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INTEGRATING GENDER INTO THE SCALE-UP OF FAMILY PLANNING AND MATERNAL, NEONATAL, AND CHILD HEALTH PROGRAMS

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



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Integrating Gender into the Scale-Up of Family Planning and Maternal, Neonatal, and Child Health Programs

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This publication was prepared by Elisabeth Rottach,¹ Karen Hardee,¹ Rima Jolivet,² and Rachel Kiesel¹ of the Health Policy Project.

¹ Futures Group, ² White Ribbon Alliance

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Introduction

International initiatives, including the Millennium Development Goals and the U.S. Government's Global Health Initiative, are increasingly recognizing that gender strongly influences the health outcomes of women, men, and children. Evidence shows that gender inequality is a significant barrier to achieving improved family planning and reproductive health. Multiple studies have shown that gender factors, such as women's status and empowerment (i.e., in education, employment, intimate partner relationships, and reproductive health), are linked with women's capacity to access and use maternal health services, a critical component of maternal health (Gill et al., 2011). Still, family planning is typically viewed as the responsibility of women, with programs targeting women and overlooking the role of men—even though men's dominance in decision making, including contraceptive use, has significant implications for family planning (Schuler et al., 2011) and access to reproductive health services (Hou and Ma, 2011).

Gender—the roles, responsibilities, behavior, and attributes that a particular society considers appropriate for men and women.

See <http://www.who.int/topics/gender>.

Relevant literature indicates that the incorporation of strategies to address gender inequality can lead to improved health and program outcomes (Barker et al., 2007; Rottach et al., 2009). Many donors and program implementers have begun to incorporate strategies and approaches that address gender barriers and constraints. However, it is not clear that regular attention is being paid to gender factors during program scale-up. Gender factors influence a range of scale-up processes, including the choice of which

Scale-Up—a process that seeks to deliberately "...increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis" (WHO/ExpandNet, 2010, p. 2).

practices to bring to scale, methods of scale-up, and strategies for reaching target populations. Throughout the scale-up process greater awareness of underlying gender norms and factors could strengthen scale-up efforts through improved understanding of the family planning and maternal, neonatal, and child health (FP/MNCH) issues at hand. A more in-depth understanding of the situation informs development of strategies for *how* to increase reach and access to and use of the intervention.

We conducted a literature review to identify and analyze whether systematic attention to gender factors during the planning and process of scaling up FP/MNCH programs improves the effectiveness of that process. Our hypothesis is that incorporating gender strategies during program scale-up would in fact achieve better programmatic outcomes (e.g., wider availability of health services, health interventions institutionalized and sustained) and health outcomes (e.g., increased contraceptive prevalence rate, decreased maternal mortality rate) among their clients.

Scale-Up of Health Interventions

The term “scale-up” is widely used throughout health literature; however, no universal definition exists. This paper uses the definition of scale-up from ExpandNet, a global network seeking to advance the science and practice of scaling up. The World Health Organization (WHO)/ExpandNet (2010) guide defines scale-up as “deliberate efforts to increase the impact of health innovations tested in pilot or experimental projects so as to benefit more people and to foster policy and program development on a lasting basis” (p.2).

There are four types of scale-up: horizontal, vertical, functional, and spontaneous (WHO/ExpandNet, 2010):

- **Horizontal scale-up**, also known as expansion or replication, is one of the most commonly used scale-up approaches. It is the replication of an innovation in other geographic areas or the extension of a program to reach a larger or different population.
- **Vertical scale-up** is the institutionalization of an innovation through policy, political, legal, regulatory, budgetary, or other health systems changes (also see Hardee et al., 2012).
- **Functional scale-up**, also known as diversification or grafting, involves testing or adding a new innovation to one that is already being scaled up.
- **Spontaneous scale-up** is the diffusion of an innovation without deliberate efforts to spread the innovation.

We examined the first three types (i.e., scale-up that is a planned and guided process). We did not focus explicitly on the scale-up of gender-integrated programs, though these programs are included where appropriate, but rather on how gender has been integrated in the process for scale-up.

Scale-up efforts have been guided by many frameworks, approaches, and guides. Table 1 provides a list and brief descriptions of scale-up methodologies cited in the literature, as well as a discussion on how the frameworks address gender.

Table 1: Scale-Up Frameworks and Approaches

| Names/Authors | Description | How the Framework Addresses Gender |
|--|--|--|
| ExpandNet framework (Simmons et al., 2007, 2010) | <p>Types of scale-up: vertical, horizontal, diversification, and spontaneous.</p> <p>Elements of the framework: innovation, resource team, scale-up strategy, user organizations, and the environment.</p> <p>Strategic choices for scale-up: dissemination and advocacy, organizational process, costs/resource mobilization, and monitoring and evaluation.</p> | One of the framework's underlying principles is "respect for human rights, equity, and gender perspectives," which states that "...scaling up should ensure attention to human dignity, the needs and rights of vulnerable groups and gender perspectives, as well as promote equitable access for all to quality services." |
| Investing in Midwives and Others with Midwifery Skills to Save the Lives of Mothers and Newborns and Improve their Health (UNFPA/ICM Joint Initiative) | <p>A framework for addressing issues of scaling up midwifery at the community level.</p> <p>Factors in scale-up: equity approach, education and training, enabling environment, stewardship, resource mobilization and management, supervision, monitoring and evaluation, and political commitment to access for all.</p> | The program guidance remarks on the importance of gender equality, gender sensitivity in service provision, and gender-sensitive policies and practices in the process of scaling up human resources for midwifery service. |
| From Vision to Large-Scale Change: A Management Framework (Cooley and Kohl, 2006) | Field-tested framework with 10 tasks under the categories of developing a plan; establishing the preconditions for scaling up; and scaling up. Includes such tasks as legitimizing change, building a constituency, mobilizing resources, and modifying organizational structures. | NA |
| Implementing Best Practices Consortium, Guide for Fostering Change (2007) | A phased approach to scaling up, including forming the change coordination team, defining the need for change, planning for demonstration and scale-up, supporting the demonstration, and going to scale. | NA |
| Improvement Collaborative Approach (USAID, Health Care Improvement Project) | An approach to improving healthcare that focuses on a single technical area and spreads existing knowledge or best practices to multiple settings through teams of professionals. | NA |
| Maternal and Child Health Improvement Program (MCHIP) Framework (Fujioka and Smith, 2011) | A conceptual map applied in 30 countries that includes global actions, national strategic choices, program implementation, sustainability (institutionalization), and monitoring and evaluation. | NA |
| Options for Large-Scale Spread of High Impact Interventions (Massoud et al., 2010) | Presents the scientific basis for spreading healthcare innovations based on 20 years of experience in quality improvement in the U.S. and developing countries. Illustrates a range of approaches that can be chosen: affinity group approach, campaign approach, executive mandates, extension agents, emergency mobilization, improvement collaborative approach, leadership development, and natural diffusion. | NA |

Gender Barriers to Scale-Up

Program scale-up can be hindered by numerous barriers, including **supply barriers** (inadequate infrastructure, lack of financial and human resources, unsupportive policies and regulations, and weak health systems), and **demand barriers** (reluctance to use services, lack of transportation, and cost-prohibitive fees for service) (Koblinsky et al., 2006). And many of these barriers are rooted in socio-cultural contexts, including gender norms. When not addressed throughout scale-up processes, gender-related barriers and constraints contribute to limited reach and scale of health interventions:

- At the household and community levels, gender-related barriers can **reduce demand and access** to health services and impede the scale-up of interventions to other geographic areas. These barriers include a lack of women's autonomy, lack of support for women from family and community, and high healthcare costs (Koblinsky et al., 2006).
- Inattention to underlying gender norms while planning for scale-up can **result in discriminatory services** (e.g, those that do not consider men's needs), even if unintentional, and **gender inequities** in access and use (Battistella Nemes et al., 2006; Mangham and Hanson, 2010; Pokhrel et al., 2005).
- When institutionalizing a health practice, ignoring existing gender roles and norms (e.g., women's preference for female providers to insert intrauterine devices) can lead to **resistance to a new policy or practice** by clients, health providers, communities, or policymakers (Koblinsky et al., 2006; Mangham and Hanson, 2010).
- Many governments have made commitments to promoting gender equality; however, such political commitment does not often translate to increased resources or funding to gender-responsive programming (Grown et al., 2006). **Insufficient resource mobilization for scale-up that integrates gender** could significantly limit the reach and effects of scale-up efforts.
- At the project level, integrating gender into the scale-up process is challenging due to the **limited knowledge and experience in gender** of program planners and implementers and resource team members. Training can increase awareness of the benefits of gender integration and improve skills for integrating gender into scale-up (Health Policy Project, 2012).

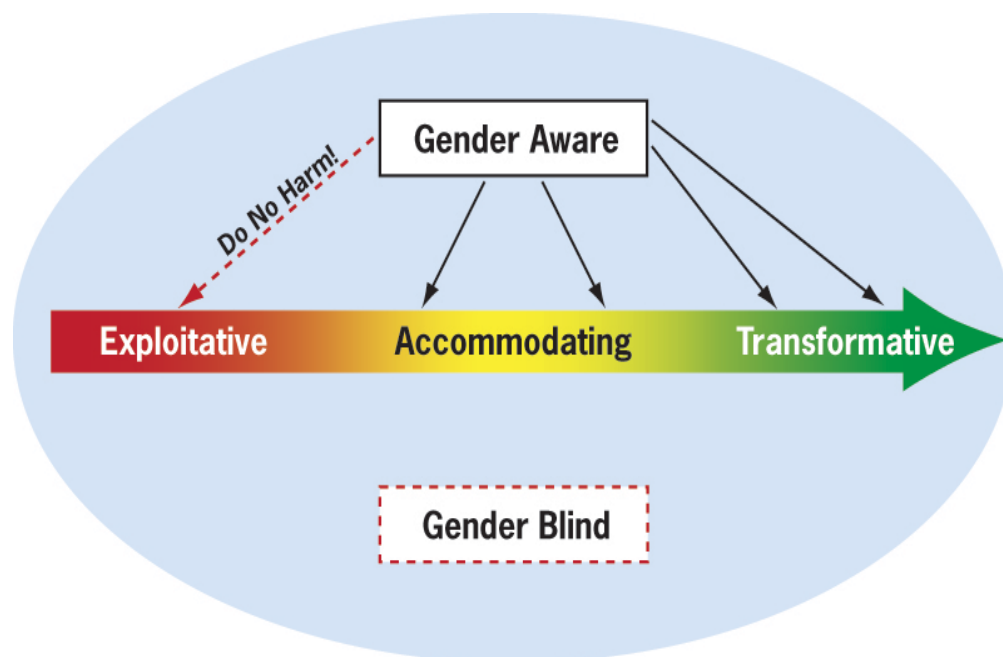
The importance of adequately addressing gender in the design and implementation of efforts to scale up family planning, maternal and child health, and child health programs should not be overlooked. Program managers should consider gender barriers while designing, implementing, and monitoring projects and interventions in order to increase the effectiveness and sustainability of scale-up efforts.

Meeting the Challenges of Scale-Up: Gender Integration

The Gender Integration Continuum

To adequately address the gender barriers to scale-up, the process of gender integration can be applied to strengthen scale-up efforts. Gender integration is the process of taking into account gender norms and the differences and inequalities between men and women in program planning, implementation, and monitoring and evaluation.¹ The USAID-funded Interagency Gender Working Group² (IGWG) has developed a “Gender Integration Continuum,” a framework and tool for understanding the extent to which gender has been addressed in programs (see Figure 1). The continuum categorizes approaches by how they treat gender in the design, implementation, and evaluation of programs and policies.

Figure 1: Gender Integration Continuum



According to the continuum, programs and policies can be either gender blind or gender aware. **Gender-blind programs** do not explicitly articulate how gender issues are being addressed; how gender affects program objectives; or how the objectives, content, structure, or management of programs may affect gender outcomes. In other words, a gender-blind program ignores—often unintentionally—underlying gender constraints and opportunities and is carried out without specific mention or consideration of these underlying gender considerations. **Gender-aware programs** and policies, on the other hand, deliberately examine and address the environment in terms of gender and consider how gender influences program objectives (Caro, 2009). Gender-aware programs may take myriad approaches to incorporating gender considerations in program design and implementation, including conducting gender analysis,

¹ See http://www.usaid.gov/our_work/cross-cutting_programs/wid/gender/index.html.

² See <http://www.igwg.org>. This framework draws from a range of efforts that have used a continuum of approaches to understanding gender, especially as they relate to HIV. Also see Gupta, 2000; Gupta et al., 2002; and WHO/ICRW, 2009.

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developing strategies to address gender barriers and constraints, monitoring gender-related outcomes, and measuring impacts the program has on gender equality.

The continuum illustrates three strategies for gender integration:

1. **Gender-transformative strategies** seek to address gender constraints directly by challenging inequitable gender norms. Examples of gender-transformative strategies include promoting the status of women, addressing power imbalances between women and men, or encouraging critical reflection among women and men of gender norms and roles.
2. **Gender-accommodating strategies** also acknowledge gender constraints; however, instead of challenging inequitable norms, such strategies seek to accommodate or compensate for them. These types of strategies may acknowledge gender constraints and design programs to “work around” the constraints so as to improve access to or use of health services. Gender-accommodating strategies may include engaging men as decisionmakers in family planning or conducting advocacy with community leaders to support family planning.
3. **Gender-exploitative strategies**, found on the left side of the continuum, take advantage of rigid gender norms and existing imbalances in power to achieve the health program objectives. These types of approaches can exasperate existing gender inequality and undermine program efforts in the long term. One example of a gender-exploitative approach is to reinforce men’s dominance in decision making in order to increase contraceptive use. Gender-exploitative approaches are not appropriate strategies for gender integration. As Caro (2009) noted, “The overall objective of gender integration is to move toward gender transformative programs/policies, thus gradually challenging existing gender inequities and promoting positive changes in gender roles, norms, and power dynamics.”

Gender approaches may not fall neatly under one integration category. For example, one strategy may be accommodative in one context and transformative in another, or an accommodative strategy may unexpectedly lead to transformative outcomes such as positive changes in gender norms. The continuum is a useful tool for understanding the range of gender-integration approaches and how they address inequitable gender norms.

Steps for Gender Integration

Gender integration is an iterative process that occurs throughout a program. While a framework specific to integrating gender into scale-up processes does not exist, important lessons can be drawn from the process for integrating gender into programs and policies. The five steps of gender integration include the following:³

1. **Gender analysis.** Collect data on gender relations, norms, roles, and responsibilities in relation to the health needs to be addressed by the program and analyze that information to identify gender-based constraints and opportunities. Gender analyses should be conducted throughout the program.
2. **Strategic planning.** Using the results of the gender analysis, examine and revise program objectives to strengthen linkages between gender and health goals. It is important to define

³ The process of gender integration described here is adapted from Caro 2009.

gender objectives so as to explicitly articulate what the program is trying to achieve in terms of gender outcomes, such as increasing gender equitable attitudes. Gender objectives will be useful in identifying appropriate approaches to meet those objectives.

3. **Designing and adapting.** Design interventions and approaches in support of gender and health objectives. Consideration should be given to whether gender accommodating or gender transformative approaches, or a combination of the two, would be most effective in achieving both improved gender and health outcomes. Findings from the gender analysis should be used to inform the development of gender approaches.
4. **Monitoring.** Develop indicators to measure progress toward gender and health outcomes, as well as the implementation process. Special emphasis should be placed on monitoring how the program is meeting the needs of women and men. Throughout implementation, it is important to re-examine the gender analysis to determine whether additional constraints or opportunities are emerging and then adjust the program accordingly.
5. **Evaluation.** Evaluate the effectiveness of the program in achieving gender and health outcomes. Evaluations can help to determine whether program activities are affecting gender and health outcomes as intended and to inform redesign, where necessary.

Gender Integration in Scale-Up Methodologies

There are numerous approaches and frameworks to guide the scale-up of health programs, but gender has largely been ignored in the majority of scale-up frameworks. Two exceptions are the United Nations Population Fund-International Confederation of Midwives (UNFPA-ICM) Joint Initiative program guidance and the ExpandNet framework, both of which incorporate a gender perspective.

Scale-up Methodologies that Include a Gender Perspective

UNFPA-ICM: Asserts the importance of gender equality, gender sensitivity in service provision, and gender-sensitive policies and practices in the process of scaling up human resources for midwifery services. Although the document does not provide specific guidance on operationalizing gender-sensitive scale-up processes, further technical guidance on scaling up midwifery programs are being developed.

ExpandNet: Mentions gender perspectives as an underlying principle of the framework: "respect for human rights, equity and gender perspectives," with the recommendation that "...scaling up should ensure attention to human dignity, the needs and rights of vulnerable groups and gender perspectives as well as promote equitable access for all to quality services." This principle is mentioned in the ExpandNet nine-step guide for developing a scale-up strategy, but the guidance fails to provide a definition of gender perspectives and lacks clear guidance or resources about how to operationalize gender perspectives throughout the scale-up process.

Other scale-up frameworks (see Table 1 on page 3) make no mention of gender or gender integration, a critical gap in the scale-up literature. Given that there are numerous gender-related barriers to scale-up, without a scale-up framework or guidance on how to address these barriers, the success and effectiveness of scale-up initiatives may be limited.

Integrating Gender into Priority Interventions for Scale-Up

One commonality across all the scale-up frameworks is that any approach or intervention to be scaled up must first be piloted and shown to have some level of effectiveness or success. Pilot projects and interventions are a foundational component of scale-up, and therefore, it is important to look critically at the priority interventions identified for scale-up and understand the degree to which they integrate gender.

Many donors and nongovernmental and other organizations have undertaken efforts to identify and prioritize approaches and interventions that are effective in improving health outcomes and could be brought to scale. These are often referred to as evidence-based, best, proven, or good practices. These practices include a range of interventions, services, and programs that have some level of evidence of effectiveness or success. These practices can fall in several categories: clinical practices or services (e.g., use of misoprostol to prevent post-partum hemorrhage), packages of interventions (e.g., essential newborn care), methods of delivery (e.g., social marketing channels or community health workers), and management or programmatic activities (e.g., supportive supervision).

It is difficult to assess the level of gender integration in lists of best practices because of a lack of available information on the selection criteria used for identifying the practices. On the surface, however, it appears that clinical practices and services are largely gender blind⁴ (i.e., according to the Gender Integration Continuum, they do not explicitly articulate how gender issues are being addressed, how gender affects program objectives, or how programs may affect gender outcomes). This would not be surprising, as the focus of clinical practices is on medical procedures and outcomes rather than on equitable access, treatment, or delivery. More information about the selection criteria is needed, however, before this determination can be made.

Nevertheless, clinical practices and services that do not explicitly integrate gender (and therefore are not considered gender-integrated) can be delivered or implemented using gender-integrated approaches. For example, the Extending Service Delivery Project used various gender-integrated approaches to deliver healthy timing and spacing of pregnancy (HTSP) messages and education in India and Egypt. The project engaged husbands and mothers-in-law in seminars to discuss the benefits of HTSP and worked with communities (husbands, mothers-in-laws, religious leaders, and local authorities) to change social norms around contraceptives (Bitar, 2011).

Other examples of gender-aware best practices in literature can be used to support delivery of and access to clinical practices and services. These practices include working with social networks to change social norms in support of family planning; consulting women on how services can meet their needs; involving women in changes and monitoring quality (USAID, 2011); engaging men in FP counseling; and conducting advocacy in gender-based violence or girls education.⁵ There is increasing evidence of the impact of gender integration on health outcomes and on basic program implementation; however, more rigorous monitoring and evaluation of these gender-aware delivery methods is needed to understand how they influence and affect scale-up, both in terms of spread and institutionalization (horizontal and vertical scale-up).

⁴ A prerequisite of any gender-integrated project or intervention is that it be gender-aware. Therefore, any gender-blind intervention would not be a gender-integrated intervention.

⁵ This list of best practices was developed by the Extending Service Delivery Project and disseminated during its end-of-project workshop in June 2011 in Washington, DC.

Examples of Gender-Integrated Scale-Up Efforts

Program managers and planners interested in integrating gender in scale-up face myriad challenges, as each setting is unique, program objectives may differ, and applying the elements from a framework on an operational level can be difficult for institutions lacking prior experience. What the literature shows, however, is that incorporating at least some elements from evidence-based frameworks and best practices makes a difference in how programs function and whether gender considerations are addressed.

At the same time, there is no specific roadmap that a given program can follow to ensure gender integration in scale-up. The following three case studies—which illustrate both successes and challenges—are therefore instructive in how different programs addressed integration. Each started with a commitment to do so and found ways to be both strategic and flexible in creating approaches to meet their objectives. Importantly, all three case studies applied a systematic approach to scale-up and provide lessons learned for integrating gender into scale-up efforts.

The Warmi Project—Bolivia

The Warmi Project, implemented in Bolivia by Save the Children, Inc., started in 1990 as a demonstration project in Inquisivi Province (Gonzalez et al., 1998). The project used a participatory methodology, now termed the Community Action Cycle, to improve maternal and neonatal health at the community level. The Community Action Cycle consists of four phases: autodiagnosis, or problem identification and prioritization; planning together; implementation; and participatory evaluation.

Following a successful demonstration project, the project began an expansion phase of the Community Action Cycle in eight of Bolivia's nine departments, reaching more than 500 communities and 200,000 women of reproductive age. Save the Children held participatory workshops and follow-up coaching and mentoring visits in each region throughout the country to train nongovernmental organizations and district ministry of health facilitators in the Community Action Cycle methodology. Project partners were given the flexibility and support to adapt the methodology to their local context, but in general, project partners used the following scale-up strategies:

- Develop, implement, and document a successful demonstration project
- Disseminate project methods and results
- Advocate to build consensus and influence policy
- Mobilize resources
- Define the organizational structure and philosophy of the national project
- Establish agreements with partners (Ministry of Health and nongovernmental organizations)
- Provide training and technical assistance
- Coordinate activities with partner agencies
- Develop and use monitoring and evaluation systems
- Sustain health improvements and use of the project methodology in the future

The Warmi Project developed and implemented a systematic scale-up strategy that overlapped in many ways with the scale-up framework developed by ExpandNet (2010). For example, scale-up began with a demonstration project to test the effectiveness of the Community Action Cycle. The scale-up strategy included both horizontal scale-up (expanding geographic coverage to more than 500 communities) and

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vertical scale-up (the Warmi methodology was included in the national health plan as an approach to working with communities to improve maternal and neonatal health).

Scale-up results showed that, nationwide, 445 Warmi women's groups were organized and, in all cases, the methodology helped to increase women's participation in the community. Women's group members developed their own communication skills and learned how to plan interventions and negotiate with other community organizations to improve health conditions. Unfortunately, there were insufficient resources to measure health outcomes during the national scale-up phase.

From a gender perspective, the Warmi Project exemplifies how gender can be integrated into a scale-up methodology. Beginning with the pilot test, the intervention itself integrated gender by empowering women and meaningfully involving men and increasing their interest and participation in maternal and neonatal health. The evaluation of the pilot project included gender-related indicators, including women's participation in the community and men's attitudes toward women's groups.

Bolivia: Gender-Integrated Strategies During Scale-Up

- Used results of the pilot test to advocate and build consensus for scaling up the approach—increasing how women's reproductive health was valued, garnering support for the methodology, institutionalizing it in the national health plan, and raising the status of community midwives by including them in the district referral network.
- Considered gender norms in disseminating and expanding the methodology to new communities, as the methodology was encouraging women's participation in community and household decision making; thus, considered the socio-cultural factors specific to each community and made adjustments when necessary.
- Monitored and evaluated gender-related indicators throughout scale-up, providing evidence on the impact on gender outcomes.

Community-based Health Planning and Services Scale-Up Model—Ghana

The Ghana Community-based Health Planning and Services (CHPS) initiative is a national program designed to scale up a health service model that utilized community nurses and volunteers to improve health and family planning services (Nyonator et al., 2007; Nyonator et al., 2005). The program undertook significant efforts in designing and testing the health service model prior to scale-up. This rigorous testing and evaluation is credited as being one of the critical factors leading to its success.

In 2000, once the service model was developed, the government of Ghana launched the CHPS initiative, a national program for scaling up the use of community nurses and volunteers in this way. The model for national scale-up included logistical, staffing, and training components, including preliminary planning, community entry, creation of community health compounds, posting of community health officers, equipment procurement, and volunteer deployment.

An assessment in 2004 showed that the CHPS initiative had made significant progress since it was first launched. In 2004, 105 out of 110 district health management teams had initiated planning activities. Scale-up has been supported by the institutionalization of CHPS in government policies, a key step in creating an enabling environment for change. The service model continues to be adapted to the local context through demonstration districts in each region, with peer training across districts used as the basic model for national expansion.

Ghana: Gender-Integrated Strategies During Scale-Up

- During community entry, engaged a broad range of stakeholders, including village leaders, men, women, and health workers, to assess their perceived needs of health services and inform adaptations to the program.
- Provided community volunteers with a six-week training course in community health mobilization, which emphasized promoting family planning and reproductive health among men and engaging their support and participation.

Importantly, the CHPS initiative incorporated a number of gender-integrated practices and approaches throughout the scale-up process. First, during the testing of the innovation, the project was attentive to the needs of both men and women and elicited their input on how to address gender constraints in the service model. During the scale-up phase, expanding the service model to new communities included two important gender-integrated strategies.

A study conducted by Adongo and others (forthcoming) showed that during pilot testing (an experiment known as the Navrongo Community Health and Family Planning Project), male mobilization strategies combined with family planning service provision were effective in significantly reducing the total fertility rate in the experimental villages. According to the same authors,

volunteers who joined the program following completion of the study did not receive training in male mobilization methods, an unfortunate omission. Interestingly, they found that during the expansion phase, areas not implementing or that had not initially implemented the male mobilization approach did not see significant decline in fertility rates. It appears that scale-up of the CHPS could have benefitted from institutionalization (vertical scale-up) of the male mobilization approach, which proved successful in combination with health service provision.

The experience in Ghana with this national, government-led initiative to scale-up health services using a gender-integrated scale-up strategy, demonstrates that gender strategies can have a positive impact on health and gender outcomes; however, institutionalization of such approaches is necessary to sustain their continued expansion to other areas.

Increasing Health Service Visits and Family Planning Use among Young Women—India

The final case study illustrates the importance of addressing gender barriers throughout the scale-up process. In collaboration with the Extending Service Delivery Project, the Population Council led a project to scale up high-quality antenatal and postpartum care in Uttar Pradesh, India (Bitar, 2011). The program sought to expand such care through a package of interventions that included integrating family planning counseling into antenatal care and postpartum services; expanding family planning and maternal, neonatal, and child health education to husbands, mothers-in-law, and community leaders; introducing community worker supervision; and fostering coordination and partnerships.

India: Gender-Integrated Strategies During Scale-Up

- Engaged men in FP counseling and included them as a target audience for FP messages and education.

Following an operations research phase, the project was replicated in 52 villages. To implement the package of interventions, several activities were carried out: training of community health workers and

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private practitioners; implementation of education campaigns targeting women, husbands, mothers-in-law, and opinion leaders; and the establishment of a supervision system. Findings from an analysis of the replication showed a number of positive program and health outcomes. Results included increases in the proportion of community health workers who counseled on family planning and safe motherhood issues, greater use of family planning methods by couples in the communities studied, and increases in antenatal care visits.

The project also identified numerous challenges, ranging from logistical and operational to socio-cultural constraints. One key challenge was the existing patriarchal society in rural India. The fact that men are the household decisionmakers posed challenges for increasing contraceptive use among program participants, since women in the program did not always have the autonomy to decide whether to use contraceptives or which method to choose. Within the intervention, additional strategies could have included empowering women to negotiate contraceptive use and efforts to increase shared decision making. Within the scale-up process, additional strategies could have been used to advocate for or support women's contraceptive use and reproductive rights.

Lessons Learned from Integrating Gender into Scale-Up Efforts

During our analysis of case studies and other gray and published literature, we identified many lessons learned in scaling up health interventions that address gender (see the Recommendations section). Importantly, we noted that scant evidence exists on the impact of gender integration on the effectiveness of scale-up efforts, both in terms of programmatic outcomes (e.g., wider availability of health services, health interventions institutionalized and sustained) and health outcomes (e.g., increased contraceptive prevalence rate, decreased maternal mortality rate). Moreover, we found few scale-up frameworks and methodologies that systematically integrate gender into the process of program scale-up. Likewise, few programs have systematically integrated gender throughout the scale-up process. Even those that did integrate gender into the scale-up process did not adequately monitor and evaluate the effects of addressing gender in program planning or design, making it difficult to ascertain the true impact of gender integration on scale-up. The following are some of the key lessons identified:

- **Increasing access to a health service, promoting social or behavior change, or improving the use of health products all require increases in demand** (Implementing Best Practices Consortium, 2007). Gender norms can act as barriers to demand creation by not appropriately meeting the needs of women or not addressing the concerns of men. Understanding the socio-cultural environment, including gender roles and norms, is critical to achieving improved health outcomes (Bitar, 2011; Gonzalez et al., 2008; Nyonator et al., 2007; Nyonator et al., 2005).
- **Engaging a broad range of stakeholders representing men's and women's groups** is important for program effectiveness (Gonzalez et al., 2008; Nyonator et al., 2007; Nyonator et al., 2005). Increasing ownership and acceptance of an intervention or practice is increased dramatically when communities are engaged and drive the process. Ensuring broad representation can increase the likelihood that the intervention meets the needs of women, men, and vulnerable populations.
- When scaling up a given intervention to other geographic areas—such as expanding family planning to remote areas—**the intervention and scale-up strategy may need adjusting to fit different contexts in terms of gender** (Bitar, 2011; Gonzalez et al., 2008). Adaptation of an intervention to new contexts, without comprising the fidelity of the intervention, is critical to its acceptance and success. Additionally, acceptance of and buy-in to the intervention being scaled up can be improved through the application of gender-integrated strategies to deliver a best practice (Gonzalez et al., 2008; Nyonator et al., 2007; Nyonator et al., 2005).
- **Government commitment, in terms of policy and additional resources, is necessary in effectively scaling up gender approaches and integrating gender into the scale-up process** (Nyonator et al., 2007; Nyonator et al., 2005).
- **Improved monitoring and evaluation systems are needed** to understand how integrating gender into scale-up frameworks and processes can affect the effectiveness of scaling up health interventions.

Key Actions to Integrate Gender into the Scale-Up Process

A critical appraisal of scale-up methods and selected experiences by different programs and in various countries with scale-up suggests that insufficient attention is paid to gender. Given the known impact that addressing gender factors can have 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.

To systematically integrate gender into the scale-up process, program planners and managers should consider the following steps and recommendations. Given the limited evidence on the impact of operationalizing these recommendations, all could warrant further investigation:⁶

Preliminary Phase: Integration into scale-up frameworks and approaches

- **Integrate gender into scale-up frameworks and approaches.** There are many opportunities and entry points for integrating gender into scale-up frameworks. As an important first step, authors and developers of scale-up frameworks should more clearly articulate the role of gender in scale-up processes. This adaptation should also include development of guiding principles for a gender-integrated scale-up process. Lastly, existing gender integration frameworks can be adapted to provide concrete guidance on operationalizing gender integration in scale-up.

Step 1: Pilot testing

- **Conduct a gender assessment.** Identify and address gender barriers and opportunities relevant to scale-up, as a part of the process for assessing scalability of a best practice. It can be viewed as a process for screening a best practice to understand how it would influence gender outcomes and what, in terms of gender, should be monitored. Gender assessments should help inform decisions about how to scale up and guide development of a scale-up roadmap. Assessments should be conducted throughout the scale-up process to ensure adequate monitoring and evaluation of the program in terms of gender outcomes.
- **Develop approaches to address gender that can be brought to scale.** A number of gender-integrated pilot or small-scale and time-intensive projects have been tested and shown to improve health and gender outcomes. Emphasis should be placed on testing gender-integrated innovations to determine costs and feasibility of scaling up the interventions.

Step 2: Planning and team formation

- **Form a gender diverse resource team.**
 - Engage a broad range of stakeholders representing women's and men's groups and vulnerable populations. Meaningful participation from myriad stakeholders ensures that

⁶ Many recommendations were discussed during the *Expert Meeting on Policy Implementation and Gender Integration in Scale-Up of FP/MNCH Best Practices*, held December 12, 2011, at Futures Group in Washington, DC.

multiple perspectives and opinions inform the design and implementation of health programs. Broad engagement also increases cultural sensitivity, awareness of underlying gender barriers and constraints, and community ownership. Consider as well that women and men are not homogenous groups and therefore should be further disaggregated by age, ethnicity, and other relevant characteristics.

- **Provide gender training, support, and team building.**
 - As part of the team-building process, provide training on rights and gender integration or gender mainstreaming. The data from the gender assessment can be used to inform the training's content and tailor it to the gender context.
 - Support development of a shared vision among the resource team of the practice to be scaled up and the gender dimensions and considerations connected with the practice.
- **Develop gender objectives.**
 - Using the results of the gender assessment, develop scale-up and program objectives for gender equality.

Step 3: Development of a scale-up strategy

- **Map strategies to address gender-based constraints and opportunities.**
 - Conduct a mapping exercise to identify how and when to address gender-based constraints and opportunities and reduce gender equality gaps throughout the scale-up process. A mapping tool or similar exercise will help ensure that the findings from the gender analysis are brought into the planning and strategy development process and can inform the development of a gender-aware scale-up strategy. See the Maternal and Child Health Improvement Program's scale-up framework for a sample mapping tool that could be adapted to integrate gender (Fujikoya and Smith, 2011).
- **Mobilize resources.**
 - Mobilize resources for gender-integrated programs through advocacy to decisionmakers and policymakers. Adequate political commitment and financial resources for scaling up health programs using approaches that address gender considerations in a systematic way are crucial to success, both in terms of programmatic outcomes and health outcomes. Emphasis should be placed on increasing commitments for integrating gender throughout the scale-up process.

Step 4: Monitoring and evaluation

- **Measure gender-based constraints and opportunities.**
 - Use the results of the gender assessment to inform development of the monitoring and evaluation plan to better understand how gender factors influence the process, outcomes, and impact. The monitoring and evaluation plan should include gender-specific indicators and benchmarks, as well as the collection of sex-disaggregated data. The process of scale-up, as well as health and gender equality, should be measured.
 - Overall, little evidence exists on the role of gender in the scale-up process. Program planners and implementers have an important role in building the evidence base for gender integration and scale-up so health decisionmakers worldwide can better understand how to design, implement, and monitor scale-up efforts that will lead to equitable and more sustainable health outcomes.

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Step 5: Implementation

- **Make the scale-up process participatory and inclusive.**
 - Establish feedback mechanisms to enable proper monitoring and ensure that necessary adjustments can be identified.
- **Monitor discrimination and the exercise of rights.**
 - During implementation, scale-up programs should monitor discrimination against or perceived by women, men, and vulnerable groups to ensure equitable access to services and products and fair and respectful treatment by health providers.

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For more information, contact:

Health Policy Project
Futures Group
One Thomas Circle, NW, Suite 200
Washington, DC 20005
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
<http://www.healthpolicyproject.com>