

An Assessment of the High Impact Package (HIP) Program for HIV in Selected Hospitals in Ghana

Quality Health Partners
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GHANA



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1. Korle-Bu Teaching Hospital
2. Koforidua Regional Hospital
3. Effia Nkwanta Regional Hospital
4. Sunyani Regional Hospital
5. Kumasi South Regional Hospital
6. Tamale Regional Hospital
7. Ridge Hospital
8. Hohoe District Hospital
9. St. Francis Xavier Hospital
10. Akyem Oda District Hospital

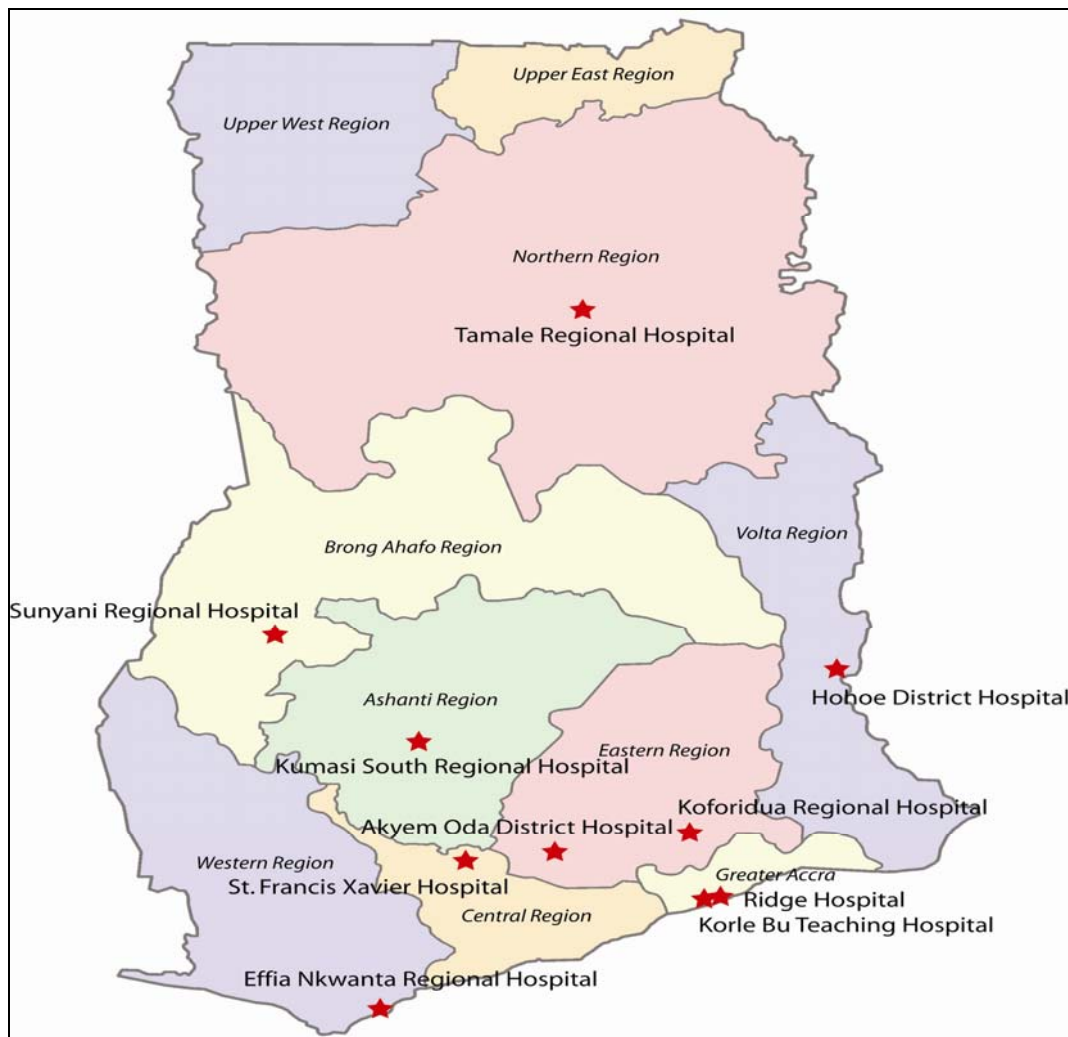
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LIST OF ACRONYMS

| | |
|----------|---|
| ANC - | Antenatal Care |
| ART - | Antiretroviral Therapy |
| BCC – | Behavior Change Communication |
| COPE - | Client-Oriented, Provider-Efficient Services |
| CT - | Counseling and Testing |
| DDNS - | Deputy Director of Nursing Services |
| FP - | Family Planning |
| HIP - | High-Impact Package (of HIV and AIDS interventions) |
| HIV – | Human Immunodeficiency Virus |
| MARP - | Most-at-Risk Populations for HIV infection |
| IP - | Infection Prevention |
| MH - | Model of Hope Volunteer |
| MSM - | Men who have Sex with Men |
| NACP - | National AIDS/STI Control Program |
| OPD - | Outpatient Department |
| QHP - | Quality Health Partners (project of USAID/Ghana) |
| PEPFAR – | President’s Emergency Plan for HIV/AIDS Relief |
| PLHIV - | People Living with HIV/AIDS |
| PMTCT - | Prevention of Mother-to-Child Transmission |
| SHARP - | Strengthening HIV/AIDS Response Partnerships |
| STI - | Sexually Transmitted Infection |
| TB - | Tuberculosis |
| USAID - | U.S. Agency for International Development |
| VCT - | Voluntary Counseling and Testing |

MAP OF GHANA: SELECTED ASSESSMENT SITES



Selected Assessment Sites:

1. Korle-Bu Teaching Hospital
2. Koforidua Regional Hospital
3. Effia Nkwanta Regional Hospital
4. Sunyani Regional Hospital
5. Kumasi South Regional Hospital
6. Tamale Regional Hospital
7. Ridge Hospital
8. Hohoe District Hospital
9. St. Francis Xavier Hospital
10. Akyem Oda District Hospital

EXECUTIVE SUMMARY

To complement the government's efforts in addressing the needs of HIV patients, QHP in collaboration with SHARP, NACP and with funding from the President's Emergency Plan for HIV/AIDS Relief (PEPFAR) initiated the High Impact Package (HIP) program. Launched in June 2006, HIP activities support the provision of a continuum of care (including antiretroviral therapy (ART)) for PLHIVs at selected health facilities.

The package includes:

- Client-Oriented Provider Efficient approach for Antiretroviral Therapy services (COPE-ART) exercises for problem-identification and problem solving
- Stigma and Discrimination Reduction coupled with improved infection prevention practices for clinical and non-clinical service providers
- Infection Prevention training for family or support caregivers of PLHIVs
- Health Facility and PLHIV Community/Facility dialogue forums to establish linkages and referral networks as well as to foster community support in the continuum of care
- Technical updates on Tuberculosis-HIV (TB-HIV) co-infection national policy and national treatment guidelines
- Contraceptive Technology Updates to foster Family Planning –HIV (FP-HIV) service integration and improve access of PLHIVs to FP utilization
- Models of Hope Volunteers (MH Volunteers) – liaising with SHARP-trained peer volunteers to undertake support activities related to counseling and clerical duties at ART clinics

Objectives

The objectives of the assessment were to assess:

1. the effect of the HIP programme on services in HIP facilities
2. the level of service utilisation in the HIV units of the selected facilities
3. perceptions of key stakeholders about the effect of the HIP activities
4. the effectiveness of the HIP programme as an HIV intervention strategy

Assessment Design and Methodology

The assessment used a pre and post intervention time series design that consisted of an analysis of monthly routine data on HIV service utilization from sites that participated in the HIP programme. The assessment design also enabled the assessment team to evaluate and compare the trend of service uptake over time, particularly the time period over which HIP interventions were introduced.

The Senior Manager of Monitoring and Evaluation at QHP provided technical oversight of the assessment. An independent consultancy team was then hired to support the implementation of the assessment. The lead consultant, along with 2 data collection officers confirmed the study protocol, refined and designed additional data collection instruments, pre-tested data collection instruments, coordinated the assessment, developed data entry screens, processed data, analyzed data for key themes and trends, and wrote a report on findings.

Ten (10) facilities were selected out of thirty (30) supported facilities for this assessment. The assessment team carried out in-depth interviews as well as collected service statistics for further analysis. This report presents key themes, perceptions, and findings from in-depth interviews held. Findings from HIV service utilization data, however, present quantitative analyses of client service uptake during the time of HIP interventions. Both types of analyses contribute towards determining the degree to which HIP activities were effective.

Limitations

- Selected providers were busy providing services to clients and had limited opportunities to speak at length. This may have affected the responses by the provision of limited commentary, in certain instances. Seven out of an anticipated fifty-nine respondents were not available for commentary.
- Indicators collected at the QHP level had slightly altered terminology than at the facility level. Terminology used at the QHP level was tracked as ‘total number of clients registered for care with the ART clinic’. Data from facilities were collected as ‘number of new clients receiving HIV clinical care’ and the ‘number of HIV+ clients attending HIV/Care treatment services’.
- Selected facilities collect data as a regional center and as an individual facility. In certain instances, regional data was provided in lieu of facility-specific data. This may have caused inaccurate comparisons of regional and facility-specific service utilization data on rare occasions.
- Data for some of the months within the 2006 to 2009 time period were not available at selected facilities; thus affecting graphs which may appear as sharp dips. These dips are a reflection of a lack of data for that given month and not an indication of declining performance. Such occurrences were minimal and have been duly annotated.

Findings

Overall, HIP activities were lauded as successful, useful, sustainable, and effective. Interview data from fifty-one (51) respondents concluded that the HIP activities have left a positive impression on facility level staff. Responses from in-depth interviews also revealed strong levels of satisfaction with most components of the HIP Package.

Data across facilities revealed that it remains inconclusive as to whether improvements in service quality directly affected the number of new clients receiving HIV care. As reported from in-depth interviews however, improvements in service quality may have contributed to increased numbers of clients accessing care and returning for care.

Overall, QHP was well-regarded amongst service providers and enthusiastically encouraged to continue service provider training as frequently as possible, particularly its components of Stigma Reduction Training, Infection Prevention Training, COPE exercises, and COPE Action-Planning. A strong majority of providers has seen immediate changes in client-provider relationships where clients are visibly more happy, comforted and satisfied. Providers additionally valued increased capacity building in the areas of Infection Prevention, Family Planning, and Tuberculosis management.

Key stakeholders were highly supportive of QHP activities and found their relationships to be successful, synergistic and complementary. SHARP viewed itself as having the MARP focus whereas QHP was perceived to have more focus on the general population. And this collaborative effort proved successful by the opinion of the QHP-led HIP team and SHARP team.

From the perspective of the NACP, service quality improvements for both the client and provider were a compulsory part of the Ghana’s national HIV/AIDS strategy. HIP activities, particularly COPE action-planning and stigma reduction, help facilities to identify and resolve problems using self-initiated ideas and available resources from supporting agencies. More importantly, facilities and communities are able to play an active role in addressing facility-specific issues and concerns. Overall, the NACP is satisfied with the ongoing HIP activities across facilities.

1.0 INTRODUCTION

1.1 Background

Contextual History of the Development of the HIP Program

The Government of Ghana (GOG) has a goal to reduce HIV transmission through comprehensive prevention, care, treatment and support interventions targeting the general population, especially women and children, with assistance from the Global Fund to Fight HIV/AIDS (GFATM), Tuberculosis and Malaria and other development partners including the United States Government (USG). Since 2003, there has been an aggressive scale up by Ghana's National HIV/AIDS and STI Control Programme (NACP) in a bid to attain universal coverage over the country in Counselling and Testing (CT), Prevention of Mother-to-Child Transmission (PMTCT) and Antiretroviral Therapy (ART) services. At present, NACP has provided over 400 health facilities (hospitals, health centres and stand-alone clinics) with specialized training, drugs, consumable supplies, laboratory set-up assistance and refurbishments. These inputs notwithstanding, a gap still remained between the anticipated versus actual levels of service uptake. For example, less than 16% of persons with advanced HIV infection needing ART actually received services according to 2007 national data. Uptake of services over the period has been limited by factors such as stigma, service provider work overload, inadequate supervision, weak linkages and referral mechanisms, a limited confidentiality system, and insufficient HIV interventions specifically targeting PLHIVs and other Most at Risk Populations (MARPs) among several others.

Since FY06, the Quality Health Partners (QHP) project has collaborated with the Strengthening HIV/AIDS Response Partnership (SHARP) project and the National AIDS/STI Control Programme (NACP) to contribute to the country's HIV response by implementing a package of tools and interventions dubbed the High Impact Package (HIP). HIP is aimed at improving access to quality services, especially for MARPs, across the entire continuum of HIV prevention, counseling and testing, treatment, care and support services.

As indicated below, the aim of HIP aligns with goal number four (4) of the QHP project:

1. Strengthened policies and systems to ensure comprehensive delivery of quality services in the public and private sector
2. Improved quality of care and services at regional and district level and below
3. Strong and effective platform for monitoring and evaluation of the SO7 Elements and sub-elements through quality data collection and analysis
4. Improved quality of care for HIV patients in high prevalence areas

1.2 HIP Program Elements

1.2.1 Components of the Program and Target Facilities

To complement the government's efforts in addressing the needs of HIV patients, QHP in collaboration with SHARP, NACP and funding from the President's Emergency Plan for HIV/AIDS Relief (PEPFAR) initiated the High Impact Package (HIP) program. Launched in June 2006, HIP activities support the provision of a continuum of care (including antiretroviral therapy (ART)) for PLHIVs at selected health facilities.

Definition:

The High Impact Package (HIP) is a series of approaches, trainings, and tools aimed at improving access to quality services across the continuum of HIV care (prevention, counseling and testing, treatment, and care and support services).

The package includes:

- Client-Oriented Provider Efficient approach for Antiretroviral Therapy services (COPE-ART) exercises for problem-identification and problem solving
- Stigma and Discrimination Reduction coupled with improved infection prevention practices for clinical and non-clinical service providers
- Infection Prevention training for family or support caregivers of PLHIVs
- Health Facility and PLHIV Community/Facility dialogue forums to establish linkages and referral networks as well as to foster community support in the continuum of care
- Technical updates on Tuberculosis-HIV (TB-HIV) co-infection national policy and national treatment guidelines
- Contraceptive Technology Updates to foster Family Planning –HIV (FP-HIV) service integration and improve access of PLHIVs to FP utilization
- Models of Hope Volunteers (MH Volunteers) – liaising with SHARP-trained peer volunteers to undertake support activities related to counseling and clerical duties at ART clinics

QHP focuses on quality service improvement at the health facility level using Engender Health’s Client Oriented Provider Efficient services (COPE) tool for problem-identification and problem-solving, involving all levels of staff in the process. Additional elements of the package include training of clinical and non-clinical staff at the facility level in reducing HIV-related stigma and discrimination to help make facilities friendlier towards MARP. Other components of HIP include integration of FP into routine HIV services, supporting HIP sites to implement TB/HIV collaborative activities, and skills-building assistance for PLHIV support groups.

The HIP activities complement capacity-building programmes in CT including VCT, ART, and Behavior Change Communication (BCC) currently supported by the NACP and other stakeholders. HIP activities seek to address structural and systemic factors contributing to sub-optimal quality HIV services and low uptake of services by PLHIVs and MARPs. The HIP strategy hinges on a continuous engagement and collaboration with health facilities through initial roll-outs and follow-ups to review quality of care issues. The follow-ups provide opportunities for facilities to reinforce ‘best practices’ and also to receive updates on emerging strategies in HIV/AIDS prevention, treatment, care and support.

The HIP activities were first implemented in ten (10) facilities with the involvement of seventy-two (72) MARP support groups between July 2006 and June 2007 and expanded to cover fifteen (15) additional facilities by September 2008. To date, QHP and collaborating partners have implemented HIP activities at thirty (30) sites that provide a complement of services including ART to PLHIVs. The sites include the nation’s two teaching hospitals and all ten (10) regional hospitals that serve the majority of the HIV population accessing formal care, treatment and support. (See Table 1.0 List of Facilities that has Implemented HIP Activities)

Table 1.0 List of Facilities that has Implemented HIP Activities

| REGION | FACILITY NAME |
|-----------------------|-----------------------------------|
| GREATER ACCRA | 1. KORLE-BU TEACHING HOSPITAL |
| | 2. RIDGE HOSPITAL |
| | 3. POLICE HOSPITAL |
| | 4. TEMA GENERAL HOSPITAL |
| | 5. 37 MILITARY HOSPITAL |
| | 6. DANGBE EAST DISTRICT HOSPITAL |
| ASHANTI REGION | 7. KOMFO ANOKYE TEACHING HOSPITAL |
| | 8. KUMASI SOUTH REGIONAL HOSPITAL |
| | 9. OBUASI GOVERNMENT HOSPITAL |
| | 10. MAMPONG DISTRICT HOSPITAL |
| VOLTA REGION | 11. HOHOE DISTRICT HOSPITAL |
| | 12. HO REGIONAL HOSPITAL |

| | |
|---------------------------|--------------------------------------|
| | 13. NKWANTA DISTRICT HOSPITAL |
| | 14. DZODZE DISTRICT HOSPITAL |
| EASTERN REGION | 15. KOFORIDUA REGIONAL HOSPITAL |
| | 16. AKYEM ODA DISTRICT HOSPITAL |
| | 17. DONKORKROM PRESBYTERIAN HOSPITAL |
| | 18. NSAWAM DISTRICT HOSPITAL |
| | 19. BEGORO DISTRICT HOSPITAL |
| CENTRAL REGION | 20. CENTRAL REGIONAL HOSPITAL |
| | 21. ST. FRANCIS XAVIER HOSPITAL |
| WESTERN REGION | 22. EFFIA NKWANTA REGIONAL HOSPITAL |
| | 23. TARKWA GOVERNMENT HOSPITAL |
| | 24. EIKWE CATHOLIC HOSPITAL |
| BRONG AHAFO REGION | 25. SUNYANI REGIONAL HOSPITAL |
| | 26. TECHIMAN-HOLY FAMILY HOSPITAL |
| NORTHERN REGION | 27. TAMALE REGIONAL HOSPITAL |
| UPPER EAST REGION | 28. BOLGATANGA DISTRICT HOSPITAL |
| | 29. BAWKU PRESBYTERIAN HOSPITAL |
| UPPER WEST REGION | 30. WA REGIONAL HOSPITAL |

HIP enables facilities to liaise with SHARP-targeted communities such as Men who have Sex with Men (MSM), Female Sex Workers (FSW) and People Living with HIV (PLHIV) to reach them with prevention, sensitization and education programmes in order to improve their service-seeking behaviour.

1.2.2 Stages of HIP Implementation

HIP is implemented in three stages:

- 1) The first stage is a HIP launch, where the package of activities and the rationale behind the package is introduced to key stakeholders from the facility and community levels, and includes senior management or representatives at the regional and district health directorates.
- 2) The second stage involves the actual roll out of the HIP activities at the facility level over a two-week period. This is led by trained local facilitators from the facilities involved and often with support of technical or program officers from the QHP and SHARP projects.
- 3) The third stage comprises follow-ups for monitoring and evaluation of implementation of quality improvement action plan which is the main output at the end of stage two. This is combined with supportive supervision of other interventions introduced at stage two such as integration of TB-HIV, FP-HIV, Infection Prevention practices by family caregivers and data collection among others.

Roll-out or sustainability of HIP relies on a foundation of strong local capacity and ownership and hence involves capacity-building. Training-of-Trainers (TOT) workshops aimed at developing the skills of on-site facilitators to lead COPE exercises is part of the HIP Program. During the TOT, participants are given an overview of the HIP Program, taken through the COPE exercise, and introduced to the COPE tools and principles of adult learning. Participants learn how to improve their strengths and adequately prepare for the COPE sessions at health facilities. The TOT representative also promotes buy-in for the COPE methodology by endorsing the Quality Improvement (QI) process at his/her respective facility and assisting with the roll-out of HIP activities.

Across 2006 and 2007, five to six-day TOT workshops were held to assist selected providers to become facilitators. The trainings developed participants' skills to primarily lead COPE exercises. Participants then applied skills learned over two days of field practice where they facilitated actual COPE exercises at HIP facilities. Participants then ended the workshops with discussion on key next steps for follow-up on COPE action plans managed by colleagues and hospital management.

The stigma reduction training is a stage two activity also requiring a TOT workshop. Combining training elements of Infection Prevention, this training lasts two to three days and seeks to help reduce stigma and discrimination against clients who visit the facilities. Providers who receive Stigma Reduction/IP training also receive a half-day orientation in a Job Training Aid for Teaching Caregivers. Providers train family caregivers on how to prevent infections and promote good health practices. In order to carry-out this training, providers first observe QHP staff train as many as eight family caregivers.

The entire HIP program was designed to be participatory, with facilities taking the lead in the planning, facilitation and implementation of the action plan. QHP's role is to provide technical assistance as well as ensures buy-in at the national, regional and district levels. QHP also ensures participation at the community-level through collaboration with SHARP. Stigma, discrimination and quality issues from the client perspective are collected by SHARP, and the information is fed-back to the facility in the presence of the key community level stakeholders. The facility is then given the opportunity to respond to the concerns raised by clients. During this time, key concerns are added to the facility level action plan for implementation.

2.0 ASSESSMENT OBJECTIVES, DESIGN AND METHODOLOGY

2.1 Assessment Objectives

The objectives of the assessment were to assess:

1. the effect of the HIP programme on services in HIP facilities
2. the level of service utilisation in the HIV units of the selected facilities
3. perceptions of key stakeholders about the effect of the HIP activities
4. the effectiveness of the HIP programme as an HIV intervention strategy

2.2 Sampling

The assessment was conducted in ten (10) out of the thirty (30) supported facilities. These facilities were purposively selected by the duration of time elapsed since the introduction of HIP to the facility¹ and representation of hospitals at the teaching, regional or district levels.

. The ten facilities selected were:

1. Korle-Bu Teaching Hospital
2. Koforidua Regional Hospital
3. Effia Nkwanta Regional Hospital
4. Sunyani Regional Hospital
5. Kumasi South Regional Hospital
6. Tamale Regional Hospital
7. Ridge Hospital
8. Hohoe District Hospital
9. St. Francis Xavier Hospital
10. Akyem Oda District Hospital

The following health personnel and key stakeholders were purposively selected for interviews. (See Table 2.0 Respondent Sample Size by Function)

Table 2.0 Respondent Sample Size by Function

| Respondent Sample Size by Function | | |
|--|-------------------------|---------------------|
| In-depth interviews | Sample size/site | Total sample |
| Health Personnel | | |
| Head of Unit/Administrator/DDNS ² | 1 | 10 |
| HIV Coordinator | 1 | 10 |
| Other HIV Service Providers | 1 | 10 |
| Data Managers | 1 | 10 |
| Clients Perspectives | | |
| Models of Hope | 1 | 10 |
| Other Stakeholders/Partners | | |
| NACP | 1 | 1 |
| SHARP | 1 | 2 |

¹ Facilities where HIP was introduced after September 2008 were not part of the sample as they were new to the program and did not yet benefit from the full package of activities.

² Deputy Director of Nursing Services (DDNS)

2.3 Assessment Design and Methodology

The assessment used a pre and post intervention time series design that consisted of an analysis of monthly routine data on HIV service utilization from sites that participated in the HIP programme. The assessment design also enabled the assessment team to evaluate and compare the trend of service uptake over time, particularly the time period over which HIP interventions were introduced.

The Senior Manager of Monitoring and Evaluation at QHP provided technical oversight of the assessment. An independent consultancy team was then hired to support the implementation of the assessment. The lead consultant, along with 2 data collection officers finalized the study protocol, refined and designed additional data collection instruments, pre-tested data collection instruments, coordinated the assessment, developed data entry screens, processed data, analyzed data for key themes and trends, and wrote a report on findings.

2.4 Methods for Data Collection

Both qualitative and quantitative methods of data collection were used in this assessment.

The qualitative methods included:

- Desk review of related HIP activity reports including focus group and direct observation data from a stigma reduction assessment undertaken in December 2008
- In-depth interviews with health service providers, management of NACP and other stakeholders ³
- Semi-structured interviews with providers at the facilities, both clinical and non-clinical staff. The assessment team sought perspectives, insight, and suggestions at the following levels:
 - Head of Unit/Facility in Charge/ DDNS
 - HIV Coordinator
 - Health Care Worker(s) in the HIV Unit
 - Data Manager
 - Model(s) of Hope
- Additional client perspectives from focus groups interviewed by SHARP have been incorporated to provide a holistic view of the effectiveness of the HIP Program.

The quantitative methods included:

- Collection, review, and comparison of service statistics collected at the health facility level
- Undertaking trend analysis considering timing of HIP activities focusing on one key indicator: *Enrollment into HIV care, including OI/ART (new and continuing)*
- Analysis of data derived from semi-structured interviews

2.5 Data Collection, Entry and Analysis

The assessment team responsible for data collection consisted of 1 QHP M&E Manager, 1 Lead Consultant, and 2 Data Collection Officers. The team collected interview data and service statistics from ten (10) HIP facilities, representatives from SHARP and NACP.

The assessment team visited all ten sites to conduct in-depth interviews and collect data; however selected sites did not make all staff available for interviewing purposes. Fifty-one (51) respondents were interviewed; whilst seven respondents that were not available included; three Models of Hope, two HIV Unit Coordinators, one Data Manager, and one Health Care Worker.

³ Clients perceptions of services were already documented through the Stigma Assessment and so no client interviews were done.

Service statistics were collected at each facility and entered into excel spreadsheets to develop charts and undertake trend analysis. Frequency tables were generated from in-depth interviews and service utilization data. In order to better appreciate any CT service uptake changes related to the implementation of HIP activities, the HIP programme launch start dates are illustrated in the charts over the 2006 – 2009 timeframe.

2.6 Informed Consent

The assessment procured signed informed consent forms from all respondents before gathering information (with the exception of three telephone interviews where informed consent was only verbally obtained). The aims and objectives of the study were thoroughly explained with the promise of access to information from the report through the facility.

2.7 Assessment Limitations

Some limitations during the assessment as described below may affect the validity of the data:

Facility Level

- Selected providers were busy providing services to clients and had limited opportunities to speak at length. This may have affected the responses by the provision of limited commentary, in certain instances. Seven out of an anticipated fifty-nine respondents were not available for commentary.

HIV Service Utilization Data

- Indicators available at the QHP level had slightly altered terminology than at the facility level. Terminology used at the QHP level was tracked as ‘total number of clients registered for care with the ART clinic’. Data from facilities were collected as ‘number of new clients receiving HIV clinical care’ and the ‘number of HIV+ clients attending HIV/Care treatment services’.
- Selected facilities collect data as a regional center as well as an individual facility. In certain instances, regional data was provided in lieu of facility-specific data. This may have caused inaccurate estimates of service utilization data on rare occasions.
- Data for selected months within the 2006 to 2009 time period were not available at selected facilities; thus affecting graphs in the form of sharp downward spikes. These spikes are a reflection of a lack of data for the given month as opposed to the suggestion of declining performance. Such occurrences were rare and have been duly noted.

3.0 LITERATURE REVIEW

A literature review was carried out to synthesize HIP-related QHP records from 2006 to 2009. Four components emerged as critical aspects to HIP activities:

1. COPE Exercises
2. Stigma Reduction/IP training
3. Updates on TB/HIV and FP/HIV integration
4. Community Meetings

Table 3.0 below illustrates a summary of documents used for the literature review in Section 3.0 Literature Review. Reviewed documents primarily consisted of twenty-four (24) COPE plans, fifteen (15) COPE Plan follow-ups, thirteen (13) facility and training trip reports, six (6) facility trip reports regarding follow-ups, and seven (7) facility community meeting documents.

Table 3.0 Summary of Documents Used in the Literature Review

| REGION | FACILITY NAME | COPE Plan | COPE Plan Follow-Up | Training Trip Report | Follow-Up Trip Report | Fac. Comm. Meeting |
|---------------------------|----------------------------------|-----------|---------------------|----------------------|-----------------------|--------------------|
| GREATER ACCRA | KORLE-BU TEACHING HOSPITAL | X | X | | | |
| | RIDGE HOSPITAL | X | X | | | X |
| | POLICE HOSPITAL | X | X | | | |
| | TEMA GENERAL HOSPITAL | X | X | | | |
| | 37 MILITARY HOSPITAL | X | | | | |
| | DANGBE EAST DISTRICT HOSPITAL | X | | X | | |
| ASHANTI REGION | KOMFO ANOKYE TEACHING HOSPITAL | | | | X | |
| | KUMASI SOUTH REGIONAL HOSPITAL | X | X | X | X | |
| | OBUASI GOVERNMENT HOSPITAL | X | X | X | | |
| | MAMPONG DISTRICT HOSPITAL | X | | | | |
| VOLTA REGION | HOHOE DISTRICT HOSPITAL | X | | | X | |
| | HO REGIONAL HOSPITAL | X | X | | X | |
| | NKWANTA DISTRICT HOSPITAL | | X | X | X | |
| | DZODZE DISTRICT HOSPITAL | | | X | | X |
| EASTERN REGION | KOFORIDUA REGIONAL HOSPITAL | X | X | X | | |
| | AKYEM ODA DISTRICT HOSPITAL | | | X | | |
| | DONKORKROM PRESBYTERIAN HOSPITAL | X | X | | | |
| | NSAWAM DISTRICT HOSPITAL | X | | | | |
| | BEGORO DISTRICT HOSPITAL | X | | | | X |
| CENTRAL REGION | CENTRAL REGIONAL HOSPITAL | X | | X | | |
| | ST. FRANCIS XAVIER HOSPITAL | X | | | X | X |
| WESTERN REGION | EFFIA NKWANTA REGIONAL HOSPITAL | X | X | | X | X |
| | TARKWA GOVERNMENT HOSPITAL | X | | X | | |
| | EIKWE CATHOLIC HOSPITAL | | | | | |
| BRONG AHAFO REGION | SUNYANI REGIONAL HOSPITAL | X | X | | | |
| | TECHIMAN-HOLY FAMILY HOSPITAL | X | X | | X | |
| NORTHERN REGION | TAMALE REGIONAL HOSPITAL | X | X | X | X | |
| UPPER EAST REGION | BOLGATANGA DISTRICT HOSPITAL | X | X | X | | X |
| | BAWKU PRESBYTERIAN HOSPITAL | X | | X | | |
| UPPER WEST REGION | WA REGIONAL HOSPITAL | | | X | X | X |

Additionally, Table 4.0 Summary of HIP Trainings, illustrates those trained in the various HIP program offerings from May 2005 to July 2009. QHP trained a total of 2,747 people in stigma reduction. Of this total, 43% underwent Stigma Reduction Training from October 2007 to September 2008. Additionally, QHP conducted COPE-ART training for a total of 1,176 people. In the initial year of HIP activities, only 30 participants were trained, but in the three subsequent years, ten times more participants were trained 451 in 2006/2007; 332 in 2007/2008; and 363 in 2008/2009. QHP only conducted PMTCT and STI training during the initial May 2005-Sept 2006 time period. During this time, 20 and 62 people received PMTCT and STI training, respectively.

Finally, training in IP Clinical Care and IP for Family Caregivers did not begin until October 2007. A total of 614 people received IP Clinical Care training, with 65% of trainings occurring between October 2008 and July 2009. A total of 2,961 people received training in IP for Family Caregivers, with the number of participants in October 2008-July 2009 at more than double the number participants in October 2007- September 2008. Even though QHP only began conducting IP Training for Family Caregivers in October 2007, it has the highest number of participants trained than any other training. Stigma Reduction Training stands as second training with the highest number of participants.

Table 4.0 Summary of HIP Trainings

| HIV/AIDS (Get HIP!) Dates | Stigma | COPE-ART | PMTCT | STI | HIV/TB Brief | FP/HIV Brief | Referral Meeting | IP Clinical Care | IP for Family Caregivers | Total |
|---------------------------|-------------|-------------|-----------|-----------|--------------|--------------|------------------|------------------|--------------------------|--------------|
| May 2005-Sept 2006 | 83 | 30 | 20 | 62 | 75 | 75 | 33 | 0 | 0 | 378 |
| Oct 2006-Sept 2007 | 705 | 451 | 0 | 0 | 468 | 499 | 237 | 0 | 0 | 2360 |
| Oct 2007-Sept 2008 | 1186 | 332 | 0 | 0 | 509 | 509 | 0 | 395 | 951 | 3882 |
| Oct 2008-July 2009 | 773 | 363 | 0 | 0 | 885 | 605 | 855 | 219 | 2010 | 5710 |
| Total | 2747 | 1176 | 20 | 62 | 1937 | 1688 | 1125 | 614 | 2961 | 12330 |

3.1 COPE Exercises

The COPE exercises aimed to improve facility services by having participants identify systemic problems through self-assessments, client interviews, and record reviews. The participants then analyzed root causes of facility problems in order to create detailed solutions to issues preventing quality care at their facilities. The action plans generally included about 15-20 problems, the causes, recommended actions, and the people responsible for resolving the problems. The action plans also included timelines for implementing solutions.

3.2 Problems Identified from COPE Action Plans

As part of the COPE exercises, the staff from the thirty (30) HIP facilities created twenty-four (24) COPE Action Plans, and fifteen (15) COPE plan follow-ups. When reviewing these plans, the following fifteen (15) problems and associated solutions emerged as common themes.

1. *Staffing.* An issue of primary concern for most of the hospitals was inadequate staffing, as many hospitals did not have enough trained personnel to provide quality services for high client loads.

This concern has been difficult to address, and some hospitals have been completely unsuccessful in improving staffing shortages. At Koforidua Regional Hospital, for example, uncertainty of funds delayed plans to train more staff. Additionally, a follow-up at Police Hospital reported that attempts to

secure qualified providers for ART who could be available 24 hours a day failed, as there were not even any eligible doctors to attend an invitation by NACP for STI/OI training.

Other hospitals were similarly unsuccessful with acquiring more staff at the time of their follow-up, but they had intentions of pursuing possible solutions. For example, Ridge Regional Hospital did not have enough counselors for VCT and ART services, and so it was waiting for NACP to review the situation and for SHARP to finish pre-testing a training module to train more personnel. Another facility, Tema General Hospital, planned to integrate HIV care with OPD since it still could not offer 24 hour emergency services for adverse ARV reactions.

However, in contrast with these struggles, other hospitals successfully made staffing improvements. Korle-Bu Teaching Hospital hired more lab technical staff, for example. Additionally, Techiman Holy Family Hospital trained six additional staff in ART/CT/PMTCT services.

2. *Wait times.* A majority of the facilities reported that clients had to wait too long for services. Often, this long wait time was due to the inadequate staffing mentioned above. Additionally, lack of available space worsened facilities' long wait times. In response, hospitals had mixed success in their efforts to improve the situation. At Ridge Hospital, one counseling room was not adequate for the number of clients the facility received, and so one physician provided an additional room by seeing ART clients in his general consulting room. Furthermore, Kumasi South Regional Hospital successfully reduced waiting time with more facilitative supervision. Other hospitals, however, had less success. Even though Korle-Bu Teaching Hospital procured additional rooms for pharmacy services, long waiting times remained because pharmacy staff was small in number and unwilling to take on additional duties. At another facility, Police Hospital, only one doctor saw adult ART clients, and since management was unable to identify additional doctors, the hospital's partial solution was to ask clients to come on other days besides clinic days. Finally, Obuasi Government Hospital simply reported that long waiting times remained unsolved.
3. *Follow-up mechanisms.* Primarily because of lack of staff and time, a majority of hospitals reported that there were no follow-up mechanisms for defaulting clients and clients testing HIV positive. Success in rectifying the problem varied. Ho Regional Hospital successfully began training community health nurses and social welfare staff to follow-up on HIV positive clients. However, other hospitals faced major obstacles. Effia Nkwanta District Hospital, for example, was still struggling to negotiate an increase in staff, and Police Hospital reported that it needed to fix technical data software problems before it could track defaulters. At the time of its COPE plan follow-up, Korle-Bu Teaching Hospital similarly had not completed follow-up procedures for defaulting clients.
4. *Referral systems.* Many hospitals noted poor referral systems to psychosocial services, legal services, and community-based providers. The primary cause was that facilities were simply not aware of such services and because facilities did not engage in enough collaborative efforts. To address the issue, facilities created inventories listing community organizations, and began networking with community groups. However, hospitals need to take these steps further. For example, the inventory Nkwanta District Hospital created listed only one NGO, and at Bolgatanga District Hospital, SHARP had not yet compiled an inventory list of organizations because it was awaiting the approval of a grant. More discussion on referrals is included in the facility community meetings section of this review.
5. *Record keeping.* Many hospitals pointed out problems in recording standard relevant information, such as clients' vitals and sexual practices due to lack of equipment, oversight in the creation of checklists and forms, and inadequate staffing for heavy loads of clients. Responses to the problem have been largely positive. For example, Bolgatanga Regional Hospital was successful in both assigning health aids to help with measurements and acquiring necessary measurement equipment. At Police Hospital, stickers with additional checklist items successfully supplemented insufficient forms. At Tamale Teaching Hospital, Models of Hope volunteers successfully assisted staff in record keeping. Finally, at Korle-Bu Teaching Hospital, student nurses began to assist the duty nurse in taking vitals.

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6. *Client stigmatization.* Many facilities indicated that staff members discriminated against clients. Stigma Reduction trainings and other sensitization efforts were the primary response to this problem. For discussion on the effectiveness of these programs, see the next section of this review.
 7. *Client/PLHIV input.* Many facilities noted that PLHIV are not involved in the planning, monitoring, and evaluation of HIV and AIDS services. In response, Tamale Regional Hospital reported that it was successful in meeting regularly with PLHIV associations. Koforidua Regional Hospital added a suggestion box that had not yet received any suggestions, and created a client information center that addresses clients' issues. Donkorkom Presbyterian Hospital reported that four times a week, its receptionist made public announcements that educated clients on their rights and informed them of where to send their complaints and suggestions. Finally, Sunyani Regional Hospital established a customer complaint unit and prepared questionnaires for bi-annual client interviews.
 8. *Cleanliness.* Many hospitals commented on inadequate and unclean washrooms, and through the COPE plans, made great progress. For example, while Tamale Teaching Hospital had not yet trained more cleaners or set up a better system for monitoring cleaners at the time of its follow-up meeting, it did successfully provide more cleaning supplies, use the PA system to make announcements on proper washroom use, and increase the water supply. Donkorkom Presbyterian Hospital improved cleanliness by ordering bigger dustbins and improving supervision of orderlies. Finally, Koforidua Regional Hospital contracted a waste management company and reactivated the Quality Assurance Team that conducted a client satisfaction survey and successfully enforced cleanliness standards.
 9. *Signage.* A majority of hospitals mentioned that their facilities lacked signs and posts to direct clients. For some hospitals, the lack of signs was simply an oversight, but for other hospitals, staff feared that signs would create stigma. At the time of its follow-up meeting, Nkwanta District Hospital created provisional signs and responded to fear of stigmatization by sensitizing staff on the protocol for setting up CT and ART services. Other hospitals had not yet put up signs. Obuasi Government Hospital, for example, was waiting to hear from the Regional Coordinator, and management at Sunyani Regional Hospital felt that even provisional signs were not economical at the temporary ART services site.
 10. *Privacy.* Several hospitals show concern over lack of privacy due to limited facilities. In response, these hospitals intend to procure additional rooms, provide curtains and screens to partition rooms, create signs to prevent people from entering during counseling, etc. For example, at Korle-Bu Teaching Hospital, lack of space made physical examinations, procedures, and counseling sessions easily seen and overheard. In response, the hospital provided four (4) additional counseling rooms and four (4) additional consulting rooms, ensured physical examinations and procedures were private, and started to renovate two rooms for lab services.
 11. *Infection prevention protocols.* Many hospitals note that their staffs are not as aware of infection prevention as they should be. Ridge Hospital has posted laminated posters with infection prevention protocols, had trained staff sensitize additional staff at the unit level, and scheduled further staff training. More information on Infection Prevention training is found in the Stigma Reduction/Infection Prevention training section of this review.
 12. *Knowledge on PEP.* Almost all hospitals report that PEP protocols are not posted and are not always followed. In response, hospitals intend to adapt national PEP protocol, post protocols in prominent places, and sensitize staff through training. For example, protocol has already been posted in Ho, and in Tamale sensitization is scheduled to happen in addition to posting. Donkorkom Presbyterian Hospital similarly posted protocol information and conducted in-service training.
 13. *Knowledge on client rights.* A majority of facilities were also concerned that staff were not adequately aware and respectful of client confidentiality and client rights. In fact, several facilities stated they had no written guidelines. To ensure clients rights, facilities created guidelines to post throughout their facilities and sensitized clients and staff on client rights issues. For example, Tamale Teaching Hospital provided daily PA and radio announcements and audio-visual material for clients, oriented all nurses

and doctors on client rights, posted policies, and had plans of monitoring staff and client knowledge on rights through surveys.

Feedback on COPE Exercises:

COPE exercise participants generally received training enthusiastically, and gave positive feedback wherever possible.

One medical superintendent from Koforidua Regional Hospital was impressed with the COPE Exercise, saying:

One of the hallmarks of NGOs such as Engender Health is their ability to apply simple techniques with very minimal resources [such as providing lunch for participants in this instance], to produce very useful and important interventions and products. The contents of this document [the COPE Action Plan], would have cost us manifold to achieve if we had engaged a consultant to help us identify our problems and prescribe solutions.”

Additionally, a significant aspect of the COPE Exercise was that it involved all levels of management and staff, re-inspiring communication and collaboration. An anonymous participant from Kumasi South Regional Hospital, stated,

“I am very much surprised by the fact that ordinary staff members, who have gathered here these few days, have been able to produce this document (the COPE Action Plan) which is a great asset... It shows me that staff is very knowledgeable, and this gives me great hope, that together we can contribute to improving quality no matter our level or standing in work at this facility.”

14. *Knowledge on services.* Many hospitals reported that not all of their staff had adequate knowledge of the services provided at their facilities. To address the issue, Koforidua Regional Hospital began training to introduce all staff to all departments and units in the hospital. Ridge Regional Hospital took a different approach by posting and distributing information about services for all staff to access.
15. *Information sharing of training.* Several hospitals reported that there were no mechanisms for sharing information gained at workshops. Nkwanta District Hospital noted that lack of time due to work overload was the cause of the problem. At the time of its follow-up meeting, the hospital had still not put in place a mechanism for downstream training. Sunyani Regional Hospital, on the other hand, started monthly ward/unit conferences during which staff could share their new knowledge, and supervisors began enforcing that staff members submit workshop reports within two weeks of their training. These measures to ensure the dissemination of information are especially important considering that the solutions to a number of the previous problems involved training in particular areas.

3.3 Analysis of COPE Action Plan Implementation

Overall, the implementation of the COPE Action Plans was successful according to feedback from training participants. The majority of tasks from action plans had been addressed or at least attempted. A source of

success for the plans was by listing names of specific focal persons, and by listing specific dates when results would be achieved. Participants commented that this created an enormous sense of accountability and ownership.

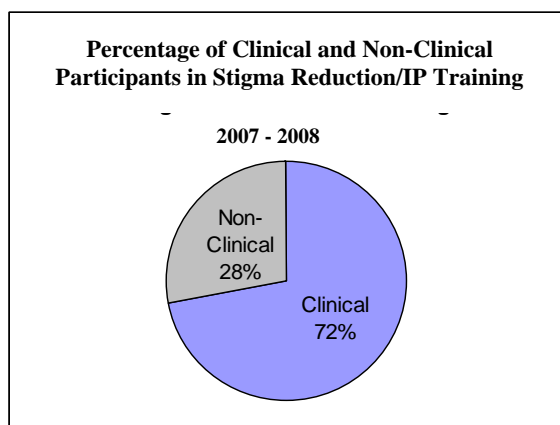
Follow-up was also necessary in creating further accountability and yielding positive results. Sometimes, follow-ups were a necessary reminder to accomplish tasks that were very achievable but simply been neglected, as some participants admitted. For example, at Tema General Hospital selected staff failed to record clients' heights, and even though the action plan recommended that the facility should acquire measurement tools, no one had requested it by the time of the follow-up. Some facilities did not take further action until the follow-up review team helped to encourage finding an alternative solution. For example, at Police Hospital, an attempt to solicit funds for sign-boards was unsuccessful, but after reviewing this unsuccessful attempt at the follow-up meeting, the Hospital Director was able to find an alternative way to obtain signage.

Finally, other problems on the action plan remained yet to be accomplished because participants commented that the problems were complex and difficult to solve. For example, Police Hospital administration made continuous petitions to police administration for more emergency vehicles without success. Additionally, as mentioned above, inadequate staffing was a major issue that activities such as redrawing rosters and schedules as well as increasing community health nurses had not been able to be addressed. For example, Kumasi South Regional Hospital drew up a new timetable for staff, but a lack of medical personnel still prevented the facility from having 24 hour emergency services. Similarly, at Obuasi Government Hospital, assigning staff specific roles in the pharmacy was unable to prevent long wait times, and while National Service personnel were helping, the problem was still not solved.

3.4 Stigma Reduction and Infection Prevention

The stigma reduction/IP trainings helped to explore participants' personal attitudes towards HIV/AIDS in order to challenge fears and prejudices. The stigma reduction aspect of the training addressed topics including client rights, HIV/AIDS stigma and discrimination, recognizing one's own stigmatizing actions, and testimonials by PLHIV. The IP aspect of the training covered topics including HIV transmission and personal/professional risk, standard IP precautions, prevention of needle-stick and sharp instrument injuries, and PEP protocols. The two aspects of the training complemented each other in that the IP training minimized and controlled participants' fears of transmission, which serve as a driving force behind stigmatization.

Figure 1.0 Ratio of Clinical to Non-Clinical Participants in Stigma Reduction/IP Training



From 2007 to 2008, QHP facilitated Stigma Reduction/IP Trainings for an average of 54 staff per facility. Of the five reviewed reports that delineated between clinical and non-clinical staff, the average ratio of clinical to non-clinical participants was 5:2. Although it is advantageous that both clinical and non-clinical staff were involved in training, unresolved stigma issues from non-clinical staff could still affect the quality of care at any of the levels.

Most hospitals rated the trainings as beneficial, and went on to share that they would have liked to have training more often for all staff. In terms of the usefulness of the Stigma

Reduction/IP trainings, participants gained significant knowledge, as reflected in training pre and post-test scores below. According to recent studies that reviewed the scores of 713 participants, the overall mean scores improved from 76% in the pre-test to 88% in the post-test, indicating an 11 percentage point gain.

When asked what staff would do differently as a result of the training, answers included,

—“*adhere to standard infection prevention precautions*”

-
- “educate other colleagues that did not get the opportunity to participate”
 - “respect the rights of clients”
 - “apply standard precautions in dealing with all clients”
 - “show empathy to HIV and AIDS clients”
 - “stop acts of stigma and discrimination against AIDS patients”

Overall, staff expressed a sincere desire to change their behavior as it relates to stigma and discrimination of HIV patients. Moreover, staff expressed countless examples of the immediate and significant changes that took place as a result of reduced stigma at the facility level.

3.5 Appraisal of Stigma Reduction Interventions

The following perspectives, examples, and statistics are from a previously conducted study entitled “A Rapid Appraisal of HIV-related Stigma and Discrimination Reduction Interventions in selected health facilities in Ghana (2009).” This report assesses stigma reduction interventions at a sample of HIP facilities, some of which were also reached during this assessment. The report evaluates the extent of changes in HIV stigma since the introduction of stigma reduction interventions, which include the COPE exercises, the training program on “Reducing HIV-Related Stigma and Discrimination and Improving Infection Prevention,” as well as follow-up activities at selected HIP facilities.

The study found that discriminatory practices towards PLHIVs have declined. Stigma reduction interventions have reduced fears of causal transmission and countered the moralizing attitudes that drive discrimination. While discrimination in units outside of HIV units still negatively impacts quality of care, discrimination in these units has declined so that overall, clients are more satisfied with services at health facilities. The clients noted that at HIV units especially, the friendliness of staff is a welcome refuge from the discrimination they face in their communities, and so “anticipated” HIV stigma by health workers does not appear to prevent MARP from seeking care.

Limitations of stigma reduction interventions are that not all hospital staff receives training. An insufficient number of staff works in liaising departments such as the OPD, where institutional and structural changes do not largely result from HIP trainings. Therefore, new or untrained staff may “reintroduce” stigmatizing attitudes.

The stigma reduction study recommends that hospital staff continue to receive stigma and discrimination training with a focus on issues such as managing indirect disclosure, strengthening weak linkages within target communities, and creating sustainable structures to ensure that stigma reduction interventions are in the budget.

3.6 Infection Prevention Training for Family Caregivers

Providers are to give training to family caregivers on how to prevent infections and promote good health practices. A total of 83 clinical staff who received Stigma Reduction/IP training at the facilities assessed, also received job aids for teaching caregivers. Implementation of this training has had mixed success. Follow-up trips in July 2008 to Komfo Anokye Teaching Hospital, Effia Nkwanta Regional Hospital, and St. Francis Xavier Hospital, found that providers at the three facilities together had trained a total of 174 family care givers. An August 2008 follow-up trip found that 9 very motivated providers Nkwanta District Hospital had trained 162 family caregivers in, and that 6 at Hohoe District Hospital had trained 105 family caregivers. Similarly successful were 6 providers at Wa District Hospital and 12 providers at Techiman-Holy Family, who trained 117 and 210 caregivers respectively in September 2008. As QHP conducted Job Training Aid for Training Family Caregivers throughout 2007 and 2008, it is evident that while some facilities had been able to train the expected minimum of 10 caregivers per clinical staff instructor trained, others could not achieve this target even after several months.

QHP staff doing the follow-ups observed that the majority of trained clinical staff were not training family care givers or were not recording evidence of such trainings. Ho Regional Hospital, for example, had had difficulty implementing training for family caregivers because providers perceived the training as insignificant because

family caregivers were not considered medical professionals. The visiting QHP staff took efforts to re-establish the rationale behind training family caregivers, and later follow-ups in August and September 2008 to different hospitals were more positive and resulted in providers showing more enthusiasm and dedication to the training of the caregivers.

3.7 Updates on TB/HIV Dual-Infection Management Policy and Guidelines

TB-HIV Dual Infection updates across facilities generated useful discussion and provided a platform to demonstrate the effective use of the national TB screening tool as well as enhancing case-finding efforts for any of the two diseases at whichever point of entry in the clinic one is made. However, several program and operational challenges were noted to affect the smooth implementation of the policy and guidelines. QHP staff observed during follow-up visits, that TB/HIV had not yet adequately been integrated across most facilities. For example, at Effia Nkwanta Regional Hospital, the TB screening tool was not being used because of a misinterpretation of what constituted screening versus diagnosis. At another facility, Komfo Anokye Teaching Hospital, the TB screening tool was not being used out of concerns that its implementation would entail more work. Although providers were enthusiastic about rectifying the issue, the fear of increased workload led to inactivity. At St. Francis Xavier Hospital and Tamale Teaching Hospital, providers were not using the tool and staff complained of weak links between the HIV providers and TB providers. Similarly, at Wa Regional Hospital, providers screened HIV positive clients for TB but were not using the TB screening tool. At Hohoe District Hospital, there was no system in place for TB/HIV integration. At Techiman-Holy Family however, although there was a system in place for integration, as providers routinely referred HIV positive clients to the TB clinic for TB screening and the TB clinic regularly screened for HIV, the recommended TB screening tool was not used. Therefore, the fairly inadequate findings of initial follow-up visits demonstrated the necessity of creating more collaboration between HIV and TB providers, and of ensuring proper understanding use of the TB screening tool.

There were, however, some successful examples of strong TB/HIV collaboration and the use of the screening tool at Ho Regional Hospital, Korle-Bu Teaching Hospital, and Ridge Hospital. For example, by September 2008 Korle-Bu Teaching Hospital screened 800 clients after training MH Volunteers on the use the TB screening tool.

3.8 Updates on FP/HIV Service Integration Opportunities

FP/HIV updates were conducted with the objective of helping providers to become more proactive in helping clients express their fertility intentions and decide on appropriate FP methods for spacing or limiting pregnancies according to their desires. Integration assists PLHIVs to obtain the desired number of pregnancies while minimizing HIV transmission to their spouses and children. Across the majority of the trainings, the FP/HIV presentations generated much debate as most participants were surprised to learn that PLHIV have the right to reproduction. By the end of the training however, participants came to understand that all clients, irrespective of their HIV status, have the right to reproduction. At the end of the training, each health facility outlined methods to implement FP-HIV integration and designated focal persons to carry out these plans.

The five FP/HIV follow-up visits reviewed from field reports during this study revealed both successes and challenges. Success was found at Ho Regional Hospital, where HIV Counselling and Testing services occurred in FP as well as ANC and ART centers. Facility records showed that in one month, twenty-four (24) FP clients were tested, and of those, four (4) tested positive and were referred to the ART center. Similarly, QHP staff observed that FP/HIV services were strengthened. For example, outreach FP providers to the Techiman-Holy Family Hospital gave Family Planning presentations and condom demonstrations at the ANC and have plans to do the same at the CT/ART clinic. At other facilities, however, providers are in the process of better establishing FP/HIV integration activities, as in the case of Hohoe District Hospital and Wa District Hospital.

3.9 Facility-Community Meetings

Records of facility-community meetings were reviewed for the following seven hospitals:

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1. Ridge Hospital
 2. Effia Nkwanta Regional Hospital
 3. Dzodze District Hospital
 4. Begoro District Hospital
 5. St. Francis Xavier Hospital
 6. Bolgatanga District Hospital
 7. Wa Regional Hospital

The purpose of these meetings was to ensure that communities become better informed over time about HIV-related services at facilities. Another aim was to ensure that community and facility stakeholders had a better understanding of obstacles affecting clients' access to services. Most importantly, the advent of the facility-community meetings was to provide a forum and opportunity for collaboration, information sharing and linkages of community-based and facility-based services for PLHIVs. In particular, the need to improve or facilitate referrals received emphasis at several of these meetings as described by the following examples:

- *Financial Constraints.* Dzodze District Hospital, Begoro District Hospital, and St. Francis Xavier Hospital all recognized that financial constraints of transport on the part of the client were a major obstacle to effective referrals.
- *Fear of disclosure.* To avoid disclosure, attendees at Wa Regional Hospital's community meetings agreed that referrals should not include client identifiers.
- *Contacts and collaboration.* St. Francis Xavier identifies lack of contacts from the referral center as a primary factor inhibiting proper referral procedures. To address the same issue at its facility, Wa Regional Hospital's community meetings involved case scenarios in order to help attendees understand the inventory of resources available so that they could make effective referrals. Additionally, Effia Nkwanta Regional Hospital proposed to strengthen referral between itself and Community Service Providers by having staff occasionally visit support groups during their meetings.

Communities of PLHIVs that participated in the meetings were often represented by active support groups or associations that existed within the catchment of the health facilities. Effia Nkwanta Regional Hospital, for example, reached out to seven PLHIV associations, and met with six of them in September and October of 2006. In October 2007, Bolgatanga District Hospital succeeded in reaching out to one hundred and fifty-seven (157) PLHIV from five support programs. And in early June 2009, Dzodze District Hospital met with the Community Collaborative Care & Support Project that involved seven HIV support groups, as well as MH volunteers.

In determining the way forward, each facility decided to hold regular quarterly community meetings. Attendees also scheduled meetings between facilities and Community Based Organizations (CBOs), as well as meetings between facilities and Community Service Providers. Follow-up mechanisms were put in place to confirm the regularity of such meetings.

3.10 Recommendations from QHP Staffs' HIP Program Monitoring Activities

After conducting trainings and follow-ups, QHP staff that conducted program monitoring activities commonly made the following recommendations that have been summed up from their trip reports:

- *Liaise with NACP to provide more staff for CT/ART/PMTCT services.* Inadequate staffing is a major problem for facilities that results in work overload and sub-optimal treatment of patients. The addition of personnel would help to more equitably share the workload and eventually result in better service quality
- *Liaise with NACP to provide supplies and additional support.* Several sites lacked supplies that QHP and NACP can provide. For example, the CT and ART rooms at Effia Nkwanta Regional Hospital were

unfurnished and poorly ventilated, so QHP committed to refurbishing the center. Similarly, Dangme East District Hospital and Akyem Oda District Hospitals needed cabinets and cupboards in which to store CT and ART files. Additionally, QHP offered to acquire male and female condoms for Wa Regional Hospital.

- *Organize additional HIP training.* While there have been setbacks in implementing new skills and knowledge, HIP trainings have been beneficial overall. It was recommended that QHP provide training for additional staff as well as that of refresher trainings.
- *Follow-up on HIP activities in order to continue momentum.* Follow-up on COPE plans ensured that focal persons were accountable, and provided an opportunity to reflect on problems that facilities faced. Follow-up on the Stigma Reduction/IP Trainings verified that stigmatization was reduced and that providers adequately trained caregivers. Follow-up on TB/HIV integration was especially important considering that most reviewed facilities had difficulty using the TB screening tool. Also, better follow-up on community meetings could have ensured more productive collaboration and communication.

An Example from a Community Facility Meeting:

Effia Nkwanta Regional Hospital

In September and October of 2006, SHARP and QHP visited Effia Nkwanta Regional Hospital to conduct trainings. During this time, SHARP mobilized PLHIVs, MSMs, and FSWs to establish referral links with ART and STI treatment centers and engage in community dialogue on client likes and dislikes of facility services. A total of seven (7) PLHIV associations were identified in Western Region, where a majority of the groups attended the meetings except for a group in Bogoso that was unable to make a scheduled meeting.

PLHIVs particularly liked the friendly staff, the constant supply of ARVs, and the availability of regular laboratory services. Among the issues they disliked were lack of confidentiality, long wait times, and discrimination from some staff. The recommendations from PLHIVs were that staff should receive training to show empathy, patience, and non-discrimination. Also, PLHIVs recommended that ARV treatment should be free and that service schedules be expanded to reduce overcrowding and long wait times.

The MSM community expressed that they felt they had no access to STI, VCT, and HIV/AIDS services because of the humiliating discrimination they experience at facilities designated for the general population. MSMs recommended that staff be understanding so that they can seek treatment and later counsel their peers to seek treatment.

Finally, FSWs reported that they were happy with the STI services they received, although many of them felt that they did not have access to HIV services because they fear stigma and fear dying once they know of their HIV status. FSWs recommended that Pap smears should be added to STI services and that treatment should be subsidized to make it affordable.

4.0 FINDINGS FROM IN-DEPTH INTERVIEWS

As indicated in Section 2.0 Assessment Objectives, Design and Methodology, ten (10) facilities were selected out of thirty (30) supported facilities for this assessment. The assessment team carried out in-depth interviews as well as collected service statistics for further analysis.

This section presents key themes, perceptions, and findings from in-depth interviews held. A smaller level of quantitative analysis from in-depth interviews is also presented. Section 5.0 Findings from HIV Service Utilization Data, however, presents quantitative analyses of client service uptake during the time of HIP interventions. Both types of analyses contribute towards determining the degree to which HIP activities were effective.

4.1 Perspectives of Facility-in-Charges and DDNSs

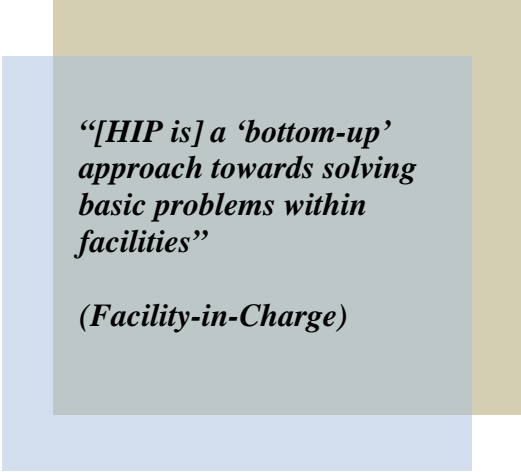
Analyses of responses from senior-level respondents to in-depth interviews showed that, staff (defined as Facility-in-Charges/DDNS) had a strong understanding of the purpose of HIP activities. Respondents generally defined HIP activities as enhancing the lives of PLHIVs through improved service delivery.

Several other respondents at this level were able to independently articulate what HIP meant to them; it was described as a program that increases access to health-delivery services through improved provider services. Selected respondents went on to share that the HIP activities were a collaborative effort between QHP and the facility to reduce stigma and improve the lives of those living with HIV. The overall definition and understanding of the HIP program, however, was disproportionately skewed towards the stigma reduction training program, and at times it was as if the HIP program's unique aim was that of stigma reduction.

Additionally, respondents were probed to share their understanding of the intended aims of the HIP project. Respondents generally defined the HIP activities as improving service delivery to HIV clients. One Facility-in-Charge succinctly stated, *"The HIP program is an accelerated and collaborative effort to assist people living with HIV/AIDS. It complements the efforts of stakeholders already on the ground dealing with HIV/AIDS every day."* While a DDNS stated, *"[The HIP Package] improves people's awareness and view of [how] we should view people living with HIV/AIDS."* These statements acknowledge an understanding of HIP activities with a sense of shared ownership of results.

Several other senior-level staff found it difficult to isolate and determine the level of increases in client service uptake due to QHP's contribution. Given the collaborative nature of HIP activities alongside the "Know Your Status" campaign and other NACP-led trainings, senior-level staff felt that many factors contributed to improved service delivery at the facility level. One senior-level respondent best stated this concern by saying, *"There is an overall improvement, but it is also attributed to other NGOs as well, and come to think of it, other partners too!--NACP, GAC, but not particularly or only QHP. The stigma reduction trainings, however, did have an impact but there is more to be done. Anyway, the percentage of those trained [by QHP] was small."*

Therefore, it was difficult to ascertain the extent to which senior level staff felt that QHP contributed to increased client service uptake. The general sentiment was that HIP activities alongside other HIV activities collectively contributed to a sense of improved quality of care.



"[HIP is] a 'bottom-up' approach towards solving basic problems within facilities"

(Facility-in-Charge)

Although interaction with senior level management was brief, the assessment team was able to probe for more feedback. It was found that senior-level direct involvement in HIP-related activities was low, where most were informed of trainings and activities through subordinate reports. Senior-level management knowledge on the purpose, aims, and objectives of HIP, nonetheless, was quite high despite its over-emphasized stigma angle.

All of the senior-level respondents commented on improvements in provider-client relationships. Of the interview responses at this level, responses were unanimously powerful. Respondents were amazed at the rapid improvements in client-provider relationships as a result of QHP-led trainings. *“The staff are so well-versed and receive clients well... in a nice, humane way. And, there is also an avenue whereby you (the provider) are traced if you do not treat patients well.”*

Additionally, staff within neighboring departments to the HIV Unit/Department undisputedly saw changes in behavior/attitude toward HIV/AIDS patients. One respondent exclaimed, *“...originally, the other staff would cut-off HIV/AIDS patients from the rest of the hospital. Now, on the wards they are treated like any other patient. They are no more treated as outcasts!”* Thus significant improvements have been observed in terms of provider approaches to client care.

Senior-level staff was also asked to share their opinions on the current trends of HIV/AIDS. From compiled responses, it has become clear that PLHIVs have developed a greater sense of confidence in identifying their needs as well as seeking the appropriate health care services. Senior management across facilities noted that although every effort has been made to integrate and mix patients so that particular services are not isolated for HIV patients alone, there is a growing backlash to these efforts. HIV patients have become more conscious of their rights and are now demanding specialized and separated services, thus becoming more comfortable to be isolated without fear of stigma. Perhaps a challenge that facilities may face will be to balance the integration of HIV care into general facility services and the need to foster a special environment for HIV patient care. Some senior level management agree with the advent of removing special associations with HIV, stating, *“HIV is not any different than malaria, TB, and other diseases; we need to stop vertical training and funding. The attention that QHP provides to HIV is really about stigma. HIV is about the breakdown of an immune system which happens in so many other diseases, not just HIV alone.”* Therefore, in the coming years, as HIV becomes a disease that is more commonly treated and accepted, there may be a shift in approaches such as HIP activities in general.

Other respondents commented that family support for PLHIVs was improving and they could see that PLHIVs were accompanied more and more by family and support networks. Stigma issues, however, still remained with the socio-cultural acceptance of PLHIVs.

Additional observations made across facilities included management’s identification of HIV amongst the aged and the youth. A DDNS commented, *“HIV/AIDS is occurring with senior secondary school students at an alarming rate.”* While another respondent pointed out that the infections may not be new infections but rather discovered at late stages within older generations not accustomed to condom-use.

As a final part of in-depth interviews with senior-level management, the following list of recommendations was made:

- The financial resources and inputs for facility improvements are not always available, but facilities should be seeing to it that action plans are still being fulfilled using as many alternative methods as possible.
- Trainings should be more inclusive of staff, non-clinical staff specifically at the lower levels
- More outreach awareness is needed for the youth and the aged, who seem to be emerging as newly identified MARPs
- Due to increasing numbers of PLHIVs presenting themselves across facilities, infrastructural investments into reception areas should be a priority
- Staff have suggested performance-based incentives to boost overworked staff and encourage more interest in improved service delivery

-
- Few respondents stated the need to re-evaluate national health insurance regulations as to why selected HIV/AIDS costs may not be covered

4.2 Perspectives of HIV Coordinators/Unit Heads

From the perspective of HIV Unit Heads tasked to coordinate HIV care and services, they were summarily satisfied with recent facility-level improvements. All the HIV Coordinators interviewed were somewhat more knowledgeable than senior management about the elements of the HIP package. This familiarity may be due to job function as their responsibilities are directly linked to HIV matters. Still, no respondent was able to make reference to all the underlying elements of the HIP Program.

Likewise, HIV coordinators were more directly involved in the planning of HIP program activities such as COPE trainings, COPE exercises, COPE Action Plan Development Sessions, Stigma Reduction Trainings, Community and Facility Referral Meetings, as well as ART, PMTCT, and FP trainings.

When asked their views on the effectiveness of the HIP Program, respondents unanimously agreed that the HIP program was effective. However, slight differences emerged in respondents' interpretation of the HIP package. This lends to the concern that their opinions of effectiveness were based upon their understanding of the package components.

Selected responses from the 'Interview Questionnaire for Head of Unit/HIV Coordinator' were as follows:

When asked about what respondents knew about the HIP collaboration between QHP and GHS, the following were some of the predominant responses.

- *"Its an HIV program"*
- *"It is how to reduce stigma/discrimination"*
- *"A strategy to improve ART that cuts across to other service areas"*
- *"A series of training programs in stigma and COPE"*
- *"Stigma reduction trainings and follow-ups"*
- *"Provider training on stigma and infection prevention"*
- *"I am not always informed but it is linked to stigma"*
- *"It is high impact package to improve HIV with trainings for providers"*

From these responses, it can be assumed that the effectiveness of HIP activities are more so an impression of the effectiveness of stigma training activities. More emphasis may be needed on other HIP components, or at a minimum, to raise awareness of the other package components and its inter-relationships.

Additionally, respondents were asked about the usefulness of other components of the HIP program, such as the COPE action plans, stigma and discrimination reduction trainings, and updates in TB/HIV and FP/HIV. A strong majority of the respondents found the trainings to be useful, but also commented on the realities of integrating TB and FP at the facility level. Respondents gave mixed reviews as to whether tools and strategies learned in trainings were actually put into effect. For example, one respondent shared that FP and TB at the facility level were not integrated as advised in the training. Another responded, however, shared that TB screening tools were used at the facility level to the point where they created a 'revolving door' relationship with the TB department. Another respondent commented on Family Planning as a normal service that did not discriminate against HIV/AIDS patients in any way. Despite these successes, the variation in responses as to whether TB/HIV and FP/HIV integration was actually happening leads to the conclusion that alternative training methods are needed. Respondents seldom commented about infection prevention trainings and few coordinators who were interviewed could comment on infection prevention activities facilitated by QHP.

HIV Coordinators were also asked their opinion as to whether the HIP activities had the potential to affect client service uptake –or as to whether HIP activities have helped to increase client service uptake. All but one respondent gave enthusiastic responses to this question. One respondent commented, *"Yes when they [the ART*

clinic] started, just a few people would come in. Now, they are up to 150 on clinic days.” The majority shared that due to the immediate reduction in discrimination felt by the client, the client would encourage others to seek services. One respondent stated, *“The care in the ward was poor originally but providers are better now.”* This perception of increased client service uptake is further supported by HIV Service Utilization Data from Section 5.0.

As a last part of the interview, HIV coordinators gave a wide range of suggestions to improve HIV service delivery:

- QHP should continue sensitizing new staff with trainings and orientation or developing guidelines for trainers to conduct trainings for new staff because more regular QHP-led trainings are needed to sensitize more staff
- The scope of provider training was small and the duration too short, therefore more efforts should be taken to lengthen QHP-led trainings in scope, duration, and intervals.
- As QHP-led trainings were a subset of trainings to additional GHS trainings, it was recommended that GHS standards for quality be integrated into QHP trainings so that there is coordination in terminology, process, and approach
- Select respondents indicated that a fresh perspective may be needed to gain more acceptance of the TB screening tool
- QHP should provide some financial support for MH Volunteers; although once money starts being distributed, it is difficult to avoid abuse. Nonetheless, the fear of abuse should not be an excuse for ignoring the voluntary contributions of MH Volunteers.
- Clients may need additional support for transport in order to make appointments and seek needed care
- Prayer camps cause problems where HIV patients do not come for care until the late stages; a specialized form of sensitization is needed to teach people on how to avoid exacerbating health conditions through prayer camps.

4.3 Perspectives of HIV Health Care Workers

Randomly-selected health care workers from each facility’s HIV Unit were interviewed for their opinion on the effectiveness of HIP as an HIV intervention. These health care workers provided the most valuable feedback of all interviewees due to their level of involvement in HIV care, treatment and support services.⁴

On average, those interviewed held (over 68 months) or an average of five years working experience within the HIV Unit. All respondents participated in at least one HIV training within the last three years. Additionally, the scope of their involvement in QHP-led HIP activities was particularly strong (see Table 6.0);

Y=yes, have participated; N=no, have not participated

⁴ Nine out of ten health care workers gave responses to feedback, whereas the tenth health care worker (*from Korle-Bu Teaching Hospital*) was not available for commentary.

Table 5.0 Summary of HealthCare Workers' Participation in HIP Activities

| Have you been involved in any way in the HIP Activities? | Hohoe | Koforidua | ENRH | Sunyani | Kumasi South | Tamale | Ridge | KBTH | St. Francis Xavier | Akyem Oda |
|--|-------|-----------|------|---------|--------------|--------|-------|------|--------------------|-----------|
| Training in Cope? | Y | Y | Y | Y | Y | Y | Y | / | Y | Y |
| COPE Exercise? | Y | Y | Y | Y | N | Y | Y | / | Y | Y |
| COPE Action Plan? | Y | Y | Y | Y | N | Y | Y | / | Y | / |
| Stigma Reduction? | Y | Y | Y | Y | N | Y | Y | / | Y | Y |
| Community Facility Mtg? | N | Y | Y | Y | Y | Y | Y | / | Y | N |
| Other? | Y | Y | Y | Y | N | Y | Y | / | N | Y |

This strong level of involvement and experience gives them an elevated level of credence. By nature of their job function, they have also observed the practical application of QHP-led trainings and updates on the job. Table 6.0 Ratings on the Effectiveness of HIP Activities by Health Care Workers additionally highlights ratings that health care workers gave on selected HIP statements. Respondents were given the option to rate anywhere from 0 = disagree - to - 5 = completely agree.

Table 6.0 Ratings on the Effectiveness of HIP Activities by Health Care Workers

| Ratings on the Effectiveness of HIP Activities: Perspectives of Health Care Workers 0 = disagree - to - 5 = completely agree | | | | | | | | | | | | |
|--|--|-------|-----------|------|---------|--------------|--------|-------|------|-------------|-----------|------|
| | STATEMENT | Hohoe | Koforidua | ENRH | Sunyani | Kumasi South | Tamale | Ridge | KBTH | St. Francis | Akyem Oda | MEAN |
| 1 | Provider attitudes towards clients have improved as a result of the stigma reduction trainings | 5.0 | 5.0 | 5.0 | 4.0 | 5.0 | 5.0 | 5.0 | / | 5.0 | 3.0 | 4.7 |
| 2 | Your participation in the development of COPE actions plans has increased your involvement in addressing HIV needs of clients in your facility | 5.0 | 5.0 | / | 5.0 | / | 5.0 | 5.0 | / | 5.0 | 2.0 | 4.6 |
| 3 | COPE is a useful tool in identifying client and provider needs | 5.0 | 4.0 | 4.0 | 5.0 | / | 5.0 | 5.0 | / | 5.0 | 4.0 | 4.6 |
| 4 | Community participation in the HIV activities at the facility level has improved with the introduction of the QHP supported facility-community meetings. | 5.0 | 4.0 | 1.0 | 5.0 | 4.0 | 3.0 | 5.0 | / | 4.0 | 1.0 | 3.6 |
| 5 | The HIP program activities have contributed to an increase in client access to HIV care in your facility? | 5.0 | 5.0 | 3.0 | 4.0 | 3.0 | 4.0 | 5.0 | / | 5.0 | 4.0 | 4.2 |
| | MEAN | 5.0 | 4.6 | 3.3 | 4.6 | 4.0 | 4.4 | 5.0 | n/a | 4.8 | 2.8 | |

Respondents gave a combined average score of **4.7 out of 5.0** to the statement, “Provider attitudes towards clients have improved as a result of the stigma reduction trainings.” This score was the highest of all statements. Respondents generously praised the effectiveness of stigma reduction trainings. Respondents viewed the training as a way to get staff to be more open and enthusiastic about managing the disease. Additionally, respondents noted that the stigma trainings educated staff on how to interact with patients. A

health care worker respondent commented, *“The health workers at the ward now accept HIV clients, and it makes our work easier”*.

Respondents gave a combined average score of **4.6 out of 5.0** to the statement *“Your participation in the development of COPE actions plans increased your involvement in addressing HIV needs of clients in your facility”*. Several respondents admired the level of responsibility and power that was given to staff to solve everyday basic problems. One respondent commented, *“People [staff] don't like being pushed. The [COPE] action plan gives joy!”* Other respondents appreciated that they were assigned duties and tasks, and that the action plan had a strong follow-up aspect. Another respondent stated, *“I was part of it and so I made sure it was accomplished.”*

Respondents gave a combined average score of **4.6 out of 5.0** to the statement *“COPE is a useful tool in identifying client and provider needs.”* Respondents were generally impressed at suggestions made by their peers. The COPE exercise allowed them to express their needs, although many staff did not get a chance to participate. Health workers most appreciated the experience to assess their clients' needs.

Respondents gave a combined average score of **3.6 out of 5.0** to the statement, *“Community participation in the HIV activities at the facility level improved with the introduction of the QHP supported facility-community meetings.”* This statement caused the most reticence from respondents. The facility/community meetings posed a challenge because they were not regular. Although of the meetings that did occur, respondents spoke highly of its benefits. Some mentioned that the facility/community meetings helped with the flow of referrals while others admired the collaborative atmosphere of government, civil society and PLHIV associations.

Respondents gave a combined average score of **4.2 out of 5.0** to the statement *“The HIP program activities have contributed to an increase in client access to HIV care in your facility.”* The majority of respondents felt that increased client access was more linked to the outreach efforts of other stakeholders and from those of the respective facility rather than HIP per se. In the instance of HIV patients returning to facilities as a result of good treatment, health care workers were convinced that the QHP-led trainings contributed to an improved quality of service. A respondent stated, *“People are accessing care more now because of the – “Get to Know your Status Campaign”*. Yet another respondent noted *“The stigma reduction training helped us to let clients know that they can feel comfortable and welcome to come”*. Although these may be varying perspectives as to why client service uptake has increased, respondents generally confirmed that QHP-led HIP activities were a contributing factor.

Respondents additionally highlighted major changes since the introduction HIP activities. The most frequently mentioned improvement was related to client-provider relationships. Health care workers genuinely felt that clients were more satisfied, happy, and comfortable with the level of care received at facilities. Provider to provider relations also improved as a result of HIP activities because non-HIV providers are now more willing to take HIV patients in their wards. Also, respondents observed that fear and ignorance had reduced significantly because providers were better educated about the facts of HIV transmission. Staff additionally felt the impact of infection prevention trainings because providers would seek treatment and react more calmly to emergencies. Overall, health care workers strongly believed that those who have participated in any HIP activity were sensitized and well-informed to HIV/AIDS.

Respondents shared the following comments where the HIP program could have done differently:

- Several respondents complained that the COPE training did not select a representative number of staff from all departments and from all levels. Some suggested it would have been better to have equal representation of units and departments and include more people in COPE Trainings.
- It was suggested that every 3 to 6 months, there should be some training in the following categories (FP, PMTCT, CT)

- Some respondents claimed that QHP was too concentrated on the clinical staff. It was suggested that the training be more focused more on non clinical staff (e.g., orderlies, security, etc...)⁵
- HIP should be able to help the HIV Unit better trace those who are lost to defaulters
- Initially, QHP did not consult NACP to get HIV service data and so QHP should get permission for that access.⁶
- Respondents also requested training on CD4 count and follow-up
- Respondents also made notice of community/home-based care and how some form of motivation for TOTs was needed to address its issues with workload and its logistical inadequacies
- A strong majority of respondents felt that MH Volunteers were being forgotten and that they should get to add their voices; Respondents felt that more advocacy is needed to advance the agenda of MH Volunteers as workers in the HIV Unit.

Respondents went on to make the following comments and suggestions for improvement of HIP or HIV services:

- Respondents indicated that there is a need for more regular facility-community meetings to better address referral issues, facility issues, and client concerns. The community facility meetings need to increase in frequency. The meetings are helpful because PLHIVS get more knowledge and access to resources. It also relieves the providers from having to go home-to-home.
- MH Volunteers should be eligible for employment as they show passion and dedication to the job. Health care workers felt strongly that the Models of Hope had been long promised support, but have never been given a token for running the clinic.
- Respondents felt that lower level staff should be more involved in HIP activities and have increased opportunities for training. There is a need to sensitize more health workers from all categories.
- By the opinion of selected health care workers, QHP came in for regular supervision and has done well, but their relationship with NACP is still not clear. It appears as if several agencies came to facilities to carry out different activities but the coordination points are not clear.

4.4 Perspectives of Data Managers

Data Managers were asked to recapture service statistics on HIV indicators from as far back as January 2006 up to July 2009. The Data provided are further analysed within Section 6.0.

Data Managers were additionally asked to respond to the three interview questions below:

- 1 Have you noticed any major trends in the data?
- 2 Has anything in particular influenced the data?
- 3 If there are discrepancies, what do you think may have caused it?

Their collective responses were as follows:

With the exclusion of one data manager, all data managers perceived an increase in the number of new infections at their facilities. Some respondents stated, *“The number of positive cases keeps increasing. Since 2006, the number of people assessing care keeps jumping each year.”* Another respondent added *“[There are] increasing numbers of people coming [into the clinic] with HIV because of a lack of education”* Yet another respondent stated, *“the figure keeps increasing”*. *“..More people are being put on drugs. This is happening because they come late. They seek herbal treatments and they come in with terminal infections, and rather report late.”* Another respondent commented, *“The number of infections is increasing. The stigma reduction campaign makes people feel easier about coming out to seek services.”*

⁵ These responses may be due to the fact that clinical and non-clinical staff was separated for selected trainings. Therefore, it may be from the perspective of either group that the other group was not represented. When in reality, both clinical and non-clinical staff were trained but in different groups.

⁶ In the initial stages of HIP implantation, issues with access to NACP data were resolved.

These and other comments reflect the general sentiment felt by data managers that HIV infections are on the rise. In terms of what may be influencing the data, data managers held many opinions with varying reasons and justifications. The majority of data managers felt, however, that the infections were not new but rather old infections now presenting themselves. The main reason data managers provided for the infections now presenting themselves was the “Get to Know Your Status” campaign led by NACP, SHARP and other implementing partners at the community level. Data managers strongly believed that this campaign influenced a greater number of people to get tested, thus increasing the number of newly discovered case from increased CT volume. Other data managers believed that people are getting more and more aware of care and support services due to facility-specific outreach efforts. Although most data managers agreed with the link between “Know Your Status” campaign outreach activities and increased CT service uptake, data managers did not necessarily agree with the link between QHP-led provider trainings and increased CT service uptake.

Lastly, the majority of data managers felt confident about the quality of their HIV data in terms of accuracy, completeness and validity. However, they did make reference to the tedious nature of reporting to NACP and additionally to QHP. Data managers additionally noted that any data discrepancies may be due to transcription errors on the part of QHP and/or late reporting on the part of the facility.

4.5 Perspectives of Models of Hope Volunteers

Since not all sites had MH Volunteers ready and available to be interviewed, the assessment team was able to conduct interviews at only seven (7) out of ten (10) sites reached. Interviews with the MH Volunteers were extremely insightful as they provided dual perspectives as both service providers and clients. The unique dual status of MH Volunteers makes them ideal respondents as both perspectives contribute to a holistic understanding of service quality.

MH Volunteers were first asked the length of time they were involved in association meetings as well as facility-community meetings. Of those interviewed, the average length of time of involvement with associations was 14 months on a month-to-month basis. Their involvement with facility-community meetings, however, was less frequent than planned because meetings occurred once or twice a year. When asked about the major differences between facility-community meetings and association meetings, MH volunteers were clear to express their preferences and comfort levels for PLHIV association meetings over facility-community meetings. They enjoyed the once-a-month experience of being amongst themselves to talk openly and freely in the association meetings. MH Volunteers did, however, stress the importance of facility-community meetings as an uncommon opportunity to express concerns to facilities and learn about non-clinical services available to them. The overall feedback on community/facility meetings was that they occurred too infrequently but were helpful in raising issues and raising awareness of HIV services.

MH Volunteers did not, however, get as much of a chance to share their frustrations and coping mechanisms at the facility-community meetings as they would have liked. Furthermore, MH Volunteers suggested sending representatives to facility-community meetings as many did not feel confident to talk and express themselves in plenary.

It should be noted that during the MH Volunteers interviews, PLHIV association meetings took higher precedence than that of facility community meetings. Despite efforts to keep the interview focused on facility-community meetings, MH volunteers focused on the PLHIV association meetings as more critical and central to their psycho-social well being. When asked to rate the usefulness of association meetings, seven out of seven individuals gave a score of **5.0 out of 5.0**, ranking the association meetings as the most useful meeting for their daily lives. Given these responses, it may prove helpful to channel messages through MH Volunteers and their respective PLHIV associations.

5.0 FINDINGS FROM HIV SERVICE UTILIZATION DATA

Service utilization data was collected across facilities to analyze trends in client access to HIV care to determine increases, decreases, and begin to explore and link reasons why facilities vary in client access. Clients require ongoing support from facilities to successfully adhere to ARTs and lifestyle regimens. The quality of HIV facilities and services plays a large role in attracting and maintaining client populations at each facility. The provision of quality services further reinforces the facility as a desirable point of service, while encouraging more patients to seek VCT and other services such as Family Planning and Tuberculosis.

All facilities within this assessment (10 out of 10) saw clear and suggestive increases in the number of new clients accessing HIV from 2006 to 2009. The resulting exponential growth in the number of new clients receiving HIV client care, however, could be a result of several factors.

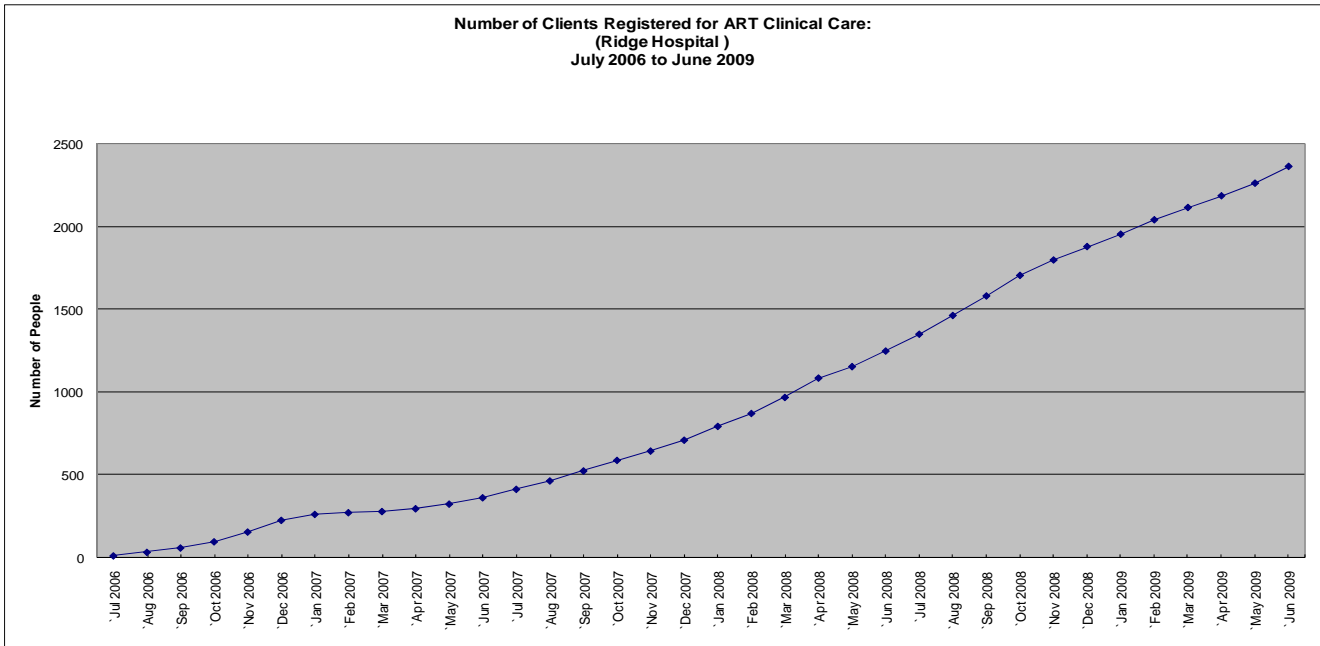
Graphs showing service uptake by each facility are illustrated below. Graph figures show cumulative numbers for clients registered for HIV Care. Data across facilities revealed that it remains inconclusive as to whether improvements in service quality directly affected the number of new clients receiving HIV care. As reported from in-depth interviews however, improvements in service quality may have contributed to increased numbers of clients accessing care and returning for care.

There were some challenges in establishing a link between increased service utilization and HIP activities due to the multitude of HIV activities occurring at the time of HIP activity roll-out. Increases in client service uptake could be attributed to a number of activities (i.e. NACP campaigns, donor agency HIV/AIDS activities, VCT outreach services, mobile VCT programs, etc.) Responses from in-depth interviews and literature review data indicate that elements of the “Get to Know Your Status” and “Who are you to Judge” campaigns were also ongoing at the same time as HIP. These campaigns aimed to drive MARPs to seek CT services, thereby possibly affecting the number of new clients to receive HIV care. Additionally, NACP and SHARP carried out HIV activities such as the “Text Me Flash Me” counseling hotline that specifically referred and encouraged MSMs and FSWs to seek CT services. Also, facility level staff confirmed that facilities conducted their own outreach activities, encouraging the community at large to seek CT services. These facility-level outreach activities also helped to increase CT numbers. In conclusion, there are a number of contributing and confounding factors to increased CT service uptake.

RIDGE HOSPITAL

Comments:

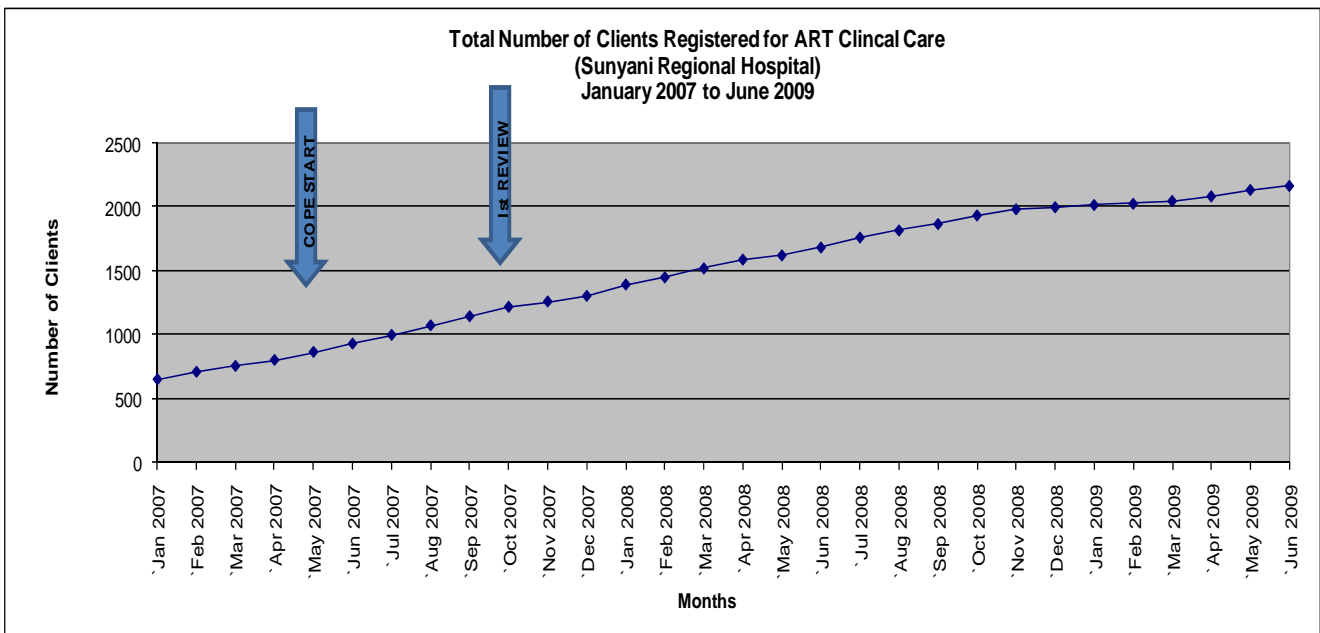
Data from the number of clients receiving HIV clinical care are illustrated from July 2006 to June 2009, taking into consideration the start dates of COPE and the 1st Review. Client service uptake stayed at relatively low levels from October 2006 to May 2007. However, Ridge Hospital saw the most dramatic increase overall from 11 clients in July 2006 to 2,363 in June 2009.



SUNYANI REGIONAL HOSPITAL

Comments:

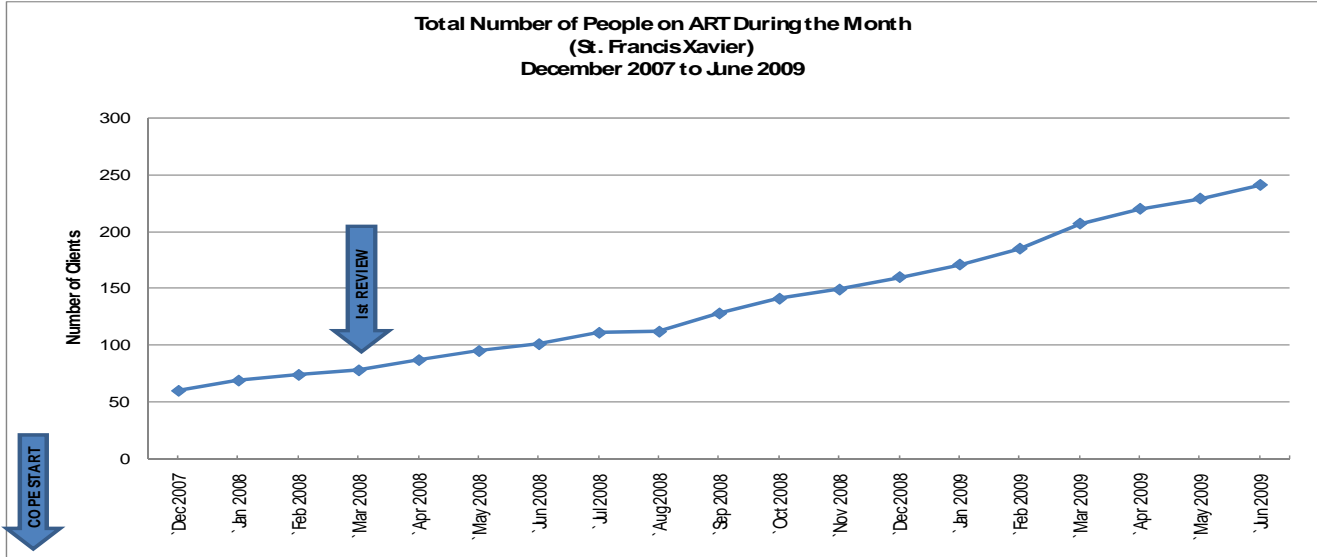
Data from the number of clients receiving HIV clinical care are illustrated from July 2007 to March 2009, taking into consideration the start dates of COPE and the 1st Review. Client service uptake essentially tripled from 651 in January 2007 to 2167 in June 2009.



ST. FRANCIS XAVIER HOSPITAL

Comments:

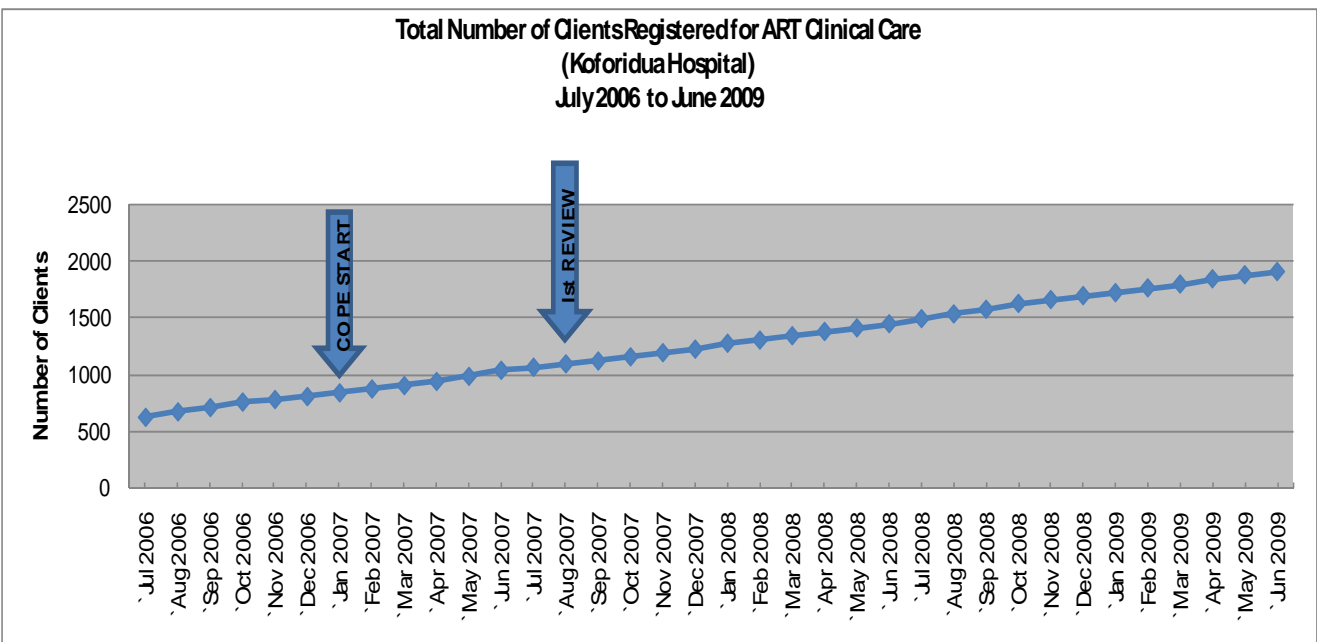
Data from the number of clients receiving HIV clinical care are illustrated from December 2007 to June 2009, taking into consideration the start dates of COPE and the 1st Review. Client service uptake saw a steady and progressive increase from December 2007 to June 2009, where the number of clients quadrupled from approximately 60 to 241 clients.



KOFORIDUA REGIONAL HOSPITAL

Comments:

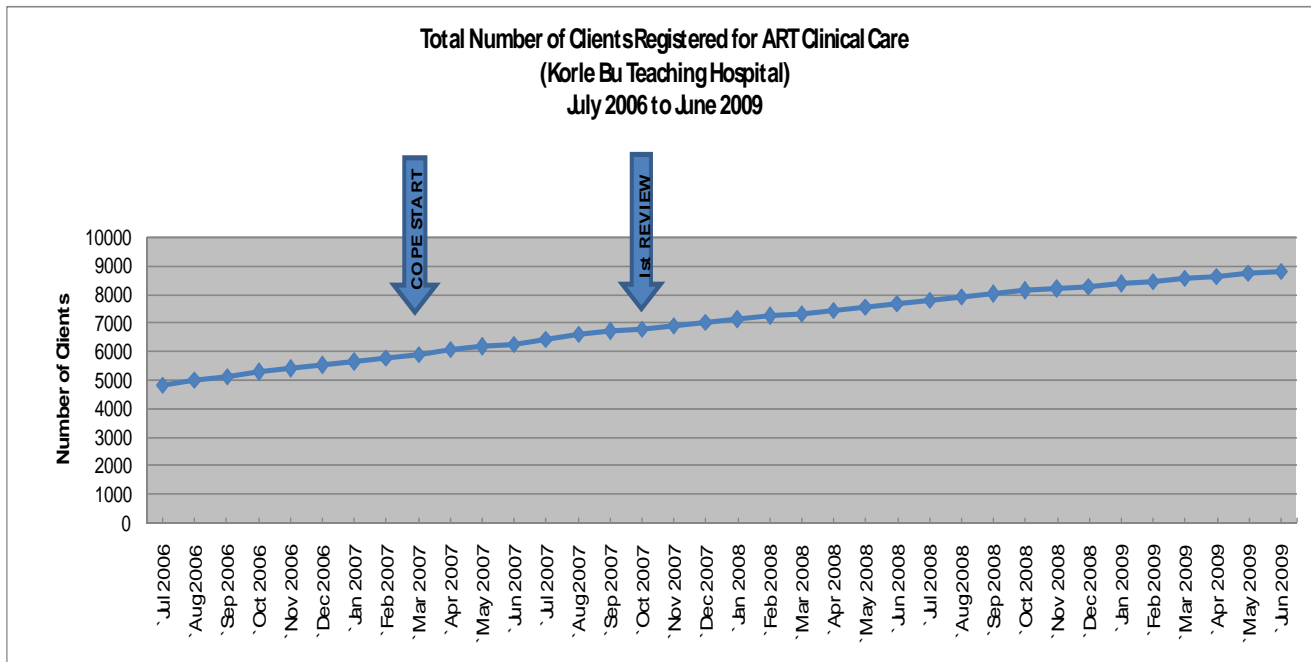
Data from the number of clients receiving HIV clinical care are illustrated from July 2006 to June 2009, taking into consideration the start dates of COPE and the first review. Client service uptake saw a steady and progressive increase from July 2006 to June 2009, from 620 clients to 1,905 clients. The COPE start dates and 1st Review dates, in this case, occurred along a pattern that was already increasing from August 2006.



KORLE-BU TEACHING HOSPITAL

Comments:

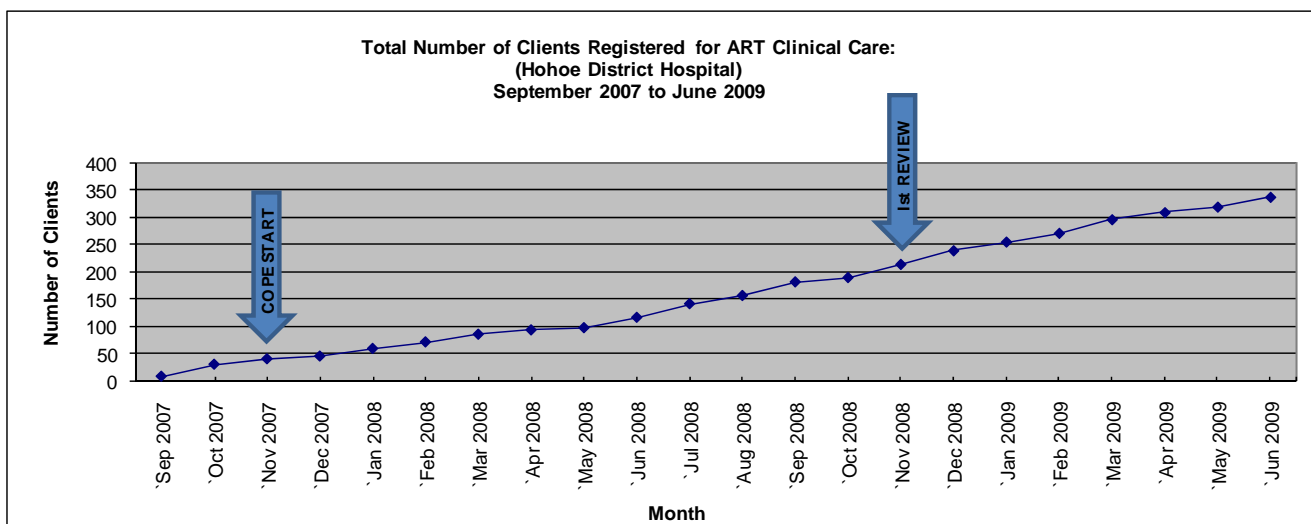
Data from the number of clients receiving HIV clinical care are illustrated from July 2006 to March 2009, taking into consideration the start dates of COPE and the 1st Review of COPE. From July 2006 to June 2009, the total number of clients grew from 4,836 clients to 8,802 clients. The COPE start dates and 1st Review dates, in this case, occurred along a pattern that was already increasing from August 2006.



HOHOE DISTRICT HOSPITAL

Comments:

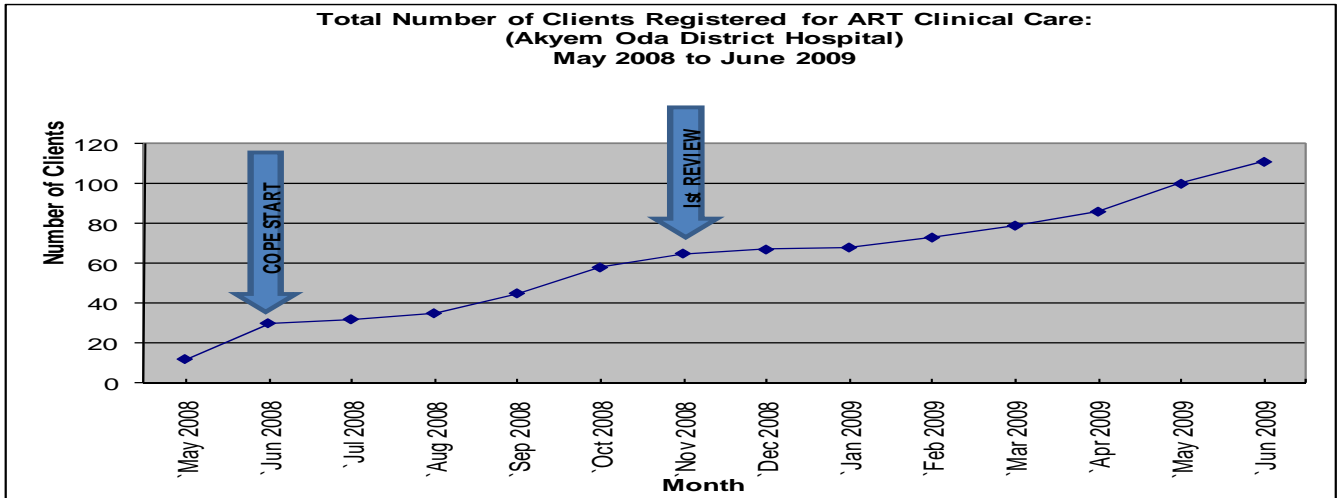
Data from the number of clients receiving HIV clinical care are illustrated from September 2007 to June 2009, taking into consideration the start dates of COPE and the 1st Review of COPE. Client service uptake saw a steady increase from September 2007 to June 2009 from 9 clients to 337 clients respectively.



AKYEM ODA DISTRICT HOSPITAL

Comments:

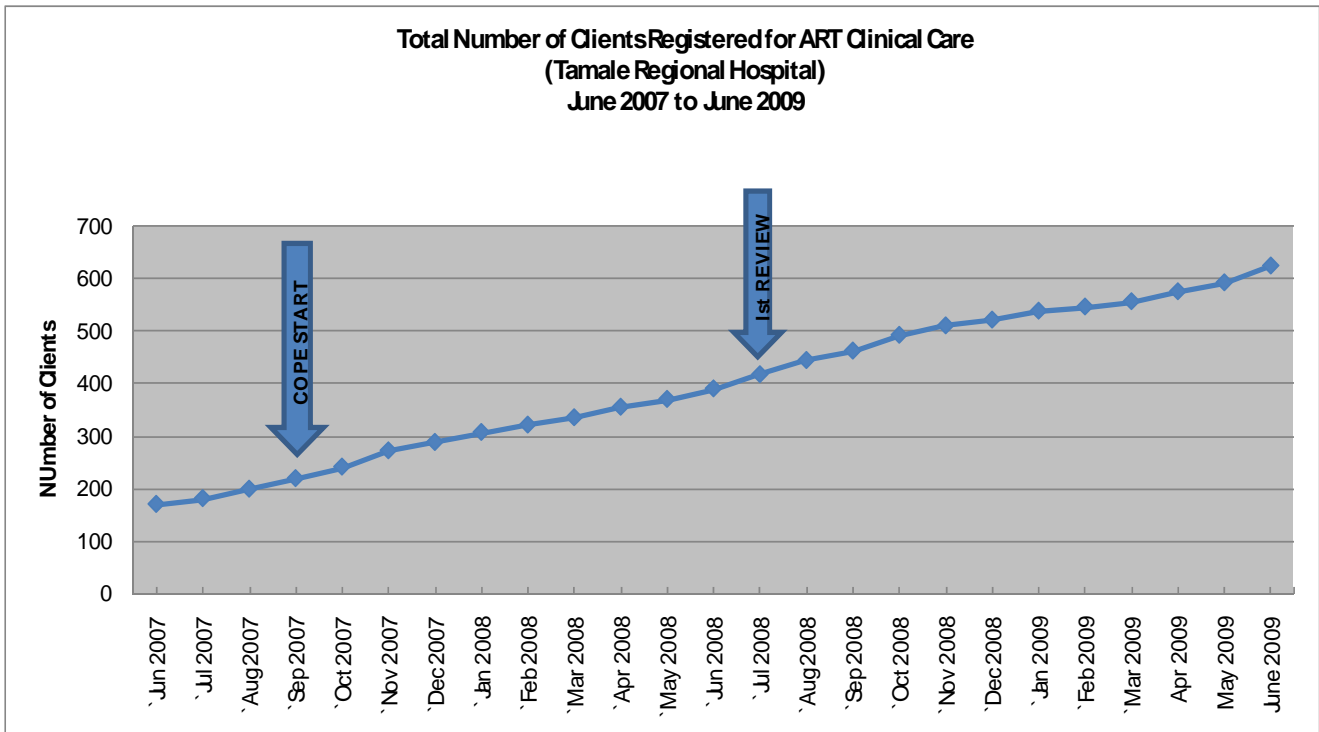
Data from the number of clients receiving HIV clinical care are illustrated from June 2008 to March 2009, taking into consideration the start dates of COPE and the 1st Review of COPE. Client service uptake saw a tremendous growth in the number of new clients across from 12 in May 2008 to 111 in June 2009.



TAMALE REGIONAL HOSPITAL

Comments:

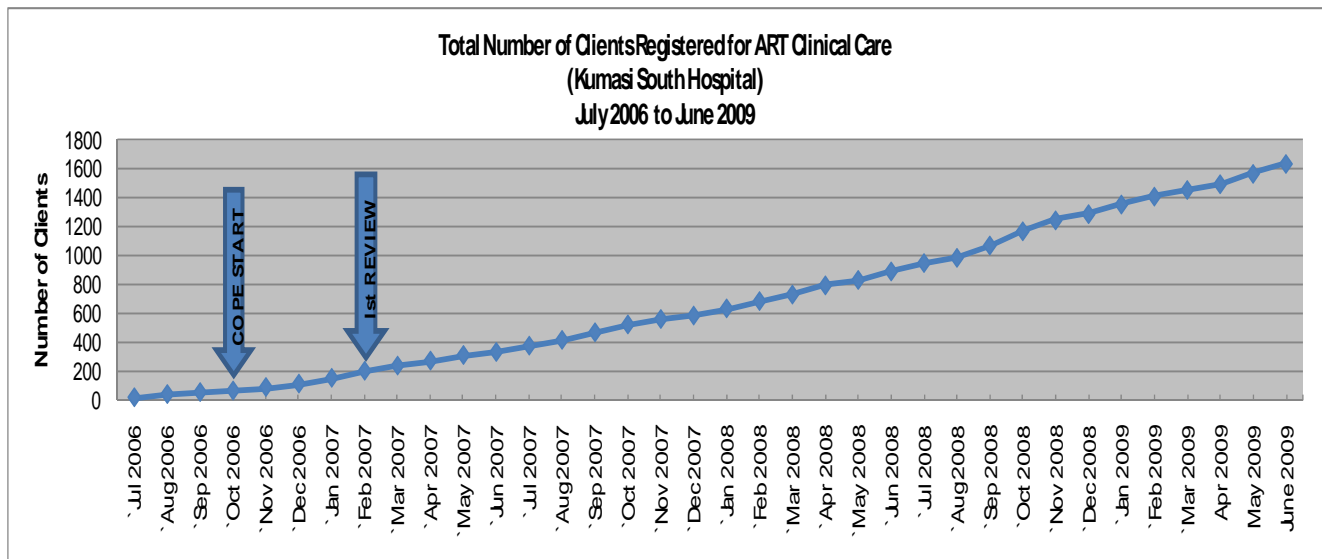
Data from the number of clients receiving HIV clinical care are illustrated from June 2007 to March 2009, taking into consideration the start dates of COPE and the 1st Review of COPE. Client service uptake saw a three-fold increase in the number of new clients from 169 clients to 623 clients.



KUMASI SOUTH REGIONAL HOSPITAL

Comments:

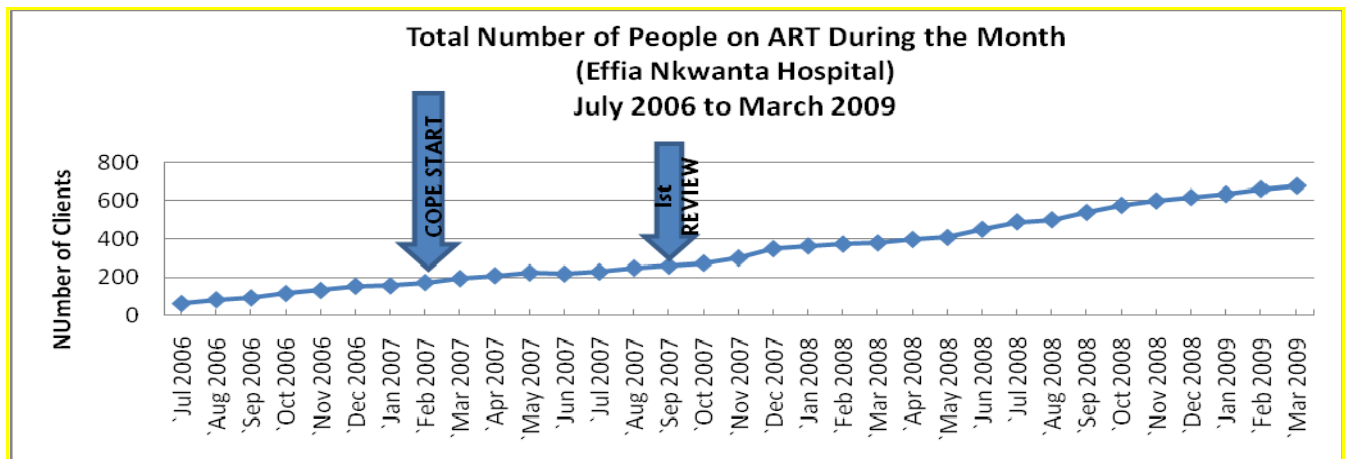
Data from the number of clients receiving HIV clinical care are illustrated from July 2006 to June 2009, taking into consideration the start dates of COPE and the 1st Review of COPE. The total number of clients underwent considerable growth from 12 clients in July 2006 to 1,694 clients in June 2009.



EFFIA NKWANTA REGIONAL HOSPITAL

Comments:

Data from the number of clients receiving HIV clinical care are illustrated from July 2006 to October 2008, taking into consideration the start dates of COPE and the 1st Review of COPE. Client service uptake saw a steady and progressive across the time period. The total number of clients grew from 219 clients to 1,154 clients. Improvements in service quality may have been contributing factors to increases in the number of clients across the time period.



6.0 CONCLUSION & RECOMMENDATIONS

Overall, HIP activities were lauded as successful, useful, sustainable, and effective.

To review, the evaluation sought to assess the overall impact of HIP using the following objectives:

1. the effect of the HIP programme on services in HIP facilities
2. the level of service utilisation in the HIV units of the selected facilities
3. perceptions of key stakeholders about the effect of the HIP activities on their HIV programme
4. the effectiveness of the HIP programme as an HIV intervention strategy

Interview data from fifty-one (51) respondents conclude that the HIP activities have left a positive impression on facility level staff. Responses from in-depth interviews also reveal strong levels of satisfaction with most components of the HIP Package. From interviews, COPE trainees admired the level of responsibility and power that was given to staff to solve everyday basic problems within facilities. Respondents generously praised the effectiveness of stigma reduction trainings. Although successful at a number of facilities, Family Planning and Tuberculosis management may need additional attention and intervention within the continuum of HIV care services. Additionally, facilities may need a more systematic way of knowing and sharing current HIV/AIDS services because facility-community meetings are too infrequent.

Key stakeholders were highly supportive of QHP activities and found their relationships to be successful, synergistic and complementary. SHARP viewed itself as having the MARP focus whereas QHP was perceived to have more focus on the general population. And this collaborative effort proved successful by the opinion of the QHP-led HIP team and SHARP team.

From the perspective of the NACP, service quality improvements for both the client and provider were a compulsory part of the Ghana's national HIV/AIDS strategy. HIP activities, particularly COPE action-planning and stigma reduction, help facilities to identify and resolve problems using self-initiated ideas and available resources from supporting agencies. More importantly, facilities and communities are able to play an active role in addressing facility-specific issues and concerns. Overall, the NACP is satisfied with the ongoing HIP activities across facilities.

From various sources interviewed, QHP was well-regarded amongst service providers and enthusiastically encouraged to continue service provider training as frequently as possible, particularly its components of Stigma Reduction Training, Infection Prevention Training, COPE exercises, and COPE Action-Planning. A strong majority of providers has seen immediate changes in client-provider relationships where clients are visibly more happy, comforted and satisfied. Providers additionally valued increased capacity building in the areas of Infection Prevention, Family Planning, and Tuberculosis management.

All facilities within this assessment (10 out of 10) saw clear and suggestive increases in the number of new clients accessing HIV from 2006 to 2009. Overall, the selected facilities saw unanimous growth in the number of new clients receiving HIV client care from 2006 to 2009. And the graphs in Section 5.0 Findings from HIV Service Utilization Data show that increasing trends happened spontaneously and did not seem to have been influenced by HIP introductions or roll outs.

Gaps Identified

1. Due to the number of activities contributing to increased client service uptake and CT service uptake trends that do not show influence by HIP introductions, it is inconclusive as to whether QHP-led HIP activities contributed to increased client service uptake. Staff at the facility level, however, does confirm that HIP activities affected client service uptake as an influencing factor for clients to come to facilities and return to facilities.

For future assessments, more clear and direct causal linkages between HIP activities and successful outcomes may rather be (a) client satisfaction surveys from those directly emerging from facilities; (b) ratings of providers at specific facilities through randomized PLHIV surveys; or (c) Analysis of defaulters and losses to follow-up due to poor service quality. These sources may provide stronger and more direct evidence of the effectiveness of HIP activities in future assessments.

2. It was also noted, however, that there were lost opportunities to track data at the level of MARPs. Given that HIP is especially geared towards MARPs, data managers should have had early guidance on data collection tools at the MARP level. The assessment team was not able to isolate and/or analyze trends for MARPs from the general population. Therefore, the assessment team could not present information and conclusions on this significant target groups.

Recommendations

From the Perspective of Facility-in-Charges

- The financial resources and inputs for facility improvements are not always available, but facilities should be seeing to it that action plans are still being fulfilled using as many alternative methods as possible.
- Trainings should be more inclusive of staff, non-clinical staff specifically at the lower levels
- More outreach awareness is needed for the youth and the aged, who seem to be emerging as newly identified MARPs
- Due to increasing numbers of PLHIVs presenting themselves across facilities, infrastructural investments into reception areas should be a priority
- Staff have suggested performance-based incentives to boost overworked staff and encourage more interest in improved service delivery
- Few respondents stated the need to re-evaluate national health insurance regulations as to why selected HIV/AIDS costs may not be covered

From the Perspective of HIV Unit Heads /HIV Coordinators

- QHP should continue sensitizing new staff with trainings and orientation or developing guidelines for trainers to conduct trainings for new staff because more regular QHP-led trainings are needed to sensitize more staff
- The scope of provider training was small and the duration too short, therefore more efforts should be taken to lengthen QHP-led trainings in scope, duration, and intervals.
- As QHP-led trainings were a subset of trainings to additional GHS trainings, it was recommended that GHS standards for quality be integrated into QHP trainings so that there is coordination in terminology, process, and approach
- Select respondents indicated that a fresh perspective may be needed to gain more acceptance of the TB screening tool
- QHP should provide some financial support for MH Volunteers; although once money starts being distributed, it is difficult to avoid abuse. Nonetheless, the fear of abuse should not be an excuse for ignoring the voluntary contributions of MH Volunteers.
- Clients may need additional support for transport in order to make appointments and seek needed care
- Prayer camps cause problems where HIV patients do not come for care until the late stages; a specialized form of sensitization is needed to teach people on how to avoid exacerbating health conditions through prayer camps.

- Several respondents complained that the COPE training did not select a representative number of staff from all departments and from all levels. Some suggested it would have been better to have equal representation of units and departments and include more people in COPE Trainings.
- It was suggested that every 3 to 6 months, there should be some training in the following categories (FP, PMTCT, CT)
- Some respondents claimed that QHP was too concentrated on the clinical staff. It was suggested that the training be more focused more on non clinical staff (e.g., orderlies, security, etc...) ⁷
- HIP should be able to help the HIV Unit better trace those who are lost to defaulters
- Initially, QHP did not consult NACP to get HIV service data and so QHP should get permission for that access. ⁸
- Respondents also requested training on CD4 count and follow-up
- Respondents also made notice of community/home-based care and how some form of motivation for TOTs was needed to address its issues with workload and its logistical inadequacies
- A strong majority of respondents felt that MH Volunteers were being forgotten and that they should get to add their voices; Respondents felt that more advocacy is needed to advance the agenda of MH Volunteers as workers in the HIV Unit.

Respondents went on to make the following comments and suggestions for improvement of HIP or HIV services:

- Respondents indicated that there is a need for more regular facility-community meetings to better address referral issues, facility issues, and client concerns. The community facility meetings need to increase in frequency. The meetings are helpful because PLHIVS get more knowledge and access to resources. It also relieves the providers from having to go home-to-home.
- MH Volunteers should be eligible for employment as they show passion and dedication to the job. Health care workers felt strongly that the Models of Hope had been long promised support, but have never been given a token for running the clinic.
- Respondents felt that lower level staff should be more involved in HIP activities and have increased opportunities for training. There is a need to sensitize more health workers from all categories.
- By the opinion of selected health care workers, QHP came in for regular supervision and has done well, but their relationship with NACP is still not clear. It appears as if several agencies came to facilities to carry out different activities but the coordination points are not clear.

HIP activities as an intervention complement national programmes in CT including VCT, ART, and BCC currently carried out by NACP and other stakeholders. As an intervention, HIP activities sought to address on-the-ground factors such as stigma, service provider work overload, inadequate linkages and referral mechanisms, insufficient HIV interventions targeting PLHIVs and MARPs, and compromised confidentiality systems. Data from this assessment support that HIP activities have empowered sites to institutionalize a fair level of service quality improvements. To continue on with these positive accomplishments, however, the QHP-HIP Team may need to reassess its technical updates and follow-up mechanisms to provide and even stronger level of support. In this way, facilities will be encouraged to reinforce 'best' practices and apply technical updates on emerging strategies in HIV/AIDS prevention, treatment, care and support. Overall, government stakeholders, hospital facility staff and development partners found HIP activities to be valuable and effective in improving the quality of services in HIV/AIDS prevention, treatment, care and support.

⁷ These responses may be due to the fact that clinical and non-clinical staff was separated for selected trainings. Therefore, it may be from the perspective of either group that the other group was not represented. When in reality, both clinical and non-clinical staff were trained but in different groups.

⁸ In the initial stages of HIP implantation, issues with access to NACP data were resolved.

APPENDIX 1

INTERVIEW LIST

| | LOCATION | DATE | INTERVIEW TYPE | NAME | EMAIL |
|----|-------------|--------|---------------------|----------------------|--|
| 1 | KORLE-BU | Aug-09 | Data Manager | Perfect Dzandu | |
| 2 | KORLE-BU | Aug-09 | MH volunteer | Anonymous | |
| 3 | RIDGE | Aug-09 | HIV Worker | Mercy Acqua-Hayford | |
| 4 | RIDGE | Aug-09 | HIV Coordinator | Mercy Acqua-Hayford | |
| 5 | RIDGE | Aug-09 | MH volunteer | Anonymous | |
| 6 | HOHOE | Jun-09 | HIV Coordinator | Kwami Doe | |
| 7 | HOHOE | Jun-09 | HIV worker | Emma Amuzu | |
| 8 | HOHOE | Jun-09 | Facility in charge | Dr Edwin Danoo | |
| 9 | HOHOE | Jun-09 | Data Manager | Felix Mensah | |
| 10 | HOHOE | Jun-09 | MH Volunteer | Anonymous | |
| 11 | ST. FRANCIS | Jun-09 | Nurse Manager | Joyce Dam | Joycedam69@yahoo.com |
| 12 | ST. FRANCIS | Jun-09 | Sister in Charge | Josephina Hernandez | stfrancishsc@yahoo.com |
| 13 | ST. FRANCIS | Jun-09 | HIV Coordinator | Dr. John Ekow Otoo | johnotoo@yahoo.com |
| 14 | ST. FRANCIS | Jun-09 | Data Officer | Richard Acquah | faithfuldream-gh@yahoo.com |
| 15 | ST. FRANCIS | Jun-09 | MH Volunteer | Anonymous | |
| 16 | AKYEM ODA | Jul-09 | Midwifery Officer | Suzy Ofori | |
| 17 | AKYEM ODA | Jul-09 | Nursing Officer | Amaning Darko | |
| 18 | AKYEM ODA | Jul-09 | Municipal Director | Dr. Qaw Otichere | micheal-otchere@yahoo.com |
| 19 | AKYEM ODA | Jul-09 | Facility in Charge | Dr. Bonsu | |
| 20 | AKYEM ODA | Jul-09 | HIV Coordinator | Essie Baiden | |
| 21 | AKYEM ODA | Jul-09 | Pharma Technologist | George Osae Anseh | georgeansah86@yahoo.com |
| 22 | AKYEM ODA | Jul-09 | MH Volunteer | Anonymous | |
| 23 | TAKORADI | Jun-09 | DDNS | Mary Mildred Hayford | |
| 24 | TAKORADI | Jun-09 | Health Care Worker | Effie Josiah | |
| 25 | TAKORADI | Jun-09 | HIV Coordinator | Dr. Roland Sowa | |
| 26 | TAKORADI | Jun-09 | Data Entry Officer | Gifty Ann Cdeman | giftyann2002@yahoo.com.co.uk |
| 27 | TAKORADI | Jun-09 | Stigma reduction | George Alhassan | |
| 28 | TAKORADI | Jun-09 | MH Volunteer | Anonymous | |
| 29 | TAKORADI | Jun-09 | MH Volunteer | Anonymous | |

| | | | | | |
|----|-----------|--------|-----------------------|-----------------------------------|--|
| 30 | KOFORIDUA | Jun-09 | HIV Worker | Mary Obare | |
| 31 | KOFORIDUA | Jun-09 | Data Manager | Richard Ansong | |
| 32 | KOFORIDUA | Jun-09 | Facility in Charge | Dr. Obeng Apori | reghspkof@yahoo.com |
| 33 | KOFORIDUA | Jun-09 | Senior Nurse Officer | Mary Asare | |
| 34 | KOFORIDUA | Jun-09 | Data Manager | Richard Ansong | m-ansong@yahoo.com |
| 35 | KOFORIDUA | Jun-09 | MH Volunteer | Anonymous | - |
| 36 | KUMASI | Jul-09 | HIV Worker | Akosua A. Bandoh | kwagem@yahoo.com |
| 37 | KUMASI | Jul-09 | Facility in Charge | Mary Mensah-Ghana | |
| 38 | KUMASI | Jul-09 | Data Manager | Victoria Boachie | boachie@yahoo.co.uk |
| 39 | KUMASI | Jul-09 | HIV Coordinator | Dr. Alberta Nyarko | |
| 40 | SUNYANI | Jul-09 | HIV worker | Cordelia Yeboah | gdufie@yahoo.com |
| 41 | SUNYANI | Jul-09 | Facility in Charge | Daniel Asare | danielasare@yahoo.com |
| 42 | SUNYANI | Jul-09 | HIV Coordinator | Grace Yeboah-Asuama | |
| 43 | SUNYANI | Jul-09 | Data manager | Danso K. Sydney Rosemary Afrakoma | sydneymcvan@yahoo.com |
| 44 | SUNYANI | Jul-09 | MH Volunteer | Anonymous | |
| 45 | TAMALE | Jul-09 | HIV worker | Christiana Alekuu | |
| 46 | TAMALE | Jul-09 | Principal Pharmacist | Emmanuel Kuikey | kuekue@yahoo.com |
| 47 | TAMALE | Jul-09 | DDNS | Elizabeth Damsel | - |
| 48 | TAMALE | Jul-09 | Data Manager | Paul Yik Potey | yikpoto@yahoo.com |
| 49 | SHARP | Aug-09 | Acting Chief of Party | Lucy Shillingi | lshillingi@aed.ghana.org |
| 50 | SHARP | Aug-09 | HIV Technical Expert | Nana Ofosua Clemente | |
| 51 | NACP | Sep-09 | Director General | Dr. Nii Acquaye Addo | |

APPENDIX 2

Data Collection Forms: Interview Guide for Facility in Charge

Name:

Title/Organization:

Phone Number:

Email:

1. How do you understand and interpret the HIP program?
2. Have you participated in any HIP activities?
3. After the introduction of HIP, have you noticed any change in client/provider relationships?
4. Have you noticed any trends in HIV the data, the spread of the disease?
5. Any suggestions to improve the HIV program?

APPENDIX 3

Data Collection Forms: Interview Guide for Head of Unit /HIV Coordinator

Name:

Title/Organization:

Phone Number:

Email:

1. What do you know about the HIP Programme implemented by QHP in collaboration with the GHS?
2. In what ways have you or any of your staff been involved in the planning of the HIP programme activities in your facility?
3. How have you or your staff been involved in the implementation of the HIP programme activities?
4. What are your views on the effectiveness of the HIP programme? Has it improved the quality of HIV service provision in this facility? Which of the programme areas would you consider very useful and why?
 - COPE action plan development?
 - Stigma and reduction trainings?
 - Trainings in TB-HIV collaboration?
 - FP-ART integration, Infection Prevention efforts?
5. Would you say the HIP programme has the potential to increase client service uptake in any way? Probe for reasons
6. Would you say the HIP programme has actually helped increase client service uptake in this facility and if so in what ways?
7. What do you think could have been done differently and how?
8. What suggestions do you have for improving the programme?

APPENDIX 4

Data Collection Forms: Interview Guide for Health Care Workers in HIV Unit

Name:
Title/Organization:
Phone Number:
Email:

I am representing the Ghana Health Service and the Quality Health Partners (QHP) to collect information to assess the impact of the HIV Programme supported by QHP. This information will be used to assess the performance of the programme and to redesign programs to improve services in future. You can refuse to answer any question. Your participation or non participation will not affect your ability to participate in training or receive equipment from the Quality Health Partners project. There are two sections to this instrument- The first is an interview and the second, review/collection of service statistics. The interview will not take more than 30 minutes. The whole process should not take more than 2 hours. We are asking for your help to ensure that the information collected is accurate.

Do you have any questions for me?

If you have any questions after this interview – you can contact Mr. Richard Killian – Chief of Party of the Quality Health Partners Project or Angela Bannerman – the Monitoring and Evaluation Manager at this number (021 778558).

Can we begin now?

 SIGNATURE OF HEALTH WORKER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT

| | |
|--|--|
| Name of Region: _____ Name of the Hospital _____ Telephone Number of Contact: _____ Date: _____ | REGION CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> |
|--|--|

| | | | |
|---|--|----------------------------|--|
| 1 | Record worker's gender | Male.....1 Female.....2 | |
| 2 | How long have you been working in the HIV Unit? | ____Years ____Months | |
| 3 | Have you participated in any HIV training in the last three years? | No -----0 Yes-----1 | |
| 4 | Have you been involved in any way in the HIP! Activities supported by the Quality Health partners? | No -----0 Yes-----1 | |

| | | | |
|---|--|---|---|
| 5 | Which of the following activities have you been involved in? (Read responses and circle all that apply) | Training in COPE | 1 |
| | | COPE Exercise | 2 |
| | | COPE Action Plan Development | 3 |
| | | Stigma Reduction Training..... | 4 |
| | | Community and Facility Referral meetings..... | 5 |
| | | Other-..... | 6 |
| | | (Specify) | |

Circle the number that most closely corresponds with your opinion (0 is the lowest and 5 is the highest) please also provide reasons for your response

| | Statement | RATING | 0 – lowest | 5 -highest | Reasons for response | | | | |
|----|---|--------|------------|------------|----------------------|---|---|---|--|
| 6 | a) Provider attitudes towards clients have improved as a result of the stigma reduction trainings? | 0 | 1 | 2 | 3 | 4 | 5 | | |
| 7 | b) Your participation in the development of COPE actions plans has increased your involvement in addressing HIV needs of clients in you facility? | 0 | 1 | 2 | 3 | 4 | 5 | | |
| 8 | c) COPE is a useful tool in identifying client and provider needs | 0 | 1 | 2 | 3 | 4 | 5 | | |
| 9 | d) Community participation in the HIV activities at the facility level has improved with the introduction of the QHP supported facility-community meetings. | 0 | 1 | 2 | 3 | 4 | 5 | | |
| 10 | e) The HIP programme activities have contributed to an increase in client access to HIV care in your facility? | | 0 | 1 | 2 | 3 | 4 | 5 | |

11) In your opinion, have there been any major changes since the introduction of the HIP program?

12) In your opinion, can you cite examples of where the HIP Program could have done things differently?

13) What suggestions do you have for improving the programme?

APPENDIX 5

Data Collection Forms: Interview Guide for Data Manager

Name:

Title/Organization:

Phone Number:

Email:

1. Have you noticed any major trends in the data?
2. Has anything in particular influenced the data?
3. If there are discrepancies, what do you think may have caused it?

Table for capturing Service Statistics on HIV indicators

| | Number of new clients receiving HIV clinical care | Total number of clients receiving HIV clinical care | Number of new clients receiving HIV clinical care | Total number of clients receiving HIV clinical care | Number of new clients receiving HIV clinical care | Total number of clients receiving HIV clinical care | Number of new clients receiving HIV clinical care | Total number of clients receiving HIV clinical care |
|---------|---|---|---|---|---|---|---|---|
| Jan '06 | | | Jan '07 | | Jan '08 | | Jan 09 | |
| Feb 06 | | | Feb 07 | | Feb 08 | | Feb 09 | |
| Mar 06 | | | Mar 07 | | Mar 08 | | Mar 09 | |
| Apr 06 | | | Apr 07 | | Apr 08 | | Apr 09 | |
| May 06 | | | May 07 | | May 08 | | May 09 | |
| Jun 06 | | | Jun 07 | | Jun 08 | | | |
| Jul 06 | | | Jul 07 | | Jul 08 | | | |
| Aug 06 | | | Aug 07 | | Aug 08 | | | |
| Sep 06 | | | Sep 07 | | Sep 08 | | | |
| Oct 06 | | | Oct 07 | | Oct 08 | | | |
| Nov 06 | | | Nov 07 | | Nov 08 | | | |
| Dec 06 | | | Dec 07 | | Dec 08 | | | |

Most of these data have already been collected over the period—the exercise will be to validate the data and to fill in where gaps exist. Data will cover two main indicators, which are:

- Number of new clients receiving HIV clients care and
- Total number of clients receiving HIV clients care

APPENDIX 6

Data Collection Forms: Interview Guide for Stakeholders- NACP

This section to be answered by the In-Charge of NACP or his Representative

As you are aware, the Quality Health partners and the SHARP programme have been collaborating with the NACP in the implementation of the High Impact Package (HIP) programme. We would like to know:

1) Your perceptions of the level of collaboration NACP has had with QHP in the implementation of the HIP programme?

2) How would you rate the overall success of the HIP Programme?

0 1 2 3 4 5

3) In what ways have you or any of your staff been involved in the planning of the HIP programme activities?

4) How have you or your staff been involved in the implementation of the HIP programme activities?

5) In what other ways has NACP collaborated with the Quality Health Partners and the SHARP programme in the HIP programme intervention?

6) What are your views on the effectiveness of the HIP programme in improving quality of HIV service provision in the facilities?

7) How would you rate the overall effectiveness of the QHP project?

0 1 2 3 4 5

8) Would you say the HIP programme has the potential to increase client service uptake in any way? Probe for reasons?

9) What suggestions do you have for the implementation of the HIP programme?

10) What do you think should have been done differently and how?

11) Name one thing that you will most remember about the HIP Programme?

APPENDIX 7

Data Collection Forms: Interview Guide for SHARP

As you are aware, QHP and SHARP have been collaborating with the NACP in the implementation of the High Impact Package (HIP) programme. We are assessing the programme and would like to ask you a few questions relating to the programme.

1. How would you assess your collaboration with QHP in the planning and implementation of the HIP programme?
2. In what areas have you found your collaboration to be most useful? Probe for reasons.
3. How would you rate the overall success of the HIP Programme?

0 1 2 3 4 5
4. What are some of the challenges you have encountered in your collaborative work with QHP in the implementation of the HIP programme? Probe for reasons.
5. What are your views on the effectiveness of the HIP programme generally in improving quality of HIV service provision in the facilities for:
 - MSMs
 - Sex workers
 - For PLWHIV
6. What do you think should have been done differently and how?
7. What suggestions do you have for improving the programme?

APPENDIX 8

Data Collection Forms: Interview Guide for MH Volunteer

Name:

Title/Organization:

Phone Number:

Email:

1. Why do you think facility community meetings are necessary?
2. What do you like the most about the meetings?
3. What do you like the least about the meetings?
4. Is there enough representation?
5. Do the meetings help you in any way?
6. Please rate the usefulness of the meeting?
1 2 3 4 5
7. What facilities can be doing to better support you?
8. How often do you meet?
9. How long have you been using the facility as a PLHIV?
10. How many meetings have you attended?
11. Any other comments?



QHP HIV Programme Assessment

The National AIDS Control Programme (NACP) in collaboration with the Quality Health Partners (QHP) Project would like to inform you about the HIP programme assessment as well as to invite you and some members of your staff to participate in the activity.

The Quality Health Partners project has since June 2006 collaborated with the Strengthening HIV/AIDS Response Partnership (SHARP) and the National AIDS/STI Control Programme (NACP) to implement a package of tools and interventions dubbed the High Impact Package (Get HIP!). HIP is aimed at improving access, especially for most at risk populations (MARPs), to quality services across the entire continuum of HIV prevention, counselling and testing, treatment, care and support services. This programme has been ongoing for the past four years starting from 10 facilities in year one, expanding into additional 15 facilities in year two and currently being implemented in 30 facilities.

Although monitoring data have been collected over the period, and one component of the programme evaluated, the effect of the full package of activities has not been assessed. The purpose of this assessment is to determine the effect of the project and learn lessons on its implementation for future programming.

Please understand that your participation is entirely voluntary, and there is no penalty to you if you decide not to participate. You may choose not to answer any question.

If you need to contact us with any questions, please contact Angela Bannerman, the Sr. Manager for Monitoring and Evaluation at the Quality Health Partners project (021 778 558 or 0244 277 395) or Dr. Nii Acquaye Addo, Project Director of the National AIDS Control Programme (021 678 457-8).

If you agree to participate in this research on behalf of your facility, please sign below.

Signature