

Mother to Mother SHIONOGI Project

Promotion of Maternal, Newborn and Child Health (MNCH) through community empowerment in Upper Manya Krobo District, Ghana Annual Report (Year 3)

July 29, 2026

(Project Period for Year 3: June 2025 to May 2026)

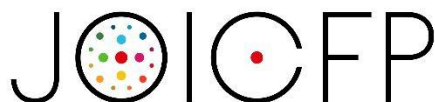
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1. Project Overview

Project Name	Promotion of Maternal, Newborn and Child Health (MNCH) through community empowerment in Upper Manya Krobo District, Ghana
Project Site	Asesewa, Anyaboni, Akateng, Sekesua and Otokpe Sub-districts, Upper Manya Krobo (UMK) District, Eastern Region, Ghana
Project Period	June 2025 to May 2026 (3 rd year)
Target Population/ Beneficiaries	72,160 including 105 community health volunteers (CHVs) (90 Maternal Child Health Promoter (MCHP) and 15 Over-the-Counter Medicine (OTCM) Sellers, 64 Healthcare Workers (HCWs), 112 Community Health Management Committee (CHMC) members
Total Budget	JPY 29,000,000
Project Goal	To improve access to MNCH services including prevention of childhood diarrhea
Objectives	1. To improve quality MNCH services including prevention of childhood diarrhea 2. To increase knowledge and awareness on MNCH including Antenatal Care (ANC), facility deliveries, Postnatal Care (PNC), and Family Planning (FP) and prevention of childhood diarrhea 3. To strengthen community support network for MNCH including prevention of childhood diarrhea

2. Context and Challenges

2-1. The Environment Surrounding Pregnant and Postpartum Women in Ghana

Ghana's maternal mortality rate remains high at 263 deaths per 100,000 live births (as of 2020), approximately 66 times higher than that of Japan.¹ This project, supported by Shionogi & Co., Ltd. since June 2023, aims to improve the health of pregnant/postpartum women and newborns, particularly in Upper Manya Krobo District, Eastern Region, where maternal and child health conditions are especially severe. This region is also where JOICFP implemented a community-based Sexual and Reproductive Health and Rights (SRHR) program from 2021 to 2022.

Upper Manya Krobo District in the Eastern Region, where the project is implemented, lacks basic developed infrastructure such as roads. The northern part of the district borders Lake Volta, and in some areas, the only option for reaching health facilities is by boat. Depending on the area, the distance to a health facility ranges from 10 to 20 kilometers, making physical access one of the biggest challenges in maternal and child health. In districts with poor access to health facilities, many pregnant women choose to give birth at home with the help of unskilled birth attendants, such as traditional birth attendants. In fact, only about 45.8% of deliveries in the district are assisted by skilled birth attendants (SBAs) (2023 District Health Administration (DHA) data), which is significantly lower than the national target of 90%. Improving physical access is essential to achieving SDG Goal 3 and Universal Health Coverage (UHC).

There are 47 health facilities in the district, comprising 1 district hospital, 4 health centers (HCs), 1 private maternity home, and 41 CHPS² compounds, which are positioned below HCs. In remote areas, health

¹ State of the World Population report 2024, UNFPA

² CHPS: Community-Based Health Planning and Services

facilities often lack accommodation nearby for HCWs, making it difficult to provide the intended 24-hour healthcare services. On-site housing for HCWs is therefore essential.

Many facilities also lack sufficient space to ensure privacy, and due to inadequate equipment, they are unable to provide proper delivery care. To increase facility-based deliveries, it is important to raise awareness about ANC, childbirth, PNC, and FP, and to encourage the use of health facilities. However, even when pregnant and postpartum women who have been educated on these matters visit the facilities, if quality services are not available, it does not lead to improved health outcomes. In fact, it discourages women from continuing to seek care.

2-2. Children Under Five and Diarrheal Diseases in Ghana

Diarrheal diseases are the fifth leading cause of death among children under five in Ghana, accounting for 9% of under-five mortality (2021).³ Contributing factors include poor sanitation, contaminated drinking water sources, inadequate nutrition, parental poverty, illiteracy, and limited years of schooling.⁴ According to the project's baseline survey, only 45.0% of residents in the target area had correct knowledge about water and sanitation, and just 34.1% practiced proper handwashing. Ghana's treatment rate for diarrhea using Oral Rehydration Solution (ORS) is also low at 48%, even when compared with other African countries.⁵

3. Project Indicator Goals and Achievements

In response to the above challenges, the project established the following project objective and three outcomes and implemented activities over a three-year period.

Project Objective:

To improve the health of pregnant women and children under five in the project areas.

Outcomes:

- 1. The quality of maternal and child health services is improved.**
- 2. Knowledge of maternal and child health among community members is improved through health education and awareness-raising activities conducted by CHVs and OTCM sellers.**
- 3. Community-based support systems for maternal and child health are strengthened toward self-reliance and sustainability.**

This chapter first summarizes the major achievements under each outcome, followed by an assessment of the level of achievement against the 20 project indicators.

3-1. Major Achievements by Outcome

Outcome 1: Improved Quality of Maternal and Child Health Services

To improve the quality of maternal and child health services, a Maternity Waiting House (MWH) and maternity ward were constructed adjacent to Akateng Health Centre in Akateng Sub-District, with the MWH representing the first facilities of their kind established in Ghana. In Sekesua Sub-District, a CHPS, a borehole, and nurses' quarters for HCWs were constructed in Sutapong. Medical equipment and furniture were also provided to the newly constructed maternity ward and CHPS.

To support the sustainable operation of MWHs and facilitate their expansion to other areas, the project developed Ghana's first Maternity Waiting House Operation and Management Handbook.

The project also organized community-based painting workshops at the MWH, maternity ward, and CHPS constructed under the project. Through paintings incorporating messages on the walls of the facilities, the workshops aimed to enhance community members' knowledge of maternal and child health and childhood diarrhea prevention, while also fostering a sense of community ownership of the facilities.

³ The Ghana Health Service (2021)

⁴ <https://www.imedpub.com/articles/diarrhoea-among-children-under-five-years-in-ghana.php?aid=19364>

⁵ The State of the World's Children 2023

In addition, training was provided to HCWs on maternal and child health, prevention and management of diarrhea among children under five, Mama and Papa Classes, and Client-Friendly Care. As a result, systems were established at each facility to enable the continued implementation of Mama and Papa Classes. The project also supported the implementation of the national accreditation training for Community Health Nurses (CHNs) to become Community Health Officers (CHOs). The training covered the CHPS policy; the respective roles and responsibilities of CHNs and CHOs; methods for effective planning, implementation, monitoring, and evaluation of activities; the importance and practical application of supportive supervision (SSV) for CHVs; the roles of CHMCs; and activities such as household visits and school health programs. Through this training, the project supported CHNs in advancing their careers to become CHOs, who are able to undertake a broader range of healthcare and community health activities. This contributed to strengthening the capacity of health personnel at the community level and improving the quality of CHPS services.

Outcome 2: Improved Knowledge of Maternal and Child Health among Community Members

To improve community members' knowledge and health practices related to maternal and child health, including the prevention and management of diarrhea among children, training was provided to CHVs and OTCM sellers, together with participatory Social and Behaviour Change Communication (SBCC) activities. As a result, continuous health education and awareness-raising activities for community members and referral systems to health facilities were strengthened, contributing to improved knowledge of maternal and child health and the promotion of appropriate health practices among community members.

Outcome 3: Strengthened Community Support Systems for Maternal and Child Health

To strengthen community support systems for maternal and child health, the capacity of CHMCs was strengthened, and income-generating activities (IGA) were supported to help ensure sustainability after the completion of the project.

In addition, Sustainability Plans and Communication Action Plans (CAPs) were developed in each Sub-District, and their implementation was continuously reviewed through regular meetings, orientations, and monitoring conducted by the CHMCs. At the end of the project, a final dissemination meeting was held to review the project achievements and share a commitment among stakeholders to continue project-related activities after project completion, led by DHA.

The roles and responsibilities for these continued activities were stipulated in an MOU with the DHA.

3-2. Achievement of Project Indicators

Of the 20 project indicators, 12 achieved their targets, while 6 did not. One indicator had no target value set. The following sections present the achievement status of each indicator, categorized into those that achieved their targets and those that did not, followed by an analysis of the factors contributing to the results.

<Achievement of Indicators and Analysis of Contributing Factors>

Indicator 2: "Deliveries assisted by skilled birth attendants" (87% achieved against the target of 60%)

The project placed considerable emphasis on improving infrastructure for safe facility-based deliveries, including the construction of a maternity ward, MWH, CHPS facilities, and nurses' quarters for HCWs, as well as on strengthening the capacity of HCWs to provide quality healthcare services through training. The substantial achievement of the target for deliveries assisted by skilled birth attendants can be considered one of the outcomes of these activities.

The endline survey found that, at Akateng Health Centre, the proportion of women who delivered at a health facility was significantly higher among those who had used the MWH than among those who had not. The survey also found that women who had participated in at least one of either the Mama and Papa Classes or awareness-raising sessions based on the SBCC strategy were significantly more likely to have delivered at a health facility

than those who had not participated in either activity. These activities are therefore also considered to have contributed to the achievement of this indicator.

Furthermore, the qualitative component of the endline survey confirmed that traditional birth attendants (TBAs) had begun to play a role in referring pregnant women to health facilities. It was also reported that awareness was growing among community members of the risks associated with deliveries assisted by TBAs, and that social norms surrounding home deliveries, which had previously been common in the community, were beginning to change. These changes in health-seeking behaviour and social norms are also considered to have contributed to the increased proportion of deliveries assisted by skilled birth attendants.

Indicator 3: “Proportion of women receiving PNC within 48 hours of delivery” (101% achieved against the target of 100%)

The proportion of women receiving PNC is generally closely associated with the rate of facility-based deliveries. While Indicator 2, “Deliveries assisted by skilled birth attendants,” reached 87%, the proportion receiving within 48 hours reached 101%, exceeding the target by a considerable margin.

According to the DHA, the figure exceeded 100% because women who delivered at home also received PNC. In other words, while the denominator used to calculate the indicator was based on the number of facility-based deliveries, the numerator also included women who had delivered at home.

Interviews conducted as part of the endline survey with the DHA, CHMC members, Sub-District leaders, and other stakeholders indicated that community members had come to understand that PNC is not a service to be used only when a problem arises, but rather an essential health service that should be routinely accessed. In addition, the endline survey found that the proportion of respondents who knew that PNC should be received within the appropriate timeframe—within 48 hours of delivery—increased from 8.2% at baseline to 29.1%. Although this level remains insufficient, the improvement in knowledge may have contributed to increased uptake of PNC.

Indicator 4: “Proportion of people receiving FP services” (80.1% achieved against the target of 58%)

This was another indicator that substantially exceeded its target. One of the contributing factors identified by the DHA was the large number of FP campaigns conducted in 2025.

The endline survey also found a substantial increase in the proportion of respondents who reported having discussed FP with their partner, from 40.5% at baseline to 74.4%. This suggests that community members’ interest in and understanding of FP has increased. Changes in awareness resulting from community-based awareness-raising activities and the implementation of Mama and Papa Classes are considered to have contributed to increased utilization of FP services.

Indicator 7: “Proportion of children aged 12–23 months who completed their vaccinations” (102.5% achieved against the target of 100%)

This indicator had already reached a high level of 99.2% at baseline in 2022 (DHIMS II). The project maintained a similarly high level each year, ultimately achieving 102.5%.

One of the main factors contributing to the sustained high vaccination coverage was the Ghana Health Service (GHS)’s regular implementation of mass immunization campaigns. These campaigns are generally conducted over approximately one week, followed by an additional follow-up period known as “mop-up,” during which children who have not yet been vaccinated are identified and encouraged to receive vaccination. As vaccinations are provided free of charge during these campaigns, children have greater opportunities to receive the required vaccinations, contributing to the maintenance of high coverage.

According to the DHA, the final figure exceeded 100% because health facilities in the five target Sub-Districts also counted children who came from outside the five Sub-Districts.

Indicator 8: “Number of maternal and child health referrals to health facilities by CHVs and/or OTCM sellers” (9,886 achieved against the target of 3,600)

This indicator was one of the most substantially overachieved indicators. The target was substantially exceeded not only in the final, third year, but consistently throughout the three-year project period.

One contributing factor was that a certain number of CHVs and OTCM sellers had previously received training and become familiar with SBCC activities through other projects. In addition, the repeated SSV and monitoring

activities conducted jointly with the DHA, including through the Project Steering Committee (PSC), are considered to have contributed to the substantial achievement of the target.

The endline survey reported that OTCM sellers were also contributing to disease surveillance beyond the scope of the project, such as identifying suspected tuberculosis cases among customers purchasing cough medicine and referring them to health facilities. The survey also found that approximately 90% of referred clients subsequently visited a health facility. Some OTCM sellers even accompanied adolescents seeking FP services, voluntarily taking on roles similar to those of CHVs as a result of the training.

These findings suggest that integrating CHVs and OTCM sellers into the referral system was one of the most innovative aspects of the project. This included establishing a system whereby the number of referrals and condoms distributed was reported monthly, enabling the DHA to monitor these activities.

Indicator 9: “Handwashing practice (%)” (82.7% achieved against the target of 55%)

This indicator reached 82.7%, substantially exceeding the target of 55% and more than doubling the baseline level of 34.1%.

As a direct project activity to promote handwashing, childhood diarrhea prevention education was incorporated into SBCC activities. Awareness-raising activities based on the SBCC strategy are therefore considered to have contributed to this result. The endline survey reported that handwashing using Veronica Buckets⁶ had become a routine practice in households, churches, food-selling stands, schools, and other settings.

Indicator 10-a: “Proportion of infants exclusively breastfed until six months of age” (81.2% achieved against the target of 80%)

The proportion of infants exclusively breastfed until six months of age increased from 77.2% at baseline to 81.2%, thereby achieving the target of 80%.

Nearly all women surveyed at endline (94.9%) understood the importance of exclusive breastfeeding. In addition, exclusive breastfeeding was the topic most frequently identified by participants as one of the topics they remembered from the SBCC sessions. These findings suggest that awareness-raising activities based on the SBCC strategy contributed to the achievement of this indicator.

Indicator 12: Number of recommendations reflected in government commitments, guidelines, or policies related to maternal and child health through advocacy (Target: 3; Achieved: 5)

Three recommendations and outputs under this indicator were developed and approved: (1) the MOU (Appendix 1), (2) the MWH Operation and Management Handbook (Appendix 2), and (3) the SBCC tools (Appendix 3). In particular, the MWH Operation and Management Handbook was the first of its kind developed in Ghana, making it a particularly significant achievement. The Handbook was revised and strengthened based on evidence from the master’s thesis of Mr. Frank Addai, who joined JOICFP as an intern after graduating from Nagasaki University. His thesis received the President’s Award, and a paper based on the research is currently being prepared for publication in an academic journal. The Handbook was not developed by JOICFP alone; officials from the DHA, HCWs, and community members participated in its development, and it was finalized through multiple rounds of consultation and revision. By incorporating both academic evidence and the experiences and needs of community members, the Handbook can be regarded as an output that reflects community ownership. Regarding the SBCC tools, the DHA has committed to expanding their use to the other two Sub-Districts not covered by the project, using black-and-white copies so that the tools can be reproduced and used without relying on external support.

Furthermore, the project achieved two additional results beyond the development of these outputs by institutionalizing project achievements within the government system. First, the monitoring tool developed under the project to monitor SBCC activities conducted by CHVs, SSV by CHMCs, and implementation of Sustainability Plans developed at the Sub-District level was formally incorporated into the monitoring items used in Kobo Collect for quarterly monitoring by the DHA. This established a mechanism for continued monitoring as part of the government’s routine activities after project completion, and its operation has already commenced.

⁶ A simple handwashing facility consisting of a bucket fitted with a tap. It enables handwashing with running water in areas without piped water systems and is widely used at health facilities, schools, and other settings across West Africa.

Second, a staff member employed by the project as an Assistant Field Officer was subsequently recruited by the DHA and will take over the activities initiated under the project as a government staff member. This is expected to facilitate the transfer of knowledge and implementation mechanisms developed through the project into the government system and support their continued implementation after project completion.

These five achievements were not incidental results realized at the end of the project. Rather, they were the outcome of JOICFP's continuous dialogue and consultation with the DHA throughout the project, as well as advocacy efforts aimed at institutionalizing and sustaining the project's achievements. As a result, the mechanisms and human resources developed through the project have been incorporated into the government system, establishing a foundation for the continued implementation of maternal and child health activities after project completion.

Indicator 13: Retention rate of CHVs and OTCM sellers (Target: 100%; Achieved: 100%)

As demonstrated by the achievement of other indicators related to activities conducted by CHVs and OTCM sellers (Indicators 8 and 14), their activity retention rate remained high throughout the project period, reaching the target of 100%. This was supported by mechanisms that encouraged continued engagement, including ongoing SSV by CHMCs and the provision of volunteer kits through the project.

In addition, the Sustainability Plans developed in each Sub-District included a mechanism for replacing CHVs whose activities were inactive with new volunteers. Continuous community-led monitoring and improvement efforts also contributed to sustaining their activities.

Indicator 14: Number of community members participating in maternal and child health awareness-raising activities conducted by CHVs, OTCM sellers, and others (Target: 10,300; Achieved: 14,551)

This was another indicator that maintained a high level of achievement throughout the project and substantially exceeded its target. As described under Indicator 13, the mechanisms and activities introduced by the project to maintain the motivation of CHVs and OTCM sellers were a major contributing factor.

Among the 350 participants in awareness-raising activities who were included in the endline survey, 97.5% reported remembering at least one SBCC session topic. Regression analysis conducted as part of the endline survey confirmed that SBCC activities conducted by CHVs and OTCM sellers had independent effects on several health-related behaviours, with significant improvements particularly observed in appropriate management of childhood diarrhea and appropriate disposal of children's faeces.

Interviews conducted as part of the endline survey also highlighted the advantage of SBCC sessions being conducted face-to-face on a one-to-one basis, allowing participants to discuss sensitive topics such as FP and ANC while maintaining privacy.

Indicator 15: Satisfaction among women who received maternal and child health services (Target: 100%; Achieved: 100%)

This indicator was newly introduced in the second year of the project. Therefore, the baseline value was obtained through a rapid survey conducted in 2024. At baseline, 95% of the 152 women who responded to the survey and had received maternal and child health services reported being either "moderately satisfied" or "very satisfied," compared with 100% at endline. The proportion of women who reported being "very satisfied" also increased from 80% at baseline to 84% at endline.

The areas with particularly high satisfaction were the friendly attitudes and respectful treatment provided by HCWs, with 84% of respondents reporting that they were "very satisfied" at endline. The project provided training to HCWs on Client-Friendly Care, and these efforts are considered to have contributed to the improvement in satisfaction.

Indicator 16: Number of women using the Maternity Waiting House (MWH) at Akateng only (Target: 150; Achieved: 276 cumulative users)

Indicator 17: Number of deliveries at the health centre with an MWH at Akateng only (Target: 120; Achieved: 273 cumulative deliveries)

The MWH was constructed with project support in 2024 and began operating in February of the same year. The average number of users per month increased steadily from approximately 9 in 2024 to 10 in 2025 and 12 in 2026, indicating that use of the facility is becoming increasingly established within the community.

The endline survey found that 94.6% of the 91 respondents living in Akateng were aware of the MWH, indicating an exceptionally high level of awareness. “Safe delivery” was the most frequently cited benefit of using the MWH, confirming that community members had gained an understanding not only of the facility’s existence but also of its role and significance. This high level of awareness and understanding is considered to be a result of the continuous awareness-raising activities conducted by the project based on its communication strategy. In addition, cases were identified in which women decided to use the MWH after being encouraged by previous users or their family members, suggesting that high user satisfaction contributed to further uptake through information sharing within the community.

Interviews conducted as part of the endline survey further demonstrated the contribution of the MWH to safe delivery. One user commented:

“I gave birth at night. Because I was staying at the MWH, I was able to move to the delivery room as soon as labor started, which made me feel very safe.”

The MWH is the first facility of its kind established in Ghana and serves as an important access point for pregnant women living in remote areas, particularly those residing across the Lake Volta, to access timely delivery care in emergencies. By reducing the risks associated with geographical barriers to accessing delivery services, the facility has made an important contribution to protecting the lives and health of mothers and children.

<Indicators Not Achieving Their Targets and Analysis of Contributing Factors>

Indicator 1: Proportion of women receiving at least four ANC visits (Target: 90%; Achieved: 84.3%; Not achieved)

The achievement rate for this indicator was 84.3%, falling short of the target of 90%. According to the DHA, one of the main contributing factors was the tendency among pregnant women to delay their first ANC visit until the second or third trimester, making it difficult for them to complete four or more visits.

The endline survey found that women with higher levels of education were more likely to have attended at least four ANC visits. It also showed that women who had given birth three or more times were more likely to have completed four or more ANC visits than first-time mothers and women who had given birth once or twice. Improving educational attainment is a structural factor that is difficult to address through a short-term project intervention, and the project faced limitations in terms of its duration and available resources.

Economic barriers, including transportation costs, as well as transportation availability and distance to health facilities, were also identified as major barriers to accessing ANC. These are structural challenges associated with geographical conditions and household economic circumstances. Although the project sought to address these barriers through the establishment of the MWH, maternity ward, and CHPS facilities, as well as income-generating training, there were limitations to the extent to which such structural issues could be resolved within the project period.

Nevertheless, interviews conducted as part of the endline survey confirmed that behavioural change regarding ANC attendance was steadily taking place within the community. HCWs reported that, whereas pregnant women previously did not seek ANC until the second or third trimester, they were increasingly seeking care soon after discovering their pregnancy. A focus group discussion participant also stated, “This was the first time I attended ANC four times during my pregnancy. I gained knowledge and confidence through the Mama and Papa Classes.”

These findings suggest that the new behaviour of seeking ANC from the early stages of pregnancy is gradually becoming established in the community and that the awareness-raising activities implemented by the project contributed to improvements in health-seeking behaviour.

Indicator 5: Number of cases of diarrhea among children under five / number of diarrhea cases treated (ORS and zinc) (Target: 750/750; Achieved: 1,135/1,135; Not achieved)

The number of diarrhea cases among children under five was 1,135, and all 1,135 cases received treatment.

Although all identified cases were treated, the number of cases exceeded the target of 750 or fewer, resulting in the indicator being classified as not achieved.

The increase in the number of cases requiring treatment may partly reflect the effects of the project’s SBCC strategy. Through awareness-raising activities, community members’ understanding of childhood diarrhea and awareness of the importance of appropriate treatment improved, which may have encouraged more caregivers to seek treatment at health facilities and other appropriate points of care. In fact, the endline survey showed a

substantial increase in the proportion of respondents with sufficient knowledge about diarrhea, from 48.7% at baseline to 83.6% at endline.

Interviews with OTCM sellers conducted as part of the endline survey also indicated that fewer customers were purchasing antibiotics for children with diarrhea based on their own judgement without a diagnosis by a health professional. These findings suggest that the project made an important contribution both to establishing a system in which children with diarrhea could receive appropriate treatment and to promoting appropriate care-seeking behaviour among community members.

Indicator 6: Proportion of children under five with diarrhea (Target: 5%; Achieved: 8.3%; Not achieved)

The proportion of children under five with diarrhea was 8.3%, falling short of the target of 5%. However, the endline survey confirmed improvements in knowledge and practices related to diarrhea prevention and appropriate home-based care.

In particular, the use of ORS for children with diarrhea remained high at 69.4%, while the use of zinc increased from 21.3% to 39.3%, indicating improved understanding of appropriate home-based care.

Participation in SBCC sessions was also significantly associated with the practice of appropriate home-based care, demonstrating that community-level awareness-raising activities based on the SBCC strategy contributed substantially to improvements in health-related behaviours.

Significant improvements were also observed in knowledge related to WASH. The proportion of women with appropriate WASH knowledge increased by 24 percentage points from baseline. In addition, the proportion of households using improved drinking-water sources increased from 72.7% to 89.3%, while the proportion of women practicing appropriate handwashing reached 90.9%. Participation in SBCC sessions was also significantly associated with appropriate disposal of children's faeces, confirming that continuous awareness-raising contributed to improvements in hygiene practices.

At the same time, the sanitation environment, which is one of the underlying factors contributing to diarrheal disease, remained a challenge. At endline, 59.9% of households were still using unimproved toilet facilities, and open defecation continued in some areas. One contributing factor was a local institutional constraint under which public toilets can only be constructed within the premises of public facilities. This creates a structural challenge to improve sanitation infrastructure across the wider community.

As an alternative approach, the project promoted household latrine construction and improved hygienic living environments through SBCC activities. While substantial improvements were observed in WASH-related knowledge and behaviours, the extent to which infrastructure-related challenges could be addressed within the project period was necessarily limited.

Thus, although the number and proportion of diarrhea cases did not reach the respective targets, clear achievements were observed in the treatment of all identified diarrhea cases, as well as in the prevention of diarrhea, appropriate care-seeking and home-based care, and improvements in WASH-related knowledge and hygiene practices. Going forward, a key challenge will be to further consolidate these achievements and strengthen hygiene practices and preventive measures in order to reduce the incidence of diarrhea itself.

Indicator 11: Community members' knowledge of maternal and child health and childhood diarrhea (Target: 70%; Achieved: 67.0%; Not achieved)

The achievement rate for this indicator was 67.0%, approaching but falling short of the target of 70%.

Nevertheless, the greatest improvements in knowledge were observed in the area of maternal and child health. The endline survey found that awareness of the importance of ANC and danger signs during pregnancy reached 99.7% and 100%, respectively.

As described under Indicator 9, improvements in knowledge related to diarrhea and other child health issues also contributed to the establishment of handwashing practices and increased use of safe water sources. These improvements in knowledge are considered to have been supported by the continuous implementation of awareness-raising activities based on the SBCC strategy, together with ongoing monitoring of these activities.

Indicator 18: Number of participants in Mama and Papa Classes (Target: 3,640; Achieved: 1,713; Not achieved)

The number of participants was 1,713 against the target of 3,640, and therefore the target was not achieved. Nevertheless, the endline survey confirmed that the Mama and Papa Classes made a substantial contribution to improving participants' knowledge and promoting behavioural change.

Of the 182 women who were aware of the Mama and Papa Classes, 80.8% had actually participated. Among participants, 88.7% reported positive changes in their partners' behaviour. Specifically, increased male involvement was reported in areas such as household decision-making related to maternal and child health, accompanying women to ANC visits, and preparing for childbirth.

The most common reason given by women who did not participate was "lack of time." This suggests that further consideration should be given to implementation approaches that better accommodate community members' daily schedules and living conditions in order to increase participation.

The qualitative survey also identified numerous specific examples demonstrating the direct impact of the Mama and Papa Classes on participants' health-related behaviours. One participant stated, "When my water broke, the knowledge I gained from the Mama and Papa Classes helped me understand that labor was approaching, so I was able to go to a health facility immediately. I do not think I would have known what to do if I had not attended the classes." Another participant explained that she had attended ANC four times for the first time during her current pregnancy as a result of what she had learned through the Mama and Papa Classes. The effectiveness of the Mama and Papa Classes was also highly valued by health-sector stakeholders, not only community members. Officials from the DHA described the Mama and Papa Classes as "one of the most effective SBCC activities," indicating that their effectiveness was recognized consistently from the community level through to the health administration level.

Thus, although the number of participants fell short of the target, the Mama and Papa Classes can be considered to have promoted changes in knowledge, attitudes, and behaviours among participants and their families, contributing to increased use of maternal and child health services and greater male involvement.

Indicator 19: Couple-years of protection (CYP) provided through family planning services (Target: 6,047.88; Achieved: 3,937.24; Not achieved)

The achievement for this indicator was 3,937.24 CYP against the target of 6,047.88, and therefore the target was not achieved.

The results were reviewed and discussed with the public health nurse responsible for managing DHIMS at the DHA and JOICFP's Country Manager. The following factors were identified as the main reasons for the lower-than-target achievement.

First, the 2026 target was set based on the 2022 achievement of 5,039.9 CYP. However, the method for calculating CYP subsequently changed, and condoms, which had been included in the calculation in 2022, were excluded from the calculation thereafter. Consequently, there was a difference in the assumptions underlying the target setting and those used to calculate the actual achievement.

Second, the project initially anticipated an increase in the use of long-acting contraceptive methods, such as implants and intrauterine devices (IUDs). However, these methods can only be provided by a limited number of qualified HCWs, such as doctors and midwives. The training required to strengthen the provision of long-acting methods was conducted during the latter part of the project, and their uptake therefore did not increase as much as initially anticipated. As long-acting methods make a relatively large contribution to CYP, the slower-than-expected expansion of these methods is considered to have affected the overall achievement. Thus, although the number of users of family planning services increased through family planning campaigns and community-level awareness-raising activities, the target for CYP was not achieved because the uptake of long-acting contraceptive methods, which make a substantial contribution to CYP, did not expand as anticipated.

At the same time, as described above, the project substantially exceeded the target for Indicator 4, "Proportion of people receiving FP services." From the perspectives of increased community awareness of FP services, improved access, and increased utilization, the project achieved clear and tangible results. Therefore, while the project contributed to expanding the use of FP services, the results suggest that further efforts are required to strengthen human resources and service delivery systems for long-acting contraceptive methods, which have a greater potential contribution to CYP.

Data for the Project Areas (Five Sub-Districts of UMK)

The data used to assess the project indicators for the five Sub-Districts of UMK, the project target areas, are presented below by data source.

Indicators Assessed Using DHIMS II Data

The data cover all five project-targeted Sub-Districts and are based on officially collected data from the DHA. The final values for each indicator were assessed using DHIMS II data for 2025 (January–December 2025). Data for January–May 2026 were not used to determine the achievement status of the project indicators, as these data may be revised in the future and are not expected to be finalized in DHIMS II until January 2027 or later. The data for January–May 2026 are provided in Appendix 4 for reference.

	Indicators	DHIMS II 2022 (Jan -Dec)	DHIMS II 2023 (Jan -Dec)	DHIMS II 2024 (Jan -Dec)	DHIMS II 2025 (Jan -Dec)	Targets (2026)
1	ANC 4+ (%)	80%	81.7%	92.6%	84.3%	90%
2	Skilled delivery (%)	45%	51.3%	51.9%	87.6%	60%
3	PNC within 48 hours of delivery (%)	98%	97.8%	98.0%	101.1%* ¹	100%
4	FP uptake (%)	57%	51.7%	54.8%	80.1%	58%* ²
5	U-5 diarrhea cases (#)/ Treated cases (#)	1297/1297	1363/1363	1338/1338	1135/1135	750/750
6	U-5 diarrhea cases (%)	11.5%	11.8%	10.6%	8.3%	5%
7	Children (12-23 months) fully immunized (%)	99.2%	90.9%	94.0%	102.5%* ³	100%
8	Referrals by CHVs/OTCM sellers (#)	2,754	1,793	4,257	9,886	3,600
10	Exclusive breastfeeding (EBF) at 3 months (%)	99%	99.90%	98.9%	98.3%	_* ⁴
19	Couple Year Protection (CYP)	5039.9	4055.05	3775.59	3937.24	6047.88

Indicators Assessed Using DHA Data

The indicators were assessed using data independently collected by the DHA for the five project-targeted Sub-Districts. The final values for Indicators 13 and 14 were based on the annual figures for January–December 2025, while those for Indicators 16, 17, and 18 were based on cumulative figures as of the end of the project in May 2026.

Data collection for Indicators 16, 17, and 18 began in 2024, when the use of the MWH and the Mama and Papa Classes commenced.

	Indicators	2022 (Jan - Dec)	2023 (Jan - Dec)	2024 (Jan - Dec)	2025 (Jan - Dec)	2026 (Jan - May)	Accumulative number	Targets (2026)
13	Retention rate of CHVs/ OTCM sellers	92%	100%	100%	100% (Final value)	-	-	100% (Annually)

14	# reached through CHVs/ OTCM sellers	10,162	8,635	12,881	14,551 (Final value)	-	-	10,300 (Annually)
16	Number of MWH users	-	-	97	118	61	276 (Final value)	150 (Accumulative #)
17	Number of deliveries by MWH users	-	-	97	117	59	273 (Final value)	120 (Accumulative #)
18	Number of people participated in Mama Papa Class	-	-	411	793	509	1,713 (Final value)	3640 (Accumulative #)

Indicators Assessed Using Data from the Baseline and Endline Surveys Conducted under the Project

The baseline and endline surveys were conducted using limited samples drawn from each of the five project-targeted Sub-Districts, rather than covering all residents of the five Sub-Districts (baseline: n=487; endline: n=541). Therefore, these data are survey data and do not constitute official statistical data collected by the DHA.

	Indicators	Baseline Survey Result	Endline Survey Result	Targets 2026
9	Handwashing practice (%)	34%	82.7%	55%
10-a	Exclusive breastfeeding (EBF) up to 6 months (%)	77.2%	81.2%	80%
11	People's knowledge on MCH and childhood diarrhea (%)	44%	67.0%	70%

Indicators Assessed Using Other Data Sources (e.g., Monitoring Data)

	Indicators	Base Value	Final Value	Targets 2026
12	Commitments made, recommendations reflected in policies/ guidelines, by the government at different levels (#) (*5)	-	5	3
15	Satisfaction rate of MCH services (%) (*6)	95% (As of October 2024)	100%	100%

*1 . The achievement rate exceeding 100% is attributable to women who delivered outside health facilities subsequently receiving PNC.

*2 For Indicator 4, "Proportion of people receiving FP services," condoms were no longer included in the calculation from 2023. Following consultation with the DHA, the target was therefore revised from 60% to 58% in June 2025.

*3 Achievement rates exceeding 100% are attributable to users residing outside the five project-targeted Sub-Districts being included in the count.

*4 The indicator for exclusive breastfeeding was defined as exclusive breastfeeding until six months of age. After monitoring began, it was found that DHIMS collected data only up to three months of age. The three-month figure is therefore presented for reference only. As it is not the project indicator, no target was set ("—").

*5 As this indicator is not included in DHIMS II, the results are based on monitoring data collected by the project. The five achievements were: (1) signing of the MOU; (2) development of the MWH Operation and Management Handbook; (3) development of the SBCC tools; (4) formal incorporation of the monitoring tool developed by the project into the Kobo Collect monitoring items used by the DHA for quarterly monitoring; and (5) recruitment of a project staff member by the DHA, who will take over the activities initiated under the project. This is expected to facilitate the transfer of the knowledge and implementation mechanisms developed through the project into the government system and support continued implementation after project completion.

*6 Indicator 15 is not included in DHIMS II and was therefore assessed using project monitoring data. The baseline value was based on user satisfaction data collected in October 2024, while the endline value was based on user satisfaction data collected during the final evaluation in April 2026. In both cases, the values represent the combined proportion of respondents who reported being “moderately satisfied” or “very satisfied.”

4. Project Implementation Results

4-1. Project Plan and Achievements

The project was designed to achieve the following three outcomes in order to improve the quality of maternal and child health services, including the prevention of diarrhea among children: Outcome 1) Improved quality of maternal and child health services; Outcome 2) Improved knowledge and awareness of maternal and child health among community members; and Outcome 3) Strengthened community support networks for maternal and child health.

For the achievement of each outcome over the three-year project period, please refer to Section 3. Project Objective and Achievement Status above.

4-2. Planned Activities

The following activities were planned for the project as a whole to achieve each of the above outcomes.

Year 1	Year 2	Year 3
June 2023 - May 2024	June 2024 - May 2025	June 2025 - May 2026
Overall 0-1 Baseline survey 0-1 Dissemination meeting of the baseline survey outcomes 0-1 Project start-up meeting 0-2 Monitoring plan development 0-2 Semiannual and annual reports 0-8 Regular monitoring Output 1 1-1 Training for health staff on MNCH including prevention of childhood diarrhea / Mama papa class (replacing customer care training in the first year) 1-2 MWH construction 1-5 Painting workshop for MWH 1-6 MWH launching ceremony 1-7 Workshop on management of MWH Output 2 2-2 Training for CHVs/OTCM sellers on MNCH and prevention of childhood diarrhea	Overall 0-2 Semiannual and annual reports 0-3 Joint monitoring before Project Steering Committee (PSC) and PSC meetings 0-5 ⁷ Workshop to develop sustainability plan and support on communication action plan finalization 0-6-3 Satisfaction survey (A survey assessed satisfaction with ANC, delivery, postnatal, FP, and childhood diarrhea services at HCs and CHPS in each sub-district) 0-8 Regular monitoring Output 1 1-1 Training for health staff on customer care incl. Mama papa class training 1-3 Maternity wing construction & installment of medical equipment (Akateng) 1-4 Construction of a CHPS compound and a borehole &	Overall 0-2 Semiannual and annual reports 0-3 Joint monitoring before Project Steering Committee (PSC) and PSC meetings 0-5 Implementation and review of the sustainability plan pilot 0-6-1 Endline survey 0-6-2 A simple survey on the effectiveness of SBCC targeting CHVs, pregnant and breastfeeding women, and their families 0-6-3 Satisfaction survey (A survey assessed satisfaction with ANC, delivery, postnatal, family planning, and childhood diarrhea services at HCs and CHPS in each sub-district) 0-7 Final dissemination meeting 0-8 Regular monitoring Output 1 1-1-2 Training of Community Health Nurses (CHNs) 1-4 Construction of nurses quarter (Sutapong)

⁷ 0-4 is not in use, therefore not listed.

	installment of medical equipment (Sutapong) 1-5 Painting workshops (Akateng HC and Sutapong CHPS) 1-6 Launching ceremonies (Akateng HC and Sutapong CHPS) Output 2 2-1 Workshop on how to use SBCC tools 2-3 Development of SBCC tools based on communication strategy 2-4 Workshop to develop Communication Action Plans (CAPs) 2-5 Conduct SBCC activities in the community based on CAPs Output 3 3-1 Meeting with CHMC and support on implementing CAPs 3-2 Orientation for CHMC on supportive supervision for CHVs and OTCM sellers	1-6 Launching ceremony of the nurses quarter (Sutapong) Output 2 2-1 Refresher training of CHVs/OTCM sellers (incl. JOICFP apron use) 2-3-1 Printing of SBCC tools for CHMC members 2-3-2 Development and printing of MWH Operation and Management Handbook 2-5 Conduct SBCC activities in the community based on CAPs Output 3 3-1 Annual review meeting with HCWs and CHMC 3-2 Income Generating Activities (IGA) training for CHMC
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4-3. Year 3 Project Implementation Results

Reporting period : June 1st, 2025 – May 31st, 2026

Annual Plan	Progress Status
0. Overall project	
0-2 Semiannual and annual reports	To monitor progress and measure project achievements, two types of data were obtained monthly from the DHA: (1) utilization of maternal and child health services and services related to childhood diarrhea in the project areas; and (2) activity records of CHVs and the number of referrals made to health facilities. These data were reported in the quarterly, semi-annual, and annual project reports. As part of the monitoring process, the project reviewed the following measures with the DHA for indicators where progress had been particularly slow and remained a challenge: • Indicator 2: Proportion of deliveries assisted by skilled birth attendants: In early October, eight midwives were newly assigned across the Sub-Districts, of whom six were deployed to the five Sub-Districts targeted by the project. One of these midwives was assigned to Sutapong CHPS. This information was also communicated to the community. • Indicator 6: Proportion of children under five with diarrhea: Awareness-raising activities were conducted through CHVs to encourage households to establish household latrines. Given financial constraints and other practical considerations, digging a pit was identified as the most feasible approach in many households. Under regulations established by the Ministry of Sanitation and Water Resources

	and the Ministry of Local Government, public toilets can only be constructed at locations where public facilities are present. Therefore, in rural areas without public facilities, the project adopted an approach of promoting household latrine construction. At the Akateng Health Centre site, where the maternity ward and MWH are located, a public toilet was confirmed to be under construction by the Akateng CHMC. JOICFP verified the implementation of these measures through routine monitoring, as well as monitoring conducted during the field visit by the Project Manager of JOICFP headquarters, Ms. Yoshidome, in January–February 2026.
0-3 Joint monitoring before Project Steering Committee (PSC) and PSC meetings	- On 4 November, a joint monitoring was conducted to assess the current situation with relevant stakeholders, followed by a PSC meeting on 5 November. A total of 38 participants attended from the DHA, District Assembly, District Education Directorate, CHMC, leaders of the respective Sub-Districts, JICA, and JOICFP. In addition to members of the JOICFP Ghana team, Ms. Yaguchi and Ms. Hashimoto from the JOICFP headquarters participated. - Each Sub-District presented the progress of activities under its Sustainability Action Plan. Reported activities included regular CHMC meetings; SSV of CHVs by CHMC members; meetings between CHMCs and CHVs; replacing inactive CHVs with new members and providing on-the-job guidance and support; and implementation of Mama and Papa Classes. - Progress against the project indicators was also discussed. The newly constructed Sutapong CHPS, maternity ward and MWH at Akateng were highlighted for their contributions to improving maternal and child health. The meeting also discussed indicators where progress remained below expectations, namely Indicator 2, “Proportion of deliveries assisted by skilled birth attendants,” and Indicator 6, “Proportion of children under five with diarrhea.” The measures taken to address these issues are described above in Section 0-2, “Monitoring and Evaluation.” - Another issue identified was the lack of electricity at Sutapong CHPS. The District Chief Executive committed to allocating the necessary budget for connecting the CHPS to the electricity supply in the new budget beginning early the following year. However, during the project implementation period, the central government budget for the first quarter of 2026 had not yet been allocated, and the electrical works could therefore not be carried out. In the meantime, the CHPS has been able to maintain essential health services on an interim basis by using a generator purchased under a previous project. - JOICFP, together with the DHA, continues to advocate with the District Assembly for the early release of the necessary budget and implementation of the electrical works, and will continue to follow up on this issue.
0-5 Implementation and review of the sustainability plan pilot	- From 17 January to 4 February 2026, Ms. Yoshidome, Project Manager, conducted a field visit to monitor whether the Sustainability Plans and CAPs were being implemented as planned in each Sub-District. - The monitoring was jointly conducted by the UMK DHA and JOICFP, with the participants divided into two teams: Team A: SBCC activities – Ms. Yoshidome, a DHA representative, and two JOICFP Ghana staff members Team B: Sustainability Plans, CAPs, and SSV – a DHA representative and two JOICFP Ghana staff members - To enable the DHA and project staff to continue conducting monitoring using

	a standardized approach, a monitoring tool was developed and used during the visit (see Appendix 5). The main findings were as follows: ○ Sustainability Plans: In four of the five Sub-Districts, all except Otrokpe, activities were confirmed to be implemented in accordance with the plans. In Otrokpe, however, the CHMC members were inactive and meetings were not held regularly. The main reason was an issue with the management structure of the CHMC. As the CHMC Chairperson also serves as the community leader, the Chairperson has not been able to adequately fulfil the role of supporting the functioning of the committee, including appointing members and reviewing its membership when necessary. In response, the DHA met with the community leader, and possible measures, including reorganizing the committee with new members where necessary, were discussed as future actions. ○ CAPs: In Anyaboni, several key activities were identified and integrated into the Community Health Action Plan (CHAPs), which is developed quarterly. These activities included holding community dialogue sessions and visiting churches and schools to conduct health-related activities. Due to scheduling constraints, this aspect was confirmed only in Anyaboni. ○ SSV: CHMCs were confirmed to be appropriately using the SSV checklist and providing feedback to CHVs, including on the use of dialogue cards. However, follow-up actions to address identified issues were not being adequately implemented. The DHA and JOICFP Ghana team therefore provided advice, as needed, on the actions to be taken following SSV. • During the debriefing with the UMK DHA, it was confirmed that the monitoring tool used during the visit had subsequently been incorporated into the Kobo Collect tool routinely used by the DHA. The tool has since been introduced for use in the Directorate's quarterly monitoring.
0-6-1 Endline survey	On 29 January 2026, the questionnaire was finalized in consultation with the external researcher. Training was then provided to the research assistants on 4 February, followed by field data collection and preparation of the survey report. The contents of the report, including the analytical methods, were reviewed and refined through discussions among the JOICFP headquarters, the JOICFP Ghana team, and the external researcher. The results of the endline survey were presented by the external researcher at the final dissemination meeting, following which the report was finalized. For details of the endline survey, including its methodology, analytical methods, and results, please refer to Appendix 6.
0-6-2 A simple survey on the effectiveness of SBCC targeting CHVs, pregnant and breastfeeding women, and their families	To assess the effects of SBCC activities, a rapid survey was conducted at baseline in May 2025 and at endline in December of the same year. As in the baseline survey, questionnaires were administered to 30 information senders (26 maternal and child health promoters and four OTCM sellers) and 30 information destinations. Overall, improvements were observed. Among information senders, increased confidence in conducting awareness-raising activities using the SBCC tools was confirmed, while among information destinations, the frequency of participation in awareness-raising sessions increased. For details, please refer to Appendix 7.

0-6-3 Satisfaction survey	As part of the endline survey, an endline satisfaction survey was also conducted. The baseline satisfaction survey was conducted from 8 to 10 October 2024, during Year 2 of the project. For details, please refer to pp. 48–49 of Appendix 6.
0-7 Final dissemination meeting	Approximately 120 participants, including government officials from the regional health authorities, HCWs, and community stakeholders, attended the final dissemination meeting, where the project’s achievements and lessons learned were shared. At the beginning of the meeting, a message from Shionogi & Co., Ltd. was introduced through a video and a message read on behalf of the company. This was followed by presentations on the project overview, key achievements, and initiatives for sustainability, as well as a video showcasing the project implementation process and achievements. The MWH Operation and Management Handbook was also officially launched, and the results of the endline survey were presented, confirming the project’s contribution to improving health service delivery. In addition, stakeholders from each project area presented good practices and lessons learned. Government representatives expressed their commitment to continuing the operation and support of project activities after completion, and JOICFP and the DHA signed an MOU to establish a framework for sustained collaboration. The meeting was also covered by <i>Daily Graphic</i>, a national newspaper in Ghana (see Appendix 8).
0-8 Regular monitoring	- Regular monitoring of CHVs and OTCM sellers was continued. For CHVs, monitoring confirmed the implementation of various activities within the community, household visits, submission of monthly reports, referrals to health facilities, and follow-up with clients. For OTCM sellers, monitoring confirmed the provision of education on FP, maternal and child health, and the causes of diarrhea, referrals to nurses responsible for their respective areas, and submission of monthly reports. - At the same time, regular monitoring identified insufficient use of the dialogue cards. During Ms. Yoshidome’s field visit from 17 January to 4 February 2026, SBCC activities in each Sub-District were therefore monitored with a particular focus on the use of the dialogue cards. The monitoring was conducted in the following four steps: ➤ Step 1: The CHV’s SBCC session using the dialogue cards was observed using a checklist. Following the observation, both the information sender and information destination were interviewed based on the checklist. ➤ Step 2: Using the Easy Planning Board, the CHVs and the monitoring team visualized the messages delivered, target groups, and communication channels by placing stickers on the board. Where stickers were missing, the CHV was asked to commit to delivering the relevant messages before the next monitoring visit. This served as a nudge to encourage CHVs to deliver all messages, as they tended to focus on messages with which they were most comfortable. ➤ Step 3: Further encouragement was provided using the Black Star Challenge Sheet (see Appendix 9). The Black Star Challenge Sheet lists all messages identified in the Communication Strategy and allows volunteers to plan when each message will be delivered and, once delivered, color in the corresponding star. The sheet was also intended

	to encourage CHVs to deliver all of the messages. ➤ Step 4: JOICFP staff explained the purpose and practical use of the information cards included in the dialogue cards, which visualize health-related data using bar graphs. The cards are intended to encourage communities to consider questions such as, “Why is the situation in our community worse than in other areas?” and “What are the underlying factors?” Prior to Ms. Yoshidome’s field visit, the Shionogi & Co., Ltd. focal person had also identified key points to be observed and information to be collected regarding SBCC activities. Accordingly, information was collected on these points as part of the monitoring (see Appendix 10).
1. Quality MNCH services including prevention of childhood diarrhea is improved	
1-1-2 Training of Community Health Nurses (CHNs)	• The training was conducted in two sessions, from 23 to 25 September 2025 and from 30 September to 2 October 2025, with the three-day training program divided into two groups. A total of 50 CHNs from the five Sub-Districts participated. The training was delivered by five facilitators, comprising two district representatives and three representatives from the DHA. • The training followed the nationally prescribed program for CHNs to qualify as CHOs. The training covered the CHPS policy; the roles and responsibilities of CHNs and CHOs and the differences between them; effective approaches to activity planning, implementation, monitoring, and evaluation; the importance and methods of SSV of CHVs; the roles of CHMCs; household visits; and school health activities. • Upon completion of the training, all 50 participating CHNs qualified as CHOs.
1-4 Construction of nurses’ quarters (Sutapong)	• The selection of a contractor for the construction of nurses’ quarters at Sutapong Clinic was undertaken during Year 2. JOICFP sought the support of Mr. Samuel Tetteh, who had provided technical assistance during the construction of the maternity ward. Mr. Tetteh developed selection criteria based on the contractors’ track records, proposed work schedules, and estimated costs. After obtaining quotations from three contractors, he conducted a comparative analysis, and Jedark Royal Limited, which received the highest score, was selected in consultation with the UMK DHA (see Appendix 11, “Contractor Selection Analysis Report for the Construction of Nurses’ Quarters”). • On 14 July 2025, JOICFP and Jedark Royal Limited signed the construction contract. The nurses’ quarters were initially scheduled for completion by the end of November to early December 2025. • A ground-breaking ceremony was held on 24 July 2025 at the construction site adjacent to Sutapong Clinic. Approximately 20 participants attended, including the Director of the DHA, DHA officials, members of the CHMC, District Assembly representatives, JOICFP staff, and community members from surrounding areas. • At the ceremony, the contractor presented the design of the planned nurses’ quarters. The original design provided nurses’ quarters for two HCWs. However, the community and DHA requested that the design be modified to accommodate three HCWs, as at least three HCWs—a midwife, community

	nurse, and rural health nurse—are expected to be assigned to the clinic. Given the remote location of the area, ensuring that HCWs can reside near the facility was considered essential for the provision of health services, and increasing the number of rooms was therefore deemed a necessary modification. • The contractor subsequently prepared a revised design. On 14 August, JOICFP and the contractor agreed to amend the contract on the conditions that the additional cost resulting from the increased number of rooms would be covered by the construction company as part of its CSR contribution and that the original completion schedule would remain unchanged (see Appendix 12, “Revised Design of Nurses’ Quarters”). • The revised nurses’ quarters consist of three bedrooms, each with a toilet and shower, kitchen, terraces, and one living room. • Construction progress was monitored by Mr. Prince Yaw Asemoah, an independent construction specialist contracted as the Project Supervisor and not affiliated with the construction company. He visited the construction site weekly and submitted monthly progress reports to JOICFP. The nurses’ quarters were completed as scheduled at the end of November 2025.
1-6 Launching ceremony of the nurses quarter (Sutapong)	• An opening ceremony for the newly completed nurses’ quarters at Sutapong was held on 4 December 2025. Participants included the Regional Health Director, District Chief Executive, Director of the DHA, members of the CHMC, and CHVs. JOICFP was represented by staff from the Ghana office and Ms. Ward from the headquarters, who was on a field visit from 29 November to 7 December 2025. • Prior to the ceremony, the Regional Health Director visited Sutapong CHPS and raised concerns that the donated equipment and materials could not be fully utilized because the clinic had not yet been connected to the electricity supply. During the ceremony, the District Chief Executive committed to connecting the CHPS to the electricity supply within the first quarter of 2026. In the meantime, essential health services have been maintained on an interim basis through the use of a generator purchased under a previous project. • The opening ceremony was also covered by a national newspaper in Ghana (see Appendix 13).
2. Knowledge and awareness on MNCH including ANC/facility delivery/PNC/FP and prevention of childhood diarrhea is increased	
2-1 Refresher training of CHVs/OTCM sellers (incl. JOICFP apron use)	The activity was cancelled due to a budget shortfall caused by exchange rate fluctuations.
2-3-1 Printing of SBCC tools for CHMC members	Due to a budget shortfall resulting from exchange rate fluctuations, the SBCC tools intended for CHMCs were not printed. The remaining copies of the SBCC tools developed under the project were handed over to the DHA so that they can be used as needed after project completion. This is expected to enable the DHA to take the lead in their continued use and dissemination after the completion of the project.

2-3-2 Development and printing of MWH Operation and Management Handbook	• The draft MWH Operation and Management Handbook, which had already been prepared, was further revised and improved during the project. • Mr. Frank Addai, a former staff member of the JOICFP Ghana office at the beginning of Year 1 of the project, subsequently studied at Nagasaki University as a graduate student and completed his master's degree in September 2025. His master's thesis examined the factors motivating or hindering the use of the MWH through both qualitative and quantitative research conducted directly with relevant stakeholders in the field. The thesis received the President's Award from Nagasaki University and is currently being prepared for publication in an academic journal. During his internship with JOICFP, Mr. Addai made a significant contribution to improving the MWH Operation and Management Handbook by incorporating evidence from his master's research into the Handbook. • During Ms. Ward's field visit in December 2025, the contents of the Handbook were reviewed and revised in consultation with relevant staff of the DHA. • The contents were further discussed with the Akateng CHMC and other community stakeholders during Ms. Yoshidome's field visit in January 2026, and the Handbook was finalized based on their feedback. • The finalized content was subsequently reviewed by Shionogi & Co., Ltd. The design was then refined by the JOICFP communications team at the headquarters, and the final Handbook was distributed at the final dissemination meeting held in May 2026. • To facilitate wider dissemination, the Handbook was also made publicly available on the JOICFP website. https://www.joicfp.or.jp/jpn/column/ghana-mwh-2026report/
2-5 Conduct SBCC activities in the community based on CAPs	As described under Activity 0-8, CHVs continued to conduct various activities within their communities, household visits, submission of monthly reports, referrals to health facilities, and follow-up with clients. OTC medicine sellers continued to provide education on family planning, maternal and child health, and the causes of diarrhea, make referrals to HCWs responsible for their respective areas, and submit monthly reports. In addition, volunteer kits were distributed to support the activities and motivation of CHVs. Each kit contained a backpack, T-shirt, rubber boots, raincoat, and flashlight.
3. The community support system for maternal and child health, including childhood diarrhea, is strengthened for sustainability	
3-1 Annual review meeting with HCWs and CHMC	• Regular meetings of the CHMCs were confirmed to be taking place as needed. During Ms. Yoshidome's field visit, she attended the regular meeting of the Akateng CHMC as an observer on 31 January 2026. The following was confirmed: ➢ The agenda for the meeting included (1) a financial report, (2) discussion of IGA, and (3) recruitment of a security guard. ➢ Regarding IGA, the committee discussed plans for fish farming, collecting GHS 5 from health center users (for which the committee had also submitted a written request for consultation to the DHA), and fundraising through mosques and churches. The committee planned to

	invite religious leaders the following week to explain the purpose of the fundraising initiative. ➤ Participants included the health center in-charge, a midwife, religious leaders, businesspeople, and school teachers. • The annual review meeting was cancelled due to a budget shortfall caused by exchange rate fluctuations. It was decided that the progress and activities that would have been reviewed at the annual meeting would instead be covered through the monitoring activities described above.
3-2 Income Generating Activities (IGA) training for CHMC	The IGA training was conducted over three days, from 7 to 9 April 2026, with participants divided into three batches according to their respective areas, with each batch attending a one-day training session. A total of 102 participants took part, comprising 34 HCWs and 68 CHMC members. The training was facilitated by the DHA's Public Health Nurse and Health Promotion Officer, the District Director of Agriculture, the District Director of Fisheries, and JOICFP staff. In addition to reviewing the roles and responsibilities of CHMCs, the training covered IGA, particularly agriculture and aquaculture, resource mobilization, household financial management, and bookkeeping. The training aimed to strengthen the practical knowledge and skills needed to support community health activities and promote the sustainability of CHMC-led activities.

5. Year 3 Schedule (Actual)

Activities	Q1			Q2			Q3			Q4		
	6	7	8	9	10	11	12	1	2	3	4	5
0. Overall project												
0-2 Semiannual and annual reports		Annual		Quarterl			Semi-annual			Quarterl		
0-3 Joint monitoring before PSC and PSC meetings												
0-5 Implementation and review of the sustainability plan pilot												
0-6-1 Endline survey												
0-6-2 A simple survey on the effectiveness of SBCC												
0-6-3. Satisfaction survey												
0-7 Final dissemination meeting												
0-8 Regular monitoring												
1. Quality MNCH services including prevention of childhood diarrhea is improved												

1-1-2 Training of CHNs												
1-4 Construction of nurses' quarter (Sutapong)						Completion						
1-6 Launching ceremony of the nurses' quarter (Sutapong)												
2. Knowledge and awareness on MNCH including ANC/facility delivery/PNC/FP and prevention of childhood diarrhea is increased												
2-3-1 Printing of SBCC tools for CHMC members											Handover of Remaining Materials	
2-3-2 Development and printing of MWH Operation and Management Handbook											Print	Distribution
2-5 Conduct SBCC activities in the community based on CAPs												
3. The community support system for maternal and child health, including childhood diarrhea, is strengthened for sustainability												
3-2 IGA training for CHMC												

6. Project Sustainability

1. Collaboration with the local health authority

The project was implemented in close collaboration with the Regional Health Directorates and DHA in accordance with the policies of the GHS. Through the PSC and regular monitoring, the DHA actively participated in monitoring project progress and addressing challenges, while continuously reviewing and supporting the implementation of the Sustainability Plans developed by each Sub-District.

As a result, the MOU signed at the end of the project explicitly stipulates that the UMK DHA is responsible for implementing and continuously reviewing the Sustainability Plans. Specifically, the responsibilities of the DHA include maintaining the facilities and equipment established under the project; maintaining community-level health education and referral systems; providing technical support to CHMCs; continuously supervising and developing CHVs and ensuring the availability of materials required for their activities; supporting IGA for CHVs; maintaining the provision of quality health services through continuous supervision of HCWs; and ensuring a stable supply of essential commodities such as medicines, delivery kits, and contraceptives.

In this way, the community health activities and maternal and child health service delivery mechanisms established through the project were incorporated into the existing systems and responsibilities of the DHA, thereby establishing a foundation for their continued operation after project completion.

In addition, a staff member who served as the Assistant Field Officer under the project was subsequently recruited as a staff member of the DHA. In this capacity, the staff member continues to follow up on and support the continuation and institutionalization of activities initiated under the project.

Thus, the implementation mechanisms for community health activities and maternal and child health services established through the project have been institutionally integrated into the existing systems and responsibilities of the DHA. Furthermore, the placement of a staff member with in-depth knowledge of the project within the DHA has established an additional foundation for the activities to continue and further develop under government leadership after project completion.

2. Strengthening the Community Health System

As described above, the MOU signed at the end of the project explicitly identifies the responsibilities of the DHA, including maintaining the provision of quality health services through continuous supervision of HCWs and ensuring a stable supply of essential commodities such as medicines, delivery kits, and contraceptives. This established a foundation for the maternal and child health services strengthened through the project to continue within the existing systems of the DHA after project completion.

In addition, the project developed Ghana's first MWH Operation and Management Handbook. The Handbook systematically compiles standard procedures and key considerations for the operation and management of MWH, and is expected to serve as a reference when considering the establishment and operation of MWHs in other areas in the future.

Furthermore, the introduction of IGA for CHMCs supported the establishment of a mechanism through which communities can secure the funds needed to maintain the health facilities developed under the project, including the MWH, and to continue health awareness-raising activities in the community. These efforts are expected to contribute to greater continuity of community-led facility management and health activities.

3. Capacity Building of Community

In this project, emphasis was placed on strengthening the capacity of community members to ensure the sustainability of activities. This was based on JOICFP's approach of establishing community-led activities by continuously strengthening the capacity of stakeholders, reviewing activities, identifying challenges, and making improvements, using the existing community health system as a foundation rather than introducing new mechanisms.

During the project period, the planned refresher training for CHVs and OTCM sellers could not be conducted due to the impact of exchange rate fluctuations caused by the appreciation of the Ghanaian cedi. Nevertheless, the retention rate of CHVs and OTC medicine sellers remained at 100%, while the number of participants in maternal and child health awareness-raising activities conducted by these personnel continued to increase and substantially exceeded the target. In addition, certificates were distributed to all CHVs to help maintain their motivation.

These results suggest that the activities conducted by CHVs and OTCM sellers are likely to continue even in the absence of additional support such as training. These outcomes are also considered to have been achieved through the continuous monitoring and establishment of a support system implemented in collaboration with the DHA, CHMC, CHVs, and other stakeholders.

7. Stories of stakeholders and beneficiaries

Yunis, a User of the Akateng Maternity Waiting House

Yunis has five children, including a six-month-old child whom she gave birth to after using the Akateng MWH. Of her five children, she gave birth to four at home by herself, without assistance from either a traditional birth attendant or a midwife.

She used the MWH after her husband encouraged her to stay there before delivery. She brought a basin, food, and other necessities with her. She found the facility very clean and comfortable, with everything she needed, including mattresses, towels, and a shower room.

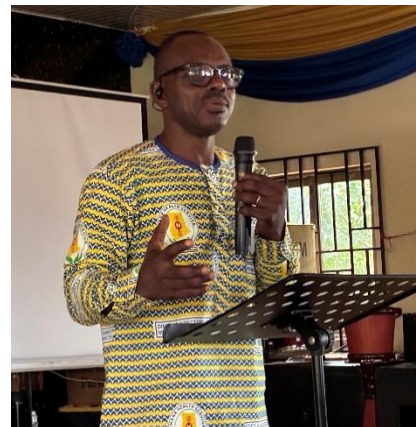
After she gave birth, a midwife came to monitor her condition and encouraged her to breastfeed. Her husband was also pleased that she had used the MWH, and she said she was truly glad that she had been able to use the facility.



Dr. Abdul Aziz Abdulai, Director of the UMK District Health Administration

I believe this project has been beneficial in strengthening the activities of the GHS. FP, maternal and child health, adolescent health, ANC, skilled delivery, and PNC services had already been provided before the project. However, through training for staff of the UMK DHA, other stakeholders, CHVs, and community members, their motivation and skills were improved, which supported and further strengthened these activities. As a result, awareness was raised, mothers and young girls were better able to access health services, and our data also improved. Furthermore, I believe the project helped to bridge the gap between the UMK DHA and CHVs, enabling closer collaboration. As the project was implemented over three years, some of the effects have not yet been reflected in the data, but I am confident that the data will continue to improve as a result of the capacity that has been strengthened.

All activities implemented under the project will continue. Collaboration with CHVs and OTCM sellers will be maintained, and the SBCC tools developed under the project, as well as the MWH and CHPS facilities constructed under the project, will continue to be used and maintained. The end of the project does not mean the end of the activities; rather, they will continue through their integration into the programs of the DHA. I believe the biggest change observed among community members over the three years has been that members of the CHMC and CHVs have started submitting reports in writing. This was a result of the capacity building provided through the project. CHMCs had been active even



before the project, but they did not submit reports, and we could only observe their activities during monitoring visits. Now, we are able to discuss issues based on the reports, which I consider a major change. Going forward, the UMK DHA will promptly address the areas that require action and work to bring about further significant changes.

Helen Jamesey, Midwife at Sekesua Health Centre

This project has been very beneficial in promoting male involvement in maternal, newborn, and child health. This has helped prevent delays in seeking health care, and the men who participated have now become agents of change. We will continue to hold the monthly meetings that we, as HCWs, organize and conduct at the facility.

Regarding the biggest changes observed among community members over the three years, male involvement has increased significantly in relation to attending at least four ANC visits, delivery assisted by skilled birth attendants or delivery at health facilities, receiving PNC within 48 hours of delivery, and the use of FP services.



Peter Danso, Member of the Asesewa CHMC

Through this project, volunteers were trained and supported, and health infrastructure was developed, which improved knowledge of maternal and child health in my community, Asesewa. I believe our activities have been improved as more CHMC members gained knowledge of maternal and child health and we were provided with tools related to maternal and child health. Through this project, community members have become more willing to visit CHPS facilities to receive maternal and child health services.

I believe that the activities carried out through the project will continue. Specifically, these include regular visits to community members by HCWs and CHMC members; recruiting additional volunteers and replacing volunteers when they leave the community; and collaborating with health facilities to support volunteers. I believe these activities will be led by the DHA, CHMCs, HCWs, the UMK District Assembly, chiefs, and Queen Mothers.

Regarding the biggest change observed among community members over the three years, pregnant women who are themselves members of the community have become more comfortable using health facilities for maternal and child health services. As a result, the utilisation of PNC and ANC has increased, as has the number of deliveries taking place at health facilities.



Teye Rebecca Doe, CHV in Anyaboni

I believe the project has been beneficial because, through my health education and awareness-raising activities, most pregnant women now seek care at health facilities as soon as they find out that they are pregnant.

Even after the project ends, I will continue my activities by conducting regular household visits.

Regarding the biggest change observed among community members over the three years, just as pregnant women understand the importance of ANC, breastfeeding mothers also understand the importance of health check-ups for infants and young children. I believe a major change has been the resulting decrease in cases of diarrhoea among children.



8. Key Features and Significance of the Project

In addition to developing health infrastructure such as health centres and MWHs, the project aimed to strengthen the community health system as a whole by implementing an integrated set of interventions, including capacity building for HCWs, CHVs, and CHMCs, as well as participatory SBCC activities. In addition, by combining maternal and child health interventions with measures to prevent and manage diarrhoea among children under five, the project promoted the establishment of a system in which health authorities, communities, and community members work together to address health issues in a comprehensive and sustainable manner.

Furthermore, from the outset of the project, efforts were made with a view to policy uptake and sustainability after project completion. These included the development of the MWH Operation and Management Handbook and various plans in collaboration with the GHS, as well as the implementation of a dissemination meeting, with an emphasis on institutionalization and potential expansion to other areas. In particular, by focusing not only on strengthening the health system at the district level but also on the Sub-District level, which is central to the actual delivery of health services, the project contributed to establishing a foundation for communities to take ownership of and sustain and further develop maternal and child health services.

9. Acronyms and abbreviations

- ANC: Antenatal Care
- CAP: Communication Action Plan
- CHAP: Community Health Action Plan
- CHMC: Community Health Management Committee
- CHN: Community Health Nurse
- CHO: Community Health Officer
- CHPS: Community-Based Health Planning and Services
- CHV: Community Health Volunteer
- CYP: Couple-Years of Protection
- FGD: Focus Group Discussion
- IGA: Income Generating Activities
- IUD: Intrauterine Device
- DHA: District Health Administration
- DHIMS: District Health Information Management System
- FP: Family Planning
- GHS: Ghana Health Service
- HCW: Healthcare Worker
- MCHP: Maternal Child Health Promoter
- MOU: Memorandum of Understanding
- MWH: Maternity Waiting House
- ORS: Oral Rehydration Solution
- PNC: Postnatal care
- SBCC: Social and Behavioural Change Communication
- SDGs: Sustainable Development Goals
- SRHR: Sexual and Reproductive Health and Rights
- SSV: Supportive Supervision
- TBA: Traditional Birth Attendant
- UHC: Universal Health Coverage
- UMK: Upper Manya Krobo
- WASH: Water, Sanitation and Hygiene

【Appendix】

Appendix 1. MOU

<https://shionogi.box.com/s/vduc00qksaakbqx8xrkc6joxezcbqlu>

Appendix 2. Maternity Waiting House Operation and Management Handbook

<https://shionogi.box.com/s/reh6o7b0tw6tp9t1z0gi46ivwx3l78cm>

Appendix 3. SBCC Tools

<https://shionogi.box.com/s/1p7p8bc7zjqk7nytanyiu2z7u0omfhq6>

Appendix 4. Service statistic data and Community Activities Data of the project area (5 sub-districts, per month)

<https://shionogi.box.com/s/tr9n85rp57asnoxqmktr43z9jikqvfa1>

Appendix 5. Monitoring Tool

<https://shionogi.box.com/s/cgz69i21g3f923s85dhwp54l3r7hsoru>

Appendix 6. Endline survey (survey questions and report)

<https://shionogi.box.com/s/kf5ymuqkkh9fpf014bmfvj49g9d6cw2l>

Appendix 7. Results of SBCC effectiveness survey (2nd time)

<https://shionogi.box.com/s/iqvur46kktpiix0t8hptclrqv4zx19vv>

Appendix 8. Article in a Ghanaian National Newspaper on the Final Dissemination Meeting

<https://shionogi.box.com/s/oa8wsml4jp2bj5ilpwr08miznqnqos36>

Appendix 9. Black Star Challenge Sheet

<https://shionogi.box.com/s/jvxuxn13soaeaqmu9xlp6y4s98b0alu>

Appendix 10. Rapid Survey Results from Ms. Yoshidome's Mission Trip

<https://shionogi.box.com/s/qvu7fqu82x7h25mgo80kgrecl6updxmr>

Appendix 11. Contractor Selection Analysis Report for the Construction of Nurses' Quarter

<https://shionogi.box.com/s/ov5fz2u8e74jqmm24jshj8p3bui0nf7>

Appendix 12. Revised Drawings of the Nurses' Quarters

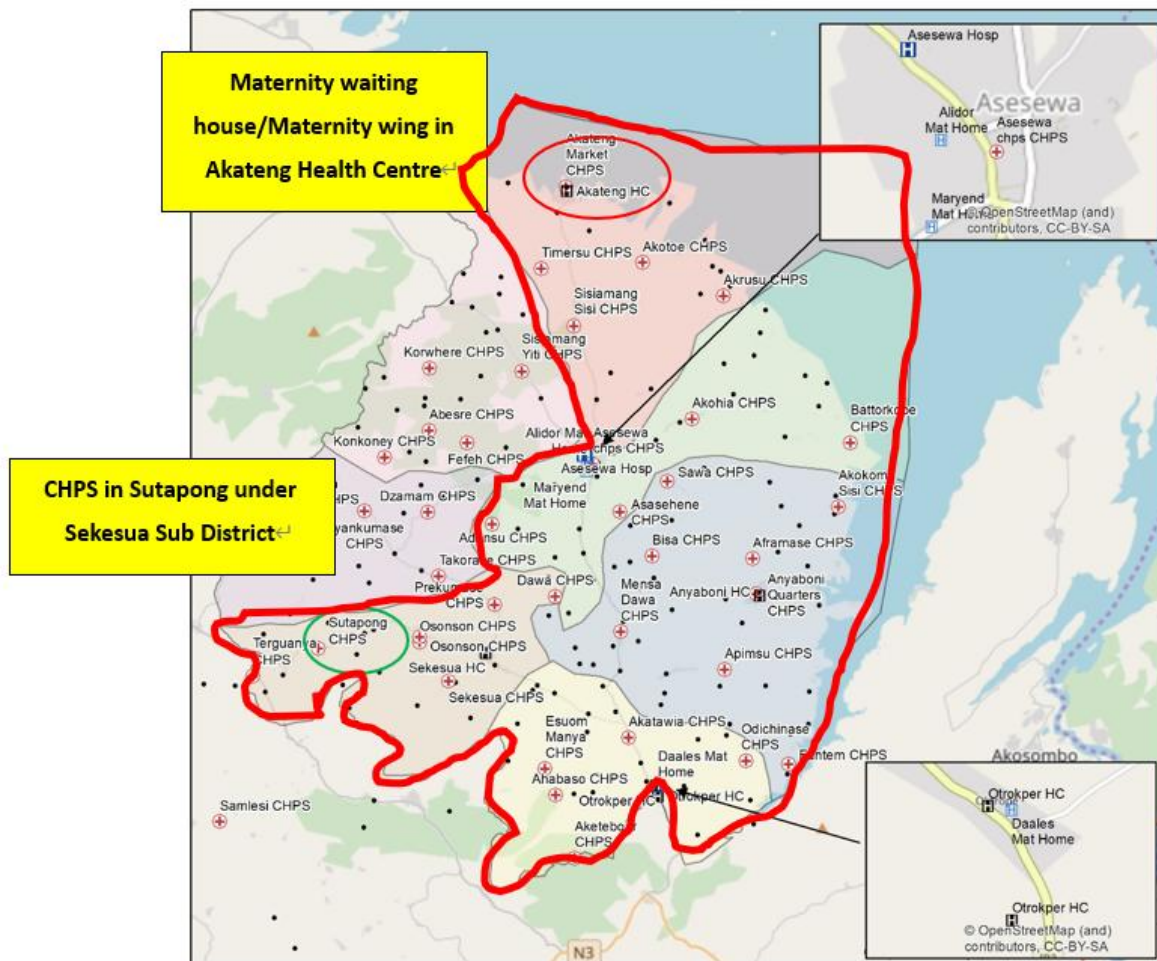
<https://shionogi.box.com/s/5xqjqppimsa2f7mvqotxmllbn3j8s2gb>

Appendix 13. Article in a Ghanaian National Newspaper on the Opening Ceremony of the Nurses' Quarters in Sutapong

<https://shionogi.box.com/s/zdwg8n9fplzthjbbbg3p4kfy38swa4wb>

Appendix 14. Map of the project site

Health Facilities in Upper Manya Krobo District



Appendix 15. Activity Photos



0-3 Joint monitoring before PSC and PSC meetings (Photo: Joint monitoring conducted prior to PSC in November 2025.)



0-3 Joint monitoring before PSC and PSC meetings (Photo: PSC meeting, November 2025.)



0-5 Implementation and review of the sustainability plan pilot (Photo: Monitoring of the implementation of the Sustainability Plan, January 2026.)



0-7 Final dissemination meeting (Photo: Final dissemination meeting, May 2026.)



0-7 District Health Directorate staff member explaining the process of developing the Maternity Waiting House Operation and Management Handbook at the final dissemination meeting, May 2026



0-7 Participants watching a video message from Shionogi & Co., Ltd. at the final dissemination meeting, introducing the journey of visiting and jointly assessing potential sites and discussing the project repeatedly before its launch, May 2026.



0-8 Regular monitoring (Photo: JOICFP staff interviewing an OTCM seller about their activities in the Asesewa Sub-District, February 2026.)



0-8 Regular monitoring (Photo: The Director of the District Health Directorate and JOICFP staff monitoring the activities of CHVs, January 2026.)



1-1 Training for health staff on customer care incl. Mama papa class training (Photo: Mama and Papa Class held at Sekesua Health Centre, December 2025.)



1-1 Training for health staff on customer care incl. Mama papa class training (Photo: A man asking a question during a Mama and Papa Class held at Sekesua Health Centre, December 2025.)





1-1-2 Training of Community Health Nurses (CHNs)
(Photo: Training session held in the Asesewa Sub-District, September 2025.)



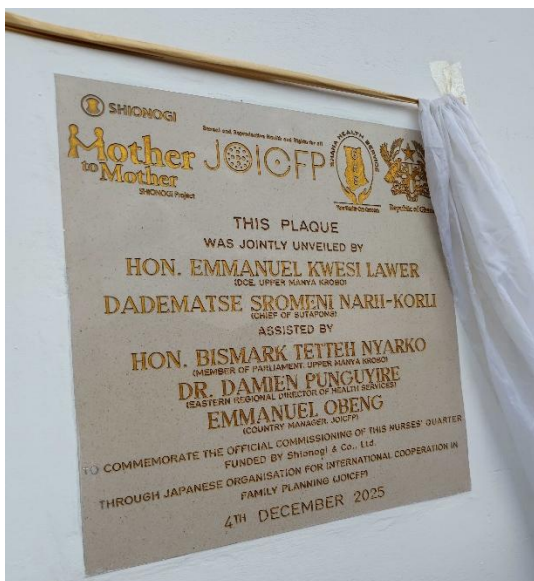
1-4 Construction of nurses quarter (Sutapong) (Photo: Ground-breaking ceremony, July 2025.)



1-4 Construction of nurses quarter (Sutapong) (Photo: Completed nurses' quarters, November 2025.)



1-6 Launching ceremony of the nurses quarter (Photo: District Health Directorate officials, HCWs, and JOICFP staff cutting the ribbon at the opening ceremony, December 2025.)



1-6 Launching ceremony of the nurses quarter (Photo: Plaque unveiled at the opening ceremony, December 2025.)



2-3-2 Development and printing of MWH Operation and Management Handbook
(Photo: JOICFP staff reviewing and discussing the contents of the Handbook with members of the District Health Directorate and HCWs, December 2025.)



2-3-2 Development and printing of MWH Operation and Management Handbook
(Photo: Final review workshop on the Maternity Waiting House Operation and Management Handbook, attended by representatives from the District Health Directorate, CHMC members, CHVs, and JOICFP, January 2026.)



2-3-2 Development and printing of MWH Operation and Management Handbook
(Photo: JOICFP staff handing the completed Maternity Waiting House Operation and Management Handbook to a midwife at the Akateng Maternity Ward and Maternity Waiting House during the final dissemination meeting, May 2026.)



2-5 Conduct SBCC activities in the community based on CAPs (Photo: A CHV conducting a household visit and providing health education on childhood diarrhoea using the dialogue cards, June 2025.)

2-5 Conduct SBCC activities in the community based on CAPs (Photo: Distribution of volunteer kits to CHVs, July 2025.)



3-2 Income Generating Activities (IGA) training for CHMC (Photo: IGA training session, April 2026.)



Beneficiary: A new mother who stayed at the Akateng MWH and gave birth safely, June 2025.



Beneficiary: A new mother who stayed at the Akateng MWH and gave birth safely, November 2025.



Beneficiary: A new mother who stayed at the Akateng MWH and gave birth safely, November 2025.