



African Health Markets for Equity

Qualitative Evaluation

Final Report | 2013 – 2019

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Overview

African Health Markets for Equity (AHME) was an ambitious program that strove to make health markets work better for poor populations by bringing a more comprehensive approach to quality private primary care in Ghana and Kenya. While AHME did not achieve its ultimate goal as envisioned, the program generated valuable findings around: health equity; the role and experiences of small private providers in LMIC health systems; public-private partnerships; and effective design for a complex program implemented across several organizations and sites.

As found by the AHME partners and confirmed by the Quantitative Evaluation, AHME-supported facilities did not reach poor clients in the early years of the program. Responding to findings that location is a key driver of provider choice, the partners began to franchise in poor, rural areas, achieving an increase in wealth quintile one (Q1) and two (Q2) patient attendance. Our findings with private providers suggest that participating in the AHME interventions helped them attract more clients overall and, in some cases, this meant more Q1 and Q2 clients. However, our interviews with patients across wealth quintiles suggest that cost of service is not only a concern for low-income clients, as those in higher wealth quintiles also reported paying on credit and negotiating prices. Becoming enrolled in National Health Insurance (NHI) did help patients defray costs, even in Ghana when the NHIS virtually stopped all reimbursements. However, clients knew little about the benefits to which they were entitled and in Kenya a number of women across rounds of data collection reported barriers to using their NHIF card.

According to our data, small private providers often feel detached from the larger health system and, as a result, are intimidated by interactions with the government bureaucracy overseeing that system. In these cases, the AHME partners were able to act as effective intermediaries between providers and government by creating more transparency and consistency in government processes, and by liaising with government officials on behalf of franchised providers. This intermediary role may prove especially important during times of policy transition, which both Kenya and Ghana experienced consistently during the course of AHME. However, future projects seeking to emulate the AHME model should consider whether the policy environment is favorable for the proposed package of interventions before launching a complex program. Similarly, considering whether the proposed package of interventions is appropriate to the program's goal and ensuring that implementing partners have clear roles, responsibilities, and lines of accountability are crucial to the successful implementation of a program like AHME.

As the field itself has changed since the beginning of the program, both the AHME implementing organizations and government partners have in turn become more institutionally prepared and open to incorporating the lessons outlined in this report into strategic plans, as well as daily practice. Although AHME's external reach has been limited, we believe that this internal learning will help direct the participating organizations in the future through their responses to shifting donor priorities in the era of Universal Health Coverage (UHC).

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Acronyms

African Health Markets for Equity	AHME
Ghana Health Services	GHS
Ghanaian cedi	GHC
Harnessing non-state actors for better health for the poor	HANSHEP
Health Facilities Regulatory Agency	HeFRA
Health Insurance Subsidy Program	HISP
Ethical Review Committee	ERC
Free Maternity Services	FMS
Focus group discussion	FGD
In-depth interviews	IDI
International Finance Corporation	IFC
Innovations for Poverty Action	IPA
Kenya Medical Research Institute	KEMRI
Kenyan shillings	KSH
Marie Stops International	MSI
Marie Stopes Kenya	MSK
Marie Stopes Ghana	MSG
Medical Credit Fund	MCF
National Health Insurance	NHI
National Health Insurance Agency (Ghana)	NHIA
National Health Insurance Scheme (Ghana)	NHIS
National Hospital Insurance Fund (Kenya)	NHIF
Population Services International	PSI
Population Services Kenya	PS Kenya
Program Management Unit	PMU
Qualitative Evaluation	QE
United States Dollar	USD
Universal Health Coverage	UHC
University of California, San Francisco	UCSF
Wealth quintile one (poorest)	Q1
Wealth quintile two (poor)	Q2

Policy Context

The AHME initiative lasted seven years and took place during periods of significant change for the administrative and health systems in both Ghana and Kenya. Externalities are an important factor in any intervention or study; frequently unavoidable, often un-measurable, always of concern when seeking to understand a health system intervention such as AHME. The policy, governance, and financing contexts in Kenya and Ghana changed in ways that inevitably created externalities which must be kept in mind while considering how AHME was implemented and what effects it had.

In Ghana, the most significant changes to the health system began in 1996 when the Ministry of Health, which until then had combined the roles of financing, overseeing, and delivery services in one entity, was divided into two parts. The Ghana Health Services (GHS) was created as a public service entity charged with management of all health services other than teaching hospitals. Critically, GHS employees are outside of the civil service and GHS managers are not required to adhere to civil service rules. The GHS remains entirely funded by public money. The Ministry of Health now is responsible for policy, resource mobilization, and overall health system regulation. In 2003, the National Health Insurance Scheme (NHIS) was created to fund health service provision, supported largely by a new 2.5% Value Added Tax and a 2.5% Social Security Insurance Trust tax. Demonstrating its significant effect on the health system, from its inception to 2016, NHIS hospital attendance quadrupled. However, the system has struggled to reach individuals living in poverty and their enrollment has been limited. Pilot initiatives supported by the NHIS since AHME began in 2013 have sought to facilitate enrollment by poor families through waivers of the approximately \$10/year premium. However, the expansion of these initiatives has stalled given the larger financial uncertainty of the NHIS as a whole. Other initiatives, such as the introduction of electronic enrollment and re-enrollment systems for members, capitation pilots, and electronic claims filing have all been piloted during the AHME program timeframe. In

2016, a Presidential Committee recommended shifting the NHIS to focus on primary care services and away from hospital care. This aligns with the new UHC priorities of Ghana and has led to more interest in enrolling private providers as reimbursable members of the Scheme.

In Kenya the changes which most affected the AHME context began contemporaneously with the initiative itself. In 2013 a national process began to devolve control of health facilities to the 47 counties. Funding to counties moved to overall block-grants, leading to wide variation in per capita spending on health services depending on local priorities. In the same year, a direct federal funding of services was put in place to assure Free Maternity Services (FMS) in public facilities under the management of the Ministry of Health. The National Hospital Insurance Fund (NHIF) was expanded during the early 2000's, and in 2014 with World Bank supported a Health Insurance Subsidy Programme (HISP) to subsidize enrollment for the poor. In 2015, a low-cost NHIF package, SupaCover, was introduced to subsidize enrollment into NHIF by informal sector workers. The following year widespread strikes, first by doctors and later by nurses, brought much of the public health system to a standstill. FMS ended the same year and was replaced in 2017 with Linda Mama, a program with a similar goal that is managed by the NHIF to fund delivery services in public and enrolled faith-based and private facilities. Universal Health Coverage (UHC) was announced as a national goal in 2017, and in 2018 the World Bank announced plans to pilot UHC in 4 counties, subsuming the HISP pilots.

In both Ghana and Kenya, political turbulence outside of the health sector made policy directions on national funding, private sector engagement, and health priorities unclear for extended periods. The AHME partners, and their collaborators within the administration at local and national levels, worked to maintain stable relationships and operations despite the shifting landscape around them.

Process Evaluation

Executive Summary

The Qualitative Evaluation (QE) of the African Health Markets for Equity (AHME) team interviewed AHME partners and relevant stakeholders across five rounds of data collection in 2013, 2014, 2016, 2017, and 2019 in order to capture the evolution of the partnership, the development of relationships between the AHME partners and government, and lessons learned for future initiatives of similar size and scope. This report includes findings from all five rounds of data collection with an emphasis on findings from 2019, which have not already been covered in the 2017 comprehensive midline report. In addition to interviewing key stakeholders (e.g. the AHME partners, donors) across all rounds of data collection, beginning in 2016 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 the AHME partners and their changing perceptions of private providers. We also interviewed experts and global stakeholders in the fields of private provision of care and health financing to get a snapshot of AHME's influence on the field at large.

Perhaps the most important lesson learned from AHME relates to the mismatch between the program's stated goals and its design. While the goal of AHME was to attract low-income patients to quality, affordable health-care at franchised clinics using demand-side financing, neither the partnership arrangement nor the tools included in the intervention package were designed primarily to achieve this end. The partnership originally was designed as a consortium of equals; this "forced marriage" resulted in competition and lack of accountability among the partners, while both social franchising and voluntary National Health Insurance (NHI) membership have been shown to primarily serve wealthier populations. After re-configuring the AHME consortium into a prime-sub model and making an effort to franchise clinics in low-income areas, the partners have had more success. However, some interviewees felt that AHME had only begun to lay the policy groundwork necessary for such an ambitious program and the results of this work will take time to play out.

Over the last few years of the project the AHME partners were successful in developing and leveraging close personal relationships with NHI officials, which helped to alleviate government misperceptions of the private sector and smooth bureaucratic processes for the AHME providers. To some extent, governments in

both Kenya and Ghana have institutionalized lessons learned and programs from AHME, and AHME partners now contribute at the highest policy levels by serving on UHC working groups. However, the partners should work to better institutionalize relationships in order to continue effectively collaborating in a rapidly changing policy environment. Lessons learned from AHME have also been built into strategic plans at the partner organizations, suggesting that these learnings have been useful both internally as well as externally among the partners. Nevertheless, without a clear communications plan from the beginning and with differing timelines for the evaluation teams, the dissemination of these learnings beyond those immediately involved in AHME remains limited.

Background

The Institute for Global Health Sciences at University of California, San Francisco, in collaboration with Innovations for Poverty Action (IPA), conducted a qualitative process evaluation to document and describe AHME's operational 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 were:

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 2019. In each round of data collection, five since the beginning of the project, the process evaluation 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 agencies and the AHME Theory of Change, including how the assumptions behind the Theory of Change were challenged in the field, how the Theory of Change shifted since the start of AHME, and whether it was being used as a tool for meeting the goals of AHME. In Round 4 (2017), the process evaluation focused on AHME's continued engagement with the NHI systems and how the partnership had evolved since its inception. In the final round (2019), the process evaluation focused on the relationship between the partners, the partners' relationship with the NHI systems, and plans for sustainability. In this comprehensive analysis, we integrate findings from across the five 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 five 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. In addition, we have interviewed experts in the field on what broader impact beyond the partnership AHME has had, if any. These interviews were conducted at different stages in 2013, 2014, 2016, 2017, and 2019. Finally, we conducted exit interviews with the Grameen Foundation when they exited the partnership in 2015, and with PharmAccess when they exited the partnership in Kenya in 2017.

A detailed description of the methods, ethical approvals, study population descriptions, and analysis plan are outlined in the [Appendix](#).

High-level Lessons Learned from AHME

Policy Lessons Learned from AHME for Future UHC Projects: AHME 2.0

Perhaps the most important lesson that came out of AHME is related to the franchise networks' initial failure reaching the project's target population. While AHME aimed to connect patients in the lowest two wealth quintiles in Kenya and Ghana with quality, affordable private care, the partners themselves discovered early on that the social franchise clinics were primarily reaching wealthier clientele. As several interviewees commented across rounds of data collection, the evidence overwhelmingly suggests that social franchises around the world tend to serve higher-income clients. It was also pointed out that the original design was based on limited analysis of the extent to which poorer patients in LMICs would be served by health insurance. The combination of a franchise model for service expansion with a financing model based on insurance, was indicative, interviewees pointed out, of a mismatch between AHME's design and the goal of reaching the poor that it set out to achieve. In short, supply did not translate automatically into demand as envisaged in the original AHME Theory of Change.

I think AHME has shone light on the interconnectedness of, for example, having a financing instrument, but you still have to stimulate demand among a population. This is something I've learned and observed over a number of years...you ask people are they interested, they say "yes." Are they willing to pay, they say "yes." But they don't follow through, or they might follow through once, but they don't renew and they don't remain enrolled in the program.

Global Stakeholder

To the AHME partners' credit they were willing to admit this mistake and, upon learning that location is a major driver of provider choice, took measures to franchise more clinics in poorer areas in addition to overhauling the original Theory of Change into a simpler 5-point framework. Internal data generated by the partnership suggests that efforts to franchise in low-income areas had some effect,¹ which suggests that other social franchise networks aiming to reach lower-income clients should try a similar approach.

¹ Verde Hashim, Catherine. (2018) Successfully reaching the poor with clinical social franchising of sexual, reproductive, maternal and child health services – the experience of Ghana's BlueStar health network. Presentation at the Fifth Global Symposium on Health Systems Research. Liverpool, UK October 8-12, 2018.

In the final round of Process Evaluation data collection, the QE team asked interviewees what AHME 2.0 would look like. Responses to this question provided rich insights into the lessons learned from AHME and how these lessons can be applied to future interventions promoting UHC. One such lesson was related to AHME's ambitious scope and scale. When asked about the design of future AHME-like interventions, one implementing partner recommended limiting the scale of the project in order to maximize its impact within a smaller subset of clinics.

So, I would definitely re-focus and make sure the impact is felt better and also relationships are more enhanced when you are working with probably 10 counties as opposed to going to 47 counties. Then you are spreading yourself too thin.

Implementing Partner, Kenya

Interviewees also pointed to the importance of working simultaneously on policy, supply, and demand. AHME was an ambitious project for its limited duration and many interviewees recognized the challenge of trying to work on all pieces at once, particularly following the early departure of the International Finance Corporation (IFC) as the partner initially charged with policy advocacy. In the wake of the IFC's early exit from the partnership, PharmAccess built on connections already formed through AHME and became a primary lead on policy advocacy in Ghana. Policy advocacy in Kenya, in later years especially, occurred primarily as a byproduct of the linkages developed between implementing partners (MSK and PSK) and government officials as they worked together toward the AHME goals. Based on these experiences, several stakeholders suggested that in future projects of this scope it will be important to ensure that the health policy landscape is favorable to the project's underlying goals before any implementation work takes place.

I think a lot of advocacy has to be done like as groundwork before we start a lot of these interventions. So, I almost think kind of starting with that we are ensuring the [NHI] service package includes family planning, ensuring that there is an easy way for the poor to be covered, if not everyone free of charge. And kind of ensuring that, like, all the right things are in place before we really go for it. I mean, that step is hard. We have limited ability to affect what governments do, but I think it's better – I would make sure everything is in place before we really started.

Implementing Partner, London

Recognizing the importance of implementing a project like AHME within a favorable policy environment was comparatively easy; achieving it was not. The constant shifts in health policy in both Kenya and Ghana posed a

major challenge for the project. As outlined in the Policy Context section of this report, both countries went through major policy transitions during the course of AHME, which influenced the patients, service providers, and implementing partners as well as the stakeholders interviewed for the Process Evaluation. Changes in the ways in which providers were reimbursed for services and disruptions in funding in Ghana created an environment of instability for providers in which they were concerned that their patients might lose trust in them, while devolution in Kenya added layers of bureaucracy that providers often had trouble navigating on their own. Thus, a question for future UHC interventions is how to balance bottom-up implementation against a constantly evolving policy environment. Should implementation and policy be tackled simultaneously or, if separately, in what sequence? This question was echoed by one donor agency representative reflecting on the challenges of implementation in an ever-changing policy environment.

So, we put boots on the ground, tried to get people to navigate some of those big mandate challenges. But then there would be a big bang approach kind of reform that was actually more important than a lot of the incremental work... But you can get very busy with that work and [at] the end of the day what is happening now, which is the NHIF reform, which is what we need to happen in Kenya for that to become a vehicle of UHC and to have the mandate of a social health insurance agency. [At] the end of the day you're going to float more boats for the objectives that we had for AHME than optimizing for contract [by] contract for a specific provider profile type...we learned [to] be careful at being really good at implementing things that are going to change.

Donor

Further, it was not only the changing policy environment that posed a challenge for the AHME partners, but working with government agencies that were in constant flux with frequent staff turnover made it even more difficult to advance AHME's goals. As many interviewees noted, however, while personal ties between implementers and government officials took time and effort to establish, it was these ties that ultimately helped to overcome the inertia and delays inherent in working with a large formal bureaucracy.

So it was a key learning to us that ... we usually think of government and government agencies as bureaucrats difficult to carry along, which is true. And what we learned in AHME is that the difficulty is getting our missions aligned. And when we get our goals aligned, it sometimes actually runs faster than us.

Steering Committee Member, Ghana

A related lesson was to use these personal linkages to navigate policy change more efficiently, as the AHME partners often felt they could pick up the phone and call a contact at the NHI's when questions arose. Still, institutionalizing these individual relationships becomes increasingly important in the context of a constantly changing bureaucracy.

Building a Successful Public-Private Partnership: from Forced Marriage to Successful Consortium

As noted in the midline Qualitative Evaluation report (2017), the initial AHME governing structure was based on a consortium-of-equals model. This structure proved challenging for several reasons. First, there was not enough hierarchy to hold partners accountable for achieving their deliverables. Second, because the project's demand-side model was still in the design process as AHME began, the awarding of funding for this piece of the program was delayed. The partners in the consortium were therefore competing among themselves for these reserved funds, which resulted in challenges building consensus and making decisions among the AHME partners for the first several years of the project. Across later rounds of process data collection, there was a strong consensus that the consortium model was a failure that cost AHME several years of productivity and should not be repeated in future projects.

AHME had a very strange governance structure. [...] I would never do that governance structure for any grant, it was very complicated... You know, governance structure coordination and responsibility needs to follow funds as well. If funds are not following accountability it becomes tough. So, first of all the layering, there were just too many layers. Thank God they changed them somewhere half-way in between because we had the steering, we had the leadership, we had the country and the leadership was really [...] crazy. I don't think we ever agreed on anything.

Steering Committee Member, Kenya

Once the demand side funding was awarded in 2015, AHME's governance structure was changed to a more traditional prime-sub model with Marie Stopes International (MSI) taking the lead and housing the Program Management Unit (PMU). This change in governance structure was one of the factors leading to the departure of several partners: the Grameen foundation left in 2015 and IFC departed in 2017. Meanwhile, PharmAccess shifted its focus to work primarily in Ghana, although still providing technical assistance on SafeCare in Kenya until 2017. While the AHME partners often said they felt as though they were in a "forced marriage" in the first few years of the project, once

these new roles were institutionalized and roles and responsibilities were clear, the partners reported a more collaborative and functional relationship.

We haven't had any animosity or tension [...] and I think it was good that there were no expectations from the consortium that deliverables were intertwined. I think when that happens in a consortium it becomes quite difficult. So the fact that each PS-K and MS-K had their own network of providers was complementary in terms of reaching a wider range of private providers that neither one could have done on their own. So, then it made it an easier collaborative relationship in that we weren't directly competing, for example, with the same providers, which does sometimes happen in these kind of donor-funded projects. So, that enabled us to maintain a good working relationship with them that was more collaborative than competitive.

Steering Committee Member, Kenya

Barriers to Dissemination and Shared Learning

In the final rounds of process evaluation interviews for the QE, participants not directly involved in AHME were asked what they knew about the project. While most had a solid general understanding of the project and its goal, most felt that dissemination efforts around the AHME findings have reached only a small cadre of experts. For one stakeholder, the question of whether or not AHME achieved a broad reach in its messaging was a moot point:

R: *I mean, I would kind of flip that question a bit. Is it important that it's well known or not? I would say it's not. Because unlike something like JLN [Joint Learning Network] it is not intended to last. It makes its impact, achieves some policy wins and ultimately moves the needle on health system performance in some way.*

Global Stakeholder

This was not a uniform opinion: a number of stakeholders both external and internal to the project felt that dissemination efforts had fallen short and that the project was not well known as a result. Interviewees cited several reasons why dissemination of AHME findings had been inadequate. First, the project had no communications plan from the beginning, which made it challenging to develop a plan only once findings had started to roll out, and to coordinate these efforts across the partners and evaluation teams. Like the AHME consortium itself in the beginning, this process also suffered from a lack of clear leadership and changes in staffing that created difficulties with accountability. Indeed, the consortium structure may

have provided little incentive for one partner to take the lead on publicity and outreach around the AHME brand. Further, the PMU was hesitant early on to publicize AHME's accomplishments out of concern over strained relationships between consortium partners and with those that exited the project early.

So, for a long time actually AHME purposefully went a little bit under the radar because of all the partnership difficulties.

PMU Member, UK

These larger existential problems were exacerbated by practical issues, such as the decreased importance of HANSHEP and the lack of a centralized AHME website that could be easily located and searched.

Another reason for the lack of promotion may be due to a perceived misalignment of AHME's goal of promoting strategic purchasing for primary care with the partners' traditional focus on family planning and reproductive healthcare. While interviewees at MSI, Marie Stopes Kenya (MSK), Population Services Kenya (PS Kenya) and Population Services International (PSI) indicated that these organizations are moving in new directions with strategic plans that seek to expand their scope – partially thanks to learnings from AHME – the organizations were not structured to accommodate work around the larger health market when AHME began and did not consider messaging around health financing and primary healthcare to be a primary concern. This made it challenging, in some cases, both to operate AHME and also to garner buy-in for the project within the organizations themselves.

I think there was a slight missing link which made people not kind of really buy into [the] AHME mechanism. And I think that's where we've really like struggled in some cases. [...] All the way through all the way to London people [...] there was just a lack of understanding of like actually this could mean that we are around for longer in terms of Bluestar and the women can access services for longer. [...] It was very much like "why are we getting involved in this?"

Implementing Partner, Ghana

This lack of buy-in at the partner organizations themselves created institutional environments in which the AHME partners felt they had little leverage to promote their work both within and outside of their respective institutions.

The identities of the lead implementing partners as primarily family planning providers, and in MSI's case as an organization that provides safe abortion services, created further complications in terms of receiving public support from local politicians. Due to the political

climate and prevailing sentiments around these services, some of the partners felt that the politicians they worked with were often careful about publicly supporting the work of such organizations.

Let me be frank with it... behind the cameras they continue to sign memorandum of agreements with us and they really continue to seek our services because they know what is happening, but they just don't want to confront the community and take a stand in that.

Implementing Partner, Kenya

Finally, several interviewees felt that the shifting timelines and delays in producing findings on the part of the RCT contributed to the limited dissemination efforts. As they pointed out, there was little to say about AHME until the results of the RCT were published, and both the partners and donors were concerned that communication about the successes and failures of AHME might conflict with the still unreported results of the RCT.

I think that's part of the problem. That you want to go around holding big events and having fancy websites and emailing everybody the whole time when you haven't got anything to tell them for the next three years. That is a challenge.

Global Stakeholder, London

While both the QE team and the AHME partners were actively engaged in publishing reports and journal articles, and presenting at international forums in the final stages of the project, these efforts appear to have had limited effect. Among a few global stakeholders who suggested that AHME had "failed" in previous rounds of interviews, more positive messaging around AHME and what it had accomplished came across in the last round of interviews. Still, knowledge of AHME was minimal among government officials and the majority of global stakeholders. For example, when asked what they knew about AHME, a Kenyan NHIF official who had been tangentially involved with the project responded:

R: I've just seen their logo. I know they deal with private sector mostly and healthcare providers and in Kenya I have noticed a few of the providers having some branded AHME logos and upon a little inquiry it's like they help them do capacity building, they work together with them to bring up issues to do with their quality. So, it's like a collaboration. So, I know that it's just a group in the country which is interested in health service provision because I see them working with providers. At least that is just an overview but I am sure there is much more than that.

I: That's actually a pretty good overview. Do you know which providers or which organizations are involved in AHME?

R: No. Not any specifically. But they could be accredited to us also.

I: Do you know anything about any lessons that have come out of AHME?

R: No.

Government Official, Kenya

As a result of this limited reach, final dissemination of the AHME RCT, in Kenya especially, may require concerted effort to reach key government stakeholders.

Developing & Institutionalizing Relationships with Government

AHME's Influence on Government Attitudes Towards Private Providers

Given that private providers make up a significant proportion of the healthcare landscape in both Kenya and Ghana² and that the public sector does not have the capacity or geographic reach to provide quality care for all citizens,³ the goal of achieving Universal Health Care (UHC) by 2030 in both countries will require a combination of private and public healthcare providers working under much expanded and coordinated NHI programs. Furthermore, the NHI's will need to develop a new business model that will enable private clinics to expand their reach beyond urban markets to encompass those living in poverty in rural areas.

Misperception & Mismatch Between the Public & Private Sectors

One impediment to integrating the two sectors is mutual misperception and mistrust. As described in the midline QE report,⁴ one reason for this mistrust cited by

implementing partners was the NHI's traditional focus on large, publicly-funded and centrally-located health facilities. Smaller private clinics were seen as profit-driven and "commercially-minded," in contrast to the "service-oriented" public clinics. On the public sector side, this mistrust therefore appeared to be based on a misperception of the business model of private providers. On the one hand, the QE team heard from a number of providers across rounds of data collection that they felt it was their duty to serve their community and many of the AHME-supported providers operate small or medium-sized clinics that do not generate large profits. Further, while workers' salaries and facility infrastructure in public facilities are subsidized by tax revenues and do not rely entirely on funds generated from patient fees, private facilities rely exclusively on revenue brought in by services to cover all operating expenses. Thus, the fiscal dependence of private clinics on claims makes them extremely vulnerable to below-market reimbursement rates from the NHI's and delays in claims processing; a vulnerability that is not shared by public facilities. This exclusive dependence of private clinics on income from services may account for the government officials' perception that private clinics are only concerned with income at the expense of providing services. Interviews across rounds of data collection suggest that, while government officials recognize the importance of the private sector to achieving UHC, this perception of the private sector as a purely profit-seeking venture remains.

[T]here is a miscommunication of what the private sector is. [...]The thought is that the private sector is just profit and that they are just used to make more money. But not everyone is there to make so much money. People just want to survive, to be a bit sustainable. They can be able to pay their salary, meet their basic expenses, pay a few of their staff, just make something small on the top and serve the very poor. But that misconception about the private sector is what needs to change.

Implementing Partner, Kenya

The NHI's in both Kenya and Ghana originally were designed to serve the public sector, making it more challenging to effectively incorporate private providers into the system in addition to adding extra work to change a system that is largely operating based on inertia. Further, as indicated by interviews with providers, private providers already feel as though they operate outside the government-run health system in many respects. This feeling of disconnect in addition to the low reimbursement rates offered to private providers makes integrating into a system not designed to serve them all the more daunting and challenging.

- 2 Wang H, Otoo N, Dsane-Selby L. (2017) Ghana National Health Insurance Scheme: improving financial sustainability based on expenditure review [Internet]. Washington, D.C.: World Bank. Available from: <https://openknowledge.worldbank.org/bitstream/handle/10986/27658/9781464811173.pdf>; Kenya Ministry of Medical Services, Kenya Ministry of Public Health & Sanitation. Accelerating Attainment of Health Goals: The Kenya Health Sector Strategic and Investment Plan (KHSSP) July 2013–June 2017 [Internet]. Kenya Ministry of Medical Services and Ministry of Public Health and Sanitation; No Date. Available from: <http://e-cavi.com/wp-content/uploads/2014/11/kenya-health-sector-strategic-investment-plan-2013-to-2017.pdf>.
- 3 Kimathi, L. (2017) Challenges of the Devolved Health Sector in Kenya: Teething Problems or Systemic Contradictions? (42)1: 55-77; Adua, E. et al. (2017) Emerging issues in public health: a perspective on Ghana's healthcare expenditure, policies and outcomes (8)3: 197-206.
- 4 Institute for Global Health Sciences, UCSF. (2017) African Health Markets for Equity Quality Evaluation Comprehensive Report: 2013 – 2017. San Francisco, CA: University of California San Francisco.

[T]he [NHI's] design is really for the public sector and then the private sector has been added on almost like an afterthought. [...] [The] reimbursement rates [...] are very low and it is suppressing active participation in the scheme. But even though they know that and they know that they are an important actor nothing is really done to adjust to – and you know you want to see something a little more active going on in terms of this kind of purchasing mechanism. I don't see that. There is a lot of inertia.

Implementing Partner, Kenya

AHME's Role in Smoothing Public/Private Relations & Forging New Linkages

Since some of AHME's implementing partners already had extensive experience working with government ministries on family planning, HIV and other initiatives, AHME was able to leverage these existing relationships and use them to both enhance relationships and build new ones. To this end, the fact that both sides already shared the goal of reaching the poorest populations with quality healthcare eased the creation of new relationships, and working together in this shared endeavor subsequently enhanced the NHI's understanding of the needs of private providers. In the last round of data collection, for example, one government official in Ghana spoke very positively about his experience working with the AHME partners to make Health Facilities Regulatory Agency (HeFRA) licensing more accessible to private providers and another discussed what he had learned when Marie Stopes Ghana (MSG) organized for governmental officials to visit some of its BlueStar facilities:

It was good because I had heard about them, but I didn't know where they are or how they look like. And see if a project has a goal to make sure that the poor can also access public facilities it is only proper that you yourself should know the kind of facility they are talking about. I didn't know them. I've heard about BlueStar, but I didn't know how they looked like. And so we went there to familiarize ourselves, to know how they are operating, their challenges and those kind of things. And we noticed that most of them were being managed by individual, some of them were maternity homes and those kind of things, and all the things we were discussing was the issue of sustainability of business.

NHIA Official, Ghana

In Kenya, the inclusion of the CEO of PS Kenya in the NHIF reforms committee also signaled that the government had come to see the value of including more

voices representing private providers, and specifically those represented by the AHME partners, in the reforms process.

Aside from influencing the attitudes of government ministries about the feasibility of working with private providers, the AHME partners also positioned themselves as intermediaries between government and private providers, helping to smooth accreditation and quality control processes on both sides. Stakeholders in both Kenya and Ghana spoke of the NHI's limited capacity to make in-person visits to private facilities, which in turn slowed down accreditation and curbed their ability to monitor quality. In this context, the AHME partners stepped in to assist providers with the accreditation process by ensuring that providers were prepared for in-person quality checks ahead of time and acting as a liaison between the NHI and providers. Government officials in Ghana recognize the value of the networks for streamlining the empanelment process.

I mean I will say with Marie Stopes it's really taken a burden off us, a burden of having to deal with little little facilities. So, they kind of bring them together, kind of group so that if there are issues we can deal with issues once through Marie Stopes instead of dealing with each one of these facilities.[...] By them acting like mediators between us and these little facilities they've taken a chunk of the burden off us so that instead of us having to deal with little things they are able now to bring together their charges so [...] we issue one check instead of [...] many [...]. And instead of collecting one application after the other we can collect applications in bulk and work on them in bulk.

Government Official, Ghana

In Kenya, PS Kenya has taken this intermediary role a step further by piloting an aggregator model that will act as an ongoing intermediary between the NHIF and network providers for a fee, making up for gaps in government capacity:

Kenya is awfully undermanned and under-financed to really engage with these large numbers of private providers in both of these countries. And so lots of bottlenecks and lots of breakdowns and I think it's a shared challenge. It's the empanelment process and the – yeah just the facility assessments and so on. They don't have teams or sufficient people to carry those out and private providers apply and they never appear. So, it's kind of a vicious cycle and that's where this idea of aggregation comes in to hopefully be one approach that could help reduce the kind of one to one to one interaction that's in place right now, because

there is never going to be the resources to do that. And frankly it should be necessary. It's just better ways to do that.

Global Stakeholder

Another benefit of AHME's enhancement of networks of smaller private clinics has been to create a unified voice in policy and implementation discussions with government insurers.

I think that the perspective of private providers was well serviced by the program in both of those countries in particular the smaller facilities. I think that the presence of those networks kind of working across issues with the purchasing agencies, having a collective story has been beneficial because I think that even today the fact that [the CEO of PS Kenya] is sitting on the NHIF reform panel. [...] Her core is social marketer and franchiser who has been working in and out with these facilities. And it just it never would have happened without AHME. So I think that's been really positive.

Donor

As a result of working together in these ways, the AHME implementing partners recognized that, although working with government has been slow, government officials' attitudes toward the private sector appear to be changing:

I think government has no option than to recognize that increasingly the private sector is becoming a major player in the health sector... And government is now more open to learning more about the private sector than they did before. As I indicated, for instance, HEFRA is more experienced in licensing facilities within the public sector. They don't have much experience with the private sector and it's one of the things they want to learn from us just to understand how the private sector works.

Implementing Partner, Ghana

Institutionalization of AHME Learnings and Relationships at the Government Level

Despite the departure of IFC from playing a policy role in AHME, the remaining partners have built on the connections forged by the IFC and successfully stepped up to take on the role of advocating for specific policies to facilitate the implementation of AHME deliverables.

So, our engagement with the Ministry of Gender, the ministry of health and HEFRA were all typically policy roles that would have been played by the IFC. But with their exit from AHME we had to step into that space. And I think it's been good for us because we have been able to steer the policy in the direction

of private sector engagement and making sure that enrollment challenges are addressed at the policy level... So we have learned a lot about how to engage in a policy space through AHME.

Steering Committee Member, Ghana

Further, by forming trusting working relationships with the NHI's and working together toward the same goals, the AHME partners ensured that the results of these public-private partnerships were relevant to the public sector and could in turn be taken up by government outside of their work with AHME. Government officials in both countries confirmed that programs developed in partnership with AHME, such as the Proxy Means Test in Ghana and the Health Insurance Subsidy Program (HISP) pilot in Kenya, were indeed taken over by the NHI's for scale-up. In addition, NHI officials said that they continue to work closely with the AHME partners in some cases, almost considering them part of the NHI team.

Yes, we work together so closely such that they can even now just be staff members of NHIF... So, it becomes one team. We no longer even say, "No, NHIF you are the ones who have not done A, B, C, D," it becomes collective. We need to do A, B, C, D because this has not happened. No blame games, no confusions. It becomes one.

NHIF Official, Kenya

A major success of AHME in institutionalizing public/private partnerships is the fact that the government actively consults and collaborates with these partners to design future healthcare policy in addition to providing a technical assistance role once policies start to roll out. Examples of this include PS Kenya's involvement supporting communications and outreach for the NHIF and MSG's work with the NHIA to implement a pilot funding long-acting reversible contraceptives through NHIS.

Institutionalization is Key to the Sustainability of AHME Programs

A key measure of sustainability of an intervention beyond the end of donor funding is the degree to which the programs are institutionalized into the missions of the implementing agencies and that support for these initiatives is institutionalized into government policies. Responding to broader currents in the field and prompting from donors, AHME implementation partners have clearly expanded their missions from primarily work on family planning and sexual and reproductive health to a broader set of goals around improving capacity and quality of primary care. Experiences from AHME have therefore shaped implementing partners' internal strategies as they pivot to respond to this new

environment. Part of what made AHME challenging was that some of the partners were not institutionally set up to do this kind of work, and this capacity was built over the course of the project.

In the process of expanding the scope of their services, AHME implementers were also forced to take on policy advocacy after the departure of IFC. This forced them to collaborate with government ministries at a more personal level, producing the type of informal relationships that ensure that organizations can navigate the complex government bureaucracy to accomplish their goals. However, it will be important to maintain these relationships and develop them over time so that they are institutionalized between organizations and not just interpersonal, making them more sustainable over the long term. The evaluation interviews suggest that this is beginning to happen as AHME implementers populate policy working groups within the government.

AHME may not have revolutionized the space around providing access to the poor, but I think there has been a lot of leadership that has been provided through AHME on how social franchises can reach that segment of the poor and, of course, it's provided conversation starters around that space. But also, what it's done is it's provided catalytic financing to test a couple of models. We would never have tested the network management organization, we would have never tested what it means to accredit small and medium level health facilities, we would have never tested what it means to go to the communities and breakdown health insurance and then link them to enrollment and link them to care if AHME didn't come. Government would have never recognized what is social franchising, what role do they play. So, I think to a large extent in my opinion AHME has achieved its goal of reaching the poor. It might not see those results in the life cycle of the project, but it's been very instrumental in providing thoughtful leadership and starting conversations and projects that will live beyond its project life. So, I think there is a lot of sustainability in the work that AHME has done.

Implementing Partner, Kenya

In addition to using learnings from AHME internally, AHME's work with NHI accreditation has served as a proof of the concept that private providers can be empaneled within NHI's (particularly in Kenya). This has influenced other NGO's to continue similar work with AHME partners, thus ensuring some continuity and sustainability beyond the end of AHME.

We would want to, if we are allowed to, we would like to really just partner with PSI our

partner to sort of pick up where AHME leaves off and to craft our own way from there to again learn and support the Tunza Platinum providers in particular. But it could be the whole network to increase their reach if you will; so their number of contracts, or to perform, and we have to define what we mean by performance. For example, improving the sustainability of the practices. So, that might happen by seeing more patients or seeing patients who are paid through a third party provider and that's a stream of revenue that may be more sustainable or may be more reliable.

Global Stakeholder

Continued close working relationships between government agencies and AHME's implementing partners ensure future collaboration on the relicensing of facilities in the NHI networks.

We've also worked with Marie Stopes with respect to the registration and licensing of certain maternity homes in Ghana. And then, I don't know if you know, currently we have on their premises we have an office in their Marie Stopes... they are like our landlord. And we've also in the registration and license of health facilities they've tended to be like cooperating with us with respect to our dealings with the facilities. So they want to build like a network where they will bring all of them together in one place. So they pay for their fees and things like that with respect to the charges that are supposed to be levied on them by law. And they also want to be, in fact we are still working on that, to be intermediaries between us and those facilities so that if there are issues they will be able to go and explain it to them in a way that will make our relationship with them more fluid and easier. So those are the kind of things that we've been dealing with the two organizations.

Government Official, Ghana

Conclusions & Recommendations

The findings from the final AHME Qualitative Evaluation suggest that there was an initial mismatch between the project's goals and its component parts, particularly the use of social franchising to reach poor populations with healthcare, the Theory of Change and the organizational structure of the partnership. Once the AHME partners recognized these mismatches, they began to course correct with some degree of success. First, franchising clinics in low-income areas appears to have increased AHME's reach among poorer clientele.

Second, once the new Theory of Change was developed and the leadership structure was streamlined, the remaining AHME partners were better able to work together toward the AHME goals. These findings suggest that, particularly in the context of such an ambitious project, alignment of goals and instruments (e.g. partners, tools, funding) at the beginning of the project is crucial.

The public-private partnerships established through AHME have begun the work of overcoming the mistrust

and misperceptions between the public and private sectors and smoothing bureaucratic processes for private providers on the ground. The personal linkages established between AHME partners and NHI's and other government agencies will be critical to the future design and roll-out of UHC in Kenya and Ghana, particularly in times of policy transition. The extent to which some learnings have been institutionalized within the AHME partner organizations and the NHI's is promising and suggests that the AHME partnership has proven valuable for those in the know.

Executive Summary

The Qualitative Evaluation (QE) of the African Health Markets for Equity (AHME) program interviewed providers and patients from both franchised and non-franchised facilities, as well as conducted focus group discussions with community members living in the facility catchment areas, in order to capture: perceptions of health services; factors influencing provider choice; experiences with the AHME interventions; and experiences with National Health Insurance. In addition, the QE team conducted focus group discussions with franchise representatives in the final round of data collection to better elucidate the provider experience of the AHME interventions. This report is a comprehensive overview of our findings from four rounds of data collection (2013, 2015, 2017, 2018) in both Kenya and Ghana.

In 2013, 2015, 2017, and 2018 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 understand providers' experiences with the AHME interventions and with the National Health Insurance schemes, as well as to understand non-franchised providers' interest in programs like AHME. The team also interviewed clients exiting franchised and non-franchised facilities in 2013, 2015, 2017, and 2018, 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. The QE team conducted focus group discussions with franchise representatives in both Ghana and Kenya in 2018 to better understand the delivery of the AHME intervention package and provider experiences with the package.

Providers generally liked the AHME interventions and reported few challenges participating in the program. In particular, providers often expressed pride in what they had accomplished as a result of being part of AHME, such as improving clinical quality and business skills. Often feeling detached from the larger health system in their country, providers especially appreciated being able to “walk together” with the franchisors through complex bureaucratic processes and noted that

programs such as SafeCare helped them “put things in place” before undergoing government inspections. Indeed, while most Ghanaian providers were NHI-accredited prior to AHME's implementation, a significant number of Kenyan providers were able to become accredited over the course of the program with the franchisors' help.

Discussing the services at private facilities, patients preferred the private facilities for treatment they felt was more respectful, familiar, and effective than what they would receive at a public facility. Patients also reported overall positive experiences with the NHI's, although they knew little about the details of their coverage. An equity analysis of patients sampled from the lower two wealth quintiles in 2018 suggests that poorer patients are concerned with service cost, although not necessarily more so than their counterparts in higher quintiles who also reported paying for services on credit or negotiating prices when they did not have enough cash.

Background

Scope of Work

The Institute for Global Health Sciences at the University of California San Francisco led the QE of the AHME program, in collaboration with Innovations for Poverty Action (IPA). The QE 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

This report includes data collected between July 2013 and August 2018. Data collection was conducted with providers in 2013, 2015, 2017, and 2018; with clients in 2013, 2017, and 2018; and with Franchise Representatives in 2018.

Objective 1 was designed as a complement to the quantitative Impact Evaluation to help interpret and contextualize the quantitative findings. However, during 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 QE 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 NHI accreditation 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 four rounds of data collection with providers, three rounds of data collection with patients, and one round of data collection with Franchise Representatives focused on experiences with the AHME interventions and with the NHI's. The research questions guiding the most recent round of data collection (2018) are as follows:

Providers

1. What are the providers' experiences with and perceptions of the franchising, MCF, SafeCare, and NHI's interventions?
2. What factors influence uptake of the franchising, MCF and SafeCare, and NHI's interventions?

Patients

1. How do patients decide where to seek healthcare (for themselves vs. their children)?
2. What have patients' experiences been like:
 - With franchised vs. non-franchised clinics? With public vs. private health facilities?
 - Enrolling with and using NHI?

Franchise Representatives

During the final round of data collection (2018) focus group discussions (FGDs) were conducted with franchise representatives to better understand information received from providers and patients. These FGDs were designed to answer the following questions

1. What was the recruitment process for providers into the franchise and what are providers experiences with the franchise?
2. What is the NHIS accreditation process for providers and what is the Franchise Representative's role in this process?
3. What is the recruitment process and experience for providers joining the other AHME interventions (SafeCare/MCF)?

Methods

This report draws on data from three rounds of client exit interviews, four rounds of provider interviews with both AHME members and non-AHME practitioners, one round of community member FGDs, and one round of FGDs with franchise representatives. These interviews were conducted at different stages in 2013, 2015, 2017, 2018.

The methods details, ethical approval, study population descriptions, and analysis plan are outlined in the [Appendix](#).

Providers

Franchising

Why Join

In most cases, providers learned about the franchise from colleagues who were already part of a network, through professional associations (e.g. the Ghana Registered Midwives Association), or through their own previous experience working with MSI or PSI. Across rounds of data collection, providers joined the franchise network because they were interested in training and quality improvement opportunities, which a couple of providers in Kenya noted are offered regularly to public sector providers, but not to the private sector. Echoing these sentiments, one provider in Kenya joined the network to feel a sense of "belonging:"

I: What did you see as the benefits of joining?

R: At least the sense of belonging (laughing) now that I was leaving the ... the ... public sector. I didn't know, I felt I was floating, but now when Tunza came in I felt at least I had a partner that I could whisper to (laughs) my ... my concerns...So, I wanted that sense of belonging so that I could not feel like I was floating.

Nurse at a Tunza Facility, Eastern, Kenya

Several providers in both countries thought these trainings would help them better serve their communities with reproductive health services. Providers also joined the franchise due to the prospect of free or reduced rates on commodities and equipment, and demand generation activities to help them grow their business. A few providers had friends or colleagues who had benefited from joining a franchise network, which prompted their interest in joining. For one provider in Kenya, seeing a friend benefit from NHIF accreditation made the Amua network's accreditation assistance seem especially attractive:

By the time I was joining [the franchise network] NHIF was not that active though I had seen friends of mine...a friend of mine was joining. Not that he had joined this [franchise network] but he gotten NHIF, it has really lifted him up. So, when [the recruiter] mentioned the NHIF I became more interested because these other ones, support and training you can still get them anywhere else, but that aspect of NHIF was my main interest.

Clinical Officer at an Amua Facility, Rift Valley, Kenya

Among non-franchised providers, there often was interest in joining a franchise to benefit from trainings, commodity supply, and marketing. However, some of these providers stipulated that a franchisor must be trustworthy and respectful to attract them.

Why NOT Join

When asked why they had not joined a franchise, non-franchised providers interviewed in 2018 often cited logistical issues, such as a lack of timing or staff for training, a recent move or change in clinic ownership that necessitated more internal work before applying for franchising, or a lack of funds. In a few cases, non-franchised providers cited a lack of follow-up from the franchise, or had joined a competing franchise (DKT in Ghana). In one case, the owner of a private clinic in Kenya felt “betrayed” because he had made a number of changes to his facility in hopes of becoming franchised, but was denied based on what he perceived to be a small issue. These reasons largely align with those given by non-franchised providers interviewed in earlier rounds of data collection, although concerns around providing abortion services did not surface among non-franchised providers in Ghana in this latest round of data collection, as it had in earlier rounds of data collection. This may, however, be related to the small sample size covered in 2018.

Benefits

As found in earlier rounds of data collection, providers interviewed in 2018 especially appreciated the trainings they received from the franchise networks, which

the providers felt helped them provide a wider range of quality services. According to the providers, this expanded range of services enabled them to attract more patients. In many cases, providers specifically mentioned attracting younger women for family planning services and in Ghana several providers suggested that new medical abortion services were particularly relevant for this population. Indeed, providers in Ghana were enthusiastic to receive abortion-related training, which they felt enabled them to help their community by saving lives.

These little girls who become pregnant and then they go and – there was one who came. I said, oh, I don't do it. But before I realize she came in the morning like this and the following morning by this time I heard she is dead. Why happened? They went and grind uh, bottle for her to drink and then she died. So, when [BlueStar] came and they were discussing all these things with us and I was willing to help my community people so I accepted.

Midwife at a BlueStar Facility, Volta, Ghana

However, while providers felt that franchising helped them increase their client load across rounds of data collection, when asked if they felt they were serving populations of different socioeconomic status in the 2018 round of data collection, most providers reported that they hadn't seen a change in client wealth profile and suggested that they continued to serve their immediate community. So, as the AHME partners found, providers already serving poor communities continued to serve this patient population, while providers situated in wealthier areas continued to serve this population as well.⁵

Obviously, where we are situated, our market is always the poorer.

Administrator at a BlueStar Facility, Accra, Ghana

While providers often reported that the supply of commodities they received from the government was unreliable, they felt they benefited from a steady supply of free or low-cost commodities from the franchises. As a result of these low prices, several providers specifically noted that they were able to offer family planning for a reduced price, making these services more accessible to their clients. In some cases, providers felt that offering a wider variety of services and having a steady supply of commodities on hand helped them to attract more clients in general. Demand creation activities

5 African Health Markets for Equity (2018). Snapshot 11: Social Franchising and Equity. <http://www.hanshep.org/our-programmes/AHMEresources/snapshot-11-social-franchising-and-equity>

conducted by the franchise networks, such as mobile outreach and free family planning days further helped to increase client flow. However, these activities and their benefits in generating client flow were mentioned far more often in Kenya than in Ghana. Still, a number of providers in both countries mentioned that their patient load had increased since joining the network. Providers also said they benefited from free or subsidized equipment provided by the franchise networks, and from monitoring and supervision activities that providers felt helped them achieve and maintain higher levels of quality.

Although providers interviewed during previous rounds of data collection rarely mentioned networking and peer-to-peer learning as benefits of franchise participation, providers interviewed in 2018 in both Kenya and Ghana said they appreciated being connected with other providers in the network to share learnings and best practices, and to refer patients for higher levels of care. Providers suggested that these connections helped them offer better quality care to their patients:

One thing I got during the annual review was to see the performance of other people and what we could also learn from them to improve. That was my first time getting in touch with BlueStar so it serves as an eye opener. I asked myself why is it that we did not receive any awards, what we can do to improve ourselves. Through that I ended up interacting with other health care providers and knowing the things that they put in place to improve their services and for them to achieve the targets that they have been given. So it has been, it has given me the opportunity to know others, other providers and what they are doing, yeah.

Administrator at a BlueStar Facility, Central, Ghana

Similarly, franchise representatives interviewed in 2018 described using WhatsApp groups to communicate with providers when they weren't able to make in-person visits to individual facilities. The representatives said they shared documents with providers via the groups and fielded questions, in addition to communicating with individual providers regarding their SafeCare Quality Improvement Plans. Providers reported participating in these groups, although they appeared more enthusiastic about peer-to-peer learning in person and being able to call another provider with a question or to refer a patient. However, these reports from both providers and franchise representatives suggest that the franchise networks have been successful at attempts to foster more connection and interaction among providers, perhaps helping to create the sense of "belonging" desired by private providers who have nowhere else to turn with questions and concerns. In addition, it was clear that the support offered by the

franchise representatives was widely appreciated. As one provider in Ghana noted, the franchise representatives offer emotional support in addition to quality monitoring and regular check-ins with providers: "They are human. Sometimes, they come and we have problems and they try to cheer us up. They encourage us." (*Midwife at a BlueStar Facility, Ashanti, Ghana*)

Challenges

Providers generally faced few challenges participating in the franchise across rounds of data collection. Challenges raised in 2018 that also came up in earlier rounds of interviews include delayed or inadequate commodity supply from the franchisors, meeting demands for data and reporting, and feeling overly monitored by the franchise. Time and money were major concerns for providers, so they also were concerned about the costs associated with being part of the franchise (e.g. annual fees, costs to support community mobilization) as well as the time required to participate in trainings and scheduling time to meet with franchise representatives when they came for monitoring activities. While providers often valued community mobilization efforts, they sometimes complained that events such as "Amua Leo" days to offer free family planning created the sense in the community that they should always expect free services in addition to crowding clinics and making it difficult to serve cash-paying clients.

NHI Accreditation Assistance

While most providers in Ghana were already NHI-accredited and faced few obstacles having their accreditation renewed, many providers in Kenya were going through this process for the first time and reported a number of challenges. Across rounds of data collection, providers complained of a lack of communication from the NHIF office after their application was submitted, paperwork going missing after submission, long timelines to become accredited, a lack of clarity around the terms of accreditation, and corruption.

In response to these challenges, the franchisors began to offer NHIF accreditation assistance in 2015. In Rounds 2 (2017) and 3 (2018) of data collection, Kenyan providers expressed their appreciation for the franchisors and their role as intermediaries that helped the providers navigate a complex system. A number of providers noted that doing things like participating in practice clinic inspections with the franchisors helped them to "put things in place" before embarking on the official accreditation process. Once applied, assistance from the franchisors, such as following up with the NHIF offices, made providers feel they were able to "walk together" through accreditation. Providers often noted that they felt alone or helpless when interacting with the government, so being able to "walk" with the

franchisors made the process feel less daunting and also run more smoothly.

They have also helped me which I had not foreseen to ... to get the NHIF faster because they were concerned that they would even follow up with the region office. And that was actually very... very commendable. Yeah, they were concerned, they have walked along with me, mmm.

Nurse at a Tunza Facility, Eastern, Kenya

Although providers in Ghana did not require assistance with NHIS accreditation, licensure under the Health Facilities Regulatory Agency (HeFRA) became a stricter requirement for accreditation during AHME's tenure and the BlueStar network discovered that few franchised facilities had licenses that were up-to-date. This prompted BlueStar to launch a licensure assistance program similar to that offered by Tunza and Amua in Kenya. While this program was somewhat new when data was collected from Ghanaian providers in 2018, several providers were aware of the program and had participated. As in Kenya, these providers liked that the franchisor facilitated interactions with HeFRA, making the process less of a burden for providers in addition to making it easier to obtain the necessary license.

Yes, so once you, your name is included eh by Marie Stopes, it makes it easier for you to register, yeah.

Administrator at a BlueStar Facility, Central, Ghana

SafeCare

Benefits

Across rounds of data collection, providers appreciated learning about quality improvement and often felt proud of the progress they made through SafeCare. In a number of cases, providers liked being able to offer higher quality services to their patients and in some cases they suggested a connection between their ability to offer quality services and sustain their business:

I: Okay when [the SafeCare representative] came, what attracted you to join that program?

R: Actually for...for me I was willing to, you see this is a business eh you have to offer quality services to the patients.

Clinical Officer at an Amua Facility, Nairobi, Kenya

Providers also felt that SafeCare made it easier for them to both become NHI-accredited (most applicable to providers in Kenya) and to renew their accreditation (most applicable to providers in Ghana); in this regard, providers often suggested that SafeCare helped them “put things in place” for the accreditation process.

Organization-wise too, it put us like putting our house in order per se. So, when NHIS wants to do an accreditation assessment for the second time this year, we didn't struggle. Because most of the things that they were relying on, as in the assessment tools they were relying on, had already being given to us by SafeCare.

Administrator at a BlueStar Facility, Accra, Ghana

Beyond working specifically with the NHI's, in the final round of data collection one provider felt that having SafeCare improved his relationship with government in general, saying “When they know you know about SafeCare they are free with you, so am working comfortably.” *Clinical Officer at an Amua Facility, Eastern, Kenya*

Challenges

The expense of making clinical improvements to align with SafeCare standards was by far the most commonly cited challenge among providers across rounds of data collection.

I: What are the challenges of participating in safe care?

R: It's, it requires a lot of let's say funding. Most of the things are fund-based and if you want quality, you need to, I think you need to put in more resources. So, it's more resource intensive and eh, yes, basically, that is the challenge.

Administrator at a BlueStar Facility, Accra, Ghana

Interestingly, in the final round of data collection one provider in Ghana reported that they were planning to stop accepting NHIS coverage because SafeCare has made them realize they need a steady income in order to provide quality care, and NHIS reimbursement delays prevented them from realizing this goal. In addition, while many providers are required to make physical changes to their facility in order to continue to advance through SafeCare, providers often cited restrictions on their ability to make structural changes to rental properties as a barrier to progress.

Medical Credit Fund (MCF) and Business Support

Why/Why Not Join

While joining SafeCare was generally an easy choice for providers, who were eager to join a free quality improvement program that appeared to be integrated into the franchise package, participating in MCF was less clear cut. Early in the program, when AHME offered access to MCF loans with support to secure the loan, uptake was relatively low. Providers in both countries generally displayed a sense of distrust towards bank loans that came with interest payments and conditions providers felt were complex and difficult to understand. Indeed, providers in Ghana were

particularly reluctant to take a loan when NHIS reimbursement payments were severely delayed and they were unsure how they would pay the loan back. However, among the few who did take loans, experiences in both countries were generally positive with providers noting that they had used the extra funds to buy new equipment or make improvements to their clinics.

Once the AHME partners in both countries started offering different business support and financing products, providers became much more enthusiastic about this piece of the intervention package.

Receivables Financing (Ghana)

In response to severe reimbursement delays from the NHIS, PharmAccess developed a financing product called Receivables Financing in 2016. This product gave providers the opportunity to use NHIS claims as a loan guarantee, allowing them to receive a bank loan equal to 70% of their submitted claims; this loan was then paid back by NHIS and the provider receives the remainder of the payment at that point minus interest. While providers in Ghana had previously been nervous to take an MCF loan in the face of payment uncertainty from the NHIS, they appeared much more interested in Receivables Financing. As one provider noted, this intervention felt less intimidating than taking a regular bank loan:

This one is not like a loan. You have worked for it, you have the clients, you have taken your claims, they've vetted the claims. This is the amount you are collecting. It amounts to maybe 250 million [old Ghana Cedis], then maybe they will take 50 million or they will take 45million and give you 200, is ok, you can use it to do your business. That one I like it a lot.

Midwife at a BlueStar Facility, Northern, Ghana

Business Support (Kenya)

In Kenya, the AHME partners largely discontinued the formal financing piece of the MCF intervention in 2017, instead instituting a more general business support program (sometimes referred to as “Business 4 Health”) that continued to offer the business assessment used to approve providers for MCF loans, but with more of a focus on teaching the providers basic business management skills and helping them understand the value proposition of NHIF accreditation. As one Business Advisor expressed during an FGD: “Basically, we start from what was your dream when you set out to start [a health facility]? What was your dream?...So, where are you right now? What is your strategic plan to get there?” (*Business Advisor, Kenya*)

However, a few providers interviewed in the final round of data collection continued to associate business support with loans, speaking positively about the potential for loans to assist them with buying new

equipment or “bridge the gap” in financing when they were trying to make quality improvements through SafeCare. Speaking directly to the Business 4 Health program, other providers said they appreciated the opportunity to learn more about business practices in order to better run their facility and understand their revenue flows: “Even book keeping is very important because that's the thing that can make you to know whether are you making a business or you are not making a business.” (*Community Health/Auxiliary Nurse at a Tunza Facility, Eastern, Kenya*)

Benefits of Receivables Financing & Business Support

Providers in both Kenya and Ghana appreciated receiving training and support in learning how to run their facility as a business, with many noting that basic accounting and record-keeping was new to them. In Ghana, where the BlueStar franchise attempted to train providers in the EasyBooks accounting software, several providers mentioned that the software was too challenging for them to use regularly. However, the training helped them understand the benefits of basic accounting, which resulted in these providers keeping their own records on paper. For providers in both countries, the ability to track income flows and manage stocks made them feel they had better control over their business and could better plan and sustain it into the future.

You see in terms of (short pause) [stammers] you see we...we are in business and we have to accept that we are in business. I don't have any other employment except this. Now for this business to run we have to run it professionally where we account for each and every cent that we get...for each and every cent that we get. So, in terms of this we are able to save and budget in terms of what do we need based on the money that we have, what can we acquire. You cut your coat according to your size.

Clinical Officer at a Tunza Facility, Nairobi, Kenya

This aspect of Receivables Financing was especially important for providers in Ghana, who otherwise felt that NHIS reimbursement delays prevented them from adequately planning and running their business.

Challenges with Receivables Financing & Business Support

Across rounds of data collection in both Kenya and Ghana, providers who engaged with MCF financing generally faced similar challenges understanding the terms of the loan. Providers also mentioned the onerous paperwork required to receive a loan. This issue continued to appear in the context of Receivables Financing as well, leaving some providers to wonder if waiting for a delayed loan was any better than waiting for payments directly from the NHIS. While providers reported few challenges participating in other aspects

of business support, some said that implementing new learnings around bookkeeping and tracking drug stocks could take awhile to implement and required regular support from franchise representatives.

NHI Accreditation

Provider Knowledge

Provider knowledge of how the NHI's worked and exactly what these schemes covered was generally low in both countries across rounds of data collection. However, when providers were asked whether or not the NHI covered family planning in the final round of data collection, most providers in Ghana were able to decisively respond that family planning was not covered. Some providers even noted that they had either advocated for the inclusion of family planning in the benefits package or were aware of recent advocacy efforts to do so. One provider pointed out the hypocrisy in covering maternity care, but not family planning:

If the children have... the person has 10 children and decide to deliver every year, health insurance will cover the children's treatment. So, it's like the health insurance not taking family planning [is] a non-motivator. So, we were saying that, if they include the family planning, it will reduce the number of pregnancies the people are having because they know that one is insured. For instance, somebody coming for Jadelle, you will collect 10 cedis, he too don't have it, they will go and get pregnant.

Midwife at a BlueStar Facility, Northern, Ghana

Conversely, providers in Kenya were much less certain regarding whether or not family planning is included in the NHIF package with most providers saying they "don't know" or were "not sure" about coverage for this service.

Why Join & Benefits of Accreditation

While NHIF accreditation was relatively new to many providers in Kenya, most reported that they would apply to renew their accreditation when the time came. Several providers noted that their patients seemed to be well served by NHIF and worried that they would lose clients who had already been capitated to their facility if they failed to renew. Others mentioned that accepting NHIF was part of their social responsibility and allowed them to serve low-income patients. Suggesting that NHIF membership will only continue to grow, one provider said she would renew because, "I can understand the way Kenya is going." (*Director at an Amua Facility, Coast, Kenya*)

Despite significant delays in reimbursement from NHIS, nearly all providers in Ghana affirmed that they would apply to renew their accreditation when the time came. When asked why they would renew, most providers

noted that they would lose clients if they didn't accept NHIS and their patient population wouldn't be able to pay for services without the coverage. So, they reasoned that the facility was better off accepting late payments from NHIS than reducing their client load or receiving nothing from patients who couldn't pay. As one provider said when asked if she would renew her clinic's accreditation when the time came.

Why won't I apply? Because in any case it is like delivery; when you are in labor, if the pain is killing you and you say I won't deliver, but when you see your baby and the baby is okay, you will want another child. And besides that, we are in business... So, without NHIS... we are like marriage now, without we the providers, there is no NHIS, we are three; the client, the provider and the NHIS.

Midwife at a BlueStar Facility, Northern, Ghana

Similarly, some providers felt it was their duty to serve their community, which they were unable to do without accepting NHIS due to their location in an impoverished area.

Among those providers in both countries who were not NHI-accredited, several providers in Kenya were going through the accreditation process at the time they were interviewed. Others hadn't applied because they knew that their facilities did not yet meet the minimum requirements for accreditation; several of these specifically mentioned that they were being advised by the franchise through this process. While most providers in Ghana were accredited, those who did not accept NHIS either cited the extreme reimbursement delays for discouraging them from participating or expressed concern that, given the popularity of NHIS among potential patients in their community, their small facility would be overwhelmed by demand.

Benefits of NHI Accreditation

Across rounds of data collection, providers in both Kenya and Ghana agreed that accepting NHI coverage increased their client load, encouraged patients to seek healthcare more regularly, and drew patients into care earlier when they previously would have waited to seek treatment or would have self-medicated rather than visiting a clinic. Some providers also appreciated that NHI accreditation signaled quality to potential clients and felt that regular monitoring visits from NHI officials helped them to maintain quality services. Further, providers felt that they were better able to reach and serve low-income patients with the NHI's.

I: Has accepting NHIF changed the way you treat patients who used to have trouble paying for services?

R: Yeah, it has helped a lot ... it has helped a lot because a number of them now just come in walking, “I have the card” [laughs] ehhh “How are you going to make your payment?” “I have the card” [laughs] ehhh “I have the card”. “Which card do you have?” “I have NHIF.” So, for us ones what we need to do is just check on the payment if they are up to date we give out the services, yes.

Director at a Tunza Facility, Nyanza, Kenya

A number of providers mentioned that low-income patients were far less likely to negotiate prices or ask to pay on credit when they had NHI coverage; this was a clear benefit to providers primarily serving poor populations, as they could rely on a more regular income stream. Since the AHME partners in Kenya were making a strong push for providers to apply for the Linda Mama contract toward the end of the project, in the final round of data collection (2018) we specifically asked providers about their experiences with Linda Mama. While providers often complained of low reimbursement rates under Linda Mama, similar to our findings regarding NHI contracts in general, these providers regularly noted that they had previously offered maternity services for free when a patient required it, but Linda Mama at least allowed them to be paid a small fee on a regular basis. Since private insurance providers in Kenya recently started to require NHIF accreditation in order for a provider to participate in private insurance, this seems to be another way in which NHI accreditation has the potential to help providers maintain profitable, sustainable businesses.

Serving Low-Income Populations

Most providers in both countries felt that lower-income patients benefited from NHI coverage because it helps them to pay for services, even if it doesn't always cover the full cost of a visit:

I: Okay has accepting NHIF changed the way you treat patients who used to have trouble paying services?

R: Yeah.

I: Mmmh how?

R: Because now they come and go but the earlier you could charge the patient,” No I don't have enough money,” but today it is just treating and going home

Administrator at a Tunza Facility, Central, Kenya

Whether due to intentional or unintentional misunderstanding of the system, Kenyan providers sometimes admitted to charging clients on top of their NHIF coverage, which could be a barrier to access for low-income clients. However, providers in Ghana mentioned top-up charges more often due to significant reimbursement

delays from the NHIS. Still, some providers in Ghana felt that even if patients were charged a top-up fee when using their NHIS card, any coverage from NHIS made care more accessible for poor patients than paying out of pocket. Conversely, other Ghanaian providers suggested that poor patients tend not to enroll in NHIS in the first place and that high- and middle-income patients tend to benefit more from NHIS.

Challenges with Accreditation

Across all rounds of data collection, the challenges faced by Ghanaian providers due to delays in NHIS reimbursement cannot be overstated. Providers often mentioned being money rich, but cash poor: “As it is now, the revenue increases only on our books but [smiles] but then, the, the cash – yes, once we deliver the service and we submit a bill, we've accrued the revenue but as to, when you receive the cash that's where the problem lies.” (*Administrator at a Private Facility, Ashanti, Ghana*) As a result, providers regularly reported difficulties paying staff, stocking drugs, and covering other basic facility expenses, such as rent. In order to mitigate these difficulties, providers often took on debt, which they then had trouble paying off. In addition and, to the detriment of the patient population AHME aims to serve, providers regularly mentioned charging patients a “top up” fee when they use their NHIS card to cover services: “Providers had to find other ways of surviving including charging erm some top ups on services and top ups on drugs just to survive.” (*Medical Director at a BlueStar Facility, Central, Ghana*) Further, while AHME aims to increase provider quality, the NHIS payment delays affected providers' ability to maintain a minimum level of quality, let alone make improvements. As one provider mentioned, “given the payment delays you have to cut your coat according to your size.” (*Midwife at a BlueStar Facility, Northern, Ghana*), suggesting that providers need to balance needs across an entire facility and sometimes cut corners in order to maintain financial stability.

I: What are some of the benefits your facility has enjoyed from NHIS?

R: Mmmh, have we enjoyed anything? I can't think of any...For revenue, I would say that they haven't paid us for more than let's say 10 months (laughs). **So what, if that is enjoyment then I wouldn't know what a punishment is.**

Doctor at a Private Facility, Greater Accra, Ghana

Other challenges providers in Ghana mentioned included restrictions on the types of drugs and services low-level providers are allowed to claim for reimbursement, difficulties processing reimbursements, and a lack of communication from the NHIS regarding changes in policy. In addition to impacting clinical quality, providers felt that such challenges undermined trust in

their relationship with their patients; an element that is important for patient retention.

Despite these serious challenges, most providers felt that accepting NHIS was not a choice; their patient population was largely enrolled in NHIS and so they had to maintain accreditation in order to attract clients. Further, providers felt they had no recourse if they complained to NHIS because they were in a “master-servant” relationship and therefore had no power.

Kenyan providers also sometimes faced payment delays, although these were not as extreme as those experienced by their counterparts in Ghana. Kenyan providers also complained that patients don’t understand NHIF coverage well; an issue that came up less often in Ghana where the NHIS is more established and a larger proportion of the population is covered. In addition, some providers mentioned competition from community-based insurance schemes run by county government, as schemes such as Makueni County’s universal healthcare program only cover services in public facilities.

Providers asked to discuss their experiences specifically with Linda Mama during the last round of data collection expressed concern that Linda Mama reimbursement rates are too low and providers sometimes requested top-up fees from patients as a result. One provider also mentioned the challenge of a lack of continuity between Linda Mama and regular NHIF coverage, such that if a woman has any health issues following the birth of her child (e.g. fistula) she then has to apply separately for the NHIF national scheme in order for these treatments to be covered. While most providers did not report differential treatment for patients with Linda Mama, one provider did note that he keeps women covered by Linda Mama separate from other patients. Since Linda Mama reimbursement rates are so low, this provider didn’t want more patients to find out about Linda Mama and turn to this coverage instead of paying cash.

Experiences with Capitation

Although the Ghana NHIS ran a capitation pilot that overlapped with AHME for several years, due to the program’s limited geographic and temporal scope the AHME-supported providers had limited experience with capitation and yielded little data on capitation in Ghana. Thus, data on provider experiences under capitation comes from Kenya for the purposes of this report. While Kenyan providers interviewed in Round 3 (2017) had mixed understandings of how capitation works, in the last round of data collection (2018) providers gave more consistent responses when asked to describe capitation. Further, fewer providers suggested that they charge patients out of pocket once they exceed the “cap” of 100 KSH/month covered by NHIF under capitation. Instead, providers were more likely to suggest

that they might limit services to patients who tried to claim too much. However, some providers expressed frustration that patients don’t fully understand what they are entitled to under capitation in the first place and feel they are being cheated when providers inform them that all services are not covered by NHIF; an interaction that can undermine patient-provider trust. For some providers, on the other hand, capitation provided incentive to maintain a higher level of quality in order to both attract and retain clients:

You have to now pull up your socks. You have to now stock good drugs, you have to treat them well aahh, because actually if a person chooses you and you don’t offer what she or he expected after six months he or she has a chance to change your facility and go to another facility. So, if you are not careful, you lose almost everybody. So, the challenge is that you have to, to, to maintain quality and maintaining quality means money.

Nurse at a Tunza Facility, Central, Kenya

In addition to these challenges of having to pay for quality and feeling like they had to limit services under capitation, some providers also reported struggling to enroll enough clients that capitation made financial sense for their facility. Conversely, providers who felt they had a sufficient number of capitated clients said that risk pooling under capitation allowed them to treat some patients for free. Some of these providers also felt that the large number of clients capitated to their facility signaled quality to other potential clients and attracted more lucrative patients, such as civil servants covered under the NHIF’s fee-for-service national scheme, to the facility. In addition, a number of providers appreciated receiving lump sum payments under capitation, which allowed them to buy equipment, make improvements to the clinic, and stock drugs. Since NHIS reimbursements were so delayed in Ghana, providers there often received lump sum payments as well by default. While most Ghanaian providers suffered hardships as a result of these delays, a few saw value in bundling payments, with one provider noting: “These people [NHIS] are saving money for us.” (*Midwife at a BlueStar Facility, Accra, Ghana*)

Patients

Provider Choice

As found by the AHME partners, location is one of the most important factors that determines provider choice and many patients who participated in the Qualitative Evaluation mentioned that they attended the clinic where they were interviewed partly because it was convenient or close to where they lived. In addition, the way patients were treated by a provider was one of the most important factors that determined where

they went for care in both Kenya and Ghana. Most patients discussed being treated well by the provider in the past, which prompted them to return to the same provider for care. Being treated well has two meanings for many patients. First, clients reported returning to facilities where they had been treated effectively before. Second, patients reported returning to a provider who treats them with kindness and respect, suggesting that compassionate care is also important to patient retention.

You must see to it that the nurses and doctors are friendly that you can tell them your problems to help you to solve it. There are some hospitals that when you visit, the nurses are not friendly. Those hospitals nothing will compel me to go because I am coming with my problem and you need to help me solve my problems, that is why.

Patient at a BlueStar Facility, Ashanti, Ghana

Patients also mentioned that it is important for them to be attended to quickly and often complained about having to stand in line all day to see a provider in a public facility. In addition, many patients also appreciated seeing the same provider each time they went to the facility. This provided consistency in care and patients felt they were treated more effectively by a provider who had a better understanding of how to treat them or their children based on past experience. It was also common to hear that patients like being able to ask the provider questions, which is not allowed by all providers.

Brand Recognition

In Kenya, the brand of the franchise networks did not drive provider choice⁶ across rounds of data collection. When asked if a patient knew of the franchise organization that ran the clinic where they were receiving care, interviewers received a mix of responses. While a few patients knew that the franchise provided family planning services, for the most part patients said they had heard the name of the franchise before, or may have seen signs in the facility where they were interviewed, but they didn't necessarily draw a connection between the franchise name and a particular brand identity.

I: Okay, have you ever heard about Amua or Tunza?

R: Yes, I have heard, because this hospital is Amua.

I: Mmmmh, and where did you first learn about Amua?

6 African Health Markets for Equity (2018). Snapshot 11: Social Franchising and Equity. <http://www.hanshep.org/our-programmes/AHMEresources/snapshot-11-social-franchising-and-equity>

R: I came to this hospital, and I saw it was written Amua

I: You saw it was written Amua?

R: Yes

I: And is there anything you know about Amua?

R: Nothing

Patient at an Amua Facility, Rift Valley, Kenya

Similarly, the franchise brand name did not drive provider choice in Ghana. However, more than half of the patients who were asked had not heard of the Bluestar name even though they were interviewed at a Bluestar facility.

Comparison: Public vs. Private Facilities

In both Kenya and Ghana, patients most commonly mentioned two main differences when asked to compare private and government facilities. First, almost all respondents said that they had to wait a long time to be seen at a government facility, as opposed to the relatively quick service they received at a private facility. The second difference the majority of respondents mentioned is that services are free at government facilities, while one has to pay for services at private clinics. However, many patients felt that paying for services was worth it, either because taking a day off work to wait at the government facility would cost them more than a private provider would charge, they wanted to ensure they would be seen within a reasonable timeframe, or they felt they got better quality service at a private facility.

I: And in terms of cost, how is this clinic different from health – government health centers and hospitals?

R: Mm, okay. Because they do take their time to, take care of you the cost is a bit higher than the government hospital but because you also want you welfare, you continue coming because you know that at the end of the day even if you pay high you are being offered a good service.

Patient at a BlueStar Facility, Central, Ghana

In Kenya, clients also complained that government facilities are often out of drugs and patients have to purchase prescriptions from outside the facility, while at private facilities they were able to get the medicine they needed from the facility.

R: In government there is no payments done and you can go there without money and you won't get drugs. You come here you pay and go home with medicine.

Patient at an Tunza Facility, Eastern, Kenya

Less common, but also mentioned by respondents in both Kenya and Ghana was that providers in the

government facilities often spend less time with patients, sometimes scold or speak rudely to patients, and are more likely to prescribe medicine than take the time to do a full exam.

In terms of quality of care patients had conflicting opinions regarding who provides better care. In Kenya, some felt government hospitals offered better quality, while others felt private providers offered better services. In Ghana, a few respondents mentioned that private facilities are cleaner than government facilities and have better equipment. However, a number of respondents in Ghana didn't think there was any difference between government and private facilities.

Clinic Experience

In both Kenya and Ghana, most patients described their experience at the franchise facility as “good” or “ok”. When asked to explain what they meant, these patients said that they had been treated well or that the facility staff was kind and friendly. Some mentioned having been seen quickly or that the treatment they received was effective, while others appreciated the facility's cleanliness. Across rounds of data collection, very few respondents discussed having had a negative experience at the facility where they were interviewed.

Opinions regarding the cost of services differed both within and across rounds of data collection in both countries. Regardless of NHI status, many of the patients interviewed did have to pay for services and/or drugs when visiting a franchised clinic.⁷ Some clients felt the cost was low while others felt it was high. In each round of data collection, a few respondents regularly mentioned that they had trouble paying for the services they received, or they'd had trouble paying in the past. When asked how they handled this situation, many borrowed money from family or friends, paid a reduced rate, or paid on credit. As mentioned above, although it was common to hear that patients felt the price for services at the franchise clinic was expensive, many said it was worth it to be treated nicely or to receive effective treatment.

And here where I have come for the services am happy because I haven't wasted my time. Even though it's a lot of money, but am happy with the services. The doctor has checked on us and we haven't found any challenges, we... have been served well. So, I just appreciate for their services, yes.

Patient at an Amua Facility, Nairobi, Kenya

Since the first two rounds of data collection with patients yielded few differences in experience between franchised and non-franchised clinics, in Round 3 the

⁷ The Qualitative Evaluation team has no way of verifying whether or not these costs were appropriate.

Qualitative Evaluation team did not collect data from any clients at non-franchised facilities. Therefore, the team cannot draw any conclusions regarding quality of services at franchised versus non-franchised facilities and we expect that this will come from the Quantitative Evaluation.

National Health Insurance

Knowledge of the NHI's

Across rounds of data collection, patients in both countries were unclear regarding which specific services and drugs were covered by the NHI's, although there was widespread agreement in Round 2 (2017) of data collection that basic drugs such as paracetamol would be covered by insurance. In most cases, patient knowledge of NHI coverage was experiential such that, when they were prompted to discuss which services and drugs were paid for by the NHI's, clients tended to report on services or drugs they had received themselves in the past.

R: Sometimes you visit the clinic with your NHIS card and when they prescribe some drugs for you, they will tell you health insurance does not cover it. So, you have to pay.

I: Have you experienced this before?

R: No. Only when I had a blood transfusion. Health insurance doesn't cover blood transfusion, does it?

Patient at a BlueStar Facility, Northern, Ghana

Since many women in Ghana told our interviewers that they had first registered with the NHIS when they became pregnant, it therefore followed that most women knew of NHIS maternity coverage. Still, a number of patients interviewed in Ghana said they wished that more drugs and services were covered; this was particularly true for those who were aware that they used to pay less out of pocket when the NHIS was adequately funded. However, these concerns did not outweigh the appreciation Ghanaian clients felt for having their healthcare costs offset any amount by the NHIS.

While Kenyan patients generally knew less about health insurance, how it works, and what it covers than their counterparts in Ghana, this seemed to change as data collection progressed with patients interviewed in the final round (2018) answering more confidently when asked whether or not they had NHIF themselves and how they used NHIF to pay in the clinic. Although these patients did not appear to know more about the services and drugs covered by their NHIF membership than clients interviewed in Ghana, they also were less likely to report having paid anything out of pocket for their clinic visit. Further, by the final round of data collection, almost all women interviewed knew that NHIF coverage was available to anyone, not just those in formal employment, for a monthly fee.

I: And must you be employed to get NHIF?

R: It is not a must to be employed.

I: Okay.

R: Even if you are doing your business so long as every month you pay five hundred.

Patient at an Amua Facility, Coast, Kenya

Why Enroll/Renew

In both countries, money came up regularly as a barrier to enrolling in or renewing NHI coverage. Women claimed that they couldn't afford registration fees and, in Kenya, the monthly premium of 500 KSH for Supa Cover coverage was seen as too high.

I: What do you wish to be done differently?

R: I wished the government promotes it in a way that the renewal cost can will be affordable to the needy so that everyone will be able to register to attend to their health needs.

Patient at a BlueStar Facility, Ashanti, Ghana

Since pregnant women in Ghana qualify for free enrollment into NHIS, this may be one reason why many women across rounds of data collection reported that they had only enrolled after becoming pregnant. Ghanaian clients also reported that they were moved to the front of the line for enrollment when they were pregnant and did not have to wait long. Conversely, many women complained of the long lines at enrollment centers, which sometimes required them to wake up well before dawn in order to secure a place, and the lack of connectivity and faulty equipment that slowed down the enrollment process even further. These long wait times were a deterrent to patients who hoped to enroll in or renew their NHIS coverage. In Kenya, while few patients complained about the NHIF enrollment process, several said they hadn't enrolled because they didn't understand the process or the benefits of having NHIF coverage. Others thought NHIF was only for formal sector employees and therefore did not apply to them if they worked in the informal sector. However, patients in both countries regularly mentioned that they had applied for NHI coverage because they were encouraged by their provider; this was especially true for pregnant women in Ghana.

Patient Treatment & Frequency of Use

In line with the NHIF's more recent wide-scale rollout in Kenya and the relatively low coverage numbers there, patients interviewed in Kenya were less likely than their Ghanaian counterparts to use their NHI coverage every time they visited a health facility. When asked how often they paid for services using NHIS in the final round of data collection, many Ghanaian women even appeared confused by the question, mentioning how often they had to top up their NHIS coverage to pay for lab tests

or drugs; the assumption being that the NHIS always covered clinic visits and any payment on the client's part would be in addition to, not in place of, that coverage. Conversely, using NHIF coverage at every clinic visit was not the default option for patients in Kenya, although clients interviewed in the last round of data collection appeared to use their coverage more frequently than those interviewed in earlier rounds. Although these clients gave few specific reasons why they did not use their NHIF coverage on a regular basis, several mentioned that their husband was the main cardholder for their household and they were not always able to use the coverage as a result. This was because either they could not always carry the NHIF card with them when they left the house, or because they lived separately from their husband and therefore could not easily access either the card or the health facility where they were registered under capitation.

I: And which hospital did you choose [under capitation]?

R: Here I have not chosen, eeh because that time I was in Mombasa. So that card itself is with...with my husband, eeh.

I: So, you didn't use it?

R: I have never used it again apart from that time when I was admitted [in Mombasa].

Patient at a private facility, Embu County

However, many clients mentioned using the coverage regularly for their children, who they felt needed health-care more often and more urgently than themselves.

Across rounds of data collection, patients in both countries generally reported positive experiences using NHI coverage. However, when asked to compare their own treatment with that of a cash-paying client, patients gave mixed responses. In Kenya, the majority of patients did not see a difference in the treatment they received when they used NHIF vs. when they paid in cash. However, patients sometimes felt they were treated more quickly or received better drugs when using NHIF coverage, because providers know that patients covered by NHIF can definitely pay.

I: Do those providers treat you differently when you pay with the NHIF card?

R: Yeah if you pay with the card they give you the expensive drugs because they know those people will pay but if you don't have that they pull you down because they do not trust you.

Patient at a Tunza Facility, Nyanza, Kenya

The same was generally true for patients in Ghana, the majority of whom felt that treatment was the same whether paying with NHIS or with cash. Some clients thought that patients using NHIS coverage were served

more quickly than those paying with cash and noted that providers would sometimes scold patients who did not have NHIS or at least advise them to apply for coverage; this was especially true for pregnant women.

I: And do providers I mean health professionals, the nurses do they treat you differently if you pay with NHIS as a patient?

R: Ok we are not treated differently, they will even advice you that why are you not using the NHIS because they know the importance that it helps reduce cost a lot. Yes, it helps reduce cost a lot so when you have the NHIS they even like it, when you don't have it they know that you are really paying a lot. So they will even advise you to erm, erm enrolled on the NHIS yes.

Patient at a BlueStar Facility, Ashanti, Ghana

However, some clients thought that cash-paying clients received preferential treatment. These clients felt those paying in cash were treated more quickly, received higher quality drugs, and were even treated more kindly. One client thought this was because providers respected those who were paying in cash, while another client thought the facility would rather receive money immediately than wait to be reimbursed by NHIS.

NHI Coverage & Healthcare Accessibility

In both Kenya and Ghana, patients agreed across rounds of data collection that NHI coverage makes healthcare more affordable and, by extension, more accessible. Clients said that they were more likely to visit a health facility when sick if covered by the NHI and many interviewees noted the importance of having NHI coverage in case of emergency. To this end, it was common for clients in Ghana to suggest that NHIS coverage literally saves lives.

I: Please, I want to know what benefits have you gained from the NHIS; your friends and family using NHIS, what benefits did they get from using NHIS?

R: We've gotten a lot of benefits because about five years ago, I collapsed due to BP [blood pressure]. When I was taken to the hospital, they took very good care of me and didn't collect anything [money]. First that it was cash and carry, if we don't have money like I will die.

Patient at a BlueStar Facility, Volta, Ghana

Patients also appreciated that NHI coverage gave them access to a range of provider types (both public and private), which was especially useful in Kenya when both government doctors and nurses went on strike at different points in 2017.

In Kenya, patients did not face many challenges with NHIF. Although patients occasionally complained that certain medicines and services were not covered, it was not clear if they were being charged inappropriately or if they simply were not aware of which services and drugs were covered under the insurance package. In Ghana, where patients had more experience with the NHIS, a number of clients expressed concern regarding the drugs covered under NHIS with many patients reporting that they had to pay for drugs prescribed to them and some feeling they received lower quality drugs when paying with NHIS. Further, more than one patient noted a lack of consistency, saying they sometimes paid for certain drugs or services, while other times these same drugs and services were covered by NHIS. These complaints are consistent with Ghanaian providers' statements that they sometimes charge patients for services that should otherwise be covered when they face severe reimbursement delays from the NHIS.

Knowledge of Capitation

Patients in both countries were generally aware of capitation and understood that this system required them to register with one particular facility to receive services. However, patients occasionally complained that the facility where they were registered was not convenient for them, or expressed concerns that capitation limited their ability to shop around for different providers. In Ghana, official policy around capitation has been in flux and patient interviews conducted in 2018 reflected this. Some patients noted that they were required to register with a specific clinic to receive services (although capitation payments to health facilities were put on hold in 2018), while others reported that they had previously registered with a facility, but were able to use their NHIS coverage at any facility at the time of the interview.

Equity Analysis

The findings below reflect a subset of patients from both Kenya and Ghana who were screened for wealth quintile and recruited into the study because they fell within AHME's target population of clients in wealth Quintiles 1 and 2 (Q1/Q2).

Provider Choice & Accessibility

Just as findings produced internally by the AHME partners suggested that proximity is one of the key factors in determining provider choice, almost all Q1/Q2 clients interviewed in Kenya said they chose to seek services at the clinic where they were interviewed because it was near their home. This issue was less commonly cited among patients in Ghana, although one patient noted that she attended the closest clinic partially because she had registered there for NHIS under capitation.

As expected for clients in the two lowest wealth quintiles, provider choice also was affected by cost. This occurred in a couple of ways. First, a number of Q1/Q2 patients in Kenya mentioned that they preferred accessing services in public facilities because they are cheaper than private providers.

I: Now when they get the problem of coughing and cold, where do you mostly take [your children]?

R: I take them to a public hospital.

I: Okay and what is the reason why you like taking them there and maybe not here [to the private facility]?

R: They treat the children well there, and also the payment there is not like here, eh.

Patient at an Amua Facility, Eastern, Kenya

Among those who preferred to see a private provider, the ability to negotiate prices or pay for services on credit made these providers more accessible than they would have been otherwise.

I: Mum I was asking today that you have treated this child here, how much have you paid?

R: Around sh.300

I: Sh.300, what do you think about that money, is it expensive or less?

R: It is less; sometimes he can't ask you to pay everything but can accept installments. Even when you have no money, he can still treat the child for you.

Patient at an Amua Facility, Eastern, Kenya

However, as noted above, previous rounds of data collection not focusing on Q1/Q2 patients have similarly found that clients valued the ability to pay on credit or negotiate prices when visiting a private provider and some patients outside of Q1/Q2 mentioned these benefits in the last round (2018) of data collection as well. These findings suggest that private health services may be prohibitively expensive for patients across a range of wealth quintiles, and private providers can increase their accessibility and appeal by accepting a range of payment options for patients paying out of pocket.

What makes me come here most of the time is because I get help in many ways. I can come here without cash, but they help me. Then, after two or three days when I get the money and bring it.

Patient at a non-franchised facility, Coast, Kenya

Notably, Q1/Q2 patients interviewed in Ghana hardly mentioned cost when asked why they preferred one provider over another. These patients also tended to

consider the cost of services at a private clinic more reasonable than their Kenyan counterparts. However, because almost all Q1/Q2 patients interviewed had NHIS coverage to offset their out-of-pocket costs, this likely affected their perceptions of affordability.

Similar to their non-Q1/Q2 counterparts across rounds of data collection, clients also said they liked visiting a private provider who: was caring and respectful; took the time to listen to them; had a reliable supply of drugs; and provided effective services that assured patients wouldn't have to return for multiple treatments.

While only a few Q1/Q2 patients interviewed in Kenya had NHIF coverage, having NHIS coverage in Ghana did seem to have some effect on provider choice. Ghanaian patients also suggested that having NHIS coverage gave them more options when choosing a provider.

Well, some of the eh the private clinics they accept this thing, the health insurance. It covers some parts and the hospital too, the government hospital too, that one too is the same thing. So, any of them.

Patient at a BlueStar Facility, Ashanti, Ghana

Public vs. Private

When asked to compare their experiences at public versus private facilities, clients in Kenya offered mixed responses regarding which sector offered more affordable services. While some patients appreciated the free services at government facilities, others suggested that the indirect costs associated with visiting a public facility (e.g. transportation, lost wages due to long wait times) were too high to justify seeking services in the public sector. This is consistent with findings from previous rounds of data collection across wealth quintiles, as outlined above.

I: And if you compare that 100 is it more if you compare with the (stammering) other hospitals, is that money more or less?

R: It is less because let's say you can serve me by 20 shillings. That is announced there that if you come for the family planning you pay 20 shillings for the number, then you get to be treated free, isn't it?

I: That one of the government?

R: Yes, if we compare I see they are so much because it wastes my time the whole day that I can go do a job and be paid 500 shillings. So I feel 100 [to be treated at the private clinic] is less it comes and goes.

Patient at a Tunza Facility, Eastern, Kenya

As mentioned above, cost of services came up less often among Q1/Q2 patients interviewed in Ghana. However, one patient specifically noted that she

preferred accessing services at government facilities, where she was sure she could use NHIS to cover her costs.

I: Ok, so would you prefer to normally go to a public hospital instead of a private clinic? **R:** Some of the privates don't accept the NHIS, but with the public facilities they accept NHIS.

Patient at a BlueStar Facility, Central, Ghana

Regarding quality of care, Q1/Q2 clients interviewed in both countries generally felt that the quality of care offered in private facilities was similar to that found in the public sector. However, several patients agreed that private providers had a more consistent supply of drugs, a concern that came up more often in Kenya, and appreciated the shorter wait times at the private facilities. Conversely, one Kenyan patient said she preferred visiting a government facility when her children needed care because she was able to see a specialist there; she did not mind the long wait as a result.

I: That children doctor, why do you like him? The children doctor why do you decide to even queue until night?

R: (Chuckles) because the children doctor knows so much [more] about the children than adults. An adult you can just be treated even at the chemist, because you understand yourself and where you don't feel good you say test me, but a child there is something... I am asking why is he called the children's [doctor] is because he has studied about the children.

Patient at a Tunza Facility, Eastern, Kenya

Clinic Experience

When asked about their experience visiting a franchised clinic, Q1/Q2 patients differed little from their counterparts in their perceptions. These patients generally appreciated the respectful and thorough care they felt they received. Interestingly, patient perceptions of the amount they were charged at the clinic did not necessarily align with their ability to pay. For example, one patient interviewed in Kenya said she wasn't able to pay for her services at the clinic that day and had to return at a later date with payment, but still did not consider the cost of services to be unreasonable. Indeed, while few patients reported paying nothing for their visit, most felt the cost of their visit was reasonable and a number of patients noted that the clinic where they were interviewed was less expensive than other private clinics.

NHI's

Patient Knowledge & Accessibility

While very few of the Q1/Q2 patients interviewed in Kenya had NHIF coverage, most had a basic understanding of the program and how it works. Still, this

program was generally less familiar to Kenyan interviewees than to their Ghanaian counterparts, and Kenyan patients were less sure that the NHIF was relevant to them. Reflecting this sentiment, one interviewee said:

I: And you why have you never been interested in applying [for NHIF]?

R: Me if I explain to you...I usually see that most of the people that usually register for this card let's say they are employed...and another one is someone that is disturbed with a certain disease and he/she says let me register for that card and I wait for those three months that I am being told [to wait for the card to arrive] and I be helped there [at the clinic]. So, I got to know that, that person is just because s/he is being burdened by a certain disease. This other one says that let me go and take the card because I am employed. **So, you see it has owners.**

Patient at a Tunza Facility, Eastern, Kenya

Few Kenyan Q1/Q2 clients had NHIF to begin with, but those who did have coverage did not report using it regularly. Ghanaian patients reported using their NHIS coverage more frequently and Q1/Q2 clients interviewed in Ghana also had the sense that they could use NHIS to pay at any health facility, giving them more choice in Ghana's health marketplace.

More familiar with the NHIS than their counterparts in Kenya, patients in Ghana also generally understood how health insurance works, although they rarely knew exactly which drugs and services were covered. When asked how much they had paid for their visit to the clinic the day they were interviewed, almost all patients reported having made some kind of out-of-pocket payment on top of their NHIS coverage with few patients suggesting they had been charged incorrectly. Indeed, most of these clients felt it was important to have NHIS in order to cover some costs ranging from basic clinic visits to catastrophic expenses. However, when it came to NHIS registration and renewal, Ghanaian patients did appear to realize the benefits of programs meant to serve key populations with free healthcare. Several patients said they had never paid registration or renewal fees for NHIS with one patient noting that she had trouble registering with NHIS until she became pregnant a second time:

I registered for the first time, I didn't receive the card. When I became pregnant the second time, I registered again and I still didn't receive it. So I decided not to register again because I tried two times but didn't receive my card. Then when I got pregnant with this baby, they insisted I register. This time I registered and I had my card.

Patient at a BlueStar Facility, Northern, Ghana

These reports align with findings outlined above in which patients across wealth quintiles suggested that providers encouraged or even forced them to register for free coverage under NHIS once they became pregnant.

Q1/Q2 patients interviewed in Kenya were less likely to see the financial benefits of having NHIF coverage and several said they hadn't applied for coverage due to monetary concerns; these patients said that the monthly premium of 500 KSH for the informal sector (SupaCover) plan was more than they could afford. Concerns around cost also came up in Ghana, although less often.

Patient Treatment Under the NHI's

Patients in both countries believed they were treated equally to clients paying out of pocket when they used NHI coverage. In Ghana, some even perceived that they were treated better than clients who pay with cash, suggesting that paying out of pocket was more likely to invite ill treatment from providers:

...if you have the insurance, they will attend to you but when you don't have it, what they will say won't be nice. I know if you have insurance, it will help you more than if you do not have it.

Patient at a BlueStar Facility, Northern, Ghana

As noted above, this finding is similar to findings from previous rounds of data collection that did not sample specifically for wealth quintile. Clients have previously suggested that providers may feel more secure accepting patients that have NHIS coverage because providers feel they can legitimately expect to be paid in this case. It is therefore worth noting that this sentiment is shared across sociodemographic groups, suggesting either that private providers in Ghana worry about being paid regardless of whether or not they suspect their clients have the actual ability to pay, or that even those who do not fall into the lowest two wealth quintiles in Ghana are sufficiently poor that covering healthcare costs out of pocket is a financial burden.

Process Evaluation Methods

Sample Description

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, the Kenyan Ministry of Labor, and the Ghanaian Ministry of Gender, Children and Social Protection. In the first year of the evaluation, we also interviewed financial institutions that were involved in the AHME partnership at the time. In the final two rounds of the evaluation, we interviewed leaders in the global health community working in the field of social franchising and private provision of care as well. The process evaluation themes and respondent groups are outlined in Table 1.

Sampling Strategy

For the majority of process evaluation interviews, in each year of the evaluation the UCSF team 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. These interviews were conducted in person where possible or over Skype. 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

Table 1: Process Evaluation Themes and Respondent Groups by Year

	Year 1 (2013): Design and Establishing the Partnership	Year 2 (2014): Operationaliza- tion and Short Term-Impacts	Year 3 (2016): Theory of Change	Year 4 (2017): Sustainability, Government Engagement, External Influence	Year 5 (2019): Sustainability, Government Engagement, External Influence
Country-level AHME partners	20	15	18	11	13*
Headquarters- level AHME partners (Project Management Unit, some steering committee members, donors)	4	2	12	2	10
Policy makers and government officials		2	7	5	6
Financial institutions	2	N/A	N/A	N/A	N/A
Global health community	N/A	N/A	N/A	9	8

*Two individuals were interviewed together for a total of N = 12 interviews.

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 and duration of their involvement with the AHME partnership, some participants were only interviewed once, while others participated in several rounds of interviews.

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 consultants hired specifically to assist with Rounds 3 – 5 of 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 two interviews were recorded using a digital recorder. When two interviewees 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) and UCSF staff was responsible for back-checking interviews to ensure accuracy.

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

Ethical Review

Initial approval was received with “Exempt” status from the Institutional Review Board of the University of California San Francisco for the AHME evaluation on 13 June 2013. Approval was also received from Ghana Health Services Ethical Review Committee (ERC) on 28 June 2013 and Kenya Medical Research Institute (KEMRI) approval on 28 October 2013. Since this study was granted “Exempt” status in 2013, the UCSF team was not required to seek approvals from UCSF for amendments made to the original protocol during subsequent rounds of data collection. Approvals for the final round of data collection were received from KEMRI on 7 February 2019 and from the ERC on 26 January 2019.

Provider/Client 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 (Marie Stopes Kenya), Tunza (Population Services Kenya) and BlueStar (Marie Stopes Ghana) networks. During Rounds 2–4 of data collection the franchisors 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. By Round 4 of data collection, most franchised providers were receiving all of the interventions, in which case providers were sampled according to region. 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 eight 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. Over the four rounds of data collection we aimed to interview different clinics participating in the AHME interventions but there was some overlap between rounds.

In addition, three rounds of exit interviews with clients were conducted in 2013, 2017, and 2018. 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.

In select rounds of data collection, focus group discussions (FGDs) were conducted with populations expected to provide more detail and depth for our analysis. In round 1 of data collection, these focus groups involved community members in both Ghana and Kenya. 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. FGDs were also restricted to respondents with at least one child, as a number of questions dealt with child health scenarios.

In the final round of data collection, FGDs were conducted with franchise representatives who worked directly with providers. These included: 11 franchise officers in Kenya and three in Ghana who liaised with providers regarding issues related to franchising, such as conducting regular site visits and monitoring clinical data; nine business advisors in Kenya who assisted providers with maintaining and growing their clinic as a business, sometimes with obtaining loans, and with obtaining NHIF accreditation; and 2 SafeCare officers in Ghana who worked with providers on issues related to the SafeCare intervention, such as conducting annual assessments and providing assistance with quality improvement activities. To select these FGD participants, the AHME implementing organizations were contacted and asked to provide the names of at least three franchise representatives of each type (franchise officers, business advisors, SafeCare officers {Ghana only}) who would be willing to talk with the QE team.

Ethical Review

Initial approval was received with “Exempt” status from the Institutional Review Board of the University of California San Francisco for the AHME evaluation on 13 June 2013. Approval was also received from Ghana Health Services Ethical Review Committee (ERC) on 28 June 2013 and Kenya Medical Research Institute (KEMRI) 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 4 (2018) of data collection were received on 15 June 2018 from the ERC, 22 May 2018 from UCSF, and 17 July 2018 from KEMRI.

Data Collection, Processing, and Analysis

Field staff who conducted the in-depth, semi-structured interviews with providers and clients were recruited by Innovations for Poverty Action (IPA). Staff were then trained by IPA and UCSF on qualitative interviewing and the field guides that would be used during each round of data collection. To conduct 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. The FGDs with franchise representatives were conducted by the UCSF team during routine visits to Ghana and Kenya.

All IDIs and FGDs were recorded using digital recorders. The IDIs and community FGDs 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. All of the franchise representative FGDs were conducted in English. Recordings were translated (where necessary) 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 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.

Demographics

Female Community FGDs: 2013		
	Kenya	Ghana
Participants	58	50
Average number of children	3	3
Education level		
None	1	3
Primary	26	11
Jr./Secondary	22	33
Tertiary	9	3
Age		
18-22	17	5
25-35	19	23
36-49	22	22
Marital status		
Single	21	17
Married	36	31
Widowed	0	2
Divorced	1	0

Male Community FGDs: 2013		
	Kenya	Ghana
Participants	41	20
Average number of children	2	3
Education level		
None	1	2
Primary	16	2
Jr./Secondary	16	12
Tertiary	8	3
University	0	1
Age		
18-22	8	0
25-35	22	13
36-49	11	7
Marital status		
Single	2	5
Married	39	12

Ghana Patient Demographic Overview			
	2013	2017	2018
Number of IDIs	20	30	30
Franchised	100%	76%	100%
Non-franchised	0%	23%	0%
Average age	32 years old	31 years old	31 years old
Average # of children	3	3	2
NHIS coverage	N/A	90%	76%
Average time to reach facility	25 Minutes	19 Minutes	20 Minutes
Average wait time to see provider	57 Minutes	50 Minutes	38 Minutes
% of patients who reported no payment for visit	67%	67%	30%
Reported average payment for visit*	4.72GHC (1.01 USD)	10.77 GHC (2.31USD)	21GHC (4.51 USD)
Transportation to visit			
Walked	39%	40%	27%
Taxi	33%	23%	37%
Public transit	28%	30%	33%
Motorbike	0%	0%	3%
Other	0%	7%	0%

Education			
No formal education	10%	17%	17%
Primary education	6%	7%	17%
Middle junior high school	50%	46%	27%
Secondary/senior high school	22%	17%	23%
Vocational/trade school	6%	10%	10%
University	6%	3%	6%
Monthly income*			
200GHC or below (43USD)	n/a	1	53%
201-500GHC (43-107USD)	n/a	30%	27%
501-1,000GHC (108-215USD)	n/a	17%	17%
1,001-2,500GHC (215-537USD)	n/a	3%	0%
2501 - 5,000GHC (237-1,074USD)	n/a	0	3%
Wealth quintile			
Q1	n/a	n/a	17%
Q2	n/a	n/a	20%
Q3	n/a	n/a	17%
Q4	n/a	n/a	17%
Q5	n/a	n/a	30%

*Used March 1, 2017 currency conversion rate

2013: 2 participants did not provide demographic information so n= 18

2017: 1 respondent did not identify how they got to the clinic or how long it took

Kenya Patient Demographic Overview			
	2013	2017	2018
Number of IDIs	26	30	30
AMUA	7	20	14
Tunza	19		15
Non-franchised	0	10	1
Average age	26	29	29
Average # of children	2	2	2
NHIF coverage	13	14	18
Average time to reach facility	22 Minutes	19 Minutes	22 Minutes
Average wait time to see provider	15 Minutes	9 Minutes	6 Minutes
% of patients who reported no payment for visit	31%	7%	37%
Reported average payment for visit*	191KES (2USD)	964 KES (9USD)	277 KES (3USD)
Transportation to visit			
Walked	50%	60%	67%
Taxi	8%	3%	0%
Public transit	23%	7%	17%
Motorbike	19%	20%	13%
Other/unknown	0%	10%	3%
Education			
No formal education	12%	10%	3%
Primary education	50%	23%	50%
Secondary/senior high school	23%	37%	27%
College	12%	27%	13%
University	4%	0%	7%
Monthly income*			
10,000KES or below (95USD)	n/a	67%	53%
10,001–20,000KES (95 -190USD)	n/a	17%	30%
20,001–30,000KES (190-286USD)	n/a	3%	13%
30,001–40,000KES (286-381USD)	n/a	3%	3%
40,001 – 50,000KES (381-476USD)	n/a	0%	0%
Unknown	n/a	10%	0%
Wealth quintile			
Q1	n/a	n/a	23%
Q2	n/a	n/a	17%
Q3	n/a	n/a	7%
Q4	n/a	n/a	17%
Q5	n/a	n/a	37%

*Used March 1, 2017 currency conversion rate

2013: Patients who reported paying nothing includes two people who paid with a voucher

2017: 2 respondents did not identify if they had NHIF; 1 respondent did not identify how long it took to get to the facility; 4 respondents did not know how long they waited; 2 respondents did not know the price of the visit; 1 respondent did not provide education level

Ghana Providers Demographic Overview				
	2013	2015	2017	2018
Number of interviews	23	30	28	33
BlueStar facilities	23	27	20	20
Average age	55 years old	53 years old	56 years old	47 years old
Males	4	9	12	17
Females	19	21	16	16
Average years in practice	26	28	29	19
Owners of facility	57%	80%	61%	58%
Region				
Ashanti	30%	0%	25%	24%
Brong Ahafo	0%	0%	4%	0%
Central	0%	4%	0%	15%
Eastern	0%	37%	0%	9%
Greater Accra	70%	41%	46%	24%
Northern	0%	0%	0%	9%
Volta	0%	0%	25%	18%
Western	0%	18%	0%	0%
Provider title				
Midwife	4%	8%	43%	36%
Nurse	9%	22%	7%	3%
Medical Assistant	26%	3%	4%	3%
Medical Officer	0%	0%	0%	0%
Community Health/Auxiliary Nurse	35%	28%	0%	0%
Clinical Officer	0%	3%	0%	0%
Health Assistant	9%	6%	0%	0%
Doctor	4%	11%	21%	9%
Other/unknown	13%	19%	25%	48%
Facility type				
Hospital	0%	20%	25%	33%
Maternity home	48%	40%	36%	24%
Clinic	43%	30%	39%	33%
Health center	0%	0%	0%	9%
Pharmacy	9%	0%	0%	0%
AHME interventions				
NHIS	n/a	22	27	29
SafeCare	n/a	16	14	22
MCF	n/a	4	9	9

2013: 1 provider did not share their age; 1 provider did not share the number of years practicing

2015: interviewed 30 providers at 27 different facilities; 2 respondents did not provide how long they have been practicing; 1 respondent had just registered for SafeCare but did not yet have an assessment (not included in SafeCare count); facilities that were “in process” of rolling out NHIS (2 facilities) are not included in the NHIS count

2015 & 2017: 1 provider identified the facility as both a clinic and maternity home, this facility is counted as a clinic above
 2017: 1 provider did not share information on AHME Interventions
 2018: 6 providers did not specify how long they had been practicing
 Clinic overlap: two clinics overlapped between rounds 2 and 3, three clinics overlapped between rounds 2 and 4, eight clinics overlapped between rounds 3 and 4, and two clinics overlapped between rounds 2, 3 and 4.

Kenya Providers Demographic Overview				
	2013	2015	2017	2018
Number of interviews	24	57	50	47
Average age	49 years old	47 years old	41 years old	45 years old
Males	9	31	32	35
Females	15	26	18	12
Average years in practice	21 years	20 years	17 years	19 years
Owners of facility	75%	74%	68%	74%
Region				
Central	0%	0%	18%	15%
Coast	0%	0%	18%	15%
Eastern	71%	32%	12%	17%
Nairobi	29%	37%	16%	17%
Nyanza	0%	0%	28%	15%
Rift Valley	0%	31%	8%	21%
Provider title				
Medical Doctor	8%	9%	8%	6%
Nurse	42%	42%	30%	32%
Community Health/Auxiliary Nurse	17%	9%	7%	2%
Midwife	4%	2%	11%	0%
Clinical Officer	21%	17%	28%	45%
Other/unknown	8%	21%	16%	15%
Facility type				
Clinic	71%	62%	50%	43%
Hospital	17%	9%	16%	13%
Health Center	8%	8%	10%	28%
Maternity home/nursing home	4%	19%	6%	6%
Pharmacy	0%	2%	8%	3%
AHME interventions				
Amua	42%	48%	30%	42%
Tunza	58%	40%	30%	42%
NHIF	37%	35%	38%	45%
SafeCare	n/a	38%	56%	74%
MCF	n/a	21%	54%	38%

2013: 1 facility identified itself as both a clinic and maternity home, this was categorized as a clinic above
 2015: 57 respondents from 52 facilities; 1 respondent did not provide their age; 9 respondents did not provide how long they have been practicing

2017: Interviewee choose a number of different titles so n=61; 5 respondents did not provide the type of facility

2018: 2 facilities chose "other" for facility type, not included in the count above

*Unknowns for AHME interventions were counted as not participating

Clinic overlap: seven clinics overlapped between rounds 1 and 3; three clinics overlapped between rounds 1 and 4; two clinics overlapped between rounds 2 and 4; one clinic overlapped between rounds 3 and 4; and one clinic overlapped between round 1, 3, and 4.

Dissemination Materials

Journal Articles (in development)

Equity Lessons from a Large Scale Private-Sector Healthcare Intervention in Ghana and Kenya (In preparation)

A qualitative exploration of private providers' experiences implementing social franchise interventions to improve quality of care in Kenya (In preparation)

Bridging the Gap with a Gender Lens: How Two Implementation Research Datasets Were Repurposed to Inform Health Policy Reform in Kenya (Under review at *Health Policy and Planning*)

Mediating Street-Level Bureaucracy to Standardize Health Policy and Increase Access to Small Private Providers in Kenya (Under review at *Health Systems and Reform*)

Commentary: What Diffusion Theory can tell us about why lessons from health systems innovations are slow to spread (Under review at *Gates Open Access*)

Seeking Care in the Context of Social Health Insurance in Kenya and Ghana (Under review at *BMC Public Health*)

Published Journal Articles

Suchman, L (2018) [Accrediting private providers with National Health Insurance to better serve low-income populations in Kenya and Ghana: a qualitative study](#). *Int J Equity Health* 17(179) doi:10.1186/s12939-018-0893-y

Suchman L, Hart E, Montagu D, (2018) [Public-private partnerships in practice: collaborating to improve health finance policy in Ghana and Kenya](#). *Health Policy and Planning*, 33(7) doi:10.1093/heapol/czy053

Sieverding M, Onyango C, Suchman L (2018) [Private healthcare provider experiences with social health insurance schemes: Findings from a qualitative study in Ghana and Kenya](#). *PLoS ONE* 13(2). doi:10.1371/journal.pone.0192973

Sieverding M, Briegleb C, Montagu D (2015) [User experiences with clinical social franchising: qualitative insights from providers and clients in Ghana and Kenya](#). *BMC Health Serv Res* 15(49). doi:10.1186/s12913-015-0709-3

Reports

AHME Policy Brief (2019): [Gender Disparities in NHIF Access and Use: a barrier to achieving UHC in Kenya](#)

AHME Short Report (2019): [Equity](#)

AHME Short Report (2018): [Market Condition 3: Facilities Contracted](#)

AHME Short Report (2018): [Market Condition 4: Quality Services Available](#)

Comprehensive Report (2017): [African Health Markets for Equity Qualitative Evaluation Comprehensive Report: 2013-2017](#)

Posters and Presentations

Prince Mahidol Award Conference - January 2020 (Panel): Service Delivery and UHC in the Private Sector

Dissemination Meeting at Population Services International - September 2019 (Presentation): Poor Patients, Private Providers & Purchasing for Health: Lessons from the African Health Markets for Equity (AHME) Evaluation

Dissemination Meeting at USAID - September 2019 (Presentation): Poor Patients, Private Providers & Purchasing for Health: Lessons from the African Health Markets for Equity (AHME) Evaluation

Dissemination Meeting at Abt Associates - September 2019 (Presentation): Poor Patients, Private Providers & Purchasing for Health: Lessons from the African Health Markets for Equity (AHME) Evaluation

Dissemination Meeting at the World Health Organization - July 2019 (Presentation): Poor Patients, Private Providers & Purchasing for Health: Lessons from the African Health Markets for Equity (AHME) Evaluation

International Health Economics Association Conference - July 2019 (Poster): Incentivizing Quality in LMIC Private Healthcare Provision

Dissemination Meeting at the London School of Hygiene & Tropical Medicine - June 2019 (Presentation): Poor Patients, Private Providers & Purchasing for Health: Lessons from the African Health Markets for Equity (AHME) Evaluation

Dissemination Meeting at the UK Department for International Development - June 2019 (Presentation): Poor Patients, Private Providers & Purchasing for Health: Lessons from the African Health Markets for Equity (AHME) Evaluation

AHME Dissemination Meeting in Kenya - March 2019 (Presentation): Insights into Government-Private Provider Relations from the AHME Qualitative Evaluation

AHME Dissemination Meeting in Ghana - March 2019 (Presentation): Public-Private Relationships in Health-care: Findings from the AHME Qualitative Evaluation

International Conference on Family Planning - November 2018 (Poster): Equity in Family Planning Access and the Effects of Growing Urbanization in sub-Saharan Africa

International Conference on Family Planning - November 2018 (Presentation): Shifts in Family Planning Funding Under Social Health: Insurance Schemes Projected Effects on Private Sector Service Provision

Fifth Global Symposium on Health Systems Research - October 2018 (Presentation): Mediating "Street-Level Bureaucracy"

Fifth Global Symposium on Health Systems Research - October 2018 (Presentation): Seeking Care in the Context of Social Health Insurance in Kenya and Ghana

American Society of Tropical Medicine and Hygiene Conference - November 2017 (Poster): Making health markets work for low-income populations in Kenya and Ghana: How changes in National Health Insurance financing affect private providers