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STRENGTHENING HEALTH OUTCOMES FOR WOMEN AND CHILDREN

Lessons from Senegal

FOSTERING GENDER-RESPONSIVE, ADOLESCENT-FRIENDLY HEALTHCARE IN A YOUNG POPULATION

The Senegal experience

THE PROJECT

Countries where populations have a youth bulge need a context-based, differentiated strategy to implement programs to save lives and improve the wellbeing of women, children, and adolescents. *Strengthening Health Outcomes for Women and Children* (SHOW) project[i] in Senegal is an example of working for the health and wellbeing of women and adolescent girls and bringing gender into focus in such circumstances.

The SHOW project[ii] is a gender-transformative initiative aimed at increasing the quality, availability, utilization and accountability of essential Maternal, Newborn and Child Health/Sexual and Reproductive Health (MNCH/SRH) services to reduce maternal and child mortality amongst marginalized and vulnerable women, specifically adolescent girls, and their children in targeted regions across five countries (Bangladesh, Ghana, Haiti, Nigeria and Senegal).

With support from Global Affairs Canada (GAC)[iii], Plan International Canada worked in partnership with Plan Country Office, the Government of Senegal, and Local Non-Governmental Organization (LNGO) partners to deliver the SHOW project between January 30, 2016 and September 30, 2022. In August 2020 and March 2021, the SHOW project received two Costed Extensions (CE) from GAC focused on the Coronavirus Disease 2019 (COVID-19) response in Bangladesh, Senegal, Ghana and Nigeria.

In Senegal, the SHOW project was implemented[iv] in nine districts of the country. The districts belonged to the regions of Kaolack, Louga, Tamba, Kedougou, Sedhiou, Ziguinchor, and Dakar, including the vulnerable peri-urban area of Pikine. The districts were selected in collaboration with the Ministry of Health (MoH) based on MoH priorities, community consultations, donor mapping, and Demographic and Household Survey (DHS) results.

The project started with a comprehensive situation analysis, which comprised a desk review and consultations with stakeholders, a baseline survey of households and health facilities, and a qualitative exploration of gender-related issues in the overall health and social environment. Informed by this situation analysis, the project adopted gender-transformative, rights-based approaches to build the foundations of Gender-Responsive and Adolescent-Friendly (GRAF) healthcare in poor and underserved regions of the country. The project aimed to bring this transformative change by enhancing access to and raising awareness surrounding Maternal, Newborn, and Child Health/Sexual and Reproductive Health and Rights (MNCH/SRHR), including family planning. Aligned with the United Nation's *Every Woman Every Child Global Strategy for Women's, Children's, and Adolescent's Health* to achieve the Sustainable Development Goals 3 (health & wellbeing) and 5

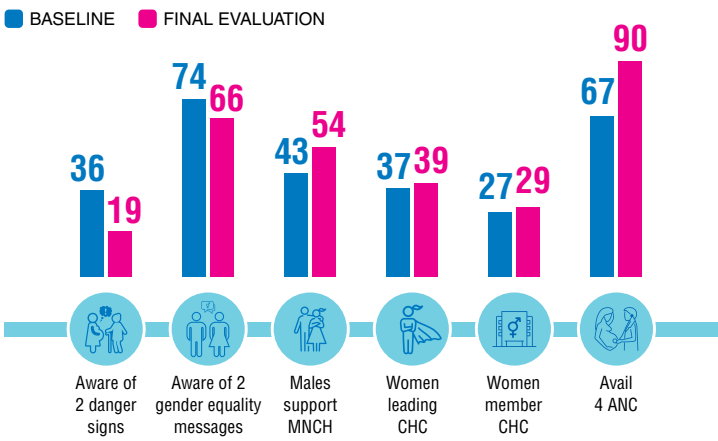
FIGURE 1: THREE PILLARS OF SHOW STRATEGY AND THEIR OUTCOMES IN SENEGAL

COUNTRY CONTEXT

Population: 17 million
Fertility rate: 4.4%
MMR: 315/100,000
<5 mortality: 45/1000
Newborn mortality: 22/1000

SEVEN REGIONS

Population: >3 million
Below poverty: 79%
Child marriage: 11% - 57%
Modern contraceptives: 26%



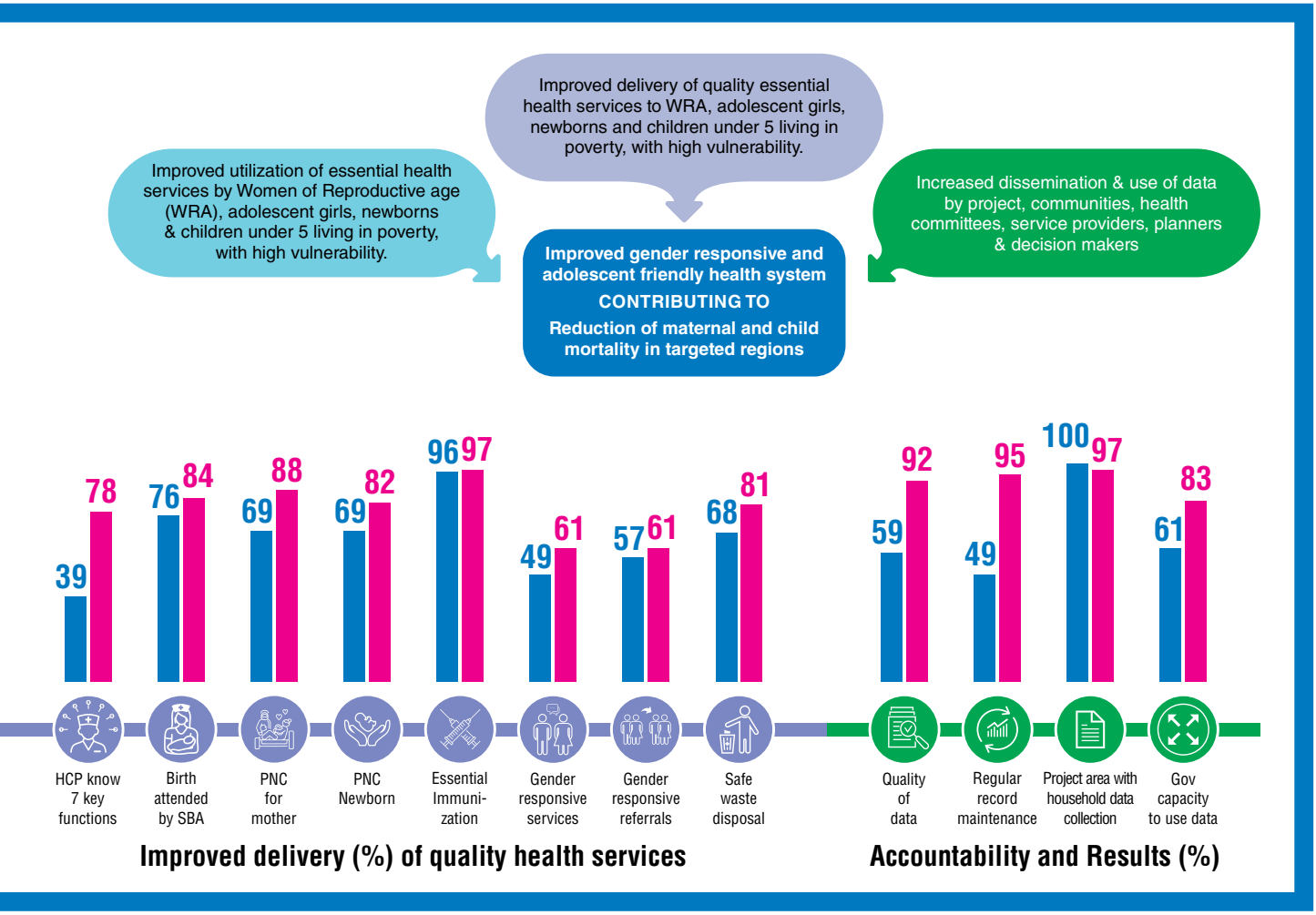
Improved utilization (%) of essential health services

(gender equality), the project worked on three parallel streams:

1. Building the individual and collective agency of women and adolescent girls by enhancing their decision-making power in the household, community and health committees and engaging men as partners and beneficiaries of gender equality in the continuum of MNCH/SRHR care.
2. Health Systems Strengthening to improve the availability, accessibility, quality and gender- and adolescent- responsiveness of MNCH/SRHR services.
3. Improving data collection, analysis, data sharing, and its utilization in the decisions to ensure accountability of health services to the communities, particularly women and adolescent girls.

SHOW achieved[v] a cumulative reach of 1,400,586 direct beneficiaries, of whom 566,464 are women (140,347 aged 15-19 and 426,117 aged 20-49) and 493,697 are men (117,885 boys aged 15-19 and 376,812 men aged 20-49). The project also reached a number of indirect beneficiaries at different levels, including 1300 health service providers and 1312 Community Health Workers (CHWs). Moreover, the project reached 270 village savings and credit association members, 38 fathers' clubs, 36 Family Life Education (FLE) clubs, 14 husbands' schools, and 218 grandmothers' groups.

The project evaluations[vi] conducted at baseline and end line showed overall improvement in all intervention areas aimed at improving health service utilization. However, two indicators, i.e., awareness about danger signs during the continuum of pregnancy and knowledge about



gender equality, dropped over time (Figure 1). All indicators for the second pillar of SHOW strategy, i.e., improving the delivery of quality health services, improved during the project's life. All but one indicator related to community-based and gender-sensitive data systems and accountability - the project's third pillar- showed improvement.

The SHOW project addressed the gender inequality that women and girls of reproductive age experience across the spectrum of relationships, structures (both in households and community), and a multi-tiered health system. The project and its stakeholders co-created an evidence-informed, robust model applicable to a sustained and contextualized gender transformative change. The results indicate that SHOW elements can be systematically integrated across different health system levels to optimize health and gender equality outcomes. Learning lessons and managing knowledge from such projects is vital to facilitate evidence-based decision-making in future programs.

Knowledge management is a process of generating, curating, adopting, disseminating, and managing evidence[vii]. The present report is a documentation of the knowledge gleaned from the design, deployment, implementation, and conclusion stages of key select initiatives of the SHOW project in Senegal. Developing these lessons involved three steps: a desk review of the program documents and reports, discussions with project staff in Senegal and Plan International Canada, and a member-checking of the findings. Discussions focused on the broad functions of the project, namely demand generation, service provision, results and accountability, project operations, and sustainability. The project's theory of change, implementation challenges, measures to address them, observed results, and emerging best practices were explored.

This lessons-learned report is a triangulation[viii] of findings from various perspectives. The methodological triangulation involved examining quantitative survey data and asking "why" questions emerging from it. Theoretical triangulation comprises exploring the views of several stakeholders to develop a holistic picture from multiple perspectives, and environmental triangulation involves taking care of the perspectives coming from diverse geographical or social locations. Lessons learned from these discussions and data analysis are presented under five headings on the following pages. A summary of the best practices is also included in a tabulated form.

LESSONS LEARNED FROM THE PROJECT

1. DEMAND SIDE OF HEALTH SYSTEM STRENGTHENING

Empowering women, engaging men, and the local community were core aspects of the project's strategy, emphasizing adolescent health literacy, enhancing men's support for women's decision-making, and strengthening Village Savings and Loans Association (VSLA) for women's financial autonomy. The objective was to increase the knowledge of women and their families about MNCH/SRH and gender equality, increase the number of women in a leadership role, and improve men's support of women. Senegal's overall population is youthful, with a median age of 18. The country has a defined Health Policy with some strategic programs directly applicable to MNCH: the Strategic Reproductive Health Plan 2012 – 2015; the National Child Survival Strategic Plan 2007 – 2015; and the Community Health National Strategic Plan 2014 – 2018. SHOW leveraged the opportunities these policies provided for bringing a gender focus to the strategies and their implementation.

Challenges

The rollout of the strategy met several challenges that emerged from a combination of poverty, illiteracy and long-held family values and a patriarchal society. For example:

- As a norm, women hide their pregnancy for the first 12 weeks in Senegal, which posed a barrier to their availing of Antenatal Care (ANC) visits
- The culture of not disclosing pregnancy because of shame was particularly strong in the case of adolescents who showed a higher reluctance to avail ANC; even talking about it was difficult. However, a transition in the attitudes of adolescents and their families and community was also notable, whereby the adolescents could be more independent and open about their personal life and SRHR decisions
- A highly patriarchal culture posed a strong barrier to gender transformative change

Course correction

TIn a conservative and patriarchal setting, the SHOW team took several steps that addressed the social and demand-related issues in an integrated way. The project engaged community-based organizations (CBOs) and their volunteers to visit women in their households and talk to them. The household visits provided an opportunity to pay personalized attention to their issues. Coupled with this, the meetings of VSLAs- a valued platform for women's financial interests- were also used to have group discussions about women's health issues and the importance of accessing appropriate services before, during, and after pregnancy. Grandmothers enjoy a strong influence in household affairs,

but their lack of awareness about modern approaches to healthcare was a barrier. The SHOW team activated Grannies Clubs to enhance their knowledge and enable their support for women and adolescent girls. Lastly, the team addressed the barriers of negative masculinities by increasing male involvement through husband groups (called Husband Schools). After listening to grandmothers about men's role in their wife's and babies' health, and the same from religious leaders in the church or mosque, men would discuss these issues in husband schools and learn solutions from each other.

Results

These steps helped create a gender-responsive and adolescent-friendly environment in households, communities and health facilities. Women's leadership and participation in the Community Health Committee (CHC) and men's support towards women improved over time. The attitudinal improvement was also reflected in health-seeking behaviors as the proportion of women availing of four antenatal checkups also increased. However, the knowledge retention about danger signs during pregnancy and about gender equality dropped a bit from baseline to endline.

- The proportion of women who received ANC from a qualified health professional at least four times during pregnancy increased from 64% to 74% between baseline and endline.
- Women's membership in CHC improved from 27% to 29%, while the leadership in CHC also improved from 37% to 39%. Men's support for MNCH also improved from 43% to 54%, i.e., an increase of 11 percentage points during the project life.
- There was a decline in the proportion of WRAs and their male partners who could name two danger signs, falling from 36% to 19%. The knowledge about GE also dropped from 74% to 66% during this time. A bigger contribution to this decline came from adolescent girls.
- Behavior and attitude indicators that improved show a higher increment among the WRA aged 20-49 years than the younger counterparts aged 15-19 years. Likewise, the knowledge indicators that declined over time also show a higher decline among the younger age group. These differentials indicate the need for more nuanced communication approaches for the younger age groups.
- In the qualitative discussions about women's groups, the WRA 15-19 years who availed antenatal care informed that they found participation in older women's groups more valuable than their own groups. This finding was contrary to the common belief that younger women want separate groups than older women.

Best practices

- Grandmothers have a strong influence on men and the overall family affairs; involving them in MNCH/SRH discourse at the family and community level works for the projects
- At the community level, religious leaders also influence men; leveraging their sway by engaging with clergy is a good strategy
- One size fits all does not work when engaging with youth through IEC materials and strategies. MNCH/SRH projects need to develop designs that are human-centred and audience-specific, and responsive to the gaps highlighted by the implementation monitoring for their improved effectiveness.
- Demand strategies work better when linked with health facilities that provide client-centered approaches for gender-responsive and adolescent-friendly health services.

2. IMPROVED DELIVERY OF QUALITY ESSENTIAL MNCH AND SRH SERVICES

The seven regions where the SHOW project worked had high levels of poverty among the people and dilapidated status of health facilities. Lack of quality services and unfriendly provider attitudes were reported as critical factors among women and adolescent girls' gender-related barriers to accessing services. The project focused on infrastructure rehabilitation, providing equipment and building staff capacity through training. In addition, the project also aimed at creating *adolescent-friendly health spaces* in health facilities.

Challenges

A project working on improving health services for better health outcomes while aiming for its interventions to be sustainable can face several challenges. Examples include:

- Changing the attitudes and practices of Health Care Providers (HCPs) to integrate gender equality and encourage women and adolescent girls to access health care facilities
- A mismatch between the availability of health staff during the afternoon and evening hours when women could conveniently come after finishing their household chores, or other work responsibilities
- The preexisting ethos of service delivery with more focus on clinical skills and less emphasis on human-centred approaches with a total lack of gender sensitivity, especially toward adolescents

Course correction

SHOW rehabilitated a total of 46 health facilities, equipped 48 health facilities and trained 1,300 service providers to improve the provision of GRAF MNH/SRH services. Notably, the project also advocated for space available for men in the waiting rooms and an increase in the availability of adolescent-specific resources and BCC materials. In partnership with the MOH, the SHOW team revised the training materials and manual for Basic Emergency Obstetric and Newborn Care (BEmONC), embedding a gender-sensitive and adolescent-friendly approach into the capacity-building program of healthcare providers. Leveraging human-centered designs, the team, in consultation with health facility staff and endorsement of the health ministry, created adolescent-friendly spaces where the health needs of adolescents could be addressed by trained staff.

The project worked with staff to build their capacity to be gender sensitive and adolescent-friendly to the clients. Moreover, the team advocated with the health facility and district health management to enhance the availability of staff at the health facility so that women, when they visit the health facility, find the staff available and accessible. To sustain the GRAF/MNH SRHR care, the SHOW team emphasized supportive supervision. Three essential elements were focused to make supportive supervision effective and sustainable beyond the project's life. One, the supervisory staff were also trained as master trainers on GRAF healthcare to have full knowledge of the subject for which supervision is required. The same orientation was also provided to CHC members as they had the overall leadership of a health facility. Two, the existing government checklists were adapted by integrating GRAF elements into them to minimize the number of tools and burden of work during supervision activities. Three, SHOW provided continuous on-job capacity building to supervisors through joint supportive supervision visits with government personnel over the life of the SHOW project.

Results

The investments in health service delivery returned positive results, visible in comparing indicators from the baseline to the endline.

- The proportions of live births attended by Skilled Birth Attendant (SBA) increased over time. The increase was higher from 74% to 96% (22 percentage points) among WRA aged 20-49 years than adolescent mothers, who improved from 78% to 96% (18 percentage points) during the same time.
- Availing postnatal care (PNC) within two days of delivery increased overall. The increase was 71% to 88% (17 percentage points) among WRA aged 20-49 years while from 66% to 88% (22 percentage points) among the WRA aged 15-19 years.
- The space available for men in the general waiting room increased from 14% at baseline to 29% of the health facilities at the end line. Similarly, the availability of Behavior Change Communication (BCC) materials related to adolescent pregnancy increased from 56% to 66% over the project's life.
- There was an overall improvement in satisfaction with gender-responsive services and referrals. The older WRA showed higher service satisfaction (76% increasing to 81% versus 80%, increasing to 83%) while younger WRA felt more satisfied with referrals (66% rising to 90% versus 60% to 80%) over the life of the project.

Best practices

- Improving service provision involves strengthening health workers' skills and providing appropriate equipment and infrastructure to create a user-friendly, safe and confidential environment for service delivery.
- Strengthening the capacity of providers on MNCH/ SRH and gender, combined with advocacy within the health authorities on gender mainstreaming, contributes to filling the gender gap in service provision
- In demography characterized by a youth bulge, focusing on service delivery to meet the needs of the younger population brings significant results and improves the overall indicators of health and population.

3. DATA FOR ACCOUNTABILITY AND RESULTS

Improved data collection, data sharing and its utilization for decisions at several levels of healthcare was the third strategic pillar of the SHOW project. It required developing and adapting an existing system (CommCare with partners Africare) that ensured inclusion of women and adolescents from the community, data disaggregation, and its sharing with all the stakeholders for shared decision-making during joint review sessions- heralding a culture of transparency through data sharing and accountability.

Challenges

The proposed modifications to the existing data system met several challenges. Notably:

- The acceptability by the system of the inclusion of women and adolescent girls from the community- a new element to the existing Health Management Information System (HMIS)- was low
- The Monitoring and Evaluation (M&E) staff available with the departments and ministry of health to implement the new data system was deficient in number, and the distances to cover for the field visits were huge
- In addition to scarcity, the skill level of the available staff in the department of health also needed some boosting
- The language of some indicators was confusing, and had to go through several iterations before finalization.

Course correction

The project team started by carrying out advocacy meetings with the MOH officials, a process maintained throughout the implementation of this pillar of the SHOW project. With this initial onboarding, the team, in collaboration with M&E stakeholders, started developing the data collection tools and management software. Adequate revision and

validation of the revised tools were done to ensure that the tools capture precise data. Afterwards, the team created an android-based data system to capture and upload data in real-time. The use of technology also reduced travelling distances in the field that the data team had to cover. Additional M&E staff were hired and the entire team trained on the new tools where necessary. Lastly, the project started sharing data with the community through community forums in ways that community members could understand, comment on, and participate in relevant decisions. To ensure a consultative process through all phases, the team organized a total of 15 review meetings under the leadership of local authorities, with the effective participation of community members, and eight meetings of the project steering committee, which provided oversight to M&E development, in addition to several other functions.

Results

The corrective measures to address the challenges faced by the data collection mechanisms produced the following results:

- Recording of the data from the community and its reporting in disaggregated form has started and is well integrated into the country's HMIS
- As illustrated by the SHOW evaluation indicators, the data management capacity of the government, the record maintenance at the health facility, and the quality of the recorded data, all three areas improved over the project life
- Data sharing with the community enhanced accountability and improved evidence-based decision-making by the system

Best practices

- A comprehensive data collection system includes data from the community and requires sufficient staff and technical capacity along with complete ownership of the government to implement such a data system fully
- The validation of tools with the government M&E staff to modify the indicator language before the digitization helps collect meaningful, reliable and locally usable data
- Effective data systems achieve completeness when the participating communities can also access the data, understand it, and participate in decision-making, based on this data.

4. PROJECT OPERATIONS

Being a multi-partner, multi-stakeholder project, SHOW was a complex intervention that aimed to improve gender equality in society as a pathway to improved survival and health of mothers, children and adolescents in eight districts belonging to seven regions of the country. Aligned with the policies of Global Affairs Canada, SHOW started as an MNCH project focusing on gender equality; SRHR added later to its mandate. The project was implemented through the Government of Senegal's health facilities and Civil Society Organization (CSO) partners, including CRS and PanAfrica. SHOW had clear conceptual design and activity plans, an efficient rollout of these plans, and a learning system for effective operationalization. Our explorations of the operations of the SHOW project reveal some important findings summarized below.

Challenges

Aiming to bring a social change at the household, community and health facility level that leads to improvement in health indicators, the project worked with several departments and stakeholders. This multi-sectoral coordination faced several challenges, which are as follows:

- Coordination with state machinery, especially MoH, and making sure that activities are in line with Government strategies while also fulfilling the community needs
- Harmful societal and patriarchal norms were difficult to change through traditional health education messaging
- Finding appropriate staff from a patriarchal community for a health project with social ambitions was not easy
- COVID-19 posed unforeseen challenges during the culminating phases of the project, including the endline evaluation

Course correction

The project realized the two primary challenges early in its implementation and adopted two cardinal strategies for outcomes with sustainable effects. Firstly, to address the long-held cultural norms of considering pregnancy taboo, the project engaged Community Based Organizations (CBOs) working on feminist issues and reached the community through their community-based workers. Secondly, the team involved state authorities in this multi-stakeholder project so that the interventions enjoy the likelihood of adoption by health, as well as other departments and ministries. Lastly, the project evaluation was delayed so as to prevent community transmission of COVID-19 and protect health workers in the field. Meanwhile, the support to the communities through awareness raising about COVID-19 protection and provision of personal protective equipment (PPE) continued during the extended phase of the project.

Results

The measures proved helpful in the operationalization of the project. Following are some salient results:

- The decentralization of decision-making through PSC, TAG and management through locally responsible mechanisms like CHCs played an important role in achieving program objectives.
- The district management teams actively participated in various workshops and supported the implementation of training sessions. In addition, they monitored the community actors and organized the management of the use of the equipment and ambulances in collaboration with the local authorities to ensure their sustainability.
- State law revised the age of marriage, increasing it from 15 to 19 years

Best practices

- The decentralized mechanisms like PSC and TAG for oversight and CHCs for local leadership and management improve the efficiency and effectiveness of multi-partner, multi-stakeholder, complex projects
- Innovations brought in by development projects are implemented successfully and have good chances of sustainability if these are delivered through the existing government systems
- A health project working through a social pathway and involving different sectors and departments performs optimally if the partners and stakeholders are involved right from the beginning for their understanding, ownership and continued support.

5. SUSTAINABILITY

SHOW's sustainability plan consisted of a four-dimensional framework: 1) Institutional: institutional/managerial capacity of communities and authorities to sustain the gains of the project; 2) Technical: maintaining the quality of interventions; 3) Financial: financial capacity of communities to afford the services, complemented by the commitment of government/authorities to allocate financial resources to support the continued implementation of the interventions; and 4) Social: Generating change in individual attitudes and behaviours that is transformational and sustainable over time, ideally by generating intergenerational change within families and communities.

Challenges

The sustainability of a donor-funded project can be challenging because the per capita resources available for implementation are sizeable compared to the ongoing government resources. The challenges become compounded when a project is implemented in the setting of poverty. For example, women may not travel to a distant health facility for ANC because of monetary reasons, in spite of knowing the importance of ANC. Similarly, in an underserved area, the community may not fully understand the commitments and responsibilities of their government and how to respond to inefficiency.

Course correction

The project took several corrective measures to address the challenges, including:

- Involved the Ministry of Health in all data monitoring activities to enable the health authorities to maintain and manage the innovations introduced by the project (ICT tools for HMIS).
- Strengthened the monitoring of SHOW field activities to ensure data quality by government staff, partners and community representatives. 27 joint monitoring visits were carried out during the reporting period.
- Focused on the institutional arrangements (engaged partners like UNFPA with a mandate to raise awareness) so that awareness-raising initiatives like husband schools continue after the project
- Created 238 village saving groups (AVEC) for resource mobilization and the ability of women to pay the MNCH/SRH service fees
- Organized interactions between adolescents, parents or other caregivers and influential community leaders through awareness sessions, dialogue, celebrations of special events and focus groups on an identified problem in the community.

Results

- UNFPA is supporting the Ministry of Woman Affairs to continue the Husband Schools. VSLAs are self-sustaining, while adolescent spaces (in health facilities) are being supervised jointly by the health facility staff and adolescents themselves
- Community groups that oversee their facility's performance are active even after the conclusion of the project
- The peer-support groups of adolescents (both boys and girls) actively work and continue their social mobilization.

Best practices

- Developing a sustainability plan that addresses all aspects of continuation of the beneficial strategies, and sharing and reviewing it in collaboration with partners, improves the sustainability of a project
- In resource-poor settings, leaving the hardware like vehicles, computers and handheld devices for continued implementation of activities after the closure of the project is helpful
- Engaging local communities, especially women and girls, in the planning and decision-making processes is pivotal for all aspects (institutional, technical, financial, and social) of sustainability.

SUMMARY OF THE BEST PRACTICES FROM THE SHOW PROJECT IN SENEGAL

Demand for woman and adolescent girl-focused MNCH/SRH care

- Grandmothers have a strong influence on men and the overall family affairs; involving them in MNCH/SRH discourse at the family and community level works for the projects
- At the community level, religious leaders also have an influence on men. Leveraging their sway by engaging with clergy is a good strategy
- One size- fits all does not work when it comes to engaging with youth through IEC materials and strategies. MNCH/SRH projects need to develop designs that are human-centred and audience-specific, and responsive to the gaps highlighted by the implementation monitoring for their improved effectiveness.
- Demand strategies work better when linked with health facilities that provide client-centered approaches for gender-responsive and adolescent-friendly health services.

Health services with a focus on gender equality

- Improving service provision involves strengthening health workers' skills and providing appropriate equipment and infrastructure to create a user-friendly, safe and confidential environment for service delivery.
- Strengthening the capacity of providers on MNCH/ SRH and gender, combined with advocacy within the health authorities on gender mainstreaming, contributes to filling the gender gap in service provision
- In demography characterized by a youth bulge, focusing on service delivery to meet the needs of the younger population brings significant results and improves the overall indicators of health and population.

Accountability through improved data sharing

- A comprehensive data collection system includes data from the community and requires sufficient staff and technical capacity along with complete ownership of the government to fully implement such a data system
- The validation of tools with the government M&E staff to modify the indicator language before the digitization helps collect meaningful, reliable and locally usable data
- Effective data systems achieve completeness when the participating communities can also access the data, understand it, and participate in decision-making, based on this data.

Operationalization

- The decentralized mechanisms like PSC and TAG for oversight and CHCs for local leadership and management improve the efficiency and effectiveness of multi-partner, multi-stakeholder, complex projects
- innovations brought in by development projects are implemented successfully and have good chances of sustainability if these delivered through the existing government systems
- A health project working through a social pathway and involving different sectors and departments performs optimally if the partners and stakeholders are involved right from the beginning for their understanding, ownership and continued support

Sustainability

- Developing a sustainability plan that addresses all aspects of continuation of the beneficial strategies, and sharing and reviewing it in collaboration with partners, improves the sustainability of a project
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[i] Global Affairs Canada. https://w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/d001999001

[ii] Plan International Canada. https://plan-international.org/case-studies/health-and-gender-equality-strengthened-in-5-countries/

[iii] Global Affairs Canada. https://w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/d001999001

[iv] Plan International Canada. https://plan-international.org/case-studies/health-and-gender-equality-strengthened-in-5-countries/

[v] Plan International Canada. Final report (January 2016-June 2022) Project Number: D-001999

[vi] Plan International Canada. Final report (January 2016-June 2022) Project Number: D-001999

[vii] Agency for Healthcare Research and Quality, 2019. How learning health systems learn: lessons from the field

[viii] Guion, L.A., 2002. Triangulation: Establishing the Validity of Qualitative Studies. Institute of Food and Agricultural Sciences: University of Florida, Department of Family, Youth and Community Sciences

Acronyms

AHC: Adolescent Health Corner

BEmONC: Basic Emergency Obstetric and Neonatal Care

CBO: Community Based Organization

CHMIS: Community Health Management Information System

CMW: Community Midwife

DGHS: Director General Health Services

DHIS: District Health Information System

EmONC: Emergency Obstetric and Neonatal Care

FWV: Family Welfare Visitor

GE: Gender Equality

HMIS: Health Management Information System

IMNCI: Integrated Management of Childhood Illnesses

LNGO: Local Non-Governmental Organization

LMIC: Low- and Middle-Income Country

M&E: Monitoring and Evaluation

MoH&FW: Ministry of Health and Family Welfare

PIP: Project Implementation Plan

PNC: Postnatal Care

SBA: Skilled Birth Attendant

SHOW: Strengthening Health Outcomes for Women and Children

TAG: Technical Advisory Group

UH&FWC: Union Health and Family Welfare Centre

VSLA: Village Saving and Loan Association

WRA: Woman of Reproductive Age

AWP: Annual Work Plan

ANC: Antenatal Care

CHC: Community Health Committee

CHW: Community Health Worker

CSO: Civil Society Organization

DHS: Demographic and Health Survey

DWA: Department of Women Affairs

GAC: Global Affairs Canada

GRAF: Gender-Responsive, Adolescent-Friendly

HFA: Health Facility Assessment

IEC: Information, Education, Communication

IYCF: Infant and Young Child Feeding

LAMB: Lutheran Aid to Medicine in Bangladesh

MART: Maternal Awareness and Referral Tracking

MNCH: Maternal, Newborn and Child Health

MoW&CA: Ministry of Woman and Child Affairs

PMF: Performance Measurement Framework

PSC: Project Steering Committee

SBCC: Social and Behavior Change Communication

SRH: Sexual and Reproductive Health

TfD: Theatre for Development

UH&FWC-MC: Union Health and Family Welfare Centre Management Committee

WATCH: Women and Their Children's Health

YPSA: Young Power in Social Action

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Plan International Inc.
245 Eglinton Avenue East
Suite 300
Toronto ON M4P 0B3
Canada

416 920-1654
1 800 387-1418
info@plancanada.ca
plancanada.ca

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