

Integrating Gender from Start to Finish, Inside and Outside: Lessons from Afghanistan's Health Services Support Project



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This document is part of a series of case studies to showcase how gender can be integrated into Jhpiego's programs. It describes the process of gender integration, best practices, lessons learned, and outcomes.

Jhpiego is an international, nonprofit health organization affiliated with Johns Hopkins University. For more than 40 years, Jhpiego has empowered frontline health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidence-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world's most vulnerable populations.

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Table of Contents

Afghanistan Context and Background	1
HSSP Overview.....	3
The Gender Integration Process.....	4
Creating a Gender-Sensitive Enabling Environment within HSSP	4
Integrating Gender into Program Activities	6
<i>Gender Indicators</i>	6
<i>Gender Research</i>	6
<i>Defining Gender</i>	8
<i>Gender Workshops and Training Activities</i>	8
<i>Family Health Action Groups</i>	8
<i>Gender Support to the Ministry of Public Health</i>	9
<i>Gender and the Quality Assurance Process</i>	10
<i>Gender and Midwifery</i>	11
Lessons Learned and Best Practices.....	16

Summary of Lessons Learned and Best Practices

Conduct a gender analysis. Conduct a gender analysis of organizational policies and procedures, technical competency of staff, design and implementation of activities, and project results and outcomes.

Include gender indicators and targets in the project's performance monitoring plan. Once the performance monitoring plan is established, monitor and routinely report on the results. If the project isn't achieving its gender-related targets, project staff can assess why.

Promote gender equity through human resources. Gender equality often requires deliberate human resource action, such as including language in job descriptions indicating that women are strongly encouraged to apply, and encouraging staff to help seek out strong female candidates if they are underrepresented in certain positions.

Leadership matters. If a leader prioritizes gender and gender-sensitive practices, it will become a priority for the rest of the staff, too.

Start where you can. In places with very rigid gender norms, it may be necessary to work within the cultural context and promote gender accommodating activities if transformative activities are not yet possible, that is activities that worked around existing gender differences and inequalities.

Integrate gender but also have unique gender-related activities. To the extent possible, integrate gender into all program activities, but also have separate, unique gender activities so you can see and measure progress.

Don't give up! Change happens. Don't be discouraged by naysayers or slow progress. As the old Afghan saying goes, "drop by drop a river is made."

As I looked around the room, I chuckled to myself and wondered whoever said that Afghan women were disempowered. Of course, many Afghan women face challenges due to gender constraints and barriers imposed by culture, tradition, and conflict, but as I looked out before me at the women with arms raised and hands clasped, singing the midwife song, I thought such barriers did not hold these women back, not the 500+ midwives from every province in the country who have convened in Kabul to participate in the Afghan Midwives Association annual congress. These women are proud, confident, and competent. With the education, training, support, and employment they have received, they are empowered to travel around their communities and save lives, and both men and women respect them for it. These are the midwives of Afghanistan. But they weren't always as competent and empowered. They got that way with a lot of help and support.

—Denise Byrd, Jhpiego Country Director/Chief of Party of the Health Services Support Project (2008–2012)

Afghanistan Context and Background

Afghanistan has a long and complicated history, which unfortunately includes decades of conflict and some of the worst development indicators in the world, particularly among women and children. According to the United Nations Development Programme's (UNDP's) Human Development Index 2014,¹ Afghanistan ranks

169 out of 187 countries on the index. Gender inequality is a contributing factor to Afghanistan's poor ranking overall. According to the UNDP's 2013 Gender Inequality Index,² Afghanistan ranks 149 out of 151 countries. The index reflects gender-based inequalities in the following three areas (See Table 1 for specific data):

**Table 1. Afghanistan Indicators
UNDP Gender Inequality Index 2013**

Percent of parliamentary seats held by women	27.6%
Percent of adult women who have reached secondary or higher level of education	5.8%
Percent of adult men who have reached secondary or higher level of education	34%
Maternal mortality ratio	460/100,000
Adolescent birth rate	86.8%
Female participation in the labor market	15.7%
Male participation in the labor market	79.7%

- *Reproductive health*, which is measured by maternal mortality and adolescent fertility rates, both of which are very high in Afghanistan;
- *Empowerment*, which is measured by the share of parliamentary seats held by each gender and the attainment of secondary and higher education by each gender, which stands at a male to female ratio of almost 7 to 1; and
- *Economic activity*, which is measured by the labor market participation rate for each gender, with a male to female ratio of more than 3 to 1.

¹ UNDP. 2014. Human Development Index Data [data file]. Retrieved from: <http://hdr.undp.org/en/data>

² UNDP. 2014. Human Development Index Data: Table 4: Gender Inequality Index [data file]. Retrieved from <http://hdr.undp.org/en/content/table-4-gender-inequality-index>

Gender inequality has long existed in Afghanistan; however, under the Taliban these inequalities were exacerbated. During their rule from 1996 to 2001, the Taliban severely oppressed women by restricting their movement, denying their right to work and obtain an education, physically abusing them, and restricting their access to health services.³

What is Gender?

The term “gender” refers to social norms that men and women follow, because of the way society is organized. Unlike sex, which is universal, biological, and unchanging, gender roles and relationships within societies and families are learned, vary among cultures (as well as among social groups with the same culture), and change over time.

Source: *Afghanistan National Gender Strategy 2011–2015*

Since the collapse of the Taliban in late 2001, gains have been made, yet many challenges remain to women’s full and equal participation in economic, political, social, and cultural life. Poverty, discriminatory practices, gender-based violence (GBV),⁴ early and forced marriage, honor killings, and poor access to education are among the challenges that Afghan women faced then and continue to face now.

Afghan society is widely acknowledged as being highly patriarchal and conservative, with defined roles for men and women—roles that restrict women’s movements and decision-making power. Women are often unable to act independently or to access health care; they are rarely able to leave the home without a male companion. Health-seeking behavior is greatly constrained by the lack of female health providers in Afghanistan because culturally, women are generally permitted only to seek care from women. Yet, health is an essential prerequisite for the effective participation of women and men in all areas of life and an essential component of development.

After the fall of the Taliban, another area of major concern was the poor or absent health system and services for everyone, particularly for women. As a result, the lifetime risk of maternal death was between 1 in 6 and 1 in 9, which translated to one woman dying every 27 minutes⁵ and approximately 60 out of every 1,000 newborns dying in the first month of life.⁶ To address this issue, starting in 2003, Afghanistan embarked on a path to development that included billions of dollars invested in building the country’s health systems with the help of various donors and implementing partners, including the Rural Expansion of Afghanistan’s Community-based Healthcare (REACH) program, funded by the U.S. Agency for International Development (USAID).⁷

These investments led to significant progress toward improving access to health care services. Yet by 2006, although access to these services had improved, many challenges remained, including: a high maternal mortality ratio; a shortage of trained health workers, especially female health workers; and

³ Human Rights Watch (2010) p. 16. Retrieved from: <http://www.hrw.org/sites/default/files/reports/afghanistan0710webwcover.pdf>

⁴ According to the World Health Organization’s *Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals: Module on Gender-Based Violence* (2005), “Gender-based violence includes all forms of violence involving women and men in which the female is usually the victim. The term ‘gender-based’ is used to highlight the need to understand violence within the context of women’s and girl’s subordinate status in society. Such violence cannot be understood, therefore, in isolation from the norms, social structure, and gender roles within the community, which greatly influence women’s vulnerability to violence.”

⁵ Bartlett LA et al. 2005. Where giving birth is a forecast of death: Maternal mortality in four districts of Afghanistan, 1999–2002. *Lancet* 365(9462): 864–870.

⁶ Lawn JE et al. 2005. Four million neonatal deaths: When? Where? Why? *Lancet* 365(9462): 891–900.

⁷ From 2003 to 2006, Jhpiego worked as a partner on the REACH program, which was led by Management Sciences for Health.

social and cultural constraints to women’s access to services. In addition, the mountainous landscape and winter weather in parts of Afghanistan, as well as insurgency violence, were and continue to be significant challenges to accessing high-quality health services.

To address some of these remaining challenges, in 2006 USAID/Afghanistan issued Jhpiego an Associate Award under the Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (ACCESS) program—the Health Services Support Project (HSSP).

HSSP Overview

Led by Jhpiego with partners Save the Children and Futures Group, the USAID-funded HSSP, which ran from July 2006 through October 2012, sought to improve the quality of services provided to women of reproductive age and children under the age of five. In support of this strategic objective, USAID established five intermediate results (IRs) for HSSP and all activities were implemented in support of them.

The first IR focused on *strengthening and developing systems that support service delivery quality*. To do this, the project focused on: 1) building the capacity of nongovernmental organizations (NGOs) delivering the basic package of health services (BPHS), and 2) improving the quality of service delivery at the BPHS health facilities. A key achievement under this IR was establishing, implementing, and supporting a process to improve the quality of health services and improve the performance of health providers—the Quality Assurance (QA) process—in 505 health facilities in 21 out of 34 provinces.

The second IR focused on *increasing the number and performance of BPHS providers, especially women in rural and underserved areas*. HSSP supported the improved performance of providers in a number of ways, including: developing a variety of training packages (learning resource packages) for in-service clinical and non-clinical training; providing on-the-job training; conducting supportive supervision visits; and sharing technical resources, among other activities. By the end of the project, HSSP had trained more than 17,000 health care workers, supervisors, faculty and Ministry of Public Health (MoPH) staff in clinical and non-clinical competencies. In addition, HSSP increased the number of female health providers by supporting the system for and issuing grants for midwifery education programs, as well as by supporting the professional association for midwives, the Afghan Midwives Association (AMA). By the end of the project, 1,056⁸ new midwives had graduated from 13 HSSP-supported schools.

The third IR focused on *improving the capacity and willingness of communities, families, and individuals to make informed decisions about their health and promoting health-seeking behaviors*. Under this IR, implemented by Save the Children, HSSP developed a number of information, education, and communication (IEC) materials; developed several job aids; and mobilized health facilities and communities to maintain and strengthen their linkages, among other activities.

⁸ Over 3,000 midwives have been trained and deployed since 2002 and HSSP trained over 1,000 of these midwives, representing almost 33% of the total workforce.

The fourth IR, implemented by Futures Group, focused on *integrating gender awareness and practice into BPHS*. This was primarily accomplished by: integrating gender into the QA process and promoting high-quality, gender-sensitive service delivery; training a variety of stakeholders, including health facility staff, in gender and GBV; and promoting key gender-sensitive themes—such as respectful treatment of women at health facilities, male engagement in reproductive health and maternal and child health, and empowering women for decision-making in health care—via radio and television programs, among other activities.

Lastly, the fifth IR, which was added during the fourth year of the project, was a combination of the other four IRs but focused on *strengthened health systems in the South and Southeast* of Afghanistan.

It's worth highlighting that HSSP was the only USAID-funded health project with a specific gender IR, IR4. In addition, although the purpose of the fourth IR was to integrate gender into service delivery, gender was at the core of HSSP, underpinning all of its activities, management practices, and organizational culture.

The Gender Integration Process

Creating a Gender-Sensitive Enabling Environment within HSSP

To meet IR4, HSSP recruited staff to support this result, including a national Gender Officer. HSSP initially recruited a male Gender Officer⁹ who had previously worked closely with an expatriate gender expert on an earlier USAID-funded health project. Hiring a male in this position was a deliberate attempt to highlight the point that gender didn't simply refer to women and that men are and should be involved in gender integration and programming activities. HSSP continued to strengthen the Gender Officer's capacity through mentoring, on-the-job training, and e-learning courses. However, this capacity building in gender extended beyond the Gender Officer and the IR4 team. HSSP prioritized raising awareness about gender issues and gender-related programming for its entire staff, regardless of their positions, through a number of activities, including brief, two-hour or half-day gender awareness orientations, gender updates and discussions during technical team meetings, gender orientations and updates during annual staff retreats, and occasional one-day gender training events for all staff. These activities helped to reinforce the importance of gender-related programming and to ensure that all staff, regardless of their position, had at least a basic understanding of HSSP's gender work.

Since HSSP's mandate was to support others to integrate gender into their activities, HSSP leadership thought it would be prudent to conduct an internal audit of its own practices to identify the extent of gender integration and identify areas for strengthening staff and systems. Among the many existing tools, HSSP used the Gender Integration Index,¹⁰ developed under the USAID-funded Health Policy Initiative project, to measure gender integration into organizational policies and procedures, as well as program activities. The index asks staff to discuss and answer a variety of

⁹ Throughout the project, HSSP hired both male and female gender officers and advisors.

¹⁰ The Gender Integration Index can be found at: (http://pdf.usaid.gov/pdf_docs/Pnadp917.pdf)

questions related to: organizational policies and procedures, technical competency of staff, design and implementation of activities, and project results and outcomes. Sample questions include:

- Does the organization provide both female and male staff with equal access to training activities and extension services to facilitate professional development?
- Is gender a required skills area when hiring new technical staff?
- Does the program conduct a gender analysis¹¹ of activities? If so, were activities developed to address identified constraints and opportunities?

While sparking dialogue on gender issues within each department of the organization, HSSP discovered that it had some areas to strengthen. For example, although HSSP promoted exclusive breastfeeding for the first six months after delivery of a baby, it did not have a place for new mothers among its own staff to breastfeed their babies.

Therefore, a room in the HSSP office was identified to serve as a breastfeeding room and a full-time babysitter was hired. This afforded new mothers the opportunity to bring their babies to work and encouraged exclusive breastfeeding.

Once I asked for a show of hands—How many of you were promoted from within? More than half of the room raised their hands. This was good for both men and women, and fostered loyalty and trust among staff.

—Denise Byrd, Jhpiego Country Director & HSSP Chief of Party (2008-2012)

Later, this room grew into a childcare room with up to five babies and two care givers. Female staff often expressed that they would have not been able to continue working outside the home, had it not been for the opportunity to bring their babies to work. Moreover, not only female staff benefited; it was not unusual for a male staff member who was having a stressful day to visit the childcare room for a short break and some smiles. Having the babies at the office created a better environment for women and men. During the next annual retreat after the change, staff observed that several staff members, men and women equally, mentioned that they were proud of the “babies’ room” in the office.

HSSP’s paternity policy was another area the gender integration index identified for strengthening. While HSSP was encouraging male involvement in reproductive health and safe motherhood, HSSP did not have an equitable leave policy that encouraged this among its own staff. Therefore, a paternity leave policy was added to encourage fathers to take the time to support their wives and new babies.

Finally, HSSP strengthened female leadership on the project. HSSP learned that if a senior position was available, even if it was for a female-dominated content area such as midwifery, men would still apply and sometimes be the stronger candidate because they traditionally have been afforded more professional development opportunities and education. Therefore, HSSP decided that if it was to promote the capacity building of women, it needed to start with its own hiring and staff capacity

¹¹ According to USAID, a gender analysis is a systematic analytical process used to identify, understand, and describe gender differences and the relevance of gender roles and power dynamics in a specific context. Such analysis typically involves examining the differential impact of development policies and programs on women and men, and may include the collection of sex-disaggregated or gender-sensitive data. Gender analysis examines the different roles, rights, and opportunities of men and women and relations between them. It also identifies disparities, examines why such disparities exist, determines whether they are a potential impediment to achieving results, and looks at how they can be addressed (*Tips for Conducting a Gender Analysis at the Activity or Project Level: Additional Help for ADS Chapter 201* [3/17/2011]).

building and promotion practices. As a result, HSSP was committed to building technical, management, and leadership capacity of its entire staff, particularly female staff, and to *promoting from within*, which resulted in strong female leaders within the project. Consequently, HSSP attracted and retained both qualified men and women. In fact, of all USAID-funded health projects, HSSP had the most female staff—23 females out of 125 total staff, (including administrative or support staff) or 18%—and the most female leaders (three out of 10, or 30%). While 18% is still far from equal, it's significant in Afghanistan, especially when considering some projects only had one or two female staff in administrative positions.

Integrating Gender into Program Activities

Gender was integrated into HSSP program activities in a number of ways, from formative design and indicators, capacity building with providers, community outreach efforts, and technical assistance to the MoPH.

Gender Indicators

The HSSP performance monitoring plan, for example, included the following indicator under IR4: *percent of QA participating facilities achieving 80% or above score in gender area in follow-up external assessments*. Having a gender IR and gender indicators in the performance monitoring plan required the program designers and staff to prioritize, plan, budget, measure, and report on gender-related activities throughout the project.

Gender Research

A key gender-related foundational activity was gender research. During the first year of the project, HSSP identified key research questions it wanted to answer to inform program activity design and implementation. After developing a scope of work and obtaining both local and Johns Hopkins University Ethical Review Board approvals, HSSP contracted a local organization to conduct research to explore the level of knowledge, attitudes, and practices among women and men that prevent women from seeking reproductive health services in the public health system. Eight provinces (Badakhshan, Baghlan, Bamyan, Daikundi, Faryab, Herat, Logar, and Paktia) were selected at the primary stage to ensure representation of various ethnic groups (Pashtoon, Tajiks, and Hazaras), internally displaced persons, Kuchis,¹² and returnees. “From these provinces, key informants were selected for in-depth interviews and focus group discussions (FGDs) through purposive sampling of different population groups, including: women of reproductive age, heads of household, religious leaders, village leaders, school teachers, and health professionals. The interviews and FGDs were conducted...in both rural and urban areas and used a semi-structured questionnaire with open-ended questions.”¹³

Due to a number of factors, the research findings were not finalized until the end of the project. However, HSSP did not wait for the final results to begin utilizing the data and information coming

¹² Kuchis are the nomads of Afghanistan and one of the most vulnerable groups in the country.

¹³ Health Services Support Project. Qualitative Research on Gender Barriers to Improved Maternal Health: Final Report. October 2010.

from the research. Instead, a preliminary analysis was conducted and the findings helped to inform program strategy and implementation throughout the project. The research provided useful information about the nature and type of gender barriers to health care utilization that women face in their homes, communities, and within the health sector, as well as recommendations for how to minimize these barriers. (See Text Box for details).

HSSP Gender Barriers to Improved Maternal Health in Afghanistan

The study found that respondents are generally aware of the availability of public health services, good health practices, potential complications during pregnancy, and the benefits of using contraception and having small families. However, several factors may contribute to poor maternal and child health and the underutilization of health facilities, including:

- Lack of women's decision-making power to seek health services.
- Family planning decisions usually being made by male members of the family and mothers-in-law.
- Shortage of female health staff, especially in rural areas.
- Lack of 24-hour maternal health services.
- Overcrowding and extended waiting times at health facilities.
- Transportation and geographic barriers.
- Economic barriers.

These findings suggested a need to develop a long-term strategy aimed at reducing these barriers to women's health care utilization. Recommendations for inclusion in this strategy included:

- Advocacy efforts for women's rights, education, empowerment, and health need to be scaled up and aimed at different population groups, especially men, health providers, tribal and religious leaders, and politicians.
- Political will should be mobilized to modify tradition, sensitize men to women's issues, and empower women to make decisions about their health.
- Women's rights should be strictly enforced by law enforcement authorities.
- Men should be better targeted with health promotion IEC campaigns for women's rights.
- To mitigate the shortage of health female staff, women should be provided with more health care training opportunities and should be incentivized to work in rural and underserved areas. In addition, the role of female staff in the provision of health services should be emphasized in health policies, which must be acknowledged and supported by male health staff.
- To address transportation and geographic barriers to health care access, the primary health system should expand its coverage to reach people in rural areas. Basic reproductive health services—particularly antenatal care, family planning, delivery and postnatal care—should be provided at the community level.
- Because lack of education is a major barrier to the uptake of health services, efforts to increase enrollment of girls in schools should be intensified, particularly in rural areas.

The research findings and recommendations not only helped to inform HSSP program activity design and implementation, but also policies at the national, NGO, and health facility levels. Specifically, the initial results of the research helped to inform the content of the HSSP *Gender Awareness Training* manual, pre-service education and in-service training, and the QA process. For example, the research found that key family planning decisions, such as family size and birth spacing, are usually made by male members of the family, although the mother-in-law often plays a substantial role as well. Therefore, HSSP's behavior change communication materials, pre-service and in-service training materials, and QA standards and strategies encouraged health providers to counsel both men and women, including the mother-in-law, on family planning/birth spacing. Importantly, the final results of the research also validated aspects of various training materials and

approaches already in existence and employed by HSSP. Later, the disseminated findings helped to inform the MoPH's *National Gender Strategy* and *National Reproductive Health Strategy*.

Defining Gender

Working under the leadership of the MoPH's Gender and Reproductive Rights Unit, HSSP led the effort to reach consensus on the meaning of *gender*, using language that was understandable to everyone. There is no Pashto or Dari word for gender so either the English word is used, which holds no meaning for most, or it is mistranslated as *sex*. Therefore, it was important to have a word or phrase that was meaningful in Dari and/or Pashto. The phrase agreed upon in Afghanistan was "*the roles and responsibilities of men and women in society*." Having a common understanding with a locally developed definition was important to help to clear up many misconceptions that gender programs and activities were only focused on women's programs and activities. While it is true that many gender programs in Afghanistan tended to focus on women, this was due in large part to the gross inequalities and unique challenges experienced by women in Afghanistan.

Gender Workshops and Training Activities

HSSP also developed a supplement to the MoPH's gender awareness training manual, which was essentially the World Health Organization's manual *Transforming Health Systems: Gender and Rights in Reproductive Health: A Training Manual for Health Managers* (2001). The HSSP supplement focused on the three themes related to the BPHS QA standards that were identified as key by the project's gender advisors—promotion of gender-sensitive interpersonal communication and counseling, male involvement in maternal health, and women's empowerment and decision-making. Once the three themes were identified, HSSP integrated them into all of the QA standards, and also created a separate set of gender standards. HSSP then used the training manual supplement to train NGO and health facility staff.

To institutionalize gender-sensitive service delivery within the BPHS sites and respond to requests for support, HSSP also developed a GBV training manual, which it used to train health facility and NGO staff.

Family Health Action Groups

Another important HSSP activity was HSSP's establishment of Family Health Action (FHA) groups that empowered and mobilized women in communities by building their capacity to take important decisions and actions to improve their families' basic health practices. Additionally, FHA groups provided a forum for women to come together and discuss issues important to them in a context that is comfortable and culturally appropriate. In a culture where women have few opportunities for mobility and interaction outside of the home, such groups are important. HSSP provided financial and technical support to identify, train, and support FHA groups in nine provinces of Afghanistan, with a total membership of 680 women. These groups worked to increase appropriate use of health services by communities through raising awareness about basic health care, nutrition, hygiene, and cleanliness, and by linking families to community health workers, as needed. HSSP conducted an assessment of 47 FHA groups and found that the women involved all claimed to feel more

knowledgeable and confident, and were “better at correctly naming signs of newborn sickness, danger signs during pregnancy, delivery and postpartum, and types of family planning methods.”

In addition, success stories collected from community health workers, FHA group members and families anecdotally demonstrate that FHA group intervention is indeed educating families about basic health practices and linking families to community health workers when necessary.¹⁴ (See text box). As a result of these findings, the Afghanistan MoPH decided to expand this approach nationally. To assist them in doing this, at the end of the project HSSP handed over to the Community Based Health Care Department all of the guidelines, training manuals, and tools it had developed for FHA groups.

FHA Group Member Empowered with Knowledge that Helped Save a Baby's Life

Demonstrating the power of FHA groups, Fatima, a member of an FHA group in Bamyán Province, intervened in a serious health case involving an infant that needed hospitalization and might have died without it.

“It was a cold winter day when the mother came to my home and told me that her baby son was sick with a fever and breathing problems,” Fatima explained. “I accompanied her to her home and visited the sick baby. Based on what I learned from the community health worker, I knew that the baby had respiratory tract danger signs, like stridor and chest in-drawing. He also had a fever and would not breastfeed.”

Fatima believed the situation was critical and suggested that the parents take the baby to the hospital. However, the father did not believe the baby needed to go to the hospital—and he was also clearly worried about the cost. Fatima explained that the baby had a serious respiratory tract infection; if he didn't go to the hospital right away he might die. Still, the father resisted until Fatima told him it was free of charge. Finally, the father agreed and they took the child to the nearest health facility. Fortunately, the child recovered within a week.

“The child's family thanked me for my assistance. I am proud and happy that I am an FHA group member who can take part in improving of the villagers' awareness and healthy lifestyles,” said Fatima.

Gender Support to the Ministry of Public Health

Another important set of activities conducted by the HSSP gender team was to provide technical and/or financial support to various departments within the MoPH. For example, HSSP provided capacity building support and funded the salary of the MoPH's only official Gender Advisor, who is charged with the responsibility of pushing through many of the proposed gender-related policies and reforms. This was important because without this support, many of the key gender policy documents and strategies may not have been developed and accepted at the MoPH.

Another example of HSSP technical support to the MoPH on gender was the review and inclusion of language and evaluation criteria related to gender in a request for proposals for BPHS service delivery grants. Project staff later helped to review and score the proposals to ensure these criteria were met. It's worth noting that HSSP was not invited to do this; rather, HSSP staff requested and advocated for the importance of including gender language and criteria in the request for proposals.

¹⁴ Health Services Support Project. Evaluation of the Family Health Action Group Intervention. March 2012.

Gender and the Quality Assurance Process

The QA process was in many ways the foundation of HSSP. An amalgamation of Jhpiego’s Standards-Based Management and Recognition (SBM-R) process and Save the Children’s Partnership Defined Quality (PDQ) approach, the QA process used gender-sensitive, evidence-based standards and community input to measure the quality of services provided, thereby allowing users—whether they be community members, provincial health officers, health providers, or supervisors—to identify and address performance gaps. If gaps were related to lack of knowledge or skills, or if skills needed to be standardized, HSSP provided support in the form of training. Following training, performance was re-assessed using the same tool to ensure the provider was practicing the newly learned skills.

The first step in this four-step process (see Figure 1) was to identify and/or develop QA standards, initially in the following 13 technical areas: family planning, antenatal care, normal labor and delivery, postpartum, management of complications, care of the sick newborn, integrated management of childhood illnesses, expanded program of immunizations, tuberculosis, infection prevention, health facility management, drug supply management, and behavior change communication.¹⁵ During the first year of the project, HSSP held a multi-sectoral, participatory gender indicators workshop to define gender-sensitive service delivery practices, develop gender standards, and integrate those standards into the national QA standards tool. Rather than having separate gender standards, however, a decision was made to review the standards in the 13 areas and ensure that they all contained language that was gender-sensitive. To do this, the team reviewed all of the standards through a gender lens and consensus was built around how to modify the standards to be gender-sensitive. For example, verification criteria for a behavior change communication standard was amended to include the language, “...that are directed toward both men and women,” to make it more gender inclusive. In the normal labor and delivery standards, language was amended to encourage the provider to invite the pregnant woman and her birthing “companion” into a room. This gender-neutral language empowers the woman to decide who should be with her during delivery and offers the opportunity for men to be included. Following these amendments, the MoPH central QA Committee approved these “gender-sensitive” standards during a workshop in April 2007.

Once the standards were gender-sensitive, teams began to utilize them to assess provider and health facility performance, the next step in the QA process. HSSP supported teams to conduct baseline assessments in a number of health facilities. Following the completion of the baseline assessments, HSSP identified those health facilities that had gaps related to achievement of the gender standards and provided appropriate support to narrow those gaps, which often included training.

Not long after beginning implementation of the QA process, HSSP realized that although integrating gender into the entire tool was important, doing so made it difficult to measure progress

Figure 1. SBM-R Process

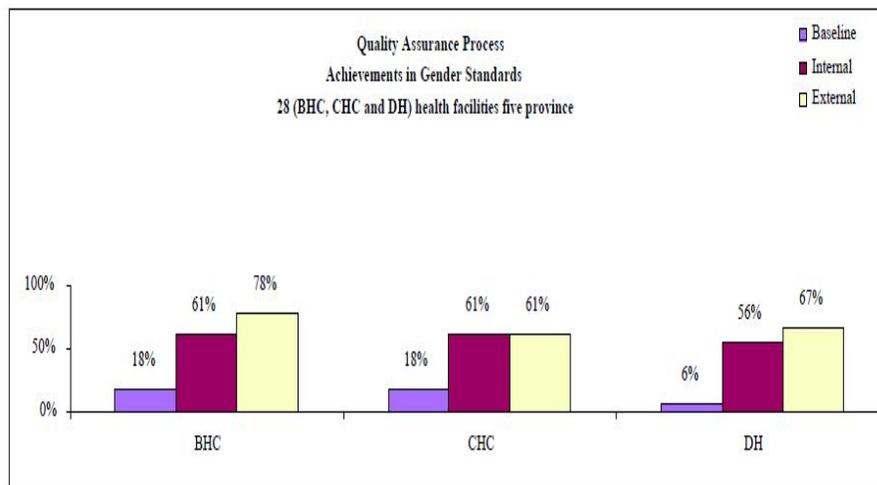


¹⁵ By the end of the project, HSSP had developed standards for 21 different technical areas.

in the area of gender. Therefore, in response to feedback from USAID and in order to simplify assessment and scoring of gender standards, HSSP added another area to the QA tools that separated out the gender standards—Area 14 (See Annex 1).

Area 14 was comprised of nine gender-sensitive standards from other various areas in the QA tool. By this time, HSSP had developed the gender training manual supplement that highlighted three themes: 1) promotion of gender-sensitive interpersonal communication and counseling, 2) promotion of women’s empowerment and decision-making, and 3) promotion of male involvement, especially in reproductive health. Therefore, the nine gender-sensitive standards—while coming from other areas such as family planning, behavior change communication, facility management, antenatal care, and normal labor—were organized according to these three specific gender themes throughout the QA standards. This ensured consistency of the HSSP message and made it much easier to assess the health facility’s performance in integrating gender into the BPHS, and consequently, to provide support to address performance gaps. For example, the graph below highlights the improvement in the achievement of gender standards over the course of a QA cycle (baseline assessment, internal assessment, and external assessment) for 28 health facilities in five provinces. The improvement over time is in part a result of the support provided by HSSP to address gaps identified during baseline assessments.

Graph 1: Achievements in Gender Standards

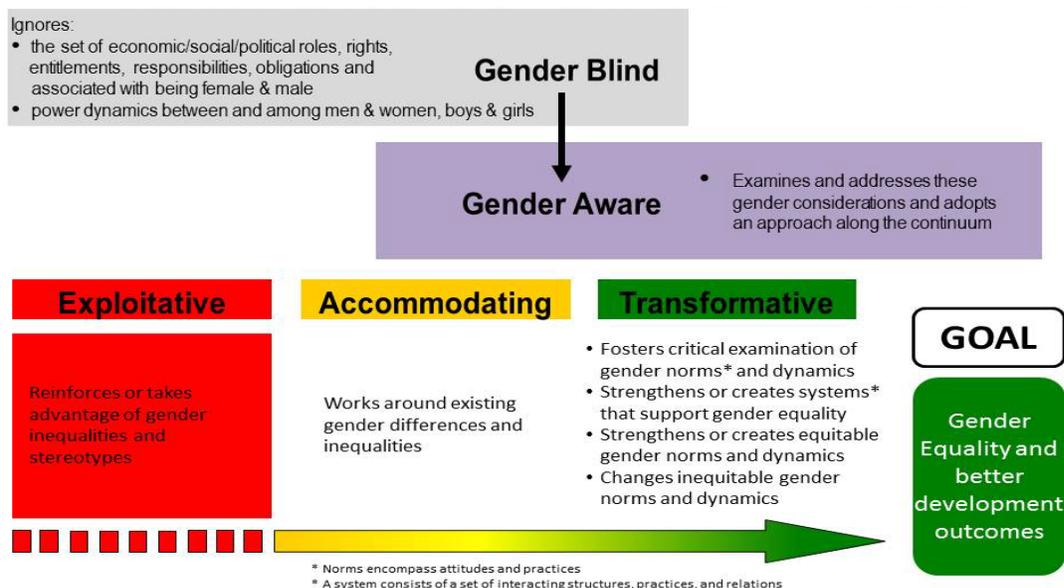


Gender and Midwifery

HSSP’s support for the midwifery profession was both **gender accommodating** and **gender transformative**.¹⁶ It was gender accommodating mainly for midwifery clients—women in the community—because it accommodated or worked around existing gender norms and inequalities. For example, the culture dictates that for the most part, women only be seen by female health providers. Rather than challenge this norm, HSSP’s efforts worked within those cultural constraints and simply trained more female health providers.

¹⁶ The gender integration continuum is a tool, designed by the Interagency Gender Working Group, “for designers and implementers to use in planning how to integrate gender into their programs/policies....It takes users from gender blind to gender aware programs, towards the goal of equality and better development outcomes.” http://www.igwg.org/igwg_media/Training/FG_GendrIntegrContinuum.pdf

Figure 2. Gender Equality Continuum Tool



This was important, because unfortunately after years of war and Taliban rule, there was a severe shortage of trained female health providers. HSSP addressed this shortage by issuing grants to NGOs to implement hospital and community midwifery education programs. By the end of project, HSSP had issued grants to 13 schools to graduate 1,056 competent midwives.

Without specifically claiming to be a transformative gender project, HSSP offered midwives one of the best avenues for empowerment while at the same time contributing significantly to improved health of mothers and their families. Therefore, for midwives, midwifery education was transformative because it contributed to reducing gender inequality for them, addressing all three areas of the Gender Inequality Index:

- *Reproductive health:* Midwives graduated with skills and competencies that enabled them to save the lives of mothers and their babies and deliver comprehensive reproductive health services. The Afghanistan Minister of Health, Dr. Suraya Dalil, in numerous speeches cited the increase in the number of competent practicing midwives as a major contributing factor to the reduction of maternal and infant mortality in Afghanistan.
- *Empowerment:* Women who graduated from accredited midwifery education programs received quality higher education in their chosen field, and many of them held positions of leadership within their organizations, communities, and the AMA—a notable achievement in a country where women rarely have an opportunity to work outside the home.

- *Economic Activity:* Due to HSSP employing a health workforce planning¹⁷ approach to selection and recruitment of midwifery students, upon graduation between 84% and 100%¹⁸ of the graduated midwives went on to work in health facilities within their communities and earned incomes to help support their families.

Another interesting consequence of educating, graduating, and deploying these empowered midwives into the communities was the effect they sometimes had on those communities. For example, in addition to bringing lifesaving skills, competent midwives also served as examples of women challenging the perceptions that many have of women. Specifically, midwives are mobile and often empowered to speak up and challenge heads of households to save a life (see text box below). This is not the norm in Afghanistan. Therefore, these women can also serve as strong female role models in their communities, hopefully paving a path to employment and empowerment for future generations of young women. By helping to slowly challenge existing attitudes and norms about women in the community, midwifery education and midwives themselves are gender transformative.



Young Midwife Takes Charge, Saves a Life

She may be young, but on this day in the village of Shahidan, Shahrbanoo proves to be a woman of confidence, conviction, and capability. While surveying the village women's health, the community-educated midwife knocks on the door of a small house where she knows a pregnant woman has given birth. "How is the mother?" Shahrbanoo asks. The man at the door refuses to let her in. Shahrbanoo moves onto the next house. But when her survey work is done, the HSSP-supported midwife returns to the house where she had been turned away. She knocks firmly: "I am a midwife. I am here to help." The man is skeptical that this young woman can help his wife. He has given up hope. Shahrbanoo insists that she enter. The man lets her in. The man's wife, a mother of six, is still bleeding after giving birth. Shahrbanoo examines her. The mother is likely to bleed to death if the placenta isn't removed. There isn't enough time to get her to a health facility and Shahrbanoo is without her midwifery kit. But she finds a plastic bag to protect herself, uses it as a glove and, with the skills she has learned in midwifery school, reaches in and removes the retained placenta, and gently massages the uterus. The bleeding stops. This is the first life this young midwife has saved, and with confidence and resolve she is ready to save even more. Chosen to attend midwifery school with the support of her community, Shahrbanoo shows through her work that their trust in her is well-deserved.

¹⁷ A health workforce planning approach involves reaching a balance between the demand for health workers and the supply. In the case of midwifery, the number of required midwives was identified and then students were recruited and trained accordingly, with the understanding that after graduation they would be deployed to work in facilities in their communities that had a need for a midwife.

¹⁸ Since definitions and measurement of deployment varied over the life of the project, exact percentages are not available. The 84–100% deployment figure refers to community midwifery education graduates from HSSP-supported schools. This data comes from HSSP project monitoring and evaluation reports.

To strengthen and empower the midwifery profession, HSSP provided technical and financial support to the AMA, which was established in May 2005 with support from the USAID-funded ACCESS program, led by Jhpiego. Graduates from the accredited midwifery schools are encouraged to become members of the AMA, whose ultimate goal is to support high-quality health care for women, newborns, and communities, as well as to provide professional development opportunities, social capital, social participation, and a system of support for its members.

With HSSP support, the AMA advocated for the midwifery profession at the policy level, organized professional development opportunities to strengthen members' knowledge and skills, and provided a unified network of students and practicing midwives to share experiences. By providing such support to its members, the AMA helps to further empower midwives.

Internationally recognized as a member of the International Confederation of Midwives, the association boasted a membership more than 2,000 midwives with provincial chapters in all but one province (Helmand) across Afghanistan.

Each year, the AMA commemorates the International Day of the Midwife when hundreds of midwives from around the country and their supporters gather for the annual AMA congress in Kabul to celebrate their unwavering commitment to improving maternal and newborn health, and to raise their hands and voices to sing the midwifery song.¹⁹ These women who previously had little agency²⁰ within their communities and homes now have mobility, income, and the respect and admiration of men and women in their communities. They are empowered midwives and women, and their impact goes beyond the lives they save.



Midwives singing the midwifery song at an AMA annual congress.

¹⁹ The midwifery song, written by an Afghan midwife, is sung by the midwives at each AMA Congress and celebrates the midwives from each province throughout Afghanistan, as well as the mothers they support.

²⁰ Agency refers to one's capacity to act independently and make one's own choices.

Lessons Learned and Best Practices

There are important lessons and best practices related to gender integration that can be learned from the experiences of HSSP. The project was fortunate that USAID included an IR related to gender. Implementers don't always have control over influencing the donor's requirements or IRs, but they can ensure that gender is integrated from the start regardless of the stated IRs.

Conduct a gender analysis. Conduct a gender analysis of organizational policies and procedures, technical competency of staff, design and implementation of activities, and project results and outcomes. Identify and address gaps identified in the analysis. Early in the project, HSSP began the process of conducting research to inform program activity design and implementation. In hindsight, the results were not surprising and perhaps a rapid assessment or a desk review of available research data would have resulted in the same findings and recommendations in less time. Therefore, a lesson learned is to start with a rapid assessment and/or desk review and to only collect more data if it's needed. Also, if collecting more data, it's not necessary to wait to use the information to inform program activities and implementation until the research is complete.

Include gender indicators and targets in the project's performance monitoring plan. Once the performance monitoring plan is established, monitor and routinely report on the results. If the project isn't achieving its gender-related targets, project staff can assess why, perhaps by conducting a gender assessment. Assessing gender indicators annually is also an important lesson learned, since staff and programs change and evolve over time, and routine measurement often leads to improved outcomes. Finally, require sub-recipients/grantees to report on gender indicators, too.

Promote gender equity through human resources. Another important lesson learned is that it's important to be deliberate about ensuring gender equality in the workplace. Gender equality often requires deliberate human resource action, such as including language in job descriptions indicating that women are strongly encouraged to apply, and encouraging staff to help seek out strong female candidates if they are underrepresented in certain positions. Moreover, ensuring female staff retention and equity in upward mobility may mean creating female-friendly workplaces, through initiatives such as daycare rooms. Moreover, all staff must be sensitized and trained on gender equitable attitudes and practices so that they, too, can understand and reflect the behavior that the project is promoting in the community.

Leadership matters. Leaders set the tone and environment of an organization. If a leader prioritizes gender and gender-sensitive practices, it will become a priority for the rest of the staff, too. Moreover, including a gender focal point can provide leadership in gender integration and is a good way to ensure that gender receives the attention it deserves.

Start where you can. In places with very rigid gender norms, it may be necessary to work within the cultural context and promote gender accommodating activities if transformative activities are not yet possible. When HSSP first started, the gender focal point planned to promote gender transformation through activities that focused on changing inequitable gender norms and dynamics. Unfortunately, as previously mentioned, gender is very sensitive in Afghanistan and too much talk of women's empowerment and transformation can be dangerous. Simply having women in the workforce was

threatening to some men, and it was not unheard of for female staff working with American organizations or women's empowerment programs to be targets of threats, kidnappings, and bombings.

Therefore, initially HSSP focused on gender accommodating activities; that is, activities that worked around existing gender differences and inequalities. For example, when the gender focal point learned that the norm was to also pay for males to accompany a female participant to a training course, she was shocked and wanted to institute a policy of "no funding for male escorts." However, she was informed that doing so would result in far fewer female training participants, especially from more conservative provinces. Moreover, by allowing this gender accommodating practice, HSSP could plant the seeds for transformation. With more women receiving HSSP training, more women were improving their capacity and skills, and hopefully becoming more empowered. Also, in some cases the male escorts sat in the back of the room and listened to the training. This had the positive unintended consequence of engaging and educating men.

Integrate gender but also have unique gender-related activities. To the extent possible, integrate gender into all program activities, but also have separate, unique gender activities so you can see and measure progress. For example, HSSP did this by integrating gender into QA standards, but also had a separate section to highlight gender-specific standards to ensure not only that gender did not get lost or forgotten, but also, more importantly, that it was also monitored. Likewise, the project also had specific gender activities and training activities under IR4.

In hindsight, HSSP missed the opportunity to more formally target the accompanying males with behavior change communications to raise awareness about issues such as gender and GBV, safe motherhood, and general public health messages. It is important to look for opportunities throughout the project to promote gender integration. To do so, advocacy with partners, including government, may also be necessary. Since Ministry counterparts often do not have gender staff or focal points, it is important to support and build their gender capacity and to advocate for and support gender-related activities. For example, had HSSP not requested and offered to draft gender language and evaluation criteria for the BPHS RFPs, it may not have been included.

Don't give up! Change happens. Don't be discouraged by naysayers or slow progress. As the old Afghan saying goes, "drop by drop a river is made." HSSP's stated purpose was always to improve the quality of health services, improve the performance of providers, promote health-seeking behaviors, and ensure gender-sensitive service delivery within the BPHS. As the project continued, however, it was clear that HSSP was doing much more. Through gender integration, HSSP was in fact transformational.