Health in Africa Initiative and Its Impact on Women-owned Private Health Enterprises in Ghana

The World Bank Group in partnership with the Bill and Melinda Gates Foundation, established the Health in Africa (HIA) Initiative in 2008. Its mission is to catalyze sustained improvements among the poor in Africa by increasing access to quality private sector health-related goods and services as well as to provide financial protection against the impoverishing effects of illness.

BACKGROUND

The HIA Initiative was launched in Ghana in September 2012. It was committed to supporting the Government of Ghana to undertake relevant policy and legislative reforms that enable enhanced development of the private health sector with a focus on health facilities owned by women to enhance their viability, competitiveness, and sustainability. The predominant private health service provider facility types owned by women are maternity homes. The program focused on creating an opportunity to enhance the private health sector in general but emphasized women-owned private sector health facilities to make them more viable, competitive, and with an enhanced sustainable capacity. To measure the impact, private maternity homes were used as an indicator. It is assumed that changes in functional capacity and capabilities of private maternity homes would sufficiently serve as a proxy of change in other facilities. We provided specific interventions and achieved outcomes as shown in table 1 below:

<table>
<thead>
<tr>
<th>Activity implemented with HIA support</th>
<th>Output/Outcome achieved</th>
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<tr>
<td>Establish private-public dialogue (PPD) and develop Private Health Sector Policy and Implementation Plan to improve growth of the private health sector, including scope expansion for maternity homes.</td>
<td>PPD platform and private sector policy and plan developed. Policy on scope expansion secured for private maternity homes.</td>
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<td>Develop a Legislative Instrument (LI) for the Health Institutions and Facilities Act, Act 829, 2011, to harmonize the public and private health sector facilities categorization.</td>
<td>LI and new licensing, accreditation, and credentialing developed reducing the process from 37 to 12 steps.</td>
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<td>Build capacity and provide supportive supervision to increase licensing and accreditation success rate of private sector health facilities under the National Health Insurance Scheme (NHIS).</td>
<td>256 private providers trained in collaboration with Marie Stopes International Ghana and Pharm Access Foundation.</td>
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<td>Support the transformation of women owned enterprises into viable and sustainable businesses.</td>
<td>64 Business Plans developed with HIA and Pharm Access Foundation support.</td>
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A baseline survey was conducted in November 2012 and a post-intervention survey in November 2014 to measure how interventions impacted women-owned private sector health facilities in Ghana. These before and after surveys were designed to determine if there would be:

1. An increase in essential maternal and child health services accessed by the population through the private health sector

2. An increase in the Disability Adjusted Life Years (DALYs) averted among women and children who assessed health services through maternity homes

3. An increase in preventable deaths averted among women and children through the private maternity homes

4. An improvement in the volume of health services provided by women-led enterprises such as maternity homes, and improved revenue generation under the NHIS

For the death averted and DALY analysis, we drew on the co-efficient used by Marie Stopes International Ghana. We calculated revenue by using the NHIS- and facility- determined tariff rates for the Malaria and Integrated Neonatal, Maternal and Childhood Illnesses services and an average of facilities cost for calcium, deliveries, and related services for health centers.

Nationally, the number of maternity homes successfully licensed and accredited rose from 114 in 2012 to 296 in 2014 after HIA supported interventions. About 51 percent of the increases were maternity homes that had not been re-licensed for over 5 years. A significant rise in family planning services was observed among the private maternity homes between 2012 and 2014. Oral contraceptive uptake rose from 14,282 in 2012 to 40,551. The corresponding DALYs averted rose from 573 to 1,627. Long-term contraceptive use also saw a significant increase for 10 year IUD from 887 to 3,087 and 5 year hormonal implant from 2,772 to 7,784. The two service uptake increases are very important, as they provide higher safety against loss of productive life.

The volume of Artemisinin-based combination therapies (ACT) treatment more than doubled, resulting in a fourfold increase in DALYs averted between 2012 and 2014. However, the distribution of long-lasting insecticide-treated nets through maternity homes was significantly reduced by about 90 percent.

The introduction of new services such as Integrated Maternal and Childhood Illnesses (IMCI) resulted in similar high uptake among service providers. Oral Rehydration Salts (ORS) rose from 3,554 to 12,920, zinc from 3,300 to 12,570 while Acute Respiratory Infections Pre-packaged treatment rose from 5,570 to 66,938 resulting in a rise from 33 childhood deaths averted to 105 saved lives. The rapid increases in services lead to a corresponding increase in revenue. Revenue increased from USD 628,420 in 2012 to USD 3.93 million in 2014 (2012 dollar equivalent prices).

**LESSONS LEARNED**

*Lesson 1: Public-private dialogue should promote mutually beneficial goals*

Using structured systems of public-private dialogue yielded positive response from policy makers. It was important that public-private dialogue was not pursued as an end in itself, but focused on achieving results within a specific time frame. When advocating for increased private sector participation, the evidence needs to be precise, measurable, and unambiguous and should resonate with sector priorities. The presentation style is best kept simple, preferably without PowerPoint presentations, using language that the public sector and development partners identify with. It was more effective for technical directors to use think-tank approaches to investigate the evidence in a liberal academic environment, but less effective for policy and political decision makers. For the latter group, seminar style approaches backed by policy briefs with clear decision points for consideration proved more effective. Pursing a single goal rather than multiple goals at a time also worked better and allowed for a highly focused dialogue. In this case, scope expansion for the private sector in reducing
child and maternal morbidity and mortality was the single focus. The focus on maternity homes as a reliable and preferred service outlet managed by competent women professionals proved effective. It was clear that once the public and private sectors find a common ground to dialogue, they collaborate and partner to achieve each other's goals.

**Lesson 2: Providing technical assistance in policy and legislation development consolidates decisions**

The question of ‘when does policy become a Policy’ is a difficult one to grasp, especially in settings where public statements made by the President, Ministers of State and Agency heads are considered policies and yet lack definitive direction on how they may be implemented. This introduces a high level of uncertainty, and commitment becomes low on the part of all stakeholders. The situation gets complicated when the President, Ministers, or Agency heads change rapidly. For example, between 2012 and 2014, HIA directly worked with the Ministry of Health of Ghana, which had six different ministers, two chief directors, and three heads of institutions; civil and public servants thus become uncomfortable when proposed policy reforms have long-term implications and changes have significant impact on the status quo. To improve and prevent these issues, the following are necessary:

a. When an official makes a major ‘policy’ statement on the health sector that is likely to undermine or promote private sector growth, it is important to quickly investigate it with evidence. As time is of the essence, use expert knowledge in the form of a think-tank participatory approach instead of literary research. A timely approach addressing this proved to be useful. This allowed for the process to be institutionalized and ingrained as part of main stream opera-
tions of the sector in the normal course of policy implementation and reform.

b. Where the statement has long-term reform effects, leveraging legislative reform to affect policy change may be necessary. This allowed us to crystallize the policy provisions into legislation or signed documents as a basis for reforms. However, from our experience, this may take up to 4 years. Drawing on alternative sector instruments may be useful in effecting change. In Ghana, we used the Common Management Arrangements of the Sector Wide Approach of the Health Sector and ensured that the reform agenda was captured in an Aide-Memoire, a signed compact between development partners and the government. The process gave public servants a high level of certainty and legitimate authority to engage in the policy reform process;

c. It is highly advised that sponsored reform be accompanied by technical assistance for capacity and systems development to support interpretation, application, and inspectorate functions. The result is a consistent application of the standards and norms developed as part of the policy implementation process.

Lesson 3: Partnerships based on complementary skills yield rapid results

Building partnerships and leveraging the skills and resources of other partners in areas where the World Bank does not directly engage provided several advantages. As part of the process, HIA recognized the service delivery competencies available in other institutions that have practical and on-the-field operations such as Marie-Stopes International and Pharm Access Foundation. By partnering with these institutions, it was possible to engage with their accredited women private owned health enterprises and directly test the policies and legislations developed to demonstrate rapid results. This enabled evidence to be generated on how policies have been translated into actions and the outcomes communicated to decision makers and development partners. Completing the full cycle from policy to implementation to evidence of results strengthened the case for engaging the private health sector.

CONCLUSION

The HIA three pronged approach of providing advisory services in (i) private-public dialogue, (ii) legislative and regulatory reforms, and (iii) leveraging technical capacity and access to finance have had significant impacts on developing and sustaining the private health sector. In the process, the HIA has developed unique skills that can be used to support and attain other organization-wide objectives and goals.