GENDER RESPONSIVE ADOLESCENT-FRIENDLY REFERRALS IN THE SHOW PROJECT: ENSURING PREGNANT WOMEN & ADOLESCENT GIRLS REACH HIGHER LEVELS OF CARE

OVERVIEW

Maternal, newborn and child, mortality is one of the greatest public health disparities of our time. Ninety nine percent (99%) of maternal deaths occur in poor countries and most of these deaths are preventable[1]. Complications during pregnancy and childbirth are the leading cause of death for 15 to 19 year-old girls globally. Similarly, more than half of under-5 child deaths are due to diseases that are preventable and treatable through simple, affordable interventions[2]. In 2010, *Every Women Every Child*[3] was launched and in 2015, there was a renewed and urgent call for action to build on the successes gained during the Millennium Development Goal (MDG) era to improve maternal and child health. As such, a new blueprint for the future was established to sustain the MDG gains, whilst putting into action the Global Strategy for Women's, Children's and Adolescents' Health[4]. Seventeen (17) Sustainable Development Goals (SDGs) were developed and, more specifically, SDG three (3) aims to reduce the global maternal and under-5 mortality to fewer than seventy (70) maternal deaths per 100,000 live births and twenty-five (25) under-5 deaths per 1,000 live births, respectively, by 2030.

1. Shimamoto K, Gipson JD. (2019). Investigating pathways linking women's status and empowerment to skilled attendance at birth in Tanzania: A structural equation modeling approach. PLoS ONE 14(2): e0212038
2. https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality
3. *Every Woman Every Child* is an unprecedented global movement that mobilizes and intensifies international and national action by governments, multi-laterals, the private sector and civil society to address the major health challenges facing women, children and adolescents around the world.
4. World Health Organization. (2015). Every woman, every child, every adolescent: achievements and prospects: the final report of the independent Expert Review Group on Information and Accountability for Women's and Children's health. World Health Organization.

To reach these targets, a strong commitment by all stakeholders is required in the implementation of the initiatives that address the different development goals. To avert maternal and newborn deaths (SDG 3), the priorities for action include the provision of quality maternal care, delivered through a resilient health system with well-staffed health facilities that can manage routine and emergency maternity care[5]. These priorities encompass high coverage of quality antenatal care, skilled care at birth, postnatal care for mother and baby, as well as care of small and sick newborns[6]. A vital component to a successful maternity care program is the implementation of a well-functioning referral network. The ability to refer during pregnancy is essential to ensure pregnant women (with high risk of complications) and newborns reach immediate and appropriate care[7].

Pregnant women and new mothers should be treated as close to their homes as possible at the primary care level which meets the relevant level of expertise[8]. The referral system serves as an important 'back-up function' for life-threatening complications which require management and skills that are only available at higher levels of care[9], if needed. It is the responsibility of health care workers to make appropriate referrals in response to the level of indicated risk, but for this to be feasible, a system must be in place to link the following three levels of care together:

[FIGURE 1] The three levels of care

1. Family/ Community

2. Health Center
First line health facilities such as health posts

3. District/ Local Hospital
First referral level for emergency care

When a referral system is implemented and utilized appropriately, it can be expected to decrease maternal and newborn morbidity and mortality[10].

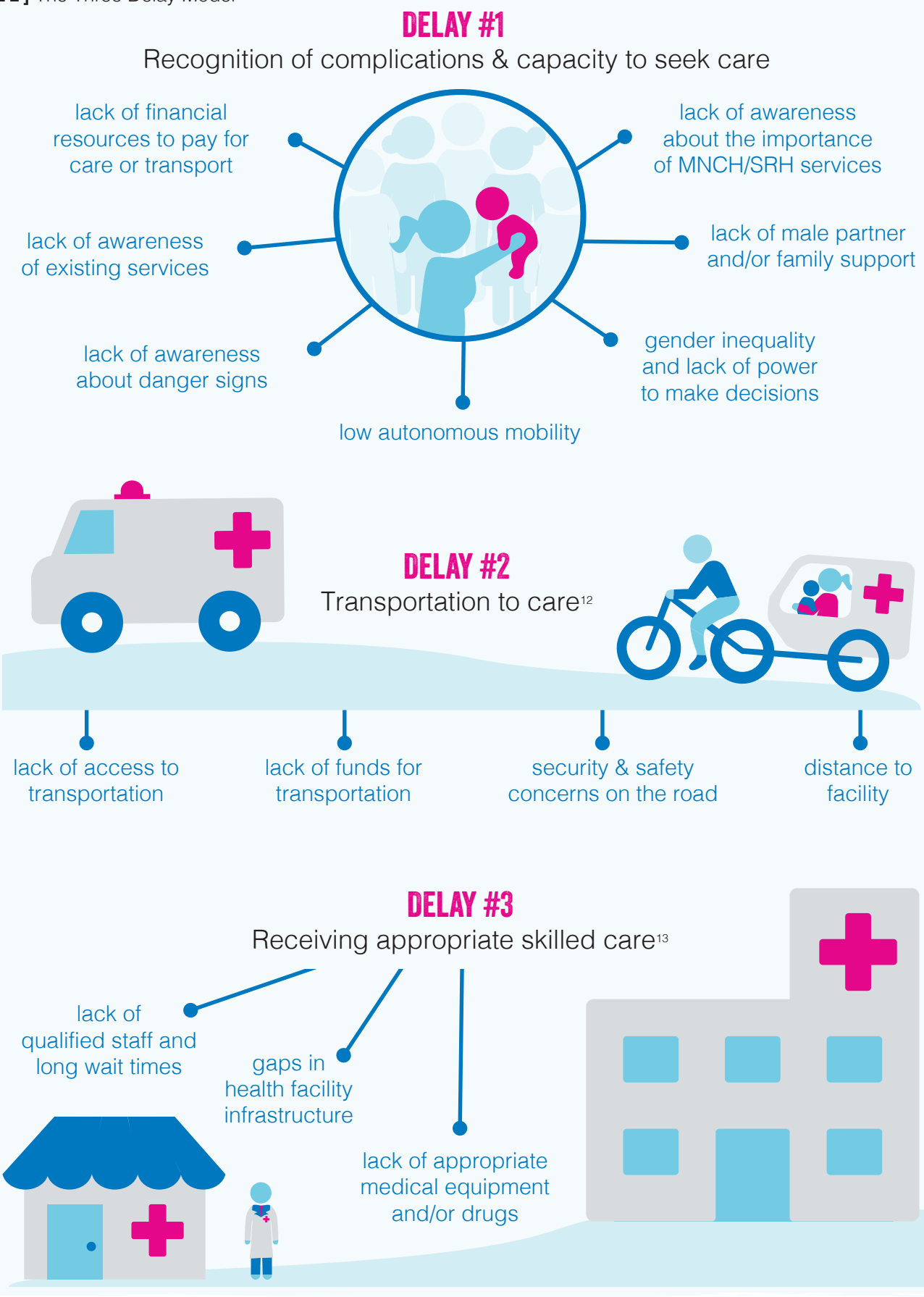
Health worker counsels a pregnant woman at the health facility in Senegal.

BARRIERS IN ACCESSING MATERNAL CARE

Despite ongoing efforts to strengthen referral systems worldwide, there are still a substantial number of pregnant women who do not reach referral hospitals. Reasons for this reflect both health service determinants (e.g., capabilities of lower levels, availability of specialized personnel, training capacity, organizational arrangements, cultural issues, political issues and traditions), as well as general determinants (e.g., population size and density, terrain and distances between urban centers, pattern and burden of disease, demand for and ability to pay for referral care, gender inequity). Thaddeus and Maine's Three Delay Model[11] coupled with a further analysis of a woman's social environment, provides insight into the reasons why women and adolescent girls are prevented from accessing the maternal care they need, ultimately contributing to maternal deaths. This model, introduced in 1994 and still relevant today, identified three groups of community and/or health service constraints faced by women when trying to access safe childbirth. See **[FIGURE 2]** on page 3.

5. Koblinsky M, Moyer CA, Calvert C, Campbell J, Campbell OM, Feigl AB, et al. (2016). Quality maternity care for every woman, everywhere: a call to action. Lancet 2016;388 (10057):2307–20.
6. https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality
7. Andrea B. Pembe, Columba K. Mbekenga, Pia Olsson & Elisabeth Darj (2017) Why do women not adhere to advice on maternal referral in rural Tanzania? Narratives of women and their family members, Global Health Action, 10:1, 1364888,
8. Jahn A, De Brouwere V. Referral in pregnancy and childbirth: concepts and strategies. In: De Brouwere V, Van Lerberghe W. (2001). Safe motherhood strategies: a review of the evidence. Antwerp: ITG Press. p. 229–246.
9. WHO (1994). Mother-Baby-Package: Implementing safe motherhood in countries, Maternal Health and Safe Motherhood Programme, WHO, Geneva.
10. Jahn A, De Brouwere V. (2001). Referral in pregnancy and childbirth: concepts and strategies. Antwerp: ITG Pressp. 229–246.
11. Thaddeus S, Maine D. (1994). Too far to walk: maternal mortality in context. Soc Sci Med. (38): 1091–1110.

[FIGURE 2] The Three Delay Model



12. Graner S, Mogren I, Duong LQ, Krantz G, Klingberg-Allvin M. (2010). Maternal health care professionals' perspectives on the provision and use of antenatal and delivery care: a qualitative descriptive study in rural Vietnam. BMC Public Health 10:1.

13. Molina G, Vargas G, Shaw A. (2011). Compromised quality of maternal healthcare in a market economy: Medellín, Colombia 2008–2009. ColombiaMédica 42:294–302.

Expanding on the Delay 1 barriers mentioned above, a pregnant woman or girl's social environment reveals complex influences that may prevent women from adhering to the referral advice given by health workers, ultimately impacting her ability to reach the referral hospitals. A 2017 qualitative research study by Pembe et al in Tanzania revealed that pregnant women and other actors have ways of evaluating the risks and complications of referrals, which differ from the biomedical perspective of health workers[14]. The results of this study indicate that there are four (4) dimensions that play a role in this risk evaluation conducted by pregnant women and other actors. The dimensions include:

1. Power
Subordination of women

2. Economic
Financial capability of pregnant woman and husband to pay for referral

3. Affection
Pregnant woman's intention to go for referral being in direct conflict with the need to take care of their children and families at home

4. Symbolic
Sociocultural relations that may hinder a pregnant woman's ability to access the appropriate services

Altogether, each of these dimensions are intertwined and influential in the decision-making process conducted by the pregnant mother and other relevant actors upon receipt of professional advice for a referral.


A group of mothers visiting the clinic for a check up in Ghana.

REFERRALS IN THE SHOW PROJECT

Strengthening Health Outcomes for Women and Children (SHOW) is a 4.5-year multi-country gender transformative project funded by Global Affairs Canada and Plan International Canada. Its objective is to reduce maternal and child mortality amongst vulnerable women and children in targeted regions of Bangladesh, Ghana, Haiti, Nigeria and Senegal.

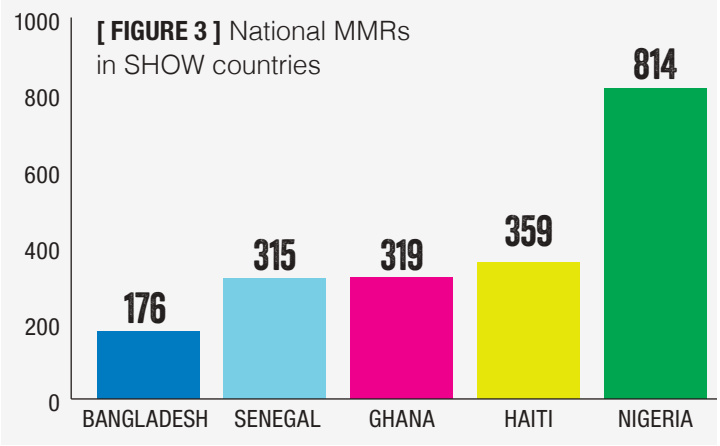
To achieve this objective, the quality, availability, utilization and accountability of essential maternal, newborn and child health (MNCH) and sexual and reproductive health (SRH) services are being improved in the five countries. On the supply side, the SHOW project's implementation of health systems strengthening initiatives for the provision of maternity care, tailored to each country context, and inclusive of gender responsive and adolescent friendly referrals are anticipated to reduce maternal and newborn mortality amongst vulnerable community members. These referrals are responsive to the unique needs and barriers that women and adolescent girls face when accessing MNCH/SRH services. They are safe and respectful, as well as supported and strengthened by an enabling environment of referral systems and structures that have the potential to ensure referral compliance and remove barriers such as fear of referrals, as well as financial and logistical constraints that cause delays in referrals.

HOW TO MAKE REFERRALS GENDER RESPONSIVE & ADOLESCENT FRIENDLY?

- ☐ Ask whether a partner or family member can accompany them
- ☐ Explain the reason for the referral to them
- ☐ Suggest appropriate transportation methods
- ☐ Listen to and address, where possible, the concerns of adolescent girls
- ☐ Fill out the appropriate forms properly and provide duplicates to the patient
- ☐ Treat the patient with dignity, respect, privacy and confidentiality
- ☐ Accommodate and involve the partner or family member

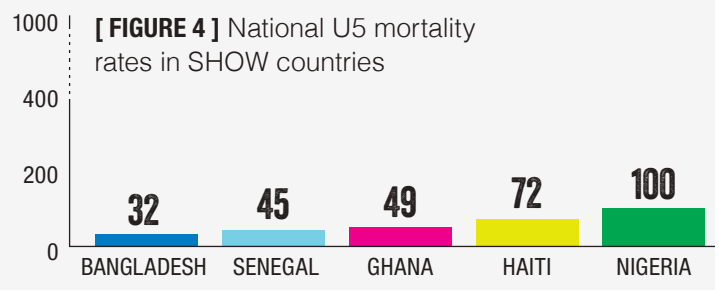
14. Andrea B. Pembe, Columba K. Mbekenga, Pia Olsson & Elisabeth Darj (2017) Why do women not adhere to advice on maternal referral in rural Tanzania? Narratives of women and their family members, Global Health Action, 10:1.

The national maternal mortality ratios (MMRs) between SHOW project countries varies, with the lowest rate observed in Bangladesh, followed by Senegal, Ghana, Haiti and finally, Nigeria[15].



There is also regional variability within the project countries, indicating the presence of populations experiencing more dire outcomes in comparison to other regions. For example, within Ghana, the MMRs in Northern (531), Eastern (538) and Volta (706) regions (targeted regions under the SHOW project) are significantly higher in comparison to the national average.

Similarly, the national under-five (U5) mortality rates (per 1,000 live births) also differs between SHOW project countries **[FIGURE 4]**, as well as within the different project sites of the same country. UNICEF 2017 survey data results reveal the lowest national U5 mortality rates are seen in Bangladesh and the highest rates are seen in Nigeria.



At the time of project implementation, intra-country variability was reported in the project areas with higher rates visible in Sokoto State, Nigeria (185) as well as Kedougou (154) and Sedhiou (142), Senegal. Infant mortality rates (per 1,000 live births) are also lowest in Bangladesh (27) and highest in Nigeria (65). Neonatal mortality rates[16] (NMR; deaths per 1,000 live births) are lowest in Bangladesh (18), followed by Senegal (21), Ghana (24), Haiti (28), and, again, the highest NMRs are seen in Nigeria (33).

A pregnant woman in Bangladesh arrives at the health facility.

GAPS IN EXISTING REFERRAL SYSTEMS

The starting point for referral systems was different in each SHOW country, so project activities were planned and implemented in consideration of the contextual differences, including consultations and partnership with governments to achieve institutional buy-in.

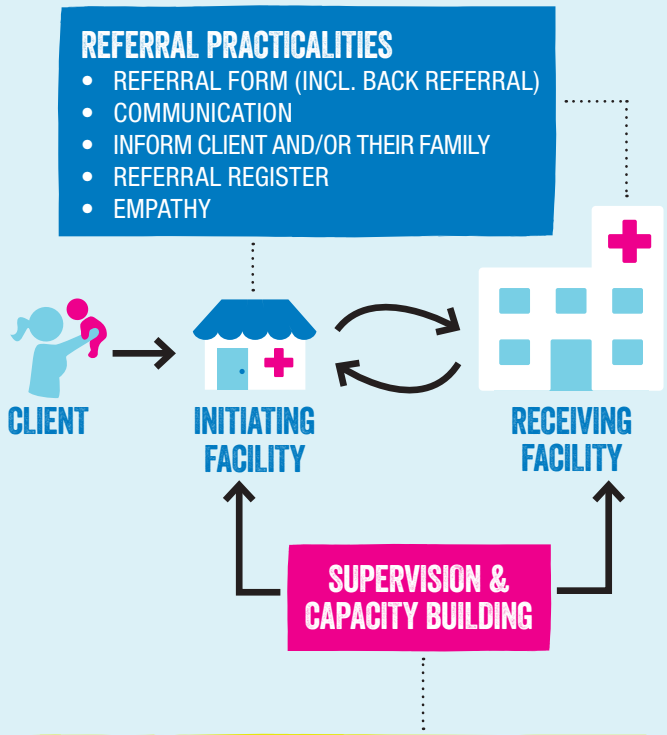
To respond to the needs of individual project countries' referral systems, an analysis was conducted at the onset of the SHOW project to gain more insight on the specific gaps in the existing maternal and newborn referral system. Baseline survey data as well as the Health Facility Assessments helped to inform the gap analysis outlining how SHOW countries were doing and where Plan International could best intervene by looking at how referrals were conducted, as well as a review of specific documents, protocols and processes within primary facilities.

The project implementation plan, guided by the World Health Organization (WHO), classifies the emergent issues into the following four components of a referral system **[FIGURE 5]**.

15. Trends in Maternal Mortality: 1990 to 2015 by WHO, UNICEF, World Bank and United Nations Population Fund

16. United Nations Inter-agency Group for Child Mortality Estimation (UN IGME): https://childmortality.org

[FIGURE 5] Components of a referral system[17]



THE HEALTH SYSTEM constitutes multiple levels and each level needs to be functioning appropriately for a referral system to work. This includes formalizing relationships between service providers and their ability to refer appropriately, as well as follow the agreed protocols for care at a given level of service. At the onset of project implementation, one of the gaps expressed by health professionals across SHOW countries was a lack of connection between the different levels of the referral system. As a result, there was an increased number of self-referrals, causing underutilized entry point facilities and overloaded (number of patients exceeds their capacity) referral facilities. There were critical gaps noted with the capacity of health service providers (Ghana, Nigeria) in their ability to identify danger signs in patients, as well as the necessity of a referral. Lastly, transportation and communication systems used to ensure timely and safe, gender responsive, and adolescent friendly referrals were inadequate in the different project countries. For example, the transportation systems in Ghana and Haiti were unable to accommodate for the poor road conditions and long distances to the health facilities; and in Nigeria, there was a reported lack of government commitment in the transportation operations. Key informants in Senegal and Bangladesh identified communication deficits in transportation management, as well as the absence of an end-to-end tracking system for referrals, respectively. Specific weaknesses were also noted in the project baseline data around information sharing during referrals regarding transportation options and considerations of providers towards the specific needs of women and adolescent girls. In busy primary health facilities with poor Community Emergency Transport System (CETS) options, insufficient attention is given to pregnant women and new mothers, particularly adolescents, which is often exacerbated by the lack of male accompaniment.

THE INITIATING FACILITY activities are the starting point of a pregnant mother's journey towards higher levels of care. It is here where gender responsive and adolescent friendly referrals need to be carried out based on agreed referral protocols. As such, health care workers need to be trained on the national referral protocols and be capable of providing the necessary care at that health care facility, as well as providing a referral in the case of an emergency. They also need to be equipped with the skills for treating clients, including adolescents, with dignity, respect, privacy, confidentiality, and without fear of discrimination. Within the SHOW project countries, a lack of appropriate training of health care providers to provide gender responsive and adolescent friendly referral services was observed in all countries.


A community health worker assists a young mother and child in Ghana.

17. Based on Harahap N, Handayani P, Hidayanto A. (2019). Barriers and Technologies of Maternal and Neonatal Referral System in Developing Countries: A Narrative Review. Informatics in Medicine Unlocked. 15. 100184. 10.1016/j.imu.2019.100184.

THE RECEIVING FACILITY is closely connected to the initiating facility and their clinical as well as administrative activities related to referrals are complementary. Clinically, a patient should be assessed thoroughly, and case management should be provided with the highest quality of care. Gender responsive and adolescent friendly service delivery inclusive of referrals should be provided with the associated administrative responsibilities, including:

1. **Filling out the referral form, register and any other documentation required** to ensure any information relating to special investigations, findings, diagnoses and treatments are communicated

2. **Ensuring that the referral form returns** to the initiating facility when the patient is ready

In all five countries, gaps were identified in the required documentation that facilitated communication between the different facilities and there was poor follow up after mothers and children were referred. Altogether, this compromised the overall quality of care provided to mothers and children.

THE REFERRAL PRACTICALITIES start with the network of service providers properly filling out the standardized referral form, inclusive of a written record of the clinical findings, any treatment given before the referral, specific reasons for making the referral, as well as a clear designation to which facility the patient is being sent. Securing arrangements with the receiving facilities, including the estimated time of arrival of the patient, as well as tracking them via a referral register are also important. Overarching all activities is the need that referrals are conducted in an empathetic manner towards the patient and if the patient is very ill, a health care worker accompanies them to the receiving facility. In the SHOW project countries, there were expressed concerns related to these referral practicalities. For example, in Bangladesh, the existing manual referral system is conducted in the absence of reliable information about the condition of a mother or child, who would accompany the mother and the age (disaggregation) of the mother or child. Again, this compromises the overall quality of care provided to the mothers and children.

Ambulances at the health facility in Nigeria.

HOW THE SHOW PROJECT IS STRENGTHENING THE NATIONAL REFERRAL SYSTEMS

The SHOW project identified and implemented interventions that complement and strengthen the referral system in being able to provide gender responsive and adolescent friendly referrals in each of the five SHOW countries. The initiatives include improving transportation, communication, as well as service delivery, as part of a comprehensive package of health services fulfilling the needs of all women and adolescents, whilst providing adequate referral services associated with the appropriate levels of care.

IMPROVING TRANSPORTATION

A reliable and functioning transportation system is paramount to ensure pregnant women and girls can reach the higher levels of care that they need in a timely, respectful and safe manner following a referral protocol. The establishment of a CETS strengthens the links between the health facilities, whilst facilitating transportation during emergencies.

Plan International's response to each country's CETS encompassed local solutions and modes of transportation suitable for different terrains. This strategy aimed to ensure the availability of vehicles for the different project countries' respective CETS, as well as a sustainable provision of fuel and an ongoing maintenance plan.

Motorcycle ambulance in Haiti.

[FIGURE 6]

EQUIPMENT FOR REFERRALS PROVIDED IN SHOW COUNTRIES:

41 NEW RICKSHAWS

12 NEW AMBULANCES

11 MOTORCYCLES

28 RICKSHAW BATTERIES

22 STRETCHERS

960 FIRST AID KITS
FOR TRANSPORT OPERATORS

137 LIFE JACKETS
FOR BOAT OPERATORS

In Nigeria, the project focused on training transport providers, and did not purchase any transportation options. In Ghana and Senegal, the local solutions identified by community and health facility staff (based on the use of existing transport system) were transport cars (e.g., cars, vans, motorbikes, boats) as well as local taxis (used for referrals from the community to health huts), respectively.

Sources of funding for fuel and maintenance of the vehicles was variable across the different project countries but, in general, they were sourced via loans from Savings Groups, as well as health ministry and community health committee (CHC) budgets. One of the early project lessons regarding the linkage with Savings Groups was that linking Savings Groups to the CETS enabled pregnant women and families to reach the care they needed without the financial worry that could inhibit their movement and also provided CETS drivers with confidence that they would receive payment.

"I did not know what to do when I was told that I would be referred to Bincheratanga Health Center. But I became happy when the gentleman (Carrier) said he was going to take us with his bike to Bincherantanga Health Center. If it was not thanks to this gentleman (the owner of the means of transport), we could not have found a way. I do not know what would have happened to me, but thanks to God, I went and was able to give birth safely and I came home with my baby."

– Bilignetob, Ghana

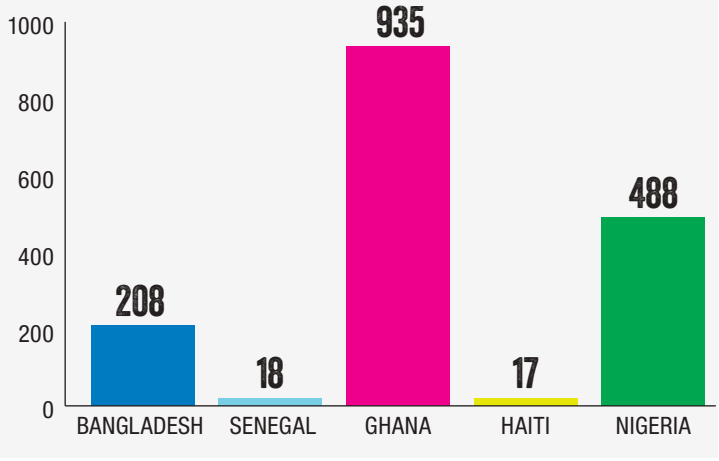
In order to ensure that all pregnant women and girls, as well as their accompanying attendants, were treated with dignity, respect and sensitivity through the CETS, training for associated transport operators and union representatives was a complementary intervention innovated by the project.

[FIGURE 7]

A TOTAL OF 1,666 TRANSPORT OPERATORS

WERE TRAINED ON GENDER RESPONSIVE AND ADOLESCENT FRIENDLY REFERRAL PROTOCOLS

(an intervention not previously carried out by the respective country CETS)



A transport operator in Bangladesh brings a patient to the health facility.

Initial feedback suggested that this kind of training had a positive effect on the referral experience amongst patients.

"I noticed so many times that I have carried referred patients/risky mothers from UH&FWC to higher centre and then I also got empathised with the crucial moment of the patient and tried so far I can support them with full heart. So, I feel very proud to be a part of the life-saving activities as a rickshaw/ van puller under this SHOW project."

– Mr. Anowarul Haque, Van driver,
Dimla, Nilphamari, Bangladesh

Finally, a safety net for poor patients was provided in Bangladesh and Ghana to ensure that poor pregnant mothers were able to reach higher level health care facilities, even if they couldn't afford it. In Ghana, household members were encouraged to join local Savings Groups, so that in the event of an emergency, the fuel cost for the CETS motorbikes could be covered using loans from the Savings Groups (safety net support); whereas in Bangladesh, the project provided direct financial support to cover the costs of transportation, clinical investigations and medications for patients identified as 'ultra-poor', following a Poverty Wealth Ranking.

"I am very happy by getting support from the SHOW project. If I didn't get the support, then I have to sell my one cow for the money. The SHOW project saved my family as I haven't sold the cow."

– Woman community member
from Nilphamari, Bangladesh

.....

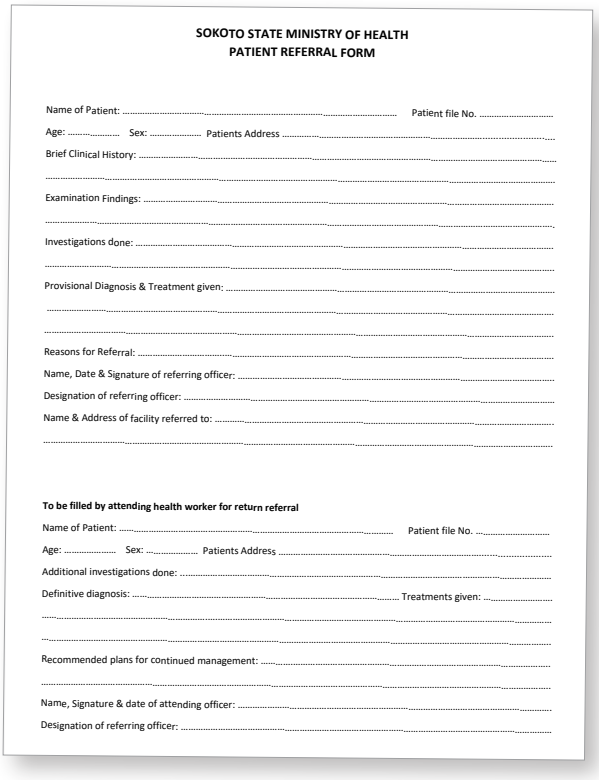
"When my wife was referred, I did not have money for the gasoline of the motorcycle provided by the driver, so I went to borrow money at the VSLA for the fuel for the bike. I am happy that my wife gave me a little boy in all security."

– CETS beneficiary, Ghana

IMPROVING COMMUNICATIONS

The use of different communication mediums, such as referral forms, cards and registers, strengthens referral linkages while providing timely services for referred patients. A referral form **[FIGURE 8]** is the most common communication tool used across the project countries as it is designed to facilitate communications in both directions of the different health care facilities. Typically, the initiating facility completes the top part of the outward referral and the receiving facility completes the lower part of the referral form.

[FIGURE 8]



SOKOTO STATE MINISTRY OF HEALTH
PATIENT REFERRAL FORM

Name of Patient: ..... Patient file No. .....
Age: ..... Sex: ..... Patients Address .....
Brief Clinical History: .....
.....
Examination Findings: .....
.....
Investigations done: .....
.....
Provisional Diagnosis & Treatment given: .....
.....
.....
Reasons for Referral: .....
Name, Date & Signature of referring officer: .....
Designation of referring officer: .....
Name & Address of facility referred to: .....
.....

To be filled by attending health worker for return referral

Name of Patient: ..... Patient file No. .....
Age: ..... Sex: ..... Patients Address .....
Additional investigations done: .....
Definitive diagnosis: ..... Treatments given: .....
.....
.....
Recommended plans for continued management: .....
.....
Name, Signature & date of attending officer: .....
Designation of referring officer: .....

This form facilitates timely health care provision for the pregnant mother as well as provides a platform for communication between the different facilities (e.g., making appointments, providing feedback to the originating facility). In tandem, the referral registers are used for written communication and documentation of each referral. In the project countries, standardized referral forms and registers were modified and developed (where unavailable) to ensure a tracking system that allowed for effective gender responsive and adolescent friendly referrals. They were also updated to reflect government referral guidelines in SHOW's project countries (Bangladesh, Ghana, Nigeria), and then printed and distributed to the different health facilities.

In addition to the referral forms, cards and registers, standard communication methods, such as the radio, phone or fax, was used in tandem as a complementary measure to help strengthen the referral process. In the project countries, mobile phones and tablets were provided to facility-based health care providers in areas with existing networks to

strengthen referral linkages and provide timely services to referred patients. These communication tools were used to make calls and send SMS messages to stakeholders along the referral chain, including trained transport operators.

Plan International has also implemented alternative user-friendly software that performs the same task as a standardized referral. Innovative ICT-based solution that supported real-time information sharing among networked service providers for referrals form is presented on either a mobile phone or tablet. In turn, end to end monitoring of the referral status of a pregnant mother and child is carried out and health care workers collectively manage cases with the highest quality of care. An additional advantage to this real-time solution is that it doesn't pose the challenges associated with the use of a paper-based practice in remote environments. For example, in Bangladesh, the maternal awareness and referral tracking system (MART) was implemented to strengthen the referral system, as well as increase education and awareness in MNCH/SRH, see **[FIGURE 9]**. The MART software allowed health care providers to send SMS messages in substitution to the existing manual process. The system also sends out voice SMS messages to communicate important MNCH/SRHR health topics (e.g., antenatal care, breastfeeding, safe delivery, family planning) to women and their family for educational purposes.

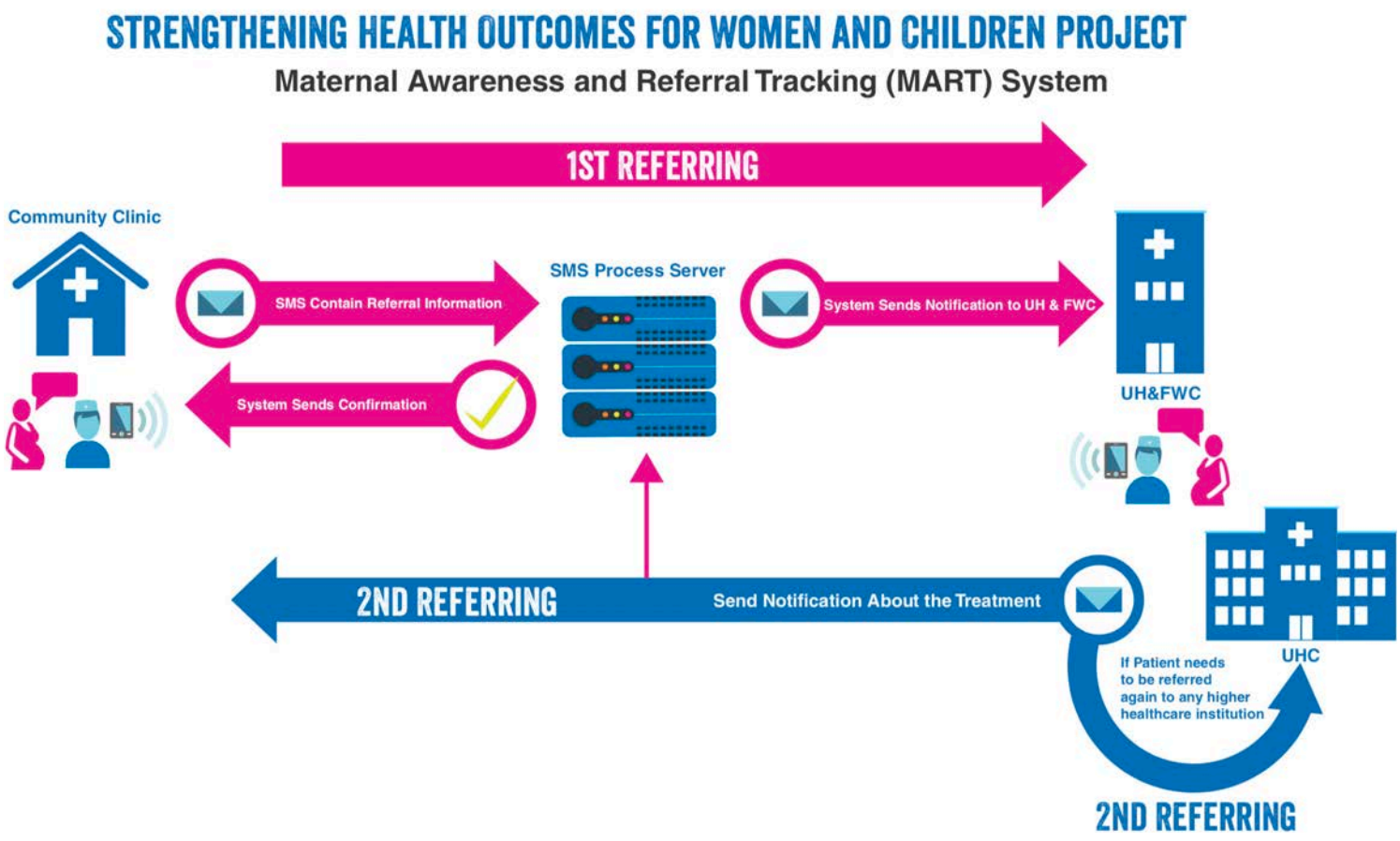
"Pregnant women will refer frequently in the hospital by this system and will get better delivery services; it is absolutely good step on behalf of SHOW project."

– Dr. Sumon Debnath, Medical Officer, MCWC, Barguna, Bangladesh

Furthermore, in Nigeria, the ICT-based solution is currently a pilot study that is taking place in three (3) public health centers located in three (3) geographical zones within the state. This solution uses a facility appointment system where:

1. **The health facility** to which a woman has been referred would be informed before her arrival
2. **The woman** would be called or messaged to be reminded of her appointments
3. **Community-based health volunteers** would be asked to confirm that the follow-up visits had taken place.

[FIGURE 9]



Finally, in Senegal, the CommCare ICT platform allowed community stakeholders to identify and register pregnant women in the first trimester of pregnancy and refer them to health facilities. This provided health care workers with a real time detailed map of the locations, as well as status of pregnant women and children under-5 in their respective catchment areas for easy follow-up.

IMPROVED SERVICE DELIVERY

The referral protocol is another essential component towards achieving effective and efficient health service delivery linkages across the levels of care. This protocol facilitates the realization of a good and functioning referral mechanism where all patients are managed appropriately, regardless of their sex, age or ability. They are also used as guidelines to inform the MoH on the delivery of gender responsive and adolescent friendly referral services.

There was variability amongst the project countries regarding the status as well as openness to revisions to the national referral protocols. In all five countries, the referral protocols were revised to include gender responsive and adolescent friendly components, which involved adding specific language on ensuring proper communication during the referral process on the reason for the referral, the importance of referral compliance, transportation options, what would happen at the receiving facility, as well as encouraging male accompaniment during referral.

Altogether, to strengthen referral services, facility-based health care providers participated in 3-day trainings on the reviewed referral protocols inclusive of the complementary gender responsive and adolescent friendly components. The training curriculum for health facility staff looked at how gender norms affect women's and adolescents' lives and health, and how providers' own gender-related biases and attitudes affect their interactions with their female clients, and in some cases with male partners or clients. It encouraged health care service providers to promote and protect their clients' rights to confidentiality, non-discriminatory treatment and informed consent before exams, procedures, treatments and referrals. All countries included gender responsive and adolescent friendly components in the training. In Senegal, the revised training curriculum with gender responsive adolescent friendly components, was subsequently endorsed by the MoH as national policy. Likewise, for Nigeria, following the decentralized health system in the country, the project worked closely with stakeholders in developing a Sokoto state referral policy that was endorsed by State MoH for implementation. In Ghana, the revisions to the referral protocol to include gender responsive and adolescent friendly components were made at the regional level, but not national level, as this would be a longer-term activity that would take longer than the timeline of the SHOW project. These efforts for endorsement by government at varying levels is due to close consultation processes with MoH and filling needs that have been identified for improved protocols by government stakeholders.

[FIGURE 10] The number of facility-based staff trained on referral protocols in each country.

Country	Total No. of **facility-based health staff** trained on (reviewed) referral protocols	Total No. of **female facility-based health staff** trained on (reviewed) referral protocols	Total No. of **male facility-based health staff** trained on (reviewed) referral protocols
Bangladesh	**407**	**281** (69%)	**126** (31%)
Ghana	**3360**	**1073** (32%)	**2287** (68%)
Haiti	**96**	**45** (47%)	**51** (49%)
Nigeria	**2749**	**2505** (91%)	**244** (9%)
Senegal	**250**	**169** (68%)	**81** (32%)

"Every health service provider should know about gender responsive referral. Through this training I received a clear idea about referral protocol system. Hopefully I can provide better service than before."

– Menti Chakma, FWV, Logang UH&FWC, Panchari Bangladesh

A young mother speaks with a health worker in Ghana during a consultation visit.

IMPACT OF GENDER RESPONSIVE & ADOLESCENT FRIENDLY REFERRALS (MIDTERM RESULTS)

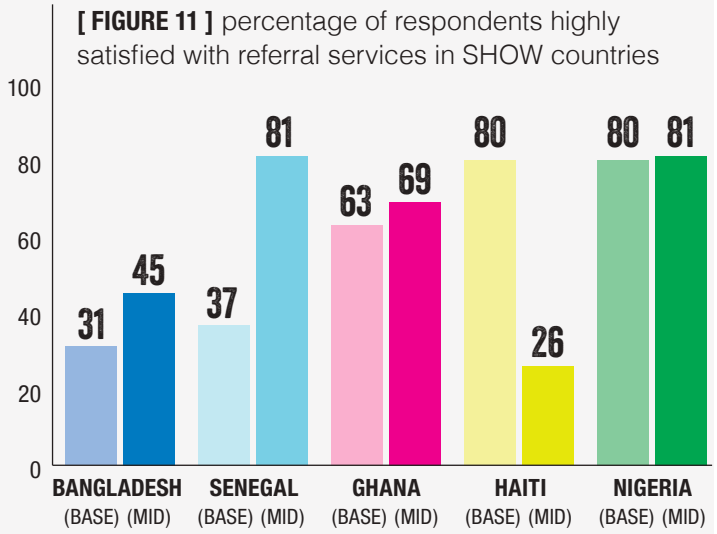
SHOW's midterm progress in some of the core indicators explored around referrals, demonstrated mixed results and progress around a few aspects. These highlighted two elements of our programming and helped to make adjustments to some of the interventions. First, is that knowledge and behavior changes emerging from Plan International's training need to be part of a supportive supervision regime. Change in deep seated practices and behaviors of health practitioners requires time and ongoing support. Secondly, mixed results can be expected where some providers have integrated training into their work, while others have not yet done so, or need to be part of additional refresher training opportunities. Refreshers are especially important when health providers at primary levels are required to play so many diverse roles in day-to-day health provision.

A further note is required to outline the limitation of the data collection methodology, which relies largely on recall of available health providers during facility assessments. Those providers may not always be the ones initiating referrals or party to the most recent trainings or protocols provided in the facility, which underlines the importance of refresher trainings and supervision. At midterm, across all project countries, the following key discussion topics emerged during referral service provision: checking with patients if any of their family members can accompany them; explaining the reason behind providing a referral; suggesting transportation methods; and listening to and addressing any concerns the patients might have. While mixed results were observed, increases in health providers *suggesting transport methods* was noted in Bangladesh (which increased from 71% at baseline to 75% at midterm). Discussions regarding *explaining reasons for referral* increased from 36% to 100% in Haiti, and improvements were observed for all four key discussion topics in Ghana. In Senegal, midterm data showed improvements for all topics, except when *checking if anyone from family can accompany the patients to the referred facility* (which decreased from 59% to 45%). These results identify the areas in each country that require further review and strengthening.

The level of satisfaction of female users and their male family members with the referral services was also measured during the midterm survey[18]. Responses were solicited on a 4-point scale: highly satisfied; somewhat satisfied; somewhat dissatisfied; and very dissatisfied.

The percentage of respondents who reported that they were highly satisfied with the referral services that they received increased in Bangladesh, Nigeria and Senegal[19]. It decreased in Haiti and remained stable in Ghana.

[FIGURE 11] percentage of respondents highly satisfied with referral services in SHOW countries



The main reasons given for satisfaction with the referral services included: good quality of care as well as competence and friendliness of health facility staff. It was the poor attitudes of health care workers and the long waiting times which resulted in dissatisfaction amongst clients.

When reporting on *general* level of satisfaction (highly and somewhat satisfied together), results clearly indicated that nearly 100% of respondents reported that they were *generally* satisfied with the referral services the they received across all project countries.

Health worker in Bangladesh counselling a patient during an ANC visit.

18. The sample size was small due to fewer respondents reporting referral to a higher-level health facility.

19. During the baseline survey, in Senegal, 54 out of 55 male respondents in intervention areas, who reported that the mother or index child had been referred, "did not know" their level of satisfaction.

LESSONS LEARNED

The process of strengthening the referrals services across all five countries in the SHOW project has generated many lessons learned from gender transformative referral programming to date. The lessons learned include:

- Training providers on the gender responsive and adolescent friendly referral protocols is important to ensure that women and adolescent girls are respected, in particular when discussing consent or ensuring confidentiality of unmarried adolescents. Sufficient time also needs to be allocated for training providers on referral protocols.

- Establishing linkages between transport operators and health facilities is important for strengthening the overall referral management system.

- Linking Savings Groups to the CETS enables pregnant women and families to reach the care they need without the financial worry that could inhibit their movement and provides CETS drivers with confidence that they will receive payment.

- Due to different terrains (mountains, poor road conditions), local context and consultation is required to ensure certain vehicles and motorcycles are used or adapted for the best provision of safe, reliable and comfortable transport.

- When mobile phones are available to the health care staff providing emergency medical care, including referrals, they can better respond to referral practicalities associated with the provision of quality referral care.

- Ongoing monitoring, supervision and refresher training is important to ensure that referral forms and registers are properly filled out, as these monitoring tools enhance overall quality of care throughout the referral process.

- While Plan International's support to the improvement in communications for referrals was seen positively by implementers and partners and contributed to improved quality and information for referrals, challenges and lessons were noted in the process. First of all, project level changes proposed by NGOs such as Plan International do not always lead to national level sustainable change and securing commitments for sustainable changes in communication protocols requires advocacy and continuous efforts to demonstrate the results of the changes proposed. Often this level of sustainable change goes beyond the project timelines.

- Securing the commitment of governments to adopt innovative ICT-based solution for tracking referrals is an ongoing effort. In some contexts, despite training and software being provided, willingness and commitment by the government to continue these ICT systems has been weak and requires continued advocacy efforts.

Health worker in Senegal completing reporting forms.

Savings groups, like this one in Ghana, help women finance CETS trips to care facilities.

Adolescent girls at an education session in Haiti.

CONCLUSION

Plan International's SHOW project is making notable strides in the implementation of gender responsive and adolescent friendly referral services at primary and secondary health care facilities. Our theory of change suggests that a focus on these elements in referral, alongside other interventions, can improve the provision of maternal and neonatal health outcomes. The operations and practicalities associated with an improved referral system have been addressed through Plan International's provision of tangible inputs such as transport vehicles, as well as any supporting equipment and fuel to ensure the physical transport of mothers, newborns and their accompanying attendant from one health facility to another. Furthermore, the important communication and documentation tools such as referral forms, cards and registers have been revised to improve gender responsive and adolescent friendly referral tracking. The overall referral system was also reinforced through the provision of mobile phones and tablets to facility-based health care providers for appropriate use. In some countries, innovative ICT solutions were implemented as a more progressive means of improving quality and replacing the problematic paper trail of referral forms. Finally, revisions conducted to the national referral protocols in four SHOW countries paved the way for guidance on how to ensure all clients are treated with dignity, respect and sensitivity along the continuum of care.

All these material inputs would not be realized as contributions towards gender responsive and adolescent friendly referrals without the complementary capacity building initiatives conducted alongside these inputs with the relevant health providers and complementary staff. Transport operators, union representatives and facility-based health care providers were all trained on the gender responsive and adolescent friendly referral protocols, as well ICT based 'tools'. In some countries, these trainings were conducted based on newly revised training manuals. Collectively, these trainings equipped the relevant point people with the knowledge, skills and tools to provide appropriate gender responsive and adolescent friendly referral services based on their position along the continuum of care.

A young family visiting the clinic in Senegal.

By working at both community and health facility level, and in close partnership with the MoHs in each country, the SHOW project was able to draw attention to critical issues in gender responsive adolescent friendly referral, and systematically improve the overall referral system.

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