Gender Norms Transformation Across the Lifecourse: The Art & Science of Implementing GREAT

COMMUNITY ACTION CYCLE (CAC)

1. How does CAC interface/link with existing traditional community structures? Can you comment on sustainability of CAC?
   The CAC does not prescribe activities or outcomes. Rather, it simply outlines a participatory process through which communities will identify, prioritize and act upon problems. Phase 1 is when you prepare to enter and work in communities. Here you will orient government officials at different levels to get their buy-in to your work, form and build capacity of the Community Mobilization Teams, and plan on how you will mobilize different communities. A series of tools or technical notes is available and can be used to: (a) conduct an inventory of resources, (b) guide interviews with community leaders to develop community profiles, (c) identify who is affected by different issues in a community, (d) conduct a checklist of preparations needed for orientation meetings, (e) guide on use of mini-dramas to introduce sensitive issues in these meetings and (f) provide a clear and accessible of how changing gender norms can lead to happier and healthier communities.

   As a participatory process for a core group of community members to engage the government, community members and other stakeholders in action to address gender inequity, gender-based violence, and sexual and reproductive health for adolescents, CAC is not only sustainable but also promotes the sustainability of community-based changes by building community capacity to address issues collectively.

2. Does the CAC address staff capacity and biases related with gender related issues? I ask as most of our staff are part of the community and share some of the values as the community, including the discriminatory ones.
   CAC addresses community capacity and biases related to gender issues, not specifically for staff. However, as part of GREAT, exploring gender issues is a critical value of the way we work and not just a desired outcome. As such, staff regularly participate in what we have called "gender pulse checks" and critical reflections around gender norms as part of their consortium and stakeholder meetings each quarter. We also held a "Looking Inward First" workshop where staff explored their own values of gender before starting up the project.

3. Is the CAC approach similar or different from what CARE calls "Social Analysis and Action"?
   CARE's Social Analysis and Action framework/guide is similar in terms of the goal of community mobilization for exploring social factors underlying reproductive health and the inclusion of steps/phases, but with different details (e.g. includes transforming staff capacity, Most Significant Change methodology). While we used CAC, we know there are many models/approaches for engaging communities and achieving local buy-in. We encourage the use of proven, systematic community mobilization/engagement approaches as a way to build community ownership and galvanize results of an intervention package. The objective of mobilizing the community is more important than using CAC specifically.

VILLAGE HEALTH TEAMS (VHT)

4. I would like to know which techniques were used under GREAT to track referrals made from the community to health centers.
   VHTs made referrals to health centers and reported in their Ministry of Health and GREAT forms the kinds of referrals made. We did not track referrals specifically. There were monthly referral meetings attended by

both the health workers and the VHTs mainly to address issues concerning referrals. At the monthly referral meeting, VHTs bring in their compiled data of how many people they had referred. The referral form also included a space for feedback, which the VHT gives to the client to confirm they had received a service. The VHT then files the referral form to verify receipt of services. All our surveys and qualitative efforts asked adolescents about their experiences with referrals and health center/staff services once they arrived.

5. How did you manage the scale-up strategy design challenges that the VHT interventions faced?
   We are not sure which design challenges are referenced here. However, during scale-up, we continue to regularly meet with VHTs during Reflection Meetings to hear their achievements, challenges, and challenge management. In order to build skills and knowledge, we coordinate Refresher Trainings for VHTs, and involve all health staff.

6. I am interested in the Rapid Facility Assessment that was done in health facilities to look at elements of youth friendliness. Was an endline assessment also done and did you see changes at facility level? Would you be happy to share this tool?
   As we were focused more on community-based intervention and links to services, we did not do an endline facility assessment. The endline survey addressed interactions with VHTs and adolescents' satisfaction with the same, with changes seen in service seeking behavior particularly among newly married/parenting adolescents. Below is the facility assessment tool.

Table 12: Checklist of Adolescent-Friendly Qualities

	Qualities	Yes	No	Suggestions for improvement
Health Facility Qualities				
1	Located near a place where adolescents — female and male - congregate? (Youth center, school, market, etc.)			
2	Open when convenient for adolescents — both female and male – such as evenings, weekend?			
3	Are clinic hours or spaces set aside specifically for adolescents?			
4	Are sexual and reproductive health services offered for free, or at rates affordable to adolescents?			
5	Are waiting times short?			
6	If facility serves adults and adolescents, is a separate, discreet entrance available for adolescents to ensure their privacy?			
7	Do counseling and treatment rooms allow privacy (sight and sound)?			
8	Is a Code of Conduct in place for staff at the health facility?			
9	Is there a transparent, confidential way for adolescents to submit complaints or feedback about sexual and reproductive health services at the facility?			
Provider Qualities				
1	Have providers been trained to provide adolescent-friendly services?			
2	Have all staff been oriented to confidential, adolescent-friendly services? (Receptionist, security guards, cleaners, etc.)			
3	Do staff demonstrate respect when interacting with adolescents?			
4	Do providers ensure the clients' privacy and confidentiality?			
5	Do providers set aside sufficient time for client-provider interaction?			
6	Are peer educators or peer counselors available?			
7	Are health providers assessed using quality standard checklists?			
Program Qualities				

1	Do adolescents (female and male) play a role in the operation of the health facility?			
2	Are adolescents involved in monitoring the quality of sexual and reproductive health service provision?			
3	Can adolescents receive services without the consent of their parents or spouses?			
4	Is a wide range of sexual and reproductive health services available? (Family planning, prevention and treatment of sexually transmitted infections, HIV testing and counseling, pre/postnatal and delivery care)			
5	Are there written guidelines for providing adolescent services?			
6	Are condoms available to both young men and young women?			
7	Are sexual and reproductive health educational materials or posters on site, designed to reach adolescents?			
8	Are referral mechanisms in place? (for emergencies, mental health and psychosocial support, etc.)			
9	Are adolescent-specific indicators monitored? (e.g. number of adolescent clients, disaggregated by age and sex)			
	Totals			
Key: 0-13 'yes' ticks: Services not adolescent-friendly 14-20 'yes' ticks: Services somewhat adolescent-friendly 21-25 'yes' ticks: Services very adolescent-friendly				
Adapted from African Youth Alliance/Pathfinder International, Save the Children & UNFPA				

7. Are the formative research and health facility assessment tools and reports available?
   The formative research report is available here. Please email irhinfo@georgetown.edu if interested in the Facility Assessment tools.

8. How did you encourage health center staff to support VHTs?
   Health center staff was oriented and attended monthly Reflection Meetings with VHTs during the pilot phase. Additional advocacy occurred during district coordination meetings. From the beginning when we selected the VHTs to work with, we were emphasizing the importance of health staff support and mutual trust and acceptability of VHTs. In fact, health center staff were involved in selecting the VHTs we worked with. During the trainings, we bring both VHTs and health center staff together, which provided an opportunity to get to know each other. When a health center staff meets a VHT at a health facility, they are better able to work together, have meetings together and event share VHT reports. Also, it is important that the VHT report to health center staff, especially those staff in charge, or the staff member charged with liaising with the VHTs. Health center staff also provided integrated quarterly support supervision, and monthly mentorship and data verification support

TOOLKIT

9. Would it be possible to use the toolkit to educate also the parents?
   Yes. The toolkit components, especially the board game, may be used to educate parents and other adults. Note also that there are specific versions of the toolkit materials for newly parenting adolescents as well. Even the very young adolescent flipbooks are a useful tool for parents to learn about puberty and gender norms so they are better able to talk to their children about these issues.

RADIO SERIAL DRAMA

10. Do you have concerns about men listening more than women to radio dramas (71 vs 48 %), boys being more likely than girls to participate in VYA toolkit exercises in school, etc.? Of course men need to change their gender norms, but is there any possibility that these imbalances in participation might be skewing progress against girls and women? Is there any way to evaluate impact of men's/boys' changes on women & girls?
    These are interesting questions. We are exploring the many critical interactions and power dynamics involved in SRH and GBV behavior change through analysis of the cohort study data. It is important to note though that engaging men may also be catalytic for changes among women and communities rather than contradictory or undermining of women's progress.

11. It would be great to highlight how the "expected" was computed.
    Due to broad coverage of the radio drama even in control areas, effect sizes for the GREAT project interventions were obtained as difference-in-difference estimates from models using propensity score matching. Linear regression was used to obtain the effect sizes. Counterfactual outcomes (what would have been expected in absence of exposure) were generated for the exposed and compared to actual observed outcomes. Please see the endline report for additional details here.

MISCELLANEOUS

12. What are some of the norms that have persisted even in areas where GREAT project has been implemented?
    Although norms around gender equality are changing, those related to gender-based violence (e.g. women tolerating violence to keep their families together, violence being a private matter between husband and wife) still persist. This, however, is realistic given the nature of transforming social norms such as those related to violence. Some work also continues to be needed around broad acceptability of adolescent family planning use.

13. After the webinar is there a certificate? In addition, are there handouts or PowerPoint slides to be provided?
    PowerPoint slides are available here. Unfortunately, we do not plan to give out certificates for this webinar.

14. Would you be able to share all the materials, including those mentioned in Camille's presentation for developing relevant dramas that cover all the area they need to cover to be effective?
    Please visit the GREAT project page here for all GREAT materials. Specifically for the Radio Serial Drama tools that Camille mentioned, take a look at the Pathways to Change toolkits:
    http://www.pathfinder.org/publications-tools/pathways-to-change-game.html,
    http://www.pathfinder.org/publications-tools/Pathways-to-Change-Moderators-Handbook.html

15. What do you mean by the "Most Significant Change methodology"?
    Some resources for Most Significant Change here.

16. I'm curious to know about staff buy-in to the project. How did project leadership ensure staff fully supported activities? We know that at times staff promote practices and norms that they themselves do not support. I'm interested in knowing how the project ensures staff are fully committed to the objectives.
    Exploring gender issues is a critical value of the way we work and not just a desired outcome of the GREAT project. We believe that transformation begins with ourselves and as such, staff regularly participate in 'gender pulse checks' and critical reflections around gender norms as part of their consortium and stakeholder meetings. See question 2.