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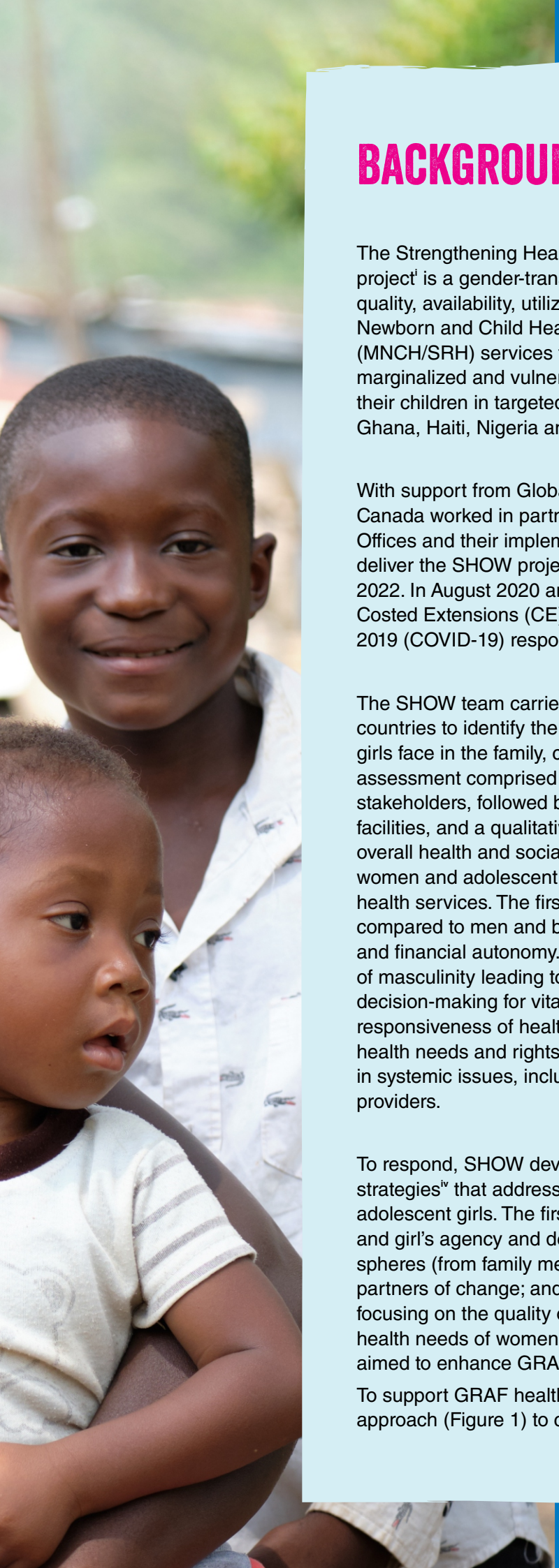
PLAN INTERNATIONAL

STRENGTHENING HEALTH OUTCOMES FOR WOMEN AND CHILDREN

Lessons Learned in Plan International Canada's Gender-Transformative SHOW Project



BACKGROUND

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

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

The SHOW team carried out a comprehensive assessment[iii] in all five countries to identify the barriers to healthcare that women and young girls face in the family, community, and at the health facility. The assessment comprised of an initial desk review and consultations with stakeholders, followed by baseline surveys of households and health facilities, and a qualitative exploration of gender-related issues in the overall health and social environment. The assessment revealed that women and adolescent girls face three types of barriers to accessing health services. The first is women and girls' low status and agency compared to men and boys leading to their lower decision-making power and financial autonomy. The second is the prevailing patriarchal notions of masculinity leading to men's low participation in care roles and shared decision-making for vital health care services. The third is the lack of responsiveness of health care institutions to the sexual and reproductive health needs and rights of women, especially adolescent girls, reflected in systemic issues, including the attitudes and practices of health providers.

To respond, SHOW devised three intersecting gender-transformative strategies[iv] that addressed the condition and position of women and adolescent girls. The first strategy focussed on strengthening women and girl's agency and decision-making; the second engaged men across spheres (from family members to socio-cultural gate-keepers) as active partners of change; and the third strategy addressed systemic gaps by focusing on the quality of care that is respectful and responsive to the health needs of women and adolescent girls. Together, these strategies aimed to enhance GRAF health services and outcomes.

To support GRAF health services, SHOW employed a three-pronged approach (Figure 1) to contribute to the following intermediate outcomes:

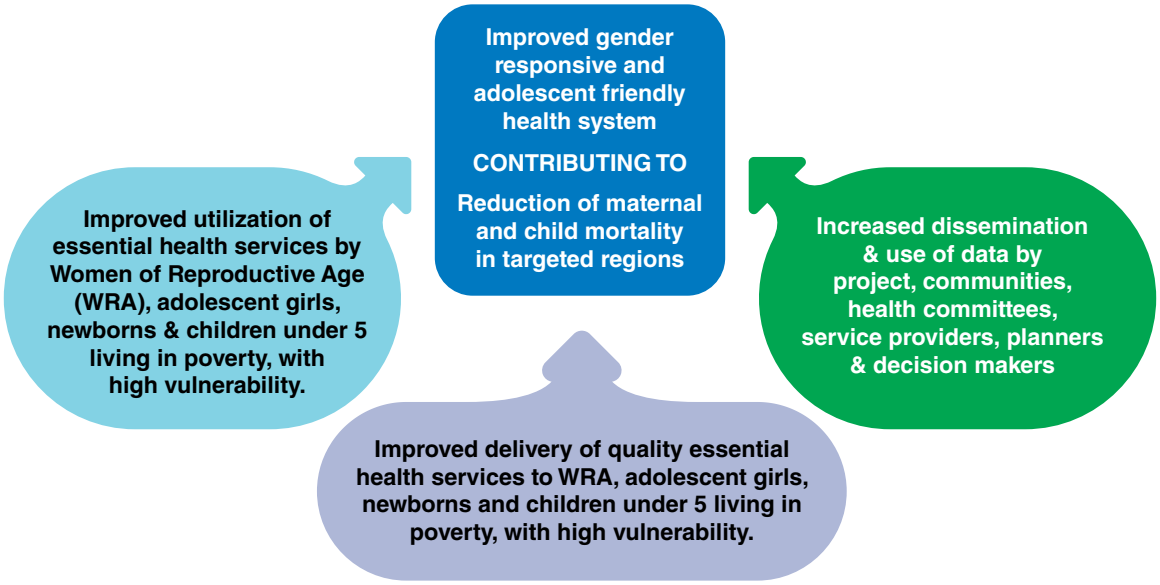


FIGURE 1: THREE-PRONGED APPROACH OF THE SHOW PROJECT IMPLEMENTED IN FIVE COUNTRIES

- Improved utilization of essential health services by Women of Reproductive Age (WRA), adolescent girls, newborns and children under five living in poverty, with high vulnerability
- Improved delivery of quality essential health services to WRA, adolescent girls, newborns, and children under five living in poverty, with high vulnerability
- Increased dissemination and use of data by project, beneficiary communities, health committees, service providers, planners, and decision-makers

The project developed a logic model along with detailed project implementation plans and followed a performance management framework for the evaluation of progress within a set frequency. Data collection was conducted at baseline, midterm, and endline in which both quantitative surveys and qualitative discussions were carried out with project participants, partners, and stakeholders.

The final evaluation[v] adopted the following three-pronged methodology:

- Household surveys of 5,834 individual respondents, including 642 WRA aged 15-19, 3,167 WRA aged 20-49 and 2,025 male partners. The primary respondents for the household surveys were adolescent and adult mothers 15–49 with a child under two years of age. Male partners/male family members of the primary respondents were also surveyed using a separate questionnaire;
- Health facility assessments were completed at 548 health facilities across the five countries. A health facility assessment was conducted with facilities in the same geographic areas where the household and adolescent surveys were conducted
- Qualitative data collection to provide supplementary data triangulation through 72 key informant interviews and 122 focus group discussions in the five countries.

This lesson learned exercise is a documentation of the knowledge developed from the design, implementation, and conclusion stages of the SHOW project, and will inform future programs. The process of documenting these lessons involved three stages including a desk

review of the program documents and reports, discussions with in-country project staff and Plan International Canada, and a member-checking of the findings. Discussions focused on the following functions of the project:

1. The demand side of the health system strengthening
2. The supply side of the health system strengthening
3. Accountability and results
4. Project operations
5. Sustainability
6. Shared vision
7. Localization

The project's theory of change, its implementation, challenges during implementation and measures to address them, results, and emerging best practices were explored. The analysis involved three types of triangulation[vi]. The methodological triangulation involved examining quantitative survey data and addressing "why" questions emerging from it during our qualitative explorations. The theoretical triangulation meant exploring the views of several stakeholders to develop a holistic picture from multiple perspectives. Lastly, for the environmental triangulation, we ensured exploring the perspectives from diverse geographical or social locations.

Our discussions highlight that each country and its regions where SHOW was implemented, were unique in their context. Healthcare delivery in Bangladesh, Nigeria, and Senegal had their pitfalls due to lack of resources, especially human resources. The culture and society were patriarchal and conservative in these three countries. Ghana, on the other hand, had a reasonable healthcare delivery under the Ghana Health Services (GHS), and the society was more open to discussions on SRH compared to the other SHOW countries. Haiti, because of ongoing political instability and economic meltdown, was altogether different. Both the healthcare delivery and the society were unstable and posed considerable challenges to the project implementation. It is, therefore, understandable that the implementation of the same strategy produced a variable degree of results in different countries.

The following pages present the summary of lessons learned from all thematic areas. For each thematic area, we present a broad strategy, challenges faced during its implementation, measures taken to address these challenges, results, and the lessons learned from the whole process.

LESSONS LEARNED FROM SHOW IMPLEMENTATION IN FIVE COUNTRIES

1. DEMAND SIDE OF THE HEALTH SYSTEM STRENGTHENING

1.1. SHOW strategies

To improve knowledge, attitudes and service utilization practices, SHOW implemented several context-based strategies for awareness raising and social mobilization. These included household visits of Community Health Workers (CHWs), women's groups, men's groups, grannies' clubs, adolescent groups, and the dissemination of social and behavior change messages through various channels. Influencers like traditional and religious leaders were also engaged in awareness raising and mobilization of communities leveraging their platforms of influence. Furthermore, for greater reach, communication techniques such as radio messaging and community drama were employed. The meetings of Village Saving and Loan Associations (VSLAs) were also used as messaging platforms. Women's empowerment, their participation in financial and health-related decisions, and men's support towards female members of the household were promoted.

1.2. Challenges and measures to address

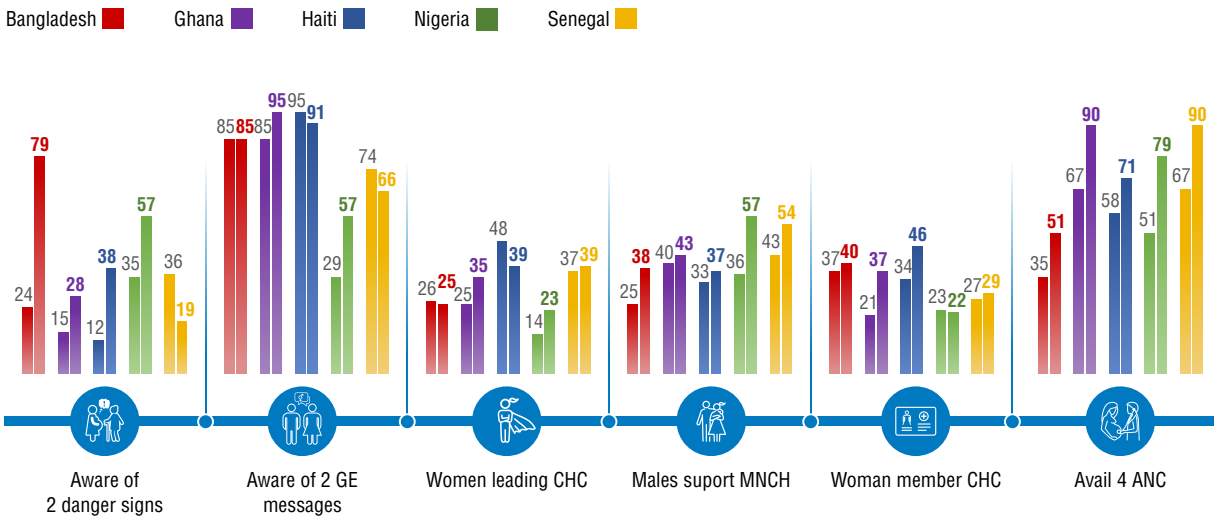
Low literacy of the group (women, men, adolescent) members as well as their group leaders was a major challenge in countries where group methodology was used to disseminate messages. Owing to the inability of these members to read manuals, the project had to develop alternate resource materials. So, manuals were modified to include more pictures for better communication. Being under-resourced communities the mass media and Internet access were low, because of which the project could not engage technological innovations at mass level. This was addressed by developing short videos that could be disseminated via mobile phone where possible.

Some of the audience like religious leaders needed Information, Education, Communication (IEC) materials specific to their needs. In Nigeria, for example, a book was compiled with references from the Holy Quran and Hadith to fulfill this requirement. Reaching adolescent groups, including the out-of-school boys and girls was a challenge. Through champions of change groups and peer educators, the project identified out-of-school adolescents to involve in the group discussions. As much as possible, the project adopted a contextually relevant and comprehensive approach to reaching communities with targeted, gender-integrated messages.

1.3. Results

A holistic view of the indicators representing this pillar (Figure 2) from all five countries brings important insights. In general, the awareness raising and social mobilization efforts achieved the desired improvements. However, the gradient was variable across the indicators, between countries and within populations. Across indicators, the knowledge about MNCH/SRH issues and utilization of health services improved more than women's leadership and social capital. Between countries, Ghana and Nigeria showed an improvement in all the demand-side indicators. Between populations within one country, the age-disaggregated data showed a lesser degree of improvement in knowledge and service utilization among younger WRA (girls aged 15-19 years) than the older women (20-49 years) except in Ghana where this improvement was higher among the younger age group.

FIGURE 2: DEMAND SIDE OF SERVICE UTILIZATION (%) AT BASELINE AND ENDLINE IN FIVE SHOW COUNTRIES



1.4. Lessons learned

1.4.1. Translation of gender equality knowledge into health-seeking and decision-making practices takes time and requires sustained multi-faceted engagement at household, community, and health facility levels: Health knowledge and health service utilization improved more than the attitudinal dispositions towards gender equality, which is understandable because changing the deep-rooted social norms is a long-term process. Across all countries, more needs to be done at the household, community, and societal levels to encourage and support women to take up leadership roles. Being more analytical about the likely reasons and more strategic in future programs is the way forward.

1.4.2. Adolescents are key stakeholders in health and gender equality programs: Peer-to-peer education and counseling among adolescents was one of the main demand strategies. In Ghana and Nigeria, where the degree of improvement in demand-related indicators (e.g., knowledge of two danger signs) is higher among the young WRA (15-19 years), the utilization of services (e.g., availing 4 ANC from a skilled health provider) is also higher in this age group. In countries where improvement in demand-related indicators among young girls was less, the overall improvement in service utilization too was less remarkable. Notably, involving adolescent in a leading role in the programs that focus on their health brings impetus; an important lesson emerging from the SHOW project.

1.4.3. Intergenerational dialogue improves self-efficacy among youth, brings harmony between generations, and paves the way for healthful behaviors: Involving adolescents as peer counselors was adopted by all the countries as a demand-improvement strategy. Ghana implemented this strategy by empowering adoelscent boys and girls and promoting dialogue between them, their parents, and the community elders. SHOW envisaged that this intergenerational dialogue will improve the SRH knowledge of adolescents, build their own as well as others' confidence in their agency, and will stimulate system strengthening through their involvement and leadership. The results from Ghana demonstrate that this strategy worked. The knowledge about gender equality increased more i.e., 13 percentage points among young WRA (78% to 91%) than the 7 percentage points among the older (87% to 94%) WRA. The women's participation in organized community groups also improved more i.e., 52 percentage points (22% to 74%) in adolescent girls than the 37 percentage points (22% to 59%) among the older women. A similar higher gradient of improvement is observable in the service utilization indicators discussed in the next (supply side of health system strengthening) section, highlighting the effectiveness of intergenerational dialogue.

1.4.4. Communication strategies improve joint decision-making between couples- a gateway to generational development: Several strategies like CHW's household visits, group activities of men, women, and adolescents, and involvement of influencers promoted the couple's joint decision-making, which significantly improved over the life of the project. The WRA reported making financial and family planning decisions jointly with their male partners in Haiti, Nigeria, Senegal and Bangladesh. Behavior change literature about family and reproductive health has a plethora of information on how interspousal communication works as a gateway behavior to family decisions that have long-term implications for the family's health and society. Learning from the SHOW experience (Compendium of Promising Practice in Gender Transformative Health Programming), the future Social and Behavior Change Communication (SBCC) strategies can include joint decision-making, in addition to interspousal communication, as a robust set of measurable indicators for such programs.

2. SUPPLY-SIDE OF HEALTH SYSTEM STRENGTHENING

2.1. SHOW strategies

This part of the SHOW strategy addressed the systemic gaps in health service delivery by focusing on the quality of care that is respectful and responsive to the MNCH/SRH needs of women and adolescent girls. Improving the infrastructure through refurbishments, providing equipment, supplies, and vehicles including ambulances where necessary, and enhancing the capacity of healthcare providers by training them on gender-responsive and adolescent-friendly health care were the major elements of this strategy. Additionally, bringing in better Primary Health Care (PHC) management with improved leadership and supportive supervision, and involving local communities in the management and accountability of their healthcare was also ensured. Establishing the Community Health Committees (CHC) and encouraging women to become a member and lead the governance, management, and accountability was a critical step toward improving the quality and delivery of health services.

2.2. Challenges and measures to address

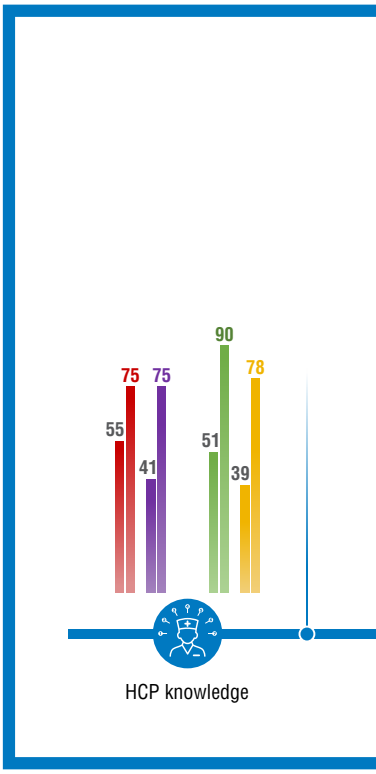
The challenges to service delivery were context-based, mostly specific to the country and project intervention areas. For example, in Ghana, the distances between communities were long, roads were bad, and traveling in the rainy season impossible. Some of the project communities lived on islands requiring boats to reach them. Due to accessibility

issues during the rainy season, SHOW teams planned the training of health care workers and meetings in these areas ahead of the rains. In Haiti, the ongoing political and frequent lockdowns often forced the postponement of meetings and training workshops, which was addressed through the rescheduling of events. The religious extremists were a continuous threat to community-based activities in Nigeria, which was addressed by collaborating with well-respected religious leaders from different sects leading advocacy efforts on the project.

Another impediment was the attitudinal change among the Health Care Providers (HCPs), as they belonged to the same patriarchal society. They found it difficult to change their attitudes towards women, especially adolescent girls. In Nigeria, for example, the HCPs would ask for the husband's permission for contraceptive services. They believed that the husband's permission was a legal requirement, even though there was no such law in place. The SHOW training of health workers on the delivery of GRAF MNCH/SRH services specifically addressed this confusion.

Another issue impeding the health service delivery, common to several countries was the lack of trained human resources and inadequate policies to address the human resource deficiencies. The SHOW team leveraged the country's task-shifting policies and trained the community-based workers to operate at the health facility to address the human resource deficiencies. The upgrading of Community Based Health Volunteers (CBHVs) in Nigeria and CHWs in Bangladesh to community-based Skilled Birth Attendant (SBA), after their capacity enhancement, are examples of leveraging these task-shifting policies.

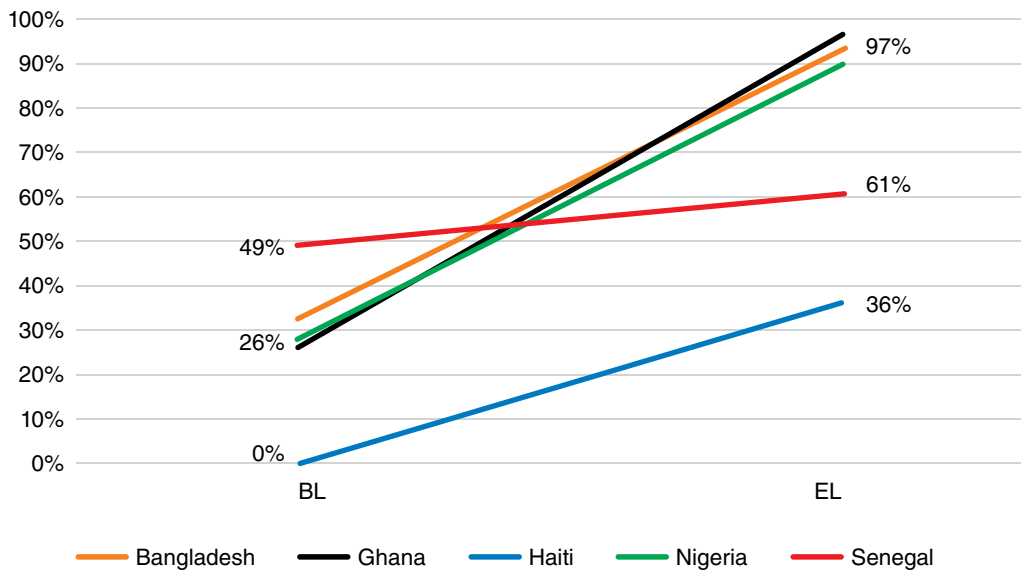
Women's role in leadership and management was minimal, and communities were not accustomed to having women in leadership roles. The SHOW team specifically focused on this area, provided training to the woman and adolescent girls, encouraged them to become members and leaders of the community health committees. Alongside, the project sensitized men in these management structures about participatory and gender-equitable management practices.



2.3. Results

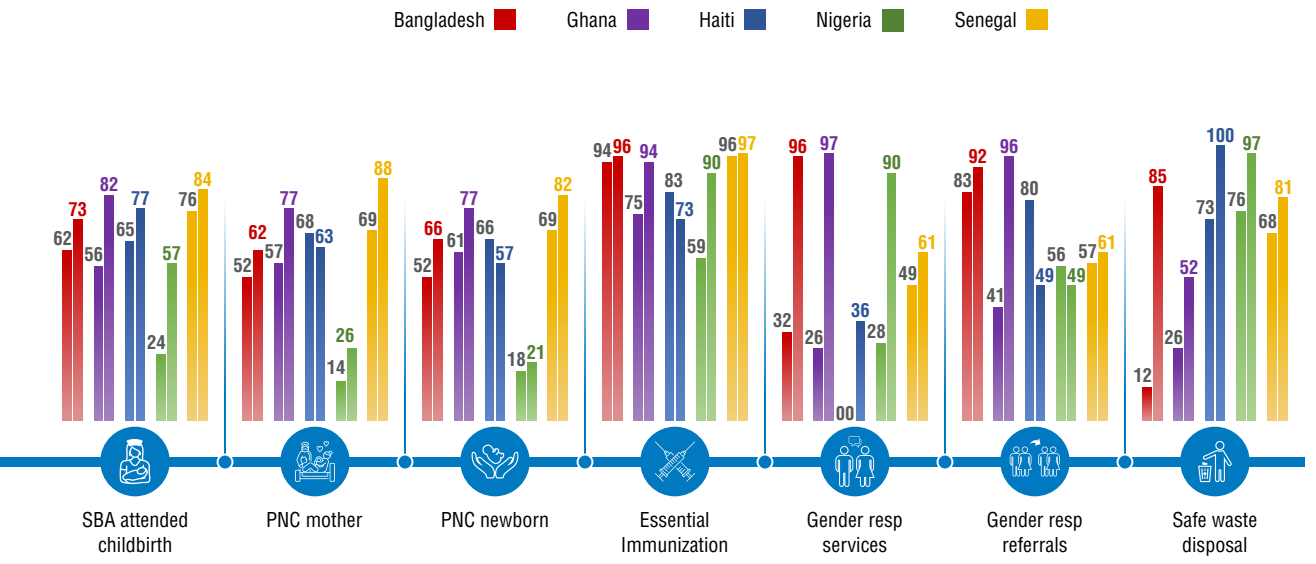
The level of gender responsiveness and adolescent friendliness of health service provision in SHOW-supported health facilities improved (Figure 3) according to the Health Facility Assessment (HFA). Health facilities in Bangladesh, Ghana, and Nigeria achieved a 94%, 97%, and 90% adolescent-friendly and gender responsiveness level by endline, after an increase from baseline by 62%, 71% & 62%. In Haiti, facilities at baseline had a zero adolescent-friendly and gender responsiveness score that progressed by 36% at the endline. Senegal recorded a 12 percentage point increase from a baseline of 49% to endline status of 61%. Further work is required in Haiti and Senegal to improve the provision of adolescent-friendly and gender-responsive health services.

FIGURE 3: LEVEL OF GRAF MNCH/SRH SERVICES IN SHOW TARGET AREAS IN FIVE COUNTRIES



A detailed look at the supply side of health system strengthening (Figure 4) provides an opportunity to unpack the performance of different segments of service delivery. The number of live births attended by SBA improved in all countries. The postnatal care both for mothers and newborns improved in all countries except Haiti. Gender-responsive services and referrals also improved in all countries except for Haiti. The referrals declined a bit in Nigeria as well.

FIGURE 4: DELIVERY OF QUALITY HEALTH SERVICES (%) AT BASELINE AND ENDLINE IN 5 SHOW COUNTRIES



2.4. Lessons learned

2.4.2. Supporting quality health services requires participatory community mechanisms, especially in rural settings: The community health committees (CHC) were a key mechanism to ensure the delivery of quality health services as well as keep the facilities connected and grounded to the needs of the serving communities. They provided oversight to the planning, implementation, and management functions of a health facility. The involvement of women in these committees helped improve the gender focus. Providing birthing facilities 24 x 7 was a major problem in several countries because of deficient human resources trained in midwifery services. The committees played an important part in enabling this service. In Bangladesh, because of the smaller number of SBAs, the committee decided to provide training to the community health workers, upgrade them to the level of SBA, arrange their salary, and advocated with the government to continue her services till a midwife is deployed there.

2.4.2. Adolescents need differentiated and targeted approaches to improve their health seeking and health service utilization behaviors: In the earlier section about increasing demand for quality health services, Ghana was the country where improvement in knowledge about gender equality and improvement in participation in organized community activities by adolescent girls (15-19 years) was higher than the improvement among older WRA. A similar gradient is observable in the utilization of health services in Ghana. The proportions of deliveries attended by SBA for WRA aged 20-49 years improved from 58% to 81% (23 percentage points), while it improved from 48% to 86% (38 percentage points) for adolescent girls. Similarly, postnatal care for WRA 20-49 years increased from 62% to 77% (15 percentage points) while this increase was from 38% to 78% (40 percentage points) for adolescent mothers. Ghana is different from other SHOW countries in several respects. The services provided by Ghanaian Health Services (GHS) are more organized, and Ghanaian society is more open and permissive. The intergenerational dialogue brought in by the SHOW team in Ghana seems to be the additional catalyst that enhanced youth involvement in family, community and systemic decisions paving the way for better health outcomes.

2.4.3. Policy engagement is crucial to find entry points with the government for sharing of data or advocacy: To begin with, the SHOW team reviewed the existing policies and identified points it could leverage in each country. For example, in Ghana, Health Sector Gender Policy was in place since 2009. Similarly in Nigeria, the Child Rights Act (2003) existed for some time, but needed leverage for its promulgation as law. SHOW built on these documents and provided an impetus to the efforts in each country through partnerships and advocacy. The trickle-down of policy into practice happens by developing and disseminating guidelines and engaging with the stakeholders. For this, SHOW developed service delivery guides on GRAF MNCH/SRH services by drawing upon the existing guidance from World Health Organization (WHO), adding strong gender lens to the components of accessibility, relevance, and participation. This inclusion and modification were led by the Ministry of Health in each country in partnership with its line departments and endorsement of the relevant government offices.

3. ACCOUNTABILITY AND RESULTS

3.1. SHOW strategies

In some countries, many women and adolescent girls do not visit a health facility unless there is a health emergency. Owing to several reasons, they don't seek care or rely on older women in the house for antenatal care, as well as prefer to have childbirth at home. Tracking and tracing them in the community is the only way to capture their data so that the magnitude and nature of their health issues can be documented. Moreover, in the overall category of WRA, the magnitude of SRH issues in adolescent girls (e.g., getting pregnant and being high risk), would not become visible because data is not disaggregated. To address both, and to improve quality, SHOW proposed a community-based, digitized data collection system enabled through handheld devices and Internet technology. Sharing the findings from this data with the community to involve them in planning and management decisions of their health facility was part of this strategy. Ultimately, this Community Health Management Information System (CHMIS) could be incorporated into the National Health Management Information System.

At the same time, assessing the SHOW project's progress and effectiveness was also important for which, a logic model and Performance Measurement Framework (PMF) were developed. To this end, SHOW conducted mixed method data collection at three time points: baseline, midterm, and endline. Data from the survey, disaggregated according to age and sex and organized along the three strategic pillars i.e., demand side of health system strengthening, the supply side of health system strengthening, and accountability and results (measured as 100, 1200, and 1300 series of PMF) of SHOW project was used to assess program effectiveness.

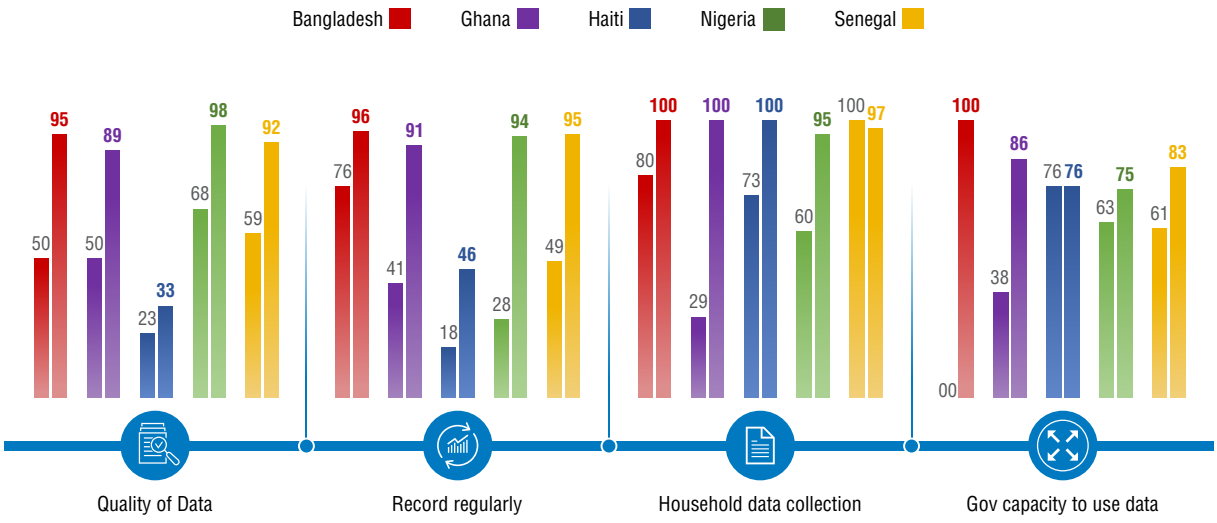
3.2. Challenges and measures to address

The initial steps including the development and validation of tools, their translation to French in Haiti and Senegal, and training of the relevant staff to collect data, consumed a lot of time. The data collection tools were modified with pictorials in countries like Nigeria where the literacy level of the data collecting team was a challenge. When finalized, the digitization process started for which the bureaucratic delays became a hassle. In Haiti, the approval of the consultant for digitization did not materialize until the end of the project. The component was successfully integrated into the national Health Management Information System (HMIS) in Nigeria and Senegal. Despite advocacy, Bangladesh and Ghana did not allow access to their HMIS. Data was compiled and shared locally at all the health facilities with management, especially with the CHCs during the visioning workshops.

3.3. Results

Improved data collection capacity of health workers, supportive supervision of their monitoring staff, and enhanced capacity of government officials to use data for decision-making resulted in an overall strengthening of the results and accountability system. All four indicators related to this pillar including the data management capacity of the Government, record maintenance at health facilities, data collection in the community, and quality of the recorded data improved over the life of the project (Figure 5). Importantly, household-level data is being collected in all the countries. Collection and reporting of age-disaggregated data is now part of the HMIS in two countries (Nigeria and Senegal) and two age brackets for WRA i.e., 15-19 years and 20-49 years are regularly reported and information utilized for decisions. .

FIGURE 5: RESULTS AND ACCOUNTABILITY INDICATORS AT BASELINE AND ENDLINE IN 5 SHOW COUNTRIES



3.4. Lessons learned

3.4.1. Collecting community-level data is feasible with partner buy-in of tools and approaches: Health systems in different countries do not collect community-level data because of the lack of resources. It is generally believed that community health workers engaged in health promotion activities may not be able to use data collection tools and record accurate data. In the SHOW project, the team successfully trained the CHWs and they were able to use handheld devices or paper-based data collection tools and capture data consumable for important local decisions.

3.4.2. Age- and sex-disaggregated monitoring data is a critical contribution to demonstrating the progress for intersectional gender equality: The exercise of collecting annual monitoring data about men's perceptions of supporting women, and women and adolescent girls' views on access and use of facilities in the community combined with qualitative discussions, unraveled the inequalities that exist in the families, community and society to which the routine data systems are not sensitive. For example, in a polygamous society, the 17 years old girl who is the third wife of a man, will likely not have a voice equal to the first wife, who is older, and has several children already. This adolescent pregnancy may be more likely to have reproductive complications (e.g., high-risk pregnancy) which may go unnoticed if the health system does not reach out and record her information.

3.4.3. Balancing "M" and "E" in the monitoring and evaluation is crucial for greater project learning and adjustment: The baseline, midterm, and endline evaluations were helpful for the measurement of the SHOW project's progress and overall learning at the end of the project. The annual review and the ongoing monitoring of the implementation process, to identify issues and challenges, and working with the team to address these challenges in real-time was even more useful. An ongoing process of learning lessons and incorporating them for program adjustment has more value and could be encouraged at the expense of the midterm evaluation. Being a gender-focused project that has an adolescent girl as an important stakeholder and beneficiary, knowing whether the communication approaches adopted to have a dialogue with these girls about gender equality, interspousal communication, antenatal care, etc. are appropriate or not, is important. What differentiated methods and mediums of communication can we adopt if the message is not reaching them, is also important. Moreover, is the knowledge enhancement leading to improvement in attitudes and practices, and if not, what changes are required within our strategy, are additional questions.

4. PROJECT OPERATIONS

4.1. SHOW strategies

SHOW was a complex endeavor in several ways. At the partnership level, it engaged with the Ministry of Health and its downstream departments along with their officials and health staff, other ministries like the Ministry of Women's Affairs, Civil Society Organizations (CSOs), and other partners from the development sector. Coordinating and maintaining good relations with local departments has been a hallmark of the SHOW project. A key function was maintaining the relationship with the donor, Global Affairs Canada (GAC), and carrying out public engagement for the Canadian citizenry.

At the strategic and management level, SHOW required oversight and ownership of several tiers of the country's health policy and system. A Project Steering Committee (PSC) was constituted in each country for advising on the project's strategic direction, reviewing progress, and holding the project team accountable for the work plans and targets. The PSC was chaired by the Country Director of Plan International and co-chaired by the Director of Health or their representative in each country. A Technical Advisory Group (TAG) was also formed in each country to advise the project on technical issues and guidelines in the context of that country.

At the programmatic level, SHOW's theory of change required shifting gendered social norms toward gender-responsive and adolescent-friendly behaviors in the household and community, and woman- and adolescent- friendly services at the health facility. This required a certain catalytic change in the system. At the implementation level, it involved coordinating with several stakeholders including local officials, health facility staff, and community-based health workers to bring a synergistic effect. A key implementation aspect was refurbishing the health facilities, providing equipment, and carrying out capacity building of the health providers. In Haiti, the project also provided free-of-cost medicines donated by Partners in Health Canada.

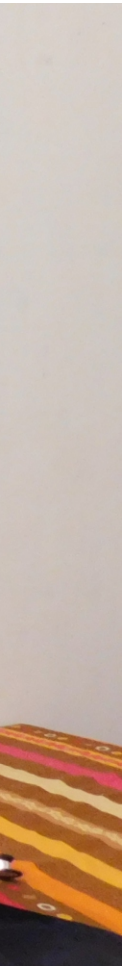
4.2. Challenges, and how they were addressed

Coordinating with the National and local Health department and their officials and maintaining effective partnerships was a challenge. In Bangladesh, the officials did not attend project meetings for a long time because their participation fee was being negotiated. In Haiti, the unstable social-political situation often impeded coordination meetings and processes. The Bangladesh issue was addressed by having frequent discussions with them and then negotiating to have approvals from the donor. In Haiti, frequent rescheduling of the training sessions and meetings was the only solution.

Based on the country's context, carrying out operations often faced additional unique challenges. For example, in Ghana, the SHOW communities were located far apart and inaccessible during rainy season. Moreover, some of the communities lived on the islands with difficulty in access during rains.. keeping these factors into accoutn, the team scheduled the training and meetings before the rainy season.

The project steering and technical advisory committees helped when the project faced challenges that required a modification to the implementation or monitoring strategy. In Nigeria, for example, the PSC advised careful recording of postnatal care data separately for the mother and the newborn, and not to assume that if the mother has received postnatal care, the newborn has also received this care. Similarly, in Ghana, the TAG noticed that creating and organizing two separate groups of adolescent boys and girls was diluting the efforts and advised combining the two, using a single curriculum, which proved effective.

The drug donation component in Haiti involved many steps, offices, procedures, and requirements. The team fulfilled these requirements which included ensuring that the donated drugs are on the essential drug list of Haiti, maintaining a supply chain, obtaining customs clearance, storage, inventory management, and ultimate dispensing of the medicines. In the end, two rounds of essential drugs and supplies were delivered to the project-supported health facilities.



4.3. Results

The measures resulted in transparent governance processes, effective partnerships, and adequate capacities; all helping to achieve the desired results. SHOW team had an excellent working relationship with government offices at the federal, state, district, and below levels, and with partner CSOs and communities in all the countries. Having a Plan International office at the national level in the capital improved the effectiveness of these partnerships. With capacity building, SHOW achieved adequate number of staff at various levels ready to galvanize the gender transformative approaches of the project in the health system, their peers, and the community. The capacities for data collection and gender-responsive services also improved, reflected in the improvement of these indicators. SHOW project's success demonstrates that a close engagement with local government from project inception is essential to ensure ownership. Indeed, as reported by various stakeholders, the engagement of religious and community leaders makes a difference when implementing such a complex intervention that focuses on actualizing behavioral and social norm change.

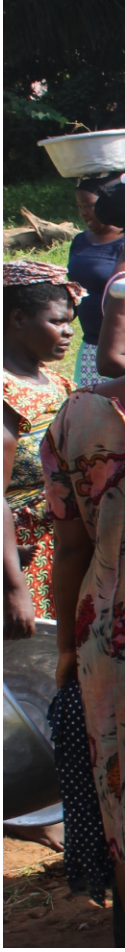
4.4.Lessons learned

4.4.1. Establishing management structures improves the accountability, quality, and completeness of the project activities: Being a complex, and multi-partner, multi-stakeholder project that supported communities and health facilities to provide gender-responsive and adolescent-friendly health services, the project needed good governance. Forming a steering committee, and a technical advisory group, improved the project accountability, quality, completeness, and chances of sustainability during and after the project implementation.

4.4.2. Contingency planning is crucial in the wake of emerging disasters and shocks which are becoming more frequent: SHOW was supported through costed extensions to respond to the challenges that emerged with COVID-19. However, such extensions consume time which is crucial while responding to an unforeseen emergency. A key lesson is the need for contingency planning, flexibility, and adaptability to deal with unplanned shocks such as COVID-19, which the projects may not be able to forecast at inception. This contingency planning is also critical for context-specific challenges such as political instability, which SHOW experienced in Haiti and relates to fragile and conflict-affected settings.

4.4.3. Working directly with the community and local government actors is pragmatic in an unstable socio-political environment: SHOW was primarily designed to support the government in their healthcare delivery by bringing in value addition through the GRAF healthcare strategy. In Haiti, the unstable social-political situation did not allow to ensure complete ownership of the government and effective execution of SHOW strategy in true spirit. Working with local communities, and private, non-profit organizations worked well and can be considered by projects working with unstable governments and weakened public health care in such situations.

4.4.4. Supplying medicine needs a careful evaluation of the situation before including it in the project's scope of work: The show experience tells that logistic management of medicines and drugs can be lengthy and complicated- a process that may involve several other departments, in addition to the health ministry, both in the sending and the receiving country. A careful look into all these requirements, the advantages, and the challenges must be carried out before embarking on a decision about supplying donated/imported medicines as part of a project.



5. SUSTAINABILITY

5.1. SHOW strategies

Donor-supported programs often face questions about the continuation of benefits beyond their life. Considering this while aspiring to preserve gender transformative change in the system, SHOW devised its sustainability strategy along four dimensions. Institutional sustainability i.e., the government owns some of the innovations like the introduction of community-based, age-disaggregated data into HMIS for its continuation after the SHOW concludes. Technical sustainability i.e., adequate arrangements are made (e.g., pool/number of master trainers at various levels) to maintain the quality of interventions brought in by the SHOW project. Financial sustainability i.e., government and communities invest resources for the continuation of GRAF MNCH/SRH care in the short and long term respectively. Social sustainability i.e., the individual and collective behavior improvement continues helping to break the vicious cycle of transferring disadvantage from one generation to the other. The SHOW team, along with partners, reviewed this strategy from time to time to ensure its ownership and applicability after the close-out of the project.

5.2. Challenges and measures to address

The biggest challenge in institutional sustainability was the lack of a sustained process within the Government departments and ministries to regularly update curricula and training mechanisms for health providers. SHOW team addressed this by involving the Ministry of Health (MOH) and related offices like Director General Health, academia and development partners in Nigeria and GHS in Ghana, to modify all relevant training materials incorporating GRAF principles and global standards into these resources. Training materials, no matter how good, are ineffective if an adequate number of training staff is not available to train the next cohorts while maintaining the quality and completeness of the training. SHOW prioritized that sufficient number of trained master trainers are available at all levels, and the government considers their role and availability for on-going capacity building of the health care workers within the health care system.

The financial challenges to sustainability are usually present in low-resourced economies and the SHOW project was no exception. To address this, the project encouraged women to avail VSLAs for their financial sustainability and the CHCs on decisions for collective benefit. The social dimensions of sustainability i.e., the continuation of positive attitudes and behaviors, is the most challenging aspect as the reminder messages and cues to action are likely to wane off, once a project is closed down. For this, the project made an effort that where possible, the CHWs who live closer to the community and can help in maintaining linkages between community and health services, remain available after the project. Discussions were held with the government as well as with community stakeholders to facilitate these arrangements at the local level.

5.3. Results

The training materials, curricula, and other resources, all developed in partnership with Government departments, are available to the respective departments to carry out future training that focuses on GRAF MNCH/SRH care. Where feasible, Government and partner staff, duly trained as master trainers are also available. The VSLAs and community health committees are working for the individual and collective continuation of beneficial services in most countries. The household visits of CHWs, and support groups of women, men, and adolescent boys and girls are also alive and working to continue the behavioral and social dimensions initiated by the SHOW project. The continuation of CHWs has also materialized where they were not part of a primary healthcare program. In Nigeria, for example, the State government decided that 1032 CBHVs will continue as part of their public healthcare system. In Bangladesh, the CHCs raised money to support the services provided by CHWs after the closeout of the SHOW project.

5.4. Lessons learned

5.4.1. Close alignment with existing training programs improves sustainability: SHOW ensured that rather than bringing in new policy drafts and training programs, it leverages the existing policies and embeds new components in the existing training programs. The Health Sector Gender Policy in Ghana and Child Protection Act in Nigeria are two examples of policy advocacy, while revision of training standards and curricula on Life Saving Skills and Family Planning to include the elements of gender-responsive MNCH/SRH care in Nigeria is an example of embedment of GRAF into regular training programs. These examples illustrate that if a time-bound, donor-funded project aims to facilitate a long-term change in public policy and programs, aligning its interventions with the existing initiatives is an effective strategy.

5.4.2. In-service training of health providers should have a GRAF component to ensure a long-term adoption of gender norms among the health professionals: The SHOW experience informs that gender-responsive and adolescent-friendly health services can pave the way for improvement in the survival, health, and well-being of mothers and adolescents, reducing gender vulnerabilities and realisation of individual rights.. The health providers usually lack GRAF approaches and the nuances involved, but focused training can improve their attitudes and practices. Moving forward, including the GRAF component into the in-service training of healthcare providers, and advocating with health ministries, health departments, and Schools of medical education for this can ensure the long-term adoption of this innovation.

5.4.3. Behavior change is a continuum- assessment of where people are before the intervention, and ensuring the continuity of change after the intervention, contributes to a sustained change: Behavior change is often a critical part of development interventions. New projects usually assume that their behavior change strategy will have to be developed from scratch, ignoring the change along the continuum because of earlier interventions. SHOW ensured that critical elements for the continuation of behavior change like CHWs and their household visits, women's, men's, and adolescent's groups, and the visioning workshops continue beyond the project, becoming a living legacy, in addition to their achievements recorded in project documents. This legacy and its sharing for future consumption are crucial for a sustainable change in individual behaviors and the social environment.

6. SHARED VISION

6.1. SHOW strategies

SHOW aimed at bringing gender equality as a means to the larger goal of improved survival and wellbeing of women and children. Women, men, adolescents, community influencers, health providers, and policymakers- everyone had a role to play in this journey. SHOW worked with all of these stakeholders to bring visibility to the health and well-being issues of women, especially adolescent girls.

6.2. Challenges and measures to address

Gender equality was a new, somewhat utopian idea for communities where SHOW was being implemented. Introducing it as a new norm to be adopted by households, communities, and health providers was a slow and consuming task. Moreover, there was the challenge of each segment seeing it only from their perspective and losing sight of the long-term objectives. For example, women, especially adolescent girls, hesitated to go to health facilities because of the unwelcoming behaviors of health providers they had experienced in the past. Improving the attitude of these health providers and making health services more responsive was achieved by presenting this responsiveness as part of the shared vision, being overseen by the community health committees.

6.3. Results

The interspousal dialogue and positive discussions with influencers such as grandmothers, mothers-in-law at the household level, support groups of men and women organized by CHWs, and the involvement of social influencers in the community, brought

a higher sense of collective action towards gender equality. Through improved infrastructure, and enhanced capacity of health providers at health facilities the increased demand for health services for women and adolescent girls was addressed. The improved data system captured the situation in the community as well as the health facility in sex and age- disaggregated ways to inform how effectively this system is working.

6.4. Lessons learned

6.4.1. Platforms like the visioning workshops are a useful methodology for creating a shared vision and carrying out sustained efforts for its achievement: The practice of visioning workshops by involving all the stakeholders in project areas including men and women, health providers, community, and health system, works well for projects that aim to achieve health outcomes through social pathways like gender equality. The involvement of the community through awareness raising, and improved capacities of health providers through training, bring the two sides to the shared vision of a society where mothers, newborns, children, and adolescents are surviving and growing to achieve a better life, health, and wellbeing.

6.4.2. Data systems that capture the true numbers and are open to all stakeholders including the program beneficiaries bring impetus to the spirit of shared goals: The data system that captures the true number of women and adolescent girls in the community and those attended by health providers at the health facility shows whether the momentum for achieving that shared vision is adequate and whether any bottlenecks are present. Sharing these results and the progress with the community, and making decisions for the next cycle together, fulfills the spirit of a shared vision.

7. LOCALIZATION

7.1. SHOW strategies

SHOW was conceptualized to address the gaps identified in the health care systems of the implementing countries. Based on existing evidence about both the gaps and the relevant solutions, the project had a compelling theory of change with robust implementation plans and precise monitoring and evaluation indicators. However, the implementing countries had their context characterized by the overall political situation, national and local policies, governance structures, level of resources, number of health staff and their competency levels, community demand and acceptance of services, and the overall cultural and social dynamics. Through the involvement of stakeholders at all levels, and by holding frequent consultations, the SHOW team created a middle ground to work in partnership with the national and local health system, civil society, communities, and health providers and reached a stage where it was acknowledged as a technical assistance project that had local relevance.

7.2. Challenges and measures to address

Donor-funded programs often face the perception of being top-down, out of sync with the local conditions, system, and culture, and inadequate for the magnitude of the problem they try to address. The SHOW team measured up by taking appropriate steps at the right time. Foremost, the geographical areas, including the province, the district, and the local administrative unit were selected by the partner country. LNGOs and health systems were the major partners for the implementation and service delivery. Moreover, SHOW engaged the relevant stakeholders in pre-design consultations and after the projects were approved, by including them in PSC and TAG in each setting to ensure local ownership in all the countries. For relevance, the team started by examining the national and local, mother and child health policies with which SHOW aligned.

Working with national policymakers in Ghana and demonstrating how the SHOW objectives would help GHS achieve the country's Health Sector Gender Policy enhanced the chances of the localization of SHOW strategies. Likewise, SHOW worked with the State government in Sokoto, Nigeria, and positioned that SHOW's efforts about increasing the legal age of marriage are aligned with the state's responsibility of promulgating the Child Protection Law. For ensuring the local ownership of training and capacity building, SHOW brought the health officials, technical experts, and relevant development agencies on board to revise the training guidelines of health professionals and include gender responsiveness to the standards and training curricula. Lastly, for cultural appropriateness and acceptability, the existing influencers like 100 Women's Groups in Nigeria, Husband Schools in Senegal, and Adolescent Peer Groups in Ghana were engaged to increase the chances of individual behavior change and collective action.

7.3. Results

SHOW achieved almost all of its targets with high chances of sustained local adoption of its interventions, while also fulfilling the compliance requirements of Global Affairs Canada. Haiti was one exception where the quality and health service delivery targets could not be achieved, but this was due mainly to the unstable socio-political situation in the country. Improving SRH knowledge and attitudes toward adolescents, and enhancing the coverage of quality health services for this prioritized population was wholesomely achieved in Ghana, and to a large extent in Bangladesh and Nigeria. This adoption of a strikingly new approach for improving adolescents' health is an example of a successful localization. Being able to adapt the original strategy or plan by engaging oversight bodies like PSC and TAG, where required, was critical in this success. Merging the male and female adolescent groups into one, carrying out training of health providers before the rainy season in Ghana, and involving religious leaders in the curriculum for the training of health providers in Nigeria are a few examples of adaptation that proved effective for the localization of the project.

7.4. Lessons learned

7.4.1. Involving all stakeholders at each pivot of decision-making helps in smooth implementation and long-term adoption of innovative strategies: Adhering to the primary blueprint provided by the donor agency and at the same time, being responsive to the local context of the implementing country can be a test of the balancing capability of the project team. Involving all the stakeholders in the planning and pivotal decision-making and reaching consensus through oversight bodies like steering committees and groups of technical experts is an effective strategy in these circumstances.

7.4.2. Aligning innovations to the existing policies and strategies, and taking a system-strengthening position improves program effectiveness. Policy development and the trickle-down of its implementation guidelines is a long and sluggish process. Development projects like SHOW that do not have the luxury of a very long time, do well if they identify existing policy initiatives and align their work for further refinement or implementation of these policies. Likewise, an innovation that works through capacity building of the existing human resource and does not require new hirings with likely financial implications for the government, has a higher chance of local acceptability and effectiveness.

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

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Acronyms

CBHV: Community Based Health Volunteer

CHC: Community Health Committee

CHMIS: Community Health Management Information System

CHW: Community Health Worker

CSO: Civil Society Organization

GAC: Global Affairs Canada

GHS: Ghana Health Services

GRAF: Gender-Responsive, Adolescent-Friendly

HCP: Health Care Providers

HFA: Health Facility Assessment

HMIS: Health Management Information System

IEC: Information, Education, Communication

LNGO: Local Non-Governmental Organization

PHC: Primary Health Care

PMF: Performance Measurement Framework

PSC: Project Steering Committee

MNCH: Maternal, Newborn and Child Health

MOH: Ministry of Health

SBA: Skilled Birth Attendant

SBCC: Social and Behavior Change Communication

SHOW: Strengthening Health Outcomes for Women and Children

SRH: Sexual and Reproductive Health

TAG: Technical Advisory Group

VSLA: Village Saving and Loan Association

WHO: World Health Organization

WRA: Women of Reproductive Age

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