Title : Public Private Partnership In Health Care Delivery-A Story From Ghana

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Abstract

Background: Since 2010, HIV prevalence rate among pregnant women in the Central region of Ghana had been above 2% among pregnant women, prevention of mother to child transmission (PMTCT) of HIV service access coverage below 30% ,with 15% of the providers been trained. In order to improve this ugly medical and social picture, a better health delivery process involving the health system, the community and the service providers was evolved by the district health management teams from 2013- 2015.

Methods: All the 20 health district teams in that region trained every staff providing service at the antenatal clinics and reproductive women in PMTCT service provision. Key community leaders, family heads and faith-based leaders were also educated during the same sessions on the importance of PMTCT for population. Teaching and learning techniques like story-telling, performance evaluation, behavioral assessment, role play, cooperative and collaborative learning, and sharing of ideas were paramount.

Results: There was an increasing trend in the uptake of PMTCT service demand and provision for pregnant women during the intervention period. The proportion of antenatal mothers receiving PMTCT provision for 2013, 2014 and 2015 at the local level was 24.7%, 63.3% and 95% respectively. The HIV prevalence rate has consistently been below 2%.

Conclusions: The public and private stakeholders are two essential components of the health system, and task shifting as a necessary health care delivery tool can prove to be an efficient initiative in an atmosphere of open and distance learning.

Background:

Since 2010, HIV prevalence rate among pregnant women in the Central region of Ghana had been above 2% among pregnant women, prevention of mother to child transmission (PMTCT) of HIV service access coverage below 30% ,with 15% of the providers been trained. We incorporated the services of private service providers from 2013 to improve HIV services. A 2006 report from WHO on antiretroviral therapy coverage and a subsequent report released by the Joint United Nations Programme on HIV/AIDS (UNAIDS) on the barriers to scaling up HIV services both show that shortages of human resources for health represent a key bottleneck (24,25,26). One study looking specifically at the delivery of HIV services, found that the quality of HIV care provided by non-physician clinicians was similar to that provided by medical doctors who were HIV experts and better than that provided by medical doctors who were not HIV experts (21). We went in with the angle of not-for- profit one. In order to improve this ugly

medical and social picture, a better health delivery process involving the health system, the community and the service providers was evolved by the district health management teams from 2013- 2015. This paper is assessing how this initiative was implemented and the subsequent outcomes realized. Reports from the Central regional health directorate in Ghana indicated low of PMTCT from 2000 to 2010, a whole decade of struggling to improve quality HIV service for a generalized epidemic. Though the first AIDS case was recorded in Ghana in 1986 (1), the region had its first Anti-Retroviral Treatment center (ART) in 2006. HIV services had started as far back as 1986, but all AIDS cases were managed at the regional hospitals. There were 20 health district health directorates with many health facilities, both public and private. To make the driving principles for public private partnerships as rooted in 'benefit to the society' rather than 'mutual benefit to the partners' and should center on the concept of equity in health, this initiative was expected to perform and generate such outcomes. That partnership had shown positive increased coverage in health care delivery and utilization in many countries (10). It has been shown elsewhere that health services based on this task shifting can be delivered by a range of different providers and can involve both the public and non-state sectors (2). Community health workers are also playing an increasingly important role in health systems in high-income countries such as the United States of America where they have been shown to be particularly helpful in improving access to health care for vulnerable and underserved groups (4,5,7). Due to limited supply of health staff during this AIDS epidemic in Ghana, Community health workers have been engaged by many districts in this region since the year 1986. Community health workers were trained in comprehensive HIV care and management including the identification and referral of people living with HIV/AIDS; counselling; the execution and interpretation of rapid HIV testing; follow-up of stable clients on first-line antiretroviral therapy; monitoring and support of adherence; dispensing of drugs prescribed by a qualified provider; and tasks related to the prevention of mother-to-child transmission. A similar thing had been done in both Haiti and Rwanda (10). This is a key point on the importance of task shifting in engaging community health workers who were not in the public health sector, but had contributed immensely.

Another area of consideration was that, there is a consensus in literature that community health workers could play an important contributory role in countries trying to increase access to HIV services and that these human resources remain underutilized (3, 13, 27).

The status of HIV prevalence level among pregnant women attending Antenatal clinics in the region had been above 2% from 2000 to 2009. Despite the sharp rise in 2011 (4.7%), the prevalence rate had been below 2% from since 2010 (11). Training meant to build the capacity of health staff in PMTCT and other HIV services had started briskly in 2002 for district health facilities in the region to augment the activities at the regional hospital could not be effectively sustained. The enthusiasm of the trained staff were

quickly dashed as higher client turn out at the new facilities with refurbished resources started to have a toll on the smaller number who had not travelled for greener pastures or vacated their posts. Many health facility teams became dysfunctional, except where those who remained in the performance realm were those with passion and dedication. During monitoring visits and annual health service performance reviews, it was not uncommon to hear messages of community entities and structures evolving and participating meaningfully to improve health status of their people in a not-for –profit fashion. These helped the regional health directorate to encourage all the 20 district health directorates, in conjunction with their local and political leaders, to create a mechanism with greater participation of all identifiable organizations and social groups to contribute to health in a coordinated manner under the power of task shifting and partnership for the benefit of the society. Explaining the processes which the program would undertake, and encouraging them to rely on their capacities as people with wisdom and strength, the motivation was better enough for them to embrace this novel idea of public –private partnership in PMTCT care and management.

Methods:

Due to the peculiar problem of staff shortage in HIV services in this region, we accepted to use a multidisciplinary model approach of Task Shifting involving there different system: Task shifting II – The extension of the scope of practice of nurses and midwives in order to enable them to assume some tasks previously undertaken by senior cadres (e.g. non-physician clinicians and medical doctors). Task shifting III – The extension of the scope of practice of community health workers (often called non-professional health workers or lay providers), including people living with HIV/AIDS, in order to enable them to assume some tasks previously undertaken by senior cadres (e.g. nurses and midwives, non-physician clinicians and medical doctors). Task shifting IV – People living with HIV/AIDS, trained in self-management, assume some tasks related to their own care that would previously have been undertaken by health workers. The multiplicity of the approach was believed to cause a harmonized and synergic effect of beneficial and efficient health outcomes.

In all the 20 district, the respective health management teams in the trained all staff providing service at the antenatal clinics and reproductive women in PMTCT service provision. Key community leaders, family heads and faith-based leaders were also educated during the same sessions on the importance of PMTCT for population. Teaching and learning techniques like story-telling, performance evaluation, behavioral assessment, role play, community engagement, health campaign, health advocacy, team dynamics, client participation in health, cooperative and collaborative learning, and sharing of ideas were paramount. This approach of using Open and Distance Learning to facilitate the in engagement of other people to participate in a public private partnership and ensuring in task shifting for the common good has

left a powerful imprint in the formulation of future health system in Ghana. The supply side of the PMTCT service provision saw almost a 10 fold increase of trained and dedicated staff in every district. Quarterly and performance annual reviews, and updates on PMTCT services from other regions in Ghana, Africa and other continents were enough to encourage and empower countries the staff to put up their best. Community members volunteered to be selected through the approval of the community at large as Community health workers. Every district had selected its volunteers by December 2012 to commence the activities from January, 2013. The volunteers including chiefs, community queens, opinion leaders, faith based organizational leaders, teachers, farmers, antenatal clinic attendants, in and out –of school youth and their leaders, district assembly men and women, AIDS patients and people living with HIV; were trained to educate family members, husbands, family heads, relatives and colleagues of pregnant women to attend Antenatal Clinic and enroll themselves in safe motherhood initiatives, care, support and management. A subset of the Community health workers went up further to participate in screening clients who were due for PMTCT services, testing them and documenting their activities for evidence based analysis. Periodically, supervisory visits and monitoring at the district and the community level, health data were analyzed to assess weak linkages for adequate support. A rewarding scheme for performing health teams, community members, and new productive initiatives identified were rewarded in cash and kind. Task shifting moving smoothly on the wings of open and distance learning actually made the programme highly successful.

The Community queens group used their societal role as embodiments of power and authority to rally the eligible clients easily and presented them as such to the health centres and hospitals. The faith based organizational leaders also performed well by advocating and encouraging their members who were pregnant to participate in the program. It became a routine offer of support and reminder that the communities would organize themselves at a durbar ground where deserving clients who had observed all their appointment bookings for Antenatal services were reward in kind. Using the safe-motherhood and focused antenatal approach, mother –baby pairs were an essential part of the program, linking all pairs to care consequentially. These activities facilitated the demand side of PMTCT at all health facilities and or at every contact with the health system. Task shifting and the major involvement of the private stakeholders for these results has been commended by the national level as a better initiative.

Early community health worker programmes assumed a pool of willing volunteers but, in time, lack of payment proved to be a major cause of workforce attrition (14,15, 18,). There is virtually no evidence that volunteerism can be sustained for long periods (17). Most of the evidence reflects low activity rates and high drop-out leading to the ultimate collapse of community health worker programmes where payment, or other appropriate and commensurate incentives, are not adequate (16,17). For example, in South Africa

the lack of payment for community health workers resulted in a high rate of attrition and threatened the effectiveness of the community-based tuberculosis programmes (23). One study of community health worker programmes in Sri Lanka concludes that large-scale volunteer programmes will be characterized by high attrition and low activity rates and will only be sustainable under particular enabling conditions (16). In our program, the community health volunteers were given enablers in kind such as periodic meetings, appraisals, commendations, priority in health facility attendance, family members identified and seen earlier at health facilities, identification bags and T shirts, community parade and annual reward for performance.

Results:

There was an increasing trend in the uptake of PMTCT service demand and provision for pregnant women during the intervention period. The proportion of communities receiving PMTCT provision for 2013, 2014 and 2015 at the local level was 24.7%, 63.3% and 95% respectively. The HIV prevalence rate has consistently been below 2%. Early Infant Diagnosis (EID) was initiated to provide quality assurance and support for all infants exposed to HIV infection. Though the EID samples had to be sent to another region 100 kilometers away for assessment and analyzes, it was seen as a necessary venture worth taken to make the health decision making process for the exposed child, mother and family strongly and viably complete. The region having been consistently with the highest prevalence of Syphilis in Ghana since 2000, used this partnership program to coordinate testing and screening of clients for prompt treatment. All clients with opportunistic infections were properly treated free of charge. Every mother attending Antenatal clinic was advised to register with the National Health Insurance Scheme to remove financial access barrier to ensure quality service access and enhanced healthy life chances. The region won four different awards in PMTCT service provision at the national level, from 2013 to 2014. The region awarded certificate of achievements for all deserving communities and volunteers. Many health staff started to align themselves with the success of the program, reducing workload and releasing more time for doctors and midwives to perform other needed jobs. Furthermore, people living with HIV/AIDS reported high levels of satisfaction with their health care. Staff appreciation of capacity building which had evolved in them, changing their curriculum vitae and having enhanced chances in furthering their education. During the recent outbreak of Ebola Virus Disease in the West Africa Sub-region, 12 staff from this cohort were in Liberia to provide treatment and support, due to their background in viral disease management. The indirect benefit from the space created for private participation in partnership with the public sector health delivery system is a platform to launch new effective and promising initiatives for some time to come. We never thought a mixture of a task shifting and open and distance learning could stretch its wings over Liberia from Ghana.

Discussion:

A number of studies have sought to systematically compare service delivered by community health workers with the traditional medical model. One review of 43 studies found that community health worker programmes showed greater efficiency in certain interventions, such as immunization uptake, but not in others (25). There are varied opinions on community health workers in the light of task shifting for achievements in health care service delivery. However it may be, every health management team deserves the right to test the waters and assess what she can achieve. Other studies have concluded that community health workers can achieve better patient outcomes at some cost saving in comparison with clinic-based care (8, 12, 22). When the community health worker understands that the community needs her contribution to cause an improved outcome in their health status leading into wealth creation and reduced disease burden the task is half done. The participation of the community health volunteers in task shifting programs does connotes dedication, responsibility and service to ones kinsmen. The success of community health workers in non-HIV programmes such as those cited above is supportive evidence that they can also be a successful component of HIV service delivery. In the context of HIV, recent studies have shown that antiretroviral therapy programmes with community involvement, including the involvement of community health workers, have resulted in lower rates of patient loss to follow-up than programmes without community involvement. A number of other studies conclude that community health workers can contribute to significantly better outcomes for service users on antiretroviral therapy (9, 20). Indeed, our program has shown that health care service delivery is not only the purview of the public health sector, but when the partnership is linked with the private sector the synergy is a gargantuan one.

Conclusions:

The public and private partnership of stakeholders are two essential components of the health system, and open and distance learning as a powerful tool of motivation to push a task shifting initiative into place can cause the needed synergy for better outcomes in the pot of collaborative, participatory and mutual approach. Then, it could be a growing map of social dividend.

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