In partnership with Canada

PLAN INTERNATIONAL

# STRENGTHENING HEALTH OUTCOMES FOR WOMEN AND CHILDREN

## Lessons from Ghana

# INTERGENERATIONAL DIALOGUE

A catalyst for a gender-responsive and adolescent-friendly health system in Ghana

# THE PROJECT

Ghana has a well-organized health system, with the public sector predominantly responsible for policy design, system development and service provision. Involving communities as partners in health care decisions can significantly improve the system's performance. The *Strengthening Health Outcomes for Women and Children* (SHOW) project[i] in Ghana is an example of building such partnerships between the community and the health system to improve the system's performance for the health and wellbeing of women, children and adolescent girls.

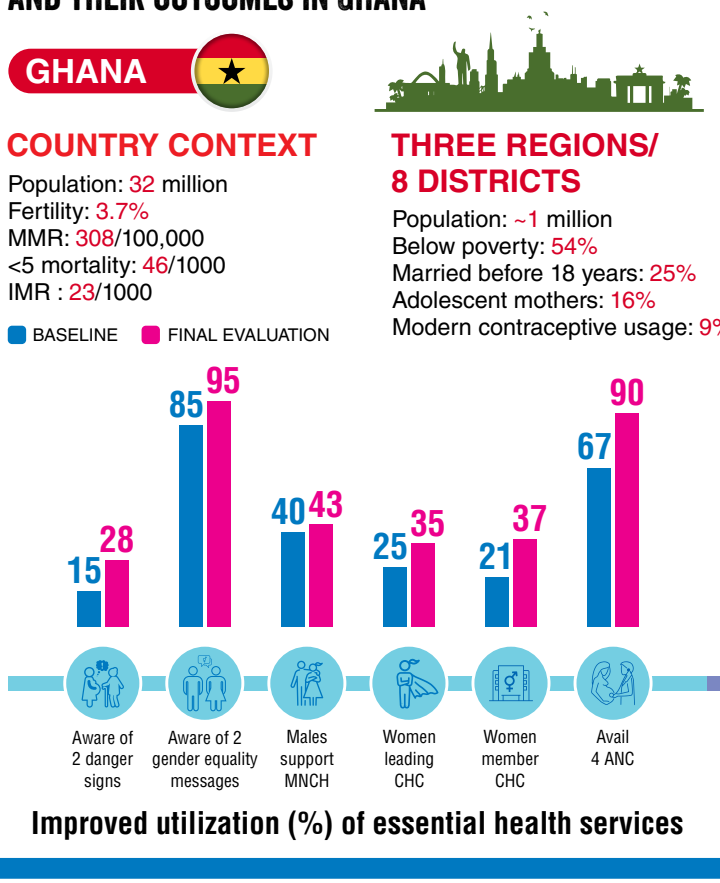
The SHOW project[ii] is a gender-transformative initiative aimed at increasing the quality, availability, utilization and accountability of essential Maternal, Newborn and Child Health/Sexual and Reproductive Health (MNCH/SRH) services to reduce maternal and child mortality amongst marginalized and vulnerable women, specifically adolescent girls, and their children in targeted regions across five countries (Bangladesh, Ghana, Haiti, Nigeria and Senegal).

With support from Global Affairs Canada (GAC)[iii], Plan International Canada worked in partnership with Plan Country Office, the Government of Ghana, and Local Non-Governmental Organization (LNGO) partners to deliver the SHOW project between January 30, 2016 and September 30, 2022. In August 2020 and March 2021, the SHOW project received two Costed Extensions (CE) from GAC focused on the Coronavirus Disease 2019 (COVID-19) response in Bangladesh, Senegal, Ghana and Nigeria.

In Ghana, the SHOW project was implemented in eight districts from three regions of the country. The districts belonged to the Northern, Volta, and Eastern regions of Ghana, and were mostly inhabited by vulnerable populations experiencing heightened poverty. These districts were selected in collaboration with the Ministry of Health (MoH), based on MoH priorities, community consultations, donor mapping and Demographic and Household Survey (DHS) results.

The project started with a comprehensive situation analysis, which comprised a desk review and consultations with stakeholders, a baseline survey of households and health facilities, and a qualitative exploration of gender-related issues in the overall health and social environment. Informed by this situation analysis, the project adopted gender-transformative rights-based approaches[iv] to build the foundations of Gender-Responsive, Adolescent-Friendly (GRAF) health care underserved districts of the country with high rates of poverty. The project aimed to bring this transformational change in the health system by enhancing access to and raising awareness surrounding Maternal, Newborn, and Child Health/Sexual and

**FIGURE 1: THREE PILLARS OF SHOW PROJECT AND THEIR OUTCOMES IN GHANA**

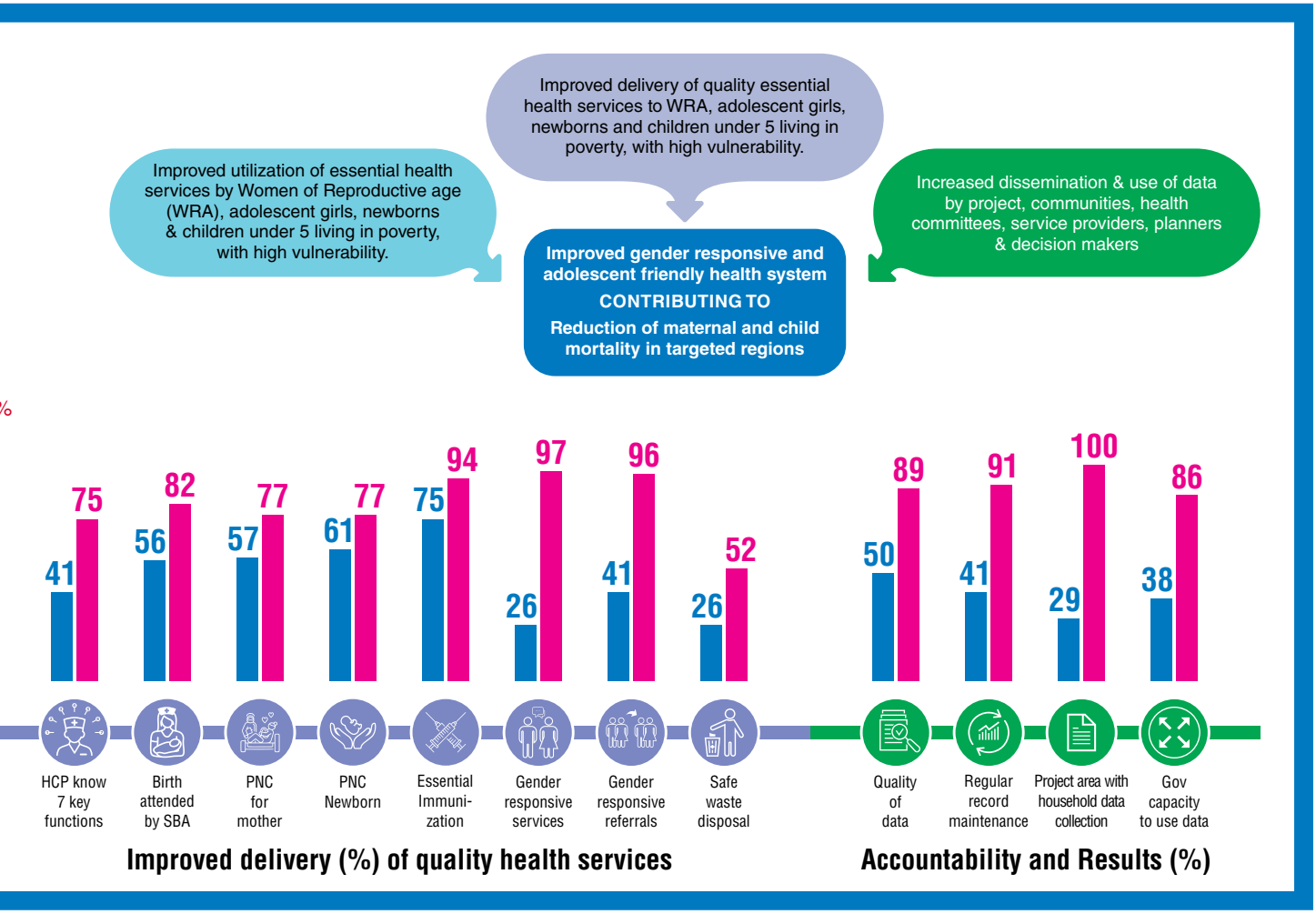


Reproductive Health and Rights (MNCH/SRHR), including family planning. Aligned with the United Nation's *Every Woman Every Child Global Strategy for Women's, Children's, and Adolescent's Health* to achieve the Sustainable Development Goals 3 (health & wellbeing) and 5 (gender equality), the project worked on three parallel streams:

1. Building the individual and collective agency of women and adolescent girls by enhancing their decision-making power in the household, community and health committees, and engaging men as partners and beneficiaries of gender equality in the continuum of MNCH/SRHR care.
2. Health Systems Strengthening to improve the availability, accessibility, quality and gender- and adolescent- responsiveness of MNCH/SRHR services.
3. Accountability of health services to the communities that they serve, particularly women and adolescent girls, by improving data collection, analysis, data sharing and its utilization in decision-making.

SHOW in Ghana achieved[v] a cumulative reach of 379,119 direct beneficiaries. These included 103,381 women and 86,293 men aged 20-49 years, 75,547 adolescent girls and 70,707 adolescent boys aged 15-19 years, and 21,975 girls and 21,216 boys under five years. The project also reached indirect beneficiaries at different levels, including 1,004 health service providers (504F and 504M), 5,330 Community Health Volunteers (CHVs), (2,338F and 2,992M) 378 government officials, 26,034 village savings & loans association members, 480 Fathers' Clubs and 476 mothers' groups.

The project evaluations[vi] conducted at baseline



and endline showed (Figure 1) improvement in all the intervention areas designed to improve service utilization of essential health services; the first pillar of the project. Likewise, all the indicators for the second pillar, the delivery and quality of health services, significantly improved. The data for accountability and results indicators also showed remarkable improvement in this third pillar, over the life of the project.

The SHOW project addressed the gender-related barriers that women and girls of reproductive age experience across the spectrum of relationships, structures (both in households and community) and a multi-tiered health system. Along with its stakeholders, the project co-created an evidence-informed, robust model, applicable for sustained and contextualized gender-transformative change. The results indicate that SHOW elements can be systematically integrated across different levels of a multi-sectoral health system to optimize health and gender equality outcomes. Learning lessons and managing knowledge from such projects is vital to facilitate evidence-based decision-making in future programs.

Knowledge management is a process of generating, curating, adopting, disseminating and managing evidence[vii]. The present report is a documentation of the knowledge gleaned from the design, deployment, implementation and conclusion stages of key select initiatives of the SHOW project in Ghana. The process of learning these lessons involved three stages including a desk review of the program documents and reports, discussions with project staff in Ghana and Plan International Canada, and a member-checking of the findings. Discussions focused on the broad functions of the project under demand generation, service provision, results and accountability, project operations, and sustainability. The project's theory of change, implementation challenges, measures taken to address these challenges, results observed and the emerging best practices were explored.

This lessons-learned report is a triangulation[viii] of findings from various perspectives. The methodological triangulation involved examining quantitative survey data and asking "why" questions emerging from it. Theoretical triangulation comprised exploring views of several stakeholders to develop a holistic picture from multiple perspectives, and environmental triangulation involved taking care of the perspectives coming from diverse geographical or social locations. Lessons learned from these discussions and data analysis are presented under five headings on the following pages. A brief summary of the best practices is also included in a tabulated form.

# LESSONS LEARNED FROM THE PROJECT

## 1. DEMAND SIDE OF HEALTH SYSTEM STRENGTHENING

The SHOW project was implemented in resource-poor areas, where about 40% of the population did not have access to potable water, and over half resorted to open defecation[ix]. Access to mass media in such underserved areas was low. Therefore, interpersonal communication by health workers in community groups, or health facility visits was an important strategy to increase awareness and improve behaviours. Men dominate the family and social landscape in Ghana, as they have the power to make financial and other important decisions. Adolescents are more than a quarter of the total population, but their health knowledge and health care needs are not met. Through women's, men's, and adolescents' groups and through individual sessions, SHOW aimed to empower adolescents and women with gender equality and MNCH and SRH knowledge. The project also aimed to engage men and the local community and health care providers in a Gender Responsive and Adolescent Friendly (GRAF) health care environment. Several strategies complemented these groups at the community and health facility level. These include: enhancement of women's leadership in community groups; improving women's financial autonomy through Village Savings and Loan Associations; and increasing women's active participation and leadership in the Community Health Committees (CHCs) that are tasked with overseeing the health facilities.\

### Challenges

The rollout of the demand side of health system strengthening met several challenges, which emerged from a combination of an overall situation of poverty and lack of access to media, and deprivations among women and adolescent girls, including illiteracy, and long-held family values that form within the norms of a patriarchal society. For example:

- Rather than adopting mass and social media, the project relied on group discussions and interpersonal communication, which could make the process didactic if the facilitator did not encourage dialogue.
- The group leaders were not able to generate discussions without any resource materials. When structured manuals were given to them, the project realized that they did not have adequate literacy to use these manuals.
- Deeply rooted patriarchal norms and values posed challenges in the acceptability and adoption of gender equality messaging, attitudes and behaviors. While men faced social censure and hesitation in modeling new masculinities, women and girls struggled to adopt the new gender socialization, which had not been part of their worldview previously.

## Course correction

The project addressed low literacy by revising the IEC materials and training manuals, making their content more pictorial, and less text-based. This was done for the manuals and materials for all the group interventions, including women's groups, daddies' clubs, grannies' clubs, and adolescent groups. The modification ensured that the manuals and materials are user-friendly for health workers and easy-to-understand for the audience. Group leaders were retrained in using the adapted materials for optimal effect. For enhancing the financial autonomy of women, the VSLAs were promoted; these financially attractive platforms were also used for disseminating MNCH/SRH and gender equality sensitization. The community-based volunteers visited women at their households to talk to them on issues of mother and child health, gender equality, the role of men in care work and women's financial autonomy. Using the opportunity, they also had discussions with husbands during their household visits.

To address prevailing patriarchal norms, SHOW devised a multi-faceted male engagement strategy in which men's groups were formed to foster positive masculinities. Local leaders and influencers were engaged to bring a shift in the way masculinity is conceptualized. Men, after participating in group sessions regarding their role in their wife's and babies' health, would discuss these issues in their meetings and learn from each other. Through structured home assignments, they would also socialize the learnings with their families and peers. The engagement strategy included introducing male role-models, including adolescent role-models, and promoting gender equality through documentaries, panel discussions and drama. The project organized adolescent groups for boys and girls in safe spaces and encouraged them to hold regular discussions about their problems and likely solutions with elders in the family and community. The project also supported them to establish age-specific VSLAs for financial autonomy.

## Results

The overall strategy, along with the course correction, helped the project achieve an environment in which women and adolescent girls felt an increased sense of empowerment and agency, along with a higher level of responsiveness from the health system. Specifically:

- The frequency and quality of discussions amongst women's groups, men's groups and adolescents improved, which is reflected in the high level of knowledge about gender-responsive and adolescent-friendly health care.
- A striking improvement in the knowledge, attitudes and practices of adolescents was observed, which can be attributed to the awareness-raising and social mobilization activities carried out by the adolescent groups.
- The proportion of women members in organized community groups improved by 40 percentage points overall (22% improved to 62%) and, more importantly, this improvement was 52 percentage points (22% improving to 74%) for adolescent girls. This shows that effective engagement with adolescents can bring higher dividends for social interventions.
- The knowledge about danger signs during pregnancy and gender equality also improved overall amongst women and adolescent girls. The improvement in knowledge leading to enhanced level of practices was visible; the availing of antenatal care services improved overall and most significantly among adolescent girls.

## Best practices

- The IEC materials and manuals for behavior change and social mobilization activities work well when they are developed through participatory approaches, pretested with intended audiences and revised taking into account the literacy level of the audience.
- While a project advocating for gender equality considers men as a natural audience, it is equally important to take gender synchronized approaches and communicate with women and girls.
- Investing in adolescent boys and girls to improve their knowledge, attitudes and practices and to enhance their social capital. This not only ensures the adoption of desired behaviors but also the sustainability of social change.

# Intergenerational dialogue - connecting adolescents and older adults

## Problem

- In impoverished areas with patriarchal norms, women's health and social issues were not prioritized. There was a risk that, without prioritization and leadership, the health system improvements contributed by SHOW may not produce optimum results and would not be sustained after the project.

## Solution

- Adolescents, who form a significant proportion of the population in Ghana, face a range of health and social challenges as they grow.
- Initiation of sexual activity without adequate knowledge and skills for protection makes them vulnerable to unwanted pregnancy, unsafe abortion, and sexually transmitted diseases.
- High prevalence of early marriage and childbearing is associated with higher maternal mortality and morbidity, as well as with neonatal and infant mortality amongst pregnancies that occur in adolescents.
- Pregnant adolescents also bear negative social consequences and often must leave school, reducing their employability and leading to long-term economic implications.

## Solution

- SHOW created a safe space for adolescent boys and girls to access accurate, evidence-based information on SRHR, GE, and their right to access MNH/SRH services.
- Adolescent boys' and girls' clubs were formed including both in-school and out-of-school adolescents.
- Community-level engagements were conducted, such as "Evening with adolescents" , in which adolescents spent time with community leaders (mentors).
- Increasing adolescents' knowledge and enabling their leadership in SRHR issues was the objective.

## Results

- Post-intervention, the adolescents demonstrated a significant improvement in knowledge on pregnancy and modern contraceptive delaying/spacing.
- They had higher confidence to access information on SRH issues from people in their community with adequate knowledge and skills to communicate this information.
- Teachers, mothers, nurses, doctors, and community health workers were ranked among the top sources of information on modern contraception, pregnancy, and HIV/AIDS.
- Mothers were cited as the main source of information by both boys and girls.

## 2. IMPROVED DELIVERY OF QUALITY ESSENTIAL MNCH AND SRH SERVICES

In Ghana, an autonomous mechanism called Ghana Health Services (GHS), is responsible for delivering health services. GHS was created by the government under the National Health Ministry. The public health care system is divided into three levels: primary, secondary, and tertiary. To improve coverage in the rural areas, the government has started three programs: Community-Based Health Planning and Services, Health Extension Worker Program, and Health Promotion Assistant program. There is a national Gender Health Policy (2009) and a decentralized system of gender units/focal points attached to the health departments. The situational analysis carried out by the SHOW project revealed that women in these areas traditionally hide their pregnancy for the first two trimesters. When they finally wish to seek attention, they may not have access to money and transport to reach the health facility. Once they reach the health facility, a skilled health provider may not be available. Based on this assessment, and working within the government system along with its partners and stakeholders, SHOW worked on building infrastructure in 40 health facilities, providing training to improve health workers' capacity and competencies in 203 health facilities, and creating a referral system to enable GRAF health care in the focus areas.

## Challenges

A project working on improving health services for better health outcomes, while aiming for its interventions to be sustainable, can face several challenges. Here is a brief summary of the challenges that SHOW faced:

- Difficult terrain and lack of transport facilities was a major challenge. Women and girls living in remote areas could not reach a health facility because they did not have access to a vehicle (or a boat, if they lived on an island).
- Most of the referrals were made from one facility to the other because of the lack of trained human resources at that place. These were most often in complicated emergency situations.
- In general, the health care providers were not sensitive to the needs of adolescent girls for their SRH requirements. The overall professional environment also did not consider this lack of attention as a problem.
- Although there was a Gender Health Policy in place, many staff in health system did not know about the policy or the related requirements.
- There was a lack of understanding of the gender differentials that underlie health situations and outcomes. Also, there were not many women at the planning and governance levels who could understand and/or address gender issues in health.

## Course correction

To address the challenges, the project built on the existing Gender Health Policy. This involved inter- ministerial/department advocacy with higher levels, followed by developing guidelines in collaboration with the health ministry, and cascading the implementation of these guidelines through trainings at the lower tiers of the health system. A major contribution was mainstreaming gender into the quality-of-care standards in the training resources for clinical care of women, adolescents and children, adopted by the GHS. To address the capacity issues, the project provided training in a cascaded manner. Along with GHS and partner organizations, the project carried out training on Basic Emergency Obstetric and Neonatal Care (BEmONC), Integrated Management of Newborn and Child Illnesses (IMNCI), and Infant and Young Child Feeding (IYCF). These were followed by training on post-abortion care, and management of sexual and gender-based violence. During each training, an adolescent-friendly approach was emphasized, including openness and understanding to help with the problems face by adolescents, especially girls.

To address the transportation issues, SHOW supported the Community Emergency Transport System (CETS), which is composed of a network of motorbike, boat and automobile drivers who transport women, adolescent girls, and children to health facilities. Most women used funds from VSLAs to pay for the cost of these services or for fuel for boats, motorbikes and tricycles. The drivers provided their phone numbers to health providers and the CHWs passed the numbers on to the families of women and children. The project also supported the network by training the CETS drivers on basic first aid, gender-related barriers in accessing health care, the importance of male engagement in MNCH/ SRHR, and gender-responsive and adolescent-friendly referrals. In particular, the project encouraged the drivers to make space for an accompanying family member during MNCH/SRH emergencies, so that women and girls could have the support they need during these moments.

## Results

The investments in health service delivery returned positive results, which were visible in the comparison of indicators from baseline to endline. Importantly, the age-related differentials (adolescent and older WRA) also improved.

- After receiving training on essential obstetric care, the proportion of deliveries that were attended by Skilled Birth Attendants (SBAs) improved from 56% to 82% (26 percentage points). The attendance for adolescent girls improved from 48% to 88% (38 percentage points).
- Similarly, postnatal care for all women increased from 57% to 77% (20 percentage points). For adolescent mothers, it improved from 38% to 78% (40 percentage points).
- Overall, the children receiving essential immunization improved by 19%. This improvement went up for girls by 22%, emphasizing a positive effect on provider and health system's gender sensitivity.
- Health care providers' knowledge of key functions improved by six percentage points, while the health facility's waste disposal system improved by 26 percentage points.

## Best practices

- Having a policy document is important, but it also has to be combined with implementation guidelines, information dissemination, monitoring of the implementation process, and necessary modifications to complete the policy cycle.
- Gender-responsive systems develop when systematic examination of intersectional gender issues is carried out and addressed in an ongoing process, not just at baseline to fulfill a requirement.
- The effectiveness of gender-responsive health service delivery has to be embedded in the health system's core mandate, including health rights and quality of care standards for health personnel. Policy and guidance must be followed up by professional training and recurrent in-service mentoring.

# 3. DATA FOR ACCOUNTABILITY AND RESULTS

The four objectives of the third strategic pillar of SHOW (data for accountability) were: 1) collecting data from households; 2) data digitization and disaggregation by age and sex; 3) sharing and utilization for decisions by stakeholders; and 4) ultimate adoption by the health system. The project developed tools, including ICT-based tools, which the health-facility staff and the Community Health Volunteers (CHVs) used for data collection from health facilities and communities. To ensure effective data collection, CHVs were trained before the commencement of data collection and provided refresher training.

The project enhanced capacities within the existing system by introducing digital technology into the data system, to introduce a culture of transparency through data sharing and accountability.

## Challenges

The proposed modifications to the existing data system met several challenges. Notably:

- Tracking women and adolescent girls in the community, and collecting and entering their data was not a preexisting practice. Significant effort was required in providing training and ongoing mentoring and supervision to build the capacity of CHVs.
- The health system was not ready to integrate the community-based and digitized data collection into the District and National Health Information System.
- There were not enough Monitoring and Evaluation (M&E) staff to supervise the community- and facility-based data collection teams. The distances to cover for monitoring in the communities were huge, resulting in a significant work burden.

## Course correction

The project team, in collaboration with the government health system, established a mechanism for the community-based data collection and developed a digital application for its management, called DataWinner. An iterative process of developing and refining the data system was adopted. Data collection from the project's communities was both paper-based and used mobile technology. The project trained CHVs in the first year on

data collection and then organized a refresher training in the second year. Two districts had digital data collection, while the remaining six districts conducted paper-based data collection. These two methods completed the process from all the 480 project communities.

In addition to the CHVs, M&E staff of the relevant health facilities and CHC members were also trained to monitor and use data respectively. The project organized quarterly coordination meetings with GHS (a total of 128), during which the project team provided stakeholders at the district level with information on the project. Other fora such as the Technical Advisory Group (TAG) and Project Steering Committee (PSC meetings) also provided an opportunity to share data with stakeholders. The project organized dissemination workshops after the baseline, midterm and endline evaluations to share data with stakeholders at national and district levels.

## Results

The corrective measures to address the challenges faced by the data collection mechanisms produced the following results:

- The data collection and management system improved at the health facility level. Comparing the baseline values with the endline, the regularity increased (41% - 91%); capacity of stakeholders, including CHC members improved (38% -75%); household data collection took place (29% - 100%); and quality of data, including age- and sex- disaggregated data improved (50% -89%) during the life of the project.
- In the SHOW-supported, GHS-coordinated quarterly meetings for data sharing, reports from maternal and newborn mortality audits were reviewed. This enabled self-assessments of staff performance, including actions and inactions that contributed to the occurrence of maternal and newborn deaths in their health facilities. The information helped take measures to avert further mortalities and to improve maternal and newborn health outcomes.
- These quarterly meetings also served as a platform for specialists, such as obstetrician gynecologists, to provide mini refresher training on BEmONC and other lifesaving skills and to enhance the knowledge of health staff, especially midwives and physician assistants.

## Best practices

- In many cultures, women and adolescent girls may not visit a health facility for their SRH problems. Identifying them in the community and capturing their data is essential for knowing the exact magnitude of MNCH and SRH issues.
- Likewise, disaggregating women's data according to age is key to understanding the issues that young girls face around reproductive and sexual health problems. These are usually masked when data is not disaggregated.
- The hallmark of a learning system that that believes in accountability was represented by carrying out audits of maternal and newborn mortalities, reflecting on what went wrong at the household, community and health facility and how it could be prevented, and involving local community into this process.

# 4. PROJECT OPERATIONS

SHOW was a multi-partner, multi-stakeholder project that aimed to improve gender equality in society as a pathway to improved survival and health of mothers, children and adolescents in eight districts belonging to three regions of the country. Aligned with the policies of Global Affairs Canada, SHOW started as mainly an MNCH project focusing on gender equality, with SRHR added to its mandate later. Implementation of the project was through government and local partners. The respective District Health Directorates of the GHS led the implementation of the service delivery, while four CSOs including Pro-Link, Philip Foundation, NORSAAC, and ISRAD were responsible for the mobilization of communities. The Plan International Ghana team provided technical support on the ground, while Plan International Canada provided overall backstopping and technical support.

## Challenges

- SHOW was a complex project from the conceptual, implementation, monitoring and governance perspectives. Long distances and difficult terrain added to this complexity.
- In addition to communities located at long distances via road and difficult-to access areas during rains, SHOW also worked with communities on islands, which required the use of boats. This demanded additional project costs and took a toll on project staff travel time, vehicle maintenance, and fuel.
- Working with only the government system for service delivery partly aligned with the project's goals of health system strengthening, but also increased risks; bottlenecks in one system could compromise the whole project.
- In one of the SHOW regions, another GAC-supported project "Children Believe" was underway carrying out MNCH activities similar to the SHOW project in five communities, risking a likely duplication of activities and waste of resources.

## Course correction

The Plan International team built on the lessons learned from Women and Their Children's Health (WATCH), a similar project implemented in Ghana earlier, and utilized a participatory approach to design, plan, implement, manage, and monitor the project activities. From the onset, the Project Implementation Plan (PIP) and subsequent Annual Work Plans (AWPs) were developed in close collaboration with all partners and stakeholders during a series of workshops in which each activity, budget and plan was discussed. The project put in place governance structures, including the Project Steering Committee (PSC), the Technical Advisory Group (TAG) and Project Management Team (PMT), with the PSC being the highest governance body responsible for endorsing the PIP and AWPs before final approval by GAC.

For terrain issues, the project invested in an adequate number of vehicles, including ambulances, to facilitate field activities and case referrals. To maximize work and ensure efficient use of resources, the hard-to-reach communities were prioritized, and the project carried out training sessions and other community engagements ahead of time for the communities that become inaccessible during the rainy season. Leveraging the networking that took place during WATCH, the project signed a Memorandum of Understanding (MOU) with GHS. This helped the smooth flow of money and minimum hassles in the health care delivery focus areas. Locally, SHOW engaged influencers like tribal chiefs, queen mothers and community durbars, who carry clout with the local populations.

## Results

The measures taken to address known and emerging challenges helped in the successful operationalization of the project:

- The leadership, governance, and management mechanisms put in place worked well through the life of the project. They provided guidance and facilitated mutual coordination and buy-in wherever required.
- All indicators representing the three pillars of the SHOW strategy improved over the life of the project, with significant improvement in the results for adolescent girls, according to the disaggregated data.
- Prioritizing the communities located in far-reaching areas or on the island and carrying out activities ahead of the rainy season was helpful. At the same time, this also indicated that projects should carry out a cost-benefit analysis while planning for such communities.

## Best practices

- Leveraging the lessons learned from earlier projects, using the existing networks and maximizing the use of resources developed by earlier project cycles enhances efficiency and effectiveness.
- While it is important to reach the hardest to reach and impoverished communities with the worst health outcomes, working out a cost-benefit strategy and looking for out-of-the-box solutions (like engaging local influencers) helps in successful implementation.
- Accurate mapping of the communities in need and the projects supporting them helps with better planning and minimizes duplication of activities and waste of resources.

# 5. SUSTAINABILITY

For a social and health intervention project, sustainability is the ownership and continuation of the beneficial strategies by the individuals, community and the larger system, beyond the life of that project. Being a donor-funded project with fixed duration, SHOW developed its sustainability plans and reviewed them from time to time in collaboration with partners and stakeholders. The four prongs of the plan that it envisaged after its completion included: 1) institutional i.e., GRAF care capacities are sustained and also multiplied, 2) technical, i.e., quality of interventions is maintained, 3) financial i.e., government and communities invest in GRAF in the short and long-term respectively, and 4) social i.e., individual and collective behavior improvement continues and translates into generational transfer of health and wellbeing.

## Challenges

Sustainability of a donor-funded project can be challenging because the per capita resources are sizeable compared to a large-scale, province-or country-wide program, which usually suffers a lack of resources. The challenges become compounded when a project is implemented in impoverished settings. For example:

- The infrastructure may not be maintained or the equipment may be lost or stolen, or its functionality may not be preserved.
- The health system may stop using the capacity-building resources and systems organized by a donor-funded project, or may not incorporate the innovations (e.g., a community-based, digital data system) into the existing system.
- The women may not travel to a distant health facility for services because of monetary reasons, time poverty or other issues, despite knowing the importance of that service. Similarly, in an underserved area, the community may not fully appreciate the commitments and responsibilities of their government and the ways to hold them accountable in case of inefficiency.

## Course correction

Mindful of the likely challenges to the sustainability of the project mentioned above, the show team took certain measures for a sustainable adoption of its interventions. The team, along with local stakeholders, carried our periodic monitoring visits to ensure proper equipment and adequate refurbishment was available. These visits took place throughout the project duration as well as at the end of the project.

Women and adolescent girls in communities were trained as members/leaders within CHCs, and encouraged to participate in CHC meetings. The CHCs acknowledged and demonstrated ownership of the community health management information system and periodically reviewed the data to assess progress and make future decisions. The capacity-building resources were developed for technical sustainability in collaboration with other partners (e.g., UNICEF) or by building upon the resources that they had created. An effort was made that all clinical skill-based training programs have a gender equality component and that GE be emphasised during the trainings.

The ability of women and adolescent girls to travel to a facility depended on whether or not they have money. The SHOW team focused on VSLAs and participation of women and adolescent girls into these schemes for their financial autonomy. Linking the Community Emergency Transport System (CETS) with VSLAs was another significant measure. CETS was composed of a network of motorbike, boat and automobile drivers who transported women, adolescent girls, and children to health facilities. Most women used funds from VSLAs to pay for the cost of services or for fuel for boats, motorbikes and tricycles. For social and behavioral sustainability, community groups such as the Daddies' Clubs, Mother Support Groups, Adolescent Clubs and Grannies' Clubs were continuously sensitized to bring desired individual behavioral and social changes and to ensure sustainability of the gains made.

## Results

- All vehicles and equipment provided by the SHOW project are still available with health facilities and in functional condition
- The capacity-building programs and training resources now include a gender equality component, relevant support materials and trainers equipped cascade gender equality learning down to the next levels.
- The SHOW-supported CHCs are functional and their female membership and leadership has been sustained during and beyond the project.

## Best practices

- Where available, building on the knowledge and networks from earlier projects (e.g., WATCH in Ghana) helps enable smooth implementation and improves the chances of sustainability.
- Engaging local communities, especially women and adolescent girls, into the local planning and decision-making processes is pivotal for the sustainability of the SRH program.
- In addition to robust interventions and data, sustainability requires effective social mobilization, and advocacy at all levels.

# SUMMARY OF THE BEST PRACTICES FROM SHOW PROJECT IN GHANA

**Demand for woman and adolescent girl focused MNCH/SRH care**

- The IEC materials and manuals for behavior change and social mobilization activities work well when they are developed through participatory approaches, pretested with intended audiences and revised taking into account the literacy level of the audience.
- While a project advocating for gender equality considers men as a natural audience, it is equally important to take gender synchronized approaches and communicate with women and girls.
- Investing in adolescent boys and girls to improve their knowledge, attitudes and practices and to enhance their social capital. This not only ensures the adoption of desired behaviors but also the sustainability of social change.

**Health services with a focus on gender equality**

- Having a policy document is important, but it also has to be combined with implementation guidelines, information dissemination, monitoring of the implementation process, and necessary modifications to complete the policy cycle.
- Gender-responsive systems develop when systematic examination of intersectional gender issues is carried out and addressed in an ongoing process, not just at baseline to fulfill a requirement.
- The effectiveness of gender-responsive health service delivery has to be embedded in the health system's core mandate, including health rights and quality of care standards for health personnel. Policy and guidance must be followed up by professional training and recurrent in-service mentoring.

**Accountability through improved data sharing**

- In many cultures, women and adolescent girls may not visit a health facility for their SRH problems. Identifying them in the community and capturing their data is essential for knowing the exact magnitude of MNCH and SRH issues.
- Likewise, disaggregating women's data according to age is key to understanding the issues that young girls face around reproductive and sexual health problems. These are usually masked when data is not disaggregated.
- The hallmark of a learning system that that believes in accountability was represented by carrying out audits of maternal and newborn mortalities, reflecting on what went wrong at the household, community and health facility and how it could be prevented, and involving local community into this process.

### Operationalization

- Leveraging the lessons learned from earlier projects, using the existing networks and maximizing the use of resources developed by earlier project cycles enhances efficiency and effectiveness.
- While it is important to reach the hardest to reach and impoverished communities with the worst health outcomes, working out a cost-benefit strategy and looking for out-of-the-box solutions (like engaging local influencers) helps in successful implementation.
- Accurate mapping of the communities in need and the projects supporting them helps with better planning and minimizes duplication of activities and waste of resources.

### Sustainability

- Where available, building on the knowledge and networks from earlier projects (e.g., WATCH in Ghana) helps enable smooth implementation and improves the chances of sustainability.
- Engaging local communities, especially women and adolescent girls, into the local planning and decision-making processes is pivotal for the sustainability of the SRH program.
- In addition to robust interventions and data, sustainability requires effective social mobilization, and advocacy at all levels.

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## Acronyms used

AHC: Adolescent Health Corner

BEmONC: Basic Emergency Obstetric and Neonatal Care

CBHV: Community Based Health Volunteer

CHMIS: Community Health Management Information System

CSO: Civil Society Organization

EmONC: Emergency Obstetric and Neonatal Care

GHS: Ghana Health Services

HCP: Health Care Providers

HMIS: Health Management Information System

IMNCI: Integrated Management of Childhood Illnesses

LNGO: Local Non-Governmental Organization

M&E: Monitoring and Evaluation

MOH: Ministry of Health

PIP: Project Implementation Plan

PMT: Project Management Team

SBA: Skilled Birth Attendant

SHOW: Strengthening Health Outcomes for Women and Children

TAG: Technical Advisory Group

WATCH: Women and Their Children's Health

AWP: Annual Work Plan

CETS: Community Emergency Transport System

CHC: Community Health Committee

CHW: Community Health Worker

DHS: Demographic and Health Survey

GAC: Global Affairs Canada

GRAF: Gender-Responsive, Adolescent-Friendly

HFA: Health Facility Assessment

IEC: Information, Education, Communication

IYCF: Infant and Young Child Feeding

PHC: Primary Health Care

MNCH: Maternal, Newborn and Child Health

MOU: Memorandum of Understanding

PMF: Performance Measurement Framework

PSC: Project Steering Committee

SBCC: Social and Behavior Change Communication

SRH: Sexual and Reproductive Health

VSLA: Village Saving and Loan Association

WRA: Woman of Reproductive Age

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