African Health Markets for Equity

Qualitative Evaluation

Comprehensive Report:

2013 – 2017

Institute for Global Health Sciences
University of California, San Francisco
EXECUTIVE SUMMARY

The story of African Health Markets for Equity (AHME) is a story of using National Health Insurance to link supply (private providers) with demand (clients) in order to shift health markets toward providing quality healthcare to low-income patients in Kenya and Ghana. AHME has, on the one hand, affected how private providers work with National Health Insurance (NHI) systems in order to better serve low-income populations. On the other hand, it is gradually influencing the ways in which patients interact with the health system writ large. The partnership has accomplished these shifts by acting as a mediator between NHIs and private providers, offering itself as a package deal to both parties that helps them achieve their own larger, sometimes idealistic (e.g. achieving Universal Health Coverage) goals. Serving as both an interlocutor and a technical assistance partner that communicates roadblocks and aids policymakers and providers in overcoming them, the AHME partners have in turn helped to advance the initiative’s own goals.

In the realm of policy, AHME has made some significant gains, though this work has moved slowly due to both internal and external bureaucracy. Lack of clarity among the partners around their individual roles early in the process had repercussions for establishing relationships with government and, later, for determining which successes are directly attributable to AHME. Perhaps AHME’s biggest success in the policy arena has been developing “symbiotic” partnerships with the NHIs. These partnerships have evolved and strengthened through shared goals and sustained interactions, allowing the relationships to develop over time. Continuing and institutionalizing this kind of government-private engagement will be an important and likely challenging step for the partnership moving forward beyond the life of AHME.

On the supply side, market pressure has come to play a major role in pushing providers to become NHI-accredited and to establish viable businesses as more and more of their clients are enrolled in the NHIs. In this context, the AHME interventions are increasingly desirable for their potential to simultaneously assist with (re)accreditation, quality of care, and business acumen. Indeed, several providers noted the ways in which the separate interventions could work together, such as quality improvement done through SafeCare easing the NHI accreditation process – similar to what was imagined by the AHME designers. This suggests that providers appreciated the integrated AHME package. However, while providers are increasingly drawn into the NHI system, they rarely understand it well. This lack of understanding resulted in uneven treatment of patients and lack of clarity around clinic finances; issues that the AHME partners could help to address going forward.

On the demand side, while more patients are becoming enrolled in the NHIs and exerting pressure on providers to become accredited, patients in both countries sometimes have difficulty maintaining enrollment due to cost (Kenya) and long wait times for re-enrollment (Ghana). These barriers are particularly relevant for low-income populations, pointing to systemic challenges that AHME will need to address in order to achieve real supply/demand complementary improvements. Further, continuing to expand the franchise networks so that they reach currently under-served low-income communities will be crucial.

The effects of the integrated AHME design are fractured, imperfect, but unmistakably evident. By more clearly integrating efforts on policy, supply, and demand through the project end date of March 2019, we expect AHME to increase its impact on private health markets beyond what any one component of the partnership might achieve alone.
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PART I: PROCESS EVALUATION
EXECUTIVE SUMMARY

The Qualitative Evaluation of the African Health Markets for Equity (AHME) team interviewed AHME partners and relevant stakeholders across four rounds of data collection in 2013, 2014, 2016, and 2017 in order to capture the evolution of the partnership, particularly how partners coordinate and collaborate, and the revision of the AHME Theory of Change. In 2016 and 2017, we interviewed representatives from the National Health Insurance Agency (NHIA) in Ghana and the National Hospital Insurance Fund (NHIF) in Kenya to learn about their experiences working with AHME and their changing perceptions of private providers. We also interviewed external experts in the field of health financing in Round 4 of data collection (2017) to capture AHME’s influence on the field at large. This report is a comprehensive overview of our findings from all four rounds of data collection thus far.

External stakeholders interviewed in 2017 felt that AHME has garnered attention in the field, and particularly that the supply and demand integration component was influential at both the national and international levels. While interviewees were also quick to identify some of AHME’s perceived failures, they lacked in-depth information about most of AHME’s activities and expressed frustration that they didn’t know more about AHME’s successes as well as its challenges.

Since its inception, the AHME partnership has evolved from an envisaged partnership of equals to a prime-sub model whereby Marie Stopes International (MSI) is the lead partner holding others accountable for their workplans. This shift occurred as it became clear that partners sometimes had uneven clarity around their particular mandate, which, along with findings that AHME was not reaching its target populations, also prompted a refinement of the Theory of Change. The Theory of Change has since been updated to reflect a five-pronged approach to making health markets work for low-income populations, and the AHME membership has changed with the realignment of workplans; two partners at the global level (the Grameen Foundation and the International Finance Corporation (IFC)) have exited the partnership and one, Society for Family Health, has exited at the country level due to the closure of AHME’s work in Nigeria in March 2017. In addition, the PharmAccess Foundation has maintained involvement in Ghana while pulling back in Kenya.

The AHME partnership has seen a lot of success in developing relationships with the NHIs, which has resulted in a mutually beneficial feedback loop between providers on the ground and higher levels of government, with the AHME partners acting as mediators. This feedback loop has helped to prompt policy change and also allows the franchise networks to better assist providers in navigating bureaucratic systems. However, the extent to which these relationships are sustainable is unclear.

Since connecting supply (NHI-accredited providers) with demand (NHI-enrolled patients) has been an ongoing challenge for AHME, we suggest that it will be important to maintain and strengthen ties with NHI officials in both countries to both facilitate partnerships between officials, franchise representatives, and outreach workers on the ground, and to sustain these efforts beyond the life of AHME. Further, a more robust dissemination plan will be critical for sharing accurate, complete information about AHME’s lessons learned with interested parties in the field.
BACKGROUND

The University of California, San Francisco, in collaboration with Innovations for Poverty Action, is conducting a qualitative process evaluation to document and describe AHME operation processes in Ghana and Kenya, and their positive and negative impacts on the overall markets and institutional environments in which they function. The specific activities of the process evaluation are:

**Activity 2.1:** Examine the ways AHME partners coordinate and collaborate at the global, strategic level and at the country, operational level.

**Activity 2.2:** Examine the ways AHME partner institutions learn and innovate as a result of the AHME project.

**Activity 2.3:** Examine how and why AHME has influenced the National Health Insurance systems’ perspectives on the integration of private providers into national health payment systems in Ghana and Kenya.

**Activity 2.4:** Study lessons learned through AHME activities and their effect on practices of non-AHME institutions and programs engaged in similar work.

**Activity 2.5:** Examine how and why the AHME Theory of Change has evolved since the program’s inception. Consider the implications of these changes for future programs that aim to strengthen the role of the private sector in health systems or service delivery.

This process report includes data collected between July 2013 and June 2017. In each round of data collection, four since the beginning of the project, the process evaluation has focused on a different activity. The Round 1 (2013) process evaluation focused on the planning phase and first year implementation activities. This included the overall vision for AHME, partner management and organization structure, leadership structure and participatory decision-making, and partner relationships, including public sector engagement. Round 2 (2014) of the process evaluation focused on the finalization of the design phase and early stages of program implementation, as well as the process of engaging with stakeholders external to the AHME partnership. In Round 3 (2016), we examined the partners’ engagement with National Health Insurance (NHI) agencies and the AHME theory of change, including how the assumptions behind the theory of change have been challenged in the field, how the theory of change has shifted since the start of AHME, and whether it is being used as a tool for meeting the goals of AHME. This year (2017), the process evaluation focused on AHME’s continued engagement with the NHI systems and how the partnership has evolved since its inception. In this comprehensive analysis, we integrate findings from across the four rounds of data collection, examining how the partnership, implementation, relationships with the public sector, and challenges and successes have developed over time.

METHODS

This report draws on data from four rounds of key informant interviews with partners at the headquarter, region, and country levels, as well as their public sector counterparts at the NHIA, NHIF,
and the Kenyan Ministry of Labor. These interviews were conducted at different stages in 2013, 2014, 2016, and 2017. In addition, we conducted a round of exit interviews with one partner, the Grameen Foundation, when they left the partnership in 2015.

The methods details, ethical approval, study population descriptions, and analysis plan are outlined in Appendix A.

RESULTS

AHME’S INFLUENCE ON THE HEALTH FINANCING FIELD

Interviews with representatives from national government agencies in Kenya and Ghana, international foundations, donor agencies, NGOs, and research organizations have illustrated both the perceived successes and failures of the AHME initiative to-date and have provided some insights to explain the context in which perceptions of AHME have developed.

External Communication

Information on AHME is limited outside the immediate partnership

Even within AHME partner organizations, knowledge of AHME is limited at senior levels. As a result, opinions of AHME are largely based on personal contacts and informal information, and these impressions are supplemented rather than supplanted by the limited public presentations or disseminated documentation on the program.

Outside of the partnership agencies, information on AHME is even more limited. As a result, experts we interviewed in international agencies, donors, and NGOs who are aware of AHME and the lessons being generated from it were frustrated that their own limited knowledge is not shared more widely either internationally or among the technical groups within their own organizations who work on the same issues where AHME is focused. As many respondents noted, international discussion on integrating private sector service provision and government financing – “supply” and “demand” in the parlance of the AHME initiative – happen without any reference to lessons coming from AHME. This is due to lack of awareness regarding the experiences and results coming from AHME, compounded by uncertainty among those “in-the-know” about how the positive lessons from AHME measure against the initiative’s failures.

almost every meeting I’m going to I’ve got the Dutch, the Canadians, I’ve got national governments ...saying ‘how do we deal with financing?’ and I don’t hear AHME coming up. (AHME Partner, Global)

Question: do you think AHME is well known?
R: No... I have explained it like 100 times here. (International Donor)

Recognized Successes

AHME has been successful in shifting high-level discussions around supply-side health financing

Respondents also mentioned quite a number of successes. These successes primarily centered around the effect that AHME has had on shifting discussions among international donors and implementers.
from supply-side only (social marketing or social franchising) to what respondents felt was a more appropriate integration of both supply and demand; of service provision, demand-creation, and financing. By advancing both the practice and documentation of this kind of integration, AHME’s leadership has changed the acceptability of this kind of discussion for the better, facilitating the shift that others in the field believe is needed.

The lessons of integration have affected both AHME partners and organizations unaffiliated with AHME.

*learning from Kenya, Ghana… applying in Philippines, Bangladesh, Nepal, Pakistan, Zambia. [AHME] has influenced it, in terms of domestic financing agenda...and how you assess poverty.* (AHME Partner, Global)

*In every document we refer to AHME because it also gives us the credibility because it's not like something we cooked up. It's something which, you know, a bunch of very bright people across the world have come up with then it has the support of the World Bank and Gates Foundation and others and they have reviewed them and found them to be a good approach. So it is good for us. It's reassuring for us to know that [demand-supply integration] is doable and it is also reassuring for us to communicate to others with the full knowledge that this will not be – actually the methodology will not be questioned.* (INGO Director)

Many respondents also thought AHME had made significant advances in building an evidence base around the need for, and possibility of, better performance measurement which will ultimately lead to better program design. Implementing partners spoke about how a focus on measurement and reporting, using indicators and performance areas from the AMHE work, was spreading to programs in other countries, as well as among donors and government officials. Indeed, the data management tools AHME developed and the program’s use of data to identify low-income populations for recruitment into targeted social programs was mentioned as having been inspirational to the NHIs:

*we use several alternatives but we thought it’s not scientific enough, so AHME comes in handy to filling that gap to identify this poor household for enrollment into the scheme.* (NHI Leadership)

Indeed, many respondents mentioned that poverty-targeting tools, which were refined within AHME and then applied elsewhere, were a key outcome of the initiative. Respondents felt this development was influencing programs of different kinds in many countries. However, interviewees did make a distinction between the important lessons of better measurement and the less positive lessons of the AHME program itself:

*if they really want to serve the poor this wasn’t the way to do it in the short term.* (International Donor)

Those lessons wouldn’t have been possible, though, without the focus on measurement that AHME brought. And this focus has been eye-opening beyond AHME itself:

*funny enough it’s just not AHME that didn’t reach the poor enough, let’s say. It did much better than some of our other initiatives.* (International Expert)

Failures

External stakeholders could name AHME’s failures, but only understood them vaguely
Many respondents mentioned AHME’s failures or negative lessons-learned, but the same people who spoke of these failures had only a general understanding of the initiative’s shortcomings and were frustrated that their own understanding was not more robust. Most often, interviewees mentioned the closure of work in Nigeria as a clear indication that AHME was not going well. Interviewees also mentioned the reduction in partners and shortcomings in: reaching high patient volumes, particularly among low-income populations; creating anything even approaching a sustainable value-proposition for private providers; and convincing the NHIs to accept SafeCare accreditation as equivalent to in-house accreditation.

A number of respondents also highlighted the lack of early integration into the overall health system and national health financing framework as particular shortcomings that hobbled AHME’s potential. Interviewees thought that AHME should have adopted a more system-wide perspective, or total-market-approach in the terminology of one respondent. Without this approach from the beginning, interviewees thought AHME’s potential to accomplish three key goals was limited.

First, a context where successful government-funded support for private provision is backed by systems that make this goal viable. So far, according to one respondent, such systems have been effective only in more developed middle-income countries, and while some of the AHME countries (certainly Kenya and perhaps Ghana) are building the kind of regulatory and payment system that could allow implementation of a pro-private financing mechanism, Nigeria clearly wasn’t. A more comprehensive health system view of what AHME set out to achieve from the beginning would have made it clear that Nigeria was unlikely to provide the “demand” side systems or financing.

Second, a linkage into national and global policy-making so that the lessons derived from AHME are part of larger systems-level discussions both within and across countries. Again, this shortcoming was noted particularly with reference to financing and UHC discussions at the government level. It also was suggested that platforms such as the Joint Learning Network (JLN) might have offered an untapped opportunity to be part of discussions around both national healthcare financing mechanisms, and how governments intend to both conduct strategic purchasing from private providers and conduct accreditation or quality-assurance oversight among these providers. Respondents suggested that, if AHME partners had participated in these kinds of discussions early on, this might have allowed either adjustments to the AHME design, or influence over policy decisions made in the JLN or national governments, through feedback from AHME experiences.

Third, closer attention to financing and cost-management could have been one part of a more strategic sustainability plan for AHME. This was mentioned, on the one hand, in terms of considering long-term financing from governments, NHIs, or other insurers. On the other hand, interviewees suggested that thinking about sustainability beyond the initial grants early on might have forced cost-savings and simplification of some components of the AHME program from the beginning.

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**EVOLUTION OF THE AHME PARTNERSHIP**

The AHME partnership has evolved at both the global and country level since the initiative’s inception. In this section we examine how the overall functioning of the AHME partnership has evolved over the course of the project, pointing specifically to early challenges and how they were resolved.
Changes in Management

There has been a shift in how the partnership is managed from a consortium model to a prime/sub model, providing clarity and reducing competition

The AHME partnership was designed as a consortium of equals in which each organization had an equivalent relationship with the funding organizations. This is in contrast to a prime (or lead) and sub model, where one organization, the prime, is awarded a contract from the donors and other organizations are subcontracted through the primary organization. AHME was designed so that partners would be organized on a consensus basis. However, from the beginning partners experienced challenges within the consortium-of-equals model. On the one hand, the lack of empowered leadership within AHME led the donors to take on a more hands-on role. Marie Stopes International (MSI), which was designated as a lead-among-equals within the consortium, did not have full authority to manage the other partners. This led to confusion and frustration among the partners.

_The consortium model is...difficult for some partners to live with because there is a strong sense of everyone as equal partners, but it’s not easy for [MSI] to manage with that._ (AHME Partner, Global)

The decision that all partners would be regarded as equals remained a challenge for two reasons. First, little structure was in place to hold partners accountable for achieving their deliverables. Several interviewees mentioned that the lack of a clear lead on the project led to delays, unclear scopes of work, and a lack of accountability in the design phase of the AHME interventions, and particularly when the demand-side work was being developed. As one interviewee noted:

_They had this whole idea of bringing a bunch of organizations together like this, in a collaborative way...[but] the way that it was structured has contributed to the challenges that are occurring today, particularly for organizations that are accustomed to a prime-sub relationship. There is a prime who gets the contract. You are a sub; you have certain deliverables. The accountabilities are clear._ (AHME Partner, Global)

Second, because the demand-side workplan hadn’t been finalized when the initial AHME contracts were awarded, funding for this piece of the program was held in reserve pending design completion. The partners were therefore left to compete among themselves for the reserved funds. Coupled with the loose partnership structure, this competition resulted in challenges building consensus and making decisions among the AHME partners. As one partner described:

_At the worst of times you get chaos. Where it’s not clear who is calling the shots. It’s not clear who the decision maker is. Certain behavior like being a little more aggressive in your negotiation seems to get rewarded. So at its worst, it can really be unproductive._ (AHME Partner, Global)

By 2015, the design of the demand-side work had been finalized and MSI took on an expanded role as AHME lead, which changed the hierarchy within the partnership and the way that other partners interacted with the donors. Donors expected that MSI would be the prime; the organization that would communicate information about AHME to the donors. However, while the leadership has become clearer since MSI was appointed AHME lead, some partners are not satisfied with the change. One implementing partner suggests another solution for future partnerships: having an independent organization manage the partnership.
If you have a partnership with this much money on the table, because at the end of the day we are all partners that also live with getting money and getting money for our organization, leading a consortium, it’s important that you are independent. If there is one lesson learnt from my end, I would say if you have a hundred-million-dollar project, please give the management to an independent organization whose only role is to make the partnership successful. And the fact that one of the main organizations was leading as well as beneficiary hasn’t made it easier. *(AHME Implementing Partner, Kenya)*

**Changes to Partner Membership & Impacts on Ability to Meet AHME’s Goals**

Since the partnership began, three partners have exited the partnership and one has shifted their involvement

An initial lack of clarity around roles in the AHME partnership, including what was expected of individual partners, the competencies and goals each brought to the table, and the ways in which they were meant to work together, has resulted in three partners exiting AHME since it began. The Grameen Foundation, originally appointed to lead AHME’s ICT workstream, exited the partnership in 2015. In 2017, the International Finance Corporation (IFC) also left the partnership. The IFC led AHME’s policy-level work through their existing partnerships with government in both Ghana and in Kenya. The Society for Family Health (SFH) in Nigeria exited the AHME partnership in the same year, although we have little data on this change due to the Qualitative Evaluation’s mandate to work only in Kenya and in Ghana. In the case of both Grameen and the IFC, it became clear from interviewing representatives from each organization that there was a misalignment between the competencies and priorities of these individual organization and the direction that the AHME partnership was taking.

*Seeing AHME’s request of [organization], it didn’t match any of our core competencies or strategic objectives.* *(AHME Partner, Global)*

*We don’t have an issue with working with any of the partners. It’s just the whole setup of AHME and the leadership and the whole mechanisms as to how partners were supposed to work and interact that then became a bit acrimonious, but no we have no issues.* *(AHME Implementing Partner, Kenya)*

Meanwhile, the PharmAccess Foundation (PAF) has shifted its role within AHME. While PAF has retained its role in Ghana and even expanded activities to include a new intervention (Receivables Financing), the way that PAF engages with AHME in Kenya has changed. Rather than having PAF provide services directly through AHME, the two service-delivery partners (MSK and PSK) use funds to contract for SafeCare and use their own staff to work with providers on the ground. Other areas of work that PAF was involved in – demand-side financing and the Medical Credit Fund (MCF) – have concluded.

**From Shared Vision to Meaningful Collaboration**

**Collaboration has become more meaningful as the AHME structure and individual partner roles have become clearer**

In early reports, partners reported that they had challenges with understanding the perspectives of other partner organizations. In Round 2, it became clear that the partners had developed a shared understanding of the goals of AHME, and of their own place in the structure of the initiative. One
partner describes how the AHME organizations once worked in silos, but have developed an appreciation for other partners and work streams through the country meetings.

*We’ve gone past the prep stage where nobody was very sure, how do this all fit together? That has really helped through just watching the various leadership meetings go by and our country meetings. You can start seeing people appreciating that all these things will converge at one point or the other. The Safe Care component, helping the accreditation of NHIF, policy helping has pushed demand side financing. Before it was very siloed, and everybody is driving their own agenda. But we’ve seen a lot more appreciation through our monthly forums of the partnership and how we can grow on each other.*

*(AHME Implementing Partner, Kenya)*

Another partner describes how developing a deeper understanding of the different partners was essential in a partnership focused on health markets, because they relied on other partners for the success of their interventions.

*There is a lot of dependency in terms of the work we do. Like at [organization], we don’t have our own clinics. We have to work through the technical support partners...So it’s called upon us to really see how to fit in, to really accommodate the different components of the organizations and see: how are we going to move together to achieve these targets? So that calls for a deeper understanding. That calls for a compromise and collaboration.*

*(AHME Implementing Partner, Kenya)*

In the most recent round of the evaluation (2017), partners were connecting with each other and sharing expertise in meaningful ways. One important point of collaboration is the partnership between PharmAccess and the social franchise networks to implement SafeCare. PAF has trained staff at the franchise networks to conduct SafeCare assessments and to issue quality improvement plans. The franchise networks have now taken over health worker recruitment and training themselves, effectively streamlining this process into the franchises.

*For us, we work very, very closely with PharmAccess because of SafeCare. Right now we have about over 220 facilities that are on SafeCare. And we like the partnership because when it comes to the quality, we continue to get the technical support from them, training, and we’ll go to the ground with them to conduct, for example, the advanced assessments. So I would say that has worked very well. And we feel empowered. They also conducted TOTs [training of trainers] for our team. So for now they’ve actually moved from doing the basic assessments with us and they give us the green light: “you can do the basic assessments perhaps we only need to come in when you are doing the advanced assessments.” So we are doing okay with them.*

*(AHME Implementing Partner, Kenya)*

PharmAccess continues to provide technical support and training for conducting quality assessments at the social franchised clinics. In addition to collaborating with the franchises to train them to use the SafeCare technology, PharmAccess has also trained business advisors at the franchises on the Medical Credit Fund.

Between the franchise networks themselves, there is also evidence of sharing information, data, and expertise. For example, MSK has adopted PSK’s Business Improvement Plan to use with its franchised clinics. As one implanting partner in Kenya said:
Marie Stopes and PS-Kenya, for example, have a lot of things they do collaboratively. They tell us “this is what we are learning on empanelment. You try it out.” “Okay, let’s go together out there and see what’s going on.” There has also been a lot of cross learning. So it’s really come of age. There is a lot more collaboration between, especially service delivery partners; the PharmAccess, Marie Stopes and PS-Kenya are stronger than anywhere else because of that whole piece. (AHME Implementing Partner, Kenya)

While the relationship between these organizations was characterized by competition at the start of the initiative, now the franchise organizations are working together as collaborators, each with a specific role to play in the AHME partnership.

IMPLEMENTATION CHALLENGES AND SUCCESSES

Follow-up from the Pop Council Midterm Report

Still limited overlap between the supply- and demand-side interventions

In 2015, the Population Council produced a Midterm Review of AHME (Appleford and Bellows 2015). This report critiqued the AHME partnership for having a “misalignment in work streams” and lack of synergy between the interventions. Part of this misalignment was the result of delays in the design of the demand-side work, which was implemented in the year following the supply-side interventions. Indeed, the original AHME proposal (Marie Stopes International 2012) did not specifically include NHI enrollment to address demand-side financing, but instead listed several options (e.g. vouchers, health savings accounts) and the NHIs were decided on later, creating a disconnect in the timing of the supply- and demand-side interventions. So, while AHME developed the technology for identifying and enrolling the poor in NHIS in Ghana and assisted with implementation, initially there was no geographic overlap between the program pilot districts and the locations of franchised clinics. Similarly, in Kenya, while AHME assisted NHIF with the HISP pilot, a dearth of NHIF-accredited clinics made it difficult to connect HISP-enrolled clients to accredited AHME clinics. While more recent efforts to increase franchise reach in the Ghana pilot districts and to empanel more franchise clinics in Kenya aim to address these challenges, the initial disconnect in timing in both countries affected intervention overlap early on.

The evolution of the Theory of Change and its underlying assumptions offers an additional explanation for why AHME has had difficulties bringing supply- and demand-side work together thus far. In Round 3 of the process evaluation, we asked partners about assumptions underlying the Theory of Change; one of the most frequently discussed assumptions was the ability of social franchises to reach Q1 and Q2 populations. Several respondents pointed out that the original vision for quality private sector delivery to low-income populations assumed that social franchise networks did, or would be able to, reach Q1 and Q2 clients. At this time, it was understood that the main barrier to Q1 and Q2 populations accessing services through social franchised clinics was their inability to afford services at these facilities. In turn, it was assumed that demand-side financing mechanisms would automatically increase access to the AHME clinics by allowing low-income patients to pay for quality healthcare.

The idea behind the demand side financing was to remove that financial barrier, that by allowing Q1 and Q2 to access the private providers who are in the social franchise networks,...just improving the quality of private providers or expanding the scale of the private providers and the scope of services that they provide is in itself not sufficient to ensure that the poor can benefit from it given that there are financial
barriers for the poor to access, and so that’s why the original intent of the program was to also have the demand side piece which would work to reduce the financial barriers. (AHME Partner, Global)

However, as mentioned above, due to the delay in design of the demand-side work, the original Theory of Change did not account for the limited geographic overlap between Q1/Q2 populations and NHI-accredited AHME clinics. In fact, the majority of Q1/Q2 populations in both Kenya and Ghana live in rural areas where there are few private clinics eligible for inclusion in AHME, although the networks are making efforts to change this. So, as implementation began and as the partners reviewed equity data from the franchises, it was clear that this limited geographic overlap created difficulties for reaching the poor through the franchised clinics, as was initially proposed in the Theory of Change.

Something you need to incorporate into the Theory of Change is that you don’t just need to remove the financial barriers and sort out the quality, but you need to make sure that if you can remove or reduce the financial barrier that you are also making sure that there are clinics in the right places to serve the people that we want them to serve. We didn’t think enough about that. (AHME Partner, Global)

Further, it is not clear that there was widespread agreement on the evidence base for the key assumption underlying the Theory of Change to begin with. While a number of interviewees said that social franchises were believed to reach low-income populations, others thought that the project designers were aware of evidence suggesting that social franchise networks, or private facilities in general, do not adequately reach poor populations. Still other partners suggested that adequate evidence may not have existed before the start of the AHME project, so that the equity data that first came out of AHME took the partners by surprise.

Maybe there wasn’t that much was known or people hadn’t really examined so much that the equity scores in the social franchise was so poor. I mean everyone was surprised when we got the first round and it showed that 0% or 0.04% of people in Kenya were accessing in Q1. AHME itself might have shot itself in the foot a bit because if we go back to the original proposal, it talked a lot more about Q1 and Q2 us reaching the poor. (AHME Partner, Global)

Regardless of whether the partners were aware of the reach of the franchised clinics early on, equity data from the initial years of the AHME program made clear it that the social franchises had not been reaching poor populations. AHME clinics were worse than expected when it came to reaching their target populations, but their experience aligned with broader evidence that private providers serve a smaller proportion of Q1 clients and a greater proportion of Q5 clients compared to both public and private-religious providers (Olivier, Shoju, and Wodon 2012).

More recent data from Kenya has shown that franchised clinics from both key AHME partners – Marie Stopes, Kenya (MSK) and Population Services, Kenya (PSK) – have a clientele that is wealthier than that of either government or faith-based clinics, and which is essentially identical to the clientele of for-profit clinics (Chakraborty et al. 2017). Notably, the percent of Q1 and Q2 patients found in 2016 (Ibid.) was significantly higher than that found in 2014; the figure reported in the Population Council report. This shift could be attributed to: the application of an updated benchmark for assessing wealth; an aggressive outreach campaign undertaken by the AHME partnership to recruit poor patients; intensified efforts to franchise and empanel clinics in rural areas where low-income populations are more likely to
live; or a combination of factors. Regardless of how this shift can best be explained, it is good news for the equity component of the AHME objectives.

**Successes in Supply, Demand, and Policy**

**Supply and demand overlap is still limited, but developing; successes have been achieved in individual areas**

Two years after the Population Council midterm review was conducted, it is still largely true that the supply, demand, and policy components of the program have not overlapped to improve health markets for the poor in the way that AHME envisaged. However, the partnership has achieved individual successes in all three areas of the health “market”—supply, demand, and policy. On the supply side, AHME has improved franchises by increasing scale and scope, and facilitating the NHIF accreditation process on behalf of clinics in Kenya. On the demand side, AHME has supported the HISP pilot and also provided communications support for Supa Cover in Kenya, in addition to working on the Common Targeting Mechanism (CTM) pilot in Ghana, and on outreach and recruitment programs targeting low-income patients in both countries. Within the realm of policy, AHME has influenced the NHIF accreditation process in Kenya so that it is now easier to empanel small private providers. These are important accomplishments and point towards a more effective and more integrated way of working within AHME, with a growing focus on activities that advance the overall partnership goals and a decreased focus on the narrower goals of individual partners.

**DEMAND SIDE ACCOMPLISHMENTS**

AHME’s greatest accomplishments may hinge on how successful they are at integrating private providers into government led National Health Insurance schemes, and then working with those schemes to expand coverage to the poor. Because of, or certainly together with AHME, the NHIs in both Ghana and Kenya have made great strides in both of these areas.

The government of Ghana has adopted a central system and rigorous approach to identifying the poor, with AHME playing an acknowledged role supporting the identification and enrollment of the poor in the National Health Insurance Scheme. This has been facilitated through a digitized Common Targeting Mechanism tool and supply of biometric machines in the nine pilot districts. AHME developed the software to make this possible and the Ministry of Gender, Children and Social Protection is applying the same tool to target the poor for other social protection programs, including conditional cash transfer programs.

**SUPPLY SIDE ACCOMPLISHMENTS**

AHME has introduced or facilitated key improvements that have become normal within the franchised providers, making them stand out among private clinics, particularly in Kenya. For example, during the 2017 interviews 60% of PSK providers were working on Safe Care quality improvement plans and among franchised AHME clinics, NHIF contracts—non-existent in 2013—had become commonplace by 2017.

In both Kenya and Ghana the expanded scope of services incorporated into the franchise package, long an unachieved goal of AHME, has taken off. While not universal by any means, franchisees now increasingly offer IMCI, antenatal care, and basic emergency obstetric care.
Kenya, the NHIF accreditation process still requires a lot of advocacy on the part of the franchises, and clinics continue to report challenges with this process (delays, lost paperwork, being denied accreditation because of clerical errors like misspelling the clinic name). The effects of devolution are not yet clear, but there are concerns, and some indications, that this may add another level of bureaucracy, further straining the relationship between private providers, government regulators, and NHIF funders.

More optimistically, it is possible that AHME is changing not just its own operations, but it is also making social franchising, and particularly franchising to serve low-income populations, more attractive for private providers. As one implementing partner in Kenya pointed out, increasing revenue for franchise clinics through NHIF accreditation opens up the possibility for clinic owners to expand into under-served areas.

For the private sector...if we have more of the social franchise networks as part of – that have been accredited by NHIF it means they are able to increase their revenue, improve the quality of care, probably and also expand their physical location. A lot of the social franchise networks are located in urban centers so I mean it would be great if at the end of this program based on the fact that if I own a social franchise network I’ll be able to generate revenue, improve my quality and I can now maybe open one in a more rural setting. I mean I think that will be really good for the government. It will really be good for government and AHME.

(AHME Implementing Partner, Kenya)

POLICY ACCOMPLISHMENTS

The policy engagement, led by IFC and PharmAccess, has been key to the success of AHME. That engagement, established and now able to continue without those two organizations’ active effort, laid the groundwork for other AHME partners to develop strong working relationships with the NHIs in both Kenya and Ghana.

In Kenya, this partnership can be seen in AHME’s successful lobbying to include non-doctor clinics – those most likely to serve rural and urban poor populations – in the NHIF outpatient scheme.

EVOLUTION OF THE PARTNERSHIP WITH NATIONAL HEALTH INSURANCE AGENCIES

The Public/Private Relationship at the Start of AHME

Public sector suspicion toward private sector at the start of the project

At the start of the AHME project, several interviewees reported suspicion between the public and private sectors. Although we do not have data from NHI officials in early rounds of the evaluation, it is telling that NGO implementers felt their public sector counterparts viewed the private sector as profit-focused and self-interested.

The public sector thinks that the private sector are merchants, they are only profiteering, they are only looking for profits...The public sector thinks that they are socially minded but the private is commercially minded, so something that you always have to know that that’s the perception that the public sector has about the private sector. (AHME Implementing Partner, Ghana)

This interviewee suggests that the opposing goals of the public sector as “socially-minded” and the public sector as “commercially-minded” could impede their ability to successfully collaborate. Another
interviewee draws a similar comparison between the public sector as “good seeking” and the private sector as “self-seeking”:

[The public sector] were quite open to it, but they still had some reservations [I: Which were?] Of course the private sector was seen more as self-seeking than the public good seeking so that remained an issue. (AHME Implementing Partner, Ghana)

In addition to the viewpoint that the public and private sectors have fundamentally different goals and approaches, some interviewees suggested that the two sectors were in competition with one another.

They still see them as competition instead of complementary to whatever NHIS is doing. There is a private sector unit but I don’t think they do much to help the private facilities compared to what say [AHME partner] and other organizations are able to do for the private facilities... maybe it’s something that we can add to what we are doing with NHIS, letting Ghana Health Service to support more in their work and see them as partners at the community level rather than competition for clients (AHME Implementing Partner, Ghana)

Because clients can choose freely between public and private healthcare facilities, this interviewee suggests that the public sector may be hesitant to collaborate with private facilities if there is the impression that private facilities are taking away potential clients from public facilities. Given the perception that the private sector was likely to be “commercially-minded,” “self seeking,” and competition for public healthcare providers, the state of affairs at the start of the AHME project was for the public and private sectors to keep to themselves.

On the part of government, this suspicion may have come from lack of information about private providers in general. At the start of the project, NGO collaborators perceived the public sector to have limited knowledge of private providers and social franchise networks.

I think they were trying to understand what [social franchising] is, I mean I wouldn’t lie, I think they were trying to understand what is it. (AHME Implementing Partner, Ghana)

Another interviewee suggested that while the government is knowledgeable and willing to collaborate with the private sector across other areas, they are less knowledgeable about the potential benefits of collaborating with private sector healthcare providers specifically.

They are quite open to working with the private sector nowadays. I think when you look at the key direction of the whole government, they are all very focused on working with the private sector to improve access. I think they are learning a lot from other sectors, infrastructure, energy, roads and things like that, on the role of the private sector. So there is general momentum across Africa to leverage on the role of the private sector. But there is a slow movement towards formal engagement of the private sector in the [health] sector. Why is that? I think it’s just because of lack of information on what the private sector could do. (AHME Implementing Partner, Kenya)

Interviews from early rounds of data collection provide a baseline of knowledge for how the public and private sectors viewed each other when the AHME project began. Our data suggest, from the AHME partners’ perspectives, that their views were characterized by negative evaluations of the other sector, a
perception that the sectors had misaligned or competing goals, and limited knowledge about the benefits of working with one another.

**Motivations for Public/Private Collaboration**

Shared goals and readily available support motivated the public sector to collaborate with the AHME partners

*And I think that for us as NHIA our motivation for joining this is the fact that it’s coming to help us achieve our core mandate. And the core mandate of NHIA is to ensure equitable access to … to ensure universal health coverage. To ensure universal health coverage for members and to achieve that universal health coverage you need to cover the poor. If you neglect the poor there is no way we can achieve universal health coverage. And so it comes in handy to ensure that our core mandate of universal health coverage is achieved. And that’s why we should support to make it happen* (NHIA Official, Ghana)

*I can tell you that is also supported within the same partnerships. In fact we are doing that squarely with the PSK that is the Population Services and it is actually one of the things that we are proud that we are doing with the partners. I fact it is actually PSK which is paying for the roadshow that has been going on from May and it has tremendously brought us what we want…by that time we were registering about 36,000 people per month [in Supa Cover], but as last month, in August we registered over 80,000. So you can see from April we moved from 36,000 to 80,000* (NHIF Official, Kenya)

Given the perceived tensions between the public and private health sectors in Kenya and Ghana, what motivated the public sector to collaborate with their private-sector counterparts? As described above, the AHME Theory of Change shifted over time to include a greater emphasis on National Health Insurance as the mechanism through which the demand and supply pieces of the initiative could come together. The AHME partners were therefore motivated to work with the NHIs in order to realize this goal. From the perspective of the NHI officials, though, our data indicate that the public sector lacked the capacity in some areas to achieve their mandate to provide health coverage to all citizens. Thus, the public sector was motivated to collaborate with the private sector so that they could benefit from their technical support and financial resources. Interviewees, from NGOs and national health insurance agencies alike, recognized that the public sector faced challenges and could benefit from the assistance offered by the NGOs that represented the private sector. Further, the AHME partners approached the NHIs and offered assistance for free, making it easy for the NHIs to accept the offer to work together. One interviewee described how the public sector needed help with the issue of assuring consistent quality across health clinics:

*Interviewer: Do they see added value with working with private provider networks?*

*Respondent: They do. In fact, they even told us “we really want you to discuss how you can help us with quality issues.”* (AHME Implementing Partner, Kenya)

AHME partners working with the private sector were able to complement existing public sector programs by providing their expertise in areas like quality assurance, marketing, and community outreach. Thus, the public sector came to view the nonprofit organizations as a resource to help them solve their problems.
I will say they are very receptive, they are ready to roll, because they know they have problems. They acknowledge those bottlenecks. If you talk them, they will tell you, these are the problems. They’re receptive in designing solutions with us to solve the problem. We just had a meeting with them, they are good, receptive and they are ready to work with AHME in exploring these solutions. (AHME Implementing Partner, Ghana)

In addition to the expertise of the organizations representing the private sector, the broad reach of private sector providers was appealing to the National Health Insurance agencies. According to one AHME implementer in Kenya, the NHIF was aware that their public facilities would not reach poor populations, which piqued their interest in collaborating with AHME. Indeed, government officials came to see private providers as another means to achieve their goal of universal health coverage by filling important gaps in their ability to serve both rural and poor patients, including through the spread of access to NHI-accredited facilities.

I think the value is there because, for NHIF of course you want as much as you are providing these services you want to have a network of facilities that are across everywhere so that you are not limiting access to services for the members and they also have facilities where they can select services, because it works both ways, if there are no [NHI accredited] providers where I live, I will not pay for NHIF because it doesn’t make sense, so I think it’s really demand driven (Former NHIF Official, Kenya)

Further, public sector representatives discussed the benefits of working specifically with franchised private providers. As officials from both the NHIF in Kenya and the NHIA in Ghana noted, partnering with social franchise networks was seen as especially valuable to the NHIs because the networks ensure a baseline level of quality for private clinics.

At least you know there are these providers where the quality is being checked, then I think it adds value to NHIF definitely knowing that you have a range of providers that are already checked and you don’t have to put so much effort in that area in terms of quality monitoring (Former NHIF Official, Kenya)

Recognizing the benefits of working with private providers, one interviewee at the NHIF went so far as to call private sector facilities “saviors” of the public sector because they increase access for rural beneficiaries. Over the course of the AHME project, the public sector therefore came to see that partnering with the private sector clinics could benefit, rather than compete with, their mission.

However, some interviewees suggested that the desire to work with the private sector wasn’t driven by the added value of private facilities or social franchise networks, but was merely demand driven. Several respondents argued that the public sector simply would not be able to meet increasing demand for health services without private providers. As one AHME partner suggested, the government had “no option” but to collaborate with the private sector because a significant proportion of their beneficiaries rely on the private sector for their healthcare:

The government has no option. Some of the research that has been done has shown that 55% of all health services consumed by Ghanaians are provided by the private sector....So it gets to a point where the government has no option but to bring the private sector onboard and I think government recognizes that (AHME Implementing Partner, Ghana)

Development of the Public/Private Relationship

Sustained collaboration contributed to a shift in government’s view of the private sector

The public sector expressed some motivation or need to partner with the private sector, but the nature of that collaboration was especially important for the evolution of their perspective about private sector healthcare. One AHME partner, the IFC, was initially brought into the partnership because they had pre-existing relationships with government. One AHME partner in Kenya suggested that, indeed, the IFC was a critical entry point to establish a relationship between AHME and the NHIs:

_But one of the things I think AHME did well was the IFC bit, the policy bit of putting a partner who is respected by the government to try and make the change, policy issues and decisions... it will really influence how AHME looks like in future because you are influencing decisions at a very high level, not just say it impacts all of us as implementers, so if we really focus on the good policy issues the project definitely thrives_ (AHME Implementing Partner, Kenya)

While the IFC initially acted as an intermediary between the NHIs and the other AHME partners, these partners formed a relationship with their public sector counterparts by working on the design and implementation of several pro-poor programs that were designed in collaboration with government: the Health Insurance Subsidy Program (HISP; targeting low-income households) and Supa Cover program (targeted to informal sector workers) in Kenya and the pilot of a Common Targeting Mechanism tool for identifying poor populations Ghana.

Developing the public/private relationship was a lengthy process that involved research, assessments, writing and presenting reports, and regular communication between the leadership of the AHME consortium and various government agencies. As one interviewee recalls, developing the terms of their collaboration required several in-person meetings.

_We’ve had about six or seven different meetings......that’s formally sitting down to negotiate the DSF [demand-side financing] program. And we had several meetings just sitting down and talking about what needs to be done. I’ve met with the Chief Executives on a one-on-one basis, and by chief executives I mean all of them: The minister, the Director General of the Ghana Health Service, The Chief Executive of the NHIA, and then the presidents of the associations. We’ve met with parliament thrice as a body, sitting down and discussing what should be done, presented the evidence that we have._ (AHME Implementing Partner, Ghana)

In the design stage, AHME partners met with public officials at several levels of government. Another interviewee recalls the iterative process of research, presenting options for collaboration, and finally developing detailed work plans and budgets for the collaboration.

_Then the teams went back to now further develop those [plans for collaboration]...going back to the government and saying “this is likely to be the option; now give us more information,” and get also some commitment from the government for those particular options...So we are at a point where now we are developing detailed work plans and budgets around this and also getting commitment from government and other partners._ (AHME Implementing Partner, Kenya)

Rather than approaching the National Health Insurance agencies by prescribing plans of action, the collaboration built on mutual problem-solving and the AHME partners working with continuous
feedback from the NHIs. This process of designing and implementing pro-poor programs allowed both parties to learn about their respective communication styles, which in turn allowed them to work together more smoothly.

When the programs moved past the design phase, it remained critical for the AHME partners to meet regularly with the NHIs. Thus, the development of formalized arenas for meeting, such as the HISP technical working group in Kenya, was essential to furthering the success of their collaboration. Meeting formally, in-person, and on a regular basis both strengthened the relationship and created avenues for the AHME partners to open up discussions about other areas of interest and to influence the public sector’s view of private providers:

AHME has created space, and so we can go beyond what they have been doing, engaging different units of the government, and then starting to talk about other aspects which the public sector is not aware of, and they become interested in the private sector. (AHME Implementing Partner, Kenya)

Current State of the Public/Private Partnership through AHME

A “symbiotic relationship” between AHME and public sector partners

Interviews with the AHME partners and with government officials suggest that mutual suspicion, or at least the partners’ perception of mutual suspicion, has waned since AHME began. Several implementers specifically reported noticing a change in how they work with government over the course of the AHME project, and that NHI representatives now view private provider networks as partners more so than in the past. As one interviewee described: There is more willingness on the part of the government to want to engage more actively with the private sector and even willing to take some level of risk. (AHME Implementing Partner, Ghana)

Working with the different NGOs and institutions has been a plus for NHIF and it goes even beyond us. When we are doing the scale up [of the HISP program], targeting more beneficiaries country wide, increasing the numbers, we will be able to say that it was not just a public institution affair, it was a public-private partnership. We were able to collaborate at various aspects of the projects so going forward it would propagate the need for more private public partnerships, even in the country. (NHIF Official, Kenya)

Unlike the suspicion and mistrust that the AHME partners perceived in the early rounds of the evaluation, NHI officials see how public/private collaboration can allow them to make more progress towards their goals now and in the future. Further, AHME has not only influenced government’s willingness to collaborate with the partnership, but partners perceived a shift in their views of the private sector, particularly smaller clinics that were unattractive to the public sector in the past.

For a long time, the government never really used to empanel private sector facilities especially of our level. They were more interested in Nairobi hospital, Gertrude’s and all those big facilities...But now you have these small providers...they were not attractive at all...We’ve changed that. So now they see the smaller facilities from a different lens. So I think that without even really like changing policy which are very hard things to change but really just making them see the point. (AHME Implementing Partner, Kenya)
An important benefit of the relationship between AHME and government partners has been the development of a feedback loop, whereby the AHME partners act as an intermediary to communicate private provider experiences directly to the NHIs. This feedback loop is mutually beneficial, a conduit where the practices and challenges of private providers are channeled to the public sector. In turn, the AHME partners also act as communication channels from the NHIs back down to the ground, keeping providers informed about government policies and helping them navigate challenging bureaucracy.

But now increasingly they have seen the value of this partnership and what we’ve seen is you can actually – now we can be able to influence... This is the feedback we are hearing from the providers and then they channel back to the branches and the branches act on it. So it’s been a very symbiotic relationship and it’s a journey but we are proud of it. (AHME Implementing Partner Kenya)

We were able to sit as a team because we were now with PharmAccess, PS-Kenya and MS-Kenya most of it now on the ground because that’s where now the communication strategy was being implemented and we were able to work out the small issues...Now, here we are with MS-Kenya who have that person in the village or they have that clinic down in the village or PS-Kenya who has that community health worker who works with that beneficiary welfare committee person. So with time we were able to be able to know how to utilize those people. (NHIF Official, Kenya)

Several concrete changes have developed as a result of this cycle of feedback. In Kenya, for example, feedback from the AHME implementing partners influenced a change in the licensing required for NHIF accreditation, which made accreditation cheaper and more accessible for small private providers. In addition, the NHIF streamlined their accreditation process, temporarily replacing the in-person inspection requirement with a self-administered checklist partly in response to communications with AHME partners.

The Future of Public/Private Healthcare Partnerships

The future of public/private partnerships will focus on engaging networks as a bundle

As the NHIs and the private sector continue to develop their relationship, several AHME partners said they envision a continued collaboration and increased role for the private sector to work with the public sector in Kenya and Ghana. In this regard, both AHME partners and NHI officials suggested that the future of private/public partnerships, and partnerships with social franchise networks in particular, will focus on engaging with networks as a bundle rather than with individual providers. With this vision in mind, the AHME partnership has plans to pilot both an Aggregator Model in Kenya and a Hub-and-Spoke model for the franchise clinics in Ghana through the end date of the project. In both countries, these efforts have the potential to make the NHI accreditation and payment process more efficient for both government and providers. The Aggregator Model, for example, aims to present the structured bundled network to insurance companies for empanelment. Ideally, this model will give consumers access to a panel of quality-credentialed providers in return for lower premiums, lower out-of-pocket costs, or both.

However, as the partnership between AHME and the NHIs continues to develop through the end of the project, the partners will need to address key issues and challenges that have arisen thus far. First, the NHIs do not have a specific organizational policy toward working with the private sector, which several interviewees suggested is particularly important for the aggregator pilots to be successful. This kind of internal policy may also open avenues for institutionalization around, for example, the technical
assistance provided by the AHME partners. Further, some partners said they still struggle to make the benefits of the private sector known to government officials, including the benefits of working with a social franchise network. After several years of collaboration, some AHME partners weren’t sure if their public sector counterparts really understood the concept of social franchising and its broader value.

Finally, it became clear from multiple interviews with both AHME partners and government officials that the NHIs often perceive themselves to be working with a particular AHME partner or partners, but not necessarily with the AHME partnership as a whole. While there appears to be consensus among the partners that they are less concerned with the NHIs knowing the AHME brand than they are with developing sustainable public/private relationships, the challenges of collaboration between a large, international consortium and a government bureaucracy are many. As one NHIF official specifically said:

*Every institution has its own way of working, from World Bank the way it’s big, to small institutions, usually there is bureaucracies, protocols, processes which you have to tolerate and be patient with. Like if we are ready, PharmAccess is not ready, they have to talk to Netherlands, then come back and talk to us, get AHME, the entire group on board when you come back. That bouncing back and forth can take a lot of time. The same for us [the NHIF], we have to go slow, our Ministry of Health, Treasury. So that channel of flow can really delay. And it’s more so for public institutions than I’ve seen in private institutions...Health in Kenya is political. Poverty in Kenya is political and combining the two, you have a disaster. So you have to balance and involve very many stakeholders and talk to very many people so things can get moving.* *(NHIF Official, Kenya)*

**CONCLUSIONS & RECOMMENDATIONS**

The findings from the AHME Qualitative Process Evaluation thus far suggest that, since its beginning, the partnership has evolved into a more clearly structured entity with a refined and coherent Theory of Change that more adequately meets the initiative’s objectives. Participation in the AHME consortium has in turn shifted such that the form of the partnership (the membership and individual roles of each member) better fits its function (strengthening health markets to serve the poor). These findings suggest that the partnership would have done well to establish a clear leadership structure from the beginning, rather than assuming that a consortium of “equals” with unclear roles and potentially competing interests would operate productively as a whole. While MSI’s role as the AHME lead seems to be working, the partners could also have considered hiring an external organization to take on AHME’s management, thereby preserving the equal status of the individual implementing partners. Further, having a clear Theory of Change with a strong underlying evidence base and concrete steps to achieve the partnership’s goals, and aligning these steps with the partners’ core competencies, could have improved efficiency from the beginning of the project.

However, our findings also suggest that the partnership first had to expand before it could contract in order to meet its goals; the IFC was integral to connecting the rest of the partners with the NHIs and the PharmAccess Foundation provided the SafeCare toolkit and trained franchise representatives to work with providers on SafeCare (which it still continues to monitor in Ghana while also providing hands-on support with Receivables Financing). So, a Theory of Change and accompanying workplan with a phased approach to partner involvement could have been another effective approach.
In terms of connecting the supply and demand aspects of the AHME initiative, though, timing has been an ongoing challenge. Due to a lag in the demand-side intervention rollout, it has been difficult for the partners to bring the two key components of the program together such that low-income populations ultimately use National Health Insurance to access quality services at NHI-accredited AHME clinics. Progress has been made, but must continue if plans to increase communication campaigns and outreach in the final phase of AHME are able to fully address this key gap.

In terms of developing a sustainable relationship with the NHIs, the AHME partners have been quite successful. First operating through IFC’s pre-established ties with government and then building upon shared goals and offering sustained assistance through regular meetings and collaboration, the partners have been able to develop stronger relationships with government. These relationships, and the collaborative work that has fostered them, also have informed public sector views of working with the private sector in healthcare. This piece seems critical for AHME’s success if the partnership really does hope to transform the larger health market. However, as several interviewees noted, there are challenges remaining if the partnership wants to achieve sustained success at this higher level. These are primarily related to government financing, quality assurance and regulation, and AHME’s integration into a sustainable relationship with government.

Further, respondents beyond the immediate AHME partnership agreed that the overall concept of integrating supply and demand has already been influential at both the national and international levels. Lessons learned from AHME, particularly regarding supply/demand integration, therefore have great potential for uptake across the field more broadly. However, this will require a more robust dissemination plan, like the plan currently in development, that specifically targets interested stakeholders with more detailed messaging around AHME. This messaging should address the lessons coming from the initiative, including the specifics of AHME’s perceived failures (e.g. pulling out of Nigeria), in addition to the partnership’s successes.
PART II: PROVIDER/PATIENT EVALUATION
EXECUTIVE SUMMARY

The Qualitative Evaluation of the African Health Markets for Equity (AHME) program interviewed providers and clients from both franchised and non-franchised facilities, as well as community members living in the facility catchment areas, in order to capture: perceptions of health services; factors influencing provider choice; experiences with the franchising program; and experiences with National Health Insurance. This report is a comprehensive overview of our findings from three rounds of data collection (2013, 2015, 2017) in both Kenya and Ghana.

In 2013, 2015, and 2017, field staff recruited by Innovations for Poverty Action (IPA) conducted in-depth interviews with providers participating in the social franchise networks (Amua and Tunza in Kenya and BlueStar in Ghana), as well as additional interviews with select non-franchised private providers. The aim of the interviews was to describe providers’ experiences with the AHME interventions and with the National Health Insurance schemes, and to understand non-franchised providers’ interest in programs like the AHME interventions. The team also interviewed clients exiting franchised and non-franchised facilities, and conducted focus group discussions with community members in facility catchment areas (Round 1 only), in order to understand factors that influence provider choice, perceptions of and experiences with health insurance, and client experience at franchised and non-franchised facilities.

Providers were generally positive about the AHME interventions, especially franchising and SafeCare, and particularly appreciated learning about Quality Improvement, which they felt helped them serve their patients better. NHI accreditation was increasingly common among providers, particularly in Kenya, by Round 3 of data collection. A number of providers were motivated to become accredited due to client demand, and thought that NHI accreditation helped them better serve low-income populations. However, it was unclear whether increased client flow, even with accreditation, resulted in an increase in revenues and a more viable provider business model.

Clients appreciated the services at both franchised and non-franchised facilities, particularly when compared to public hospitals. They especially noted the prompt attention and respectful service at the private clinics. Although clients complained of disrespectful and slow treatment at public facilities, both they and community members thought the public sector provided the most comprehensive care. It was increasingly common for patients to have NHI coverage by Round 3 and most reported positive experiences using NHI, although some clients in Kenya paid for their coverage without using it and patients in Ghana complained that coverage was limited. However, maintaining coverage could be a challenge due to difficulty keeping up with monthly payments (Kenya) and long wait times to re-enroll (Ghana).

Our findings have particular relevance to the role that AHME can play in the changing health systems in both Ghana and Kenya over the coming years. We recommend that AHME partners emphasize their work as a mediator between providers and government, focusing on better educating both providers and patients on NHI programs. Stronger outreach to potential patients to both connect them to the AHME clinics once enrolled in NHI and educate them on NHI benefits has the potential to increase client load in both countries – a perceived key benefit of AHME participation mentioned by many providers.
BACKGROUND

SCOPE OF WORK

The Institute for Global Health Sciences at the University of California San Francisco was contracted to lead the Qualitative Evaluation of the AHME program, in collaboration with Innovations for Poverty Action (IPA). The Qualitative Evaluation is part of a larger Impact Evaluation led by the University of California, Berkeley, on the impact of AHME on health access, quality of services, and health outcomes. The following section focuses on Objective 1 of the Qualitative Evaluation:

1. To assess the drivers of provider and client attitudes towards quality of care, options for care, and health seeking behavior in Ghana and Kenya, and how AHME impacts these, and;

This provider/client report includes data collected between July 2013 and March 2017. Data collection was conducted with providers in three bi-annual rounds throughout this period (2013, 2015, 2017) and with clients in two rounds (2013 and 2017).

Objective 1 was designed as a complement to the quantitative Impact Evaluation to help interpret and contextualize the quantitative findings. However, part way through the first-year of fieldwork, it was decided that the Impact Evaluation would take place only in Kenya. The Qualitative Evaluation is therefore the only evaluation of AHME in Ghana. Although the results of the Qualitative Evaluation cannot be taken as a substitute for representative, program-level data, and cannot produce statistical estimates of the impact of AHME, the findings have independent value and are intended to provide a descriptive account of how the AHME interventions are experienced by providers and their clients.

OBJECTIVES OF THE QUALITATIVE EVALUATION

Under Objective 1 of the Scope of Work (referenced above), the Qualitative Evaluation has four main activities:

1. Examine the perceptions of potential users about accessibility and quality of services in AHME catchment areas
2. Assess the influence of social franchise expansion and service integration on provider acceptability and experiences
3. Assess the influence of other AHME interventions, namely MCF/SafeCare, DSF, and ICT on provider perceptions of services and quality, and the acceptability of these interventions from the provider perspective
4. Examine the ways in which the AHME program affects expectations, beliefs, and health seeking behavior among clients and clients’ choice to seek care, and where to seek care in the AHME catchment areas

QUALITATIVE EVALUATION RESEARCH QUESTIONS (FINAL ROUND):

Research questions across all three rounds of data collection with providers and two rounds of data collection with patients generally focused on experiences with the AHME interventions and, in more
recent rounds, with the NHIs. The research questions guiding the most recent round of data collection (2017) are as follows:

**Providers**

1. What are the providers’ experiences with and perceptions of the franchising, MCF and SafeCare interventions?
2. What factors influence uptake of the franchising, MCF and SafeCare interventions?
3. How have providers interacted with NHIF/NHIS?

**Patients**

1. How do patients seek healthcare?
2. What have patients’ experiences been like:
   - With franchised vs. non-franchised clinics?
   - Enrolling with and using NHI?

**METHODS**

This report draws on data from all three rounds of client exit interviews, provider interviews with both AHME members and non-AHME practitioners, community member focus groups, and other expert key informants. These interviews were conducted at different stages in 2013, 2015, and 2017.

The methods details, ethical approval, study population descriptions, and analysis plan are outlined in Appendix A.

**RESULTS**

**PROVIDERS**

**EXPERIENCES WITH THE AHME INTERVENTIONS**

**Franchising**

Providers appreciated knowledge and skills-building through the franchise; an increase in client volume associated with franchise participation didn’t necessarily correspond to increased revenue

Overall, providers were happy with the franchise intervention across all three rounds of data collection. As one midwife at a BlueStar clinic interviewed in Round 3 said, *So they have really come to make things softer and easier for us.* Specifically, providers appreciated: opportunities to increase their knowledge and build skills; bringing in more clients after expanding services under the franchise; monitoring and oversight; a steady commodity supply; opportunities to make facility improvements; and being part of a network.

**Building Knowledge & Skills**

Across rounds of data collection, providers overwhelmingly cited training and building their knowledge...
base as the greatest benefit of being part of a franchise network. This was also a main motivator for joining the franchise in the first place. A number of providers said they appreciated the training offered through the franchise and specifically mentioned learning about: family planning methods; abortion and post-abortion care; infection prevention; safe motherhood; client relations; and records-keeping. Providers also saw access to interventions like SafeCare and MCF as a benefit of being part of the franchise, and several Ghanaian providers specifically mentioned that programs like SafeCare and trainings through BlueStar were free of cost. One provider in Ghana mentioned they were able to get trainings through BlueStar that they couldn’t otherwise access through the Ministry of Health, which was not “including” them.

Not only did providers appreciate the trainings offered through BlueStar, but many of them reported implementing their learnings in the clinic:

That’s the infection prevention. Ohhh, as for that one, they blew our mind. Then we did not know, and we only washed our hands with water and went our way. But now they have taught us how to mix the infection prevention. They have taught us a way of mixing it such that, when you do, we will not contract any sickness we are treating nor will the patient contract any new sickness to take home. (Midwife at a BlueStar clinic, Ashanti, Ghana)

In one case, a provider said that implementing their learnings about patient privacy had specifically helped them make family planning services more accessible to younger women:

And also it helps us for the privacy – normally, the young, young girls, when she is coming for family planning and meets an elderly person then it’s like she’s shy. So when you see the students then we give her directions then they come into this room. As in, go and see the doctor and after the doctor come and sit and wait for me. So it made way for the young, young girls to do FP, so that it can help. There is someone who wants to do but she is shy, as in this little girl and you about to do a family planning. So that also help to know if she is a young girl, there a place for them and when the elderly come we have a place for them also. So they are not together like that... (Midwife at a BlueStar clinic, Ashanti, Ghana)

Increased Client Volume

Most providers interviewed in both Ghana and Kenya reported an increased number of patients after joining the franchise. Providers attributed these increases to an increase in the number of services offered, branding, and demand creation from the franchise networks. Particularly after they started offering a wider range of quality services under the franchise networks, most notably family planning, a number of providers felt they were able to attract more clients to their clinics. According to providers in both countries, clients would visit a clinic to use the new services and then continue to return for additional services as well. While some Ghanaian providers in earlier rounds of data collection faced challenges attracting clients for family planning services due to low demand, in Round 3 a few providers said that family planning services are more in demand than they used to be, because people want smaller families and recognize the need for birth spacing. One provider reported that some women have even started bringing their husbands to family planning visits.

Branding

While the franchise brand name didn’t motivate most providers to join, some Kenyan providers did
report specifically seeking out Tunza because they had friends who had good experiences with the network and they “admired” the branding; one Amua provider also wanted to be “associated” with Marie Stopes. However once franchised, a number of providers across all three networks cited network branding as a reason for increased client flow and suggested that clients had more confidence in the branded clinics:

*You know Amua is an organization that when the community hear about it then they get motivated a lot. So with Amua we’ve been able to see a number of a good number of patients because, they just hear oohh Amua they are working together with Amua. Oohh then they say Amua actually provides the best reproductive health care services. Then they say no let’s go to [clinic name].* (Clinic Staff at an Amua clinic, Nyanza, Kenya)

*Because they know TUNZA people they are qualified...they offer quality services.* (Nurse at a Tunza clinic, Eastern, Kenya)

*Everybody is aware after mentioning BlueStar.* (Midwife at a BlueStar clinic, Ashanti, Ghana)

Several providers across both countries also said that patients recognized Marie Stopes as a trusted family planning provider, even if they didn’t recognize the franchise brand name. While providers in Ghana were less likely to attribute brand recognition to their clients than their counterparts in Kenya, in Round 3 Ghanaian providers were more likely to suggest that clients recognized the BlueStar name than they were in earlier rounds of data collection. However, most of the patients we interviewed did not recognize the BlueStar name, despite having been interviewed in a BlueStar clinic.

**Demand Creation**

Providers, especially in Kenya, also appreciated demand creation activities. One provider specifically mentioned that the franchise helped them spread word of their NHIF accreditation status to community members:

*So in that process of doing Mobilization and with their good connections with the community health eeeh... volunteers and health workers, they can help as aaaah, mobilized [sic] people and get to know that we are now accredited for NHIF.* (Clinical Officer at an Amua clinic, Nairobi, Kenya)

However, different types of demand creation activities appeared to have different outcomes. While several providers thought that offering free services during “medical camp” days encouraged clients to come back for paid services, it was not clear whether potential clients reached by Community Health Volunteers were coming in.

As we found in earlier rounds of data collection, an increase in client volume was only associated with increased clinic revenues among some of the providers in Kenya and most of the Ghana providers didn’t associate joining BlueStar with a boost in clinic income. Since providers regularly cited cost as a barrier to improving their clinics, our findings suggest that in some cases, whatever financial gain the providers made by attracting more clients may have been offset by the increased cost of maintaining standards of quality required to maintain franchise membership.

**Other Benefits**

Other benefits of franchise participation included monitoring and oversight, a steady supply of commodities, and being part of a network. While some Ghanaian providers interviewed in Round 2 of data collection felt overly monitored by the franchise, this did not come up in Round 3. Instead, providers appreciated regular attention and having someone to call with questions. In addition, providers said they were able to offer clients reliable and affordable access to family planning commodities through their participation in the franchise. A couple of providers in Kenya specifically mentioned that some of the benefits of joining the franchise network, such as subsidized commodities, are not usually enjoyed by private providers.

Further, providers appreciated being part of a network, which could function, on the one hand, as a broker to “close the gap” between its members and government:

*Respondent: So those gaps that were there between us and the government...were closed by Tunza.*
*Interviewer: For instance which gaps?...*
*Respondent: Like now when you go to trainings...the seminars and the trainings we use the government policies* (Nurse at a Tunza Clinic, Central, Kenya)

Other providers across rounds of data collection also appreciated the chance to network with other franchised providers and demonstrated a sense of collective identity through the franchise, with one Round 3 Amua provider calling the network a “big family” and one Tunza provider in Round 1 stating:

*It is a network. I would say, now, we are eating the good name of Tunza...If one of us maybe, decides to soil the Tunza [name], it might [spread] to you.* (Clinic Staff at a Tunza clinic, Nairobi, Kenya)

**Challenges**

Providers generally cited few challenges with franchise participation. Ironically, while providers regularly said that consistent commodity supply was a benefit of being part of a franchise network, an irregular commodity supply also was a common complaint. This was particularly true among Amua members in Kenya. Further, one Tunza provider suggested that only supplying contraceptives isn’t sufficient when clinics lack other basic commodities:

*But there are other commodities because if at all you give me...you give me the IUCD, without the gloves, without the needles without the...the other the barrels the needles whatever... What do you expect me to do and yet I am not charging this patient.* (Clinical Officer at a Tunza clinic, Coast, Kenya)

In relation to the irregular commodity supply, in early rounds of data collection a number of providers in Kenya cited lack of follow-through as a major challenge, particularly feeling like the franchise had made promises (e.g. providing a consistent flow of commodities) they had yet to keep. In this context, some providers felt they were reporting regularly to the franchise without receiving anything in return. However, this concern came up less in Round 3 of data collection, when providers were more likely to see franchise monitoring and oversight as a benefit in itself and wanted more of it. As mentioned above, providers in Ghana also saw franchise monitoring as a benefit in the latest round of data collection and, unlike the Kenya providers, did not complain of an inconsistent commodity supply from BlueStar. However, some Ghanaian providers wanted BlueStar commodities to be cheaper so that they could better compete with public facilities.
Franchise demand creation activities, such as Tunza community mobilization days, also received mixed reviews from providers. As mentioned above, some providers did find franchise demand creation to be helpful for spreading word about their clinic among potential clients. However, several Amua providers in early rounds of data collection were disappointed that demand creation activities hadn’t increased client flow as much as they hoped and this concern came up in Round 3 as well. Some Tunza providers also felt that events like Tunza Day confused clients by offering free services only on select days.

Other challenges that came up in early rounds of data collection among Kenyan providers, but were of less concern to those interviewed in Round 3 included: the challenge of attending trainings when a clinic had few staff to attend to patients this challenge was particularly true for Amua clinics, which tend to be smaller than Tunza clinics; and the cost of making improvements or implementing new services recommended by the franchise. In Ghana, some providers feared that the stigma around abortion would affect their reputation in the community, but this came up less in Round 3.

**Non-Franchised Providers**

The non-franchised providers interviewed cited several reasons why they hadn’t joined a franchise network or didn’t care to do so. In Ghana, the non-franchised providers had all been approached by BlueStar, but refused participation. In Round 3 of data collection, two of these providers weren’t able to join the franchise because they refused to offer abortions for religious reasons; another thought they couldn’t join BlueStar because they didn’t qualify for NHIS accreditation. A couple of other providers felt they were adequately served by other programs they were involved in to provide family planning; one mentioned a UN-sponsored program and another provider said they had an arrangement with the government to provide family planning services. One provider had been approached by BlueStar and was interested in joining the network, but was still waiting for follow-up at the time of her interview.

In Round 2 of data collection, non-franchised providers in Kenya reported that they might be willing to join a franchise, but felt they hadn’t been given adequate information or follow-up when visited by a recruiter. In Round 3 of data collection we only conducted interviews with non-franchised providers who were part of the control group for the AHME Randomized Controlled Trial. Therefore, these clinics had never been offered the franchising intervention and so the providers were not prompted to discuss franchising during their interviews.

**Accreditation Assistance (Kenya)**

Providers liked being able to “walk together” through NHI accreditation with the franchisor which could also “push” the process along for them

While providers in Kenya were more interested in pursuing NHIF accreditation in later rounds of data collection, they generally lacked information on the accreditation process. This lack of information discouraged those providers who found the process daunting. Among providers who had attempted to go through the accreditation process, Kenyan providers interviewed in Round 2 cited difficulties with hold-ups in the accreditation process and having to “push” to keep the process moving forward. These hold-ups included: paperwork being lost; lack of feedback on improvements required for accreditation; having to make a number of changes to meet accreditation requirements; and having to wait for a board meeting to receive final approval. Those who were interested in receiving assistance from the franchise

to apply for NHIF requested: more information on the benefits of NHIF and how to apply; review of the accreditation requirements, possibly with a pre-assessment from the franchise; tips from other accredited providers; and financing to assist with necessary improvements. In addition to direct assistance, some providers also mentioned that working through the franchise would help them avoid informal payments to officials during the accreditation process.

While AHME didn’t introduce the NHI accreditation assistance intervention in Kenya until 2015, we did find that providers interviewed in Round 1 of data collection felt that being part of a franchise gave them more visibility and legitimacy in the eyes of the public sector and providers interviewed in Round 3 echoed this sentiment:

*I think Tunza has really been an eye opener to us, because one thing [is that] the government never recognized the private sector and especially the clinics. We have never seen inspectors from the government coming to give us supervision support. In fact it’s through Tunza that we’ve been able to be introduced to the government.* (Clinic Staff at a Tunza clinic, Nairobi, Kenya)

Among the providers who were receiving accreditation assistance by Round 3, most had very positive feedback on the intervention and said that the franchises helped them navigate the accreditation process by: clarifying the process and requirements for accreditation; providing them with materials to prepare for assessment, such as the accreditation assessment checklist; ensuring they had the proper credentials in place to apply; and advising them on improvements to make before inspection. Representatives from the franchises also helped the clinics “push” the accreditation process along and providers were grateful that the franchises acted as a partner in a process that otherwise felt confusing and overwhelming to them:

*So when we went to the next meeting, he still came...“How many people are through with the process“? We... were so few. So he asked us what is... “What’s your problem”? He explained, unlike for me I gave the experience, the sharing I have shared with that doctor of [name of a place mentioned]. Then I was told, “No, you were not to follow that process, follow the process with us, let’s walk together.”* (Nurse at an Amua clinic, Nairobi, Kenya)

Indicating the level of partnership some providers felt with their franchise representative, several mentioned the Amua representative by name and one provider praised him for being very “active” in helping clinics become accredited.

**SafeCare**

**Providers sometimes confused SafeCare with the franchise; found it helpful for NHI accreditation**

Among those who joined SafeCare in both Kenya and Ghana, most said they saw the benefits of SafeCare in terms of improving overall quality in their facilities and receiving outside support; an attraction made strong because the program was free. Several providers in both countries were interested in learning about clinic management, how to better reach and work with clients, and general clinic safety/infection prevention. One provider in Kenya mentioned that they joined SafeCare because it was an “international” program, which indicated to them that it was reputable. Providers not participating in SafeCare mainly noted they would be interested in a program that would help them to
improve their clinics, but when talking about how they would like to improve, these providers commonly cited stocking drugs and commodities and buying new equipment as main concerns; concerns that don’t fall directly within the realm of SafeCare.

Providers were unclear about SafeCare’s relationship to the franchise network, sometimes conflating the program with the franchise itself (e.g. suggesting that SafeCare supplied them with family planning commodities). This was particularly true in Kenya, where the AHME interventions have more recently been offered as a comprehensive package under franchise membership, while providers in Ghana were slightly more clear that SafeCare was a separate program offered through BlueStar. In both countries, though, some providers were skeptical of the need for SafeCare. They suggested SafeCare was “almost the same” as franchise membership, which already addressed their quality improvement needs.

In Rounds 2 and 3 of data collection, providers in both Kenya and Ghana generally were impressed by SafeCare’s comprehensive approach. They particularly appreciated having a SafeCare assessor come to their clinic to identify “weaknesses” or “lapses” and then provide them with specific suggestions and “road maps” for addressing these gaps. Further, providers often mentioned new ideas they had gotten through SafeCare by name, such as: infection prevention; organization and standardization in the clinic; managing drug stocks; record keeping and human resources; and patient confidentiality. Several providers across both countries also suggested that the lessons they learned about customer care helped them retain patients or attract new ones. Finally, one provider in Kenya suggested that SafeCare made quality improvements more manageable and realistic to implement than guidelines that had been provided by the government.

Further, providers generally agreed that SafeCare was useful in the NHI accreditation process. A number of providers in Kenya said that participating in SafeCare either helped them become accredited with NHIF, or they signed up for SafeCare with the goal of easing the accreditation process. In both cases, providers had the sense that SafeCare helped them put things “in place” before undergoing an NHIF inspection. This was particularly true because providers saw an overlap between the areas that SafeCare aims to improve and the specific requirements of NHIF, such as infection prevention and waste management.

So you find that what NHIF required, we had already implemented through SafeCare. (Midwife at a Tunza clinic, Nairobi, Kenya)

Similarly, although most providers in Ghana were accredited with NHIS before joining AHME, a couple of the providers interviewed thought that having SafeCare earlier would have helped with their accreditation process and a couple of others anticipated that SafeCare would make re-accreditation easier. One provider had in fact implemented SafeCare before becoming re-accredited and said that the program helped improve her clinic’s rating:

You know the first time the accreditation was done, I had grade “D” and later on when I learnt all these things in addition, the grade moved up to grade “B”...When you put things in place, and everything is in order, when they (NHIA) comes your accreditation grade (rating) goes up. (Midwife at a BlueStar clinic, Ashanti, Ghana)
Providers in both countries cited the cost of implementing SafeCare improvements as the major challenge of participation, while some mentioned: difficulties getting staff to adopt new practices; challenges related to staff time required for trainings and also extra time for senior staff to supervise junior staff; adequately staffing facilities to cover expanded services, such as a laboratory; and space constraints, particularly for providers who are renting their clinic space and can’t expand.

**Medical Credit Fund**

Providers liked MCF business training, were skeptical of loans

While providers in both Kenya and Ghana understood the Medical Credit Fund (MCF) to be a loans program, it was just as common for providers in Kenya to talk about both loans and business training in relation to the intervention. Providers in Ghana were more likely to speak only about loans in relation to MCF. In all three rounds of data collection, providers in both Kenya and Ghana expressed interest in obtaining loans to expand their clinics and the services offered, and to buy new equipment. Kenyan providers thought that external financing would help them achieve these goals more quickly than financing improvements on their own and providers in Ghana similarly suggested that finances were their main challenge when it came to making improvements in their clinics. A few Kenyan providers in Round 3 also mentioned that they could use a loan to buy drugs that were difficult to stock and a couple of providers in the same round thought they could use a loan from MCF to make the improvements required by SafeCare. One of these mentioned that NHIF accreditation would be the next step after making the SafeCare improvements.

Among those who had taken loans in Ghana, a couple had very positive experiences; one of these providers reported using an MCF loan to acquire new equipment and the other used the money to pay salaries and rent. While a few providers in Kenya felt they benefited from MCF loans, some providers interviewed in Rounds 1 and 2 considered the MCF interest rates to be too high or were already repaying another loan. These concerns came up less in Round 3, when a couple of providers instead mentioned that opening up a separate bank account for the clinic was an obstacle to taking a loan. Interestingly enough, one non-franchised provider didn’t feel it was worth it to invest in improving the clinic without having NHIF accreditation, because this was the only way community members would be able to afford the services:

*Because right now even if I took a loan and maybe I improved our lab or maybe I brought in some more drugs, it would still be a problem because the community wouldn’t afford. So NHIF accreditation would open up opportunities. Even for me now taking a loan and doing something else to improve the services...knowing that the community would afford.* (Doctor at a non-franchised clinic, Coast, Kenya)

Similarly, another provider felt more comfortable taking a loan knowing that they were already NHIF-accredited and would have steady income to take away the “fear” of repaying.

Providers in both countries expressed concerns about their ability to pay back loans. This was a particularly relevant concern in Ghana, where providers were generally mistrustful of borrowing money and also faced long payment delays from NHIS. In addition, providers specifically expressed concern about how long it would take them to re-pay the interest on a loan:
Respondent 1: I planned to go for the loan and get a land and build. But if I don’t take care I can’t finish paying before I die...
Respondent 2: The interests on the loans are huge
Respondent 1: yeah. It’s much. (Midwife at a BlueStar clinic, Ashanti, Ghana)

Indeed, difficulty repaying the loan and unclear requirements were common complaints across both countries in all rounds of data collection. Providers cited challenges repaying loans during the specified period, noted that applying for a loan could be complicated and time-consuming, requirements were sometimes inflexible or unclear, and they had mixed opinions on whether loan a from an MCF-affiliated bank was any better than a loan from a non-affiliated bank.

Across rounds of data collection in both Kenya and Ghana, providers were generally positive about their experiences with the business training component of the Medical Credit Fund (MCF) intervention. Notably, a couple of providers in Kenya said they had started their clinics without thinking of them as businesses, but realized they needed training to properly manage the clinic: Yeah we...we are health providers but at the same time we are businessmen (Nurse at a Tunza clinic, Central, Kenya). Providers who had participated in the trainings were able to mention specific changes they had made in their facilities, such as: bookkeeping; drug stock management; HR organization; and succession planning. However, while providers felt this information was valuable, it was not clear from the interviews whether or not the clinics had benefited financially from the business trainings. Training which would lead to increased revenue was a key factor determining whether or not to join MCF:

If I can’t get enough clients obvious this participation will not benefit me a lot. (Nurse at an Amua clinic, Coast, Kenya)

Other than the issue of staff time that also came up for providers participating in SafeCare, providers rarely cited challenges with the MCF business training.

Receivables Financing (Ghana)

In response to growing recognition that providers in Ghana were severely affected by NHIS reimbursement delays, PharmAccess developed the Receivables Financing intervention to guarantee loans to providers using NHIS claims forms. During Round 2 of data collection we identified several types of expenses that providers had trouble covering due to payment delays. These included: stocking medicines; paying employees; covering utilities and other operating costs; and paying for quality improvements. In order to cover these costs, providers reported buying medicines on credit, taking out loans, using personal money to subsidize clinic costs, and relying on cash-paying clients.

The Receivables Financing intervention rolled out only shortly before we conducted Round 3 of data collection. During this round of data collection, we found that a few providers had been offered the intervention, but had not yet received follow-up. These providers expressed interest in the intervention, which they recognized as a more reliable opportunity for reimbursement of their NHIS claims. However, consistent with their feelings about loans in general, the providers remained skeptical of taking loans and paying interest. One provider who was participating in the intervention cited challenges similar to
those raised among MCF participants, suggesting that the process was cumbersome and it took a long time to actually receive the loan. Further, it was unclear how the loan would be re-paid given the payment delays from NHIS:

*We thought after they’ve given us the money within one month, the National Health Insurance people will pay them...We’ve entered the second month and say they haven’t paid them. So I’m getting worried.*
(Midwife at a BlueStar clinic, Ashanti, Ghana)

**EXPERIENCES WITH NATIONAL HEALTH INSURANCE**

**Why Join & Benefits of Accreditation**

Providers join NHI due to patient demand, consider it critical to business viability and serving the poor

It was common for both Kenyan and Ghanaian providers to report that they sought out NHI accreditation due to client demand. While this trend was relatively consistent across rounds of data collection in Ghana, in Kenya client demand became a strong motivator only recently. Since NHIF coverage for patients other than civil servants is relatively new in Kenya and outpatient coverage was added to this scheme only in 2015, few AHME providers were accredited at the start of the project. At this point, our research suggested that market pressure to join NHIF was relatively low among providers. By the third round of data collection in 2017, though, 233 clinics (125 PSK and 108 MSK) had been accredited and providers were likely to report that they had applied for NHIF accreditation due to client demand. Providers felt they could financially benefit from NHIF due to increased client volume and regular lump sum payments through the outpatient capitation scheme. Further, while earlier rounds of data collection indicated that a number of providers were unfamiliar with the various NHIF packages, the providers we interviewed in Round 3 were more familiar with both the inpatient and outpatient schemes for the general public. Providers were less familiar with newer programs such as Linda Mama (Free Maternity Services) and Supa Cover (a program to cover informal sector workers).

By attracting more clients, providers in both Kenya and Ghana hoped to increase clinic revenues. While there was generally consensus among providers that NHI accreditation did increase client volume, though, it was unclear in both countries whether this increase translated into more profit. As we have pointed out in earlier reports, this disconnect may be due to the increased cost of improving quality standards among clinics who are either franchised, or participating in SafeCare, or both. However, particularly in Ghana, providers may not be realizing more profits due to NHIF payment delays and low reimbursement rates.

**Serving Low-Income Populations**

Particularly from Round 3 of data collection, it is clear that NHI accreditation allows providers in both Kenya and Ghana to better serve low-income clients while also maintaining a viable, if not highly profitable, business. In Round 1 of data collection some providers in Kenya expressed concern about finances, which were constrained by the low-income patient population they served. Indeed, providers in both countries cited clients’ frequent inability to pay as a reason why they decided to apply for NHI accreditation in the first place. Providers in both countries suggested that NHI accreditation was in fact
essential to maintaining their business viability, particularly for clinics serving a low-income population:

*If you not accepting, look...look, look at the people who are around, they are all poor... *Without NHIS you can’t operate in a clinic they better shut down your clinic, yeah.* (Doctor at a BlueStar clinic, Greater Accra, Ghana)

In addition, some providers felt that NHI accreditation enabled them to serve a wider patient population than they had served previously, including low-income patients. As one provider in Kenya said:

*Coz people used to see us initially like this place is expensive it is for the rich. But due to NHIF now we encounter all groups. All classes. So if somebody goes there he or she says but I was treated at [clinic name] And they are like, with which card, NHIF. So the... the... that thing of a hospital for the rich...It’s now over.* (Auxiliary Nurse at a non-franchised clinic, Nyanza, Kenya)

**Challenges with the NHIs**

Providers faced challenges with NHI payment delays, and patients’ lack of understanding; had difficulty understanding capitation risk-pooling

Providers in both Kenya and Ghana commonly faced challenges with payment delays, processing claims, and patients’ lack of understanding of NHI coverage. While some Kenyan providers complained of delayed payments from NHIF, this problem was far more pronounced in Ghana. Providers interviewed in Ghana frequently cited payment delays as their greatest challenge with NHIS and this was true across all three rounds of data collection. These delays ranged from 3-4 month delays in Round 1 (2013) to providers in Round 3 (2017) commonly citing payment delays of 9-12 months. In the face of these delays, providers often faced challenges stocking drugs and paying staff. To manage the financial shortfall, providers reported operating on credit (particularly with pharmacies in order to stock drugs), paying some clinic costs out of their own pocket, or charging clients on top of NHIS reimbursement rates. One provider had her own internal system that functioned like health insurance risk pooling, whereby she charged clients with minor ailments in order to cover the costs of more expensive treatments for others:

*The clinic must take money from one patient and use it to buy drugs to cater for another patient whose sickness is severe and at the verge of death. Ahaaa. It may even happen that at the time, the patient at the verge of death may have no money, and must you leave that person to die? No. you will not leave that person. You must find something to do so that that person can also come back to life.* (Midwife at a BlueStar clinic, Ashanti, Ghana)

Ghanaian elections held shortly before Round 3 of data collection resulted in a change in power and a promise from the new government to prioritize the NHIS. As of Fall 2017, the newly-elected government had begun to pay out NHIS reimbursements due through March 2017, the effects of which could not be captured for this report.

In addition to payment delays, providers in both countries regularly faced difficulties processing claims and complained that reimbursement rates were low. This was especially true in Ghana, where providers
also faced challenges with restrictions on the drugs and services reimbursed by NHIS.

Finally, in both Kenya and Ghana a number of providers faced challenges with patients who don’t adequately understand NHI coverage; this lack of understanding was also reflected in interviews with clients. A couple of providers in Ghana mentioned that patients expect all of their services to be free under NHIS, but due to reimbursement restrictions for smaller providers, they cannot offer NHIS patients the same services given at a larger facility. Patients therefore demand services for free that smaller providers cannot offer and some providers said they had lost clients as a result. Some providers also felt that these differential reimbursements forced them to treat patients differently according to their NHIS status, offering more comprehensive services to clients not covered by insurance. As so many patients pointed out in their interviews, trust between patient and provider is an important aspect of provider choice. Such differential treatment, or even the perception of differential treatment due to misunderstanding of the system, has the potential to undermine patients’ trust in their providers. As one non-franchised provider in Kenya noted:

*If they are not taught they come with the card and the person insists. Then you tell the person no it is not like this they feel like you are lying to them. So they like [sic], that trust is off.* (Auxiliary Nurse at a non-franchised clinic, Nyanza, Kenya)

**Experiences with Capitation**

Capitation schemes were rolled out in select pilot districts in Ghana and across outpatient-accredited facilities in Kenya. These posed particular challenges for providers in both countries. On the one hand, providers appreciated the concept of receiving lump sum payments at regular intervals, but in Ghana this potential benefit was complicated by widespread payment delays from the NHIS. Providers interviewed in the pilot districts during all three rounds of data collection generally had very negative feedback on capitation. While some had hoped that regular lump sum payments from NHIS would be financially beneficial, these clinics ultimately suffered the same payment delays and low reimbursement rates that were affecting providers across the country.

Further, providers in both countries had difficulty understanding capitation as a way to pool financial risk across a patient population. Instead, they saw the payments as a cap on the amount they were able to spend on an individual patient during the payment period.

*Interviewer: How much do they allocate under capitation for one patient maybe…?*
*Respondent: 500 [KSH], inclusive of lab.*
*Interviewer: One treatment or…?*
*R: Yeah, one treatment. Not more than five hundred for outpatient.* (Nurse/Midwife at a Tunza clinic, Eastern, Kenya)

As a result of this misunderstanding, particularly in Kenya, providers regularly mentioned limiting the services they provided to clients paying with NHI so as not to exceed the client’s monthly allotment and risk losing money for the clinic.

While providers had difficulty understanding the financial aspects of capitation, they all understood that
NHIF payments are tied to the number of clients registered with their particular facility. As a result, similar to our findings in Ghana, a lack of understanding around facility registration among patients also proved challenging at the clinic level. Several providers complained that patients came to their clinic expecting free treatment even though they were registered elsewhere. Further, some providers reported that they were losing clients to other facilities as a result of competition under capitation.

_The capitation is decreasing our savings...the other facility has taken all our customers._ (Midwife at a BlueStar clinic, Ashanti, Ghana)

In some cases, providers suggested that patients were registering with competing clinics that offered more services or had more highly-qualified staff. There was also suspicion that larger clinics with more resources were recruiting clients and even paying their registration fees; one client interview suggested that this may indeed be the case.

In response to complaints from providers, recent reports suggest that the capitation pilot is on hold in Ghana pending an actuarial study, although patients are still being assigned to clinics. In addition, there has been debate in Kenya around whether or not to continue operating on a capitation model for the outpatient scheme, although no permanent changes have been made as of yet.

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**PATIENTS**

**PROVIDER CHOICE**

**Provider Choice**

Patients often referred to clinic by a friend or family member; brand recognition was low

In both Ghana and Kenya, most clients reported that they had first attended a franchised facility because they were referred by a friend, family, or community member. Similarly, community members interviewed in Round 1 focus groups stated that they learned about healthcare providers through word-of-mouth or referrals from their personal networks. Media and TV were also sources of healthcare information, but community members in Ghana noted that illiteracy was a barrier to many people understanding billboards and other written forms of advertisement. In Ghana, a number of clients returned to the franchised clinics with their children after receiving antenatal care or giving birth there because they valued continuity of care. This concern came up less often in Kenya.

In slight contrast to clients interviewed at private clinics, community focus group members in Round 1 also expressed a preference for clinic proximity. For common health issues, like pregnancy, community members in Ghana said they would seek out whichever facility was closest. Some patients interviewed at private clinics in both countries expressed similar preferences, particularly regarding pregnancy care, noting that clinic proximity and open hours are important in case a woman has an emergency or goes into labor in the middle of the night.

**Brand Recognition**
Overall, only a few clients in both countries were familiar with the franchise brand; in Round 1, most of these were Tunza clients who had learned of the franchise through the radio. However, several clients interviewed in Round 2 in Kenya had heard of Amua outside the clinic as well. One mentioned seeing an Amua billboard on the side of the road, while a couple of others mentioned hearing of Amua on the radio. One client interviewed at a Tunza clinic recognized Tunza because it provides free check-ups. Almost none of the clients interviewed at franchised clinics in Ghana had heard of BlueStar in Round 1 of data collection and this was true in Round 2 as well, despite being interviewed while exiting a BlueStar facility in both cases.

As noted above, illiteracy was also an issue for brand recognition among community members. One focus group specifically noted that they did not know what the BlueStar poster meant, because they could not read it. However, they did recognize its name and images, and could identify the association between BlueStar and family planning. None of these community members, though, reported ever having visited a BlueStar facility.

Public vs. private

Patients prefer private clinics for respectful treatment, public facilities for comprehensive services

Patients overwhelmingly cited the caring, respectful treatment they received at private clinics and shorter wait times as the reasons why they would visit a private clinic over a public facility. In comparison to private providers, many clients thought that staff at public health facilities were at best over-worked and disinterested in serving patients, and at worst disrespectful.

Those for the government mostly if we go, you get that you are there and the Doctor is busy concerned with other things, he is not even in a hurry with you. And like here when you just arrive here [the private clinic], you are attended to, mostly those doctors who are here are so many it’s not only one Doctor. Which problem do you have...Like everyone wants to help you, they have the heart to assist you. So we see that here is better than public. (Patient at a Tunza clinic, Nyanza, Kenya)

Kenyan patients also cited drug supply as a reason for choosing a private clinic, which they said was more reliable than at public facilities. In contrast, patients in Ghana often had to pay for their own drugs at the private clinics or were sent out to fill prescriptions. This aligns with provider reports that they had trouble stocking drugs in the face of long delays in NHIS reimbursements.

While patients expressed an overall preference for private providers, clients in both countries perceived that they could access a wider range of services at a public hospital than they could at a private clinic, and often thought that staff at public facilities were better qualified than private practitioners. These perceptions held true across rounds of data collection. As a result, clients sometimes reported seeking out public facilities when they believed they were in need of more services or specialized equipment.

Clients and community focus group participants in both countries also noted that public facilities are cheaper than private clinics. When it came to provider choice, this was more a concern for community members interviewed in Round 1 focus groups than for clients interviewed in private clinics in both rounds of data collection. When weighed against the benefits of a private facility, though, cost was less of a concern than reliability and quality of treatment, and clients interviewed in Round 2 generally
thought the charges incurred at the private clinic were reasonable. These findings align somewhat with our findings from Round 1 of patient interviews, though several clients in Kenya said they would visit a government facility if they didn’t have money; an alternative that did not come up in Round 2. Further, some clients noted that the franchise clinic costs were comparatively less than other private clinics in the area.

Finally, practical matters governing the healthcare landscape came up in several Round 2 patient interviews in Kenya, when the country’s government-employed doctors were on strike. In this round, a few Kenyan patients said they chose a private provider because they didn’t feel they were able to get adequate service in a public facility due to the strike:

*You know, right now, all the doctors are on strike and so even if there is...the medical services in the government hospitals are not good. Even when we went there, we were forced to come to this private hospital. Because we went there and the medical services were not good.* *(Patient at an Amua clinic, Eastern, Kenya)*

**Clinic Experience**

Patients value respectful care and personal relationships at private clinics; little difference between franchised vs. non-franchised clinic experience

Most clients in both Kenya and Ghana said they continued to seek care at private clinics because of the caring, respectful way they were treated. Further, clients in both countries valued the personal relationships they had developed with their providers; a number of clients in Ghana characterized their provider as having “patience” or being like an “aunty” or “brother” to them. These personal relationships sometimes gave patients access to clinic staff at off-hours, allowed them to negotiate prices or pay on credit, or receive only a partial dose of drugs if they could not afford a complete regimen. In addition, clients felt they could talk openly with clinic staff and, as some clients in both countries noted in Round 2, private providers were more likely than providers in public facilities to give them adequate time and listen to their complaints once they were in the examination room. Patients felt this extra time with a provider gave them more of an opportunity to adequately discuss their health issues.

Experiences with Franchised vs. Non-Franchised Clinics

Generally, there was little difference in the way clients described their experiences at franchised versus non-franchised clinics, and clients were pleased with their treatment across private providers. Some clients at franchised clinics in Ghana mentioned being educated by their provider about their health, while one client at a non-franchised facility expressed a desire for more education, which she said she had experienced at another private clinic. However, this was not a pattern that showed up in the data and our small sample size of non-franchised clinics in Ghana makes it difficult to draw strong conclusions comparing the two types of providers. It is not surprising, though, that patients would perceive little difference between the franchised and non-franchised clinics. Since the non-franchised clinics in our sample met the criteria to participate in the franchises, but either refused participation (Ghana) or were
specifically excluded from participation for the sake of the AHME randomized controlled trial (Kenya), even the non-franchised clinics likely meet a minimum standard of quality of care.

EXPERIENCES WITH NATIONAL HEALTH INSURANCE

Knowledge of the NHIs

Knowledge of NHI coverage limited to personal experience; greater among patients in Ghana than in Kenya

Knowledge of NHI coverage among clients interviewed in both Kenya and Ghana tended to be experiential; when asked which services were covered by the scheme they often cited services they had received themselves, but had little knowledge of specific services or programs beyond their own experience. Patients generally understood that NHI doesn’t cover all services or drugs, but often weren’t able to cite specific services that are or are not covered. This level of knowledge among clients is consistent with our findings from both interviews with patients and community focus group discussions in Round 1 of data collection. The exception to this trend in Round 2 was free maternity services, particularly among women in Ghana, which many clients seemed to know because they had used the program themselves. Kenyan patients interviewed in Round 2 also were aware that outpatient services were new to the NHIF scheme, though few were able to identify other programs that had only recently rolled out, such as Supa Cover. Finally, patients in both countries were generally aware that paracetamol would be covered by the NHI, but they regularly reported having to pay extra for other drugs with little differentiation among them. Indeed, some clients were aware of their lack of knowledge regarding NHIS services and expressed a desire to learn more about NHIS coverage from their providers:

We will also beg of them to tell us exactly what the health insurance covers. Because sometimes when you go to the hospital you will be told that the health insurance does not cover “Drip” and some of the drugs too are not covered by it...it does not cover admission beds too. So we don’t know what exactly the health insurance covers, so we want them to make known to us the exact things that when you go to the hospital the health insurance will cover, so that we become aware. (Patient at a non-franchised clinic, Greater Accra, Ghana)

Despite their confusion around the specifics of NHIS coverage, patients in Ghana generally understood how health insurance works. Patients in Kenya were less clear about how to use their coverage, which may help explain why they tended to use NHIF to pay for services less often than their counterparts in Ghana. In several cases, clients mentioned that their husband held their NHIF card and they weren’t able to use the card unless he had given it to them. While some of these patients said they were aware that they could provide the clinic with their NHIF ID number in the absence of a card, they either didn’t have the number with them or still seemed unsure about using their ID number in place of the physical card.

Further, a few clients in Kenya were confused about whether or not they had NHIF coverage themselves or through their husbands and mentioned challenges registering their children, indicating confusion around the enrollment process and the extent of individual versus family coverage. This confusion seems to be linked to the lack of clarity around whether or not a patient needs to be physically in possession of an NHIF card in order to be covered at the clinic; some patients think they should get their own registration just so they can have their own card, despite being included under their husband’s
Out-of-Pocket Payments

Related to general lack of knowledge around NHI coverage, patients in both Kenya and Ghana often reported having paid for some services or drugs out of pocket while visiting the private clinic, but weren’t sure if they had been charged correctly. This lack of information affected patients’ perceptions of clinic charges. Clients in Kenya did not expect completely free services under NHIF and were more likely to feel satisfied with the amount they had paid in the clinic than their counterparts in Ghana. However, Kenyan patients also were more likely to report that they had paid nothing for their clinic visit, including drugs.

While most patients in Ghana reported that the fees they paid felt reasonable, these patients were more likely to expect free services, which may be a result of having received more comprehensive coverage when NHIS first started operating with adequate funding. Patients who were charged for services they had previously received for free felt that making any kind of payment was inappropriate. Further, across rounds of data collection patients in Ghana specifically expressed concern that NHIS doesn’t cover enough services or drugs, resulting in patients having to make additional cash payments at the clinic or visit a pharmacy to pay for medications out of pocket. A few patients reported that they didn’t even bring their NHIS card with them to the clinic because they felt it didn’t provide adequate coverage:

Respondent: Mm, me, to me, right now I don’t have health insurance. I have the card alright but it’s at home. When I visit the hospital, I go with money.
Interviewer : Okay, okay, okay, why?
Respondent : Because when I even possess the health insurance it covers nothing. Mm. (Patient at a Bluestar clinic, Ashanti, Ghana)

In this context, patients sometimes felt cheated by a system that they believed no longer functioned properly. Conversely, while lack of drugs and insufficient coverage of drugs under NHIF came up as a concern facing community members during our Round 1 focus groups in Kenya, this did not come up as a common challenge in our Round 2 interviews.

Why Enroll/Renew

Patients enrolled to reduce healthcare costs, allowed enrollment to lapse due to difficulties at registration site (Ghana) or cost (Kenya)

Clients in both Ghana and Kenya were generally aware that NHI is useful for reducing costs and making healthcare more affordable, and commonly cited this as a benefit and a reason for enrolling. Indeed, a couple of Kenyan clients who were not enrolled in NHIF, or who were visiting the clinic with a family member who was not enrolled, noted that they would have paid less for their visit if they had NHIF coverage. Some patients reported enrolling specifically because their children required expensive healthcare and they realized that NHIF would help them cut costs. Since NHIF enrollment is required in certain workplaces (e.g. for civil servants), several patients also noted that they were registered simply because registration was compulsory.
Doctors employed as civil servants in Kenya’s public hospitals went on strike from December 2016 – March 2017 and a few providers mentioned they thought that the strike had affected their business. While this concern did not come up often in patient interviews, one patient suggested that it was particularly beneficial to have NHI coverage during this time and said she had enrolled due to the strike. Without NHIF to cover costs at private clinics during the strike, this client suggested, *those who don’t have the card suffers a lot* (28-year-old patient, Eastern, Kenya). Another was under the impression that she could only use her NHIF card at a government hospital, and said she had been forced to go to a private hospital and pay for services due to the strike.

While patients in Ghana were more likely to be enrolled in NHI than those in Kenya, interviewees in Ghana still cited a couple of reasons why they would not re-enroll or had allowed their enrollment to lapse. The most commonly cited cause for allowing enrollment to lapse was long wait times at NHI registration centers. Clients often reported leaving their home at 3:00 or 4:00am to join the line for registration and then waiting a full day to go through the process. Some spent all day waiting only to be told to return the next day when the machines used for registration were experiencing connectivity issues. Further, a couple of clients reported having been asked for informal payments to move the process along more quickly and they were clearly critical of this practice. Conversely, several women noted that they were pushed to the front of the line and enrolled for free when they were pregnant.

In addition to long wait times at registration sites, some patients decided not to re-enroll because they didn’t see any benefit from it:

*So after the treatment, the drugs prescribe – sometimes the doctor writes prescription and if you have Health Insurance they will tell you they don’t have but when you are buying with cash they will be able to get some for you...So I normally see it as – I registered for when the Health Insurance was introduced about 12 years ago, but as it expired I’ve not re-apply for it again.*  (Patient at a Bluestar clinic, Ashanti, Ghana)

Patients in Kenya faced different barriers to enrollment, commonly citing cost as a challenge with initial registration and some clients similarly reported allowing their enrollment to lapse because they could not make the monthly payments. In these cases, the NHIF requires patients to pay a penalty for a lapse of less than one year, while those who have neglected to pay for more than a year must renew their membership and wait 60 days for re-activation. These requirements made it even more challenging for clients to maintain or renew enrollment during times of financial hardship. Similar to the Ghananian patient quoted above, a few Kenyan patients also said they didn’t see enough financial benefit in continuing to pay for insurance when they still incur charges in the clinic. Some patients reported paying for NHIF even though they didn’t actually use their insurance card when visiting a clinic. Since NHIF fees are automatically deducted from workers’ salaries, it is possible that these interviewees did not have control over whether or not they paid for NHIF coverage, which would help to explain their continued payments.

**Patient Treatment & Frequency of Use**

Patients had positive experiences using NHI; provider accreditation less likely to influence provider choice in Kenya than in Ghana
As we found in Round 1 of data collection in both Ghana and Kenya, patients enrolled in the NHIs generally reported positive experiences in Round 2 as well. In Ghana, patients used their NHIS cards very regularly to access services and generally felt they were treated well when they paid with NHIS. However, patients disagreed on whether they were treated better or worse than cash-paying clients. In some cases, clients felt they were treated better or faster than patients paying with cash, which one Kenyan client suggested was because providers know that patients covered by NHIF are definitely able to pay. Conversely, some patients suggested that clients paying with cash received better services and higher-quality drugs than those paying with NHI. This perception aligns with reports from some providers in Kenya, a number of whom said they do treat NHIF-enrolled patients differently out of concern for cost. This was particularly relevant for outpatient services under capitation.

While a number of Ghanaian clients reported that they use NHIS to pay for services every time they go to the clinic, clients in Kenya did not report using NHIF every time they accessed health services. Some had only used NHIF one or two times, even though they had been enrolled for years. In most cases, clients said they didn’t use the NHIF card at every clinic visit because they sometimes visited clinics that don’t accept NHIF. One client expressed surprise when she learned that she could use NHIF at the clinic she was attending, a reaction consistent with provider choice trends in Kenya, where patients were less likely to choose providers that specifically accepted NHIF as opposed to clients in Ghana who were more likely to seek out providers that accept NHIS. This trend may be due to a dearth of accessible NHIF-accredited clinics as much as patients’ lack of information regarding the accreditation status of individual clinics.

**NHI Coverage & Healthcare Accessibility**

**NHI coverage makes healthcare more accessible, particularly for people with low income**

Patients interviewed in both Kenya and Ghana commonly suggested that the main benefit of the NHIs is that they increase healthcare accessibility by making care more affordable; this was sometimes linked specifically to the benefit of affordable maternity services. Clients said that they were more likely to visit the clinic when they weren’t feeling well or had an antenatal appointment because they knew NHIS would cover their costs:

*Because with the card, if I go anywhere and I’m registered – when I’m sick, I just take it along with me. With that you don’t fail to go to the hospital because of lack of money, right?* (Patient at a Bluestar clinic, Ashanti, Ghana)

*Because if you have it and sickness strikes even if you do not have money you will not worry because the card will pay. You’ll just be sorted.* (Patient at a non-franchised clinic, Coast, Kenya)

One patient in Ghana specifically suggested that NHIS makes private healthcare more affordable, because it covers all of her services regardless of whether she is attending a public or a private facility. Further, a number of patients in both countries saw a link between the NHIs and access to healthcare for people with low income. Patients in Kenya commonly noted that NHIF is helpful in cases where someone has “no money” or a “lack” of money and one patient noted that NHIF was especially useful for the “under privileged people.”

**Experiences with Capitation**

Patients understood capitation, did not have strong opinions about the scheme

Unlike providers, a number of whom were frustrated with the capitation pilot program in Ghana, or confused by the concept in Kenya, patients didn’t express strong feelings about capitation. Clients were generally informed about the concept and the need to register with a particular clinic. One patient in Kenya framed capitation as a positive thing, noting that it gave patients the opportunity to choose the clinic where they wanted to seek treatment. However, at least one patient in Kenya said she visited a clinic where she couldn’t use NHIF because she was registered with another clinic under capitation and this clinic was not convenient for emergencies, which may also be related to our finding that NHIF-accredited facilities were less accessible to patients in Kenya than those in Ghana. One Ghanaian patient similarly suggested that capitation limits the ability to shop around for different providers while another described being incentivized to register with a particular clinic under the auspices of receiving free NHIS registration; this dissuaded her from completing her registration.

CONCLUSIONS & RECOMMENDATIONS

Providers tended to report positive experiences with the AHME interventions across all rounds of data collection. Franchised providers in both Ghana and Kenya particularly appreciated having the support of an outside body with which they could “walk together” to improve services in their clinic and to help them navigate bureaucratic systems; a finding supported by a study recently conducted among Amua franchise providers in Kenya (Appleford and Owino forthcoming). This support was especially relevant in the case of NHIF accreditation (Kenya) or re-accreditation (Ghana), but providers clearly valued the learnings and hands-on support they received through franchise trainings and through SafeCare as well. Improving their services, particularly under the auspices of an International NGO (INGO), was a point of pride for providers. They often cited specific improvements they had made to their clinics and regularly noted that they were working with an INGO (MSI was cited most often in Round 3 of data collection) to make these improvements, which they felt indicated a level of respectability and high standards.

However, the extent to which providers were ultimately able to make recommended physical improvements to their clinics often was limited by finances, including the need to rent rather than own a clinic, resulting in space restrictions. While MCF loans initially were meant to address providers’ financial limitations, providers in both countries (but particularly in Ghana) remained skeptical of loans throughout our three rounds of data collection. As a result of this skepticism and processes that providers characterized as complex and confusing, uptake was low and the MCF loans have been discontinued in both countries. It remains to be seen whether the new Receivables Financing intervention in Ghana will prove more popular. While our findings indicate that providers in Ghana feared taking loans of any kind in the face of long NHIS payments delays, recent efforts to catch up on reimbursements at the NHIS may have an effect on providers’ confidence in their own abilities to re-pay.

By our final round of data collection in 2017, providers in both Kenya and Ghana commonly cited market pressure (demand from clients) as a main reason to seek out NHI accreditation. This was an especially notable change in Kenya, where NHIF accreditation was much less common in Round 1 of data collection and providers rarely felt they needed to be accredited to attract patients. In Ghana, market pressure created a dilemma for providers, one of whom said, The insurance is helping us but it is also killing us (Midwife at a BlueStar clinic, Ashanti, Ghana). Here, providers felt NHI accreditation was necessary to
maintain their patient population, but long payment delays from the NHIS resulted in severe financial shortfalls at the clinics. As a result, providers often operated on some level of credit, whether borrowing drugs from a pharmacy or taking a personal loan from a bank.

Once accredited with NHIF, providers in Kenya appreciated receiving regular payments through the outpatient capitation system, which they felt alleviated the need to negotiate prices with lower-income patients, or even provide services for free when patients couldn't pay. Indeed, providers in both Kenya and Ghana noted that having NHI accreditation allowed them to serve a wider patient population, and particularly patients with low income. However, providers in both countries and across all three rounds of data collection, particularly in Kenya where the NHIF outpatient scheme is much newer, displayed varying levels of understanding in terms of what the NHIs cover and how exactly they work. Regarding capitation in particular, providers in Kenya and those in the capitation pilot districts in Ghana clearly interpreted capitation payments as a cap on the amount they were allowed to spend on individual patients per visit, as opposed to a risk-pooling scheme meant to be shared across an entire patient population. This regularly led to treating patients with reduced services or writing prescriptions for patients to purchase drugs outside the clinic.

In most cases, providers in both countries also agreed that NHI accreditation brought in more patients and also that it allowed them to serve poorer patient populations. However, it was unclear whether an increase in patient volume resulted in an increase in revenue, furthering the clinic’s financial viability. This may be a productive area for AHME to expand its reach; providers participating in MCF were very positive about the business training component of the intervention and often mentioned learning about bookkeeping. The AHME partners should consider encouraging providers to track client flow and income against expenditures so that they can better grasp how client flow coupled with NHI accreditation affects their clinic as a business.

Among patients, views of the franchised clinics, but also views of private providers more generally, were very positive. Clients in both Ghana and Kenya were particularly appreciative of the respectful treatment they received at private clinics as opposed to the treatment they received at public hospitals. Respectful treatment for most patients included not only the way that providers interacted with them, but also being served quickly and efficiently. As one client in Kenya noted, Government you are delayed until you give up (Patient at a non-franchised clinic, Coast, Kenya). When they were able, clients were very willing to pay for what they perceived to be better services at these clinics, as opposed to government hospitals where services were much cheaper or free.

In line with our findings on market pressure to become NHI-accredited among providers, clients in Ghana were more likely not only to be enrolled with NHIS, but also to use insurance when they visited the clinic. Conversely, several clients in Kenya mentioned that although they had NHIF and made regular payments, they did not actually use it to pay for health services. This may be a result of NHIF policy, whereby the monthly enrollment fee is automatically deducted from workers’ paychecks, although we cannot confirm this. Clients in both countries reported challenges either enrolling (Ghana) or maintaining enrollment (Kenya) in the NHIs. This was for reasons of cost in Kenya and due to long wait times at NHIS registration sites in Ghana. Among those who did use NHI to pay for services, clients in both countries felt they were treated the same as clients paying out of pocket, with some patients reporting that they were treated better than cash-paying clients. These perceptions did not align with
reports from providers, who sometimes said they gave patients paying with NHI reduced services because NHI reimbursement was limited or, in the case of Ghana, severely delayed.

The disjoint between provider treatment reports and patient perceptions under the NHIs points to a particular challenge we found that seems to stem from lack of understanding of how the NHIs work and what exactly is covered among both patients and providers. Since providers don’t fully understand how the system works, particularly under capitation, they sometimes felt patients were taking advantage by “overusing” services. In turn, providers sometimes charged patients for services they felt weren’t covered under the NHIs. And in Ghana in particular, where patients recalled a time when the NHIS covered more services for free, patients felt providers were taking advantage of them by charging for drugs or services they believed were included in their NHI registration. Appleford and Owino (forthcoming) drew similar conclusions linking the lack of information among both patients and providers to reduced services and the erosion of trust under NHIF. Since trust is a key aspect of the provider-patient relationship, the mistrust that can result from a simple lack of understanding of NHI coverage seems an easy one for AHME to address through its community outreach efforts and also through more provider education.

Finally, private providers feel like they don’t have a voice in the health system the way that public health practitioners do. This results in dissatisfaction and alienation, particularly in Ghana, and confusion about how the system works, particularly in Kenya. AHME has potential to mitigate these effects by minimizing inconsistencies in policy as it is handed down to both providers and patients, and by providing a means to connect providers more directly to government processes. We suspect that devolution in Kenya may have an effect on provider engagement and understanding of health policy as well. We recommend that, in addition to the interventions currently underway, AHME should pay particular attention to new activities that allow the partnership to act as a mediator between clinics and government moving forward. AHME’s plans to explore a “hub-and-spoke” capitation model for clinics in Ghana and the proposed Aggregator Model in Kenya seem promising.
REFERENCES

Works Cited


Appleford, G. and Owino, E. (Forthcoming) National Hospital Insurance Fund Tariffs – What are the Effects on Amua Franchisee Businesses?


Background References


To examine AHME’s operation processes and impacts, we collected and analyzed data from key informant interviews with partners at the headquarter, region, and country levels, as well as their public-sector counterparts at the NHIA, NHIF, and the Kenyan Ministry of Labor. In the first year of the evaluation, we also interviewed financial institutions that were involved in the AHME partnership at the time. In the latest round of the evaluation, we interviewed leaders in the global health community as well. The process evaluation themes and respondent groups are outlined in Table 1.

### Table 1: Process Evaluation Themes and Respondent Groups by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Theme</th>
<th>Respondent Groups</th>
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<tr>
<td></td>
<td>Year 2 (2014): Operationalization and Short Term-Impacts</td>
<td>Headquarters-level AHME partners (donors and members of the Project Management Unit): 15, Policy makers and government officials: 2, Financial Institutions: 2</td>
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**SAMPLING STRATEGY**

Each year, UCSF and IPA coordinated with the AHME implementation team to contact staff from each partner organization in Ghana and Kenya and invited them to participate in an interview. Interviews with county-level partners were conducted in person in Accra and Nairobi. Government officials were identified through referrals by interviewees and were also interviewed in country. Headquarters-level AHME partners were identified from among members of the donor organizations, Steering Committee, and Leadership Team. Global health financing experts external to the AHME partnership were selected for their position in the field and their proximity to the initiative; experts had heard of AHME and had...
some experience with it, but were not directly involved. These interviews were conducted by phone or by Skype and lasted approximately one hour. Depending on the extent of their involvement with the AHME partnership, some participants were only interviewed once while others participated in several rounds.

DATA COLLECTION, PROCESSING, AND ANALYSIS

In-depth, semi-structured interviews with AHME partners, government officials, and other relevant stakeholders were conducted by UCSF’s Qualitative Evaluation team, including one consultant hired specifically to assist with Round 3 and Round 4 data collection and analysis. Potential interviewees were identified according to their role in the AHME partnership or their relationship to AHME as a relevant stakeholder. Potential interviewees were contacted by email and, after giving their consent, participated in an interview either in-person or over Skype. Interviews lasted approximately 60 minutes and all but one interview was recorded using a digital recorder. When one interviewee did not consent to being recorded, the interviewer took written notes instead. Recordings were transcribed by a team of transcriptionists hired through Innovations for Poverty Action (IPA). UCSF staff was responsible for back-checking interviews to ensure accuracy.

All interview transcripts were coded by the UCSF team and consultant using Atlas.ti, a widely-used qualitative analysis software. We used an open-coding approach, in which codes are derived from the data. Codes were refined over the course of the four rounds of data collection to allow for new priorities in analysis while ensuring continuity across rounds.

ETHICAL REVIEW

We received initial approval with “Exempt” status from the Institutional Review Board of the University of California San Francisco for the AHME evaluation on 13 June 2013. We also received Ghana Health Services Ethical Review Committee (ERC) approval on 28 June 2013 and Kenya Medical Research Institute (KEMRI) approval on 28 October 2013. Prior to each round of data collection the QE team submitted amendments and received approval from all three review boards for any changes made to our protocol. Approval for Round 4 (2017) of process evaluation data collection was received from UCSF on February 28, 2017.

PROVIDER/PATIENT EVALUATION METHODS

SITES AND RESPONDENT SELECTION

During each round of data collection Marie Stopes International (MSI) and Population Services international (PSI) provided the QE team with lists of providers franchised under the Amua (MSI, Kenya), Tunza (PSI, Kenya) and BlueStar (MSI, Ghana) networks. During Rounds 2 and 3 of data collection they also provided lists of providers who had been contacted to join the franchise, but had declined. The QE team used these lists to design a sample that represented providers with a mix of experiences with the AHME interventions; some providers (non-franchised) had received none of the interventions, while some franchised providers were participating in SafeCare, some were participating in the Medical Credit
Fund (MCF), and some were participating in both SafeCare and MCF. Although NHI accreditation is not itself an AHME intervention, we also selected facilities based on their accreditation status with an aim to equally represent both accredited and non-accredited facilities. Interviews were conducted with providers in a range of facility types across six regions in Kenya and seven regions in Ghana during the three rounds of data collection. Within each facility, we instructed field staff to request an interview with the owner of the facility or a staff member with the greatest knowledge of facility management.

**Table 2: Data Collection Regions in Kenya and Ghana**

**Kenya**

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**Ghana**

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<td>Greater Accra</td>
<td>16</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Western</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Volta</td>
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<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Table 3: Data Collection by Facility Type in Kenya and Ghana**

**Kenya**
In addition, community members took part in Focus Group Discussions (FGD) during Round 1. In order to maximize the likelihood of capturing descriptions of market effects from the AHME interventions, we restricted selection to community members, both women and men, in the areas surrounding a few key providers who also participated in interviews. The FGDs were stratified by gender and by age group (18-24, 25-35, and 36-49) in order to form more homogenous groups and facilitate conversation. We also restricted FGDs to respondents with at least one child, as a number of questions dealt with child health scenarios.

Finally, we held two rounds of exit interviews with clients in 2013 and 2017. In order to best align with the Randomized Controlled Trial in Kenya, interviewees in both countries were selected for gender (women only), age (between 18-49 years of age), and number of children (interviewees were required to have at least one child aged 5 years or less). Respondents also had to be exiting one of the selected franchised or non-franchised clinics.
ETHICAL REVIEW

We received initial approval with “Exempt” status from the Institutional Review Board of the University of California San Francisco for the AHME evaluation on 13 June 2013. We also received Ghana Health Services Ethical Review Committee (ERC) approval on 28 June 2013 and Kenya Medical Research Institute (KEMRI) approval on 28 October 2013. Prior to each round of data collection the QE team submitted amendments and received approval from all three review boards for any changes made to our protocol. Approvals for Round 3 (2017) of data collection was received on 16 November 2017 from ERC, 12 December 2017 for UCSF, and 17 January 2017 for KEMRI.

DATA COLLECTION, PROCESSING, AND ANALYSIS

Field staff who conducted these in-depth, semi-structured interviews with providers and clients were recruited by Innovations for Poverty Action (IPA) and trained by IPA and UCSF on qualitative interviewing and the field guides that would be used during that round of data collection. Field staff went to clinics where providers had already agreed to participate and consented the providers prior to conducting a 60-minute interview.

Field staff recorded all IDIs and FGDs using digital recorders. These interviews were conducted in the language the respondent was most comfortable using, with some interviews being conducted in the local language, some in English, and some a mixture of the two. Tapes were translated and transcribed simultaneously by a team of transcriptionists. IPA research assistants in Ghana and Kenya were responsible for back-checking interviews, including ensuring translation accuracy.

After the back-checking process was concluded, IPA transferred the transcriptions to UCSF for analysis. All IDIs and FGDs were coded by the UCSF team with some assistance from IPA using Atlas.ti, a widely-used qualitative analysis software. We used an open-coding approach, in which codes are derived from the data. Codes were refined over the course of the three rounds of data collection to allow for new priorities in analysis while ensuring continuity across rounds.

STUDY POPULATION

Table 4: Distribution of IDIs & FGDs conducted in Kenya and Ghana

KENYA

<table>
<thead>
<tr>
<th></th>
<th>Provider IDIs</th>
<th>Patient IDIs</th>
<th>Community Member FGDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1 (2013)</td>
<td>24</td>
<td>26</td>
<td>99</td>
</tr>
<tr>
<td>Round 2 (2015)</td>
<td>57</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Round 3 (2017)</td>
<td>50</td>
<td>30</td>
<td>0</td>
</tr>
</tbody>
</table>
GHANA

During Round 1 of data collection (2013) a total of 20 exit interviews were conducted with clients from selected franchised facilities. Two of these patients concluded their interviews without providing demographic information, so the demographic profiles we have collected for this round are based on a sample size of N=18. The average age of interviewed clients was 32 years. Clients had three children on average, and 42% of clients had children under five years of age. Only three respondents had less than a junior secondary education. Half of the respondents had junior secondary education, and the remainder had a secondary education or higher. 67% of patients paid nothing for their visit. For those who paid, the average amount was 14 Ghana Cedis (USD 6.60). 39% of patients walked to the facility where they received care, 33% took a taxi and 28% used public transportation. The average time it took patients to reach this facility was 25 minutes with one patient traveling 60 minutes to receive care. The average wait time to see a provider was 60 minutes but most patients reported waiting 20-30 minutes.

During the second round (2017) of data collection with clients we conducted a total of 30 exit interviews with clients at 26 different facilities. 23 of the clients had visited a BlueStar facility while seven had been seen by a non-franchised provider. The average age of patients interviewed was 31. Just over two thirds of the patients had a middle school education or lower with five having received no formal education. Of the 23 patients who saw a franchised provider half reported a monthly income of 200GH or below (USD 44.45). Out of the seven patients who saw a non-franchised provider, six provided their income and all had a monthly income of more than 200GH (USD 44.45). Patients reported spending an average of 11GH (USD 2.45) for the care they received. All but three of the patients interviewed were covered by NHIS. A little over one third of patients walked to the facility where they received care. The average time it took patients to reach this facility was 19 minutes with one patient traveling up to 90 minutes to receive care. The average wait time to see a provider was 50 minutes with one patient waiting up to 6 hours.

Differences in educational and income level between Round 1 and Round 2 of data collection may be explained by a shift in sampling strategy. During the time between 2013 and 2015 it became clear that AHME clinics were serving higher-income populations and the AHME partners made a more concerted effort to reach low-income clients, the QE team instructed field teams to disproportionately select for interviewees at clinics in poorer neighborhoods to better capture the perspectives of AHME’s target population.

<table>
<thead>
<tr>
<th></th>
<th>Provider IDIs</th>
<th>Patient IDIs</th>
<th>Community Member FGDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1 (2013)</td>
<td>23</td>
<td>21</td>
<td>72</td>
</tr>
<tr>
<td>Round 2 (2015)</td>
<td>30</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Round 3 (2017)</td>
<td>28</td>
<td>30</td>
<td>0</td>
</tr>
</tbody>
</table>

CLIENTS: GHANA
We conducted a total of 26 exit interviews with clients from selected franchise facilities during our first round of data collection (2013). We interviewed seven clients from Amua facilities, and 19 from Tunza facilities. Due to low client attendance, and in spite of extending recruitment days, the field team faced difficulties recruiting patients from Amua facilities. The average age of interviewed clients was 26 years. Only three clients had none/less than a primary education and nearly half of the clients had a primary education; the remaining had a secondary education or higher. Half of the patients interviewed had NHIF and half did not. 31% of patients paid nothing for their visit; two of these patients used a voucher. For those who paid, the average amount was 276 Kenyan shillings (USD 3.18). Half of the clients walked to the facility where they received care. The average time it took patients to reach this facility was 22 minutes with one patients traveling up to 90 minutes to receive care. The average wait time to see a provider was 15 minutes.

During the second round of data collection with clients (2017) we conducted a total of 30 exit interviews with clients at 30 different facilities in Kenya. 20 of the clients had visited a franchised facility while 10 had been seen by a non-franchised provider. The QE team was not able to obtain a breakdown of clients interviewed by franchise (Tunza versus Amua) for this round of data collection due to staff turnover at IPA. The average age of patients interviewed was 29 years old. Just under two-thirds of the patients had a secondary education or higher with only three patients who had never gone to school or completed primary school. There was little difference in the income level of patients who went to franchised providers versus non-franchised providers. Out of the 10 patients who saw a non-franchised provider, nine provided their income level and just over 75% made 10,000 KSH (USD 98.03) or less. Out of the 20 patients who saw a franchised provider, 18 provided their monthly income and just under 75% made 10,000 KSH (USD 98.03) or less. Patients reported spending an average of 964 KSH (USD 945) for the care they received. 14 patients interviewed had NHIF and 14 reported not having NHIF; two clients did not know if they had NHIF coverage or not. The majority of clients (18/30) walked to the facility where they received care. The average time it took patients to reach this facility was 19 minutes with one patients traveling up to 90 minutes to receive care. The average wait time to see a provider was 9 minutes.

In Round 1 of data collection, we conducted 10 FGDs with a total of 72 community members in Ghana. Three FGDs were conducted with men (a total of 20 participants with approximately seven participants per group) and seven FGDs were held with women (a total of 52 participants with approximately 5-8 participants per group). Table 5 shows the distribution of FGDs by age group and gender. The team encountered difficulty in locating respondents age 18-24 with children, so this age group is under-represented in the sample.

Table 5: Distribution of FGDs by Age Group and Gender

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Community members had on average 2.5 children and about a third had children under five years of age. The majority were married, and nearly 90% identified as Christian. A quarter of respondents had less than a junior secondary education, half had a junior secondary education, and the remaining quarter had a secondary education or higher.

**COMMUNITY MEMBERS: KENYA**

We conducted 10 FGDs with a total of 99 community members in Kenya. Four FGDs were conducted with men (a total of 41 participants with approximately 8-10 participants per group), and six FGDs were held with women (a total of 58 participants with approximately 10 participants per group).

**Table 6: Distribution of FGDs by Age Group and Gender**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>25-35</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>36-49</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Community members had on average 2.4 total children and 1.4 children five years or younger. Three-fourths of community members were married, and nearly all identified as Catholic, Protestant, or Adventist. One-third of community members lived in rural areas. Only two community members had no education or less than a primary education. Eighty percent of community members had either a primary education or a secondary education and the remaining had a college/vocational education.

**PROVIDERS: GHANA**

During the first round of data collection (2013), 23 provider IDIs were conducted with franchised providers in Ghana. Nearly half of the providers interviewed were midwives and the average number of years in practice was 26 years (minimum 3, maximum 48). All but four of the providers interviewed were women. Just over half of the providers were owners of the facility where they were interviewed. The majority of the franchised providers had joined the BlueStar network two-to-four years prior to the interview.

During the second round of data collection (2015) a total of 30 IDIs were conducted with providers from 27 health facilities. 27 of the IDIs conducted were with BlueStar providers and three were with non-franchised providers. The majority of providers interviewed were either nurses or midwives and the average number of years in practice was 28 years (minimum 3, maximum 48). 77% of the providers interviewed were women, 85% of providers were owners of the facility, and the average age of the
providers was over 52 years.

During the third round of data collection we conducted a total of 28 IDIs with providers in Ghana. 20 of these interviews were with BlueStar providers and 8 were with non-franchised providers. 16 of the providers were women and 12 were men. Nearly half of the providers interviewed identified as midwives, likely reflecting the gender breakdown of this round, and 60% of those interviewed owned the facility. The majority of providers had either attended training college or university and the average number of years practicing was 29 years.

Out of the 27 clinics where IDIs were conducted in Round 2, 15 had NHIS accreditation, four were practicing in both SafeCare and MCF, 13 were only participating in SafeCare and none were only participating in MCF. Out of the 28 clinics where IDIs were conducted in Round 3, 27 had NHIS accreditation, 8 were participating in both SafeCare and MCF, 6 were participating in only SafeCare and 1 was participating in only MCF. Compared to our Round 2 sample, the Round 3 clinic sample skew towards clinics with NHIS accreditation because the majority of franchised clinics had accreditation at this point and we also decided to focus our data collection in capitation pilot districts, furthering limiting the potential sample size. Information regarding clinic accreditation status was not collected during the first round of data collection. A summary of this information can be seen in table 7.

**Table 7: Distribution of Ghana Clinics by AHME intervention**

<table>
<thead>
<tr>
<th>Round of data collection</th>
<th>Franchised</th>
<th>NHIS accreditation</th>
<th>SafeCare only</th>
<th>MCF only</th>
<th>SafeCare &amp; MCF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana Round 2 (n=27)</td>
<td>24</td>
<td>15&lt;sup&gt;1&lt;/sup&gt;</td>
<td>13</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Ghana Round 3 (n=28)</td>
<td>20</td>
<td>27</td>
<td>6</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

**Providers: Kenya**

During the first round of data collection (2013) we conducted a total of 24 IDIs with providers in Kenya. We interviewed 10 providers from Amua facilities and 14 from Tunza facilities. The majority of providers interviewed were nurses or midwives with an average of 21 years practicing. Nearly two-thirds of providers were women and three-fourths of providers were owners of the facility.

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<sup>1</sup> This number does not include one clinic that had recently become accredited with NHIS, but had not yet implemented the program.
During the second round of data collection (2015) we conducted 57 IDIs with providers from 52 health facilities. The majority of providers interviewed were nurses with an average of 21 years practicing. Just over half of the providers interviewed were men. Nearly three-fourths of the providers were owners of the facility with an average age of 47 years.

A total of 50 IDIs were conducted with providers during the third round of data collection in Kenya. 15 of the providers were members of the Amua network, 15 were members of the Tunza network, and 20 were non-franchised providers who were part of the control group for the AHME Randomized Controlled Trial. 70% of the providers interviewed owned the facility and nearly half identified as either a nurse or a clinical officer. 32 of the providers were men and 18 were women. The majority of providers had a college diploma/certificate with an average of 20 years in practice.

Out of the 52 clinics where IDIs were conducted in Round 2, 32 had NHIF accreditation, 9 were practicing in both SafeCare and MCF, 11 were only participating in SafeCare and 2 were only participating in MCF. Out of the 50 clinics where IDIs were conducted in Round 3, 19 had NHIF accreditation, 26 were participating in both SafeCare and MCF, 2 were participating in only SafeCare and 1 was participating in only MCF. This information was not collected during the first round of data collection. A summary of this information can be seen in table 8.

**Table 8: Distribution of Kenya Clinics by AHME intervention**

<table>
<thead>
<tr>
<th>Round of data collection</th>
<th>Franchised</th>
<th>NHIS accreditation</th>
<th>SafeCare only</th>
<th>MCF only</th>
<th>SafeCare and MCF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 2 (n= 52)</td>
<td>46</td>
<td>32</td>
<td>11&lt;sup&gt;2&lt;/sup&gt;</td>
<td>2&lt;sup&gt;3&lt;/sup&gt;</td>
<td>9</td>
</tr>
<tr>
<td>Round 3 (n= 50)</td>
<td>30</td>
<td>19</td>
<td>2&lt;sup&gt;4&lt;/sup&gt;</td>
<td>1&lt;sup&gt;5&lt;/sup&gt;</td>
<td>26</td>
</tr>
</tbody>
</table>

<sup>2</sup> This number does not include one facility where the provider was unsure if they were participating in SafeCare or not.

<sup>3</sup> This number does not include two facilities where the providers were unsure if they were participating in MCF or not.

<sup>4</sup> This number does not include one facility where the provider was unsure if they were participating in SafeCare or not.

<sup>5</sup> This number does not include three facilities where the providers were unsure if they were participating in MCF or not.
LIMITATIONS

There are several limitations to this study that should be kept in mind. First, due to the time required to analyze and write up such a large amount of data, some changes have been made in the AHME program since our last round of data collection. We have acknowledged these changes where appropriate, but we will not be able to capture their effects until our final round of data collection. Also, because our mandate has been to evaluate the AHME program in Ghana and in Kenya, we have little data on AHME’s (recently concluded) work in Nigeria, which has occasionally come up in the course of the process evaluation. While we include some analysis of processes surrounding the program’s work in Nigeria, this analysis is necessarily limited.

Since the data analyzed here was drawn from specific franchise networks, the findings from the Qualitative Evaluation cannot be generalized to all franchised providers and their clients in either Kenya or Ghana. Further, the QE team relied on AHME partners Marie Stopes International (MSI) and Population Services International (PSI) to identify and gain access to franchised providers. While this tactic was important to gain provider trust, it likely led to a degree of courtesy bias because providers associated the evaluation team with the franchises. The same may be true for client exit interviews.

The Qualitative Evaluation team did not verify providers’ statements about the impact of the AHME interventions on their profits and client loads against their clinic records. Similarly, we could not check client statements regarding the amount they paid for a clinic visit against the clinic’s financial records. Finally, we did not verify reports regarding challenges with the National Health Insurance schemes, such as alleged requests for informal payments from both providers and patients. The information presented in this report is instead based on providers’ perceptions of how the AHME interventions have impacted their businesses, including perceptions of NHI accreditation. The report is also based on patient perceptions of quality of care in private clinics and reported experiences with the NHIs.
FUTURE PLANS

The QE team has applied for a supplement to extend the AHME Qualitative Evaluation until October 2019 in alignment with the Quantitative Impact Evaluation team’s timeline. This proposed extension will allow for two additional rounds of data collection at both the AHME partner level, and among providers and patients in both Kenya and Ghana as follows:

<table>
<thead>
<tr>
<th>Endline Activities</th>
<th>Kenya</th>
<th>Ghana</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Provider Interviews</td>
<td></td>
<td></td>
<td>Jun - Jul 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jul - Aug 2018</td>
</tr>
<tr>
<td>Patient Focus Groups</td>
<td>Kenyan</td>
<td>Ghana</td>
<td>Jun - Jul 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jul - Aug 2018</td>
</tr>
<tr>
<td>Partner Interviews (Informal)</td>
<td>Kenyan</td>
<td>Ghana</td>
<td>June 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>July 2018</td>
</tr>
<tr>
<td>Gov’t Interviews (Formal)</td>
<td>Kenyan</td>
<td>Ghana</td>
<td>April 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>May 2019</td>
</tr>
</tbody>
</table>

During these additional rounds of data collection, the QE team will focus on a set of revised research questions meant to align with AHME’s key identified areas of health market impact (policy, supply, demand), and designed with input from donors and partners. These questions are:

1. Has AHME had an impact at the policy level in Kenya and Ghana? To what extent has it influenced public/private partnerships in health?
   a. Have government attitudes towards the private sector changed as a result of the AHME partnership?
   b. What came of special initiatives to enroll poor populations in NHI schemes in Kenya and Ghana? To what extent have these pilot initiatives been institutionalized?

2. How effective has AHME been in helping to generate demand for quality private providers?
   a. Once poor households are identified through AHME-supported NHI pilot programs, do those identified actually enroll?
   b. Once poor populations are enrolled in NHI, do they access services in AHME clinics using their insurance?
   c. Does provider accreditation status influence client choice? In what ways?

3. What role do the AHME interventions play in enabling private providers to supply health services to poor populations? Which interventions are most effective for ensuring provider supply and/or quality?
   a. Have provider accreditation support activities been effective? If yes, how? If not, why not?
   b. Have providers reacted to NHI accreditation in ways that affect client health?

4. What is the potential for AHME’s effects to be felt beyond the initiative’s official end date? In what ways might AHME continue to influence stakeholders across the lines of policy, supply and demand?
   a. How has AHME informed the conversation around social franchising at the global level?
   b. What kinds of lasting effects has AHME had at the level of national governments?
   c. What broader impact has AHME had at the level of the private provider landscape?
d. What is the potential for efforts to increase poor enrollment in the NHIs to have long-term effects on client demand?

The QE team will produce one additional comprehensive report at the end of the supplement period (October 2019), as well as four short reports focusing on the areas of policy, supply, demand, and sustainability as outlined above, and five articles for academic publication. The team will work with the AHME partnership to disseminate these publications and also to present interim findings at various international forums according to a mutually agreed upon dissemination plan that is currently in development.