



Using ICT to Enhance Equal Involvement of Men and Women in Maternal Healthcare

Health Child | Uganda

I INTRODUCTION

This case study presents the work and experiences of a Ugandan community health organisation which introduced ICT-enabled solutions in the provision of maternal healthcare. The study begins with a description of context then goes on to discuss what organisation staff and stakeholders learnt from using a variety of ICT tools and services to support women and men's engagement with maternal and child health in Ugandan communities. These lessons learnt are presented along with good practices and the conditions required for such practices to be implemented effectively.



1.1 The context

Health Child, a Ugandan NGO established in 2006, has implemented child health programmes which aims to increase the access of pregnant women to health services. These programmes ultimately aim to reduce maternal, neonatal, and child mortality.

The goals of the maternal and child health (MCH) programmes are to increase antenatal care attendance, enhance birth preparedness, increase deliveries in health facilities, increase the uptake of postnatal care services, and support greater and more informed family planning. By partnering with Connect4Change (C4C), Health Child integrated ICT solutions into key interventions and activities of this MCH programme.

Until recently, Health Child's key approach to implementing these programmes in the communities was through Family Support Groups. In realising that women's access to health-related decision-making is greatly affected by their economic status, these Family Support Groups

evolved into Village Saving Loans Associations (VSLAs)¹ to increase women's access to and use of financial resources to meet their health-related needs. In this case, these needs were specifically focused on pregnancy and postpartum care. In addition, VSLAs act as a platform for the communities to hold dialogues and learn about the core focus areas of Health Child.

Health Child works closely with health workers and community representatives to implement its activities. This includes working with Village Health Teams (VHTs)², health centre staff, and Community Based Trainers (CBTs) who support and monitor the VSLA groups.

On the topic of location and focus group participants, this case study was carried out in the Jinja district. The good practices and conditions for success came from focus group discussions with 34 female and 24 male participants. This included the staff of the implementing organisation.



1: A VSLA is a self-reliant group of people who save together and take small loans from those savings. The activities of the group run in cycles of one year, after which the accumulated savings and the loan profits are distributed back to members. The VSLAs run using the pooled sources of members, there is no external support. Most of the VSLAs are women only, a few are mixed or men-only. Health Child requires that in the mixed ones the ratio of women to men is 4:1 and women hold leadership for the key positions.

2: Village Health Teams serve as the primary, village-level health contact for all villages in Uganda, the equivalent of a low-level health centre. The members should be capable of relaying basic health information to their neighbours, as well as pointing villagers to the right locations for various levels of health care.

2. GOOD PRACTICES THAT PROMOTED EQUITABLE PARTICIPATION AND BENEFITS-TAKING FOR BOTH WOMEN AND MEN

The good practices that have emerged from Health Child's work partly concern specific ICT tools and services and partly programme approaches. Programme approaches included the use of different ICT tools utilised in combination. Both are presented below along with the gender-related changes that are attributed to the ICT tools and services.

2a. Mobile phone SMS texting and voice messaging

Health Child used SMS and voice messaging to provide information and education on maternal healthcare, including messages on antenatal and postnatal care, birth preparedness, family planning, and messages encouraging male involvement in health-related activities. Village Health Teams (VHTs)³ played a critical role in Health Child's SMS and voice-message supported interventions because of their ability to reach communities and influence gender-related change. An example of this was VHTs receiving messages instructing them to inform female community members about their scheduled antenatal visits. This was especially important for female community members who did not have a mobile phone. For those women who had phones, VHT members received messages simply to remind them to attend their antenatal visits.

The way messages were delivered turned out to be important. VHTs were encouraged to deliver messages at times when both the husbands and wives were at home which gave couples the opportunity to have in-depth discussions about maternal and child health issues and ask questions they might have. VHTs would also use these moments to encourage husbands to support their wives actively during pregnancy and in preparing for birth. In instances where the husband owned a phone, they too were signed up to receive messages so that VHT visits and discussions could be reinforced.

During the course of implementation, Health Child introduced some changes regarding the use of SMS messaging:

- a. Health Child found out that the *sex of the person in voice messages* mattered. The community did not find the original man's voice appealing which resulted in Health Child changing to a female voice. Moreover, the community recognised the original person behind the voice and further objected since he had become controversial due to his

behaviour. At that point, Health Child ended his involvement. Both men and women said they preferred the female voice because they felt it was more inviting.

- b. Health Child also found that the *kind of messages that were sent and to whom* mattered. In analysing the success rate of text message sent to women about antenatal care, birth preparedness, and postnatal care, Health Child noticed an interesting occurrence: the outcome was influenced by the kind of messages that were sent and the extent to which they involved men as active players. **“Men did not seem to appreciate the messages and sometimes asked why they were being sent to them and yet they concerned their wives. We realised that we had to get men on board because many of them own the phones, control resources and make decisions in the households.”** As men are the key players in enabling women's access to maternal health, Health Child adjusted the content of its messages to target them more directly. Specific messages are now sent to each husband referring to his wife's situation. Messages include information such as which trimester his wife is in, the need to remind her to get antenatal care, and the need to accompany her to the health centre. The messages for the woman would be directed to her and include content about her specific situation.
- c. Health Child further found that *mobile phone ownership and use* influenced the uptake of messages. During the course of implementation, Health Child put more effort on ensuring that their records included *telephone contacts of those closest to the women or those who could pass on the messages to them*. To inform their strategies, Health Child conducted a survey on 'how text messaging supports mobilisation for family planning uptake and adherence'. The study showed that although 75% of the women who had

3: Health Child worked through VHTs to implement some of its interventions in the communities particularly the home based care programmes, facilitation of community dialogues, and awareness creation and knowledge sharing on maternal health issues. VHTs are respected community members who support local government health initiatives at community level. With the support of local community leaders Health Child identified both male and female VHTs to support their work in the communities.

received the SMS messages turned up at health facilities for family planning services, only 40.8% owned a mobile phone and received the messages directly. Upon further examination, it was found that the women who did not own a phone had received the messages from their husbands or from VHTs. Reflecting on this finding, Health Child noted the importance of understanding and working with the existing information networks around the women. To understand better the actual issues around the uptake of messages communicated via mobile phones, Health Child carries out specific surveys on on-going interventions to assess the effectiveness of a particular tool and to be able to respond appropriately and immediately to whatever emerges. Such surveys are conducted either through an interactive SMS-messaging platform or through a call centre where staff conduct exit surveys through mobile phone based conversations⁴. Additionally, Health Child holds focus group discussions and feedback meetings amongst cohorts of women and men.

- d. Informed by feedback from the VHTs⁵ and joint discussions on how to respond to challenges well, Health Child included specific ICT tools to better involve men. This included appropriate SMS messages and the use of other ICT tools (like community radios, videos, and board games - see below). For instance, VHTs (particularly women) had been the key recipients of SMS messages announcing family planning outreach activities that were organised by Health Child. They in turn sent the messages to men and women who owned a phone, followed by visits to the women to encourage and mobilise them to attend the activities. In one area however, a group of VSLA members recounted that the VHT, which had been informing and mobilising women to attend family planning meetings, began to experience hostility from husbands. This was likely due to the fact that women were targeted specifically whereas their husbands were not directly informed, a choice that women advocated as they did not think their husbands would support them. The husbands did not receive the VHT's activities well partly because it was done without their consent but also because they were apprehensive about the idea of family planning generally. After Health Child analysed the causes of men's reactions further, it discovered that in general, men were ignorant about family planning and actually wanted to be a part of the decision making process and help choose which planning method to use. In response

to these findings, Health Child initiated a comprehensive training programme for men on family planning and on the use of the ICT tools mentioned above.



The adjusted practices on targeting the right people with messages tailored to their role and interest can be called good practices concerning mobile phone-based messaging. This is evidenced by the following findings:

- Both men and women expressed high appreciation for the SMS messages because of their frequency and feeling of 'personalisation'. People's biggest challenge in receiving messages was a lack of electricity to charge their phones. This seemed to be a bigger problem for women because men often leave their homes in the morning to charge their phones at trading centres. Women on the other hand, cannot leave home and have to depend on their children who go to school. This results in women missing messages or getting them late. The second major challenge has been regarding illiteracy. However, to overcome this, women often ask their friends or husbands to read the messages for them. Alternatively, they were happy with voice messaging because it allowed them to understand messages accurately.
- The VHTs said that being 'carriers' of the SMS messages about antenatal care made their work easy especially because the messages were specific for each woman and both women and men felt special receiving a message from Health Child. According to the VHTs interviewed, **"the community members, especially the husbands accepted us, received us with respect, and were comfortable to ask questions or seek any other support they needed."** The VHTs delivering the messages enabled discussions that would otherwise probably not take place. This is because they provided a safe environment for conversation between spouses. Men were even challenged by their fellow men to discuss issues related

4: Both means of conducting surveys were administered by Connect4Change (C4C)'s technology partner TTC Mobile

5: Health Child had encouraged VHTs to note the responses of both men and women as they did their work, and as community members who understand the context very well they were able to provide feedback to Health Child.

to maternal health which broke 'gender taboos' in a positive way considering that these are traditionally seen as a female domain.

- Male involvement in supporting expectant mothers increased. Examples of this include men accompanying their wives to health centres for antenatal care and delivery, taking responsibility to provide financially for their wives in regard to preparing for birth, and participating in decisions such as where to give birth and ensuring antenatal care attendance. This can be attributed to sending personalised and relevant SMS and voice messages to men. Some men even began taking their children for immunisation to support their wives who had other children to take care of at home.
- Men's knowledge about maternal health increased, as did their appreciation of family planning. These increases were attributed to intensified sensitisation about family planning through the use of text messages and other ICT tools, which took place after Health Child discovered that the knowledge levels of men were low and their attitudes negative.
- Amongst women, results show that they are more informed about their health, are able to prepare for childbirth, are able to attend antenatal clinics, and are more empowered to make health-related decisions at home because of the messages and the support from VHTs. Female respondents noted that several things were especially important: 1) the better preparation for birth through being able to finance the mama kit⁶ and 2) the regular attendance of the antenatal clinics.



Because of the success of the messaging programme, Health Child also used these tools to enhance participation in VSLAs. In practice, this was done by encouraging attendance, saving money for mama kits, and participating in community dialogues. SMS text messages were sent to VSLA members reminding them about key principles of the VSLA including a reminder of the next meeting day. Through the VSLAs, both women and men committed a percentage of their weekly savings to health care which enabled them to meet their needs and those of their families.

Moreover, Health Child has begun the process of developing a new mHealth solution – the Star Life Card – which is a digital smart card that allows people to save money for health purposes on the card and use it to access health services at participating private clinics and hospitals. This will enable members to access needed health services faster since they will not need to wait for weekly group meetings during which cash withdrawals take place.



6: A mama kit contains plastic sheeting, razor blades, cotton wool (gauze pad), soap, gloves, cord ties, and a child health card. It includes an instruction sheet in both English and Luganda. All of the supplies are sealed so that they remain sterile until needed.

2b. Video-based instruction and basic computer training

At the start of the ICT integration programme, Health Child provided ICT training to VHTs (and health workers - see below) in order to build their capacity to support their communities on issues of maternal and child health. The training used a lot of practical video clips, provided VHTs with basic computer skills and taught them how to use the internet to access maternal health related information. Male VHTs showed more interest in the computer training than the female VHTs, although the interest of some females increased over time and they kept on using the skills acquired. Reasons for women's lower attendance included their heavy workload, low literacy levels and their unfamiliarity 'machines'.

The trainings were housed at Health Child community resource centres with computers and internet provided by Health Child which the VHTs could access easily. However, Health Child was required to move the centres from community locations to their offices which resulted in VHTs and health workers finding it difficult to access computers and search for information. That said, one female VHT in Soweto village shared that she extended her skills to access websites on her phone and occasionally uses it for reference.

The combination of computer skills training and video-based instruction for both male and female VHTs can be considered a good practice as evidenced by the following findings.

- The VHTs who attended the trainings said the experience had enabled them to increase their knowledge and understanding of maternal health: **“what we learnt from the computer stayed with us because it was pictorial, pictures imprint themselves on the mind and do not go away easily. I could recall them whenever I was training the community members.”**

- The computer and internet training also enabled the VHTs to gain confidence to respond to questions asked by community members; **“when the community asked difficult questions, we would write them down and search for them on the internet in the next training.”**
- The mixed training of the male and female VHTs contributed to respect and cooperation between the two genders. The men felt their female counterparts were at the same level with them. The training also demystified conversations about sexual and reproductive health leading to male VHTs being able to teach and address 'sensitive issues' and increase male involvement in areas traditionally known to be the exclusive domain of women.

The training has not only built the capacity of VHTs but has also had a broader effect: the VHTs' work in communities has earned them respect and built the confidence of the female VHTs. Their emerging leadership was evident during the study. The female VHTs (as well as VSLA leaders) reported that they were now bolder and could speak in public with confidence. Two female respondents said that they were now able to speak confidently on radio talk shows whilst another said she frequently asks pastors for the opportunity to give talks in churches. Another female VHT provides support to a health centre's maternity ward in her area as well as providing assistance to an HIV focused NGO (TASO) in its work on Prevention of Mother-to-Child Transmission. These personal and professional advances are examples of increased aspiration of VHT members to serve community health goals as well as their increased ability to act on their aspirations.



2c. Interactive community events – radio and video

Health Child used community radio and video shows to sensitise and educate large numbers of people with key messages on maternal and child health, sanitation, and hygiene. The people participating in the focus group discussions highlighted the positive role of community radio because of the excitement it created, its use of local languages, and its being interactive and reaching everyone at the same time. These ICT tools also seemed to get more people interested in Health Child's activities more broadly.

When Health Child gained new insight on the critical role men play in enabling or limiting women's access to maternal and child health care, they further adapted both tools to maximise their usefulness:

a. In the rural areas of Uganda, markets are popular places where men often converge. With this in mind, the project organised *community radio events on market days* as organisers could be sure that a good number of male listeners would be there. At these events, which are moderated by VHTs or health workers, loud speakers are used to sensitise people on health-related issues. People calling in with questions or issues were usually men whereas women (typically young) mostly came in person or wrote their

questions down on paper for privacy reasons. Such community radio events using loud speakers provided opportunities for dialogue and sensitisation on issues that men and women struggle to discuss together such as family planning.

- b. They developed *quiz SMS texts* which were sent to those who attended the events to facilitate further participation and information sharing within the community. These SMS quizzes were specifically targeted at couples and the couples that won the contests received prizes. This seemed to attract men to participate and supported couples to engage in discussions about the issues as they attempted to respond to the questions.
- c. They developed *special radio talk shows targeted at men* and conducted by health personnel, Health Child staff, and VHTs. This was done because men are most likely to own radios or to listen whilst in the company of other men in bars.
- d. They began to *screen videos in video halls* where men were likely to be found for entertainment purposes. Health Child staff would request the local video hall owner for a few minutes before a movie or game to show the video and facilitate a brief discussion on the subject addressed in the video.



2d. Other non-technological ICT tools

In addition, Health Child developed various non-ICT tools to attract and inform community members, especially men. Examples of this were board games and playing cards that were designed with messages about family planning and health and especially designed for men to use at their regular meeting places. The games were designed



in such a way that they generated discussions on the issues. Some, for example, had questions that players would have to answer which would spark off a discussion or conversation. Health Child also put up 'inspirational corners' at strategic points in health centres such as close to antenatal care rooms and immunisation rooms. These showed the best and worst practices of real-life community cases and were illustrated by testimonies and a picture of the actual person and his or her experience.

Two types of good practices have to do with programme approaches in which a combination of the ICT tools mentioned above are used: tailoring ICT solutions to address the needs of men as key actors in access to maternal health and working in partnership with health institutions and designing relevant ICT tools for them.

Good Practice: Tailoring ICT-based solutions to address the needs of key actors (particularly men) in access to maternal health

When Health Child initiated its maternal and child health programme, it mainly targeted women and so did its ICT solutions. SMS texts were sent to expecting mothers to remind them about preparing for childbirth, attending antenatal clinics, and taking on family planning after giving birth. The messages were sent directly to the women who had phones and in the case of those who did not have phones, were sent to VHTs and the respective contacts the women had given when they joined the programme. Through monitoring, feedback, and review processes, Health Child noted that the outcome in terms of numbers, level of preparedness, quality of care, and sustainability were not only dependent on the women. It was noted that their husbands had a key role to play because they were still the key decision makers at the household level and in most cases, owned the phones. One of the staff reported **“we saw that when you visit the community, it is men who come out first so they have a lot of influence. We discovered that men still dominate ICTs so we had to work through them, they still dominate decision making so it is important that they are involved right from the start. We saw the need to develop approaches that reduce resistance from the men, we needed to win them over first. Even if the women were our target, we needed to involve the men. We needed to develop an ICT package for men that addresses their needs and obligations including finding them in the places where they are - in trading centres, on market days, that is places**

where there is money”. Therefore, men were seen as critical players in women's access to maternal and child healthcare, including the provision of money to meet their wives' needs for birth preparedness or decision making around family planning uptake and methods. Health Child made various adjustments in the ICT tools and/or the way they were using them to attract and involve men. Having analysed the needs of men and their preferences for certain tools/methods (for example Health Child found that men were not enthusiastic about attending community dialogues), they made adjustments. Most are mentioned under the ICT tools and services above:

- a. *Personalising SMS messages* for husbands to support their wives to access good maternal healthcare.
- b. *Looking for places where men are likely to be found:* market days to hold community radio events, video halls to show videos with a short discussion thereafter, radio shows broadcast in bars, and the like.

We call this tailoring of ICT-based solutions a good practice in view of the experiences and views brought forward in the study which hinted at significant gender changes in the communities related to health. These include:

- The willingness and cooperation of men to support their wives because the personalised messages made them feel respected, challenged, and motivated to take action.

- Significant changes in male attitude about maternal health and in regard to supporting their wives as described above. The fact that a male VHT dealt with so-called women's issues or issues that were considered taboo had a positive impact on the willingness of other men to engage in these issues as well.
- Reduction of domestic violence resulting

from conflict around family planning issues. This was mentioned by both male and female members of VLSAs in one specific area. The involvement of both men and women in family planning discussions has resulted in better relationships between men and women and 'lightened' the burden for women particularly around issues of child spacing.



Good Practice: Building the capacities of health-related partner institution staff and designing relevant ICT tools for them

In implementing its programme of increasing access to maternal health and uptake of family planning, the community health centres in particular were critical stakeholders. Through surveys and feedback from the VHTs and community members, Health Child noted that health centre staff attitudes, skills, and levels of confidence had a negative influence on the possibilities of expectant mothers to access good services. Therefore, Health Child included capacity building for the health workers (midwives and nurses of both genders) using videos, having them participate in the community radio events and radio talk shows, and in running and managing family planning outreach. Some of the centres also had inspirational corners where Health Child put pictorial and narrative experiences of community members on issues of maternal health. The health centre workers were also amongst the recipients of SMS texts especially the interactive, promotional and quiz messages on issues of maternal healthcare. Based on the views of the few health workers participating in the study, the use of the ICT tools had a more lasting effect in general and also on the relations between midwives and the husbands of expecting/new mothers.

- The messages kept issues of maternal health in their minds **“They challenged us and got us discussing issues related to maternal health care, they helped us recall some things that**

we had forgotten”. Others, who had been involved in a training on caring for the new born and the new mother, said that **“the video is still imprinted on my mind, it helps me to visualise the danger signs, as a male health worker who did not do midwifery. I saw great benefit in this because for the community, whoever is working at the health facility is seen as a doctor who can help, whether male or female so they call you. This has helped me and I am sure the male nurses to have more confidence to help the women”**.

- The work of health workers has been made easier and more efficient. Due to the text messages with information from Health Child and from the government (alerts on epidemics and other issues), they do not physically have to inform the communities. The health workers also send the data they collect weekly to the district health offices using text messaging.
- Midwives said they felt more confident now, have been able to reduce neonatal mortality, and are more responsive to the needs of pregnant women and to those of their male partners. They ‘respect’ men who accompany their wives for antenatal clinics and attend to them first knowing that they have done something ‘special’. This has motivated more men to accompany their wives to the clinics and challenged other men to do the same.

3. CONDITIONS AND PROCESSES THAT FACILITATE THE GOOD PRACTICE APPROACHES

The ICT-related practice approaches that were described above have enhanced equal participation of women and men in maternal healthcare programmes and have increased equitable benefits for women and men at the household level. The case study also shed light on a few factors that are critical to the success

of these ICT-related good practices, especially those that are related to conducive organisational practices and processes. The ICT programme appears to have triggered organisational change and the urge to take more action to increase the organisation's and programme's gender responsiveness.

Critical Factor: Existing gender sensitive programme approaches

Health Child is strongly aware of the importance of learning from its experiences and using the lessons to influence new action. With that in mind, it uses an action research based methodology to implement its programmes. Programme interventions are carried out and continuously reviewed through various activities and processes which include, but are not limited to, 1) reviews with community members after an activity is implemented by field staff or VHTs, 2) joint analysis of field reports by staff, and 3) analysis of quantitative data collected on that particular activity. The data collection tools used during these review processes are sex disaggregated so they enable Health Child to note the gender-related trends or emerging issues regarding that particular issue. All the information is shared, analysed, and interpreted during organisational meetings. In practice, this takes place in several ways, one example

being weekly organisation-wide Skype meetings to enable inclusion of staff of all the offices in the different locations. The adjustment of ICT approaches described above was the result of Health Child's gender sensitive action research based methodology.



Critical Factor: Openness to gender dynamics during programme implementation

Through Health Child's monitoring and learning systems, certain gender-related challenges emerged. Amongst these in particular, was that the ICT tools were not addressing the needs and interests of other critical stakeholders, particularly those of men. Health Child saw the importance of knowing and using relevant gender statistics, assessing what ICT tools were accessible, who the most common users and owners of the ICT tools were, and how willing they were to participate in Health Child programmes. As one staff member put it; **“We realised that in working with ICT, it was critical to get feedback on a routine basis to know the existing or changing needs of the men and women.”** For obtaining feedback on a routine basis and for that information to be useful, Health Child had to make some key organisational changes:

- First, it had to strengthen its *mechanisms of collecting and analysing the information* in an organisation-wide context. Health Child did this by ensuring that the VHTs collected the relevant information and shared it through reports and monthly meetings with the programme staff responsible. Staff who carried out field activities also compiled reports and shared them. Weekly staff meetings were designed to include participatory reflection on key emerging issues brought forward by the teams responsible for an activity, ensuring that all staff, including the ICT officer who presides over the quantitative reports, participated in addressing issues and concerns.
- Second, *the routine monitoring and evaluation processes* on activities needed room to

make adjustments at each stage in terms of strengthening the gender aspect in collecting and analysing information. For example, the VHTs would ask what men thought about some of the trainings or issues in order to bring out their questions and concerns. This enabled Health Child to respond with new ICT-supported actions that were gender responsive in that particular context.

- Third, there is a need to further *build staff capacity* in understanding gender dynamics and using gender analysis skills. As one of the staff members highlighted: **“Because we work on issues of maternal health and involved men in the process, there was an assumption that we are all well versed with gender issues, I think we can benefit from training on gender sensitive programming. In the beginning when it was mostly about capturing numbers it was not critical, but as time went by and there was a need for deeper analysis especially in regard to getting men on board, we saw that we needed more gender competence.”** The need for these skills became even more apparent as Health Child had taken on new initiatives like the VSLAs in which maternal health issues are integrated. The SMS texts and voice messages related to the VSLAs are gender neutral and mainly focus on motivating participation in the VSLA. VSLAs are beginning to surface existing and emerging changes in current gender dynamics as a result of women beginning to own resources. One of the women groups that was visited expressed bitterness towards men and shared how even though they have money now, they cannot tell their husbands about it or even use it for household needs which the man is supposed to provide. This is indicative of potential conflict around resources which Health Child has realised and which could eventually have an effect on women’s health

too. The upcoming innovation of the Star-Life Card will likely influence both men and women and issues of access and control may come in affecting women’s access to and use of health services. At the moment, Health Child does not have a particular tool to enable dialogue around gender issues within the VSLA. It will require more knowledge, skills and competence on gender programming for staff to enable them to develop and integrate gender responsive ICT solutions in these innovations at the appropriate time. In this respect, according to Health Child, the ICT programme contributed to capacity building through learning forums organised by the wider Connect4Change programme in which organisations doing similar work to Health Child came together every 6 months for ICT-related information-sharing events to jointly draw lessons from what they were doing.

- Fourth, Health Child realised that it needed to *develop a more holistic gender approach* in its interventions as opposed to addressing the particular needs of only one group: **“We saw that it was important to be on top of gender dynamics in the field and address them as they arose, and for any ICT solution to be successful, it must take into account both women and men”**. This need became visible when Health Child’s analysis of field data showed that even when women had relevant information about accessing maternal health, many of them did not have resources to do so and neither could they negotiate in a situation of lack or total dependency on men: **“We saw that gender empowerment especially in poor communities should be seen in partnership with economic empowerment”**. This eventually led to forming the VSLAs particularly for women, although Health Child insists that men too are members.



Critical Factor: Strong leadership in increasing gender responsiveness at the organisational level

The role of organisational leadership in enabling the gender focused data collection and analysis cannot be underestimated. Health Child noted that they have had to learn to make time particularly during the weekly meetings (which sometimes stretch through the morning) even when they have very busy schedules. Such a strong organisational leadership role is also imperative when it comes to facilitating staff development and other human resources issues, budgeting, and the like.



Health Child felt the need to balance the gender composition of its staff better and took efforts to do so. Since then, the ratio female to male changed from 11:2 to 13:5. The staff believe that female dominance amongst employees has

influenced the interventions: **“Everything had a very feminine face, the community would note and comment, our partners too had noted it. It was sometimes difficult for women to appreciate the views of men in the communities or convince them about male-related issues.”** In the process of bringing in more male staff, they discovered that the men brought on board aspects and views previously missing in the organisation: **“we were able to see the different paradigms and perspectives of men and their views were very instrumental in formulating SMS texts targeting men”**.

Some of the programme staff expressed the need for Health Child to institutionalise gender approaches in its work further by developing a gender policy for the organisation. Such a policy should include how it works with the community and staff members feel strongly that it needs to be developed using participatory methodologies that include the communities they work with. Having such a policy in place will enable a common understanding of the organisation’s approach to gender issues and provide guidelines for developing interventions, including ICT-based ones. It would also enable budgeting for the ICT solutions in the planning stages of new programmes as Health Child was not able to sustain some of its ICT-supported programmes due to the end of Connect4Change project funding.

This case study forms part of an IICD publication on gender equality in ICT4D titled ‘*Promoting Equal Chances for Women and Men to Use and Benefit from ICT-enabled Solutions*’ (2015)

ABOUT IICD

The International Institute for Communication and Development (IICD) was a non-profit foundation that specialised in Information and Communication Technology (ICT) as a tool for development. IICD was mainly active in sub-Saharan Africa and Latin America, where we brought about technical and social innovations that created and enhanced development opportunities in economic development, agriculture, education, governance, and health.

ABOUT GRF

The Gender Resource Facility (GRF) provides expert advice, technical assistance and knowledge services on gender equality and women’s rights to the Dutch Ministry of Foreign Affairs, its embassies and partners.

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