Gender Equality Strategy Impact Report

Empowering women, adolescent girls and communities towards healthy, full-term pregnancies and a healthy start for newborns

ACKNOWLEDGEMENTS

This report was written by the Born on Time Gender Equality working group under the leadership of Dominique LaRochelle (Save the Children Canada) and compiled by Élisabeth Cloutier. The team included Socorro Maminta (World Vision Canada), Saifullah Chaudhry (Plan International Canada), Sarah Anderson (Save the Children Canada) and Marie Bettings (World Vision Canada).

The working group acknowledges the collaboration of respective agency staff members from Plan International in Bangladesh, World Vision International in Ethiopia, Save the Children International in Mali and members of the teams in Canada. Funding for this important work was made possible by Global Affairs Canada and the Johnson & Johnson Foundation.

Most importantly, we would like to thank all of the women, men, adolescent girls and boys, local leaders, government officials, health care professionals, and health facility staff who shared their experiences over the years and were willing to actively take part in this unique gender-transformative initiative.

Published by The Born on Time Consortium

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Suggested Citation: World Vision Canada, Plan International Canada, Save the Children Canada. (2021). Gender Equality Strategy - Impact Report

Cover photo: Plan International Bangladesh

Photo credits: Paul Bettings, Benjamin Eagle, Girls' Globe/Marta Miklinska, Asaduzzaman Rassel

Graphic design: Mickey Hioe Design

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INTRODUCTION
Born on Time

Born on Time (BOT) is a unique program – truly a global first around the issue of prematurity prevention. The program is the first public-private partnership dedicated to the prevention of preterm birth, now the leading cause of death in children under five globally. Combined, Bangladesh, Ethiopia and Mali contribute more than one million preterm births each year, with preterm birth rates ranging from 12 to 19% [1].

To address prematurity, Born on Time targets risk factors related to unhealthy lifestyle/behaviors, maternal infections, inadequate nutrition, and limited access to contraception that can lead to babies being born too soon. These risk factors are exacerbated by gender inequalities and power imbalances, and as such, Born on Time has been placing a strong focus on the integration of innovative approaches that address discriminatory social and gender norms and risk factors that negatively impact the maternal, newborn and reproductive health of women and girls, as well as their newborns.

Working closely with local governments and community stakeholders, this five-year initiative brings together the collective experience of World Vision Canada and World Vision Ethiopia, Plan International Canada and Plan International Bangladesh, Save the Children Canada and Save the Children Mali, to work towards a future where every child is born on time.

Thanks to the BOT project, we are starting to see more adolescents, including girls, frequenting health facilities, as well as more men accompanying their wives"

Ruth Dite Mah Diassana
Midwife, Mali

[1] Every Preemie Scale Report, 2019

LIST OF ACRONYMS
In alphabetical order

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
ASACO	Association de Santé Communautaire (Community Health Committee – CHC)
BOT	Born on Time
CAD	Canadian Dollars
CANWACH	Canadian Partnership for Women and Children's Health
CEFM	Child, Early and Forced Marriage
CHC	Community Health Committee
CHW	Community Health Worker
COVID-19	Coronavirus Disease
CSBA	Community Skilled Birth Attendant
GBV	Gender-Based Violence
HCP	Health Care Provider
IGA	Income-generating activities
IPV	Intimate Partner Violence
LINC	Lifestyle, Infection, Nutrition and Contraception
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
PNC	Postnatal Care
PTB	Preterm Birth
SBCC	Social and Behavior Change Communication
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
UH&FWC	Union Health & Family Welfare Centres
WHO	World Health Organisation
WRA	Women of Reproductive Age

FOREWORD

When asked why the work on preterm birth is so important, Mukta, a Community Health Worker in Rangpur, Bangladesh, replied, "I'm part of a system that's taking care of people. Women suffer a lot in our communities, especially during pregnancy and delivery. Through Born on Time, they now know that there are services [at the health clinic] and that these are for free. When I see a mother deliver a healthy baby that I have counselled through a pregnancy, it makes me so proud. It is my happiness."

Across Bangladesh, Ethiopia and Mali, these stories of transformation for women, adolescent girls, and their communities, are taking place every day – both by women and girls themselves, as well as through champions and allies committed to a vision of health and wellbeing for all. Champions like Meryem, a community leader who was married at 12 years old and now fights to end child marriage in Ethiopia. Or Sifat, a young male champion and ally of women and girls in Bangladesh who advocates for equality. And Ruth, a committed midwife in Mali whose life's work has been dedicated to supporting women and adolescent girls' empowerment. Champions like these are central to Born on Time's work as we address the scourge of preterm birth through gender-transformative programming.

Since program design back in 2015, the integration of gender equality as a bedrock approach to the risk factors of preterm birth and the health and wellbeing of women and girls was paramount. An in-depth gender analysis demonstrated that women and adolescent girls in Bangladesh, Ethiopia and Mali all faced pervasive gender inequalities and power imbalances preventing them from accessing and using maternal and newborn health services.

Leveraging the experience of Save the Children, Plan International and World Vision, the Born on Time consortium was able to integrate the learnings and good practices from other projects into the design of Born On Time, thus making it a truly integrated and gender-transformative maternal and newborn health program.

The result of this early work was a Gender Equality Strategy, which became the core approach at the forefront of the actions taken in the program. Three main pillars of the Gender Equality Strategy were developed: empowering women and adolescent girls; engaging men and boys as active partners for change; and engendering newborn and reproductive health services. To ensure it was grounded in evidence, the strategy was refined after a full year of implementation of the program.

Transforming discriminatory social norms and shifting power imbalances were essential components towards the realization of women and girls' reproductive rights, including the right to healthy pregnancies and childbirth. Born on Time has proven that by investing in women and girls' empowerment, engaging men and community leaders to create a supportive environment for women and girls to realize their sexual reproductive health and rights, and by strengthening health systems to be more responsive to their specific needs, gender transformative health programs can be designed, implemented and monitored to achieve sustainable impact.

Five years on, as formal programming ends, we are confident that the work begun to provide empowering opportunities for women, adolescent girls and their communities, thus also ensuring healthy, full-term pregnancies and a healthy start for newborns, will inspire others to take this important work forward and move us all towards a future where every child is born on time.

Marie Bettings
Program Director
Born on Time

Dominique LaRochelle
Head of Gender Equality and Program Impact
Save the Children Canada

PRETERM BIRTH: AN OVERVIEW

Every year, approximately 15 million babies are born too soon. Preterm birth complications are now the leading cause of death in children under 5 years, with an estimated one million premature babies dying each year [2]. As preterm birth statistics rise in many low and middle-income countries, prevention of preterm birth is emerging as a critical catalyst towards healthier, thriving children around the world.

Research has shown that more than 75% of preterm birth deaths can be prevented with low-cost, practical interventions [3]. Interventions that promote family planning, empower women and adolescent girls, and improve the quality of health care before, between and after pregnancy, significantly reduce preterm birth rates. Prevention work is nuanced and tough, yet it matters in ways that deeply shape a society's notions of wellness, equality and dignity for all.

And prevention is at the core of Born on Time – a program that believes that every mother has the right to a healthy, full term pregnancy and every newborn has the right to thrive.

[2] WORLD HEALTH ORGANIZATION (WHO) 2019
[3] WORLD HEALTH ORGANIZATION (WHO) 2019

ASSESSMENT OF GENDER-BASED BARRIERS TO MATERNAL AND SEXUAL & REPRODUCTIVE HEALTH

When the Born on Time consortium came together in 2015 to design the BOT program, it developed a comprehensive gender analysis to inform the design of the program. The gender analysis revealed that women and adolescent girls in Bangladesh, Ethiopia and Mali all face common gender inequalities and power imbalances that prevent them from accessing and using health services.

The pervasive discriminatory social norms in place impact their ability to access sexual and reproductive health (SRH) and maternal and newborn health (MNH) services in particular, as well as their ability to make their own decisions in regard to their health and the health of their children. The gender analysis showed that women and girls' limited autonomy and decision-making power – particularly with regard to health seeking behaviors and key issues such as pregnancy, birth spacing or child rearing – as well as their lack of financial independence, were found across all three countries, and all contributed to marginalization in accessing SRH and MNH services.

Although manifested in different ways, the gender-based barriers faced by women and adolescent girls in all three countries are driven by the same root cause: gender-based discrimination, resulting in unequal power dynamics between girls and boys, and women and men. As such, it was crucial for Born on Time to address the discriminatory social norms that fuel power imbalances and impact the realization of women and girls' rights and health outcomes.

Major Gender-Based Barriers Identified in the Gender Analysis

Women and girls' limited agency and empowerment related to most aspects of their life, including their sexual and reproductive health and rights

Harmful traditional practices such as child, early and forced marriages (CEFM) are key factors contributing to preterm birth (PTB) and poor maternal and newborn health outcomes. Violence against women and girls is also a known risk factor for preterm birth and can lead to pre-partum and post-partum depression as well as other morbidities, and is a serious violation of women and girls' human rights. Women and girls' limited autonomy and decision-making power, particularly with regard to health seeking behaviors and other key issues, is also a key barrier.

Limited engagement of married adolescent boys and men in their partner's pregnancy and care

Rigid gender roles often contribute to a lack of support and awareness of women's reproductive health needs among male family members. For example, this can create a situation in which women and girls have to engage in excessive workload both at home and on the farm, even when pregnant, since men often do not take on or support this work because it is contrary to dominant gender roles and norms.

Lack of gender-responsive health services

Cultural and religious taboos, myths and beliefs – which have clear gender underpinnings – also increase the risk of preterm birth given that they limit pregnant women's preventive and care-seeking behaviors. Exclusion from community level health governance structures also limits their voices from being heard, resulting in the provision of services that are often ill-adapted to their unique needs and realities. Gaps in the provision of gender-responsive health services are also a critical gender-based barrier that prevent women and girls from seeking the health services they need.

Born on Time is a truly gender transformative program that works to address the root causes of gender inequalities placing women and adolescent girls at greater risk of preterm birth. The results of the gender analysis have been used to create a Gender Equality Strategy for the project, in order to develop an adapted response focusing on the key issues, which were limiting pregnant women and girls' preventive and care-seeking behaviors.

THREE MAIN PILLARS OF THE GENDER EQUALITY STRATEGY

PILLAR 1 – Empowering women and adolescent girls

- Addressing knowledge gaps through both targeted and broad education and awareness raising activities related to sexual and reproductive health and rights (SRHR), including risk factors that lead to preterm birth, lifestyle factors, danger signs and the importance of accessing services, such as antenatal care (ANC), delivery by a skilled birth attendant, postnatal care (PNC), postpartum family planning, etc.
- Throughout the program, all education initiatives directed at women and adolescent girls used integrated and stand-alone messaging on gender equality.
- The program worked to increase women and girls' social capital through a range of actions, such as establishing or strengthening existing support groups seeking to build the agency of women and girls, support them to raise their voice and increase their social visibility and decision-making capacities within households and communities, as well as sensitization and mobilization of other key household influencers and decision-makers (e.g. mothers-in-law, grandmothers, etc.).

PILLAR 2 – Engaging men and boys as active partners for change

- Working with community gatekeepers, such as religious leaders, so that they can contribute to reducing harmful traditional norms and practices which perpetuate gender inequality, including CEFM and other forms of gender-based violence (GBV).
- Engaging men as active partners of change, notably through social and behaviour change communication activities. Among the initiatives organized were targeted male partner education and formation of male community groups to foster improved couple communication, gender equitable relationships (including power relations, re-distribution of care responsibilities, including household chores) and decision-making on key MNH and adolescent sexual and reproductive health (ASRH) matters, as well as educating men on preterm birth risks, and prevention.

PILLAR 3 – Engendering newborn and reproductive health services

- Engendering newborn and reproductive health services, notably through capacity building activities on the gender equality dimensions of MNH and ASRH with health services providers and decision-makers, including community health committees, in order to support the delivery of quality, gender-responsive and adolescent friendly maternal, newborn health services.
- This pillar included supervision, coaching and mentoring visits led by the project teams and their partners from health districts teams. It also provided the development and implementation of resources and checklists for clinical mentors to use in evaluating gender-responsiveness of health facilities. For example, many health facilities now have toilets that are separated for women and men, as well as spaces and hours reserved and dedicated for adolescents. There are specific spaces for male family members who accompany women to health services, and women and adolescent consultation rooms ensure confidentiality. In certain cases, the services are available 24 hours a day, seven days a week, with the presence of staff who have been trained on gender-responsive and adolescent-friendly health facilities.

PILLAR 1 – Empowering Women and Adolescent Girls

Throughout the project, targeted activities were implemented in all three countries to address knowledge gaps, and to ensure the enhancement of women and girls' leadership skills. All education and learning initiatives with women and adolescent girls included explicit messaging on gender equality, which were systematically reviewed through a gender equality lens to ensure the development of focused gender-transformative content.

Increasing women and girls' social capital through support groups

The BOT consortium established and/or strengthened existing support groups of women and adolescent girls to raise their voice, increase their social visibility and decision-making capacities within households and communities. In Bangladesh, this included

i. identifying and mobilizing elder women's "Decision-maker Groups", specifically bringing together family influencers such as mothers-in-law, mothers and grandmothers, to conduct community sensitization on MNH, as well as sexual and reproductive health and rights;

ii. establishing adolescent girls' peer-education groups and leveraging

iii. the annual *bou-shashuri mela* (daughter-in-law and mother-in-law fairs). The *bou-shashuri mela* is a traditional gathering, and has been organized by involving local governments, health and family planning departments and community level health and support groups. It has been a yearly edutainment event at the Union level to provide a recreational opportunity, while at the same time using the platform to share the program's gender transformative messages on nutrition, the harms of CEFM, misinformation about preterm birth, harmful practices and taboos around SRHR and the importance of gender equality. These fairs have focused on amplifying women's decision-making capacity at the family level, breaking existing gender stereotypes, roles and attitudes, and bringing positive changes within households and communities.

"I have the financial means which allow me to access health services [...], to contribute in the purchase of food for my household, to pay school fees for my children [...]"

Assetou Traore,
Solidarity Fund Member, Mali

Mobilization and capacity development

A key element of increasing social capital for women and girls in all three countries has been the mobilization to increase women membership and leadership in existing community-based forums, e.g., Community Health Committees, Health and Family Planning Standing Committees, Union Education and peer groups to promote the voice of women and girls in public spaces, as well as gender equality. This practice has shown to increase women's representation and participation in these structures and to collaborate within their mandates to include actionable plans towards the prevention of preterm birth, as well as address many of the harmful practices which can lead to preterm birth including gender-based violence, CEFM, gender-based discrimination, etc.

Targeted and broad education

Born on Time addressed knowledge gaps of women and adolescent girls through targeted and broad education, as well as awareness raising activities related to gender equality and SRHR, including risk factors that lead to PTB, lifestyle factors, danger signs and the importance of accessing services such as antenatal care, delivery by a skilled birth attendant, postnatal care, postpartum family planning, etc.

In Ethiopia, Women's Dialogue Groups were organized as a support mechanism for women of reproductive age (WRA) which provided them with a safe space to learn, discuss gender-based issues around PTB, MNH and SRHR, and hone their life skills, including leadership, communication and negotiation.

Across
the three countries

1,031,071
women

&

275,614
adolescent girls were reached through program activities.

Solidarity funds

In Mali, solidarity funds were established to support women's economic empowerment. During the implementation of the program, 75 women's groups were created, for a total of 2,250 participating women. Every group (composed of 30 members) received an initial capital of $1,190 CAD granted by the BOT program to help start their income-generating activities (IGA). Through these successful IGAs, the women were able to double their capital after one year of running their businesses.

The new capital that each group was able to produce has been partially used as health insurance for women and children under five years old to access SRH/MNH services. Part of these funds were also distributed to an additional 14 women's groups in neighboring villages to start their own solidarity funds and IGAs. These income-generating activities have enabled them to have greater access to their own incomes and as a result, the members have reported greater economic decision-making power and autonomy in their households, and ability to contribute financially to the needs of their families.

Addressing the issues through intergenerational dialogue

Child, early and forced marriage (CEFM)

The BOT program worked with adolescent girls' groups were trained not only on sexual reproductive health but also on their rights (SRHR) and nutrition. They encouraged them to speak with their parents to prevent CEFM, which is one risk factor of pre-term birth. As a result of these trainings, the adolescent girls acquired knowledge about their own SRHR.

In Mali, parents of adolescents were engaged in community intergenerational dialogue sessions about gender equality and the adolescent sexual and reproductive health of their children.

Some of our colleagues had unwanted pregnancies before the arrival of this project because they had not received this training. I thank the BOT project for allowing me to acquire knowledge about adolescent sexual and reproductive health as well as adolescent nutrition."

Oumou S Dembele,
Participant of BOT Program Mali

The Story of Oumou: growing with her peers and her community

Oumou, a sixteen-year-old Malian adolescent girl, had limited knowledge and awareness regarding puberty, how to manage her menstrual cycle, how to prevent pregnancy and infection, and the importance of good nutrition during her teenage years. She had no idea about the consequences of CEFM and could not advocate against it within her friend group.

She did not know about PTB, its causes and how to prevent it for a teenage girl. Born on Time convinced her to join a group of adolescent girls that was trained on ASRH and adolescent nutrition. The program also encouraged the young girls to speak with their parents to combat CEFM, which is among the key risk factors of PTB. The project supported the functioning of a sexual and reproductive health service and supported the supervision and monitoring of the activities of adolescent groups.

As a result of this training, Oumou acquired knowledge about adolescent sexual and reproductive health. She is now familiar with puberty, how to manage her menstrual cycle and how to prevent pregnancy and infections. She is eating better than before, educating other adolescent girls about sexual and reproductive health, and advocating with the village chief to ban early and forced marriages of adolescents in her community.

"Our friendships are stronger here because we can share openly about what we're going through"

Morion
Peer Educator, Bangladesh

PILLAR 2 – Engaging Men and Boys as Active Partners for Change

One of the pivotal gender-transformative approaches of Born on Time has been the inclusion of men and boys as proactive partners of change, and to engage them fully in the realization of gender equality for all, given their power and influence within their households and communities.

The program has engaged men and boys through targeted interventions, including explicit messaging on gender equitable behaviors and relationships, and on the importance of their participation throughout the MNH/SRH continuum of care. For each of the activities held during the program, guidance and training was provided to field staff on effective male engagement techniques, and motivational messages were adapted to the interests of each group.

The various groups of men and boys have been trained on gender equality as a core issue relating to preterm birth, with groups carrying out outreach activities from their own platforms to promote utilization of MNH/SRH services by WRA and adolescent girls, spread awareness regarding the risks factors for preterm birth, and contributing to the reduction of harmful traditional norms and practices which perpetuate gender inequalities in their respective communities.

Across
the three countries

447,938
men

&

171,003
adolescent boys
were reached through
program activities

Peer groups

Adolescent boys' peer education groups were established and trained on MNH/SRHR, gender equality, preterm birth risks, as well as CEFM and GBV prevention. As with older men, the approach for mobilizing boys has been to foster positive masculinities premised on equality and girls' rights. This entailed reviewing ASRH curriculum from other projects, as well as adapting messaging and content to the evolving capacity of the children, adolescents, and of peer educators and facilitators on gender equality and rights promotion.

Born on Time engaged men and boys as active agents of change through social and behavior change communication (SBCC) activities, including the formation of male engagement dialogues and adolescent peer groups. These interventions aimed to foster improved couple communication and gender equitable relationships and decision-making on key MNH and ASRH matters, prevention of GBV, including intimate partner violence (IPV) and CEFM, as well as to provide education on PTB risks and prevention.

Religious Leaders

The program worked on the formation of Change Maker Groups to bring together key community opinion leaders. The systematic engagement of community gatekeepers, such as faith leaders, was put in place so that they could actively promote utilization of MNH and ASRH services, spread awareness regarding the risks factors for PTB from their platforms and spheres of influence and contribute to reducing harmful traditional norms and practices which perpetuate gender inequality, including CEFM and other forms of GBV.

Imams, pastors, priests and other faith leaders, mobilized and engaged men in the promotion of gender equality and risk factors of prematurity and how the two are interlinked. During these sessions, religious leaders used verses from the Quran and the Bible that call for the engagement of men and this has enabled many men to become active partners for change.

Fathers' Clubs / Husbands' Schools

The program established Fathers' Clubs and Husbands' Schools and/or leveraged existing ones. The men were taught about their positive role in better health outcomes for their wives and children, based off of the program's gender-responsive lifestyle, infection, nutrition and contraception (LINC) risk factors approach.

Results

The project showed that men have started to accompany their wives to health services, and they have supported their wives as members of women's groups to carry out income-generating activities. In some areas, men were also engaged to support women by celebrating International Women's Day, and International Day of the Girl, where some men have accepted that their daughters and teenagers can, and should, share their opinions and lived experiences in public, which was not the case at the beginning of the program.

In Bangladesh, the men under the Fathers Clubs curriculum, jointly developed by Plan International and Promundo, went through series of reflective sessions on gender equality, and the important role of men within the continuum of maternal, newborn and child health (MNCH) care to prevent preterm birth.

Decision-Maker Groups

The creation of household male decision-maker groups mobilized male family elders, particularly fathers-in-law, fathers and grandfathers, to foster improved couple communication, gender equitable relationships – including distribution of household labor and power relations – and decision-making on key MNH/SRHR matters, as well as educating men on preterm birth risks and prevention.

I thank the members of the Husbands' Schools and the BOT Program for making me aware of the importance of gender equality for the good health of my population and its development."

Mr. Diamoutene Sanogo,
Chief of Danderesso village, Sikasso Health District, Mali

PILLAR 3 – Engendering Newborn and Reproductive Health Services

Given that women and adolescent girls often do not utilize services due to the facility environment and/or the health providers' attitudes, Born on Time worked to address these barriers, along with other health service delivery strengthening activities. Three key measures were used to promote institutionalized gender-responsive and adolescent-friendly service provision: capacity building, refurbishing of health facilities, and supportive supervision and mentoring.

Capacity Building

Born on Time focused on building the capacity of community health workers (CHWs), community skilled birth attendants (CSBAs), and facility-based health staff regarding the gender-related barriers women and adolescent girls face in accessing care and compliance with treatment. This entailed a review of technical curricula of health providers with a gender equality lens, development of complementary training content, training of trainers, and training of health providers. The focus of the content was on practical knowledge creation, on how to deliver gender-responsive and adolescent-friendly services as a component of quality of care, particularly respectful attitudes and behaviors. Other health service providers were oriented on gender and adolescent responsive health care to create greater understanding amongst different cadres of health providers.

To better address the issue, BOT conducted training needs assessments in sample health facilities. In Ethiopia, the assessment report revealed that in all health centers and hospitals there was a significant training gap on compassionate, women-friendly health services. As a result, Born on Time adapted existing health service training curricula to include gender-responsive material. This was included within each of the health training sessions. The project also developed training materials for community health workers, which were integrated into ongoing trainings. In all trainings, gender equality, CEFM and GBV were key components.

In Mali, the project team successfully carried out multiple capacity-building initiatives with health providers and members of the Community Health Committees (ASACOs) to improve their health services to be more gender-responsive and adolescent-friendly. These initiatives also included supervision, coaching and mentoring visits led by the program team and its partners from health districts teams.

The project ensured the training of different health committees for inclusion of gender-responsiveness and adolescent-friendliness in health facility management techniques and for gender responsive referral mechanisms in general.

Across the three countries, Born on Time trained 22,685 health-care providers, of which 19,836 were female.

Refurbishment of health facilities

In all three countries, the refurbishment of health facilities was undertaken in order to address gender and age-related dimensions pertaining to privacy and confidentiality. For example, putting in screens for privacy so that accompanying husbands could also participate in counselling or putting in place breastfeeding corners, as well as youth corners. These needs originally emerged through the program's Health Facility Assessments.

In Bangladesh, walls of Union Health and Family Welfare Centres (UH & FWCs) were embellished with motivational gender-transformative IEC messaging, particularly in the waiting areas for men to build their understanding of key preterm/MNH issues, the importance of male engagement, gender equality and other LINC factors impacting preterm birth, as part of facility refurbishment.

Supportive supervision and mentoring

As a component of the sustained and institutionalized quality of care element, mid- and first-line supervisors oriented and facilitated their peers to ensure supportive supervision and mentoring integrated gender-responsiveness and adolescent-friendliness.

This entailed a review of the supportive supervision grids and checklists, adding gender-responsiveness and adolescent-friendliness components in the standardized tools, while developing a training and orientation module, and conducting the training of supervisors. The job support was also extended to these supervisors.

In all three countries, BOT developed checklists for trained clinical mentors to evaluate the gender-responsiveness of the health facilities. Clinical mentors used the checklist whenever they conducted mentoring in the health facilities and presented the findings to the health facility management team to take appropriate action for further improvement of the health services from a gender equality perspective.

IMPACTS OF THE BORN ON TIME PROGRAM

The impacts of Born on Time were measured throughout the project. A selection of both baseline and endline study findings are presented in this report to demonstrate the improvements realized under each component of the program. The data is separated by the Gender Equality Strategy's three pillars of intervention.

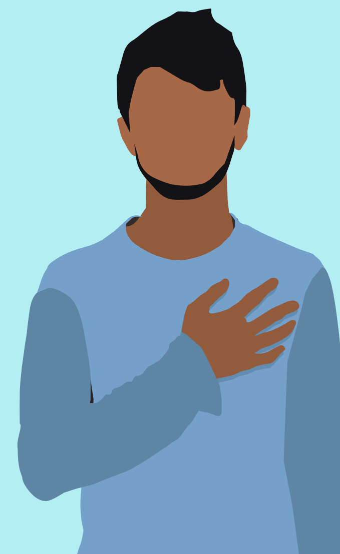
IMPACT DATA

BANGLADESH

1 Empowering women and adolescent girls

BEFORE		NOW
22.5%	Women of reproductive age (WRA) who know at least 2 danger signs during the continuum of care	47.8%
63.1%	WRA currently using a modern method of contraception	69.4%
11.2%	WRA reporting equitable decision-making power within the household in relation to seeking health care information and services for themselves or their newborns	30.8%

2 Engaging men and boys as active partners for change



BEFORE		NOW
51%	Average level of knowledge of male partners on key gender equality messages related to MNH/SRHR	85%
17.2%	Male partners reporting equitable decision-making power within the household in relation to seeking health care information and services for WRA or their newborns	43.8%

3 Engendering newborn and reproductive health services

BEFORE		NOW
27%	Facility-based healthcare providers (HCPs) who knew at least 2 key standards of gender-responsive and adolescent-friendly service provision	85%
6%	CHWs who knew at least 2 key standards of gender-responsive and adolescent friendly service provision	80%
40.3%	Extent to which health facilities have achieved gender-responsive standards in providing MNH/SRH for WRA	72.5%

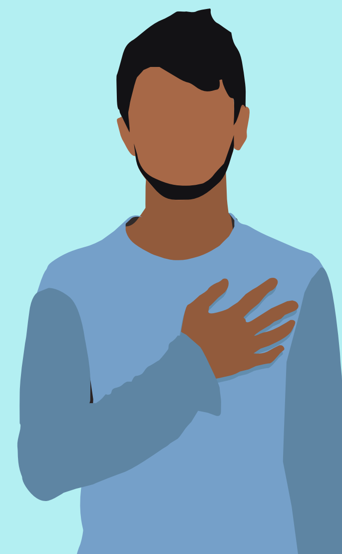
IMPACT DATA

ETHIOPIA

1 Empowering women and adolescent girls

BEFORE		NOW
41.3%	WRA 20-49 currently using a modern method of contraception	51.5%
4.5%	WRA 15-19 who know at least 4 risk factors for preterm births	8.6%
15%	Leadership positions in organized community groups occupied by women members	56%

2 Engaging men and boys as active partners for change



BEFORE		NOW
85.8%	Male partners reporting equitable decision-making power within the household in relation to seeking health care information and services for WRA or their newborns	86.4%
67.3%	Male partners who consider a husband to be justified in hitting or beating their wife	46.8%

3 Engendering newborn and reproductive health services

BEFORE		NOW
55%	Facility-based HCPs who knew at least 2 key standards of gender-responsive and adolescent-friendly service provision	82%
90%	CHWs who knew at least 2 key standards of gender-responsive and adolescent friendly service provision	100%
0%	Community Health Committees (CHCs) that have action plans for healthy pregnancy, delivery and care for the newborn that are gender responsive and adolescent friendly	100%

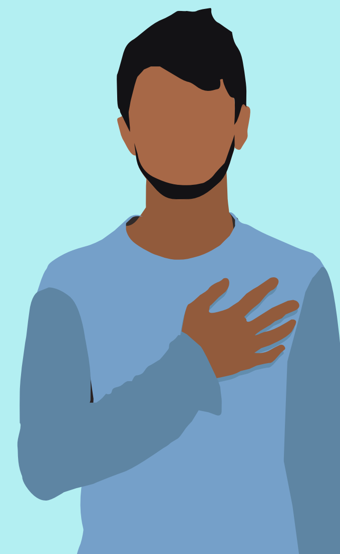
IMPACT DATA

MALI

1 Empowering women and adolescent girls

BEFORE		NOW
12.8%	WRA 20-49 currently using a modern method of contraception	33.8%
3.4%	WRA 15-19 who know at least 4 risk factors for preterm births	13.4%
9%	Leadership positions in organized community groups occupied by women members	19%

2 Engaging men and boys as active partners for change



BEFORE		NOW
5.9%	Male partners reporting equitable decision-making power within the household in relation to seeking health care information and services for WRA or their newborns	19.5%
69.9%	Male partners who consider a husband to be justified in hitting or beating their wife	53.5%

3 Engendering newborn and reproductive health services

BEFORE		NOW
50%	Extent to which health facilities have achieved gender-responsive standards in providing MNH/SRH for WRA	87.5%
76%	CHWs who knew at least 2 key standards of gender-responsive and adolescent friendly service provision	99%
0%	CHCs that have action plans for healthy pregnancy, delivery and care for the newborn that are gender responsive and adolescent friendly	91%

BANGLADESH – STORIES OF CHANGE

The Power of Partnership, Education and Courage

A decision can change a life

A few months ago, 14-year-old Hafcha made one of the most courageous decisions she has ever made – a decision that actually changed the course of her friend Assamoni's future.

In Bangladesh, more than half of all girls are married by the time they're 18, and 32% before they have reached 15 years old [4]. With little knowledge of their bodies or reproductive health, many end up as young mothers, often at risk of maternal mortality and/or morbidities, and giving birth to premature babies.

Assamoni learned through a family member that she would join those ranks by force. "After I heard about my marriage, I told my parents I wasn't ready. I wanted to keep studying, but they wouldn't listen."

Assamoni and Hafcha became friends at an adolescent peer group that meets every other week in a small community room at the centre of their village in rural Bangladesh. The 20 teenagers cover topics across the sexual and reproductive health and rights spectrum, including how to handle peer pressure, menstrual hygiene management, gender equality, and the importance of increased decision-making over their own lives and futures.

[4] Asia Child Marriage Initiatives (ACMI) Research Report

Leading with compassion

Leading the group through each session is 16-year-old Morion. She leads with confidence, passion and warmth – things you do not need a translator for. Morion is a peer-educator working to raise awareness among girls her age around their sexual and reproductive health and rights through the Born on Time program.

Born on Time has been supporting these girls as they meet, trying to address many of the risk factors of prematurity, including CEFM. Marrying too young often puts girls in increased danger of intimate partner violence, early pregnancies, and sexually-transmitted infections – all added risk factors for preterm birth.

A born advocate, Morion is fiercely loyal to the group of girls sitting in a circle in front of her. "If I only become an advocate, that's not good enough for me. I have to act." When Morion and her friends heard about Assamoni's impending marriage, they showed up at her home, trying to convince her parents that this was not only wrong, but illegal.

When her parents moved her to her grandmother's village to try and hide the wedding, Assamoni was devastated. And when Assamoni did not show up for the group's regular meeting, Hafcha knew something was wrong.

That's when she picked up the phone and dialed the country's national hotline for child marriage.

"We already know all the harmful things that come with child marriage," Hafcha explains. "I didn't want one of my friends to go through that." Once the call was placed, a support team including law enforcement and community leaders showed up in time to stop the marriage.

Morion is quick to give credit back to Assamoni herself. "Assamoni led the process against her own child marriage by speaking out in the first place," Morion exclaims. "We just came together to support her."

"Assamoni led the process against her own child marriage by speaking out in the first place. We just came together to support her."

Morion
Peer Educator

Assamoni's face beams with pride. The power of partnership, education and courage have allowed to change the narrative not only around women and girls' empowerment, but also around preterm birth. Excited about how she can help others, Assamoni remarks, "I know I can mobilize others to do this work as well. We are running and becoming stronger!"

It is young women like Assamoni, Morion and Hafcha who are going to slowly chip away at the generational burden of gender inequality and write a new future for themselves and their future children, if they choose to have them.

ETHIOPIA – STORIES OF CHANGE

New outlook, new outcomes

Challenging harmful cultural and discriminatory gender norms that perpetuate inequality helps to empower women, but it is not always easy.

Ehitnesh, a mother of four in Ethiopia, had concerns when her husband Ayelign began attending Born on Time's male engagement sessions. In a group with thirty-five men, Ayelign learned about harmful practices that can lead to preterm birth and what they, as husbands, can do to support their wives, especially helping to decrease their workload during pregnancy. However, Ehitnesh felt that "a feminine character is attributed to a man who does housework." She was nervous about what her community would think. But after taking part in Born on Time programming, Ayelign and Ehitnesh both found themselves challenging some of their views.

"When I became pregnant, Ayelign took care of me. He encouraged me to eat healthy foods. When I gave birth to Gebre, he accompanied us to health centre visits, where we got vaccines. Ayelign didn't use to do laundry, but now he helps. He gets me a helper when we host large social gatherings" said Ehitnesh.

"After BOT sessions, my wife also decided to start growing her own crops to supplement our family income. She's saving her own money. I'm very proud of my wife. I want her to keep progressing and improving her status," said Ayelign. "I want to make sure that my kids go to school. I want my sons to be better fathers" said Ayelign.

"I want [my daughter] to be able to make her own decisions, to choose whom to marry and to be able to send her own children to school." Ehitnesh, BOT Participant, Ethiopia

By challenging long-held beliefs and discriminatory gender norms, Ehitnesh and Ayelign are helping tip the scales towards better futures and health outcomes for all of their children, and even perhaps one day, their grandchildren.

"I want [my daughter] to be able to make her own decisions, to choose whom to marry and to be able to send her own children to school."

Ehitnesh
BOT Participant, Ethiopia

Women empowering each other

The story of Tenagne

Tenagne is 25 years old and lives in south Gondar, Ethiopia, with her husband and two young children. In her community, Born on Time established a women's dialogue group to provide a safe space where women could help empower each other. The group is facilitated by a peer-leader who has been trained to lead educational discussions on topics like gender equality issues around maternal and child health, family planning, and the prevention of intimate partner violence. In this group, women support each other to overcome barriers to translate their newfound knowledge into action.

"Women are wiser now. We discuss how we should get contraception right after the christening of our child," says Tenagne.

"We don't want another baby while nursing the one we just gave birth to. We tell each other that our babies will not thrive if we have more before the current ones have had a chance to be well fed". Tenagne's participation in the women's dialogue group has helped improve her marriage, her health, as well as her baby's health.

"My husband has also changed", she shares. "He is convinced that we should wait to have another child because we want our little boy to be strong enough. You see, I had a stillbirth a few years back. My husband and I still feel the pain. We don't want to lose another child."

MALI – STORIES OF CHANGE

Assetou's Empowerment Through Solidarity Funds

Assetou Traore lives in Sikasso, Mali, with her husband and three children. Before Born on Time, Assetou shared that she has had difficulty accessing health services due to both financial barriers and her lack of decision-making over her own health. She was not aware of what preterm birth was, or how to prevent it, and added that her husband used to make decisions on his own regarding how resources should be allocated at the household level – including medical decisions.

"I thank the BOT program for changing the status of my life. For the moment, my husband and his family take me with a lot of consideration."

Assetou Traore
Participant of BOT Program, Mali

Assetou confessed that she felt unhappy that she could not contribute financially to her family members' wedding celebrations, which is an important aspect of Malian culture. Women in her community, like other communities across many parts of the country, show a low demand for maternal health services largely due to their limited economic and decision-making power.

This results in low utilization of maternal health services and therefore, a high vulnerability of these women to maternal mortality, morbidity and a higher prevalence of preterm birth.

Limited economic and decision-making power meant that health needs often went unmet for women such as Assetou since husbands and other family members were not aware of – or did not respect – women and girls' rights to health, nor their health needs, and often controlled their mobility.

This discrimination by their husbands led to challenging domestic and social interactions in both their households and in society, which as a result, left women less confident to speak up for themselves and their own needs. As part of its comprehensive intervention, Born on Time organized associations for women and trained them on preterm birth, its causes and prevention pathways, as well as in the management of solidarity funds through the implementation of income-generating activities.

Assetou's Story: Gaining Respect, Confidence and Strength

Born on Time provided these women's associations with solidarity funds and supervised, coached and mentored them so that they could effectively manage their income-generating activities, and better sensitize their neighbours on preterm birth and gender equality.

The project's male engagement strategy heavily involved male partners so that they also understood what preterm birth is, as well as its causes and effects. Men and boys were engaged in dialogues about gender equality and the importance of equitable decision-making in the household.

Assetou testified that with her new financial situation, she was able to access maternal and child health services. Last, and most importantly, she shared that her husband and other family members now considered her as equal to them.

"I feel empowered and important."

Assetou Traore
Participant of BOT Program, Mali

A Community Health Worker's Testimony

"Before the arrival of the BOT program, I had never seen Assetou or her children consulting the health services that I manage. She had many financial difficulties, which prevented her from accessing health services. She was among the vulnerable women of childbearing age in our village. Since she had the training on preterm birth and fund management, and received the solidarity funds, I see her regularly seeking maternal health services. She also brings other family members to the health post, so they can receive appropriate health care services. She has grown into a very happy and helpful person. The BOT program really helped Assetou change her life."

Aminata Kone, Community Health Worker
Sikasso Region, Mali

LESSONS LEARNED

Throughout the five years of Born on Time, program interventions have been assessed, evaluated and modified, to better address the needs of the participants. Here are a few of the many lessons learned in Bangladesh, Ethiopia and Mali.

Consultation essential before action

It was key to consult WRA to learn directly from them about the barriers they face and their ideas and solutions. With the relevant information collected, the program managed to provide activities, projects and workshops empowering women and adolescent girls to overcome these barriers and to ensure true, long-lasting changes in their communities.

Participation of multiple actors is key

Engaging men and older women in project activities, who play the role of both influencers and gatekeepers, helped to achieve objectives more easily compared to only female-beneficiary focused activities. Men, as well as older women, remain key decision-makers and influencers in the home. The fathers' groups training was helpful in bringing about changes among men and encouraging engagement across the continuum of MNCH care. The engagement of older women, who act as custodian of gender norms, also served to help transform discriminatory gender norms and male engagement in MNCH care.

In fact, the program demonstrated that any approach seeking to improve women and girls' empowerment and improve gender equality for all should use the socioecological model in order to engage multiple actors at the same time towards greater change: women and girls, men and boys including husbands, religious and traditional leaders, other influencers such as mothers-in-law, health and protection service providers, gatekeepers, etc. All of these actors should be engaged and trained on gender equality, women and girls' empowerment and rights, including MNCH and SRHR, to enable an environment where women and girls can exercise their rights, access and control resources, and make decisions about these resources, including when to seek health care.

Targeted motivation, training, and facilitation of decision makers' groups and change makers' groups have also proven to help increase male engagement and raise awareness on LINC risk factors in the community. Engaging faith leaders also contributed to examining harmful traditional practices and rigid socio-cultural norms that discriminate against women and girls and positively influence many aspects of their lives. This catalyzed long-lasting change in project communities as faith leaders used their significant influence and power to support the transformation of rigid mindsets and discriminatory practices.

Adolescent girls and boys' participation in different community groups has also been validated as an important component of improving demand for ASRH. Some of the community groups that engaged adolescents in the fourth year of the program included change makers' groups, management committees and adolescent groups for both boys and girls. These groups provided a platform for adolescents to raise their concerns freely and it is because of this engagement that adolescent friendly health services were strengthened, child marriages were prevented, girls advocated for continuing education, and raised awareness on preventing adolescent pregnancy.

Dynamic tools ensure easier communication

The program team observed that service providers were more comfortable sharing information about LINC risk factors when they were able to utilize social and behavior change communication (SBCC) materials, particularly information boards and video clips on LINC risk factors.

Messages on MNH/SRHR, including gender equality and PTB, that could be disseminated effectively to a range of audiences through theatre for development shows were highly efficient. As the audience was mixed, messages were introduced through humor and narrative devices, and were very relatable to everyday life for maximum resonance.

Social events provide powerful learning opportunities

Attendee testimonials affirmed that social events, such as the *bou-shashuri mela* in Bangladesh, were a popular place where BOT could increase knowledge about gender equality, PTB and improve health-seeking behaviours of the community. This specific activity also leveraged the role of mothers-in-law in household decision-making.

Events such as participatory mobile cinema in Bangladesh and Mali were also an opportunity to facilitate dialogue and discussions between parents and adolescents on gender equality and ASRH, especially when the subject was taboo. BOT organized intergenerational dialogues in the communities following participatory mobile cinemas and theaters where adolescents spoke directly with their parents, and village leaders.

Solidarity funds in Mali also proved to be a great opportunity to support women's empowerment, independence and solidarity. Fostering solidarity between women through such projects was an effective strategy to enhance their power from within, and their collective power for greater change.

THE CHALLENGES OF A GLOBAL PANDEMIC

The coronavirus disease (COVID-19) pandemic, which began to undo the efforts of the four years of the project with the resurgence of adolescent pregnancies and gender-based violence (including CEFM) in households, has been a serious challenge for the BOT team.

To mitigate this challenge, the program developed messages on behaviors to be adopted by parents and husbands during the COVID-19 period, in order to guarantee the rights of women and adolescent girls. BOT technically and financially supported the dissemination of these messages through multiple communication channels, including radio.

“Dear parents, early and forced marriage is responsible for premature births and even maternal deaths. Let us finish our studies first…”

“Dear parents, we have the same abilities as boys and can manage our country in the future. Let us finish our studies so that we can contribute to the development of our country.”

- Adolescent girls, Mali
International Day of the Girl, 2018

2020 CANWACH PARTNERSHIP AWARD

The Canadian Partnership for Women and Children's Health (CanWaCH) is a proud membership of more than 100 non-governmental organizations, academic institutions, health professional associations and individuals partnering to improve health outcomes for women and children in more than 1 000 communities worldwide.

In 2020, the third annual CanWaCH Awards for Canadian Excellence in Global Health and Gender Equality recognized the significant contributions of Canadians in seven key areas: Leadership, Gender Equality, Measuring Impact, Rising Star, Savvy Communicator, Private Sector Excellence and Partnership.

The Born On Time Gender Equality Working Group, led by Save the Children Canada in close collaboration with Plan International Canada and World Vision Canada, won the 2020 CanWaCH Partnership Award for the collaborative gender equality work done under the Born on Time program.

Born on Time is the first public-private partnership dedicated to the prevention of preterm birth, bringing together the collective expertise of World Vision Canada, Plan International Canada, Save the Children Canada, the Government of Canada and Johnson & Johnson.

bornontime.org