Working together with the community

Documentation on
Protecting the Lives of Pregnant Women in Africa
– Community-centered Sustainable Health Promotion Program

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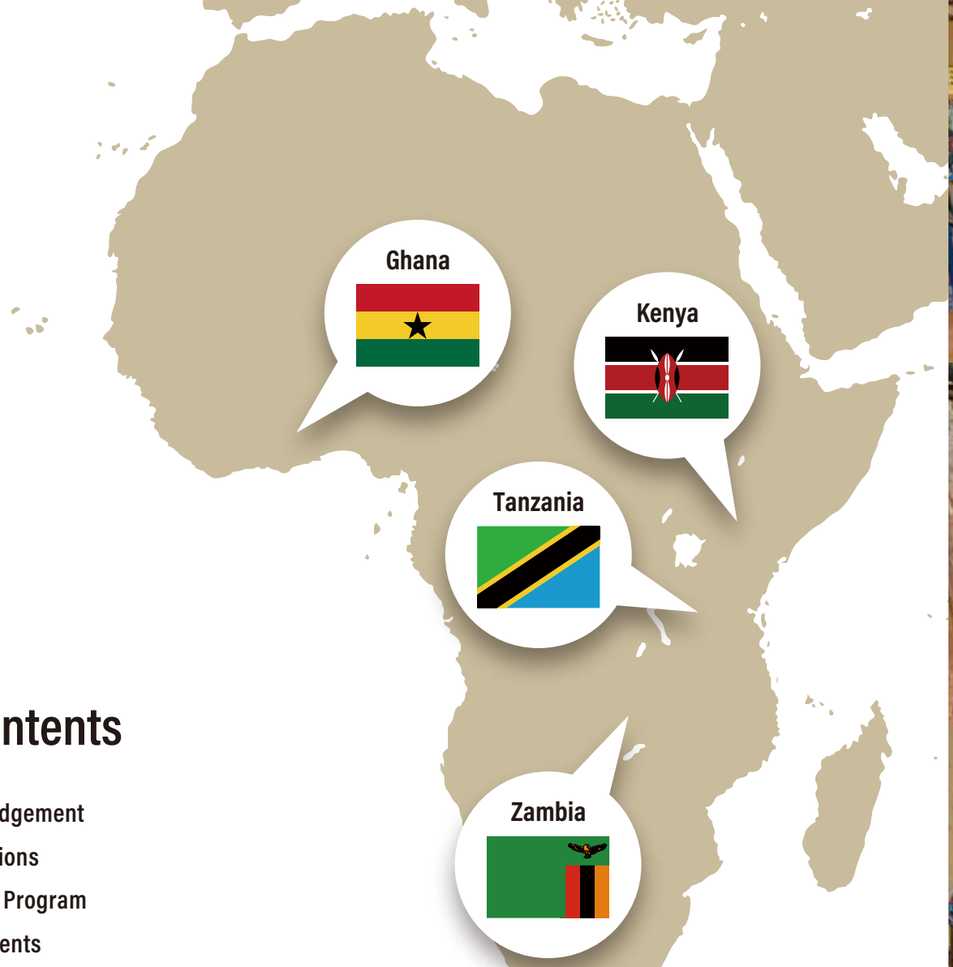

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Cover photo : Kabatila Kavat, Youth Champion, Kenya

Acknowledgement

With the aim of contributing to the well-being of pregnant women and girls from marginalized groups in Ghana, Kenya, Tanzania and Zambia, the program "Protecting the lives of pregnant women in Africa" was implemented by Japanese Organization for International Cooperation in Family Planning (JOICFP) in collaboration with respective governments and NGO partners of four African countries from 2018 to 2022, with the support from the Takeda CSR Global Program.

We extend our sincere gratitude to Takeda Pharmaceutical Company for supporting JOICFP and this program for five years. We would also like to thank all the stakeholders and implementing partners in four countries for the successful implementation, which came with many achievements, lessons learned, and good practices. Special thanks go to the community people, including community health volunteers, youth volunteers, community health committee members, health care workers, and government officials, for their high commitment and ownership. Even when the COVID-19 pandemic disrupted access to health services from 2020 to 2021, all of the stakeholders made best of efforts to continue the project activities and provide regular services while carefully preventing infection. These efforts are very much appreciated. COVID-19 could not stop us, but made us more resilient and creative.

This documentation was developed with two objectives: (1) to compile good practices and lessons learned from the five years of program implementation, which are the results of joint efforts of more than 4,500 change agents from communities, and (2) to share them with those who are interested in sustainable, community-centered health programs to promote sexual and reproductive health and rights for all.

We sincerely hope that those who live in the communities will embrace this program, continue activities that promote positive change, and to even add new ideas that would make the program their own. Again, we would like to send our heartfelt appreciation to our partners for their strong collaboration, commitment, and dedication in promoting SRHR of women and girls in Africa.

Mayumi Katsube
Executive Director
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Abbreviations

5S : Sort, set, shine, standardize, sustain
ANC : Ante-natal care
BCC : Behaviour change communication
CHC : Community health committees
CHMC : Community health management committee
CHV : Community health volunteer
CHW : Community health workers
COVID : Coronavirus disease
DHMT : District health management team
DHO : District health office
EC : Emergency contraception
FAQs : Frequently asked questions
FP : Family planning
HCW : Healthcare worker
HFMC : Health facility management committee
IGA : Income-generating activity
JOICFP : Japanese Organization for International Cooperation in Family Planning
MWH : Maternity waiting house
OTCM : Over-the-counter medicine
PE : Peer educator
PNC : Post-natal care
PPAZ : Planned Parenthood Association of Zambia
SMAG : Safe Motherhood Action Group
SRH : Sexual and reproductive health
SRHR : Sexual and reproductive health and rights
SSV : Supportive supervision
TOT : Training of trainers
YC : Youth Champion

About the Program

Program purpose

Access to quality RH services (ANC, Facility-based delivery, PNC, FP) for women in reproductive age (15-49) in the project sites is increased in Ghana, Kenya, Tanzania and Zambia

Local government partners

Ghana: District / municipal health offices of Suhum, Kwahu East, Birim North, Akyemansa, Upper Manya Krobo, Lower Manya Krobo, and Yilo Krobo, Easter Region

Kenya: Sub-county health offices of Makadara, Kamukunji and Kibera, Nairobi County and Nyeri Central, Nyeri County

Tanzania: District health office of Bahi, Dodoma Region

Zambia: District health offices of Mpongwe, Masaiti, and Lufwanyama, Copperbelt Province, and Kapiri Mposhi, Central Province

Target areas and Population

Ghana: Total population: 718,263
Seven districts in Eastern Region: Suhum, Kwahu East, Birim North, Akyemansa, Upper Manya Krobo, Lower Manya Krobo, and Yilo Krobo

Kenya: Total population: 981,416
Four sub-counties: Makadara, Kamukunji and Kibera, Nairobi County and Nyeri Central, Nyeri County

Tanzania: Total population: 247,746
Twelve wards in Bahi District, Dodoma Region

Zambia: Total population: 584,174
Nine sites in Mpongwe District, 11 sites in Masaiti District and 3 sites in Lufwanyama District, Copperbelt Province
Three sites in Kapiri Mposhi District, Central Province

Funded by

Takeda Global CSR program

Protecting the lives of pregnant women in Africa

by increasing access to quality RH services (ANC, facility-based delivery, PNC, FP) for women in reproductive age (15-49) at the project sites in Ghana, Kenya, Tanzania and Zambia

Approaches	Actions	Good practices
1. Social and behavior change communication	▪ Communication strategy development by community people ▪ Obstacle-based message creation ▪ Communication action plan development ▪ Media tools development and utilization training ▪ Recruitment and training of community health volunteers ▪ Health promotion activities by community health volunteers ▪ Increasing information contact points in community	BCC Ambassadors as key agents for reaching mass (Kenya) Community dialogues on SRHR with film shows (Tanzania) Male engagement through Male Champions (Tanzania)
2. Quality SRH service delivery	▪ Skill improvement of health care workers ▪ Increasing access points for SRH services ▪ Better work environment ▪ Client friendly services	Partnering with OTCM sellers (Ghana) 5S for advancing the quality of SRH care at the facility level (Ghana) Increasing adolescent SRH service uptake through intersectoral collaboration (Tanzania)
3. Community-centered sustainable mechanism	▪ Capacity enhancement of CHC/CHMC ▪ Income-generating activities / local resource mobilization ▪ Supportive supervision for community health volunteers	Local resource mobilization by community members (Kenya) Supportive supervision mechanism for volunteers (Ghana) Community ownership by CHC (Zambia) Participatory sustainability planning & testing (Tanzania)

Achievements

4
African countries worked in

16
Districts/Sub-counties worked with

1,038
Health workers trained

3,695
Volunteers trained

1,138,737
Community people reached

	Ghana	Kenya	Tanzania	Zambia
Note	7 districts Baseline 2018 Achievements as of September 2022*	Baseline 2018 Achievement as of June 2022	Baseline 2018 Achievement as of March 2022	7 sites Baseline 2018 Achievement as of September 2022
ANC+4 visit	70.6% → 83.4%	52.5% → 102%	30.7% → 102%	15% → 48.2%
Facility-based skilled deliveries	43.6% → 50.9%	64.2% → 111%	61.4% → 99%	19.4% → 39.6%
PNC uptake	51.1% → 55.2%	73.8% → 98%	45% → 99%	19.1% → 37.2%
FP uptake	24.3% → 37.6%	66.9% → 94%	66.7% → 69%	74% → 99.7%
Adolescents accessing FP services	4.8% → 7.3%	17.9% → 79%	NA → 48,544	380 → 950
No. of trained volunteers	1,430	799	394	1,072
No. of trained health care workers	873	83	44	38
No. of community people reached with health information	274,797	282,980	376,288	204,672
No. of community people who received FP and ASRH service	50,288	168,432	142,084	48,638

** Baseline data for the newly joined 6 districts are based on the data of 2020.*

Good practices

Social and behavior change communication

- BCC Ambassadors as key agents for reaching mass / Kenya
- Community dialogues on SRHR with film shows / Tanzania
- Male engagement through Male Champions / Tanzania

Quality SRH service delivery

- Partnering with OTCM sellers / Ghana
- 5S for advancing the quality of SRH care at the facility level / Ghana
- Increasing adolescent SRH service uptake through intersectoral collaboration / Tanzania

Community-centered sustainable mechanism

- Local resource mobilization by community members / Kenya
- Supportive supervision mechanism for volunteers / Ghana
- Community ownership by CHC / Zambia
- Participatory sustainability planning & testing / Tanzania

Social and behaviour change communication

BCC ambassadors as key agents for reaching mass

Kenya

Background & context

- In the early stages of the project, community health volunteers (CHVs) and Youth Champions (YCs) developed communication strategies and messages to effectively deliver sexual and reproductive health and rights (SRHR) messages to community people.
- Due to COVID-19, home visits and group discussions by CHVs and YCs became impossible.
- During an exercise to review the communication strategy, the project team found it necessary to strengthen the mass approach. The project team decided to find persons who have already established their information routes to access mass targets in the community.
- Support from influential members of the community was also necessary, but they could not be reached by the CHVs and YCs.

Implementation details

1. CHVs and YCs together with county health officers went to the community to identify candidates for "Behaviour Change Communication (BCC) Ambassadors". Those selected were schoolteachers, religious leaders, youth leaders, Nyumba kumi (ten households) leaders, police, chiefs, and sellers (e.g., vegetable sellers in the market, etc.) who do have the information routes in their works.
2. Two hundred and ten candidates were trained as BCC Ambassadors through a 5-day training. They were provided with basic knowledge about the project, SRHR, key messages to disseminate, and their roles.
3. Various SRH tools including the message pad, flip charts, and JOICFP Aprons（an apron with a clear pocket for flip charts) were provided to BCC Ambassadors. The obstacle-based Message Pad was one of the useful tools produced by the project together with the community people in a participatory way.
4. After the training, BCC Ambassadors started passing the key messages to the community in their workplaces. Ambassadors also referred individuals to health facilities.
5. They report directly to the link health facilities or through CHVs in a simple reporting format including referral slips on a monthly basis.

Most significant change

1. With the participation of the BCC Ambassadors, the number of people who received SRH information increased from 30,686 in 2019 to 52,952 in 2020 even under various restrictions in health education sessions during the COVID-19 pandemic.
2. Incorporating religious leaders as part of the BCC Ambassadors was one of the core strategies under this intervention. One of the most significant changes was the training of one of the Muslim religious leaders from a mosque at the project site. Since the training he has continued passing the key messages by incorporating them in the Ijumaa teachings (Friday prayer teachings) as well as Madrasa teachings (Islamic religious teachings). This was a win because the project gained entry to disseminating correct SRHR information to the Muslim community in their natural setup. Juma (the Muslim religious leader) passes key messages and links the community to relevant health services.

Other effects

The number of referrals under the project was low when it was just the YCs and CHVs offering referrals. Eight months after the BCC Ambassadors were trained, referral cases increased from an average of 25% to an average of 60% of the number of people reached with correct information.

Sustainability

- A kind of teamwork was established within the community, consisting of sub-county health officers, facility officers, CHVs, YCs, BCC Ambassadors, etc. under the community health committee (CHC). The community became self-standing without any outside support.
- Close cooperation between the sub-county team and other stakeholders, including BCC Ambassadors, CHVs, and YCs made it easy in handing over the project's activities to the community.
- Being recognized as a part of the sub-county health promotion team is a motivation for the BCC Ambassadors.
- The activities of BCC Ambassadors do not require extra funds except for initial training and BCC tools.

Tips for future programs

- With the engagement of community members who have fixed routes to disseminate information, SRHR messages could reach a wider audience. This approach can apply to other areas.

Social and behaviour change communication

Community dialogues on SRHR with film shows

Tanzania

Background & context

- Bahi District, the project area, had the highest teenage pregnancy and maternal mortality rates in the country. In regard to SRHR, many people still believe rumors and superstitions. Many pregnant women choose to give birth at home without any prenatal checkups. Sexual and reproductive health and rights (SRHR) is more of a "women's matter," and few people know that men can receive medical advice and care.
- Project members, including community health volunteers and people from the communities, developed messages aimed at deconstructing cultural habits, practices, and attitudes that prevent women from accessing Sexual and Reproductive Health (SRH) services. SRH topics were taboo in the Bahi District, and it was difficult to talk about such issues openly.
- By showing films related to SRHR topics, and discussing them afterward, villagers can think and talk about themselves objectively. Even issues such as gender-based violence and violence against children can be discussed with the support of neutral facilitators.
- Such opportunities helped create an environment where SRHR issues could be discussed openly. Organizing film shows in rural villages where entertainment is scarce is an effective way to attract and gather many people (150 to 300 people at a time).

Implementation details

1. Film shows were planned and organized by a facilitation team of community leaders, government officials, teachers, and various experts such as paralegals and healthcare workers.
2. To attract as many people as possible:
   - Chose places where people usually gather (e.g., schools, market centers, and recreation centers);
   - Planned shows at times men were more likely to gather after work (e.g., evening time like 19h to 21h);
   - Created a program with entertainment, recreation, energizer, film shows, and discussion; and
   - Promoted shows in advance with the help of community health volunteers, peer educators, Male Champions, health staff, and local government officials (ward executive officer, village executive officer, and village/street chairperson). The team used the public announcement system to notify everybody one hour ahead of the show.
3. To address "taboo" topics:
   - Topics were decided in consultation with the ward and village executive offices, health staff, and community volunteers, considering the situation of each village. Examples of the topics were: danger signs during pregnancy, sexually transmitted diseases, teenage pregnancy, parenting and family care, drugs and substance abuse, gender-based violence, and violence against children. Films with educational and entertainment elements were chosen.
   - After showing films, participants talked first to raise questions. Then the experts answered the questions and provided information. After that, there was some time for participants to share their opinions and issues in the community to think together.
   - Some issues, especially gender issues, were sensitive. Creating a friendly and safe environment for the participants to speak their minds freely without fear of conflict was very important.

Most significant change

As a result of the film shows, two villages began building health centers by themselves.
For example, in one village, there was a screening of a film on teenage pregnancy. After watching the film, the facilitator asked the audience "why did this happen in our community?" People said their opinions such as "the girls could not complete their education," "there are no basic health services in our village," and "health facilities are too far away."
The community decided to collect money and in-kind donations to build a health center.

Other effects

The film shows increased the visibility of the project to the community. The after-the-show dialogue helped make maternal health and SRHR become community agendas.

Sustainability

We started developing a sustainability plan to hand over the film show activity to Bahi District in August 2021. Since facilitation skills are critical for this activity, JOICFP team members transferred them. Also, a facilitation guide for film shows and community dialogue was developed.

Tips for future programs

- Strong facilitation skills for community dialogues after watching films are the key to promoting positive change. The facilitator needs to control the discussion, where different perspectives come up, encourage all groups to participate, talk about sensitive issues, and appreciate everyone's opinions.
- The films need to cover various topics and other priorities of the community such as policies and laws related to SRHR, parenting, child protection, governance, and social accountability.

Social and behaviour change communication

Male engagement through Male Champions

Tanzania

Background & context

- Among most families in Tanzania, men are the decision-makers. Even if women and girls understand the importance of their own health, they may not be able to access sexual and reproductive health (SRH) services against their fathers' or husbands' decisions. Men still decide many important family issues like the economy, health, education, etc. Men in Tanzania, especially in rural areas, would only listen to the opinions of influential men. There was a need to find male influencers to successfully raise awareness among men on SRH issues.
- The baseline study conducted by the project found that men were reluctant of having their wives use family planning services. Also, men were not aware of their sexual and reproductive health and rights (SRHR) needs.
- Focusing only on women and girls cannot change the situation. The project took an approach to promote male engagement by reaching 25,000 male adults through SRHR and gender-related sessions.

Implementation details

1. The project team shared the idea of recruiting Male Champions with the Bahi District health office, and it was agreed to start advocating toward the community leaders to obtain their understanding of SRHR issues.
2. The project team and the Bahi District health office had many discussions with various community leaders to deepen their understanding of SRHR and to overcome their shyness to talk about SRHR issues openly in public.
3. The project team and Bahi District health office discussed and developed the selection criteria of the Male Champions.
4. The community leaders nominated Male Champions together. One hundred and nine Male Champions were selected. Among the Male Champions were teachers, religious leaders, traditional leaders, civil servants, bodaboda drivers (motorcycle taxi drivers), etc.
5. They were trained on sexuality, gender issues, SRH services, voluntarism, the importance of male engagement, male SRH needs, etc. in a 5-day training course. Communication tools such as brochures, a message list and guidebooks were provided.
6. After the training, the Male Champions conducted group sessions. They also provided information on film shows and outreach clinics to the community, especially to men.
7. The Male Champions kept track of their activities and submitted monthly reports to health facilities. They also participated in the monthly meetings at nearby health facilities as part of the CHV team, health facilities as part of the CHV team.

Most significant change

1. The number of men reached by the Male Champions increased dramatically. In the initial half of FY2019, only 7,776 male adults were reached by community health volunteers (CHVs), but in the latter half of the year, 28,700 males were reached by the Male Champions.
2. Men understand more of the importance of male involvement in SRH and maternal health. They became more supportive of their wives and daughters receiving services. It has become common for males to accompany their wives to visit health facilities for antenatal care (ANC) resulting in more facility deliveries. Changes in men's behavior were also observed in childcare. More men are bringing their children to clinics.
3. Previously men were reluctant to visit health facilities to receive sexually transmitted infections treatment and other SRH services. But now the community at large and men think it is normal for men to go to the health facilities to receive SRH services.

Other effects

- Men realized they had SRH needs.
- Some Male Champions gained further trust from community members. They were selected as leaders of the community.
- Some Male Champions were promoted to community health workers, a position to support local health initiatives under the Ministry of Health.

Sustainability

- Supportive supervision and monitoring by local partners to the Male Champions continued after the end of the project. Monthly follow-up meetings, regular supervision visits, phone calls, etc. are made to ensure the continued activities of the Male Champions.
- The Tanzanian government is now focusing on making male engagement a national standard for reproductive, maternal, newborn, child, and adolescent health promotion. A member of the project team joined the Ministry of Health to develop the Male Engagement National Training Package.

Tips for future programs

- It is essential to first have numerous discussions with community leaders to have a common understanding that SRH issues are not just women's issues, but men themselves, and that men's understanding and engagement are critical to tackling the SRH issues in the community.
- It is crucial to select Male Champions from Influential men by their community members under the supervision of local government leaders following the recommended criteria.
- In order to reach more men in the community, group sessions by Influential men as Male Champions at places where men gather daily are effective to disseminate information and influence their mindsets and attitudes among men about SRH-related issues.
- Close support and supervision for Male Champions by health care workers, community health management team, project staff, and community leaders are necessary to keep motivating Male Champions and sustaining their activities.

Quality SRH service delivery

Partnering with OTCM sellers

Ghana

Background & context

- Difficulty of in-person communication by volunteers to provide information and services during the COVID-19 pandemic.
- Difficulty and fear for community people to visit health facilities during the COVID-19 pandemic.
- Over-the-counter medicines (OTCM) sellers are frequently the first point of call for people in need of health services. Community-based small pharmacies can serve as service points, especially in rural areas, where the health facilities are far from home.
- OTCM sellers have strong patronage and are relied on by community people as the first point of call.
- If the OTCM sellers are equipped with sexual, reproductive, health, and rights (SRHR) knowledge, information, supplies, and skills to prevent infections, and learn control protocols, they can be easy-to-access service points linked with health facilities.
- OTCM sellers' service statistics were not captured in official statistics before (e.g., numbers of pills, emergency contraception, condoms distributed, and counseling provided).

Implementation details

1. Engaged association leaders: OTCM sellers have a union of sellers. The group was identified and adopted to support the project.
2. Meetings were organized to reorient the association leaders on the project and reactivate their interest in the roles they have been assigned.
3. Three trainers, who were key players in the project, were assigned for the training of OTCM sellers in each district. They are the district public health nurse, the health promotion officer, and the health information officer.
4. Training of Trainers (TOT): The project conducted a training/workshop for three trainers per district) by five facilitators including the regional director of public health, and the regional maternal health coordinator.
5. Training of OTCM sellers: A floating monitoring team led by the project manager and a district health office director, visited the sites to provide the necessary support to the trainers during the step-down training for OTCM sellers. A 3-day training on SRHR and 2-day training on Infection prevention and control were provided.
   The 64 licensed OTCM sellers were trained for the six districts. The sellers agreed to collaborate with the project to disseminate SRHR information and services and to provide data in line with project output indicators. They were all connected to health facilities in their respective communities.
6. Tools: The project provided OTCM sellers with various behavior change communication (BCC) tools including Message Pads, FAQs, flip charts, etc. as well as simple reporting tools such as referral slips, with orientation on how to use them.
7. The trained OTCM sellers provided SRHR messages and counseling to their customers and sold medicines and contraceptives. They also referred their customers to health facilities. Training on communication skills and SRHR information allowed the sellers to communicate better with customers and won their trust.
8. Public health officers conducted quarterly supportive supervisory visits with relevant officers and the JOICFP team to the OTCM sellers.
9. The OTCM sellers also participated in quarterly facility-based meetings
10. The OTCM sellers sent monthly reports by reporting tools on the number of contraceptives, counseling, and referrals done to the link facilities.

Most significant change

1. The number of people who accessed SRHR services (contraceptive distribution, medication, etc.) at community pharmacies almost doubled from 876 in September 2021 to 1,628 in September 2022.
2. The number of people who received SRHR information at community pharmacies (consultation, distribution of pamphlets and brochures, etc.) soared from 7,219 in September 2021 to 15,979 in September 2022. The OTCM sellers are on board and are now discouraging the use of EC as a regular family planning method. The family planning acceptance rate also went up following the involvement of the OTCM sellers.
3. The OTCM sellers became a bridge between the customers and health facilities. They have a good relationship with young girls especially, through selling ECs. The OTCM sellers referred them to health facilities to encourage the use of contraceptives.
4. The sellers' motivation originally came from a business perspective. But through this project, they recognized themselves as part of the community that contributes to the development of adolescents and young people.

Other effects

- The sensitized OTCM sellers counsel young people against the use of ECs, resulting in a decrease in their use of ECs and an increase in contraceptive use.
- A strong collaboration between the OTCM sellers and the district health offices.
- The OTCM sellers boost referrals of clients to health facilities, which results in increased service uptake.

Sustainability

- Current contraceptive use, update on standard operating procedures related to drugs regulations, and the need to refer clients in need to health facilities were shared among the OTCM sellers at association meetings.
- The government and health facilities welcomed collaboration with OTCM sellers since they can provide services during the pandemic and collect more detailed data on contraceptive distribution in communities.
- Stakeholders such as the coordinating directors and leadership of the OTCM seller union of each district committed to playing their roles with no equivocation.
- The program is to be incorporated into the routine Ghana Health Service program of the respective districts to guarantee the sustainability of the project.

Tips for future programs

- OTCM sellers can extend their scope of services and business, improve their expertise and get support and advice from health experts. It became a win-win partnership.
- Integrating OTCM sellers in the health delivery system ensures that the health facilities can get service statistics from OTCM sellers and increase referrals from the communities.
- It is better to train two persons per store if the owners are not usually at the store.
- Electronic technology should be introduced for collecting data from the OTCM sellers since both the health staff and the OTCM sellers are hard-pressed with time. Paper-based reporting may be highly ineffective.

Quality SRH service delivery

5S for advancing the quality of SRH care at the facility level

Ghana

Background & context

- The following conditions were commonly seen at the health facilities in the project area before the project:
  - Low acknowledgment of the importance of client-centered services among health service providers
  - Inadequate management of medical consumables and medicines that takes time to find things and sometimes causes stock out.
  - Inadequate management of client files. It took more than 15 minutes to find a folder of a client since there was no tracking system.
  - Lack of orderliness in the workplace. Even the corridor was littered with things.
- The project introduced the 5S (sort, set, shine, standardize, sustain) approach and exercises to improve the attitudes and behavior of healthcare workers in the area of work environment improvement.
- 5S is a good entry point to realize the importance of improving the working environment. By reducing wastage, overburden, and inconsistencies, 5S results in immediate and visible effects.
- It can also motivate staff members to be self-aware of the efficiency and efficacy of their work. It becomes the first step to improving the quality of services by reviewing one's way of working including relationships with clients.

Implementation details

1. One-day 5S overview and implementation training were organized for frontline healthcare workers including sub-district leaders.
2. One-day 5S monitoring and supervision training was organized for selected staff including some district and sub-district heads.
3. Facility heads organized a step-down training for their staff. An officer was designated to supervise and monitor 5S implementation at the facility level. Regular supervision of 5S implementation at the facility level was ensured.
4. Facility heads submitted the collated results to the District Health Information Officer quarterly.
5. Sub-district heads conducted quarterly peer-review evaluation exercises within their localities and collated records, using the 5S spider score sheet.
6. A team from the district health office conducted routine evaluations at all the facilities and compiled results.
7. An award system was instituted to reward high-performing facilities to motivate staff to improve service delivery. At the annual review meeting of the district health office, the top three facilities are awarded for their high performance on 5S.
8. A WhatsApp platform was created, and regular updates were shared among the monitoring team.
9. One year after the initial training, the trainees received a refresher training to update and advance the 5S activities.

Most significant change

1. There is orderliness at the facilities for easy operation i.e., labeling, numbering, zoning, and taping. things are put in boxes with labels to show what is inside. There are protocols/guidelines/standard operating procedures to maintain the work environment in the same manner.
2. Whenever a new staff member is assigned to a health facility, other staff members will conduct training on 5S to maintain an organized environment.
3. The staff members of the health facilities became creative and took initiative. For example, some staff made dust-bin boxes from cardboard, another made an activity clock from cardboard, etc.
4. High standards of cleanliness are maintained at the health facilities.
5. The healthcare workers embraced the concept of 5S that 'it is NOT a cleaning campaign but quality improvement and a basis of organization management'. It became easier and faster to find things. As a result, the waiting time of clients decreased. The clients' flow in health facilities was improved. It makes it easier to check the stock status and can prevent inadvertent stock out. First Expired, First Out (FEFO) is applied on medicines and some non-medicine consumables so as to avoid expiry.

Other effects

- Discipline among health workers on how to organize themselves improved and they are "keepers" of each other.
- Competition among facilities becomes one motivation to keep conducting 5S.
- The orderliness and cleanliness in some facilities attract more clients.

Sustainability

- Regular quarterly monitoring with a checklist
- Annual performance review to award top three facilities
- On-the-job training for the new staff members

Tips for future programs

The most important points for sustainable 5S and quality improvement are the following

- Make it a discipline for all the staff of a health facility
- Regular support and contact by the head of a health facility
- Commitment of the leaders
- To consider 5S not as an additional task, but as one of the original duties which benefits to reduce the burden of the worktheir works

Quality SRH service delivery

Increasing adolescent SRH service uptake through intersectoral collaboration

Tanzania

Background & context

- Teenage pregnancy and maternal mortality rates are the highest in the country in Bahi District. Because of the stigma against young people when they accessed sexual and reproductive health (SRH) services, they did not visit health facilities. A youth-friendly environment for young people where they can access SRH services without being seen by other adults was necessary.
- Before the project, schools only invited healthcare workers (HCWs) to conduct pregnancy tests and not for health education and counseling because the needs were not known. Schools were not aware of the gap between schools and health facilities in terms of sexual and reproductive health and rights (SRHR) service provision for adolescents and did not have special programs on SRHR for students in the Bahi district. Schools did not have enough budget for health activities. Intersectoral collaboration was necessary to ensure information and services reached the youth and to meet the specific need of preventing pregnancies.
- The number of trained HCWs who can provide adolescent- and youth-friendly reproductive health services was severely limited.
- The Ministry of Education in Tanzania did not allow pregnant adolescent girls to stay in schools until November 24, 2021. Preventing early-age pregnancy among female students was critically important for girls to keep studying.

Implementation details

1. Before starting health education at schools, HCWs and school professionals discussed adolescent health issues including adolescent pregnancy. Discussions were also held with the students' parents to create awareness and reach a consensus.
2. HCWs were trained to provide adolescent-friendly reproductive services. The trained health staff regularly went to schools to provide health education sessions in their free time in coordination with schoolteachers. At schools, HCWs can only conduct awareness activities, according to the Ministry of Education's guidelines. So, they provided information to students about which SRH services are available at healthcare facilities so that students can visit clinics by themselves. Health education sessions held at schools by HCWs help build trust between the HCWs and the adolescents, which makes it easy for adolescents to go to health facilities to consult with HCWs.
3. The health facilities were open when students could easily visit, and adults were not around. This was from 15:00 to 17:00 on Fridays and 16:30 to 17:30 on weekends.
4. The project also trained adolescents both in and out of school as peer educators.
5. The school health teachers were trained on SRHR for adolescents and the necessity of education. They were also trained as mentors to the peer educators who conducted extracurricular SRHR sessions at schools.
6. In total, 47 youth clubs were established. Youth clubs at schools were established by trained health teachers and peer educators, who provided health education sessions to other students at the ex-curriculum time. The youth clubs also organized sports events (football), games, and folk media (drama and songs), inviting both children in and out of school to provide SRHR information.
7. Several youth clubs supported out-of-school youth through income-generating activities (IGA) such as agriculture, small animal keeping, and tailoring.
8. Film shows were conducted at schools. The project team sometimes asked teachers to stay in another room so students could open up during discussions.

Most significant change

1. A total of 48,544 adolescents used SRH services at health facilities, which is 162% of the target number (30,000).
2. Cases of sexual abuse and teenage pregnancies at schools dropped, especially at boarding schools. At one of the primary boarding schools within the project site boys used to ask girls sexual favors in exchange for meat for dinner. Through the project, the students learned that this was a kind of sexual abuse, and this practice stopped. After interventions by the project, no teenage pregnancy cases were reported at the school.
3. Testimonies from teachers and HCWs at one of the secondary schools and a dispensary admitted that students became more open about SRHR-related issues when talking to teachers and HCWs. The number of students seeking family planning (FP) /SRH services has increased at health facilities.

Other effects

One of the schools in the project area was a school for the deaf. Some of the students were trained as peer educators to conduct health education sessions with their peers using sign language.

Sustainability

- At schools, peer educators and schoolteachers developed a sustainability plan to continue health education sessions. Peer educators continued to organize group and one-on-one sessions under the supervision of school health teachers.
- Peer educators also ran youth club activities at schools. New members are being recruited with the support of school health teachers.
- Health facilities also continue providing health education for adolescents and youth while blocking time at the clinic for adolescents.
- The government of Tanzania directed each school to conduct peer reproductive health education sessions, sports, games, and folk media as extra-curricular activities. This guidance is expected to encourage the continuity of the activities.

Tips for future programs

- Developing a joint action plan by health workers and schoolteachers is the first important step in filling the adolescent SRHR service gap between schools and health facilities.
- By setting up dedicated hours for adolescents and youth at clinics, young people can come to receive SRH services easily.
- Different strategies and approaches are necessary to target in-school and out-of-school adolescents respectively to reduce teenage pregnancy. The project proposed the Bahi Health Office strengthen the collaboration between health facilities and community structures, such as families and CHVs to approach out-of-school adolescents.
- In addition to the SRHR education for out-of-school adolescents, IGAs, skill development, a one-stop clinic day for adolescents that provides reproductive and child health care and treatment clinic, and other general health services, and entertainment programs are to be provided to mobilize the youth to come for services.

Community-centered sustainable mechanism

Local resource mobilization by community members

Kenya

Background & context

- The necessity of local resource mobilization hit the heart of the project manager when she visited Japan in 2018 to participate in the first joint planning workshop under the Takeda Project. She learned from experiences in Japan and Sudan the importance of communities taking the initiative in improving public health.
- As the project progressed, issues related to sexual and reproductive health and rights (SRHR) that were not anticipated and budgeted emerged. One of the reasons for teenage pregnancies among in-school girls was due to the lack of money to purchase sanitary pads. Some adolescent girls sold sex for money. In addition to health education activities, free sanitary pads were essential, so resources were needed.
- In order to sustain the activities, communities needed to find resources locally without relying on external funding after the project ended. The project manager anticipated that the key community agents, namely community health volunteers (CHV), Youth Champions (YCs), and Behavior Change Communication (BCC) Ambassadors gain skills to mobilize resources by themselves, it will become a sustainable mechanism.

Implementation details

1. The project manager first shared the concept of local resource mobilization among the project team, CHVs, and YCs and motivated them by telling them "We can try!"
2. She shared this concept with government partners. They first showed reluctant reactions. She decided to include the sub-county officials in the training. The training helped them understand the importance of SRHR education and services, and how crucial resource mobilization is for sustainable projects.
3. The project manager looked for a consultant as a trainer on resource mobilization since it needs technical expertise like writing skills of an effective proposal, etc. Together with the project team, the consultant developed a training program, especially for domestic resource mobilization by the community.
4. A total of 120 participants, community health committee (CHC) members, YCs, and sub-county officials enrolled in a 4-day training. During the training, the participants developed action plans through group work for their local resource mobilization.
5. After this training, CHC members, and YCs together with sub-county officials, started approaching local industries, individual donors, and private companies as 'community work.'
6. Seventy-two CHC members were trained on monitoring their resource mobilization activities by the project team.
7. Soon after the training, the COVID-19 outbreak came. Resource mobilization had to start on a small scale within the community.

Most significant change

1. The trained youths in Kibera began a (sanitary) pad drive aimed at mobilizing pads and funds to procure pads to distribute to adolescent girls in the slums to reduce teenage pregnancy. YCs raised 53,000 Kenyan shillings (approximately USD430) in mobile money by using SMS (short message service). Attractive dancing events and other entertaining events were organized for sensitization and fundraising.
2. In Makadara Sub-County, CHC members successfully mobilized resources from local organizations, foundations, and companies in the sub-county. The CHC members negotiated and submitted a proposal to five organizations and private companies to equip health facilities with medical and office equipment. A printing machine, delivery beds, and other medical equipment for a maternity ward were donated. Through CHC's lobbying, the Sportspesa foundation provided equipment for the maternity ward with an equivalent worth 1.7 million Kenyan shillings (approximately 14,000 US Dollars).

Other effects

Interventions were recognized by the National Council for Population Development. This drew the interest of the director general of the council to visit the site and learn more about the intervention and incorporate them into national programs.

Sustainability

The sanitary pad drive is still continuing and resource mobilization for the maternity equipment happened in 2021 and 2022, or over one year since the training. The trained teams were selected from government existing structures such as sub-county health management teams, health facility management teams, youth committees, and community health structures hence resource mobilization efforts will be carried on in their natural setups.

Tips for future programs

- The resource mobilization by CHC should be mainstreamed in existing government and community structures to ensure sustainability and ownership.
- The training should include youths as they are more conversant with their needs.

Community-centered sustainable mechanism

Supportive supervision mechanism for volunteers

Ghana

Background & context

- The following challenges emerged as the project progressed:
  - The high dropout rate among community health volunteers (CHVs), who were the key actors in raising awareness and smooth referral of individuals to health services.
  - Low rate of active CHVs
  - The necessity of a mechanism to sustain CHVs' motivations and activities
  - There was no support for CHVs from the District Health Directorates
- The project introduced supportive supervision (SSV) as a systematic supportive mechanism for CHVs. The expected effects of a systematic, community-based SSV include the following:
  - By conducting the SSV within a compact area, monitoring and supervision are easy to manage and health workers are encouraged to visit communities regularly.
  - By having supervision sessions regularly, local health administrations can accumulate data.
  - The CHVs will have more opportunities to receive refresher training as OJT (on-the-job training).
  - Supervisory visits improve the relationship between health workers and CHVs and tied them together.

Implementation details

1. In order to facilitate the regular SSV activities, District Directors of Health Service, JOICFP, and some district health officers developed a draft checklist as an SSV tool. The checklist focused on the activity areas of the CHVs. The list was intended to be used by the community SSV teams consisting of 2 community health management committee (CHMC) members and 1 health staff for each area.
2. The draft checklist was tested on a small scale for selected communities. After the test results were reflected in the draft checklist, it was finalized.
3. The checklist was introduced to project areas, and SSV teams (1 health staff and 2 CHMC members for each community) were trained for regular SSVs using the checklist.
4. The two CHMC members took on the task of training other CHMC members on how to use the SSV tools including the checklist.
5. The SSV teams visited CHVs on a quarterly basis.
6. Other project areas adopted the checklist and received training.

Most significant change

1. CHVs welcomed stronger supervision. They felt recognized by the health staff and CHMC members and were motivated. As a result, the volunteers' attrition rate declined. Through the SSV with questionnaires and interviews, CHVs said that their ties with health staff strengthened because of increased communication. Health staff became more supportive towards CHVs after making frequent regular visits with the checklist.
2. CHVs' activities increased from 38,750 in September 2021 to 46,142 in September 2022. This is almost a 120% increase in one year. The number of people reached by volunteers increased from 43,710 in September 2021 to 68, 170 in September 2022, or almost a 160% increase in one year.
3. Change in commitment and the way of oversight within the health management structure advanced continuous supervision.

Other effects

In Ghana, there was no system to manage CHVs. The SSV tool can be a game changer for the broader health system by strengthening the capacities of CHVs to improve health delivery at the community level.

Sustainability

- SSV for volunteers was integrated into sub-district routine quarterly SSVs.
- SSV is implemented within the community and by the community members, so extra costs, such as transportation fees are unnecessary.
- SSV of the CHVs became part of the performance appraisal of health staff by the decision of the Suhum Health Directorate.
- Capacity building for CHMCs by the District Health Directorate is planned to keep them updated on new development.

Tips for future programs

- Extending supervision to CHVs helps to reduce the attrition rate and improves overall performance.
- The checklist must go under periodic review, even after the project end. The district health offices should review and revise the checklist to cater to needs that change at the grassroots level.
- It is cost-effective to work with CHMCs because they live in the communities and are in touch with volunteers.

Community-centered sustainable mechanism

Community ownership by CHC

Zambia

Background & context

- The Japanese Organization for International Cooperation in Family Planning (JOICFP) and its counterpart, the Planned Parenthood Association of Zambia (PPAZ), have been nurturing a long-standing, trusting relationship since 1987. Some PPAZ staff well understand JOICFP's community-centered reproductive health approach to mobilize people and facilitate engagement. This community health approach has been handed down within PPAZ by the staff in charge of the PPAZ/JOICFP projects.
- The local leaders and local government officers at the project sites were well acquainted with JOICFP and its community approach and welcomed the new project by Takeda.
- There was plenty of accumulated knowledge and experience including good practices obtained from preceding projects.
- The approach was selected because the community health committees (CHCs) would enhance ownership from the top level to ensure continuity of activities after the end of projects and programs.

Implementation details

1. The project team and district officers selected target communities that have high reproductive health needs, a certain size of the population, existing Safe Motherhood Action Groups (SMAGs: community health volunteers), a high commitment of district health officers as well as the communities for health promotion activities and social change.
2. One of the key approaches to ensure sustainability was to engage all the stakeholders from the very beginning. The project team organized CHCs for all the target communities. The CHCs were based on neighborhood health committees, which are operated under government policy.
3. The committee membership consists of traditional community leaders, schoolteachers, health staff, etc. The SMAGs and peer educators also became members of this committee after advice from the project team. Since the participating communities were those with the highest needs and will, the members' ownership and commitment were strong.
4. The main objective was improving maternal health. The CHC discussed and decided on how to improve maternal health. The committee discussed specifically what kind of activities to do, along with detailed planning. By choosing options and making decisions on their own, communities had stronger ownership and commitment toward the project.
5. Members attend monthly meetings and an annual review meeting to review the community action plan and discuss urgent matters.
6. Members have their own roles in the community. For instance, teachers support peer educators in and out of school, and support sessions for youths.
7. The CHC members from new sites visited existing project sites to learn from their experiences.
8. The district health officer regularly monitored the CHC's reporting including accounting for improved quality of project documentation.

Most significant change

1. Before the project started, target communities were waiting for help from the outside. But now they are aware of their capabilities and are gradually becoming self-standing. For example, some communities built maternity waiting houses (MWHs) with their own funds and labor. Funds were raised through income-generating activities (IGAs), support from local companies (money/in-kind), donations from individuals, etc.
   - In one community, the local government provided a flour mill for income generation.
   - At another community, one company collected donations to cover the construction fees of an MWH.
   - Four communities have constructed MWHs through community-based initiatives so far.
2. Access of pregnant women to health care facilities was improved with the introduction of MWHs. Pregnant women can stay at an MWH four weeks prior to the expected delivery date, which is located next to a clinic. The fee to stay is free. Staying at the MWH is safer for pregnant women as they would not have to walk long distances when in labor. Facility-based deliveries by skilled birth attendants increased. While the target was 39.4% of facility-based deliveries by the end of 2022, the actual rate was 39.6% at the end of 2022.

Other effects

- Self-help movements led by CHC stimulated other communities to do a similar attempt.
- The Ministry of Health is considering this project as a community-operated model SMAG program in the country.
- Endorsement by the local leadership improved resource mobilization in the community
- Inter-sectoral collaboration between health and agriculture was facilitated.
- The model of IGAs by CHCs was replicated in Ghana to strengthen the sustainability of the project.

Sustainability

- In most of the project communities, CHCs are still functioning, self-sustaining, and responsible for protecting the health of the people, especially women, children, and adolescents.
- After the training of traditional leaders as part of the CHC members, they have become strong supporters and promote SRHR activities, especially for adolescent sexual and reproductive health.
- The CHC recruits and replaces volunteers when the volunteers relocate to other sites or cannot continue their roles. The CHC gives initial training to volunteers. CHCs connect the community with healthcare facilities.
- Close supervision and promoting networks with other sectors (department of agriculture etc.) help create a sustainable environment.
- Through monitoring, the district office knows the details of communities and can quickly provide support.
- Good teamwork: the close collaborative relationship between health workers and the volunteers.

Tips for future programs

- Use existing mechanisms like the neighborhood health committee as CHCs rather than creating a new entity.
- Involve all the stakeholders from the onset of the project.
- Engagement of experts to ensure IGAs are viable and running well in all project areas.
- Conduct more monitoring activities for better feedback from beneficiaries.
- Support volunteer-led sensitization activities, and work closely with traditional leaders to promote them.
- Spend more time with the volunteers in the community to provide technical support and to ensure that community sensitization is carried out accordingly.
- Appreciation and recognition of voluntary work by CHC are very important.

Community-centered sustainable mechanism

Participatory sustainability planning & testing

Tanzania

Background & context

- Even though sustainability plans were discussed and developed in JOICFP projects, they were not always implemented after JOICFP left and the impacts of the projects were often lost. This time, JOICFP decided to pilot a sustainability plan during the project period to determine its feasibility and ensure that it could be continued after the end of the project without JOICFP.
- The local government offices, community health volunteers (CHVs), community health committee (CHC) members, and other beneficiaries of Bahi District expressed the need to continue the efforts.

Implementation details

1. JOICFP staff held a series of discussions with the district health department and community health committees (CHCs) to develop a sustainability plan. The committee members included village leaders, health care workers, volunteers trained by the project, community representatives, traditional leaders, religious leaders, teachers, and other members responsible for improving the health of the local people. What to sustain beyond the project life was first discussed and agreed.
2. The sustainability plan included a "handover plan" and its "detailed implementation steps." The plan and implementation steps were developed by the Bahi Health Office with support from JOICFP. Activities required to ensure the implementation of sustainability plans were detailed in the "hand-over plan." "Detailed Implementation steps" and "flowchart of the detailed implementation steps" described what to do and who would do it to continue activities after the end of the project.
3. A flowchart for each activity was printed and hung on the wall of activity sites, such as at the health facilities, schools, and the room of ward executive officers, so those who are concerned can check the flow and assign persons.
4. The members went over the question of "How much do we actually need to implement this activity?" and more importantly, "Is there any way we can do it without a budget?" many times to minimize the cost as much as possible to make the plans feasible.
5. The process of testing the ideas, revising, and reworking the plan lasted more than six months.
6. Finally, an action plan was developed to ensure sustainability, and a "hand-over ceremony" was held at the end of the project period for all to gain confidence and boost motivation.

Most significant change

1. CHC integrated project activities into its action plan to sustain their implementation at the community level after the project phase-out.
2. Bahi district council has integrated the project interventions into comprehensive council health plans for budget reallocation and sustainability of the interventions.
3. Multiple sectors including education, health, community development, planning, and the agricultural department, integrated health-related interventions in routine activities.
4. Community development and agricultural department supported income generation activities that allowed community health workers to provide reproductive, maternal, newborn, child, and adolescent health interventions sustainably at the community level.
5. Planning department at the district council level approved the requested funds by the district health department to support the sustainability of project-related activities.

Other effects

Bahi District was the first district to continue systematic interventions for sustainability under the JOICFP project. Their efforts served as a reference to other projects, such as Ghana, Zambia, and Burkina Faso.

Sustainability

- The JOICFP project team visited some of the communities in the Bahi District after the end of the project. The team confirmed that the activities were handed over to the Bahi Health District Office. Film shows, school-based education, adolescent and youth-friendly services, health education sessions by volunteers, and monitoring and supportive supervision of the volunteers by health care workers were done properly.
- Detailed implementation steps were documented so the plan would be implemented even after personnel changes.

Tips for future programs

- The concept of sustainability should be shared from the beginning of the project and put into practical terms.
- The strategy should be documented and tested at various levels with district, ward, and village level authorities, health care workers, and community volunteers.