

Gender Technical Brief

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Overall Achievements

Over the past five years, MCSP has developed tools and strategies to address gender-based constraints and opportunities related to reproductive, maternal, newborn, child and adolescent health (RMNCAH) outcomes and integrated these into national strategies, training packages and quality improvement tools. In Ghana, Nigeria, Mozambique, and Tanzania these tools have been institutionalized by their ministries of health and scaled up through national programs. Through the identification and analysis of gender issues pertaining to RMNCAH in select settings, MCSP has drawn new insights on the impact of addressing gender norms, roles and relations as it relates to RMNCAH care-seeking, service utilization, and other health outcomes.



Nigeria: Blessing Oji rests with her husband, Peter, after delivering her third child. Photo by Karen Kasmauski/MCSP

Improved quality of care for RMNCAH by ensuring respectful, gender-sensitive service delivery across the continuum of care in five countries

In India, Nigeria, Mozambique, Rwanda, and Tanzania, MCSP worked with health providers, facilities and policy makers to ensure that women and men have equal access to high quality care that ensures accessibility, privacy and confidentiality; patient-centered care that respects women's dignity, autonomy and agency; respectful provider-client interactions; and appropriate infrastructure and commodities all of which meet the needs of women and, as appropriate, their partners.

Key achievements:

- In 2019, MCSP conducted a mixed-methods study in Rwanda that examined the gender-based discrimination and mistreatment by health providers in reproductive and maternal health services in Rwanda. The study demonstrated that health care providers' attitudes around quality of care improved with more equitable gender attitudes.
- From 2016-18, MCSP improved the quality of service delivery in health facilities in Nigeria, Tanzania, and Mozambique using Jhpiego's Standards for Gender Sensitive Service Delivery, a supervision tool that allows facilities to assess themselves through a participatory process with providers and incentivizes them to improve based on a scoring system. Hundreds of providers have been trained to implement the tool and scores have increased in the areas of respectful communication and care, privacy and confidentiality,

and male engagement. The tool subsequently integrated into existing national quality improvement initiatives in Mozambique and Tanzania to position it for scale-up of its use across the country.

- From 2017-2018, in Nigeria MCSP facilitated participatory workshops on gender and respectful maternity care with the aim of reducing gender-based discrimination leading to mistreatment of health workers and clients. MCSP trained 30 core facilitators and 1,000 health providers on the Health Workers for Change (HWFC) curriculum, which uses a participatory approach to help providers address gender inequities, attitudes, and barriers to delivering high-quality care.
- In Tanzania, MCSP developed a facilitation guide to sensitize, build skills and mentor health workers on gender, RMC, youth-friendly services, and male engagement sensitization, skills-building, and mentorship of health providers. The guide has subsequently been applied with health workers under the USAID-funded Boresha Afya program and is slated to be finalized as a curricula by the Ministry of Health.
- From Jan 2017 through Sept 2018, in India, MCSP partnered with the Indian organization Centre for Catalyzing Change (C3) to train 21,943 community health workers (CHWs), nurses, and community health committee members; 2,501 facility-level providers; and 546 district- and state-level officials on gender-sensitive family planning (FP) services that respect women's autonomy, dignity, and privacy.

Framework for engaging men in RMNCAH preventative and care services at both the facility and community-levels defined and applied in four countries

From 2016-2018, MCSP worked to engage men in RMNCAH health-seeking and service delivery in Mozambique, Nigeria, Rwanda, and Tanzania. Men play a key part in RMNCAH, yet they are often neglected in outreach and service delivery. In many countries, men make most household decisions about sexual behavior, the use of family planning, family size, whether to give birth in a facility or at home, whether a sick child will be brought to a health facility, allocation and control of household assets, and the division of household labor. Additionally, men themselves have their own health needs and right to services.

Key achievements:

- In October 2016, MCSP conducted a baseline study in Mozambique using a gender-specific module of the MCSP Knowledge, Practices and Coverage Survey that includes questions on male roles in RMNCAH. The study identified that when men are involved in birth preparedness and complication readiness planning, women are more likely to deliver in a health facility. It also found that when couples that communicate about family planning, they are more likely to practice birth-planning and complication readiness and deliver at a facility rather than at home.
- In Mozambique, Nigeria and Tanzania, MCSP found that facility-based providers and community health workers, respectively, can substantially increase male participation in RMNCAH through education and encouragement around male involvement in RMNCAH.
 - In Tanzania, more than 10,000 community members, including more than 4,000 men, participated in community-gender dialogue sessions led by CHWs from 2014-2017. In Mara, 91% of men who participated indicated that they are willing to



Bonifácio Elias, a community health agent and member of the Community Health Committee, teaches a birth planning session to the community of Munheune, in Muecate district, in Nampula. Photo by Fernando Fidélis/MCSP

educate others at community and church meetings about the role of men in RMNCAH.

- In Nigeria, MCSP developed posters, a pamphlet, and a job aid to raise awareness and to help providers counsel clients on how men can contribute to their family's health. MCSP also built the capacity of 101 pre-and in-service providers as training facilitators on male engagement in March 2018 and provided privacy screens to 10 key facilities. As a result of these interventions, male participation in family planning (FP), antenatal care (ANC), and labor and delivery increased by nearly four times in 1 year, from 1,483 men accompanying their female partners to FP, ANC, and labor and delivery in June 2017 to 5,487 in June 2018.
- In Mozambique from October 2016–June 2018, MCSP trained providers in 86 health facilities to offer high-quality couples counseling that supported male involvement in birth preparedness and complication readiness planning. From October 2016–June 2018, MCSP built the capacity of 10,597 CHWs in 29 districts to integrate gender and male engagement approaches into health promotion activities. These efforts resulted in 30,982 couples jointly developing joint birth plans, including choosing a health facility at which to deliver, saving money and arranging transport, and selecting a supportive birth companion.
- In Rwanda, MCSP reached 9,727 couples and young people in six districts with a local adaptation of the Bandebereho MenCare+¹ curriculum developed by Promundo and the Rwanda Men's Resource Center. Group sessions led by peer champions engaged expectant fathers and their partners to promote men's involvement in maternal, newborn, and child health; family planning; caregiving; and preventing domestic violence.

Mitigating RMNCAH risks posed by gender-based violence (GBV)

Worldwide, one in three women experiences gender-based violence (GBV), leading to devastating impacts on her health and well-being, including death, disability, HIV and other sexually transmitted infections, miscarriage, late entry into antenatal care (ANC), low-birthweight babies, depression, and suicide.

MCSP works to prevent GBV and link survivors to high-quality care through community engagement, skills building for providers, monitoring and improving the quality of GBV services, and incorporating appropriate GBV screening into health services.

Key achievements

- In Ghana, Guinea, Haiti, Madagascar and Rwanda, MCSP developed and updated training materials and quality improvement tools that were adopted by ministries of health for on-going use.
- In Ghana and Madagascar, MCSP developed a 1.5 hour e-learning module on the first-line response for GBV, which reflects recommendations by the World Health Organization². These have been integrated into pre-service curricula for community nurses and midwives in Ghana and into in-service curricula for antenatal care providers in Madagascar.
- In Guinea, MCSP facilitated the development of national training curricula for health workers on responding to GBV, which reflects global guidance and best practices on the same.
- MCSP piloted a quality assurance tool for GBV health services that was developed by Jhpiego with support from CDC, PEPFAR and WHO in Haiti and Rwanda in order to provide critical feedback on the relevance and applicability of the tool in a lower-resource GBV setting (Haiti) vs. a higher-resource GBV setting (Rwanda). The tool was rolled out across 12 MCSP-supported facilities that provide GBV services in both countries and was adapted by the Rwandan Ministry of Health for national use in 45 Isange One Stop Centers, which provide comprehensive services for GBV in one

¹ See: <https://men-care.org/resources/bandebereho-facilitators-manual-fathers/>

² WHO. 2013. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva.

location, including, medical, legal and psychosocial services, usually within a hospital. Additional achievements included improving identification of GBV survivors, empathetic counseling, special care for child and adolescent survivors, and ensuring privacy.

- In Guinea, Nigeria and Rwanda, MCSP trained health providers on the appropriate provision of GBV services and reached thousands of GBV survivors.
- In Conakry, Guinea, MCSP established a network of seven health facilities comprising 42 health care providers with 125 community educators, 10 paralegals, and school/university committees to support GBV survivors. We conducted 180 educational sessions on GBV reaching 13,000 people, including security forces and local government officials.
- In Rwanda, MCSP reached over 14,938 GBV survivors with health services, and built the capacity of 173 trainers and 1,500 health providers to offer post-GBV care between October 2016 and March 2018.
- In Nigeria, MCSP conducted a rapid assessment of facility readiness and provider knowledge, attitudes, and practices. Findings showed that GBV information, services, and referrals were not provided to survivors. MCSP subsequently built the capacity of 101 health care providers from March–June 2018 to offer GBV first-line support and basic clinical care, and produced referral directories for Kogi and Ebonyi states.
- In Namibia in July 2018, MCSP trained providers on the provision of post-GBV care, particularly first line support, which involved empathetic counseling, safety planning, and referrals.

Empowering female health workers

Women make up 70% of the global paid health workforce, yet they face discrimination in terms of compensation and workforce advancement compared to their male counterparts. Challenges include gender discrimination resulting in unequal pay, violence and sexual harassment, restricted mobility outside the home, and the burden of balancing pregnancy and family care with their job. MCSP addressed these barriers by sensitizing midwives and midwifery students on gender and building skills on addressing gender issues health services, facilitating FP education and services to students, fostering supportive working and learning environments for women, and working with schools to create sexual harassment and pregnancy policies.

Key achievements:

- In Liberia, MCSP trained clinical mentors on gender-responsive teaching methods to improve the gender-sensitivity of teaching practices. In addition to gender-responsive curricula, the program also integrated learning objectives on gender sensitivity, gender as a determinant of health, GBV, and female genital mutilation and into pre-service training for health providers and built skills of providers in these areas. From March 2018, MCSP trained and supported peer FP providers to provide family planning counseling and modern contraceptive methods to 219 students. MCSP also trained 10 students from Tubman National Institute of Medical Arts as Gender Ambassadors who educated 150 students and staff about FP methods, sexual harassment prevention, and available school support for pregnant students.



Midwifery students in the Simulation Lab with an instructor at the Phebe School in Liberia. Photo by Erica Chin/MCSP

- In 2017, the project worked with preservice institutions to generate demand for female students to enroll in laboratory schools and male students to enroll in midwifery schools, upending traditional gender roles. Laboratory preservice institutions experienced a 100% increase in student enrollment in 2019, with female students representing 26% (three times greater than 2016 enrollment). From 2016 to 2018, male enrollment increased in midwifery institutions from 20 to 80 males out of 528 total students.
- In Nigeria in 2017, MCSP trained over 30 core facilitators and 1,000 health providers on the Health Workers for Change (HWFC³) approach, which uses a participatory approach to help providers address the gender inequities, attitudes and barriers to delivering high quality care. Participants created action plans to address gaps and challenges, and reported the following outcomes, among others, from HWFC:
 - Improved interpersonal communication, empathy with clients
 - Expanded hours for emergency maternity care through additional security staff at facilities, adjusted duty rosters, and overnight accommodation for midwives
 - Infrastructure improvements: clear signage, ventilation, handwashing stations, reconstructed labor wards, and privacy screens in 10 key facilities allowing companions to attend births
 - Improved privacy during medical examinations and labor.

Global leadership for development and dissemination of gender policies, standards, and other resources

Contributions to global dialogue on gender inequality as a factor in mistreatment during childbirth.

- MCSP conducted a review to examine how gender inequalities contribute to mistreatment during childbirth, entitled “[Expanding the Agenda for Addressing Mistreatment in Maternity Care: A Mapping Review and Gender Analysis](#)”, which was published in *BMC Reproductive Health* in August 2018. Preliminary findings were also presented at an MCSP-hosted and expert consultation on respectful maternity care and the FIGO/SAGO conference in 2016 and will be highlighted at events at Women Deliver 2019.

Contributions to global dialogue and guidance on engaging men in reproductive, maternal, newborn, and child health by co-chairing the Male Engagement Taskforce of the USAID Interagency Gender Working Group

MCSP co-chairs the USAID Male Engagement Taskforce of the Interagency Gender Working Group, which was re-launched in 2017. In this role, MCSP co-developed guidance for engaging men as clients, partners, and agents of change for RMNCAH. Specific activities include the following:

- Learning and exchange events hosted by MCSP on engaging men in RMNCAH have contributed to an improved enabling environment for gender-transformative program implementation. In February 2018, MCSP hosted a panel on engaging men in maternal and newborn health that drew over 50 participants from the global health community.
- Further, new guidance on male engagement will be developed in 2019 in partnership with the Institute of Reproductive Health and the Population Council, co-chairs of the taskforce, in consultation of other members of the taskforce.

³ UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. (1995). *Health workers for change: a manual to improve quality of care*. Geneva: World Health Organization. <http://www.who.int/iris/handle/10665/63192>.

Contributions to the standard measurements of gender equality and empowerment in RMNCAH

- MCSP developed a set of comprehensive tools to assess respectful maternity care and factors driving mistreatment, including questions around gender-based attitudes, norms and practices that affect both clients and providers.
- MCSP composed women's and men's gender modules for the Knowledge, Practices, and Coverage household survey, which includes questions related to who decides to use key RMNCAH services, as well as measures of gender norms. The module draws on a review of gender and empowerment indicators that have been associated with improved RMNCAH behaviors and outcomes as well as consultations with internal and external experts on gender and health to include their inputs and expertise. It is the first comprehensive survey module that includes specific questions on gender roles and dynamics in relation to RMNCH.

What more could be done?

The agenda for addressing gender inequities that undermine RMNCAH is still in the early stages. Although promoting women's access to health information and services is a critical first step to women's broader equality and empowerment, there is still much work to do to better define and measure the impacts of the above-described gender interventions to determine which are high impact. Specifically, further evaluation is needed to measure the impact of GBV screening, counseling, and referrals on uptake of antenatal care and family planning services, as well as mitigation of ongoing GBV. Moreover, evaluation of approaches to promoting respectful care, including a standards-based quality improvement, and social behavior change participatory workshops, such as Health Workers for Change, are essential to understanding how these interventions can help end preventable child and maternal death.

Finally, many questions remain on how and whether engaging men in RMNCAH leads to improved uptake of such services as facility-based births and maternal, newborn and child health outcomes. We also need to better understand how to appropriately engage men; particularly to avoid the potential of limiting women's agency and choice. Further work in future programming can support this kind of evaluation.

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