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The PEPFAR Local Capacity Initiative Evaluation Findings in Ghana

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Introduction

The Local Capacity Initiative (LCI) strengthened the capacity of civil society organizations (CSOs) to support policy advocacy, with the ultimate goal of improving health services for key populations (KPs) affected by the HIV epidemic.[1] The United States President's Emergency Plan for AIDS Relief (PEPFAR) funded the initiative from 2013–2018 to help local CSOs create an enabling environment for PEPFAR's objectives.

The United States Agency for International Development (USAID) funded a local partner to implement the People for Health project in Ghana between 2015 and 2020. People for Health implemented interventions that strengthened CSO capacity and mobilized citizen groups to advocate better health services. LCI funding supported the integration of KP-specific interventions in the general health policy advocacy strategy of People for Health. Key population citizen groups included men who have sex with men (MSM), sex workers, and people living with HIV (PLHIV). MEASURE Evaluation, which is funded by USAID and PEPFAR, conducted an evaluation of People for Health in Ghana in 2019.

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[1] Key populations include men who have sex with men, sex workers, people who use injectable drugs, and transgender people.

This issue brief provides an overview of the most significant change findings from the evaluation of the People for Health project in The Greater Accra and Eastern Regions. A separate brief presents the evaluation methods.[2]

People for Health aimed to increase citizen inputs into government health programming through the following activities: capacity building at the grassroots and district levels, regional participatory monitoring and evaluation (PM&E) network forums, monitoring for compliance with the Patients' Charter of the Ghana Health Service,[3] and sensitization on stigma and discrimination experienced by PLHIV and KPs. Figure 1 illustrates the Participatory Monitoring and Evaluation Framework. This framework has four steps. First the project improves policy literacy using media and community sensitization sessions. Then, the project assists citizens with gathering evidence and engaging in policy dialogue using that evidence. And finally, the program supports citizens in monitoring the responsiveness of stakeholders. The capacity building strategy was designed to reach citizens' groups, CSOs, and district health management teams (Figure 2) to build capacity in the following areas: community mobilization, empowerment, budget tracking, program and service skills for KPs, and the Patients' Charter. The LCI provided three years of funding to strengthen policy advocacy capacity for KPs, to improve access to quality HIV services. The People for Health project combined LCI funding with USAID mission funding in a five-year program that covered all health areas, including HIV. In its first three years, the project engaged KP groups; addressed HIV program and service delivery issues, such as stigma and discrimination, with all stakeholders; and addressed the Patients' Charter with all citizen groups and other stakeholders.

Figure 1. Participatory monitoring and evaluation framework

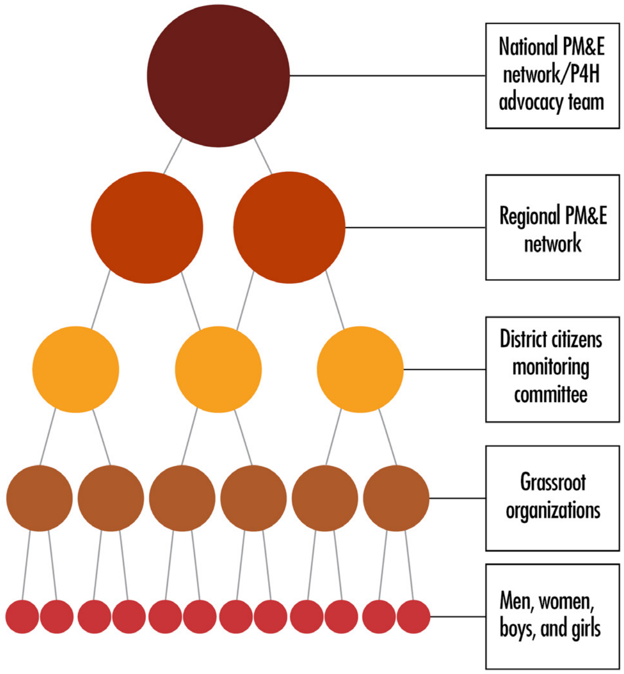

Figure 2. Capacity building strategy

The evaluation findings are presented in sections highlighting point of view, significant changes, mechanisms of change, game changers, and attribution of change. Point of view is based on the characteristics of the evaluation participants. Significant changes shared by the participants are organized by point of view. Mechanisms of change shared by participants are presented across all points of view, as are game changers and attribution.

Point of View

As a part of the evaluation, twenty-nine people were interviewed about the healthcare system, their involvement with People for Health activities, and stories of change related to their participation in the activities. The research team learned about the People for Health project from the point of view of citizens, CSO focal persons, health workers, and the district health workers. Nineteen of those interviewed were men, and ten were women—fifteen from the Eastern Region and fourteen from the Greater Accra Region. Citizens were from women's groups and youth groups that usually attract young men as members; six were from PLHIV groups, four were involved in groups for MSM, and three were involved in groups for female sex

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[2] Freyder, M. (2020). The PEPFAR Local Capacity Initiative Evaluation Methods in Ghana. Chapel Hill, NC: MEASURE Evaluation. Retrieved from https://www.measureevaluation.org/resources/publications/fs-19-416/

[3] Ghana Health Service. (2002). The Patients' Charter. Accra, Ghana. Retrieved from http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=46

workers (FSW). Through these interviews and stories of change, we can understand barriers to care, implementation of program activities, and program outcomes from the point of view of a KP member, while also exploring the same issues with people who are not disenfranchised in this way and people who provide health services. Multiple points of view provided us with a well-rounded and detailed depiction of how policy advocacy capacity building supports increased access to quality HIV services.

Significant Changes

Significant change stories were collected from every participant. After reviewing the stories, the research team grouped them into three domains: community sensitization, personal empowerment, and institutional change. Community sensitization stories provided details about People for Health activities with community members, community health management committees (CHMCs), and district citizens' monitoring committees (DCMCs). Participants provided details of the community mobilization and capacity building strategies rolled out by People for Health—i.e., sensitization programs on the Patients' Charter and several health topics, orientations on the roles and responsibilities of CHMCs, and leadership trainings. In these stories, participants described changes in community member engagement in meetings, decision making, and monitoring accountability for specific projects taken on by local health teams. Participants also described changes in individual community members' awareness of their rights and responsibilities concerning their own healthcare, specifically screenings for infectious diseases or chronic conditions. Women's groups, youth groups, PLHIV groups, and providers told these stories. Key populations did not report stories related to community sensitization.

Key population participants focused mostly on personal empowerment stories. Other citizens' groups provided additional personal empowerment stories. Providers told two personal empowerment stories—one about a client who filed a complaint about illegal charges for a hospital birth that resulted in a mandatory training for all health staff of that district on the Code of Ethics for the Ghana Health Service[4] and another about several clients who returned to the clinic to explain that their medications resulted in intolerable side effects. These clients had participated in a sensitization about the Patients' Charter. A women's group member also had a story of woman speaking up about being overcharged at a birth, which resulted in the return of the woman's money. A youth group member provided a story about linking a newly diagnosed HIV-positive community member to care. Four personal empowerment stories were provided by members of KPs. Strong, fully developed stories of personal empowerment were provided by MSM. One group member provided a detailed story of changes he saw in the way health workers treated him after his knowledge and confidence improved as a result of participating in a session about the Patients' Charter. For example, service providers no longer asked questions about his personal relationships. Another MSM group member told a story of working with his peers on understanding their responsibilities to attend follow-up appointments and lab tests to receive the best care. Sex workers also provided stories that included themes such as speaking up for client rights and having enough confidence to ask questions. However, these stories were less developed and less specific.

Institutional change stories led with structural and procedural changes that occurred within the healthcare system at a health facility or a health administration unit. The participants connected these changes to specific People for Health activities based on their observations. Participants of every type told institutional change stories. Two participants, a youth member and a district health worker, reported the renewal of a hotline (phone or text) to report complaints within the healthcare system. Local providers shared significant change stories about a new CHPS (community-based health planning and services) compound, attributing the new compound to a significant increase in community engagement with local and district-level authorities supported by People for Health. Many participants (providers, PLHIV, MSM, and FSW) told stories of institutional change at Tema General Hospital. Analysis across the stories provided rich details of changes at the ART clinic at Tema. One participant explained the ART clinic was converted to a general clinic for adults, which was a positive change supporting a decrease in stigma and increase in access to general services. A few others described the difficulties of that change, providing examples about the main entrance having taxi drivers and increased foot traffic from the general public. Types of positive changes at Tema General Hospital observed by PLHIV, MSM, and FSWs were moving the ART clinic entrance to the back and moving and the taxi stand away from the main entrance. The stories narrated about the changes at Tema were very rich in detail. Participants noted significant changes in wait times and clients' overall experience at the clinic being more respectful. Participants connected these changes to the

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[4] Ghana Health Service. (2001). Code of Ethics for the Ghana Health Service. Accra, Ghana. Retrieved from http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=45

sensitization sessions on HIV stigma and discrimination, sensitization sessions on the Patients' Rights Charter, and highly responsive involvement of the DCMC. Almost all stories of institutional change cited the Patients' Rights Charter activities and the DCMC as mechanisms for the positive changes.

Mechanisms of Change

Mechanisms of change are a key type of data that are produced by the most significant change technique. For this study, mechanisms of change are intermediate outcomes culled from all 29 stories collected at the time of the in-depth interview and from the criteria for top stories provided by focus group participants. These data are presented across all domains of change and all points of view, providing common mechanisms of change and leading us to generalizability within the program. These mechanisms of change are commonly recognized across all types of participants and all types of outcomes and can be used as lessons learned for future programming to improve health policy advocacy in this context.

Mechanisms of change

- P4H Global sensitization programs on the Patients' Rights Charter and HIV
- Stigma and discrimination trainings for healthcare workers
- CHMC roles and responsibilities orientation
- Leadership training for CHMC members
- CHMC engagement of community members
- Performance and commitment of CHMC members
- Community member awareness of rights and responsibilities
- Getting commitments and following up on commitments

Participants noted that People for Health sensitization sessions led to changes in their communities. Examples are awareness sessions for community members about the Patients' Charter and awareness sessions for the healthcare workers on the Patients' Charter and the Code of Ethics. Participants also mentioned sensitization sessions about HIV stigma and discrimination and the durbars on HIV services, reproductive health services, and malaria. Several stories mentioned the CHMC orientation session on roles and responsibilities and the leadership training associated with that orientation. These activities are the inputs or impetus for change in the community. Within those same stories, awareness of roles and responsibilities, performance, and commitment of members of the CHMC and DCMC were pivotal and are considered mechanisms of change. Other stories noted galvanizing highly motivated community members and acquiring commitments from the municipal assembly as mechanisms of change. Participants noted information sharing at every level of community engagement. This might be dismissed as unremarkable, but introducing new information to the correct people to change the healthcare environment is not a simple task, and participants viewed information sharing as a key change story element. Therefore, it is included here as a mechanism of change. Participants also noted the use of information in their stories. For example, one youth group member was able to reach out to someone who was newly diagnosed with HIV, counseling and connecting the person to care. Numerous stories from many points of view describe community members understanding and asserting their rights and responsibilities. This demonstration of rights and responsibilities is presented as an intermediate outcome in some stories and celebrated as the ultimate outcome in others. What is key to understanding this theme is that patient responsibilities were presented as individual *and* communal.

Game Changers

Game changers are stakeholders who are active in making the changes in the stories. These stakeholders can be people or institutions. The game changers noted by study participants were community members, case managers, CHMCs, focal persons from CSOs, DCMCs, municipal assemblies, the National Health Insuranace Scheme, and People for Health.

Attribution of Change

In-depth interview participants were prompted to tell stories of change related to their experiences with People for Health. After telling a story, each participant was asked the following question: How, if at all, has the work under People for Health contributed to the changes in the story? All participants told a story that attributed changes to People for Health. A few participants noted additional support from the Ghana Health Services.

Criteria for Significance

Focus group discussion participants chose to share (retell) the stories from their interviews with their peers. Participants were then asked to rank the stories. As they ranked the stories, participants discussed their criteria for the rankings, expanding on why the stories were important or significant. Criteria for the most significant stories are summarized below:

1. Demonstrated a sense of community ownership or high level of volunteering as a part of the activity
2. Demonstrated how a community sensitization on HIV services enabled a youth group member to provide support and linkages to care for a recently diagnosed member of the community
3. Demonstrated that community sensitization sessions on patients' rights and responsibilities, posters, and fliers—along with the commitment of the DCMC to improving access to health—led to the cooperation of hospital administration and healthcare professionals [on wait times and respectful treatment of KP members]
4. Demonstrated results that made a broad array of services [Community-Based Health Planning and Services site] available to a large number of community members
5. Demonstrated results that made services available to a hard-to-reach rural area
6. Demonstrated results that made a service immediately available to a client within her own community

Most Significant Change Stories

Top stories chosen by the three focus groups provide a list of the most significant changes resulting from the People for Health project between 2016 and 2019. These are results of the rankings completed by the participants during the focus group discussions. The members of the general population group that included PLHIV chose a story about a youth group member who had received P4H Global HIV sensitivity training and was subsequently able to support a woman who was recently diagnosed with HIV. The top story from the KP group was about the improved quality of service delivery by healthcare workers to KPs at Tema General Hospital in response to sensitivity training and new structures to support the Patients' Charter. The providers chose to highlight a community's new CHPS compound. Both top stories identified P4H Global interventions, community sensitization, CHMC roles and responsibilities orientation, and leadership training as examples. The stories identified highly motivated community members and commitments from the municipal assembly as mechanisms of change.

Conclusions

Significant changes identified across all stories collected during in-depth interviews were organized by the three domains, community sensitization, personal empowerment, and institutional change (Table 1).

Table 1. Significant change story domains

	Theme	Story title
Providers 1	Community sensitization	A Dream Come True
Providers 2	Institutional change	Good News about P4H Yarewa Community-Based Health Planning and Services site
KP group	Institutional change	The Change Has Come
General population group	Personal empowerment	P4H Has Come to Transform Life

A critical finding was that MSM and FSWs reported no significant changes under the domain, community sensitization, whereas stories with this theme were shared by women, youth, and PLHIV. However, four out of the seven MSM and FSW participants provided change stories of personal empowerment. This difference in change story domain is an important observation that merits further exploration by the program and future evaluations. It is possible that marginalization of KPs in society translates to a lack of community-level power or discourages people from identifying as part of a KP community. It may be that MSM and FSWs constantly defend their self-worth and dignity and are, therefore, more concerned with personal identity and empowerment than identifying with a particular community.

An important caveat is that the personal empowerment stories of MSM and FSWs were very different. Although the FSWs were similar to MSM in that they provided no community sensitization stories but did provide personal empowerment stories, FSW stories were similar to those shared by women's group members. Specifically, the stories were about having enough confidence to speak up for themselves and to ask questions. The small number of FSW participants and the lack of strength of the story development of those who did participate leads the research team to conclude further exploration of the needs of FSWs is important.

Institutional change stories were reported across all types of participants. However, within this domain, there were notable differences. General group members shared stories about the hotline to report complaints and stories about a new rural health center that will affect access to healthcare. However, PLHIV, MSM, and FSWs provided institutional change stories about the ART clinic at Tema General Hospital, noting improved wait times and respectful interactions as significant changes. Participants saw these changes as a decrease in stigma and discrimination and increase in access to care.

Capacity building mechanisms of change included the CHMC orientation on roles and responsibilities and the leadership training. Intermediate outcomes associated with capacity building were CHMC member awareness of roles and responsibilities and performance of CHMCs. Civil society organization capacity building was not addressed in the change stories provided by participants. However, CSO focal persons who participated in the evaluation told stories that clearly demonstrated they were trained and fully engaged in the PM&E process.

Mechanisms of change reported by participants that related to the PM&E Framework and the Patient Right's Charter were community sensitizations sessions, information sharing at every level of community engagement, and use of information. In an example of a highly valued story about using information (which was the top story), a youth member who had learned about HIV services and patient rights and responsibilities then supported a newly diagnosed woman through her initial response to the diagnosis and her journey to access HIV care. Many stories across many points of view note community members understanding and asserting their rights and responsibilities related to healthcare. An important finding is that patient responsibilities were presented as both individual (speaking up, attending follow-up appointments) and as communal (supporting a community member, CHMC performance.)

Changes in advocacy capacity and practices were reported to take place among individual citizen group members. Improved capacity and performance of advocacy groups, CHMCs, and DCMCs, was also reported.

Group member perceptions about healthcare were positively influenced by the Patient's Rights Charter awareness activities, including flyers, posters, and sensitization sessions. This was reported through the personal empowerment and institutional change stories.

All community sensitization stories clearly outline positive influences on citizen participation in health policy programming, whether it was noted as a mechanism of change or framed as the ultimate outcome.

Most significant changes

1. Increased awareness and community participation supporting issues related to health
2. Uptake of general health services
3. Increased attention from the National health insurance scheme authorities in communities that have mobilized, leading to increased registration and renewals
4. MSM perceptions about their own healthcare responsibilities, for example follow-up appointments and lab work
5. MSM experiencing decreased wait times and increasingly respectful treatment of MSM in health centers
6. Youth group member able to counsel a newly diagnosed HIV clients
7. linking a new HIV client to care and treatment

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