Partners in Population and Development (PPD)
An Inter-Governmental Organization
Promoting South-South Cooperation

Ministry of Health
Republic of Ghana

UNFPA

Ghana Adolescent Reproductive Health Project

SHARING BEST PRACTICES

Addressing RH, Population and Development Challenges

Case from GHANA

December 2020

Biography of the Consultant

Mr. Bernard Erasmus Kojo Vikpeh-Lartey

Bernard Erasmus Kojo Vikpeh-Lartey is a Community Development Consultant with over 20 years experience in development work. He worked with Population Counciland Jhpiego both American International NGOs and others reputed organizations. He was the team leader for a National NGO, called Centre for the Development of People (CEDEP), for ten years. His technical expertise includes managing projects on community health, Malaria, Population, Family Planning, community mobilization and participation, advocacy, conducting training and research, developing HIV/AIDS activities and providing technical support to projects.

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Acronyms

ARH	Adolescent Reproductive Health
AR	Ashanti Region
ASRH	Adolescent Sexual and Reproductive Health
BAR	Brong Ahafo Region
CBO	Community Based Orgnanization
CSO	Civil Society Organisation
CSE	Comprehensive Sexuality Education
CHSE	Comprehensive Health and Sexual Education
DA	District Assembly
DFID	Department for International Development
DHIMS	District Health Information Management System
FGE	Futures Group Europe
FGMS	Finance and Grant Management Specialist
GES	Ghana Education Service
GDHS	Ghana Demographic and Health Survey
GHARH	Ghana Adolescent Reproductive Health Project
GHS	Ghana Health Service
GoG	Government of Ghana
IP	Implementing Partner
ISRAD	Institute of Social Research and Development
MDG 5	Millennium Development Goal 5
MOH	Ministry of Health
MLGRD	Ministry of Local Government and Rural Development
MGSP	Ministry of Gender and Social Protection
NGO	Non-Governmental Organisation
NPC	National Population Council
NYA	National Youth Authority
NSC	National Steering Committee
OCA	Organisational Capacity Assessment
PPAG	Planned Parenthood Association of Ghana
PTA	Parent Teacher Association
QPR	Quarterly Project Report
RCC	Regional Coordination Council
RHD	Regional Health Directorate
SHS	Senior High School
SMC	School Management Committee
SHEP/MoE	School Health Education Programme/Ministry of Education
SBCC	Social Behavioral Change Communication
HFFG	Hope for Future Generation
USAID	United States Agency for International Development
YOLO	You Live Only Once (A television serial)
YMK	You Must Know
WAHO	West African Health Organization
WILDAF	Women in Law and Development in Africa

Foreword

Partners in Population and Development (PPD) is an inter-governmental organization of 27 Developing Countries from Asia, Africa, Latin America, and Middle East and North Africa (MENA) regions, launched in 1994 at the International Conference on Population and Development (ICPD) held in Cairo, Egypt with the mandate to institutionalize and promote South-South Cooperation (SSC) in Reproductive Health, Family Planning and Population related issues for the implementation of the ICPD Program of Action. Through exchange of knowledge, experiences and best practices among its member countries and other developing countries, PPD contributed in creating opportunities for launching efficient and transformational SSTC programs, considered as best alternative approaches to achieve ICPD and the 2030 Agenda for Sustainable Development in developing countries.

In 2019, PPD and UNFPA jointly documented 2 best practices from Kenya and Tunisia which were published in UNOSSC South-South Galaxy (Volume 3: South-South and Triangular Cooperation for Sustainable Development). In 2020 and as the whole world experienced the social and economic disruption, particularly in health system caused by COVID-19 pandemic, PPD with the support of UNFPA has documented nine (9) best practices from Bangladesh, China, Egypt, The Gambia, Ghana, India, Morocco, Vietnam and Thailand, highlighting the issues related to reproductive health, family planning, maternal health, adolescent health, gender equality, population and development.

I strongly believe that sharing best practices is a key tool to promote South-South Cooperation and this document will help other countries to adapt and replicate the ideas to solve similar issues in the beneficiary countries.

I wish to express my sincerest thanks and appreciation to the Government of the Republic of Ghana through the Ministry of Health and Family Welfare for their strong engagement to South-South Cooperation and continued support to PPD as witnessed by the documentation of the "***The Ghana Adolescent Reproductive Health Project (GHARH)***" and the commitment to share it with other developing countries.

Adnene Ben Haj Aissa
Executive Director

Outline of Documentation of Best Practices

	General Information Sheet on the Country and Project setting:	
1.	Name of the Country	Ghana
2.	Name of the State or Province in the Country	Brong Ahafo Region (in all 27 Districts) and Ashanti Region (3 Metropolitan Assemblies)
3.	Type of Community	All districts in Brong Ahafo Region three Metropolitan Assemblies in Ashanti Region
4.	Number of Beneficiaries	Over 459,000 (Reached with ASRH messages and over 205,000, (Adolescents provided with ASRH Services) and (Over 8,081 Individuals trained)
5.	Kind of Intervention	Adolescent reproductive health with the following components: 1) Adolescent-Friendly Health Corners, 2) Adolescent Clinic Days, 3) School Health Clubs, 4) YOLO/YMK, 5) Mobile Application.
6.	Implementing Institution	MOH/GHS, GES/SHEP, NYA, NPC, UNFPA, USAID and five (5) NGOs namely: PPAG, HFFG, MAP+, WILDAF and ISRAD
7.	Details of Institution with e-mail address	
8.	Head of the Institution	Ministers, Regional Directors, Executive Directors, and Country Directors, etc,
9.	Implementation Period	January, 2014 – September, 2017
10.	Budget:	12.3 Million Great British Pound Sterling.

Profile of Ghana

Ghana is a country located along the Gulf of Guinea in West Africa. It is bordered to the north by Burkina Faso, Côte d'Ivoire to the west, and Togo to the east. To the south is the Gulf of Guinea, with a coastline of about 560 km. The country has a total land area of approximately 238,535 km2. The Greenwich Meridian passes through the port city of Tema, while the equator falls just 3o below the country.

Ghana is a unitary democratic republic headed by an elected President, with separation of power among the Executive, Legislature and the Judiciary. It operates a decentralised local government and administration system consisting of 16 administrative regions which are sub-divided into 260 Metropolitan, Municipal and District Assemblies (MMDAs).

The population of Ghana is currently estimated to be at 30 million. Ghana's population has increased rapidly over the years from 6.7 million in 1960 to 24.6 million in 2010 with more than half of the population (51%) being females. With an inter-censual growth rate of 2.5 percent, the population is expected to double in 28 years. Ghana is a fast urbanizing country with nearly 55 per cent living in urban areas and by 2030 65% of the population will residing in urban areas.

The age and sex structure of the population reflects a youthful population with 38 percent of the population under 15 years of age. With such a youthful population, there is an in-built momentum for further growth. Ghana is experiencing a demographic transition with both fertility and mortality levels declining.

Life expectancy at birth is currently estimated to be 64 years (63 years for males and 65 years for females). Maternal mortality is still at 310 from a high 451 deaths per 100,000 live births while under-five mortality has declined from 155 deaths per 1000 live births in 1988 to 60 in 2014.

The use of modern contraceptives among women in Ghana has increased in fourfold between 1988 (5.2 percent) and 2014 (22%) with a corresponding decline in TFR from 6.4 to 4.2 within the same period. However, there is a high unmet for family planning among 1 in 3 women.

In 2009, Ghana attained lower middle-income status. Ghana has a GDP of $66.98 billion and a capita income of $2,202 in 2019. The largest contributor to GDP is the service sector (53%) followed by agriculture (24%) and manufacturing (10.5%). The remaining 12.5 per cent is made up of mining, petroleum and construction. Approximately 11 per cent of the population lives below the international poverty line of US$1.90 per day.

Project Overview

The Ghana Adolescent Reproductive Health (GHARH) project provided quality sexual and reproductive health (SRH) services to adolescents as the core mandate. To promote this idea a number of service delivery platforms were rolled out by GHARH partners to meet the special needs and circumstances of adolescents. The project was initially implemented in one region (all 27 districts of the Brong Ahafo Region) and later up scaled to another region (three Metropolitan Assemblies of the Ashanti Region).

The GHARH Project supported the establishment and operationalization of 54 Adolescent-friendly Health Corners, 36 Adolescent Outreach Clinics and 457 School Health Clubs. There were over 459,000 beneficiaries (Adolescents and Youths) who were reached with ASRH messages, over 205,000 Adolescents and Youths were provided with ASRH Services, over 129,000 ASRH information materials were produced, over 8,081 individuals were trained by the project and over 803 Adolescent service platforms were established by the GHARH Project.

The implementation period for the GHARH Project lasted from January, 2014 to September, 2017 with a budget of £12.3 million United Kingdom Government fund through DFID. The ultimate goal of the Project was to improve Maternal and Adolescent Reproductive Health (ARH) outcomes in order to enhance progress towards the achievement of MDG 5.

Implementing Institutions/Development Actors

The project Implementation was done through a multi-Agency led coordination framework with the National Population Council Secretariat (NPCS) working closely with the Ministry of Health/Ghana Health Service (MOH/GHS), the Ghana Education Service/School Health Education Programme (GES/SHEP), the National Youth Authority (NYA) and the Regional Coordination Councils (RCCs) of the Brong Ahafo and Ashanti Regions. The 27 District Assemblies in the Brong Ahafo Region and 3 Metropolitan Assemblies in the Ashanti Region were the direct implementers of the district level grant activities. The GHARH Project was managed by the Futures Group Europe (FGE), now the Palladium Group. The Project oversight was provided by a National Steering Committee which guided programme implementation process.

There were five (5) Non-Governmental Organisations (NGOs) recruited on to the Project as part of the implementing partners (IPs) to support the implementation of the GHARH intervention in the Brong Ahafo Region. These NGOs were: 1) Planned Parenthood Association of Ghana (PPAG), 2) MAP International, 3) Hope for Futures Generation (HFFG), 4) Institute of Social Research and Development (ISRAD) and 5) Women in Law and Development in Africa (WILDAF). The first three (3) NGOs worked in the area of service provision whilst the remaining two (2) also worked in the areas of research and advocacy.

Overview of the Practice, Objectives and Results

1. Adolescent-Friendly Health Corners:

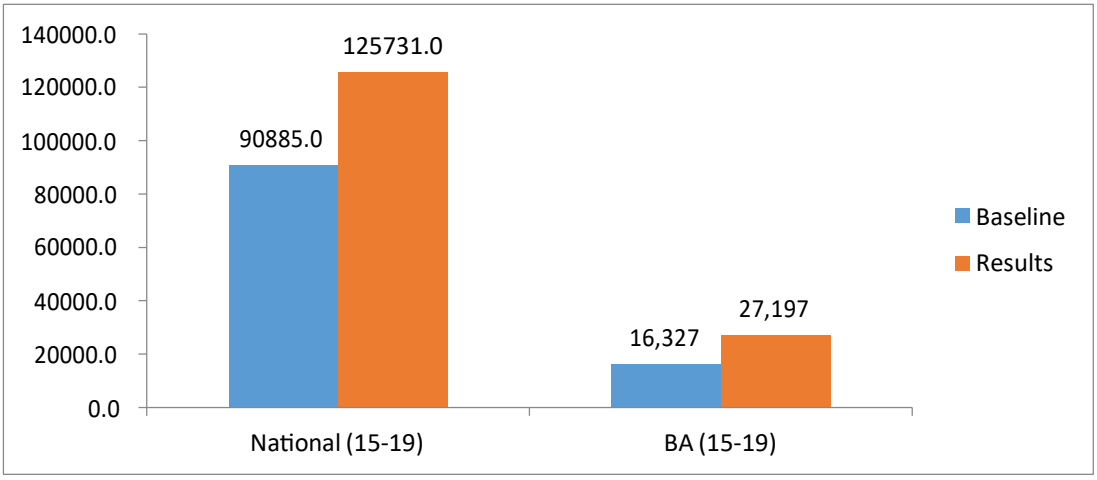
The 'adolescent-friendly health corner' was a health intervention strategy developed by the GHARH Project to provide a conducive environment for the provision of sexual reproductive health (SRH) services in a clinical setting. The 'adolescent-friendly corners' were intended to serve adolescents better by responding appropriately to their needs, particularly regarding hours of operations, and limiting stigma and other barriers associated with accessing services in regular clinical settings. In collaboration with GHS, the GHARH project successfully supported the establishment of fifty-four (54) 'Adolescent-Friendly Health Corners' within the project period, two (2) each in all the 27 districts in the Brong Ahafo Region. All 54 adolescent-friendly corners were renovated, furnished and supplied with minor medical equipment and are still in use providing services including counseling, family planning, health screening (including for STIs and HIV), pregnancy testing, ante-natal and post-natal care services and health education. The adolescent-friendly health corners are also used for recreational purposes in order to attract adolescents and provide a welcoming environment for the adolescents.

A well-trained qualified nurse providing sexual reproductive health service to an adolescent at a designated 'Health Corner'

2. Adolescent Health Outreach Clinics (Adolescent Clinic Days):

GHARH supported the adoption of adolescent clinic days to reach adolescents with SRH information and services. This was done mainly through service outreach. GHARH collaborated with GHS/RHD to set aside one day of the week as an adolescent only clinic day for the provision of free, targeted ASRH and family planning services. This was informed by the realization that adolescents were uncomfortable accessing reproductive health services in the presence of adults. Staff managing these clinics were enthusiastic nurses and healthcare workers who had received specialized training under GHARH. Data obtained from tracking service utilization showed that these outreach clinic days contributed to service uptake among adolescents.

The chart below presents the breakdown of service uptake among adolescents in the Brong Ahafo region.



Source: DHIMS March 2017

Figure 1: Uptake of family planning service among adolescents at baseline and completion

3. Adolescent School Health Clubs:

The 27 districts in the Brong Ahafo region committed to strengthen School Health Clubs as platforms to provide health information to adolescents and young people to allow them to make informed decisions and choices. The core values of the clubs were promoting abstinence, responsible sexual behaviours and choices, assertiveness in dealing with peers and adults, leadership, problem solving and communication skills, while also providing counseling and referral where necessary and promoting understanding of sexual and reproductive health issues.

In 2015, 457 Adolescent Health Clubs were set up and inaugurated in junior high schools in the Brong Ahafo region. Peer educators and school-based SHEP Coordinators were also trained to lead and manage the club activities. As part of capacity building for students and teachers, five (5) Non-Governmental Organisations (NGOs) were contracted under the GHARH project to provide technical support to the clubs. Debates were also organized for schools to compete among themselves.

The launching of School health clubs in Sunyani in the Brong Ahafo Region.

4. Communication, Mass Media and Advocacy:

Another area of major accomplishment of the GHARH project was communications, use of mass media and advocacy activities. The GHARH project developed, produced and aired a multi-agency coordinated mass media campaign. The project initiated the weekly airing of major television drama series – YOLO (You Only Live Once) and YMK (You Must Know). The combined package was a collaboration between two GHARH partners, the National Population Council (NPC) and Ghana Health Service (GHS).

YOLO was a 13 episode drama series that educated, entertained and provided guidance on issues that affected adolescents, including their sexual and reproductive health. The YOLO series had two (2) target groups. The primary groups were young people between the ages of 10 to 19 and 20 to 24 years. The secondary target groups were parents, guardians and the extended family as well as stakeholders at different levels of policy and decision-makers, community and opinion leaders and the media etc. The GHS 'chit chat' in-studio discussion sessions complimented YOLO and provided a platform to discuss the issues raised in the drama by a diverse team of technical experts, young people, Queen mothers, Chiefs and Opinion leaders, addressing both traditional and modern perspectives in responding to adolescent sexual reproductive health issues.

Active social media engagement was also packaged into the campaign, with YOLO accounts created on Facebook, Twitter, Instagram and YouTube during August and September, 2015. Each of these platforms provided details on YOLO initiative and included content appropriate for adolescents on reproductive health.

5. Advocacy:

In addition to the Government partners who were provided with grants under the GHARH, five (5) civil society organisations (CSOs/NGOs) were recruited to implement grants at the community levels. The CSOs/NGOs complimented the work of the district assembly grantees. Hope for Future Generation (HFFG) and Institute of Social Research and Development (ISRAD), two of GHARH's NGO partners, reached out to traditional, religious and community leaders to sensitize them about ASRH issues, and garnered their support. A total of 103 queen mothers and 350 Chiefs, religious and traditional leaders were oriented on ASRH and pledged their support for the advocacy efforts in their districts and communities.

6. Mobile Application:

Additionally, GHS completed the first phase of the re-design of the AHDP website and GHS- ADH-Mapp mobile application in support of e-learning for service providers and increased access to information for young people.

The GHS-ADH-Mapp won the Ghana Health Service special award for best innovation for the year 2015. The Mobile Application is available for download on the Google play Store, and there are currently 417 service providers and health managers using the application for various purposes. The e-learning core system has been designed and an instructional designer assisted with the electronic programming of content.

Background and Justification:

Within the context of DFID's support for interventions that were meant to assist the achievement of MDG 5 in Ghana, a Business Case was developed in early 2012 to strengthen programming for adolescent sexual and reproductive health (ASRH). GHARH had the aim of improving maternal and adolescent reproductive health (ARH) outcomes in order to improve progress towards MDG 5.

According to the 2010 Ghana Population and Housing Census, adolescents and young people aged 10 – 24 years accounted for about one third of the population. Unplanned/unwanted pregnancies and high rates of abortion (sometimes unsafe) in young people was a significant problem as a result of early initiation of sex (including coerced sex) and low use of condoms and other modern contraceptives. Although there were positive trends (e.g. increasing age at first sex, increasing adolescent contraceptive use and decreasing adolescent birth rates, pregnancy in young people, particularly adolescents), remained a challenge that had important implications for Ghana's achievement of MDG 5.

It was also important for the health and development of adolescents, particularly girls; for their potentials to benefit and contribute to their families and communities as they transitioned to adulthood.

Reproductive health outcomes among adolescents were a challenge, although some notable progress was being observed. Data from the 2014 Ghana Demographic and Health Survey (2014 GDHS) indicated that one in ten teenagers has already had a child (11%) and another 3 percent were pregnant with first child and among 19 year olds, close to one-third (29%) have begun childbearing.

The survey further showed that adolescent childbearing occurred more among rural than urban counterparts (17% versus 12%). In this context rural, hard to reach communities and older adolescents needed to be reached more with appropriate interventions.

On contraceptive use, it was estimated that maternal mortality could be reduced by 25% to 30% if women had access to and used modern methods of contraception. The 2014 GDHS showed that contraceptive prevalence rate for modern methods for all women was only 22 percent. Yet, only 39 percent of the current need for family planning (FP) was being met by modern methods and the gap was greatest among the less educated, the poorest households, and adolescents aged 15 – 19 years, where nearly two-thirds had unmet need.

A study showed that among women (including young people) with an unmet need, 45% had access to and a favorable attitude towards contraceptives, 32% had access but did not have a favorable attitude, and 23% did not have access.

Many factors accounted for the high levels of unwanted pregnancies, both individual factors (for example lack of knowledge and skills) and also more distant determinants; rural domicile, poverty, lack of access to education and health services/family planning commodities and harmful social/cultural norms, including attitudes to pre-marital sex and pervasive gender inequalities.

In Brong Ahafo as elsewhere in Ghana, socio-cultural and economic factors, such as early marriage, inadequate parental communication, low educational attainment (on both parents and adolescents) and widespread poverty made it challenging for young people to lead well-informed and healthy reproductive lives. While some activities existed in the Brong Ahafo and the other regions to address these issues, they needed to be strengthened along with a more holistic model that mobilized local community actors to better integrate service provider efforts.

Comprehensive health and sexual education for in-and-out-of-School adolescents, as well as increase contraceptive usage amongst young people was needed and young people themselves needed to be more engaged in this process. Stakeholders in youth development, who influenced young people's social and cultural environment, such as parents, teachers, traditional leaders and local governments also needed to be more engaged and well informed about adolescent sexual and reproductive health (ASRH) issues.

The GHARH project in the Brong Ahafo region aimed to have a positive impact on young people's sexual and reproductive health by responding to different determinants of ASRH at individual, inter-personal, organisational, community and structural levels, including attention to both the demand side and the supply side aspects of the provision of health services and commodities.

1. Why was the Practice/Project important?

The Practice/Project was important because of the following:

- The need to increase young people's access to appropriate health information;
- The need to increase young people's access to and use of health services;
- Enhanced the social, legal and cultural environment for the improvement of young people's health;
- The need to improved young people's participation in the implementation of services, to generate demand and increase utilization;
- To ensure improved the management of programmes for young people's health, including resource mobilization;

2. Challenges and Constraints

Some of the main challenges/constraints faced by the GHARH Project in meeting its objectives were:

- Delays in procurement related to the refurbishment of the 54 ARH Corners,
- Extended period of finalizing work plans,
- Personnel changes at the District Assemblies necessitating the need for additional capacity building,
- Utilization of programme's Technical Assistance Fund (TAF) was initially slow,
- Inadequate funding compelling districts to prioritize and plan for few activities,
- Inconsistence in data reporting,
- Poor team work among some districts,
- Staff turn-over contributing to change in team membership-this affected continuity,
- The period for implementation of project activities was relatively short,
- Religious/Cultural sensitivity served as barriers to ASRH programming need to address social norms more broadly.
- Ensuring sustainability of the ARH programming as the programme came to an end was a big challenge,
- Implementation of School Health activities, particularly those aspects related to the content of the curriculum for Comprehensive Sexuality Education (CSE) and the clear focus on abstinence only messages,
- The preparation, analysis and submission of end-of project reports from the Brong Ahafo Region grantees took a much longer time than expected.

Goals and Principles

The project had the ultimate goal of ensuring that more girls and women were empowered to achieve their full potential.

The intervention further addressed the following four (4) key objectives:

- Improve access to and utilization of quality health services by adolescents,

- Improve access to appropriate health information by adolescents and youth aged 10 to 24 years,
- Create a supportive environment for the development of the adolescent friendly health services,
- Strengthen the Government of Ghana's capacity to implement and manage delivery of the ARH programme (Multi-Sectoral Coordination and Partnerships).

The implied principles of the project were:

- The right of young people to information on their sexual health
- The right of young people's access to and use of family planning services
- The right of young people to participate in implementation of services that affect their health.

To achieve the stated objectives, the project focused on increasing awareness, knowledge and provision of ASRH services; developing friendly ASRH services and building provider capacity; generating evidence-based data through various operations researches to improve uptake of ASRH services and increasing access to and availability of affordable family planning commodities.

Therefore, in line with the project outputs, in the first year, the project implementing partners conducted sensitization fora with stakeholders, policy makers and the general public, organized community durbars and floats across the 27 districts and promoted the use of radio stations/community information centres to create demand and use of ASRH services. These awareness-raising activities were designed to create supportive environment in the various communities. Through the adolescents' health corners, access increased for adolescents to benefit from ASRH service provision and awareness was raised about the reproductive health consequences regarding early childbearing. About 54 adolescent health corners were established and assessed for service provision and 457 School health clubs were also established across all the 27 districts in the Brong Ahafo region.

Description including Activities, Achievements, Outcomes and Impact:

1. Main activities of the project

To effectively tackle ASRH issues in the focused region, GHARH partners across the 27 districts implemented the under listed core activities to increase access to services and create significant awareness on ASRH issues:

- Refurbished 54 ARH Corners to expand service outreach,
- Stakeholders' forum to sensitize gatekeepers on ASRH issues,
- Demand creation activities
- Orientation meeting for GES managers of the School health programme,
- Orientation meeting to sensitize Pastors and Imams,
- Community durbars,
- Talks on ASRH in churches and mosques,
- Orientatedd women and men's groups on ASRH,
- Used radio and community information centres to create awareness on ASRH,
- Sensitized basic school PTA and SMC Executives on ASRH,

- Used outreach clinic days to targeted adolescents with RH services,
- Formed out-of-school youth clubs,
- Drama/cultural displays in communities,
- Sensitized out-of-school adolescents living with disabilities on ASRH issues,
- Orientation for out-of-school youth parents for increased parental guidance and support,
- Organized fan games/sports "edutainment" for out-of-School adolescents in major com munities to create awareness on ASRH issues,
- Sensitized Queen mothers on ASRH,
- Organized Monthly ante-natal and child welfare clinics day for adolescents,
- Established and launched School Health Clubs at the Junior High School level,
- Identified role models to visit selected schools to interact with and mentor in-School adolescents on ASRH issues,
- Organized sensitization programme for out-of-school youth targeting (beauticians, tailors, skilled men associations),
- Capacity building for out School youth leaders,
- Trained head teachers, basic school coordinators and guidance and counseling coordinators at the Junior High School level,
- Trained Healthcare providers and supervisors for 5 days on ASRH counseling and family planning methods,
- Trained and orientated in-school peer educators on ASRH manuals and club activities,
- Trained out-of-school peer educators,

2. Achievements to date in respect to outcomes:

Key achievements under the GHARH Project to date included the following:

- Contributed to an improved policy and enabling environment for the prioritization of ASRH in Ghana,
- Three (3) major policy and strategy documents in relations to the project finalized: 1) The Revised National ARH Policy – 2016, 2) The Adolescent Health Service Policy and strategy – 2016 – 2020 and 3) The Revised NPC strategic Plan – 2017 – 2024.
- Established multi–stakeholders coordinating structures at National and Regional levels,
- Over 204,805 adolescents reached with ASRH services,
- Fifty-four (54) Adolescent Health Corners refurbished to provide ASRH services,
- Established 457 Adolescent School Clubs to educate, promote and provide ASRH services,
- Introduced ASRH information dissemination using mhealth Technology to increase demand for and provide quality ASRH services,
- Over 8,081 individuals successfully trained,
- Over 803 services platforms, including School Health Clubs established and made functional.
- Over 129,000 ASRH information materials produced.
- Over 459,000 individuals reached with ASRH messages.
- GHARH's Operations Research findings have increased the ASRH evidence-based and informed programming.
- Built research capacity and leadership within local academic institutions and research centres in fostering policy dialogue in Ghana,

- Created a forum for the National Steering Committee on ARH to share experiences and knowledge on ARH programming and also facilitated effective collaboration amongst partners,
- Use of the Media, both Traditional and Social Media, helped to create an enabling environment for Social Behavioral Change Communication (SBCC),
- Increased in family planning acceptors,
- Reduced Teenage Pregnancy rates among adolescents,
- Improved relationship between service providers and adolescents,
- Outreach services catered for the needs of out-of-school adolescents,
- Increase in the numbers of adolescent friendly health facilities across the Country,
- Establishment of School Health Clubs have deepened the understanding of ASRH issues among in-school adolescents.

3. Summary of strengths and weaknesses

In spite of the numerous successes chalked by the GHARH Project, the project had its strengths and weaknesses. These strengths and weakness of the GHARH Project could be summarized into achievements and constraints which have been boldly explained in the above sections.

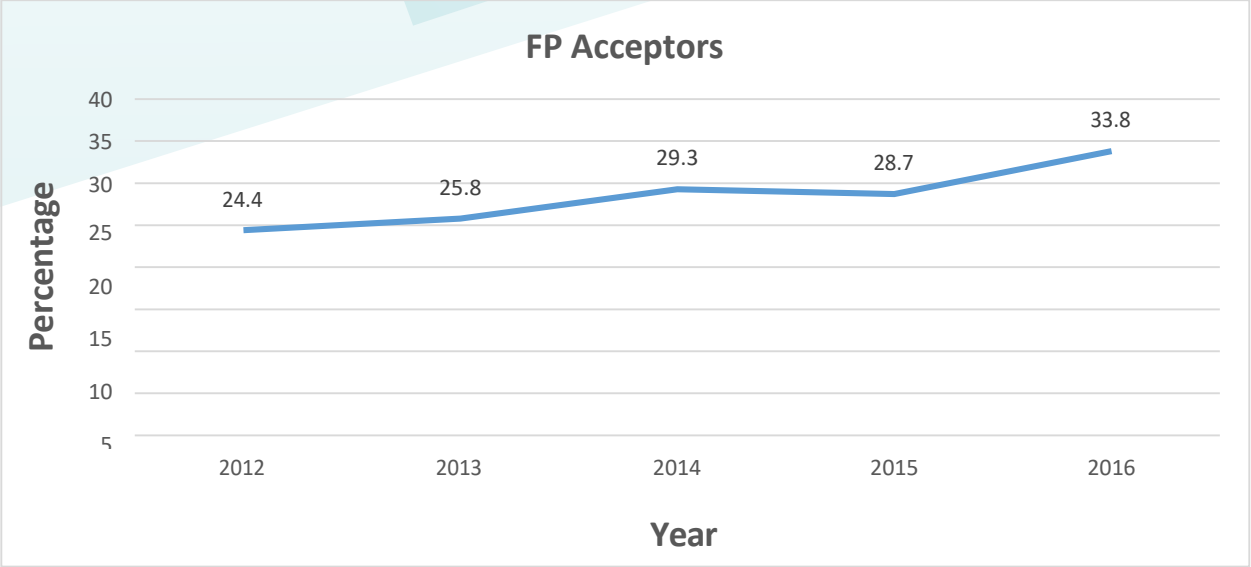
Outcomes and Impact

The implementation of the Project in the Brong Ahafo region led to the reduction in teenage pregnancy and abortion rates partly due to the high family planning uptake among adolescents; the effective management of adolescent sexual and reproductive health issues due to the creation of Adolescent Health Corners and School Health Clubs; and improved relations between health service providers and adolescents which has boosted the adolescent's confidence and trust in health care facilities.

The GHARH Project implemented in the Brong Ahafo Region achieved its set objectives and also made impact on the targeted beneficiaries, thus the youth and adolescent population in the focused region. By the end of the GHARH Project there were over 459,000 individuals who had been reached with ASRH messages. The project also designed and produced over 129,000 ASRH information materials which were distributed to youths and adolescents in the region.

Concerning service delivery, the GHARH project was able to provide ASRH services to over 205,000 youths and adolescents in the project coverage areas. The GHARH Project also trained over 8,081 individuals who worked on the project as well as targeted adolescents and youths from the communities that implemented the project.

The GHARH Project was able to establish over 803 adolescent service platforms which offered opportunities to the youth and adolescents to chat, exchanges ideas/messages on ASRH issues.



Planning and Design Experience

1. Process of planning:

The planning and design of the GHARH project was based on the adolescent reproductive health situation in the country and ongoing efforts at improving ARH. Initial planning activities involved extensive review of relevant national strategies and project documents. The review identified five key pillars of the strategy set for the period 2009-2015.

Capacity strengthening of implementing institutions: The project also identified and defined capacity strengthening needs at national, regional and district levels. The project utilised a facilitated self-assessment exercise to undertake the organisational capacity assessment (OCA). The capacity assessment process supported the NPC and organisations involved in ARH in Ghana to establish a baseline of capacity in key areas. The assessment promoted organisational dialogue, learning, and standard-setting; and informed the development of the capacity strengthening plan for addressing organisational priorities.

Formation of steering and technical committees: At the governance level a multi-sectoral National Steering Committee was constituted as the highest body at the technical level to govern the strategic direction and monitoring the progress of the project at the national level. Similarly, a Regional Technical Committee and District Technical Committees were formed to provide technical direction to the project at the field level and the Regional and District Assemblies, and worked closely with the project team.

Development of Operational Plans: The drafting of the district and ARH sector plans was done to facilitate the grant making process. Two (2) Consultants were contracted by DFID to work with NPC to develop National, Regional and District plans for the GHARH Project. The plans contained activities related to the five (5) Objectives of the Ghana Strategic Plan on the health and Development of Adolescents and young people 2009 – 2015 that would improve the health of and development of

adolescents aged 10 -19 years in Brong Ahafo Region. The Consultants then rated the adequacy of the plans' readiness for grant award.

Selection Approach: The project business case pre-determined the implementation arrangements for the project and made a clear case that the project would be led by Government Partners (NPC, GHS, GES/SHEP and NYA) and the RCC in Brong Ahafo Region. This process was re-enforced through capacity strengthening support to ensure that Government Partners were able to effectively coordinate and manage a multi-sectoral ARH Project.

Inclusion of NGOs: Several consultations informed the importance of including NGOs/CSOs/CBOs and the private sector in the partnership arrangements to implement ARH activities. Particularly for the social environmental context enablers, NGOs have shown strong capacity to develop and implement programmes at the community level. Forging partnership between NGOs and Government Agencies had proved a win – win strategy for delivery on the project objectives. DFID Stakeholders' assessment clearly showed that the Ghana programme environment had seen several strong NGOs emerge with requisite capacities to implement ARH programmes. Organisations such as Planned Parenthood Association of Ghana (PPAG), IPAS, Marie Stopes International, Creative Storm, Christian Council of Ghana and a number of Community-based Organisations (CBOs) had contributed to adolescent health and development interventions.

Proactive Proposal Solicitation: As part of the due diligence requirements and value for money propositions, an active proposal solicitation process was designed to capture the inputs and contributions of local talents and research institutions with the needed capacities to contribute their expertise to project implementation activities.

Grant Making Process: Based on the 'Core Package' of interventions recommended for funding, a phased grant roll-out process was adopted. The GHARH finance and grant management specialist and team developed a system and disbursement schedule to support the roll-out of the grant funds. Using a set of criteria developed and informed by pregnancy rates in the 27 districts of the Brong Ahafo Region, nine (9) districts were selected for the first phase roll-out. The FGE grant management team carried out due diligence assessment in the districts prior to grant awards. This was followed by training and orientation of key finance staff at the district Assemblies on the grant manual and disbursement and fund management guidelines provided to the districts in readiness for grant disbursement. A direct channeling of funding modalities was agreed and endorsed by the National Steering Committee (NSC). Funds followed directly from the project account to an identified account at the District Assemblies and funds were expended and reported on.

Immediately following the completion of the first tier districts grant disbursement, the second tier districts were rolled-out, and then followed by the third tier districts rolled-out. Managing the grant portfolio was a critical success factor and had been considered in all aspect of the grant making cycle. This took into account the conduct of full due diligence and risk assessment to ascertain the level of grantees' financial control systems and support provided where necessary to ensure all grantees met minimum standards. The results from these process and the requirements for fund disbursements informed grantee agreements and setting a framework for evaluation and annual audits.

The grant making process outlined above also envisaged a shift to performance based-payments, when grantees' work plans were fully developed and informed by the results of key action research findings.

The grantee agreements would then be adapted to the specific needs of each district and the contribution to the project outcomes as defined in the logframe. The contracts would thus become reimbursable performance-based milestone contract with all their grantees.

In planning to roll-out this component, GHARH recognized that it might not be possible for the districts to pre-finance their activities and thus the project would aim to have agreements that allowed the district assemblies to transition from payment advances to reimbursable milestones payment in alignment with the progression of achievement of their contribution to the project outcomes. Similarly, the timing of disbursements would be adapted for each grantee to optimize the balance between minimizing transactional costs and financial exposure. It was possible that disbursement timelines would vary as this balance evolved with the progress in project execution and achievement of targets.

2. Representativeness:

At the Technical level, the National Steering Committee (NSC) was the highest body governing the strategic direction and monitoring the progress of the project and constituted representatives from; 1) NPC, 2) GHS, 3) GES, 4) NYA, 5) MOF, 6) MLGRD, 7) GAC, 8) NDPA, 9) PPAG, 10) UNFPA, 11) DFID, 12) MGSP. The Brong Ahafo Regional Technical Committee and the District Technical Committees controlled the technical directions of the project at the field level. These bodies advised the regional and district assemblies which worked closely with the project team.

3. Community engagement:

Another key component of the GHARH Project was community engagement and collaboration with traditional and religious institutions (Chiefs/Queen mothers and religious leaders) to create a supportive environment for smooth implementation of the project. Traditional authorities still wield considerable power in their communities though they are often inaccessible to adolescents and young people. The chiefs, queen mothers, elders and women leaders can also be influential in their communities if adequately sensitized/educated, along with the general community members on ARSH issues.

4. Local institution building (including through informal networks):

A rapid assessment of the National Population Council (NPC) and other Government of Ghana (GoG) capacity needs related to technical direction, coordination, implementation, and monitoring of ASRH programmes was carried out to establish a baseline of NPC's capacity needs in critical areas, promote organisational dialogue, learning, and standard setting; and inform the development of capacity strengthening plan for addressing organisational priorities. The final report established a clear plan of support to help the NPC better implement its mandate of coordinating population and reproductive health, including ARH, advocacy and data-use mandate of the organisation.

There were other regional and district capacity assessments that conducted a rapid assessment of the Regional NPC office, district coordinating structures and nine (9) implementing partners to determine their capacity needs for the implementation of the GHARH-funded activities. The outcome of these assessments was the provision of technical and logistical support to enhance project implementation.

5. Sustainability plans (including through links to other projects):

The GHARH project did not develop an explicit sustainability plan; however, sustainability was embedded in its design. To ensure sustainability of the project, most of the programmatic components were built on existing structures. For instance the youth Adolescent Health corners concept already existed on a limited scope and needed expansion; and the SHEP and school health clubs already existed in some schools but needed to be either expanded or revamped. It also relied on already existing facilities and staff of the implementing institutions. Furthermore, the intervention had a gradual pull-out plan. It is worth noting that implementation thrived on whole- system approach where the teenagers, families, community leaders, political leaders, health staff and educational institutions worked as a team.

6. Description of evaluation activities taken to date:

DFID embarked on an independent evaluation of the GHARH programme to assess the model and to inform the design of the follow-on programme which was under development. The operations research (OR) component of GHARH generated a wealth of evidence which addressed gaps in knowledge, and was used to improve programme implementation and informed future ASRH programming in Ghana, and elsewhere. In 2016, there were three OR studies that were undertaken. The findings of the OR studies were not used only to inform the GHARH programme, but national policy as well. For example the revised National ARH Policy (2016) and the revised Adolescent Health Service Policy and Strategy for 2016-2020 had also been completed and validated by national stakeholders.

The OR component further investigated key areas not sufficiently covered by routine programme data or secondary data sources. The OR tested and validated the Business Case's TOC. Three OR studies completed to date:

- *Enhancing sexual and reproductive health service delivery to adolescents in Ghana:* provided perspectives from adolescents in the Brong Ahafo Region on services and ARSH health concerns. This influenced the training programme for health workers, placing more emphasis on condom availability and influencing the design of "corners". It addressed how best to engage traditional and religious leaders - an important component of the Theory of Change. The NGO grantees therefore strengthened linkage with these society gatekeepers.

- Adolescents' Views on Sexual and Reproductive Health in Ghana's Brong Ahafo Region : This revealed dynamics around early sexual debut among adolescents. It also revealed the best means to engage on such sensitive issues (peer to peer support is the most preferred method and social media in increasingly influential). It clearly pointed to the need to provide information on the correct use of contraceptives, especially condom which was the preferred method for adolescents. It also pointed to the importance of internet, and television as trusted sources of information for reaching young people. Social media was identified as an important medium of communication for behavior change. GHARH therefore developed a mobile app for provision of information and GHARH social media outreach reached many adolescents. The study also recommended means to strengthen youth friendly service provision and trained providers to provide quality services and adopt more approachable presence at facilities.

Partnerships

1. Overview of implementing institutions:

The project implementation was supported by a multi-agency led coordination framework which had Futures Group Europe now the Palladium Group, an international advisory as the project manager and technical advisor.

The National Population Council (NPC) which is the statutory body that advises the Ghanaian Government on population matters and coordinates the population sector served as the project coordinator. The NPC coordinated and worked closely with the Ministry of Health/Ghana Health Service (MOH/GHS), the Ghana Education Service/School Health Education Programme (GES/SHEP), the National Youth Authority (NYA), the Regional Coordinating Councils (RCCs) of the Brong Ahafo and Ashanti Regions as the main implementing partners as well as some civil society organisations (CSOs). As the public health care provider, the Ghana Health Service through its Family Health Division was responsible for the main programme component of providing free adolescent-friendly Health services and commodities through youth corners and outreach clinics delivered through public health facilities.

The GES provided access to in-school children for Sexuality education in schools, including resources for teachers and the facilitation of school health clubs. The in-school adolescents are growing as enrolment rates are increasing in Ghana; at the same time the GES had a School Health Programme (SHEP) that provided the leverage on which to expand access.

The National Youth Authority (NYA) which worked mainly with out-of-school youths assisted the project to reach youth groups that were not in school especially in mobilizing youth groups who were registered with the Authority.
Finally because the project was implemented in districts and at the regional levels, decentralized offices of the coordinating agency (NPC) and the implementing agencies (GHS and GES) present in these regions and districts who were more familiar with the local conditions led in the service delivery and community mobilization together with local CSOs.
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2. Role of government:

The Ghana Government through its multi – sectoral agencies such NPC, MOH/GHS, MOE/GES/SHEP, NYA, RCCs, DAs etc played very critical roles in the implementation process of the GHARH Project in the Brong Ahafo and Ashanti Regions. Some of these multi-sectoral agencies already had existing structures at the national, regional and district levels which came in handy to accelerate the implementation process of the intervention. The GHARH Project only had to rehabilitate these abandoned structures spread over all the districts that implemented the GHARH Project.

3. Civil society partnerships:

Selected Civil Society Organisations (CSOs/CBOs) namely: PPAG, MAP+, WILDAF, Curious Minds, Youth Action Movement, Marie Stopes International and ISRAD partnered with the GHARH project to implement the community mobilization component which was essential for reaching most of the out-of-school youth and promoting community acceptance of the programme components targeting adolescents who were out of school.

4. Role of multi-lateral agencies:

Multi-lateral agencies such as DFID, USAID, UNFPA, WHO, HFFG etc played a very important role in the implementation of the GHARH Project. Funding for the GHARH Project was provided by the British Government through DFID. During the implementation periods of the GHARH Project multi-lateral agencies such as USAID, WAHO and UNFPA also funded some components of the project when the GHARH Project was scaled-up and extended into the Ashanti Region from January to September, 2017.

Monitoring and Evaluation

The project did not conduct a baseline study because of available data from service statistics and survey reports on the situation of adolescent reproductive health at national, regional and district levels. The GHARH project however required the submission of quarterly and annual progress reports on the implementation process, success and challenges. Also, in the course of the project there were three operations research studies from which lessons learned were used to strengthen programme delivery. One such lessons learnt from the operations research for example led to the deployment of mobile application to provide relevant information to service providers and young people.

Successes and Lessons Learned

The GHARH project had so many successes and lessons that are worth sharing:

- The most remarkable lesson of the GHARH project is the benefit of multi-sectoral collaborations. The collaboration was responsible for the success of the project and the collaborating institutions realizing the benefits of multi-sectoral collaboration continued to work together. This kind of collaboration was required for the success of adolescent programmes because of the diversity in the backgrounds of adolescents. For instance while some adolescents are in school others are out of school; the involvement of MOH/GHS, GES/SHEP, NYA, and NGOs/CSOs/CBOs ensured that both in-school and out-of-school adolescents were covered.

- Another lesson learnt is that having programme components built around existing structures promoted sustainability. The concept of youth corners existed in facilities and needed expansion; the expansion relied on already existing GHS and GES facilities and staff. This saved the project additional cost and ensured that when the project ended the existing structures could sustain it.

- Community engagement and accountability, particularly with teachers and local authorities including chiefs, queen mothers, and elders, proved to be key in ensuring support and buy- in for the establishment and ongoing operation of youth corners, and the broader provision of ASRH services at community level.

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- Institutionalized national planning and ownership through setting up of the NSC which provided a platform for partners to discuss both policy and operational issues to facilitate ARH programme implementation.

- The importance of accurate, timely and accessible data for evidence-informed programming and on-time reporting was a key lesson for the programme. Findings from OR suggested that adolescent corners were important platforms for delivering health services and information to adolescents, provided services were tailored appropriately and staffed adequately with trained health workers

- While it is already known that both traditional and social media are powerful tools when targeting young people with reproductive health information and messages, the GHARH project has demonstrated that coverage could be wider. The project operated in only two regions in terms of service provision, yet the media components reached the entire nation. The TV series, YOLO (You Only Live Once) became a national sensation overnight and due to its popularity, the TV series has continued up to 2020 after the project ended in 2017. The TV series has been uploaded on YouTube with some episodes exceeding 1 million views at the time of this report. It has also been translated into French for wider circulation beyond Ghana.

- Using peer Educators to share and discuss ASRH information with their peers is an effective way of increasing education and information on ASRH issues,

- Collaboration among all stakeholders (Traditional authorities, IPs, District Assemblies etc) commitment and thorough planning,

- Effective collaboration has ensured the incorporation of ASRH issues into the School Curricula

Future Plans: extensions that are currently being implemented

The project was initially implemented in only one region (Brong Ahafo).The Government Partners took a decision to recommend Ashanti Region for the scale up plan. This plan was carried out by the Government partners by first consolidating the work in the Brong Ahafo Region and withdrawing gradually based on an exit strategy. After the pull out, components like Adolescent youth corners that were built on existing structures have remained. Other components that fell within the priority areas of some NGOs/CSOs/CBOs and funding agencies continued to receive support. The mobile app and informational materials continued to operate with international donor funding from the West African Health Organisation and UNFPA. Another media component which is the TV serial (YOLO) for example continues to run in TV stations with national coverage with support from Communicate4Health (USAID) and remains popular among young people.

Replicability and Scalability to promote South-South Cooperation

1. Pre-requisites for replication in other developing countries:

In order for the programme to be successful in other developing countries the following will be required:

- Strong institutional collaboration: – The core implementation support should be directed at key areas of institutional strengthening at the national, regional and district levels. Strong institutional collaboration between Governmental multi-sectoral agencies, funding agencies, NGOs/CSOs/CBOs, religious leaders and Traditional authorities etc. are some of the pre-requisites that will assist other developing Countries within the South-South Cooperation platform to successfully replicate and scale-up Ghana's GHARH Project. Without strong collaborations amongst the above-mentioned institutions and agencies it will be very difficult for any developing Country to successfully replicate and also up-scale the Ghanaian 'Story'. The OR Findings of the GHARH Project indicated that the success of the Ghanaian Project was achieved mainly because of the excellent team work spirit exhibited by the well-trained staff of the implementing agencies.

- Sustainability planning: Successful replication of the project will require sustainability planning. In the case of Ghana, since the project was built on existing structures sustainability was largely guaranteed. Countries that are implementing most of the programme components from scratch should have a clear sustainability plan at inception. To ensure sustainability, countries will need to create demand through print and electronic media, churches, mosques, health facilities etc where there is easy access to information and services.

2. Experiences in replicating in other countries through South-South Cooperation:

2.1.Suggested steps for replication in other countries

Countries interested in replicating the practice in their own counties could consider the following suggested steps:

- Broader consultations and institutional collaboration to build consensus and develop institutional architecture for coordination and implementation.
- Undertake an extensive review of policies and interventions that have been implemented to improve adolescent reproductive health.
- Adequate planning and consultation at the formative stages of the project with due consideration for building on existing implementation structures, partnership and community engagement.
- Well-coordinated implementation and strong monitoring mechanisms.
- Gradual pull out and/or scale up based on lessons learnt and sustainability planning that was carried out at inception.

3. Potential partnerships (what would be provided willingly and upon request)

The National Population Council of Ghana (NPC) played a coordination role in ensuring the success of the GHARH project and is willing to provide any assistance regarding its technical expertise and further documentation on the project. The NPC is prepared and willing to connect/liaise with implementing government institutions in Ghana to member Countries that want to replicate Ghana's success story in the GHARH project. NPC has in the past hosted Countries interested in study tours to learn about good practices and will offer the same opportunity for learning more about the GHARH project.

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Appendix 1: Contact Details of Implementing Institutions

SHEP COORDINATORS (BRONG AHAFO REGION)

15. **Beatrice Manu**
    D/SHEP/GES
    Mob: 0208229128
    Email: beatricemanu@yahoo.com

16. **Agasiba James**
    D/SHEP/GES
    Mob: 0208311960
    Email: agsibajames@yahoo.com

17. **Nsenyi Ama Priscilla**
    D/SHEP/GES
    Mob: 0206639257
    Email: priscillansenyi@gmail.com

18. **Dziwornu Moses Kwasi**
    D/SHEP/GES
    Mob: 0209423674

19. **Brenya Samuel**
    SHEP/GES
    Mob: 0200880163
    Email: Samuelbrenya699@gmail.com

20. **Sakyi Augustine**
    SHEP/ GES
    Mob: 0502238212
    Email: sakyiaugustine@gmail.com

21. **Kyeremeh E**
    GES
    Mob: 0208245640

PARTNERS AT THE REGIONAL LEVEL (B/A)

22. **Pascal Assan Edwards**
    National Youth Authority
    Mob: 0269241527
    Email: pasedwards@yahoo.com

23. **Anthony Nimako**
    GES
    Mob: 0209057980
    Email: anthonynimako@yahoo.com

24. **Dr. O.K. Afreh**
    GHS/RHD
    Mob: 0243264153
    Email: afrehok@yahoo.com

NGOs

25. **Asante Gilbert**
    MAP International
    Mob: 0201798920
    Email: agilbert@map.org

26. Patricia A. Boasiako
    Mariestopes International
    Mob: 0206516602
    Email: Patricia.antwi-boasiako@mariestopes.gh.org

CASE STUDY DRAFTING TEAM

27. **Bernard Erasmus Kojo Vikpeh-Lartey**
    Independent Consultant
    Mob: +233-20 8128541, +233-26-8393307
    Email: benvikpehlartey@yahoo.com

PPD SECRETARIAT
Partners in Population and Development (PPD)
PPD Secretariat Building Complex
Block-F, Plot 17/B&C, Sher-E-Bangla Nagar
Administrative Zone, Agargaon, Dhaka-1207
Tel: +88-02 9117842, 9117845
Fax: +88-02 9117817
Email: partners@ppdsec.org
Web: www.partners-popdev.org

PPD AFRICA REGIONAL OFFICE
Statistics House, Third Floor, Room 3.2
9 Colville Street, P.O. Box 2666
Kampala, Uganda
Telephone: (+256) 414-705-446
Fax line: (+256) 414-705-454
Email: aro@ppdsec.org
Web:www.partners-popdev.org/aro

CHINA PROGRAM OFFICE
No.30 Rd. Dong Xianfu, Taicang,
Jiangsu, 215400, China,
Tel: +8651253719188, Fax: +8651253719126