WATCH
Women and Their Children's Health

Community-Based Health Interventions to Save Mothers, Newborns and Children

Consolidated Final Report
November 2011 – September 2015

Submitted: August 28, 2015

Foreign Affairs, Trade and Development Canada
Affaires étrangères, Commerce et Développement Canada
Canada

Project undertaken with the financial support of the Government of Canada provided through Foreign Affairs, Trade, and Development Canada (DFATD).

Plan

Plan to change the world

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[1] Country PMFs are based on the EAWP (PIP) approved global PMF. The presented PMFs represent the latest approved versions (March 2015) and reflect historical changes as noted in project semi-annual and annual reporting.

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Acronyms

ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
ASC	Community Health Worker (Mali)
ASACO	Community Health Association (Mali)
BCC	Behaviour Change Communication
BDHS	Bangladesh Demographic and Health Survey
BEmONC	Basic Emergency Obstetric and Neonatal Care
CBO	Community-Based Organization
CC	Community Clinic
CG	Care Group (Zimbabwe)
CCCD	Child-Centered Community Development
CCMG	Community Clinic Management Group
CEAA	Canadian Environmental Assessment Act
CHMIS	Community Health Management Information Systems
CHN	Community Health Nurse
CHO	Community Health Officer (Ghana)
CHP	Community Health Promoters or Child Health Policy
CHPS	Community-Based Health Planning and Services Compounds
CHW	Community Health Worker
CIDA	Canadian International Development Agency
C-IMNCI	Community-Based Integrated Management of Neonatal and Childhood Illnesses
CM	Community Mobilizers
CMHC	Community Managed Health Care
CS	Child Survival
CSC	Country Steering Committee
CSBA	Community Skilled Birth Attendant
CSCOM	Community Health Centre (Mali)
CSG	Community Support Groups
CSREF	Referral Health Centre (Mali)
CSP	Country Strategic Plan
CSV	Village Health Committees (Mali) i.e. Comité Villageois de Santé
DA	District Assemblies
DFATD	Department of Foreign Affairs, Trade, and Development Canada
DGFP	Directorate General of Family Planning (Bangladesh)
DGHS	Directorate General Health Services (Bangladesh)
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DTC	Directeur technique de centre santé (Mali)
EAWP	Extended Annual Work Plan
EPI	Expanded Program for Immunization
ESDO	Eco-Social Development Organization

ESOG	Ethiopian Society of Obstetrics and Gynaecology
ETAT	Emergency Triage Assessment and Treatment
FANC	Focused Antenatal Care
FENASCOM	National Federation of Community Health Associations (Mali)
FC	Family Centre
FGM	Female Genital Mutilation
FWC	Family Welfare Clinics
FWV	Family Welfare Visitors
GE	Gender Equality
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Services
GoB	Government of Bangladesh
GoG	Government of Ghana
HBLSS	Home-Based Life Saving Skills
HDA	Health Development Army (Ethiopia)
HEP	Health Extension Program
HEW	Health Extension Worker (Ethiopia)
HMC	Health Management Committees
HMIS	Health Management Information Systems
HSDP	Health Sector Development Plan
IEC	Information Education Communication
IMNC	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organization
ITN	Insecticide-Treated Nets
IYCF	Infant and Young Child Feeding
LAMB	Lutheran Aid to Medicine in Bangladesh
LM	Logic Model
LNGO	Local Non-Governmental Organization
MA	Medical Assistant
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MI	Muskoka Initiative
M/F	Male/Female
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
MO	Medical Officer
MO-MCH	Medical Officer – Maternal and Child Health
MoH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare (Bangladesh)
MoHCW	Ministry of Health and Child Welfare (Zimbabwe)
MoWCYA	Ministry of Women, Children and Youth Affairs (Ethiopia)
MOU	Memorandum of Understanding
MSG	Mother Support Group

MW	Midwife
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
OGSB	Obstetrics and Gynaecology Society of Bangladesh
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Treatment
PALS	Program Accountability and Learning Systems
PIE	Plan International Ethiopia
PMC	Project Management Committee
PMF	Performance Measurement Framework
PNC	Postnatal Care
PCC	Project Coordination Committee
PMT	Project Management Team
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PRODESS	Health and Social Sector Development Program (Mali)
PSC	Project Steering Committee
PU	Program Unit
RH	Reproductive Health
RN	Registered Nurse
SOGC	Society of Obstetricians and Gynaecologists of Canada
TAG	Technical Advisory Group
TBA	Traditional Birth Attendant
ToT	Training of Trainers
U5	Under Five (years of age)
U5MR	Under Five Mortality Rate
UN	United Nations
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
VHW	Village Health Workers
VSLA	Village Savings and Loan Associations
WASH	Water, Sanitation and Hygiene
WCBA	Women of Child Bearing Age
WCYAO	Women, Children and Youth Affairs Office (Ethiopia)
WHO	World Health Organization

Section 1: Executive summary

With the overall goal to reduce maternal, neonatal and child mortality amongst underserved populations in 25 districts and sub-districts of five priority countries (Bangladesh, Ethiopia, Ghana, Mali and Zimbabwe), Plan's Women and Their Children's Health (WATCH) project was implemented over a 3.5 year period from November 25, 2011 to September 30, 2015. The project was supported by DFATD's Partnerships With Canadians Branch (PWCB), with a value of $25,780,160 (CAD) at a 3:1 cost share ratio between DFATD and Plan Canada (DFATD $19,335,120; Plan Canada $6,445,040).

WATCH was closely aligned with the priorities championed by the Government of Canada at the Muskoka 2010 G8 Summit and as laid out in the resulting Muskoka Initiative on Maternal, Newborn and Child Health (MNCH). Furthermore, WATCH adhered to the UN Global Strategy for Women's and Children's Health launched at the Summit for the Millennium Development Goals (MDGs) in September 2010.

Plan Canada implemented the project in partnership with five Plan country offices in Bangladesh, Ethiopia, Ghana, Mali and Zimbabwe and their governments and local non-governmental organization (LNGO) partners, as well as the Society of Obstetricians and Gynecologists of Canada and their counterparts in Bangladesh and Ethiopia. Plan was also a member of the Muskoka Initiative Consortium (MIC), which partnered with the Hospital for Sick Kids/University of Toronto Munk School on a Knowledge Management Initiative.

Design and approach

With an overarching ultimate outcome of improved maternal, neonatal and child health in five MNCH priority countries, the WATCH project contributed to the achievement of Millennium Development Goal targets 4 and 5 by scaling up an integrated package of proven, cost-effective health interventions along the continuum of care; maximizing local stakeholder involvement (especially women); strengthening joint accountabilities; and promoting sustainable, locally rooted solutions. As such, WATCH addressed the two following intermediate outcome results: 1) increased use of preventative and responsive practices in maternal, newborn and child health (MNCH) by community members, especially women and their male family members; and 2) strengthened and more responsive[2] health care systems to reduce maternal, neonatal and child mortality. In order to achieve these outcomes, the WATCH program employed a two-pronged strategy to address aspects of MNCH on the 'supply' side (improving quantity/quality of health care services, staff MNCH skills, outreach capacity of health facilities) as well as on the 'demand' side (increasing awareness of women, men and children in communities on the importance of accessing skilled health care, adopting behavioural change and involving themselves in community health management).

Recognizing that gender inequality is a pivotal determinant of poor MNCH outcomes, WATCH included an overarching gender equality (GE) strategy encompassing three approaches: 1)

[2] Responsive health systems meet the needs of women and youth seeking MNCH services through 1) friendly and supportive staff 2) timely services and accurate information.

strengthening women and adolescent girls' agency and decision-making by building their knowledge about MNCH and GE, building their social and economic capital, and strengthening their voice in local health governance; 2) engaging men across spheres (from family members to socio-cultural gate-keepers) as active partners of change by increasing their understanding and support for MNCH and GE; the thrust of which was to create an enabling socio-cultural environment for GE and MNCH; and 3) addressing facility-based deficits in meeting the practical and strategic needs of women and men through a range of actions promoting quality care that is respectful and responsive; this approach focused on creating a client-focused and inclusive institutional environment. This strategy was successfully implemented by all WATCH countries through context-relevant and fully integrated Gender Equality Action Plans.

WATCH utilized a participatory approach to implementation, planning and management. The project implementation plan or extended annual work plan (EAWP) was finalized in March 2012, stemming from a series of five country-level EAWP workshops with deep participation of government and LNGO partners. The EAWP and its core guiding documents were reviewed and continuously refined as the project progressed during each annual work planning process, in response to reassessment of risks, level of financial expenditure, analysis of monitoring data, and country-level inputs from project steering committees. These committees leveraged the participation of representatives from Plan (Plan Canada and Plan Country Offices), DFATD, Ministries of Health (national and subnational levels), relevant health and development organizations (i.e. UNICEF) and local NGO partners. Their overarching role was to monitor project progress; ensure alignment with any relevant national policies or strategies; advise implementation partners on recommended actions as required to ensure smooth implementation during the course of the project; and provide strategic input and direction with respect to transition/project handover.

Furthermore, during the course of the project, four key sharing and learning opportunities were organized by Plan Canada to bring country teams together. These occurred in April 2012 at a gender equality and monitoring and evaluation (M&E) workshop in Toronto; November 2013 at an experience sharing and learning workshop in Zimbabwe; May 2014 at the MNCH Summit in Toronto; and June 2015 at the MIC-KMI Results Symposium, also in Toronto.

Results and performance

Overall, 282,537 women[3] in WATCH-supported areas accessed and utilized MNCH services including four antenatal visits and/or delivery by a skilled health professional. In addition, an estimated 590,676[4] children accessed critical vaccinations for measles, pentavalent 3 and/or oral rehydration therapy. The project also contributed to building the capacity of 2,022 health facility personnel (41.4% female), 63,080 community health workers (95.6% female), and 42,753 (95.6% female) community mobilizers/volunteers.

[3] Reach numbers are statistically adjusted for all target communities for the period of Jan 2013 to December 2014. For Ethiopia and Mali these are adjusted for all working communities based on sampled communities. Please note that these include multiple responses. Maternal reach does not include tetanus or PNC, to reduce additional multiple responses.

[4] These figures include multiple responses (same children who have received both ORT and vaccinations).

The WATCH project fully measured and reported on all project outcome indicators as outlined in the global project PMF and the final approved country-specific PMFs (as per Annex B) which evolved from the global project PMF. The end line report detailing these results was submitted to DFATD in July 2015. As well, all output targets as per the country PMFs have been met and reported on through project semi-annual and annual reporting.

In line with the approach taken in the semi-annual and annual reports, seven core performance indicators (included in the UN Commission on Information and Accountability for Women and Children's Health and Muskoka Initiative Indicators) are markedly analyzed in this report. All key indicators show an increase from baseline results to end line results, as detailed in Section 5.2.

With regard to maternal health indicators:

- % of women aged 15-49 who received antenatal care by a skilled health provider at least four times during pregnancy increased from **45.5% to 62%**.
- % of live births attended by a skilled health personnel increased from **48.8% to 64.7%**.
- % of mothers of children 0-23 months who received two doses of tetanus increased from **46.7% to 55.5%**.
- % of mothers and babies who received postnatal care visits within three days of childbirth increased from **43.8% to 75.7%**.

With regard to child health indicators:

- % of children aged 0-24 months who received at least three doses of pentavalent vaccine increased from **53.7% to 75.7%**.
- % of infants aged 0-6 months who were exclusively breastfed increased from **64.9% to 77.8%**.
- % of children vaccinated against measles increased from **58.6% to 79.3%**.

These results have been influenced by project interventions on both the demand (community) side and the supply (facility) side that jointly addressed the three delays[5] preventing women and children from accessing quality health services: 1) the delay in seeking care, 2) the delay in reaching care, and 3) the delay in receiving care.

To address the delay in seeking care, multiple complementary interventions increased community members' knowledge of basic MNCH issues, including how gender-related barriers impede access to and utilization of MNCH services. This information was disseminated through community support groups (e.g. Care Groups in Zimbabwe, Mother Support Groups in Bangladesh, VSLAs in Mali); household visits by community health workers and/or volunteer community mobilizers; peer educators; information, communication and education (IEC) materials; public theatre performances; radio programs; and docudramas. As a result of this outreach and sensitization, end line results show an increase in the percentage of women of child bearing age who can recognize and address at least two danger signs along the continuum of care (pregnancy, delivery, postpartum, neonatal). Furthermore, efforts to engage

[5] International Journal of Gynecology& Obstetrics, Volume 107, Supplement, October 2009, pages S5-S19.

men (e.g. through Daddies' Clubs in Ghana, Gender Equality Champions in Zimbabwe, and Agricultural Development Armies in Ethiopia) have improved men's attitudes and support regarding the use of MNCH services. In fact, end line results show that 78.7% of all women stated their male partners/family members were "very supportive" of their utilization of MNCH services. Further details on men's involvement in MNCH based on the findings of Plan's male engagement research, *Men Matter: Engaging Men for Better MNCH Outcomes*, are available in Section 8.1.

Women's delay in seeking care is also influenced by their lack of agency and decision-making power at the household and community levels. The project helped to address this issue by encouraging women to become active members of community and facility health committees and providing them with training on leadership, while also conducting gender-sensitization with male partners, as well as community leaders and gate-keepers. Furthermore, women's economic and social capital (which influences their ability to share control over household finances and decisions) was elevated through participation in Village Savings and Loan Associations (VSLAs) in four of the five WATCH countries[6]. The end line survey revealed that 83.3% of women feel they have the skills and ability to make decisions on various topics related to MNCH, and 89.3% of men stated that women have such decision-making ability.

To mitigate the delay in reaching care, the WATCH project aimed to improve referral systems at primary and secondary health care levels, and increase women's access to transportation. For example, in Ethiopia, health centres were provided with national referral protocols (which were supplemented with information on how to integrate gender considerations into the referral process) and health professionals were trained on these protocols. In addition, transportation and communication support for referrals was provided through fuel, vehicles (e.g. auto rickshaws in Bangladesh), and mobile phone air time. In Ghana, Community Emergency Transport Systems were established in 120 communities, enabling women to arrange transport to health centres with drivers who live within their communities. These interventions, among others, helped to facilitate 15,178 referrals to primary care, and 13,243 referrals to secondary care[7]. In Zimbabwe and Ethiopia, the second delay was also addressed by constructing and/or equipping maternity waiting homes near health facilities for women to reside in a few days or weeks before they give birth. These waiting homes eliminated the need for women (including those from remote areas and/or those who had experienced danger signs during their pregnancy), to seek transportation and/or travel far distances right before they go into labour.

The delay in receiving care concerns the quality and responsiveness of health services at facilities. Targeted health centres across all WATCH-supported countries were renovated and/or equipped with essential supplies and medicine; and health facility personnel received technical training and supportive supervision to improve their knowledge and skills. Trainings included Basic Emergency Obstetric and Neonatal Care, Integrated Management of Childhood Illnesses, safe motherhood, infection prevention, Helping Babies Breathe, and provision of gender-sensitive and adolescent-friendly care. In Ethiopia and Bangladesh, BEmONC training and

[6] Bangladesh not included.
[7] Between January 2013 and December 2014.

supportive supervision at health referral facilities was conducted in partnership with the Society of Obstetricians and Gynaecologists of Canada (SOGC) through its sister organizations, the Ethiopian Society of Obstetricians and Gynecologists (ESOG) and the Obstetrical and Gynecological Society of Bangladesh (OGSB). Some health centres received gender-friendly upgrades; for example in Bangladesh, renovations included waiting rooms and separate toilets for women and men, breastfeeding corners, and private rooms for antenatal care checkups. Bangladesh was also able to reactivate 24/7 safe delivery services in 47 community health centres (known as UH&FWCs), enabling women to give birth with a skilled attendant at any time of the day or night. These supply-side improvements likely contributed to the increase in satisfaction level with MNCH services, which rose from 72% to 93.7% for women aged 15-49, and 90.3% to 92.2% for men.

Effective governance and information management within health systems also helps to address the delay in receiving care, by using monitoring data to identify gaps in MNCH service delivery and then developing action plans to improve performance. The WATCH project strengthened health systems by training community and district level health committees on governance, leadership, gender and responsiveness to key MNCH issues. These committees helped to oversee the management and operations of health facilities, and provided a forum for community members (including women) to review MNCH monitoring data and to participate in health decision-making. WATCH also strengthened data collection and health information management in communities and facilities. For example, in Bangladesh, community health workers collected data on mothers and children with PC Tablets, which was integrated into the government's electronic District Health Information System. In Ethiopia, the accuracy of tracking women and children was improved by training Health Extension Workers (HEWs) on existing Community-based Health Information Systems, and training HEW supervisors on Health Management Information Systems. By having more timely and accurate information, government stakeholders are better positioned to improve MNCH service delivery.

Challenges and lessons learned

Several challenges were faced during the course of the project, however, actions were taken to address or mitigate the challenges and lessons were learned in the process. The first was timely procurement for facilities, particularly BEmONC equipment and medicines in Ethiopia and solar refrigerators in Mali. Procurement was delayed in both countries: in Mali, an international supplier needed to be pursued as the refrigerators specified were not available locally; and in Ethiopia, the procurement process needed to be centralized and submitted to government, as well as tendered to private suppliers (where necessary) as not all items could be procured at the regional level. Despite these delays, all equipment was successfully obtained and delivered to facilities before project closure. This challenge highlighted the need to conduct the facility assessments and associated procurement processes as early as possible, as well as to conduct a more comprehensive market analysis on the availability of equipment/supplies in country.

The second key challenge was maintaining the motivation and quality of work of volunteer community health workers and mobilizers/peer educators. Some were inclined to move away and seek full-time work (as in Mali), while others already had heavy work burdens within their

households and communities, and found it difficult to take on additional duties associated with WATCH interventions and data collection (as in Ethiopia). To address this, incentives were provided (i.e. tools, uniforms, means of transport, community awards and recognition) and in some cases workloads were decreased or additional support was provided by either other cadres of health workers or additional CHWs/CMs. Despite some natural attrition (which is to be expected when implementing such projects in hard to reach areas), the project was able to successfully train and retain high numbers of community health workers and volunteers, who remained committed and were key actors in achieving successful health outcomes.

Third was engaging and obtaining buy-in from difficult-to-reach men, conservative faith groups, and traditional birth attendants (TBAs) or healers. Men (particularly fathers of unmarried adolescent girls and women) were initially resistant to GE messages mainly due to traditional male dominance and strong socio-cultural norms; while faith groups (i.e. the Apostolic sect in Zimbabwe), TBAs and healers were resistant to modern medicine offered at formal health facilities; and, in the case of TBAs, concerned about their loss of vocation, income and status. Due to this social and cultural resistance, the project deployed specific strategies to engage these groups, such as persistent messaging through male role models/champions, village leaders, community groups, and edutainment, as well as lobbying/engaging more liberal-minded or moderate religious leaders, and engaging TBAs as trusted channels of messaging within their communities, including in relation to referrals from community to facility (as in Ghana). Additional lessons learned are outlined in Section 12 at the end of this Final Report.

Despite such challenges, the WATCH project fully utilized its budget and achieved significant results in project-supported areas, which have contributed to helping the governments of Bangladesh, Ethiopia, Ghana, Mali and Zimbabwe to achieve their goals to decrease maternal, newborn and child mortality. Increases across all key Muskoka indicators reflect the success of the project's comprehensive, complementary demand and supply-side interventions, which were guided by a robust monitoring and evaluation (M&E) system, and delivered by very dedicated committed local partners with the support of governing committees in all five countries.

As described in Section 11, several factors contributed to the success of the WATCH program. The project was anchored to each country's nationally adopted policies, strategies and/or road maps focusing on MNCH, and accordingly aligned interventions with established government health systems and approaches (i.e. the Health Extension Program in Ethiopia, or the Community Access to Essential Care strategy in Mali). The project also fostered sustainability by training and operationalizing community groups (i.e. Care Groups in Zimbabwe, Change Maker Groups in Bangladesh), who took ownership over community mobilization and MNCH education, and therefore have the requisite knowledge, structure, and support of their communities and local government to continue their efforts. Finally, the project demonstrated effective utilization of resources by adapting and/or expanding interventions in response to the monitoring of expenditure/identification of savings, as well as analysis of monitoring data and ongoing risk mitigation. For example, in response to opportunities to reinforce results identified mid-project, rickshaw vans were purchased in Bangladesh to provide additional support for referrals, and solar fridges were purchased in Mali to store vaccines and maintain cold-chain at

primary care health centres with a view to improving the rate of vaccination for tetanus, measles, and pentavalent.

Going forward, such success factors and learning, especially in the key areas of GE/male engagement, M&E, and community mobilization, will help to inform design and implementation of future MNCH projects.

Section 2: Introduction

This final report for Plan's Canada's Women and Their Children's Health (WATCH) project reflects on the implementation of MNCH interventions and results achieved across five countries: Bangladesh, Ethiopia, Ghana, Mali and Zimbabwe. With support from the DFATD's Partnerships With Canadians Branch (PWCB), Plan Canada implemented the WATCH project over a period of 3.5 years, from November 25, 2011 to September 30, 2015, with a value of $25,780,160 (CAD), at a 3:1 cost share ratio between DFATD and Plan Canada (DFATD $19,335,120; Plan Canada $6,445,040).

The aim of the WATCH project was to reduce maternal, neonatal and child mortality amongst underserved populations in 25 districts and sub-districts of five priority countries. The project contributed to the achievement of MDG targets 4 and 5, by scaling-up an integrated package of proven, cost-effective health interventions. The project used a community-based approach to improve the quality of community outreach and MNCH services, while encouraging health-seeking behaviours and improved health care management. Plan Canada implemented the project in partnership with five Plan country offices in Bangladesh, Ethiopia, Ghana, Mali and Zimbabwe and their governments and local non-governmental organization (LNGO) partners, as well as the Society of Obstetricians and Gynaecologists of Canada and their counterparts in Bangladesh and Ethiopia. Plan was also a member of the Muskoka Initiative Consortium (MIC), which partnered with the Hospital for Sick Kids and the University of Toronto Munk School on a Knowledge Management Initiative. This consolidated final report represents the period of November 2011 to September 2015 and is organized into 12 Sections, with applicable Annexes, as outlined in the Contribution Agreement.

Section 3 (Project summary) provides an overview of the project design, project stakeholders and project governance, and **Section 4 (Project context)** explains country level context. **Section 5 (Project performance)** includes a summary of beneficiaries reached, as well as a summary of consolidated project results achieved across the countries at the immediate, intermediate and ultimate outcome levels, in comparison to baseline. This section also includes country specific attachments with project results and an analysis and interpretation of key MNCH Muskoka indicators within each of the five countries. On a consolidated level, all seven key Muskoka indicators increased from baseline to end line. The project has fully reported on all PMF results indicators in the end line study report already submitted to DFATD, and output results through project reporting[8]. **Section 6 (Project management)** describes the processes

[8] Semi-annual and annual project reports submitted as per CA to DFATD.

and key actions within the project's start-up, implementation, monitoring and reporting, and closure phases. **Section 7 (Risk management)** provides a review of the project's prevailing risks across the five countries and how they were managed and/or mitigated. **Section 8 (Cross cutting themes and priorities)** includes a discussion on the project's Gender Equality strategy, along with discussion on environment, health governance and knowledge management. A review of the financial budget management for WATCH can be found in **Section 9 (Budget management),** and **Section 10** presents the **Final financial report,** which indicates that the full project budget has been fully utilized as reported. Finally, the project's **Success factors** and **Lessons learned and recommendations** can be found in **Sections 11 and 12** respectively.

Section 3: Project summary

Project rationale and justification

Plan's Women and Their Children's Health (WATCH) project was conceived to reduce maternal, neonatal and child mortality amongst underserved populations in 25 districts and sub-districts of five priority countries (Bangladesh, Ethiopia, Ghana, Mali and Zimbabwe).

Despite progress in IMR and CMR in these countries, neonatal and maternal deaths remain high. Maternal mortality rates across the five countries range from 194 per 100,000 live births (Bangladesh), to 676 per 100,000 live births (Ethiopia); and under-five mortality rates range from 53 per 1,000 live births (Bangladesh) to 95 per 1,000 live births (Mali). Many of these deaths occur within the countries' poor, remote, populations, which have limited access to quality health care, as well as strong social and cultural norms that support unsafe home births without a skilled attendant and prevent women from seeking antenatal and postnatal care. These populations are also heavily reliant on services provided by community health workers, who are often overworked and unpaid. In addition, many of the primary health facilities closest to remote communities lack the necessary equipment, supplies, and skilled health professionals. As a result, maternal deaths are caused by preventable conditions such as haemorrhage, eclampsia, infection, or obstructed labour; neonatal deaths are often caused by pneumonia, meningitis, birth asphyxia and premature death; and child deaths are mainly due to infections acquired after birth associated with poor hygiene, lack of information on adequate newborn care, and/or poor feeding practices.

Moreover, prevailing gender dynamics and inequalities are important contributing factors to the three key delays in accessing MNCH services across all WATCH countries. Firstly, lack of access to relevant information means that women, and sometimes their male partners, are unable to recognize signs of danger during pregnancy or childbirth. Related to this lack of information is women's lack of decision-making power relative to her husband, mother-in-law or other family members who tend to make the decision on behalf of the expectant mother. This results in the **first delay in seeking care**. Adolescent girls often feel they have no choice but to go to untrained traditional birth attendants (TBAs) because of the negative attitudes they experience from health staff in health facilities due to their non-marital status. The **second delay in reaching care** or arriving too late to the health centre, is perpetuated by women's lack of ownership and control over resources such as money, transportation or telephones required

to arrange travel to the health facility in order to benefit from ANC, PNC and Skilled delivery services. Women's workload and domestic responsibilities, such as child care, further deter women from seeking services at health facilities with negative impacts, particularly during an unforeseen complication. TBAs also delay referrals to the health facilities because it means loss of income for them if the woman delivers at the health facility. Finally, once at the health facility, severe shortages in skilled health staff mean that women and sometimes their spouses must wait for hours before being seen by a health provider or if arriving during the night a health provider may not be available at the clinic. These obstacles, combined with a lack of value associated with women's time (in relation to their workloads), means that they are sometimes asked to return more than once in order to access a service, thereby creating disincentives for women to seek formal health care for MNCH services, hence the **third delay: receiving care.**

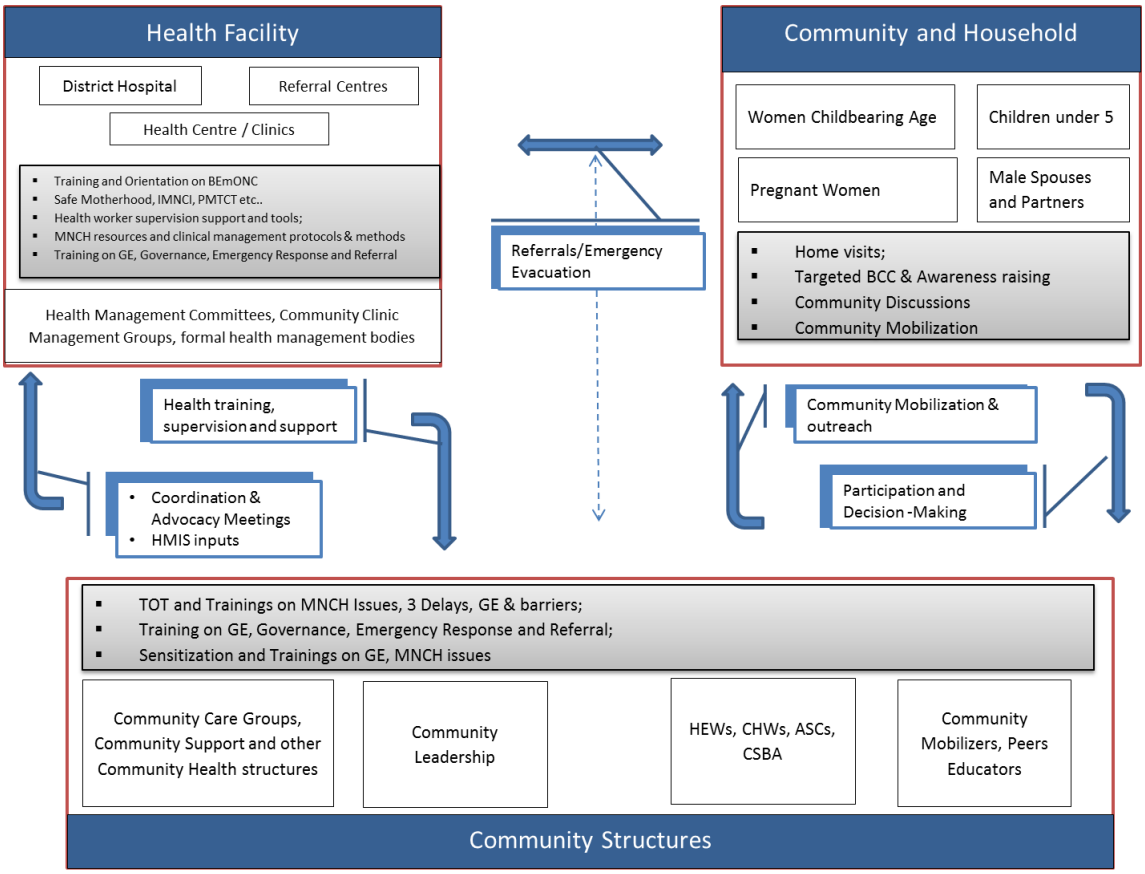
In response to these challenges/gaps, WATCH contributed towards the achievement of national MDG targets 4 and 5, by scaling-up an integrated package of proven, cost-effective health interventions. The project took an integrated approach to community and facility-based maternal, newborn and child health programming, to maximize local stakeholder's (especially women) involvement, encourage scale-up of affordable packages of evidence-based interventions along the continuum of care, strengthen joint accountabilities and promote sustainable, locally rooted solutions. Moreover in terms of global relevance, WATCH was intimately aligned and responded to the priorities championed by the Government of Canada at the Muskoka 2010 G8 Summit and as outlined out in the resulting Muskoka Initiative on Maternal, Newborn and Child Health (MNCH). As well, WATCH adhered to the UN Global Strategy for Women's and Children's Health, which was launched at the Summit for the Millennium Development Goals (MDGs) in September 2010.

Project strategy

To address prevailing MNCH challenges and gaps, including associated GE barriers, the project defined an overarching ultimate outcome of an *Improved maternal, neonatal and child health for underserved populations in 25 districts and sub-districts of five MNCH priority countries* and further identified two Intermediate Outcomes: **1) Increased use of preventative and responsive practices in maternal, newborn and child Health (MNCH) by community members, especially women and their male family members; and 2) Strengthened and more responsive[9] health care systems to reduce maternal, neonatal and child mortality.** To achieve these common outcomes, each country adopted a two-pronged strategy to address 'supply side' issues (improving quantity/quality of health care services, staff MNCH skills, outreach capacity) and 'demand' side issues (increasing awareness of men, women and children in a community on the importance of accessing skilled health care, adopting behavioural change and involving themselves in community health management), as illustrated in Figure 1 below:

[9] *Responsive health systems meet the needs of women and youth seeking MNCH services such as 1) friendly and supportive staff 2) timely services and accurate information.

Figure 1: WATCH project strategy



WATCH developed a common set of results (see Annex A: Global LM) across each of the five countries and country-specific performance management frameworks (see Annex B: Country PMFs). Each implementing country had its own locally defined set of activities as presented during the EAWP with work break down structures to achieve output results, in accordance with locally based policies, capacities, gaps and priorities in their target regions. Common to all country strategies were the training of community health workers (e.g. HEWs, CSBA, ASC, etc.) and community volunteers (e.g. Community Mobilizers, *relais, HDAs,* peer educators) on key MNCH issues using various national best practice guidelines and models. These trained health workers and volunteers were frontline agents charged with raising awareness, sensitizing and mobilizing communities to recognize, prevent and respond to basic MNCH issues. The project also trained and equipped community support or care groups to sensitize and mobilize (women, men, community and religious leaders etc.) at the household and community levels. A variety of social mobilization approaches were employed, including home visits, community forums, courtyard meetings, behaviour change communication (BCC) campaigns, radio, drama groups and events on specific thematic days i.e. World Health Day and Breastfeeding Day. To increase accountability and ensure responsive health interventions, community members – particularly women – were supported with needed skills and confidence building measures to actively participate, influence and guide decisions of community health management committees. For instance, in Ghana both community health management committee and Facility Health

management committee members received trainings on governance, leadership, gender equality and appropriate responses to MNCH issues. Through various mobilization activities, the project began to tackle persisting traditional socio-cultural beliefs, stigmas and taboos, particularly relating to existing gender inequalities (women's participation and decision-making and male engagement), adolescent youth and religious (Apostolic faith) views which impede health-seeking behaviours and utilization of MNCH services (including ANC, Prevention of Mother To Child Transmission (PMTCT), IMNCI, skilled delivery, PNC and clinic visits for childhood illnesses).

From a 'supply' side perspective, across the five countries WATCH strengthened health systems at the district, sub-district and health facility/post level to provide quality and responsive[1] women and youth-friendly health care services. This included training of government health workers on BEmONC, Emergency Transportation and Triage, IMNCI, PMTCT, and Safe Motherhood, along with the systematic integration of GE content into all MNCH trainings. Recognizing the importance of the referral system (particularly from community to facility), project activities focused on providing necessary training on referral protocols and necessary resources (i.e. communication and transportation resources). Moreover, the project supported health system management and coordination through management training at health facility levels, developing quality control mechanisms, and strengthening supportive supervision mechanisms and organizing review and planning meetings. To further ensure quality health services provision, health facilities, maternity wards and maternity waiting homes were rehabilitated and equipped to provide integrated MNCH services, including ANC, PMTCT, clean and safe delivery, IMNCI, BEmONC and family planning.

Project stakeholders

This project was undertaken with the collaboration and engagement of both international and country-specific stakeholders.

DFATD (previously CIDA) exercised overall responsibility for the general direction and financial control of the project funded by the Government of Canada. It monitored and approved project implementation, the pace of results achieved and undertook project evaluation, monitoring and financial audits (as relevant). DFATD was mandated to ensure that the deliverables are consistent with project documents and that budgets adequately correspond to work plans.

Canadian stakeholders included **Plan Canada** as the principle project lead to manage, administer and oversee the WATCH project under the terms and conditions of the contribution agreement with DFATD (then CIDA). As the WATCH program promotes the standards of BEmONC to save the lives of women with obstetric complications during pregnancy and childbirth and newborns intra-partum, via partnership with the Society of Obstetricians and Gynaecologists of Canada (SOGC) and its sister organizations, the Ethiopian Society of Obstetricians and Gynecologists (ESOG) and the Obstetrical and Gynecological Society of Bangladesh (OGSB) as technical partners to implement training and supportive supervision to strengthen quality of Emergency Obstetrical and Newborn Care (EmONC) at health referral facilities in project intervention zones. Through the WATCH knowledge management

component, Plan worked collaboratively with Save the Children, Care and World Vision to demonstrate the impact and lessons learned from the KM members' interventions funded under the Muskoka Initiative and to showcase the results of this major Canadian investment in MNCH.

At the country level, stakeholders included **Plan Country Offices** (Bangladesh, Ethiopia, Ghana, Mali and Zimbabwe) which provided project oversight, coordination and facilitation, and supported staff and partners in the implementation of activities. **Government stakeholders** (National MoH and Local MoH district and sub-district level, as well Ministry of Women Affairs, Gender and Community Development (Zimbabwe) and Ministry of Women, Children and Youth Affairs (MoWCYA) (Ethiopia) as WATCH interventions were designed to work within existing government policy and align with national strategic roadmaps / frameworks, and to support and enhance existing programs and deliver services through official government MNCH delivery systems. Thirteen **local NGO Partners** were engaged to support implementation of the project at the district and community level in each country. Furthermore, through both Government and LNGO partners, the project engaged with **community level health workers and volunteer mobilizers or peer educators** to conduct community mobilization, education and extension of health services to key project beneficiaries, as identified in the next paragraph.

The key stakeholders in WATCH are arguably the direct and indirect beneficiaries (identified in the EAWP) whom the project ultimately aimed to engage and communicate with in line with Plan's CCCD[10] methodology. The 'demand'-side activities (described above) of the WATCH program across the 5 countries expressly targeted vulnerable populations in each country. These included low income, rural women of child bearing age and pregnant women (many of whom face gender inequalities and insecurity), male partners or family members, and newborns under 1 and children below 5 years. Please refer to section 5.1 for description of project reach.

Governance structure

The WATCH project developed a governance structure which allowed for solid accountability as well as transparency amongst project stakeholders.

Country-level or provincial-level Project Steering Committees (PSC) were in place in 4 of 5 countries[11], and these committees convened at least on an annual basis. Each PSC leveraged the participation of representatives from Plan (Plan Canada and Plan Country Offices), DFATD (where applicable in country), Ministry of Health (national and regional/district levels), relevant health and development organizations (e.g. UNICEF, etc.) and local NGO partners. In general, country/provincial level PSCs; monitored overall project progress (including progress towards targets and financial expenditure); ensured alignment with any relevant national policies or strategies; advised the implementation partners on recommended actions as required to ensure

[10] Child centred community development is a rights-based approach in which children, families and communities are active and leading participants in their own development. It enhances their capacity and opportunity to work together with others to address the structural causes and consequences of poverty at all levels.

[11] Ethiopia there was some reticence by the Federal Ministry of Health to establish a national Project Steering Committee as the Ethiopian health care system is decentralized and all operations, such as health project cycle management, are the responsibility of local governments. The Federal Ministry of Health is responsible for developing policy, strategy and regulatory frameworks, and does not engage at the operational level.

smooth implementation during the course of the project; and provided strategic input and direction with respect to transition/project handover.

At the regional or district levels, operational management committees were organized to facilitate the coordinated implementation of project activities in each country, identify challenges, risks and associated strategies to mitigate; and make recommendations to PSC (where relevant) in relation to WATCH interventions. Often, this consisted of Plan Country Office and Program Unit teams, Ministry of Health (sub-National) at regional and/or district, sub-national offices of Women, Children and Youth Affairs ministries (as applicable), and local NGO partners. For instance in Ethiopia, quarterly district review meetings, including representatives from District and Regional government, Plan, ESOG, Local NGO partners and other stakeholders allowed for discussion on implementation and results through supervision and monitoring. In Mali, district-level steering committees were established which provided a forum for district level stakeholders (regional and district government and LNGO partners) to review implementation and address issues.

In terms of demonstrating strong grant management, compliance and accountability in line with the DFATD contribution agreement, Project Management Teams (PMT) were based in each Plan Country Office implementing the project. The PMT operated at national-level and provided necessary support services: finance, administration, monitoring and evaluation, technical expertise (Health and Gender) and knowledge management.

With respect to the MIC-KMI, please refer to Section 8.4 for a brief governance discussion.

Section 4: Project context

This section reports on contextual factors that influenced project implementation/performance and/or achievement of results.

4.1 External factors

Across all WATCH countries, external factors arose that occasionally delayed the implementation of certain project activities. However, distinct measures were taken in order to minimize delays and/or avoid irrevocable impacts by working with local partners, government departments and communities to reschedule and/or adapt activities.

Politically, the most disruptive event occurred in Mali, where the northern region faced insecurity and displacement as a result of armed Jihadist rebel threat and a coup d'etat in March 2012. Although WATCH project regions were not directly impacted, the instability caused the government to declare a state of emergency throughout all territories in January 2013, enacting a ban on all communal gatherings and demonstrations. Certain community mobilization activities (e.g. community theatre performances and Balani shows) therefore had to be deferred

for approximately six months. Bangladesh experienced periodic strikes or 'hartals' and unrest,[12] causing some activities to be rescheduled, and staff to compensate for lost working days by working on weekends or additional hours during the week. However, throughout these periods, Plan Bangladesh maintained close coordination and communication with its local government and INGO partners, who routinely provided updates on the security situation and its potential implications on program delivery.

Bangladesh was the only country to experience a **natural disaster** that impacted project activities. In May 2013, Tropical Storm Mahasen hit the costal belt area, including the project region of Barguna Sadar. This slowed down implementation of WATCH activities and contributed to lower levels of antenatal care, postnatal care and skilled birth attendance in some areas. In order to achieve project targets, in the post relief period, the frequency of meetings with community support groups and Union Health and Family Welfare Centers was increased from quarterly to monthly, and mothers (particularly those identified as high risk) received reminder phone calls close to their date of delivery.

Socio-cultural factors posed some barriers to project implementation, as deep-rooted traditional or religious beliefs made women and their male partners hesitant to seek services at health facilities. For example, in Zimbabwe, the Apostolic religion (which has a significant following in certain project areas) undermines the use of modern health care. To overcome this barrier, the project engaged in frequent discussions with religious leaders and influential community members (i.e. Lead Mothers and Fathers) to raise awareness about the benefits of formal health services, as well as the dangers of avoiding these services. In some parts of Ethiopia, immunization is considered taboo, and there is a myth that vaccines have negative effects on children's reproductive health and their psychological development. These myths were confronted by the project through community sensitization led by Health Extension Workers and Health Development Armies, as well as through widespread government immunization campaigns (elaborated further below). The generally positive results noted in section 5.2 in both Zimbabwe and Ethiopia for maternal (ANC, PNC, skilled delivery) and child health immunization indicators suggest that socio-cultural factors did not overwhelmingly hinder overall achievement as BCC/IEC efforts had a good influence. In Mali, some women seek their first ANC visit late in their pregnancy term due to their tendency to hide their pregnancy until it is physically visible. Other socio-cultural beliefs that delay ANC include the fear of acknowledging a pregnancy too early, or the fear of losing a child due to speaking about the pregnancy with a third party (i.e. a health worker). Despite community sensitization/awareness efforts, these behaviours and beliefs in part may have contributed to the lower result in seeking four ANC visits observed in Mali.

Direct **socio-economic** influences on the project arose in Ghana and Mali. In Ghana, a depreciation of the Cedi in Year 3 (2014) of the project, led to a rise in the prices of local goods and services, which in turn increased WATCH's administrative and operational costs (i.e. the

[12] Caused due to political instability as the current government had moved forward with a war crimes tribunal to prosecute atrocities from the 1971 war of independence from Pakistan which has exacerbating political tensions and caused strikes on a regular basis; Also, strikes were organized by opposition party supporters as they boycotted elections in 2013.

cost of fuel). To help cushion against the increase in fuel prices, local NGO partners were given additional funds for fuel for their motor bikes and generator sets. Despite this economic downturn, the project benefitted from exchange rate gains due to the Cedi's depreciation against the US dollar. These gains were channeled into the implementation of additional program activities in Years 3 and 4, such as training Queen Mothers and Gender Equality champions; supporting the GHS's organization of child health promotional activities; and procuring play kits for Daddies' Clubs and Mother Support Groups to encourage more frequent and vibrant meetings, which contributed to the sustainability of project interventions. In Mali, the project experienced difficulty retaining community-based peer health educators (*relais*), as some left their communities to look for more remunerative work in the artisanal gold-mining. The project mitigated this risk in Year 2 by providing additional incentives/compensation to *relais* to decrease turn over and keep them motivated to stay in their communities, as well as by reinforcing the level of human resources through the recruitment of additional community health workers (ASC).

Across all countries, public health interventions led by the government and other organizations complemented WATCH activities and outcomes. For example, government Ministry of Health-led immunization campaigns (measles, meningitis, tetanus etc.) helped to increase vaccine coverage in project areas, as well as reinforce WATCH messaging on the importance of vaccinations for women, infants and children. Despite improved project results, these campaigns required the time of some government staff who were also responsible for leading WATCH project activities, and as a result, project activities were deprioritized until the campaigns were over. In addition, where the opportunity arose, WATCH collaborated with other organizations implementing MNCH programs in the intervention areas. For example, in Ethiopia, WATCH coordinated with a USAID-funded project to train HEWs in Integrated Community Case Management and the Health Management Information System; and in Mali, WATCH coordinated with UNICEF to provide community health workers and volunteers with materials for record-keeping and registration. In Mali WATCH also coordinated the recruitment of community health workers (ASC) with a USAID funded project which was closing out to ensure their continuity through involvement in WATCH.

In terms of **disease outbreaks**, the West African Ebola epidemic had a bearing on WATCH, as seven cases were identified in Mali in 2014 (two project districts, Kita and Kangaba, share a border with Guinea, a hotspot of epidemic). When cases were identified, health professionals within the ministry were restricted in their movements and required to remain at their health posts. This stalled/delayed WATCH's planned training and supervision activities with governmental health staff at the primary health care level. Furthermore, some of Plan's community mobilization efforts were adapted to include education and messaging on the theme of prevention against Ebola. The epidemic also caused some hesitancy among community members to go to health centres, which in turn impacted the uptake of key MNCH services (i.e. antenatal care in Kangaba). In Ghana, in 2014, a cholera outbreak manifested in some major cities. This was Ghana's worst outbreak to date. In response, the Ghana Health Service mobilized a massive educational prevention campaign. The WATCH project was implicated to

support information dissemination and sensitization on cholera, with support from the CHOs and nurses within various CHPS and health centers in WATCH-supported communities.

4.2 Internal factors

WATCH monitoring, data collection at the household level posed challenges within several WATCH countries. In some communities, volunteer community health workers or mobilizers were trained on the data collection tools, but they had difficulty understanding how to properly use them. Sometimes the tools (including survey questions) were not comprehensible enough, or the volunteers did not have a high enough literacy level to read and record questions and answers accurately. In some instances, the community health worker structure and mandates did not accommodate for a data collection role. This challenge was overcome by simplifying the data collection tools and providing additional training to volunteer community health workers on the amended tools, as well as recruiting additional human resources, i.e. enumerators and data entry clerks, where possible. See addition details in Section 7 related to risk management.

Procurement delays arose in Mali and Ethiopia due to Plan needing to adapt and change from the initially anticipated strategy in response to market and/or government procurement challenges encountered with suppliers, limited or insufficient availability of medication and equipment at regional and/or national level. In Mali, after receiving multiple bids for solar powered fridges to support the vaccination cold chain at CSCOMs, Plan Mali opted to undertake an international procurement from a UK-based company “Sure Chill”. This was decided following lengthy consultation with the MoH, as they identified Sure Chill Fridges as meeting the necessary specifications for the Malian Health System context, and for which the MoH has the requisite experience to install and maintain the fridges. Hence, conforming to MoH specifications resulted in a more costly and lengthy procurement than what was initially anticipated. In Ethiopia, due to challenges with governmental procurement process at the regional level, Plan changed in consultation with government the procurement process from a decentralized (regional-level) approach to a centralized one, to be undertaken through the Plan Ethiopia Country Office. This change caused delays, as responsibilities over procurement logistics had to be shift from local partners to national level, alternate approvals from government nationally and new agreements and suppliers (with private sector where government did not have supply) had to be developed, and supplies had to be centrally (in Addis Ababa) validated (particularly for medications) before delivering to the respective regions. In Ghana, updated information from Ghana Health Service on health facilities and catchment communities identified some alterations resulting in some WATCH communities not being directly aligned with a WATCH-supported health facility, resulting in a ‘mismatch’. This was mitigated by identifying twenty nine additional health facilities and providing basic MNCH and BEmONC equipment (as appropriate) in 2014. Overcoming these procurement challenges was a boost to Ethiopia and Ghana in realizing positive results as demonstrated in their ANC, Skilled Delivery, PNC and Immunization indicators (Section country Attachments 2 and 3 respectively); however, in Mali, the late procurement of solar fridges may not have fully benefited the project to improve immunization related results (see Section 5.2), but will have a contribution past the project life.

Throughout the project, there was some turnover of WATCH staff members/partners due to internal promotions, the increasingly competitive market conditions in some countries, and maternity leave coverage. These changes did naturally have an effect in terms of some program management and implementation workloads increasing/shifting for other WATCH staff in-country. However, recruitment to replace HR gaps was overall swift and succession planning and orientation to streamline new members was undertaken by Plan country management with support from Plan Canada.

When and where possible, the WATCH project leveraged work from other projects to strengthen implementation and outcomes. For example, in Mali, WATCH coordinated with another ongoing DFATD-funded program, PAGES (Promoting African Grassroots Economic Security), to engage with established Village Savings and Loans Associations (VSLAs). These VSLAs initiated through PAGES were leveraged by WATCH as a platform for MNCH education and health financing. Similarly in Ghana, Plan Ghana's leveraged another project called *Banking On Change* funded by Barclays Bank, which increased the number of VSLAs in most of the WATCH-supported communities. In addition, to avoid duplication and build on quality implementation, WATCH in Bangladesh linked with an adolescent sexual reproductive health (ASRH) project in Barguna, and a Human Resources for Health (HRH) project in Hatibandha. Collaboration with the ASRH project included engaging its youth and staff, and leveraging some of its educational materials; while linkage with HRH involved leveraging some of its community skilled birth attendants for referrals and home-based care in communities where the projects overlapped.

In Ghana, WATCH was leveraged by a new USAID project grant which Plan Ghana is recipient through the University of Research (URC). Plan Ghana will be aligning its 'demand' side efforts in community mobilization and integration of GE in MNCH messaging in Volta regions to contribute to the broader project which will sustainably support improved health-service delivery by strengthening systems vital to ensure access and quality, while mobilizing communities and building Public Private Partnerships (PPPs) to maximize coverage.

4.3 Gender equality, environment, governance

For specific details on activities, challenges and lessons pertaining to these cross-cutting themes please refer to Section 8.

Across all WATCH countries, there were few significant changes or circumstances pertaining to these themes that influenced project implementation or outcomes. All countries were operating in favorable regulatory environments when it came to executing their Gender Equality Action Plans, as governments had subscribed to international conventions promoting equal rights, and established national policies promoting gender equality. Although national-level policies supported WATCH's gender equality action plans, local socio-cultural beliefs and practices regarding gender norms and roles posed barriers to these plans. As a result, a great deal of community sensitization through influential groups and individuals was carried out to challenge these norms and encourage behaviour change Initiatives promoting male engagement

exemplifies how the mentioned socio-cultural contextual factors have been tackled and positive results have been achieved as further elaborated in Section 8.1.

One community-level change that were reported as favoring health-promoting gender relations was the establishment of local bylaws that encouraged male involvement in MNCH (i.e. sanctions against men who did not accompany their partners to health facilities). There were no unintended, negative consequences of these bylaws, such as men becoming more dictatorial or violent with their wives in response to being mandated to defy traditional gender norms. In some countries (particularly Ghana), men who supported their wives with household work and child care occasionally experienced stigmatization or ridicule, but this was mitigated by encouraging community leaders (i.e. tribal chiefs and religious leaders) to exemplify this behavior themselves, as well as promote it in various public forums, i.e. church, mosque, etc. Stigmatization of male involvement in MNCH also decreased over time as men's supportive behaviors became more common and accepted.

Environmental assessments were conducted before construction of maternity waiting homes in Zimbabwe, and an environmental monitoring report was developed after renovating health centres in Mali. All structures were built in accordance with local and Canadian environmental legislation standards, and no policy changes affected the execution of these outputs. Please see section 8.2 for further details.

Influential changes from a health governance or policy perspective were notable in Mali and Ghana. Plan Mali signed agreements (MOUs) with the national and regional heath Directorate levels. In light of the previously mentioned political crisis in 2012 and subsequent election, the health governance structure in relation to national and regional health directorates remained intact. However, this did incur some ministerial and bureaucratic staff turnover during the course of the project. As a result, at the referral health centre level, some activities like supervisions and trainings experienced delays, causing Plan Mali to negotiate and amend annual reporting and funding schedules to extend deadlines for activity implementation. At a more community/municipal level the participation of traditional birth attendants (TBAs) in WATCH was ambiguous. In Mali TBAs were previously accepted by the government health system, but are not included in current national health priorities or strategies. However, TBAs continued to exercise influence in communities, with pregnant women seeking their services at home rather than going to deliver at a health centre. In Ghana, similarly many communities established bylaws stipulating that TBAs should refrain from conducting deliveries and tied sanctions to this. In both countries, the WATCH project engaged TBAs through IEC sensitization of women on the importance of seeking health services at a facility, while also providing training and sensitization to TBAs on danger signs during pregnancy and childbirth, thus encouraging them to promptly refer pregnant women to the nearest health facility if complications arose. The impact to project results of the involvement or influence of TBA is difficult to attribute but in Mali their presence in communities may have contributed to the lower rates of deliveries observed at facility over home deliveries as discussed in Attachment 4 of this report.

Section 5: Overall project performance assessment

5.1 Reach

Between January 2013 and December 2014[13], an estimated 282,537 women[14] in WATCH working areas accessed and utilized MNCH services including 4 ANC visits and/or delivery by a Skilled Health Professional. An estimated 590,676[15] Children under 1 year of age accessed critical vaccinations for measles, Pentavalent3 and/or ORTs for children under 5 years of age. The project also contributed to building the capacity of 2,022 health facility personnel (41.4% female), 63,080 community health workers (95.6% female), and 42,753 (95.6% female) community mobilizers/volunteers[16].

Table 1: Reach of key maternal and child health interventions, January 2013 to December 2014

	BGD	ETH	GHA	MLI	ZIM	Project
Women Accessing 4th ANC visit and/or Skilled Delivery	**64,170**	**135,324**	**16,058**	**54,663**	**12,322**	**282,537**
Under 19 year	13,999	7,144	4,818	13,380	3,790	43,131
20-49 years	50,171	128,180	11,240	41,283	8,532	239,406
Children that have received Crucial Vaccinations for Measles and/or Pentavalent3[17]	**48,153**	**111,745**	**5,158**	**61,255**	**28,122**	**254,433**
Girls Under 1	23,600	57,848	2,736	30,263	14,250	128,697
Boys Under 1	24,553	53,897	2,422	30,992	13,872	125,736
Children with diarrhea who have received ORTs	**8,489**	**208,146**	**3,358**	**110,984**	**5,266**	**336,243**
Girls Under 5	4,391	103,807	1,758	51,951	2,594	164,501
Boys Under 5	4,098	104,339	1,600	59,033	2,672	171,742

[13] This reflects reach for the period of data collection. If entire project implementation period between November 2011 and March 2015 were reflected a greater number of people could have been accounted in MNCH services received.
[14] Reach numbers are statistically adjusted for all target communities for the period of Jan 2013 to December 2014. For Ethiopia and Mali these are adjusted for all working communities based on sampled communities. Please note that these include multiple responses. Maternal reach does not include tetanus or PNC, to reduce additional multiple responses.
[15] These figures include multiple responses (same children who have received both ORT and Vaccinations).
[16] The EAWP (PIP) reach figures, based on available governments population census and demographic data, were 135,866 pregnant women, 596,260 children below 5 years, 9400 community-level health workers and mobilizers, 1,308 government health workers; Please note that these figures reflect the population that the project anticipated to reach and are not comparable with the actual reach figures presented here (in section 5.1) as they are an indication of services received or trainings undertaken.
[17] Pentavalent 3 applicable for Ethiopia, Mali and Zimbabwe and includes multiple responses.

Table 2: Number of health personnel and community workers trained

	BGD	ETH	GHA	MLI	ZIM	Project
Health Facility Personnel Accessing Technical Trainings[18]	**334**	**500**	**535**	**349**	**304**	**2,022**
Females	161	248	170	154	105	838
Males	173	252	365	195	109	1,094
CHWs Accessing Training on MNCH Issues[19]	**1,620**	**56,134**	**753**	**1,850**	**2,723**	**63,080**
Females	1,359	55,972	410	418	2,151	60,310
Males	261	162	343	1,432	572	2,770
Community Mobilizers/Volunteers Accessing Training on MNCH Issues[20]	**87**	**38,783**	**955**	**1360**	**1,568**	**42,753**
Females	28	38,566	575	427	1263	40,859
Males	59	217	380	933	305	1,894

5.2 Achievement of results

The following section highlights results achieved since baseline for key performance indicators as outlined in the WATCH Performance Measurement Frameworks (Annex B[21]) Included in this are the core Muskoka indicators, denoted by ●.

All results are presented as an average (mean) of the five WATCH countries unless otherwise noted. In some cases, results are only relevant to certain countries as indicated in the country-level PMF and are indicated in appropriate footnotes below. Country specific Baseline and End Line figures as well as targets and variances are available in the individual Country result attachments (1-5) of this report. For a detailed description on the methodology for data collection, sampling and analysis of these results, please refer to the *WATCH End Line Report* submitted to DFATD in July 2015.

Intermediate outcome 1100: Increased use of preventative and responsive practices in maternal, newborn and child health by community members, especially women and their male family members

Performance Indicator		Baseline	End Line
Percentage of women aged 15-49 with a live birth who received antenatal care by a skilled health provider at least 4 times during pregnancy[22] ●	**Total**	**45.5**	**62.0**
	Under 19	42.1	62.1
	Age 20-49	44.4	61.9
% of mothers of children 0-23 months old who received prophylaxis during ANC treatment for malaria when pregnant with their youngest child[23]	**Total**	**69.1**	**69.0**
% of infants aged 12-23 months who received 3 doses of pentavalent	**Total**	**53.7**	**75.7**

[18] Technical trainings for all facility staff as well as Community Health Officers (CHOs) in Ghana who received IMCI, HMIS, HBB, referral protocol, infection prevention, BEmONC, safe motherhood, and/or maternal and newborn death audits trainings among others. Includes multiple responses.
[19] Includes community health workers (CHWs), village health workers (VHWs), and health extension workers (HEWs). Includes multiple responses.
[20] Includes community mobilizers, HDAs, ADAs, Peer Educators, Relais, and Queen Mothers trained in MNCH, referral, safe motherhood, community mobilization, GE, home-based care, and/or ASRH in Y3 (community mobilizers captured under the community health worker category in Y2).
[21] The global PMF presented during the EAWP, was the basis for country-specific PMFs included here in annex B. These are in line with the historically updated PMFs submitted and approved with semi-annual and annual reporting.
[22] Baseline values by age recalculated to include disaggregation for all five countries, whereas previously it included four.
[23] Indicator relevant for Ghana and Zimbabwe. Baseline recalculated for comparability with end line.

Performance Indicator		Baseline	End Line
(disaggregated by sex)[24] ●	Girls	48.1	74.2
	Boys	48.7	77.1
% of children vaccinated against measles (disaggregated by sex) [25]	**Total**	**58.6**	**79.3**
	Girls	61.5	79.4
	Boys	60.9	79.2
% of children (disaggregated by sex and age) 0-59 months with diarrhea who received oral rehydration therapy[26]	**Total**	**80.1**	**84.0**
	Girls	87.5	87.0
	Boys	71.4	81.7
% of infants (disaggregated by sex) aged 0-6 months who are exclusively breastfed [27] ●	**Total**	**64.9**	**77.8**
	Girls	60.1	80.8
	Boys	57.4	74.9
% of mothers of children 0-23 months who received 2 doses of tetanus (disaggregated by age)[28]	**Total**	**46.7**	**55.5**
	Under 19	49.2	60.3
	Age 20-49	44.6	54.9
% of pregnant women (disaggregated by age) who accepted an offer to be tested for HIV[29]	**Total**	**71.5**	**82.2**
	Under 19	72.6	81.1
	Age 20-49	72.8	82.8

[24] Indicator relevant for Ethiopia, Mali and Zimbabwe. Baseline recalculated for children aged 4-23 months old for comparability with end line.
[25] Baseline recalculated for children aged 9-23 months old for comparability with end line data. Sex disaggregation not available for Ghana or Zimbabwe at baseline.
[26] Relevant only for Bangladesh. Baseline recalculated to include this country only.
[27] Indicator not applicable to Ghana, however included in baseline and end line calculations.
[28] Women who received 2 or more TT doses during their last pregnancy. Baseline value for Zimbabwe recalculated to include 2 doses or more, whereas previously was reported as 82.4% for any dose of TT.
[29] Indicator relevant for Ethiopia and Ghana. Baseline recalculated as previously reported DHS figure of 18.9%. Data is based on women who received HIV during any ANC visit, which is consistent at both points in time.

Intermediate outcome 1200: Strengthened and more responsive health care systems to reduce maternal, neonatal and child mortality

Performance Indicator		Baseline	End Line
% of births attended by skilled health personnel[30]	**Total**	**48.8**	**64.7**
	Under 19	52.5	70.1
	Age 20-49	48.4	64.4
% of mothers and babies who received postnatal visits within 72 hours of delivery[31]	**Total**	**43.8**	**75.7**
	Under 19	48.9	78.0
	Age 20-49	49.1	75.8
# of facilities upgraded and meeting safe birth and newborn care quality standards[32]	**Total**	**3.5**	**44.3**
Level of satisfaction of project supported communities of MNCH services available to them (disaggregated by sex and age)[33]	**Total**	**69.4**	**92.9**
	Women 15-49	72.0	93.7
	Adolescent Girls 15-19	-	94.8
	Women 20-49	-	94.2
	Men	90.3	92.2

Immediate outcome 1110: Increased knowledge of basic MNCH issues, including how gender barriers contribute to the 3 delays, among women of child bearing age, and their relevant male family members

Performance Indicators		Baseline	End Line
% of WCBAs capable of recognizing a minimum of two danger signs along the continuum of care	**Overall Continuum**	**43.2**	**58.8**
	Under 19	35.2	51.1
	20-49	51.0	60.0
	Pregnancy	**44.4**	**65.3**
	Under 19	36.1	55.7
	20-49	52.6	66.8
	Delivery	**47.5**	**57.4**
	Under 19	39.1	51.6
	20-49	55.8	58.2
	Postpartum	**38.1**	**52.5**
	Under 19	30.7	44.2
	20-49	45.5	53.9
	Neo-Natal	**-**[34]	**60.0**
	Under 19	-	53.0
	20-49	-	61.2
% of relevant male family members of WCBAs capable of recognizing a minimum of two danger signs along the continuum of care[35]	**Overall Continuum**	**59.2**	**45.6**
	Pregnancy	60.0	53.2
	Delivery	56.4	35.0

[30] Baseline recalculated to ensure comparability with end line.
[31] Ibid.
[32] Indicator relevant for Bangladesh, Ghana and Mali and inclusive of those with essential birth and newborn equipment.
[33] Baseline for women inclusive of all implementing countries except Ethiopia; rate for men includes Mali and Bangladesh.
[34] Data available for Mali only (2.5% for under 19 and 25.5% for 20-49) and thus not included in mean.
[35] Baseline figures recalculated for comparability with end line. Does not include Zimbabwe.

Performance Indicators		Baseline	End Line
	Postpartum	60.3	37.7
	Neo-Natal	-	50.5
% of WCBAs that know at least two strategies for addressing a minimum of two danger signs along the continuum of care[36]	**Overall Continuum**	**27.7**	**74.1**
	Under 19	21.6	64.1
	20-49	33.8	75.9
	Pregnancy	**21.8**	**77.6**
	Under 19	14.3	65.0
	20-49	29.2	79.8
	Delivery	**15.7**	**74.1**
	Under 19	11.2	65.0
	20-49	20.2	75.5
	Postpartum	**28.7**	**69.6**
	Under 19	19.8	59.9
	20-49	37.6	71.5
	Neo-Natal	**13.7**	**75.2**
	Under 19	2.6	66.4
	20-49	24.8	77.1
% of relevant male family members of WCBAs that know at least two strategies for addressing a minimum of two danger signs along the continuum of care	**Overall Continuum**	**50.0**	**67.6**
	Pregnancy	43.9	69.1
	Delivery	28.7	61.4
	Postpartum	54.4	64.7
	Neo-Natal	43.0	75.2
% of WCBAs who know how HIV can be transmitted from an HIV-positive mother to her child[37]	**Total**	**69.1**	**73.3**
% of relevant male family members of WCBAs who know how HIV can be transmitted from an HIV-positive mother to her child[38]	**Total**	**75.0**	**72.2**

Immediate outcome 1120: Enhanced ability of women and girls to make decisions related to accessing MNCH services

Performance Indicator	Baseline	End Line
% of women holding influential leadership positions (management, board, etc.) of local Health Care Committees (HCC)	19.5	38.5
% of women who perceive that they can make management-level decisions at local HCCs	-	86.8
% of men who perceive that local women have the capacity and the right to make actionable decisions related to MNCH at local HCCs (level of decision making)	-	89.3

[36] To maintain consistency among all countries, those who know at least one strategy were considered for baseline and end line. Baseline figures for individual phases along the continuum include Bangladesh and Mali only.
[37] Indicator relevant for Ethiopia, Ghana and Zimbabwe.
[38] Relevant for ETH, GHA and ZIM, however the baseline figure is not available for GHA.

Immediate outcome 1130: Increased girls' and women's utilization of responsive MNCH services along the continuum of care

Performance Indicator		Baseline	End Line
# of women utilizing MNCH services (disaggregated by age, type of service along the Continuum of Care, and frequency of service)	**Total**	**N/A**[39]	**565,715**
	Under 19[40]	N/A	67,507
	20-49	N/A	392,097
Attitude of relevant male family members towards the utilization of MNCH services by their related female family members[41]	**Total**	**51.4**[42]	**87.5**
	Adolescent Girls 15-19	-	79.9
	Women 20-49	-	78.1
	Women 15-49	-	78.7
	Men	85.1	96.3

Immediate outcome 1210: Increased knowledge and skills of male and female government health workers to deliver quality MNCH health services while being sensitive to socio-cultural issues

Performance Indicator	Baseline	End Line
% of health workers who are able to recognize the 7 key signal functions for BEmONC according to country standards[43]	-	72.3 (70.8 female)
% of health workers or SBAs who have performed at least 5 safe and clean deliveries according to curriculum[44]	7.4	75.7 (92.4% of females 66.6% of males)

Immediate outcome 1220: Improved gender-sensitive referral systems at primary and secondary health care levels

Performance Indicator		Baseline	End Line
# of referrals received at primary levels from the communities	Total	N/A[45]	15,178
# of referrals received at secondary level from the primary level[46]	Total	N/A	13,243
Level of satisfaction of women users of the referral systems regarding its responsiveness to their needs[47]	**Total**	**57.3**	**87.3**
	Under 19	-	92.5
	20-49	-	86.4

[39] Baseline not applicable as reach is presented as cumulative figure for end line. Figures adjusted for all target communities for the period of Jan 2013 to Dec 2014. For Ethiopia and Mali, these are adjusted for all working communities based on sample communities. Includes 4 ANC visits, TT2, PNC within 72 hours and skilled delivery. Multiple responses included.
[40] Disaggregation by age for PNC and Tetanus began for most countries in 2014.
[41] Indicator relevant for Bangladesh, Ghana and Zimbabwe only.
[42] Baseline available for Ghana only. 51.4 % represents the result as perceived by women. Indicator measures the % of women who perceive they receive support from their husbands or male family members; and the % of men who provide support to their wives or female family member.
[43] Includes ETH, GHA, MLI and ZIM. BGD only collects the number of FWCs trained (See Country Report).
[44] Indicator relevant for Ethiopia and Ghana only. End line drawn from Y3 monitoring data.
[45] Indicator relevant for Ghana, Mali and Zimbabwe; Baseline not applicable as final referral figures reported as a cumulative number drawn from Y2 and Y3 monitoring data.
[46] Indicator relevant for all implementing countries except Ghana.
[47] Baseline includes ETH and ZIM, while the end line result includes Ethiopia, Ghana, and Mali.

Immediate outcome 1230: Improved utilization of MNCH resources and application of clinic management techniques by primary health care

Performance Indicator	Baseline	End Line
% of health clinics who report increased use of referral cell phones[48]	26.6	73.2
% of health facilities who report increased usage of BEmONC equipment[49]	2.5	63.2
% of health facility staff who report increased use of health management techniques, quality control checklists, HMIS, and follow-up tools	-[50]	80.6
% of health facilities that comply with the proper waste disposal protocol[51]	8.9	73.4: Waste disposal policy or procedure; 65.3 incinerator; 45.6 placenta pits; 88.2 have secure boxes for sharps

5.3 Interpretation of core MNCH results

The following section outlines the results and analysis[52] of seven key performance indicators, specifically the UN Commission on Information and Accountability for Women and Children's Health and Muskoka Initiative Indicators. The interpretation of data and key performance indicators, include the following:

1. % of women aged 15-49 who received antenatal care by a skilled health provider at least 4 times during pregnancy
2. % of mothers of children 0-23 months who received 2 doses of tetanus
3. % of live births attended by a skilled health personnel
4. % of mothers and babies who received postnatal care visits within three days of childbirth
5. % of infants aged 0-6 months who are exclusively breastfed
6. % of children aged 0-24 months who received at least 3 doses of pentavalent vaccine
7. % of children vaccinated against measles

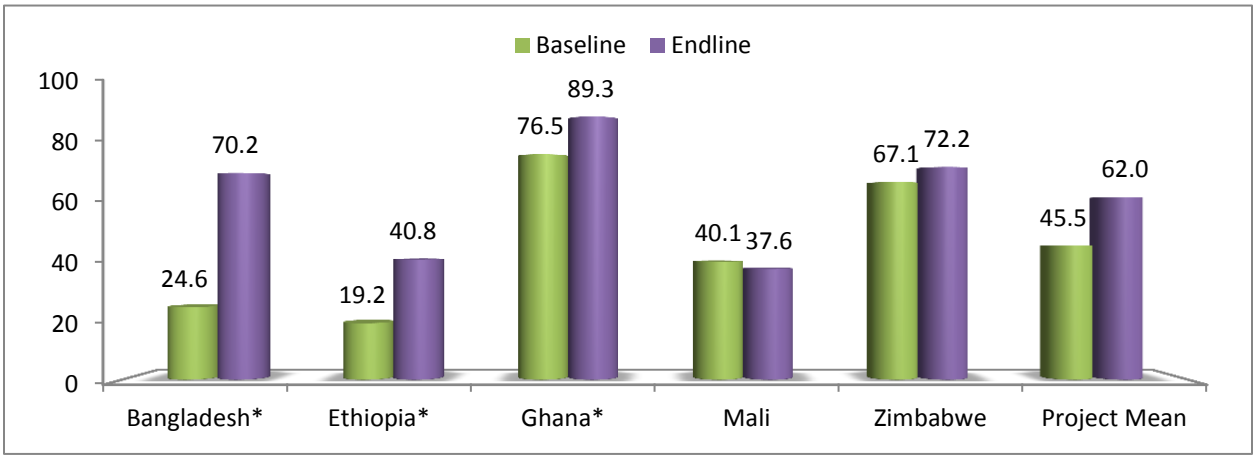
Country-specific results which demonstrate a statistical significance from baseline are denoted with a * in relevant graphs.

5.3.1 Antenatal care by a skilled health provider at least four times during pregnancy

Overall, 16.5% more women surveyed had received antenatal care (ANC) at least 4 times during pregnancy at the time of the end line survey (62.0%) compared to the baseline (45.5%). The highest rate of ANC4 was reported in Ghana (89.3%), while the lowest was reported in Mali (37.6%). The greatest change occurred in Bangladesh, with an increase of 45.6%.

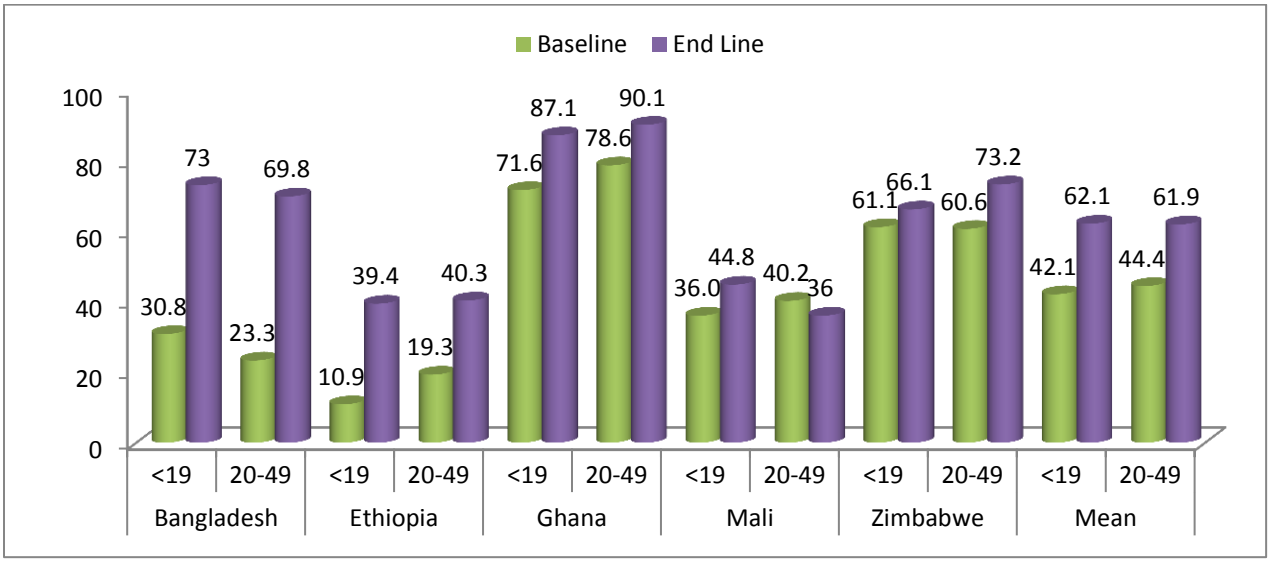
[48] Baseline collected for Zimbabwe only, however end line inclusive of Ethiopia, Ghana, Mali and Zimbabwe.
[49] Indicator relevant for Ethiopia, Ghana and Mali; Baseline recalculated for purpose of comparability.
[50] Mean baseline value not available due to differing units (facilities/personnel) among countries. Refer to End line Report for individual country results.
[51] Indicator relevant for all implementing countries, except Zimbabwe.
[52] Analysis refers to the narrative and factual description of findings, trends and patterns based on presented data, plus the interpretation of this data based on contextual and programmatic factors.

Figure 2: % of women aged 15-49 with a live birth who received antenatal care by a skilled health provider at least 4 times during pregnancy, by country



In terms of age disaggregation, the proportion of adolescent girls who had received four or more antenatal care visits increased 20.0% from baseline (42.1%) to end line (62.1%). Among women aged 20-49, the rate increased 17.5%, from a baseline of 44.4% to an end line result of 61.9%. Overall, the difference between the two age groups at the time of the end line survey was only 0.2%. The highest rate of ANC4 among adolescent girls (87.1%) and women (90.1%) were both reported in Ghana, while the lowest rate among adolescent girls was found in Ethiopia (39.4%) and the lowest rate among women aged 20-49 was found in Mali (36.0%).

Figure 3: % of women aged 15-49 who received antenatal care at least 4 times during pregnancy, by age



With exception of Mali, all countries have experienced increases. Overall for all the countries, awareness and knowledge of pregnant women, male partners and families on MNCH issues, safe motherhood, safe delivery and dangers signs, have been increased through community

sensitization, BCC sessions, with the commitment and collaboration of various community leaders and support groups. Another factor for the observed increases included the tracing of defaulters (pregnant women who fail to attend the planned ANC consultation) as well as quality supportive supervision provided by district health officers to primary care health centers and from primary care health centres to frontline workers and communities. Another contributing factor was the provision of adequate ANC materials and equipment such as blood and urine tests kits, blood pressure monitors, blood sugar monitors, adult scales, fetal stethoscopes (which were provided in Bangladesh and Ghana) which improved the quality of service provided to pregnant mothers.

In Ghana, where the baseline was already high at 76.5%, the project provided key ANC equipment and strong support for the implementation of the Focused-ANC (FANC) policy. Further to which, outreach sessions integrating ANC services provided at the community level were a key element of success in Ghana.

In Bangladesh, there are a large range of health care providers who are recognized and allowed to provide ANC consultations which helped to increase ANC coverage due to the wider accessibility of the service for pregnant women. These include: Community Skilled Birth Attendants, Family Welfare Assistants and Female Health Assistants, who were available at community level and were trained by the project. As in Ghana, they ensured close follow up of pregnant women but they went further to identify and categorize pregnant women as high/low risk, by age group and identify physical conditions for which special care and counseling was needed. Of note, blood tests were provided free of charge.

In Mali, the low financial resources available to pregnant women considerably limited their access to ANC, due to costs relating to transportation and ANC related clinical fees such as for blood testing. Women also indicated that they did not access ANC due to their husbands' refusal to accompany them to a facility. Despite the project's efforts to address these barriers by supporting women's income generating activities through VSLAs and Solidary Funds, as well as creating awareness on GE (through community theatre and awards) and promoting male engagement, women were not able to fully benefit from added financial resources, and they did not always gain the full support of male partners. Moreover, supply-side reasons for the low ANC rates include inadequate provision/availability of ANC outreach services within communities due to a shortage of personnel and limited resources (e.g. transportation for matrons like motorbikes).

In the project globally, slightly fewer adolescent girls (42.1%) were utilizing ANC4 at baseline compared to the older age group (44.4%). The only exceptions in this trend were in Bangladesh and Zimbabwe where a slightly higher or nearly equal proportion of adolescent girls respectively received ANC4 relative to women between 20-49 years. Recognizing the unique gender-related and other socio-cultural barriers[53] faced by adolescent girls in accessing MNCH services and

[53] Socio-cultural barriers include: access to accurate MNCH related information, lack of experience, lack of financial means, very low decision-making capability in families due to their age, high dependency on their male partners/families and in most cases high level of stigma and punitive attitudes associated with early pregnancy if unmarried and unresponsive service delivery in facilities.

the high risk faced by this age group such as the cultural practice of families taking over the management of a first pregnancy in Zimbabwe and sending the expectant mother away to her parent's home for delivery often resulting in missing an ANC visit; or the reported feeling of shame/shyness deterring girls from accessing facility care in Ethiopia and Mali due to lack of privacy and resultant loss of dignity; or health service provider attitudes in Ghana - all countries endeavoured to reach these girls through a range of actions tailored to their specific needs. For example Zimbabwe mobilized peer-educators and adolescent lead mothers and fathers in Care Groups; Ghana organized youth groups including YSLAs and both these countries supported the establishment of youth corners in facilities and utilized adolescent friendly IEC materials; Mali used *balani* (edutainment for youth) shows; Bangladesh carried out focused young couple counseling; and all countries integrated sensitization regarding the special issues and risks for adolescent girls in varying degrees through broader BCC actions as well as male engagement and women's support group formation. All countries also integrated an adolescent focus in the training of health service providers and community outreach workers. A combination of these initiatives and their effects (such as increased knowledge about the danger signs over the continuum of care [from 3.3 percent in the baseline to 51.1 percent at end line], increased male support and improved service delivery) has contributed to the parity observed in utilizing ANC4 between the two age groups at end line, with the younger cohort at a slightly higher level of service utilization, which is notable given all countries faced immense challenges in reaching adolescent girls (please see Section 8.1 Gender equality). Finally, the additional insights can found in the MIC-KMI research report on Adolescent mothers' perceptions of antenatal care services (Ghana, Tanzania).

The noted global increase in ANC4 utilization by older women (20-49) at end line is equally indicative of the effects of the concerted efforts made by all countries to address gender-related barriers, especially addressing the first delay in accessing care, in tandem with service improvement activities. Initiatives contributing to this achievement include: more knowledgeable women on MNCH issues and care services through activities such as the pregnant women's forum in Ethiopia, Mother Support Groups and Queen Mothers in Ghana and similar women's support groups in Mali and Bangladesh, as well as the outreach work of CHWs and broader BCC; more financially capable women through participation in VSLAs in all countries except Bangladesh; more vocal women in community health committees through focused interventions to strengthen women's participation in local health governance in all countries, and thereby more empowered women who are better able to take MNCH decisions, together with their partners (and families) who are also more supportive of MNCH due to the targeted male engagement activities undertaken in some countries such as Daddies' Clubs in Ghana, Gender Equality Champions in Zimbabwe, male Agricultural Development Armies in Ethiopia and change-makers in Bangladesh, who all focused on impressing the importance of men's engagement in MNCH, including attending facility services such as ANC and towards broader gender equality for better MNCH outcomes.

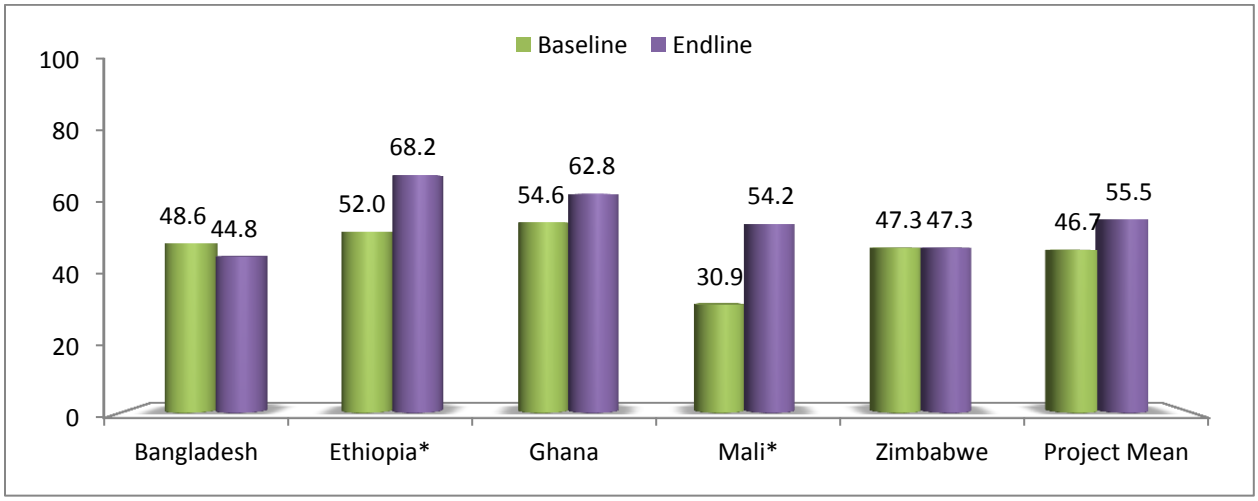
Notwithstanding these gains and in spite of the efforts made by countries, far too many women and adolescent girls are still not receiving ANC4 and among the various reasons cited by them (Refer to End Line Report Section 4.1.1.3 "Reasons for not using ANC" submitted July 2015)

the gender and age related barriers continue to pose challenges. In Mali for example, "husband's refusal" articulated by some 22.2% under 19 women and 11.2% of older women underlines the prevailing male dominance in MNCH matters and "feeling shame" cited by some 55% of adolescent girls in Ethiopia points to the insensitivity of service delivery, as well as the entrenched cultural practice of disclosing a pregnancy late.

5.3.2 Mothers who were fully vaccinated against tetanus (TT2)

Overall the rate of women receiving two doses against tetanus during pregnancy increased by 8.8% from the baseline (46.7%) to the end line (55.5%). The highest rate was reported in Ethiopia at 68.2%, while the lowest rate was reported in Bangladesh at 44.8%. The greatest increase occurred in Mali (23.3%) from a baseline of 30.9% to an end line of 54.2%.

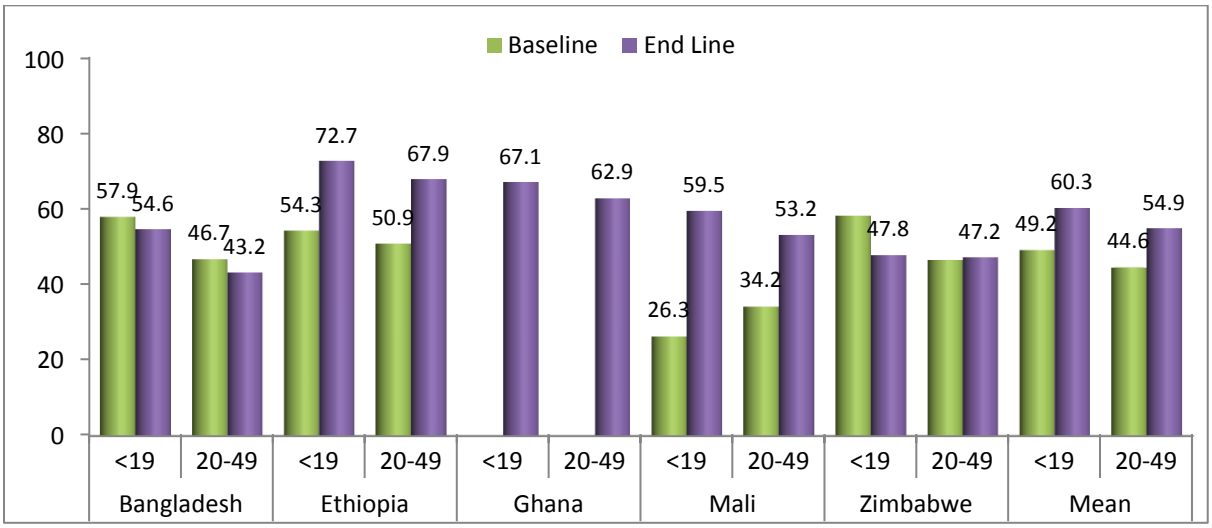
Figure 4: % of mothers of children 0-23 months who received 2 doses of tetanus, by country



The key explanations to support the overall increase are the combined approach of community sensitization and BCC through various channels (radio, drama et.); along with improved supportive supervision and monitoring systems which were reinforced through the project. In addition, consistent support has been provided by the project to ensure the supply of vaccination cold chain and community outreach interventions in some countries, which are both critical for improved TT2 vaccine coverage amongst pregnant women; The project also held project data review/analysis meetings of collected monitoring data which helped to target efforts on improving indicators including TT2, which required more programmatic emphasis.

In Mali, the government organized TT2 national immunization campaigns which helped to bolster this indicator. The project also supported outreach immunization activities at community level of vaccinators through the provision of logistical support via motorbike provision and also financial resources to support the implementation of monthly immunization planning meetings at health districts.

Figure 5: % of women who received two or more doses of TT, by age



The rate of vaccination was 5.4% higher among adolescent girls (60.3%) compared with women aged 20-49 (54.9%). The rate increased for both adolescent girls (11.1%) and women (10.3%), compared with baseline figures of 49.2% and 44.6%, respectively. The highest rates of vaccination for both adolescent girls (72.7%) as well as women aged 20 and older (67.9%) were found in Ethiopia.

It is important to note that the end line result of 55.5% for TT2 does not equate to the proportion of pregnant women who were fully vaccinated against tetanus in all country contexts. Some pregnant women did not receive TT2 during pregnancy because it was not necessary. Of the survey respondents who did not receive 2 doses of TT, 38.9% explained that they had received the requisite two doses of TT during a previous pregnancy (50.1% of women aged 20-49 and 18.6% of adolescent girls). Hence, generally, older women who are likely to have had a previous pregnancy it is less likely they would require TT2 vaccination in a current pregnancy.

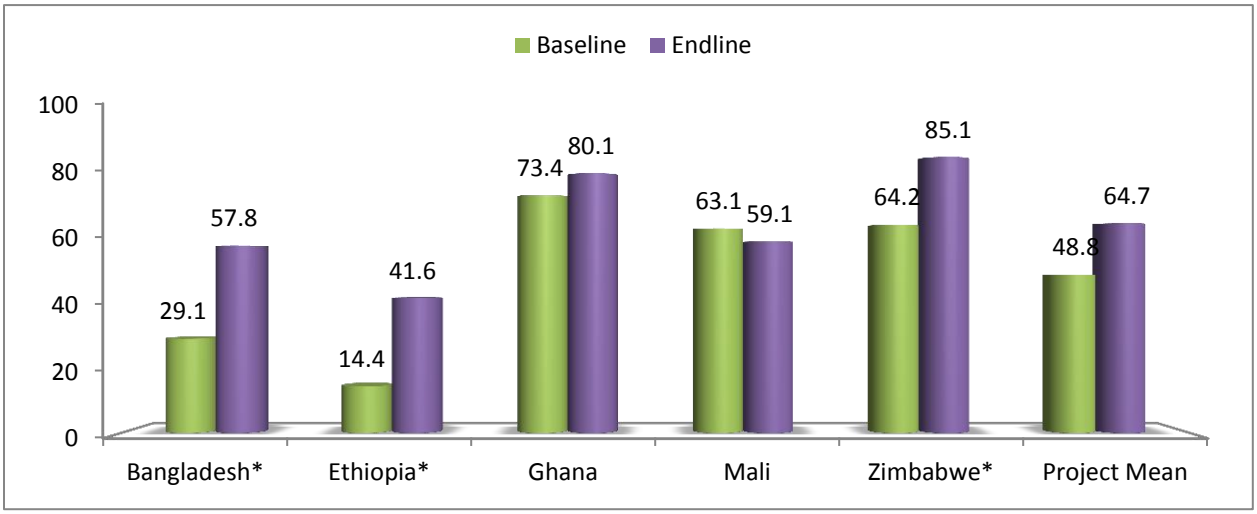
In Bangladesh, the rate of TT2 slightly decreased as women had been previously vaccinated (as evidenced through vaccination cards) during other pregnancies or during their adolescence; 82.1% of respondents who did not receive TT2 stated that they were informed by health facility personnel that they did not require 2 doses due to the fact that in Bangladesh women are provided with a tetanus booster which rendered them fully protected against tetanus. Similarly, in Ghana and Zimbabwe, 60.2% and 80.7% of women (respectively) who did not receive TT2 indicated that they had received 2 doses during a previous pregnancy.

However in Ethiopia and Mali, the primary reason given by the respondents who had not received TT2 for having not received TT2 was the fact that they had not visited the health facility regularly, with 33.9% and 98.7% of women who had not received TT2 (respectively).

5.3.3 Live births attended by skilled health personnel

Overall, the proportion of women who delivered with assistance of skilled health personnel increased by 15.9% from the baseline (48.8%) to the end line (64.7%). The rate was highest in Zimbabwe at 85.1% and lowest in Ethiopia at 41.6%. Ethiopia, however, along with Bangladesh, reported the greatest increase from the baseline. Ethiopia increased 27.2% from a baseline of 14.4%, and Bangladesh increased 28.7% from a baseline of 29.1% to an end line of 57.8%.

Figure 6: % of live births attended by skilled health personnel, by country



This result constitutes a solid MNCH achievement since it is a difficult indicator to change. Various factors have contributed to this result which include improved awareness and knowledge on MNCH issues, including awareness creation around the importance of seeking referral to SHP services through community health workers; improved quality services at health facilities due to skilled/trained health care providers on BEmONC and provision of appropriate medical equipment, medications and materials for clean and safe delivery by SHP.

In some countries such as Zimbabwe and Ethiopia access to maternity waiting homes was a major contributing factor which enabled women to be closer to health facilities at around the time of their due date and thus constituted a mitigation strategy to avoid undertaking distant and difficult transportation and related issues during the time of labour. In Ethiopia, where the greatest change was experienced, particular emphasis was made to promote the development of birth preparedness plans at household level, which were closely supported and followed up by HDAs, HEWs and midwifes through a functional pregnant women tracking system. This was also complimented by pregnant mother's forums which focused messaging to encourage skilled birth attendance at health facilities.

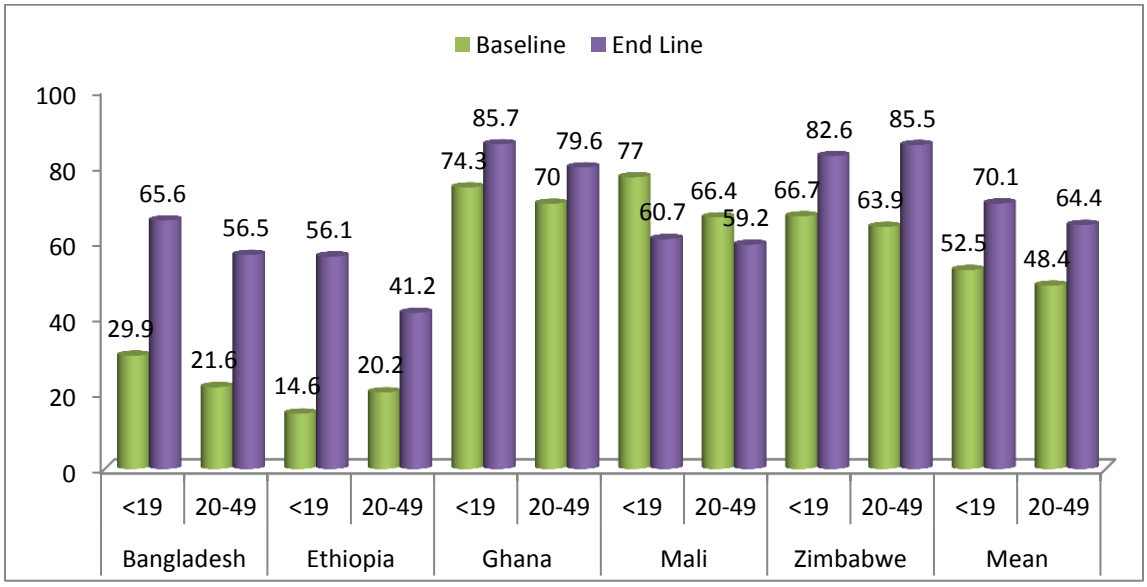
Transportation to health facilities was also improved, particularly in Ghana with the CETS, in Bangladesh with auto rickshaws, and in Ethiopia with traditional ambulances (i.e. beds built with local materials by community members who carry it with pregnant mothers) and fuel support for modern ambulance services. Finally the health facilities were updated to provide a more friendly

environment for women to deliver in a setting with some comforts of their home environment, for instance in Ethiopia this included the provision of traditional ceremonies (coffee and porridge).

In Mali, despite concerted efforts to build awareness and confidence of women to deliver with the assistance of skilled health personnel, a lower result to baseline was observed. Some reasons shared by women who delivered at home and which influenced this result include the short period between the beginning of labour and delivery due to a fast labour; home delivery being seen as more convenient due to the distance and poor road conditions (especially during rainy season) to get to the health facility; and socio-cultural beliefs and practices, such as the unease of women arriving too early and waiting to give birth (as this is perceived by mothers in law, other women and even midwives as the women being weak); and superstitions (e.g. seeing a source of water) which could bring bad luck or death .

In terms of age disaggregation, the percentage of skilled delivery increased by 17.6% for adolescent girls under 19 from baseline (52.5%) to end line (70.1%). Similarly, the rate of skilled delivery increased by 16.0% for women aged 20-49, from 48.4% at the baseline to 64.4% at the end line. Overall, the rate for adolescent girls was 5.7% higher than the rate among women 20-49. The highest rate for adolescent girls was reported in Ghana (85.7%), while the highest rate for women 20-49 was found in Zimbabwe (85.5%). The greatest difference between age categories was found in Ethiopia, where the rate was 14.9% higher among adolescent girls (56.1%) compared with women 20-49 (41.2%).

Figure 7: % of live births attended by skilled health personnel, by age



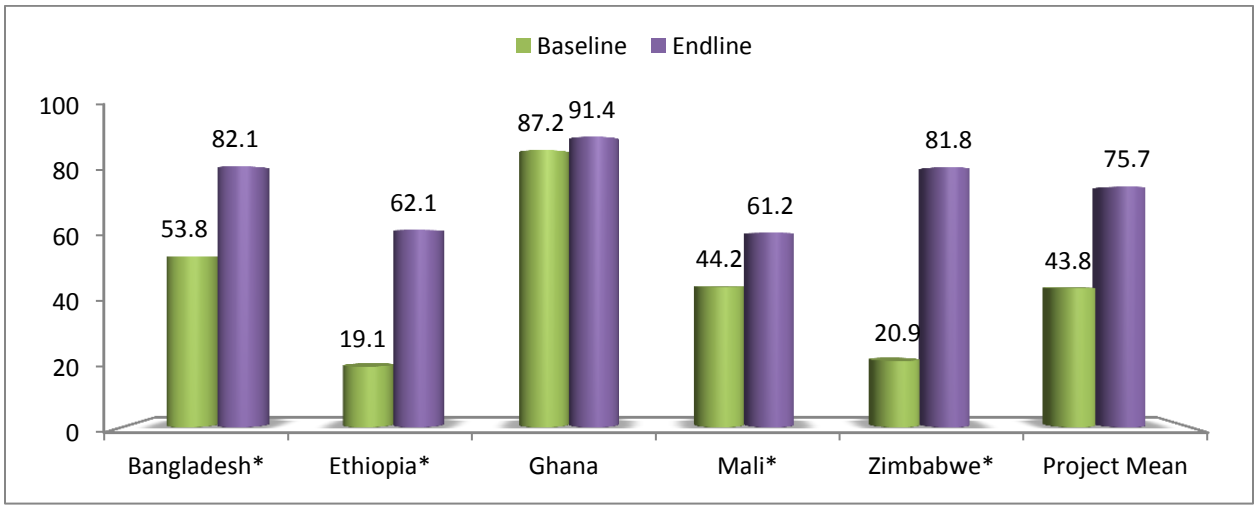
From a gender equality perspective, delivery with assistance from a skilled health personnel is perhaps the most sensitive to male support compared to utilization of any other MNCH services due to prevailing gender-related norms and roles. This is because it may entail a woman leaving her home and being admitted into a facility resulting in having to leave her household responsibilities and the care of other children. Even where the service can be utilized at home, it

entails a cost that families may not be prepared for. In light of these challenges, all countries focused on preparing women and particularly their male partners on the importance of delivery by a skilled health personnel through all means of outreach, education and communication as noted above and the introduction of community bylaws such as in Ghana and Zimbabwe prohibiting home delivery. Key contributors to these results are focused education of men (and women and adolescent girls) on the importance of skilled delivery in all countries and initiatives that facilitated access to transportation and funds (such as CETS in Ghana and VSLA funds in all countries except in Bangladesh).

5.3.4 Mothers who receive postnatal care within three days of childbirth

The overall proportion of women who receive postnatal care (PNC) within three days of child birth increased by 31.9% from the baseline (43.8%) to the end line (75.7%). The highest rate was reported in Ghana (91.4%), while the lowest rate was found in Mali (61.2%). The greatest increase from baseline to end line was reported in Zimbabwe, where PNC within 72 hours rose 60.9% from baseline (20.9%) to end line (81.8%).

Figure 8: % of mothers and babies who received postnatal care visits within three days of childbirth, by country

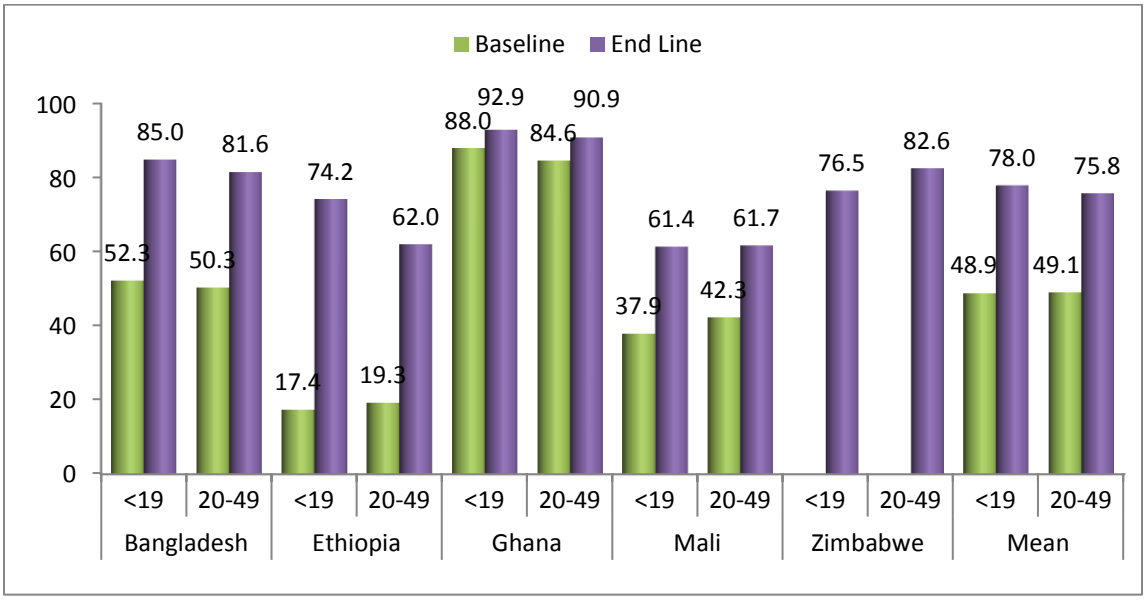


The WATCH project improved health service quality by training health personnel on BEmONC and safe and clean delivery, which PNC is an integrated module. These efforts have contributed to the positive results achieved with this indicator across the project. Through the increased awareness and knowledge of women on MNCH issues, the expectation for quality health service has been raised and thus, mothers are more likely to pay more attention to health care providers' practices, including PNC service. It also makes recall easier when this is assessed through surveys or qualitative discussions. A particular focus was also made to sensitize women who had home births to ensure they received PNC services either through community-level outreach activities organized by health care providers or at health facilities. Notably in Ethiopia, there was a change in the health policy introduced by government and rolled out during WATCH implementation through training on HMIS/CHIS and supportive supervision interventions, which

mandated outreach PNC services to be delivered within three days or 72 hours (as opposed to the previously recognized 6 day period) by HEWs for women who deliver at home.

Overall the proportion of women who received PNC within three days increased by 29.1% for adolescent girls from baseline (48.9%) to end line (78.0%), and 26.7% for women 20-49, from 49.1% to 75.8%. Overall, the rate among adolescent girls was 2.2% higher than the rate among older women. Ghana reported the highest rate of PNC within 3 days for both adolescent girls an (92.9%) and women aged 20-49 (90.9%). The lowest rate for both age categories was found in Mali, with 61.4% of women under 19 years old and 61.7% among women 20 years and older.

Figure 9: % of mothers and babies who received postnatal care visits within three days of childbirth, by age

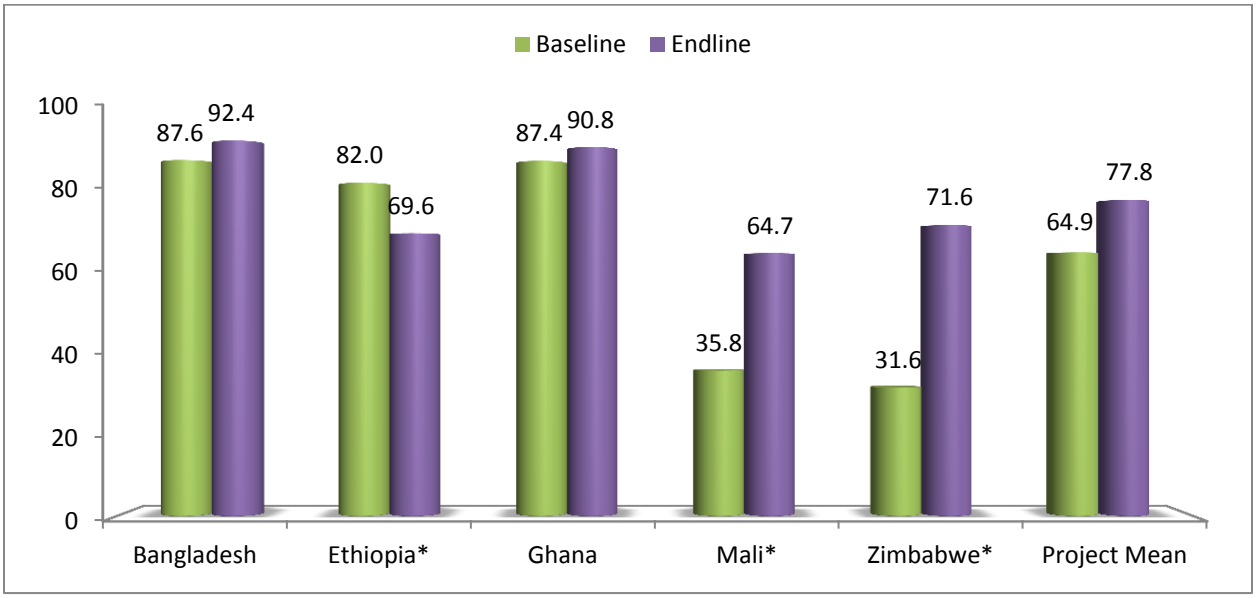


Sociocultural barriers for accessing PNC such as the seclusion of a delivered mother and the newborn baby for up to 40 days (days vary in countries) in all countries was a challenge, especially for the younger women due to their limited voice and influence in families. Furthermore, the low sociocultural priority accorded to PNC, once a visibly normal and healthy baby was born, posed further challenges in breaking these practices. Under 19 girls started off at baseline at a slightly lower level of PNC utilization (48.9%) compared to older women, but the noted higher utilization of PNC at end line by under 19 women may be due to better education of younger girls and their partners and also because overall more of them are delivering at facilities unlike the other age group. Furthermore, greater knowledge of communities (through the concerted BCC initiatives and focused education of women and men by CHWs and other means) about the danger signs relating to post-natal period especially for adolescent girls created an environment for greater utilization of PNC. Conversely, older women (20-49) who tend to deliver at home due to past patterns may not see the necessity of PNC either for themselves or their newborn.

5.3.5 Exclusive breastfeeding of infants under six months

Overall the proportion of infants aged 0-6 months old who were exclusively breastfed increased by 12.9% from baseline (64.9%) to end line (77.8%). The highest rate was found in Bangladesh, at 92.4%, and the lowest rate in Mali at 64.7%. Mali, however, reported one of the greatest increases in exclusive breastfeeding, with the end line result 28.9% higher than the baseline of 35.8%. The overall highest increases were reported in Zimbabwe, where the rate increased 40.0% from baseline (31.6%) to end line (71.6%).

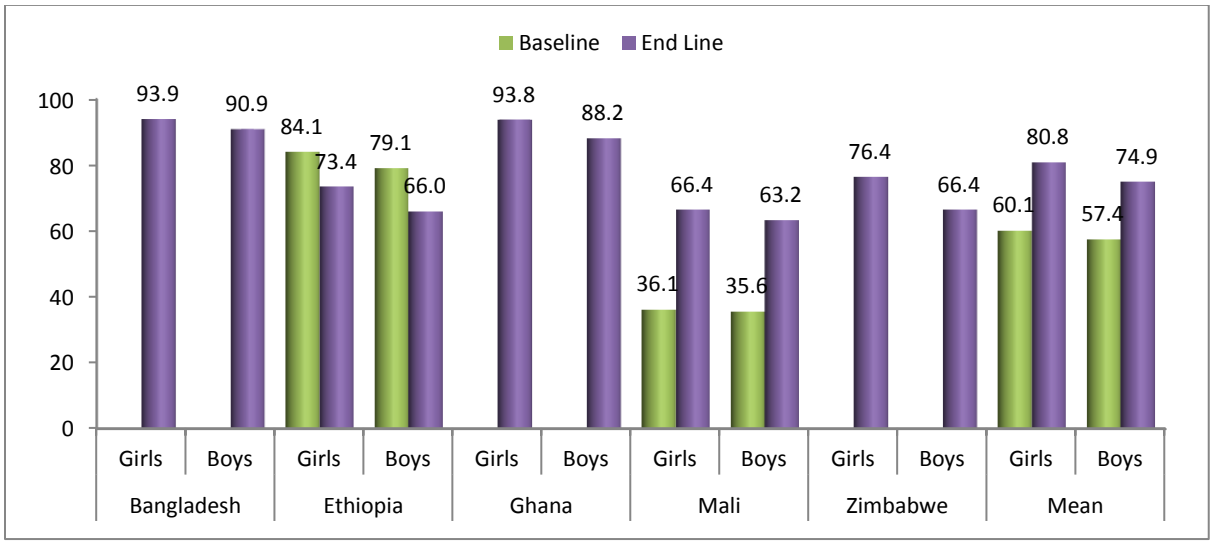
Figure 10: % of infants aged 0-6 months who are exclusively breastfed, by country[54]



Overall the rate increased for both girls and boys[55]. The rate was among girls (80.8%) increased 20.7% from the baseline (60.1%). Among boys the rate increased 17.5% from a baseline of 57.4% to an end line of 74.9%. The highest rate for both girls and boys was noted in Bangladesh, with 93.9% and 90.9%, respectively. The greatest gender gap was noted in Zimbabwe, where the rate for girls (76.4%) was 10.0% higher than the rate for boys (66.4%)

[54] EBF is not an indicator in GHA, but was collected and is included in the overall project average.
[55] Disaggregated baseline data only includes ETH and MLI, while disaggregated end line results include all five countries.

Figure 11: % of children 0-6 months exclusively breastfed, by sex

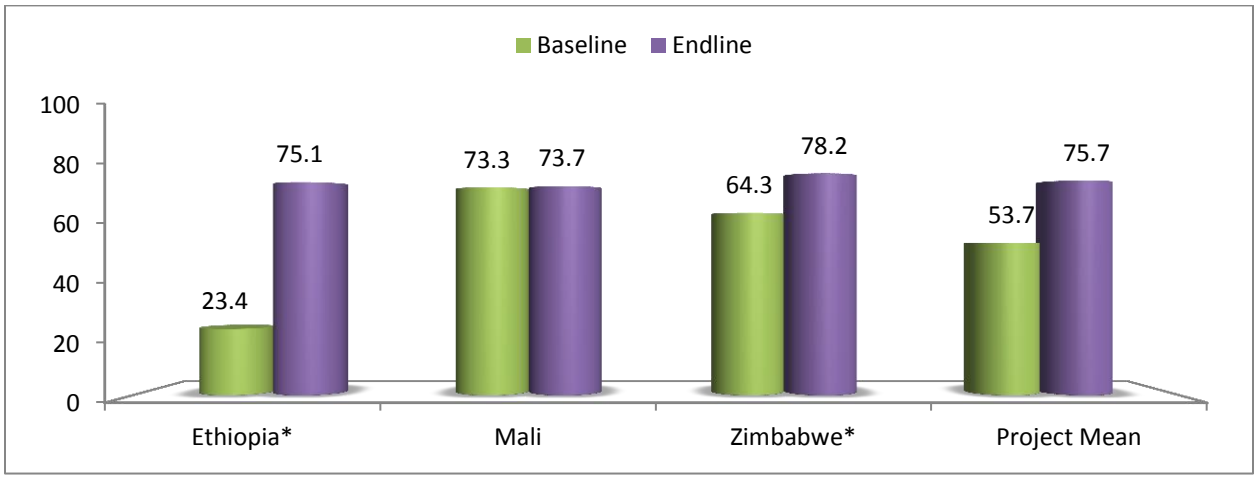


The increase in EBF overall indicates a big shift and change in practice by not only mothers but also the whole family including male partners by providing adequate support to mothers, enabling them to ensure exclusive breastfeeding to children less than 6 months by often overcoming social and cultural practices as well as misconceptions and misbeliefs. This has been achieved through tremendous sensitization efforts conducted jointly by CHWs in communities and by health care providers in health facilities and also through various communication channels and social mobilization. In Mali, a locally held belief is that breast milk does not provide sufficient hydration to an infant and families resort to giving supplemental water. As such, during IEC and community mobilization session with families, a demonstration was included to show that breast milk contains more than 80% water. Also among all the indicators (ANC, PNC, SBA, TT2, Measles, Penta) this is the only one which does not require additional effort from a third person (like a health care provider); there is no need for transportation means to access the services; and the breast milk is available readily as soon as the family commits to and take the decision to practice EBF. While breastfeeding rates have more or less equally increased for both boys and girls across countries (excepting Ethiopia) from baseline to end line, in all countries the pattern of fewer boys being breastfed compared to girls has continued between the two points of time. Indeed the overall slight gender gap of some 2.7% between boys and girls at baseline has increased slightly to some 5.9% at end line, pointing to the continued disadvantage of boys with respect to breastfeeding. Despite concerted efforts to underscore the equal benefits of breastfeeding for boys and girls, it has been challenging to break prevailing cultural misconceptions regarding boys being more hungry than girls and needing more food and nourishment to grow strong across countries and the cultural pride of fathers in carrying their baby sons around with them taking them away from mothers for long periods resulting in supplementary feeding. Both these cultural practices point to the continued lower gender-based social value of girls and son preference.

5.3.6 Children who received three doses of pentavalent[56]

The proportion of children aged 4-23 months who received 3 doses of pentavalent increased 22.0% from the baseline (53.7%) to the end line (75.7%). The highest rate was reported in Zimbabwe (78.2%), followed by Ethiopia (75.1%) and Mali (73.7%).The greatest increase was observed in Ethiopia, where the rate of vaccination increased 51.7% from baseline (23.4%) to end line (75.1%).

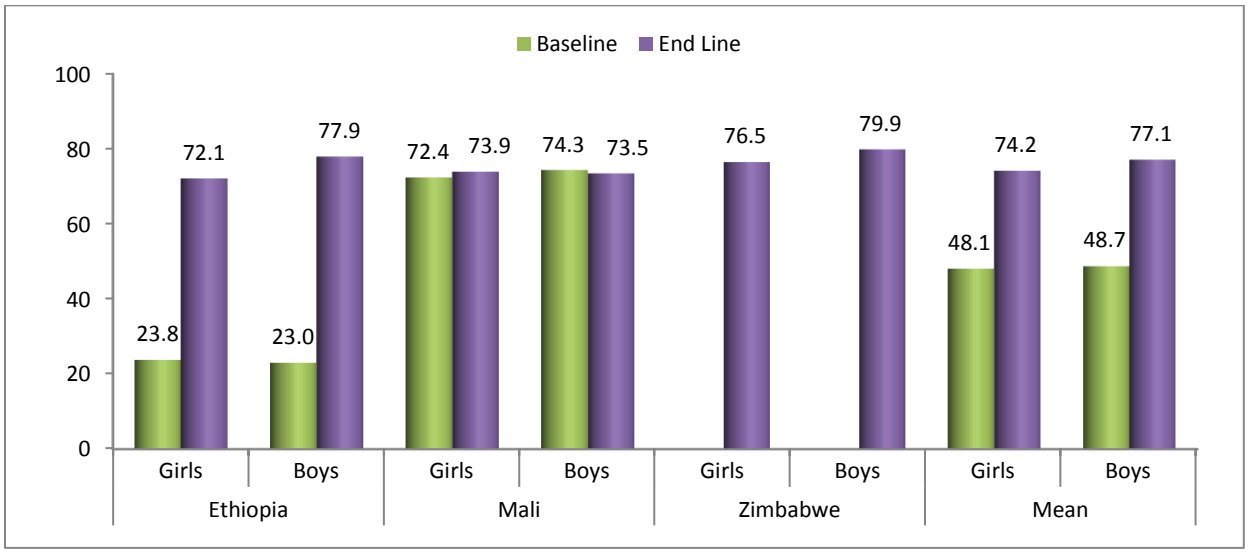
Figure 12: % of children aged 4-23 months who received at least three doses of pentavalent vaccine, by country



The rate of vaccination among girls increased 26.1% from baseline (48.1%) to end line (74.2%), and the proportion of boys receiving three doses of pentavalent increased 28.4% from baseline (48.7%) to end line (77.1%). Overall the proportion of boys being vaccinated was 2.9% higher than the proportion of girls. The highest rate of penta3 among both girls and boys was reported in Zimbabwe, with 76.5% and 79.9%, respectively. The gap between the girls and boys was highest in Ethiopia, where the rate was 5.8% higher for boys (77.9%) compared with girls (72.1%).

[56] This indicator is applicable only to ETH, MLI, and ZIM.

Figure 13: % of infants aged 4 months and above who received three doses of pentavalent, by sex

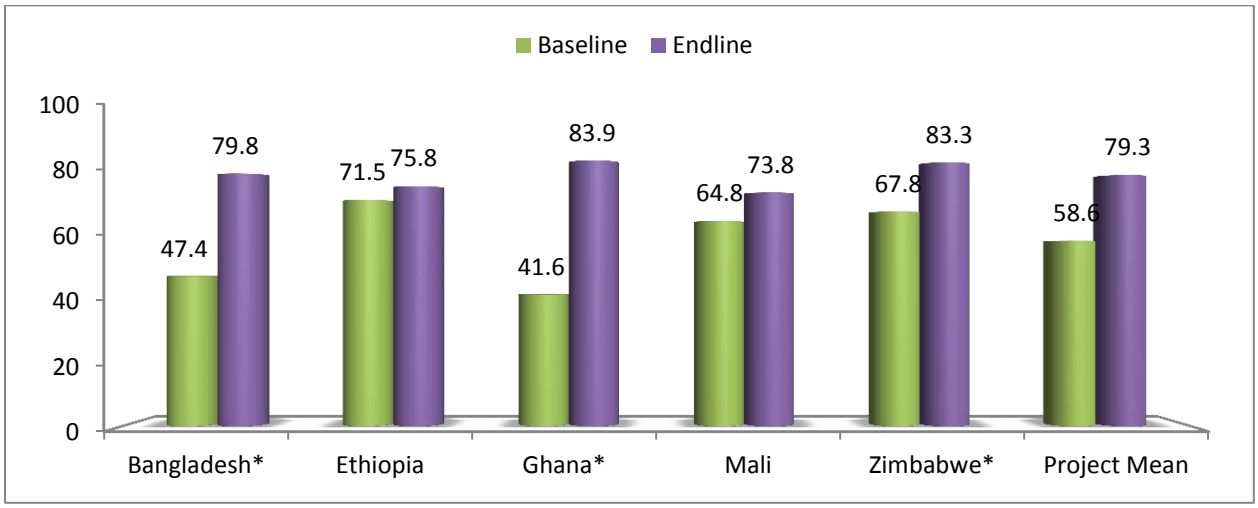


These results are due to extensive support provided by the project to improve the quality of the cold chain system and to enhance immunization outreach sessions, thus ensuring the availability of quality vaccines close to communities. In Mali, the performance for three doses of Pentavalent has stayed even from baseline. Despite the project's various interventions, frequent shortage of vaccines and inadequate organization and storage of vaccines in health centres was an ongoing issue. To address this, the project procured solar fridges; however, their late arrival in the project meant that this contribution was not captured at the time of the end line survey. The various sensitizations, IEC sessions and social mobilization on the importance of getting children immunized were successful despite the fact that mothers have to seek the service thrice either at the facility or at the outreach point. Misconceptions, misbeliefs and sociocultural barriers related to vaccination were also addressed through the project as the increase in the rates for both boys and girls indicates. However an anomalous slight widening of the gender gap has taken place (from relative gender parity at baseline i.e. 0.6% to a gap of some 2.9% at end line with more boys being immunized relative to girls) for which there appears to be no apparent gender-related cause as the gap does not manifest in a similar pattern for measles below.

5.3.7 Children vaccinated against measles

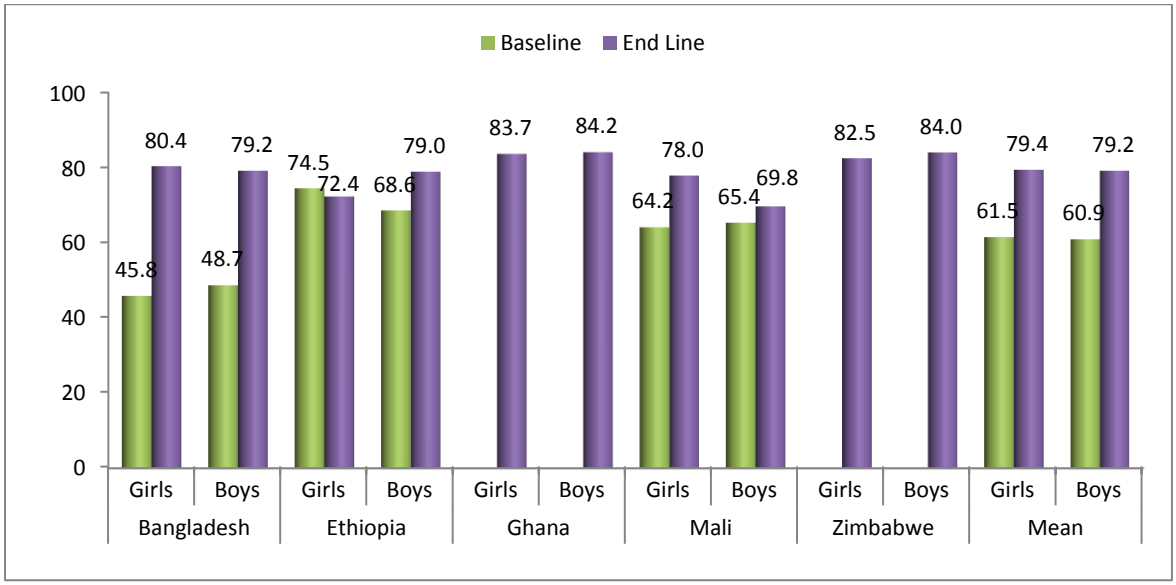
The percentage of children aged 9-23 months vaccinated against measles increased 20.7% from baseline (58.6%) to end line (79.3%). The highest rate of vaccination was found in Ghana (83.9%), which also reported the greatest increase (42.3%) from baseline (41.6%). The lowest rate of vaccination against measles was found in Mali, with 73.8%.

Figure 14: % of children vaccinated against measles, by country



The proportion of girls and boys vaccinated against measles at the time of the end line survey differed by only 0.2%, with 79.4% and 79.2%, respectively. This represents an increase of 17.9% from the baseline of 61.5% for girls, and 18.3% increase from the baseline of 60.9% for boys. The highest rates for both girls and boys were reported in Ghana, with 83.7% and 84.2%, respectively. The largest gender gap occurred in Mali, with the rate of vaccination 8.2% higher for girls (78.0%) compared with boys (69.8%).

Figure 15: % of children aged 9-23 months vaccinated against measles, by sex



Similar to other vaccination indicators, the same reflections of factors which contributed to the increase vaccination rates are relevant here. Moreover, this vaccine is provided to the baby only one time for children 9-12 months old, not requiring mothers to re-visit clinics on multiple occasions (such as for Penta-3). It should be noted that in Ghana, there was a change in the

policy in 2012 promoting a second booster at 18 months for vaccination against measles, which has contributed to the observed result.

5.4 Implementation of the WHO Commission on Information and Accountability (CoIA) for Women's and Children's Health

As articulated in the EAWP, the WATCH project design put focus on measuring performance and maintaining accountability to WATCH stakeholders – including donors, local governments such as ministries of health, local NGOs and CBOs and the women, children and men the program ultimately aimed to assist.

WATCH aligned with the guiding principles set out by the UN Commission on Information and Accountability for Women's and Children's Health. This high-level group of 30 health experts and global leaders, co-chaired by Tanzania's President Jakaya Kikwete and Prime Minister Stephen Harper of Canada, was established at the request of the UN Secretary-General in January 2011 following the launch of the Global Strategy for Women's and Children's Health at the MDG Summit. The WATCH program was guided by four fundamental accountability principles advocated by the UN Global Strategy and the Commission:

1) Focus on national leadership and ownership of results;
2) Strengthen countries' capacity to monitor and evaluate;
3) Reduce the reporting burden by aligning efforts with the systems countries use to monitor and evaluate their national health strategies;
4) Strengthen and harmonize existing international mechanisms to track progress on all commitments made.

As mentioned in the EAWP, WATCH aligned with the ten practical recommendations set out by the Commission in its May 2011 report "Keeping Promises, Measuring Results," which laid out a framework for accountability to "hold donors accountable for their pledges and hold countries responsible for how well the money was spent to accelerate progress towards the health-related MDGs" extending to both donors and project level investments. Of the recommendations, three were of direct relevance to WATCH.

The project contributed to Recommendation #1 relating to *vital events reporting and strengthening*. Broadly, the project worked to reinforce quality of health care provided and reporting systems where possible. In Ethiopia, this involved facilitating HMIS training for health supervisors and CHIS trainings and support for HEWs. In Mali, health agents were trained in maternal and newborn death auditing. In Bangladesh, mentioned below, the ICT4 Health pilot was working towards linking with the national DHIS system directly.

Recommendation #2 was also very relevant as the WATCH program aligned where appropriate to report on 5 of 11 MNCH indicators which enabled stakeholders to track progress on reproductive, maternal and child health, disaggregated for gender and other equity considerations like age. Indicators included in WATCH results reporting were 1) antenatal care coverage by skilled health provider at least four times during pregnancy; 2) skilled attendant at birth; 3) postnatal care for mothers and babies; 4) exclusive breastfeeding for six months and 5) three doses of combined diphtheria-tetanus-pertussis vaccine immunization coverage.

The WATCH program has also contributed to Recommendation #3 – *promoting innovation*, particularly the integration of information and communication technologies (ICTs). Bangladesh included an ICT for Health pilot intervention supported through the Ministry of Health to use tablet-based community data collection approach to integrate with the wider HMIS system (DHIS2). In terms of tracking referrals, the software allowed follow-up on services access by mother, children as well as attendance by male partners. In Ethiopia and Zimbabwe, the project committed to logistical health system support with air time on a monthly basis to facilitate transportation (by ambulance) and ensure timely referral of women and children to the next level of health care.

In summary, overall the WATCH indicators showed improvements from baseline and processes used were in alignment with accountability norms and standards.

Section 6: Project management

The project management of the WATCH project leveraged several approaches/strategies in alignment with the project cycle progression i.e. **1) implementation planning and project startup, 2) project implementation, 3) monitoring and reporting and 4) project closure**, to ensure accountable, coordinated and efficient processes and management across five countries. DFATD's result-based management (RBM) strategy and tools, over the 3.5 year duration of the project, was applied across all five WATCH countries as it related to the appropriate phase of the project cycle, as discussed below. For information on project management of MIC-KMI, please refer to Section 8.4

6.1 Implementation planning and project startup

From November 2011 to April 2012, the development of key project guiding documents and strategies i.e. an overarching **work plan, schedule and budget and GE strategy** (approaches of strategy are specified in Section 8.1) were articulated through the Project Implementation Plan (PIP) or Extended Annual Work Plan (EAWP) which was submitted to DFATD in March 2012. The development process consisted of a series of five country-level workshops with an overall objective to develop a common understanding of WATCH project results, the means for measuring performance, highlighting and elaborating risks and their mitigation measures. Through small focus group activities and plenary sessions, discussion and critical debate, the workshops held between December 2011 and early February 2012 allowed stakeholders to validate the main RBM tools, strategies, work plans, schedules and detailed budget, and sought confirmation from key partners and beneficiaries of other management documents found in the submitted EAWP.

The implementation planning stage relied on deep consultation and collaboration with project partners (LNGOs and Government) to ensure that the EAWP was validated and feasible across all project stakeholders. For the EAWP sessions in each country, participants included Plan country staff and Plan Canada team, representatives from key WATCH partners (government health officials at national, regional and district level), local NGO representatives and representatives of local municipalities where appropriate.

SOGC and Plan Canada signed a letter of agreement in April 2012 following the country-level workshops. Thereafter, SOGC signed MOUs in June 2012 with its sister organizations OGSB and ESOG.

In terms of **governance** at the country-level, the EAWP process was also an opportunity to define the overarching management and governance structure for the project which ensured solid accountability as well as transparency amongst project stakeholders. As discussed in section 3, the EAWP considered the intended project steering committees and mechanisms for this in each country.

To establish **financial** accountability and compliance in accordance with the WATCH project contribution agreement, the grants finance team at Plan Canada provided critical oversight, capacity building, and compliance training to each Country Office (including local partners) and supported the EAWP budget process, as well as asset register management.

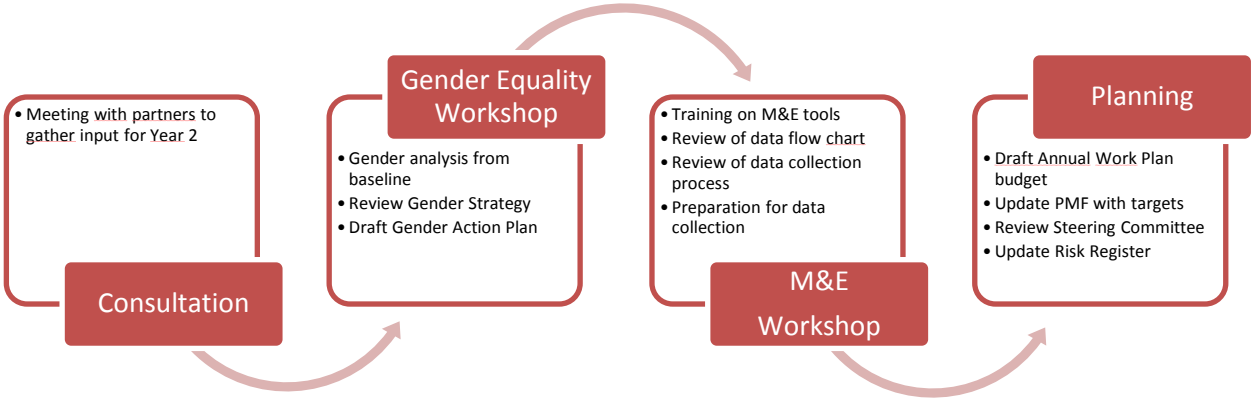
In terms of **logistics and startup activities**, the five plan Country Offices were responsible for ensuring MOUs with relevant key stakeholders and local implementing partners were signed and strong working relations were established and/or strengthened. In Ethiopia, it should be noted that at the end of 2011, the government of Ethiopia endorsed a new NGO guideline that required CSOs to allocate 70% of their budget directly on programs and only 30% in administrative costs. Due to the prolonged time taken to seek clarifications with government partners (as they were still trying to understand how to implement tis directive) on how to interpret and apply this new 70/30 guideline, this resulted in a process of signing official project agreements with government bodies later than anticipated. In Ghana the MOU nationally with GHS was delayed and after a series of follow up efforts by a high level delegation from Plan Ghana on the pending national-level MOU between the National GHS and Plan Ghana, the GHS Director General signed the National Government Partnership Agreement in July 2014. In terms of establishing appropriate **implementation, monitoring and reporting** for the project strategies: subsequent to the completion of the WATCH EAWP (PIP) a gender equality and monitoring and evaluation (M&E) workshop was held April 2012 in Toronto, with representatives from all five participating countries and SOGC. The objective of this workshop was to elaborate the design of the WATCH M&E system to effectively capture project results and integrate a gender-equality focus across all project interventions. The workshop strengthened the country participants' knowledge and understanding of GE and M&E, and aligned the five country systems to the overall program measurement framework. The key outcomes were the refinement of the country level PMF for monitoring and an operational Gender Equality Strategy specific to each country.

6.2 Project implementation

From May 2012 to March 2015 project implementation of activities was undertaken. Plan Country Offices were responsible for providing project oversight – ensuring that high quality work and technical standards were maintained – and activities were implemented in accordance with annual work plans and budgets, using the results expressed in the logic model for overall direction. Operationalizing the project's strategy and approach at the country level (Bangladesh,

Ethiopia, Ghana, Mali and Zimbabwe), Plan's country offices prepared country specific work plans, logic models, risk registers, performance measurement frameworks and annually reviewed and refined activities as per country contexts (see Section 3), prevailing risks (see Section 7) and monitoring data collected. Between November and December 2012, country-level workshops were held to operationalize the Gender Equality Strategy through a GE Action Plan (GEAP) and Monitoring and Evaluation tools and processes. These workshops were integrated with the Year 2 annual work planning processes illustrated in Figure 16.

Figure 16: Summary of AWP development approach for WATCH Year 2



To assure quality and accountability for implementation of the project in each country a governance mechanism was established for the project through national level and/or regional and district project steering committees as applicable. As detailed in Section 3, these committees were convened annually and included key project partners and stakeholders. Moreover, they provided critical inputs for consideration and validation in the AWP review cycle in-country. This fed into the 5 country consolidated AWP which was submitted for DFATD approval.

To ensure that operational work plans were aligned to EAWP and Annual Working Planning (AWP) and variances from the previous year were accounted for to DFATD, Plan staff and key partners, an annual work plan cycle was carried out for Years 2 and 3/4 (the latter was combined with Year 3 since Year 4 implementation was limited to January-March 2015). The objectives of the AWP workshops for Year 2 and 3/4 at the country-level were to: 1) review the overall project context and model, including a reflection on previous year implementation and a review of Plan and DFATD financial and program compliance requirements; 2) discuss activities for the coming year to be integrated from the GE action plan, M&E preparation tasks and partner consultations; 3) re-confirm PMF targets as set during the year 2 AWP process (as necessary); and 4) collectively refine and validate the draft annual work plan and budget. Workshop participants included program managers, finance managers and technical specialists from Plan Canada, Plan Country Office and Program Unit staff, government health services

representatives (national, regional and district) and local NGO partners as well as representatives from SOGC, OGSB and ESOG (where appropriate). The workshops were very participatory in nature and encouraged participants to actively provide input and feedback through a series of small group activities, presentations and plenary sessions that invoked critical discussion and reflection. The country level AWP documentation was consolidated by Plan Canada and subsequently submitted to DFATD for review/approval. Lastly, where applicable, procurement planning and activities were carried out by each individual country level, following the guidance and procedures of the Plan Country Office and of the relevant national government authorities, in alignment with DFATD compliance requirements.

6.3 Monitoring and reporting

Throughout the project life, Plan Country Offices employed the RBM framework as the key reference tool for monitoring and assessing progress towards achievement of project results. Plan Canada supported the WATCH implementing teams to utilize key program management tools (PMF, gender equality action plan, risk register, annual work plans, budgets and implementation schedules) established during Year 1 and reviewed/updated annually, with a special focus on M&E tools (starting in Q1 of 2013 – Year 2) to capture the progress of MNCH interventions. Critical capacity, management and technical support was delivered through a team of dedicated program/compliance managers, a communications officer with critical technical inputs provided remotely and field visits from GE, Health and M&E technical advisors. Plan Canada also supported Country Office grants accountants to oversee and monitor expenses, prepare for audits, and support capacity building of local partners, as well as prepare budgets, variance analysis and forecasts over the duration of the project. Through technical support visits, any compliance related questions or issues raised by project country teams and partners were addressed accordingly.

Plan Canada and Plan country teams communicated on a monthly basis to review monthly work plan progress, discuss emerging issues and opportunities, address risks and challenges and review financial forecasting, variance and budgets, and relevant communications materials. Monitoring on project implementation progress through local NGO and Government partners was also carried out regularly by Plan staff that linked directly with regional/district partners.

In Years 2 and 3, monitoring data (community and facility) was collected, reviewed and interpreted, with a concerted focus on key Muskoka indicators. Plan Canada supported this process through data analysis workshops in each implementing country. This process was linked with the annual work planning process to facilitate reflection of monitoring data findings in relation to work planning to account for programmatic adjustments to bolster underperforming indicators observed through monitoring. For more detailed information on data analysis please refer to Section 8.

Implementation progress was reported semi-annually and annually to DFATD which consisted of country-level and overall project consolidated reports, including narrative, performance and financial reports on project progress. Please refer to Annex E for a list of all such reports.

Of note, SOGC was responsible to report to Plan Canada on the nature of progress and budget utilization for their partners in Bangladesh (OGSB) and Ethiopia (ESOG). However, in each applicable country the Plan country office and respective SOGC sister organization leveraged country communication protocols and approaches to coordinate implementation locally. SOGC was able to establish good working relationships with its sister professional associations and a clear value add was SOGC's ability to facilitate exchange of knowledge, know-how and information from OGSB and ESOG. SOGC's involvement in WATCH reinforced the management and reporting capacities of these professional organizations to implement maternal health projects and provided a credible supportive 'outside' perspective to improve performance in BEmONC training and supportive supervision of health care professionals.

Plan facilitated communications and learning across countries through a SharePoint site, as well as an experience sharing and learning workshop in November 2013 in Zimbabwe. The workshop included participants from each of the five implementing countries, as well as representatives from other Muskoka-funded MNCH projects, the Zimbabwe Ministry of Health, the Canadian Embassy in Zimbabwe, the Society of Obstetricians and Gynaecologists of Canada, Sick Kids Hospital in Toronto, and Plan Tanzania. At the workshop, participants shared key project findings and insights; learned about progress/innovation (and research) in other countries, as well as the challenges faced in other countries and how they were mitigated; and identified key opportunities for enhanced WATCH program implementation for the remainder of the project. Program managers from each of the five countries also had an opportunity to share their projects' results, challenges, and best practices during workshops and discussions held at the Plan Canada office during the MNCH Summit in May 2014, and the MIC-KMI Results Symposium in June 2015.

6.4 Project closure

This phase of the project cycle was principally undertaken between April and September 2015. This was an intensive period and process managed by the Country Offices and supported by Plan Canada.

Plan Canada undertook the project end line survey in coordination with the Country Offices led by a global consultant with five separate local country consultants. This was a process which followed a rigorous timeline that began in November 2014 and was completed and submitted to DFATD in July 2015. The reason that this end line process started so early was so that it could feed into the MIC–KMI data analysis process managed by Sick Kids. This end line data was also used for WATCH performance assessment and analysis (for key Muskoka indicators) as presented in Section 5.

Close out management processes in each of the WATCH countries involved partner contract reviews to ensure appropriate and legal requirements were met for termination of partner sub-agreements, particularly with respect to human resource management. An asset disposal plan (ADP) was created, consolidated by Plan Canada for all countries and submitted to DFATD and approved in April 2015, followed by physical disposal of assets. Please refer to Annex K for details of the ADP. Almost all assets were disposed of as planned, except for a generator and

two laptops that were retained by Plan Ghana and Plan Zimbabwe respectively in order to support other ongoing or future projects. A few other minor variances in asset disposal are outlined in Annex K. Processes for final financial and narrative reporting were coordinated with support from Plan Canada and administered by Plan Country Offices with their partners.

All program implementation activities ended in March 2015 and thereafter each country initiated its own specific project transition and handover process that included communities, LGNO partners and government partners. Close out workshops were held with LGNO partner staff to discuss the community handover process. In addition, meetings were held with community opinion leaders to reinforce key messages and solicit support and supervision for continued community-based activities. At the regional or district level, meetings were arranged with local government partners to share end line results, lessons learned, and best practices. At the national level, close-out events were organized within each country (see dates and descriptions in the Table 3), with representatives from the Ministry of Health, local NGOs, and DFATD in attendance. At these workshops, videos, presentations, and take-home collaterals showcased WATCH results, successes and lessons learned.

In Canada, a detailed presentation on WATCH's results, best practices, and lessons learned was delivered to DFATD in Ottawa on May 7, 2015. In addition, close-out workshops were held at the Plan Canada office on June 22-23, 2015, with the participation of program managers from each of the five implementing countries. These workshops included discussions on the project's gender equality strategy, success factors, and lessons learned. Each country also produced their own poster to capture key activities and results. These posters were presented to Canadian fundraising vendors, as well as at the MIC-KMI Results Symposium (note: posters are included on the USB key with all other WATCH communications materials).

Table 3: Summary of close out events

Country	Dates	Description of event
Bangladesh	May 24, 2015	Close out workshop held in Dhaka. Participants included DFATD, NGOs and MoH officials from central, regional and district level.
Ethiopia	June 12 , 2015	Close out workshop was held with implementing LNGOs and MoH from national, regional and district level. Workshop objectives were to share project implementation experiences, lessons learned and best practices; share WATCH end line results; and acknowledge donor and stakeholder contributions.
Ghana	June 16-18, 2015	3-day workshop with all implementing LNGOs and GHS partners. Workshop objectives were to share/validate results from the end line study; share lessons learned and challenges encountered and mitigated; and make recommendations for future programming opportunities in MNCH.
Mali	June 9-11, 2015	3-day workshop with all implementing LNGOs and MoH partners. Workshop objectives were to conduct the final WATCH project steering committee meeting and share results from the end line study.
Zimbabwe	May 28, 2015	WATCH close-out meeting held at the provincial level for project hand-over; this was preceded by district level close out sessions in May 2015.

In conclusion, Year 1 (2012) was focused on project startup; Years 2 and 3 (2013-2014) on implementation; and Year 4 (2015) on project closure. For additional information, please refer to the Annex C (tombstone data and project milestones), Annex D (list of partners), Annex E (list of reports, MIC-KMI deliverables, and communications material), and Annex F (list of consultants).

6.5 Public relations

WATCH's approach, activities, results, and lessons learned were presented by Program Managers and Technical Advisors (from Plan Canada and/or Plan offices in the five implementing countries) in various public forums. A variety of communications collateral, including power point presentations, posters, and/or summaries (please refer to Annex E for the full list of materials) was developed and shared at international conferences including: Women Deliver (May 2013); Canadian Conference on Global Health (November 2013, November 2014); MenEngage Global Symposium (November 2014); and the 14th World Congress on Public Health (February 2015).

In May 2014, Prime Minister Stephen Harper hosted an MNCH Summit in Toronto, and Plan Canada organized an event at its office to share progress and results of Plan's MNCH work with senior Canadian government officials, Plan donors, corporate partners, CAN-MNCH network group members, youth, international visitors, and media. Various communications materials were gathered from project implementing countries (i.e. photos, video, letters of appreciation), and used to showcase the personal impacts of Plan's projects. In addition, MNCH ambassadors (program managers, community health workers, nurse/midwives, and mothers) from Tanzania and Zimbabwe travelled to Canada to speak at the event and provide media interviews. This event garnered significant media attention for Plan, DFATD, and the issue of MNCH in general.

In June 2015, an MNCH Symposium was hosted by the Hospital for Sick Children's Centre for Global Child Health to present combined results and research from projects implemented by the four INGOs in the Muskoka Initiative Consortium: Plan Canada, World Vision Canada, Save the Children Canada, and Care Canada. The symposium was attended by MNCH practitioners, researchers, senior government officials, and media. A wide range of collateral showcasing WATCH was developed for this event, including posters, postcards, infographics, two-page project summaries, a research report summary (on male engagement in MNCH), and an end line results summary. All of this public-facing collateral included appropriate DFATD recognition, based on requirements stipulated in the contract agreement. These materials were on display in a "marketplace" area, where symposium attendees circulated between sessions and asked questions about the content presented.

Throughout the project, local media within the implementing countries published articles (in print and online) or broadcast stories highlighting the scope and achievements of WATCH. Examples of these media clips have been shared in previous project reports.

Section 7: Risk management

During the EAWP stage, each of the five WATCH countries developed country-specific Investment Risk Registers, which were consolidated into the WATCH global Investment Risk Register at the EAWP and submitted to DFATD accordingly. Throughout the duration of the project, the country Investment Risk Registers were operationally reviewed and updated accordingly during semi-annual and annual reporting, as well used to inform the annual work planning process. The discussion below assesses the operational, development, financial and reputational risks which were referenced in the initial PIP global Investment Risk Register and encountered in some or all of the five countries during project implementation.

The first key operational risk identified was related to the anticipation that the '*Motivation and the quality of Community Health Workers (CHWs) work will be low due to the volunteer nature/low pay and higher expectations placed upon them by the project'* (OP1). This risk event occurred and impacted the project in Mali, Ghana and Ethiopia. In **Mali** community mobilization, education and sensitization relied on community-based peer educators or *'relais' and t*he risk of turnover and drop out by trained *relais* was experienced in districts bordering the gold mining zones in Kita and Kangaba, as community members left to seek employment opportunities which paid more. In **Ethiopia,** Health Extension Workers (HEW), who already carried heavy work burdens, experienced increased workloads based on the expectations placed upon them by the WATCH project especially in relation to data collection, which contributed to attrition. In **Ghana** this risk emerged and was more focused on the motivational levels of volunteer Community Mobilizers becoming low due to volunteer fatigue in target communities, intensified by increased expectations as a result of additional trainings and workload in program implementation and monitoring (data collection) activities for WATCH.

To mitigate the risk associated with volunteer CHWs, strategies included: 1) provision of additional incentives like small radios, boots, shirts, uniforms etc. to support the CHWs when implementing project interventions; In Ghana additional compensation for the added work like for data collection and in Ethiopia, CHWs as per government directive could receive additional compensated for increased workload but project negotiated that they were able to receive an allowance to attend meetings 2) provision of appropriate means of transport for CHWs (e.g. bicycles) complemented by reimbursement/compensation for transportation/meal costs incurred, especially for those volunteers who were expected to travel far away from their communities; 3) promotion of an appropriate continuity of engagement and supportive supervision from health system authorities, as well as opportunities for engagement in health committees and health centre management committees, which helped CHWs to feel more technically supported and that their voice was being considered in the health system; 4) increased visibility and levels of respect/status by community members and local community leaders by encouraging public recognition for the important contributions that volunteer CHWs made to their communities, which made them feel more valued; 5) reduction in the workload of individual CHWs through shifting of tasks across CHWs, increasing the number of LNGO animators (in Mali) and improving the coordination and partnership between of volunteer HDA structure and HEWs (in Ethiopia) to ensure quality support for community outreach and

mobilization efforts; and 6) opting to support some trainings as residential rather than non-residential (in Ghana) which helped maintain committed participation for a quality training especially for female participants for which travelling long distances on a daily basis was difficult; likewise providing trainings closer to the village level minimized women's travel time in Ethiopia.

Another key operational risk which carried high likelihood and impact was **OP2** i.e. **'***to put performance measurement systems in place in a timely manner so that progress to results can be demonstrated in the short 3.5 year implementation life of the project'. A*s described in Section 4, a prevailing challenge was collection of monitoring data at the household level and subsequent entry of the data into the monitoring system, which was experienced by several countries, intensified during the project. In Ethiopia, Ghana and Mali data collection was very challenging in Year 2 as he capacity of HDAs in Ethiopia, *relais* in Mali and Community Mobilizers in Ghana to effectively collect data proved to be more challenging than originally assumed, so adaptations needed to be made to reflect the reality on the ground. This was addressed by simplifying the data collection forms, where possible; working more closely with government health system to ensure that performance measurement was aligned to the district and regional level targets (Ghana); and the provision of additional human resources to help ensure timely and quality data collection.

In terms of development risks, natural (anticipated as Dev-5), health or political disasters (both unanticipated) were encountered in several countries. Risk management was challenging due to the unpredictable nature of such events which had broad operational and programmatic impacts in the project implementation, but the risks were mitigated effectively to minimize the impact on the achievement of results. As identified in Section 4, the Ebola epidemic in the West Africa sub-region (e.g. neighbouring Guinea) affected implementation in Mali, while in Bangladesh, a tropical storm/cyclone struck the project`s implementing Upazilas (especially Barguna Sadar). In both cases, Plan was able to support communities through existing programmatic and disaster risk reduction strategies which guided project team operations and through providing guidance and education in community level interventions so that communities could be become more sensitive and better equipped to minimize the likelihood of further public health crises or natural disasters. In Bangladesh, Plan Bangladesh had its own contingency plan and staffs were trained in emergency protocols and emergency communication. As such, team members are trained to rapidly adapt their interventions using emergency resources available from Government of Bangladesh.

Similarly, unpredictable security risks encountered in Mali and Bangladesh were experienced throughout the project duration. In Mali the socio political crisis and conflict in the country, particularly in the north, imposed some challenges to Plan Mali operations at both the Country Office (Bamako) and Program Unit (field) levels. The risk to certain activities at community was realized with limitations to community mobilization activities and limited staff movements due to security and potential volatility in WATCH operational areas. In Bangladesh, political instability manifested in generalized strikes or "hartals" interrupted project activity implementation and temporarily delayed achievement of specific outputs. Responsive actions included ensuring

SOPs (Standard Operating Procedures) for staff/partners were followed; maintaining close coordination and communication with local government and INGOs; and routinely provided updates on the country situation and potential implications on program delivery to key stakeholders. The projects compensated for lost working days by working on weekends and adding extra hours on normal working days, and temporary delays in progress were overcome.

A development risk which carried a high likelihood for several countries but was particularly associated with Zimbabwe and Ghana was **DEV2** regarding the '*Resistance by TBAs, traditional healers and conservative faith groups to adopting gender sensitive health-seeking behaviours resulting in the persistence of harmful traditional practices'.* In Zimbabwe, close attention by the project was given to apostolic religious groups who traditionally resist modern medicine, due to the potential of the spread of communicable diseases, morbidity and mortality rates amongst children and mothers. The project approach to engage such groups was effective and the impact of this risk was reduced to 'low' as the project progressed as successful awareness-raising and outreach efforts to engage more liberal-minded apostolic groups and traditional male and female leaders served as an entry point to reach more conservative groups. In Ghana, socio-cultural resistance by Traditional Birth Attendants, Herbalists, Spiritualists and Wanzams (traditional male circumcisers) in project-supported communities had a high risk of impeding full integration of gender equality and overcoming barriers to the achievement of gender equality (GE) outcomes. The project minimized the impact through a proactive strategy of implementing a well-defined GE Action Plan, including multiple orientations, sensitization and trainings touching a variety of actors, leaders and community structures at the community level, including the [TBAs, Herbalists, Spiritualists and Wanzams (traditional male circumcisers)]. Particularly important was the engagement and education provided for community chiefs, Queen Mothers and opinion leaders around Gender Equality, which has strategically lowered the likelihood of community social and cultural resistance. As well, to tackle the entrenched and structural nature of inequality between men and women required focused, sustained and accelerated attention, for instance the screening of documentaries on male role models and the inclusion of the male role models in radio discussion programmes.

A **financial risk** highlighted by all countries was **FIN2** i.e. the risk that '*funds will not be used for their intended purposes, funds will not be properly accounted for, and/or services delivered will not be commensurate to funds transferred'.* To ensure that this risk was mitigated appropriately, the five Plan Country Offices and Plan Canada conducted staff and partner training on DFATD and Plan financial and compliance regulations (including procurement and eligibility of specific costs) throughout the first year and on an annual basis thereafter, and also established stringent financial procedures and tracking mechanisms for project expenditures. In addition, all offices leveraged Plan`s internal control system, which includes annual internal audits, anti-fraud and anti-corruption policies, a `whistle-blower` policy to protect employees who come forward with information on misuse of funds by their colleagues or superiors, and multiple approval levels (in accordance with the principle of segregation of duties), as well as support from Plan Canada, the Plan Regional Offices, and Plan International Headquarter as/when appropriate. For the WATCH project, all transactions in the field and head offices were reviewed for any suspicious fluctuations. Stringent financial monitoring and controls were exerted regularly through monthly

calls, monitoring visits and during annual work planning, as per an established schedule, with all monitoring compliant with General Accepted Accounting practices. The findings of a donor audit conducted in late 2013 (covering the period of November 2011 through December 2012) noted the expenses claimed were in compliance, in all material respects, with the financial terms established in Appendix C of the Contribution Agreement.

With respect to the Global IRR, several risks (FIN1; DEV1; DEV3; DEV4; REP1) were identified but not included in the discussion as their likelihood and probability remained low and did not require specific action and/or country mitigation strategies were effective to prevent the risk. In addition to the risks that were anticipated in the initial Investment Risk Register, there were also two additional risks identified during the course of the project, which were mitigated effectively to avoid any negative impact on the delivery of the project or on the achievement of results.

An **unforeseen financial risk** was the fluctuation of stable exchange rates experienced in some countries, which had the inadvertent impact of generating additional resource availability for project implementation. In Ghana, there was a continuous depreciation of the Ghana Cedi against the major foreign currencies such as the US dollar and the British Pound. This scenario resulted in budget gains for the country, after the preparation of the AWP and Budget for Year 3/4. These gains were used to reinforce activities like Safe Motherhood and child health promotion activities to ensure that indicators on skilled delivery by a health professional attained results at par with ANC and PNC, and also that child immunization attained a rate of 100% with drop out being effectively eliminated.

An unanticipated operational risk was the timely procurement of facility based equipment. This was particularly acute in Ethiopia (due to lengthy processes and government bureaucracy at multiple levels) and in Mali in relation to improving cold chain through the purchase of solar fridges. In both cases a significant level of effort was exerted to ensure the procurement was completed in a timely and appropriate fashion and required that the project team leverage an alternative mode of procurement which was to centralize in Ethiopia (i.e. so that procurement was conducted by the Plan country office rather than at the regional level) and in Mali, the Plan country team undertook an international procurement to ensure the appropriate product as per government standard was obtained as the requisite materials were not available in the local market.

In summary, the original risk assessment outlined in the global Investment Risk Register at the time of the EAWP (PIP) submission was valid, and the strategies which were employed during the project enabled the project teams to appropriately respond to changes in the likelihood and impact of anticipated risks, as well as to risks that emerged during project implementation. As such, the impact of the key risks on the immediate and intermediate outcomes was minimized.

Section 8: Cross-cutting themes and priorities

8.1 Gender equality (GE) strategy

The WATCH Extended AWP recognized gender inequality as a key determinant leading to the three key delays in accessing MNCH services across all WATCH countries identified in respective country gender assessments conducted at the beginning of the project. Though the effects of gender issues varied by degree and nature within each country's specific socio-cultural context, three clusters of issues and barriers were consistent and pervasive that had a direct bearing on poor MNCH access, utilization and outcomes. Broadly these included: 1) low status of women and girls contributing to their disempowerment including: low access to MNCH information often due to low literacy, mobility restrictions and low agency to seek information and care; lack of access to and control over financial resources rendering women (and especially adolescent girls) financially dependent on men and unable to allocate money for MNCH care autonomously; disproportionate burden of work (productive and reproductive); high rates of child early and forced marriage and teenage pregnancy; low representation and influence in community health decision-making forums that in turn often results in MNCH services that are not relevant to or cognizant of their needs; and traditional customs, myths and practices surrounding pregnancy, child birth and child care that are imposed on women (especially young adolescent ones) by families. 2) lack of or low involvement of and support from men in MNCH in attending MNCH services, and also in support to women through the continuum of care. Key factors underpinning this low engagement of men include traditional gender roles and norms that exclude men from taking active roles in MNCH, and low levels of information on MNCH and gender equality issues. 3) overall environment at health facilities that hampers women and men from accessing and utilizing MNCH services. This included inhospitable and unresponsive behaviours of health staff towards clients (especially adolescent girls) and their male partners, as well as the lack of amenities, such as separate waiting areas or washrooms for men resulting in compromised dignity of clients on the one hand, and the exclusion of men from the MNCH continuum of care, on the other.

To address these complex underlying gender-related barriers at the household, community and facility level towards achievement of the two WATCH gender equality outcomes. A comprehensive WATCH GE strategy was articulated in Annex H of the EAWP, which was subsequently refined and sharpened upon reflection, at the Sharing and Learning Workshop held in Zimbabwe in November 2013, with a more strategic broadening of the scope of male engagement initiatives recognizing the critical importance of engaging community leaders and gate-keepers through various context appropriate and innovative actions. The GE Strategy was implemented through three targeted gender transformative approaches designed to break-down GE barriers noted above. These included: 1) strengthening women and adolescent girls' agency and decision-making by building their knowledge about MNCH and GE, building their social and economic capital, and strengthening their voice in local health governance; 2) engaging men across spheres (from family members to socio-cultural gate-keepers) as active partners of change by increasing their understanding and support for MNCH and GE; the thrust of which was to create an enabling sociocultural environment for GE and MNCH; and 3) addressing facility-based deficits in meeting the practical and strategic needs of women and men through a

range of actions promoting quality care that is respectful and responsive; this approach focused on creating a client-focused and inclusive institutional environment. Highlights of key lessons, best practices and challenges are presented below.

8.1.1 Operationalizing the GE strategy

By and large, the GE strategy was successfully implemented by all WATCH countries through context-relevant and fully integrated Gender Equality Action Plans (GEAPs), which were continuously refined in light of systematic data analysis as part of the AWP planning process. Key learning relating to successful implementation includes:

1) The establishment of multi-tiered GE expertise, including a full-time WATCH GE Coordinator (in four countries, with part time support provided in Ethiopia) supported full-time by GE Advisors from Plan Canada, ensured quality integration of GE across all WATCH actions and built staff and partner capacity on GE with some specific efforts to ensure the sustainability of such capacity building. For example in Bangladesh, WATCH supported its local NGO partners to develop their organizational GE policies and establish local GE networks. This resulted in greater partner commitment to GE organizationally, as well as joint initiatives such as the celebration of International Women's Day (IWD) with local networks (IWD newsletters showcasing WATCH's GE activities and outcomes were created in 2014 and 2015 and shared by in-country WATCH teams with their local stakeholders; these are referenced in Annex E and provided on the USB accompanying this report).
2) The high level of buy-in on GE by WATCH staff, particularly senior management, ensured shared accountability and responsibility for implementation. This buy-in was an outcome of very early and ongoing sensitization on the importance of addressing GE issues in MNCH, embedded in gender equality policies of Plan and DFATD.
3) In countries where there was inter-project collaboration for GE and/or close engagement of the country office GE Adviser, several opportunities were leveraged to increase the effects of initiatives (e.g. linkage with the DFATD-funded START project (November 2013 - March 2014) on child early/forced marriage (CEFM) in Zimbabwe resulted in exceptional access to traditional chiefs and apostolic leaders; and VSLA cross-learning between Promoting African Grassroots Economic Security through Education and Skills (PAGES) and WATCH in Ethiopia enabled a strong education component in VSLA). A good practice in Zimbabwe was the active office-wide GE network that created the opportunity for learning and joint planning.
4) Analysis with stakeholders of project monitoring data starting as of Year 2 with a gender lens provided the necessary evidence for targeted and informed planning of activities in AWPs, and contributed to stakeholder commitment and ownership.

Key challenges of implementation included the heavy onus of integrating GE across interventions/activities and jurisdictions with limited GE staff in countries; uneven linkage between country GE Advisors and WATCH GE Coordinators; and above all the limited duration of GE initiatives in communities and facilities. Essentially activities kicked-off in Year 2, leaving little time for these new concepts to take root in very patriarchal and traditional societies and requiring longer term and sustained intervention.

8.1.2 Effectiveness of the GE strategy

1) Empowering women and girls

In all countries, adolescent girls were more difficult to reach due to the various circumstances that surround their pregnancy, including social stigma and their higher mobility. In future programs, there is a need to deliberately increase the number of platforms to reach out to adolescent mothers (and fathers); there is a need to purposefully and systematically harness their own agency for peer outreach; and there is a need to further develop messages that are adolescent and gender friendly, providing information and advice that is devoid of any judgment. Several good practices were undertaken in WATCH, such as targeted young couple counseling in Bangladesh on MNCH, GE and delaying pregnancy, which included elder family members; targeted cultural activities for adolescent girls in Mali (i.e. balani shows); peer-educators and adolescent lead mothers/fathers in Care Groups in Zimbabwe; and adolescent girls' groups and YSLAs in Ghana. Each of these initiatives provided safe spaces for adolescent girls (and boys) to learn about MNCH, GE and share their experiences. Despite these activities, persistent challenges were encountered, such as the bias of health outreach workers (CHWs etc.) regarding adolescent pregnancy despite training (ingrained attitudes are difficult to dispel); unavailability of adolescents on account of work or school to participate in peer education and other initiatives; and limited adult support for adolescent girls (especially unmarried) to participate in initiatives.

The four countries (excepting Bangladesh) implementing VSLA (mixed and single sex) found it an effective platform to mobilize communities for sensitization and education on GE and MNCH, given financial concerns are of interest to everyone, and therefore ensured their availability and consistent attendance. Integrating BCC activities with VSLA had a multiplier effect, not only on BCC interventions but also on disposable household income, joint accountability and social cohesion on MNCH and GE reported by VSLA members. Hajia, a VSLA member in Ghana, used the knowledge and assets from her VSLA to start a palm oil production factory with a few other members: "*Thanks to this new business that we began, I am now able to have money to cater for my needs and my family's needs too*," Hajia said. "*I no longer wait for my husband to give me money before I can visit the health facility and attend to other such needs.*" VSLAs have also increased women's social status, due to their increased income and assumption of leadership roles within the groups.

Establishing quotas for women's representation (government or community established) in local health committees (in all countries except Zimbabwe, ranging from 10% in Mali to 50% in Ethiopia) is a useful mechanism to increase women's presence in committees; however increased representation does not necessarily ensure women's confidence to articulate their concerns. Thus, leadership training for women was therefore critical, together with gender-sensitization for male members, which were both carried out by the 5 countries. Additional examples of good practices include Bangladesh's work with the Directorate General of Family Planning (DGFP) to update the Operational Manual for UH&FWC, which includes an emphasis on the importance of GE in FWC committees; and Mali's creation of women-exclusive committees to support health committees and bring forward women's voices. The most common challenge in increasing women's representation in local health committees during WATCH was

that most committees were pre-formed with tenures for around three years, making it difficult to increase the number of women or their representation in leadership positions. Furthermore, even where quotas existed, these were hard to fill due to prevailing gender norms. Where opportunities came up, countries moved forward in strengthening women's representation in committees.

2) Engaging men

Across countries, one of the key learnings was that success in engaging men was achieved when there was buy-in of religious/traditional leaders. These leaders are highly revered and when men see their leaders taking up initiatives, they emulate them. Hard-to-reach men required persistent visits to their homes, social spaces and workplaces. To change behaviours and attitudes of very difficult men (men who did not want to buy into GE), local male role models and other peer influencers were effective, however this was cost and labour intensive. The most difficult to reach men are fathers of unmarried adolescent girls and women. Leveraging existing male community structures (e.g. male Agricultural Development Armies in Ethiopia) was an efficient means to reach men. VSLAs also offered a good avenue for engaging men in the long-term. The identification and capacity building of community male GE champions (e.g. in Ghana and Zimbabwe), male role models and men's groups (i.e. Daddies' Clubs in Ghana) were examples of good practices, as these are locally recognized men who have influence in communities. Targeted onboarding of religious leaders (e.g. through change-maker groups in Bangladesh) was another good practice that encouraged wide dissemination of GE and MNCH messaging. Several challenges were encountered in engaging men. These included resistance of men to GE messages (including male involvement and support to their female partners), mainly due to traditional male dominance in the communities. Male champions, male role models, Daddies' Clubs, change-makers, etc. faced resistance to GE messaging from other men as they carried out outreach, and they were also ridiculed and stigmatized for taking up non-traditional gender roles (please see Annex M: Male engagement research publication: *Men Matter: Engaging Men for MNCH Outcomes;* also accessible through this link: http://plancanada.ca/file/documents/MenMatter-email.pdf). If future programs intend to achieve full saturation in accessing men, especially hard-to-reach men, additional resources (i.e. male champions, role models, male CHWs etc.) would be required for more intensive outreach.

3) Gender responsive MNCH service delivery

One key lesson was that addressing GE concerns in health service delivery required working within the government structures and policy framework cross-functionally, as well as building the GE capacity of the government-appointed decision makers and community leaders. Where the mandated ministry of women/gender was engaged, the effects were wide-ranging (e.g. formal collaboration in Ethiopia and Zimbabwe resulted in some institutional initiatives, which are discussed below). Communities can be mobilized for greater uptake of services by women and male attendance; however, facilities are not adequately equipped to welcome men, creating a disincentive to attend. Examples of good practice include: working with ministries of health and gender/women's affairs in Zimbabwe to develop and disseminate a guide on gender responsiveness for use by service providers with checklists for self-evaluation (this manual will be used for health service provider training going forward, supported by the ministry of women);

training health service providers on GE and MNCH; supporting facilities to become more conducive for male participation by creating privacy screens, waiting areas, washrooms, etc.); integrating gender-responsiveness in supportive supervision and health facility assessments (e.g. in Ethiopia through a checklist used by ESOG); integrating GE as a standing agenda item in community reflection and health committee meetings; and introducing specific adolescent friendly corners (in Ghana and Zimbabwe) with dedicated staff and youth friendly IEC materials. These initiatives were important as they contributed to addressing the facility-level GE barriers faced by adolescent girls, women and their partners in accessing and utilizing MNCH services, and worked towards institutionalizing GE as a concern in health service delivery. However, these initiatives were not uniformly applied and there is limited assurance that they will be carried forward by government over time, due to capacity gaps and the 'siloed' nature of government structures addressing health and GE. However, there is recognition by government that GE issues are important determinants, based on WATCH monitoring data and on the observed health-seeking behavioural differences between WATCH-supported and other communities. Several challenges were faced by all countries in implementing this component of the GE strategy. Firstly, it was difficult to build capacity within health departments to substantively integrate GE policies and then put them into action. There is buy-in in principle, but GE is often seen as a separate issue. WATCH used government technical training curricula for health care providers, which was by and large devoid of GE considerations. The project therefore provided GE components and trained trainers in implementing these additional components. There is limited evidence that the additional components were actively adopted by countries, and it is not known how effectively they were communicated by particular government trainers. Secondly, some government/community measures (in Ghana and Zimbabwe) to encourage male partner attendance could potentially have had negative consequences for unaccompanied women and adolescent girls attending facility services. This required concerted advocacy to mitigate this risk and no negative effect was reported or observed. However, the Men Matter report (see Annex M) notes these measures may have acted as disincentives for unaccompanied girls and women from accessing facilities and using traditional birth attendants instead and prompting some women to pay men to accompany them to appointments as their partners. Thirdly, facilities were mostly ill-equipped to welcome men, who culturally do not participate in MNCH services. Of all health services, it was the most challenging to garner male support during delivery because of inadequate space in facilities (several women could be in the labour ward at the same time, and a male partner of one of them therefore could not be present). Couples' counseling during ANC was also a challenge, as health provider/client ratios are too high to ensure quality and inclusive counseling. Finally, adolescent corners established were not uniformly functional or did not meet all the adolescent friendliness criteria of the World Health Organization.[57] These observations will be taken into account in f future MNCH programs.

Despite the manifold structural challenges, the WATCH end line data reveals important gains since baseline (see Section 5.2) through considerable increases in the utilization of MNCH services equally for both age groups of women (under 19 and 20-49). These achievements are the result of several factors, including improved gender-responsive and respectful service

[57] (http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf).

delivery evidenced by the high level of satisfaction (92.9%) indicated by women, adolescent girls and men. Another major contributing factor was the increased knowledge of men, women and girls on the danger signs along the continuum of care (girls under 19 have experienced a notable increase from 35.2% in the baseline to 51.1% at end line), and the strategies to address them. A key contributor was also the change in men's attitudes and support regarding the use of MNCH services, which was identified as a major barrier by women and girls: 78.7% of all women stated their male partners/family members are 'very supportive' in the utilization of MNCH services. By age group, a slightly higher rate of girls under 19 (79.9%) compared to women 20-49 years (78.1%) felt that they received adequate support, including financial support (70%), followed by support in household chores and tasks (46.4%) and accompaniment to the facility (44.2%). Similarly 81.4% of women mentioned that their spouse or other male family members made sure that there was enough supply of food for them when they were breastfeeding, particularly during the first six months. Another 30.1% of women mentioned that their male family members undertook household tasks, which the lactating mother was expected to do if she was not breastfeeding. Given prevailing gender roles, men's increased support in household work, despite the social censure they often faced in carrying out traditionally unacceptable roles, points to the project's success in contributing to more gender equitable role distribution within households (see *Men Matter: Engaging Men for MNCH Outcomes)*. Finally, the project has yielded notable results in empowering women/girls to make MNCH decisions at the household and community levels. The proportion of women holding influential leadership positions in community and facility health committees was 38.5%at end line, which doubled since baseline (19.5%). At the household level, 83.3% of women said they felt they had the skills and ability to make decisions on various topics related to MNCH, and 86.8% of women mentioned that they felt they have the ability and capacity to make decisions at the community level, particularly in health committees. This sentiment was similarly expressed by men, with 89.3% of men stating that women have decision-making ability, and 64.5% of men stating that women should 'always' be part of community decision-making. In conclusion, the evidence suggests that while improvements can always be made, the WATCH GE strategy, with its three complementary approaches, was relevant and effective in affecting critical transformations in gender relations and responsiveness in the three spheres (household, community and institutional). However, as these are transformative agendas, there is need for long-term intervention to ensure sustainability. With its sustained and comprehensive focus on addressing gender inequality as a pivotal determinant of poor MNCH outcomes, WATCH was recognized by Plan International[58] as a gender transformative program.

8.2 Environment

During the EAWP (PIP) an environmental strategy was identified as an integral, cross-cutting component of the overall implementation of Plan's WATCH program in Bangladesh, Ethiopia, Ghana, Mali and Zimbabwe. No major environmental impacts were anticipated, and the main activities with environmental considerations in WATCH included clinic waste management, minor construction and rehabilitation of health facilities and pollution prevention. Adherence to international agreements, Plan policies and host country requirements were fully respected.

[58] BIAAG Progress Report, March 2015: https://planet.planapps.org/NewsAndEvents/Features/Pages/Hitting-our-goals-for-girls.aspx

These included Canadian policies and legislation, particularly the Canadian Environmental Assessment Act (CEAA) and compliance with national guidelines, policies and legislation.

Plan Zimbabwe was the only country office which required and conducted an Environmental Impact Assessment (EIA) as per the Canadian Environmental Assessment Act (CEAA) and Zimbabwe's Environmental Management Act and in adherence with the national policies, standards and local bylaws set by Zimbabwe's Environmental Management Agency. The EIA examined fifteen mothers' waiting homes (MWH) to be constructed (including a focus on waste management practices), six MWHs to be renovated and the construction of four boreholes and rehabilitation of one borehole. The EIA was completed by the end of July 2012 and the results consequently informed the construction and rehabilitation of identified structures. The Ministry of Health standards also required that medical waste disposal facilities be provided within the boundaries of each the health centres and that minimum standards are met in relation to incinerators, placenta (Ottoway) pits, refuse pits and bottle pits. To ensure these standards were met, the WATCH Zimbabwe project team was oriented on environmental management and principles, and an action plan on environmental management was drafted in response to the EIA findings, which included continuously monitoring the functionality of the existing placenta pits and facilitating the construction of waste disposal pits in areas where they were not available. Zimbabwe's Ministry of Public Works inspected each stage of construction, ensuring that the process was environmentally sound from beginning to end.
Given the intended scope of Plan Mali's minor repairs and rehabilitation at seven CSCOMs, an EIA was not initially required. However during implementation, it was realized that two CSCOMs in Barouéli district required significant construction work beyond the expected basic rehabilitation of existing structures. This involved constructing a maternity block at the N'djila CSCOM and repainting the centre, as well as renovating the maternity block in Wondobougou. In response, a formal environmental monitoring report was developed, the conclusions of which indicated that no major environmental impacts were identified and confirmed that the constructions undertaken in Barouéli conformed to the environmental requirements and policies of Mali, as well as for the Canadian Government. Please refer to Annex F in the WATCH Year 3 Annual Report for more details.

Through their annual health facility assessments, all WATCH teams confirmed that the facilities complied with proper waste disposal protocols as per national standards and this has increased overall from 8.9% at to 73.4% at end line for WATCH facilities (see Section 5.1). In future, a consideration for more focus would be to strengthen programmatic linkages in environment and health. In particular, interventions in relation to build capacity for environmental considerations of clinical waste management and pollution prevention and promotion and management of safe and clean MNCH facilities to be of added value.

8.3 Governance

"Health governance" refers to the sustainable delivery by governments of quality health services to communities – especially to those who have little or no resources to pay for these services themselves. As previously described, the WATCH project engaged both the health system management as well as community-level management structures by leveraging a two-pronged 'supply' and 'demand' strengthening approach.

As mentioned in the EAWP, WATCH reinforced "health governance" across five countries through engaging government and civil society to strengthen the following key governance principles:

- Efficiency and effectiveness
- Participation and consensus-making
- Responsiveness
- Equity and inclusiveness
- Information collection and dissemination
- Transparency

1) Improving government health care **efficiency and effectiveness:** Across the five countries the project interventions were aligned to national health/MNCH policy and delivered in partnership with governments. WATCH played a strong role in ensuring that district primary and referral level health care facilities, systems and personnel were functional. This included providing budgetary and infrastructural support, to renovate waiting mother homes in Zimbabwe; renovating community health centres (CSCOM) in Mali; providing equipment to reinforce the vaccine cold chain in Mali; and ensuring critical medication supplies across all countries. Furthermore, WATCH provided trainings and supportive supervision to various cadre (facility-based, outreach and community-based) of health workers on ANC, PNC, PMTCT, IMNCI, IYCF, as well as essential BEmONC training and supervision in partnership with SOGC in Ethiopia (through ESOG) and Bangladesh (through OGSB). These interventions were designed to support critical government strategies and needs, and subsequently required continued governmental ownership to ensure management of infrastructure, continuation of a functional supervision and quality control structure, and coordination of human resources. Given the short 3.5 year duration of the project, commitments to maintaining the investments made during WATCH by various governments were mixed during the project closure and handover phase. However, it has been recognized during the project closure activities (see Section 6) that across the project key maternal and child health indicators (see Section 5) did improve, due in part to targeted interventions to improve efficiencies and effectiveness of the health system to serve MNCH need in WATCH intervention countries and areas.

2) **Participation and consensus-making** was fostered through the project supporting both community and health system institutional structures/processes. For instance, the training of community and district level health committees on governance, leadership, gender equality and responsiveness to key MNCH issues was illustrated in Ghana, by engaging community leadership, particularly opinion leaders, chiefs and Queen Mothers, to support women's groups and communities as role models and leaders; through such support, women have been encouraged to participate in decision-making and health governance in community health committees, as well as representatives linking to the wider health system by way of the CHPS health facility Management Committees.

3) **The principle of responsiveness** was promoted in two ways: 1) by improving the environment in which treatment takes place, as experienced by the main MNCH clients (i.e.

women, men, adolescent girls and children as elaborated in Sections 8.1; and 2) by building capacity in the health care system to effectively diagnose danger signs and transport clients to the appropriate level of care/medical expertise in a timely manner. The latter relied on strong mechanisms at the community level to educate and sensitize community members on danger signs and the importance of referral, through BCC and IEC approaches, as well as the engagement of men. The community Care Group model in Zimbabwe and Ethiopia's Health Extension Program, which mobilized Health Extension workers, stood out as effective structures which WATCH aligned with. In terms of responsiveness in relation to the second 'delay' of accessing care, successes in Ghana with the implementation of a community emergency transport system (CETS) and in Bangladesh, of the reactivation of 24/7 operational health facilities, exemplified responsiveness to the needs of women, as they are now able to seek quality care and safely give birth in an appropriate health facility with skilled staff at all times, including at night.

4) **Equity and inclusiveness:** From a GE perspective all countries have implemented a GEAP to ensure that GE is integrated throughout WATCH interventions, which included the engagement of men, men and adolescents along the MNCH continuum of care, as described in Section 8.1. WATCH in Zimbabwe made significant strides to engage apostolic religious groups that are bound by traditions and practices that did not see the value in health care treatment from modern medicine.

5) **Information collection and dissemination:** This has been a core focus of the WATCH project across all countries and involved the systematic collection of data at facility, and household levels for monitoring, as well as baseline and end line surveys to inform on project performance, as outlined in Section 8.4. From a health systems strengthening perspective: in Ethiopia, the project trained health workers on effective implementation of the health management information systems (HMIS) as well as trained outreach HEWs on Community-based Health Information Systems (CHIS) which has improved the accuracy of tracking of women and children through the family folder system. In Bangladesh, the project piloted a mobile Health (mHealth) system using tablets for data collection system linking into the wider government electronic District Health Information System. In terms of dissemination of monitoring data and supportive supervision findings within the broader health system, in Ethiopia this involved facilitating and engaging at district health management review meetings. Dissemination through these review meetings was cross-sectorial as it included the participation of other government departments like the Women Child and Youth Affairs office, which also participated in supportive supervision of HEWs and HDAs. At the beneficiary level in Mali, the project was able to ensure information flowed back to community health associations (ASACO) and local leadership through local NGO partners.

6) Finally, the WATCH project successfully achieved transparency through the engagement of a variety of community organized structures which were forums to educate, sensitize and mobilize community members on MNCH issues, and to share updates about the project with them, including monitoring data/project results. Across the five countries, these groups

included Care groups, Daddies/Mother clubs, VSLA groups, solidarity groups, community health committees etc. The project made concerted efforts to engage these groups, not only as BCC/IEC recipients and mobilizers, but encouraged these same groups and members to interact with health systems through outreach structures like HEWs, ASCs, VHWs, CHOs, CBSAs and LNGO partners to be represented and have voice and build awareness of the broader health system. For instance, in Mali, community members were encouraged to participate in health facility management through community health associations (ASACO) and thus have a clearer view into how facilities are managed.

8.4 Monitoring and evaluation

As a multi-country project, WATCH emphasized standardization of processes and provision of common indicators, while maintaining tools, strategies, and country specific performance measurement frameworks (PMF) that were responsive to local contexts. The indicators were measured in 2012 and again in 2015 with a rigorous baseline and end line study. A robust monitoring system was implemented to provide a constant flow of data for programmatic purposes as well as accountability to WATCH stakeholders, including local governments and NGOs, community based organizations, and the women, children and men targeted by the project.

8.4.1 Monitoring system

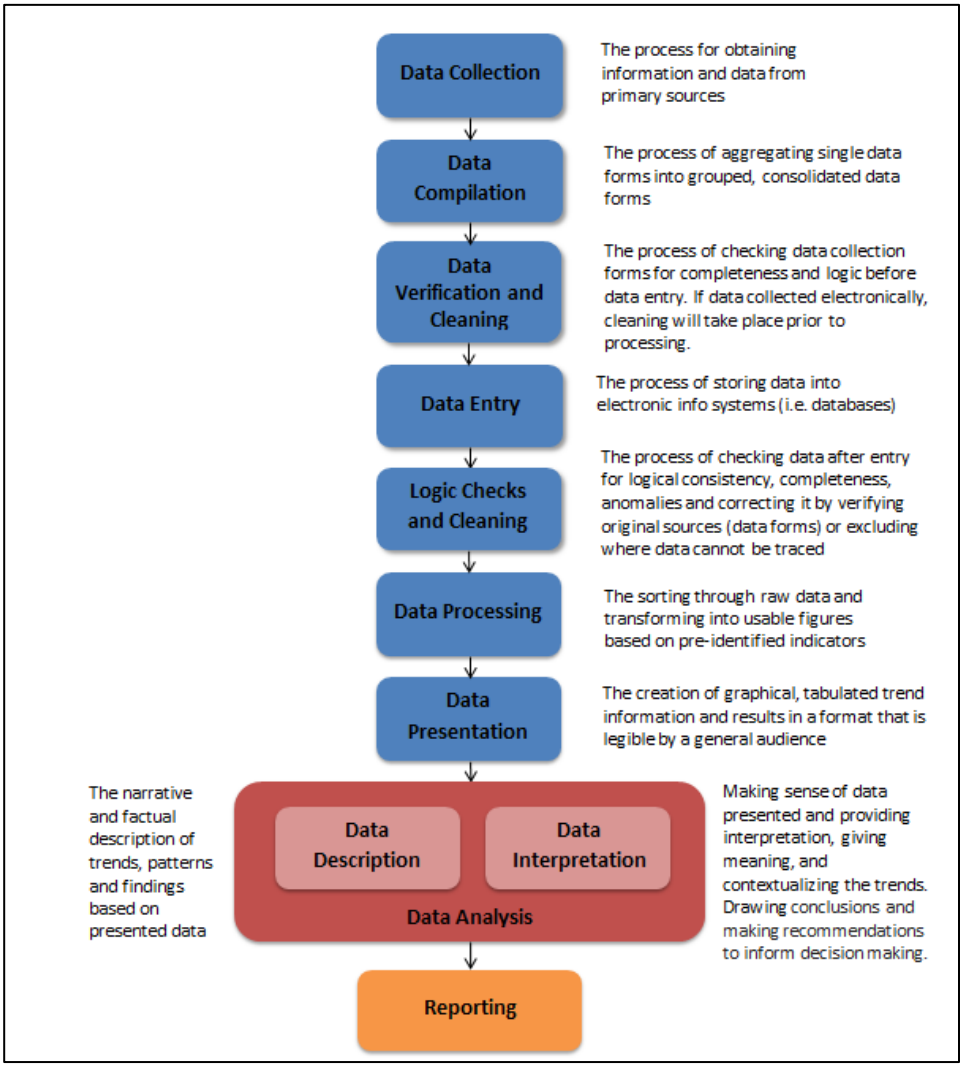
The Plan Canada M&E team provided ongoing technical support to field staff throughout the data continuum process, from collection to compilation, verification, cleaning, entry, processing, presentation, and analysis. All five implementing countries collected monitoring data from households and health facilities in project areas. Household data was collected monthly or semi-annually on key health indicators and annually on knowledge of danger signs and strategies associated with pregnancy and childbirth. Three of the five COs tied data collection to the routine home visits conducted by front line health workers. Community level qualitative focus group discussions supplemented quantitative monitoring data on an annual basis. Further MNCH data was obtained from facility registers each month, as well as during annual facility assessments. With a focus on sustainability, data collection protocols and processes were aligned with existing health information systems to the greatest extent possible.

Monitoring data from all five countries was entered on a common cloud-based database beginning in March 2013. The common database allowed for standardization across the five countries, while also providing space for country-specific indicators. In anticipation of connectivity issues, the database design accommodated offline entry. While the database was pivotal for entering, sharing, verifying, and storing data, significant effort was required to support implementing countries on the database use and troubleshooting. The database developer was engaged throughout the project to address technical challenges, as well to ensure that the content appropriately responded to country needs (please see Annex J: Intellectual Property Rights).

Along with regular remote and in-country support, M&E country office staff were engaged in initial planning workshops held in-country between November 2011-January 2012; a multi-

country workshop in Toronto in April 2012; as well as a project wide Sharing and Learning workshop in Zimbabwe in November of 2013. In Year 3 all countries participated in data continuum and interpretation workshops with LNGO partners, WATCH staff and Plan Canada technical advisors, involving analysis and contextual interpretation of key MNCH results.

Figure 16: WATCH data continuum



8.4.2 Final end line survey

In November 2014, the end line survey process began with data collection beginning in Bangladesh and following in each subsequent country. To ensure standardization across the project, Plan Canada recruited a global consultant to oversee the design, enumerator training, analysis and reporting of results across all WATCH countries. Local study leads were responsible for coordinating the recruitment of enumerators, data collection and entry. The final end line results and report were submitted to DFATD (July 2015) and key results have been disseminated through various strategies.

8.4.3 Knowledge management

Muskoka Initiative Consortium - Knowledge Management Initiative (MIC-KMI)

In the spirit of continuous learning, Plan and its INGO consortium partners fostered a positive learning environment to promote knowledge on MNCH issues across implementing countries and partners through its Knowledge Management Initiative (KMI). The consortium partnership was guided by a formal Memorandum of Understanding signed by all four Partner organisations in April 2012. Two main mechanisms were established to manage/govern the Knowledge Management Initiative: the Technical Working Group (TWG) and a Steering Committee (SC). The TWG was comprised of two representatives of each organization and met monthly since its formation in January, 2013. The Steering Committee comprised of Vice Presidents or Senior Directors of the four consortium INGOs and was charged with providing strategic direction to the KM Initiative. As the lead Partner in the INGO consortium, Plan Canada held oversight for the practical aspects of financial management, donor reporting and donor communication. Finally, the KMI Project Manager was the primary liaison between the SickKids team and the Consortium. The MIC-KMI culminated in the *"Muskoka Initiative Consortium Results Symposium: Collaborating for Change in MNCH"* in June 2015 and the presentation of consolidated results across common indicators. This event was attended by over 120 people from government, NGOs, and both Canadian and oversea stakeholders.

Two research projects were conducted in collaboration with Sick Kids Hospital, the results of which have been finalized and submitted to DFATD. The first, '*Effective Implementation of Exclusive Breastfeeding in Ethiopia and Mali Using the Consolidated Framework for Implementation Research'* was approved by DFATD in July 2015. The second research, '*Adolescent mothers' perceived value of ANC services in Ghana and Tanzania* has equally been submitted to DFATD for approval[59]. Summary infographics for both researches were presented at the June 2015 Symposium. Please refer to MIC-KMI Final Report, to be submitted to DFATD at the end of August 2015.

Internal MNCH research

Internal research on male engagement in MNCH was conducted in Year 3 in the WATCH projects in Bangladesh and Zimbabwe, as well as an MNCH project in Tanzania, which was funded through a bilateral grant from DFATD. The Burnet Institute (which was selected in Year 2) and its three country institutional partners (Centre for Sexual Health and HIV AIDS Research, Zimbabwe; International Centre for Diarrhoeal Disease Research, Bangladesh; and Ifakara Health Institute, Tanzania) submitted the final research report to Plan Canada, which was subsequently peer reviewed by two leading international experts. The final publication was widely disseminated on Plan's website at http://plancanada.ca/file/documents/MenMatter-email.pdf, shared at Zimbabwe and Bangladesh events, and on Burnet Institute's website, https://www.burnet.edu.au/publications/3862_men_matter_engaging_men_in_mnch_outcomes, and will shortly be posted on the CAN-MNCH and MenEngage network sites. The results from this research was also disseminated in each of the 3 Plan implementing countries which participated in this research, the Ontario Gender Development Network, as well as at the 2-day MNCH symposium in June 2015 noted previously.

[59] Please see Annex J: Intellectual Property Rights attributions.

Section 11: Success factors

Success factors which have contributed to the achievement of results (see Section 5) in the WATCH project have been assessed based on CIDA's (now DFATDs) framework of results and key successes, as outlined in the WATCH CA i.e. 1) relevance; 2) appropriateness of the design; 3) sustainability of value added interventions; 4) partnerships leveraged; 5) innovativeness of interventions; 6) appropriateness of resource utilization; and 7) informed and timely action undertaken. These success factors were discussed and validated through a participatory process in late June 2015, which included representatives from all 5 Plan implementing offices and Plan Canada, and reflect discussions from the WATCH close out workshops held in each country in May/June.

11.1 Relevance

The WATCH project's relevance was reflected in its 1) alignment with governmental and global health priorities; 2) utility for and need by stakeholders and beneficiaries (i.e. in alignment with various rights holders' priorities); 3) synergies/cohesion with other organizational or civil society institutions' MNCH efforts; and finally 4) the potential for scalability of key MNCH/GE interventions to a broader beneficiary and stakeholder population.

11.1.1 Governmental prioritization of MNCH

The reduction of maternal mortality and newborn and child mortality is a global priority which has been championed through several global health commitments and agendas, in particular, the United Nation's Global Strategy for Women's and Children's Health (launched at the Summit for the Millennium Development Goals (MDGs) in September 2010), the Muskoka Initiative championed by the Government of Canada at the Muskoka 2010 G8 Summit, and the UN Commission on Information and Accountability for Women's and Children's Health (see section 5.4).

Beyond global donor commitments to allocate resources to address maternal mortality and newborn and child mortality, MNCH issues remain high on the agendas of many low income nations, including the 5 implementing countries which the WATCH project supported. At the country level, governmental willingness and prioritization of MNCH in relation to maternal, neonatal and child mortality challenges was foundational to the success of WATCH interventions. As WATCH integrated/aligned its interventions with existing national health system strategies and approaches which governments had committed to through policy and action plans, the project's efforts were relevant within the national context.

In consultation with each implementing country's Ministry of Health (MoH), Plan defined its geographic implementation areas to ensure that WATCH investment was operationally aligned to areas which the government deemed low performing in terms of health indicators and/or being underserved (mostly rural) through the existing health system. Moreover, the project was anchored to each country's nationally adopted policies, strategies and/or road maps which

focused on MNCH, and the MoH's defined approaches for the health system to intervene through rural community outreach, health promotion, and community mobilization strategies to address poor MNCH health outcomes. In all WATCH-supported countries the project responded to the need to expand or operationalize various cadres of community health workers. In **Zimbabwe**, WATCH aligned with the National Maternal and Neonatal Health Road Map 2007-2015, as the project built on the existence of Village Health Workers (VHWs) to facilitate health promotion at the village level. This involved community-based health systems strengthening through equipping VHWs with the requisite knowledge, appropriate skills, basic equipment, and gender and youth-friendly attitudes to effectively and efficiently carry out their mandate. This was similarly implemented in other countries; for example, in **Mali** the WATCH project collaborated with the MoH to expand its Community Access to Essential Care (*SEC*) strategy aimed at bringing a basic health care package of essential services to reach communities, and worked in three districts where the government had an existing resourcing gap to address the shortage of needed CHWs (i.e. *ASCs*) to deliver *SEC*. **Bangladesh's** WATCH program was tied to the MoH's health and population nutrition sector development program plan and areas of intervention were identified based on zones with low indicator performance. The project enhanced health services through strengthening of the Upazila health system (UHS), which includes Community Clinic led expansion of primary health care services to women and children through community-based skilled birth attendants (CBSA). This included the reactivation of 47 UH&FWCs aligned with MoH priorities. In **Ethiopia**, the WATCH project leveraged the existing Health Extension Program (HEP) through the MoH in areas where the government had identified insufficient resourcing. Strengthening the work of HEWs was critical to improving the effectiveness of the health system and the functioning of health facilities, particularly at the health post level. Finally, **Ghana** WATCH successfully worked within the Child Health Policy and Community-Based Health Planning and Services (CHPS) strategy to provide support to improving functionality of 83 health facilities across 6 districts (including 48 CHPS compounds, 12 referral centers and 23 other health centers), and to ensure that outreach capacity at the village level through CHWs (i.e. CHOs) was resourced appropriately to function as per national protocols.

11.1.2 Stakeholders and beneficiaries

Equally important to alignment with the health system (i.e. supply-side) was for the WATCH project to align with the priorities/expectations of stakeholders and beneficiaries (i.e. demand-side for health services). This required efforts to generate buy-in from stakeholders in the project's operational areas and validate that beneficiaries had a demonstrated need for MNCH interventions. In this regard, Plan's global programmatic approach, known as Child Centred Community Development (CCCD), was at the heart of how WATCH intervened at the community level. This approach also helped to promote the inclusion of the most marginalized groups, and to hold government accountable to fulfill the rights of women, children and their families to access quality MNCH services.

Best practices were followed in all countries and included community engagement strategies, which relied on partnering with LNGOs or local entities that also had relevant experience and credibility in communities where interventions were intended. Additionally, meetings and

orientations were conducted to sensitize community leaders on MNCH and GE issues and to seek their buy-in for project implementation. Wider community mobilization and sensitization was also conducted through community social networks and gatherings to introduce the project and to explain how the project could address communities' MNCH priorities. For example, **in Zimbabwe**, sensitization meetings were conducted with Apostolic leaders to explain the importance of seeking health care services, institutional deliveries and immunizations, and also to understand why the leaders' hesitated to encourage their communities to use such services. Beneficiaries were also consulted on their knowledge and perceptions of MNCH, through focus group discussions and the participatory rural appraisal (PRA) approaches/tools, which helped community stakeholders and beneficiaries to engage in MNCH issues and prioritize local MNCH resources and services during annual monitoring. Likewise, **in Ghana**, following initial engagement of community leaders and groups, existing community health management committees created community health action plans (CHAPs) to define the needs and challenges to be addressed with the support of health personnel supported by WATCH. These CHAPs were followed and monitored by LNGO partners together with CHOs from CHPS facilities. Furthermore, to ensure that CHWs and peer educators served the needs of communities, they were selected and vetted by the community members themselves in all five WATCH-supported countries.

Finally, an important feedback loop was developed by providing community members, leaders, and municipal governance structures with the opportunity to take stock of/understand the value of monitoring data collected during the project, and the results of MNCH interventions in relation to their lives (please refer to Section 11.4, Partnerships, below).

In summary, efforts to align with the priorities/expectations of stakeholder/beneficiaries have been realized, with WATCH results (see Section 5.2) showing an increase in the level of satisfaction of project-supported communities with MNCH services from 69.4% at baseline to 92.9% at end line.

11.1.3 Synergies/cohesion with other organizations

Being aware of other programs operating in the same geographic areas was important in helping to define complementary actions and prevent duplication of activities in coordination with other organizations. **In Mali**, WATCH coordinated with organizations also working with the MoH to implement the *SEC* strategy, like UNICEF, PSI, which were USAID-funded and working in the same geographic areas. **In Bangladesh**, Plan coordinated with Save the Children, BRAC, USAID's MCHIP program, and various governmental organizations in operational areas in which they worked to engage religious leaders on referral services. Plan's DFATD-funded bilateral project, Human Resources for Health, also coordinated efforts with WATCH, particularly in Lalmonirhat, where the two projects harmonized messaging on the importance of skilled birth attendance, and ensured there was no overlap in the communities where each project rolled out this messaging. **In Zimbabwe**, the principle project collaboration was with the A Self Help Project, the Zimbabwe National Family Planning Council (ZNFPC), and the Ministry of Health and Child Care (MHCC) at the provincial and districts levels. There was also an overlap in

Zimbabwe's WATCH project areas with a Global Fund Malaria project that was providing mosquito nets and spraying to remove mosquito breeding sites. The Global Fund project therefore leveraged the existing WATCH-supported Care Groups to share messaging about malaria prevention/mitigation. Finally, **Plan Ethiopia's** collaboration with governmental bodies like the Women, Children and Youth Affairs Office (WCYAO) at the sub-national level helped to ensure that GE issues were integrated and brought forth for all project interventions.

Overall, the project has diligently coordinated with other groups (government and civil society) and leveraged synergies where appropriate, to help add value and relevance to other organization's health sector programming through WATCH interventions and vice-versa.

11.1.4 Scalability

WATCH successfully implemented several key interventions which have been recognized as having potential for being replicated to a wider population base.

From a community engagement or demand-side perspective, two interventions, VSLAs and the Care Group model have been identified for a potential increase in scale. Leveraging VSLAs was an approach adopted across several (Ghana, Mali, Ethiopia, Zimbabwe) countries to promote MNCH key messages. As the groups convened very regularly and often were organized as women's groups, they were a positive platform for BCC/IEC community engagement opportunities, as well to generate resources for women to utilize funds from Income Generation Activities (IGA) to fulfill their MNCH health service seeking needs. During the project, VSLAs have grown in number to some 1,190 groups, in Ethiopia (12 VSLAs, pilot started in Year 3), Ghana (216 VSLAs), Mali (693 VSLAs) and Zimbabwe (269 VSLAs)[60] in response to the community members own motivations to continue them, with limited external inputs, once established. **In Ethiopia,** the MoH appreciated and recognized that VSLAs – through the pilot experience undertaken and bridging of lessons from the PAGES (another DFATD-funded project managed by Plan) – are an effective communication channel as well as a viable means of women's empowerment for health decision making. **In Ghana**, as mentioned in Section 4, VSLAs specific to youth were developed to engage adolescent girls and boys on MNCH issues, which helped to reach a critical and underserved cohort of beneficiaries.

In terms of effective community engagement and the deployment of frontline health workers or community mobilizers, the Care Group model **in Zimbabwe** stands out. Using a cascading, peer group strategy, large populations were engaged to receive and subsequently disseminate MNCH messages. The Government of Zimbabwe (GoZ) has recognized this as very scale friendly approach that has minimal time and logistical costs, due to its self-propagating nature. Plan has estimated a low project cost per beneficiary of $1.47 USD. As such, the GoZ has approved the Care Group model training manual and process, and expanded the model into all seven districts of Manicaland province (WATCH worked in three of these districts). A similar approach to the CG model was used **in Ethiopia**, where rural women and households were engaged through the existing Health Development Army (HDA) model; and **in Mali**, the project operationalized the roll out of CHWs in intervention areas (in alignment with the Essential Care in the Community (*SEC)* strategy), to support the health system reach in communities through

[60] Figures reported in WATCH Y3 Annual Report.

ICCM. As these types of community-based models can serve as platforms to address health issues through task shifting and thus ensure wider health care in communities, they should be leveraged where possible, and in consideration of budget availability.

From a health facility or supply-side perspective, two interventions have been identified for potential scale up: Maternity Waiting Homes and 24/7 safe delivery services.

Maternity Waiting Homes (MWHs) were regarded as a successful approach in Zimbabwe and Ethiopia where the project improved their quality and functionality by construction (in Zimbabwe) and ensuring the availability of water, electricity and furnishings (in Ethiopia). The success of MWHs was reflected in the positive results achieved in increased births attended by skilled health personnel (see Section 5.3.3), which were in part due to MWHs enabling women to be closer to health facilities at around the time of their due dates. **In Ethiopia**, the MoWCYA has expressed[61] that MWHs are important for women in Ethiopia, based on the experience in Oromia and Amhara regions during WATCH, and hence have the potential to be further piloted/rolled out to other districts/regions.

In Bangladesh, the WATCH project reactivated 24/7 safe delivery services at UH&FWCs, and then Plan shared the 24/7 heath care service strategy that was used to reactive these health facilities through round table discussions including LNGOs and INGOs. As a result, Save the Children and the Population Council will be replicating all aspects of the 24/7 health service strategy in facilities within their working areas.

[61] Reported verbal remarks during the WATCH closing-out workshop with Stakeholders June 2015.

11.2 Appropriateness of design

The design of WATCH was influenced by the dimensions of relevance discussed above, and particularly based on consultations carried out to align the project to governmental priorities and stakeholder/beneficiary needs. Furthermore, the project was built on a strong evidence base and proven best practices along the continuum of care to strengthen health systems and engage underserved communities to seek MNCH services. As described in previous sections, WATCH delivered a balanced, two-pronged approach creating demand (community) and strengthening supply (facility) designed to achieve the stated ultimate, intermediate and immediate outcomes, as outlined in Annex A: Logic Model. This common two-pronged framework was adopted across all five countries. Elements of the design that contributed to project success and achievement of results are outlined below.

11.2.1 Reach

Given human resourcing challenges of the health system, the project adopted strategies to reach the maximum number of households in a community through direct sensitization and mobilization of communities on MNCH and critical GE messages, as well as through supply-side health system extension.

In Zimbabwe, to meet the needs of vulnerable children and mothers in very marginalized rural communities, the Care Group (CG) model was the flagship approach which allowed for the extension of the health system to the household level through a cascading Training of Trainers (ToT) model, where 1 VHW (paid through the health system) was responsible to technically support the management of 10 CGs, as well as to conduct sharing and learning on maternal and child issues with them. Each CG was composed of 10-15 volunteer community-based health educators (lead mothers/fathers). These volunteers interacted with a cohort of around 10-15 households (mostly comprised of women of child bearing age and male partners). This cascading strategy ensured high impact and high scalability to be able to reach all households in a village with current and accurate MNCH messages. Upstream support in the health system was provided through supportive supervision of the VHWs to ensure they support their CGs through expected standards. Moreover, meetings with CGs were the forum to collect critical data on the health status of households recorded by lead mothers/fathers as part of their household level interactions, and therein be able to prioritize home visits as per need/urgency.

In Ethiopia a similar strategy integrated program interventions into the existing government community engagement structure, the Health Development Army (HDA), which was developed as part of the federal MoH's strategy under the Health Extension Program (HEP) strategy. Using a similar cascading approach, Government Health Extension Workers (HEWs) and community volunteers (members of the Health Development Army, HDA) were organized such that 1 HEW was responsible to engage and oversee 32-40 HDA leaders. In turn, each HDA leader supported 5 HDA members, and each HDA member engaged with 5 local households. Delivering key messages and generating demand for services through such cascade models proved to be an appropriate and effective design which allowed for saturation in terms of reaching all households with IEC and BCC messages in project intervention areas.

11.2.2 Behaviour change

Another important community mobilization and awareness creation design aspect was the utilization of IEC/BCC strategies to promote behaviour change of WCBA, their male partners and family/community members. All countries had an IEC/BCC approach to promote key MNCH and GE topics/issues, which adhered to the local context. One critical and common method to focus IEC/BCC across the five countries was to intervene through existing community groups and establish new structures which had potential to influence a wide population. This was particularly important for the elaboration of the project's three pronged (see Section 8.1) GE strategy and for operationalizing the GE action plans developed by each country. The importance of engaging community structures to promote behaviour change is illustrated well in **Ghana's** efforts, which propelled male engagement through community support groups like Daddies' Clubs; sensitization on GE issues to community leaders and decisions-makers; promotion of male role models; organization of community based drama groups. In Ghana, the opportunity to address male engagement through the aforementioned community-based methods was critical to the success and results achieved in the project as noted in Section 5.2, particularly in relation to improved ANC and skilled birth attendance.

11.2.3 Health service outreach

The role of Community Health Workers (CHWs) in WATCH was not only important for mobilization and sensitization of community members and structures, but also to deliver specific MNCH services. This has been an important design success in Mali (via ASC), Bangladesh (via CSBAs), Ethiopia (via HEWs), Ghana (via CHOs) and Zimbabwe (via VHWs), where these CHWs have facilitated the extension of health services to the community. This has meant that women and children did not need to undertake significant travel to ascertain services like ANC, PNC and immunizations at a facility, but rather could receive such services closer to their own homes. In most countries the improvements to ANC, PNC services and immunization coverage (TT2, Penta3 and Measles) indicators (as per Section 5.2) are positively linked to the availability of such services at the community level. Furthermore, the project made appropriate investments to support the outreach functions/processes and systems delivered through health workers at facilities. **In Mali,** the opportunity to strengthen the cold chain infrastructure through solar fridges and provide logistical support through motorbikes for vaccinators, helped to achieve immunization results and deliver health services like ANC/PNC within the communities. Similarly in **Ghana,** the full extension of the CHSP strategy with home visiting and provision of ANC services was a great example of the support the project has given to operationalize community health system strategies to their fullest extent.

11.2.4 Referral services

To address instances where outreach services were not sufficient or appropriate to provide the level of care needed, the WATCH design also focused on strengthening referral systems, particularly from the community to facility level at the time of need (i.e. during labour and when complications arose). In Ghana, the locally-derived Community Emergency Transport System (CETS) mobilized and trained local drivers to provide transportation services as a priority to women needing urgent medical care. In Ethiopia, key logistical support like mobile phone air time and fuel for ambulances helped to ensure all communities have better access to referral services. In all countries, CHWs knowledge was reinforced through trainings or refreshers on

MNCH through WATCH, which included modules as well as BCC/IEC materials on the recognition of danger signs, referral strategies and protocols. These messages were communicated in turn by CHWs to the wider communities they served (via home visits, community groups and committees, community meetings, and sensitization sessions with community leaders, etc.).

11.2.5 BEmONC training and supportive supervision

From the supply-side, WATCH invested in training health personnel to respond clinically to emergency obstetrical and neonatal care (EmONC) needs, which helped to ensure that communities had confidence in health staff when deciding to access health facilities. **In Ethiopia and Bangladesh**, SOGC's partnership with OGSB and ESOG was valuable in terms of the design of training curricula and their technical expertise, particularly in establishing supportive supervision. Their efforts helped health centres **in Ethiopia** and UH&FWCs **in Bangladesh** meet BEmONC standards as outlined by their Ministries of Health. OGSB and ESOG members who participated in the supportive supervision and training of health workers were themselves government employees who are extremely involved in and knowledgeable about their nation's health system. As such, their observations, technical input and recommendations from the supportive supervision provided to primary level health care providers and to the District Health Office were highly credible and well received.

Health personnel were trained across a variety of essential skill sets, and in addition to technical trainings on BEmONC and supportive supervision, the project provided GE training for skilled health personnel too, so that they could provide gender-sensitive services at their health facilities, which met the needs of women, men and adolescent youth seeking MNCH services. Examples of gender-sensitive service delivery include: 1) privacy during appointments and delivery; 2) appropriate hours of operation; 3) being welcoming to client regardless of their social situation; 4) appropriate triage, which takes into account the stage of delivery and prioritizes women who need access to health services most urgently; and 5) elimination of facility-specific gender barriers (such as fees penalizing women who do not come with their husbands for the first ANC visit, or subsequent visits). As exemplified in Section 8.1, **Ethiopia and Zimbabwe** adopted positive practices, including checklists on gender responsiveness for health providers, integrated supportive supervision checklists, and facility assessments.

In summary, the WATCH project design included strategies to achieve optimal reach; appropriate channels to deliver IEC/BCC to achieve desired dissemination of key MNCH and GE messages; appropriate utilization of CHWs and health workers to provide services closer to their clients; appropriate mechanisms to improve the availability and timeliness of referrals; and appropriate training/supportive supervision to achieve the expected standard of quality of MNCH services.

11.3 Sustainability

During the short 3.5-year project lifespan, WATCH clearly succeeded in realizing value added contributions and innovations (elaborated below) in MNCH. The sustainability of these approaches is discussed with respect to institutional factors (including infrastructure and associated service/supply provision, training materials, mechanisms for supportive supervision,

logistical support and equipment provision) and community mobilization, ownership and engagement.

11.3.1 Institutional

During the last year of project implementation, some notable institutional/health system level commitments were made by government stakeholders. **In Bangladesh,** 41 out of 47 UH&FWCs developed and implemented sustainability plans to hand over the centres' oversight and management to local government health departments and health management committees, who will continue to monitor safe delivery services and the accountability of service providers. Plan will continue its advocacy at the central level with the Directorate of Family Planning, MOH&FW for the government to sustain services at the other 6 UH&FWCs, as well as scale up the model in other centers.

As noted previously, the maternity waiting home strategy has been a significant solution to bridging the geographic barrier which potentially delays rural women from accessing timely skilled, safe and clean delivery services at the time of labour. **In Zimbabwe**, this strategy gained wide government recognition and commitment to continue to supply the maternity waiting homes with medication and materials going forward. The project undertook 15 MWH constructions and 6 MWH renovations, as detailed in section 8.2 Environment. This infrastructure investment was in accordance with to all relevant standards as well as per recommendations stated in the environmental assessment conducted. Likewise in Ethiopia, the MWHs that WATCH supported will be operationally managed through local health committees.

In addition, government manuals and IEC materials which were developed throughout the project (i.e. the IEC toolkit (*Boite a images)* **in Mali** to which Plan contributed reinforcing GE messaging, and the revised FWC operations manual **in Bangladesh**), were developed in conjunction with the MoH and hence will have ongoing relevance and utilization by the MoH.

Supportive supervision contributed to the formation of linkages between the different levels of health care providers, and also enabled members of the obstetrical associations (i.e. CEmONC focal people/supervisors) in ESOG and OGSB to better understand the issues and realities of providing care at the community level. As the CEmONC focal people/supervisors are also instructors for BEmONC training, they plan to incorporate their experience of supportive supervision into their future teaching to become more responsive to the needs of the participants.

WATCH strategically invested in supporting critical operations of the health system, for example, provision of support (i.e. fuel support, rickshaw vans) for ambulance services and airtime, as well as equipment like motorbikes and generators. The close out asset disposal plan (Annex K) highlights how each implementing country distributed assets to either government or LNGO partners, which remain at their disposal to continue to use to provide services to communities, support community mobilization, or facilitate activities in future projects.

Finally, **in Mali**, the 44 solar-powered fridges provided by WATCH will be maintained by the Ministry of Health. As these fridges match the required government specifications, technical capacity to maintain these specific fridges already resides in the MoH, which was clearly

demonstrated during the initial installation of the fridges. These fridges are also compatible with remote monitoring technology that other partners like UNICEF are introducing into Mali.

11.3.2 Community-level engagement and ownership

First, **Plan Ghana** has recently leveraged WATCH funds as part of their cost-share for a 5-year (2014-2019) USAID-funded project called 'Systems for Health' which is led by the University of Research CO (URC), LLC. Within this project, Plan Ghana is continuing to support community mobilization efforts in Volta region, and hence has been able to directly sustain some demand-side gains that were achieved during WATCH, contributing to greater impact in Volta.

In Ethiopia, the government recognized WATCH's efforts in aligning interventions between government structures, such as the Women, Children, and Youth Affairs Office, the health bureaus, and HEWs and HDAs (who support community structures and promote community engagement). It is hoped that the government recognition of such gains in the relationships between the government structures and community structures will be leveraged to ensure that community structures will remain fully operational and supervised appropriately to carry on the efforts begun within WATCH.

The engagement of *ASC* and *Relais* **in Mali** has been a key factor in the success of WATCH, particularly for community mobilization, health education and health outreach services. Sustainability of these well-trained workers is expected, as the government intends to coordinate with other organizations/donors to link these ASC and Relais to other projects[62]. Furthermore, the critical role of ASC has been recognized by the community members served, and in certain instances, local communities have also taken ownership to keep ASCs motivated to remain and continue to work in their communities through collectively organizing community incentives, including the construction of homes and/or providing some time to tend to the ASCs' household farming duties. These are actions which demonstrate deep community appreciation and motivation to retain ASCs beyond the project.

Supporting community groups (Daddies' Clubs in Ghana and Change Maker groups in Bangladesh) has been an important approach to undertake sensitization and awareness activities to influence behaviour change amongst peer groups. In terms of male engagement, Daddies' clubs in **Ghana** have solid potential to carry on beyond the project. These male social groups meet regularly to discuss men's reproductive and sexual needs, as well as their roles in safeguarding maternal health as partners, fathers, husbands, brothers, leaders, etc. As reported in the Year 3 annual report (section 2.3), there are now 248 Daddies' Clubs across the WATCH-supported communities, with a membership of 20 in each club. The number of groups has increased from 148 in 2013, and the additional clubs since 2013 were self-initiated by communities, which demonstrate their value, effectiveness in communities, and potential for sustainability. During the last year, WATCH introduced the provision of play kits to the groups, to help with viability, as a motivation to maintain group cohesion and also to draw more men and youth to the meetings during games, making it easier to educate them. Some clubs have introduced a new way of sensitization called "play and learn".

[62] This was verbally conveyed through Plan Mali staff in relations to close out meeting / discussions had with Regional and WATCH District Health Directors.

Finally, the project foresees that another community group structure that will be sustained after the project is the VSLA groups, as these have grown of their own accord throughout the project. As such, these local economic empowerment organizations are in a position to continue with very minimal support from LNGO partners to maintain group cohesion and support their members (e.g. through solidarity funds) to mobilize resources for the MNCH needs of women and their families.

11.4 Partnership

The WATCH project demonstrated partnership through a number of facets: partnership with government to implement sustainable activities and interventions; partnerships with LNGOs to support community engagement and reinforce mechanisms for effective stakeholder communication; partnerships with community leadership to promote local acceptance and sustainability of key interventions; partnerships with SOGC, ESOG and OGSB for provision of technical expertise; and partnership with other INGOs and academia for knowledge management.

11.4.1 Partnership with and within government

At the country level, the WATCH project was designed to be undertaken in collaboration with the MoH in each of the five WATCH-supported countries and in alignment with the governments' MNCH priorities. As mentioned earlier, a crucial foundation and strength of the project was being anchored within the governments' existing strategies, policies and structures to address the challenges facing women and children across the five countries. This vital collaboration and alignment, established through Memorandums of Understanding, ensured the project gained validation from the government (MoH) entities at both national and sub-national levels (regions, district, sub-district etc.). MoH representatives also became involved with project design, work planning, implementation, and stakeholder meetings to review the project's progress and monitoring data, which ultimately increased their awareness of the project's best practices, and their appreciation of its 'value add' and opportunities for scale up. Having government partnerships also helped to gain the confidence of communities, which in turn helped to ascertain buy-in from beneficiaries and community group structures. As these partnerships were built on mutual understanding, shared vision, knowledge, skills and competency building, resource sharing, and promotion of organizational linkages, some of the key WATCH interventions have become prioritized for continued ownership by the government beyond the project, as discussed above under sustainability. For example, in addition to operationalizing the government's health system at the community level in Zimbabwe, the WATCH project's partnership with the District Health management committees helped to reinforce their ability to provide supportive supervision and key administrative functionality to address challenges and issues. Finally, in Ethiopia, the joint coordination of supportive supervision between Ministry of Health officials and the local Women, Children and Youth Affairs Offices (WCYAO) has been deemed a positive example of progressive inter-ministerial cooperation and noted as a model to potentially be leveraged in other country contexts.

11.4.2 Partnership with local NGOs

In terms of implementing the project, the partnerships with local NGOs (LNGOs) were developed for direct project implementation (i.e. in community engagement and health service delivery) in WATCH-supported communities. Often these LNGOs had longstanding relationships with the communities, leadership structures and local stakeholders, and as such, had significant contextual understanding of cultural customs and beliefs. It is important to recognize that being conversant in local languages, LNGO staff had the ability to literally interpret/translate to facilitate communication, but also had the capacity to strategically intervene in accordance with local customs and identify possible local barriers to accessing/seeking MNCH services. In turn, the partnership with Plan has helped the LNGO partners to strengthen their own organizational capacities and 'value add'. For instance, understanding and adopting the CCCD approach, and building increased awareness on child rights and the importance of child sensitive operational guidelines, child protection practices and Gender Equality principles, enhanced their organizations' programmatic depth and diversity. Operationally, their capacities have been augmented in integrating gender equality in programming, and building confidence in M&E systems/tools, particularly in community-based data collection and analysis practices. Moreover, LNGO partners served as a key communications conduit to communities and local decision-making structures, by introducing and feeding back the monitoring data which had been collected and analysed, and also sharing what they had learned during broader stakeholder meetings organized by Plan and government partners.

11.4.3 Partnership with community leadership

Facilitating partnership and collaboration between local governments and local health committees to work together more effectively has been another successful factor in the project. **In Ghana**, the organization (by LNGOs) of trainings and sensitization of local stakeholders (i.e. government and committees) on various aspects of the WATCH project has helped to ensure local sustainability of WATCH's investments in health facilities and service provision. For instance, quarterly maternal and child health coordination meetings have been facilitated at the district level with a cross-section of local stakeholders (including health officials, local municipal representatives, LNGO partners, health committees, etc.). **In Bangladesh**, this took shape in the form of quarterly coordination meetings to strengthen links between community support groups (CGS's), representatives of primary health care facilities (CCs, UH&FWCs), and Union Parishads (local government) chairmen. A specific result of this partnership forum materialized in Bhalaguri and Nawdabash, where UH&FWC Management Committees' sustainability plans included a commitment to cover the salaries of two CSBAs, and maintain 24/7 safe delivery services beyond WATCH.

11.4.4 Partnership with SOGC

The Society of Obstetricians and Gynaecologists of Canada (SOGC) and its sister organizations, the Ethiopian Society of Obstetricians and Gynecologists (ESOG) and the Obstetrical and Gynecological Society of Bangladesh (OGSB) worked as technical partners to implement training and supportive supervision to strengthen the quality of Emergency Obstetrical and Newborn Care (EmONC) at health referral facilities in project intervention zones. The contribution of SOGC, OGSB and ESOG played a positive role in the WATCH project by

ensuring that health centres and Family Welfare Centres met standards as outlined by the Ministry of Health (please also see Section 11.2.5).

Additionally, SOGC, ESOG and OGSB participated in and contributed to WATCH annual work planning and in-country data analysis workshops. Finally, a joint opportunity was realized by ESOG and Plan Ethiopia to present a poster at the World Federation of Public Health Congress in Kolkata, India in February 2015. Notably, the members of OGSB and ESOG are government employees who make up the very fabric of the health care system and occupy decision-making posts. As such, these professional associations contribute heavily to their countries' strategic plans and clinical practice guidelines to reduce maternal mortality, and thus they have been very appropriate partners for Plan. In turn, the participation of OGSB and ESOG in the project has potentially given them more visibility that will allow them to influence the public health agendas of their respective countries.

11.4.5 Partnership with other INGOs and academia

Under Intermediate Outcome 1200 (i.e. '*Increased cross-organizational collaboration among consortium partners in delivering future MNCH programming*'), the Knowledge Management Initiative brought together four of the largest MNCH-implementing INGOs in Canada (i.e. CARE, Plan, Save the Children and World Vision), to partner with the Hospital for Sick Children and the University of Toronto Munk School for Global Affairs in a project to improve MNCH knowledge, evidence and best practices to strengthen MNCH programs in seven countries of operation. Various lessons learned on such partnerships and cross-organizational collaboration (including research, advocacy and shared learning/training) have been gained through formal structures established to manage the KMI, as well as through informal engagement amongst organizations as a result of relationships developed though the MIC-KMI project. Please refer to the MIC-KMI Final Report (to be submitted to DFATD in August 2015) for further details on this partnership.

11.5 Innovation

Innovation in the WATCH project can be categorized into country-specific programmatic interventions that have contributed a recognized value add or best practice by either introducing an alternate approach, tool or process to implement a more 'traditional' MNCH intervention, or by introducing non-traditional interventions that contribute to MNCH outcomes. Many have been elaborated elsewhere, so they are briefly discussed in this subsection.

In terms of improving data collection systems and efficacy, **WATCH Bangladesh** engaged in the ICT for health pilot, as mentioned in Section 5.4, which implemented a PC-tablet based community data collection system in Chiribander, Joldhaka and Domar districts. In addition, WATCH Bangladesh leveraged an innovative model to keep track of all pregnant women who lived within the catchment area of each of the WATCH-supported clinics. Developed by a civil surgeon, Plan and its partners employed this method, which involves four concentric circles and push pins of various colors. The area between each circle represents the first, second, and third trimester respectively, while the center represents deliveries. Green push pins indicate the number of women at any given time who are in a certain trimester of their pregnancy, while yellow push pins in the center represent deliveries. Red pins represent the high risk mothers, identified by facility health workers, who require closer attention and special care. Using this

innovative model helped health workers to analyze facility attendance for antenatal care, postnatal care, and delivery. In addition, high risk women were easily identified, which enabled community health workers to more effectively reach out to those who needed additional attention, counselling, and follow-up, particularly if they do not return to the clinic. Finally, the Swim Safe initiative was piloted in Barguna and Hatibandha to address drowning, which is the second highest cause of under-5 mortality. Despite cultural practices that did not prioritise the risk of drowning, the project was successful in training children (boys and girls) under the age of five in swimming techniques and life-saving procedures. Although not conventionally considered a health intervention, within the WATCH context this effort was important to address a leading cause of child mortality.

In Mali, the project's ability to capture sex and age disaggregated monitoring data was regarded as a clear 'value add' and innovation by the MoH, which does not currently capture such breakdowns in their routine facility data. This level of disaggregated data has improved the level of analysis which was exerted on both monitoring and baseline/end line data. Moreover, this data allows for program quality to be improved during project implementation in response to more detailed monitoring data which was collected and analysed annually. In addition, adolescents were engaged effectively to develop their awareness of MNCH issues through the mobilizing power of *Balani* shows organized in WATCH-supported communities. Through dance, music and role playing animation, this strategy was often used to mobilize and entertain children and youth from several villages, and through the shows' widespread appeal and convening power for youth, the project was able to ensure that critical health messaging along the MNCH continuum of care was integrated into the mobilization efforts.

In Ethiopia, the strategy of using Family Health Cards managed by HEWs was operationalized / renewed by WATCH. These cards contain the core information and health status of entire families within a health post's catchment of villages. Through effective management by HEWs, Family Health Cards were used to prioritize outreach and to work with HDAs to ensure proper messaging and timely referral of women and children for MNCH services.

In terms of referral system strengthening from community to facility, a noteworthy innovation in **Ghana** was the establishment of Community Emergency Transport Systems (CETS), which involved a group of community-based drivers who volunteer to transport women and children from communities to health facilities. These drivers received training on MNCH (especially danger signs), gender equality, and first aid. Community mobilizers maintained drivers' contact numbers, and shared them with community members during birth preparedness consultations and in cases of complications requiring emergency transportation to facilities. This has been a very effective model that communities have taken ownership over to help address the challenge of transportation. In addition, the utilization of Daddies' Clubs (mentioned above in sustainability) to promote male engagement was considered a key innovation in integrating GE into MNCH programming (see Section 8.1 for more details).

In **Zimbabwe,** the previously detailed Care Group model was an innovative approach that built upon the strength of pre-existing community ties and trust, along with guidance from health professionals, to saturate communities with vital, contextualized, health-related knowledge.

Each volunteer mother/father, through their meetings with beneficiary families or households, cascaded the same lesson(s) using participatory approaches such as songs, role playing, games, stories and picture cards. This was a powerful and effective way to disseminate memorable messages that ultimately promoted behaviour changes. Another innovation (mentioned in section 8.1) is the Ministry of Women's development and endorsement (to be used for trainings in future) of a guide on gender responsiveness for health service providers, including a self-evaluation checklist.

Finally, as mentioned in Sections 11.1 and 11.3, the integration of VSLAs as platforms for messaging on GE and MNCH, and to help prioritize access to financial resources for MNCH services, transportation or other health needs, has proven to be a powerful integration of economic empowerment within MNCH initiatives that was leveraged in four of the WATCH-supported countries.

11.6 Appropriateness of resource utilization

The allocation of financial and human resources within WATCH has been undertaken with both an accountability lens and with a view to ensuring that resource utilization was aligned to meet the expected key programmatic results (the progress of which were tracked through monitoring data), as well as (where possible) to achieve scale and sustainability, as discussed above.

11.6.1 Utilization of financial resources

An annual work plan and associated budget were developed in close collaboration with all partners, including MoHs, in each of the five implementing countries, based on the results of AWP workshops, which provided an opportunity to reflect on progress to date/lessons learned from implementation, assess risk, review challenges and opportunities in the local operating context, and identify areas that required programmatic reinforcement. Once the five individual AWPs and budgets were prepared and consolidated, Plan Canada analyzed the overall financial situation and proposed budget re-allocations, which were then submitted to DFATD for approval as part of each AWP.

Throughout the project, financial management policies and procedures, including budgeting, accounting, forecasting and reporting, were followed with strict adherence to both Plan and DFATD's compliance requirements. Complete, accurate, reliable and timely financial information was complemented by robust monitoring data for the core MNCH indicators, which allowed the project teams to provide variance explanations in each of the Semi Annual and Annual Reports.

Utilization of resources for procurement of materials (i.e. goods, supplies and assets) was also done appropriately and in alignment with approved AWPs. All procurement for health facilities was fulfilled in response to gaps identified through facility assessments during the early stages of the project. When additional procurement needs were then later identified during annual work planning (i.e. in consultation with MoH partners and in response to 'lagging' indicators analyzed through monitoring data), budget was reallocated accordingly. In **Bangladesh,** this resulted in rickshaw vans being purchased to support patient referral from community to facility level, and both **in Mali and Bangladesh**, procurement of fridges to store vaccines and of lab reagents and medications helped to improve indicators related to vaccinations.

Finally, findings of a donor audit conducted in late 2013 (covering the period of November 2011 through December 2012) confirmed that expenses claimed were in compliance, in all material respects, with the financial terms established in Appendix C of the Contribution Agreement.

11.6.2 Utilization of human resources

The human resource allocation in the WATCH project has leveraged the skills, capacities and competencies of Plan staff and partners, complemented by 'in-kind' contributions of community members, leaders and governments. Throughout the project, there has been an appropriate balance of technical (i.e. health, GE and M&E) and program and compliance management knowledge and skills. The investment in GE, health and M&E expertise to facilitate data analysis has been crucial to the success of this project and results demonstrated. To mitigate data collection challenges, and ensure the quality and timeliness of monitoring data, additional human resource capacity was required. For example, in the Year 3/4 AWP, the need for additional human resources to focus on M&E (and communications) was identified. As a result, during Year 3, Plan **Bangladesh** recruited five new data field coordinators to focus on M&E efforts; Plan **Ethiopia** recruited three new IEC/BCC/M&E Officers to ensure timely and quality data collection and to oversee IEC/BCC and social mobilization activities, as well as three VSLA facilitators within its local partners to manage the VSLA pilot; Plan **Ghana** recruited a data entry clerk to focus on M&E efforts; Plan **Mali** recruited seven new agents based with the local NGO partners to support M&E efforts; Plan **Zimbabwe** engaged three M&E interns and one communications intern to assist with data collection, entry and documentation of stories; and Plan Canada recruited an MNCH Project Officer to support communications and reporting. Budget was also allocated for refresher training for the CHWs responsible for data collection in **Ghana**, and for the CHWs who were involved in the pilot ICT for health initiative in **Bangladesh.**

11.6.3 Investment in enhancing program quality and sustainability

During project implementation, any savings identified from previous years' salary expenditure and implementation, as well as any interest or exchange gains were systematically reinvested in refining and reinforcing targeted program interventions to further enhance program quality, thus decreasing the ratio of operational cost (e.g. salaries) to program costs, as noted in Section 9. For example, in response to exchange gains related to the Ghanaian cedi fluctuation, the project team, in consultation with government partners, identified opportunities for investment in reinforcing program quality; this reinvestment included procurement of torches for CHOs to aid in night time delivery, which was particularly relevant due to the abundance of power cuts that were experienced across the country at the time. Additionally, the importance of reinforcing the knowledge and leadership of Queen Mothers in order to promote the participation and voice of women in community governance and decision making structures was realized, therefore funds were reallocated to providing refresher training for that very critical cohort.

In terms of investments to sustain the impact of interventions over time, resources were utilized to impact several tiers of the health system to provide cohesive health system strengthening, and reinforce the competencies of core health service providers. For example, in Bangladesh, investments were made to ensure critical health resourcing and to deepen core competencies. These investments supported a series of trainings to capacitate the skilled health workforce and key stakeholders, including the community-level workforce (i.e. CHWs, CMs, FCs), local level

Health Management Committees, UH&FWC-Management Committees, Union Standing Committees, Health Service Providers, Self Help Groups, and Change Maker Groups. Despite the relatively high cost of training these layers, such investment was vital to carrying out effective community mobilization of women, men and adolescents, which was complemented by comprehensive strengthening of staff at the union level health facilities like Community Clinics and UH&FWCs, while also supporting efforts to improve referrals and the ongoing implementation of the GEAP.

From a programmatic perspective, resource allocation and utilization aligned well with the overall WATCH project strategy, which was focused on working within existing government health systems and approaches. As such, project resources were also allocated to support the budgetary gaps identified by the government, especially where there were limited health system services available to meet rural village/community health needs or demands. For example, in Mali, working within the government strategy has helped to ensure that at least some resources for CHWs are sustained beyond the timeframe of the project, as the government appreciates the critical role of the ASCs. The recruitment, training and payment of salary for CHWs (i.e. ASCs) was a key WATCH strategy, and although the cost of such ASCs was higher than originally anticipated, the investment in ASCs had a long standing impact, as their efforts and capacity to work in communities achieved strong results in WATCH. The ASCs therefore remain a valuable asset to both community members and the local government, and potentially to other future projects which may intervene in each district. As such, through coordination with local health district managers, the momentum for utilizing ASCs is expected to continue, as their 'value add' has been demonstrated during WATCH project implementation. It is anticipated that with the support of another organization(s) using ASCs to work on health programming, their presence and skills will continue to serve their communities.

11.7 Informed and timely action

Based on its effective governance structure; efficient project and risk management processes and tools; and robust financial and performance monitoring data, the WATCH project team and leadership were able to take informed and timely action to mitigate risks, respond to various opportunities and challenges, and optimize utilization of financial and human resources.

The overall governance structure (including steering committees) helped to ensure alignment with key policies/procedures, stakeholders and partners, and to respond appropriately to opportunities and challenges as they arose. The articulation of clear, feasible annual work plans allowed for project implementation to be carried out in accordance with the expectations of stakeholders and beneficiaries, and enabled reporting to be done in accordance with the schedule outlined in the CA. Key actions were identified through management and reporting processes. For example, the need for further integration of the gender equality strategy in all interventions invoked the development of detailed GE action plans in each implementing country to track this important cross-cutting theme and associated targets during the project. Based on analysis and interpretation of the abundance of monitoring data and associated budget utilization, the project team continually refined interventions in order to remain 'on track' to achieve overall project targets/results, as outlined in Section 5. In so doing, the project team maintained the integrity of the approved AWPs, but also demonstrated flexibility by incorporating

key learnings from the previous period, and accounting for key changes in the local operating environment and/or any changes to relative likelihood and/or impact of risks. These learnings and changes were gleaned from participatory annual work planning sessions with partners and Plan staff, and from observations captured during field visits. In conclusion, by taking informed and timely action, the project was able to achieve its key performance goals.

Section 12: Lessons learned and recommendations

The following section highlights the key lessons learned from the WATCH project based on examining the challenges faced by the project, in close consultation with the implementing country offices. One lesson learned is included from each of the operational, supply side, demand side, M&E and GE aspects of the project.

12.1 Operational: Procurement processes of BEmONC health supplies and equipment

One of the challenges faced by the project, particularly in Ethiopia and Mali, was the timely procurements of BEmONC equipment, and solar refrigerators in Mali. For the former, this challenge was faced as all new medicine or equipment can only be purchased through official government channels. In Year 2 however, Plan Ethiopia found a way to centralize procurement rather than being regionalized as well to utilize a private supplier where government stores could not supply certain items. In the case of Mali, similar procurement challenges of solar fridges were faced as equipment was not available in local markets. This caused a delay of 1.5 years to obtain. One of the factors for this was due to not knowing available stock in country. A more thorough market analysis at project inception would have facilitated a more timely approach to accessing such equipment.

In future, best results in this area can be achieved by conducting facility assessments and associated procurement processes as early in the project as possible e.g. preferably to begin immediately upon project start up, including a market analysis on availability of equipment/supplies in country. In addition, the use of international procurement could be considered in parallel to efforts to procure domestically. Implementing countries could also consider leveraging other organizations' experiences and processes (e.g. UNICEF who assists other organizations with international procurement) to help expedite essential equipment provision.

12.2 Supply side: The ongoing dilemma of limited health facility staff

Existing health facility to patient ratios in all five countries remained an ongoing limiting factor for WATCH. Specifically, in Bangladesh and Zimbabwe, the average ratio of health providers to population hovers at approximately 3:10,000, whereas WHO recommends a ratio of 2.3 per 1,000 people. In other cases like Mali, there is not enough qualified workforce to fill health professional roles. The lack of trained health resources for health is one of the biggest challenges in the health sector. While this is not a challenge that can be easily overcome in a sustainable way (i.e. MSF has supplied additional staff in their project) or easily able to convince government to add new staff within the lifetime of a project, several strategies and lessons in carrying out technical training for staff and equally meeting ANC, delivery and PNC needs of women in health facilities have been deemed effective by WATCH and should be considered in future interventions. In addition, in Bangladesh, while community health centres were being rehabilitated to provide 24/7 services, a series of discussions were held with local government to assign Community Skilled Birth Attendants to these facilities after they completed training. In some centres, these CSBAs helped to fill critical positions left vacant by nurses.

Rather than conducting residential trainings which often take critical staff away from facilities, on the job training as well as revised training schedules (i.e. fewer days over staggered periods) are essential to ensure critical services continue while building capacity of health professionals. In addition, best results in this area can be achieved by building a cadre of trainings at district levels to carry out on the job training, targeting weaker areas and staff with less capacity for additional training. Finally, closer coordination with other organizations to leverage similar training in order to prevent duplication is a strategy that would ensure gaps are not sustained for lengthy periods.

12.3 Demand side: MNCH sensitization and mobilization through the Care Group model

The Care Group (CG) model in Zimbabwe was a key community mobilization strategy adopted to improve the reach and quality of community outreach, and consequently to improve community members' health seeking behaviours. The model enabled key MNCH and gender equality messages to effectively reach the household level through community-based health educators (called Lead Mothers/Fathers). These educators are members of Care Groups, which meet frequently to receive training on MNCH issues from Village Health Workers (VHWs). Each VHW shares MNCH promotion messaging with 10 Care Groups, and then each Lead Mother/Father within these groups cascades the messages to 10-15 households. Care Groups therefore enable the unit of engagement to be a group of households, instead of an entire community, which facilitates more comprehensive and convincing dialogue on MNCH, as well as greater investment of Lead Mothers/Fathers in the women and men they educate and monitor. This more personal level of interaction and focused responsibility also bolsters community mobilizers' commitment to their work, and therefore drop-out rates are lower, fewer incentives are needed for retention, and less retraining is required. This cascaded approach to sensitization and monitoring also lightens the workload of the more highly trained Village Health Workers, so their time can be used more efficiently. In addition, because each Lead Mother/Father is responsible for a small group of households, their workload is relatively light, and it is feasible for them to undertake a few home visits per day.

This model was so well received by communities, that almost double the number of Care Groups were formed (2,292) than originally planned (1,144). Furthermore, the Ministry of Health and Child Care is considering replicating the Care Group model in other parts of the country, indicating the scalability and sustainability of this demand-side intervention.

Overall, the Care Group model is a recommended means of disseminating essential MNCH and GE information that can have a direct bearing on the uptake of health services and promotion of gender equality. Care Groups are also an effective means of collecting critical data on the health status and behaviours of women and children, and then prioritizing home visits as per the level of attention required.

12.4 M&E: Investment in M&E systems essential for quality data and results

Two of the main challenges faced during the project were the volume of data collected, cleaned and processed, and the frequency of data collection. For the former, during the project period over 70,000 data points were verified, cleaned and processed across five countries over a continuous basis. In terms of frequency, three WATCH countries collected data from communities on a monthly basis, while two countries utilized a sample on a semi-annual basis. One factor contributing to this volume was due to the number of indicators selected for the project. While all were deemed important by project stakeholders at the time of project inception, targeted indicators to measure core MNCH results which are aligned with government standards can help to mainstream project monitoring systems as well as focus on quality rather than quantity of data. In addition, stronger alignment of indicators would also diminish the need for parallel monitoring systems between projects and government systems. Although government stakeholders were involved in target establishment, they faced their own pressures to align with national standards that had been set vis-à-vis MDGs, which were not always appropriate for more remote and challenging areas of the country. In the future, more efforts should be made to ensure that historical trends are used to establish realistic targets and that the location of project implementation is taken into greater consideration, since Plan generally focuses its project implementation in remote areas with vulnerable populations i.e. perhaps more modest targets should be set for areas that are more difficult to implement in.

Despite these challenges, several factors contributed to the quality of data produced. First, Plan, early on, implemented a data continuum process as well as invested in direct technical support provided directly by Plan Canada, which facilitated the standardization from collection to analysis by multiple countries. Two dedicated staff at Plan Canada supported countries to validate, verify and process data as well as trouble shoot, as needed. Second, the cloud-based database ensured the availability of real time data for project use. However, the project equally piloted data collection through ICT in Bangladesh, which is a strong recommendation for any future MNCH projects of similar or greater scope and size.

In terms of final end line data generated, the project equally altered its approach using a global consultant to oversee the design and implementation in each country with country study leads as support rather than five individual consultants which were recruited for the baseline phase. This approach substantially increased the comparability of data across countries and the efficiency of consolidation of the end line data, and thus is a strong recommendation for future multi-country projects of a similar nature. An additional recommendation on this front is the

exploration of use of comparison groups in order to measure impact. In WATCH, only one of the five countries used a comparison group at baseline and end line (Bangladesh). While it required considerably more resources, the end results enabled the project to technically report on impact, rather than a difference-to-difference only.

Overall, best results can be achieved in the collection and production of quality data and the demonstration of impact when sufficient investment in M&E resources, including investment in capacity building and technical support, IT systems for data collection and storage, and enhanced involvement of government in the design of M&E systems and targeting is applied.

12.5 Gender equality: engaging men key in improving MNCH outcomes

One of the challenges in MNCH programming overall is the engagement and buy-in of male partners and family members. Initial baseline data in WATCH indicated that just under 60% of women received any type of support from male family members to access MNCH services or support in exclusively breastfeeding. While male engagement was part of the gender equality strategy for the project, it was difficult to reach men and fathers of unmarried adolescent girls and women. This included resistance of men to GE messages including male involvement and male support to their female partners, mainly due to traditional male dominance in the communities. Male champions, male role models, Daddies' Clubs, change-makers etc. equally faced resistance to GE messaging from other men as they carried out outreach and they were also ridiculed and stigmatized for taking up non-traditional gender roles *(please also see Annex M, for MNCH Outcomes).* For saturation in accessing men, especially hard-to-reach men, the resources (male champions, role models, male CHWs etc.) were insufficient.

It was learned however throughout the duration of the project that best results can be achieved in MNCH Outcomes when there is buy-in of religious and traditional leaders in the engagement of men as these are models which are highly revered and when men see their leaders taking up initiatives, they emulate them. These role models also ensure wide dissemination of GE and MNCH messaging. Second, hard-to-reach men require persistent visits to their homes and/or farms. For very difficult men (i.e. men who did not want to 'buy into' gender equality), local male role models and other peer influencers are effective as well as popular education methods (i.e. edutainment) which are culturally appropriate. However, this is time and cost intensive work and using this strategy requires significant investment. Using VSLA groups and leveraging existing community structures (i.e. ADAs in Ethiopia) for example is an equally good avenue for engaging men in the long-term. Finally, the identification and capacity building of community male GE champions (e.g. Ghana and Zimbabwe), male role models and men's groups (such as Daddies' Clubs in Ghana) are examples of good practice as these are locally recognized men that have influence in communities. Targeted onboarding of religious leaders (e.g. through change-maker groups in Bangladesh) is another good practice. Future recommendations equally include the collection of data and analysis to capture more evidence of the links between male engagement and MNCH outcomes as a means to inform other strategies.