COMMUNITY HEALTH COMMITTEES:

What enables them to flourish and support Gender Responsive and Adolescent Friendly health services?

"PEOPLE HAVE THE RIGHT AND DUTY TO PARTICIPATE INDIVIDUALLY AND COLLECTIVELY IN THE PLANNING AND IMPLEMENTATION OF THEIR HEALTH CARE."

(WHO 1978 Alma Ata Declaration)[1]

[1] UNICEF., World Health Organization., & International Conference on Primary Health Care. (1978). *Declaration of Alma Ata: International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978.* Geneva: World Health Organization.

Photo: Change Maker Meeting at Khoga Khoribari, Dimla - Bangladesh

1. INTRODUCTION

Community Health Committees (CHCs) made up of a collective of community members and health providers have emerged as an important participatory accountability mechanism to support health service provision across a range of countries. Plan International's focus has been to strengthen these committees, including their make-up and leadership credentials, for a more gender responsive and adolescent friendly structure and process.

Building on the progress made through the World Health Organization Targets *Health for All* document in Alma Ata, the 1986 Ottawa Charter for Health Promotion paved the way for strengthening community actions by empowering communities to improve ownership and control over their own health. This international agreement continues to be an essential reference for health promotion and health systems strengthening[2]. Its identified action areas and basic strategies catalyzed health reform and aligned with a process of decentralized decision making and governance structures across many countries, including the introduction of CHCs. CHCs are community groups that work together to achieve specific health goals, as well as promote community participation for health, advocacy and awareness raising[3].

CHCs are comprised primarily of volunteer members from within their community, along with field level health professionals. Some examples of the different members in a CHC include health personnel, officials, councilors, traditional leaders, as well as other female and male community representatives from the related facility catchment area[4]. At the time of the Alma Ata and Ottawa Charter framework development, CHC membership did not explicitly demand the presence and participation of women as both members and leaders in the CHC. Plan International's call for representative membership in CHCs is founded on

[2] World Health Organisation. (1986). *Ottawa Charter for Health Promotion: First International Conference on Health Promotion Ottawa, 21 November 1986*. Retrieved from https://www.healthpromotion.org.au/images/ottawa_charter_hp.pdf

[3] WHO (1989). Strengthening the performance of community health workers in primary healthcare Report of a WHO Study Group. In: WHO Technical Report Series, No. 780 Geneva.

[4] Gaudrault, M., LeBan, K., Crigler, L., and Freeman, P (2017). Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs). Program Functionality Assessment A Toolkit for Improving CHC and HFMC Programs; Aga Khan Health Service (2005). Health Facility Committees: The Governance Issue. Policy Brief No. 4. Best Practices in Community-Based Health Initiatives; Haricharan H. Extending participation: Challenges of health committees as meaningful structures to community participation.

the belief[5] that this can support health facilities to more adequately respond to the varied and unique needs of more vulnerable community members, such as women, adolescent girls and children. Greater female membership is not enough; one of the ways Plan International establishes gender responsive and adolescent friendly health services involves strengthening the make-up, training, leadership and supervision of CHCs. This article highlights our experience to date.

To recall, gender responsive and adolescent friendly services aim to meet the maternal, newborn and child health/sexual and reproductive health (MNCH/SRH) information and service needs of adolescents by addressing the individual[6], structural[7] and socio-cultural[8] barriers that hinder adolescents' access to health. To be gender responsive and adolescent friendly, health services targeted towards adolescents must be confidential, accessible, non-judgmental, available at their convenience, affordable or free and conducted by competent staff following gender responsive and adolescent friendly guidelines. Referral systems need to be in place and the health facilities themselves need to be equipped with the appropriate drugs, supplies and equipment, as well as be appealing and "friendly" through the addition of different infrastructure programs, such as adolescent corners, breastfeeding corners, auditory privacy, etc., so to provide adolescents with the health services they need. Finally, the role of CHCs in supporting these services is an important one, in that they are the link between these services and a broader acceptance of gender responsive and adolescent friendly services by community members.

The roles and responsibilities that CHC members hold vary between countries, but as a collective, they intend to serve a similar purpose related to identifying and addressing health issues within the community and supporting community health workers and/or other volunteer health cadres[9]. CHCs provide an opportunity for community members to participate, interact and partner with health services to promote health within local communities. The intention is to further elevate participation to the level of the district, where increased authority and management of health services is located, allowing communities to become instrumental in directing health services[10]. Together, the implementation of these accountabilities is intended to contribute to the overall improvement of governance in health services, as well as community participation. And in turn, each of these roles and responsibilities can bring focus on gender responsive and adolescent friendly services in the choices, priorities and decisions made by membership.

---

[5] Gaudrault, M., LeBan, K., Crigler, L., and Freeman, P (2017). Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs). Program Functionality Assessment A Toolkit for Improving CHC and HFMC Programs;

[6] At the individual level, the lack of knowledge and awareness about their sexual health and rights, the low mobility of girls to access services independently, the lack of affordability of services in addition to a lack of confidentiality on the part of health care providers, can all dissuade adolescents from seeking services

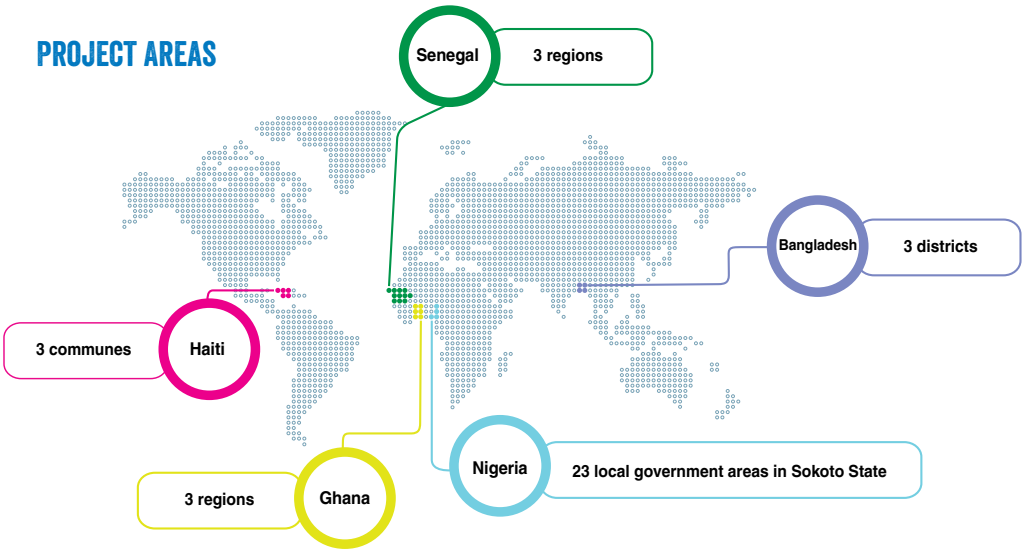
[7] At the structural and institutional levels, there are challenges related to fees for service, restrictive laws and policies surrounding available health services, judgmental attitudes of health care providers and a lack of technical capacity for gender responsive and adolescent friendly MNCH/ASRH provision

[8] At the socio-cultural level, there can be norms that dictate the behavior and sexuality of adolescents, stigma and shame surrounding sexually active adolescents as well as parents feeling ill-informed and un-prepared to provide guidance around sexuality and reproductive health

[9] Gaudrault, M., LeBan, K., Crigler, L., and Freeman, P (2017). Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs). Program Functionality Assessment A Toolkit for Improving CHC and HFMC Programs.

[10] Boulle T, Makhamandela N, Goremucheche R, Loewenson R (2008) Promoting Partnership between Communities and Frontline Health Workers: Strengthening Community Health Committees in South Africa, EQUINET PRA paper, Community Development Unit, Nelson Mandela University South Africa, EQUINET, Harare

2. SHOW PROJECT AND CHCS



Strengthening Health Outcomes for Women and Children (SHOW) is a 4.5-year, multi-country, gender transformative project funded by Global Affairs Canada and Plan International Canada. Its objective is to contribute to the reduction of maternal and child mortality amongst vulnerable women and children in targeted regions of Bangladesh, Ghana, Haiti, Nigeria and Senegal. The Gender Equality (GE) strategy embedded within SHOW promotes women and girl's empowerment, their decision-making and agency.

To improve the quality of essential health services, SHOW has taken strides focused on addressing the supply side of health systems strengthening. This includes the formation, revitalization and strengthening of CHCs for the provision of gender responsive and adolescent friendly maternal newborn and child health/sexual and reproductive health (MNCH/SRH) services at each primary health care facility in the project communities of the five countries. As Gaudrault et al. (2017) have written, CHCs can create a platform for sustainable community participation as a means of improving community health outcomes[11]. Their vision aims to improve the health of the communities that rely on the shared responsibility of a broad range of community stakeholders for the sustainable delivery of gender responsive and adolescent friendly health services.

The SHOW project aims to:

- *Tackle the root causes that prevent women, adolescent girls and their children from accessing their right to critical maternal, newborn and child health (MNCH) and sexual and reproductive health (SRH) services, with a focus on engaging men and local leaders*
- *Break down the supply side barriers that limit the provision of quality, gender responsive and adolescent friendly care for mothers, their children and adolescents*
- *Strengthen local health management information systems and improve the dissemination and use of data by local communities, decision-makers and service providers*

The presence of CHCs in the community is helping us carry out most of our public health activities.

– Ghana CHC member (Health Facility Head - Lepusi CHPS)

[11] Gaudrault, M., LeBan, K., Crigler, L., and Freeman, P (2017). Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs). Program Functionality Assessment A Toolkit for Improving CHC and HFMC Programs.

3. CHC IMPLEMENTATION FOR GENDER RESPONSIVE AND ADOLESCENT FRIENDLY SERVICE PROVISION

The SHOW project considers fundamental programmatic, structural and policy elements as it forms, revitalizes and strengthens gender responsive and adolescent friendly CHCs at each primary health care facility. To establish strong and functional CHCs, literature and field experience have shown that a list of core elements[12] (see **Figure 1** below) need to be collectively implemented for the establishment of a sound foundation, enabling CHCs to flourish. Interwoven within this list of prerequisites are the gender responsive and adolescent friendly components, including representative and effective women and adolescent girl's membership and leadership. The five (5) SHOW countries implement these essential elements as outlined below.

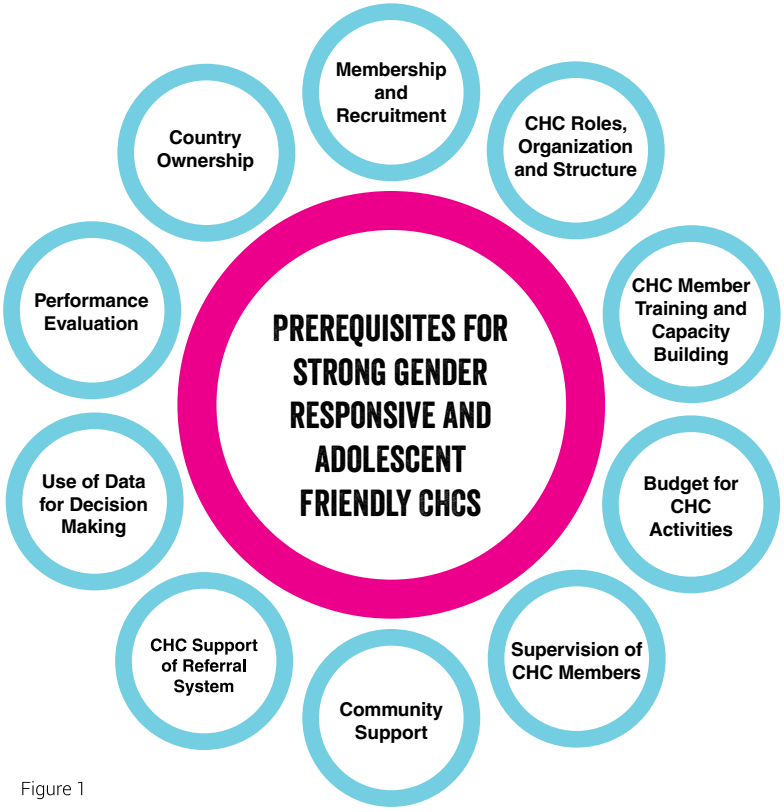


Figure 1

3.1 List of Essential Elements implemented in SHOW country projects:

3.1.1 Country Ownership of decentralized structures

Country ownership via Ministry of Health (MoH), as well as formal decentralization processes within countries, has created space for increased decentralized review and decision making, through structures such as CHCs. This has provided an opportunity for Plan's engagement within these structures. Policies or advocacy initiatives through respective Ministries were in place in four of the five SHOW program countries to inculcate gender responsive and adolescent friendly services within community health structures. For example, in Ghana, the Community-based Health Planning and Services (CHPS) policy clearly defines the role of CHCs and places emphasis on its importance in supporting primary health care. This was an entry point for Plan International to support CHCs from a gender-transformative perspective, with the aim to create CHCs where men and women can actively reflect on, question and seek to transform the inequitable gender norms related to health.

In Bangladesh, as part of SHOW's project activities, Plan International supported the completion of the government's new guidelines and an updated training manual for CHCs. The development of the training manual placed a greater emphasis on gender responsive and adolescent friendly service delivery, women's leadership and participation, as well as health care waste management. It was also coupled with a guideline which binds CHCs to include female members in the decision-making process. The manual was endorsed at the local government units in Bangladesh and its subsequent

[12] Gaudrault, M., LeBan, K., Crigler, L., and Freeman, P (2017). Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs). Program Functionality Assessment A Toolkit for Improving CHC and HFMC Programs

rollout to higher government administrative levels will pave the way for the successful implementation of future CHCs. In Nigeria, formal CHCs, committee guidelines and a training manual did not exist and Plan International supported in revitalizing the sub-committees of Ward Development Committees (WDC) to become part of facility based CHCs. The SHOW project then developed CHC guidelines in consultation with the MoH endorsing emphasis on providing gender responsive and adolescent friendly health services and allocating 30% quota for women participation, ensuring women in leadership positions and inclusion of adolescent representation. Finally, in Senegal and Haiti, there are national policies regarding the role of CHCs that exist. Government support of these structures further lays the ground work for the sustainability of CHC activities.

3.1.2 Membership and Leadership encouraging women's meaningful participation

Plan International strongly believes that women cannot solely be included as 'token' participants in CHCs, but rather it must work to transform the inherent gender imbalance in community decision making. Beyond guidelines and training products, the starting point for Plan International in the SHOW project has been changing the CHC membership and leadership structures, founded on the principle that participation of women as well as adolescent girls and boys in community groups plays an important role in achieving gender equality as well as women and girl's access to basic services in the community. Their active participation should support community health structures to respond to the varied and unique needs of the more vulnerable community members, such as women, adolescent girls and children. Furthermore, if any gender related issues surface at the community level, they will be more likely to be addressed due to better female representation as members of the CHCs.

The CHC guidelines detail the total number of CHC members and the minimum national standards for the female share of the total CHC membership in all project countries, except Senegal, which had not established any quota at the outset. While all the other countries had established quotas in their guidelines at the time of the SHOW project inception, their implementation was mixed at best. Furthermore, of the four, Bangladesh, Ghana and Nigeria also provide a quota for women reserved for leadership positions.

Table 1 shows that the quota for female membership is 30% in Bangladesh, Haiti and Nigeria whereas it is 40% in Ghana. Furthermore, the leadership positions that need to be held by women range from 30% (Nigeria) to 50% (Bangladesh). There aren't any formal commitments for adolescent representation in Ghana and Haiti, but Bangladesh and Nigeria outline formal commitments regarding adolescent representation. They each promote one (1) adolescent girl and one (1) adolescent boy for each CHC.

Representation	Bangladesh	Ghana	Haiti	Nigeria	Senegal
No. of CHC members	17	5	12	15-20	No quota
Female % fo CHC membership	30%	40%	30%	30%	No quota
No. of Adolescents	2 (1 adolescent girl and 1 adolescent boy)	No quota	No formal commitments	2 (1 adolescent girl and 1 adolescent boy)	No quota
Female % fo CHC leadership	50%	33%	No quota	30%	No quota

Table 1

A midterm survey was conducted in the five SHOW program countries (Aug-Oct 2018), including a health facility questionnaire to assess progress of female membership and leadership within the CHCs. While the health facility questionnaire was implemented, data was collected through a record review of CHC documents in the same catchment area regarding the level of women's participation in the committees. The following indicators were used for measurement of advancement in all five (5) project countries: 1) percentage of CHC leadership positions held by women; and 2) percentage of CHC members that are female.

As presented in **Figure 2**, results suggest that the level of participation of female CHC members at the beginning of the SHOW project did not meet the minimum quota (see Table 1 above) in Ghana (21%) and Nigeria (23%). Similarly, women in leadership positions in CHCs at the baseline did not meet the minimum quota (where available) in Bangladesh (27%), Ghana (25%) and Nigeria (14%). However, encouraging trends were seen in the midterm results. There was a substantial improvement in women membership and leadership from baseline to midterm across all project countries, except Senegal. The most notable improvements for increases in female membership were seen in Ghana (20 percentage points) and Nigeria (16 percentage points) whereas the most notable improvements for increases in female leadership were seen in Bangladesh (7 percentage points) and Nigeria (10 percentage points). It should be noted that despite these improvements, additional midterm results suggest that men are still occupants of most leadership positions within the CHCs.

The midterm study results have also revealed findings related to *general* challenges in women's participation in community groups, including CHCs. Across all SHOW program countries, the barriers that inhibit women's participation in decision making are mostly due to:

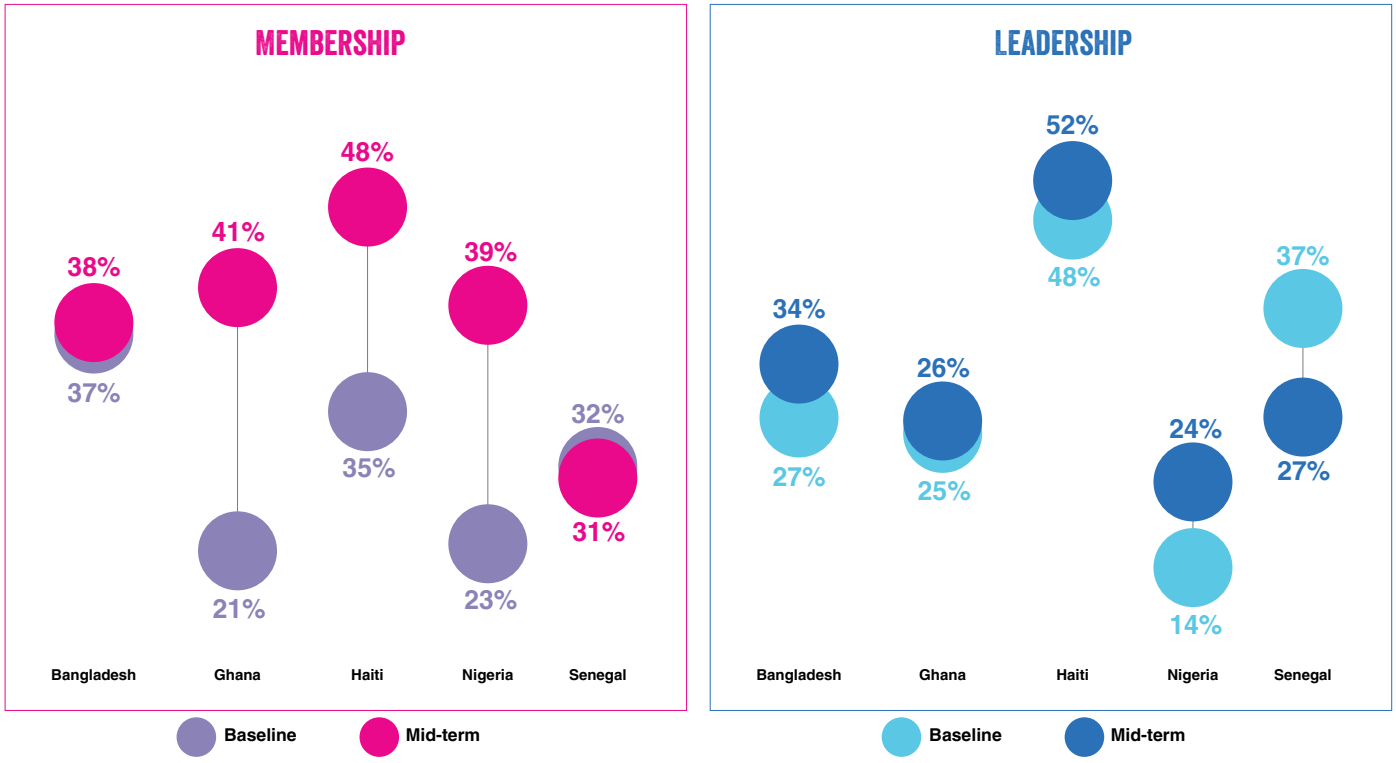


Figure 2

- meetings being scheduled at inconvenient times:
- women's opinions being sometimes disregarded:
- men taking over discussions; and
- women facing disapproval from their husbands and/or family members.

Although there were reductions in these major barriers as evidenced by women reporting, there were additional barriers to women's participation in community level decision-making that reportedly increased. For example, in Nigeria specifically, religious and social barriers to women's participation increased from 40% at baseline to 62% at midterm. Due to the small sample size of respondents[13] to this question, this increase is indicative of an overall increase in frequency with which respondents identify this barrier, but not necessarily an increase in this barrier overall.

While increasing female membership and leadership was a starting point, supporting these guidelines did not stop there. Without a deeper engagement to support both female and male members and leaders on gender responsive and adolescent friendly approaches, strategies and analysis, the efforts to get women represented in their communities would be undermined. Plan International's engagement with CHC members extended to adolescent girls and boys – and is outlined further in section 3.1.3 below.

3.1.2.1 Membership and the voice of adolescents

Ministry officials, advocates and programmers should recognize that when it comes to adolescent participation in CHCs, community members may be understandably resistant to the idea of increased involvement for multiple reasons. This includes the risk that their participation requires adolescents to be absent from their classes, security risks of young people traveling to attend meetings, or fears that their presence at health or other services will limit opportunities for discussing sensitive issues or speaking openly. At the same time, we know that – notwithstanding the barriers mentioned above - many adolescents do want to be more involved in their health, can do so (see textbox insert) and that their absence from meaningful participation may be hindering their access[14] to these services. Their voices need to be represented and considered within this decision-making structure.

[13] There was a small sample of respondents. The question was asked only to those who reported that women were not always given the opportunity to make community level decisions through participation in community level forums were asked about the reasons and barriers preventing women from participating in community level decision making.

[14] World Health Organization & UNAIDS. (2015). Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents. World Health Organization.

Additional results on adolescent participation from the Midterm study

The midterm study measured the percentage of adolescents who report that adolescents actively participate in general decision making within their communities, the results can still be used as a general proxy for how adolescents would perform within the CHC structure itself. The findings revealed variability in the five (5) project countries: active participation of adolescent girls and boys in decision making is quite frequent in Haiti (more than 75%), moderate in Senegal, Bangladesh and Ghana (30% to 50%), but not so frequent in Nigeria (less than 20%). There was no notable variation of the participation in decision making by the sex of the respondents, however, adolescent boys and girls from 18 to 19 years old reported participating a little more than their counterparts from the 15 to 17-year age group, except for Senegal. Altogether, this stand-in measure can provide a greater *general* understanding of adolescent girls and boys decision making performance in each country, it is not a direct measure of their decision-making abilities within the CHCs themselves.

As noted, only Bangladesh and Nigeria outline formal commitments regarding adolescent representation in CHCs (one (1) adolescent girl and one (1) adolescent boy for each CHC), however membership and attendance was uneven at best. In other countries, adolescent involvement or participation was encouraged through other means. For example, in Ghana, LNGO staff with the support of CHC members and Community Health Volunteers met adolescent girls' and boys' club members for knowledge sharing. This was to give CHC members a better understanding of the unique needs of adolescent boys and girls. In turn, the CHCs went back to discuss the needs and concerns of the adolescents with the health staff.

3.1.3 CHC Roles, Organization and Structure

Ensuring clarity of the CHC's organization and structure with regards to roles, expectations, decision-making and procedures is another fundamental element in establishing strong CHCs. In all five (5) project countries, there are written guidelines that provide clarity around these organizational sub-elements. Each health facility and accompanying CHC have documentation on the general rules of establishing a CHC, its functioning, relevant by-laws, the position and contact information for its members, standard protocols for CHC meetings, and templates for timesheets, minutes and action planning. This documentation also includes information related to CHC's roles and expectations, and procedures for decision-making.

3.1.4 CHC Member Training and Capacity Building

Equipping CHC members with the knowledge and skills to fulfill their roles is another fundamental element in establishing strong CHCs. As we had identified during initial assessments, many CHCs weren't fully functional or their members, in their own words, did not have the necessary capacity to fulfill their roles and responsibilities. Furthermore, women members and leaders did not always have the required leadership capabilities to do their jobs and may have been excluded from participating or leadership positions. In turn, the SHOW project conceptualized and designed CHC trainings in consultation with the relevant government officials and, in turn, developing a standard training used to train CHC members in all five (5) project countries.

The general CHC trainings (inclusive of male and female members) focused on management as well as a myriad of health and gender equality topics. The health topics were adapted to include sex and age-related barriers in accessing and utilizing MNCH/SRH services, as well as gender responsive and adolescent friendly service provision. Additional foci of learning included sexual and reproductive health and rights (SRHR) issues faced by women and adolescent girls, child, early and forced marriage, female leadership, inclusive leadership and governance, gender-based violence, quality of care, as well as the role and purpose of CHCs. Following the trainings, the participants in all countries expressed that the trainings equipped them with knowledge and skills

to fulfill their roles as well as provide a greater understanding of gender parity and the inclusion of women's participation in CHCs.

> **I never thought my voice could make a difference in my community, as I have never been a part of decision making in the community, but now that I am part of CHC leadership I was able to give a suggestion on what activity we should include in the work plan and it was accepted. I feel empowered now.**
>
> – Fatima, Female CHC leadership in Nigeria

3.1.5 Budget for CHC Activities

The availability of funding for CHC activities as well as outlining processes for fiscal management is another fundamental element for establishing strong CHCs. However, in Bangladesh, Haiti and Senegal, there isn't a budget to run CHC activities, and each country has a unique process for planning, controlling and directing financial resources. For example, in Bangladesh and Haiti there isn't a budget line item in the health sector's budget to cover CHC costs, but Bangladesh is expected to raise the funds on their own. In Ghana, there's a budget line item for CHC training, but nothing for ongoing CHC programming. In all three countries the project is advocating with the MoH for allocating budget lines for these areas to ensure sustainability. Similarly, in Nigeria, the budget line is an ongoing advocacy initiative with the government to ensure its inclusion for the upcoming annual health sector development plan for the state. Finally, in Senegal, the government has asked the community-based organizations to co-manage the CHCs with the heads of the health structures. They expect the revenue from the health services, donations and other revenue sources to cover off on the costs for CHC programming. Altogether, all the five (5) SHOW countries reported challenges related to budget and the insufficiency of funds available for CHCs to carry out their activities.

Despite these challenges and the varied management responsibilities related to the acquisition of funds and expenditures, there were notable outcomes that benefited the overall development of the different health facilities in project countries. For example, advocacy meetings between the CHCs and local governments have resulted in budget commitments for the construction of connecting roads and the provision and supply of electricity for two (2) health centers (Bangladesh), as well as the repair of a faulty borehole (Nigeria).

3.1.6 Supervision of CHCs

As noted above, proper guidelines and adequate training are both necessary to ensure CHC effectiveness in providing gender responsiveness, but these alone are not enough. As our lessons across SHOW countries have shown, supervision is an important function for maintaining positive momentum, keeping members focused on provision of gender responsive and adolescent friendly health services and ensuring good attendance at meetings. As a governance structure formed through the decentralization of services, CHCs hold lines of accountability to the local, provincial, district and/or national levels[15]. Furthermore, there's an element of supervision provided by the communities in holding the CHCs accountable for the management of their health services. Together, the CHC reporting lines are dependent on a country's respective CHC policy and the level of decentralization in administrative decision making. For example, in Bangladesh, CHCs are presided by the Union Parishad[16] Chairman however, their level of engagement can vary, ultimately impacting the CHC activities and effectiveness. In Nigeria, the

[15] The exact names of the administrative boundaries/borders are country-specific

[16] The Union Parishad is the administrative entity below the subdistrict and "governed" by its elected chairman

CHCs are supervised by civil society organizations, Plan International Staff and MoH supervisors, and in Senegal, it is the administrative authorities that are supposed to supervise the CHCs.

The frequency of visits and different activities associated with the supervision visits are known because they are included in their respective project implementation plans. They are not included in any national guidelines which specify how often supervisory visits should take place. In Ghana, there are quarterly joint supervisory monitoring visits conducted by local NGO partners and project teams at the health facilities. These visits include technical, on-site coaching and mentoring to CHCs as well as reviewing the roles of the CHCs against their performance. This review informs CHCs on areas that they are doing well, and it identifies the areas needing improvement. In Nigeria, the government is conducting routine Integrated Supportive Supervision (ISS) with health education officers and MNCH coordinators which includes looking at CHC performance.

In Haiti, Nigeria and Senegal, the tools that are used to conduct the visits include supervision checklists. These checklists include items related to gender responsive adolescent friendly service delivery for supervision of the health facilities and their affiliated CHCs.

3.1.7 Community Support

Wider community support and involvement enhances CHC activities and effectiveness because community members are aware and recognize the value of the CHC activities. CHC membership is primarily composed of influential people from within the community and community members look to their respective CHCs for guidance. These linkages serve as bridge between the community and the CHCs, ultimately enhancing community support. For example, in Nigeria, the CHCs involve community members in their different activities and data sharing initiatives, as outlined in their action plans. In Haiti, the community members consult with the CHC members on community issues.

3.1.8 CHC Support of Referral System

In all five (5) project countries, the CHCs support gender responsive and adolescent friendly referral and counter referral processes primarily related to the provision of transportation. In Ghana, CHCs oversee the transportation systems to ensure a seamless transfer of women, adolescent girls and children to advanced care. They also advocate for improved road infrastructure so that the quality of care during referrals can be improved. In Haiti, CHCs are responsible for the management of ambulance motorcycles under the supervision of the National Ambulance Center whereas, in

Photo: Mentoring support at Logang, Panchari

Senegal, CHCs provide logistical support in the form of ambulances and fuel to the communities. Finally, in Bangladesh, some CHCs pay the fees for transportation between the different levels of health care.

3.1.9 Use of Data for Decision Making

In each of the five (5) SHOW program countries, project and/or health facility data flows to and from the health system and the CHCs make use of this data. In Ghana, Nigeria and Senegal, the program documentation specifies the different health information that CHCs can access, analyze and share. This data can then be used by CHCs to inform how to address community level health issues, including how to address the gender and age-related barriers that underpin these issues. In turn, service delivery and quality issues, including the provision of gender responsive and adolescent friendly services, can be ameliorated. CHCs also use data to support their planning, supervision and future activities. For example, in Nigeria, CHCs are included in the data analysis and sharing at the health facility level and, in turn, CHCs use data to inform action planning for the overall improvement of health facility activities.

3.1.10 Performance Evaluation (including Member Recognition)

Although CHCs are not accountable to the SHOW program indicators, they are still evaluated on a regular basis as a means of monitoring and strengthening their individual functionality. In Senegal, the CHC develops an annual action plan and this is evaluated every quarter by the mayor. The mayor then shares the feedback to the community members at the general meetings. In Haiti and Nigeria, the CHCs are evaluated indirectly through program functionality (e.g., attendance by performance is an indirect measure of the performance of the CHCs) and there is no formal feedback of CHC performance provided to the community. Finally, in Ghana, CHCs are evaluated based on their different activities.

Independent of formal/informal performance evaluations, it is noted that CHC members take pride in their respective associations. To recognize their volunteer efforts through participation in trainings and beyond, independent initiatives are conducted to enhance member motivation and the possibilities surrounding improved performance in the future. Some examples of incentives included the provision of t-shirts in Ghana, hot meals and CHC identification cards in Haiti and ongoing recognition during community awareness raising sessions in Nigeria.

NIGERIAN CASE STUDY: CHC EXPERIENCE

The health system in Sokoto State, Nigeria suffers from poor community utilization of available services and poor quality of care at the health facilities (HFs). The federal tertiary institution serves over five (5) million residents in Sokoto, but the majority of the 700 public primary and secondary HFs (public health facilities, dispensaries, health posts) are state-owned. This latter cadre of HFs are grossly underfunded and understaffed. The buildings are dilapidated with insufficient materials and commodities and, the staff lack the basic skills to provide preventive and curative health services.

The Ward Development Committees (WDC) have been in existence for over a decade in Sokoto state. Their role is outlined in a National Primary Health Care Development Agency (NPHCDA) blue print and it includes working in partnership with HFs to increase the demand and utilization of health services. Their responsibilities include mobilizing host communities to make decisions concerning their health issues, advocating for community health needs and actively managing the HFs. Unfortunately, many of these WDC responsibilities haven't been realized to their full potential due to poor training, poor mentoring as well as a lack of supervision. The formation of sub-committees took place to assist with these management issues, but they were created in the wealthier and more educated urban local government areas (LGA). As such, the rural and semi-rural LGAs remained weak.

To tackle the challenge of service availability and uptake, SHOW prioritized the formation and strengthening of CHCs. CHC guidelines and training manuals were developed with a gender responsive and adolescent friendly lens, in partnership with the different state ministries such as the MoH and the Ministry of Women's Affairs. Inputs and revisions were provided by Plan International. The final documents were shared with the state to facilitate state ownership of the newly developed materials. SHOW Nigeria succeeded in forming and revitalizing two hundred and forty-four (244) CHCs in twenty-three (23) LGAs of the Sokoto State.

The composition of the CHCs that participate in the trainings included professionals in the community (drivers, school teachers, religious leaders, mechanics) as well as youth, adolescents and people living with disabilities. The minimum quota for women's participation was set at 30%.

CHC trainings were conducted in all wards by seventy-five (75) LGA representatives (34 females, 41 males) that were trained as facilitators. In the end, the one thousand seven hundred and eight (1,706) CHCs members (804 men, 514 women, 388 adolescents (168 boys & 220 girls) were equipped with the skills to improve access, quality and uptake of services provided to their respective communities.

CHC programming in Sokoto state has resulted in notable improvements in the quality of health services provided, as well as community engagement. For example, a CHC conducted a sensitization session on the benefits of ante-natal care (ANC) services due to poor utilization rates helping increase awareness in their community. Furthermore, improving health care waste management was another activity that was initiated by the CHC to increase awareness on improved waste disposal in the community as well as in general. In turn, burn and bury pits were dug in identified communities.

Lastly, advocacy efforts conducted by the CHC to government agencies and wealthy community members have resulted in promising developments. This included their restoration of a HF's water supply, fixing an ambulance and repairing school toilets. Some CHCs were so enthusiastic that they mobilized their own funds to repair damaged roofs and in one site constructed separate toilets for males and females. CHCs have performed very well with tangible results to date.

4. SUCCESSES WITH CHC SUPPORT OF GENDER RESPONSIVE AND ADOLESCENT FRIENDLY SERVICES TO DATE

Although each of the five (5) SHOW program countries exhibit varying levels of implementation of the program elements listed above, there continues to be programmatic successes revealed because of the different trainings, checklists, action plans and ongoing supervision activities that have been implemented and conducted since the January 2016 commencement of the project.

Within the CHCs themselves, there have been notable improvements. This includes improving quotas surrounding women's leadership roles in CHCs due to different initiatives, such as the implementation of sustainability plans. Midterm study results have also revealed additional findings that demonstrated an encouraging situation regarding women's participation in community groups, including CHCs. In recognition of CHCs being decision-making structures, it is important that women propose agenda items within community level forums and subsequently ensure decisions are based proposed items. Although a decreasing trend was noted from baseline to midterm[17] (in all countries except Senegal) in the proportion of women members/leaders who proposed agenda items, there was a substantial increase (in Bangladesh and Senegal) in decisions that *were* taken because of the proposed agenda items made by women. Furthermore, a large percentage of women reported that the support received from male members regarding decision-making on agenda items showed a positive trend. Finally, general work-plans have also been collectively formulated by the CHCs as their implementation paves the way to improved gender responsive and adolescent friendly service provision.

As mentioned above, to improve gender responsive and adolescent friendly service provision, the health services need to address the individual, structural and socio-cultural barriers that hinder adolescents' access to health. Furthermore, the health facilities themselves need to be equipped to provide adolescents with the health services they need. The formation/revitalization of CHCs across the SHOW program have contributed to these improvements by not only linking their communities more closely with health facilities, but also contributing to a variety of programmatic successes within their respective communities. These program activities leading to improved gender responsive adolescent friendly service provision have included health facility development, such as small scale refurbishment (repairing cracked walls, roofs, school toilet), improved water sources (repaired wells, boreholes and water passage in health facility),

[17] Relatively small number of women respondents mentioned to be leaders/members of organized community groups. The question was applicable for only those who has leadership/membership position in organized community groups.

improved waste disposal management (community sensitization on its importance, burn and bury site dug) and improved uptake of antenatal/postnatal services as well as hospital deliveries. The activities demonstrating successes have also included CHCs playing a major role in the operations of the community emergency transport system (CETS), such as adopting the role of managing the new ambulances (e.g., provision of fuel, maintenance and driver), for an improved referral system. Finally, CHCs have also supported community volunteers with the implementation of health programs, advocating for male engagement in MNCH and SRHR, conducting outreach activities to address gender-based violence and family planning, facilitating adolescent SRHR discussions within their communities and supporting adolescent club activities.

Collectively, there were eight hundred and fifty-six (856) CHCs that were either formed and/or revitalized since the commencement of the SHOW program. This includes seventy-one (71), four hundred and seventy-four (474), eleven (11), two hundred and forty-four (244) and fifty-six (56) CHCs in Bangladesh, Ghana, Haiti, Nigeria and Senegal, respectively.

This substantial number of formed and/or revitalized CHCs will help to contribute to improved gender responsive and adolescent friendly service delivery in each of the SHOW countries.

6. LESSONS LEARNED

The SHOW project has generated many lessons learned while implementing CHC programing and these include:

- Active CHCs can change the profile of a health facility with respect to service utilization, availability of quality services, and improved facility environment
- In order to remain active, CHC members require initial and ongoing training and coaching, particularly for female members
- Training on gender equality and the important roles of female and adolescent voices in the CHC is essential to foster female participation
- Regular monitoring of health facilities by CHC members ensures accountability of the health care providers, supplies and refurbishment
- Strong relationships between CHCs, government officials other partners improve both the available budget and human resources required to provide health care for women and children
- Training and non-monetary incentives can be employed to motivate CHC members over the course of their committee tenure
- Adolescent engagement in group-based activities like CHCs must be tailored to the local context to address issues in recruitment and active attendance and pay close attention to safeguarding. Where direct group participation of adolescents is not possible, other methods can be employed to have CHCs engage and have the voices of adolescents incorporated in their decisions
- Adolescents with experience in peer group/peer education or other adolescent groups are well suited for to expressing their views as members or participants in CHCs
- Building the leadership capacity of women increases their engagement both inside the CHC and also as mentors and leaders for the realization of their rights within their communities
- Sustainability of CHC activities can be achieved through continuous review and refinement of the essential elements presented

7. CONCLUSIONS

Plan International has made notable strides in the implementation of eight hundred and fifty-six (856) CHCs across the five SHOW countries. These CHCs are contributing to improved gender responsive and adolescent friendly service delivery in each of their respective primary health care centers. The representative presence of females and, in some cases, adolescents as members and leaders on the CHCs is believed to support health facilities in a manner that will more adequately respond to the varied and unique needs of more vulnerable community members, such as women, adolescent girls and children. The results to date show that important levels of female membership can be reached and replicated across countries but that ensuring adequate levels of women in leadership positions requires continued efforts in changing and challenging the norms and perceptions around gender roles at community levels. Despite some shortfalls in female leadership, the movement towards female membership and leadership has been shown to positively impact the effectiveness of CHCs in reaching more vulnerable community members. Female membership has positive knock-on effects in the community, in terms of altering perceptions and creating a cadre of mentors for young people.

While female membership and leadership is an important contributor towards improved gender responsive and adolescent friendly service delivery, it is insufficient without the other elements that contribute to strengthened service delivery. The CHC member training and capacity building initiatives that have taken place have equipped CHC members with the knowledge of not only fulfilling their roles as CHC members, but also enabling them to be more aware of the issues facing vulnerable community members and how to address them in meetings and action plans. CHC members are more knowledgeable on the importance of gender equality and the encouragement of women's meaningful participation in meetings due to gender training initiatives implemented by Plan International. All the prerequisites contribute in some way to improved functioning of health facilities.

Adolescent representation in CHCs, while not a requirement in all countries, can be further strengthened in most SHOW countries through engagement of adolescent groups indirectly where adolescent membership is not required. However the voices of adolescents are captured, CHCs are encouraged to consider protection issues around adolescent participation

Finally, the CHC leadership drives female membership and participation, as well as guides the committee's collective goal of reaching the most vulnerable community members. The ongoing supervision and mentorship of CHCs contributes to strengthened capacity of the CHC itself and within the implementation of the different activities. As a collective, each of these initiatives contribute towards strengthened gender responsive and adolescent friendly service delivery.

Learn more and get involved at **plancanada.ca**

Plan International Canada Inc.

National Office
245 Eglinton Avenue East
Suite 300
Toronto, ON M4P 0B3
Canada

Ottawa Office
130 Slater Street
Suite 1350
Ottawa, ON K1P 6E2
Canada

416 920-1654
1 800 387-1418
getinvolved@plancanada.ca
plancanada.ca

CRA Charity Registration Number 11892 8993 RR0001