people don’t explicitly mention the Percy Amendment. I think [it] becomes relevant through the ADS, for example. You know, [Percy is] a very high level kind of policy and people look much more closely at, either an Agency policy or ...a more immediately tangible policy.”</p>	<p>Rating: Low</p> <p><u>Low</u> – “The ADS is not something that you program against, I think. It’s something that you respond to and include in an RFA and a performance plan. What’s going to make you really get out there is a program, is the legislation [i.e., PEPFAR].”</p> <p><u>Low</u> – “The ADS ...has affected the operational behavior of agency staff ... but actually using the results of the analyses or interpreting the policy in practice that would have actual results is the weak link.”</p> <p><u>Low</u> – “We’ve made a lot of progress over the last 10 years, but it is not directly traceable to the ADS regulations themselves.”</p> <p><u>Low/Moderate</u> -- “Without help to understand how to make it real and doable, many people view it as a box to check off when you’re doing your design, along with the economic analysis and the social analysis. You do it and you set it aside.”</p>	<p>Rating: Low/Moderate</p> <p><u>Moderate</u> – “A mandatory reporting requirement, I think, was important. That made people have to think about it, regardless of what program you’re working on, regardless of how relevant it is. Maybe having this legislation ...gives us additional focus on gender issues, but the programs I’ve worked on haven’t done it specifically because the legislation has been in place, but just because it’s good programming and it makes sense.”</p> <p><u>Moderate</u> -- “I think those who need to know it [in OHA] pay attention to what PEPFAR guidance says. ... They’re mandated to do that.”</p> <p><u>Low</u> – “[Without leadership support] the PEPFAR strategy or legislation wouldn’t have gone beyond our Front Office.”</p>

Condition 3- Regulation/legislation structures implementation to maximize compliance from implementing agents. The three policies are rated as “low” (ADS and Percy) and “low/moderate” (PEPFAR) for the ways in which their implementation is structured (Figure 4). Respondents identified the lack of enforcement and lack of sanctions for non-compliance as a barrier to achieving the policies’ objectives, especially commenting on the ADS in this respect. As one respondent pointed out, while laws like the TIARHT Amendment have specific compliance requirements, the ADS has no specific targets or even required indicators. The degree to which all three policies are implemented depends, therefore, to a great extent on individual interest. In spite of the increased attention being paid to the ADS by the Office of Acquisitions (OAA), once the “gender box” is checked off during project design, it is up to the program officers implementing the project to follow through and ensure gender is integrated throughout the cycle; there is no formal system in place to monitor it.

In line with the Sabatier/Mazmanian framework, respondents also identified funding levels as important with respect to the implementation of the policies. They pointed out that the increased funds for HIV under PEPFAR facilitated achievement of its gender objectives, while the scarcity of funds for family planning and reproductive health programs meant that, in spite of the ADS, gender often gets “shoved to the side” as priority is given to basic FP/RH services first.

Figure 4: Illustrative Quotes on Extent to Which Condition 3 Was Met

Condition	Percy Amendment	ADS Regulations	PEPFAR Legislation
<p>3. Regulation/legislation structures implementation to maximize compliance from implementing agents</p>	<p>Rating: Low</p> <p><u>Low</u> – “enforcement has always been an issue. Even after the act or policy has been made very explicit, you need to have people who can make sure it is being enforced and you need consequences for when it is not. I don’t know that that’s always been explicit in any of these acts.”</p>	<p>Rating: Low</p> <p><u>Low</u> – “[One] challenge limiting the impact of the policy ... is the lack of enforcement. So, it’s there, it’s stipulated, it’s required ... and there’s no clear determination of what happens if that’s not met. Is it really something where a project would be potentially pulled back if gender isn’t adequately addressed? No, I don’t think that’s ever happened. And I’m not sure what the consequences are and I think that hinders it, because there isn’t really a way of monitoring in a systematic way ...”</p> <p><u>Moderate</u> – “The ADS gender requirements get a lot of traction in the Office of Acquisitions ... I have seen many times where a draft RFA is about to out on the street and OAA says, “what about gender?” and they send it back to the Bureau for additional justifications or attention to gender integration in the document.”</p> <p><u>Low</u> – “In general, a gender analysis is pretty perfunctory in project design/RFP-RFA preparation in both DC and the Missions; it is done at the end, it is fairly superficial and mostly done only so we can check off the box on the checklist.”</p> <p><u>Low</u> – “Gender has been absent in bilateral programs, even to date. ... whether or not any of this gender [policy] is implemented within bilateral programs largely depends on who’s out there in the Missions and what they care about... I’m not aware of any enforcement mechanism at all.”</p> <p><u>Low</u> – “The problem is lack of resources! When it comes to making hard choices in a very, very constrained budget scenario, gender tends to get shoved to the side, because basic bread-and-butter family planning tends to get funded. ... [But] some of us are convinced that gender truly is a gateway factor, that if we change gender norms, we would affect a lot of [other] behaviors.”</p>	<p>Rating: Low/Moderate</p> <p><u>Low</u> – “Lack of follow-up with contractors and enforcement of the policies is the main factor.”</p> <p><u>Low</u> – “It’s not so much, in the case of PEPFAR, required.”</p> <p><u>Moderate</u> – “The unprecedented flow of funds for HIV programs allowed us to do much more on gender than ever before. This was a tremendous factor determining the impact of PEPFAR. ON the barrier side, the lack of funding in other, complementary sectors has hurt – because what progress we made in HIV was not bolstered by advances in other areas, so it was incomplete and unsustainable.”</p>

Results: Non-Statutory Variables

Whereas the statutory variables in the Sabatier/Mazmanian framework refer to the legal structure of a policy, the non-statutory variables refer to the political processes affecting its implementation (Box 7). The interaction of these two sets of variables determines the policy outputs (e.g., application and enforcement of regulations) of an implementing agency. The implementation of a policy with a weak legal structure will be “very dependent upon variations in political support over time and among local settings, whereas a well-drafted statute can provide ... sufficient policy direction and legal resources to withstand short-term changes in public opinion ... and bring about the desired behavior changes in widely different local jurisdictions” (Mazmanian & Sabatier, 1989, p.30).

Box 7: Importance of the Non-Statutory Variables to Implementation

4. **The level of commitment and leadership skills of top implementing officials** are the most important non-statutory determinants of the policy output in an agency. Committed officials with sufficient political and managerial skills can influence target audiences to act in accordance with the policy, work with sovereigns both internal and external to the agency to keep them engaged over time, and institute systems to monitor implementation.
5. **Consistent support from organized constituency groups** - internal or external to the agency – keep pressure on implementing officials over time by evaluating and publishing reports on the agency’s progress, conducting awareness campaigns, and appealing to sovereigns for legislative or financial support. Sovereigns, such as a legislator or other political leader, can influence implementation through the degree of oversight they provide as well as the level of financial resources they make available to the implementing agency.
6. **The resilience of a policy to changes in the external environment** – socioeconomic or sociocultural conditions – can be a key factor in determining its success over time and across implementation locations. A shift in socioeconomic conditions, like a recession, can change people’s opinion of the issue addressed by the policy and reduce political support for funding its implementation. The emergence of a new disease or political conflict also can divert public attention away from the issue, either at a global level or in specific locations, threatening implementation unless the policy is well-crafted. The same is true in the opposite case: changes over time in public opinion or social norms may prompt leadership to more rigorously pursue implementation of a policy.

Source: Mazmanian & Sabatier (1989), pp. 30-35

The research results for the statutory variables suggest that the ADS regulation and the Percy Amendment suffer from weak legal structures, while the PEPFAR legislation is slightly more robust. Under the Sabatier/Mazmanian framework, therefore, the non-statutory variables are predicted to play a leading role in determining the success of the ADS and Percy in achieving their objectives, but implementation will be vulnerable to changes in the political environment and the setting. Respondent comments support this prediction, as described below for Conditions 4-6. Respondents also raised concerns about the susceptibility of PEPFAR to changes in the political environment: they noted the gender strategy under PEPFAR has benefited from favorable conditions to date but recognized these could change at any time and affect future implementation.

Condition 4- Top implementing officials are strongly committed to attaining the policy objectives and have the leadership skills necessary to ensure it happens.

Respondent comments on the ADS and PEPFAR indicated a rating of “moderate-to-high” for commitment and leadership skills (Figure 5). Many discussed recent increases in leadership commitment, noting that effective, top-level leadership has not always been the norm. As evidence of the commitment from top implementing officials, respondents spoke of “front office” support for hiring gender advisors in the Bureau and for increasing their ranks this year to better respond to the Global Health Initiative’s (GHI) Women, Girls and Gender Equality principle (WGGE). No respondents commented on the Percy Amendment in relation to this condition.

Figure 5: Illustrative Quotes on Extent to Which Condition 4 Was Met

Condition	ADS Regulations	PEPFAR Legislation
<p>4. Top implementing officials are strongly committed to attaining policy objectives and have skills necessary to ensure it happens</p>	<p style="text-align: center;">Rating: Moderate/High</p> <p><u>High</u> – “It makes all the difference in the world when you have the highest leadership in the Agency reiterating the point [that gender is important]. We now have our deputy administrator, Steinburg, who specifically asked for gender to be on his agenda.”</p> <p><u>Moderate</u> – “The leadership in the Bureau varies in their level of understanding and commitment to gender ...it has been relatively high in the Office of Population and RH. When I first started, there was much less higher-level commitment. It was more individualized in the leadership. It has become more consistent over the years, strengthened. “</p> <p><u>Moderate</u> – “I wouldn’t say as an organization, overall, [senior leadership] puts this agenda forward as effectively as they could.”</p> <p><u>Moderate</u> – “Over this 10-year period, leaders haven’t always known themselves how to interpret the policy or what the implications of the policy should be for programs.... Because they seem so unfamiliar themselves, the gravity of the policy isn’t matched by the promotion of it by the leadership in a way that can be effective.”</p> <p><u>High</u> – “There has been a clear message, especially this year that gender needs to be integrated into each and every project. The high level of support from leadership is evidenced by the number of gender advisors we have in the Bureau; these people have been hired to make sure we integrate gender into our project, and that is their entire job description.”</p> <p><u>Moderate</u> – “Another barrier for many years was the strong presence of the “old boys’ network” in leadership positions at USAID and their lack of support for work on gender and for these policies. Over time the old boys have retired and increasingly are replaced by men and women who are supportive of working on gender issues and recognize its importance. ...They are champions for gender and are promoting work on it in the health office and elsewhere.”</p>	<p style="text-align: center;">Rating: Moderate/High</p> <p><u>Moderate</u> – “I think leadership has done a pretty good job of stressing these policies, incorporating these policies and making them a priority.”</p> <p><u>High</u> – “PEPFAR is an interesting example where the importance of gender issues was articulated under a Republican Administration and was seen as very important and with very high-level commitment from the very beginning.”</p> <p><u>High</u> – “There’s been a marked improvement since the beginning of PEPFAR in 2003. Now, the support and very explicit mention of gender and the gender strategy and what we’re working towards comes from our Ambassador Goosby and now is picked up much more readily by leadership [at USAID].”</p> <p><u>Moderate</u> – “I think there’s been a lot more recognition and talk about it over the last 10 years.”</p>

Condition 5- Program is actively supported by organized constituency groups and a few key sovereigns throughout the implementation process. Discussing the degree to which internal and external advocates were active in supporting implementation of gender policy at USAID, one respondent commented, “I think the Office of Population has made great strides in the last decade and so has PEPFAR, but the decade before that, we were all still individuals crying in the wilderness. Now we are many individuals and it’s not a wilderness anymore; however, resources are pitiful, and so we’re still doing small things here and there.” Overall, respondents seemed to concur that gender advocates are not isolated or “crying in the wilderness” anymore (Figure 6). Their comments suggested a moderate-to-high level of support from key constituency groups, including the gender advisors (internal), the Interagency Gender Work Group (internal and external) and the PEPFAR Gender Technical Working Group (internal to PEPFAR). Respondents talked frequently and positively about the impact the gender advisors in the Bureau for Global Health have made in implementing the ADS, as they clarified the intent of the regulations, provided assistance during program design, reviewed project documents to monitor gender integration, and built the skills of program officers on gender integration. Comments related to external sovereigns were largely limited to the influential roles that the Secretary of State and the PEPFAR Ambassador have played in recent years; no respondent mentioned Members of Congress or legislative staffers as playing an active role in the implementation process.

Figure 6: Illustrative Quotes on Extent to Which Condition 5 Was Met

Condition	Percy Amendment	ADS Regulations	PEPFAR Legislation
<p>5. Program is actively supported by organized constituency groups and a few key sovereigns throughout the implementation process</p>	<p>Rating: Low</p> <p><u>Low</u> – “I think the ADS and PEPFAR I hear about more frequently from senior leadership than the Percy Amendment. That gets rolled out when people try to portray the long history of it, but Percy is probably at the bottom of the three.”</p>	<p>Rating: Moderate/High</p> <p><u>Moderate</u> – “You need to have champions at multiple levels making sure that things are happening both within and outside of the agency. And I’m not sure that’s always been consistently available.”</p> <p><u>High</u> – “If there hadn’t been an internal gender working group, I don’t think any of it would have gotten done, really...I mean, we had it turned over to us [by an Office Director], you know, “just do it.” [He] was feeling pressure from the women’s advocacy groups. ...He had to be responsive to them.”</p> <p><u>High</u> – “The champions have been hugely important in making it tangible. There’s always a role for the policy champion at the highest level saying, “this is important to me for the following reasons and I want to see it become meaningful.” But what matters even more are [the gender advisors] being able to take an abstract concept and demonstrate to people that you can implement it in practical ways that will make a difference in their programming.”</p> <p><u>Moderate</u> – “I think the champions are there. It’s more having the right and enough people to actually do the work internally and to have the money. It’s a huge difference if we have the money slated towards this. It takes it to a much higher level.”</p> <p><u>High</u>– “In the last 10 years, in OPRH, [leadership] took it seriously and hired gender specialists. We’ve been chairing the IGWG and heavily involved and pushing our projects to do more on gender.”</p> <p><u>High</u> – “There is more understanding now of gender and its impact on development, so more health officer think about it when planning programs. However, this is not because of the ADS but rather because of increased awareness among staff due to the efforts of the gender advisors and the IGWG.”</p>	<p>Rating: Moderate/High</p> <p><u>Moderate</u> – There’s an improvement now, but it’s been a long time in coming. It’s very person-dependent – who the program officer is, the contracting officer. It also depends on how strong a gender champion or advocate there is at the country level. It’s really been dependent on who is asking the questions, who is watching out for it, who has the authority and credibility to review a project design or to be involved on design teams and bring it to the table. So it’s been mixed implementation.”</p> <p><u>High</u> – “There is the Gender Technical Working Group and they have been probably the most vocal proponents of the language of the legislation and how it might be operationalized. And they do have senior support within PEPFAR, going right up to the Coordinator.”</p>

Condition 6 - Changing socioeconomic or sociocultural conditions do not weaken the causal theory or political support for attaining the stated objectives. Both the ADS and PEPFAR rated “low” on Condition 6, which represents the resilience of the policies to changing socioeconomic or sociocultural conditions, including shifts in attitudes of US voters or policymakers toward foreign assistance or a specific issue like HIV or family planning (Figure 7). Respondents noted that the level of political support from USAID leadership fluctuated over time with changes in the Administration and corresponding changes in political appointments to leadership positions in USAID. As one respondent noted, “What drives certain issues to gain prominence and have political backing or not, is an elusive process. Clearly it’s higher-level forces and a trickle-down process.” No respondents commented on Percy in relation to this variable.

Figure 7: Illustrative Quotes on Extent to Which Condition 6 Was Met

Condition	ADS Regulations	PEPFAR Legislation
<p>6. Changing socioeconomic or sociocultural conditions do not weaken the causal theory or political support for attaining the stated objectives</p>	<p style="text-align: center;">Rating: Low</p> <p><u>Low</u> – “The ADS has gone through a number of changes and I would guess it’s partly political – how important women’s issues and gender equality is under different Administrations and how much effort they want agency staff to spend on these particular issues. ... So there have been periods when things got watered down a bit [in the ADS] and then periods where more teeth were added and a lot of it is really about political will.”</p> <p><u>Low</u> – “during previous Administrations, there was a definite impact on what type of gender issue could be or could not be addressed. So the politics affected the leadership, which allowed or disabled the [gender] champions to do their work.”</p> <p><u>Low</u> – Definitely the political environment is a huge determining factor ... It doesn’t change the language [of the policy] but it’s the tone, and how many times the Administrator makes it part of their executive message.”</p> <p><u>Low</u> -- “We’ve made quite a big deal out of the last revision [to the ADS] and talking about strengthening the gender language in the ADS. Part of the problem was that it actually got dropped out [during a previous Administration] and that, for those of us who work on gender and policy and practice, it was a great tragedy, a great loss, so to get gender back in was certainly a victory.”</p> <p><u>Low</u> -- “During the last year, with the release of the GHI and the WGGE principle, there is much more attention to gender by senior leadership. Leadership is concerned that there may not be enough gender staff to fully implement the WGGE. That is a big change in the Bureau. It is because WGGE is coming from State Department and the Office of the USAID Administrator, so senior leadership in BGH is paying a lot of attention now.”</p>	<p style="text-align: center;">Rating: Low</p> <p><u>Low</u> – “It’s been mixed awareness and mixed support. So it really has very much depended on the changes in leadership both within USAID and ...what’s coming from OGAC and the deputy principals of other agencies.”</p>

Discussion

Asked to comment on whether the policies had achieved their objectives during the last ten years, respondents overwhelmingly (12 of 15) commented that implementation of gender policy in the Bureau for Global Health had mixed results. Many noted recent improvements among their peers in following “the letter of the ADS, but not the intent.” They commented that program officers include gender analysis as a rote exercise in program design but with only cursory understanding of the implications for project implementation; that more data, in the form of country-level gender assessments are available now, but many program officers do not know how to use it to inform program design; and that there are only “pockets of understanding” about gender integration among program officers in the missions. While noting a higher degree of attention to gender integration in HIV than other health areas, respondents cited inconsistent implementation of the PEPFAR gender language across HIV programming, with more frequent interventions on the “tangible” issues of gender-based violence or male norms than programming to address women’s empowerment or gender equality.

These results – reflecting on whether the actions of the target group (program officers) were consistent with the policy decisions in the three pieces of gender policy -- support the Sabatier/Mazmanian conceptual framework discussed at the start of the chapter. Weaknesses in the statutes themselves diminished the impact of the policies in spite of high levels of support from senior leadership in the Bureau for Global Health and active advocacy and support from gender champions in the Bureau and key sovereigns internal and external to USAID. The dampening effect is most notable on the Percy Amendment, which was vaguely worded, poorly structured and had almost no exposure

in the last 10 years within the Bureau; and the ADS regulations, which, in spite of recent advances in the specificity of the language, lack a sufficiently sound causal theory and any consequences for non-compliance or inducements for changing behavior. PEPFAR rated higher than the other two policies on the statutory conditions but could be further strengthened by giving more jurisdiction to implementing officials and better structuring the implementation process. Overall, implementation of the policies was vulnerable to changes in the political environment, both positive and negative, strengthening or weakening the effect of the policies over time. Improving the statutory framework for gender-related policy will make it more resilient to external influences and ensure more consistent implementation over time. The next chapter lays out a proposal for policy change, based on the research results, public policy theory and the principles of public health leadership.

Chapter 5 – Plan for Change

The results of the policy implementation analysis described in Chapter 4 point to the need to strengthen the policy framework for gender integration in USAID in order to adequately address gender equality through health sector foreign aid. During the period 2000 – 2010, neither advocacy nor leadership proved sufficient to achieve gender integration on a consistent basis in the Bureau for Global Health. A cadre of internal and external gender champions continuously advocated for and provided technical assistance and training on gender integration in the Bureau and the field missions. They led the effort in the late 1990s to include gender analysis as part of the ADS requirements in 2000 and fought to have the language reinstated and improved a decade later after it was watered down by administration officials in mid-decade revisions to the ADS. When President Bush focused his administration’s attention on HIV/AIDS, these champions helped formulate the gender language for the PEPFAR legislation in 2003 and again in 2008 and worked with program officers to develop concrete programmatic strategies to meet the objectives of the legislative language. Their efforts were reinforced, during the latter part of the decade in particular, by senior leaders in the Bureau for Global Health, USAID top leadership and State Department officials who spoke out on the importance of gender equality and improving the status of women and girls and directed resources to help achieve those objectives.

In spite of the substantial efforts put forward by advocates and top leaders, gender integration remains a goal for most USAID health offices, rather than a programming

reality, as suggested by the data collected for this study. Current initiatives at USAID and in Congress, however, provide rare opportunities to improve the policy framework on gender integration. This year, USAID hired a senior gender advisor to oversee gender integration across the entire Agency and charged her with preparing a first-ever gender policy for USAID. The new Gender Policy will serve as the policy guidance for the Agency worldwide and across all sectors, replacing the 1982 Women in Development Policy Paper and the 1996 Gender Plan of Action. While the new Gender Policy will not replace the ADS regulations, the ADS presumably will be revised again if needed to reflect the intent of the new Gender Policy once it has been adopted.

The second policy opportunity is the draft legislation in the U.S. House of Representatives for a new foreign assistance act, entitled the “Global Partnerships Act of 2011” (available at <http://democrats.foreignaffairs.house.gov/contact.asp?issue=15>). Ranking Minority Member Howard Berman presented the draft in September 2011, proposing it as a replacement for the original Foreign Assistance Act of 1961. The draft Global Partnerships Act is a remarkable example of a gender-integrated policy: it identifies gender equality as a principle of assistance, addresses sector-specific, gender-related issues throughout the document (including Chapter 3: Advancing Health¹) and contains an entire chapter dedicated to “fostering equal opportunity” for women and marginalized groups.

¹ In “Chapter 3: Advancing Health,” the draft document calls for foreign assistance activities to address a wide range of gender-related issues: gender-based violence, child marriage and female genital cutting; inheritance rights of orphans, vulnerable children and widows; sexual violence prevention and care in crisis settings; social, economic and cultural barriers to women’s access to reproductive health care; and coordination with programs that promote education for girls and women.

The draft language of the Global Partnership Act includes many references to women and girls; these may have been intended to aid understanding by readers unfamiliar with gender terminology, or they may reflect the ongoing influence of the current Secretary of State who is promoting a women-centered approach over the more dispersed and harder-to-explain gender integration approach. The chapter on health, for example, primarily uses women-centered language and omits explicit mention of men, even in the family planning section where a “men as partners” approach has become an integral part of programming. In most sections, however, the authors were careful to capture the broader meaning of gender equality for women, men, boys and girls. The mandate to foster equal opportunity (Chapter 7) includes a charge to “expand the use of gender analysis” and “integrat[e] gender considerations into all international development policies and programs” (p.184 of the draft Act). Clearly, gender advocates succeeded in getting their message across to Representative Berman, and he and his legislative staff were open to receiving the message. Nevertheless, this draft legislation has only a small chance of being considered in the current session of Congress, where attention is focused on the federal budget and debt reduction.

These two policy initiatives represent an once-in-a-lifetime opportunity for gender advocates in the health sector and beyond to influence foreign assistance for decades to come. It is urgent that the opportunity is not squandered. In a recent lecture, Esther Duflo, professor of development economics at MIT, spoke about the importance of truly understanding the issues – whatever they may be - when designing a policy to address them. Duflo posits that many policies are ineffective because they are poorly conceived: “[P]olicymaking is difficult: it requires a very good understanding of a problem. We

usually get it wrong. Policymakers, like anyone else, are often subject to the temptation of ‘lazy thinking.’ And unlike in business, there is no market test to know the impact of the policy in advance” (Duflo, 2011, p.9). While policymakers cannot predict the impact of policies in advance, they can learn from earlier experiences, and policy implementation analysis is a useful tool to assess and understand those experiences.

As USAID and Congress design new policies that will impact the way development assistance programs address gender integration in the future, the following recommendations, based on the interviews, the implementation analysis and the literature review, can inform that process. The plan for change proposes a two-pronged approach to improving the statutory framework: (1) recommendations for writing new or revising current policy, as laid out in the policy recommendations section; and (2) advocating for the two major statutory reform efforts, as detailed in the advocacy strategy section.

Policy Recommendations

The six conditions from the Sabatier/Mazmanian framework for effective policy implementation serve as a checklist for policymakers and advocates. The main weaknesses affecting the implementation of current gender-related policy within the health sector at USAID are related to the statutes themselves, rather than the political environment in which they operate. Therefore, the recommendations focus on the statutory variables in an effort to strengthen the framework from which implementing officials and advocates promote gender integration.

1. **Specify clear and consistent objectives in all gender-related policies.** All policies, including the new USAID Gender Policy, the ADS, and issue-specific policies like PEPFAR, should send a unified, unambiguous message about gender objectives in

development assistance programs. USAID program staff should know exactly what is expected of them when they read the policy, and evaluators should know what to measure, with clearly specified indicators of progress. The central message and the language used therein should be consistent across all policies: it should state gender equality as the objective; identify a women-centered approach as one strategy among many to achieve that goal; and state that the policy applies to women, men, boys and girls of all gender identities.

2. Map the causal pathways between gender integration and gender equality and provide sufficient jurisdiction to implementing officials to influence the process.

A good policy is built on sound logic. To increase the effectiveness of gender policies, policymakers should specify, in language that the majority of its target audience can understand, the steps by which gender integration in USAID's programs will lead to gender equality and improved development outcomes. Officials charged with implementing the policy must understand fully the linkages between the intervention (gender integration) and the desired outcome (gender equality) and have jurisdiction over enough of the linkages (e.g., project approval process, reporting requirements) to influence the behavior of program officers at key steps along the way. Sector-specific information on these linkages should be included in the policy itself or as an appendix, in recognition of the complexity and variety across sectors.² Policymakers should draw on existing research and commission new research as needed to provide evidence of the direct effect of gender integration in development

² The supplemental guidance to the ADS for gender integration in the health sector (USAID 2010) is an excellent example of providing sector-specific strategies to assist program officers comply with the policy.

programming on gender equality and sector-specific outcomes (e.g., health outcomes).

3. Carefully structure the implementation process and specify it in the policy.

Gender integration, by its nature, cuts across all sectors of development programming and has long been considered a “cross-cutting issue” at USAID. While designation as a cross-cutting issue implies that everyone in the agency is responsible for gender integration, in practice, it means no one office or individual has the requisite combination of responsibility, authority and sufficient funding to ensure implementation of gender-related policy. Going forward, there are several concrete steps policymakers can take in designing gender policy that will improve the extent to which it is implemented. These recommendations are based on the analysis of the interview data, but they draw heavily on the literature review as well, which provided a wealth of information about improving the manner in which gender mainstreaming processes are implemented.

- a. Specify which officials are responsible for overseeing implementation of the policy –at the agency-level, in each bureau, and in the field missions– and provide them with sufficient authority and funds to do their job.
- b. Specify the consequences for non-compliance as well as inducements for complying. As one respondent commented, the agency needs people who can enforce gender policy, and it needs consequences for not complying. If it were determined that a health project was not in compliance with applicable gender policy, for example, a suggested sanction would be making the project subject to extra oversight by a gender advisor for a one-year period, or

otherwise providing special attention geared to improving the project's gender and health outcomes. As an inducement to excel, matching funds could be made available to those projects that do particularly well at integrating gender and are able to document the ways in which it led to improved gender and health outcomes,

- c. Require gender analysis throughout the project cycle –in program design and during mid-term and final evaluations – and require that funds be assigned for that purpose.
- d. Increase the number of gender advisors in the agency, to provide technical support to program officers in the missions and Washington office until such time as the capacity for gender integration is widespread throughout the agency. Ensure that gender advisors are properly funded and have the authority and time to do the tasks.
- e. Establish and maintain a staff development program for technical officers to build sector-specific skills for gender integration in project design, implementation, evaluation and reporting. Include a certificate program to recognize individuals who master gender integration skills.
- f. Require that USAID regularly evaluate progress on achieving gender equality goals by sector and country; collect the evidence on the linkages between gender integration and gender equality; and share this information broadly within USAID as well as with implementing partners and country counterparts.

Leadership theory suggests that there are three reasons change processes fail: (1) people do not understand the sense of urgency or the vision, or there is a failure to communicate these well; (2) leadership fails to institute systems or structures that allow people to effect change – bringing the right people together at the right time will not work unless they are given the resources they need to do the job; and (3) change agents declare victory too soon, before people have internalized the new behaviors, and the change fails to “stick” (Kotter, 1996). Introducing a new policy implies a change process, and large organizations are notoriously resistant to change. The success of any new gender-related policy at USAID will depend on many factors, from the statutory variables discussed above, to the ability of change agents to form successful coalitions, communicate their vision well, and sustain the changes over time

Advocacy Strategy

Even a sound, clearly written and well-structured policy needs champions to promote its implementation within the affected organization and to ensure its continued viability. In the case of gender policy, engaging champions is critical for successful implementation: both top leadership and technocrats must assume responsibility for gender integration, as Theobald et al. (2005) and Beall (1998) argue, because it is both a political issue (e.g., Secretary Clinton’s strong support for women’s empowerment) and a technical issue (requiring, for example, public health behavior change strategies and the use of anthropological approaches to understand social norms).

Adoption of the new Gender Policy at USAID and its successful implementation across the field missions and Washington-based bureaus will require that gender advocates and technical experts both internal and external to the agency work closely

with the political leadership at USAID to craft and spread sector-specific messages about the importance of the new policy for the success of development assistance. Similarly, a coalition of technical experts and political leaders will be essential to keep gender equality an integral part of new foreign assistance legislation, ensuring that the excellent work of Representative Berman's team does not get diluted or eliminated altogether during the vetting and approval process in Congress.

In his book, *Leading Change*, John Kotter (1996) points to the importance of building coalitions to lead change: finding the right people, building trust among them and developing a common goal. Gender advocates in USAID's Bureau for Global Health have long relied on a coalition, the Interagency Gender Working Group (IGWG), to support their efforts to advance technical knowledge on gender, advocate for policy change and engage internal and external champions. The combination in the Bureau for Global Health of high levels of commitment from top leadership, a cadre of gender advisors deployed throughout its Washington offices and providing assistance to health officers in the missions, and the IGWG linking it to external gender advocates and experts, provides an ideal setting to pilot the new USAID Gender Policy and refine the messages and tools before or concurrent with a full-scale launch throughout the agency.

As a decentralized agency, USAID faces many challenges during change processes; the technical complexity of gender integration and the political sensitivities it incites only add to the difficulties of introducing changes to gender policy. Pilot testing the new Gender Policy in the Bureau for Global Health, which is well-known for its innovation in and support of gender integration, will allow the launch to benefit from the

established coalition of advocates supporting gender integration in USAID's health sector and serve as a model for other bureaus.

Advocacy efforts related to the foreign assistance legislation drafted by Representative Berman will be critical if the draft comes up for consideration by the House Committee on Foreign Affairs. Gender advocates in the health sector should join forces with other organizations promoting foreign aid reform (including the Center for Global Development), feminist organizations and those promoting social justice and human rights approaches in development assistance. By forming a coalition with these groups, gender and health advocates can increase the impact of their advocacy efforts and promote gender equality as part of a broader agenda, increasing its likelihood of being included in the final legislation.

As part of these larger efforts to strengthen the policy framework for gender integration in USAID, the researcher will seek to present the results of this research study at a variety of venues in an effort to stimulate discussion of the issues. Specifically, she will offer to present the results to USAID's Bureau for Global Health, the IGWG (gender community of practice) and various public health conferences, and submit an abstract for consideration to the Michigan State University Gender & Development Paper Series and relevant journals in the fields of gender and development and public health.

Final Thoughts

Duflo, the development economist, challenges the thinking that good policies are doomed by bad politics. She counters that failures to implement policy happen "because the whole system was badly conceived to start with and no one has taken the trouble to fix it" (Duflo 2011, p.9).

USAID has an opportunity in the coming months to fix the problems that have stymied the implementation of gender policy – and correspondingly constrained the advancement of gender equality through health sector development assistance programs. Let us hope policymakers will take the trouble to get the policy framework right: do the “legwork” to truly understand the issues involved with gender integration in USAID; incorporate that understanding into a detailed and actionable Gender Policy for USAID with clear objectives that can be measured, a sound causal theory and sufficient jurisdiction for implementing officials; work with internal and external gender advocates and top leadership to promote implementation of the new policy; and support Congressional leaders as they seek to address gender equality in foreign aid reform legislation.

The Bureau for Global Health has served as an incubator for many of the advances on gender integration in the Agency: the ADS and PEPFAR gender language, guidance on implementing gender strategies to comply with the policies, training materials and documenting the impact of gender integration on health program outcomes. USAID’s top leaders should harness the energy, commitment and technical expertise of champions in the Bureau for Global Health to do a full-scale launch of the new Gender Policy within the health sector and provide a model for other sectoral Bureaus to follow.

Health status is critical for overall development: healthy people learn better in school, are more productive at work, and participate more actively in their communities and in public life. Integrating gender into health programs ensures that all people, regardless of their sex and gender identity, participate in and benefit from development interventions that improve their health status. USAID’s gender champions have done a

remarkable job on advocacy over the past 20 years. If they have a sound policy framework to work with, the programming should finally fall into place and the policy objectives should be realized - improving the quality of life for millions of women and girls, men and boys throughout the developing world.

APPENDIX A: Semi-structured Interview Guide

INTERVIEW GUIDE

Title of Study: Gender Integration in US Foreign Assistance: a Policy Implementation
Analysis of USAID Health Sector Programming

Respondent ID Number: _____

Job Category: _____

Office/Division: _____

No. of Years at USAID: _____

- Have you heard about the Percy Amendment? (yes/no) the PEPFAR legislation's gender language? (yes/no) the ADS gender regulations? (yes/no)
- During your tenure with USAID, to what extent (and briefly, how) have you been involved in gender integration and/or addressing gender issues in the course of your duties? (extensively, some, minimally, not at all)

Briefly summarize the objectives of the Percy Amendment, PEPFAR's 2004 gender language and the 2000 ADS gender regulations, as needed. Now, I'd like to ask you to comment on several questions related to these policies during the last 10 years—whether they met their objectives and why.

1. To what extent did USAID senior leadership promote, encourage and/or require compliance with these gender-related policies and regulations?

2. To what extent did program officers act in accordance with the ADS? (e.g., conduct formal or informal gender analyses, hold contractors accountable to deliver what they wrote in proposals)
3. To what extent were the objectives of the policies achieved over the last 10 years? (Please respond for each of the 3 policies, or those which you are able to.) Did the policy (*ask for each policy*) achieve its objectives?
4. What were the main factors affecting the impact of the policies? These might include something specific to the official policy (e.g., language, enforcement mechanism, specificity of the policy) and/or politically significant factors (change in leadership, skills of leadership, policy champions, internal or external advocates, changing sociocultural or socioeconomic or other conditions).
5. How was the policy reformulated over time on the basis of experience? (e.g., in reauthorization of PEPFAR bill or 2009 revisions to ADS)

APPENDIX B: IRB-approved Informed Consent Form

CONSENT FORM

Title of Study	<i>Gender Integration in U.S. Foreign Assistance: A Policy Implementation Analysis of USAID Health Sector Programming</i>
Why is this research being done?	<i>This research is being conducted by Mary Kincaid at the University of North Carolina at Chapel Hill, under the faculty supervision of Dr. Suzanne Havala-Hobbs of the Department of Health Policy and Management, School of Public Health. We are inviting you to participate in this research project because you have policy and/or programmatic experience working in USAID's Bureau for Global Health. The purpose of this research is determine whether current gender-related policy applying to US foreign assistance yields gender-equitable health sector programming within USAID.</i>
What will I be asked to do?	<p><i>The procedures involve a 20-minute telephone interview conducted by Mary Kincaid. The interview will take place over the phone at a time convenient for you. You will be answering questions about what works well about current gender-related policy, what doesn't work and why, and what policy or other changes would improve the outcome. With your permission, the interview may be audiotaped.</i></p> <p>___ I agree to be audiotaped during my participation in this study.</p> <p>___ I do not agree to be audiotaped during my participation in this study.</p>
What about confidentiality?	<p><i>We will take all recommended procedures to keep your personal information confidential. To help protect your confidentiality, standard methods to protect privacy will be maintained. Your identity and your office affiliation will remain confidential. Only the Student Investigator will have access to your name and your office affiliation. Data will be securely stored with the researcher on a computer and audiotapes. Hard copies of data will remain in the locked cabinet in the office of the researcher. All data will be destroyed (i.e., shredded or erased) when their use is no longer needed but not before a minimum of five years after data collection. In all reports and articles about this research project, your identity will be protected to the maximum extent possible.</i></p> <p><i>Your information may be shared with representatives of the University of North Carolina at Chapel Hill if you or someone else is in danger or if we are required to do so by law.</i></p>
What are the risks of this research?	<i>There may be some risks, in terms of identification, from participating in this research study and being audiotaped. However, all information will be kept confidential as described above. Your name will not be identified or linked to the data you provide at any time.</i>

<p>What are the benefits of this research?</p>	<p><i>This research is not designed to help you personally, but the results may help the researcher learn more about how to improve gender integration in health programs. The research results have the potential to influence how health sector foreign assistance is designed and carried out in the future. As such, the benefits of this research will accrue to the US Government, to help improve the effectiveness of health-related foreign assistance, and to society more broadly -- in particular, women and men in developing countries receiving U.S. foreign assistance – by improving efforts to promote gender equality through interventions in the health sector.</i></p>	
<p>Do I have to be in the research? May I stop participating at any time?</p>	<p><i>Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study, you will not be penalized or lose any benefits.</i></p>	
<p>What if I have questions?</p>	<p><i>This research is being conducted by Mary Kincaid under the supervision of Dr. Suzanne Havala-Hobbs, Department of Health Policy and Management, School of Public Health, University of North Carolina at Chapel Hill. If you have any questions about the research study itself, please contact Dr. Suzanne Havala-Hobbs, Department of Health Policy and Management, School of Public Health, UNC-Chapel Hill, (919) 843-4621, email: Suzanne_hobbs@unc.edu.</i></p> <p><i>If you have any questions about your rights as a research subject or wish to report a research-related injury, please contact: Office of Human Research Ethics, Institutional Review Board, University of North Carolina at Chapel Hill, CB# 7097, Medical Building 52, 105 Mason Farm Road, Chapel Hill, NC 27599-7097, telephone: (919) 966-3113, email: IRB_Subjects@unc.edu.</i></p> <p><i>This research has been reviewed according to University of North Carolina at Chapel Hill IRB procedures for research involving human subjects.</i></p>	
<p>Statement of age of subject and consent</p>	<p><i>Your signature below indicates that</i></p> <ul style="list-style-type: none"> • <i>you are at least 18 years of age,</i> • <i>the research has been explained to you,</i> • <i>your questions have been fully answered, and</i> • <i>you freely and voluntarily choose to participate in this research study.</i> 	
<p>Signature and Date</p>	<p>NAME OF SUBJECT</p>	
	<p>SIGNATURE OF SUBJECT</p>	
	<p>DATE</p>	

PLEASE SIGN AND SEND BY FAX TO MARY KINCAID, 919-403-0001
 OR SCAN AND SEND TO MKINCAID@FUTURESGROUP.COM

REFERENCES

- Ashburn, K., Oommen, N., Wendt, D., and Rosenzweig, S. (2009). Moving beyond gender as usual. Washington, DC: Center for Global Development.
- Bannon, I., and Correia, M. C. (Eds.). (2006). *The other half of gender: Men's issues in development*. Washington, DC: The World Bank.
- Beall, J. (1998). Trickle-down or rising tide? Lessons on mainstreaming gender policy from Colombia and South Africa. *Social Policy & Administration*, 32(5), 513-534.
- Benería, L. (2003). *Gender, development and globalization: Economics as if all people mattered*. New York: Routledge.
- Berman, H. (2011). Discussion draft: The Global Partnerships Act of 2011. House Committee on Foreign Affairs. Available at www.democrats.foreignaffairs.house.gov.
- Boserup, E. (1990). Economic change and the roles of women, in *Persistent inequalities: Women and world development*, edited by Irene Tinker. New York: Oxford University Press.
- Caro, D. (2009). *A manual for integrating gender into reproductive health and HIV/AIDS programs: From commitment to action* (2nd ed.). Washington, DC: United States Agency for International Development (USAID) Interagency Gender Work Group (IGWG).
- Carrillo, H. (2002). *The night is young: Sexuality in Mexico in the time of AIDS*. [Worlds of Desire: The Chicago series on sexuality, gender, and culture](#). Chicago, IL: University of Chicago Press.
- Carillo, H., Fontdevila, J., Brown, J., and Gómez, W. (2008). Risk across borders: Sexual contexts and HIV prevention challenges among Mexican gay and bisexual immigrant men, findings and recommendations from the Trayectos Study. San Francisco: University of California at San Francisco, Center for AIDS Prevention Studies.
- Cornwall, A., Harrison, E., and Whitehead, A. (2004). Introduction: Repositioning feminisms in gender and development. *IDS Bulletin*, 35(4), 1-10.
- Cornwall, A., Harrison, E., and Whitehead, A. (2007). Introduction: Feminisms in development: contradictions, contestations and challenges, in *Feminisms in*

- Development*, edited by Andrea Cornwall, Elizabeth Harrison and Anne Whitehead. New York: Zed Books.
- Creswell, J. (2003). *Research design: Qualitative, quantitative and mixed method approaches* (2nd edition). Thousand Oaks, CA: Sage Publications, Inc.
- Duflo, E. (2011). Policies, politics: Can evidence play a role in the fight against poverty? Sixth Annual Richard H. Sabot Lecture, April 2011. Washington, DC: The Center for Global Development.
- Elmore, R. F. (1983, June). *Forward and backward mapping: Reversible logic in the analysis of public policy*. Paper presented at the International Workshop on Interorganizational Implementation Systems, Rotterdam, The Netherlands.
- Elsy, H., Tolhurst, R., and Theobald, S. (2005). [Mainstreaming HIV/AIDS in development sectors: Have we learnt the lessons from gender mainstreaming?](#) *AIDS Care*, 17(8), 988-998.
- Fiorino, D. J. (1997). Strategies for regulatory reform: Forward compared to backward mapping. *Policy Studies Journal*, 25(2), 249-265.
- Fleishman, J. A. (2009). *Making gender a global health priority*. (Report of the CSIS Global Health Policy Center). Washington, DC: Center for Strategic & International Studies.
- Flora, C. (1984, Fall). Women and development projects: Planned and unplanned change. *Journal of Comparative Rural and Regional Studies*, 86-94.
- Government Accountability Office (GAO) (2010). Foreign assistance: USAID needs to improve its strategic planning to address current and future workforce needs. GAO-10-496 A Report to Congressional Committees. Washington, DC: United States Government Accountability Office.
- Greene, M. and Levack, A (2010). Synchronizing gender strategies: Working with men and women to improve sexual and reproductive health and achieve gender equality. Washington, DC: Population Reference Bureau.
- Hankivsky O. (2006). Beijing and beyond: Women's health and gender-based analysis in Canada. *International Journal of Health Services*, 36(2), 377-400.
- H. R. Rep. No. 108-010 (2003). Available at http://thomas.loc.gov/cgi-bin/cpquery/10?cp108:temp/~cp1084PT7w&sid=cp1084PT7w&item=10&sel=T OCLIST&l_f=1&l_file=list/cp108ch.lst&report=hr010.108&hd_count=50&&l_t=887&&&.

- H. R. Rep. No. 109-486 (2007). Available at http://thomas.loc.gov/cgi-bin/cpquery/21?cp109:temp/~cp109s7FJj&sid=cp109s7FJj&item=21&sel=TOCLIST&l_f=501&l_file=list/cp109ch.lst&l_b=451&l_file=list/cp109ch.lst&report=r486.109&hd_count=50&&l_t=806&&#.
- ILO (2000). *ABC of Women Worker's Rights and Gender Equality*. Geneva: International Labor Organisation.
- Interagency Gender Working Group. (2000). *Guide for incorporating gender considerations in USAID's family planning and reproductive health RFAs and RFPs*. Washington, D.C.: USAID Interagency Gender Working Group.
- Interagency Gender Working Group. (2004). *The 'So What?' report: A look at whether integrating a gender focus into programs makes a difference to outcomes*. Washington, DC: USAID Interagency Gender Working Group.
- Inter-Parliamentary Union (2010). Women in national parliaments (webpage). Available at <http://www.ipu.org/wmn-e/classif.htm>
- Jaquette, J. and Staudt, K. (2006). Women, gender and development, in *Women and gender equity in development theory and practice : Institutions, resources and mobilization*, edited by Jane Jaquette and Gale Summerfield. Durham, North Carolina: Duke University Press.
- Jewkes, R. Nduna, M., Levin, J., Jama, N., Dunkle, K., Khuzwayo, N., Koss, M., Puren, A., Wood, K., and Duvvury, N. (2006). A cluster randomized controlled trial to determine the effectiveness of Stepping Stones in prevention HIV infections and promoting safer sexual behavior amongst youth in the rural Eastern Cape, South Africa: Trial design, methods, and baseline findings. *Tropical Medicine and International Health*, 11, 3-16.
- Kim, J., Watts, C., Hargreaves, J., Ndhlovu, L., Phetla, G., Morison, L., Busza, J., Porter, J. and Pronyk, P. (2007). Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa. *American Journal of Public Health*, 97(10).
- Lloyd, C. (2009). *New Lessons: The power of educating adolescent girls*. New York: Population Council.
- Longwe, S. (2000). Towards realistic strategies for women's political empowerment in Africa. *Gender and Development*. 8(3):24-30.
- Mansdotter, A., Lindholm, L., and Ohman, A. (2004). Women, men and public health: How the choice of normative theory affects resource allocation. *Health Policy*, 69(3), 351-64.

- Mazmanian, D. A., and Sabatier, P. A. (1989). In D. A. Mazmanian, & P. A. Sabatier (Eds.), *Implementation and public policy* (2nd ed.). Lanham, Maryland: University Press of America.
- Molyneux, M. (2007). The chimera of success: Gender *ennui* and the changed international policy environment, in *Feminisms in development*, edited by Andrea Cornwall, Elizabeth Harrison and Ann Whitehead. New York: Zed Books.
- Mukhopadhyay, M. (2004). Mainstreaming gender or “streaming” gender away: Feminists marooned in the development business. *IDS Bulletin*, 35(4), 95-103.
- Organisation for Economic Co-operation and Development Assistance Committee (DAC). (1998). *DAC guidelines for gender equality and women’s empowerment in development co-operation*. Paris, France: Organisation for Economic Co-operation and Development.
- Pantelides, E. and López, E. (2005). *Varones Latinoamericanos: estudios sobre sexualidad y reproducción*. Buenos Aires: Paidós.
- Patton, M. Q. (1987). *How to use qualitative methods in evaluation*. Newbury Park, CA: Sage.
- Payne, S. (2009). *How can gender equity be addressed through health systems?* (Policy Brief No. 12). Copenhagen, Denmark: World Health Organization Regional Office for Europe. Retrieved from <http://www.filderstadt.kdrs.de/servlet/PB/show/1360716/who.pdf>.
- Pressman, J. L., and Wildavsky, A. (1984). *Implementation* (3rd ed.). Berkeley, CA: University of California Press.
- Prügl, E. and Lustgarten, A. (2006). Mainstreaming gender in international organizations, in *Women and gender equity in development theory and practice : Institutions, resources and mobilization*, edited by Jane Jaquette and Gale Summerfield. Durham, North Carolina: Duke University Press.
- Reeves, H., and Baden, S. (2000). *Gender and development: Concepts and definitions* (BRIDGE Gender Report No. 55). Brighton, UK: University of Sussex Institute for Development Studies.
- Rottach E., Schuler, S., and Hardee, K. (2009). *Gender perspectives improve reproductive health outcomes: New evidence*. Washington, DC: USAID IGWG and Population Action International.
- Sabatier, P. A. (2007). *Theories of the policy process* (2nd ed.). Boulder, CO: Westview Press.

- Schuler, M. (1986). *Empowerment and the law: Strategies of third world women*. Washington, DC: Overseas Education Fund.
- Sen, G., Ostlin, P., and George, A. (2007). *Unequal, unfair, ineffective and inefficient gender inequity in health: Why it exists and how we can change it*. (Final Report to the WHO Commission on the Social Determinants of Health). Geneva: World Health Organization, Women and Gender Equity Knowledge Network (WGEKN).
- Spratt, K. (2009). *Policy Implementation Barriers Analysis (PIBA): Conceptual framework and pilot test in three countries*. Washington, DC: Futures Group/USAID Health Policy Initiative.
- Staudt, K. (1998). *Policy, politics, and gender: Women gaining ground*. West Hartford, CT: Kumarian Press.
- Staudt, K. (2004). Straddling borders: Global to local, in *Developing power: How women transformed international development*, edited by Arvonne S. Fraser and Irene Tinker. New York: First Feminist Press.
- Temin, M. and Levine, R. (2009). *Start with a girl: A new agenda for global health*. Washington, DC: Center for Global Development.
- Theobald, S., Tolhurst, R., Elsey, H., and Standing, H. (2005). Engender the bureaucracy? Challenges and opportunities for mainstreaming gender in Ministries of Health under sector-wide approaches. *Health Policy and Planning*, 20(4), 141-149.
- Tinker I. (2004). Introduction: Ideas into action, in *Developing power: How women transformed international development*, edited by Arvonne Fraser & Irene Tinker. New York: Feminist Press at the City University of New York.
- United States Agency for International Development (1982). Policy paper on women in development. Washington, DC: USAID Office of Women in Development.
- United States Agency for International Development (1991). Report to Congress: Women in development FY1989 and FY1990. Washington, DC: USAID Office of Women in Development.
- United States Agency for International Development (2008). USAID human capital strategic plan FY2009 – FY2013. Washington, DC: USAID Bureau for Policy, Planning and Learning.
- United States Agency for International Development (2009). USAID/General Notice, A-A/AID, December 8, 2009: Revisions to ADS Chapters 201, 203, 302, and 303 to

- Strengthen Gender Integration in USAID Planning and Programming.
Washington, DC: USAID Office of the Administrator.
- United States Agency for International Development (2010). Integrating gender into health programs: A guide to implementing ADS requirements. Washington, DC: USAID Bureau for Global Health.
- United States Department of State (2009). Implementing a woman and girl-centered approach to health and gender equity” (internal draft document). Washington, DC: Office of Global Women’s Issues, U.S. Department of State.
- Viveros, M., Rivera, C. and Rodríguez, M. (2006). *De mujeres, hombres y otras ficciones: Género y sexualidad en América Latina*. Bogotá: Tercer Mundo y Universidad Nacional de Colombia, Facultad de Ciencias Humanas.
- Vlassoff, C., and Moreno, C. G. (2002). Placing gender at the centre of health programming: Challenges and limitations. *Social Science & Medicine*, 54(11), 1713-1723.
- Walker, A. (2000). The women’s movement and its role in development, in *Theoretical Perspectives on Gender and Development*, edited by Jane Parpart, Patricia Connelly and Eudine Barriteau. Ottawa, Ontario: International Development Research Centre.
- Wilkins K. (2005). Constructing gender across cultural space: Japan’s international development programs. *Global Media Journal*, 4(6), 1-24.
- Williams, E. S., and Skinner, A. C. (2003). Outcomes of physician job satisfaction: A narrative review, implications, and directions for future research.” *Health Care Management Review*, 28(2), 119-140.
- World Bank (2003). Gender equality and the Millenium Development Goals. Washington, D.C.: Gender and Development Group, World Bank.
- World Health Organization (2007). Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. Geneva: World Health Organization.