



Canada 

GENDER-RESPONSIVE MNCH/SRH SERVICE DELIVERY

Guide for Health Facility Staff



Please Note: This guide was developed by Plan International Canada’s gender equality and health teams to assist health facility staff in their provision of gender-responsive MN(C)H/SRH services, primarily for use by Plan International Country Offices implementing MNCH/SRH projects. The information and guidance included in this document however, can be applied to any number of projects or organization working on improved sexual, reproductive, maternal, newborn, and child health services.

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OBJECTIVES OF THIS GUIDE

This Guide¹ is meant for the capacity building of all levels of facility based health workers as well as health planners/decision-makers, managers/supervisors for: 1) building their understanding of the interplay of gender inequality with the social determinants of health which in turn have a critical impact on health outcomes; 2) supporting them in taking up contextually relevant measures for making their MN(C)H/SRH specifically and broader health delivery systems gender-responsive.

Health programs generally focus on:

- 1) Creating demand for health services by working with men and women and adolescent girls and boys by integrating gender equality in increasing their knowledge of MN(C)H/SRH issues and services and addressing some household and community gender-related barriers facing women and girls in accessing and utilizing health services;
- 2) Addressing a variety of health service delivery shortfalls through technical capacity building of health providers, providing necessary equipment, supplies and medical commodities, putting in place clean and safe delivery mechanisms, supporting better clinic management including better data collection, strengthening community health governance structures and strengthening referral linkages.

However, it is becoming increasingly clear, that the supply side gaps in meeting the unique gendered needs of women and girls and their male partners are equally important factors that determine uptake of services. Evidence suggests, that while inadequate or poor quality of services are key reasons for low utilization by clients; inappropriate and gender un-responsive service delivery is an equally important factor for non or low utilization of services.

It is increasingly becoming clear that gender responsiveness needs to be embedded as one the intrinsic goals of any health system which has two sub-elements related to upholding the health rights and dignity of persons and client orientation. Therefore, it follows, gender-responsiveness should be seen as an inherent goal of any health system **as a core quality of service delivery** element in health system strengthening. Many countries, in varying ways articulate a commitment to addressing gender related barriers in health care-seeking through supply side measures in national (and/or sub-national) policies and/or strategies, regulatory documents for driving better MN(C)H/SRH outcomes.² The commitment is unequivocally there; there is only a need to operationalize this commitment in a context appropriate manner by taking systemic measures as described in this Guide.

This Guide sets out:

- The intersection of gender inequality with the social determinants of health and common gender-related issues and barriers women and girls and their male partners face in accessing and utilizing health care so as to sensitize health providers and planners of gender dimensions that can affect care-seeking and treatment compliance.
- Some common gender-sensitivity gaps in health service provision to orient health providers and planners in recognizing them and addressing them.

¹ This Guide draws on several resources. Primarily Promundo, CulturaSalud, and REDMAS (2013). Program P – A Manual for Engaging Men in Fatherhood, Caregiving, Maternal and Child Health. Promundo: Rio de Janeiro, Brazil and Washington, D.C. USA; Save the Children (2014). *Improving Nutrition for Mothers, Newborns and Children in Afghanistan: a Facilitator's Guide: Gender Training for Community Health Workers in Afghanistan*. Ottawa

² Such as the Health Sector Gender Policy, Ghana (2009), the Women Friendly Hospital Initiative, Bangladesh, Institutionalization of Gender Health Plan, Senegal (2015-2021) and health objectives articulated in the national gender equality policies and plans in all countries.



- A framework or “working definition” of what constitutes minimal standards of gender-responsive health service delivery that health planners and care providers can adopt according to their national protocols.
- Simple and practical actions health providers can take to make services gender-responsive across the MN(C)H/SRH continuum of care.

The content of this Guide is:

- Primarily for any organization or project implementing MN(C)H/SRH projects:
 - Advocacy meetings with national/sub-national ministries of Health and Women’s Affairs to draft PowerPoint presentations and/or handouts
 - Health service provider training material development and review that will be added to technical training such as BEMoNC, CEMoNC, F-IMNCI, HBB, KMC etc.
 - Training of trainers for health service providers (government, private or CSO)
 - Training of health supervisors and managers
 - Orientation/training of community health committees
 - Orientation/training of project partners implementing MN(C)H/SRH related activities
 - Orientation of project stakeholders

This Guide has been developed: 1) to address the knowledge gap in stakeholders (especially health system policy-makers/planners; service providers and health governance mechanisms (community health committees etc.) regarding what comprises of gender responsive service delivery for advocacy activities; 2) to provide a framework for the various capacity building activities including training of health service providers, supervisors/managers etc.; 3) to provide core content for national and sub-national advocacy initiatives with decision-makers and for orientation of community based governance structures.

This is a multi-purpose generic guide thereby requiring adaptation suited to: 1) the country context; 2) the purpose for which it will be used. For example for an advocacy/sensitization meeting with high level government officials, you would not require the practical guidance for health service providers given below, but would focus on the need for gender-responsive service provision, the national commitments (see annex 2 with brief country details please add/change as required) and the broad framework (suggested content from section 1 to 2.5 up to the box on the importance of male engagement). For training of health providers, the full content would be necessary and exercises would need to be added (suggested below in text boxes). However, during adaptation, it is recommended that as minimal as possible changes are made in the content, given the standards established here are minimal ones already.

Please note, this guide is only about **gender-responsive service delivery**, a separate guide relating to adolescent friendly service provision has been provided.

1. THE HEALTH AND GENDER NEXUS

1.1 UNDERSTANDING GENDER

Sex refers to the biological differences between women and men. These are universal and timeless. E.g. only women across time and around the world bear children and breastfeed.

Gender refers to the social interpretations and values given to being a woman, man, boy or girl. More specifically, it refers to the way behaviours and identities are determined through the process of socialization. The roles and expectations of women and men are usually unequal in terms of power, agency and control over decision-making, assets and freedom of action. They are specific to every culture and change over time.

Sex	Gender
Biological	Socially constructed
Universal	Culturally Specific
Born with	Learned
Cannot be changed or difficult to change	Changes over time

SUGGESTED EXERCISE #1: SEX AND GENDER

Ask the group of health providers/supervisors in training to brainstorm/ “Wordstorm” or free-list of words describing men and women.

Woman	Man

Questions:

- What words describe a woman; what words describe a man? Write them in the table categories.
- Which words purely represent the sex difference between men and women?
- Which words can describe both men and women?

1.2 GENDER SOCIALIZATION AND ITS EFFECTS

Socially constructed gender norms and values affect all of us all the time- from the time we are born, across our life cycles. Messages of the social difference between boys/ men, girls / women are communicated to us by institutions that are closest to us – family, community, school, religious institutions and continue to be communicated to us through society and its institutions.

SUGGESTED EXERCISES #2: GENDER SOCIALIZATION

Personal reflection in pairs

When was the first time you realized you were a boy or girl?

- What was the message that led to this realization?
- Who communicated it to you?
- Where was the message communicated?
- How did you feel?
- What impact can this have on us as boys or girls?

The effects of gender socialization

While social constructions of gender vary from place to place, inequalities between boys and girls and women and men occur everywhere; and as a result of them.

- Boys and girls **learn different skills** that give them different advantages over the other.
- Boys and girls **receive different opportunities and treatment** that give them different advantages over the other.
- Boys and girls grow up believing their **capabilities are different and develop behaviours** to conform, giving them different advantages over the other.
- Boys and girls as they grow end up taking **different roles and responsibilities** giving them different advantages over the other.

Gender socialization leading to discrimination and inequality:

Gender socialization boxes women and girls and men and women into specific roles and stereotypes and has effects at several levels with damaging consequences not only for individuals but also for society:

At the personal level

- **It violates integrity** by reducing to a single characteristic or attribute which often cannot be changed
- **It denies** means of self-fulfillment to optimal potential
- **It has a negative cumulative effect** - not a singular one-time or isolated experience; faced in multiple settings and often through the life cycle

At the societal level

- It denies social cohesion and development
- It creates instability and wealth destruction
- It reduces productivity (household and national)
- It causes poverty and exclusion



The effects of gender-based discrimination on women (and girls) by and large around the world are grave, placing women and girls at a disadvantage relative to men and boys:

- Women commonly have less decision making power (in the community and household as well as nationally).
- Women commonly do not have equal control over household or development resources.
- Woman commonly face strong access barriers to information and resources.

However, certain gender norms within a society may not necessarily lead to harmful inequalities, such as when gender norms are flexible and women and men, girls and boys, have the opportunity to make their own choices.

1.3 INFLUENCE OF GENDER ON MN(C)H/SRH OUTCOMES

The health status of women and men, girls and boys is influenced by gender also. Prevailing gender inequality and related barriers at the household, community and health facility level are key determinants of MN(C)H/SRH. While the impact of gender issues varies by degree and nature within each country's socio-cultural context, **three clusters of gender issues and barriers** are consistently pervasive that have direct bearing on poor MN(C)H/SRH access, utilization and outcomes.

1) **Low status and low agency of women and girls** *contributing to:*

- Disproportionate burden of domestic care work on women and girls
- High rates of child marriage and early child bearing
- Restrictions on autonomy, mobility and decision-making at the household level to seek MN(C)H/SRH information and services independently
- Lack of access to and control over financial resources
- High rates of Gender Based Violence
- Low educational status, low knowledge of MN(C)H/SRH and ability to access MNCH information

2) **Existing patriarchal traditions leading to lack of/low male support for MN(C)H/SRH**

- MN(C)H/SRH viewed as solely a women's concern thereby distancing or excluding men from taking up responsibility in caregiving in the household
- Low knowledge of men and boys about MN(C)H/SRH risks and issues
- Low participation in birth preparedness planning
- Low participation and support to women and girls over the MN(C)H/SRH continuum of care

SUGGESTED EXERCISE #3: KABULA'S STORY

Kabula (give local name) is a 17 year old mother of one daughter, now 5 months pregnant with another child...

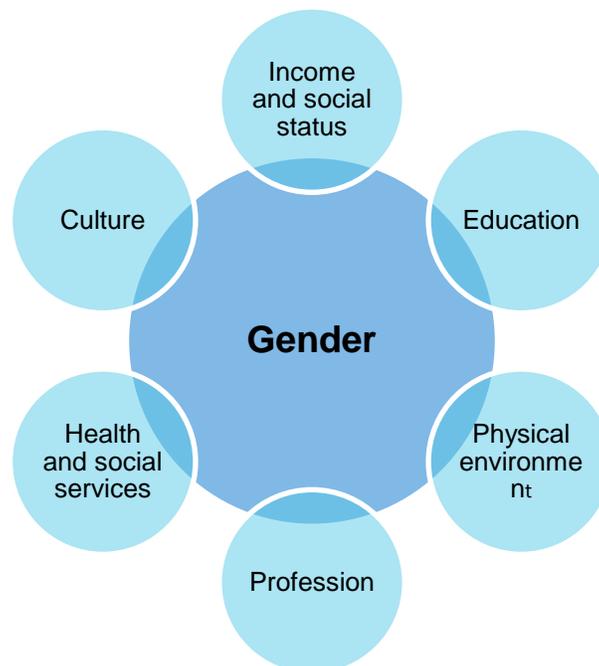
Group Discussion:

- What are key issues Kabula will face in accessing and utilizing MN(C)H/SRH services?
- Why does Kabula face these issues?

Note: Full exercise can be found in **Annex 2**.

1.4 INTERSECTION OF GENDER AND THE SOCIAL DETERMINANTS OF HEALTH

The social determinants of health refer to the conditions in which people are born, grow, live, work and age, as well as the health systems that are put in place. These are decisive factors influencing people's health. Gender has a bearing on each of the social determinants





Education: an individual's education level influences their ability to read and understand health information. Gender norms often accord lower priority to girls' education, resulting in lower educational status of women and girls relative to boys and men, thereby limiting their ability to read and understand health/MN(C)H/SRH information.

Income and social status: an individual's access to and control over resources influences their ability to purchase nutritious food and seek health care. Due to gender norms women have fewer employment opportunities, are financially dependent on men/family members, have little independent access to financial resources or decision-making over the usage of income in households, thereby reducing their financial capacity to access health/MN(C)H/SRH care. Furthermore gender norms often restrict women's mobility, requiring permission from male partners or family members, restricting travelling far if services are at a distance, women's lower financial independences often leaves them incapable of paying transportation charges, women's household workload and care work often leaves little time for them to access services, thereby compromising their ability to access social or health/MN(C)H/SRH services.

Physical environment: an individual's living conditions and work patterns influences whether they are exposed to certain pathogens, such as malaria. Gender-related roles and responsibilities relating to women's role increases their exposure to water-borne diseases due to household water sourcing, pollutants related to poor stoves due to cooking and exposure to sanitation related diseases due to their cleaning and child and elder care, thereby contributing to increased MN(C)H/SRH risks.

Profession/work: an individual's working conditions will influence what they are exposed to, such as chemicals. Due to gender related values, women tend to be employed in precarious unregulated work or work as unpaid agricultural workers in rural areas. The tasks performed by them are invariably low technology based involving hard labour, such as manual weeding, seeding, cutting etc., thereby exposing them to higher risks of contaminants and poor posture related health/MN(C)H/SRH risks.

Culture: cultural and harmful traditional practices and norms such as female genital mutilation and cutting (FGM/C), early marriage, or son preference, or dietary restrictions during pregnancy, or breastfeeding related restrictions etc. invariably affect women and girls more negatively relative to men and boys, thereby increasing MN(C)H/SRH risks and complications.

Health and social services: an individual's ability to access health and social services (such as health insurance) influences their health. Often the way health services are organized, in gender unaware ways, limits women's access. For example: hours of service provision don't fit with availability of women and their male partners; lack of privacy, lack of appropriate space for men, lack of separated toilets, etc. are forms of gender insensitive infrastructure.

SUGGESTED EXERCISE #4: SOCIAL DETERMINANTS OF HEALTH

Small group work: divide participants in three equal groups giving them two Social Determinants of Health each; ask participants to brainstorm how gender-related barriers, issues and norms influence the social determinants of health.

Groups report back in plenary.

2. GENDER-RESPONSIVE MN(C)H SERVICE DELIVERY-A CORE QUALITY OF CARE ELEMENT

2.1 SIX DIMENSIONS OF QUALITY OF CARE

The globally recognized framework³ relating to the quality of health care includes six aims for health care systems:

- **Safe:** Avoiding harm to patients from the care that is intended to help them.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Each of the above dimensions has gender-based implications, as following:

- **Safe:** In addition to safe medical procedures and treatment as well as infection free facility environments; the facility's physical environment also needs to be free of any potential of sexual harassment or abuse (both for clients and health providers) that can occur due to unsafe toilets or hallways that are poorly lit, or water source being far outside the facility for example. "Safe" also implies an environment created through protocols of privacy and confidentiality where clients "feel" safe in accessing services. This has particular salience for adolescent girls who may face social stigma in accessing MN(C)H/SRH services. Therefore an expanded definition of "safe" is required integrating gender dimensions.
- **Effective:** In addition to the critical aspect of scientifically proven beneficial services, effectiveness is also related to the capacity of clients to comply with treatment and gender plays a large part in women's and girls' capacity to adhere to prescribed treatment. For example, if bed rest is prescribed for a risky pregnancy, her gender role in the distribution of household and productive labour may be a barrier in complying. Therefore the definition of effectiveness needs to be broadened with an understanding of how gender can influence effectiveness.
- **Patient-centred:** In addition to the crucial values of patient-centred service delivery listed above, there is a need to: 1) avoid looking at a "patient" as an undifferentiated monolith. Patients are men, women and girls and boys with unique gender needs and interests; 2) ensure health care supports their health rights and autonomy. This entails broadening the concept of client-

³ Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

centeredness by integrating gender-responsiveness and active empowerment of women and girls through the elimination of protocols and procedures undermining their agency.

- **Timely and efficient:** In addition to reducing wait times and avoiding wastage of resources, that are critical to a good health system, timeliness and efficiency also relate to the way services are organized. Fragmented service provision requiring multiple visits to facilities make assumptions about the availability of time women on women's hands, unmindful of their household care and productive work and disregard the gender related barriers women face due to lack of financial resources to make frequent visits, or permission to make frequent visits. As such timeliness and efficiency need to be understood from a gender perspective in order to make these quality dimensions relevant.
- **Equitable:** Gender as understood in the definition above refers to the sex of the client, meaning that the quality of care should not be contingent on whether the client is male or female. Indeed gender cross-cuts each of the categories noted in the description above as we saw in the social determinants of health. A gender equitable health delivery system would consider gender related barriers women face in accessing and utilizing care; would address those barriers by putting in place measures that make it equally possible for women and girls to access and utilize services and would actively remove systemic barriers to their health autonomy and rights.

2.2 WHY IS GENDER-RESPONSIVENESS IMPORTANT IN QUALITY MN(C)H/SRH SERVICE DELIVERY?

As we have seen above gender inequality, gender-related barriers and issues put the health of millions of women and girls at risk. Addressing gender equality in health enables the important work to improve the health of women and girls.

Understanding and addressing gender-related causes of poor MN(C)H/SRH outcomes enables quality, appropriate and adequate service provision that:

- Meets the unique and specific needs of women and adolescent girls
- Upholds women's and girls' health rights and actively promotes their empowerment and health related autonomy and decision-making
- Recognizes the vital role male partners and fathers play in the health of women and children
- Actively promotes and expands the level of men's active and equal engagement in the MN(C)H/SRH continuum of care as well as joint parental responsibility
- Creates a health facility environment that welcomes and includes men
- Takes into account ways in which gender issues may cause vulnerability, risk and disadvantage that can affect treatment seeking and compliance with necessary treatment and care in MN(C)H/SRH.

SUGGESTED EXERCISE #5: THE IMPORTANCE OF GENDER-RESPONSIVENESS IN QUALITY MN(C)H/SRH SERVICE DELIVERY

Facilitate a group brainstorm on why gender-responsiveness is important in quality MN(C)H/SRH service delivery.

OR

Divide participants in groups of 4-5 buzz groups to discuss why gender-responsiveness is important in quality MN(C)H/SRH service delivery.

Take a quick round for inputs and top up with the content above.

Note: It is important everyone agrees with the importance of gender-responsive service delivery!

2.3 WHAT ARE SOME KEY ELEMENTS OF GENDER-RESPONSIVE SERVICE DELIVERY?

1) MN(C)H/SRH/health policy and services take gender needs and priorities into account.

- Gender responsiveness is a key component of any health operational plan that needs to be developed for the improvement of the quality of service delivery
- Evidence based: collecting using health data that is disaggregated by sex and age and a gender lens is applied
- Gender responsiveness questions are integrated in Health Facility Assessments
- Gender sensitization is integrated as a core training module for all health providers and training content is reviewed with a gender lens
- All service and treatment protocols are developed and reviewed by routinely and systematically applying a gender lens
- Voices of women and girls are equally heard and taken into account through consultation with health committees/governance structures across the board
- Quality assurance mechanisms such as supportive supervision include a gender responsiveness lens
- MN(C)H/SRH service registers/protocols specifically notate presence of men
- Structural/systemic barriers to women's and girls' health rights/autonomy and access to care are removed (e.g. user fees, bringing materials for delivery, service timing bars, male consent for any service etc.)

2) Client-provider relationships are based on principles of non-discrimination, trust, respect, inclusivity and dignity.

- Human resources for health across tiers are trained/sensitized on gender equality issues and barriers impeding MN(C)H/SRH service uptake as part of their professional training
- Gender-responsiveness guidelines are developed and communicated to staff
- Staff/facility recognition measures for gender-responsiveness are put in place
- Systems of receiving client feedback are put in place and acted upon

3) Facility environment and infrastructure is inclusive of and welcoming for male partners of women of child bearing age for MN(C)H/SRH services.

- Gender responsiveness questions are integrated in Health Facility Assessments to determine infrastructure needs
- Gender-specific infrastructure is put in place relating to:
 - audio and visual privacy of clients and their male partners;
 - safety;
 - separate toilets for men/boys and women/girls;
 - appropriate waiting areas/rooms;
- Measures to include male partners of clients during ANC counseling; delivery and PNC
- Provide gender-sensitive IEC material on MN(C)H/SRH to men highlighting their role in the MN(C)H/SRH continuum
- Facility based gender-transformative MN(C)H/SRH education sessions are routinely organized for male partners/family members of clients

SUGGESTED EXERCISE #6: KEY ELEMENTS OF GENDER-RESPONSIVE SERVICE DELIVERY

Present the **three headings** only. Break participants into three groups to identify what would need to happen in each element to make service provision gender responsive.

Groups report back in plenary.

Top up with the points under each heading after each group presentation, inviting other groups' feedback.

2.4 WHAT ARE SOME GENDER-RESPONSIVENESS GAPS IN QUALITY MN(C)H/SRH SERVICE DELIVERY?

Quality-of-care gaps are not just due to technical details or medical reasons (although these play a large and crucial part in service quality); they are also linked to ignoring gender issues and responsiveness within the health service setting. What are some of the gaps?

- **Fragmentation of services:** Often services offered do not consider the constraints women face in accessing health care including physical, socio-cultural, economic, time constraints and gender-based barriers. For example different timings for different services (family planning/child immunization etc.) or different locations for different services (ANC at one place and Tetanus vaccination at another) can create an extra burden on women who may have to come back several times to the health facility or travel between different locations to obtain the services.
- **Inappropriate or culturally insensitive staffing** such as male health providers for maternal and reproductive health.
- **Lack of adequate privacy** often resulting in client indignity (especially adolescent girls).
- **MN(C)H services tend not to permit or welcome men to accompany their partners** especially during delivery, thereby distancing men from active fatherhood right from the beginning. Though great strides have been made in recognizing the importance of engaging men in maternal, child and reproductive health, these services are still mainly targeted at women. This silos MN(C)H and reproductive health as “women’s” only issues and perpetuates prevailing gender-relates stereotypes.

- **Poor client-provider-interaction issues** that should be based on and include respect, trust, confidentiality, inclusivity, informed consent etc. can often dissuade women and men from accessing MN(C)H/SRH care. Attitudes and behaviours of health staff are critical factors.
- **Health facility infrastructure and facilities** (such as separate toilets for women and men, adequate waiting areas/rooms, space in counselling areas to include men etc.) are often not mindful of accompanying men's needs.
- Certain **service protocols requiring male consent/presence** (e.g. long-term family planning methods), thus undermining women's health-seeking autonomy and health rights.
- **Low representation of women/girls in health decision-making/governance** (community to highest level) resulting in inappropriate service provision.

SUGGESTED EXERCISE #7: GENDER-RELATED BARRIERS AT THE FACILITY

Hold a guided discussion for each point to identify gaps using cue words only but focusing on the **gender-dimensions causing barriers** e.g.:

- What the gaps in the way MN(C)H/SRH services are organized that create gender-related barriers for women's access and utilization of services?
- What about service protocols?
- What about staff/personnel attitudes and behaviours?
- What about deployment of HRH?
- What about facilities and infrastructure?

2.5 WHAT ARE THE NATIONAL GENDER EQUALITY/GENDER-RESPONSIVENESS POLICY COMMITMENTS RELATING HEALTH?

NB: Nationally relevant information can be added here.

2.6 WHAT A HEALTH SERVICE PROVIDER CAN DO TO MAKE MN(C)H/SRH SERVICES GENDER-RESPONSIVE!

A health professional, at every level, can create a gender-responsive atmosphere in the clinic setting by being mindful of and taking into account ways in which gender issues may cause vulnerability, risk and disadvantage that can affect treatment seeking and compliance with necessary treatment and care in MN(C)H/SRH. This means two things:

- Ensuring that the needs, priorities and concerns of women and adolescent girls are met and their health rights upheld.
- Recognizing the influence men have over the lives of women and children in families and communities and engaging them as productive and supportive partners in MN(C)H/SRH care.

Why is male engagement important in MN(C)H/SRH?⁴

- *Increases pre and post natal care and usage of skilled birth attendants at birth*
- *Contributes to less physical and emotional distress during labour and delivery*
- *It increases breastfeeding*
- *It increases child development outcomes*
- *Increases household income with increased women's economic participation and increases health and well-being of families*
- *And finally it improves the health and well-being of men themselves: more productive at work; less substance abuse and more satisfaction and happiness.*

⁴ Promundo, CulturaSalud, and REDMAS (2013). Program P – A Manual for Engaging Men in Fatherhood, Caregiving, Maternal and Child Health. Promundo: Rio de Janeiro, Brazil and Washington, D.C. USA.



STEPS TO GENDER-RESPONSIVE HEALTH FACILITIES

Guidance on simple steps you can take to make your health facility gender-responsive across the MN(C)H/SRH continuum of care is provided below:

For Family Planning Services

General recommendations

- Ensure that family planning commodities for men and women are available and advertised visibly with material encouraging both men and women equally to access and utilize them
- Ensure privacy and confidentiality for counseling and family planning in first and follow up visits. This includes both visual privacy and auditory privacy
- Ensure that you and your colleagues are technically knowledgeable to conduct family planning counseling with clear knowledge on the risks and benefits associated with each method (especially for adolescent girls)
- Respect the woman's/adolescent girl's/man's choice for the family planning method
- Do not underestimate a client's knowledge or assume she/he is ignorant. Acknowledge her/his knowledge-base and build on that with counselling
- Encourage the client (woman and adolescent girl) to come to the visit with her husband/partner
- If her partner accompanies her, promote family planning as the responsibility of both as a couple and not just the woman and offer commodities to the man
- If she does not want her partner to accompany her for the visit or know of her visit, respect her decision and provide the service-refrain from passing judgement by word, attitude or action
- Address any concern or fear or myths and taboos of the woman/adolescent girl and her male partner about the effects of using family planning methods
- Probe about any issues related to gender roles and norms (such as access to and control over resources and decision-making) that could impede optimal utilization of family planning services

During antenatal (ANC) care visits⁵

General recommendations

- Ensure privacy and confidentiality. This includes both visual privacy and auditory privacy. Confidentiality means that her records are kept in such a way that they cannot be accessed by unauthorised people.
- Respect the woman's/adolescent girls' dignity.
- Treat all clients with respect irrespective of her social or economic position or age or marital status.
- Respect the client's culture and value systems even if you don't agree with them.
- Carry out a two-way conversation without being judgemental or coercive.
- Do not underestimate a client's knowledge or assume she is ignorant. Acknowledge her knowledge-base and build on that with counselling.
- Inform her of each procedure, investigation, examination before you carry it out.
- Inform her of the prenatal tests that need to be carried out and their importance for her and the baby.
- Probe about any issues related to gender roles and norms (such as access to and control over resources and decision-making) that could impede optimal utilization of MN(C)H services

If the mother attends ANC without the father

- If the mother attends her health facility visit unaccompanied, ask if she has a partner and, if so, encourage that he accompany her on subsequent visits and during childbirth.
- If the mother wishes to be accompanied by the child's father but he doesn't accompany her, discuss with her how to invite him, and what steps are needed to make his presence possible. Consider giving her a letter/message or brochure (if available) addressed to the father.
- If the mother does not want her partner to accompany her, convey the importance of the father's involvement if you sense there is room for a change in her opinion.
- If the mother decides against being accompanied by the father, respect her decision. Consider exploring whether there are any behaviours or other signs within the couple relationship that could impact the health of the mother such as domestic violence, but only if appropriate and if you can refer her to violence against women services and help.
- If the father cannot accompany the mother, discuss with her other significant individuals who could come with her to the visits.
- If the father continues to be unable to accompany the mother to her appointments due to other commitments, encourage the mother to share all information with the father and involve him in the process including birth preparedness planning.

⁵ Guidance in the sections covering the continuum of care including ANC, delivery and PNC has been adapted from Promundo, CulturaSalud, and REDMAS (2013). Program P – A Manual for Engaging Men in Fatherhood, Caregiving, Maternal and Child Health. Promundo: Rio de Janeiro, Brazil and Washington, D.C. USA.

If the father attends ANC, invite him in the counselling/consultation

- Make sure there is an extra chair for him to sit.
- Thank and congratulate him for coming and encourage his participation in future ANC visits.
- Establish eye contact with both the mother and the father and actively involve him during the consultation by asking him questions and answering any questions he may have. Treat him as an equal partner.
- However, if the father takes over the conversation and answers questions for the mother, ensure that you encourage the woman to speak for herself.
- Use key moments to promote a bond between the mother, father and baby by inviting him for example to listen to the foetal heartbeat and/or to feel the baby kick during obstetric palpation.
- Motivate the father to provide emotional support to his wife (e.g. affection, empathy) and contribute in keeping the home environment happy and stress free.
- Encourage him to share an equal burden of domestic chores and caregiving stressing the need for the mother to take adequate rest and adequate nutrition.
- Share the risks associated with unhealthy behaviours such as alcohol and drug use, and physical and psychological violence. Advise the father about the negative effects on the health of the mother and child.
- Stress that antenatal, delivery and postnatal care issues are not only about the health of the mother and the child. Advise the father to look after his own health and take physical exercise, thereby creating an overall healthy environment for the mother and development of his child.
- Inform both parents of the prenatal tests that need to be carried out and their importance for the mother and the baby.
- Inform both parents about the danger signs and symptoms of pregnancy that indicate an obstetric emergency, and provide them with a list of action steps to follow if an emergency occurs.
- Create a safe and trustworthy environment where the couple can openly express any worries and concerns they may have such as health concerns, financial questions, work-related issues and couple relationship problems.
- Address any questions or concerns the couple may have regarding sexual activity during pregnancy, if appropriate. And advise them of any myths or misnomers about dietary restrictions, physical activity (such as lifting heavy weights and hard labour) or breastfeeding practices.
- Stress the importance of exclusive breastfeeding to both of them, highlighting the supportive role the father can play for successful exclusive breastfeeding for six months.
- Discuss contraceptive use to plan for or prevent future pregnancies. Emphasize that family planning is the responsibility of both of them.
- Encourage the mother to talk openly with her partner about her experiences (physical and emotional) during pregnancy.
- Encourage him to plan and prepare jointly and actively for the birth including saving money.

On the last ANC visit inform both parents of:

- Location of the mothers waiting home/maternity ward/delivery facility.
- Objects and things the mother and newborn would need during the delivery and after birth.
- Ask them who will accompany the mother during labour and delivery. Remember it is a woman's right to be accompanied during birth and she chooses who it will be.
- With consent from the mother, inform the father that his presence and support are critical for the mother and baby during labour and childbirth. Encourage the father's presence.

Note the father's attendance in the client's record in each ANC visit!

During labour, delivery, postnatal care (PNC)

At the facility

- Provide the father with specific instructions on how he can actively participate, e.g. helping the mother unpack her bags, providing emotional support by listening to the mother's concerns, and providing massage to his partner to relieve physical strain and stress.
- Ensure privacy to the couple during labour (such as a screen to protect the dignity and privacy of other clients in labour wards).
- Inform both the woman and her partner of the routine procedures/investigations/examinations that take place during labour.
- After delivery, engage the father with his child as soon as possible (in accordance with health facility policy) e.g. ask him to cut the umbilical cord, and assist in weighing the child and handing the child to the mother.
- In cases where the mother undergoes a caesarean section and is unable to provide skin-to-skin contact, ensure that the father has physical contact with the child following birth.
- Ensure the father is shown how to hold the baby in his arms if this is his first child.
- If the father does not feel ready to make physical contact with his child, give him time. It may take him hours or even days to feel physically comfortable.

When the couple is discharged

- Before the father and mother leave the maternity ward/health facility, remember to praise and thank both of them for their cooperation in the process, and thank the father for his participation.
- Inform both mother and father about caring for the newborn. Provide them with informational material (if available). Promote gender equality in parenting as an important aspect of healthy child development. Both mother and father should be equally involved in caring for children and in domestic tasks, and communicate openly with each other.
- Inform both the husband and wife about abstaining from sexual activity immediately following childbirth with prescribed period.
- Explain to both the father and mother the care required for a healing episiotomy including keeping the area clean, regular sitz baths and application of ointments etc.

- If the mother has had surgery (e.g. a caesarean section), inform the father about any special care required while the mother heals.
- Explain to the father how he can support mother and child in successful breastfeeding.
- Ensure that both father and mother understand the importance of postnatal rest and nutrition for mother. Stress the need for emotional and physical support by father while the mother is recovering her strength.
- Ensure that both father and mother understand the importance of the postnatal visits for both the mother and the baby, and encourage the father to support his wife and ensure that she attends the post natal visit as prescribed
- Remind both mother and father about contraceptive use to plan for or prevent future pregnancies. Emphasize that family planning is the responsibility of both of them.
- Inform the father about the importance of the child's health and growth check-ups, immunization etc. and encourage him to participate.

Note the husband's presence during labour, delivery and discharge records!

During referral to higher level facility

General recommendations

Making a referral mechanism gender-responsive requires understanding the need of privacy and dignity of a pregnant/postpartum woman while being transported and arranging for timely, appropriate, adequate, respectful and safe transportation to take her and an accompanying attendant, freely chosen by her from the community to the primary or higher levels of health care. This also includes:

- The necessary information regarding the referral links are communicated to the woman and her partner.
- The transportation is appropriate (i.e. there is comfortable and safe space for the woman and her partner/accompanying person), accessible and affordable (meaning that if government transport/ambulance is not available providing access to community-based system of organizing transport) and safe and respectful.

The following are key elements you can ensure to make the referral process smooth and gender-responsive:

- Be clear about your role, responsibilities and limitations
- Have the protocols of care for conditions and level of referral readily available
- Have suitable means of communication and transport.
 - Communication is generally by the referral form but may, in addition, be by radio, phone or fax (as available).
 - Where you are unable to provide an ambulance know about the existing community-based system of transport.

For the initiating facility

- When a woman arrives at the health center, attend to her (and if her partner is there) promptly, treat them with respect, privacy and confidentiality, and identify their needs.
- If the woman is alone, ask her who could accompany her stressing the importance of her husband's presence.
- Have the protocols of care handy, and be very familiar with the government regional or national

protocols for various levels of facility so you can take the right decision.

- Assess the client and gather relevant information. In an emergency situation, maintain all vital functions and minimize any further damage, while reassuring the client.
- Ensure that all required details of the information and documents that should be sent with the woman are complete and duly sent. This should include: a written record of the clinical findings, any treatment given before referral and specific reasons for making the referral. The referral form should accompany the woman (often carried by her or by the accompanying person) and give a clear designation of which facility the patient is being sent to. A carefully filled referral card can help the woman get timely attention at the receiving facility.
- If you have the means like a telephone, communicate with the receiving facility to make an appointment or other arrangements for the referral, or to let them know of the pending arrival of an emergency case. If the woman is in serious condition, regardless of whether she is accompanied, it might be necessary for you, or a colleague to accompany them to the receiving facility.
- If the patient is transported with the facility's ambulance, ensure that the driver is aware/trained of the/his responsibility for safe and respectful transfer, to treat the patient with dignity, and of the important role he can play in reassuring the patient and the accompanying person.
- The decision to refer might be frightening or distressing for the woman (especially an adolescent girl with little or no past experience) and her family so it is important that you have empathy and compassion and give the woman and her partner or other family member(s) relevant information such as:
 - Reasons and importance of the referral, risks associated with not going
 - How to get to the receiving facility – location and transport
 - Who to see and what is likely to happen
 - What arrangements for accompanying partners/family members are in place at the receiving facility and what more is required (reminding them of the necessary birth related items as required)
 - The process of follow-up on their return
- You can show empathy in understanding the implications of referral for the woman and her family by listening to the woman (and her partner/family member, if there) carefully. This is particularly important for unaccompanied adolescent girls. The woman/adolescent girl may be:
 - Frightened of the unknown, frightened of becoming more ill or even dying
 - Concerned about meeting the costs of transport, treatment and family accommodation (if these are not free)
 - Concerned about leaving house or farm or productive work that needs to be done
 - Concerned about other children at home. In this case and the one regarding housework/work, you must stress the importance of the woman's husband/spouse/family members taking care of housework and other children in her absence so she gets the necessary care and not risk her and her baby's life.
 - In all cases reassure the woman and her partner/family using a gentle and polite tone.
- Once the referral is made, register it to keep track of the referral. Make note of any concerns, reservations or fears expressed by the woman/adolescent girl and her spouse/family. Information from the register is used to monitor referral patterns and trends.

For the receiving facility

- If forewarned, you can anticipate and prepare for the arrival and receive the woman/adolescent girl and accompanying spouse/family members with their referral form to begin a thorough assessment of the patient and begin management of the case.
- To provide gender-responsive quality care in addition to the technical care, your attitude to the woman/adolescent girl, her partner/family members should include principles of dignity, respect, confidentiality and privacy. Remember the woman and her family may already be very intimidated. You must try to allay any concerns and fears.
- Furthermore in line with principles of informed consent, explain as much detail as possible the procedures, investigations and examinations that will take place to both the woman and her partner/family.
- When care has finished at your level of the facility, back referral to the original facility is important containing information on all investigations, findings, diagnosis and procedures/treatment given by the higher level facility as well as follow up expected from the lower level facility in the postnatal period.
- At both ends of the facility, the patient and her partner/family members should have the opportunity to provide feedback on the referral process through a client /user feedback system.
- Take note of the issues that may be raised to discuss with your supervisors to identify what is needed to improve things - this might include clinical training or strengthening of particular parts of the referral system or its procedures, including its gender-responsiveness.

SUGGESTED EXERCISE #8: GENDER-RESPONSIVE SERVICE DELIVERY ALONG THE CONTINUUM OF CARE

The following is a suggested exercise for training health providers/supervisors:

- Separate each component of the MN(C)H/SRH continuum of care: FP, ANC, Delivery, PNC, Referrals
- Before starting each component, quickly ask participants what their normal protocols are for each e.g.:
 - If Kabula the 17 year old woman we met in Section 1.3 (Suggested Exercise #3) comes for her first ANC or second ANC visit what do you do? Just describe the process.
- By way of a PowerPoint presentation share the content provided above
- Ask participants, if you were to carry out all the actions that are recommended, how do you think Kabula will feel and respond?
- Give handouts of the Checklist below for the specific component and ask participants to fill it out (either individually or in groups of 4-5)
- Ask for the results of their exercise focusing on steps they have identified for improvement
- Repeat for all components
- At the end of the training participants should have an action plan to make their service delivery more gender-responsive

ANNEX 1

CHECKLISTS HEALTH FACILITY STAFF CAN USE FOR SELF ASSESSMENT OF GENDER-RESPONSIVENESS⁶

For health professionals providing Family Planning Services

This checklist can help health professionals identify and act on areas in their system and behaviours where improvement may be needed to make it more gender-responsive. It can be used individually or as a group.

Attitudes

I always ensure confidentiality and privacy (visual and auditory) to the woman/adolescent/man.
YES-NO

I always treat the woman/man with respect and ensure her dignity (regardless of her age or social status).
YES-NO

I inform her/him of all the choices available to them with benefits and side-effects.
YES-NO

If the woman/adolescent girl comes to the FP visit alone, I ask about the male partner.
YES – NO

I address the importance of the male partner's involvement in family planning and joint decision-making.
YES – NO

If the woman/adolescent girl decides they do not wish their male partner's presence, I respect that decision and provide them the service any way.
YES - NO

I provide guidance and information on family planning directly to the male partner.
YES – NO

I address the concerns, fears, myths and taboos about family planning with both of them.
YES-NO

Protocols

I encourage my colleagues to actively promote gender equality and male partner's involvement.
YES – NO

I record the male partner's presence at each visit.
YES – NO

⁶ Self-assessment checklists for ANC, delivery and PNC have been adapted from Promundo, CulturaSalud, and REDMAS (2013). Program P – A Manual for Engaging Men in Fatherhood, Caregiving, Maternal and Child Health. Promundo: Rio de Janeiro, Brazil and Washington, D.C. USA.



There are protocols in place on how to involve male partners during FP visits.
YES – NO

Resources and health facility environment

The facility provides a one-window operation for women/men/adolescents so all services can be accessed by in one visit.
YES-NO

The facility has extended hours of operation for working male partners.
YES – NO

The facility provides space for an accompanying partner, such as an extra chair in the consultation room.
YES – NO

There are separate men's and women's restrooms.
YES – NO

The facility provides male focused family planning education materials and sessions.
YES – NO

Posters and art on the walls include positive images of men in Family Planning.
YES – NO

The facility has tools/resources for health professionals on gender equality and male engagement.
YES – NO

The facility offers or refers health professionals to training on gender sensitivity and gender equality.
YES – NO

We provide campaign material promoting gender equality and involved fatherhood.
YES – NO

Where the answer is "NO", what can we do as professionals to better include the expectant father and promote gender equality? Who is responsible for each task? By when will this be carried out?

For health professionals providing ANC

This checklist can help health professionals identify and act on areas in their system and behaviours where improvement may be needed to make it more gender-responsive. It can be used individually or as a group.

Attitudes

I always ensure confidentiality and privacy (visual and auditory) to the mother.
YES-NO

I always treat the mother with respect and ensure her dignity (regardless of her age or social status).
YES-NO

I inform her of every investigation or procedure that may be required for informed consent.
YES-NO

If the mother comes to the ANC visit alone, I ask about the father.
YES – NO



I address the importance of the father's involvement during pregnancy.
YES – NO

I provide guidance and information directly to the father about antenatal and postnatal care.
YES – NO

I encourage the father to participate actively in birth preparedness planning.
YES-NO

When the father is present, I provide information and guidance on how he can support the mother during pregnancy.
YES – NO

I encourage the father to be present during childbirth.
YES – NO

Protocols

I encourage my colleagues to actively promote gender equality and father's involvement.
YES – NO

I record the father's presence at each appointment.
YES – NO

There are protocols in place on how to include the father during ANC visits.
YES – NO

Resources and health facility environment

The facility provides a one-window operation for mothers so all services can be accessed by her in one visit.
YES-NO

The facility has extended hours of operation for working fathers.
YES – NO

The facility provides space for an accompanying partner, such as an extra chair in the consultation room.
YES – NO

There are separate men's and women's restrooms.
YES – NO

The facility provides father-focused parenting education materials and sessions.
YES – NO

Posters and art on the walls include positive images of fathers.
YES – NO

The facility has tools/resources for health professionals on gender equality and male engagement.
YES – NO

The facility offers or refers health professionals to training on gender sensitivity and gender equality.
YES – NO

We provide campaign material promoting gender equality and involved fatherhood.
YES – NO



Where the answer is “NO”, what can we do as professionals to better include the expectant father and promote gender equality? Who is responsible for each task? By when will this be carried out?

For health facilities providing labour, delivery and postnatal care

Attitudes

I always ensure confidentiality and privacy (visual and auditory) to the mother.
YES-NO

I always treat the mother with respect and ensure her dignity (regardless of her age or social status).
YES-NO

Inform her of every investigation or procedure that may be required for informed consent.
YES-NO

If the mother comes to the visit alone, I ask about the father.
YES – NO

I emphasize the importance of the father’s presence during childbirth.
YES – NO

I encourage the mother’s partner to be present during delivery (with the mother’s consent).
YES – NO

I provide guidance and information directly to the father about postnatal care.
YES – NO

I provide guidance on how fathers can provide physical support to the mother during childbirth (e.g. through touch, such as massage).
YES – NO

I encourage skin-to-skin contact between baby and mother.
YES – NO

I encourage skin-to-skin contact between baby and father.
YES – NO

I hand the infant to the father so that he can hold his child in his arms.
YES – NO

Protocols

I encourage my colleagues to actively promote gender equality & fathers’ involvement.
YES – NO

We register the father’s presence or absence during the antepartum period.
YES – NO

We register the father’s presence during delivery.
YES – NO

There are guidelines in place on gender equality and how to engage fathers during childbirth.
YES – NO



We show fathers how to register their child in the civil or population registry (and obtain a birth certificate).
YES – NO

We explain to father the importance of postnatal visits for the mother and the baby
YES – NO

We inform both parents about the availability of contraception methods and the process to access
the family planning services
YES – NO

Resources and facility environment

There is adequate infrastructure to incorporate fathers in labour and delivery.
YES – NO

The facility provides childbirth-related education materials for fathers.
YES – NO

Posters and art on the walls include positive images of fathers.
YES – NO

We offer education for expectant fathers.
YES – NO

The facility has tools/resources for health professionals on gender equality and male engagement.
YES – NO

The facility offers or refers health professionals to training on gender sensitivity and gender equality.
YES – NO

The facility has separate toilets for women and men.
YES – NO

Where the answer is “NO”, what can we do as professionals to better include the expectant father and promote gender equality? Who is responsible for each task? By when will this be carried out?

Referrals

At Health Centers and Hospitals:

- A focal person for referral is assigned. Among his/her tasks are to:
 - serve as a liaison between levels
 - act as a contact/focal person
 - ensure that the next level is alerted
 - track referrals in and out
 - monitor adherence to set protocols and gender-responsive referral practices
 - assist with transport
 - follow up with feedback and inform about system enhancements or breakdowns (e.g. ambulance not in service, surgeon on vacation)
- I always take the time to explain the need for the referral to both the woman and her partner/family member.
- I always take the time to explain to the ambulance driver the importance of treating the woman with dignity during the transfer.



- I always address any concerns fears the woman or her accompanying partner/family member may have.
- I always treat the woman and her partner/family member with dignity and respect.
- All facility staff responsible for referrals, including drivers have been trained on gender sensitivity and gender equality.
- The facility has tools/resources for health professionals on gender equality and male engagement.

Where the box is not ticked out, what can be done to ensure gender-responsiveness? Who is responsible? By when will these be done?

ANNEX 2

KABULA'S STORY – AN EXPERIENTIAL GROUP EXERCISE

The experience of married adolescent girls and young women is illustrated in the Story of Kabula. This story is an experiential exercise that can be used in the training of health providers/supervisors to raise awareness of these stakeholders on the gender-related barriers women and adolescent girls face in accessing care.

Opening

Kabula (Give a local name) is a 17 year old adolescent girls. She lives in a village named _____. Kabula has a much higher chance of dying in childbirth as someone in their twenties and her child is much more likely to die in childbirth than women of any other reproductive age group. If a mother dies during childbirth, the child is 10 times more likely to die. Kabula like most rural women will likely give birth at home with neighbours and no skilled birth attendants and if there are complications, she is likely to lose her life or that of her child. She has not received more than one antenatal care visit and will likely not receive a postnatal care visit. She cannot get to the nearest health facility because it's too far to walk and she is burdened by household chores. Like many other women, her husband and/or family elders make decisions on whether she receives health care or not. These are everyday realities faced by women in rural _____ (name the country where your project is being implemented).”

Instructions

1. Ensure a large enough space for all participants to stand in a circle.
2. Come to the session with a big roll of wool or string.
3. Ask for a volunteer to be a fictional girl/Kabula.
4. Ask her/him to stand or sit on a chair in the middle of the circle and to hold the ball of wool.
5. Ask everyone to stand around Kabula.
6. Explain that everyone is a part of Kabula's story. Ask all the participants to imagine that they are in a rural area.
7. You will narrate parts of her story, statement by statement, and they will have to explain why the girl is in that particular situation. You will help them by reformulating the questions behind the statement.
8. Explain to the group that every time a gender issue or barrier is identified with the statement, Kabula has to pass a ball of wool to the person who identified the gender issue and then they wrap it around themselves and give the ball back to her and she has to wrap it around herself before the next statement is read aloud.
9. Another facilitator will write the gender barrier identified by each participant.
10. As the gender-related barrier is identified, ask the question “why is it like that?” and let participants respond.

Example: Read the first statement of the opening: “Kabula has a much higher chance of dying in childbirth as someone in their twenties and her child is much more likely to die in childbirth. If a mother dies at childbirth, the child is 10 times more likely to die.”

Ask the question: “Why is Kabula and her child likely to die?”

At the end of the story, Kabula will be entirely wrapped.

When all the statements are read aloud ask people the following questions:

- What do you see/observe?
- To Kabula: how do you feel?
- As health providers, what can your role be once you understand these barriers?



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Plan International Canada Inc.

National Office

245 Eglinton Avenue East
Suite 300
Toronto, ON M4P 0B3
Canada

Ottawa Office

130 Slater Street
Suite 1350
Ottawa, ON K1P 6E2
Canada

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



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