PLAN INTERNATIONAL

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GENDER-TRANSFORMATIVE HEALTH PROGRAMMING

A Compendium of Promising Practices and Lessons Learned from Plan International's SHOW Project

2022

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ACRONYMS

ANC	Ante-Natal Care
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AWP	Annual Work Plan
BEmONC	Basic Emergency Obstetric and Neonatal Care
CBHV	Community Based Health Volunteers
CBO	Community-Based Organization
CEDAW	UN Convention on the Elimination of all Forms of Discrimination Against Women
CEFM	Child, Early and Forced Marriage
CETS	Community Emergency Transport System
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHO	Community Health Organization
CHW	Community Health Worker
CRC	UN Convention on the Rights of the Child
CSO	Civil society organization
DFATD	Department of Foreign Affairs, Trade and Development (now Global Affairs Canada)
DGFP	Directorate General Family Planning
ETAT	Emergency Triage Assessment and Treatment
EVF	Education a la Vie Familiale
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FMOH	Federal Ministry of Health
GAC	Global Affairs Canada
GBV	Gender-Based Violence
GE	Gender Equality
GEAP	Gender Equality Action Plan
GES	Gender Equality Strategy
GRAF	Gender Responsive and Adolescent Friendly
HF	Health Facility
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTP	Harmful Traditional Practice
IEC	Information and Education Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
INGO	International Non-Government Organization
IO	Intermediate Outcome
KII	Key Informant Interviews
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation and Learning
MLSS	Modified Life Saving Skills
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MSG	Mothers' Support Group
NGO	Non-Governmental Organization
PHC	Primary Health Care
PIP	Project Implementation Plan
PMF	Performance Measurement Framework
PNC	Postnatal Care

PP	Percentage points
PSA	Public Service Announcement
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBA	Skilled Birth Attendance
SBCC	Social and Behavior Change Communications
SHOW	Strengthening Health Outcomes for Women and Children
SMS	Short Message Service
SPHCDA	State Primary Health Care Development Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TA	Technical Advisor
TBA	Traditional Birth Attendant
TfD	Theatre for Development
TOT	Training of Trainers
TVET	Technical and Vocational Education and Training
VSG	Village Savings Group
VSLA	Villages Savings and Loans Associations
WASH	Water, Sanitation and Hygiene
WDC	Ward Development Committee
WHO	World Health Organization
WRA	Women of Reproductive Age
WRO	Women's Rights Organization

INTRODUCTION

Strengthening Health Outcomes for Women and Children (SHOW) was a 4.5-year (January 2016–September 2020) gender-transformative health project, implemented in five countries: Nigeria, Haiti, Bangladesh, Ghana, and Senegal. The ultimate objective of SHOW was to contribute to the reduction of maternal and child mortality amongst vulnerable women and children, including adolescent girls, in targeted remote, underserved regions of each country. To achieve the project's ambitious objective, outcomes and activity streams contributed to the improvement of the quality, availability, utilization, and accountability of essential maternal, newborn, and child health (MNCH) and sexual and reproductive health (SRH) services. Plan International implemented SHOW in the five project countries in partnership with the respective governments, local non-governmental organizations, and strategic technical partnerships in Canada and the United States. In August 2020, SHOW was awarded a one-year costed extension to respond to COVID-19 in Bangladesh, Ghana, Nigeria, and Senegal. Activities under the extension phase are not covered in this compendium[1].

Plan International's Global Policy on Gender Equality and Inclusion (2017) requires the whole organization to embed its work within the international human rights standards and principles articulated in the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). A key element of Plan International's approach to health programming is its conviction that gender equality is an intrinsic principle, premised on the fundamental human rights to non-discrimination on any ground, and a foundational requirement for improved health outcomes. A comprehensive Gender Equality Strategy (GES) was therefore central to the SHOW project design, intending to transform unequal power relations between women and men, boys, and girls. The purpose of this compendium is to provide documentation of, and lessons learned from the development, implementation, and results

of the project's Gender Equality Strategy in order to contribute to the evolution of promising practices in gender transformative programming, and discussions within the community of practice.

This compendium is organized into five sections as follows: Section 1 provides an overview of the methodology and findings of the SHOW gender equality analysis that formed the basis for the Gender Equality Strategy; Section 2 describes the project's Theory of Change and Gender Equality Strategy, including the strategy's 3 pillars (women's and girls empowerment, male engagement, gender-responsive, and adolescent-friendly service provision); Section 3 provides an analysis of the design and implementation of the activity streams supporting the GES, by the pillars, and presents key project results; Sections 4 highlights key lessons learned from the SHOW GES experience; and finally, Section 5 lists the technical documents created to support implementation and document learning.

1. *In August 2020, the SHOW project received a costed extension from Global Affairs Canada (GAC) to contribute to the COVID-19 response in Bangladesh, Senegal, Ghana and Nigeria. The CE started in August 2020 and ended on June 30, 2022. Activities under the COVID-19 extension phase are not covered in this Compendium as the nature of activities did not change significantly. However, more emphasis was placed on content regarding the burden of unpaid care work on women and girls in the wake of COVID-19 including country specific studies and advocacy with local women's rights organizations (WROs); and gender-based violence (GBV) prevention using all channels of awareness raising such as social behaviour change communication (SBCC) and male engagement described below. Learnings from the COVID-19 response phase are documented separately.*

SECTION 1:
SITUATION ANALYSIS

The broader health sector has increasingly recognized[2] gender inequality and intersectional power dynamics as a prevailing driver of poor health outcomes, particularly for women and girls, and recognized a corresponding need to respond with a transformative approach that addresses the root causes of gender inequality. Plan International has likewise continued to strengthen gender analysis and gender transformative programming as a cornerstone of its health programs. Plan International found gender inequality as the dominant element of understanding and addressing poor Maternal, Newborn and Child Health (MNCH)/Sexual and Reproductive Health and Rights (SRHR) outcomes. Therefore, gender equality (GE) has been central in the design and implementation of Plan International's MNCH/SRHR programming and its flagship Strengthening Health Outcomes for Women and Children (SHOW) project – a multi-year[3], multi-country, and Global Affairs Canada-funded gender-transformative project – implemented in five countries comprising of Bangladesh, Ghana, Haiti, Nigeria and Senegal.

The challenge for all health programming and one made more complex in multi-country programs, is to strike a balance between an aligned approach to gender transformative programming that can be brought to scale across all project locations, and one that is sufficiently flexible to respond to the contextual realities that characterize gendered power dynamics across diverse cultures. To meet this challenge, it is essential to have a strong understanding of both the common and unique gender equality issues and dynamics related to MNCH/SRHR experienced by women and girls in targeted programming areas across the five countries. The following provides an overview of the process through which Plan International conducted its foundational gender equality analysis and the key findings that informed the SHOW project's Gender Equality Strategy (GES).

2. https://www.thelancet.com/series/gender-equality-norms-health
3. SHOW initial Project Duration: Jan 2016–Sept 2020

1.1 SITUATION ANALYSIS PROCESS

The establishment of a foundational understanding of the gender equality dynamics within each SHOW project country was achieved through information gathering and data collection at key stages of project design and start-up. The following section briefly describes these components:

- **Desk research** and **community and stakeholder consultations** to support the initial project design and proposal development phase
- During the inception phase, integration of key gender equality considerations and questions within the **baseline** study design as well as the project's country-level **Health Facilities Assessments (HFAs)**
- A comprehensive qualitative **Gender Equality Assessment**

DESIGN PHASE

- Desk Research
- Community & Statekholder Consultations

INCEPTION PHASE

- Baseline Evaluation
- Gender Equality Assessment
- Health Facilities Assessment

1.1.1 PROPOSAL AND SITUATION ANALYSIS RESEARCH

At the proposal development phase, two broad approaches were taken to establish an initial understanding of the gender equality dynamics most relevant to women and girls' MNCH/SRHR behaviours, barriers, and outcomes: desk research and community and stakeholder consultations.

Desk research for each country included a gender equality analysis of the following data sources:

- Government policies and protocols related to health and gender equality, women's and girls' rights;
- National Demographic Health Surveys, in particular data related to SRHR Maternal Mortality Rate (MMR), age of marriage and sexual debut, antenatal care (ANC), postnatal care (PNC), skilled birth attendance (SBA), contraceptive use, and gender equality (violence against women/girls, decision making patterns in health (where the data was available), and women and girls' access to information and media, education level, access/control over income and resources);
- Published reports of the UN System as well as the Country and Shadow Reports of national NGOs for the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Concluding Observations to countries by the CEDAW Committee;
- Relevant publications by academic, development, and health practitioners that have studied behaviours and barriers to women/girls related to MNCH/SRHR.

In addition to, and informed by preliminary desk research, **community and stakeholder consultations** were held with almost 900 people across the five SHOW countries. Through key informant interviews (KIIs) and focus group discussions (FDGs), consultations were held with adolescent girls & boys, women of reproductive age, men, local community leaders, officials from Ministries of Health and Women's Affairs, data services, regional/state & local health services, and local implementing partners.

Community/stakeholder consultations had the dual purpose of i) identifying unique gender-based barriers, specific needs and constraints of women, adolescent girls, and male partners affecting mothers and children's access to health services; ii) understanding how power relations between women and men affect maternal, neo-natal and child health. Four areas of inquiry were explored with various stakeholders:

i. Barriers to accessing MNCH/SRH services

Informants were asked about the proximity of services and taboos and traditions as well as household-level decision-making patterns that affect access to and use of services related to MNCH/SRHR at different stages within the continuum of care. The consultation explored some of the household-level constraints (such as permission to seek health care services/mobility constraints, time constraints, etc.) that women and girls face related to accessing services such as SBA, ANC/PNC, vaccinations, and family planning. It also explored what role was held by other family members like grandmothers or mothers-in-law, and in the case of polygamous households, head/first wives, around the MNCH continuum of care.

ii. Male engagement

Informants were asked about decision-making patterns for men at the household level related to the continuum of care for MNCH/SRH. The consultation explored the nature of male support around MNCH/SRHR, their behaviours, and the social norms that drive, support, or prevent it. Moreover, it also explored what could encourage or promote increased male support or positive MNCH/SRHR related decisions and behaviours.

iii. Decision-making in health centers and committees

Specific informants were asked about the role of women in public decision making including in health management committees and local government decision-making related to MNCH/SRHR, as well as challenges and barriers to women's participation in these health-related and other decision-making bodies.

iv. Visits to a health facility

Informants were asked about specific barriers that limit access to MNCH/SRH services at health facilities for women and men, and adolescent girls, as well as exploring possible solutions to these barriers in general and that could be affected by health service providers themselves. These queries were intended to highlight some of the systemic gaps in gender-responsiveness and adolescent-friendliness of services and were subsequently further explored in the project's Health Facilities Assessments carried out in each of the SHOW countries.

Specific gender equality analysis for each of the five SHOW countries was generated using the described approach to desk (secondary) review and community/stakeholder consultations and alignment between the key gender-related barriers in each country was identified to build the broad strokes of the SHOW project's Gender Equality Strategy to include at the proposal stage.

After donor approval and contract signing, two key deliverables were triggered at the project inception phase: the Baseline Survey and the qualitative Gender Equality Assessment. This next stage of information gathering, described below, added comprehensive detail to each country's gender equality analysis and provided the additional data needed to co-create detailed activities and content with staff and partners in each country and the program wide GES.

1.1.2 BASELINE SURVEY AND GENDER EQUALITY ASSESSMENT

The **Baseline Survey** is designed primarily as an accountability tool to respond to indicators of progress included in the project Performance Measurement Framework (PMF), but a good baseline also can and should include the collection of data that supports ongoing interpretation to improve and strengthen programming including through the Annual Monitoring Data. For Plan International's SHOW project, this dual-purpose was central to the design of the methodology and tools for its 5-country baseline study, and gender equality dimensions were integrated to support the initial situation analysis and to assess the degree to which the project could achieve its gender equality outcomes and objectives by setting targets. It should be noted that MNCH indicators took prominence in the agreed-upon PMF and that the integration of SRHR in programming was not strongly reflected in the PMF.

The SHOW baseline survey employed two tools to collect data: a household survey and a health facility questionnaire. The baseline health facility (HF) questionnaires were further strengthened with detailed country-level Health Facilities Assessments, aligned with WHO and national government tools, including gender-responsiveness and adolescent-friendliness dimensions; these were subsequently validated by governments, and used for programming targeting quality, gender-responsiveness, and adolescent-friendliness of service delivery and systems strengthening. These tools were administered in a sample of intervention communities in each country. The household survey was administered to mothers with at least one child under 2 years old, and a men's questionnaire was administered to their male partners/husbands or other male family members. From the midline onwards, efforts were made to include a separate survey of unmarried adolescents to respond to programmatic changes as more SRH content was integrated into the SHOW project. The health facility questionnaire was administered to all selected health facility staff in the target communities.

[TABLE 1] LIST OF INDICATORS AT HOUSEHOLD LEVEL

PMF Indicators	
1	% of women aged 15–49 who received antenatal care (ANC) by a skilled health provider at least 4 times during pregnancy (disaggregated by age that is 15–19 years and 20–49 years)
2	% of children aged 12–23 months vaccinated against measles (disaggregated by sex)
3	% of live births attended by skilled health personnel (disaggregated by age of mothers)
4	% of mothers, and percentage of babies, who received postnatal care (PNC) within two days of childbirth (disaggregated by age)
5	% of Women of Reproductive Age (WRA) (disaggregated by age) and their male family members who know at least 2 danger signs and related strategies along the continuum of care
6	% of WRA (disaggregated by age) and their male family members who know at least 2 key gender equality messages related to MNCH/SRHR[4]
7	Average level of support provided by male family members for the utilization of MNCH/SRH services by female family members (disaggregated by women, men, and adolescent girls)[5]
8	% of women who are members of organized community groups (disaggregated by age and type of group)
9	Average level of satisfaction of WRA (disaggregated by age) and their male partners with the quality and responsiveness of MNCH/SRH services
10	Average level of satisfaction of female MNCH/SRH users (disaggregated by age) and their male family members with the MNCH/SRH referral system

Data collection tools were designed to respond to the indicators listed and highlighted in blue in **[TABLE 1]** and **[TABLE 2]** in the baseline household and facility level survey.

Additional gender equality elements were included in the household survey beyond those required to respond to the indicators above. First, surveys collected demographic data which allowed analyses to explore factors that often intersect with gender, such as age, marital status, number of children, level of education, and economic status. Second, within the series of questions measuring behaviours related to the MNCH/SRH continuum of care, women and men were asked the main reasons for not accessing MNCH/SRHR services as well as who the central decision-maker was around seeking and accessing care. Finally, the survey included a section on 'Gender Equality and Decision Making'. This section included questions exploring attitudes towards and patterns of household decision making between men and women around decisions related to health and other key decisions such as the marriage of children, education, and household resources. The role of women in community level decision making and their participation were also explored in the household survey.

The Health Facility questionnaire also included key facility-level indicators related to the achievement of gender equality outcomes. **[TABLE 2]** lists the Immediate Outcome-level indicators from the PMF that were collected at the facility through the facility questionnaire. As is described in the Theory of Change in Section 2, the achievement of Immediate Outcomes was supported by project activities such as training of facility staff and measured by associated output-level indicators (for example, # of

4. *Note: the following proxy indicator is used due to a skip logic error at baseline: % of women and their male family members who believe that women should participate in decision making at household and community level.*

5. *Note for the calculation of this indicator: averages were taken from survey respondents who ranked male support during the MNCH continuum of care as 'high' out of a 4-point scale (high, fair, poor, very poor). Points on the continuum included ANC, delivery, PNC, family planning, breastfeeding.*

health care providers trained on gender-responsive and adolescent-friendly (GRAF) service provision).

[TABLE 2] LIST OF INDICATORS AT HEALTH FACILITY LEVEL

PMF Indicators	
1	% of CHC (Community Health Committee) leadership positions held by women
2	% of CHC members that are female
3	% of health facilities that provide gender responsive and adolescent friendly referral services
4	% of health facilities that utilize environmentally safe waste disposal methods
5	% of health facilities that provide gender responsive and adolescent friendly MNCH/SRH services
6	% of facilities where records are maintained regularly
7	% of project areas with household level monitoring data collection

The Health Facility Assessment collected data on overall service provision, infrastructure, and supplies. Areas of analysis related to gender specifically included the gender responsiveness and adolescent friendliness of service provision and infrastructure, as well as the level and nature of female participation in CHCs. The design of these variables was based on the SHOW project's Global Guidelines on Gender Responsive and Adolescent Friendly Service Provision[6] and also specific service readiness adapted using the WHO global standards for quality healthcare services for adolescents. Elements of Gender Responsive Service Delivery and Referrals[7] that are measured in the HFA include:

i) The degree to which MNCH/SRHR policy and service take gender needs and priorities into account;

ii) The degree to which client/provider relationships are based on principles of non-discrimination, trust, respect, and dignity;

iii) The degree to which clinic environment, infrastructure, transport/referral mechanisms are inclusive and welcoming to male partners of women of reproductive age. This includes, for example, questions about the type and frequency of training on gender equality provided to health facility staff, the nature of communication with female clients, and the physical availability of space for male partners in waiting areas.

The second component of data collection and analysis during the inception phase of SHOW was the **Gender Equality Assessment**. This multi-country gender assessment served to complement the baseline study and provide more in-depth contextualized qualitative data on the underlying root causes relating to MNCH/SRHR issues and experiences of women, men, and boys' and girls' realities in MNCH/SRHR.

6. *A description of these guidelines is provided in Section 5.*

7. *The composite indicator for GRAF service delivery is made up of various criteria and captures data on availability of privacy, consultation rooms, accommodation of male spouse in the consultation room, provision of separate toilets for males and females and the type of and approach to giving information to women, adolescent girls and male partners or family members during counseling. The composite indicator for GRAF referral services includes data on facilitating accompaniment for patient, communication about referral, suggestion of transportation methods, and response to concerns and questions related to the referral. These individual criteria were weighed 1–3 points, with facilities scoring at least 50% for MNH/SRH/ referral services and 80% for FP services counted for the indicator.*

[TABLE 3] GENDER EQUALITY ASSESSMENT AREAS OF INQUIRY[8]

• Gender norms and assumptions • Norms regarding early marriage and pregnancy • Gender division of labour (the productive, reproductive, and community roles of women/girls, men/boys) • Women and girls' participation and decision making at the community level (with a comparison of the qualitative and quantitative data on decision making) • Access to resources and decision making in the household broadly and specifically to MNCH/SRH • Family planning/birth spacing decisions	• Male support and involvement in MNCH/SRH and barriers to male involvement • Attitudes toward gender-based violence • Perceptions regarding the availability of gender-responsive and adolescent-friendly MNCH/SRH services • Barriers to access and uptake of MNCH/SRH services for adult women, men, and adolescent boys and girls • Participants' recommendations for improvements at the household, community, and health facility levels for improving uptake and utilization of MNCH/SRH services.

Data collection was carried out by locally engaged consultants in each country, using standardized tools developed by Plan International specifically for SHOW, and translated into the appropriate local languages. A variety of qualitative tools were used for conducting consultations: key informant interviews and focus group discussions in each of the countries in SHOW project locations, and these included focused questions and discussion, as well as mapping and ranking. These tools were designed to explore a deeper understanding of the gender dynamics most relevant to women's and girls' experiences around the continuum of MNCH/SRH care. They included a variety of questions related to the gendered division of household labour, decision making power, access to and control over resources, as well as discussion questions related to health supports during the continuum of care within the community and at home and perceptions regarding gender-based violence.

By conducting purposive consultations with groups disaggregated by sex, age, and marital status the assessment was able to gain diverse perspectives and while no generalizations amongst the sub-groups could be drawn, some alignment between these groups provided key insights to gender equality norms and practices. In each of the five SHOW countries, at least one FGD was conducted with the following groups: married adolescent girls, unmarried adolescent girls, adolescent boys, men, older women (50+), adult women of reproductive age (20–49). KIIs were conducted with targeted stakeholders that varied between countries, but consistently included members or leaders of the community health committees, health facility staff, and traditional or religious leaders.

The Gender Equality Assessment report included an analysis of the qualitative data, as well as integrating relevant findings from the baseline surveys to provide a more full gender equality situation analysis, and descriptive analysis is annexed to the report for each of the five SHOW countries.

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1.2 SITUATION ANALYSIS RESULTS[9]

The following section provides an overview of the gender analysis findings as described in relevant SHOW project documents, including the Baseline Report, the gender equality analysis from the proposal, and the Gender Equality Assessment. The findings are organized into three areas: the low status and agency of women and girls; low male support for MNCH/SRHR; and a lack of responsiveness of MNCH/SRH services to gender and adolescent considerations. These gendered aspects of women's health-seeking behaviour and access to quality care are the basis of the SHOW project's Gender Equality Strategy (detailed in Section 2).

1.2.1 LOW STATUS AND AGENCY OF WOMEN AND GIRLS

The central driving factor of gender inequality across the five countries within the SHOW project are the social norms that define and perpetuate the subordinate position of women and girls vis-à-vis men and boys. The situation analysis conducted for the SHOW project identifies how gendered social norms translate to barriers for women and girls at the household and community levels for positive MNCH/SRHR behaviours and outcomes, and it discusses specific examples of how this applies within each country.

The analysis ranged from the description of common and expected aspects of gendered norms, such as the gendered division of household roles, to some of the more specific daily realities of gender inequality, such as mistrust and stigma associated with the use of modern family planning. Importantly, it is noted within the Gender Equality Assessment reports that while variations are found amongst the five SHOW countries, these differences are for the most part in degree rather than substance – which is to say that the prevailing social and gender norms summarized below were generally held in common at the time of baseline data collection across the targeted communities across five countries.

- Women and men largely follow rigid **gender roles** wherein women are expected to manage all care and domestic responsibilities such as housework, child and elderly care, and contribute to domestic income-generating activities. These roles are typically associated with a lower status vis-à-vis the status associated with men who are heads of household and breadwinners. This uneven division of labour places a heavy burden on women and girls, taking up much of their energy and contribute to their **time poverty**. As a result, this uneven workload limits their participation, leadership and decision making in community

> **"Yes, it's us. We do the cleaning, the dishes, we take care of the children and we serve our parents." When asked what the boys do, one replied "Sleep and ask: 'where is dinner'."**
>
> – Girls' FGD, Senegal

9. *Content for this section is from the SHOW Gender Equality Assessment unless otherwise referenced*

activities. It is also a key factor impeding women and girls from seeking out MNCH/SRH care.

- **Women's mobility** is limited by a variety of factors, depending on the country and location, and this influences their ability to access health care services independently (or at all). In Bangladesh and in Nigeria, women's mobility is limited by social taboos surrounding women's interactions with men, other than their husbands and immediate male family members, and the associated appearance of impropriety. This taboo also prevents women from being served privately by male doctors or healthcare providers. Women and girls' mobility is also limited by a lack of independent economic resources or economic dependency on male partners or family members.
- Women in targeted communities are subject to **gender-based hierarchy** that holds women and girls as subordinate to men and boys in virtually all realms of decision making across the five countries. Men are considered the ultimate decision-makers and this power is generally attributed to their perceived 'natural' superiority, commonly based on cultural and religious beliefs. For example, almost 60% of male respondents in Senegal and approximately 90% in Nigeria said that they are the sole decision maker on management of household cash. And while the dynamic is less pronounced in Haiti and Ghana, across all countries, the sole decision-making power of men was higher than that of women[10].

> **"The role of a father, which is given to him by God, is to feed and discipline his family."**
>
> – Male FGD, Nigeria

- The expression of **masculinities** was explored, but the discussion was limited to the acceptability of their contribution to household duties and childcare, which varied between countries. In Bangladesh, norms associated with masculinity do not permit men to assist in traditionally 'female' duties, whereas in Nigeria, despite similar gendered roles, it is more acceptable for men to support their wives in household duties.
- Norms and stereotypes about **sexual activity and behaviours** are prevalent across target communities and generally reflect the prioritization of fidelity amongst women and girls, and the associated limitations applied to women and girls to prevent perceived infidelity. These include, for example in Senegal and Haiti, the assumption that mobile phones are used by women to contact men other than their husbands.
- The decision to use **modern contraceptives for family planning** is perceived as requiring the permission of the husband or male partner, and that he should decide how many and when to have children. The report notes that the desire to use family planning is widespread amongst women, and that in Nigeria, Ghana and Haiti, some women will access and use family planning without the knowledge of their husbands or partners. Attitudes and practice towards use of family planning is heavily influenced by religious traditions, especially in Senegal and Nigeria. The baseline data show a very significant range of rates of use between countries, with almost 70% use by WRA in Bangladesh and less than 5% in Nigeria[11].

10. *The decision of whether to breastfeed was the only exception to this trend.*
11. *Table 21, SHOW Baseline Evaluation Report*

And while women in general had a higher level of awareness of the benefits of delaying and spacing pregnancies across all five countries (52% of women as compared to 38.3% of men[12]) it was still an area where men were more likely to see themselves as sole decision-makers[13].

- Women find greater freedom of movement and influence in various women's groups and collectives. Examples of **women's collective support and solidarity** include the influence of female members of community health committees, and participation in community savings groups. This solidarity can also be found in polygamous households; however, it is still characterized by hierarchy amongst wives.
- While **early marriage** is publicly condemned by most, it is nevertheless prevalent across target countries to varying degrees. The factors contributing to its prevalence include cultural practices like dowry and exchange marriage, high social value placed on marriage broadly, poverty, lack of educational opportunities, and prevention of premarital sexual activity and pregnancy among girls. Decisions about when and whom to marry are similarly governed by patriarchal gender norms, with the father or other male head of household making the ultimate decision. There is growing understanding of the health consequences of early marriage and childbearing, resulting in perceived trends toward delaying girls' marriage. However, at the same time, existing socio-cultural values and notions continue to prevail resulting in the continued practice of early marriage.
- **Early pregnancy** is closely associated with early marriage in most locations. **Premarital pregnancy**, while less common in the project communities, is met with negative social consequences to varying degrees of severity across project locations, ranging from most severe in Nigeria and Bangladesh, to less severe in Haiti. Regardless of the severity, stigma, shame and abandonment are common responses from family and communities. One important consequence of premarital pregnancy across all localities is that the young mothers encounter barriers to care. Because many conceal their pregnancies, they lack access to timely ANC. When they are ready to deliver, they present with predisposed complications and unmarried girls will also encounter barriers to hospital care and facility-based deliveries.

"What will happen to her is her parents will abandon her, nobody will support her especially, she will leave home and become a commercial sex worker because she has disgraced her family."

– Religious/traditional leader, Nigeria

- Women's **participation and decision making at the community level** is more varied across the SHOW project countries, as are attitudes towards their participation. What could be generalized is that women do participate actively in multiple types of community groups, albeit in varying degrees, including taking part in decision making, however final decisions at the community level tend to be dominated by men. There are also a variety of barriers that constrain women's ability to participate, including mobility constraints, time poverty, negative gender stereotypes related to women's capabilities, and social norms around interaction

12. *Amongst men and women who reported using some form of modern contraception, Table 22, SHOW Baseline Evaluation Report.*
13. *According to HHDM data, men in NGA, BGD and GHA are more likely to identify themselves as the sole decision maker about the use of FP than are women.*

of women and men outside the family circle. The variations among the project countries indicate somewhat more scope for participation in Haiti and Senegal, less so in Nigeria and Ghana, and minimally in Bangladesh. In the baseline data, the greatest barrier to women's community-level decision making identified by women was "Women's opinions are disregarded," (50.5% both age groups of women), compared with 44.6% for men, while for men the barrier cited most often was "Women do not have the capacity" (54.8%), a barrier not mentioned by any of the female respondents.[14]

"Yes [women] contribute during meetings, they can come up with a suggestion or idea, then they meet me the chairman and I will decide if it should be implemented or not." When asked why this was the case, he replied "Because generally women are weak in making good decisions, but if they consult the chairman, he will give his inputs and will try to support them in making the good decisions."

– CHC Leader, Sokoto Nigeria

- **Participation in Community Health Committees** is varied across project countries. For the most part women participate, or are members, of CHCs. Participation in decision making is varied and limited leadership positions are held by women. Across the SHOW countries at baseline, an average of 30% of members of CHCs were women, and 30% of leadership positions were held by women (Haiti is an outlier, with 47% leadership positions held by women).[15]
- **Access to and control of resources and decision making about most household resources** is dominated by men, with some specific areas where women are consulted. Men generally control income and expenditures, and this is closely associated with their role as breadwinners. Where women are income-earners, they are more likely to have decision making power over spending. With the exception of male respondents in Haiti, more than 50% of surveyed men across the SHOW countries identified themselves as the sole decision maker on managing household cash.[16]
- **Mobile phone use** by women is controversial, especially in Haiti and Senegal, where their use raises suspicions of infidelity. Use by adolescent girls is also not acceptable for similar reasons associated with their vulnerability to pre-marital sex. There is not the same concern for adolescent boys.

14. *Table 59, SHOW Baseline Evaluation Report*
15. *Table 70, SHOW Baseline Evaluation Report*
16. *HHDM Baseline Data (table provided by Plan)*

1.2.2 LOW MALE SUPPORT FOR MNCH/SRHR

The low level of male support for MNCH/SRHR is examined in the situation analysis both as a factor or 'symptom' of gender inequality, as well as how it presents itself as a practical barrier to women and girls' ability to access MNCH/SRH health services and resources. As a symptom of gender inequality, gender norms that define and restrict women's roles to reproductive labour similarly limit men's access to this area of work and prevent them from actively participating in the continuum of care for MNCH/SRH. As a practical barrier, the prevailing patriarchal norms that maintain men as the key decision makers and resource-holders mean that the active support of male partners is not only preferable for women and girls, it is essential for their health and safety.

The situation analysis finds that prevailing patriarchal norms and attitudes in each of the countries result in: MNCH/SRH being viewed as solely a women's concern thereby distancing or excluding men from taking up responsibility in caregiving in the household; men's and boys' low knowledge about MNCH risks and issues; low participation in birth preparedness planning; low participation and support to women and girls over the MNCH continuum of care such as attending ANC visits, skilled delivery, PNC and child health services; and low value accorded to women's representation and voice in community health governance structures. The nature and degree of these implications vary between countries and the following provides an overview of key findings and variations.

- The **type of support** required by men through the continuum of care is overwhelmingly associated with their role as 'breadwinner' and is seen as financial or material support, which includes the provision of food, transportation or accompaniment to hospital or clinic, (with the important caveat and need for clarification that this accompaniment is often limited to "travelling to" but not "joining with their partner inside facilities"), or fees for services or medications. In Nigeria, the provision of 'permission' by husbands for women to attend clinics was also seen as a type of support. The **level of support** varied

across and within communities, however between 25% and 45% of women across SHOW countries characterized support from male partners during the continuum of care as 'very good'[17].

- Associated with this supportive role, however, is that **poverty is often identified as a key barrier** to the provision of adequate support by male partners, noted especially in Bangladesh and Nigeria. It is the role of men to give permission to attend health services, but also to provide the *means* – when there are insufficient resources, the support is not provided.

"The men in most cases do not come. Sometimes, no family member accompanies her, the pregnant mother comes alone. We cannot comment on this, because the family members get hurt. Most of the men think that it is the sole responsibility of a woman. On the other hand, most of them are day labourers with very low income, so they do not have time to come. The child is his wealth as well, they do not consider."

– Bangladesh health professional

17. *Table 53, SHOW Baseline Evaluation Report*

- **Lack of knowledge and awareness** amongst men on MNCH/SRHR is also a barrier to women's access to services and care. The perception of MNCH/SRH as 'women's domain' excludes men from becoming informed and able to contribute to good health-related decision making. On average, only 38.4% of male partners could identify at least 2 danger signs during the MNCH continuum of care (compared to 54.3% of WRAs), and this difference in knowledge was most pronounced in Nigeria and Bangladesh[18]. And while the proportion of men who could identify 2 strategies to address danger signs (16.5%) was only marginally lower than women (21.3%), when coupled with their decision-making power, the impact of this lack of knowledge is intensified[19].
- Social taboos associated with **ideals of masculinity** limit support for household work and facility attendance. Mostly noted with respect to health facility attendance, it is not viewed as a norm for men to attend facilities, although the exception for both seemed to be in Nigeria, where it is more relatively acceptable although still uncommon.

> **"Perception of society poses victimization/mockery of men who appear to be very supportive to the wives."**
>
> – Traditional leader, Ghana

- According to the GE Assessment, the **perception of men about their level of support** is higher than the perception that women have of their partners' level of support. However, the quantitative data does not correspond with this finding, with a comparable proportion of women and men rating their support across the continuum of MNCH/SRH care as 'very good' (35.6% and 35.3% for women and men, respectively)[20].
- Married **adolescent girls get less support from male partners** during the MNCH/SRH continuum of care; unmarried pregnant adolescent girls get no support from partners and are more likely to be abandoned by male partners and family. The stigma associated with early pregnancy is almost exclusively for extramarital pregnancy. If a girl is married young, she is expected to conceive soon after marriage and therefore is not the victim of social stigma. If her husband is young, she is less likely to get strong support.

- Attitudes towards **gender-based violence** were fairly consistent across communities in the target SHOW project countries. For the most part, although there is explicit disapproval of domestic abuse and violence, it is also commonplace and sometimes justifiable. Both men and women feel that abuse is something that women bring upon themselves (for example, through infidelity or disobedience), and there is some indication that when abuse happens the stigma is applied to the woman, not to the man. In some cases, for example in Senegal, domestic abuse or wife-beating is justified through religious teachings. How this relates specifically to the MNCH continuum of care was not explored; however, the fact that GBV is a risk in the MNCH continuum of care, its acceptance was noted at a problem to work on through GBV prevention activities.

18. *Table 49, SHOW Baseline Evaluation Report*
19. *Table 50, SHOW Baseline Evaluation Report*
20. *Table 53, SHOW Baseline Evaluation Report*

1.2.3 GENDER AND ADOLESCENT NON-RESPONSIVE SERVICES

The situation analysis examines barriers that women and girls, and men and boys, experience when attempting to access MNCH/SRH services. The studies look at barriers existing on the way to health facilities, as well as those encountered at health facilities themselves. This also includes examining barriers that specifically impact women, adolescent girls, adolescent boys, and men, as well as examining the responsiveness of services based on gender and age. Gender norms are prevalent influencing factors determining the attitudes of health service providers when they provide services to women, adolescent girls, adolescent boys, and men.

Key barriers to MNCH/SRH services include cost of transport, issues around transport and distance to facilities, availability of gender responsive and adolescent friendly services, fragmented services, inadequate services available at community-level health facilities, inadequacy of physical facility spaces that do not accommodate the needs of various women and girls and their partners such as sex separated and safe latrines, or waiting areas for men, disrespectful attitudes and behaviors of health professionals towards women and girls, lack of privacy at health facilities, and discrimination against adolescent girls and boys.

- **MNCH/SRH services are not always accessible or available** to women and girls. Several contributing factors are identified that explain why or how MNCH/SRH services fail to meet women and girls' expectations regarding accessibility and availability. In all of the project countries' targeted areas, with some exceptions in Nigeria, health facilities with the full spectrum of MNCH/SRH services are not found in every community and are often far from targeted communities. There is also a lack of consistency of services delivered at different primary health care facilities and these services are not consistently available. For example, in Haiti, women and girls reported that health facilities were not open in the evening (after regular hours) or on weekends. Availability of quality community-based and facility-based services are also an issue for services such as ANC and PNC and thus pushing many women and girls to consult traditional practitioners.
- Several **barriers to access** have been identified, including cost, inadequate services and/or facilities, staff attitudes and behaviours, issues with transportation, and low support from families. More specific barriers include language barriers for women in Senegal and cultural traditions of hiding pregnancies forcing women to postpone ANC in Ghana. **Costs**, either for services, transport, or additional unplanned costs, are frequent barriers to accessing MNCH/SRH services. **Lack of transport** options during emergencies or referrals is also an important barrier, particularly those means of transport that are suitable for pregnant adolescent women.

"Some of the women laugh at pregnant women hence going to the ANC has become a big challenge for some of us. We sometimes have to hide our pregnancy for so many months before accessing the ANC clinic because of the fear of being mocked by community members."

– Adult Women's FGD, Ghana

- **Lack of awareness** of women and girls on the importance of accessing MNCH/SRH services, when they need to go to a health facility, or of what MNCH/SRH services consist of and do is a barrier to services. In Bangladesh and Nigeria, this was cited as a poignant barrier for adolescent girls, and in Nigeria, some women expressed being fearful of medicines or procedures.
- **Accessing childbirth facilities** and utilising facility-based skilled delivery services pose unique challenges. Most women and girls recognize the importance of facility-based deliveries and recognize the risks that are associated with home deliveries, and in particular, risks to adolescent girls. Because of this, there is a greater likelihood that adolescent girls deliver at facilities. Despite this, women and girls still have difficulty accessing health facilities for childbirth services.
- **Community-level facilities are not always equipped** to be able to provide the full spectrum of quality services across the continuum of care (ANC, SBA and PNC) and there is a lack of strong referral networks to higher-level facilities in cases of emergencies, both in terms of communication between different facilities and in terms of transport between facilities.
- **Traditional birth attendants (TBAs) remain the alternative** if a health facility-based skilled delivery is not seen as a good/viable option. Reasons for preferring TBAs include these services being more available and accessible, less costly, more culturally acceptable and traditional.
- **Lack of male support (or family support)** was cited frequently as a barrier to access MNCH/SRH services. This can include families and male partners not allowing women to frequent facilities, not supporting them during pregnancy and childbirth, especially to alleviate domestic or childcare responsibilities to leave time to go to health facilities, or male partners refusing that women consult male health providers.
- **Barriers for family planning services** include religious and cultural beliefs acting as barriers to use family planning and low male support for family planning. Issues such as husbands not agreeing to use family planning, refusing to give permission to women to seek family planning at health facilities is a recurring barrier.

"Even if you want to deliver in the hospital, some people will say you are lazy and not brave."

– Married adolescent girl, Nigeria

- Barriers at health facilities are due, in part, to **inadequate facilities infrastructure**. Facilities that lack the necessary infrastructure to accommodate women who breastfeed, women who bring children to health facilities, or women who have accompanying male partners are common barriers. In SHOW project areas, only 54% of facilities have counselling rooms that can accommodate male partners and 42% have separate toilets for men and women; only 21% of facilities offer private breastfeeding corners, and only 20% include a waiting room for men[21]. Additionally, facilities lack the necessary equipment, supplies and medicines to offer quality health services.

"[Local health facilities] … are not at all well-equipped. There's no way to procure or buy materials. … This greatly affects the quality of our MNCH care. We don't have a sterilizer, no observation beds, not enough space."

– Health professional, Haiti

- **Poor health staff attitudes and disrespectful behaviors** are key issues and impediments to provision of gender responsive and adolescent friendly services across SHOW countries. Disrespectful staff and staff who withhold services if not offered bribes can also present additional barriers. The studies also include reports of staff who ignore women, either altogether, or who prioritise the needs of women who are accompanied by a male partner. Some health providers have been reported to verbally abuse clients, particularly adolescent girls, and in Nigeria, women are sometimes refused services such as family planning if they do not have the permission of their husbands.[22]

"Nurses insulting and mocking young girls e.g. asking them who impregnated them and what did the man give them after sleeping with them, no money for transportation prevent women/ adolescent girls from going for ANC."

– Older women FGD, Ghana

21. *Table 64, SHOW Baseline Evaluation Report*
22. *SHOW Nigeria GE Assessment, page 21*

- There are some existing **gender responsive** practices throughout health services[23]. For example, the relais communautaires (outreach workers) play a key role in the Senegalese health system and can act as key links between women and health facilities, as well as providing moral and emotional support to pregnant women and girls. In Nigeria, women and girls expressed receiving respectful care. However, only 27% of facilities surveyed provide gender responsive and adolescent friendly services[24], and only 47% of facilities provide gender responsive and adolescent friendly referral services[25].

> **"[Relais Communautaire] establish with the patients such a relationship of confidence that they automatically call on them for delivery and they bring them to the health facility."**
>
> – Nurse, Senegal

- **Specific barriers affect adolescent girls and adolescent boys** at health service delivery points. First and foremost, **social taboos concerning adolescent sexuality and pregnancy** prevent adolescents from accessing information on SRHR. These same taboos also prevent adolescent girls and boys from feeling comfortable when accessing and using MNCH/SRH services. These persistent beliefs and taboos can also influence the way service providers treat adolescent girls and adolescent boys who go to health facilities for SRH services. Adolescent boys and adolescent girls, as a result, often receive unsympathetic or discriminatory treatment from providers. Additional barriers faced by adolescents also include costs, distance to facilities, inadequate facilities/services, and inconvenient clinic hours.

> **"There is a difference. Because as soon as the doctor knows you're not married he can have prejudices against you and change his behaviour and not receive you in the same fashion as married women. That made me feel bad."**
>
> – Unmarried adolescent girls' FGD, Senegal

23. *See footnote 8 for related indicator explanations*
24. *Table 63, SHOW Baseline Evaluation Report*
25. *Table 68, SHOW Baseline Evaluation Report*


HAPPY

SECTION 2:
THEORY OF CHANGE AND DEVELOPMENT OF THE GENDER EQUALITY STRATEGY

A programmatic Theory of Change must respond to the situation analysis, accommodate contextual differences across targeted countries and communities, and where applicable, align with global best practices. Plan International's Theory of Change for MNCH/SRHR programming is based on community and stakeholder consultations, a rigorous analysis, embedded in conceptual frameworks that have been well-established within the global health sector as well as Plan International's health programming over decades. The Theory of Change embeds gender inequality as a central factor of poor MNCH/SRHR outcomes for women and girls with an additional and explicit commitment to gender transformative programming by designing a comprehensive Gender Equality Strategy that sought to address gender specific needs and interests as well as transform gender power relationships in the SHOW communities. The strategy lays out in detail the specific approaches and investments made throughout project implementation, monitoring and evaluation to ensure a consistent focus on and accountability for gender equality results.

The following section outlines the conceptual foundation for the SHOW Project's overall Theory of Change and then goes on to describe the Gender Equality Strategy and its role as a complementary component of the overall project design.

2.1 MNCH/SRHR THEORY OF CHANGE

In order to contribute to a reduction in maternal and child mortality, and improve overall health outcomes for women, adolescent girls and children, it is necessary to reduce or eliminate barriers experienced by women and girls to appropriate, efficient, and quality health services. Plan International's programming is therefore designed with a Theory of Change based on the position that measurable health outcomes will be improved by addressing the root causes of barriers to health services, including and especially barriers related to gender inequality at household, community, and facility levels. The MNCH/SRHR Theory of Change applies the approach to address barriers at three levels, also known as '3 Delays' model[26] for maternal mortality, to categorize key barriers and their root causes into three distinct elements of poor maternal health outcomes: 1) poor health-related decision making; 2) low access to services; 3) poor quality of services (see **FIGURE 1**).

The **first set of barriers** refer to those related to health-seeking behaviour and decision making, and usually occurs within households. These barriers occur when women and adolescent girls, their partners, and/or their family, are unable to recognise danger signs or lack the knowledge to recognize when the services of a skilled health professional may be needed. Additionally, these barriers often occur because women and adolescent girls lack the power to make and act upon decisions regarding their own health and their children's health, often due to the low status of women and girls in many households or the lack of financial resources needed to cover health care expenses and transport. Finally, women and adolescent girls, and their families, can be discouraged from seeking care if they have poor previous experiences with healthcare, or if there are cultural or social stigma and/or taboos related to seeking professional healthcare services.

The **second set of barriers** are related to impediments experienced by women and girls to reaching health services, after the decision has been made to seek care. These barriers can occur either at the household or in transit to seeking care, and can include the distance to a health center or hospital, the availability and cost of transportation, the quality of roads and transport infrastructure and topography, and security and safety concerns for women and adolescent girls travelling to health facilities.

The **third set of barriers** occur once a health facility has been reached and when women and adolescent girls face additional challenges to receiving appropriate, quality and timely health services. These barriers can be caused by poor facility infrastructure, lack of medical supplies, inadequately trained or poorly motivated health personnel or lack of sufficient and appropriate personnel, and inadequate referral systems. The barriers to care experienced by women and girls can also be exacerbated by the lack of gender responsive and adolescent friendly services available at health facilities.

Plan International's MNCH/SRHR Theory of Change proposes that addressing these key barriers and their root causes will increase uptake and availability of quality MNCH/SRH services and therefore improve health outcomes particularly of women and adolescents as a fundamental human right. Based on this, the SHOW Project sought to achieve three key outcomes:

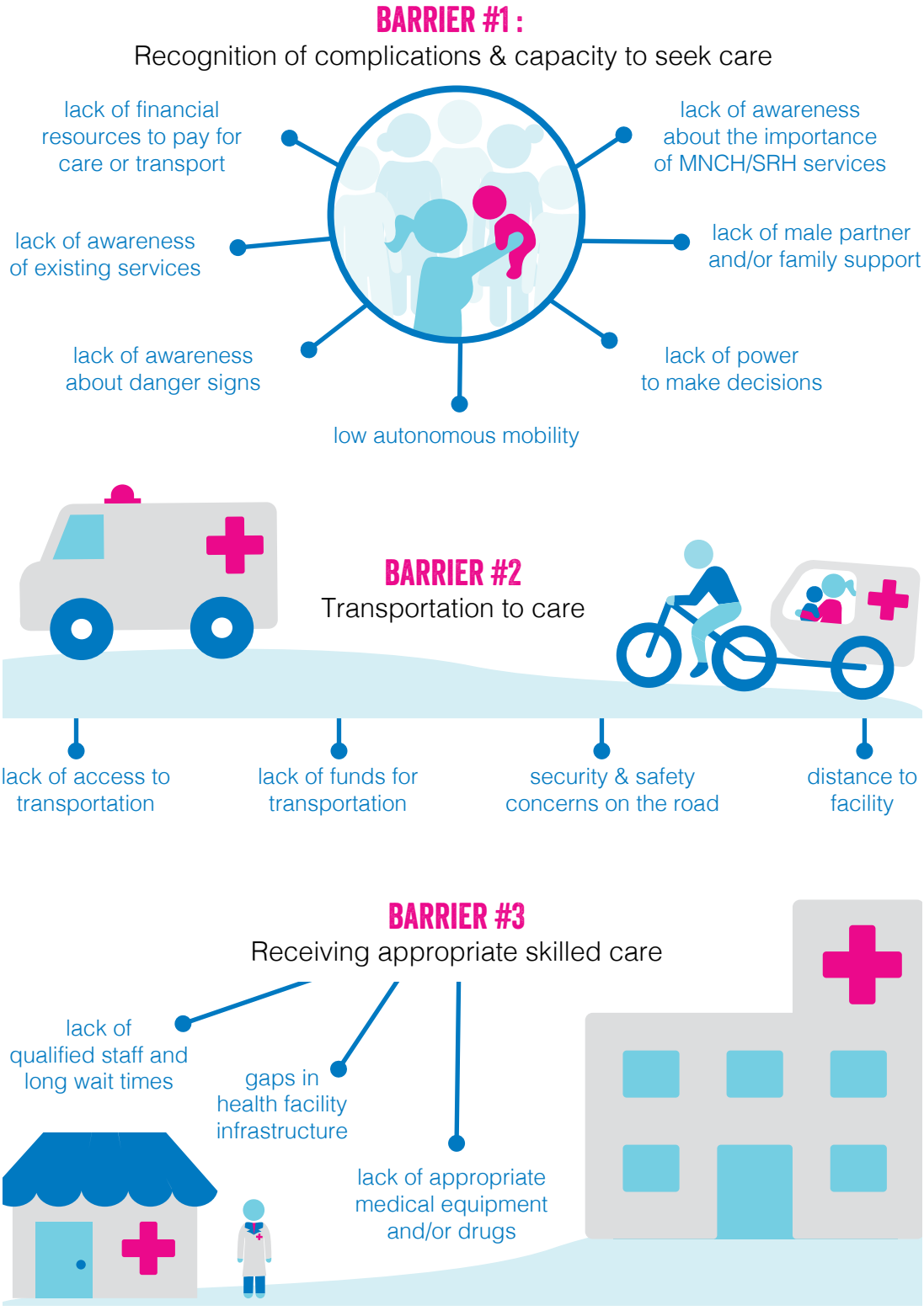
1. increasing the demand for health services;
2. improving the supply of quality MNCH/SRH services; and
3. improving the accountability of health services to rights holders.

26. *WHO, Applying the lessons of maternal mortality reduction to global emergency health, March 2015* https://apps.who.int/iris/bitstream/handle/10665/271709/PMC4450708.pdf?sequence=1&isAllowed=y

[FIGURE 1] THE 3 BARRIERS

THE 3 BARRIERS TO SEEKING CARE

Women and girls typically face 3 stages of barriers when they attempt to access adequate and appropriate maternal, newborn and child health and sexual reproductive health services (or care).

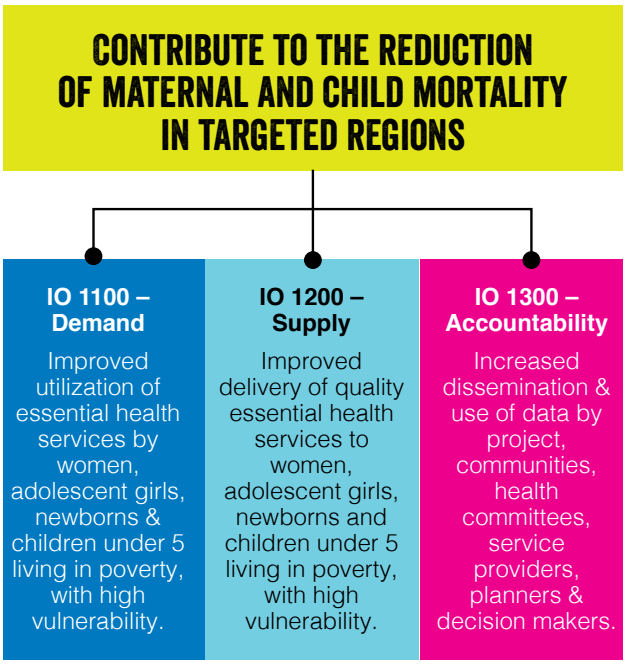


As many of the contributing factors of these three barriers are rooted in gender inequality, the Theory of Change is premised on the assumption that addressing gender inequality and fostering women's and girls' individual and collective agency and empowerment, can contribute to improved health outcomes for women, adolescent girls, and children. Agency, connotes the ability of women and adolescent girls to make informed MNCH/SRH decisions and act on them, which necessarily requires on the one hand fostering their empowerment, as an end in and of itself and working to foster an enabling household and social environment for gender equality (social capital) and addressing women's/girls' economic constraints (financial capital).

The Theory of Change described above provides the foundation for the design of the SHOW Logic Model. As described in key project documents, including the SHOW Proposal and the Project Implementation Plan (PIP), this project sought to address the root causes of high maternal, neonatal and child mortality with an Ultimate Outcome of contributing to a reduction of maternal and child mortality. Based on Plan International's context analysis of the 3 barriers, the following key areas of improvement on which to focus[27] were identified:

- Weak health seeking behavior by disadvantaged, vulnerable and marginalized WRA and their families;
- Particularly high MNCH/SRH risks for adolescent mothers[28] and high rates of child, early, and forced marriage (CEFM);
- WRA's lack of decision making capacity and low access to and control over social and economic assets due to pervasive gender inequality;
- Inaccessible, fragmented and client-unfriendly health systems;
- Low numbers and inadequate skills of community health workers (CHWs) and frontline workers to provide quality, gender responsive, adolescent friendly health care[29]; and
- Irregular tracking and use of data by health systems, and poor accountability of health services to local communities.

The SHOW Project's response to these key areas of improvement has been organized into three Intermediate Outcomes (IO): first, increasing **demand** amongst women and adolescent girls for MNCH/SRH services; second, improving the **supply** of quality MNCH/SRH services; third, improving the **accountability** of MNCH/SRH services to rights holders, in this case women and adolescent girls. These are often referred to by Plan International as 'demand-side', 'supply-side' and 'accountability' outcome areas.

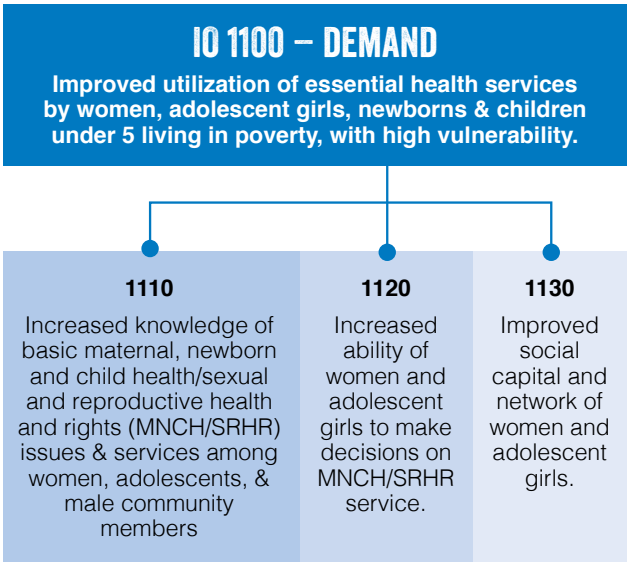


27. *These key areas are copied from the SHOW Consolidated PIP, pp.9–10*
28. *WHO, Factsheet 364, Adolescent pregnancy, Sept. 2014*
29. *https://pmnch.who.int/resources/publications/knowledge-summaries*

2.1.1 STRATEGIES TO PROMOTE DEMAND FOR AND UTILIZATION OF MNCH AND SRH SERVICES AMONG WOMEN, ADOLESCENT GIRLS & BOYS, AND MEN

The first Intermediate Outcome of the SHOW Project was to increase the demand for MNCH/SRH services amongst women and adolescent girls. Strategies under this intermediate outcome include raising awareness of MNCH/SRHR amongst women, adolescent girls and boys, and men, promoting the empowerment of women and girls, and strengthening women and girls' social capital. These strategies were designed to engage women and adolescent girls directly on MNCH, SRHR, gender equality and health services, but also to engage men and boys on these same issues. The proposition within this Intermediate Outcome was that **if** women and their partners are informed of their health needs and options, **if** women have the agency to make health-related and other decisions, and **if** women have a supportive and enabling environment for health-seeking behaviours, **then** their demand for services and healthcare will increase. Gender transformative approaches were most prominent in this outcome area where individual and household power dynamics and community social and gender norms were addressed.

Based on document reviews and primary data collection conducted by the project, the lack of knowledge and information on MNCH and SRHR is a key barrier to women and girls' access to health services.



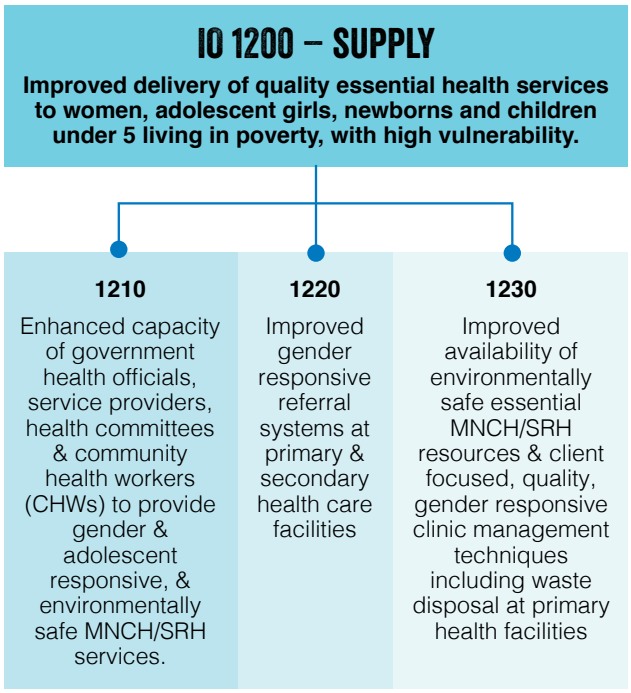
- **Immediate Outcome 1110** sought to increase knowledge of MNCH/SRHR amongst women, adolescent girls, adolescent boys, and men. Activities under this outcome focused on sharing information and knowledge with a wide range of stakeholders at the community level and include among other activities, developing gender transformative SBCC and Information and Education Communication (IEC) materials, implementing SBCC campaigns, community group meetings and raising awareness during special days and events.

- **Immediate Outcome 1120** sought to increase women's ability to make MNCH/SRHR decisions. Activities included implementation of Fathers Clubs, adolescent peer outreach and support groups for boys and girls, training and support of community role models, and training religious and traditional leaders to conduct outreach sessions within their communities. These activities also contributed to raising awareness of MNCH/SRHR and gender equality with targeted groups and encouraged women, adolescent girls and boys, and men to adopt health seeking behavior and promote gender equality.
- **Immediate Outcome 1130** aimed to improve women and girls' social and financial capital and networks through establishing and facilitating Mothers' Support Groups and Women's Groups, and Village Savings and Loans Associations (VSLA) to further strengthen women's empowerment.

Interventions that contributed to **IO 1100** addressed various impediments at both the household and community levels that contribute to the first set of barriers. In addition to increasing awareness on danger signs and critical milestones for seeking skilled care, some of the activities under this outcome also tackled issues that contribute to the second set of barriers. For example, during sessions with men's and women's groups, expectant parents were counseled on how to adequately prepare for a facility-based delivery, including identifying skilled provider and arranging transport. As a part of its design, each activity also addressed the gender-related barriers to women's decision-making abilities and their ability to access health care. Activities under this IO worked not only to increase awareness on MNCH/SRHR issues, but also on gender equal attitudes, practices and behaviors within households and communities, and on the consequences of harmful traditional practices (HTPs), such as child, early, and forced marriage.

2.1.2 STRATEGIES TO PROMOTE GENDER RESPONSIVE AND ADOLESCENT FRIENDLY (GRAF) MNCH AND SRH SERVICES

SHOW's second Intermediate Outcome was to improve the supply of quality MNCH/SRH services. Strategies under this outcome included working with health providers to improve: the availability and quality of MNCH/SRH services; the gender responsiveness and adolescent friendliness of services; and, the quality of referral services. These activities were designed to be implemented directly with project supported health facilities. Furthermore, to achieve this outcome, the SHOW Project worked closely with Ministries of Health in each of the 5 SHOW countries to improve the quality of essential health services. The hypothesis of this Intermediate outcome was that **if** the capacity of service providers are improved to provide GRAF services, and **if** referral systems are improved at both primary and secondary health facilities, and **if** the availability of essential MNCH/SRH resources are secured and equipment and supplies are increased, **then** the supply of quality and GRAF MNCH/SRH services will improve. Gender transformative approaches are most notably used for health service provider trainings, development of training materials, and supportive supervisions. A gender lens was also used to develop and analyse the assessments of physical health facility environments under this outcome along with user friendly job aids and IEC materials integrating GRAF principles.



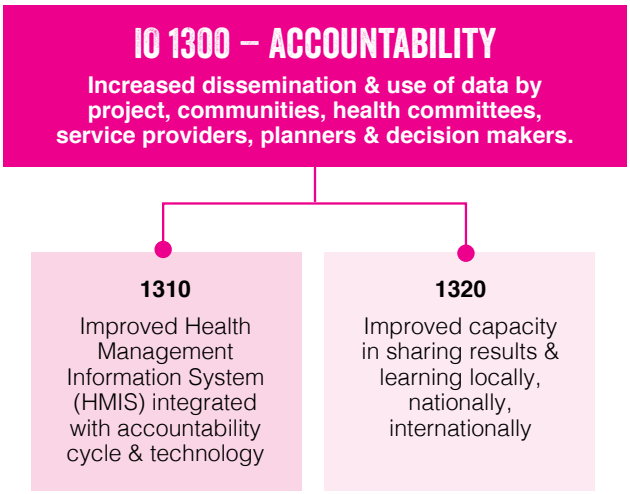
Based on document reviews and primary data collection, a key challenge identified in the delivery of quality MNCH/SRH services was the inconsistency in health providers training, the lack of training on gender responsive and adolescent friendly service delivery, and the lack of service delivery points that support quality GRAF MNCH/SRH services.

- **Immediate Outcome 1210** focused on enhancing the capacity of health service personnel such as government health officials, facility-based service providers, Community Health Workers and community health committees on high quality GRAF health service delivery through training delivered jointly by the project and health ministries. The competency trainings focused on increasing the critical skill and knowledge component of health care providers in providing quality GRAF MNCH/SRH care following global and national standards. In all countries, women's or gender ministries were key partners aligning with existing national gender equality or health policies for the empowerment of women and adolescent girls in health. A key component of this stream of activities was to build the institutional capacity of health managers and supervisors for GRAF supportive supervision.
- **Immediate Outcome 1220** specifically tackled services delivered during referrals between primary and secondary, or tertiary health facilities, and between the community and health facilities. These activities included training health providers on GRAF referral services, developing GRAF referral protocols, providing resources to facilities to strengthen referral system, supporting safe and accessible transportation from community to health facility and between health facilities, and conducting advocacy with governments to strengthen MNCH/SRH project implementation and referral systems.
- **Immediate Outcome 1230** addressed the gaps in health facilities' physical environments and available equipment and supplies. Activities under this outcome included improving the supply and use of environmentally safe health care waste disposal mechanisms, providing essential medicines, equipment and supplies to health facilities, and refurbishing health facilities to better respond to the needs (e.g. audio/visual privacy during counselling, separate toilets, breastfeeding corners, adolescent corners etc.) of women, adolescent girls, and adolescent boys, following a comprehensive health facility assessment.

These strategies to improve the supply of MNCH/SRH services mostly addressed the third barrier encountered at service delivery points. These strategies also contributed to reducing challenges for the first set of barriers since improving the quality of MNCH/SRH services creates more positive experiences for women, adolescent girls and their partners/family members, making them more likely to continue seeking health care. Furthermore, these activities also served to address the second set of barriers, specifically barriers women and girls face travelling from the community to the facility, or between facilities. These strategies also focused heavily on addressing the manifestations of gender inequality within health facilities and addressed biases held by service providers which can impede their ability to deliver quality MNCH/SRH services.

2.1.3 STRATEGIES TO STRENGTHEN ACCOUNTABILITY AND TO PROMOTE WOMEN'S LEADERSHIP

SHOW's third Intermediate Outcome was to improve the accountability of MNCH/SRH services. The corresponding strategies focused on strengthening data collection and its use by health system stakeholders. By working with Ministries of Health to strengthen the Health Management Information Systems (HMIS), increase the availability and quality of data and their use of data for decision making, and to promote more effective and greater accountability, especially to communities. The SHOW Project worked with Ministries of Health and service providers, Community Health Committees and Community Health Workers to implement these strategies. The proposition of this Intermediate Outcome was that **if** HMIS are improved and integrated with accountability mechanisms and **if** the capacity for sharing results locally, nationally and internationally is improved, **then** MNCH/SRH services will become more effectively accountable to rights-holders. Gender transformative approaches in this area included working with health systems stakeholders (government, practitioners, planners, CHCs) to promote the collection, compilation, reporting and use of sex and age disaggregated data and to encourage decision makers to consider gendered barriers to care.



The immediate outcomes for this IO were:

- **Immediate Outcome 1310** concentrated on strengthening HMIS by providing resources to improve data collection and training health service providers and health ministry personnel to analyse and use data to improve health service delivery, and to strengthen accountability to end-users in the community.
- **Immediate Outcome 1320** focused on improving the capacity of health workers and CHCs to use data to inform changes to improve the quality of MNCH/SRH services. These strategies aimed to increase the dissemination and use of data by communities, particularly women and adolescents, community health committees, service providers and health service decision makers and planners, along with project staff.

These strategies responded to the third set of barriers as improving the availability of quality, reliable and timely health information results in more efficient and informed decision making and service delivery at health facilities. Activities contributing to IO 1300 worked with all key stakeholders at the community and facility levels who are involved in managing and planning health service delivery. Additionally, the project promoted women's participation and leadership in CHCs, increasing women's presence, voice, and leadership in health planning.

2.2 TRANSFORMATIVE GENDER EQUALITY STRATEGY FOR MNCH/SRHR PROGRAMMING

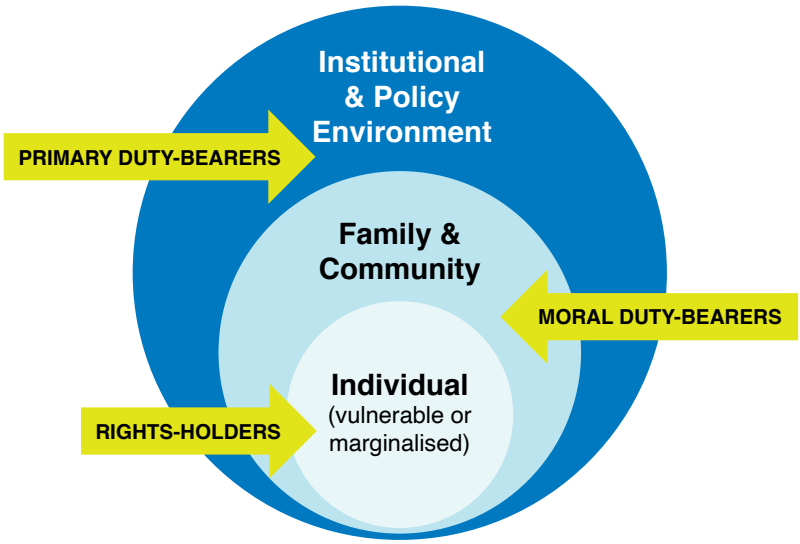
Based on preliminary research conducted by the SHOW project, including desk-based research, the baseline study, the health facility assessment and the gender equality assessment, three key clusters of gender-related barriers at the household, community, and health facility levels have direct influence on women and girl's MNCH/SRH outcomes. The three clusters being: i) the low status of women and girls; ii) low level of male support or engagement in MNCH/SRHR; and, iii) the lack of gender responsive and adolescent friendly MNCH/SRH services.

In response to the findings of the situation analysis described in Section 1.2, SHOW developed a Gender Equality Strategy that addressed each of these clusters of barriers. The GES was designed to respond to these barriers in a holistic manner and to target women, men, girls and boys directly in its efforts to reduce gender barriers impeding women and girls' access to and utilization of MNCH/SRH services. The GES also specifically targeted health service providers and health systems to address underlying facility-based gender-related barriers. The strategy's central tenet was that gender inequality affects the demand for, supply of and accountability towards women and girls of MNCH/SRH services and unless gender-related barriers are addressed systematically across each of the programmatic pillars, programmatic change to improve women and girls MNCH/SRH outcomes will not be achievable.

2.2.1 GENDER EQUALITY STRATEGY THEORETICAL FRAMEWORK

SHOW'S Gender Equality Strategy is grounded in a rights-based approach to address the three identified clusters of gender-related barriers to MNCH/SRHR outcomes for women and girls. A rights-based approach uses a socio-ecological model to determine who are the rights holders unable to fulfill their rights, who are the duty bearers morally obligated to uphold the rights holders' rights, and who are the primary duty bearing institutions who have a legal and/or political mandate to uphold the rights holders' rights. Using a socio-ecological model, the rights holders can be identified as individuals who are particularly vulnerable or marginalized, the moral duty bearers are the families and communities in which an individual lives, and the primary duty bearers are the governments, ministries, and other institutions that influence that individual's fulfillment of their rights (see **FIGURE 2**). Within this theoretical approach, all interventions of a rights-based project have as their central purpose to uphold the rights of those who are unable to fulfill them and to push moral and primary duty bearers to amend their behaviors, practices, norms, and policies to ensure rights holders are unencumbered from accessing their human rights.

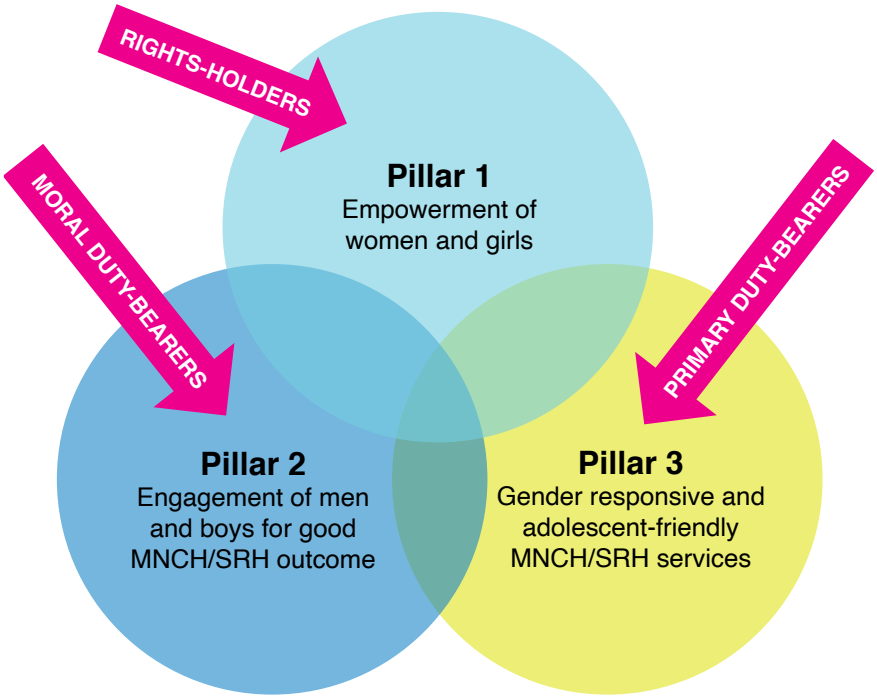
[FIGURE 2] SOCIO-ECOLOGICAL MODEL



SHOW's application of this rights-based approach places women and girls as the individual rights-holders. Men, family members, community cultural and religious leaders and community members are placed as moral duty bearers and Ministries of Health, Ministries of Women's Affairs, district level health authorities and health care providers as primary duty bearers. Primary health care providers, in the case of SHOW, occupy both the positions of primary duty bearers and moral duty bearers as they are often members of communities influencing social and gender norms and behaviors but also have a professional mandate to uphold women's and girls' rights to health. The SHOW Gender Equality Strategy's three pillars are derived from this approach with Pillar 1 focusing on the practical needs and strategic interests of rights-holders, Pillar 2 focusing on moral duty bearers, and Pillar 3 focusing on primary duty bearers (see **FIGURE 3**).

The Gender Equality Strategy's theoretical framework is also built from the Theory of Change and the approach to address barriers at three levels. Each of the strategic pillars contribute to addressing one or more sets of barriers of the model: Pillar 1 and Pillar 2 address the first and second set of barriers and Pillar 3 addresses the third set of barriers (and by extension addresses some issues contributing to the first set of barriers).

[FIGURE 3] EXPANDED GENDER EQUALITY STRATEGY



Plan International's Gender Transformative Programming

SHOW's Gender Equality Strategy is rooted in Plan International's Gender Equality and Inclusion Policy (2017) and Plan International's gender transformative approach to programming and influencing. Plan International has developed four categories of programming based on how much they contribute to Plan International objectives relating to gender transformative change: gender unaware, gender neutral, gender aware and gender transformative.

GENDER UNAWARE	Gender unaware programs do not recognize gender issues and tend to aggravate gender inequalities and cannot be implemented by any of the global Plan International entities
GENDER NEUTRAL	Gender neutral programs recognize gender issues but don't do anything about them, and so tend to reinforce gender inequalities and cannot be implemented by any of the global Plan International entities.
GENDER AWARE	Gender aware programs seek to improve the daily condition of women and girls by addressing practical gender needs. They do not try to transform gender relations. These can be applied in exceptional circumstances especially in humanitarian contexts, but also as an entry-point towards gender transformative change.
GENDER TRANSFORMATIVE	There is an explicit intention to transform unequal gender power relations. The focus goes beyond improving the condition of women and girls and seeks to improve their social position (how they are valued in society) as well as the full realization of their rights.

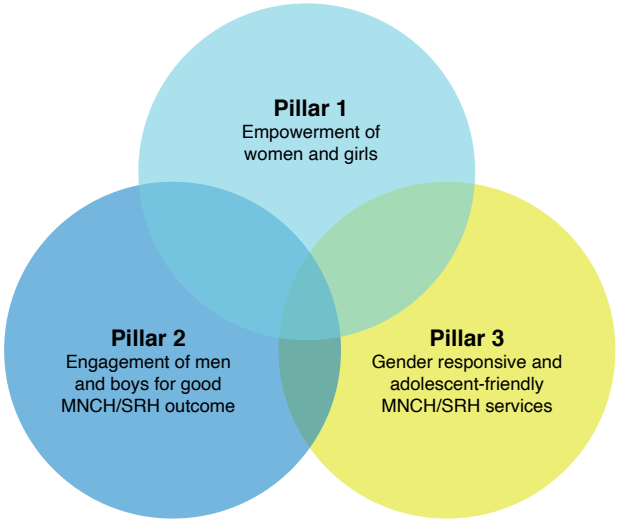
SHOW was designed as a gender transformative project and was designed to meet all of the criteria of a gender transformative program, which includes:

- An in-depth gender analysis is a central part of project design;
- Objectives, outcomes (results) and indicators explicitly aim to confront gender inequality, gender-based violence, gender roles and stereotypes;
- Addressing the root causes of inequality (social norms, cultural beliefs, values) head on in the program, and at all levels (including policy);
- Sex and age disaggregated data;
- Specific human and financial resources allocated to address the root causes of gender inequality;
- Programing targets girls, boys, women and men;
- Programing focus on women and girls' empowerment and agency and explicitly work with men and boys to promote gender equality;
- Programming aims to transform unequal gender relations and works to improve the social position of women and girls (how they are valued in society) as well as the realization of their rights.

2.2.2 THREE PILLARS OF THE GENDER EQUALITY STRATEGY

The SHOW GES presupposes that unless women and adolescent girls' individual and collective agency and empowerment is promoted as an outcome in and of itself, unless an enabling socio-cultural environment for their empowerment is fostered in households and communities; and unless health systems and service delivery respond to the needs of women and girls, MNCH/SRHR outcomes will remain low. To this end, the SHOW Project mainstreamed gender equality and the promotion of women and girls' empowerment within each of its three Intermediate Outcomes of demand, supply, and accountability addressing gender-specific issues. This approach is guided by the program's Gender Equality Strategy, which provides a cross-cutting three-pillared framework to address the gender-related barriers that impact MNCH/SRH outcomes. The three pillars are: i) empowering women and girls; ii) engaging men and adolescent boys; iii) strengthening the gender responsiveness and adolescent friendliness of MNCH/SRH services.

[FIGURE 4] SHOW GENDER EQUALITY STRATEGY



The three pillars of the gender equality strategy were developed to align with the SHOW Logic Model and the three Intermediate Outcomes of the program. First, the three strategic pillars of the strategy are cross-cutting and activities in the demand, supply, and accountability streams of the project contribute to the strategic pillars of the GES. Moreover, the three pillars of the GES contribute to

The achievement of the three project Intermediate Outcomes: Pillar 1 and Pillar 2 contribute to increasing demand for services, and Pillar 3 contributes to improve the quality of supply and the accountability of MNCH/SRH services.

Pillar 1: Empowerment of Women and Girls

The first pillar of the SHOW GES was to promote and foster the empowerment of women and girls in private and public domains. Three key goals fall under this pillar: first, to raise awareness and knowledge of MNCH/SRHR and gender equality amongst women and adolescent girls; second, to leverage this acquired knowledge and strengthen women and girls' participation and leadership in decision making at home and in communities; and, third, to strengthen women and girls' social and financial capital. The SHOW project employed four key approaches to meet these goals: SBCC, women's support groups, village savings and loans associations and working with CHCs. Each of these approaches were implemented in the five SHOW

countries but tailored to meet the unique contexts of each country. A special focus on prevention of child, early, and forced marriage and prevention of gender-based violence was woven into these approaches. This specific focus on GBV was rooted in SHOW's rights-based approach and was part of the program's mission to promote the rights of women and girls. This aspect of the strategy crosscut each of the three pillars and messaging on CEFM and GBV as well as contextually relevant harmful traditional practices such as female genital mutilation and cutting (FGM/C) were included in messaging developed for women and girls, men and boys, health providers and CHCs.

To raise awareness and increase knowledge, the SHOW project developed rights-based SBCC activities with gender transformative content on a series of topics including MNCH, SRHR, adolescent sexual and reproductive health (ASRH), gender equality, gender-based violence, CEFM, and harmful traditional practices. Information and gender transformative messaging was delivered in a variety of ways in each project area, including community drama productions, video clips, radio programs, posters and flyers, and community events. Messages have been delivered during women's support group meetings, VSLA meetings, and adolescent group meetings to ensure that these messages reached population groups targeted by the project.

SHOW's activities establishing and strengthening of women's support groups contributed to meeting all three goals for the first pillar: raising awareness of key issues as key messaging was delivered regularly during group sessions; building women and girls' social capital through engagement and networking; and enhancing their decision making capabilities. Evidence from the gender assessment demonstrated that women's collective support and solidarity found in groups can lead to women's improved freedom of movement and influence at home and in communities. SHOW country projects established new or strengthened existing women's support groups and each are adapted to meet the unique contexts of each country. All support groups were also encouraged to share information learned in the groups with their family, friends, peers, and neighbors, increasing the spread of project messaging. Adolescent girls' peer education and support groups served a similar purpose as the women's support groups. These groups were used to build solidarity and mutual support amongst adolescent girls and to share key messaging with adolescent girls. For both adolescent girls' and adolescent boys' engagement, the SHOW GE Strategy leveraged Plan International's Champions of Change for Gender Equality and Girls' Rights program: the full Champions of Change model was implemented in Haiti, and was used to develop and adapt peer education models in Bangladesh, Ghana, Nigeria and Senegal.

SHOW worked with Community Health Committees in project areas to promote the inclusion of women members and the election or appointment of female leaders. These activities helped advance women's participation and leadership of community decision making on MNCH and SRH and strengthening CHCs role in improving quality of services and bridging the gap between community and health facilities in terms defining quality care and support. These activities also included advocacy with national and district level health authorities to enforce existing quotas where they are set within CHC by-laws and increase women's participation and leadership in CHCs. Additionally, SHOW invested in training CHCs on gender-responsive and adolescent friendly clinic management to further strengthen women's decision-making capacities on these committees. Efforts to strengthen the capacities of CHC members on gender responsive and inclusive governance also contributed to building women's decision making and leadership capacities. Additional targeted capacity building on leadership were implemented in Nigeria and Ghana for women CHC members.

Village Savings and Loans Associations were established, or strengthened where previously established, in all of the SHOW project countries. VSLAs are a method to facilitate savings to create financial resources that women and girls can use to access health services, engage in income generation activities and provide an additional space to foster their social capital and collective support. SHOW has invested in developing additional training for VSLA groups that focus on female leadership, inclusive governance, financial literacy, business skill development, MNCH/SRHR, and gender equality. This way the VSLA methodology employed by SHOW contributed to meeting several of the goals under the first pillar of the GES.

Pillar 2: Male Engagement

A key aspect of gender transformative programming is engaging men and boys as partners and beneficiaries of gender equality. The SHOW preliminary studies demonstrated that a lack of engagement from male family members is a clear impediment to women's access to and utilization of health services. The second pillar of the SHOW Gender Equality Strategy was to engage men and boys in new masculinities and on issues related to MNCH/SRHR and gender equality. This second pillar had two key goals: first, to redefine masculinity norms and promote non-violent and equal relationships between men and women; and, second, to create an enabling environment favorable to gender equality and women's and girls' empowerment at home and in communities. SHOW utilized three key approaches to achieve these goals: inclusion of male engagement key messages in SBCC as well as through community-based male (and female) Gender Equality Champions and role models, establishment and support of fathers' groups and adolescent boys' group and working with religious and traditional leaders. Additionally, Plan International Canada formed a strategic partnership with Promundo US[30], now formerly known as Equimundo: Center for Masculinities and Social Justice, to ensure high quality design and implementation of this male engagement pillar.

30. *At the time when Plan International Canada formed a strategic partnership, they were still legally called and known as Promundo US. Equimundo: Center for Masculinities and Social Justice (formerly Promundo-US) works to promote gender equality and create a world free from violence by engaging men and boys in partnership with women, girls, and individuals of all gender identities. (https://www.equimundo.org/)*

Male engagement key messages were integrated within the various SBCC materials and campaigns in each of the SHOW countries. Per the GES, these were adapted for each country context and all MNCH/SRHR and GE messaging were reviewed by the SHOW project staff and Promundo US to ensure that male engagement key messages were included. These messages were also integrated into other activities and shared with community influencers, women's support groups, and fathers' groups as well as CHWs as they carried out their door-to-door and group sessions.

Male engagement groups were a key strategy used by the SHOW program, in particular through the engagement of fathers in each of the project countries. Education and peer-to-peer learning were used to facilitate deconstruction of harmful masculinity norms. The approach then supported group members to construct new masculinity norms and adopt more gender equal and non-violent behaviors at home. This approach, and curriculum, developed in partnership with Promundo US, focused on raising awareness of key issues, including MNCH, adolescent sexual and reproductive health and rights (ASRHR), CEFM, SRHR, GBV, HTPs, equitable distribution of household care work and women's decision-making, at the same time as promoting behavior change amongst men. Adolescent boy's engagement had similar goals to those set for fathers' groups. The key differences were that the groups were established based on the adolescent group structure most acceptable in each country and that curricula for these groups reflected the different national contexts for adolescent peer education in each SHOW country. They were also separated, as learning from Plan International suggests that mixing of age groups can result in younger boys and men not participating equally in the presence of older men and thereby not being a safe space for them.

Engaging religious, traditional, and influential community leaders is a crucial step to build an enabling environment for women's and girls' empowerment and to minimize the risk to women, girls, men, and boys who defy traditional gender norms. SHOW's approach to engaging leaders identified, mobilized, and trained local leaders to act as project partners to spread key messaging on MNCH, SRHR, gender equality, GBV, CEFM, and HTPs. A variety of local leaders were engaged, including local influencers who may not necessarily be recognized as religious or traditional leaders. In partnership with Promundo, training packages were developed and/or workshops for religious, traditional, and community leaders were held on the program's key messages and adapted these to the different country contexts. Leaders were encouraged to share key messages during their regular interactions with their communities, or during special events. Activities focusing on leaders' engagement have crossovers with other activities by including leaders in SBCC campaign events and encouraging leaders to attend group meetings, either as regular members of fathers' groups or as

special guests during adolescent group meeting and/or women's support group meetings.

Pillar 3: Gender Responsive and Adolescent Friendly Services

The third pillar of the SHOW GES was to improve the provision of gender- responsive and adolescent-friendly MNCH/SRH services as standard and core elements of quality of health care policies and protocols. This pillar had three key goals: first, to build capacity of health service providers; second, to strengthen the mainstreaming of GRAF approaches in MNCH/SRH service planning, governance, and supervision; third, to refurbish physical facility spaces to meet the needs of women, male partners, adolescent girls, and adolescent boys. To achieve these three goals, a number of integrated approaches were used, including training of health care providers, development of GRAF referral protocols, health facility assessments, supportive supervision, refurbishment and procurement of equipment, and advocacy with government stakeholders.

SHOW's programmatic strategies were aligned with existing national ASRH policies, gender equality policies, health policies, and with existing national GE and health commitments in each project country. These existing policy commitments were leveraged to further advocate for gender-responsive and adolescent-friendly service delivery and for strengthening these services where they do exist. These advocacy activities had several end-goals including: standardized training of service providers on GRAF services; developing or strengthening skilled birth attendance training curricula for health care provider on integrated GRAF service delivery; orienting CHCs on GRAF service delivery and clinic management; modifying supportive supervision tools with integrated GRAF criteria; and, refurbishment of existing health facilities to reflect unique needs of women and adolescents. This advocacy was also used to encourage the collection of sex and age disaggregated data and the analysis of health data with a gender lens for responsive planning and service delivery. Part of the commitments within the SHOW project to Ministries of Health also included socializing existing policies and commitments with health service providers during trainings.

Training of health care providers on GRAF service delivery was used to improve integrated MNCH/SRH service quality. SHOW trained a wide variety of service providers on GRAF including CHWs, nurses, midwives, and other primary health care providers. Training on GRAF was delivered in one of two ways: either training on GRAF was integrated into trainings on other technical areas, including referral services, BEmONC, Emergency Triage Assessment and Treatment (ETAT), Integrated Management of Neonatal and Childhood Illnesses (IMNCI), sexually transmitted infections (STIs), post-abortion care, and/or family planning, or GRAF trainings were delivered separately as standalone trainings. Ideally, GRAF should be integrated into any and all health service provider trainings to ensure discontinuation of service delivery norms and practices that are harmful to women and girls and to make the linkage of GRAF care as being core elements of quality of care and not an add-on. However, the methods of delivery GRAF training were dependent on existing curricula in SHOW countries and whether there was an opportunity to adapt them to include these approaches. This approach also necessitated the development of GRAF training guidelines by SHOW project staff and the development and/or adaptation of training curricula on GRAF service delivery in each country.

CHCs were engaged on planning, supervision, and governance of gender and adolescent responsive MNCH/SRH services to improve the responsiveness of health planning and governance. Under the project, CHCs were trained on the key messages developed for support groups (MNCH, Adolescent sexual and reproductive health rights, SRHR, GBV, CEFM, and HTPs), and their capacity was built on gender responsive and inclusive governance and clinic management, GRAF service delivery, and

female leadership. CHCs were also supported in their use and analysis of gender sensitive data for gender and adolescent responsive planning for their health facilities.

Gender responsiveness and adolescent friendliness criteria were included in health facility assessments conducted by the SHOW project to ascertain the degree to which services are gender responsive and adolescent friendly. The results from the HFA were then used by the project to influence amendments to government supportive supervision tools to include GRAF criteria. The project also supported health service supervision by conducting joint supportive supervision with Ministry of Health representatives and encouraged oversight of GRAF service practices. Finally, the HFAs indicated where physical refurbishments were needed to improve the clinic environments with regards to client privacy and dignity, and the degree to which they can accommodate male partners and/or accompanying family members. The HFAs were particularly instrumental in the development of plans for adolescent corners, which responded specifically to the needs of adolescent boys and girls.

2.2.3 DEVELOPMENT AND OPERATIONALIZATION OF THE GENDER EQUALITY STRATEGY

The SHOW project's Gender Equality Strategy was developed during the proposal stage. The GES was originally informed by findings from desk research and community consultations during the design stage of the project, the Plan International Gender Equality Policy (2011), and Canada's Department of Foreign Affairs, Trade and Development[31] (DFATD)'s Policy on Gender Equality.

The GES was further developed during the development of the Project Implementation Plan, which included a pre-PIP workshop and PIP workshop with project stakeholders and implementation partners. Additional data was collected to confirm that the strategic directions of the GES responded appropriately to existing realities of women and adolescent girls, and of men and adolescent boys. Community consultations with women, girls, men and boys, and with key project stakeholders and partners in the five SHOW countries (see Section 1 for more details). During the Pre-PIP and PIP stages, country-specific Gender Equality Strategies were also developed for each of the five SHOW countries. These country-specific strategies were aligned with national priorities and existing policies in each of the five SHOW project countries. National and district health authorities and gender-related ministries in each of the five countries were consulted to provide insight into country-specific contexts and to validate the proposed SHOW Gender Equality Strategies. The final Gender Equality Strategies for each of the five countries, together with the overall SHOW Gender Equality Strategy (sometimes referred to as the *Global GE Strategy*), were developed with the PIP reports, and were subsequently shared with relevant country level stakeholders.

Following the finalisation of the PIP, the Baseline Study, health facility assessment and Gender Equality Assessment provided additional data to support the Gender Equality Strategy. Data collected was analysed and reviewed by Plan International staff and was presented to stakeholders during the Year 2 Annual Work

31. This is now Global Affairs Canada.

Planning workshops. Data from the baseline study and Gender Equality Assessment were then used to inform possible adjustments to the country-specific GE Strategies, though none of the Annual Work Plans (AWPs) report any major changes made to the GES in response to findings from the Baseline Study or the Gender Equality Assessment[32].

This process was accompanied by the development of the annual Gender Equality Action Plans (GEAP) for each of the 5 countries. The GEAP[33] detailed specific activities and sub-activities, based on the country-specific logic model, that were implemented to achieve the objectives outlined in the corresponding GES. GEAPs were developed with the Year 1 and Year 2 Annual Work Plans; each country project developed their own GEAP. The GEAPs also served as an accountability tool and assigned responsibility and accountability to specific project staff, partner or stakeholders for each activity and sub-activity. The GEAPs also included operational actions such as capacity building plans for partners and stakeholder that were undertaken in tandem with activities to ensure a smooth implementation of the GES.

In Year 3 of the program, it was agreed by Plan International and project stakeholders to discontinue the use of the GEAP. The reasoning for this change included: i) greater accountability for all project staff to implement gender transformative programming (not just gender equality technical staff in project countries); ii) more harmonized and responsive implementation of gender equality actions for project activities, as activity timelines were readjusted. Rather than being detailed in the GEAP, those sub-activities were integrated into core project planning documents and detailed within activity descriptions of the country-specific AWP reports.

Key aspects for the implementation of the Gender Equality Strategy included the development of the programming guidelines and the partnership with Promundo-US for the male engagement pillar of the SHOW GES. A series of programming guidelines were developed by Plan International, and in partnership with Promundo US. The objectives of these guidelines were to provide practical instructions and guidance on implementing and monitoring gender transformative activities and sub-activities, primarily for use by Country Office SHOW staff and partner organisations. These guidelines were subsequently socialized to all project and partner staff both remotely and in-countries. The guidelines cover a variety of relevant topics and span both demand-side and supply-side interventions (see **TABLE 4** for a list of all the guidelines developed). Plan International Canada partnered with Promundo-US to provide technical expertise and ensure the quality design and implementation of the male engagement pillar of the Gender Equality Strategy. Promundo's responsibilities for SHOW included: developing the male engagement strategy for the program, developing the Fathers Club curriculum, developing a series of male engagement specific guidance notes, providing in-country training workshops on male engagement and the Fathers Club curriculum, providing technical reviews of SBCC materials, conducting in-country monitoring and technical assistance visits, and facilitating cross-country learning on male engagement.

32. *The documentation does not detail any additional adjustments made to any of the country GES during Year 3 and Year 4/5 work planning workshops. However, the documents note that small adjustments to activities were made based on findings from Promundo's monitoring visit conducted in Year 3.*

33. *An example of a GEAP can be found in SHOW AWP Y1 Ghana Annex D GEAP*

[TABLE 4] LIST OF GE GUIDELINES

DEMAND SIDE

- Fathers Club Manual: Engaging Men in Maternal, Newborn, and Child Health and in Sexual and Reproductive Health for the Multi-Country SHOW Program
- Guidance Note on Male Engagement in Maternal, Newborn, and Child Health/Sexual and Reproductive Health
- MNCH/SRHR Advocacy Guidance Note: Male Engagement in Maternal, Newborn, and Child Health/Sexual and Reproductive Health
- Communications/SBCC Guidance Note: Male Engagement in Maternal, Newborn, and Child Health/Sexual and Reproductive Health
- Guidance Note: Working with Religious and Traditional Leaders to Promote Male Engagement in Maternal, Newborn, and Child Health/Sexual and Reproductive Health
- Women and Adolescent Girls' Empowerment and Gender Equality in Village Savings and Loans Associations (VSLAs): Engaging Women, Men, and Adolescent Girls and Boys (GE Guidance for MNCH/SRH Programs Incorporating VSLA in Support of Better MNCH/SRH Out-comes)
- Guidance for Women and Girls' Empowerment
- Assertiveness and Leadership Training for Female CHC Members

SUPPLY SIDE

- Gender responsive MNCH/SRH Service Delivery
- Adolescent Friendly MNCH/SRH Service Delivery
- Promoting Gender Equality in MNCH/SRH Education: Guide for Capacity Building of Community Health Workers

A key component of the GES was the strong GE architecture designed into the project to support the implementation of the strategy, and to ensure consistent and high-quality integration of gender equality considerations throughout the project. GE Advisors and Specialists were hired on project teams to provide technical support to the design, implementation, and monitoring of the project. In Bangladesh, Haiti, Nigeria, and Senegal, GE Advisors were hired as part of the core project staff team. In Ghana, both a GE Advisor and a GE Specialist were brought on to contribute to the implementation of the project. In all five countries, these project team members provided technical GE support for project staff and partner training, material and tool development, and activity implementation. GE Advisors and Specialists also maintained and helped manage relationships with Ministries of Women's Affairs. The country-level GE Advisors and Specialists were also supported by GE Advisors and Specialists based in Canada. Additionally, all of the GES, guidelines and tools were socialized extensively with SHOW partner organizations and government stakeholders in each of the five countries, and with Global Affairs Canada, to ensure their endorsement and support for the Strategy's implementation.

SHOW also ensured project governance mechanisms were able to actively support the Gender Equality Strategy by providing all governance structures (Project Steering Committees and Technical Advisory Groups) training on gender equality, promoting female representation and leadership, including representatives from Ministries of Women's Affairs, and assigning GE as a standing agenda item. The GES also included that the project would create linkages and foster relationship with relevant gender equality networks and other organizations working to promote gender equality.

Implementation of the GES was measured by several indicators in the SHOW Project PMF. These indicators measured progress under IO 1100 and IO 1200 (see **TABLE 5**). Specifically, these indicators measured the level of awareness amongst women, adolescent girls and men of GE messages, the level of support provided by male family members for MNCH/SRH, the participation of women in organized community groups, and women's participation and leadership in CHCs. These indicators also measured the number of health facilities in project areas that are providing GRAF MNCH/SRH services and GRAF referral services. Additionally, the implementation of the GES was measured using monitoring data, and through regular monitoring field visits conducted by Plan International and partner staff.

[TABLE 5] LIST OF GE INDICATORS[34]

IO 1100 GE Indicators	IO 1200 GE Indicators
% of WRA (disaggregated by age) and their male family members who know at least 2 key gender equality messages related to MNCH/SRHR	% of health facilities that provide gender responsive and adolescent friendly referral services
Average level of support provided by male family members for the utilization of MNCH/SRH services by female family members (disaggregated by women, men, and adolescent girls)	% of health facilities that provide gender responsive and adolescent friendly MNCH/SRH services
% of women who are members of organized community groups (disaggregated by age and type of group)	
% of CHC members that are female	
% of CHC (Community Health Committee) leadership positions held by women	

34. Baseline values for these indicators will be discussed below in the analysis and results section.

SECTION 3:
A MODEL OF TRANSFORMATIVE CHANGE

ANALYSIS OF THE MNCH/SRHR GENDER EQUALITY STRATEGY

The following sections present detailed descriptions and analysis of the design and implementation for each of the three pillars of the Gender Equality Strategy. The sub-sections also provide unique approaches that were used in different countries and challenges that were encountered during implementation. Section 3.4: Results provides a review of the SHOW project's key gender equality results from the midterm evaluation, project reports and other monitoring activities.

3.1 EMPOWERMENT OF WOMEN AND GIRLS

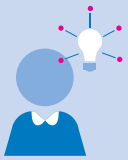
This section provides a description and analysis of the activities designed and implemented by the SHOW project to contribute to the first pillar of the Gender Equality Strategy: Empowerment of Women and Girls. The first section lays out the original design of activity streams to support this pillar of the strategy, exploring some of the country-specific design elements. The following section examines highlights and challenges during the implementation of the activity streams, and some of the strategic shifts that had to be made over the course of implementation.

3.1.1 DESIGN

Within each of the SHOW countries, a series of activity streams were designed to contribute to the project's objectives of empowering women and girls and increasing demand for MNCH/SRH services. First, these activities were intended to provide critical **information and knowledge** to women and girls on MNCH, SRHR, and topics related to gender equality. Second, these activities were intended to **strengthen women and girls' individual and collective agency** to increase their access to health services and to increase their participation in decision-making. Third, these activities were expected to strengthen women and girls' **social and financial capital** as a pathway to their empowerment.

Six approaches were integrated into the design to achieve these three goals:

INFORMATION & KNOWLEDGE



- Social and behavior change communications (SBCC) & Campaigns

STRENGTHEN WOMEN AND GIRLS' INDIVIDUAL & COLLECTIVE AGENCY

- Women's Support groups
- Engagement of adolescent girls
- Increase of female leadership in community groups
- Engaging female community leaders

SOCIAL & FINANCIAL CAPITAL

- Village Savings and Loans Associations (VSLA)/Village Savings Groups (VSGs)

A consistent strategy was employed to target women and girls as the 'rights holders' across the five SHOW countries and to respond to their common barriers related to knowledge and agency, however the individual project design varied according to the types of barriers and social resources found in each country context.

SBCC and Campaigns

Social and behaviour change communications can be defined as those communications strategies designed to impact both individuals' beliefs, attitudes, and practices, and community norms and supportive policies. Each of the designs for the five SHOW country projects have detailed approaches for raising awareness and knowledge of the programs' key messaging through SBCC and campaigns. The key messages shared throughout the project areas included messaging on MNCH, SRHR, gender equality, male engagement in MNCH/SRHR, women's participation in decision-making, gender-based violence and CEFM/HTPs, and risks of early pregnancy. The main objective for all awareness raising activities was to empower women and adolescent girls to make informed decisions on their health, while also engaging women's partners, families, and neighbors to develop attitudes favorable to women and girls' agency and empowerment.

Plan International also created additional messaging to respond to specific findings from the different countries' situation analyses. For example:

- Messaging in Senegal was designed to include emphasis on FGM/C due to its prevalence in some Senegalese project areas, whereas this was not addressed robustly in other countries. In Nigeria, messaging about family planning was rephrased as 'child spacing' to ensure acceptability in conservative Sokoto State, Nigeria.
- While household visits were also planned in all five countries to support dissemination of project key messaging to women, adolescent girls and influencers in their families in project areas, the methods identified to disseminate messaging to women varied by country: community dramas, posters, ICT based SBCC messaging, radio shows, courtyard sessions, and community events and discussions were commonly included in the SBCC approaches implemented in SHOW countries. SBCC approaches also targeted health care providers to promote respectful GRAF service delivery including curbing negative attitudes towards women and adolescent girls.

Dissemination of messaging was achieved through a variety of modalities that reflect the various opportunities within the activity streams of the project, including the use of reputable and popular media in the context of each country, and reflect the local culture and context. For example, relevant job aids were reviewed (flyers, job aids, posters, etc.) and workshopped to improve gender transformative radio and Short Message Service (SMS) messaging in local languages, English and French (as appropriate) to ensure the widest accessibility by target communities and populations.

Key gender equality messaging across all formats of SBCC included: the gendered role distribution and ensuing time poverty; importance of women's/girls' decision making and joint decision making between partners in all matters affecting their lives, specifically MNCH/SRHR; women's leadership in the public sphere, with targeted messaging for men's roles and positive masculinities. GBV, CEFM and HTPs as relevant were also addressed specifically through the SBCC activities.

Women's Support Groups

The design of the SHOW Gender Equality Strategy was heavily reliant on work undertaken within the structure of support groups for adult women, adolescent girls, and older women such as grandmothers or mothers-in-law. In recognition of the strong existing networks of women's organizations and groups, the project sought to identify and revitalize or strengthen existing women's support groups and networks, such as Self-Help Groups in Bangladesh, Mother Supports Groups in Ghana, 100 Women's Groups and Federation of Muslim Women Association of Nigeria in Nigeria, Grannies' and Mothers' Groups in Haiti and Senegal[35]. Every effort was directed at leveraging existing organic structures as opposed to creating new ones for fostering sustainability and working within contextually acceptable forums with the view of strengthening them as catalysts of change. The support groups were designed to serve several purposes:

- ✓ They were intended to be a safe space where women (and girls) could gather to build collective support and agency, and to act as safe spaces where members could learn together and gain mutual support. This safe space would also offer women and girls an important resource as they developed new attitudes towards gender norms for the duration of the project.
- ✓ They would serve as an entry point to share SHOW key messaging with women and girls and disseminate SBCC materials/messaging.
- ✓ Participants were expected to become local agents of change and share their learnings with their families and friends, particularly on knowledge related to MNCH and SRHR, related danger signs and seeking skilled care.

Unlike the structured Fathers Clubs Curriculum in the male engagement pillar (see below), few materials were planned to be developed specifically for use in women's support groups deeming their nature as being self-led. Rather, it was intended that SBCC materials developed for the project would be utilized to support learning in women's support groups. While the identification of support groups was a commonly designed approach across the five country projects, there were some distinct aspects of this activity stream identified from the design stage:

- Senegal and Ghana, specific support groups were also explicitly planned to reach traditional gatekeepers of gender norms, such as mothers-in-law and grandmothers, on issues of MNCH, SRHR, and gender equality.
- In Ghana and in Haiti, existing materials developed by the respective governments were planned to be used. In Senegal, the community-based Grandmothers' Strategy[36] materials were planned to be adapted for use by SHOW. It was only in Bangladesh that a specific guideline for women's Self-Help Groups was planned to be developed.

35. *SHOW PIP Report: Consolidated GES*

36. *The Grandmothers' Strategy is a separate initiative in Senegal to engage grandmothers in MNCH, developed and taken up by civil society organizations (CSOs). SHOW made uses of the Grandmothers' Strategy materials to design its activities with grandmothers' groups*

Engagement of Adolescent Girls

Situation assessments and design for the SHOW project explicitly included adolescent girls and boys' needs associated with MNCH/SRHR, specifically as they are related to early marriage and pregnancy, access to sexual and reproductive health services, and different communication modalities. The adolescent girls were defined in the age cohort of 15–19 years. Subsequent to the PIP, however, in response to the evolving priorities of Global Affairs Canada and the recognition of the need to more strongly align project activities with supporting approaches which explicitly include adolescent sexual and reproductive health and rights, Plan International developed a practical guidance for each country team to boost the integration and consideration of ASRHR throughout the outcome areas of project. The practical guidance supported the integration of considerations to respond to 1) individual barriers; 2) socio-cultural barriers; and 3) structural barriers.[37]

The objectives of this activity stream echoed those of engagement with adult women support groups: to provide a safe space to exchange information and build support; and as an entry point to share key SHOW messages related to gender equality and MNCH/SRHR.

As with the women's support groups, the design of these activity streams varied between countries:

- In some countries, it was planned that groups would be led and facilitated by trained adolescent peer educators (with support from Plan International, partner staff and/or CHWs); in other countries, support groups were planned to be led and facilitated by Plan International, partner staff, and/or CHWs.
- Both in Bangladesh and Nigeria, sex separated groups would be led by same-sex youth peer facilitators. However, in Nigeria the Sokoto State Ministry of Health approved the peer educator modules and its trainers conducted the training of facilitators. In Haiti, Plan International's Champions of Change for Gender Equality and the Rights of Girls project would be delivered, where sex-separated groups are brought together periodically to collaborate. Adolescent girl leaders would be trained in Ghana to deliver peer awareness raising to girls' groups, without collaboration with male adolescent groups.

37. *SHOW PIP Report: Consolidated*

VSLA/VSG Strategy

A SHOW **VSLA/VSG strategy** was designed with the objective of increasing women's economic empowerment and decision-making capacities, and to address financial barriers to accessing health services. Additionally, VSLA groups were used as an entry point through which project key messaging could be shared with women and girls related to gender equality and MNCH/ASRHR.

VSLA groups were also encouraged by Plan International and partner staff to develop a social fund, with money saved by the group to be used in the case of a health-related emergency. This strategy was intended to contribute to lowering the financial barriers encountered during MNCH emergencies. Several countries also added in their standards that dictated a majority participation of marginalised women and girls in the VSLA groups i.e. 70% where groups were mixed sex. In Haiti, Senegal, and Nigeria, the projects also included additional training for VSLA members on financial literacy and small business development.

Women's Participation and Leadership in Community Governance Groups

Strengthening women's participation in and leadership of community groups was another key aspect of empowering women and girls. This participation was specifically measured in the project's baseline through the following indicators:

- ✓ "percentage of women who are members of organized community groups", and
- ✓ "% of CHC leadership positions held by women".[38]

Community groups within which the project design prioritized women's participation and leadership vary country by country. However, the projects' key messages were designed to reinforce the importance of women's equal participation in and leadership of community groups in general. For example, Ghana and Haiti included advocacy activities with local governments and CHCs, and in Ghanaian District Health Management Committees so that women's participation in these committees was able to meet existing quotas. In Bangladesh and Nigeria, the project engaged with the respective health departments to draft guidelines for the participation and leadership of women in local health management committees. In all five countries, activities were also designed for CHC members, in particular to strengthen their understanding of inclusive governance and women's leadership. These activities were expected to contribute to increasing the participation and leadership of women in CHCs.

38. *SHOW PMF: Outcome Indicators 1120 and 1130*

Engaging Women Community Leaders

The last key approach of the Gender Equality Strategy's first pillar was to work with existing grassroots women leaders in project areas. Activities that targeted women leaders worked not only with women and adolescent girls to foster their agency and empowerment but also on addressing unequal gender norms and harmful stereotypes and practices to create a social environment that will be more conducive to women's leadership, gender equality and the rights of women and girls as well as for improved MNCH/SRHR outcomes. Women leaders were identified for their potential to become allies of the project and to help share the project's key messages with their communities and for their ability to communicate project key messages with other community leaders, particularly men.

In each project country, the project design included the provision of training for community leaders on key issues related to MNCH, SRHR and gender equality, with variance in specific focus within each country:

- In Ghana, Bangladesh, and Haiti, the project identified and trained "gender equality champions" role models or "Change-Makers" to lead their friends and neighbors to adopt new gender attitudes and behaviors. Both male and female community role models were planned to be selected as "gender equality champions" based on criteria to be agreed upon by Plan International and the communities with which it partnered to implement SHOW.
- In Nigeria, there was a specific focus on working with Ward Development Committees (WDCs) to increase women's participation in decision making and promote women's leadership. Whereas in Ghana, working directly with CHC members and traditional structures such as the Queen Mothers' Association were built into the design. The Bangladesh GES targeted multiple levels of health management, including Health Management Committees and Upazila Standing Committees.

3.1.2 IMPLEMENTATION

The approaches which fall under the first pillar of the Gender Equality Strategy were implemented in each of the five SHOW countries based on what was designed, however, shifts were made in some of the approaches during implementation in response to local contexts or project challenges. Certain approaches were given more or less focus over the project lifespan as a result of particular challenges or successes. These are described below.

SBCC and Campaigns

At the start of implementation, each country project developed an SBCC strategy to guide the review, development and dissemination of the project's health-related and gender equality messaging through active stakeholders' engagement. The SBCC strategies dedicated key materials and activities to promoting gender equality, women and girls' empowerment, and male engagement in MNCH/SRHR. Each country used a variety of methods to effectively disseminate messages including household visits and counselling, community awareness-raising sessions, community dialogue sessions, printed materials, community theatre, radio programming, and celebrations of special days.

A member of a Grandmothers' Club in Senegal wearing a t-shirt with project key messaging saying: "I encourage my daughter-in-law to use maternal, newborn, and child health services for the sake of her health and my grandchild's."

Developing a **variety of SBCC materials** was a large focus of the project. These were used during women's support groups, during adolescent peer education session, and during VSLA group meetings. For example, the *"boîtes a images"*, or image boxes, developed in Senegal and Haiti were the main Community-Based Organisation (CBO)[39] and CHW tool for community awareness raising and were repurposed as facilitation tools for women's support groups. All materials, regardless of whether they were exclusively health-focused, went through a review process to ensure integration of gender equality messaging, and also to ensure that materials were not inadvertently reinforcing harmful gender norms.

Many of the SBCC materials developed and many of the SBCC activities reached all beneficiaries of the project, such as through community broadcasts, radio programming, commemoration of special events and days, and several printed materials. Because the focus for these SBCC materials was to reach as wide an audience as possible, they integrated a variety of the project's key messages. For example, radio scripts included information on how to recognize danger signs during pregnancy while also emphasizing male support and gender equality. Few materials and SBCC activities exclusively targeted women and girls.

While detailed planning and support was provided for the development of materials specifically targeting male engagement (in particular the Fathers Clubs Manual), activities targeting women and girls (for example, women's support groups) for the most part utilized materials that had been designed for a general audience. Likewise, materials and activities developed specifically for adolescents reached both boys and girls. However, in some countries there are materials that specifically reached women and girls, for example, posters and flyers to engage grandmothers and mothers-in-law in Senegal, and video clips and Theatre for Development scripts in Bangladesh.

In all five countries, a variety of **stakeholders disseminated key messages using SBCC materials** developed for the project, including CHWs, Community Based Health Volunteers (CBHV), support group leaders, adolescent peer educators, religious and traditional leaders, partner non-governmental organization (NGO) staff, and partner CBOs, and resources were devoted to building their capacity to effectively deliver SBCC messaging. In some countries, project actors were specifically trained on SBCC materials and tools developed. For example, in Bangladesh and Haiti, CHWs were trained on the project, its health-related key messages and gender equality messages, and on how to use SBCC tools developed for the project.

39. *Community Based Organisations partnered with the project in Senegal were community organisation made up of 3-6 individuals hired by the project to help lead SBCC activities and lead community support groups.*

Summary of implementation steps of the SBCC strategy

- Country specific SBCC strategies were developed covering the objectives, content, target groups, modes and methodologies
- Available/existing national SBCC materials were gathered and underwent a systematic review to assess alignment with the Gender Equality Strategy of SHOW
- Based on the review, new and/or additional gender equality and SRHR SBCC materials were developed in accessible formats and languages
- New materials were tested with key target groups in communities for acceptability, comprehension and effectiveness
- New materials were finalized in validation meetings/workshops with key stakeholders including ministries/ departments of health and gender
- Print and electronic materials were produced
- Capacity building of partners and implementors including CHWs, women support group leaders, traditional/ religious leaders, gender equality champions etc. was held
- Roll-out of SBCC and campaigns
- Supportive supervision and monitoring of various actors delivering messaging was carried out through field visits
- Ongoing learning/documentation relating to effectiveness of messaging and challenges was carried out
- Year on year reset, revisions and new tactics as part of project AWPs for maximum outreach and effect was carried out

A mock-up for a mural depicting women's participation and leadership in community groups.

There were a few **challenges** to the implementation of SBCC strategies. 1) Significant achievements were made to include messaging promoting the empowerment of women and girls in SBCC materials and activities, **but no specific guidance was developed for SHOW's gender equality messaging on women and girls' empowerment and agency or how women and girls' empowerment should be promoted for implementors as part of the core focus of MNCH/SRHR education messaging in SBCC**; resulting in the gender equality messages being often delivered as standalone messages rather than gender inequality being framed as a key driver of poor MNCH/SRHR outcomes. Guidance and support on how to develop SBCC that is gender responsive and promotes the empowerment of women and girls was however included in the gender equality training provided to project staff and partner staff in all countries, and during Annual Work Planning sessions on SBCC. Materials were developed that specifically delivered key messages directly on women and girl's empowerment, such as GBV prevention and redress posters in Ghana, CEFM prevention posters in Nigeria and some video clips and Theatre for Development scripts in Bangladesh, radio public service announcements (PSAs) and talk show scripts in Nigeria for example. Women's leadership was also the focus of some community murals painted in Ghana and was included in the Senegal project image boxes. 2) While **empowerment messages were a component of**

many of the messaging directed at communities and stakeholders broadly, this activity stream achieved less consistency in its messaging directly targeting woman and girls themselves other than through the activities of women's and girls' groups and the activities of women leaders for example. It is to be noted however, the integration of gender equality and the empowerment of women and girls messaging in SBCC was implemented as a supporting activity stream for increasing the individual and collective agency of women and girls for broader community awareness raising and buy-in and contributing to the fostering of a broader enabling social environment and went hand-in-hand with the targeted women's and girls' empowerment activities.

The SHOW project was **successfully able to inspire change through innovative SBCC** to promote women and girls' empowerment utilizing grassroots edutainment mechanisms. For example, community theatre, led and presented by adolescent theatre troupes in Bangladesh and Ghana was successful not only at sharing important key messaging and triggering behavior change in communities, but it was also a way for the project to demonstrate the agency of adolescent girls who were active participants in drama troupes and leading change in their communities through drama (see the box below on Theatre for Development in Bangladesh). In both countries, drama troupes were also trained to lead discussions about the topics covered in dramas with their communities. Plan International Ghana also adapted traditional community fora to open dialogues between adolescents and community leaders. In these specific community sessions, called "An Evening with Adolescents", adolescent girls and boys were provided with a platform to share the issues that most affect them to community leaders, such as village chiefs and Queen Mothers. In turn, women leaders were able to use this platform to connect with adolescents from their communities and to partner with them to address issues related to gender equality and ASRHR.

In Ghana and Bangladesh, the project leveraged technology to produce SBCC video materials. Contextually relevant videos addressing gender equality topics were produced and used to disseminate key messages with women and men, adolescent boys and adolescent girls. The videos in Bangladesh were used more extensively than in Ghana since they were developed as the main SBCC tool for CHWs to use during support group meetings and household visits and could be played using a tablet provided by the project. The CHWs were also provided with specific training on how to use the videos during support group meetings, community events and household visits. In both countries, the videos served as a way to keep women, men, girls and boys, engaged in the project messaging.

Theatre for Development in Bangladesh: Empowering Youth to Lead Change

Theatre for Development (TfD) is a community theatre approach where education on MNCH, gender equality and SRHR is provided to communities through drama shows. Theatre for Development uses storytelling devices to convey important information and messages to men, women, girls and boys using language they are familiar with. The Bangladesh team employed TfD because of previous success with this method and its ability to convey messaging on difficult topics in a culturally appropriate and entertaining manner.

A special aspect of the SHOW Bangladesh TfD approach is that the selected theatre troupes responsible for putting on the dramas were largely composed of adolescent girls and boys from project communities. As a result of their participation in this activity, adolescent girls and boys have been able to develop valuable skills and have learned a great deal about gender equality and MNCH/SRHR. The leadership of adolescents, and particularly girls, in leading community discussions on topics such as GBV, girl's education and child marriage, has a ripple effect and encourages other girls to start voicing their questions and concerns at home. Messages were well received by men, women, girls and boys in Bangladesh, and testimonials demonstrate that, after viewing the productions, many women and men began to change their attitudes on issues addressed in the shows. The TfD approach in Bangladesh has allowed adolescent girls and boys to become change agents in their communities, promoting gender equality not only with their peers, but also have platforms and capacities to reach adult audiences with their messages.

In this video clip from Bangladesh, adolescent Mana explains to her husband the risks of early pregnancy and they decide together to use family planning.

An adolescent girl leads the discussion portion of a Theatre for Development show.

"After the training, I facilitated training session in Panchari, which made me much more confident and braver. I am fortunate that I have learnt a lot about MNCH/SRHR, GE issues. Now, I am working as a change agent in my society for bringing equality and improving MNCH/ SRHR service seeking practice in our area."

– Female performer

"From SHOW project I have learned about myself, how can I become self-reliant, working as a change agent for reducing gender discrimination, child marriage etc. I think I should share my thoughts and learning with other adolescents and young people in my community which makes me bold and confident to take decision of my life."

– Female performer

"SHOW project play a Theatre for Development show "Self-Dependent Rupa". My father watched this show and decided not to arrange my marriage right now. Moreover, he gave me the chance to learn hand stitch clothing. Now, I am self-dependent and can contribute to my family."

– Adolescent female audience member

"We got so much information. We will never allow our daughters to get married before 18 years old. I will discuss about this in my neighbourhood and inspire our girls to be educated so that they can grow self-reliant."

– Woman audience member

Women's Support Groups

Women support groups provided education on GE, CEFM, GBV, HTPs, and MNCH/SRHR to women, to support their development of new attitudes and behaviors, and fostered their development as community change agents. Women's support group facilitators were trained on these key issues and project messages. Support group facilitators[40] were also trained at various points in the project to support their facilitation skills.

40. *Comprised of CHWs, volunteers, 100 Women Group members, and CBOs.*

Summary of implementation steps of the women's support groups

- Identification of existing women's groups (social, trade related etc.) in each country was carried out to avoid creating new ones and leveraging organic grassroots forums
- Consultations to understand their mandates and ways of collective work were carried out in each country with identified community women's groups and to explore potential collaboration on SHOW's Gender Equality work
- Broad community discussions on the importance of women's groups and to garner support for the formation of (where none existed) and strengthening of women's support groups were carried out to create the enabling environment for women's groups to carry out their outreach work on gender equality
- Setting up/revitalization of the groups in each project community and introduction to the project objectives and gender equality ambitions was done so all groups were at the same level of understanding and commitment
- Capacity building of group leaders to facilitate project messaging and dialogue was carried out across SHOW communities
- Dissemination of project SBCC materials to group leaders
- In Year 3 a targeted modular curriculum was developed and socialized to group leaders (see narrative below)
- Supportive supervision to groups by project and partner staff was carried out through regular field visits
- Monitoring, learning documentation and reset in AWPs over the life of the project was carried out
- Discussion platforms were convened for community reflection and mutual learning for the leaders of women's and men's groups. every quarter.

Unlike the male engagement pillar of the GES (see below), there was no systematic project-wide guidance documents, curricula, or women's support group manuals developed offsetting common content and implementation methodology of the women's support groups across the five SHOW countries. The assumption was that gender transformative male engagement was a new approach in most of the SHOW communities, departing from the traditional male education activities on MNCH/SRHR requiring strategic thinking and methods to mitigate associated risks. While sizable experience with women's support groups called for each country to design their own approach to women's support groups based on previous programming, existing women's group structures and ways of working in their countries, and the specificities of their local contexts. The underlying principle was that women's support groups being self-led must set their own agendas and discussions rather than the project imposing content on them. **SBCC materials** developed for a range of project activities were distributed to facilitators to support the delivery of their women's support group sessions, such as the video clips in Bangladesh and the image boxes in Senegal. In Ghana and in Haiti, pre-existing materials, developed by the government that were revised, were used to facilitate sessions with women's support groups. This presented key **challenges** for SHOW's implementation of women's support groups in terms of **consistency of messaging and facilitation as well as the effectiveness of messaging**; midterm evaluation and reporting indicated that in several countries this approach was not leading to the desired results. 1) **The lack of structure for different sessions was a key issue**[41] encountered during women's support groups and facilitators struggled with planning sessions that prompted attitude and behavior change on gender norms and attitudes.

In response to this challenge, **additional materials** were developed for women's support group facilitators to increase the capacity of group members to become agents of change, and to ensure greater consistency of gender equality related messaging. For example, in Nigeria, additional SBCC tools representing key messages in pictorial form were developed and "100 Women" Groups were led through refresher trainings on how to use these tools during courtyard sessions. In Haiti, an additional series of sessions on gender equality topics, focusing on women's empowerment and agency, were developed to mirror the methodology of Ministry of Health Mothers' Clubs curriculum already in use. In Senegal, additional training was provided to partner CBOs on gender equality, GBV, CEFM, and FGM/C to strengthen their capacity to discuss these topics during courtyard sessions with women and girls, and with grandmothers; additional image box cards were also developed to be used by CBOs.

The image and text cards on FGM/C added to the Senegal image boxes for adults and adolescents.

41. *Documented in the SHOW Ghana Annual Report for Year 3 and in the Annual Work Plan for Year 4/5*

Mothers' Support Groups in Ghana: Updating a Trusted Approach

The SHOW Project in Ghana strengthened, revived, or established new Mothers' Support Groups (MSGs) in each project community. If facilitated effectively, such support groups have the potential to generate gender transformative social change. The MSGs were led by one or two group leaders who were trained by the project on key issues related to MNCH/SRHR and gender equality, and on how to support women and girls to participate in household and community level decision-making, especially with regards to health.

According to project monitoring[42], MSGs helped develop the leadership capabilities of members within the group and some group members also took on additional roles as peer educators to share what they learned in the groups with their neighbors and friends. Additionally, MSG leaders and members were also recognised in some of the communities as leaders because of their community outreach on MNCH, SRHR and gender equality. Testimonials indicate that this has also bolstered members' confidence and women and girls are able to take decisions about household issues, which would have previously been left to male partners.

"I always join the Mother Support Group to conduct home visits and also visit the churches in our community to educate members on the benefits of active participation of women in decision making, encouraging adolescents to live positive lifestyles and male engagement in pregnancy delivery, post-delivery and child care."

– MSG member, Ghana

Despite these initially reported successes on positive community feedback and effective sharing of health-related messaging, mid-way through the project it became apparent that the Mothers Support Group approach was not achieving its goals related to gender equality. Field visit reports revealed that group leaders were not discussing gender norms and attitudes as often as they shared key health information. The level of awareness of danger signs along the continuum of care[43] and the level of awareness of gender equality messages both decreased amongst women between the aged of 20–49[44]. The percentage of women who believed that women should participate in household and community level decision making also decreased between the baseline and the mid-term.[45]

The illustrations designed to accompany an exercise from the "Women and Girls Empowerment" curriculum.

Support group leaders needed additional tools to ensure greater consistency of gender equality messaging and to promote more transformative change amongst group members. The project responded by developing a new curriculum for facilitators. The "Women and Girl's Empowerment" curriculum follows a similar learning journey to the Fathers Clubs Manual developed for SHOW and emphasizes activities on gender norms and stereotypes. Additionally, image flashcards were developed by the SHOW Ghana team to accompany the manual in response to feedback from group leaders that group members respond exceptionally well to messaging when it is accompanied with images. Group leaders were trained on use of the curriculum and were able to roll it out in the final year of project implementation, building on early success of the Mothers Support Groups. The curriculum was socialized to all SHOW countries' project and partner staff for using in their respective women's support groups.

42. *SHOW Ghana Annual Report Year 2*
43. *Indicator: % of WRA (dis. by age) and their male family members who know at least 2 danger signs and related strategies along the continuum of care*
44. *Level of awareness of dangers signs amongst women aged 20–47 decreased from 23% at baseline to 17% at mid-term and the level of awareness of GE messages also decreased amongst women between the ages of 20 and 49 from 87% at baseline to 83% at mid-term.*
45. *Data regarding decision making from the mid-term also indicated a decrease of 8% for women who believed they should participate in household decisions and 2% for women who believed they should participate in community level decision making.*

Findings from the endline evaluation found that awareness about danger signs along the continuum of care was still generally low. In Ghana, while knowledge of danger signs during pregnancy declined among WRA at endline, their knowledge of danger signs in the other three stages improved. The endline evaluation also revealed that the percentage of WRA who believe that women should participate in household and community level decision making increased from baseline and midline and surpassed the project's targets.

A Mother Support Group session in Ghana

2) **Despite their similarities, there were key differences between support groups and courtyard sessions**. In both Senegal and Nigeria, courtyard sessions replaced the traditional support groups that were originally part of the design. The key difference between these approaches is that **there is no membership for courtyard sessions, and there is greater fluctuation in attendance**. This allows messaging to be shared with greater numbers of people and allows greater flexibility in number of participants. This also allows facilitators of courtyard sessions the ability to locate the sessions where small numbers of women already gather. However, the same bonds and support systems built with support groups are more difficult to build when women and girls do not regularly attend the same courtyard sessions.

Under the SHOW project, a new role played by women's support groups across countries was their pivotal participation in the project-instituted quarterly community reflection dialogue sessions that brought together key community stakeholders including traditional and religious leaders as well as the community health committees, health facility staff, CHWs and local ministries of health and gender to discuss their health facilities, services, analyse data and collectively resolve issues and challenges. This ensured women's voices were heard and taken into account and demonstrated the leadership of women in their communities.

Grandmothers Groups in Senegal

The Grandmothers' Strategy was implemented to leverage the community and household influence that older women and grandmothers traditionally hold in Senegal. Grandmothers' groups were formed and trained by the project on topics related to MNCH, SRHR, and gender equality, and to conduct advocacy in their homes and in their communities to promote women's and girls' rights to health and gender equality. The grandmothers' groups were instrumental to building a strong social environment in families and communities that would be receptive to changing norms related to gender and women's position.

As gatekeepers of social and relational norms, grandmothers were encouraged to think about some of the consequences of harmful traditional practices and invited to leverage their power in households to prevent these practices from occurring. For example, grandmothers group members were encouraged to discourage other family members from requesting home-based deliveries and to support their sons to make decisions jointly with their partners. In communities where visits for ANC 1 and ANC 2 have increased, health providers reported[46] to project staff that the grandmothers' groups have been instrumental in dismantling traditional beliefs that women should hide their pregnancies, preventing them from accessing ANC. One of the unforeseen benefits of this approach has been a change in the traditional relationship between women and their mothers-in-law. As a result of their participation in the SHOW grandmothers' groups, these women have more equal relationships with their daughters-in-law, listen to their concerns and provide counsel based on what they learn in the groups[47].

As a result of this success, the Grandmothers Groups became very influential at the household level and their role in the project was expanded with them in the lead. Grandmothers Groups in some of the project communities came to be a women-led mirror to the Husbands' Schools (see Section 3.2), conducting advocacy visits with religious and traditional community leaders on MNCH, SRHR, and gender equality.

A grandmother leads her group in a song.

"Our traditions were to bring any pregnant woman to the healer at the first signs of pregnancy. With our participation in the grandmothers' group, we are now more aware of the dangers that these practices present. Now, in our village, as soon as a woman becomes pregnant our first reflex is the health post. Through a system of sponsorship between grandmothers and young pregnant women, we can be sure that a woman will follow all of her appointments for her prenatal and postnatal consultations. It's a fight we won here, and the midwife is very proud."

– Grandmother from Senegal

46. *SHOW Senegal Annual Report Year 3, page 62*
47. *SHOW Senegal Mid-Year Report Year 4, page 42*

Grandmothers and mothers-in-law were targeted in their own groups in Senegal and Ghana, and sometimes participated in women's groups in Haiti, Nigeria, and Bangladesh. The use of women's support groups to engage older women, who in many of the SHOW project areas already held some leadership positions in households[48], was most prominent in Nigeria, Ghana, and Senegal. In Nigeria, 100 Women Group leaders were refocused in the later part of the project to work with older women to strengthen the agency of first-time mothers, particularly adolescent girls, to access health services. The 100 Women Group leaders were tasked with encouraging older women, particularly the mothers-in-law of married adolescent girls, to change attitudes on family planning, antenatal care, delivery and postnatal care and gender equality. In Ghana, Grannies Clubs were expected to carry out activities and community outreach similar to what was expected of the Mothers Support Group, eventually the two groups merged and grannies received the same women's empowerment training that was developed for Mothers Support Groups. In Senegal, the Grandmothers Strategy[49] engaged grandmothers to not only form their own support group but also to share messaging on MNCH, SRHR, and gender equality with their extended families and to promote women and girls' empowerment. Their capacity to engage and advocate with their community leaders was recognized in the project and they were brought on as additional project actors to advocate with local religious and traditional leaders (see the box Grandmothers Groups in Senegal).

Engagement of Adolescent Girls

The implementation of adolescent engagement activities had the dual objectives of empowering adolescent girls and of fostering new masculinities with adolescent boys, as stated in the project design (see Section 3.2.1 on Adolescent Boys' Engagement). The majority of learning outcomes from adolescent engagement activities were the same for girls and boys in Bangladesh, Nigeria, Senegal, and Ghana. In Haiti, which implemented

48. *Based on findings from SHOW GE Assessment.*

49. *CBOs in Senegal have also been trained on the Grandmothers Strategy and were provided with specific materials to help lead grandmothers' group sessions*

Plan International's Champions of Change program, learning outcomes were specific for girls and boys as the Champions of Change curriculum explicitly differentiates the learning outcomes for girls and for boys based on their participation in the program.

Specific messaging and tools targeting adolescent audiences were developed or adapted in each of the SHOW countries. Topics addressed in adolescent focused materials included gender equality, girls' empowerment, adolescent sexual and reproductive health and rights, MNCH, sexually transmitted infections, family planning methods and contraception, CEFM, GBV and harmful traditional practices. The tools developed (curricula, guidelines, and/or SBCC) varied from country to country as they responded to the specific contexts, methodology employed for adolescent engagement, and particularly the different skills and capacities of facilitators. In Haiti and Senegal, more complex manuals with series of thematic sessions were adapted for use in the Champions of Change groups and the EVF Clubs[50], respectively.

In Bangladesh and Nigeria, comprehensive peer education manuals were developed for use by adolescent peer educators. In Ghana, a set of educational flashcards and activity cards were repurposed for use in the project. Each of the materials underwent significant reviews to ensure the suitability for adolescent audiences, and to ensure that they would be appropriate for the contexts in each of the five countries. Plan International took care to review materials to ensure the protection of adolescent girls and adolescent boys participating in their programs and worked with communities and community leaders to socialize the adolescent programs before they began to minimize any potential backlash.

50. *EVF stands for "Education a la Vie Familiale" (Family Life Education) and is the name of the Senegalese Ministry of Education school-based life skills clubs.*

Summary implementation steps for adolescent engagement

- Country specific mapping of existing in and out of school adolescent groupings was conducted
- Community (parents, leaders/influencers) dialogues and mobilization for adolescent SRHR was carried out prior to initiating adolescent group sessions
    - During community dialogue session efforts were made to ensure most marginalized adolescent girls and boys were identified by community members,
- Recruitment of adolescent girls and boys to form groups where existing ones did not exist was carried out
- Country specific child safeguarding risk assessments and risk mitigation plans were developed in consultation with adolescents
- Engagement with country health and gender ministries for peer education curriculum review was systematically carried out
- Existing adolescent peer education materials (except Haiti where Champions of Change was implemented) was gathered and reviewed
- Adaptation and additional materials development (guides, manuals, IEC etc.) was undertaken and tested for effectiveness with select adolescent groups
- Materials validation workshops/meetings were conducted including with country ministries of health and gender
- Identification and training of adolescent groups facilitators was carried out
- Identification of safe venues for group sessions was systematically done in collaboration with group facilitators
- Periodic group sessions (frequency was determined by each country as appropriate with adolescent groups) were conducted
- Supportive supervision and monitoring of group sessions/activities was carried out through field visits
- Monitoring, learning documentation and reset in AWPs over the life of the project

Both Senegal and Haiti implemented adolescent engagement activities dependent on **high capacity facilitators**. In Haiti, significant resources were dedicated to ensuring adequate training for project staff on the **Champions of Change** modules and methodologies. Direct facilitation by project staff allowed the SHOW Haiti team to have better oversight on the consistency of facilitation and key message delivery in each of the Champions of Change Clubs.

In Senegal, the project relied on leveraging existing adolescent groups, the **school based EVF Clubs** (led by students and teachers) and the existing curriculum for these clubs to manage the groups. Plan International was able to participate in reviews of this curriculum already planned by the Ministry of Health and Ministry of Education and proposed using the Champions of Change methodology to further strengthen the government curriculum. In Bangladesh and Ghana, **adolescent peer educators**, both boys and girls, were selected from within communities, whereas in Nigeria these peers educators were identified by the State Ministry of Health, and trained by Plan International to lead peer education sessions with other adolescent girls and adolescent boys in their communities. In Ghana, mixed sex groups were formed, but peer educators were instructed that for certain topics it would be best to separate the group by sex to reduce feelings of embarrassment or shame from participants, or to ensure adolescent girls and boys felt safe discussing more sensitive topics. In Bangladesh and Nigeria, the male and female adolescent peer educators led groups of adolescent boys or adolescent girls, respectively. These approaches were also useful to respect the cultural and contextual standards of how to appropriately discuss such sensitive topics with adolescent girls and boys.

While overall, targeted activities for adolescents went smoothly in terms of consistency and effectiveness, **a few challenges were noted**. 1) **The project endeavoured to ensure that the most marginalized girls and boys** such as unmarried pregnant girls, adolescents identifying with diverse gender identities and adolescents with disabilities were reached. Other than adolescents with varying abilities, **this became a challenge firstly from an identification perspective** and from an integration into groups perspective given local contexts; it is a **learning** that each of these intersectional groups must be reached separately and systematically in both in and out of school contexts. 2) **The capacity of facilitators is critical especially in applying gender transformative approaches and messaging** that inherently departs from traditional models of peer education in terms of methodologies that are participatory and reflective and content that encourages examining gender norms and values.

In SHOW a range of facilitators undertook adolescents group sessions ranging from CHWs in Bangladesh, to government identified peer educators in Nigeria to project and part staff in Haiti and Senegal for example. The assumption behind identifying local facilitators was to encourage local capacity strengthening and expertise in the interest of sustainability as well as to align with objectives of local acceptability and trust. However, the challenge with this was the varying familiarity and comfort with gender equality messaging due to existing biases and stereotypes of facilitators, which was addressed through a careful selection criteria and intensive training of facilitators at the onset and through refreshers that had to be tailored and adjusted to the capacity needs of facilitators continuously. The learning is that facilitators for adolescents must first undergo a transformative reflective journey themselves to deconstruct prevailing gender biases which in turn has significant time and monetary ramifications often rendered unfeasible in relatively short duration interventions such as SHOW.

Champions of Change in Haiti

THE GLOBAL CHAMPIONS OF CHANGE APPROACH

The Champions of Change curriculum for girls and for boys engages adolescents on a journey to empowerment by building their self-esteem, strengthening their understanding of gender and how unequal gender norms impact them, learning about SRHR, discussing how they can use their collective action to prevent and address GBV, and how they can work with their peers to promote gender equality. The Champions of Change project comprises a series of five core modules for adolescent boys' groups and seven core modules for adolescent girls' groups, and two core modules to be completed together with boys and girls. The project also includes additional optional thematic modules, on CEFM and conflict resolution, for example. The project uses a **gender synchronised** approach: girl's groups and boys' groups go through their designated modules on their own and meet periodically throughout the curriculum, and at the end for the final module on advocacy and action planning, to work together to address gender inequality in their communities. The approach is designed to support adolescent boys and girls to adopt new attitudes and behaviors on gender equality and SRHR, and to eventually lead change amongst their peers and communities.

The Champions of Change project requires adequately planned resources. Adolescent boys' and girls' groups require facilitators with a high degree of capacity on adolescent group facilitation, on gender transformative programming, and who need to receive in-depth training on the Champions of Change project and methodology.

IMPLEMENTING CHAMPIONS OF CHANGE IN HAITI

Champions of Change was selected as the adolescent engagement project to be implemented as part of SHOW Haiti. Implementation started with a training of trainers' workshop for SHOW staff on the Champions of Change methodology and modules. Representatives from the Ministry of Health and the Ministry of Women were invited to the training as well to ensure their buy-in to the program. Additionally, awareness sessions on adolescent SRHR were conducted in communities as part of regular SHOW Haiti SBCC activities with community members, parents and community leaders to minimize community backlash to the Champions of Change project and ensure a safe space for adolescent participants.

Boys' and girls' groups from a Champions of Change Club in Haiti.

SHOW Haiti successfully formed adolescent clubs of about 15 boys and 15 girls between the ages of 12 and 18 in the 11 project areas. The groups were facilitated by project staff, with guest facilitation by health post staff when discussing topics directly related to health. The groups were scheduled to follow the school year as adolescents from project areas often migrated away outside of school time to visit family or to work in other parts of the country. Group meetings took place away from school structures, for example in health posts or community centers, to ensure that Champions of Change groups would be accommodating to out-of-school adolescents. (See the box in Section 3.4 Results for Champions of Change outcomes in Haiti.)

VSLA/VSG Groups

The implementation of VSLA/VSG groups in each of the five SHOW countries very closely resembled what was designed. In all five countries, special attention was taken to ensure that VSLAs/VSGs would reach the vulnerable and marginalized women and adolescent girls from project communities.

The VSLA approach for SHOW was guided at the global level by the guidance document developed by Plan International[51]. This document provided theoretical and practical guidance on how to implement a gender transformative VSLA approach, and how to coach VSLA facilitators at the field level to support gender transformative VSLAs. The guidance does not supplant a traditional VSLA approach, but instead provides complimentary guidance and materials on gender equality considerations for different phases of VSLA group formation, training and supervision. Additional guidance is also included on facilitating sessions on gender equality topics including female leadership, inclusive governance, and life skills for adolescent groups. All of the five SHOW countries made use of this document to structure their VSLA training sessions, and this document was also used to conduct supportive supervision with groups on female leadership, inclusive governance, gender equality, and MNCH/SRHR.

In all countries, Gender Equality Advisors and Livelihoods and Economic Empowerment Advisors worked closely together to ensure that VSLA groups could maximise the capacity of VSLAs to reduce gender barriers to women and girls' access to health, ultimately contributing to strengthening women and adolescent girls' empowerment and agency. In Bangladesh, a VSG methodology was implemented in only one project area, Chittagong Hill Tracts, and a unique approach, as discussed below, was designed to reflect the context of this area.

In all five of the SHOW countries, while establishing groups, the project either revitalised and strengthened existing groups by carrying out training on participatory, inclusive governance and women's rights, gender equality and women's leadership, or formed new groups following a period of awareness raising on the benefits of VSLA for women and girls as well as the benefits for families and communities. For example, in Senegal and Nigeria, groups were divided by sex and in some regions special groups reserved for adolescent girls and young women were established as existing groups were sometimes dominated by older women. In Haiti, VSLAs were composed of women and men but had 70% female membership, and more than half the groups were led by women.

Finally, over the course of implementation, many of the VSLA groups established social funds to support emergencies, and testimonials[52] indicating that VSLAs contributed to reducing barriers traditionally experienced by women trying to reach health facilities. No specific challenge was noted over the course of implementation of VSLA/VSG activities.

51. *Women and Adolescent Girls' Empowerment and Gender Equality (GE) in Village Savings and Loans Associations (VSLA): Engaging Women, Men, and Adolescent Girls and Boys: GE Guidance for MNCH/SRH Programs Incorporating VSLA in Support of Better MNCH/SRH Outcomes*

52. *SHOW Ghana Mid-Year Report for Y4, page 33*

Village Saving Groups (VSG), Bangladesh

In Bangladesh, the SHOW Project developed and piloted a tailor-made Village Saving Groups (VSG) modality for vulnerable and hard-to-reach women in Panchari, Chittagong Hill Tracts region. The methodology was developed based on a situation analysis carried out with target women and other stakeholders. Subsequently, the project carried out Poverty Wealth Ranking that allowed identification and inclusion of poor and ultra poor women in the VSGs. Based on project developed guidelines, 20 VSGs were formed and a total of 316 women became members, including poor and ultra poor women. Through a facilitated consultative process, the women agreed on i) amount of saving contribution, and ii) frequency of contribution based on their unique economic situations. This flexibility in the VSG approach, allowing poor and ultra poor women to have a say contributed to the VSGs success even among the most marginalized women. During implementation, women found pictorial IEC material helpful to understand both GE messages and to become aware of the importance of savings. To ensure full participation of those women having low literacy and numeracy skills, sessions were facilitated by literate group peers or their literate family members. Moreover, the group facilitations helped prevent some members from dominating the VSG. By the end of year four, the 20 VSGs succeeded in saving a total of equivalent to approximately CAD 9,200, lent to group members equivalent to approximately CAD 4,900, and generated approximately CAD 1,410 in profits from loan repayments.

"We will continue our VSG even if the SHOW project ended. We expect that we could increase our profit through income generating activity. Now our group members are planning to take lease of land. We want to contribute to our village poor women, so that they could get health service and could ensure basic needs. We already set example in the community. From our social fund, we helped one member to save her child's life. She also took loan from the group and repaid the loan timely. By this way, we feel secured of our life and our children's life."

– Suchada Chakma, President of Kinachan Para VSG

Summary of key implementation steps

- Mapping of existing VSLA or similar savings group structures was carried out across SHOW countries
- Review of VSLA methodology and inclusion of content related to women's/ girls' leadership, inclusive governance, financial literacy, business skill development, MNCH/SRHR, gender equality and the rights of women and girls, adolescent life skills, ASRHR was carried out along with supplemental guidance for VSLA/VSG facilitators
- The establishment and/or strengthening of VSLA groups in each project area was carried out and training of the groups on the VSLA methodology as well as conducting dialogue on additional content was carried out
- Supporting groups to acquire the necessary materials for the start of a VSLA cycle was completed
- Monitoring, supportive supervision and learning documentation was carried out through ongoing field visits

Women's Leadership in Community Groups

Increasing women's participation and leadership within community groups were direct objectives of the SHOW project (women's participation in CHCs and other community groups was measured through indicators). The implementation of this approach was grounded in three actions:

1. The promotion of women's participation and leadership at the community level as part of the project's many SBCC activities;

2. Advocacy activities to promote the meaningful participation and leadership of women, particularly in health governing bodies with local, regional, and national governing bodies;

3. Training CHC members in project areas on the importance of women's leadership and inclusive governance.

SBCC messaging on women's participation and leadership used a rights-based approach and focused on increasing women's meaningful participation in community groups, as opposed to attendance. Plan International applied a scale of participation that included "presence" or representation; ability to raise voice in meetings; being heard and taken into account and leadership. The occasion of specials days, such as International Women's Day and International Day of the Girl, were also frequently used to lead community-wide activities promoting women's participation and leadership in community groups across project areas in five countries.

The project reporting documents describe several opportunities, either with project planning processes or during specially convened events, where Plan International and SHOW partners worked to advocate for increased participation and leadership of women in community groups. Government set quotas were leveraged during these meetings and other events in Haiti, Ghana, Bangladesh, and Senegal. Specific materials were developed to support these advocacy activities, including presentations and brochures developed for certain events. Furthermore, every opportunity to feed into local CHC TORs and processes were leveraged. While, no overarching guidance on the advocacy objectives, beyond the indicator objectives set in the PMF, were defined for this activity stream, a specific module on women's leadership included in the VSLA guide developed by Plan International was used towards the promotion of women's participation in committees across countries.

Inclusive governance and the importance of **women's leadership** were common topics included in training manuals developed for CHCs. The sessions on these topics focused on leading discussions on different levels of participation and what can be considered full participation, while also examining the barriers to participation and leadership that women face in their communities. For example, in Ghana, continuous advocacy and training resulted in many CHCs achieving their quota (that two out of five CHC members be women) and women CHC members were actively involved in working with health providers to improve the gender and adolescent responsiveness of services. Similar advocacy was conducted in Haiti, Bangladesh and Nigeria with similar results. The project was successful in increasing women's membership and leadership in CHCs (See Section 3.4 on Results for more details), and the participation and leadership of women was additionally leveraged by the project to focus CHC activities on gender responsive and adolescent friendly MNCH/SRH service delivery.

Summary of implementation activities

- Data on the numbers of women in community committees was collected in the baseline for the indicator along with perceptions regarding women's participation in public life and further exploration for gender-related barriers was carried out in the project gender assessments
- Based on the data, advocacy was carried out with relevant governments including Ministries/Departments of Health and Gender/Women
- In collaboration with key local stakeholders, the TORs, guides and other processes were leveraged and reviewed to mainstream gender equality and women's leadership including setting quotas or quorums during decision-making
- As part of revitalization and strengthening of these committees, sensitization of all committee members was carried out on gender equality, inclusive governance and women's leadership together with other elements regarding the roles of these committees
- Continuous supportive supervision and learning documentation and feeding into annual AWP processes was carried out.

"I never thought my voice could make a difference in my community, as I have never been part of decision making in the community, but now that I am part of CHC leadership I was able to give a suggestion on what activity we should include in the work plan and it was accepted. I feel empowered now"

– Female CHC member, Nigeria

These activities were met with important **challenges**, however. For example, in Ghana, female CHC members faced challenges gaining support from their male counterparts, and gendered ideas about women's lesser capacities for decision making impeded women CHC members' ability to participate and lead. In response, the project organised specific training for women CHC members to further build their leadership capacities and focused on building their specific expertise on MNCH/SRHR. Additionally, in Senegal, the project encountered a series of difficulties when the government removed women's participation quotas when the national CHC mandate was updated (see Box on the Importance of Quotas in the Results section). Finally, in many contexts where CHCs were already established with a fixed tenure spanning the life of the project, changing the gendered profile of these committees posed an issue. In such cases the project worked to strengthen women's participation and create a more enabling environment for future participation of women.

Engaging Women Leaders

Recognizing that every community, everywhere has locally recognized or formalized women influencers and leaders, SHOW engaged female community, religious, and traditional leaders at various stages and in a range of activities of the project. Female leaders were engaged in SBCC activities, were included to participate in women's support groups, and were engaged to support adolescent activities. Female leaders were also targeted by the project approaches and activities intended to reach male religious and traditional leaders (these approaches are discussed in detail in Section 3.2.2). Specific materials to guide project actors on the engagement of female leaders were not developed and the resources developed for the engagement of religious and traditional leaders on male engagement in MNCH and SRHR were the main materials guiding female leaders' engagement.

In Ghana and Nigeria, Plan International leveraged existing **female leadership networks**, the Queen Mothers and the 100 Women Groups respectively, to partner with the project and support the achievement of project objectives. This partnership was more extensive in Nigeria. The 100 Women Groups were a key partner for SBCC activities targeting women and other community members, and they were the key project partner for the facilitation of women's support group activities with adult women (see the box on 100 Women Groups). In Ghana, Queen Mothers and Magajias[53] were included in many key SBCC activities to promote gender equality and women and girl's health. The Queen Mothers and Magajias were also sometimes invited to participate and/or support the activities of Mothers Support Groups and the Adolescent Groups. In both Nigeria and Ghana, the partnership between SHOW and prominent female leadership networks were a positive asset. Additionally, both the 100 Women Groups and the Queen Mothers and Magajias were frequently consulted by Plan International to understand where the project was encountering challenges and where improvements could be made. In Bangladesh, similarly, Change-maker Groups comprising of both male and female local influencers were established that included a range of female stakeholders such as teachers, wives of religious leaders (imams) and women councillors etc. for the objective of promoting gender equality and the health rights of women and girls.

In Ghana and Haiti, additional female community leaders were created in consultation with women and men in communities through community identified

53. *Queen Mothers are formal female leaders recognized in the Akan and Krobo traditions, in the Southern regions of Ghana. Magajias are formal female leaders recognized in the Northern Regions of Ghana. While Queen Mothers obtain their position through family ties, whereas Magajias are elected to this position as a result of their contributions to community life by other women living in that same community.*

selection criteria. **Community role models**, or "Gender Equality Champions", from project communities were selected and engaged by Plan International to participate in sharing key messages with their peers. In Ghana, community role models consisted of male and female volunteers from each community who partnered with the project to share key messaging with their peers. Female volunteers where tasked with raising awareness on gender equality amongst women from their communities. As "Gender Equality Champions", these volunteers were provided training on key messaging, on gender equality promotion, GBV, CEFM and on leading behavior change. In Haiti, community leaders and CHWs agreed on criteria[54] by which to select women and men from the support groups in each community who had best demonstrated the project's key messages. These men and women were recognized as "Champions of Change" in community-level ceremonies, which were used as opportunities to reinforce key messaging and to motivate the awarded Champions.

Summary of implementation steps

- Mapping of existing and potential women influencers/leaders in communities
- Onboarding dialogue with existing women influencers communicating the project's gender equality objectives and the role they could play with respect to the various activities of the project
- Community selection of potential women leaders based on self-established criteria
- Training and handing of project materials such as IEC
- Supporting ongoing outreach carried out by women influencers and leaders
- Learning documentation and feeding into year on year AWPs.

Working with Queen Mothers and Magajias in Ghana

Recognizing the existing community power that Queen Mothers and Magajias have in Ghanaian communities, Plan International had ensured their inclusion in key SHOW project activities. Queen Mothers and Magajias were active supporters of VSLA groups and adolescent peer education groups. Queen Mothers and Magajias provided support to peer educators to set up their groups and established mentor relationships with adolescent girls and with adolescent peer educators. For example, during the "Evening with Adolescent" community mobilizations, Queen Mothers and Magajias were very frequent participants, listening to adolescents voice their concerns and discussing possible solutions with them. Queen Mothers and Magajias were also highly involved in the Mothers Support Groups and the Grannies Clubs; some clubs were led by women who are Queen Mothers or Magajias, and in other clubs, Queen Mothers and Magajias were participants. Queen Mothers and Magajias were a key project partner for SHOW Ghana and took on the responsibility to educate other women and adolescent girls on MNCH, SRHR, and gender equality, with SBCC support from the project. Given their local influence in broader community decision-making, they also engaged with traditional Chiefs in Ghana for the promotion of gender equality, women's leadership in public life and the health rights of women and girls.

54. *The criteria for the selection of women and men as champions include: participation in Mothers/Fathers' Clubs, level of retention and understanding of information shared in club meetings, leadership capacity to share what has been learned with other women or men, uptake of health or gender equality behaviors promoted in clubs, and level of motivation and capacity to share information and learnings with others.*

100 Women Groups and SHOW in Nigeria, an Essential Partnership

Leveraging the existing 100 Women Group structure in Nigeria was instrumental to implementing several activities for SHOW Nigeria, including women's' support groups, engaging traditional leaders, and sharing key messages to inspire behavior change in communities. The 100 Women Groups are a coalition building process that brings together non-governmental organizations, community-based organization and faith-based organizations through networking to identify health and other development issues within their communities through participatory dialogues and to identify strategies to address them. Through this approach, Plan International was able to leverage the existing leadership of women belonging to the 100 Women Groups to support the empowerment of marginalized women and girls.

Plan International identified key members of the 100 Women Group structure in project areas that could be trained in the project's key messages on MNCH/SRHR, gender equality, early marriage, and male engagement in MNCH/SRHR. The 100 Women Groups then delivered this information through a courtyard session methodology, community outreach events and household visits, and to advocate to gatekeepers to improve the condition and position of women and girls. The 100 Women Groups in some communities also began mentoring adolescent girls and used courtyard sessions to share information specifically with married adolescent girls and first-time mothers, who often face greater challenges obtaining key information on MNCH/SRH.

The 100 Women Groups were heavily involved in many project activities. Their activities contributed to increases in women and girls' decision making in their homes, they were able to refer women experiencing danger signs to health facilities and facilitated discussions between women and their husbands on using family planning. The 100 Women Groups also had a positive influence on men's behavior change, despite this not being their key objective: during field visits, project staff noted that men were including their partners in decision making, had reduced the frequency of intimate partner conflicts, and had taken up household chores as a result of the 100 Women Groups' work.

The recognized leadership of the 100 Women Groups was also leveraged to reach family members of married adolescent girls to promote their access to essential health services. And as a project partner, the national and State-level representatives of the 100 Women Groups were involved and consulted for a number of other project activities and were involved in project governance mechanisms such as the Project Steering Committee and Technical Advisory Group.

A drawing of a courtyard session included in the training manual for 100 Women Group members.

3.2 MALE ENGAGEMENT

This section provides a description and analysis of the activities designed and implemented by the SHOW project to contribute to the second pillar of the Gender Equality Strategy: Engagement of men and boys. The first section explores the original design of activity streams to support this pillar of the strategy, exploring some of the country-specific design elements. The following section examines highlights and challenges during the implementation of the activity streams, and some of the strategic shifts that had to be made over the course of implementation.

Plan International defines "male engagement" in MNCH/SRHR (also referred to as "men's engagement" or "male involvement") as "**men taking an active role in protecting and promoting the health and wellbeing of their partners and children.**" This definition is premised on a vision of lasting and sustainable attitudinal, behavioural and relational change between partners. It views male engagement **as a broader concept rather than a list of actions or decisions in which men should participate** in the MNCH/SRH continuum of care. It encompasses:

- Men's **subjective experiences, motivations, relationships and active participation** rather than specific actions as indicative of engagement.
- Focuses on **men's agency and relationships as distinct from male participation** or involvement, which can be understood to be more passive.

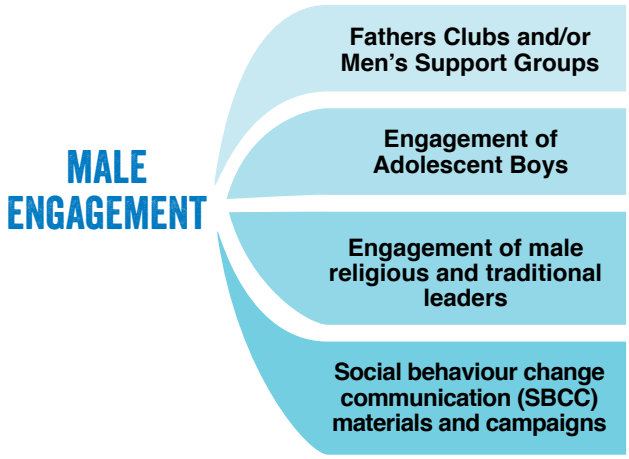
3.2.1 DESIGN

The male engagement pillar of the Gender Equality Strategy was expressly designed to create an enabling environment for women's and girls' agency by responding to the gender equality assessment findings and the important role of male partners, community members and leaders in the achievement of improved agency, gender equality and health outcomes for women and girls. To support the design of these streams and ensure high technical quality, Plan International Canada took a unique approach by engaging in a partnership with the globally recognized experts on male engagement for gender equality, Promundo US[55]. By way of a partnership agreement, Promundo provided inputs in the identification of activity streams and initial design and was central to implementation providing technical support throughout the project (see Section 3.2.2 Implementation below).

55. *Promundo US is now known as Equimundo: Center for Masculinities and Social Justice (https://www.equimundo.org/).*

Activities in this pillar had the triple objectives of addressing **low levels of awareness** amongst men and male partners on MNCH/SRHR-related issues; challenging **unequal power dynamics and decision making** at the household level that subordinate women and girls; and shifting **social norms and practice** at the community level amongst male leaders and community members to create space for women and girls' community engagements.

At the community level, four main activity streams contribute to the objectives of the male engagement pillar:



These activity streams targeted men and boys at multiple levels: within the household, across the community, and amongst community leadership. These interventions were designed to use MNCH/SRHR as the entry-point for male engagement and used an incremental approach to move from reflections, education and awareness-raising, to broader promotion of gender equality messages. In tandem with the community and household level engagement of men and boys, an activity stream to foster the engagement of men as a component of gender-responsive MNCH/SRH service delivery was implemented by building the capacity of facility based and community based health providers to leverage men's role in the MNCH/SRHR continuum of care. A key process in the project design was to ensure that these common objectives and activity streams were designed for success in each of the five SHOW countries. The following provides a description of each activity stream and some selected examples of how activity design was adjusted to respond to individual country contexts.

SHOW Project Implementation Plan: Promundo Deliverables

The strategic partnership established with Promundo for the SHOW project ran the duration of the project and can be summarized as three key categories of support:

Development of Materials	• Strategy on male engagement • Curriculum on male engagement based on Promundo's Program P • Guidance note on working with religious and traditional leaders • Strategy on advocating for Men's Engagement in MNCH/SRHR • Guidance note on working with health providers to promote gender responsive health services • Guidance note on Male Engagement SBCC
Implementation Support	• In-field training of trainers in five SHOW countries for Fathers Club/Men's Group facilitators • Technical assistance (TA) to develop health provider training • TA to develop SBCC messaging • TA to develop Canadian public engagement messaging • In-field refresher trainings in five countries
Monitoring, Evaluation and Learning	• Facilitate cross-country learning and sharing on male engagement in MNCH/SRHR • TA for monitoring and evaluating male engagement programming • Facilitate the publication and dissemination of research and lessons learned

Fathers Clubs/Men's Support Groups

This activity stream was the cornerstone of the male engagement pillar and involved the establishment of male support groups or clubs composed of male partners of women of reproductive age, referred to as Daddies Clubs in Ghana, Husbands Schools in Senegal, and Fathers Clubs in Haiti, Nigeria and Bangladesh. These groups were designed to engage men in regular and periodic group sessions based on a curriculum that would "include key messages and activities to promote critical reflection and dialogue on men's role in MNCH, family planning, caregiving and gender equality and more equitable relationships"[56]. Key messages included education on gender equality, MNCH/SRHR, ASRHR, CEFM, GBV and harmful traditional practices, promotion of women's decision making and increased men's participation in MNCH/SRH.

Although this activity stream was designed with a high degree of consistency across all five countries in the SHOW Project, key steps[57] were built into the design of this activity stream to allow for the modality and the content to be contextualized and responsive to the local population as following:

- ✓ The formation or identification of groups should first explore what existing men's groups or social gatherings of men could be mobilized to participate.
- ✓ Local leaders should be engaged to form and facilitate the men's groups.
- ✓ Groups themselves should establish their objectives, the timing and frequency of their meetings, group norms, etc.
- ✓ The curriculum would be developed by Promundo based on Promundo's Program P model, and would serve as a template for contextual adaptation in all five countries.

56. SHOW PIP Annex G: Promundo Deliverables and Timelines

57. SHOW PIP Annex H: Consolidated GE Strategy

In addition to these steps which afforded the opportunity for contextualization throughout the implementation process, there were also some minor differences in the initial design of this activity stream:

- Selection of facilitators for the male clubs varied between countries. In Haiti and Bangladesh, the clubs were facilitated by male Community Health Workers, whereas in Nigeria, male champions and community leaders facilitated the clubs and Plan International staff led the Husbands Schools in Senegal. In Ghana's Daddies Clubs, a member amongst the group was chosen by the group itself to be trained and facilitate the sessions.
- The scope and size of the activity stream varied greatly across SHOW's five countries. Using the targets identified at the PIP for the output indicator # of role models and adolescent peer educators trained on male engagement, Haiti's intervention targeted 120 trainees, whereas the other four SHOW countries were closer to 1000, with Bangladesh occupying the largest scale (1392 trainees targeted)[58].
- Some communities and Plan International Country Offices had previous experience with engaging fathers and male partners in MNCH programming, and so the design of this activity stream took the approach of adapting those familiar models and building on that knowledge base. Daddies Clubs in Ghana had been previously implemented in the Plan International Canada supported five-country Women and Their Children's Health (WATCH) project, and the UNFPA Husband's Schools model had been delivered in selected communities in Senegal covered by the SHOW project.

This core component of the male engagement pillar of the GES was also designed to overlap and support the other activity streams designed. For example, many of the participants in the Fathers Clubs would also be members of the Change Makers groups in Bangladesh and GE Champions in Ghana; the CHWs facilitating the Fathers Clubs in Bangladesh would also be doing household visits using SBCC materials on male engagement, and male members of the Fathers Clubs in Nigeria would also be receiving messages through presentations and counsel from their local Imams engaged and mobilized through the project.

58. *SHOW PIP Annexes C: PMF*

Engagement of Adolescent Boys

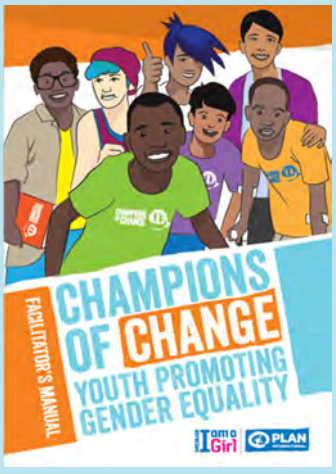
The engagement of adolescent boys was designed in recognition that: adolescent boys are at a different stage of development, in the age cohort of 15–19 years; may or may not already be fathers; are less likely to be fully economically independent; and require a different approach that considers their status as children while appreciating the role they nevertheless play and will play in the health related decisions of women and girls. The objectives with this group remained the same as adult men: to address their low levels of awareness related to reproductive health, to promote more equal and non-violent relationships with women and girls, and to challenge harmful social norms that limit women's and girls' agency and promote gender inequalities.

Integration of ASRHR considerations within the male engagement pillar was reflected in two ways:

- ✓ By including ASRHR as a topic to be addressed across male engagement activities, including work with religious and traditional leaders, influential older women's groups (Grannies Clubs, 100 Women Groups);
- ✓ By directly targeting adolescent boys through peer education and support groups[59]

59. *SHOW PIP Report: Consolidated*

Engagement activities and content were guided by existing national guidelines and policies related to ASRHR and were primarily integrated through support to or establishment of male adolescent and youth groups. In addition, this activity stream was unique within the male engagement pillar as it was not directly supported by the Promundo partnership because Plan International already had a strong and tested methodology and materials for adolescent male engagement in its Champions of Change program. Champions of Change is



Plan International's Champions of Change program for boys is a journey that guides adolescent boys through the process of self-reflection, recognition of male privilege, understanding and commitment to gender equality, exploring healthy relationships, and becoming community advocates for change. As Champions of Change they encourage their peers to challenge harmful gender norms, roles and stereotypes.

a gender-synchronized program with unique curricula for adolescent girls and boys that focuses on gender equality, non-violent relationships, girls' empowerment and positive masculinities. The boys' curriculum was designed first and provides a strong foundation for adolescent male engagement activities.

Integration in each country's PIP of engagement with adolescent boys was determined by those opportunities already embedded in the project design, the availability of a national policy or guidelines for ASRHR, and the budget considerations for additional activities. While the integration of adolescent responsiveness was very universal within the design of activities contributing to the strengthening of service delivery (see Section 3.3), the demand-side activities for engagement with adolescent boys was more diverse across the five SHOW country projects, for example:

- SHOW Haiti applied the full Champions of Change approach in its design, with mixed-sex youth groups being established across the targeted area. Structured sessions were planned according to the Champions' of Change curriculum, membership included in and out of school youth, and the support of an action plan for peer-to-peer dissemination and education after completion of the curriculum.
- Senegal planned to use existing Education a la vie Familiale (EVF) Clubs and adapt the Ministry of Health peer education guidelines, adopting key elements from the Champions of Change curriculum as needed. The PIP GE Strategy details the mobilization plans involving collaborating with the local school system, including Technical and Vocational Education and Training (TVET) and college institutions, to create linkages with existing adolescent clubs.
- Nigeria's adolescent boys' engagement activity included liaising with existing youth groups at school and in the community, training peer educators on "gender equality, adolescent reproductive health, CEFM and men's participation in MNCH based on national education material"[60], provision of adolescent friendly materials and messaging, and support for quarterly peer education sessions.
- While the design of adolescent boys' engagement activities in terms of group formation and usage of existing nationally approved materials was different across countries, common to all countries was the integration of key modules of Plan International's Champions of Change content pertaining to new masculinities and gender equality that required review, adaptation and expansion on content in existing materials.

60. *SHOW PIP Nigeria Annex H: GE Strategy*

Engagement of Male Religious and Traditional Leaders

The third activity stream in the male engagement pillar addressed the community level barriers to gender equality and women's and girls' empowerment by engaging leaders in order to generate support and buy-in, and also to invite them to act as advocates and change agents for gender equality. Support from Promundo for this activity stream involved the development of a guidance document on best practices to working with religious and traditional leaders to promote male engagement in reproductive, maternal, newborn and child health (RMNCH). The document incorporates lessons learned by Promundo, Plan International and its partners in working with religious and traditional leaders, including key messaging and tips for facilitators."[61]

This activity stream specifically targeted male religious and traditional leaders across countries and focused strongly on promoting increased decision making for women and increased awareness of and support from male partners in MNCH/SRHR. Aligned with the project's rights-based approach and using the socio-ecological model outlined above (see Section 2 on the Theory of Change), this activity stream addressed the social norms at the community level to create an enabling environment for positive and supportive male engagement in MNCH/SRHR.

A consistent yet flexible approach was designed across the five countries that allowed each country to adjust and respond to specific contextual factors such as acceptability of messaging. This approach involved:

- ✓ The identification of relevant power holders and change agents within the community;
- ✓ Their engagement and education on the purpose and scope of the SHOW project;
- ✓ Training on male engagement in MNCH/SRHR, gender equality, CEFM, GBV, and harmful traditional practices;
- ✓ Provision of materials and support for cascading of messages within their communities.

61. *SHOW PIP Promundo Timelines and Deliverables*

In addition to these steps which afforded the opportunity for contextualization throughout the implementation process, there were also some minor differences in the initial design of this activity stream:

- The targeting of leaders, even at the initial design stage, varied between countries based on the situation analyses, consultation with stakeholders and experience in the community. In several of the SHOW countries, religious leaders and institutions are extremely powerful and play a more significant role in setting and maintaining social norms, providing guidance and advice to families, and as gate-keepers to change. For example, the Sultanate Council and Fulani Association Sokoto, Nigeria are specifically mentioned as important stakeholders through which community traditional and religious leaders should be identified.
- The content of the messaging includes several distinct focuses across the five countries that respond to issues related to MNCH/SRHR relevant to their context. For example, female genital mutilation or 'cutting' is explicitly mentioned as a topic for leadership engagement in Senegal, 'child spacing' (family planning) and 'delay of marriage' (CEFM) are included as a topical focus in Nigeria and Bangladesh, and Haiti explicitly included gender-based violence as a topic focus for community leaders.

In Sokoto, Nigeria, early and frequent pregnancies are a considerable health challenge for women, especially adolescent girls. This is associated with high rates of CEFM. However, the terms 'contraception' and 'family planning' were found by project staff to be less acceptable within communities, and therefore the term 'child spacing' was adopted to refer to modern family planning practices.

SBCC Materials Development and Campaigns

Male engagement in MNCH/SRHR was integrated into the broader SBCC strategy for the SHOW project by taking two approaches: directly targeting men and boys in SBCC, and, including male engagement and gender equality messaging in the SBCC content targeting other stakeholders. This activity stream responds to the universal low level of awareness found amongst both WRA and their male partners regarding MNCH/SRHR, male support and gender equality (see Situation Analysis Results in Section 1) and therefore is a prominent activity stream in the first pillar of the GES (see Section 3.1.1).

This activity stream was one of the more participatory and ambitious activity streams, including consultation with a very wide variety of stakeholders from government officials and frontline health workers to male and female adolescents and community members in materials review and development. The plan to review and develop materials included everything from job aids for CHWs to posters and murals, radio scripts, theatre for development scripts and SMS messaging. Support for the integration of male engagement was included in the deliverables for Promundo through the development of a Guidance Note on SBCC and Male Engagement, highlighting "Promundo's lessons learned in developing different media (social media, SMS, street theater, radio, video, posters) as part of the MenCare Global Campaign" as well as a review of SBCC materials.[62]

A consistent yet flexible approach was designed across the five countries which allowed each country to adjust and respond to specific contextual factors. This approach involved:

- ✓ Existing SBCC materials and messages should be reviewed for content on male engagement and gender equality;
- ✓ New materials should be developed and/or existing materials should be adjusted to ensure male engagement and positive masculinities was included;

62. *SHOW PIP Annex G: Promundo Deliverables and Timelines*

- ✓ Direct dissemination of SBCC and mobilization through community engagement activities and meetings;
- ✓ Broader dissemination of SBCC campaigns through local, regional and national platforms.

As with other activity streams, there were some minor but key differences in the initial design of this activity stream:

- While extensive consultation was universal across all country project designs, the process of review of existing SBCC materials and development looked slightly different in each country in terms of facilitation and support. For example, materials were to be reviewed and developed in a participatory workshop in Senegal, facilitated by a National Senegal Health Education Service expert, whereas an external consultant was to be hired in Haiti to develop materials and organize consultations with key stakeholders, and in Bangladesh the Plan project team would collaborate with partners to develop content and hold consultations[63]. Each of these processes was designed with the view of ensuring multi-stakeholder buy-in and ownership and not reinventing the wheel by leveraging existing materials.
- The types of materials and delivery modality outlined in this activity stream varied between countries, depending on contextual factors such as connectivity, existing communications, literacy levels and population density. For example, radio and SMS messaging in Hausa and English would be delivered in Nigeria with a focus on promoting male engagement, while community theatre approach (Theatre for Development) was central to the Bangladesh SBCC strategy, and Haiti noted specific days of celebration that would be used as platforms for messaging, including World Contraception Day, International Women's Day and *Fête Patronale*, celebrated once a year by the Catholic Church in honor of Patron Saints of the community churches.

63. *SHOW PIP Reports from Ghana, Senegal, Haiti (Activity 1111)*

3.2.2 IMPLEMENTATION

Implementation of the activity streams that supported the male engagement pillar of the SHOW GES were more consistently implemented across the five project locations compared to the stream of activities pertaining to building the individual and collective agency of women and girls. As noted, before, this was because the approach was considered more innovative and newer in the five countries, particularly in terms of the intensity and depth of gender transformative change inherent in the approach. The technical support provided through the strategic partnership with Promundo enabled the implementation of these activities to achieve a high level of success, even while periodic adjustments and pivots were made to respond to challenges.

Fathers Clubs and Men's Support Groups

The implementation of the men's support groups (or Fathers Clubs) was launched consistently across the five project countries, beginning with key preparatory and development steps. The initial stage of implementation for this activity stream was the development of a detailed step-by-step Guidance on Male Engagement that outlined good practice in the formation of men's groups, recruitment of men, conduct of group sessions, facilitation, retention, learning and behaviour change objectives, inherent risks and monitoring of groups by Promundo; followed by the development of the Fathers Clubs Manual, based on Promundo's Program P. The **development of the manual** was coordinated by Plan International, that provided the key technical inputs on the priority health-related and gender equality content to align with the SHOW project objectives. The content and approach were informed by a review of the Gender Equality Assessments from each SHOW country, Promundo's extensive experience in male engagement programming, and the SHOW Theory of Change. It was intended for use by a variety of stakeholders including health workers, social activists, non-profit organizations, educators and others, with the aim to "promote men's involvement as caregivers as one of the multiple strategies to promote maternal and child health, family well-being and gender equality".[64]

64. *SHOW Consolidated Year 2 Mid-Year Report, page 34 (https://men-care.org/wp-conten)*

The manual was a core document that was adapted to various contexts and responsive to the specific findings of the GE Assessment in each country. The next step of implementation was therefore the **contextualization** by each country project team of the content in the manual. While minimal changes were anticipated, country teams made some adjustments to ensure the content would resonate with participants. For example, a session that addresses stereotypes in the manual was adjusted in each country to ensure that the local idioms and vernacular were reflected. The Nigeria project team integrated examples from Sokoto, and both Bangladesh and Nigeria manuals were contextualized to remove images of or reference to the consumption of alcohol and translated to Bangla and Hausa languages respectively.

SHOW Fathers Club Manual cover page in Bangla

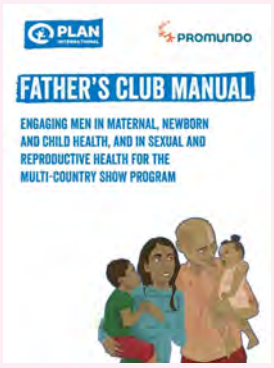
Fathers Club Manual

The Fathers Club Manual uses MNCH/SRHR as an entry point to invite male participants to explore their own ideas of gender, to examine the gendered dynamics within their own households and community and recognize its detrimental effect on their own and women's and children's health. It also encourages men to commit to a more equal, non-violent and supportive relationship with the women and girls in their lives. "The curriculum takes a gender-transformative approach, by engaging participants in actively questioning what it means to be a man or a woman in society and in challenging inequitable gender norms and power imbalances. The sessions are designed to promote critical reflection and dialogue through active participation in activities and discussions guided by a trained facilitator. The aim of such discussions is to promote long-term changes in gender relations and power dynamics, which can improve men's relations with their partners and their children well beyond the perinatal period."[65]

The curriculum is organized into 6 thematic areas:

1. Welcome
2. The Unpaid Care Divide
3. Men, Gender and Power
4. Pregnancy, Delivery and Beyond
5. Relationships
6. Planning for the Future

Within each of these thematic areas, a set of participatory activities and opportunities for homework and reflection are provided for male participants. A total of 20 activities and 16 homework/reflection assignments are included in the manual, including handouts they can share with their partners. While the manual included more general content on gender equality, it was strongly aligned with the SHOW GES objectives by exploring inequality through different stages and elements of the MNCH continuum of care and decisions around building and caring for a family. For example, participants are guided through how they can be involved and supportive in the delivery room and encouraged to recognize themselves as equal partners in the process of preparing for delivery, supporting the delivery, and post-delivery mother and childcare.



Page from the Fathers' Club Manual on Skin-to-Skin Contact

65. *SHOW Consolidated Year 2 Mid-Year Report, page 34*

Concurrent to the development and contextualization of the manual, each country began the process of identifying and recruiting male leaders/facilitators to be trained on the Fathers Clubs Manual and methodology: male champions in Nigeria; male CHWs in Bangladesh, project and partner staff in Ghana; CHWs in Haiti; male role models or 'model husbands' in Senegal. In Year 2 of the project, Promundo conducted **in-country training of trainers (TOT)** in each of the five SHOW countries. A significant difference between the countries was in their selection of facilitators for this activity: they ranged in background, experience and expertise. In order for Promundo to deliver an effective TOT, a series of questions were sent to each country team to gather information and support the customization of the TOT. One example of this customization was for Bangladesh, where additional sessions were reviewed that participants had indicated they were unsure about; and in Nigeria where additional time was planned to discuss intimate partner violence to respond to confusion about how to understand 'non-violence' in the context of the curriculum.[66] As part of the training of trainers, efforts were made that facilitators in all countries were trained to use various facilitation techniques such as role-playing, group discussions, debates, homework, and more to appeal to a diversity of men and different learning styles. The master trainers subsequently cascaded the training to all identified facilitators of Fathers Clubs.

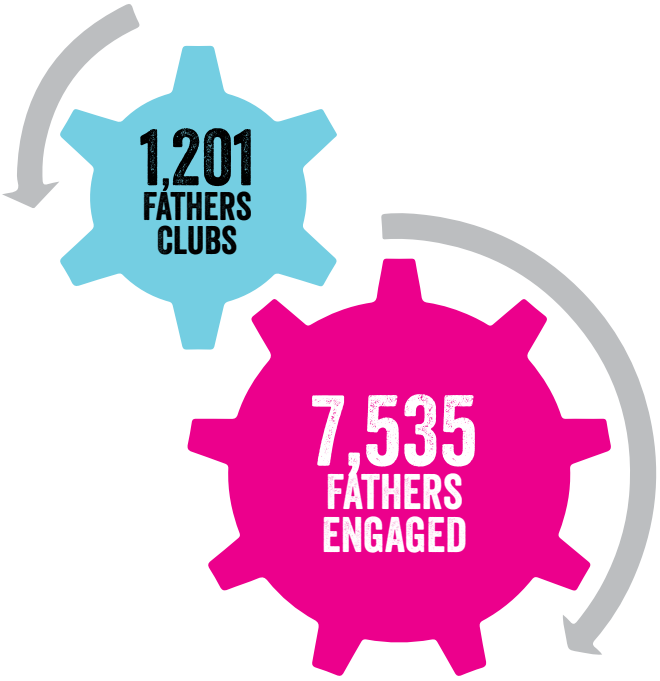
The **men's support groups were implemented** across all SHOW countries, with slight variations in the timing of activities over the course of the project, and the frequency and modality of meetings. Because Ghana had previous experience with their Daddies Clubs and required no translation of the manual, they were able to mobilize and implement slightly faster than other countries like Haiti or Bangladesh, whose teams had to arrange quality translation to Creole and Bangla, respectively. In Senegal, approval of the manual from the Ministry of Health and Social Action was slow to come and delayed sharing of the manual with the Husbands Schools as well as rolling out the volunteer Fathers Clubs until Year 4. There were also differences related to frequency and modality of meetings. In Nigeria, male champions conducted quarterly outreach meetings that conveyed the Fathers Clubs Manual messages and materials, while in Bangladesh, retention was identified as a challenge and male CHWs started targeted home visits to reach those male participants who missed sessions. In Ghana and Haiti, meetings were held monthly.

"After the training on the Fathers Clubs manual, I have gained a lot of knowledge. Men should cooperate with pregnant mothers during pregnancy, delivery and after delivery intensively. If we conduct sessions at the community level following the Fathers Clubs Manual authoritarian behavior of men will change and violence against women and child marriage will be reduced in our society. I really feel that along with us, men's group members will act as change agents in society in MNCH/ASRH and GE."

– Male CHW, Bangladesh

66. *SHOW Consolidated Year 2 Mid-Year Report, page 35*

The SHOW Project across Bangladesh, Ghana, Haiti, Nigeria, and Senegal followed a phased approach for the training of facilitators and the establishment of Fathers Clubs. Training used teach-back methodologies for trainers to strengthen facilitation skills and develop a deeper understanding of the curriculum content and process, eventually training male facilitators based in target communities in several batches. The project formed a total of **1,201 Fathers Clubs** in five countries and **7,535 Fathers**[67] went through the Fathers Clubs curriculum. These men self-selected themselves to receive the Fathers Clubs curriculum.



Some important **challenges** and **lessons learned** through the implementation of the Fathers Clubs provided an opportunity for individual projects to pivot and respond. In Ghana, project staff and Daddies Clubs facilitators found that locally designed visual aids would be more effective in communicating ideas to club participants, and they developed their own set of contextualized flash cards to support facilitators. This learning from Ghana's experience, and in response to feedback from other SHOW countries, led the broader SHOW project to develop a low-literacy, low resource version of the manual as an added component of its partnership with Promundo. The low-literacy and low resource manual employs greater usage of pictorials to convey messages as well as adds activities that do not require extensive equipment or materials. While this product was not rolled out within the SHOW project's limited time remaining, it was piloted in Nigeria in 2019. This responsive manual serves as a legacy of the project and an example of how projects can contribute to the overall learning and improvement of an organization.

While country project teams had planned for translation of the Fathers Clubs Manual to local languages, for example Bangla in Bangladesh and Creole in Haiti, the Nigeria and Ghana designs had not included a planned translation from English. One of the findings over the course of implementation was that although facilitators were fluent in English and could read and deliver the curriculum comfortably, most participants from marginalized communities did not have that level of comfort in English and facilitators were having to translate in real time. This also meant that handouts and visual supports were less easily understood by participants. In Nigeria, the translation of the Manual to Hausa took place in Y4 of the project, after Promundo's monitoring visit.

> **"Translate the manual into local language… they do facilitation in local language. Most of the facilitators are literate. They could read [but only in local language]. When we cascaded, we had to translate it into local language to allow it to be understood."**
>
> – SHOW BCC Coordinator, Nigeria

67. *Based on figures from Nigeria, Bangladesh, and Haiti only.*

Promundo Monitoring and Technical Support Visits: Year 3

As a component of their technical support for the male engagement pillar of SHOW's GES, Promundo had a mid-term in-country visit scheduled for each of the five SHOW countries. These 5-day visits had the dual objectives of providing additional technical assistance in the form of targeted capacity building sessions, and of monitoring progress, successes and challenges with the implementation of male engagement activity streams.

To prepare for these visits, a diagnostic tool was designed and delivered to key project staff and stakeholders so that the visits could be as targeted and productive as possible for each of the five SHOW countries. The tool included questions about the content and implementation of the Fathers Clubs, challenges and support needs, and status of implementation. The diagnostic tool primarily helped Promundo teams to design a refresher capacity building project to meet the specific needs of each country team. For example, in Nigeria the diagnostic tool revealed that while the health-related content was being accepted positively, messages in the manual around women's increased decision making were sensitive as a result of strict gender norms that perpetuate male leadership at the household level. In response, Promundo focused their capacity building sessions for facilitators and staff on gender transformative programming and the elements in the manual that support those kinds of changes in attitudes and behaviour.[68]

Fathers' Club Facilitator in Nigeria (above) and Bangladesh (below)

"Just last month I saw my husband post on Facebook that he made my first boy wash bowls… 'it is good to encourage our boys to help in the kitchen'. This was from somebody who was very against it…it's a big impact. He tries to support gender equality."

– LNGO Partner Staff, Ghana

"I would design the project with a focus on engaging men regarding different dimensions of engaging men, from community from institutional levels, maybe political level. Their supporting part should be ensured from family to institution. We are doing this, but the limitation is that there are huge activities and capacity development takes time. I would take 1.5 years just for design development and one quarter for testing materials and then start the project."

– SHOW staff member, Bangladesh

68. *SHOW Promundo Y3 Technical Assistance Report – NGA*

To support the monitoring component of their visit, Promundo drafted a semi-structured questionnaire that was delivered to project managers, Gender Equality Advisors and other key project staff and partners. This examined their experience and understanding of the elements of the male engagement pillar of the GES, asked them to share stories of change that they had observed within their community, and share lessons learned from implementation at mid-term. Quotes drawn from their interviews demonstrate the range of information gathered across the five SHOW countries[69].

Promundo also observed Fathers Clubs Sessions being delivered in targeted communities to gain a first-hand sense of how facilitation was being delivered and the response and participation of club members. Key findings and observations from these monitoring activities allowed them to support SHOW staff to address issues such as fidelity to the curriculum and the order of sessions, facilitation of mixed-sex sessions where it was contextually acceptable, and use of visual supports and SBCC materials.

Monitoring reports were produced for each country which included a comprehensive set of recommendations to strengthen male engagement activities in each country, with a particular focus on the Fathers Clubs activity stream. These reports were shared with country teams and the findings and recommendations were included in the project's Year 4 Annual Work planning Workshops.

"Before people used to reject all of these programs because here in our society, people are religiously dominated people. Whatever they do they want it to be in accordance with their religion. So, they will shun these programs because they think the government is just perpetuating Western ideas. But if they hear it from the religious leaders they think 'oh is that part of the Qur'an? Is that part of our Islamic tradition?' If it is part of that they will now participate in the program."

– SHOW SBCC Coordinator, Nigeria

"The most significant change in my group is: There are fathers who did not participate in household chores, but after the "Hours in Day" activity they took on the burden of domestic work for women and now are more engaged in domestic work. There are fathers who told us that their wives are now happy because they help at home. We are not sure, however, if they have discussed with their wives how to share domestic tasks."

– Fathers Clubs Leader and CHW, Haiti

"…Around equal decision-making and child marriage, the issue of age is quite sensitive. It is hard to bring up, the religious leaders are still adamant about it. In the training manual for boys and girls it is included but the Ministry of Health says issues of child marriage and equal decision-making are too sensitive and don't want us to talk about it…"

– SHOW GE Advisor, Nigeria

"[The members] think I am being paid and don't take it seriously. They think I'm being paid to say these things. They wonder why they should continue coming if I'm (as a member) am not also being paid."

– Daddies Clubs Leader, Ghana

69. All quotes from SHOW Promundo Y3 Monitoring Reports

Monitoring of Fathers Clubs sessions in Nigeria and the Husband's Schools in Senegal found that some of the messages related to women's decision making and empowerment in the curriculum were either not being delivered or the language that was being employed to encourage male support was instead adopting a tone of 'protection' or even control, inadvertently perpetuating existing gender norms and stereotypes. In the case of Nigeria, messages were paraphrased: *"We should go to the doctor to listen to what medicine she should take so we can make sure she is taking them properly" or that 'we must prevent her from lifting heavy objects."* In this way, the encouragement of male support can actually reduce the individual decision-making power of women and girls - that was pre-empted as a risk at the initial implementation planning stage.

In Senegal, due to barriers in finalizing approval of the Manual, the implementation of Husbands Schools proceeded without the gender transformative content included in the SHOW Fathers Clubs Manual, and so with the increased health-related knowledge, men began to assume a decision making role in what in some cases had previously been one of the decision making domains dominated by women such as breastfeeding. To address this, project teams in Nigeria and Senegal re-emphasized the need for supportive supervision and additional capacity building of facilitators, and in Senegal the Husbands Schools were re-engaged to introduce the key gender transformative content in the Manual once it was approved by the Ministry of Health.

Despite the differences between implementation across countries, some of which are discussed here, the Fathers Club activity stream was one of the more consistently implemented activities supporting the male engagement pillar of the SHOW GES.

SHOW Ghana illustration to accompany the Fathers' Club session on GBV

Engagement of Male Religious and Traditional Leaders

Engaging religious and traditional leaders was critical for community buy-in and lasting changes in targeted communities[70], especially change related to social norms and behaviours. The belief systems and institutions in which religious and traditional leaders are embedded strongly influence community norms and value systems – positively or negatively – particularly with regard to gender and family relations religious and traditional leaders often provide spiritual and moral guidance, but also act as gatekeepers, trusted advisors and providers of information on MNCH/SRH (and other) issues. They can therefore serve either as barriers to social change, or as strong and important allies for the transformation of community norms and practices.[71]

The foundational technical document used to support this important activity stream was similarly co-developed with Promundo as a part of the suite of technical guidance documents produced for the SHOW project. Similar to the SBCC Guidance Note (see the box on SBCC for Male Engagement), it is organized into a set of tools that guide project staff through a series of key steps for engagement:

1. Mapping Religious and Traditional Leaders;
2. Deciding which Religious and Traditional Leaders to Target;
3. Approaching Religious and Traditional Leaders;
4. Mitigating against Opposition or Backlash;
5. Training Religious and Traditional Leaders on MNCH/SRHR, Gender Equality & Male Engagement;
6. Engaging Religious and Traditional Leaders in Promoting Male Engagement in MNCH/SRHR;
7. M&E work with Religious and Traditional Leaders;
8. Long-term Engagement with Religious and Traditional Leaders.

70. *SHOW Consolidated Year 2 Mid-Year Report, page 24*
71. *SHOW Guidance Note: Working with Religious and Traditional Leaders to Promote Male Engagement in MNCH/SRH, page 2*

The tool is an insightful and practical guidance that addresses the inherent challenges, risks, and associated importance of engaging these leaders in gender equality:

> **"Religious leaders in particular need to be provided equitable alternatives to support them in contextualizing their beliefs and challenging harmful practices. This includes working with them to promote positive interpretations of spiritual, faith and religious values, which support gender justice and equality. Tools that ground MNCH/SRH and gender equality within religious texts are particularly useful, since religious doctrine is often used to justify inequitable gendered power dynamics within communities."**
>
> – SHOW Guidance Note: Working with Religious and Traditional Leaders to Promote Male Engagement

The guidance provides worksheets for key steps, suggested adaptations of Fathers Club activities for religious and traditional leaders, and an extensive list of additional resources that can be accessed for support.

Religious and traditional leaders were engaged at the very beginning of the project and provided a project orientation session to introduce them to the project and garner support, usually a 1-day session. Religious and traditional leaders overlapped with other project activities, for example they were often members or facilitators of the Fathers Clubs or Husbands Schools, or they supported adolescent groups and were involved in local community governance mechanisms such as CHCs. In Bangladesh, for example religious and traditional leaders were members of the project's 'Change Makers' groups, which consisted of both female and male community leaders and were composed of local elites, elected officials, social workers and traditional healers. In Ghana, these leaders consisted of religious leaders (Pastors and Imams), traditional and community leaders (Herbalists, TBAs, queen mothers, chiefs and elders). Most leaders identified and mobilized in each country were male, and like much of the messaging within this pillar, the project used health as an entry point for transformative messaging about gender equality and women's and girls' empowerment.

While no specific challenges such as backlash or resistance from religious and traditional leaders was recorded during SHOWs implementation across any of the countries, a few notable lessons have been learned that contributed to the smooth implementation of this pillar of activities including: 1) **Extensive and systematic ground work has to be carried out in terms of understanding core religious and traditional beliefs and values prior to engaging with these stakeholders.** This is important to ensure acceptability and productive engagement from the onset and helps eliminate any potential threat perceptions by these stakeholders. More sensitive topics such as GBV, gender power relationships need to be introduced gradually. 2) **Reflective and participatory capacity building and support to these stakeholders in embracing and imparting gender equality concepts is key and has to be built into the engagement process.** This approach recognizes that religious and traditional leaders are part of and gatekeepers of patriarchal structures that need to be deconstructed before they can be mobilized for public outreach and underscores the importance of co-creation of content and messaging that aligns with their belief systems. 3) Inadvertent reinforcement of their existing power is a real risk that needs to be effectively recognized and mitigated throughout the process of engaging with religious and traditional leaders as they carry out public outreach. A key mechanism is to facilitate periodic gender synchronized dialogue between these stakeholders and women's and adolescent's groups at the grass roots level. The mechanism leveraged by the project was the quarterly community reflection sessions and dialogues that brought all stakeholders together on an equal footing and created the enabling space for all voices to be heard, particularly through the active participation of women's support groups across project countries. This dialogue process required vigilant and purposeful facilitation by Plan International and partner staff on an ongoing basis including in terms of logistical arrangements such as venue, timing and seating arrangements.

Working with Religious Leaders in Nigeria

Plan International worked extensively with religious leaders in Sokoto State, Nigeria to co-create guidance for other religious leaders on MNCH, SRHR, and gender equality. Plan International, using a layered approach, convened a workshop with the senior hierarchy of male and female religious leaders from different schools of Islamic thought and sects selected from across Sokoto State to discuss MNCH, SRHR, and gender equality. Through this workshop, religious leaders were engaged to cascade the project's key messaging with community level religious leaders and also committed to sharing these messages with men and women in their communities. From these discussions, a Sokoto based leading religious scholar and Plan International co-created a gender integrated manual on "Islamic Perspectives on MNCH Issues" to provide additional guidance for Islamic leaders throughout Sokoto State on MNCH.

The manual provides information on MNCH and gender equality, as well as evidence from the SHOW project, and discusses how gender equality in MNCH/SRH is compatible with Islamic teachings. The manual makes reference to Quranic passages that emphasize equality between men and women. The manual is divided in 8 sections:

1. Islamic perspectives on maternal and child health issues.
2. The courageous husband is he who guarantees all the rights of his wife.
3. Care for a woman in the MNCH continuum of care.
4. Women's status before Islam.
5. Islamic position on consulting women in decision making in the family.
6. Prohibition of harsh measures depriving a woman of her rights.
7. Proper medication.
8. Child spacing.

The manual was endorsed and validated by religious leaders from different Islamic sects during a special workshop; the manual was also endorsed by the State Ministry of Health, the State Ministry of Women and Children Affairs, the State Ministry of Religious

Representatives from Sokoto Sultanate and the Ministry of Health at the launch event

Affairs, and the Sokoto State Primary Health Care Development Agency. A launch event organized in cooperation with the Sokoto Sultanate Council and the State Commissioner of Health was organized to recognize the efforts of religious leaders who contributed to the manual, and to publicise the manual with other religious leaders.

This manual was used by several religious leaders who partnered with SHOW in their community activities. Religious leaders used the manual to inform their weekly Friday sermons in mosques, and to include gender equality messages in their sermons, for example, on the importance of child spacing and on male engagement. Religious leaders also used the manual to share messaging on MNCH, SRHR and gender equality during radio shows and community events.

"In the mosque, my followers (men) and I discuss freely on disputes they have with their wives regarding child spacing and antenatal care. I encourage them to discuss and plan child spacing with their wives and take a keen interest in their health."

– Religious leader, Nigeria

SBCC materials development and campaigns

As discussed in Section 3.1 on the Women's and Girls' Empowerment pillar of the GES, SBCC was a central activity stream supporting the achievement of transformative change in the SHOW project. The SBCC activity stream employed a variety of approaches across the five SHOW countries, depending on the preferred, tested and available modes of communication best suited to reach target populations: women of reproductive age, men and adolescents. There were some targeted materials developed to exclusively be delivered to men and boys (The Fathers' Club Manual), however most of the SBCC materials developed in the SHOW project were consumed more broadly by male and female community members of different ages, and therefore took an integrated approach to health and gender equality messaging.

In order to support effective integration of male engagement messaging, a component of the Promundo partnership was the development of the guidance note specifically on effective SBCC messaging for engaging men. This guidance note was developed as a 'succinct', 'go-to' guide to support the implementation of the SBCC activity stream, including the development of individual country's SBCC strategies, the review of existing materials, the development of new materials, and the delivery of messaging. In addition to the development of this guidance note, Promundo was also engaged to review SBCC materials from a male engagement perspective to strengthen messaging, provide input and ideas, and to ensure that messages and materials were not inadvertently reinforcing harmful gender norms and stereotypes.

The project's approach to SBCC on male engagement was to include relevant messaging, based on the guidance note summarized below, in the broader collections of SBCC materials, and address issues such as male support for MNCH/SRH, joint decision making and GBV through messaging to a wider community audience. For example, in Ghana, a poster series was designed specifically to combat intimate partner violence,

including sexual violence and psychological violence, which would target the broader community and include information for victim support. In Haiti, a series of image boxes or 'flash cards' were created for use in Mothers' Groups, during household visits, and in community discussions. In Nigeria, messages were also sent using SMS messaging, specifically to Male Champions and religious and traditional leaders. Content included basic health information related to MNCH/SRH, but also male support and engagement as well as broader gender equality messaging.

"Thanks to the radio program hosted by Al Fayda FM on child marriage, I became aware of the consequences incurred by adolescent girls who marry before the age of 18. I asked my classmates to follow the program and since that day, we have not missed any."

– 17-year-old from Senegal
(as interviewed by project staff)

In addition to printed materials and written messages, storytelling in various modalities was used in several countries. In Nigeria and Senegal, radio programming series were used to reach male adolescents and women of a reproductive age and adult men. In Nigeria adolescent spokespersons were also invited in radio talk shows to discuss SRHR issues. In response to midterm evaluation findings that highlighted persistent gaps in male knowledge of danger signs, the Nigeria team developed new radio jingles to specifically target male knowledge and engagement in MNCH/SRHR.

The Bangladesh SBCC strategy included the Theatre for Development approach to story-telling (see the box on Theatre for Development), and the development of a series of 16 videos (click here to access all videos) that could be shown in mothers and fathers groups and information sessions within the community. One video has male engagement in MNCH/SRHR as its specific focus, and many of the other scripts include content that examines male engagement and how gender roles affect men and relationships. In Ghana, documentaries on adult male and female role models and adolescent male and female role models were produced for each district. In the fourth year of the project, partners in collaboration with the Ghana Health Service and community support groups screened the documentaries in all 480 SHOW communities.

Male Engagement SBCC Materials

A poster series in Ghana focuses on intimate partner violence

Image boxes in Haiti integrate GBV messages throughout MNCH learning materials

Bangladesh video clips include male engagement messages throughout a 16-clip series on MNCH/SRHR.

Flashcards and support materials for group sessions in Senegal examine gender roles and health

Good Practice in SBCC Development for Male Engagement – An Evidenced-Based Guide

Within MNCH/SRHR projects, male engagement SBCC messages can primarily serve to promote men's increased participation in MNCH/SRHR at the **individual level**, while also working to shift **broader social and gender norms** and perspectives, creating a supportive environment that promotes men as partners in health outcomes. Furthermore, SBCC can also contribute to changing **existing policies within institutions and governments**: as more and more men become engaged in MNCH/SRHR in the context of the project, this change in behaviours and norms will begin to generate momentum and demand for policies which are more inclusive of men in MNCH/SRHR.

The guidance note provides instruction on six steps for SBCC development for male engagement: 1) Examine the Evidence; 2) Pick a Priority; 3) Set a Goal; 4) Define the Messaging; 5) Deploy the Campaign; 6) Assess and Adapt. Each step is accompanied by a brief introduction, a guiding checklist, and practical examples. While the guidance is aligned with best practice in terms of SBCC development and consistent with other similar guidance notes[72], it is unique in that it shares evidence-based examples and instruction on the specific 'Do's and Don't's' of SBCC for male engagement. For example, in step 4 (Define the Messaging) some of the pitfalls and challenges of male engagement for gender equality are illustrated through examples:

DO: Stay positive: Individuals can be turned off by negativity and feel that they are being blamed rather than encouraged. This can be a common source of resistance amongst men and boys in gender transformative programming, and concrete suggestions are provided to avoid negative messaging.

DON'T: Shy away from highlighting benefits. Increased male engagement in MNCH/SRH can have mental and physical benefits for everyone: women, men, children. Highlighting these can be a motivational factor for change, or at least can often serve as a valid and welcomed entry point for a deeper exploration.

DON'T: Reinforce harmful stereotypes: Keep in mind your goal: transforming unequal power relations. It can be fun to show the "superhero dad," and sometimes that makes sense. Portraying involved fathers as saviours, heroes, protectors, or "the solution," however, can have the potential to reinforce power inequalities.

DON'T: Take an instrumentalist approach: It is important to make sure that the messages do not only ask men to act in ways that prevent harm to or improve MNCH/SRH, but also question underlying gender inequalities. Messages should actively question what it means to be a man and a woman in society and challenge inequitable gender norms and power imbalances.

Suggestions for making sure that messages go beyond an instrumentalist approach:

"Wear a condom."

Suggested change: "We took the time to learn about our options. We're planning our family together and looking forward to our future."

"Take your wife to the hospital if there are danger signs in the pregnancy."

Suggested change: "When I knew how to tell my wife's pregnancy was in danger, I took her to the hospital. Together we're making sure that our child has a safe, healthy start."

72. *For example: https://www.thecompassforsbc.org/how-to-guides/how-design-sbcc-messages; https://sbccimplementationkits.org/courses/designing-a-social-and-behavior-change-communication-strategy/*

3.3 GENDER-RESPONSIVE ANDADOLESCENT FRIENDLY MNCH/SRH SERVICES

Improving the supply and accountability of MNCH/SRH services were two expected outcomes of the SHOW project. As per the project's Gender Equality Strategy, significant efforts were made to improve the gender and adolescent responsiveness of MNCH/SRH services through an integrated approach and in close collaboration with the Government (Ministries of Health). SHOW applied similar methodologies in each country to strengthen the delivery of GRAF services. These similar approaches were guided primarily by the guidance notes developed by Plan International on Gender Responsive MNCH/SRH services and on Adolescent Friendly MNCH/SRH services which influenced all of the activities aimed at strengthening GRAF services. The guides developed by Plan International, drew on existing guidance from WHO and Promundo (particularly for the engagement of men across RMNCH services) and added content. The Gender Responsive MNCH/SRH Service Delivery guide establishes why gender is a key determinant of health outcomes by linking gender inequality to each of the social determinants of health and how gender inequality intersects with each including education level, geography, economic status etc. and can pose potent barriers in women's access to and control over health services; by demonstrably linking gender to each of the established quality of care standards; by providing a working definition of gender-responsive health service delivery and by providing detailed guidance across the MNCH/SRH continuum of care from antenatal to postnatal care and family planning as well as referrals. Similarly, the Adolescent Friendly SRHR Service Delivery guide built upon WHO standards by adding a strong gender lens to the components of accessibility, relevance, participation etc. These guides provide users with the rationale and content for both advocacy with health planners and training of health providers with practical exercises and checklists.

Unpacking gender-responsive health, particularly MNCH/SRH service delivery:

- Meets the unique and specific needs of women and adolescent girls in the organization of MNCH/SRH services as well as physical environment and infrastructure
- Upholds women's and girls' 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 and actively promotes and expands the level of men's active and equal engagement in the MNCH/SRH continuum of care as well as joint parental responsibility
- Takes into account ways in which gender issues may cause vulnerability, risk and disadvantage as an intersecting element of the social determinants of health that can affect treatment seeking and compliance with necessary treatment and care.
- Embedded in core Quality of Care standards
- Client-provider relationships are based on principles of non-discrimination, trust, respect, inclusivity and dignity

3.3.1 DESIGN

The third pillar of the SHOW Gender Equality Strategy was designed to strengthen the gender and adolescent responsiveness of MNCH/SRH services as a core element of quality of health care. In partnership with the government (Ministries of Health) in each country, activities under this pillar were designed to work with health providers, administrators and managers, with health governance structures, and within health facilities to improve the quality and availability of GRAF services. Plan International grounded this strategy in existing policies from project countries. There were three underlying goals of this pillar:

1. To build the capacity of health service providers on GRAF;
2. To strengthen the capacity of health systems planning, governance, and supervision structures to integrate GRAF approaches;
3. To refurbish the physical spaces of facilities to meet the needs of women, male partners, adolescent girls and adolescent boys.

These underlying goals fall within the larger objectives of the entire project[73]. There are several project activities that fall under intermediate outcomes which were designed to jointly contribute to health systems strengthening in project countries based on the identified needs through health facilities assessments that overall integrated a gender lens; however, not all of these activities required substantial gender equality integration.

For example, there were no gender equality components included in the design of activities focused on drugs, supplies or equipment procurement for health facilities or activities pertaining to safe waste disposal such as placenta pits had little gender equality integration.
The activities designed to achieve the goals of this pillar of the GE Strategy, and the larger project objectives, are:

1. Health facility assessment
2. Training of health providers on GRAF service delivery
3. Review of checklists and training materials with a gender and adolescent responsiveness lens
4. Supportive supervision for GRAF service delivery
5. Refurbishment of health facilities
6. Advocacy with government

73. *Intermediate Outcome 1300: Increased dissemination and use of data by project, communities, health committees, service providers, planners and decision makers*

These activities were designed to be implemented in sequence. The health facility assessment was designed to inform all of the subsequent activities and so was designed to be implemented first. Similarly, supportive supervision was designed to occur after health providers had been trained on GRAF service delivery along with all other technical trainings for quality MNCH/SRH service provision.

To support the implementation of these approaches, Plan International developed a series of guidance notes on GRAF service delivery, covering health provider training and government advocacy. The guidance notes were also intended to include male engagement as a key component of gender responsive service delivery.

For this pillar, an overall plan was developed in collaboration with government (Ministries of Health) and then adapted to meet the common and unique health system structures of the five countries where SHOW was implemented and were very similar in each country. Key differences in the designs respond to the different structures and nomenclature existing in health systems and health ministries in each country. For example, CHWs were not targeted in Nigeria as the CHW responsibilities are covered by community-based health volunteers and community-health extension workers (CHEWs). Despite such minor differences, the overall planned approaches remain similar in each country. The following provides a description of the designs for the different activities, and where adjustments were planned to respond to country contexts.

Health Facility Assessment (HFA)

As part of the project design, health facility assessments (HFA) were planned to be completed in each of the five countries. The HFAs were designed to serve as additional situation analysis tools to provide contextual information for project planning of health facility-based activities. The HFAs were planned to focus on two key areas of service delivery: **service availability** and **service readiness**:

- For **service availability**, Plan International planned to assess the physical structures of health facilities and the availability of trained health providers (such as midwives, nurses, etc.) who were deemed essential for the delivery of appropriate quality GRAF MNCH/SRH services and aspects of service utilization.
- For **service readiness**[74], Plan International planned to assess capacity of health service providers and the health facilities to deliver quality GRAF services. Two aspects of service readiness were included in the design for the HFA. First, that HFAs would look at the availability of necessary basic amenities, equipment, and medicines in health facilities. Second, the HFA was designed to assess the capacity of those providing services based on their training and what protocols and guidelines were made available to them.

It was intended that gender responsive and adolescent friendly components of service delivery would be included in the criteria and service components evaluated as part of service availability and readiness. Per the design of the project, the HFAs would then be used to tailor the other activities within this pillar to address gaps in the delivery of GRAF services. The HFA was also shared with Ministries of Health, local authorities and CHCs to support planning and encourage further investment in GRAF capacity.

74. *Specific Service readiness refers to the ability of the health facilities to offer a specific service and the capacity to provide those services through consideration of tracer items that include: trained staff, availability of treatment protocols and guidelines, specific equipment, specific medicines and commodities and specific diagnostic capacities.*

Training of Health Providers

The SHOW project focused on improving the availability and the quality of services delivered within health facilities, including referral services[75], and the third pillar of the Gender Equality Strategy was designed to improve the degree to which those services were gender responsive and adolescent friendly. Training of facility and community-based health providers on GRAF service delivery for MNCH/SRH and associated referral services was a key focus. This approach also included training those who work within the health system and are responsible for monitoring and governance, such as Community Health Committees, supervisors, and government officials.

The design of the project separated the training for CHWs, facility-based service providers and supervisors, and CHC members. While these approaches were very similar, each approach was tailored to meet the needs and mandates of each group.

The training approach for CHWs was used for training CBHV and CHEWs in Nigeria. In Senegal, the same training was provided to CHWs and CBOs, as CBOs were responsible for raising awareness on healthy practices and behaviors and CHWs were responsible for ill-health prevention. The approach for training CHWs, CBHV, CHEWs and CBOs was designed to follow these steps:

1. Review existing curriculum for CHW training with a GRAF lens;
2. Adaptation of existing or development of new training materials to include gender equality related topics such as understanding the gender-related barriers to health, SRHR, ASRHR, CEFM, GBV and male engagement to improve CHW outreach activities;
3. Development of additional job-aids on gender equality related topics specifically for CHWs, including additional counseling materials on gender equality, male engagement, and MNCH/SRHR (this includes the images boxes for Senegal and Haiti);
4. Training of CHWs on GRAF service delivery curriculum and new/adapted job-aids and tools.

The same process described above was applied to the training of facility based health providers, a key aspect of the training of health care providers was the training of master trainers (referred to as a pool of trainers in Bangladesh and Haiti), to enable a cascade of training, create a cadre of trainers who could train additional health providers outside the scope of the project, and who could be leveraged to conduct follow-up or refresher trainings.

While the approach for training CHWs and facility-based health providers followed a similar plan in each of the five SHOW countries, a few country specific initiatives can be noted in the project design:

- In Ghana, Nigeria, and Senegal, the project planned to add training on how to respond to gender equality issues, such as GBV and CEFM, within health facilities as part of the trainings on GRAF service delivery.
- In Bangladesh and Ghana, awards and special recognition for health facilities providing the highest quality GRAF services were planned as incentives for health providers to fully integrate new GRAF practices and standards.

75. Services needed to transfer clients/patients from community to facility, and referral from one facility to another, particularly in event of health-related emergencies.

With regards to referrals, additional orientations were planned in Ghana and Bangladesh for community-level referral mechanism operators. In Ghana, the inclusion of the community emergency transport system (CETS) in the community rereferral chain, prompted the planning of an orientation for CETS drivers on gender responsive MNCH/SRH referrals. Similarly, an orientation was planned for emergency rickshaw drivers in Bangladesh and taxi drivers in Nigeria.

With regards to management and governance, the project design also included training for CHCs on GRAF service delivery. As part of efforts to strengthen the general capacity of CHCs, the project design included training on leadership, inclusive governance, action planning, and resource mobilisation as well as training on thematic topics such as gender equality, MNCH, and SRHR[76]. Training for Ministry of Health representatives and other relevant government officials on GRAF service delivery were also planned to strengthen the national integration of GRAF service delivery standards and to strengthen GRAF service delivery monitoring and supervision. In all countries, ministries/departments of women/gender were also planned to be oriented on GRAF and were integrated as key partners for inter-ministerial collaboration towards the implementation of national gender equality commitments in health.

Community Emergency Transport System (CETS)

The Community Emergency Transport System (CETS) in Ghana is composed of a network of motorbike, boat and automobile drivers who transport women, adolescent girls, and children to health facilities – thus helping reduce the second barrier (movement from household to the health facility). Most women used funds from VSLAs to pay for the cost of services or fuel of boats, motor bikes and tricycles. The drivers provided their phone numbers to health providers and CHWs who can distribute them to vulnerable women and children. The CETS is particularly useful in emergency cases. The network was engaged by SHOW to support referrals. The project provided training to CETS drivers on:

- Basic first aid
- Understanding the gender related barriers in accessing health care
- The importance of male engagement in MNCH/SRHR
- Gender responsive and adolescent friendly referrals

In particular, drivers were strongly encouraged to make space for an accompanying family member during MNCH/SRH emergencies, so that women and girls could have the support they needed.

76. *Activities with CHCs were also planned to review the inclusion of women; these activities are discussed in Section 3.1.*

Supportive Supervision

The purpose of supportive supervision was to provide health workers with additional guidance on how to integrate GRAF components into their routine service delivery practices. Supportive supervision is a routine process contributing to health system monitoring and governance and is particularly useful as a follow-up to training. Within the context of SHOW, supportive supervision was expected to engage supervisors to review with health providers how their services were meeting quality standards for GRAF, and to review together where improvements could be made. Supportive supervision was identified as a key follow-up to the many trainings planned to strengthen the capacities of health providers on GRAF service delivery.

To facilitate the supportive supervision process for GRAF services the following activities were included in the project design:

- Reviews of existing supervision tools, and if necessary, development of additional tools, to ensure integration of GRAF service delivery criteria;
- Training supervisors on GRAF service delivery;
- Reviews of clinic management protocols, and development of additional protocols where needed, to ensure that health providers, and their supervisors, had appropriate tools and guidance to support quality GRAF service delivery;
- Joint supportive supervision visits with representatives from the Ministries of Health in order to further socialize GRAF service delivery concepts, practices, and tools.

Refurbishment and Procurement of Equipment

Based on HFA results, refurbishment of health facilities and equipment procurement were planned in SHOW activities across all countries. Most of these activity plans were focused specifically on essential medical equipment and supplies. However, the project design also included procurement of equipment and facility refurbishment to meet waste disposal standards, the privacy and confidentiality needs of female clients and ensure their dignity during consultations and treatment, and to ensure adequate spaces for female clients to be accompanied by a male partner. Construction/ refurbishment of youth corners/adolescent friendly spaces in some selected facilities were also planned as part of the SHOW project. The GE Strategy design included reviewing plans for these youth corners/adolescent friendly spaces to address gender responsiveness, as well as adolescent friendliness. In all SHOW countries, the project design also included the development of gender responsive and adolescent friendly IEC materials to be used in adolescent corners.

Tiles work at delivery room, Chengi

Government Advocacy

For all activities designed to strengthen MNCH/SRH service availability and delivery, Ministries of Health were key partners in all five SHOW countries together with the Ministries of Women's Affairs and/or Gender. Within the design of the third pillar of the GE strategy, several opportunities for advocacy and partnership on GRAF service delivery were identified. As previously discussed, this pillar of the strategy was designed to reflect existing national policies on GRAF service delivery in all five countries; furthermore, SHOW included socializing existing policies during CHW, health provider, and CHC trainings in partnership with Ministries of Health and Gender/Women's Affairs as part of the design for trainings on GRAF service delivery. The plans for material reviews also included conducting participatory processes for these reviews based on consultations and meetings with Ministry of Health and Ministry of Gender/Women's Affairs representatives. Similarly, consultations and meetings were planned to review all new materials to be developed by Plan International on GRAF service delivery.

Regular meetings and advocacy centered on GRAF service delivery with Ministries of Health and Ministries of Gender/Women's Affairs were planned as part of this pillar. Meetings, workshops, and other advocacy opportunities were intended to be used to work with local, regional, and national representatives for Ministries of Health to practice gender and adolescent responsive budgeting and planning for health services. The advocacy activities were also intended to ensure the sustainability of GRAF integrations to service delivery trainings, guidelines and protocols made through the project and their appropriation by Ministries of Health in each country, and thereby integrated into the country-specific SHOW intervention sustainability plans. Specific meetings and plans were developed to also conduct advocacy on GRAF referral policies, protocols mechanisms signed on to by the Ministries of Health. Finally, the project intended to conduct advocacy with the government on the use of sex and age disaggregated data, and to encourage the ministry to disaggregate data at the health facility level for more gender and adolescent responsive planning of MNCH/SRH services.

The project design also included some country-specific goals for these advocacy activities, such as:

- In Ghana, advocacy meetings were identified as opportunities to create synergies between different departments within the Ministry of Health, with the Ministry for Women's Affairs, and with other NGOs working on strengthening health services.
- In Haiti, advocacy activities were intended to also ensure gender integration in data collection and management tools used by the Ministry of health, and to advocate for the development of national level guidelines on GRAF service delivery.
- In Senegal, advocacy opportunities were identified in the project plans where Plan International could contribute to the development of the new ASRH curriculum "Construire son Avenir" by the Ministry of Health.

3.3.2 IMPLEMENTATION

The implementation of activities aimed at improving the gender-responsiveness and adolescent friendliness of MNCH/SRH services mostly followed what was designed for the SHOW project. More emphasis was placed on the training of health providers on gender and adolescent responsive service delivery in the implementation of this pillar. Moreover, many of the other activities implemented directly or indirectly supported the training-focused activities: supportive supervision was focused on ensuring that what had been delivered in trainings was being practiced; the health facility assessment was used to determine where training gaps existed; refurbishments were focused on how health providers could have environments conducive to practice what was learned in training; and, much of the government advocacy was devoted to rolling up GRAF into national health provider training materials.

Health Facility Assessment (HFA)

Health facility assessments were completed in each of the five SHOW countries. In each country, several health facilities that fell within the geographic areas where SHOW was implemented were included in the HFA conducted in that country, and the HFAs were conducted in collaboration with Ministries of Health and local authorities. As planned within the design, the HFA gathered information to ascertain the level of service availability and facility readiness to provide services. A standard set of survey tools and questionnaires were developed by Plan International for the SHOW HFAs; all tools included questions to evaluate the status of gender responsive and adolescent friendly service delivery in surveyed health facilities.

The HFA provided key information on what areas of health facilities were not meeting the needs of women, adolescent girls, adolescent boys, and men. For example, the HFAs evaluated the availability of sex segregated safe latrines at health facilities, appropriate waiting areas for women, space and information provided to male partners, and consultation and treatment areas that could meet privacy and confidentiality needs of clients. The HFAs also provided information on where health provider capacity gaps were most acute with regards to gender-responsive and adolescent friendly service delivery, such as training on gender equality and the availability of guidelines on gender responsive and/or adolescent friendly services.

In each of the five countries, the results from the HFA were used to refine the design of project-led service providers trainings to improve the gender and adolescent responsiveness of MNCH/SRH services. The HFAs were also used to develop the equipment lists and construction/refurbishment plans in each of the project countries. Equipment such as privacy screens and additional chairs for male partners in consultation rooms were included based on the HFA results. The construction and/or rehabilitation plans for adolescent friendly spaces/youth corners were also informed by the findings of the HFAs. Recognising that the project could not address all of the identified gaps for all of the facilities assessed, the HFA was also used as a tool to advocate and work further with Ministries of Health and local authorities for further investment and capacity building with respect to GRAF service delivery.

Training of Health Providers

Many activities and project resources were dedicated to building the capacity of health service providers, both those working at the community level and those working in health facilities. As part of health provider trainings, Plan International integrated guidance on the GRAF service delivery into almost all of the trainings developed for health service providers.

TRAINING OF COMMUNITY HEALTH WORKERS

Per the project design, the training of community health workers followed a very similar process in each of the five SHOW countries. The following provides some details on the implementation of these trainings.

1. Review existing training materials and SBCC/IEC tools

Before CHWs, and other community-based health workers and volunteers, were trained, Plan International conducted a review of both CHW training materials and of SBCC and IEC tools already developed in each of the five countries. The objective of the review was to determine whether gender was integrated across the available resources, identify the gaps and develop further materials. Plan International prioritized review of materials that CHWs would use during household visits and other community outreach activities focused on MNCH and SRHR. Training materials were reviewed so that the existing integration of gender equality and ARSHR issues could be evaluated. Male engagement in MNCH/SRHR was also prioritized in the review of both training materials and SBCC/IEC resources. Across countries it was found that gender equality content was not mainstreamed into the existing materials across the board, or even as a standalone component. The SHOW project leveraged all existing, particularly government approved materials and added value to the materials by integrating gender across training materials in the interest of promoting government buy-in for the additional content and sustainability.

2. Adaptation of existing or development of new training materials

Recognizing that health promotion amongst women and adolescent girls cannot be isolated from gender-based barriers, the training of CHWs on gender equality related issues was prioritized. CHWs, as discussed above, played a critical role within the SHOW project for disseminating key health and gender equality messaging to project beneficiaries. Plan International developed the "Promoting Gender Equality in Community MNCH/SRH Education: Guide for Capacity Building of Community Health Workers" early on in the project to support the adaptation of existing and/or development of new training materials for CHWs on gender equality, and on GRAF service delivery. The purpose of this document was to provide project staff in Country Offices with a training manual on gender equality issues related to MNCH/SRH complimentary to other health focused trainings that CHWs received. As many of the CHWs working with the project had already received basic training, the focus of SHOW-provided trainings was on developing new capacities, including on gender equality and GRAF service delivery.

In Haiti, for example, the project hired additional CHWs and fully trained these new CHWs using the Ministry of Health CHW training materials. In addition, a comprehensive curriculum on gender equality and SRHR was developed by an external consultant, with support from Plan International, to be delivered to CHWs following their standard training. This curriculum was designed to cover a wide range of issues pertaining to gender equality

and SRHR and provide CHWs with the capacity to share information and discuss these issues with women, men, adolescent girls and adolescent boys. This curriculum was also developed specifically to strengthen CHWs' capacity to lead discussions on these topics with Mothers' Clubs and Fathers Clubs.

3. Development of additional SBCC/IEC materials

As described in the sections on Pillar 1 and Pillar 2 above, a series of SBCC and IEC materials were developed to promote and deliver key messages. Many of the SBCC and IEC materials developed (or adapted) for the project in general were developed for use by CHWs as they were the principal actors responsible for sharing key health messaging during household visits and community outreach activities. For example, the image boxes in Haiti were designed and developed specifically with the work of CHWs in mind and were repurposed for other SBCC activities. The video clips developed in Bangladesh also had a similar design strategy of meeting CHW needs and also being repurposed for other SBCC activities. Some additional materials were also developed later in the project to accompany additional trainings on specific service areas, such as family planning and STI prevention. For example, additional counseling cards were developed for CBHVs in Nigeria on family planning.

4. Training of CHWs

In each of the five countries, CHWs were provided with additional training on gender equality and GRAF service delivery. In Bangladesh, Ghana, Senegal, and Nigeria, training focused on gender equality issues and GRAF service delivery was provided to CHWs **as part of their overall training** from the project. In Bangladesh, this training also included how to use the newly developed SBCC video clips. In Haiti, CHWs were **trained on gender equality issues and GRAF in a separate training** once

they had completed and graduated from their initial training as CHWs. In all five countries, the training on gender equality issues and GRAF service delivery was led by Plan International's gender equality staff. In terms of effectiveness and modality of training delivery, whether it is an integral part of the overall training of CHWs or a separate standalone one, no major differences were noted in the ability of CHWs to understand the link between gender inequality and health outcomes, an appreciation of gender-related barriers women and adolescent girls face in accessing health services and the importance of engaging men in their health outreach work.

Following the initial trainings of CHWs in all five countries, some additional trainings on gender equality and GRAF and some refresher trainings were also completed on a case by case basis- based on observational evidence during supportive supervision, feedback during quarterly reflection meetings in communities and feedback from CHWs themselves over the course of the project. For example, in Haiti, additional training on ASRHR, including awareness raising techniques specific to ASRHR, were implemented for CHWs.

"Through this training the concept of GE and Child Protection is clear to us. I think, learning of this training will act as a changing factor of my attitude and behaviors to ensure child protection and GE. Now I am confident on integrating GE issues in delivering MNCH messages focusing women empowerment and male engagement at community level including household visit and SBCC sessions."

– Female CHW, Bangladesh

TRAINING OF FACILITY-BASED HEALTH SERVICE PROVIDERS

Similar to the approach used to train CHWs, the trainings of facility-based health service providers had a very linear approach. The project design includes a series of trainings for health providers on a number of specific services, such as Basic Emergency Obstetric and Neonatal Care (BEmONC), IMNCI, MNCH/SRH referral services, post-abortion care, STI prevention and treatment, and family planning. In order to build capacity of health service providers on GRAF service delivery, this aspect was integrated into the health provider trainings on specific services. The sequence of steps outlined in the design section was repeated for the different trainings for service providers implemented during SHOW to improve capacity on GRAF MNCH/SRH service delivery.

All training materials used by Ministries of Health in each of the five countries were **reviewed** by Plan International. One of the goals of these reviews was to determine the degree to which the training materials integrated GRAF service delivery in the guidance given to health providers. Identified GRAF gaps in training materials were then addressed in the adapted materials or in the new materials developed for SHOW.

Plan International developed two **guidance documents** as noted above[77] to support the adaptation of training materials on GRAF service delivery. One guidance note was designed specifically to focus on gender responsive service delivery and another on gender integrated adolescent friendly service delivery. These two guidance notes include what characteristics of service delivery are needed to make them gender and adolescent responsive. The guidance notes also provide practical instruction on how to deliver health provider trainings on GRAF service delivery. These guidance notes were used extensively in each of the five countries to design the GRAF training content and materials intended for health providers. The checklists included in the GRAF guidance notes were frequently presented to health providers during trainings as well.

"After SRHR training and orientation the SHOW Project, I have learned to provide service for adolescent girls and more adolescents are coming to my health centre services. I am grateful for this training."

– Health provider, Bangladesh

As the vast majority of **training materials** used to train health providers were government curricula, there were only a few opportunities to mainstream GRAF service delivery directly into existing curricula. Most trainings included additional time devoted to GRAF service delivery added to the training already being provided on a specific service area. The length of time added to trainings varied, in some cases GRAF service delivery was given an additional day and sometimes a few hours as part of the larger training. The focus of these additional training sessions on GRAF services included gender socialisation, intersections of gender and the social determinants of health, the influence of gender on MNCH/SRH, gender as a core Quality of Care component and elements of GRAF service delivery over the MNCH/SRH continuum of care.

77. See Section 5: SHOW legacy document

While the SHOW project was unable to make the duration of training on GRAF for facility based health providers consistent across countries, which was a challenge from the perspective of optimal training intensity and depth, the project pivoted to accommodate and optimise the time provided by governments and focused on core modules such as understanding the links between gender and the social determinants of health, gender as a core element of quality of care and practical application of GRAF elements in the MNCH/SRH continuum of care. These trainings were accompanied with reading materials and practical checklists for health providers and were followed-up during supportive supervision and the provision of job-aids. A few key take aways are that for any project: 1) It is difficult to influence the approved duration of GRAF training for many reasons ranging from skepticism regarding its relevance for health service providers to avoiding keeping health service providers away from their work, regardless of basic buy-in from governments; it is therefore important that flexibility is built into the training duration to leverage the opportunity and followed up with supportive supervision, peer-to-peer learning as well as through accountability mechanisms such as CHCs. 2) Equally difficult is the mainstreaming of GRAF content into government curricula for health service providers' training. It is therefore critical that the content is directly and practically linked to their job and standards of care as well as national commitments regarding gender equality in health, followed up with robust monitoring to provide governments with evidence regarding the effectiveness of GRAF service delivery and continuous advocacy with Ministries of Health and Gender/Women's Affairs for making investments into GRAF service delivery.

While mainstreaming GRAF into existing government health provider training was challenging, there are a few notable exceptions[78] where Ministries of Health

Training Health Providers on Management of Gender-based Violence

In Haiti, Plan International helped the Ministry of Health deliver **training to health providers on management of gender-based violence***. During this training, health providers were trained on how to provide services for survivors of gender-based violence, and sexual violence in particular.

During this training, health providers learned:

- What social norms contribute to GBV;
- How to provide gender responsive services to GBV survivors;
- Safeguarding and child protection
- Service for survivors of sexual violence (psychosocial support, STI and HIV prevention, prevention of unwanted pregnancies, and linking to police and justice systems)

Following this training, each health provider received for their health facility protocol documents for responding to GBV, examples of medical certificates, and contact information for GBV-response institutions in their local areas.

** SHOW Haiti Annual Report Year 4*

78. *Additional opportunities where Plan International was able to make significant changes to government curricula to integrate GRAF service delivery are discussed in the section on Government Advocacy.*

were amenable to more thorough reviews of these curricula, and where Plan International was able to make significant changes to training materials to integrate GRAF directly into the national service delivery guidance. For example, in Nigeria, Plan International worked with the federal government to review/modify Life-Saving Skills training materials into Modified Life Saving Skills (MLSS) for CHEWs and collaborated on the development of a new training manual on family planning services, integrating GRAF into the training content. Adolescent SRH service trainings were conducted in Nigeria, in Ghana, and in Bangladesh, which were heavily focused on building health provider capacity on adolescent friendly service delivery, and how to make adolescent health services gender responsive.

"I [now] provide counseling people who come to receive health service from UH&FWC. I told them not to discriminate between boys & girls, maintain the client's privacy. I also give counseling to spouse so that they can take the responsibility of heavy workload during pregnancy, ensure rest and sleep of their wife."

– Health provider, Bangladesh

For the majority of health provider trainings, a **cascading approach** was used where trainers were trained on the material and then were responsible for cascading the training to health service providers. Many of the specific parts of the trainings on GRAF were facilitated by Plan International staff working on SHOW. In Haiti and Bangladesh, trainers also took on roles as mentors and provided supportive supervision to health providers after trainings were completed. Many of the trainings also used the GRAF services sessions to discuss with health providers what actions they can take to make the physical spaces in their health facilities more gender responsive and adolescent friendly, for example including a chair for a male partner in consultation rooms and respecting the privacy, dignity and confidentiality of their clients.

In addition to review and adapting training materials to include GRAF service delivery, SHOW project activities also included **revision of job-aids and tools** to support health providers to deliver GRAF services. In Nigeria, for example, reviews and revisions of referral guide cards were completed to integrate GRAF care elements into the referral cards. In Ghana and Bangladesh, checklists for providing GRAF services were developed for use in health facilities; these checklists include GRAF actions that service providers can take for each service area, such as ANC, STI treatment and prevention, and PNC, and provide general recommendations for providing GRAF MNCH/SRH services.

To further build capacity of health providers on GRAF service delivery, **service provider exchange visits** were facilitated in Ghana and Bangladesh. These visits allowed service providers to learn from each other, and to build their capacities by visiting neighboring health facilities and providers who more capably had integrated GRAF practices into their services. Supportive supervision visits were used to determine which providers could most use additional capacity building in the form of an exchange visit, and which providers were best suited to host a visiting delegation.

TRAINING OF COMMUNITY HEALTH COMMITTEES

Community Health Committees were engaged in many ways within the SHOW project and were trained on GRAF MNCH/SRH service delivery. CHCs have a role in health facility oversight, and therefore in order for them to have proper oversight and to contribute to the delivery of quality MNCH/SRH, training on GRAF services was included as part of CHC training. The GRAF training provided to health committees focused more on the community and facility barriers that women and girls face accessing health services. Their trainings also focused on what norms and practices can be instituted in health facilities to support the delivery of GRAF services. This engagement was successful in strengthening the abilities of CHCs to address gender barriers to health. For example, in Haiti, CHCs developed action plans to improve health in their communities and services in their facilities, several of which included addressing gender-related barriers to health. In Ghana, some CHCs used information shared during SBCC activities with adolescents to address the attitudes of service providers towards adolescent clients.

In all countries, the SHOW project engaged with Ministries of Health and Gender/Women's Affairs to review the government orientation/training/onboarding materials for CHCs and added practical training on GRAF along with other training modules to build the capacities of CHCs. In the preparatory phase of this action, several government documents such as Terms of Reference/mandate of CHCs, CHC management, and CHC guidance manuals were reviewed and strengthened. A key element of this pillar of the SHOW GES was to institutionalize gender equality across systems of governance. While the project was not able to institutionalize gender equality in the mandates and guidance materials for CHCs in all countries some notable successes were attained. In Bangladesh, the SHOW project team collaborated with the Directorate General Family Planning (DGFP), Ministry of Health and mainstreamed gender across the UH&FWC-MC training guidelines. Similarly in Nigeria, the project collaborated with Federal Ministry of Health (FMOH) and the State Primary Health Care Development Agency (SPHCDA) to mainstream gender in the CBHV manual. These documents were subsequently socialized and disseminated to all CHCs in the areas of SHOW operation.

"Our committee was inactive and less responsible about our roles and responsibilities but after getting training and attending at UH&FWC committee meeting we became sensitive consequently and the service standard of our health centre is increased day by day through project support and positive effort of committee."

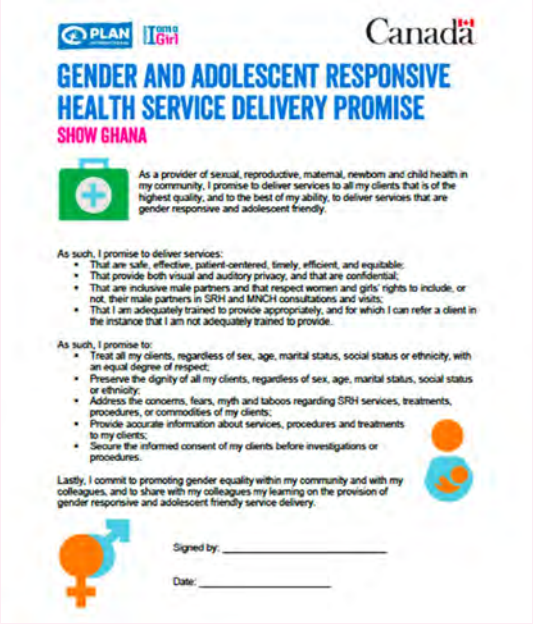
– Female CHC member, Bangladesh

Guidance Notes on GRAF Service Delivery

Three guidance notes were developed by Plan International on GRAF service delivery for use within the SHOW project:

1. Gender Responsive MNCH/SRH Service Delivery
2. Adolescent Friendly MNCH/SRH Service Delivery
3. Promoting Gender Equality in Community MNCH/SRH Education: Guide for Capacity Building of Community Health Workers

The first two guidance notes are intended to be used directly by health facility staff and by government and NGO actors wishing to strengthen health service providers on GRAF service delivery. The third guidance note is intended to be used by governments and NGO actors to integrate GRAF in CHW trainings. All three guidance notes are structured in a similar way. The guidance notes provide information on the conceptual frameworks for gender and adolescence intersections with health, as well as practical and simple training activities to help health providers understand these concepts aligning with their mandates and national/ contextual policy commitments relating to gender equality in health. The notes also include guidance for health providers on actions they can take and attitudes they can adopt to render their services more gender responsive and adolescent friendly, include checklists and tools that health providers can use in their routine service delivery.



PLAN Because I am a Girl

Canada

GENDER AND ADOLESCENT RESPONSIVE HEALTH SERVICE DELIVERY PROMISE

SHOW GHANA

As a provider of sexual, reproductive, maternal, newborn and child health in my community, I promise to deliver services to all my clients that is of the highest quality, and to the best of my ability, to deliver services that are gender responsive and adolescent friendly.

As such, I promise to deliver services:

- That are safe, effective, patient-centered, timely, efficient, and equitable;
- That provide both visual and auditory privacy, and that are confidential;
- That are inclusive male partners and that respect women and girls' rights to include, or not, their male partners in SRH and MNCH consultations and visits;
- That I am adequately trained to provide appropriately, and for which I can refer a client in the instance that I am not adequately trained to provide.

As such, I promise to:

- Treat all my clients, regardless of sex, age, marital status, social status or ethnicity, with an equal degree of respect;
- Preserve the dignity of all my clients, regardless of sex, age, marital status, social status or ethnicity;
- Address the concerns, fears, myth and taboos regarding SRH services, treatments, procedures, or commodities of my clients;
- Provide accurate information about services, procedures and treatments to my clients;
- Secure the informed consent of my clients before investigations or procedures.

Lastly, I commit to promoting gender equality within my community and with my colleagues, and to share with my colleagues my learning on the provision of gender responsive and adolescent friendly service delivery.

Signed by: _____

Date: _____

These guidance notes were used extensively by Plan International for the SHOW project, to deliver trainings to health providers specifically on GRAF service delivery and to integrate GRAF service delivery training content in other service trainings, such as family planning, post-abortion care, and adolescent SRH services. The guidance notes were also used to develop additional job aids and tools for health service providers. For example, in Ghana, health providers completing MNCH/SRH related trainings were asked to sign a "GRAF Service Delivery Promise" which served as a certificate of their training and a commitment to practice newly acquired skills. Finally, the guidance notes were also an important advocacy tool which was presented to Ministries of Health as an example of a practical training tool for GRAF MNCH/SRH service delivery.

Supportive Supervision

Without supervision activities and tools that reinforce the GRAF components of health provider trainings, health providers are less likely to continue striving to provide GRAF services. To further strengthen the quality of gender responsive and adolescent friendly services, the project included supportive supervision activities to follow health provider trainings. A similar process to the training of health providers was used to implement supportive supervision activities including reviews and development of supervision materials and training of supervisors and government partners. Additionally, joint supportive supervision visits were conducted by project staff, trained supervisors and government partners to socialize supervision tools on GRAF service delivery and to strengthen the capacity of supervisors and government partners to monitor and supervise the delivery of GRAF services. It should be noted that supervisors were often trained during master trainer trainings or in health provider trainings. In Nigeria and Bangladesh, additional clinic management tools were developed for CHCs, and Plan International provided training to CHCs on GRAF clinic management and the specially developed tools.

In all five countries, GRAF service supervision tools were developed based on the GRAF guidance notes drafted by Plan International. In Bangladesh and Ghana, supervision checklists were developed to conduct joint supervision visits; in both countries, project and partner staff were trained on these checklists and repeated the training on the checklists with government partners and health providers to socialize the use of the checklists. In Nigeria, Plan International partnered with the State Primary Health Care Development Agency (SPHCDA) to jointly develop monitoring and supervision tools for primary health care facilities integrated with GRAF service delivery components. In Senegal, Plan International worked closely with the Ministry of Health to develop new supervision tools for MNCH and SRH services which integrate GRAF service delivery.

In all five countries, supportive supervision visits were conducted jointly by project staff and health provider supervisors to monitor project activities at community level and monitor the performance of health providers and CHWs trained during SHOW activities. Within health facilities, supportive supervision visits also allowed supervisors to practice providing onsite technical assistance to health providers, and to practice making use of the developed supportive supervision tools. Key to the success of this activity in strengthening the delivery of GRAF services, was:

1. Training of health provider supervisors on GRAF service delivery
2. Reviewing and strengthening of existing government supportive supervision tools with additional GRAF components as opposed to creating add-on tools
3. Continuous on-job capacity building support to supervisors in assessing for GRAF service delivery performance that was carried out by way of joint supportive supervision visits with government personnel over the life of the SHOW project. This facilitated a deeper understanding of the importance of GRAF service delivery, objective and participatory performance assessment, government buy-in and smooth transition from the project to institutionalized GRAF service delivery in the project's country-based Sustainability Plans.

Refurbishment and Procurement of Equipment

Based on findings from the HFAs in each of the five countries, selected health facilities were refurbished, and equipment was procured to improve the quality of service delivered. Several **enhancements to the physical environment** of health facilities were completed to specifically improve the gender and adolescent responsiveness of facilities. For example, privacy screens were included in the equipment or materials procured for health facilities to help ensure that women and girls had privacy during counseling and treatment, and particularly in delivery rooms. In Senegal, this also included working with health facilities to sex-segregate existing washrooms. In Bangladesh, breastfeeding corners were added to waiting areas of health facilities to ensure privacy for nursing mothers.

Several adjustments were made in all five countries to promote **male engagement in MNCH/ SRH**. Many facilities were supported to include appropriate seating in counselling rooms to allow female clients to be accompanied by male partners during ANC, PNC, and Family Planning consultations, if they so desired. Adjustments were

"Service providers are so cooperative and friendly that it makes me very confident to talk my health issues openly. The facility is also decorated with adolescent health materials, which provides me adequate knowledge and information."

– 16-year-old girl, Bangladesh

also made to waiting areas so that they could accommodate women who were accompanied by a male partner and those who were not. In Bangladesh, separate waiting areas for male partners were added in primary health care facilities to create a more comfortable environment for men. These spaces were leveraged to engage men further in gender equality and SRHR messaging by way of SBCC/IEC materials such as wall murals and posters etc.

Adolescent friendly spaces (separate structures) or youth corners (incorporated into the facility building itself) were constructed or rehabilitated in selected facilities in Bangladesh, Ghana, Haiti, Nigeria, and Senegal. Adolescent friendly spaces/youth corners were specific areas of health facilities dedicated to providing services for adolescent boys and girls. Dedicating specific spaces for adolescent health services helped reduce some facility-based and social barriers that adolescent girls and boys face when accessing MNCH/SRH services. In all five countries, adolescent spaces were designated in select facilities and amendments were made so that these spaces would be physically distinct from the rest of the facility. For example, separate entrances were added to adolescent corners in some facilities in Nigeria. Adolescent corners in Haiti and Senegal were also equipped so that the spaces could be used to conduct adolescent outreach. In both countries, adolescent corners were equipped with audiovisual equipment and educational materials to allow health providers and peer educators to use the spaces from which to conduct adolescent SRHR awareness and education sessions.

Government Advocacy

Advocacy activities with local, regional and national government stakeholders was conducted by Plan International and SHOW partners to obtain necessary buy-in from government partners and to ensure sustainability of the achievements made during SHOW on GRAF service delivery. There were two ways in which SHOW contributed to government-level adjustments on GRAF service delivery:

1. As a consequence of the close **partnerships** that Plan International had with Ministries of Health and Ministries for Gender/Women's Affairs in each of the SHOW countries.
2. As a consequence of **direct advocacy** activities where Plan International negotiated and campaigned with government stakeholders to make necessary changes to promote GRAF service delivery.

PARTNERSHIPS

As the Ministry of Health and the Ministry for Gender/Women's Affairs were key project partners in each of the five countries where SHOW was implemented, Plan International worked very closely with these government partners in the implementation of activities aimed at improving the delivery of GRAF MNCH/SRH services. Government partners were included in all planning workshops and were included in supervision visits and training workshops. One of the key areas where this partnership achieved significant effects was the training materials of health providers. As described above, SHOW activities included reviewing government training materials designed for health service providers, CHWs, and CHCs, and strengthening them to include GRAF service delivery. In Haiti, Bangladesh, Senegal, and Nigeria, new government training materials integrating the guidance on GRAF service delivery developed by Plan International were drafted. This includes the government Midwifery Curriculum in Bangladesh and a Family Health Department training manual on clinic management in Haiti. Most of these materials and products integrating GRAF and taken up by government partners were developed as a result of already planned SHOW activities and did not require much additional advocacy.

Partnering with Ministry of Health to Develop New Health Provider Manuals in Senegal

The SHOW project timing coincided with the period when the Senegalese Ministry of Health was developing new training materials on gender responsive service delivery for health providers. The Gender Office within the Ministry of Health invited representatives from Plan International and the SHOW project to contribute on multiple occasions over the course of the project to the development of these manuals. This was an opportunity for Plan International to share the materials developed for SHOW on GRAF service delivery and experiences implementing this guidance in other health provider trainings.

The final ministry curriculum was divided into five modules:

1. Understanding gender
2. Gender and SRMNCH
3. Response to GBV
4. Gender and Response to Disease
5. Gender and WASH

This curriculum is intended to be used for health provider training, but also with actors involved in health governance and planning. Plan International's participation in the development of this curriculum.

DIRECT ADVOCACY

Advocacy activities were implemented over the course of the SHOW project to strengthen the capacity of government partners to continue providing GRAF MNCH/SRH services and to develop adequate policies and protocols at the national and regional levels to support the creation of a policy environment emphasizing GRAF service delivery. These activities include leading workshops with government partners, developing materials for use by the government, and conducting meetings with various government stakeholders to support their development of GRAF policies and protocols. For example, throughout the span of the project, Plan International advocated to the Ministry of Health in Haiti to include additional training on gender equality, SRHR, and GRAF services for CHWs. As part of SHOW, a CHW curriculum on these topics was developed and CHWs working within the scope of SHOW received this additional training. At the end of the project, with the results of CHW activities, the Ministry of Health in Haiti decided to revise their approach and to add training sessions on GE and SRHR in CHW training and to revise the national curriculum for CHW using the materials developed by SHOW.

In each of the five countries, specific activities were also undertaken by Plan International and implementing partners to advocate for the inclusion of GRAF service delivery in national and regional referral protocols. In Ghana, early recommendations on integration of GRAF service delivery into referral protocols were made at the district level; these first recommendations were made to encourage district-level health providers to ensure GRAF referrals. Following district-level buy-in for the recommendations, Plan International and SHOW implementation partners brought the recommendations to the national level where GHS agreed to incorporate the recommendations into the national referral protocols.

Significant advocacy activities on gender and adolescent responsive service delivery were accomplished in Nigeria. A training workshop was organized for senior government officials from different government bodies working on MNCH/SRH to strengthen their capacity on GRAF health services. This training was also an opportunity to discuss important concepts related to gender equality and SRHR with government partners to further strengthen their capacity and willingness to manage GRAF services. Plan International was also heavily involved, as part of SHOW, in the development of the Sokoto State Gender Responsive and Adolescent Friendly PHC guidelines, which were adopted and implemented across the State of Sokoto. Finally, GE staff working on the SHOW project provided valuable recommendations for the development of the Sokoto State Gender Policy.

Revision of Family Planning Service Guidelines in Nigeria

Following the identification of existing CHEWs and Community Health Officers (CHOs) training materials, Plan International convened a workshop with government and ministry partners, service providers, and NGO/INGO partners to review family planning materials. This review identified significant gaps on gender responsiveness and adolescent friendliness in existing materials on family planning. It was agreed that new Family Planning Service Guidelines would be developed in partnership between SHOW and the State and Federal Ministry of Health which would thoroughly integrate gender and adolescent responsiveness. Two manuals were developed: a trainer's manual and a participant manual; approved for national use in Nigeria.

Following the finalisation of the Sokoto manual, Plan International was invited to contribute to the development of a national manual on Gender Responsive and Adolescent Friendly Family Planning for service providers by the National Ministry of Health. The gender equality and adolescent friendly components of the manual were developed with technical support from Plan International and were validated and approved by the Federal Ministry of Health in Nigeria. Plan International was able to distribute and use it for service provider trainings in project areas.

3.4 EFFECTS OF THE GENDER EQUALITY STRATEGY

This section explores the effects of the SHOW GE Strategy, both as expressed in the output and outcome measurements of the project's PMF and in other monitoring and evaluation exercises. As a component of the Theory of Change, the GE Strategy should contribute to the project's ability to meet targets associated with the higher-level outcomes of the project: **if** gender inequality and the gender-related barriers impeding women and girls from accessing and utilizing MNCH/SRH services are reduced at the individual, community and systemic levels, **then** demand for, utilization of and supply of quality health services will increase, and **then** health outcomes will improve. SHOW endline data suggests that the GES has contributed to positive results across all intermediate outcomes: antenatal and postnatal care, in skilled birth attendance, and current usage of modern family planning methods, with some notably large increases amongst adolescent girls especially.

Because the three pillars of the SHOW GE Strategy were designed and implemented interdependently and in ways that each pillar would reinforce the others, the following sections will review the results of the GE Strategy first at the individual and community level, and then at the health facility level. This also reflects the demand and supply structure of the SHOW project design and reflects the projects' Theory of Change. Outcome data, qualitative evidence and testimonials all indicate that the SHOW GE Strategy had considerable effects on individuals, on families, on communities, and within health facilities across project areas. However, as this section will demonstrate, some areas of intervention had more consistent results, such as the VSLA approach and the male engagement activities, across the five countries.

3.4.1 INDIVIDUAL AND COMMUNITY LEVEL RESULTS

Within the design of the GE Strategy, the first two pillars were intended to directly impact the daily lives of women, men, adolescent girls and adolescent boys, and specifically, to change their attitudes and behaviors related to gender equality and to MNCH/SRHR. As discussed in Section 2, specific indicators were set to measure the impact of the project and were also used to monitor and evaluate the implementation of the GE Strategy.

Raising Awareness and Changing Attitudes Related to Gender Equality

As discussed in the preceding sections, a number of SBCC-related activities were designed to raise awareness of MNCH/SRHR and Gender Equality amongst women, men, adolescent girls and adolescent boys. The implementation of these activities resulted in many significant project outputs, including, but not limited to:

- 26 SBCC Video Clips on MNCH/SRHR and Gender Equality topics were developed in Bangladesh[79] over the course of the project;
- 23,900 Community Mobilization Events were organised and conducted in Ghana[80] over the course of the project;
- 3,457 Community Mobilization Events and 18 Special Event Days were organised and conducted in Haiti[81] over the course of the project;
- 294 messages played on the radio (i.e. radio jingles) in Nigeria[82];
- 39,404 IEC materials, include posters, job-aids, t-shirts, and image boxes, were distributed over the course of the project in Senegal[83]

One indicator in the SHOW PMF specifically measures the **awareness of gender equality messages** and provides an indication of related changes in knowledge and attitudes. This indicator measures the knowledge of women, adolescent girls, and men of key gender equality messages, specifically whether women, adolescent girls, and men agree that women/girls should participate in both household decision making and community level decision-making. Endline data[84] revealed strong support for women's decision-making in Ghana and Haiti, with >90% of WRA and men indicating that women should participate in decision-making at both household and community levels. In Haiti however, although the proportion of men who supported women's participation in decision-making at both arenas remained high, it showed a statistically significant dip from 97% at baseline to 91% at endline. At endline, the most significant increases occurred in Bangladesh (>30%), in Nigeria (from 29% to 57% overall) and in Ghana (from 85% to 95% overall, and most notably from 78% to 91% among adolescent girls). In Senegal, significant declines from baseline to endline were observed among adolescent girls (from 65% to 38%) and adult women (from 73% to 63%), while it remained relatively stable among men (from 79% to 83%). The reason for this contrast is not clear. However, it might be related with women having a clearer expectation of how they also needed to equally participate in the decision-making process, as their male partners[85].

79. *SHOW Bangladesh Final Report, Annex C*
80. *SHOW Ghana Final Report, Annex D*
81. *SHOW Haiti Final Report, Annex D*
82. *SHOW Nigeria Final Report, Annex D*
83. *SHOW Senegal Final Report*
84. *SHOW Final Evaluation Report*
85. *SHOW consolidated Final Evaluation report*

Throughout the SHOW countries, **several activities had notable success disseminating project messaging**, such as the Theatre for Development approach in Bangladesh and the Grandmothers' Groups in Senegal (see Section 3.1), the community mobilization activities in Ghana, the support groups for men and women in each country, and radio programs in Nigeria, Senegal, and Bangladesh, the Mothers' Support Groups in Ghana, the work of 100 Women Groups in Nigeria, and the work of CBOs in Senegal. The reporting from all five countries[86] describe how a variety of SBCC activities have worked together to raise the awareness of women, men, adolescent girls, and adolescent boys on issues related to MNCH/SRHR and gender equality, and that attitudes and behaviors, particularly those related to male engagement in MNCH/SRHR, have changed in ways that improve relationships between men and women.

Testimonials from Senegal[87] and Bangladesh[88] also demonstrated the effectiveness of the radio jingles and programs produced by Plan International in shifting attitudes on GE issues, such as CEFM. In Ghana, the community mobilization activities such as "An Evening with Adolescents", often facilitated by Queen Mothers, were recognized by community members as having been an effective way to share important information and inspire attitudinal shifts, as explained by a health service provider: *"These [Evening with Adolescents] meetings with the adolescent clubs have resulted in most of the adolescents coming for health care services at times convenient for them. Sometimes they come during break time during school days either as a group or individually. Parents no longer need to come with their adolescent boys and girls for services as a result of the cordial relationship between staff and the adolescents."*[89]

"In our days husbands were not supportive during pregnancy and we saw this as normal, but now with the education from the SHOW project, we have come to understand that women must be supported during pregnancy as a joint responsibility so I encourage my sons to do just that."

– Grannies' Group member, Ghana

"Through this [Theatre for Development] play I now realize that I was wrong then. After watching this drama, I want to tell everyone that we should never marry a girl before she becomes ready for it."

– Adult Woman, Bangladesh, after a TfD performance

"Thanks to the radio program hosted by Al Fayda FM on child marriage, I became aware of the consequences incurred by adolescent girls who marry before the age of 18. I asked my classmates to follow the program and since that day, we have not missed any."

– 17-year-old male high school student, Senegal

86. *SHOW Annual Report Y4, see Section 3.4.2 Gender Equality in the reports for Bangladesh, Ghana, Haiti, Nigeria and Senegal*
87. *SHOW Consolidated Annual Report Year 4, p.9*
88. *SHOW Bangladesh Annual Report Year 4, p.17*
89. *SHOW Consolidated Annual Report Year 4, p.9*

Male Engagement in GE and MNCH/SRHR

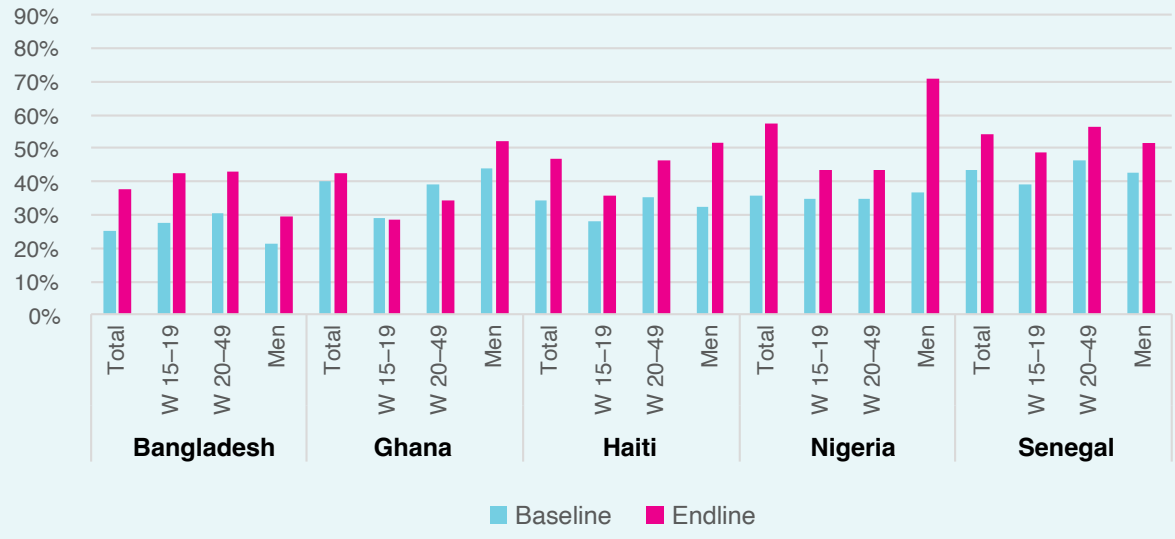
Increased male engagement was an expected effect of the SHOW GE Strategy and many activities contributed to achieving this goal:

- 428 Fathers Clubs were established in Bangladesh
- 480 Daddies Clubs were established in Ghana
- 11 Fathers Clubs were established in Haiti
- 244 Male Champions Groups were established in Nigeria
- 38 Fathers Clubs and 14 Husbands Schools were established in Senegal
- Over 3,600 sessions have been conducted with religious and traditional leaders on GE and MNCH/SRHR across the five countries

One indicator was included in the SHOW PMF to specifically measure the **level of support male family members were providing to women and adolescent girls** on matters related to MNCH/SRH. This indicator reveals the overall level of support provided by male family members for the utilization of MNCH/SRHR services by WRA. Between the baseline and endline study, the level of support rated as high among WRA increased in Nigeria, Senegal and Bangladesh, and increased among men in all five countries.

Despite some encouraging trends, endline results fell short of the targets, with a few exceptions. In Ghana, male perceptions of overall support approached the project target. In Nigeria, the target for male perceptions of overall support was exceeded, which also caused the overall target to be achieved despite targets for WRA not being met. In Senegal, the target for adult mothers was achieved, and in Bangladesh, the target for women was nearly achieved[90].

[FIGURE 5] AVERAGE LEVEL OF SUPPORT PROVIDED BY MALE FAMILY MEMBERS FOR MNCH/SRH



90. *SHOW Consolidated Final Evaluation Report; SHOW Bangladesh Final Evaluation Report*

The **Fathers Clubs** were a key activity in the SHOW design and implementation with the aim of increasing male engagement. Reporting and testimonials describe the changes that the Fathers Clubs have led to in project areas, both attitudinal and behavioral[91]. The reports[92] from all five countries include examples of new or modified behaviors adopted by men reflecting changes in attitudes towards gender equality:

- In Bangladesh, men who participate in the Fathers Clubs have reported improved relationships with their spouses and their children.[93]
- In Ghana, Daddies Clubs participants have taken on new behaviors and work together to reach out to men who are not part of the clubs to share what they have learned.[94]
- In Haiti, health providers reported seeing more fathers present during children's health visits. The Haiti Fathers Clubs also developed action plans to share what they have learned with other men in their communities.[95]
- In Nigeria, Fathers Club participants have taken on more childcare and domestic work, despite some resistance and stigma from other community members.[96]
- In Senegal, members of the Husbands Schools have changed their behaviors at home, have taken on new chores like cleaning and cooking, and are having more discussions related to health with their spouses.[97]

In all project countries, engagement of **religious and traditional leaders** was another key approach to increasing male engagement. In Nigeria, the development of the "Islamic Perspectives on MNCH" guide was used by religious and traditional leaders to challenge unequal attitudes towards gender equality amongst both community members and other leaders (see Section 3.2). Similarly, Husbands Schools in Senegal and Change Maker groups in Bangladesh, both made-up of community, religious, and traditional leaders, used their standing in communities and their knowledge of religious texts to promote gender equal behaviors at home and engagement in MNCH/SRH amongst male community members, and to advocate with other religious leaders from their communities to also promote male engagement in GE and MNCH/SRHR.

"Whatever I have is for my children. I now assist her to bath the children and prepare them for school as I mentioned earlier which I didn't usually do before."

– Fathers Club member, Nigeria

"Today, I made tea for my wife while she was cooking. Before, she would always cook for me and make tea for me, but now that's over. Nowhere in the Quran is it written that we should not support our wives with domestic chores."

– Husbands School member, Senegal

"With my experiences in the Daddies Club, I have learnt to share household chores with my wife and we also take decisions together."

– Daddies Club member, Ghana

91. SHOW Annual Report Y4, see Section 3.4.2 Gender Equality in the reports for Bangladesh, Ghana, Haiti, Nigeria and Senegal

92. SHOW Annual Report Y4, see Section 3.4.2 Gender Equality in the reports for Bangladesh, Ghana, Haiti, Nigeria and Senegal

93. SHOW Bangladesh Annual Report Y4

94. SHOW Ghana Annual Report Y4

95. SHOW Haiti Annual Report Y4

96. SHOW Nigeria Annual Report Y4

97. SHOW Senegal Annual Report Y4

DANIEL'S STORY, GHANA

Daniel is a 45-year-old man who lives with his wife and his children in the Volta region of Ghana. Daniel joined the Daddies Club established by the SHOW project in his community and became the secretary. With other group members, Daniel began to think differently about gender roles, and began to take on more domestic chores at home. Daniel now cooks family meals together with his wife, something he would never previously participate in. Yaayira, Daniel's wife, has shared that her husband now does many more chores at home including fetching firewood on his bike from the farm and fetching water for the family. Daniel also accompanied Yaayira to the health facility for her prenatal visits. Despite being ridiculed by some community members when he adopted new behaviors at home, Daniel said: **"I don't feel shy to help my wife in doing any household chores or even accompanying her to the health facility for services."**

Daniel is also an avid advocate for male engagement in his community and encourages his friends to also support their spouses at home. The leader of the Daddies' Club where Daniel is member said **"Daniel is now serving as an example for some men in community to copy. I can now observe a number of men carrying water on their bicycles for their wives."**

Other men in the community are now carrying goods on their bikes for their wives, mothers and sisters.

PEACE'S STORY, GHANA

Peace lives with her husband and four children in the Volta Region of Ghana. Before the SHOW project began work in her community, Peace and her husband argued frequently and there was a lot of conflict in their home. In their community, Peace said, traditionally a father's role is to provide money to pay for school fees, uniforms, and health care costs. Peace has noticed that since her husband joined the Daddies Club, he is helping her at home and spending more time with the family. **"Now he has learned to be at home and spend time with the family,"** Peace says. Peace and her husband now discipline the children together. She is grateful for the Daddies Clubs, as her stress and her workload has been reduced. Their older children say they are happy their father has changed, now there is peace amongst the family. Peace believes that her youngest child especially will learn these good practices and when she grows up, she will pass them on. Peace is hopeful for the future: **"I hope that my husband will continue to learn more, and that peace will prevail in the household."**

JESMIN'S STORY, BANGLADESH

Jesmin lives with her husband and her 7-year-old daughter in Barguna Union in Bangladesh. During her first pregnancy, Jesmin and her husband, Al-Amin, did not know how to safeguard her health and the baby's health: **"Earlier, I have no idea on how to take care in proper way during pregnancy. I could not bring my wife to visit doctor and not even support to do household chores,"** said Al-Amin. Jesmin had to deliver her daughter at home with an untrained birth attendant and suffered a perineal tear.

When Jesmin became pregnant a second-time, members of the SHOW-supported Change Maker group from her community and a CHW came to visit her and Al-Amin to encourage them to attend ANC visits together. Members of the Change Maker group also paid specific visits to Jesmin's father-in-law to ensure his support for Jesmin's health facility visits, and to support Al-Amin to take on household chores to support Jesmin. Throughout Jesmin's pregnancy, the president of the Change Maker group maintained a close liaison with Al-Amin and his father to ensure continued support for Jesmin. When her labor pains began, Al-Amin accompanied Jesmin and she safely delivered her second child at the health facility.

"I feel proud for my husband, now he is very caring to me and our newborn. He gives me money to go to health centre. My father-in-law also support me to do household work," said Jesmin.

Jesmin and Al-Amin also used the experiences to share information with other pregnant women and their spouses in their community. **"With the support of Jesmin and Al-Amin, I have conducted my first delivery in the same UH&FWC free of cost. I did not face any complication. Now, my child and I are well,"** said Salma, who lives in the same community as Jesmin. The President of the Change Maker Group also noted Al-Amin's changes: **"We observed a significant change in Al-Amin. He not only supports his wife, but he also motivates other men to support their wives."**

"Doing household chores in no longer shame to me. I supported my wife to do heavy work. I disseminate the message of MNCH within my community and my friends circle," said Al-Amin.

Jesmin and Al-Amin attend ANC sessions, accompanied by their daughter

SHOW Fathers Club Study and Report

Plan International was invited to contribute to Promundo's 2019 State of the World's Fathers Report. Plan's contribution was based on a qualitative study of the results of the SHOW Fathers Clubs in Bangladesh, Ghana, Haiti, and Nigeria. The results of the study were compiled into four individual reports for each of the countries and were used to contribute directly to the State of the World's Fathers Report.

QUALITATIVE DATA COLLECTION

The Fathers Club Study gathered data from almost 500 project stakeholders. Key Informant Interviews were conducted with 54 participants in the Fathers Clubs and 44 community leaders (religious leaders, CHWs, village heads, etc.). Focus Group Discussions were conducted with 204 female partners, 80 adolescent girls, and 99 adolescent boys.
The data collection tools sought to determine:

- The effects of men's participation in the Fathers Clubs on their perceptions and confidence in taking on household chores and childcare activities;
- What challenges and/or support fathers experienced changing attitudes and behaviors;
- What attitude, behavior, and relationship changes female partners and adolescent children had witnessed, either positive or negative;
- The personal effects of any changed behavior on fathers, partners, children, and community members.

"There's no loss in changing myself. Rather my relationship with the family is becoming better every day."

– Father, Bangladesh

"My parents are the closest person[s] of my life. Their relationship has improved, and they are happy. That is why I am happy too."

– Adolescent girl, Bangladesh

"Now my wife loves me very much and even my children now do appreciate and love me much due to the love I show to their mother."

– Father, Nigeria

RESULTS OF THE FATHERS CLUB STUDY

The results from the Fathers Club Study noted many positive changes amongst men, and positive reactions from female partners and adolescent children. The results from all four countries spoke to men taking up additional household chores and taking a more active role in childcare. In all four countries, men, women, girls and boys, noted improved family relationships, and more harmony in households. Changes in decision making were also noted in Ghana and Nigeria. In Bangladesh, Ghana, and Haiti, the respondents also spoke of seeing less violence at home, either between spouses, or between fathers and children. In Nigeria, there were no reports of reduced violence, however, respondents did report reductions in household conflict and arguments. In Ghana, many respondents spoke to increased affection and love in their homes resulting from fathers' changed behaviors. Consistently in all four countries, men, women, adolescent girls and boys, and community leaders attributed these changes to men's participation the Fathers Clubs.

"Now I have a good relationship with my wife and children."

– Father, Ghana

"It has improved because we can now sit down and discuss together which we didn't do before."

– Adolescent boy, Nigeria

"There is now much of understanding between us and we make all decisions together."

– Female partner, Ghana

"Before (they) quarreled very often. Several times I watched my father slap my mother. But since my father's participation in the club they have not quarreled anymore. They become very in love and that makes me happy."

– Adolescent girl, Haiti

"Working as a team allows each of us (husband & wife) to feel happy and useful."

– Father, Haiti

Strengthening Women and Girls' Agency

All of the activities under the GES contributed to strengthening the agency of women and girls directly and indirectly taking a socio-ecological approach (see Section 2). In particular, SHOW activities were heavily focused on promoting and encouraging women and girls' participation in and leadership of community groups. As part of project activities, several types of groups were strengthened and established:

- 1,419 VSLAs were operational across all five SHOW countries in the final year of implementation[98];
- 10,440 Women's Self-Help Groups and 4,176 adolescent peer education groups in Bangladesh were established[99];
- 476 Mothers' Support Groups, 431 Grannies Clubs, and 804 Adolescent Clubs were established in Ghana[100];
- 11 Champions of Change Clubs and 49 Mothers' Clubs were established in Haiti[101];
- 2,875 female VSLA members were mobilized in Nigeria[102];
- 36 EVF Clubs and 218 Grandmothers' Groups were supported in Senegal[103].

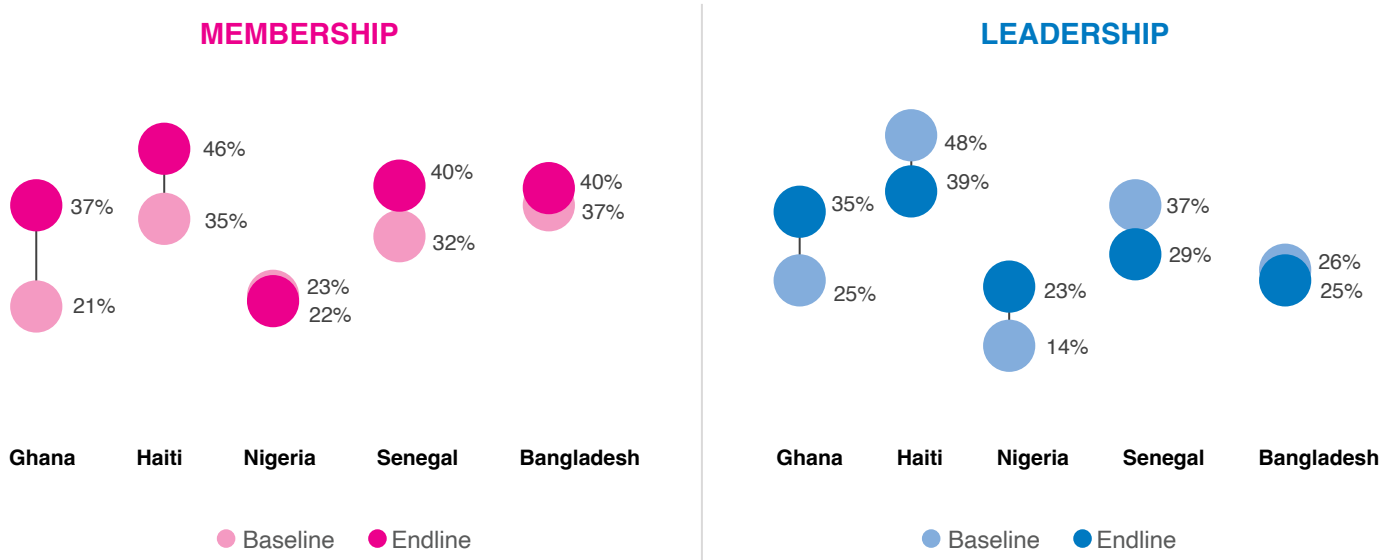
Between the baseline and end line studies, the percentage of **CHC members who are women** increased in four countries, with 16 pp in Ghana, 11 pp in Haiti, 8 pp in Senegal, and 3 pp in Bangladesh. However, in Nigeria it dropped by 1 pp. The percentage of **CHC leadership positions held by women** improved from baseline to end line across all project countries except in two countries. Women in leadership position of CHC increased 10 pp in Ghana and 9 pp in Nigeria, and remained stable in Bangladesh. However, it dropped 8 pp in Senegal, and 9 pp in Haiti.

"As a member of the Grannies Club and a representative of the Queen Mother, anytime there are issues of domestic violence, abuse or defilement, we meet with the leaders of the various groups and select people to talk to the families involved to ensure the issue is resolved. As a result, there has been a reduction in domestic violence cases in our community."

– Queen Mother, Ghana

98. *SHOW Consolidated Final Report*
99. *SHOW Bangladesh Final Report, Annex C*
100. *SHOW Ghana Final Report, Annex D*
101. *SHOW Haiti Final Report, Annex D*
102. *SHOW Nigeria Final Report, Annex C*
103. *SHOW Senegal Final Report*

[FIGURE 6] THE PERCENTAGE OF CHC MEMBERS AND LEADERS THAT ARE FEMALE



Although it was not included as an indicator, data on household decision making practices of women, adolescent girls, and men was collected during the SHOW project and was tremendously important for understanding progress on building individual agency amongst women and girls. The data collected on decision making shows some of the contributions of project activities to household level practices and shows the changes in women's decision making power that occurred during project implementation. Data was collected on whether women and adolescent girls made decisions alone, jointly with their spouses, or were excluded from decision-making on key MNCH/SRH decisions and other household decisions as listed below:

- To spend available cash at home
- To visit relatives or family
- To use family planning methods
- To send children to school
- To go to the health facility when pregnant
- To get children married
- To deliver at the health facility
- To breastfeed
- To seek medical services for herself or her children
- To purchase/sell household assets

The Importance of Quotas for Women's Leadership in Community Groups

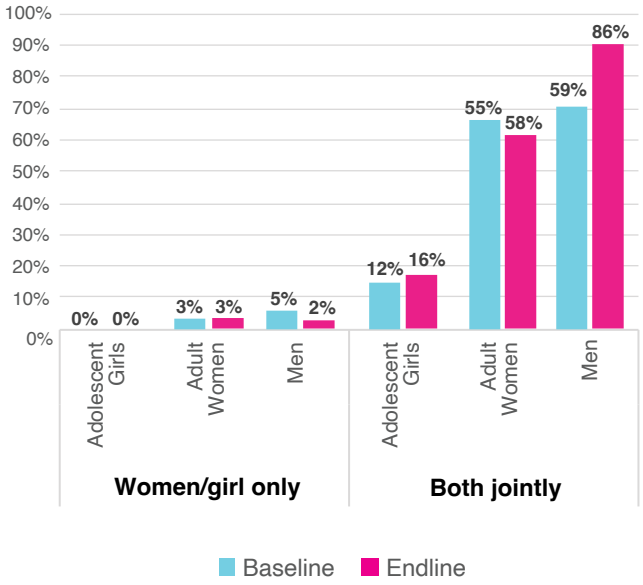
The experiences of the SHOW Project demonstrate how useful and important quotas remain to ensuring women's participation, and sometimes leadership in community groups. The case of women's participation as members of CHC in Senegal provides an excellent example. At the beginning of the SHOW Project, Senegal had a 30% quota for women's leadership in CHCs. The SHOW Baseline Assessment found that in project areas 37% of CHCs had female leaders, and that the quota had already been achieved. Mid-way through the project, the Ministry of Health in Senegal reviewed the mandates for Community Health Committees in the country. The objective of this exercise for the Ministry of Health was to review where community health committees were no longer efficient and to improve their institutional, financial, and managerial viability. Despite advocacy from Plan International representatives for the SHOW project to maintain the female membership quotas in the new CHC mandate, the Ministry of Health removed it. SHOW's indicators on women's leadership of CHCs fell in Senegal by 8 pp by endline and was below the initial quota. The Plan International Senegal team, and SHOW stakeholders, agreed that the removal of the quota had likely impacted the CHC compositions. By comparison, in Bangladesh, the project staff and stakeholders were able to continuously leverage the existing quotas for women's participation in CHC to continue to increase or sustain women's presence in these governing bodies. In Bangladesh the percentage of CHCs with female leaders remained relatively the same from baseline to endline. In the case of Ghana and Nigeria, female leadership increased from baseline to endline. These experiences demonstrate the importance of quotas as institutional tools to promote women's inclusion and leadership in local governing bodies.

Endline results suggested that adolescent and adult mothers in SHOW countries generally can decide on *breastfeeding* issues themselves, although in Haiti this appeared to be a joint decision for the majority of women. In other areas of household or health-related decision-making, results indicate that joint decision-making increased in all countries overall. In general, WRAs reported lower level of participation in decisions related to monetary issues such as *management of available household cash* and *purchasing/selling household assets*.

In terms of key decision-making issues contributing to women's empowerment, interesting gender transformative trends were observed when comparing baseline and endline results[104].

- In **Bangladesh**, it is interesting to note that only modest to no increases were observed for joint decision making for all issues among WRA, while important increases were observed among the male respondents for joint decision making, especially regarding *using family planning* (from 67% to 88%) and *sending children to school* (from 59% to 86%), as shown in **FIGURE 7**.
- In **Haiti**, similar increases in joint decision-making were observed for all domains and among all respondent groups. Particularly noteworthy are the substantial increases that both WRA and male partners reported in joint decision-making related to *getting their children married* (from 2–6% at baseline to 69–74% at endline).

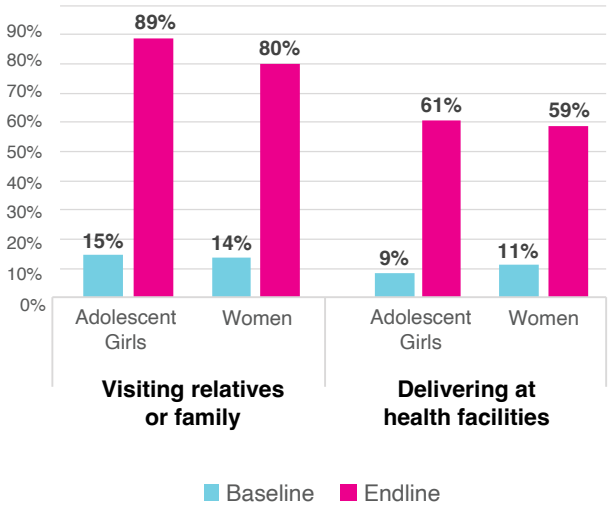
[FIGURE 7] DECISION MAKING ON CHILDREN'S EDUCATION IN BANGLADESH



- In **Senegal**, substantial increases from baseline to endline were observed in the proportion of WRA who reported joint decision-making practices on all issues, while more modest increases were noted among men. Particularly strong increases were reported by both WRA and male partners in decision-making related to the *use of FP methods*.
- In **Nigeria**, substantial increases were observed in joint decision-making in most domains. Additionally, respondents reported increased sole decision-making power for women on health-related issues such as the *use of FP methods, going to the health facility related to pregnancy, delivering at a health facility,* and *breastfeeding*. Additionally, joint decision making on visiting family reported by both women and girls increased substantially, as did decisions related to facility-based deliveries (see **FIGURE 8**);

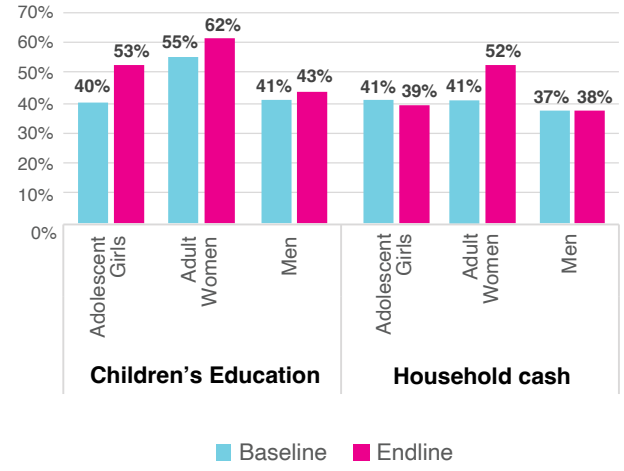
104. *SHOW Consolidated Final Evaluation; SHOW Bangladesh Final Evaluation*

[FIGURE 8] JOINT DECISION MAKING ON VISITING RELATIVES AND DELIVERY AT HEALTH FACILITIES IN NIGERIA



- In **Ghana**, WRA and men reported increased joint decision-making in all domains. Moreover, women reported substantial increases in *sole* decision-making related to the *use of FP methods* (adolescent mothers: from 7% to 51%; adult mothers: from 10% to 47%). There were modest increases in joint decision making for adolescent girls and adult women regarding children's education and for adult women regarding spending household cash. (see **FIGURE 9**);

[FIGURE 9] JOINT DECISION MAKING ON CHILDREN'S EDUCATION AND SPENDING HOUSEHOLD CASH IN GHANA



The implementation of the **VSLA Strategy** implemented within the context of SHOW, based on testimonials and case studies[105], has also demonstrated the viability of integrating women's economic empowerment activities to strengthen health programming.

The VSLA Strategy produced extensive positive outcomes for women and adolescent girls[106]. VSLA groups were established in each of the five countries and testimonials from VSLA members demonstrate the success of VSLA groups to contribute to the GES objectives, demonstrating the potential of this approach to contribute to strengthening women's social and financial capital. The groups provided a space where women could mutually support each other, and which could help alleviate financial barriers and burdens. These groups were notably leveraged to promote gender equality and the empowerment of women and girls through sessions and dialogues.

105. Testimonials included in the Y4 Mid-Year reports for Nigeria, Senegal, and Ghana

106. SHOW Consolidated Annual Report for Year 4, page 52

Many of the VSLA groups established social funds to support emergencies, which, based on testimonials[107], contributed to reducing barriers traditionally experienced by women trying to reach health facilities. The benefits of VSLAs have also moved beyond project objectives and some VSLA members have used their savings or loans to support girls' education for example. VSLAs have also provided in some areas opportunities for women to take leadership roles in resolving-community wide problems. For example:

- A woman-led VSLA group in Senegal worked with their health post and contributed to procuring essential medicines for the health-post's pharmacy.
- In Nigeria, one woman was appointed as a councillor in her Local Governing Area as a result of leadership of her VSLA group.
- In Ghana, women have reported that because of funds from their participation in VSLAs they address health issues that arise during pregnancy, they can renew their National Health Insurance Scheme cards, and have been able to expand business to support their families[108].
- In Ghana, links between VSLAs and CETS drivers have also been created in many communities, and women and girls have been able to use their VSLA savings or loans to make use of CETS transport. Understanding this, CETS drivers can be confident they will be paid and are more inclined to take part.[109]
- In Senegal, 238 VSLAs were established involving 6,691 members. Within the group, the oldest women act as godmothers for younger women and assist them when needed by giving them useful advice. The availability of savings allows women to make decisions for themselves in order to access and benefit from health services.
- In Nigeria, the impact of the VSLAs have been recognized by the Sokoto State Ministry of Women & Children Affairs and the Ministry has planned to make VSLA part of State programming for vocational skills, and the Ministry has allocated a special fund within 2020 Budget to strengthen, sustain, and expand the SHOW VSLAs[110].

The success of the VSLA approach can also be measured by the amounts that were saved by members. For instance, in Nigeria 3,680 members (2,300 F, 828 M) were involved in the VSLAs and the total amount saved for the Social Fund was $5,425 CAD and the total value of the SG Savings was $116,651 CAD. In Senegal, 6,691 members (6,281 F, 410 M) were involved in the VSLAs and saved $86,303 for the Social Fund and $1,227,284 CAD for the SG Savings[111].

Testimonials and reporting indicate that **adolescent outreach activities were successful** in sharing key information on MNCH, ASRHR, and gender equality with adolescents[112]. In Haiti, girls participating in the Champions of Change clubs reported to project staff feeling more confident and had noticed improvement in their self-esteem since joining the club. In Nigeria, testimonials from participants in the project reflect changes in behavior related to menstrual hygiene management and improved confidence amongst girls who belong to the peer education groups. In Ghana, peer educators have established mentorship relationships with younger girls and work with them to develop their leadership capacities; the goal is that younger girls can learn to become peer educators themselves through this mentorship.

"There is a change because I feel reassured to have health coverage for my whole family, we are quicker to seek medical help early in the event of illness without wasting time."

– Female VSLA member, Senegal

107. *SHOW Haiti Annual Report for Year 3; SHOW Ghana Annual Report for Year 3*
108. *SHOW Consolidated Annual Report Year 4, page 52*
109. *SHOW Ghana Annual Report Year 4, page 11*
110. *SHOW Nigeria Final Report*
111. *SHOW Nigeria Final Report; SHOW Senegal Y4 Report*
112. *SHOW Haiti Mid-Year Report Year 4, page 36; SHOW Nigeria Mid-Year Report Year 4, page 58*

Successes of the Champions of Change Program in Haiti

The Champions of Change activities in Haiti were able to have desired impacts on adolescent boys and girls, based on case studies and testimonials[113]. Adolescent girls were able to build their confidence and self-esteem and acquire valuable information on SRHR. Girls reported to their facilitators that they were happy to learn about puberty and reproductive health and were proud to have confidence and knowledge to help avoid early pregnancy. During field visits by project staff, girls from another group also expressed that the clubs had helped them gain greater confidence and to strengthen their self-esteem, and that they were now more confident to participate in leisure and sport activities along with their brothers or to ask for support from their parents. Adolescent boys expressed appreciating the variety of activities and that they were able to learn a lot in the clubs.

UNEXPECTED CONSEQUENCES OF CHAMPIONS OF CHANGE IN HAITI

There were two important unexpected consequences of the Champions of Change program in Haiti:

- Plan International was able to use testimonials and the reported experiences of Champions of Change members to advocate for the expansion of sexual and reproductive health services, particularly contraceptives[114], to the Ministry of Health. Champions of Change members expressed during the sessions the many difficulties they faced accessing contraception, and the harmful behaviors and relationships that younger adolescents engaged in with older adolescents or adults to gain access to needed SRH services[115]. Plan International was able to use these first-hand adolescent experiences to advocate for changes in policy at the Ministry level, to work with health providers to strengthen GRAF service delivery, and to strengthen CHW capacities to address ASRHR issues[116].

"Before, I knew nothing about sexual and reproductive health, but now I know what this is about."

– Adolescent girl,
Champions of Change session attendee

- Some of the adolescent groups, boys and girls together, leveraged the bonds they formed through their participation in the Champions of Change program to develop a VSLA group for their club to continue their regular meetings past the end of the project and to contribute to their economic empowerment.

113. *SHOW Haiti Annual Report Year 3*
114. *For the duration of the SHOW project, the Haitian Ministry of Health regulations prevented adolescents from being provided with contraceptive counselling or services from health providers with the consent of a parent or spouse.*
115. *SHOW Haiti Annual Report Year 3*
116. *SHOW Haiti Annual Report Y4*

3.4.2 FACILITY LEVEL RESULTS

The third pillar of the GES sought to improve the gender-responsiveness and adolescent friendliness of MNCH/SRH services. Project activities under this pillar directly contributed to improving the quality of services, and also indirectly contributed to strengthening women's and girls' empowerment and increasing male engagement. As discussed in Section 3, considerable resources were dedicated to training health providers through the development of job aids and refurbishing facilities. As a result[117]:

- 6,622 CHWs, including 4,260 women, were trained on MNCH/SRHR, gender equality, adolescent issues and mobilization.
- 2,891 health care providers, including 1,446 women, were trained on responsive MNCH/SRHR services.
- 7,311 CHWs (CBHVs), health providers and drivers were trained on GRAF referral protocols, including 3,904 female CHWs and health providers in Ghana, Nigeria, Haiti and Bangladesh.
- 1,315 CHCs received training, for a total of 10,198 CHC members trained across all countries.
- 406 health facilities were provided with equipment, supplies and waste disposal units across all countries, and 206 health facilities undertook gender- and adolescent-responsive refurbishment, taking into consideration the local natural environment.
- A significant increase was recorded on ANC attendance at least four times across the five countries, and a significant increase in skilled delivery was recorded across the five countries.
- 15 adolescent spaces were constructed in Ghana and 3 in Haiti.

The indicators included to measure the progress of this pillar considered MNCH/SRH services and referral services and looked at which facilities met GRAF criteria. They also calculated the satisfaction of women, adolescent girls, and men based on survey responses of those who had sought services. With regards to **meeting GRAF criteria**, results from the endline study revealed a continued need for improvement in the provision of GRAF referral services. Substantial increases in GRAF of referral services were observed in Ghana and Bangladesh. Endline data also revealed increases in Haiti; but despite this improvement, two-thirds of facilities at endline failed to meet the service standards. In Nigeria and Senegal, there were no significant changes between baseline and endline in the percentage of facilities meeting standards for GRAF referral services.[118]

With regards to **satisfaction with MNCH/SRH services,** endline results were also mixed. Increases in women and adolescent girls' satisfaction with services occurred in Bangladesh, Ghana, Senegal, and Nigeria, although in Nigeria the satisfaction was still low with only just a little more than half saying they were satisfied. Meanwhile, in Haiti, satisfaction levels with MNCH/SRH services significantly decreased for women and adolescent girls as well as their male partners, and in Senegal satisfaction levels decreased for male partners. Increases were also seen in women and girls' satisfaction with referral services in Bangladesh, Ghana and Senegal, and increased satisfaction of referral services among male partners in Ghana, Senegal and Nigeria. In Haiti, satisfaction with referral services went down for women, adolescent girls, and their male partners, and in Bangladesh satisfaction levels for male partners went slightly down from baseline to endline.[119]

"The nurses assured us of confidentiality, so we feel very comfortable in telling them our problems. They take time to listen to us and counsel us. Generally, there is friendly and competent staff. Adolescent corner, though limited space, provided privacy and confidentiality. They also followed COVID-19 safety protocols."

– Adolescent girls, Ghana

117. *SHOW Consolidated Final Evaluation Report; SHOW Bangladesh Final Evaluation Report; SHOW Project Final Reports for Ghana, Bangladesh, Haiti, Senegal, and Nigeria, Annex C & D*
118. *SHOW Consolidated Final Evaluation Report; SHOW Bangladesh Final Evaluation Report*
119. *SHOW Consolidated Final Evaluation Report, SHOW Bangladesh Final Evaluation Report*

There are a number of reasons that might explain this apparent reduction in satisfaction at project endline.[120] First, service users are now better informed about the quality of the services they should be receiving as a result of awareness-raising sessions in the communities. Second, this specific indicator only takes into account people who are "highly satisfied" with the services overall, not counting those who are satisfied, and it does not take into account satisfaction with the SHOW project interventions. Also, when users are not asked for their satisfaction immediately after receiving the service, the reliability of the answer is limited. Generally, caution is needed in interpreting service satisfaction as an indicator of service quality due to some of the reasons stated above plus client's perspective of service quality is just one component among other objectively measured health service quality indicators[121]. Therefore, higher expectations among WRA and men is a positive development in serving as a push factor in the demand of better MNCH/SRH services. Furthermore, a greater disaggregation into the components of perceptions of satisfaction by WRA is now seen as a more useful way to capturing this data.

When service users were asked about what they thought might have contributed to the changes, they attributed these changes to SHOW, specifically training of Skilled Health Personnel (SHP) and CHWs. SHPs and CHWs in Ghana, Haiti, and Senegal reported that they felt more equipped to provide services to the communities after their participation in trainings such as those focused on GRAF which were organized by the SHOW project. Health workers opined that the trainings equipped their knowledge, skills and confidence to do their work and enabled them to improve the quality of their services.[122]

"I am very lucky to receive GRAF health service training. This training helped sensitize me to provide gender responsive health services to patients as they preferred. I will be more careful about the adolescent girls."

– Health provider, Bangladesh

In Ghana, CHC members reported using the GRAF service delivery checklists provided by SHOW to improve their oversight of health services. *"Having received the checklist, it gave me an insight as to what to expect from service providers. It also increased my interest in supporting health workers to provide quality services to clients. We [now] hold quarterly meetings with the health workers to discuss how to improve upon service delivery which has helped in strengthening the relationship between clients and service providers as well as clients' satisfaction levels with services,"* said one Ghanaian CHC member.[123] In Haiti, health providers are taking extra care to ensure that there is appropriate seating available for both partners to sit in consultation rooms dedicated to MNCH/SRH services.[124] During monitoring visits to Nigerian health facilities, project staff noted the availability of adolescent waiting corners, counselling rooms and furniture (a sitting table and chairs), and the presence of signage indicating where adolescent specific services were located at the facility.[125]

"My capacity has improved so much in mentoring and I feel more comfortable while mentoring other service providers in the areas of administering magnesium sulphate and gender responsive adolescent friendly service provision."

– Health service trainer, Nigeria

120. *SHOW Consolidated Final Evaluation Report*
121. *Schoenfelder T (2012) Patient Satisfaction: A Valid Indicator for the Quality of Primary Care? Primary Health Care 2:e106. doi:10.4172/2167-1079.1000e106*
122. *SHOW Consolidated Final Evaluation Report*
123. *SHOW Annual Report for Year 4*
124. *SHOW Haiti Annual Report for Year 4*
125. *SHOW Nigeria Annual Report for Year 4*

SECTION 4:
LESSONS LEARNED AND RECOMMENDATIONS

The following section outlines some of the key lessons learned and recommendations from the design, implementation and monitoring/evaluation/learning of the Gender Equality Strategy of the SHOW project.

4.1 PLANNING, DESIGN, AND INCEPTION PHASE

The inherent complexity of designing a Gender Equality Strategy (GES) that is aligned across 5 countries and also responds to their *individual gender dynamics* and barriers can be challenging. From a global design perspective this can effectively be addressed by identifying core common gendered barriers, and then building into activity streams key resources and moments for further contextualization. In this way, the SHOW project was able to **successfully design a Global SHOW GES across a diversity** of communities by creating three universal pillars for the GES. While tailoring the strategy for each country to the specific experience and situation of women and girls in that community based on the gender equality assessment of the respective countries. While a consistent overall architecture of high impact actions and strategies is possible, within the pillars, approaches and stakeholders necessarily have to be contextually relevant. For example, leveraging the influence of Queen Mothers in Ghana or Grannies Clubs in Senegal to drive social norm change or the use of a variety of locally relevant SBCC platforms or whether the full Champions of Change methodology (Haiti) is applied compared to an expanded model of peer education for adolescents (Bangladesh, Ghana, Nigeria and Senegal). Achieving full consistency in approaches, while important is not critical as the only factor of success as long as: 1) the **quality** of gender transformative **content** is consistent (duly localized using local languages and examples) covering the full range of gender equality issues and domains including access to and control over resources, participation and decision-making; gendered distribution of labour/roles and responsibilities, harmful gender norms etc. ; 2) the **intensity and depth of intervention** is comparable and consistent for example creating Fathers Clubs (Ghana, Haiti, Bangladesh and Nigeria) or leveraging existing Husband's Schools (Senegal) is not the critical point as is the importance of taking participants through a participatory, reflective gender transformative journey of change through well trained facilitators; 3) the approaches are well aligned to contributing to the objectives of the GES pillars and outcome indicators that measure gender transformative change.

A strategic partnership such as the SHOW **partnership with Promundo** is highly effective in pooling expertise and experience, leveraging resources and good practice, testing and documenting innovative approaches that is mutually beneficial to the partners as well as in achieving the objectives of the GES. This can raise the profile and investment in a specific pillar or component of the Gender Equality Strategy, as was the case with the male engagement pillar of the SHOW GES. Because this investment in design and planning was so in-depth and well-resourced, the implementation and results were successful and well-documented relative to the activity streams for building the individual and collective agency and empowerment of women and girls. For example, whereas the women's support group activities took a more broad approach to their content and messaging, largely relying on the general SBCC materials developed by the project, a consistent set of guidelines and curriculum was used for male engagement, which not only propelled the male engagement activities forward with greater efficiency and consistency, but ensured a high degree of technical support for project teams. While this challenge was addressed later in the project through the development of the **Women's Empowerment Curriculum**, initial gaps and inconsistencies could have been reduced by building a more robust technical foundation into the design of this pillar.

Adequately resourcing the development of materials and curricula, as well as planned training and refresher trainings, is essential for building the skills needed to deliver gender transformative activity streams. The inherent challenge during the design and inception phase of a project is to strike the appropriate balance between adapting existing local materials that support gender equality and health programming, and the development of new materials focused on gender transformative change. Striking this balance had various challenges and successes across the SHOW project. Because the male engagement pillar was for the most part a new approach in most countries taking it beyond traditional men's education on MNCH/SRH to gender-transformative change, a curriculum could be introduced very early in the project to fill what was an anticipated national gap. However, for activities supporting women's groups, adolescents groups, health outreach, and service provision, the project planned for adapting or adding to

existing national and regional curricula requiring a detailed review of curricula, adding/adapting content and getting government approvals especially for community and facility health providers training and adolescent education. This often resulted in delays in content creation, adaptation and validation based on national contexts but was necessary for aligning with national policies and priorities and ensuring government buy-in to take the content forward after the phase-out of the project. To mitigate the expected delays, Plan International drafted a host of global multi-purpose guides and resources covering women's leadership training, GE in VSLA, gender-responsive and adolescent-friendly service delivery for community and facility based health providers related activities and additional gender transformative content from Plan International's Champions of Change for including in national adolescent peer education curricula, which contributed to mitigating delays and in providing consistent and quality content to inform the development of materials across the board. Mostly these reviews and content development was done by local technical consultants, who had variable expertise in gender equality integration. A gap was under-budgeting of resources required to carry out GE reviews and content adaptation and development that happened simultaneously for several activities and often fell on SHOW project Gender Equality staff resulting in an intensive effort burden for the GE staff. Budgeting adequately for gender equality expertise is critical. Often at design stage it is difficult to assess the full extent of this need and can be addressed by setting aside a budget for technical support and development to be used as required. This would free up time for project GE staff to focus on the overall project outcomes and quality.

4.2 IMPLEMENTATION

Gender transformative programming requires the dual approach of addressing gender barriers and social norms through targeted gender specific actions the objectives of which are to address the root causes of gender inequality and power relations by working on both the condition/practical needs and social position of women and girls (for example activities relating to male engagement or the participation of women in CHCs), while also mainstreaming gender equality throughout all activities, processes and approaches (such as activities relating to health service delivery including capacity building, facilities refurbishment, supportive supervision etc.). At the outset of the project, SHOW used a parallel tool to map out the specific gender equality elements of activities across the project during work-planning. The **Gender Equality Action Plan (GEAP)** was used during each annual work-planning process to detail the work, resources required and accountability in each activity stream to address gender equality. In Year 3, project teams reviewed the effectiveness of this approach and observed that while this provided a detailed action plan for management of gender equality integration, it was almost exclusively owned and managed by the Gender Equality Advisor and caused gender equality to be treated in a 'silo', rather than as a shared responsibility. For Year 4 work-planning, the project took the approach to integrate GE actions into the overall project workplan to create shared accountability for GE amongst project teams. While the latter approach is indeed the preferred one, it can inadvertently lead to the exclusion of gender equality staff led by other technical specialists, often when there is a time-crunch for implementation and requires a high degree of proactiveness by GE staff. Whatever the approach to gender equality programming, as there is no single best practice, it has to be coupled with ongoing empowering capacity building of full project teams on gender equality that goes beyond theoretical concepts to addressing unconscious gender related biases and attitudes to practical skills of mainstreaming gender across all activities including for technical, finance, M&E and administration staff demonstrating how gender equality is relevant to their role in the project. SHOW carried out these trainings for project and partner staff at the outset, and through refreshers over the life of the project and also for project governance structures such as the Project Steering Committees and Technical Advisory Committees across SHOW countries that included government and sector stakeholders.

In order to provide a consistent technical approach to gender transformative programming across the five-country SHOW project, a set of **implementation guidelines** was developed by Plan International in Year 1 of the project, with Promundo's support for those related to male engagement. These programmatic guidelines were developed with the objective of providing a 'one-stop shop' for project staff and partners to find the rationale, technical guidance and tools for gender equality in a variety of intervention areas, including health service delivery, engagement of traditional and religious leaders, capacity building of CHWs, VSLAs, male engagement in SBCC and others for subsequent contextualization and adaptation. The guidelines were an essential reference for Gender Equality Advisors and partners across the project, and a strong support for the development of materials and trainings. These guides were socialized in all countries with project and partner staff both remotely and in country. However, during

the Sharing and Learning Workshop held in Dakar, Senegal in 2018, some key lessons learned were shared by project staff from all five countries. While the guidelines were a strong support for gender transformative programming across SHOW, they could have been more effectively socialized across project teams at the outset, through trainings and ongoing support, and the language could have been more accessible for local partners and staff.

Gender equality objectives, especially at the community level, require engagement with a variety of stakeholders and gatekeepers because of their influence on the maintenance or challenging of social norms – key to addressing the root causes of gender inequality. This included, for example, the engagement and training of religious and traditional leaders, Fathers Clubs facilitators, community health workers and/or extension workers, community leaders and "champions". This engagement is important in order to ensure community buy-in, ownership and appropriate contextualization, and is an important factor in the success of the SHOW GES. However, these **stakeholders can often be over-burdened and under-supported**. In the SHOW project, for example, certain stakeholders were leveraged as entry points for a variety of different concurrent activity streams – leading the Fathers Clubs, household visits, supporting adolescent groups – and these reported a degree of engagement fatigue during project monitoring. Additional risks can include attrition and loss of skilled facilitators/contributors, dissatisfaction with lack of compensation/incentives, and wavering commitment due to competing responsibilities in the community and at home. A strong balance between project staff to support the implementation of activities that require high skill levels and time commitment, and engagement of community gatekeepers as volunteers (even if they are provided with incentives for their work), must be struck in order to ensure successful completion of project activities and continued community support for project objectives. Notwithstanding, the use of community volunteers to drive programming through technical skills transference is an important and effective strategy towards sustainability once the project sunsets.

Early negotiation and agreement with relevant Ministries are key for **implementation and sustainability of health service staff training in gender equality**, and project aspirations and commitments must be adjusted according to the negotiated space they are afforded by government for capacity building of service providers. Consistency was particularly difficult to achieve with respect to the building of health provider

capacities in gender responsive and adolescent-friendly service delivery, as it is often seen as an 'add-on'. As discussed above in Section 3.3, a flexible approach was taken to the integration of the principles and practices of gender responsive service delivery (based on the project guidelines) into various health service trainings, with the most common approach being the agreed-upon addition of sessions on GRAF ranging from a half to a full day, with some exceptions for deeper revisions to government trainings (for example, family planning in Nigeria). The benefit of this approach is the ability to be reflexive and responsive to government preferences and schedules, and to opportunities as they arise. The challenge with this approach is that because the interaction time was limited and the content was intended for cascade, project staff were unable to explore a deeper attitudinal change amongst service providers, and rather focused for the most part on providing examples of gender responsive actions and behaviours that they could adopt in their service provision. Ideally, health provider training on GRAF should be integrated across all health technical trainings and not as an "add-on" unpacking gender-biases and attitudes, building an understanding of the gender determinants of health, demonstrating gender as a core quality of care element and with practical skills on how to deliver GRAF services. This needs to be squarely premised on national commitments on GE, specifically in health that most countries have, coupled with evidence based advocacy with governments, including Ministries/Departments of Gender/Women's Affairs on the effectiveness of GRAF on service uptake for adoption of this capacity building module into the training curricula of health service providers, routine supportive supervision and overall health systems management that projects should undertake at the onset.

Gender transformative programming necessarily involves the changing of attitudes and perspectives towards more gender equal and inclusive behaviours and this naturally requires a specific skillset, and prolonged engagement. Investing in **sufficient gender equality technical skills** was essential in the implementation of the SHOW project's Gender Equality Strategy, and where the strongest investments were made, the activity streams supporting the GES were most robust. For example, whereas the Senegal and Bangladesh projects had a vast geographic spread and were covered by a GE technical staff based in Dakar and Dhaka respectively, it was a challenge for the specialists to remain consistently connected and provide ongoing supportive supervision to GES activity streams. By contrast, Ghana had 2 GE staff who were split geographically and worked very closely with their health counterparts, which reflected very strongly the geographic delivery of the key activity streams in the GES. By and large local partners across countries were further supported by way of GE experts for the projects, however this was variable in terms of time investment of the GE personnel. While project level GE capacity is critical in implementing gender transformative programs, it is also critical to: 1) engage with local level GE experts, especially women's and girls' rights organization who are experts in the context and are best placed to drive locally relevant and sustainable solutions; 2) build the core capacities of local project partners on GE and gender transformative programming and measurement of results.

4.3 MONITORING, EVALUATION, AND LEARNING

Planned **qualitative monitoring data is essential** to inform work-planning, course correction and adjustments to project activities to meet gender transformative outcomes and objectives. While qualitative data collection and analysis is helpful in many outcome areas, it is a particularly relevant methodology for examining progress on social and behaviour change results and exploring why or why not progress against certain targets are being achieved. This was evidenced in the SHOW project by the mid-term monitoring visits conducted by Promundo (see Section 3.2), after which the project was able to respond to the specific challenges experienced in different countries by variously adding additional technical training on male engagement materials, translating materials to local language, and redirecting some messaging that was contributing to the reinforcement of traditional gender roles. The women's and girls' empowerment pillar of the GES would have benefited from a similarly resourced and focused mid-term monitoring exercise to gauge reaction to and effectiveness of the diversity of interventions across the project specifically targeting women and girls. This would be a valuable investment in future projects as it provides an opportunity to directly capture the perspectives of women and girls and provide a level of gender equality analysis that is important for informing programming.

Changes in **women's and girls' individual empowerment and agency are challenging to monitor and measure**, especially within the context of a complex project design that already carries a heavy burden of commitment for measurement in other areas of the intervention. The key gender equality indicators included in the design of project PMF were focused on male support for MNCH/SRHR, perspectives on whether women should participate in decision making, and the level of membership and leadership of women

in community groups[126]. While these indicators did not include women's perspectives on actual changes in the level of agency or empowerment, the project data collection included a section on household level decision making practices in a variety of areas (including beyond health-related decisions) **from the perspectives of adolescent girls, women**, and male partners. During analysis, and in the effort to better understand the household level and individual level progress of change for women and girls, this datapoint proved to be a very relevant and revealing source of information (see Section 3.4 Results). Therefore, even if several additional indicators pertaining to the agency and empowerment of women and girls cannot be added at outcome level, as they may be prescribed and unchangeable or to keep the PMF lean and feasible, it is possible and desirable to add core GE questions in survey tools including baseline, mid-term and end-line that can be analysed and triangulated across other GE indicators to derive a picture of gender transformative change.

For multi-country projects, there is an incredible opportunity for **collaborative learning, sharing and capacity building between country teams and amongst technical teams** on gender transformative programming. To this end a couple of informal and formal platforms for exchange were put in place, including a Skype based chat between GE staff across countries. While initially this mechanism was employed frequently especially at inception, time differences, language, connectivity and availability challenges saw a reduction in the utility of the platform and was discontinued in Year 2 of SHOW. Instead GE Advisors at Plan International Canada played a coordination role by sharing materials, resources and emergent good practice and issues. The learning is that sharing of resources and materials is important so that country-based teams do not re-invent the wheel and can adapt resources to their contexts; however, this does not replace the value of dialogue, co-creation and shared solutions. It is important to create and sustain a dialogue space, using the best available technologies that is supportive, safe and meaningful, the importance of which needs to be well communicated to management and built into the staff's terms of reference. Additionally, the SHOW project hosted a Sharing and Learning Workshop at the mid-point of the project in August 2018 in Dakar, Senegal that was extremely valuable in terms both of sharing and workshopping common challenges across the project, but also of exploring different effective approaches to similar interventions and celebrating successes across the project. The workshop brought together key technical and management staff, and strategic partners, from each of the five SHOW countries for a five-day intensive workshop. Gender equality was mainstreamed throughout all discussions, including management, ASRHR, and monitoring, evaluation and learning (MEL), and was also the focus of a full day of workshop activities and sharing.

This collaborative sharing moment was particularly valuable for the GES in several ways: it raised the profile of the work being undertaken related to the transformative elements of the project, it alerted many staff to the need to further embed the guidelines and better understand how they can be used in their individual work, and most importantly, individual projects benefited from increased capacity and shared knowledge and shared experiences at the workshop. Building in such in-person exchange events as frequently as feasible, in addition to the remote means described above, go a long way in building a shared vision, commitment, momentum and accountability.

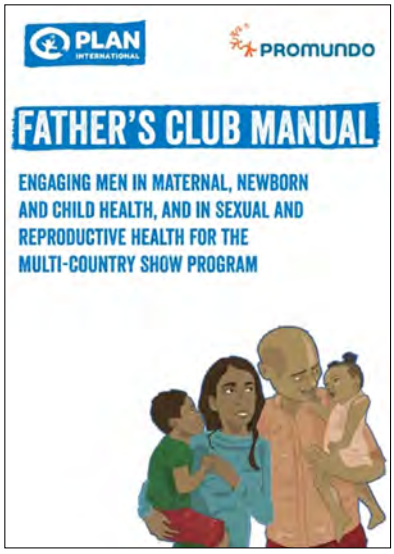
126. *See Section 1.*

SECTION 5: SHOW LEGACY DOCUMENTS

The following section provides a list of technical documents that were created during the course of SHOW's implementation that can be leveraged and utilised by others to strengthen their delivery of gender transformative MNCH/SRHR programming. Below is a brief summary of each technical document, along with its purpose within the SHOW project, who the document is intended for, and how the resource and/or tool may be applied within the scope of an MNCH/SRHR project or program.

SHOW FATHERS CLUB MANUAL

Plan International, in collaboration with Promundo, developed a manual specifically for the SHOW Fathers Clubs. Inspired by Promundo's Program P, the SHOW Fathers Club manual is comprised of 20 sessions related to gender equality and MNCH/SRHR which are designed to engage men to reflect on norms related to masculinity and fatherhood, either alone, with their Fathers Club, or with their partners. These reflections engage men to become more aware of gender inequalities and how these effect them, their partners, and their children. These sessions lead men to construct new definitions of masculinity and to adopt of more gender-equitable behaviors in their homes and communities. Throughout the manual, special emphasis is placed on understanding gender inequalities through the particular focus on MNCH/SRHR.



This manual takes a gender transformative approach by engaging male participants in Fathers Clubs to "actively question what it means to be a man or a woman in society and in challenging inequitable gender norms and power imbalances"[127]. The sessions use a variety of group activities, group reflections and discussions, and homework assignments to promote long-term changes in gender relations and power dynamics with the aim of improving men's relationships with themselves, their female partners, and their children. The sessions encourage men (and women when possible) to develop their own solutions to common challenges to men's engagement in MNCH/SHRH based on equity, equality, non-violence, and respect.

Link to SHOW Fathers Club Manual

127. *SHOW Fathers Club Manual*

THE SHOW FATHERS CLUB LOW LITERACY AND LOW RESOURCE VERSION

A second version of the Fathers Club Manual was developed by Plan International and Promundo to respond specifically to low literacy and low resource settings where Fathers Clubs may be implemented. This version of the manual consolidates the messages, activities, and session of the original manual and presents them into a more visual and easy-to-read manual and is designed to meet the literacy levels of a variety of facilitators and Fathers Club participants.

WHO CAN USE THIS RESOURCE?

Both versions of the SHOW Fathers Club Manual are intended to be used first and foremost by facilitators of Fathers Clubs, and/or of men's engagement groups. The manuals can also be used by project/program designers and implementers to develop a male engagement group approach or strategy, to design and implement trainings for facilitators. Both versions of the manual provide guidance on facilitation techniques appropriate for Fathers Club sessions.

GENDER RESPONSIVE AND ADOLESCENT FRIENDLY MNCH/SRH SERVICE DELIVERY GUIDES

Three guidance notes of GRAF MNCH/SRH service delivery were developed for the SHOW project:

1. Gender Responsive MNCH/SRH Service Delivery
2. Adolescent Friendly MNCH/SRH Service Delivery
3. Promoting Gender Equality in Community MNCH/SRH Education: Guide for Capacity Building of Community Health Workers

These three guidance notes were developed to strengthen the capacity of health service providers, along with health service planners and decision-makers, on:

- The intersections of gender inequality and the social determinants of health, the intersections of adolescent age and the social determinants of health, and the impacts of these intersections on health outcomes;
- Measures and practices to adopt to render their delivery of MNCH/SRH services gender responsive and adolescent friendly.

Each of the guidance notes are structured based on the two key areas which they aim to strengthen: the guidance notes begin with providing the foundational and theoretical knowledge on gender equality and adolescent issues, and how these interact with MNCH/SRHR and then provide practical guidance on how service providers can make their service delivery gender responsive and adolescent friendly. The guides on gender responsive service delivery and on adolescent friendly service delivery also include checklists that health providers, or supervisors, can use to determine the degree to which their services are gender and adolescent responsive.

WHO CAN USE THIS RESOURCE?

These guides are intended to be used by organisations implementing MNCH/SRH projects. The guidance notes can be used as tools:

- To conduct advocacy on GRAF service delivery with national or sub-national Ministries of Health and Ministries of Women's Affairs;
- To design and implement health service provider and CHW trainings on GRAF service delivery;
- To design and implement training for health service provider supervisors and managers;
- To orient and/or training of CHC members;
- To strengthen organisational and/or stakeholder capacities on GRAF MNCH/SRH services.

SHOW MALE ENGAGEMENT PROGRAMMING GUIDES

In collaboration with Promundo, four project guides were developed to support the implementation of the second pillar of the GE Strategy focused on male engagement in MNCH/SRHR. The table below summarizes the four guides and explains their purpose and use.

WHO CAN USE THIS RESOURCE?

The guides were designed to be used by staff and project partners who are integrating male engagement into MNCH/SRH programming. They can be used as direct implementation tools or as guidance documents to help develop activities and strategies and are designed to be used as a package.

Male Engagement Guides	Intended Use of Guide	
Guidance Note on Male Engagement in Maternal, Newborn, and Child Health / Sexual and Reproductive Health	This guide is intended to support project staff to develop and implement male engagement activities directly with men, such as Fathers' Clubs. The guide summarizes the rationale for male engagement, along with a general recommended approach and best practices. This guide was designed to accompany to the SHOW Fathers Club manual.	
MNCH/SRH Advocacy Guidance Note: Male Engagement in Maternal, Newborn, and Child Health / Sexual and Reproductive Health	This guide is intended to support project and organisational staff to conduct advocacy on male engagement in MNCH/SRHR. The guide explains policy advocacy, provides steps to creating a targeted advocacy plan, and provides lessons learned from MenCare country partners.	
Communications and SBCC Guidance Note: Male Engagement in Maternal, Newborn, and Child Health / Sexual and Reproductive Health	This guide is intended to support project and organisational staff to develop and implement SBCC campaigns and activities which have integrated messaging on male engagement. The guide provides a step-by-step approach for development male engagement sensitive MNCH/SRH SBCC materials. The guide also includes best practices on male engagement focused SBCC materials.	
Guidance Note: Working with Religious and Traditional Leaders to Promote Male Engagement in Maternal, Newborn, and Child Health / Sexual and Reproductive Health	This guide is intended to support project and organisational staff to develop and implement activities and strategies to engage religious and traditional leaders on male engagement in MNCH/SRH. The guide provides a step-by-step approach to leaders' engagement, accompanied by tools, which can be followed easily by project staff. The guide also includes some examples of other projects/ programs where this approach has been used.	

GE GUIDANCE FOR MNCH/SRH PROGRAMS INCORPORATING VSLA IN SUPPORT OF BETTER MNCH/SRH OUTCOMES

Plan International developed a specific guidance note to support the implementation of the VSLA strategy, and to ensure that gender is mainstreams across VSLA activities. The guide provides key information and guidance on:

- Why and how to use a gender transformative approach in VSLA group formation and support;
- How to support VSLA facilitators to lead and coordinate discussions on gender equality and MNCH/SRH.

The guide provides instructions on how to integrate a gender transformative approach within each step of the VSLA process, using suggested approaches and useful exercises. The guide also provides key gender-related considerations for each step of the VSLA process and provides examples of best practices to mainstreaming GE in VSLA. The guide also provides activities that can be led with VSLA facilitators to build their capacity on facilitating gender transformative VSLA groups and on facilitating sessions on GE and MNCH/SRH topics with their VSLA groups.

WHO CAN USE THIS RESOURCE?

The guide was designed to be used by project and organisational staff to design and implement VSLA strategies and activities, and to develop training materials, facilitator and/or staff trainings on gender transformative VSLA, and to provide support to VSLA facilitators working in communities.

WOMEN AND GIRLS' EMPOWERMENT: PROGRAMMING AND ACTIVITIES GUIDE

This guide was designed by Plan International to provide a curriculum complimentary to the SHOW Fathers Club Manual destined specifically for use with women's and adolescent girls' groups. The guide is designed to be used during the design and implementation of interventions focused on women and girls' empowerment, particularly within the contexts of MNCH/SRH projects. It provides some key definitions and concepts and guidance on implementing activities. The third section of the guide provides a curriculum of activities to be facilitated with women and girls' support groups, in a similar way that the Fathers Club Manual activities are designed.

WHO CAN USE THIS RESOURCE?

This guide is intended to be used by project/program designers and implementers to implement activities that promote the empowerment of women and girls. The guide can also be used directly by facilitators of women and girls support groups.

ISLAMIC PERSPECTIVES ON MNCH

The "Islamic Perspectives on MNCH" guide was developed to support project staff and religious leader engaged working with SHOW Nigeria. The guide was developed as an advocacy tool to engage religious and traditional leaders, and also as tool that could be used by religious leaders to promote gender equality and male engagement in MNCH/SRH. The guide provides evidence of gender equality's compatibility with Islam by highlighting a number of passages from the Quran that speak to equality between men and women.

In the name of Allah, the Most Beneficent, the Most Merciful

All praises belong to Allah (S.W.T) the Lord of the Universe. May His peace and blessings be upon our Prophet Muhammed (PBUH), his family and his companions up to the day of Judgement.

1. INTRODUCTION

This document illustrates how the SHOW objective and gender equity approach are compatible with Islam by providing a number of excerpts from the Quran that clearly emphasize equity between men and women. It is a resource for Sokoto state traditional and religious leaders to conduct sensitization sessions with their peers and communities on MNCH/SRHR and gender equity.

Under the Supporting Health Outcomes for Women and Children (SHOW) project, Plan International Nigeria is working with community members, local civil society organizations, and the Sokoto state government to increase the quality, availability, utilization, and accountability of essential Maternal, New-born and Child Health (MNCH)/Sexual and Reproductive Health and Rights (SRHR) services to reduce maternal and child mortality amongst marginalized and vulnerable women, specifically adolescent girls, and their children. Taking a gender equity approach, the project focuses on improving the position of women and girls by empowering women and girls, engaging men to address cultural gender-related barriers, and improving the gender-responsiveness and adolescent friendliness of facility-based services.

Islam emphasizes that righteousness and moral duty are identical in the case of men or women as women are equally responsible before Allah for their religious duties and worldly deeds as men, and they will be judged equally (men cannot take responsibility for women's deeds). It affirms, clearly and consistently, women's equity with men and their fundamental right to actualize their human potential. It is a well-known fact that, human beings are considered as the most respectable of all creation by Islam. Thus, all Islamic injunctions and laws are directed towards the protection and welfare of all human beings without exception. It could therefore be seen that Islam always aims at achieving five goals which the whole life of mankind revolves around them (المصالح) they include:

a) Protection of belief;
b) Protection of life;
c) Protection of property;
d) Protection of intellect; and
e) Protection of belonging;

Eight topics are covered in the manual:

1. Islamic perspectives on maternal and child health issues;
2. The courageous husband is he who guarantees all the rights of his wife;
3. Care for a woman in the MNCH continuum of care;
4. Women's status before Islam;
5. Islamic position on consulting women in decision making in the family;
6. Prohibition of harsh measures depriving a woman of her rights;
7. Proper medication;
8. Child spacing.

WHO CAN USE THIS RESOURCE?

This guide can be used by project or organisation staff working on gender equality and/or MNCH/SRHR programming in countries, regions, or communities where Islam is practiced. The document can be used by staff as an advocacy or engagement tool to work with religious and traditional leaders. It can also be shared with religious and traditional to use to guide their own advocacy and engagement activities on gender equality and MNCH/SRHR.

KNOWLEDGE MANAGEMENT AND LEARNING DOCUMENTS

Several learning documents have been developed at the closing of the SHOW project that catalyse the learnings from the SHOW project as well as previous experiences of programming in similar areas by Plan International and Promundo.

Specific intervention areas related to the Gender Equality Strategy have provided valuable lessons that can be applied more broadly to future programming and can contribute to evolving best practice within the sector. These have been purposefully selected and elaborated in the following documents.

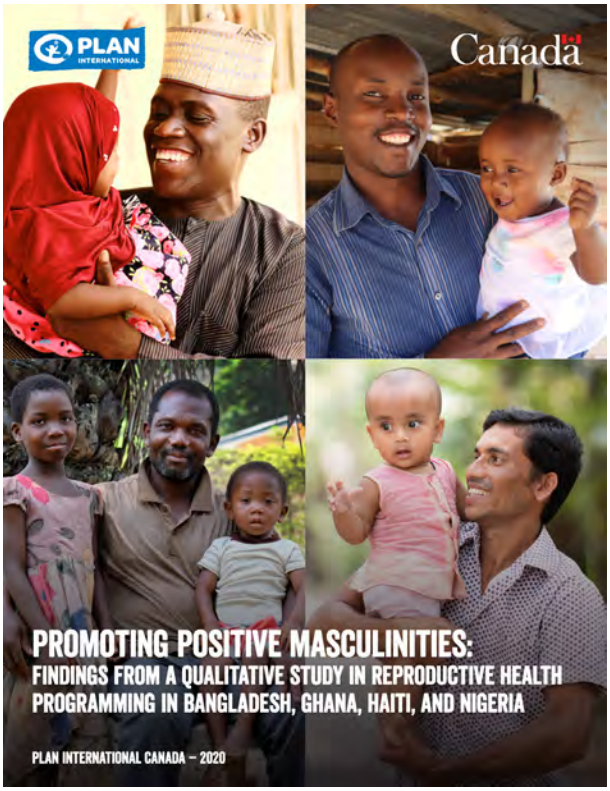
Measuring Impact of Male Engagement

PROMOTING POSITIVE MASCULINITIES: Findings from a qualitative study in reproductive health programming in Bangladesh, Ghana, Haiti, and Nigeria

Under its multi-country project SHOW (Strengthening Health of Women and Children) Plan International, in collaboration with local implementing partners, established 1,201 Fathers Clubs across all five countries and engaged 7,535 fathers[128] in twenty reflective sessions to broaden their understanding of gender equality to enable them to question what it means to be a man and a father and to promote their equitable involvement at the household level.

The study findings revealed positive change among Fathers Clubs participants.

Below are four country reports on the impact of Fathers Clubs intervention in Bangladesh, Ghana, Haiti and Nigeria.



Bangladesh: Fathers Clubs Study Findings Engaging men in the MNCH/SRHR continuum of care

Ghana: Fathers Clubs Study Findings Engaging men in the MNCH/SRHR continuum of care

Haiti: Fathers Clubs Study Findings Engaging men in the MNCH/SRHR continuum of care

Nigeria: Fathers Clubs Study Findings Engaging men in the MNCH/SRHR continuum of care

128. *Based on figures from Nigeria, Bangladesh, and Haiti only.*

Title	Description	
Role of Facilitation in Gender-Transformative Programs That Engage Men and Boys	Documents and highlights the importance of high-quality facilitation in achieving project objectives and initiating transformative change.	
Recruitment and Retention of Male Participants in Gender-Transformative Programs	Explores and documents challenges and effective strategies for recruitment and retention of male participants, based on the experience of SHOW project and other male engagement projects.	
Engaging Missing Populations in Gender-Transformative Programs	Analyzes and draws lessons learned about how and why key populations can be excluded from gender transformative programming.	
Engaging Religious Leaders in Reducing Material and Child Mortality, and Gender Equality: Field Experiences from the SHOW Project in Sokoto State, Nigeria	Describes the programmatic benefits, challenges, and outcomes of working with religious leaders in Sokoto State, Nigeria, and aims to inform future efforts to engage faith-based communities on gender equality–related initiatives.	
Community Health Committees: What enables them to flourish and support Gender Responsive and Adolescent Friendly health services?	Highlights Plan International's experience in establishing gender responsive and adolescent friendly health services through the strengthening of the make-up, training, leadership and supervision of CHCs.	

Plan International Canada is happy to share these resources. If you would like a copy, please contact Daniela Donia, Technical Quality Officer, at **DDonia@plancanada.ca**

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