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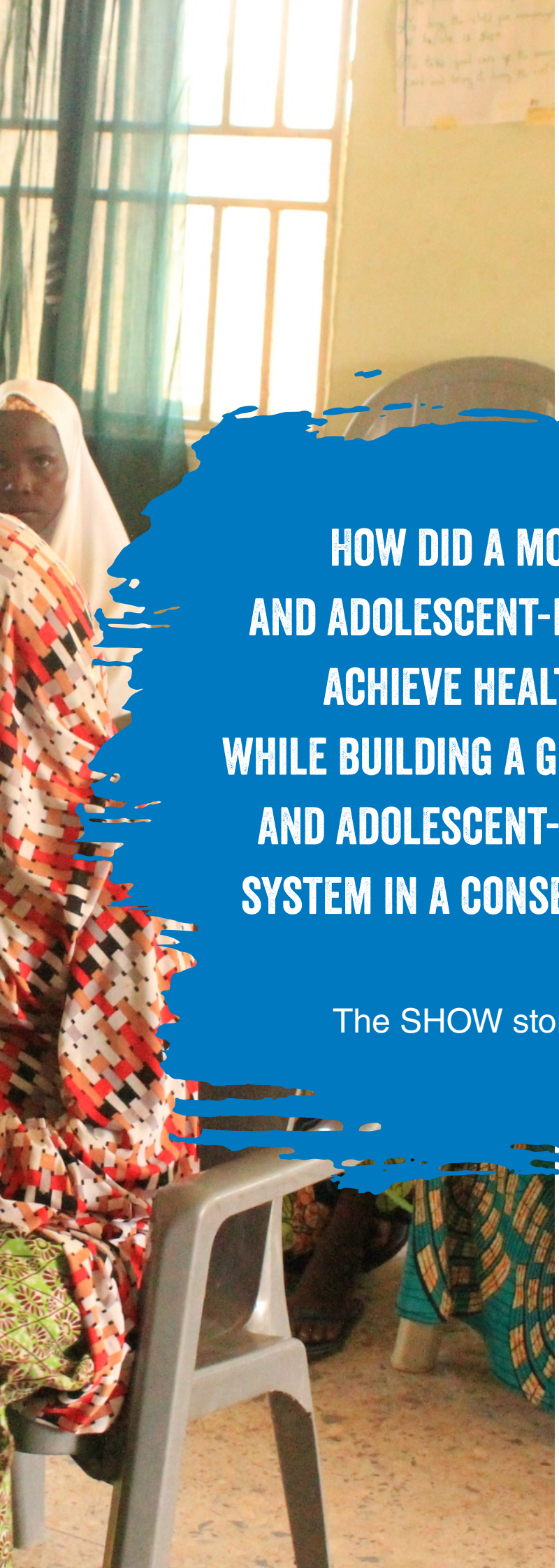
PLAN INTERNATIONAL

STRENGTHENING HEALTH OUTCOMES FOR WOMEN AND CHILDREN

Lessons from Nigeria



HOW DID A MOTHER, CHILD, AND ADOLESCENT-FOCUSED PROJECT ACHIEVE HEALTH OUTCOMES WHILE BUILDING A GENDER-RESPONSIVE AND ADOLESCENT-FRIENDLY HEALTH SYSTEM IN A CONSERVATIVE SOCIETY?

The SHOW story from Nigeria

THE PROJECT

Fewer models are available for health initiatives that promote Sexual and Reproductive Health Rights and envision gender equality in a conservative and patriarchal society. *The strengthening Health Outcomes for Women and Children* (SHOW) project in Nigeria, implemented in a poorly resourced health system and a conservative social ecology, is an illustrative example of such initiatives.

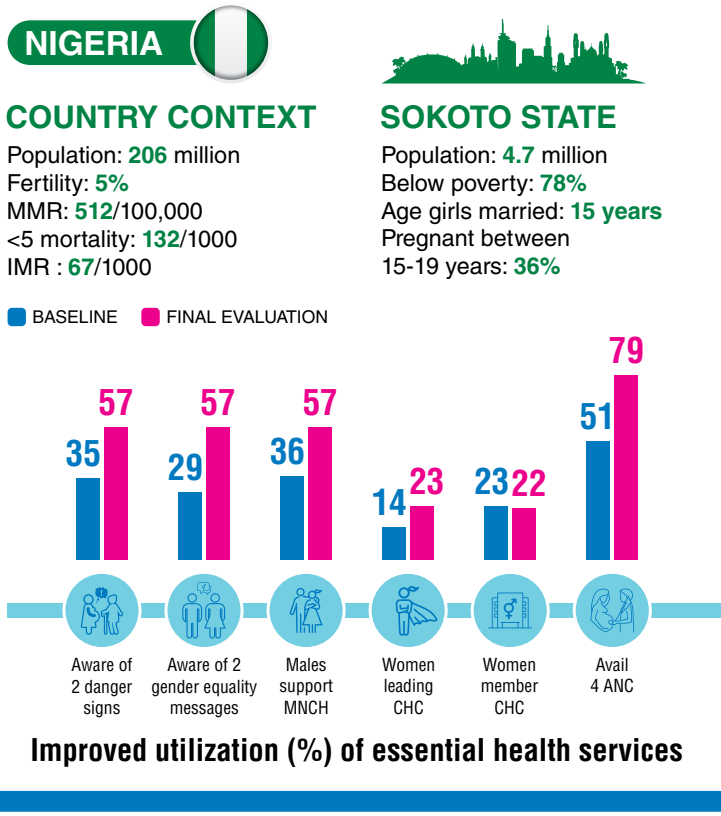
The SHOW project[i] is a gender-transformative initiative aimed at increasing the quality, availability, utilization and accountability of essential Maternal, Newborn and Child Health/Sexual and Reproductive Health (MNCH/SRH) services to reduce maternal and child mortality amongst marginalized and vulnerable 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)[ii], Plan International Canada worked in partnership with Plan Country Office, the Government of Nigeria, 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 Nigeria, the SHOW project[iii] was implemented in the Sokoto state. Adopting gender transformative and rights-based approaches, the SHOW team focused on building the foundations of Gender Responsive and Adolescent Friendly (GRAF) healthcare in a poor and underserved state of the country. The project started with a comprehensive situation analysis. This comprised of 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 aimed to improve Maternal, Newborn and Child Health (MNCH) and Sexual and Reproductive Health Rights (SRHR) in 23 Local Government Areas (LGAs) within the state.

The SHOW Project (20 January 2016 to 30 September 2022) premised (Figure 1) that sustainable MNCH and SRHR outcomes have three fundamental requirements[iv]. One, the individual and collective agency of Women of Reproductive Age (WRA) and adolescent girls, supported by men and communities, create a sustained demand for the reproductive health rights of women and girls. Two, the supply and delivery of quality essential MNH/SRH services are augmented to meet the needs and rights of women and girls. Three, the data collection and analysis, as part of monitoring and evaluation, ensure accountability of the health system to WRA and communities with efforts to promote

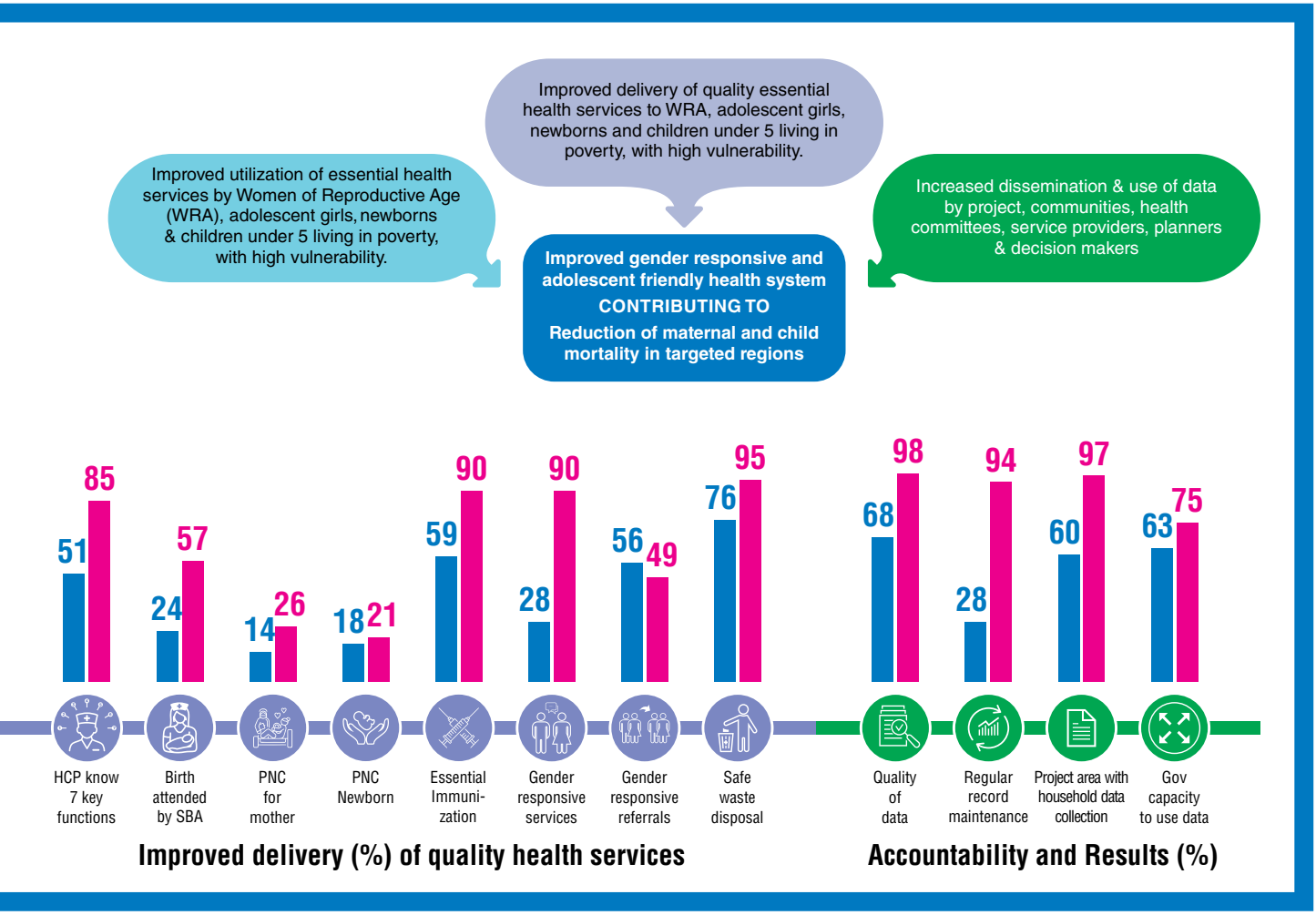
FIGURE 1: THREE PILLARS OF SHOW INTERVENTIONS AND THEIR OUTCOMES IN NIGERIA



evidence-based decision-making for MNH/SRH services. Built on this premise and aligned with the United Nation's *Every Woman Every Child Global Strategy for Women, Children, and Adolescent Health* to achieve Sustainable Development Goals 3 (health & wellbeing) and 5 (gender equality) and country-level national health strategic plans, 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/SRH care.
2. Health System Strengthening to improve the availability, accessibility, quality and gender- and adolescent- responsiveness of MNCH/SRHR services.
3. Accountability of health services to the communities they serve- particularly women and adolescent girls- by improving data collection, analysis, data sharing, and its utilization in the decisions.

In Nigeria, the project reached[v] 962,741 community members directly (630,467F, 332,274M) along with several categories of indirect participants and beneficiaries, including 311 health service providers, 2,440 Community Health Workers (CHWs), 480 government officials and 23 environmental health officers and 2,272,466 community members (1,045,390F and 1,227,076M). For this, the project worked with 184 Village Savings and Loans Association (VSLA) members, 244 fathers' clubs (male champions) and 244 mothers' groups (100 women groups), and 48 adolescent Peer Educators (24 girls and 24 boys).



The project evaluations[vi] at baseline and endline (Figure 1) showed improvement in all service utilization areas of the project except the membership of females in the Community Health Committee (CHC), which declined by one percentage point. Likewise, most health service delivery indicators showed remarkable improvement except for gender-responsive referrals, which dropped from 56% at baseline to 49% at the endline evaluation. All accountability and Results indicators also showed significant progress during the project.

The project and its stakeholders co-created an evidence-informed, robust model applicable for a sustained and contextualized gender transformative change. The involvement of officials from the health directorate and staff from health facilities to incorporate GRAF health care principles into the curricula for training on Emergency Obstetric and Newborn Care (EmONC), or Integrated Management of Newborn and Childhood Illnesses (IMNCI) are examples of this co-creation. Based on the evidence of their effectiveness, these elements can systematically integrate across different levels of the system 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 key select initiatives of the SHOW project in Nigeria. The learning of these lessons involved three steps: a desk review of the program documents and reports, discussions with project staff in Nigeria and Plan International Canada, and member-checking of the findings. Discussions focused on the broad functions of the project on demand generation, service provision, results and accountability, project operations, and sustainability. This analytical document is central to the project's theory of change, exploring implementation challenges, measures taken to address them, results observed, and emerging best practices through the life of the project.

This lessons-learned report is a triangulation[viii] of findings from various perspectives. The methodological triangulation involved examining quantitative survey data and exploring the emerging "why" questions through qualitative discussions. Theoretical triangulation comprised exploring the views of several stakeholders to develop a holistic picture from multiple perspectives, and environmental triangulation involved taking care of the perspectives coming from diverse geographical (project staff in Nigeria and Canada in this case) locations. The following sections will present lessons learned from these discussions and data analysis under five headings (demand side of HSS, supply side of HSS, accountability and results, operations, and sustainability). 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

Increasing the agency and empowerment of women and adolescent girls, men's involvement in home and care decisions, and collective action by the communities is critical for improving the utilization of GRAF health services. For this critical pillar on the demand side of health system strengthening, the SHOW project carried out three main clusters of activities. First was formulating new or supporting the preexisting support groups for adolescents and women, e.g., 100 Women's Groups or Federation of Muslim Women Association of Nigeria (FOMWAN) for the individual and collective agency. The second was the creation of Fathers' clubs and the involvement of religious institutions to enhance men's participation in household affairs, particularly childcare work. Fathers' club used education and peer-to-peer learning to facilitate the deconstruction of harmful masculinity norms and the adoption of more gender-equal and nonviolent behaviours. This approach and the associated curriculum focused on raising awareness about critical issues, including MNCH, SRHR, gender-based violence, women's decision-making and equitable distribution of household care work. The last cluster was strengthening the Village Saving and Loans Associations (VSLA) for women's financial autonomy. The VSLAs were a space where women could financially support each other through indigenous ideas for financial autonomy. The VSLAs were also a place to promote gender equality and the empowerment of women and girls through discussions.

Challenges

Despite a well-designed strategy, the real-life implementation faced several challenges. Key among them were:

- Many of the 2440 Community Based Health Volunteers (CBHVs) engaged in household visits and organizing women and adolescent support groups had limited literacy to use reference materials for effective communication and counselling to change behaviors around MNH/SRH, resulting in performance gaps.
- In a highly patriarchal and conservative community, men felt shy and stigmatized by society, if they supported their women.
- Along the similar issue of patriarchal culture, the project staff, coming from the same culture, often found it hard to communicate the virtues of gender transformative approaches and advocate actions that would support the MNH/SRH outcomes..

Course correction

The SHOW project modified the Information, Education and Communication (IEC) materials, simplified the language, and added pictures to make them user-friendly to address the literacy issues and communication skills of CBHVs. The team also reviewed the data collection tools accordingly. Following the revisions, refresher training sessions were arranged for CBHVs to enhance their skills. The project team also organized regular networking/touch base meetings of CBHVs with the health facility staff for knowledge updates and Q&A sessions to help CBHVs overcome difficulties in promoting MNH services. Considering the shift in gender norms, the SHOW team strategically engaged religious institutions by working with the decree-issuing institution (Sultanate) that enjoyed high respect among the community, the religious leaders and the policymakers. Sokoto-based leading religious scholars and Plan International co-created a gender-integrated manual on "Islamic Perspectives on MNCH Issues" to provide additional guidance for Islamic leaders throughout the State on MNCH/SRH. The high-level involvement of clergy inspired men, increasing their participation in social platforms that promoted gender equality (e.g., Fathers' Clubs) and men's role in MNCH/SRH in the light of religious teachings. The team also engaged 100 Women Groups and female Muslim clerics to highlight women's leadership roles and bring a shift in the gendered worldview of women in the project areas.

Results

The project evaluations show that the remedial actions worked. Here is a summary of the achievements of the demand side of this project.

- The communication capacity of CBHVs improved, which, together with support groups, resulted in improved health and gender equality knowledge of men and women, and women's utilization of antenatal services and skilled care during pregnancy and postnatal period.
- Male engagement activities and religious institutions' involvement improved their support for women and the MNCH issues and women's leadership role in the CHCs.
- Women widely appreciated VSLAs not only for their financial autonomy but also for the broader empowerment these VSLAs brought to them.

Best practices

- Community health workers (CBHVs in the case of the SHOW project) act as a conduit for health promotion and improved utilization of services. Paying attention to their capacity needs goes a long way in improving the effectiveness of a health system.
- Influencers can vary for different societies and different segments of populations. In a conservative society like Nigeria, engaging religious leaders at the earliest for their influence on men pay off and should be part of the strategic plans.
- Leveraging the emergent opportunities (such as the Child Protection Law) that have a broader impact, including social, economic, and gender equality, requires concerted advocacy.

Leveraging the religious institutions to promote gender equality

Problem: Nigeria is a conservative and religious society. The patriarchal norms and views of masculinity mean men have all the power and decision authority. The masculinity mindset is so pervasive that males who support their wives do not do so publicly for fear of stigmatization.

Solution: In Nigeria, religious leaders are widely respected for reliable communication, especially among rural populations with low literacy. SHOW acknowledged their influence and generated a dialogue with the Central Shura (a committee of nationally renowned religious leaders) to gain their strategic oversight and policy guidance. The result was a network of religious leaders and a powerful platform for shedding misperceptions and promoting positive MNCH/SRH behaviors, especially among men, who hold the onus of decision-making in family healthcare needs.

The project compiled a compendium of Quran and Hadith references supporting gender issues. A manual, "Islamic Perspectives on MNCH Issues," was published in the local Hausa language that facilitated the traditional/religious leaders and community dialogues and discussions. In addition to Friday prayer sermons, these leaders also participated in radio talk show discussions about gender norms, accessing skilled health care, and promoting male engagement. This also reduced potential backlash from communities around the issues of Family Planning.

Results: SHOW conducted advocacy meetings with 35 members of HOA (9F, 26M) to review the Child Rights Act and advocate its adoption by the State HOA. The State Governor signed the Sokoto State Child Protection Bill into law on 22 November 2021. It is a giant leap for children's rights in Nigeria,18 years after the Federal Government of Nigeria enacted the Child Rights Act 2003 and urged state governments to domesticate the Act into State law.

2. SUPPLY-SIDE OF HEALTH SYSTEM STRENGTHENING

The second pillar of the SHOW project responds to the increased demand for GRAF healthcare with an equally matching coverage and quality of health services. It started with a comprehensive assessment of health facilities, whereby the team identified gaps in delivering high-quality, gender-responsive and adolescent-friendly care through baseline and health facility assessment. The limited capacity of community- and facility-based staff to provide GRAF health services, shortcomings in the infrastructure and equipment at the health facility, and gaps in planning, supervision and management of services emerged as the areas for improvement. To address these gaps, SHOW focused on rehabilitating the infrastructure, providing essential MNH/SRH equipment, and enhancing staff capacities in providing competency-based care. The capacity building emphasized three areas to ensure quality GRAF MNH/SRH services. These included clinical skills, interpersonal communication skills, and supportive supervision. A new addition to the system was the creation of Adolescent Health Corners (AHC) in health facilities. The SHOW team ensured that all health system strengthening interventions leverage the capacities of the existing resources rather than hiring and deploying new staff whose continuation SHOW could not guarantee after the completion of the project.

Challenges

Working on a project that aims to improve access to GRAF MNH/SRH services along with increasing coverage and enhancing quality in a conservative society and an under-resourced system was challenging. Below are some difficulties that the service delivery side of the SHOW project faced:

- In the patriarchal settings of SOKOTO, women and adolescent girls had minimal power to make SRHR decisions, like using contraceptives. Health providers would not entertain those who would step out and reach the health facility on the pretext that fulfilling their contraceptive needs was unlawful without their husband's permission. In reality, there was no such law but a false belief that it existed.
- The lack of skilled Human Resources (HR) to provide MNCH and SRH care was a striking challenge in an under-served population.
- Creating the *Adolescent Health Corner* (AHC) was a helpful initiative. However, ensuring that adequately trained staff remains available on a sustained basis was a challenge. The pre-service training of health facility staff did not include this aspect, while providers trained in-service by the project could not stay for sufficient time because of frequent transfers.

Course correction

The first step for improving women's and adolescent girls' ability to access SRH services was favorable discussions in the households. CBHVs in their household visits and various support groups in the group meetings activated these discussions. Grandmothers also played a crucial role in helping interspousal discussions and decision-making about accessing SRH care. The second step for this improvement involved improving the attitude of health providers toward women and adolescent girls, for which the SHOW team included a Gender Equality and SRHR part to their clinical training. Using these updated resources, the team trained health workers on family planning, addressing the false beliefs (e.g., the misperception that the husband's permission was required for the wife to use contraceptives, whereas there was no such requirement) and ensuring an attitudinal change among the providers to make their services more woman and girl-focused.

The project, under the leadership of the Federal Ministry of Health (FMOH), and in consultation with academia and development partners, reviewed training manuals on Life-Saving Skills (LSS) and Family Planning (FP) to make these resources gender-responsive and adolescent-friendly for MNH/SRH care. The Modified Life-Saving Skills (MLSS) review also integrated "2016 WHO recommendations on ANC for a positive pregnancy experience (a minimum of eight ANC contacts)" and WHO's 2017 "Managing Complications in Pregnancy and Childbirth" into the modified LSS manual. The FMOH endorsed it as the "Modified Life-Saving Skills (MLSS)" training content, and national and state-level trainers used it to train staff in 244 health facilities.

For effective and uninterrupted functioning of AHCs, the SHOW team advocated with the Government to address the issue of staff transfers, specifically those trained to provide adolescent-friendly health services. The CHC also intervened in advocacy meetings with their state governments to limit staff transfers in their Primary Health Care (PHC), and these strategies were helpful in convincing the prevention of frequent transfers.

Results

Evaluations at baseline and endline demonstrate that SHOW strategies, including the remedial actions, worked. Following is a summary:

- Healthcare utilization - a combined reflection of improvement in women's agency and community's collective action (demand side) and health services (supply side) - significantly improved over the project's life. These include the uptake of four ANC checkups, delivery by an SBA, postnatal care both for mother and newborn, and essential immunization of a child. The gender-responsive referrals indicator, however, declined from 56% at baseline to 49% at endline.
- Aligned with Sokoto state's task-shifting and task-sharing policies, local MLSS trainers provided training to 488 Community Health Extension Workers (CHEWs) on providing assistance as Skilled Birth Attendant (SBA), to address the human resource shortage for skilled health care providers within the state.

  Introduction of Adolescent Health Corners materialized; the advocacy with state-level health departments reduced staff transfers and improved the availability of trained health workers at these AHCs.

Best practices

- Gender responsiveness of the health system improves when the continuum of discrimination, i.e., barriers faced by women and girls in their homes, communities and health facilities, are well understood and addressed at all levels.
- Bringing a positive shift to health workers' attitudes toward providing GRAF healthcare is critical; revision of their training materials and capitalizing on the Government's task-shifting and task-sharing policies offer an opportunity to bring this vital change to the system.
- Sustained operationalization of new additions to the health system, like Adolescent Health Corners, requires effective advocacy at the state and local level and strong community ownership and involvement to improve the system's commitment and the community's involvement and oversight of that intervention.

3. DATA FOR ACCOUNTABILITY AND RESULTS

To make the health system genuinely gender transformative, SHOW brought some fundamental changes to the Health Management Information System (HMIS). A major gap identified after discussions with the state government was the case of missing women. These were women and adolescent girls who do not visit a health facility during the antenatal, natal, or postnatal period and are never accounted for by the health system. SHOW introduced the identification and entering of information about women and adolescent girls by tracking them in the community. This Community HMIS (CHMIS) component would strengthen the existing system because HMIS used only the health facility data and did not truly reflect issues of women and girls who may avoid or may not be allowed to visit a health facility. Secondly, SHOW also introduced age and gender disaggregation to the data system to know the number and specific issues of women and girls from various age brackets. Finally, digital data collection started along with improvements in relevant capacities to improve the system's efficiency. On top of these three, the SHOW team ensured that findings are shared with the community through regular review meetings for increased transparency and accountability.

Challenges

Implementing a design that integrated community data into the health facility data and gender and age disaggregation faced several challenges. For example:

- The collection of household and community data was the responsibility of the volunteers called CBHVs. However, several CBHVs did not have sufficient literacy to fulfill this responsibility of data collection. Furthermore, the government system did not have trained M&E staff with the ability to lead the monitoring and evaluation at the health facility and district level.
- Initial evaluation exercises revealed an overabundance of record registers that would consume significant time entering data with minimal output.
- The district and state-level health officials hesitated in making fundamental changes to the national HMIS, a barrier faced in several places.

Course correction

To address the capacity of CBHVs, the SHOW team revised the data collection tools by introducing more pictures and icons to make the tools easy and user-friendly. The CBHVs received step-by-step training on using these modified tools and handheld digital devices for data collection. The training focused on coaching the CBHVs on using the equipment, understanding the new tools, and accurately collecting the data. Once collected, the PHC staff (also trained for this) consolidated and reported this community data into HMIS. Teams from the health facility and district health department received training on these M&E resources and supportive supervision to independently lead the work within the same system. Quarterly validation workshops were held to review the consolidated data to ensure quality and consistency. These quarterly workshops were also an opportunity to build the capacity of actors such as LGA M&E officers and LNGO partner staff. Finally, SHOW also facilitated training workshops on using the data for informed decision-making to help guide LGAs PHCs directors, the State Ministry of Health (SMOH) and the State Primary Healthcare Development Agency (SPHCDA) staff.

For the overabundance of record registers, the project proposed a reduced number of registers- essentially one comprehensive register- to facilitate the data collection. To improve the policy and health system ownership of a gender transformative data system that incorporates CHMIS, the SHOW team engaged with the federal Ministry of Health (MoH) and the health department in Sokoto state. Through meetings, workshops and advocacy sessions, the team sensitized them about the value of a revamped program monitoring that provides an evidence-base for a truly gender transformative health system.

Results

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

- Improved data collection capacity of CBHVs and supportive supervision of their monitoring staff resulted in an overall strengthening of the results and accountability system. All four indicators related to this pillar, including the data management capacity of the Government, record maintenance at health facilities, data collection in the community, and quality of the recorded data, improved over the life of the project.
- Collection and reporting of age-disaggregated data is now part of the HMIS, and two age brackets for WRA, i.e., 15-19 years and 20-49 years, are regularly reported and utilized for decisions.
- With the involvement of federal and state-level MoH, the feasibility of testing a gender-transformative M&E system improved and its successful implementation in Sokoto state paved the way for its adoption and implementation at scale.

Best practices

- In a gender-responsive system, data about women and girls are collected by actively reaching out to them and not just from health facility reporting. Age-disaggregation of the data enables the system to have true information about women and girls to fulfill the spirit of evidence-informed decision-making.
- Community health workers can use cell phones or Tablet-based data collection tools in primary health care settings with some capacity building. These ICT-based tools and the community-based health workers serve as the backbone of an efficient data system
- State-level piloting of community HMIS systems can be a way to determine the effectiveness, feasibility, and capacities to undertake and expand such interventions.

4. PROJECT OPERATIONS

SHOW was a complex endeavor in several ways. At the partnership level, it engaged with the Ministry of Health, Ministry of Woman Affairs, State Primary Health Care Development Agency and three civil society organizations, including Life Helper Initiatives, Hikima Community Development Initiative and Planned Parenthood Federation of Nigeria. A key function was maintaining the relationship with the donor, Global Affairs Canada (GAC), and carrying out public engagement for the Canadian citizenry. At the programmatic level, its theory of change required tilting the social norms towards gender equitable behaviors in the household and community and woman- and adolescent-friendly services at the health facility. Making it happen required a specific catalytic change and sustained implementation. A Project Steering Committee (PSC) for implementation oversight and a Technical Advisory Group (TAG) for technical guidance were formed. At the implementation level, it involved coordinating with several stakeholders, health facility staff and community-based health workers to bring a synergistic effect.

Challenges

The project faced several challenges during the operationalization of its interventions. These included:

- Plan International Canada and Plan International Nigeria managed this large partnership, comprised of public and private (non-profit) sector stakeholders, including the public engagement activities in Canada.
- In a highly patriarchal society, finding professionals who could work on gender equality, apply gender transformative approaches and become the catalyst for change was complex. Coming from the same patriarchal society, they needed a cognitive shift in their mind and a competency enhancement in their skills.
- The 2,440 health volunteers (CBHVs) were financially supported for their expenses when they traveled in the field. This required the SHOW finance staff to carry cash and deliver it to recipients after traveling long distances in unsecured areas.

Course correction

To manage such an extensive and multi-stakeholder partnership, SHOW developed governance mechanisms to provide strategic, technical, and operational advice and direction for the project implementation. The meetings of PSC and TAG ensured regular communication channels and oversight for effective implementation and governance. Staff were trained on ensuring compliance, and a local team hired from Nigeria provided the media materials for public engagement in Canada. For staff capacity, all project staff, partner staff and stakeholders received extensive gender equality training and continuous support to ensure quality. For remunerations, the project engaged with a bank and facilitated the opening of bank accounts for these volunteers to make secure and uninterrupted payments directly to their accounts.

Results

The measures resulted in transparent governance processes, effective partnerships and adequate capacities, all helping to achieve the desired results. Following is a summary:

- SHOW team had an excellent working relationship with government offices at the federal, state, district and below levels and with partner LNGOs and communities. Having a Plan International office at the national level in the capital improved the effectiveness of these partnerships.
- With capacity building, SHOW achieved adequate staff capacities at various health system levels to provide GRAF MNH/SRH care. The proportions of health facility staff who knew seven key functions related to MNCH/SRH improved from 51% at the baseline to 85% at the endline. The gender-responsiveness of services also improved from 28% to 90% during the life of the project.
- Opening the bank accounts of CBHVs solved the payment issues once and for all. In addition to resting the security issues around financial disbursements, it has also addressed the corruption issues that frequently surface when the system relies on cash payments.

Best practices

- Projects that have to engage with several levels of Government perform optimally if they have central mechanisms (e.g., office at the national level) to engage with Government effectively, other partners and the donor community to coordinate activities and avoid duplication
- Capacity-building systems of projects that envision a social transformation perform well when they aim at achieving a critical mass of change agents at all levels, who, in addition to the clinical understanding, also keep transferring their ethos to the next tier.

5. SUSTAINABILITY

Donor-supported programs often face questions about the continuation of benefits beyond their life. Mindful of this,and being a project that envisaged reduction in maternal and child morbidity and mortality through a social pathway of gender transformation in the system, SHOW devised its sustainability strategy along four dimensions. Institutional sustainability, i.e., the Government owns some innovations like introducing community-based, age-disaggregated data into HMIS for its continuation after SHOW concludes. Technical sustainability, i.e., adequate arrangements (e.g., number of master trainers at various levels) to maintain the quality of interventions brought in by the SHOW project. Financial sustainability, i.e., Government and communities invest resources for the continuation of GRAF care in the short and long term, respectively, and social sustainability, i.e., individual and collective behavior improvement, continues helping to break the vicious cycle of transferring disadvantage from one generation to the other. The SHOW team and partners reviewed this strategy from time to time to ensure its ownership and applicability after the project's close-out.

Challenge

A project that aims at changing social processes and health outcomes, and wants its interventions to continue after its closure, can face several challenges. Below are a few:

- For the continuation of interventions like CHMIS and their ownership by the health department, all steps needed fulfilment within the stipulated time. This included the design of digital tools, development of relevant capacities, rollout by the CBHVs, consolidation of data by health facility staff, and utilization of data by decision-making bodies.

- The maintenance of quality and fidelity of the SHOW training needed the availability of a certain number of master trainers, along with a mechanism of effective supervision from the higher tiers of the system.
- The 2,440 CBHVs performed two key functions: raising awareness among women and girls and carrying out community data collection. These CBHVs were not formal employees of the health system. There was a risk that their jobs will be terminated after SHOW project, stopping the two crucial services being provided by them.
- In a conservative and patriarchal society, the gains achieved through individual and collective behavior change were only nascent. They could wane off over time if longevity in their adoption was not ensured.

Course correction

Mindful of sustainability from the beginning, the SHOW team ensured that whatever intervention it introduces is evidence-based and has the potential of continuation by the Government or the community. For institutionalization, in addition to developing training resources and creating a national and state-level pool of master trainers for each training, the project focused on CHCs as the mechanism that would galvanize these institutional gains after its conclusion. Through its advocacy and required capacity building, the SHOW team convinced the SPHCDA to make CHCs a budgeted item in its annual plans. The revision of clinical training like FP and MLSS to include GRAF MNH/SRH care principles was another step toward institutional stability of the SHOW interventions.

To maintain completeness and quality of interventions, the SHOW team created a pool of master trainers at different health system levels who would facilitate upscaling capacity building while maintaining quality. As part of financial sustainability, the project advocated for the formal induction of CBHVs into the primary health care system. SHOW also introduced the upgradation of CBHVs to Community Health Extension Workers (CHEW) after their training and completion of certification to become skilled birth attendants. For the social change and enhancement of social capital, the project involved religious leaders and the Sultanate, which conveyed the acceptance of the issue of gender equality by the highest religious institution and made it easy for political leaders to

support it publicly. Similarly, all interventions leveraged existing social/community structures, such as 100 Women's Groups, and built their capacity as local resources on gender equality. SHOW worked with the Government and all stakeholders to domesticate the Child Protection Act of 2003 into Child Protection Law in 2021 in Sokoto state. This domestication is a major step toward effectively implementing clauses like the legal age of marriage (18 years) that have a long-term impact on individuals and society.

Results

The efforts came to fruition, and the following are some illustrative results of the sustainability:

- SPHCDA adopted Sokoto CHC guidelines and secured a budget line for CHCs; 50% of health facilities in Sokoto have functional CHCs after the SHOW closure
- The digital data system piloted in Sokoto state is now being scaled up to seven states of the country
- Responding to the importance of CBHVs, 1,032 are formally inducted into the public healthcare system and will continue their service. Likewise, 559 CHEWs have been trained and certified as Skilled Birth Attendants at the PHC level
- The community-owned 253 VSLAs (184 women and 69 adolescents) are now registered with Cooperate Affairs Commission; the Government approved a budget of N30 million in 2020 for their expansion and scale-up in the state.
- As a result of effective advocacy with the Government, religious leaders and community elders, the Child Protection Act has been domesticated into state law. The rules and regulations for clauses like the legal age of marriage (18 years) will have long-term health and social impact on young girls, their families, and society.

Best practices

- Developing a sustainability strategy early on, ensuring that all sustainable components are covered and reviewed in partnership with stakeholders from time to time, and ensuring timely implementation of the required steps are crucial
- Innovations like CHMIS that bring more than one valuable element, e.g., community-based data collection, which captures the "missed women," and digital technology, which improves precision and timeliness, have a higher chance of sustainability
- Likewise, combining the regulatory (Child Protection Act) with social and behavioral (engaging adolescent groups, woman groups, and religious scholars) approaches has a better chance of sustained improvement in individual behaviors and societal actions.

SUMMARY OF THE BEST PRACTICES FROM SHOW PROJECT IN NIGERIA

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

- Community health workers (CBHVs in Nigeria) act as a conduit for health promotion and improved utilization of services. Paying attention to their capacity needs goes a long way in improving the effectiveness of a health system.
- Influencers can vary for different societies and different segments of populations. In a conservative society like Nigeria, engaging religious leaders at the earliest for their influence on men pay off as part of the strategic plans.
- Leveraging the emergent opportunities (such as the Child Protection Law) that have a wider impact, including social, health, economic, and gender equality, requires concerted advocacy

Health services with a focus on gender equality

- Gender responsiveness of the health system improves when the continuum of discrimination, i.e., barriers faced by women and girls in their homes, communities and health facilities, are well understood and addressed at all levels.
- Bringing a positive shift to health workers' attitudes toward providing GRAF healthcare is critical; revision of their training materials and capitalizing on the Government's task-shifting and task-sharing policies provide an opportunity to bring this essential change to the system.
- Sustained operationalization of new additions to the health system, like Adolescent Health Corners, requires effective advocacy at the state and local level and strong community ownership and involvement in improving the system's commitment and oversight to that intervention.

Accountability and results

- In a gender-responsive system, data about women and girls are collected by actively reaching out to them, not just health facility reporting. Age-disaggregation of the data enables the system to have true information about women and girls to fulfill the spirit of evidence-informed decision-making.
- In primary health care settings, CHWs can use a cellphone or Tablet-based data collection tools with some capacity building. These CHWs equipped with ICT-based tools serve as the backbone of an efficient data system
- State-level piloting of community HMIS systems can be a way to determine effectiveness, feasibility and capacities to help undertake and expand.

Operationalization

- Projects that have to engage with several levels of Government perform optimally if they have central mechanisms (e.g., office at the national level) to engage with Government effectively, other partners and the donor community to coordinate activities and avoid duplication
- Capacity-building systems of projects that envision a social transformation perform well when they aim at achieving a critical mass of change agents at all levels, who, in addition to the clinical acumen, also keep transferring their ethos to the next tiers.

Sustainability

- Developing a sustainability strategy early on, ensuring that all sustainable components are covered and reviewed in partnership with stakeholders from time to time, and ensuring timely implementation of the required steps is crucial
- Innovations like CHMIS that bring more than one valuable element, e.g., community-based data collection, which captures the "missed women," and digital technology, which improves precision and timeliness, have a higher chance of sustainability
- Likewise, combining the regulatory (Child Protection Act) with social and behavioral (engaging adolescent groups, woman groups, and religious scholars) approaches has a better chance of sustained improvement in individual behaviors and societal actions.

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

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

[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

CBHV: Community Based Health Volunteer

CHC: Community Health Committee

CHEW: Community Health Extension Worker

CHMIS: Community Health Management Information System

CHW: Community Health Worker

CSO: Civil Society Organization

EmONC: Emergency Obstetric and Newborn Care

FMOH: Federal Ministry of Health

GAC: Global Affairs Canada

GRAF: Gender-Responsive, Adolescent-Friendly

HCP: Health Care Providers

HFA: Health Facility Assessment

HMIS: Health Management Information System

IEC: Information, Education, Communication

IMNCI: integrated Management of Newborn and Child Illnesses

MLSS: Modified Life-Saving Skills

MNCH: Maternal, Newborn and Child Health

MOH: Ministry of Health

PHC: Primary Health Care

PMF: Performance Measurement Framework

PSC: Project Steering Committee

SBA: Skilled Birth Attendant

SBCC: Social and Behavior Change Communication

SHOW: Strengthening Health Outcomes for Women and Children

SRH: Sexual and Reproductive Health

TAG: Technical Advisory Group

VSLA: Village Saving and Loan Association

WHO: World Health Organization

WRA: Women of Reproductive Age

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