In partnership with Canada

PLAN INTERNATIONAL

STRENGTHENING HEALTH OUTCOMES FOR WOMEN AND CHILDREN

Lessons from Bangladesh

LOCAL SOLUTIONS WORK BEST FOR LOCAL PROBLEMS.

The SHOW story from Bangladesh

THE PROJECT

Global health audiences have been looking for examples of how local people from Low- and Middle-Income Countries (LMICs) solve their health problems through local solutions. The *Strengthening Health Outcomes for Women and Children* (SHOW) project[i] in Bangladesh is an example of local involvement in solving local problems to improve the health and wellbeing of women and adolescent girls, and to achieve a gender-equal society.

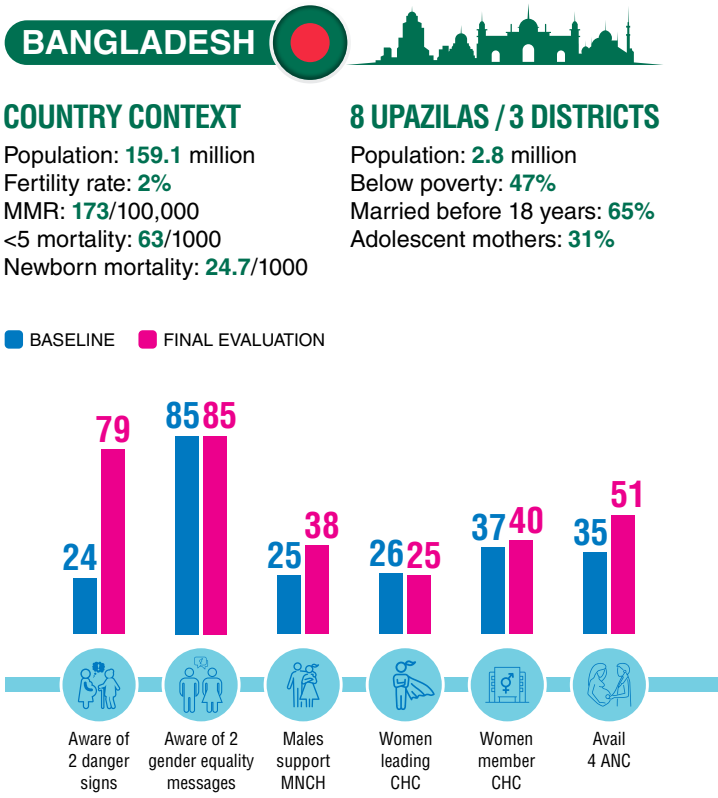
The SHOW project[ii] is a gender-transformative initiative aimed at increasing the quality, availability, utilization and accountability of essential Maternal, Newborn and Child Health/Sexual and Reproductive Health (MNCH/SRH) services to reduce maternal and child mortality amongst marginalized and vulnerable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

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

In Bangladesh, the SHOW project was implemented in eight remote and underserved areas in three districts, namely six Upazilas (Bengali alternative for sub-district) in the Nilphamari district (Sadar, Saidpur, Kishoreganj, Jaldhaka, Domar, and Dimla); one Upazila in the Barguna district (Barguna Sadar); and one Upazila in the Khagrachari district (Panchari) with high poverty and vulnerability.

The project started with a comprehensive situation analysis, which comprised a desk review and consultations with stakeholders, a baseline survey of households and health facilities, and a qualitative exploration of gender-related issues in the overall health and social environment. Informed by this situation analysis, the project adopted a gender-transformative and rights-based approach[iv] to build the foundations of Gender Responsive and Adolescent Friendly (GRAF) MNH/SRHR in poor and underserved regions of the country. Aligned with the United Nation's *Every Woman Every Child Global Strategy for Women's, Children's, and Adolescent's Health* to achieve Sustainable Development Goals 3 (health & wellbeing) and 5 (gender equality), the project worked on three parallel streams:

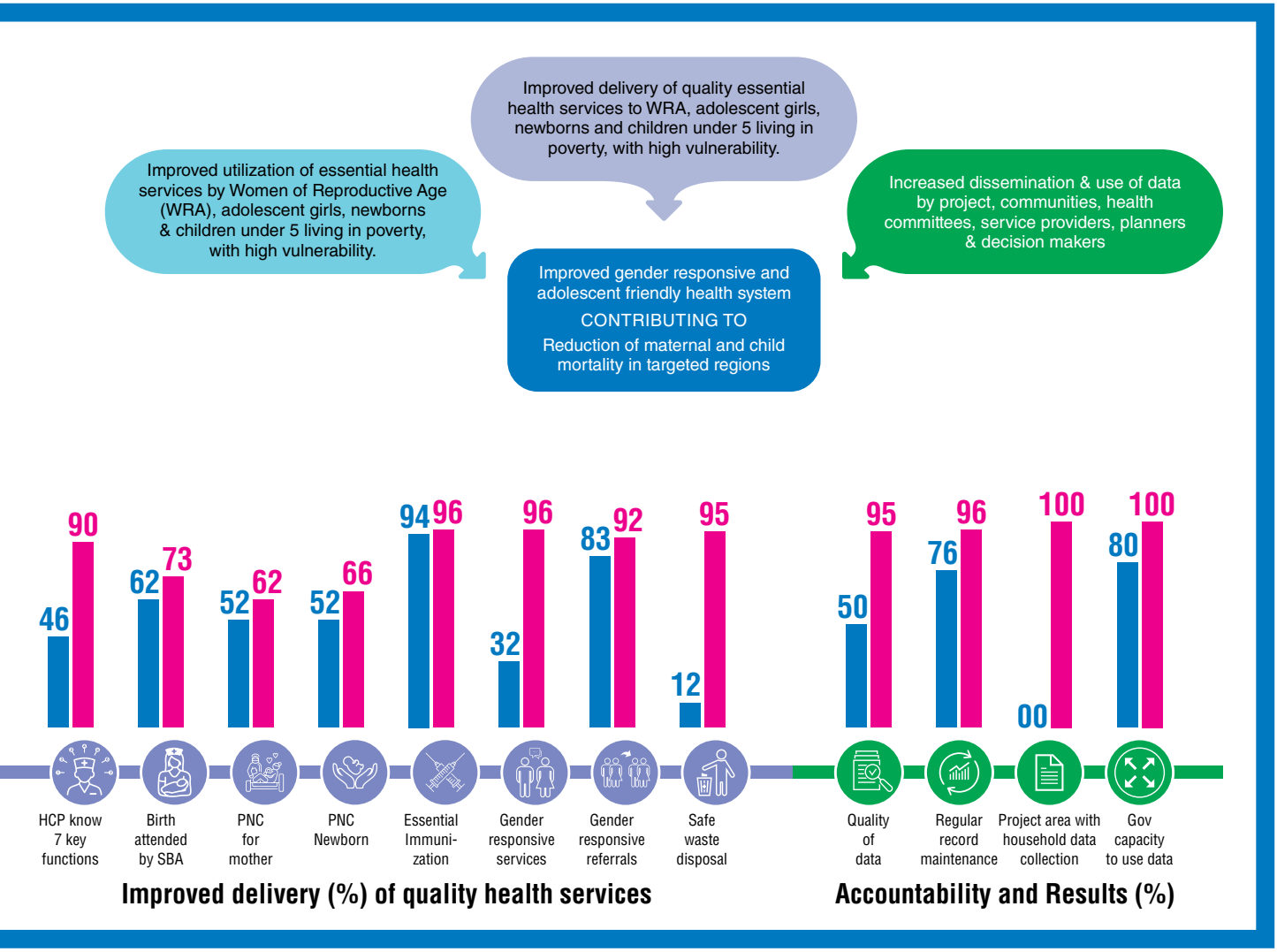
FIGURE 1: THREE PILLARS OF SHOW STRATEGY AND THEIR OUTCOMES IN BANGLADESH



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

SHOW achieved[v] a cumulative reach of 506,181 direct community members, including: 3,4174 male and 35,910 female children under 5 years, 15,647 adolescent boys and 53,820 adolescent girls, 290,108 females and 76,521 males aged 20-49 years. The project also reached a number of indirect beneficiaries, including 1,222 health service providers (1,070F, 152M), and 1,110 Community Health Workers (896F, 214M). During the process, the project supported 219 Village Savings and Loans Association (VSLA) members, 428 fathers' clubs and 13,440 mothers' groups 1,792 peer groups, and 107 changemaker groups.

The project evaluations[vi] conducted at baseline and endline showed (Figure 1) improvement in almost all the indicators of the demand-side of



health system strengthening in the country. Likewise, all the indicators for the delivery and quality of health services significantly improved. The data for accountability and results indicators also showed remarkable improvement over the life of the project.

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

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

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

LESSONS LEARNED FROM THE PROJECT

1. IMPROVED UTILIZATION OF ESSENTIAL HEALTH SERVICES

Bangladesh is a disaster-prone country. The families and children living in these disaster areas often experience the greatest poverty. Some of the areas selected for implementation of the SHOW project also belonged to this category. Bangladesh has the highest child marriage rates in Asia and the fourth highest globally[ix]. Early marriage is common among girls because men prefer to marry younger girls over marrying older girls. Dowry is common (i.e., the bride bringing some property or wealth to the groom. If a girl is older, a hefty dowry may be demanded. Families with greater poverty, therefore, tend to marry their girls early[x]. Consequently, girls commonly drop out of school to enter into marriage and parenthood, and unintendedly contribute to transferring the disadvantage to the next generation.

Working on the demand side of the health system in this context, the project focused on four streams of activities. First was working directly with the women and adolescent girls of reproductive age. This included household visits from female community health workers, use of ICT-based, behaviour-change communication materials and tools, and interactive messages through theatre for development. Theatre for Development (TfD) is a community theatre approach where education on MNCH, gender equality, and SRHR is provided to communities through live drama. Using the art of storytelling, TfD conveys important information and messages to men, women, girls, and boys in a language they are familiar with.

The second stream involved groups of women changemakers in which health educators discussed women's health and empowerment in group settings. The third set of activities, which was directed at men, organized and facilitated fathers' clubs for peer education, and involved religious leaders who influence the male population in Bangladesh. The last stream of demand activities was for adolescents. Adolescent boys and girls were trained as peer educators and worked in separate groups to engage other adolescents in discussions about sexual and reproductive health rights and responsibilities.

Challenges

Against the backdrop of poverty, patriarchy, illiteracy, and religious conservatism, the awareness-raising and demand-creation part of the project faced several challenges. For example:

- In the male-dominant family and community, women's and adolescent girls' role in decision-making was minimal. Sensitizing these women about their rights and their role in SRH decisions and empowering them to exercise their rights was not easy.
- Aligned with the same conservative culture, the religious leaders wielded a strong influence on men. However, it was challenging to talk with these religious leaders about sexual health matters so they could become effective SRHR advocates. For example, using the word abortion or sex was *haram* (sin) in this setting, necessitating a careful lexicon for communication.

- In Bangladesh, one-quarter of the total population is adolescents. Reaching out to them with clear and actionable SRHR messages was required, but difficult. Nearly half of adolescents (i.e., most girls) would soon drop out of school, limiting the system's access to them for awareness-raising activities.

Course correction

The SHOW team took several steps to address these challenges. To address the participation of women and adolescent girls, the team emphasized the representation of women and adolescent girls in community health committees (CHC). To enhance their agency and empowerment, women's and girls' presence was encouraged through Community Health Worker's (CHWs) household visits and other communications via video, mobile phone, and theatre for development. The assumption was that CHCs would perform more efficiently with women's participation and leadership, the staff would better understand the needs of WRA, and the responsive care would encourage women and girls into greater uptake of services. In tandem, women's participation in public life, namely CHCs, would contribute to their self-esteem, confidence, self-efficacy and agency, which would then contribute to improved power relationships at the household level.

To sensitize men while acknowledging the conservative society, the institution of seminary and religious leaders was involved. The training resources for this piece of advocacy avoided use of contentious terms like 'abortion' and were replaced with the term "menstrual regulation" (a method of inducing uterine bleeding) instead. Careful engagement with religious leaders would bring them on board to talk about men's responsibility toward women and children. Moreover, to make men more supportive of their spouses and children, a transformative journey toward positive masculinities was facilitated through men's groups (Father's Clubs). For adolescents, after completing their training, peer educators were involved to become advocates within their groups and facilitate their group meetings. These adolescent peer educators, both boys and girls, were selected from within communities and trained by Plan International to lead peer education sessions with other adolescent girls and boys in their communities.

Results

The results show that these corrective measures, along with the original strategic steps worked well in improving demand for and utilization of essential health services.

- The women's membership in CHCs improved, with almost a quarter of CHCs being led by women at the endline evaluation.
- Male support for women, especially relating to MNCH and SRH issues, improved by 13 percentage points during the life of the project.
- Collectively, this resulted in improved knowledge of gender equality among both males and females, significantly improved knowledge of danger signs during pregnancy, and a higher proportion (by 16 percentage points) of women availing four antenatal care visits.

Best practices

- With a contextual understanding of the audience, engagement of key stakeholders and influencers (religious leaders in this case) and appropriate modifications to the content of SBCC materials, projects can develop a collaborative relationship even with hard-to-reach stakeholders.
- The model of peer educators for adolescents is effective for issues like SRHR and applicable to future projects on similar issues, aiming to shift norms and improve behaviors among a young population.
- Involving women in the planning and accountability mechanisms, like CHC, can improve gender-responsive health care at health facilities. It also enables women's empowerment and agency at the household and community levels.

2. IMPROVED DELIVERY OF QUALITY ESSENTIAL MNCH AND SRH SERVICES

The health systems in the three districts for SHOW implementation had variable status and many were also prone to disasters. The project, therefore, started with a comprehensive assessment of health facilities through baseline and health facility assessment to identify gaps in the delivery of high-quality, gender-responsive, and adolescent-friendly care. The baseline evaluation data and gender assessment underscored that low knowledge and information on MNCH/SRH services contribute to low utilization of MNCH/SRH services. This is compounded by transport challenges and inappropriate, inadequate and disrespectful attitudes of Health Care Workers (HCWs).

The assessments also documented the limited capacity of community- and facility-based staff to deliver GRAF MNH/SRH services, shortcomings in the infrastructure and equipment at health facilities and gaps in planning, supervision, and management of services. The process also identified the Government's "Women Friendly Hospital Initiative" as an opportunity for capacity building and advocacy with government officials on gender-responsive service delivery, sustainable financing of MNCH/SRH services and institutionalization of standards. Leveraging this opportunity, SHOW focused on rehabilitating the infrastructure, providing essential MNH/SRH equipment and enhancing staff capacities in providing competency-based care. The project also strengthened the referral system in each intervention area with a new ICT-based referral monitoring system. The creation of dedicated youth corners at the health facilities was a new addition to the system. The SHOW team ensured that, rather than hiring and deploying new staff, all the system-strengthening interventions leveraged the capacities of existing resources.

Challenges

The service delivery aspect of the project faced many challenges, predominantly occurring because of poorly resourced health facilities. For example:

- The staffing at most of the health facilities was inadequate, with staff being poorly trained in providing quality MNCH and SRH services. Staff attitudes toward patients were considered uncordial and disrespectful, according to women and adolescent girls.
- The provision of SRH services was more problematic. Staff did not consider it a priority and refused to provide these services, especially to unmarried women and adolescent girls.
- Facilities did not provide round-the-clock MNCH services.
- Transportation arrangements to and from health facilities were inadequate, and the referral system was poor.
- Health facility staff did not have a system for incorporating health facility data in its planning and decision processes.
- Owing to the conservative social setting, it was difficult to convince women and adolescents from the focus areas to participate in planning and decision-making at the health facilities.

Course correction

To address these challenges, the SHOW team leveraged the learning from an earlier project, Woman And Their Children's Health (WATCH) in Bangladesh. This project focused on building staff capacity and training in Integrated Management of Newborn and Child Illnesses (IMNCI), Basic Emergency Obstetric and Neonatal care (BEmONC) and supportive supervision. The gender-responsive and adolescent-friendly (GRAF) aspect of services was emphasized in all these trainings. The lack of skilled birth attendants was addressed by training CHWs within the government system to become Community SBAs (CSBA) and be appointed at the health facility to improve round-the-clock MNCH services. Two CSBAs in each Union Health and Family Welfare Centre (UH & FWC) supported Family Welfare Visitors (FWVs) for gender-responsive MNCH/SRHR services and 24/7 safe delivery initiatives, including quality ANC, PNC and essential new-born care with timely referrals.

The project ensured infrastructure rehabilitation and provision of equipment, along with creating adolescent-friendly MNH/SRH services and trained personnel at the health facility. For effective referrals, the project initiated Maternal Awareness and Referral Tracking (MART), an Internet-based referral system. Upon finding women or adolescent girls in a community who needed the assistance of a skilled or expert health care provider, the patient was educated about the complication and referred to a hospital. The referring person sent a text message to the health provider at the facility about the arrival of that referred case at the health facility. The health provider was expected to respond via the same text message system. To expedite the referrals, the project also made transport arrangements where required. Sharing digitally collected data and making decisions based on its findings became a regular feature of the monthly meetings.

Visioning workshops were a seminal intervention in which participatory approaches were adopted and women and adolescents were encouraged to participate in the planning and decision-making activities of the facility in their area. The CHW household visits enabled discussions with women, adolescent girls, men, and mothers-in-law to convince the household that women and adolescent girls should participate in the communal activities meetings and provide input to improve services.

Results

As a result of these measures, several improvements were observed:

- Health facilities started providing round-the-clock MNCH services to women in the area.
- Adolescent-friendly MNH/SRH services became available in the dedicated youth corners of the health facilities, provided by a trained CSBA.
- Health care providers' recognition of key signal functions improved, increasing to more than double at the endline, compared to the baseline. This included functions such as intravenous antibiotic and uterogenic drug therapy to prevent postpartum hemorrhage, removal of placenta or its products, and assisted vaginal delivery.
- The quality of services provided and the quality of referrals improved. This was reflected in the improved service utilization indicators, such as high proportion of childbirths attended by an SBA, high proportion of women and newborns attended during the postnatal period, and high number of children receiving essential immunization.
- Women's membership in the CHC improved from 37% at baseline to 40% at endline, including active participation in 145 visioning workshops.

Best practices

- Adopting participatory approaches, like CHCs, to involve the community, especially women and adolescent girls, in the planning, execution, and accountability of service delivery is essential for building gender-responsive and adolescent-friendly health systems.
- Health systems that are constrained by a human resource deficiency can benefit from task shifting and task sharing options. An example of this was upgrading CHWs to CSBAs by providing training and improving their competence.
- Involving local communities in management and governance is helpful, as they can generate local resources, ensure round-the-clock availability of services, and make decisions that ensure the sustainability of such interventions beyond the life of a project.

Visioning workshops: local solutions for local problems

Problem

- In impoverished areas with patriarchal norms, women's health and social issues were not prioritized. There was a risk that, without prioritization and leadership, the health system improvements contributed by SHOW may not produce optimum results and would not be sustained after the project.

Solution

- The SHOW project improved local capacity and advocacy on gender-responsive service delivery. This was achieved through mobilization of UH&FWC-MCs with increased participation of women, visioning workshops on local fund generation, CSBA quarterly meetings at the Upazila or sub-district level and training of Union Health and Family Welfare Centre Management Committee (UH&FWC-MC) members.
- Women's participation in the SHOW visioning workshops resulted in the integration of gender equality into discussions on implementation and sustainability plans. Examples include addressing the involvement of adolescent girls in decision-making, separate toilet facilities for men and women in UH&FWCs and women's leadership.

Results

- Health service delivery improved, which stimulated decisions to bring sustainability to gender-responsive services in the area. The Shimulbari committee raised 143,513 taka (~CAD $2,000) in community funds from a raffle draw event, and multiple other CHCs secured financing from corporate houses and local Union Parishad Chairmen.
- During the 145 visioning workshops, MC members developed individual sustainability plans focused on local fund generation and women's leadership.
- Participating women continue to monitor UH&FWCs and to lobby local government for increased funding for health services. This indicates that participation at the UH&FWC-MC level may help drive women-led advocacy in the community.

Conclusion

- Prioritization of participatory project implementation at the local level improves community ownership and local resource mobilization.
- Visioning workshops are an effective mechanism to ensure local responsibility for maintaining project improvements and sustainability options.

3. DATA FOR ACCOUNTABILITY AND RESULTS

For the data for results and accountability pillar of SHOW, the project was required to develop a system that ensured the inclusion of women and adolescents from the community, data disaggregation, and data sharing with all the stakeholders to support shared decision-making during the visioning workshops. The project's ICT-focused data collection system covered all households in the SHOW project areas. The field teams collected data on key indicators from mothers who recently gave birth or had children under two years old. The system improved with support from partner NGOs, and through refresher training, data validation workshops, and hands-on experience of the data collection team. However, the process also had its challenges.

Challenges

Difficulty in gaining access to the e-register system of the Director General Family Planning (DGFP) was a major challenge, compounded by frequent changes in the leadership at the DGFP. These barriers had an impact on SHOW project's ability to generate data during the initial two years. To minimize any future delays in data collection, the decision was reached to use a separate system, with the approval of the Project Steering Committee (PSC). The lack of government buy-in to integrate the community component of the data system with the existing health management information system presented another challenge. this occurred in part due to the lack of participation from government officials in SHOW meetings where these integrative ideas were discussed and finalized. Owing to a lack of consensus on the fee that government officials would receive in recognition of their participation in the meetings, they were not in attendance at these meetings. This posed challenges to the governmental adoption of this digital data system.

Course correction

The project team, in collaboration with government officials and community stakeholders, completed the design of the digital data collection system and the tracking of women and adolescent girls in the community. The data were disaggregated according to sex and age and presented to all stakeholders at the local level. For the government's input and ownership of the process, the project negotiated an acceptable participation fee for the government officials, which enabled their engagement in the project meetings. This onboarding allowed the completion of the aforementioned steps. The frontline staff were trained and provided with devices and internet allowance and monitored regularly for data collection, which facilitated its timely completion. Online monitoring by the project staff and data-sharing at local and Upazila levels were also key to this success. The data was shared with stakeholders, especially the community health committee, during the visioning workshops for their information and decision-making.

Results

The community-based, digital data collection was adopted by local levels of the health system and the community health committees (CHC). Adoption of this data system at the local level was facilitated through the sensitization of CHCs on the gender-responsive and adolescent-friendly aspects of services that were provided at a health facility, as well as by the presence of women and adolescent girls in these committees. Most of the indicators that reflect the data management system improved over time. Specifically:

- Community-level data, which was non-existent at the beginning of the SHOW project, became available from all healthcare facilities. In Year 4, 100% of health facilities reported conducting household-level monitoring data collection, up from 80% at the baseline.
- The community health committees made decisions using this data, including the availability of round-the-clock health services that cater to the MNCH and SRH needs of the population.
- The CHC used the same data to make resource mobilization decisions and to fill the HR gaps for better human resource management.
- The participation and ownership of the process increased over time. In Year 3, for example, there were 75 community reflection sessions conducted at the sub-district level, including eight at the Upazila level and 67 at the union level. A total of 1,879 participants (1,269 men and 610 women), participated in these sessions, including health service providers, health committee members, government personnel, community leaders and religious leaders.
- Local-level advocacy and results sharing were effective in generating buy-in from local stakeholders, demonstrating concrete results such as the inclusion of budget lines for 24/7 services and CSBAs. Buy-in, however, was limited at the higher levels because of the initial issues of participation fees, combined with chronic and ongoing fragmented governance structures, which resulted in too many stakeholders and a dilution of advocacy efforts.

Best practices

- Visioning workshops are an essential mechanism to ensure that local leadership takes responsibility for maintaining project improvements and engaging in sustainability efforts after the project's end date.
- Female participation in the local leadership platforms, like the UH&FWC-MC activities, is an effective way to ensure that health facilities remain accountable to women and girls.
- Projects aiming for adoption of innovations can have differentiated approaches according to the situation and should be seen as "pilots". Adoption of an innovation at a certain level, and not by the entire system, is pragmatic in these instances so long as efficacy can be demonstrated.

4. PROJECT OPERATIONS

Being a multi-stakeholder project, SHOW had several levels of operations. It was engaged with Global Affairs Canada on the one side and, on the other side, with the government offices in Bangladesh at various levels of the health system and Civil Society Organizations (CSOs). The Bangladeshi government offices included: Ministry of Health and Family Welfare (MoH&FW), Ministry of Woman and Child Affairs (MoWCA), Director General Family Planning (DGFP), and Director General Health Services (DGHS). CSO partners included: Lutheran Aid to Medicine in Bangladesh (LAMB), Ad-Din society, and Young Power in Social Action (YPSA). The SHOW team formulated several committees, including the Project Steering Committee, Project Monitoring Committee, and Technical Advisory Group. The project organized its joint review and planning activities, including the Project Implementation Planning (PIP) workshops, Annual Work Plans, sharing of findings, and target-setting workshops. At the implementation level, the project worked with district and health facility staff, CSO partners, Community Health Workers (CHWs), and community stakeholders.

Challenges

- CSO partners were selected for their geographical penetration and capacity to deliver in the respective areas. However they generally lacked competencies in gender-transformative programming and providing GRAF MNH/SRH care.
- Government officials from various levels were reluctant to allow the use of their HMIS. This decreased the likelihood of integrating innovations, such as the data system developed by the SHOW project.
- The project was designed for people living in underprivileged areas, but reaching the ultra-poor and involving them in project planning and decision-making was a challenge.
- SHOW worked in areas that lacked necessities like electricity, to the extent that even the electric charging of the CHW tablets often became an issue.

Course correction

To increase the government's buy-in and adoption of the community data system, the SHOW team developed training guidelines in collaboration with the Union Health and Family Welfare Centre (UH & FWC) department. The DGFP office launched these guidelines in association with the SHOW project. The payment issues for the government officials that prevented them from attending meetings were negotiated and a pragmatic way of payment was reached. In addition to local-level advocacy and capacity building, advocacy meetings with higher officials were also conducted to enhance input and ownership.

The staff from partner CSOs received extensive training in gender transformative programming and providing gender-responsive and adolescent-friendly services. A poverty ranking was conducted to help the ultra-poor, who could not participate in village saving groups, and financial assistance schemes were launched. These included sponsorship through vouchers, which helped participants facing heightened poverty to pay for the expenses incurred while availing of the services. Alternate energy mechanisms, like social panels, were arranged to provide electricity at the facilities. Consultants were sent from Canada to support the public engagement activities.

Results

- Despite having several partners and stakeholders, the SHOW project achieved its results, which aimed to improve women and child health by implementing gender-responsive and adolescent-friendly MNH/SRH care.
- Project materials, including behavior change communication materials and training guidelines, were adopted by the health facility staff and the communities.
- The digital data collection and management system was adopted at the local level and improved evidence-informed decision-making in the project areas.

Best practices

- Involving the local community, especially women, brings community ownership to a donor-funded project and improves its implementation and outcomes.
- In difficult situations, it is helpful to be transparent about the procedures and find common ground between donor requirements and the realities of an implementing country.
- Certain populations will always need financial assistance, necessitating measures like a cash-support scheme.

5. SUSTAINABILITY

Sustainability is usually a major concern for donor-funded, time-bound projects. Considering these challenges, SHOW developed project sustainability plans and reviewed them from time to time in collaboration with partners and stakeholders. SHOW's sustainability plan consisted of a four-dimensional framework: 1) Institutional: institutional/managerial capacity of communities and authorities are retained to sustain the gains of the project, especially at the local level; 2) Technical: the quality of interventions introduced by the project is maintained over time; 3) Financial: financial capacity of communities is sustained so they can afford the services. This is complemented by the commitment of government/authorities to allocate financial resources to support the continued implementation of the interventions; 4) Social: the positive change in individual attitudes and behaviors and social environment is maintained over time, leading to intergenerational change within families and communities.

Challenge

The SHOW project worked with public and private (non-profit) stakeholders and aimed to achieve health outcomes through social pathways. The project interventions faced several challenges in terms of sustainability:

- The district and national level health ministry officials did not allow for incorporation of the data system (CommCare) that SHOW introduced into the national HMIS. This was partly because they did not attend the SHOW meetings due to payment issues. This institutional challenge also impinged on the technical aspects of the project, as a limited number of staff members could be trained on the new data system.
- While the SHOW project was entering its conclusion phase, the government decided to introduce a new cadre of Community Midwife (CMW). This lessened their interest in the continuation of CSBA services, a SHOW contribution to the area of task-shifting and sharing.
- On the financial side, limited resources were available to the government to scale up the innovations that SHOW introduced. Moreover, a policy shift was also being introduced. Resultantly, the continuation of CSBA services, which enabled 24/7 service delivery during the project period, was going to be compromised.
- The social sustainability of the behaviour change introduced by SHOW was challenging because of the conservative and patriarchal values prevalent in varying degrees across the SHOW jurisdictions.

Course correction

Adopting a participatory approach, the SHOW team focused on CHC activities to bring ownership and sustainability to the interventions. During the Visioning workshops, the CHCs owned the community health management information system and reviewed the data to assess progress and make future decisions. They also decided about the continuation of the CSBAs after the SHOW closeout and raised funds to cover their salaries until the CMW cadre becomes available. The committees also advocated with the government that CSBAs be given a chance to apply for the CMW training, as they were already trained by the system on many required skills.

Results

- As part of the working, SHOW contributed to the Midwifery curriculum for FWV by incorporating GE/SRHR issues in the relevant sections of the manual, which was developed and reviewed by the government.
- The SHOW-ignited CHCs moved toward financial sustainability. CHCs mobilized funds by initiating a raffle draw, local donor hunting, the Hat-Bazar collection, and Fitra/Zakat during Eid. The funds will help in addressing electricity connections, providing sign boards in front of the centers, funding road reconstruction to the facility itself and improving cleanliness of the center.
- Locally organized events also helped develop greater awareness and accountability among the target beneficiaries and stakeholders on issues relating to gender equality, GRAF service delivery, and MNCH/SRHR issues. This was especially relevant for, gatekeepers like officials from DGFP, DGHS, and Department of Women Affairs (DWA), elders and mothers-in-law.
- Women's participation in SHOW visioning workshops resulted in the integration of GE issues into sustainability plan discussions. Examples include the involvement of adolescent girls in decision-making, separate toilet facilities for men and women in UH&FWCs, and women's leadership. Participating women continue to monitor UH&FWCs and lobby local government for increased funding for health services. This indicates that participation at the UH&FWC-MC level may help drive women-led advocacy in the community..

Best practices

- Participatory approaches, when truly adopted, result in finding local solutions to the local problems, with the highest chances of sustainability.
- Engaging the local community, especially women and adolescent girls, in the local planning and decision-making processes is pivotal for sustainability.
- In addition to robust interventions and data, sustainability requires effective social mobilization and advocacy at all levels.

BEST PRACTICES FROM THE SHOW PROJECT IN BANGLADESH

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

- With a contextual understanding of the audience, engagement of key stakeholders and influencers (religious leaders in this case) and appropriate modifications to the content of SBCC materials, projects can develop a collaborative relationship even with hard-to-reach stakeholders.
- The model of peer educators for adolescents is effective for issues like SRHR and applicable to future projects on similar issues, aiming to shift norms and improve behaviors among a young population.
- Involving women in the planning and accountability mechanisms, like CHC, can improve gender-responsive health care at health facilities. It also enables women's empowerment and agency at the household and community levels.

Health services with a focus on gender equality

- Adopting participatory approaches, like CHCs, to involve the community, especially women and adolescent girls, in the planning, execution, and accountability of service delivery is essential for building gender-responsive and adolescent-friendly health systems.
- Health systems that are constrained by a human resource deficiency can benefit from task shifting and task sharing options. An example of this was upgrading CHWs to CSBAs by providing training and improving their competence.
- Involving local communities in management and governance is helpful, as they can generate local resources, ensure round-the-clock availability of services, and make decisions that ensure the sustainability of such interventions beyond the life of a project.

Accountability and results

- Visioning workshops are an essential mechanism to ensure that local leadership takes responsibility for maintaining project improvements and engaging in sustainability efforts after the project's end date.
- Female participation in the local leadership platforms, like the UH&FWC-MC activities, is an effective way to ensure that health facilities remain accountable to women and girls.
- Projects aiming for adoption of innovations can have differentiated approaches according to the situation and should be seen as "pilots". Adoption of an innovation at a certain level, and not by the entire system, is pragmatic in these instances so long as efficacy can be demonstrated.

Operationalization

- Involving the local community, especially women, brings community ownership to a donor-funded project and improves its implementation and outcomes.
- In difficult situations, it is helpful to be transparent about the procedures and find common ground between donor requirements and the realities of an implementing country.
- Certain populations will always need financial assistance, necessitating measures like a cash-support scheme.

Sustainability

- Participatory approaches, when truly adopted, result in finding local solutions to the local problems, with the highest chances of sustainability.
- Engaging the local community, especially women and adolescent girls, in the local planning and decision-making processes is pivotal for sustainability.
- In addition to robust interventions and data, sustainability requires effective social mobilization and advocacy at all levels.

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

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

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

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

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

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

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

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

[ix] ICRW, 2015, http://www.icrw.org/child-marriage-facts-and-figures

[x] Plan International Canada. Bangladesh country context. PIP Annex A

Acronyms

AHC: Adolescent Health Corner

BEmONC: Basic Emergency Obstetric and Neonatal Care

CBHV: Community Based Health Volunteer

CHMIS: Community Health Management Information System

CMW: Community Midwife

DGFP: Director General Family Planning

DHIS: District Health Information System

EmONC: Emergency Obstetric and Neonatal Care

FWV: Family Welfare Visitor

GE: Gender Equality

HMIS: Health Management Information System

IMNCI: Integrated Management of Childhood Illnesses

LNGO: Local Non-Governmental Organization

LMIC: Low- and Middle-Income Country

M&E: Monitoring and Evaluation

MoH&FW: Ministry of Health and Family Welfare

PIP: Project Implementation Plan

PMT: Project Management Team

SBA: Skilled Birth Attendant

SHOW: Strengthening Health Outcomes for Women and Children

TAG: Technical Advisory Group

UH&FWC: Union Health and Family Welfare Centre

VSLA: Village Saving and Loan Association

WRA: Woman of Reproductive Age

AWP: Annual Work Plan

CETS: Community Emergency Transport System

CHC: Community Health Committee

CHW: Community Health Worker

CSBA: Community Skilled Birth Attendant

DGHS: Director General Health Services

DWA: Department of Women Affairs

GAC: Global Affairs Canada

GRAF: Gender-Responsive, Adolescent-Friendly

HFA: Health Facility Assessment

IEC: Information, Education, Communication

IYCF: Infant and Young Child Feeding

LAMB: Lutheran Aid to Medicine in Bangladesh

MART: Maternal Awareness and Referral Tracking

MNCH: Maternal, Newborn and Child Health

MoW&CA: Ministry of Woman and Child Affairs

PMF: Performance Measurement Framework

PSC: Project Steering Committee

SBCC: Social and Behavior Change Communication

SRH: Sexual and Reproductive Health

TfD: Theatre for Development

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

WATCH: Women and Their Children's Health

YPSA: Young Power in Social Action

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