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Integrating Gender into Scale-up Mapping Tool

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Background

To achieve the greatest possible improvement in family planning (FP) and maternal, neonatal, and child health (MNCH) outcomes, successful interventions, practices, and approaches must be "scaled up." To scale up an intervention is to expand its implementation and incorporate it into the laws, policies, and structures that govern health systems. In recent years, growing recognition of the importance of scale-up has led to intensified efforts to identify and scale-up best practices in FP/MNCH and improve scale-up processes. Gender equality is central to successful and sustainable scale-up.

> Sacrificing quality (the processes and values integral to a human rights–based approach to healthcare) for quantity (expansion) should be avoided in scaling up. Because the humanistic, participatory, and gender-sensitive components of an innovation are often the most difficult to replicate on a large scale, they are often the first to be sacrificed.
>
> —World Health Organization/ExpandNet

Gender equality can significantly influence health outcomes, and many barriers to program scale-up are related to gender norms and gender inequality within the cultural context where the intervention is taking place. Incorporating strategies to address gender equality and empower women and girls can lead to improved health and program outcomes (Barker et al., 2007; Rottach et al., 2009). Failing to take into account gender equality factors—such as women's status in the family and community, men and women's roles in decision making, and gender-related discrepancies in education and access to resources—can limit the reach and scale of FP/MNCH interventions.

The literature shows that systematic integration of gender into scale-up initiatives is lacking (Rottach et al., 2012). Given the impact that addressing gender factors has on the successful implementation or adoption of proven health practices, it is reasonable to hypothesize that a more systematic approach to ensuring gender awareness in scale-up processes could significantly improve the effectiveness of such efforts. Donors and implementers should undertake efforts to integrate gender into scale-up projects, measure the impact of doing so, and share the outcomes of these efforts.

About the Scale-up Mapping Tool

The Scale-up Mapping Tool, developed by the USAID-supported Health Policy Project, provides program managers with a methodology to systematically integrate gender into scale-up initiatives. This tool focuses on addressing gender in the implementation and scale-up of a best practice rather than integrating gender into the best practice itself. The process begins with a gender-based analysis to identify factors that influence women's and men's experiences related to health and the best practice to be scaled up. The findings inform the development of a scale-up road map with a gender lens.

The tool enables the user to identify when gender-based constraints may arise during the scale-up process, and develop strategies to both address constraints and respond to opportunities to reduce gender inequality during scale-up. Lastly, the user will develop indicators to monitor both the scale-up process and the gender strategies incorporated into the process. At the end of the mapping exercise, the user will have a concrete plan outlining gender barriers that may arise throughout the scale-up process, strategies for addressing them, and indicators to monitor both the scale-up process and the gender strategies incorporated into it.

This tool features a Gender Analysis Template (Step 1; Table 1) and the Integrating Gender into Scale-up Mapping Template (Steps 2–5; Table 2). Illustrative examples for completing the mapping template are provided in Tables 3 and 4.

Step 1: Conduct a gender analysis

Gender analysis is a process by which gender inequities are identified and analyzed in a given cultural context and their implications for health and program outcomes are assessed. Complete the gender analysis table (Table 1) to identify key gender-related barriers to achieving the desired family planning and maternal health outcomes. A gender analysis must be informed by data—through the use of secondary data or primary data collection.

When conducting the gender analysis, consider how the various domains of gender influence how women and men experience health, particularly in the context of the practice or intervention being scaled up (left-most column in Table 1). The domains are

- ***Activities:*** The behaviors and actions of women and men in a particular context
- ***Gender norms:*** The roles, responsibilities, behavior and attributes that a particular society considers appropriate for women and men
- ***Power:*** Capacity to control resources and make decisions that are free from coercion. This domain considers the relative bargaining position of women and men
- ***Access to resources***: The ability to have and use financial, social, and other resources, such as education or political representation
- ***Legal rights and status:*** Rights granted to women and men based on customary, legal, and judiciary codes

Consider multiple levels of the health situation by analyzing personal and household, community, and national or enabling environment factors (Table 1).

- ***Individual and household level:*** The people most affected by the health problem and their close relationships
- ***Community and service-delivery level:*** The organizations, service structures, and providers that exist at the community level
- ***Enabling environment***: National policies and legislation, social and cultural norms, prevailing economic conditions, technology, and the natural environment

Because sociocultural norms vary greatly across geographic areas, users should consider conducting sub-analyses for each area to which the intervention will be expanded. Engaging community groups in this process can be an effective way to gather locally relevant data while promoting community engagement and ownership of the intervention to be scaled up.

For more detailed instructions on conducting a gender analysis, please consult the USAID Interagency Gender Working Group's *Manual for Integrating Gender into Reproductive Health and HIV Programs* or *Guide for Conducting and Managing Gender Assessments.*

GENDER ANALYSIS FRAMEWORK

Health Area: _____ ***Best practice:*** _____

Table 1: Gender Analysis

How does each gender domain influence women's and men's: • Health • Responses to ill-health • Access to health services	**Individual and household level**	**Community and service-delivery level**	**Formal and informal policies, laws, and customs**
Activities of women and men **Gender norms** The **bargaining position (power)** of women and men Women's and men's **access to resources** Women's and men's **legal rights and status**			

Source: Adapted from Caro, 2009

Step 2: Develop a scale-up road map

	Scale-up Phase				
	Pilot test	Partnerships and resource mobilization	Adapt, expand, and disseminate	Institutionalize	Sustain
Activities or steps for each phase					

Scaling up even relatively simple practices can be a complex process. Therefore, many frameworks and approaches have been developed to provide systematic approaches for expanding, adapting, and institutionalizing best practices, and to guide scale-up efforts.

Develop your scale-up road map by drawing on these frameworks. The road map will outline the key phases and activities to scale up the intervention (e.g., pilot test, national-level advocacy, training, adaptation and expansion to other geographic areas).

The mapping template includes proposed scale-up phases, however these are just suggestions. You may revise the phases to align with your scale-up process.

For more detailed information about developing a scale-up strategy see the ExpandNet *Nine Step Guide for Developing a Scaling-up Strategy.*

Step 3: Identify and map key gender barriers to scale-up phases

	Scale-up Phase				
	Pilot test	Partnerships and resource mobilization	Adapt, expand, and disseminate	Institutionalize	Sustain
Gender-related constraints					

Use the results of the gender analysis to identify and map the key gender barriers to the relevant scale-up phase. For example, gender norms vary significantly across geographic areas and within countries and regions. Therefore, cultural and gender beliefs could act as a barrier to expanding an intervention into new geographic areas. Laws restricting women's rights or autonomy could prevent an intervention from being institutionalized within government policies. Opposition to interventions that promote gender equality by key stakeholder groups could inhibit partnership formation and resource mobilization.

Table 3 provides examples of questions to ask in preparation for each scale-up phase to explore related gender barriers.

Step 4: Develop strategies to overcome the gender-related barriers

	Scale-up Phase				
	Pilot test	Partnerships and resource mobilization	Adapt, expand, and disseminate	Institutionalize	Sustain
Strategies to address gender-related constraints					

After identifying the key gender barriers at each phase of scale-up, develop strategies to overcome them and create an enabling environment for change. The strategies will vary extensively depending on the phase of scale-up and the gender barrier to be addressed. Examples of strategies to overcome gender barriers include delivering behavior change communication (BCC) messages that encourage men to attend antenatal visits or conducting advocacy efforts supporting gender equality legislation.

See the case study (on page 8) and Table 4 for illustrative examples of strategies to overcome gender-related barriers at each phase of scale-up.

Step 5: Develop indicators to monitor both the scale-up process and the gender strategies

	Scale-up Phase				
	Pilot test	Partnerships and resource mobilization	Adapt, expand, and disseminate	Institutionalize	Sustain
Indicators					

Lastly, develop indicators to monitor both the scale-up process and the gender strategies incorporated into it. The monitoring indicators will help program managers identify implementation barriers and make any necessary course corrections. Monitoring activities will also help identify what is working well during implementation and build on effective implementation processes.

Including gender-related indicators will help to ensure the gender lens is not lost during implementation. They will also maintain a focus on how the intervention influences women and men differently and monitor progress toward gender equality outcomes.

See the case study (on page 9) and Table 4 for illustrative examples of indicators to monitor the scale-up process and related gender strategies.

INTEGRATING GENDER INTO SCALE-UP: MAPPING EXERCISE

Project description:

Scale-up goal(s):

Table 2: Template for Mapping Gender Barriers to Scale-up Phases

	Scale-up Phase				
	Pilot test	**Partnerships and resource mobilization**	**Adapt, expand, and disseminate**	**Institutionalize**	**Sustain**
Activities or steps for each phase					
Gender-related constraints					
Strategies to address gender-related constraints					
Indicators					

INTEGRATING GENDER INTO SCALE-UP: MAPPING EXERCISE

Table 3: Sample Gender Questions to Consider at Each Phase of Scale-up

	Scale-up Phase				
	Pilot test	**Partnerships and resource mobilization**	**Adapt, expand, and disseminate**	**Institutionalize**	**Sustain**
Activities or steps					
Gender-related constraints	What constraints do women and men face in the intervention area that could impact their access to and use of the intervention? What does the intervention do to overcome the differential constraints that women and men face in accessing it? What could it do better to address these constraints? How does the intervention promote gender equality (e.g., equitable decision-making power or control over resources)?	Does the intervention enjoy broad support across diverse stakeholder groups? Are any groups opposed to scaling up the intervention? Are women, men, and sexual and gender minorities engaged in the scale-up process? Are resources in place at the national, district, and/or local levels to expand the intervention to other geographic areas with a gender lens? Are the resources sufficient to scale up and sustain the components of the intervention that address gender constraints? Are partners and stakeholders experienced in gender-responsive programming? If not, are they willing to commit time and resources to building their own capacity in this area?	What components of the intervention may need to be adapted to fit the local gender context in the expansion areas (e.g., different community practices/social norms, or other factors such as different educational and economic resources)? What gender factors may need to be addressed prior to or during roll out of the intervention to create an enabling environment for change (e.g., social norms that emphasize family planning as the women's responsibility, norms that devalue girls' education).	Do current laws around women's autonomy or adolescents' reproductive rights inhibit successful institutionalization of the intervention in policies and programs? What can be done to address these barriers? What policies need to be developed, adapted, or strengthened to ensure that women and men have equal access to the intervention?	Because gender-sensitive components of an intervention are often the most difficult to replicate on a large scale, they are often the first to be sacrificed. What steps should be taken to ensure that they are sustained? Changing social norms is a lengthy process. What long-term support (e.g., technical, financial, management) is needed to sustain efforts to promote gender equality?

Case Study for Integrating Gender and Monitoring into Scale-Up

This case study examines a maternal health program that aims to reduce maternal mortality by preventing unintended pregnancies and promoting birth spacing through the expansion of high-quality family planning services. The study includes a brief project description and a sample mapping exercise to integrate gender into scale-up.

> The intervention sought to address maternal mortality in Nepal by preventing unintended pregnancies and promoting birth spacing through the expansion of high-quality family planning services. The implementing organization trained female midwives and doctors using an updated training curriculum focused on clinical skills in family planning, particularly IUD insertion, and increasing their family planning knowledge and counseling skills. The project was pilot tested in two districts, and trained 40 doctors and midwives from more than 25 health posts. Findings from the pilot test showed a significant increase (from 53% to 89%) in trainee knowledge of family planning methods and counseling strategies. Clinical skills tests showed an average score of 86 percent in the areas of use of medical instruments, counseling strategies, and IUD insertion and removal. Moreover, family planning use increased in the health post catchment areas from 32 percent to over 48 percent.
>
> Because of the successful pilot, the implementing organization is undertaking efforts to scale up the clinical training program nationally. What steps should the organization take to ensure that gender is addressed in both the intervention itself and the scale-up strategy?

INTEGRATING GENDER INTO SCALE-UP: MAPPING EXERCISE

Project description: Address maternal mortality in Nepal by preventing unintended pregnancies and promoting birth spacing through the expansion of high-quality family planning services

Scale-up goal(s): Institutionalize a clinical training program in national in-service training guidelines, and expand the training to all 75 districts in Nepal

Table 4: Illustrative Example

	Scale-up Phases				
	Pilot test	**Partnerships and resource mobilization**	**Adapt, expand, and disseminate**	**Institutionalize**	**Sustain**
Activities or steps for each phase	Intervention is tested for effectiveness Scalability of the intervention is enhanced	Multisectoral partnerships formed to support and drive scale-up Funding allocated Community engagement and community readiness activities conducted	Intervention is disseminated and expanded to other geographic areas	Intervention is included in policies and programs	Commitment, resources, and implementation are sustained

	Scale-up Phases				
	Pilot test	**Partnerships and resource mobilization**	**Adapt, expand, and disseminate**	**Institutionalize**	**Sustain**
Illustrative indicators for monitoring scale-up	Clearly defined, evidence-based, funded intervention exists	Existence of multisectoral partnerships (horizontal and/or vertical) Funds are allocated to the practice in national and local budgets The practice is included in the current year annual operating plan Number of community members participating in community planning meetings related to the intervention, disaggregated by sex	Number of geographic sites (disaggregated by appropriate level such as region, district, block, etc.) Number of implementation sites (disaggregated by site type, such as hospital, health post, sub-health post) Availability of job aids and service protocols for the practice	Evidence of political support for the practice Examples of the practice being included or supported in national or subnational policy, strategy, guidelines, curricula, or related documents and communications	Continued monitoring and evaluation The health management information system (HMIS) is adapted to capture and report on key information on the implementation of the practice

	Scale-up Phases				
	Pilot test	**Partnerships and resource mobilization**	**Adapt, expand, and disseminate**	**Institutionalize**	**Sustain**
Gender-related constraints (use the results of the gender analysis to identify the relevant gender barriers at each scale-up phase)	Men are the decisionmakers regarding use of contraceptives, yet they often have inaccurate information about contraceptives. Women feel social pressure to have children soon after marriage and to produce a son. This social pressure can limit healthy timing and spacing of pregnancies	Family planning is considered a women's issue. Therefore, it is difficult to mobilize resources for male-friendly family planning services. Potential opposition to family planning services and programs by men, religious groups, or community groups	In new geographic areas, cultural and gender beliefs and access issues may be different. These factors will influence the acceptability of the intervention to the health workers and communities	Potential loss of fidelity to the curriculum once it goes through national reviews (i.e., removal of gender equality language; removal of modules that are inconsistent with existing policies or guidelines) Potential opposition to the intervention by political leaders	Politicians may change—political will and funding priorities may shift away from those promoting gender equality Potential changes in funding related to contraceptives—supplies may not meet women's needs
Strategies to address gender-related constraints	Adapt the training curriculum to include modules for health service providers on couples counseling on family planning and male-friendly reproductive health services Include a community mobilization component in the intervention to promote women's status	Conduct national and local- level advocacy for increased financial resources for the male mobilization component of the intervention Form partnerships with and empower women's groups to demand high-quality and regular reproductive health services at local health facilities	Conduct a brief gender analysis in new districts to tailor a community entry strategy to the gender context Engage with women's and men's groups at the community level to sensitize the community to the intervention, addressing concerns raised in the gender analysis	Engage local NGOs to monitor the curriculum review process and implementation Conduct evidence-based advocacy to change restrictive policies Identify national and local political leaders who are appropriately positioned and willing to champion the intervention	Monitor women's choice (community accountability systems) Monitor DHS data for changes in method mix and contraceptive use

	Scale-up Phases				
	Pilot test	**Partnerships and resource mobilization**	**Adapt, expand, and disseminate**	**Institutionalize**	**Sustain**
Illustrative programmatic indicators	Adapted curriculum distributed to service delivery points Number of providers trained, by type of personnel Number of clients reached, disaggregated by sex Number of couples participating in couples counseling (exit interviews at health clinics) Number of women reporting greater control over their own fertility	Number of women's groups engaged per geographic unit (region, district, block, village, as appropriate) Number of community members trained, disaggregated by sex Number of coaching sessions conducted Number of women who speak at local decision-making forums	Results of gender analysis are shared with stakeholders Number of meetings in given district with key stakeholders Key findings from meetings are incorporated into adaptations Women's perceptions of empowerment and how the intervention influences their empowerment level Men's attitudes toward family planning and female empowerment	Conduct a case study of curriculum development; findings are disseminated to key stakeholders Document desk review process Skills-based review of curriculum with providers (observation or interviews) Development/enhancement of relevant operational policies/guidance	Funds are allocated to support the curriculum roll out in national and local budgets The curriculum is incorporated into the programmatic and technical standards, norms, and practices of relevant systems Number of service delivery sites that adopt the curriculum Community members report uptake of the curriculum at local service delivery points Women's and men's attitudes toward family planning; attitudes toward gender equality

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