SF Case Study Series

HUDUMA POA
HEALTH NETWORK

KISUMU MEDICAL AND EDUCATION TRUST (KMET)
Huduma Poa
Health Network

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Kisumu Medical and Education Trust (KMET)
# ACKNOWLEDGEMENT

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**Recommended citation**


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<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APHIAplus</td>
<td>AIDS Population and Health Integrated Assistance Plus Program</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
</tr>
<tr>
<td>CH(E)WS</td>
<td>Community Health (Extension) Workers</td>
</tr>
<tr>
<td>CHMT</td>
<td>County Health Management Team</td>
</tr>
<tr>
<td>CMF</td>
<td>Central Medical Facility</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CYP</td>
<td>Couple Year Protection</td>
</tr>
<tr>
<td>DMS</td>
<td>Director of Medical Services</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GHG</td>
<td>Global Health Group</td>
</tr>
<tr>
<td>HCM</td>
<td>Health Care Marketing</td>
</tr>
<tr>
<td>HH</td>
<td>Household</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counseling</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intra Uterine (Contraceptive) Device</td>
</tr>
<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
</tr>
<tr>
<td>KNH</td>
<td>Kenyatta National Hospital</td>
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<tr>
<td>KEMSA</td>
<td>Kenya Medical Supplies Agency</td>
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<td>KEP</td>
<td>Kenya Expanded Program on Immunisation</td>
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<td>KMET</td>
<td>Kisumu Medical and Education Trust</td>
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<tr>
<td>KNBS</td>
<td>Kenya National Bureau of Statistics</td>
</tr>
<tr>
<td>KShs</td>
<td>Kenya Shillings</td>
</tr>
<tr>
<td>LARCs</td>
<td>Long Acting Reversible Contraceptives</td>
</tr>
<tr>
<td>MARP</td>
<td>Most at Risk Population</td>
</tr>
<tr>
<td>MCF</td>
<td>Medical Credit Fund</td>
</tr>
<tr>
<td>MMF</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health and Sanitation</td>
</tr>
<tr>
<td>MTRH</td>
<td>Moi Teaching and Referral Hospital</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NASCOP</td>
<td>National AIDS and STI Control Program</td>
</tr>
<tr>
<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<tr>
<td>PMFTCT</td>
<td>Prevention of Mother to Child Transmission of HIV</td>
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<tr>
<td>PS</td>
<td>Principal Secretary</td>
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<td>PSK</td>
<td>Population Services Kenya</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>QAO</td>
<td>Quality Assurance Officer</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>SF</td>
<td>Social Franchise</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>SVA</td>
<td>Single Visit Approach</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>UCSF</td>
<td>University of California San Francisco</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>USD</td>
<td>United States Dollar</td>
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<tr>
<td>VAI</td>
<td>Visual Inspection with Acetic Acid</td>
</tr>
<tr>
<td>VILI</td>
<td>Visual Inspection with Lugol’s Iodine</td>
</tr>
<tr>
<td>WHP</td>
<td>World Health Partners</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
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<td>WRA</td>
<td>Women of Reproductive Age</td>
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Executive summary

Kenya recently adopted a devolved system of governance and has divided the country into 47 semi autonomous counties. Her population is estimated at over 41 Million with an annual growth rate of 3% and a dependency ratio of 46%. Other country health and demographic indices include:- TFR 4.6; Unmet FP need 26%; IMR 52/1000; MMR 488; HIV prevalence of 5.6%. Cancer of the cervix is a leading cause of mortality in Kenya and yet only 3.2% of eligible women have ever undergone screening. The 15 counties from Western Kenya form a region of high disease burden that would benefit from well designed interventions.

To optimize efforts the government has adopted a six tier healthcare system that incorporates a community strategy with volunteer community health workers. It also emphasizes partnership with private providers and other nongovernmental organizations. The country’s demographic and health profile and structure of public and private healthcare provision, provides good opportunities to reverse the adverse health indices with a program modeled on social franchising.

Kisumu Medical Education Trust (KMET) is a Kenyan nongovernmental non-religious trust founded in 1996 whose headquarter is in Kisumu, its mission is to promote innovative and sustainable health and education programs in underserved communities and it envisions communities with accessible, sustainable quality health and education. It has several interventions, one of which is the USAID funded Health Communication and Marketing (HCM) program. Through this fund, KMET has been able to put in place a vibrant social franchise, Huduma Poa network.

Huduma Poa is a network of 80 clinics run on a fractional social franchise model to deliver high quality health services. The network strategy eliminates missed opportunities in HIV testing and cervical cancer screening; assures provision of high quality family planning services; promotes child health by adoption of the recommended IMCI protocols; and provides linkages for tertiary care.

The network is piloting the Huduma Poa Sky telemedicine that an innovative program that allows clients and their health providers to link to Doctors remotely through video-link in a central medical facility, thereby bringing specialised care closer to the underserved.

KMET uses a three pronged approach in managing the network; Quality services are guaranteed by Quality Assurance Officers who oversee clinical services in the network, a marketing team comprised of program officers and community health workers ensure sustained demand for services in the targeted communities. These two aspects are under a HCM coordinator. A health care financing aspect is the third prong with a coordinator running the medical credit fund (MCF).

Huduma Poa outlets fit a profile of clinics that have no access to credit or capital for upgrades or quality improvement. In collaboration with PharmAccess Foundation, KMET bridges this gap through the Medical Credit Fund (MCF) that provides loans to help low tier clinics in Africa improve quality. The facility has so far disbursed KShs. 43.4 Million ($15,000USD) to 18 Huduma Poa clinics. The MCF is linked to the SafeCare quality system that has standards in healthcare with accreditation and certification.

Since inception the Huduma Poa outlets have generated over 59,000 CYPs, almost 7000 children have been attended to using the IMCI protocols, 4,676 women have been screened for cervical cancer and over 25,000 individuals have been tested for HIV.

This is a case study on the conception, design and implementation of the KMET Huduma Poa health network at a given point in time.

2.0.0 METHOD

This case study was conducted between July and September 2014 and comprises of qualitative research tailored on a template designed by the Global Health Group (GHG) of the University of California San Francisco (UCSF).

A desk review of relevant literature and documents was conducted. Additionally management staff of the KMET Huduma Poa health network were interviewed. Three Huduma Poa outlets were visited and the experiences of providers sought. Community health workers (CHWs) attached to the clinics were also interviewed.

This document presents an overview of the design and implementation of the Huduma Poa Health Network, fractional social franchise at a given point in time.
3.0.0 COUNTRY CONTEXT

Kenya is one of the countries in East Africa that has a shore on the Indian Ocean. Kenya was previously governed centrally; geographically divided into eight provinces, each of which was further divided into districts. However with the promulgation of a new constitution the country is now divided into 47 counties under a devolved system of governance. These counties are further divided into sub counties, the sub counties follow the boundaries of the former districts. Kisumu Medical and Education Trust (KMET) Huduma Poa Health Network operates in two of the Western Kenya provinces (Nyanza and Western province) and adjacent areas of the neighbouring Rift Valley Province in an area that accounts for 15 of the 47 counties in the current dispensation.

3.1.0 NATIONAL POPULATION AND HEALTH STATUS

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<th>Metric</th>
<th>Value</th>
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<td>Kenyan Population (2009)</td>
<td>38,610,097</td>
</tr>
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<td>Percent urban/rural (2009)</td>
<td>32% / 68%</td>
</tr>
<tr>
<td>Current population (2013)</td>
<td>41.8 Million</td>
</tr>
<tr>
<td>Gross national income per capita (2008)</td>
<td>KShs 90,861</td>
</tr>
<tr>
<td>Life expectancy at birth (2009)</td>
<td>58.9</td>
</tr>
<tr>
<td>With HIV (Projected 2014)</td>
<td>M / F</td>
</tr>
<tr>
<td>59.5 / 65.2</td>
<td></td>
</tr>
<tr>
<td>Without HIV (Projected 2014)</td>
<td>M / F</td>
</tr>
<tr>
<td>64.2 / 71.9</td>
<td></td>
</tr>
<tr>
<td>Probability of dying under five (per 1000 live births, 2008)</td>
<td>74</td>
</tr>
<tr>
<td>Infant Mortality Rate (IMR) (per 1000 live births, 2008)</td>
<td>52</td>
</tr>
<tr>
<td>Total expenditure on health per capita (Intl $, 2012)</td>
<td>45</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP (2012)</td>
<td>4.7</td>
</tr>
<tr>
<td>Percent of total expenditure on health that is private (2012)</td>
<td>61.9%</td>
</tr>
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<td>Percent of private expenditure on health that is out-of-pocket (2005)</td>
<td>76.9%</td>
</tr>
<tr>
<td>Maternal mortality rate - MMR</td>
<td>488</td>
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<td>Unmet need for family planning (2008-09)</td>
<td>26%</td>
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<td>Contraceptive prevalence rate CPR</td>
<td>46%</td>
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<td>Contraceptive prevalence rate – modern methods</td>
<td>39%</td>
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<tr>
<td>Total fertility rate – TFR</td>
<td>4.6</td>
</tr>
<tr>
<td>HIV prevalence (adults 15-64) (2012)</td>
<td>5.6%</td>
</tr>
<tr>
<td>HIV Incidence (2012)</td>
<td>106,000</td>
</tr>
<tr>
<td>Adult literacy (15 -49yrs) m/f</td>
<td>91.5% / 84.9%</td>
</tr>
</tbody>
</table>

1. 2009, Kenya Population and Housing Census Reports vol (A,B,C) and II; KNBS; August 2010
3.2.0 POPULATION

The table above shows the estimated Kenyan population as at the last census in 2009, this gives an intercensal growth rate of 3% with slightly more than a million Kenyans being added annually. The population pyramid is heavy at the bottom, with an estimated 64% of Kenyans being under the age of 24. Moreover women of the reproductive age form nearly a quarter (24.3%) of the population. This implies an inbuilt growth acceleration as more individuals enter the childbearing age. The population increase in the future would be due to more mothers having children rather than mothers having more children. There is a possibility of population explosion if the fertility rate increases. The demographic dividend can only be reaped if this youthful population is engaged in gainful employment. Considering the high dependency ratio (46% of the population being above 64 yrs or below 15), economic growth would be stifled unless appropriate measures are taken.

Kenya Population Policy - The Kenya government adopted family planning (FP) as a program early, and has several policy statements on population and development including sessional paper no3 of 2012: Key to attaining vision 2030 of a globally competitive and prosperous Kenya; the burgeoning population has to be controlled by improving access to contraception and reducing the unmet need. Disparities in fertility within identifiable sub populations like the urban poor women are a new front in reducing the national total fertility rate. Use of the widespread private practice network fits in the multi sectoral approach that the policies call for.

Fertility - The latest Kenya Demographic Health Survey (KDHS) reveals at 4.6, the lowest ever total fertility rate (TFR) that the country has ever attained since the surveys began. Concomitantly and not surprising the contraceptive prevalence rate (CPR) had also improved to its highest ever with 39% of married women of child bearing age using the modern methods. However there are disparities with: rural areas; marginalized provinces; those of poor socio economic status and low education; having higher fertility and lower contraceptive prevalence. The government remained the predominant (57%) supplier of contraceptive commodities. The unmet need for FP (26%) is equally distributed amongst spaces and limiters. When segregated by regions Nyanza province at 32% has the highest proportion of married women with an unmet need.

Knowledge on FP is widespread - 88.5% of the women had ever heard of the injectable contraceptives, 67.2% of implants and 61.1% of the IUD. Of the women on contraception 22% were on injectables while only 2% were on the IUD, reflecting a method mix biased to the short term contraceptives. The government remained the predominant (57%) supplier of contraceptive commodities. The unmet need for FP (26%) is equally distributed amongst spaces and limiters. When segregated by regions Nyanza province at 32% has the highest proportion of married women with an unmet need.

Nyanza province has a modern method CPR of 32.9% which is below the national average, though Western province had an above average rate of 41.5% both have low IUCD usage at 0.4% and 0.8% respectively (3). The KDHS further reveals that only 5% of WRA not on contraception are being reached by field workers to discuss FP and only 9% of them who visited a health facility discussed FP with a health worker this implies that a lot of opportunity is lost on the education of potential users.

Most (73.3%) of HIV infected women of reproductive age, who were married or cohabiting, had a desire to delay pregnancy by more than 2 years, or not to have any more children. Of these 60.8% were using a modern method of Family Planning while 36% were not on any method.6


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3.3.0 CERVICAL CANCER

Data from the country’s cancer registry indicates that cancer of the cervix is the second most common cancer amongst women. The prevalence is estimated to be between 8 and 20%; and it is the leading cause of cancer mortality.

Worldwide 86% of the incidence of cervical cancer occurs in developing counties. Behavioral change, HPV vaccination, screening campaigns and early treatment of precancerous lesions are known to be effective in reducing the incidence of cancer of the cervix. However many women in Kenya present late when treatment is expensive, rare to find and not assured of cure. Countries with greater than 70% screening rates have demonstrated a marked reduction in the incidence of cancer, this compares to Kenya where the morbidity pattern is variable with some patients presenting for the first time with complications of full blown AIDS that are a challenge to manage and have less than optimal outcomes. There are regional disparities in the prevalence of HIV in the country, with the former Nyanza province where KMET is domiciled, having the highest rate at 15.1%. Though 71.3% of adolescents and adults have undergone a HIV test at least once, it is estimated that only 46.9% of those who are infected are aware of their status. Use of ART in public hospitals has led to a considerable reduction in the burden of disease.

The national strategic plan recognises the low level of community awareness on measures to prevent cancer of the cervix. Screening can be done using Pap smear or visual inspection with Acetic acid and with Lugol’s iodine. Use of the Pap smear requires expensive equipment, skill in interpretation and a delay in submission of results that in interpretation and a delay in submission of results that causes loss to follow up. Screening with VIA VIIL has a sensitivity of 67% - 79% and specificity of 47% - 86%, this compares favourably with conventional cytology whose parameters are 47% - 62% and 60% - 95% respectively, moreover VIA/VILI requires less skill and allows for an immediate diagnosis and where possible treatment if the single visit approach (SVA) is adopted.

The knowledge of one’s positive status through HIV counseling and testing (HCT) is the entry point to HIV care, treatment and secondary prevention. The ministry of health guidelines call for annual testing of all HIV negative individuals. Going by the 2013 WHO guidelines, 77.4% of the HIV infected persons in Kenya would be eligible for ART of whom only 46.9% were on treatment. It is estimated that 101,000 new HIV infections occur annually, and that approximately 1.6 Million Kenyans are living with HIV of which 650,000 are accessing ART. This leaves a treatment gap of 100,000 women and 65,000 men. New infections are increasingly occurring in heterosexual sex within stable unions, with 2% of the general population contributing disproportionately. These most at risk populations (MARP) consist of commercial sex workers, men who have sex with men (MSM) and injection drug users. Regional disparities are also noted. The Kenya roadmap to zero infections by the year 2030 calls for taking into consideration the socio-demography of HIV in designing prevention programs. With the intensification of interventions in areas of high prevalence.

Nineteen of the 47 counties with the highest HIV burden contribute to 800,000 people living with HIV and 65% of all new infections. Six of these 9 counties are in the region of operation of KMET Huduma Poa Health Network. Indeed the counties of Kisumu, Homa-bay and Siaya are specially listed as hyper - endemic HIV zones with prevalence rates above 15%. Amongst people who visited a health facility in Kenya surveyed in 2012 only 34.5% were offered HTC, and 91.5% of these accepted to be tested this no doubt implies missed opportunities in identifying the infected and initiating care before onset of full blown AIDS.

3.4.0 HIV AIDS

Infection with HIV leads to a chronic disease which if uncontrolled is invariably fatal. The prevalence of HIV in Kenya is estimated at 5.6% having declined from 7.1% two years prior. In resource scarce settings like Kenya, the morbidity pattern is variable with some patients presenting for the first time with complications of full blown AIDS.

The knowledge of one’s positive status through HIV counseling and testing (HCT) is the entry point to HIV care, treatment and secondary prevention. The ministry of health guidelines call for annual testing of all HIV negative individuals. Going by the 2013 WHO guidelines, 77.4% of the HIV infected persons in Kenya would be eligible for ART of whom only 46.9% were on treatment.

It is estimated that 101,000 new HIV infections occur annually, and that approximately 1.6 Million Kenyans are living with HIV of which 650,000 are accessing ART. This leaves a treatment gap of 100,000 women and 65,000 men. New infections are increasingly occurring in heterosexual sex within stable unions, with 2% of the general population contributing disproportionately. These most at risk populations (MARP) consist of commercial sex workers, men who have sex with men (MSM) and injection drug users. Regional disparities are also noted. The Kenya roadmap to zero infections by the year 2030 calls for taking into consideration the socio-demography of HIV in designing prevention programs. With the intensification of interventions in areas of high prevalence.

Nineteen of the 47 counties with the highest HIV burden contribute to 800,000 people living with HIV and 65% of all new infections. Six of these 9 counties are in the region of operation of KMET Huduma Poa Health Network. Indeed the counties of Kisumu, Homa-bay and Siaya are specially listed as hyper - endemic HIV zones with prevalence rates above 15%.

Amongst people who visited a health facility in Kenya surveyed in 2012 only 34.5% were offered HTC, and 91.5% of these accepted to be tested this no doubt implies missed opportunities in identifying the infected and initiating care before onset of full blown AIDS.

Approximately 1.6 Million Kenyans are living with HIV of which 650,000 are accessing ART.

However the widespread use of this important procedure is hampered by health worker inadequacy of skill and equipment not withstanding that they are inexpensive and can be made widely available.

The prevalence of HIV in patients with cervical cancer (15%) is double the national average. However 46.9% of HIV infected clients are not aware of their status, and thus will not be found in the HIV care clinics. This scenario calls for the integration of HIV testing and cervical cancer screening in the Maternal FP and Child Health clinics; the setting where women are likely to regularly attend.
One in every 19 children in Kenya dies before its first birthday while one in every 14 does not survive to the age of 5. The neonatal mortality rate of 31 per 1000 live births means that 60% of the infant mortality occurs during the first month. These figures belie remarkable progress that has been made in the five years preceding the survey. Not surprisingly, Nyanza province has the highest level of mortalities, with 1 in 7 children not living to its 5th birthday. With an infant mortality of 95 per 1000 live births, at 77% most of the children are fully immunised as per the KEPI schedule with 65% having completed the schedule by their first birthday. The Nyanza region lags behind the rest at 65% of all children.

3.5.0 Child Survival
In Sub-Saharan Africa, where Kenya is found, 70% of the child mortality can be attributed to one or a combination of five illnesses:
- Malaria
- Measles
- Diarrhoea
- Acute respiratory infections
- Malnutrition

Unless significant effort is made, these conditions will continue decimating African children beyond 2020.

In order to reduce child mortality, the Kenyan government, in collaboration with WHO and UNICEF, implemented the IMCI approach that is thought to be responsible for the improved child health indices witnessed. The IMCI guidelines are evidence-based syndromic diagnostic and treatment criteria, applicable in resource-poor settings. The generic guidelines were adapted to the country profile and support the cost-effective use of drugs to cover the illnesses that are most responsible for childhood morbidity.

The IMCI strategy calls for:
- Case management skills
- Effective health systems for management of childhood illnesses
- Family and community practices that promote child survival

In Sub-Saharan Africa, 70% of the child mortality can be attributed to one or a combination of five illnesses — Malaria, Measles, Diarrhoea, Acute respiratory infections, Malnutrition.
4.0.0 HEALTHCARE SYSTEM

4.1.0 Organisation of Public Healthcare Provision

The promulgation of the new constitution called for radical changes in the management of public health in keeping with the adopted devolved system of governance and the requirement for non-political leadership of ministries in a lean government. At the time of drafting the case study the ministry of health and sanitation was in transition and its structure was likely to change as it adjusted to the new system. The ministry headquarters was divided into directorates, the Director of Medical Services; the Director of administration and the Ministerial Monitoring and Evaluation Unit reported to the PS. The DMS oversaw 4 other directorates; including the directorate of Preventive and Promotive Health. Each directorate was further divided into Divisions. The Division of Family Health was one amongst 4 under the Preventive and Promotive Health Directorate, the Divisions are further split into units headed by a Chief. The ministerial monitoring and evaluation unit was one of those in the Division of Family Health. The Units which are also called Programs are the implementing organs at headquarters. Other programs within the ministry included the National AIDS Control Program (NASCOP).

One of the most celebrated policy directions from the new government was the provision of free maternity care.

The ministry was headed by a non-political cabinet secretary with a principal secretary (PS). The Ministry was divided into directorates, the Director of Medical Services; the Director of administration and the Ministerial Monitoring and Evaluation Unit reported to the PS. The DMS oversaw 4 other directorates; including the directorate of Preventive and Promotive Health. Each directorate was further divided into Divisions. The Division of Family Health was one amongst 4 under the Preventive and Promotive Health Directorate, the Divisions are further split into units headed by a Chief. The ministerial monitoring and evaluation unit was one of those in the Division of Family Health. The Units which are also called Programs are the implementing organs at headquarters. Other programs within the ministry included the National AIDS Control Program (NASCOP). Other mandates of the ministry were carried out by six parastatals which are governed by boards appointed by the cabinet secretary. They included 2 teaching and referral hospitals (KNH and MTRH); Kenya Medical Supplies Agency (KEMSA) that provided procurement and distribution of medical supplies; Kenya Medical Training Colleges (KMTC); Kenya Medical Research Institute (KEMRI); and the National Health Insurance Fund (NHIF) which was a mandatory social health fund for all employed persons and voluntary for the unemployed; it covers inpatient costs in public hospitals and admission costs in select private hospitals. There are other private health insurance firms in the market with a few successful Health Management Organizations (HMOs).

Service provision in Kenya is structured in a six tier system:

- Level 1 community (Community Health Workers)
- Level 2 dispensaries
- Level 3 Health centres
- Level 4 Sub-district and District Hospitals
- Level 5 Provincial (Regional) Hospitals
- Level 6 National Teaching and Referral Hospitals

These form a structured referral system from level one to six, each increasing level being better staffed and equipped. Medical doctors are found in level 4 and above; level 2 and 3 facilities are managed by clinical officers and nurses. The level six facilities are under the national government while the level 5 to 1 are under the devolved county system.

Each of the 47 counties is headed by an elected governor who appoints a county executive of health to run services. There is a county health management team (CHMT) chaired by a county director of health that implements national policy directives and county health agenda. The county is in charge of health personnel in its region using money devolved from the national treasury. The CHMT replaces the former Provincial and District Management teams.

Community Health Extension Workers (CHEWs) who are formal employees of the county health system; supervise 25 CHEWs, the CHEWs are preferably enrolled community nurses and public health technicians though some lack tertiary education. Two CHEWs and the 50 CHEWs they supervise -covering 5000 people or 100 HHs- and their respective tier 2 and 3 facilities form a community unit, also known as a level one unit.

One of the most celebrated policy directions from the new government was the provision of free maternity care.

Each CHW serves 20 households.
The sustainability of level one services depends on the degree of community ownership of health matters and the enterprise and dedication of the CHWs. The services provided by CHWs have always focused on RH due to donor support in training them in this area but they are required to provide:

- General health education and preventive services
- Promotion of specific health services e.g. FP
- Direct services like home based care and first aid
- Referral to their level 2 or three facility

The sustainability of level one services depends on the degree of community ownership of health matters and the enterprise and dedication of the CHWs considering that they are not a salaried cadre. In 2006 it was estimated that the country required 255,000 CHWs supported by 5,100 CHEWs.

In 2006 it was estimated that the country required 255,000 CHWs supported by 5,100 CHEWs.

<table>
<thead>
<tr>
<th>Registered Medical Personnel</th>
<th>No.</th>
<th>Per/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>8,682</td>
<td>21</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>37,907</td>
<td>91</td>
</tr>
<tr>
<td>BSc Nurses</td>
<td>1,666</td>
<td>4</td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td>26,659</td>
<td>64</td>
</tr>
<tr>
<td>Dentists</td>
<td>1,045</td>
<td>3</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>2,202</td>
<td>5</td>
</tr>
<tr>
<td>Pharm techs*</td>
<td>5,236</td>
<td>13</td>
</tr>
<tr>
<td>Clinical Officers*</td>
<td>11,185</td>
<td>28</td>
</tr>
<tr>
<td>PHOs*</td>
<td>8,069</td>
<td>20</td>
</tr>
<tr>
<td>PHTs*</td>
<td>5,969</td>
<td>13</td>
</tr>
</tbody>
</table>

* These figures include those who are registered and are out of the country or not practicing.

4.3.0 Staff and Hospitals

In 2006 it was estimated that the country required 255,000 CHWs supported by 5,100 CHEWs.
4.4.0 Private Health Sector and Regulatory Framework

All health practitioners in the country are by law required to be registered by their respective registration bodies and further be maintained in the register by annual licensing. Relevant acts of parliament guide the process. Doctors are registered and licensed by the Kenya Medical and Dentist Practitioners Board (KMDPB); Nurses by the Nursing Council of Kenya and Clinical officers by the Kenya Clinical Officers Council. Registration and licensing requires demonstration of proper training, an internship period and proof of continuous professional development, depending on the cadre. Private health facilities are licensed after inspection by members of the KMDPB or CHMTs. There are several unions and professional associations that serve to articulate various position statements and views of their members.

Private Health Sector and Regulatory Framework

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Public</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Faith-based organisaton</th>
<th>Total private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary hospitals (level 6)</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Secondary hospitals (level 5)</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Primary hospitals (level 4)</td>
<td>225</td>
<td>12</td>
<td>5</td>
<td>23</td>
<td>40</td>
<td>265</td>
</tr>
<tr>
<td>Other hospitals (level 4)</td>
<td>22</td>
<td>41</td>
<td>59</td>
<td>52</td>
<td>152</td>
<td>174</td>
</tr>
<tr>
<td>Health centres (level 3)</td>
<td>473</td>
<td>21</td>
<td>88</td>
<td>139</td>
<td>248</td>
<td>721</td>
</tr>
<tr>
<td>Nursing homes (level 3)</td>
<td>3</td>
<td>89</td>
<td>54</td>
<td>4</td>
<td>152</td>
<td>159</td>
</tr>
<tr>
<td>Dispensaries (level 2)</td>
<td>2,393</td>
<td>74</td>
<td>380</td>
<td>508</td>
<td>963</td>
<td>3,356</td>
</tr>
<tr>
<td>Clinics (level 2)</td>
<td>20</td>
<td>1,126</td>
<td>693</td>
<td>102</td>
<td>1,921</td>
<td>1,941</td>
</tr>
<tr>
<td>Laboratory—stand-alone</td>
<td>0</td>
<td>52</td>
<td>2</td>
<td>0</td>
<td>54</td>
<td>4</td>
</tr>
<tr>
<td>Dental clinics</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: Ministry of Medical Services and Ministry of Public Health and Sanitation, 2010

As the table above illustrates there are 6,641 health institutions, the majority 52.6% are private facilities

5.0.0 MARKET OPPORTUNITIES FOR SOCIAL FRANCHISE

1. There is a large unmet need for FP. The market share of the long acting reversible contraceptives methods (LARCs) of IUD (2%) and implants is disproportionately small implying there is room for increased FP uptake in a well-structured campaign targeting these methods.

2. The vast majority of Kenyan women have not been screened for cervical cancer, in the face of a renewed government initiative to tackle the morbidity associated with the disease.

3. The Kenyan public perceives private healthcare to be better than public health facilities, and those who can afford would rather visit them. This perception can be harnessed by weeding out quacks and building the skill of private practitioners in offering services of higher technical quality.

4. The government has expressed commitment to partner with the private sector in provision of quality healthcare to its populace.

5. A well structured and recognized community health strategy system with community health workers is in place and can be harnessed into action. The KCHS finding that only 5% of potential contraceptive users are being reached by field workers, implies an opportunity to increase uptake by structured field visits.

6. As indicated in the country context, the area of operation of KMET Huduma Poo Health Network comprises of 15 counties from the former Western, Nyanza and adjacent areas of the Rift Valley Province, these counties have the worst health indices in the country which calls for concerted effort to halt and reverse the trend. (A, B, C, 18)

Huduma Poo Health network identifies qualified private providers in their intervention area, after offering training in Family Planning, cervical cancer screening, IMCI, HIV counseling, testing and care. This is done concurrently with marketing of health in the community.


6.0.0 KISUMU MEDICAL AND EDUCATION TRUST

Kisumu Medical and Education Trust (KMET) is a non-governmental and non religious Kenyan Trust registered in 1996. It was formed by like-minded individuals concerned with the poor health indices recorded in Kisumu. Kisumu is a county on the shores of Lake Victoria and was formerly the headquarters of Nyanza Province. The residents are listed as the beneficiaries of the trust.

KMET creates, establishes and manages health education and development programs, KMET also promotes and manages medical and educational institutions to provide and sustain comprehensive clinical and educational facilities amongst underserved communities, KMET emphasises integration of health and education into core community development activities.

The organisation is in 35 of the 47 counties in Kenya. Its mission is to promote innovative and sustainable health and education programs in underserved communities and it envisions communities with accessible, sustainable quality health and education. In response to the ICPD Cairo conference it aims to integrate reproductive health into core community development activities.

The core values of KMET are captured by the acronym CHIGAID

• C - Community participation
• H - Human rights promotion
• I - Innovation
• G - Gender equity
• A - Accountability
• D - Diversity

Doctors are registered and licensed by the Kenya Medical and Dentist Practitioners Board (KMDPB); Nurses by the Nursing Council of Kenya and Clinical officers by the Kenya Clinical Officers Council.
The United States Agency for International Development (USAID), working through Population Services Kenya (PSKenya), runs the Aphiaplus Health Communication and Marketing (HCM) Program. This program recognises that there are aspects of health, which like other valuable commodity can be marketed and promoted using commercial principles.

In this regard KMET has expanded to include the following interventions

**Socio –Economic Empowerment**

- Nutrition project – Provision of nutritious supplemental feeding to vulnerable children and people living with HIV
- Community Capacity Enhancement – a project that galvanises the members of the community to understand the root causes of persistent vulnerability and under development and thus design pathways to change. Study Circles is the youth version of the project.

**Research**

- Ultrasound – KVET is currently conducting a study that is seeking to document evidence that use of the ultrasound toppings on mobile surgical units can save lives.
- Maternal Ultrasound – KVET is conducting a study that is seeking to document evidence that use of the ultrasound toppings on mobile surgical units can save lives.

**Youth Empowerment Programs**

- Youth for Youth Program – This program that is also known as the sisterhood for change, trains girls as peer educators in matters that concern SRH. In conjunction with the Safe Space and Savings program it provides vocational training and a safe space for girls recovering from sexual exploitation to develop viable options and build savings.
- Education – The program identifies the vulnerable children in informal settlements, and complements the municipal effort in ensuring their active inclusion in basic education.

**Family Health Programs**

- Comprehensive Abortion Care – Supports providers in provision of safe and legal abortion services where indicated, in addition to continued support to offer post abortion services.
- Clinical services – provides clinical services through a static clinic in the KMET health complex and a community mobile clinic to serve low income residents of Kisumu.
- Quality Healthcare Financing – In partnership with Medical Credit Fund (MCF) KMET provides financial and technical assistance to private providers to help them improve their capacity in provision of quality health care.
- Micro Insurance – In collaboration with PharmAccess Foundation and select health insurance companies, KMET improves health access through its Illma Poa health plan.
- Closing the Gap Project – Working with other local service delivery organisations and advocacy groups to increase the uptake and knowledge of quality FP and PAC services in the facilities that serve high need communities in the selected intervention areas.
- Health Communication and Marketing Program (Huduma Poa Health Network) – In partnership with SafeCare, KVET provides the umbrella of APHIAplus that finances private providers to upgrade clinics and improve quality. The MCF also incorporates a quality improvement program called SafeCare. This informal network of providers was an easy forum for both KMET and PharmAccess foundation to introduce to the providers the principles of social marketing and social franchise in response to the call for proposals by the APHIAplus HCM program. Other partners in the HCM program include Population Services Kenya (PSK), who are the lead agency and who operate the Tunza network of clinics. In a consultative process with that involved potential franchisees, their clients and affiliated community health workers the name Huduma Poa was selected. Huduma Poa is slang for “cool service” or “excellent service”.
- Huduma Poa network strategy eliminates missed opportunities in HIV testing and cervical cancer screening; assures provision of high quality family planning services and improvement of the recommended IMCI protocols that provides holistic clinical assessment and treatment of children. Prior to joining Huduma Poa network members did not have the skills to provide this service profile nor opportunity for training. This was coupled with financial support by MCF and SafeCare quality protocols.

Huduma Poa is slang for “cool service” or “excellent service”
Huduma Poa Coordinator - is the overall leader of the network and is tasked with ensuring the smooth running of both administrative and technical aspects of the entire network. While overseeing both the marketing and quality assurance team, he should ensure that:-

- He serves as an able team leader to steer the network in attaining targets and objectives.
- There is a good relationship with other stakeholders and partners including MoH.
- There is timely collection of service indicators, and preparation of a requisite reports to the KMET leadership and other key partners.
- Coordinate training of service providers and explore new interventions that are meritorious of inclusion into the Huduma Poa bouquet.

As the franchise grows the Huduma Poa coordinator indicates that he would need two assistants each to oversee the quality and demand creation aspects respectively. 

Health Communication and Marketing Officer – is responsible for designing and executing a social marketing strategy. This includes:-

- Development and implementation of a branding concept and guidelines for the network, provides services and affiliated processes.
- Monitor the placement, distribution and consumption of branded merchandise within the network area and beyond.
- Collaborates with program officers in creation of informercials and in organising events and activities that promote the network, the network supported health interventions and the Huduma Poa outlets.
- Document life interest stories and other field based non-data indicators of program achievements and successes.
- Assists in commodity safety system.
- He works under the supervision and direction of the Huduma Poa coordinator.

Quality Assurance Officers (QAO) – These are currently 4 officers and each oversees ~20 Huduma Poa outlets where they ensure compliance to the required quality standards by:-

- Building the technical competence of franchisees in the provision of the network services and affiliated processes like infection prevention. This is done through formal workshop training, facilitative supervision, on job and refresher trainings.
- In collaboration with the marketing team, plan and coordinate the success of the clinical aspects of the event days.
- Managing program logistics and ensuring commodity safety and adequacy of equipment while working hand in hand with MoH officials.
- Support providers in the management of complications.
- Ensure timely service data collection.
- On the ground liaising with MoH to assure clinics meet and over see demand creation events.

Program Officers – These 4 officers are also known as the demand creation officers and form the marketing wing of the management. They work in concert with the marketing officer and the CHWs. Their key tasks are:-

- Identification mapping and recruitment of potential franchisees in consultation with the Quality Assurance Officers.
- Creation and sustenance of demand for high quality FP and other network services within their intervention areas.
- Facilitate the recruitment, training and motivation of the CHWs.
- Supervision of the CHWs and CHWs during the organisation and rolling out of demand creation events.
- Support of marketing activities including but not limited to talk shows, branding and merchandising.
- Documentation of key achievements and clients anecdotes of program impact.
- Submission of timely reports of field marketing activities.

The program officers report to the Huduma Poa coordinator. There are other members of KMET who though not directly involved play a role in program success, these include admin, finance and HR departments. All interviewed members of staff recognize that teamwork is vital in attaining program goals and objectives. Staff operations are guided by various policy documents and manuals, e.g. the quality assurance manual; branding and marketing policy; assessment checklists etc. The network management was considering merging all these documents into one Huduma Poa standard operating procedure manual (SOPM).
7.2.0 Franchisor’s Relationship with Government

The MoH at both national and county levels recognise the need to harness the private sector to achieve health goals. Both levels recognise KMET as a partner and have invited them into several technical working groups that shape policy on maternal and child health. At the sub county and county levels KMET is a willing and active participant in the stakeholder forums. This avoids duplication of effort and allows the local health authorities to focus on other health priority areas. Out of this synergistic relationship one of the local health authorities purchased 5 cryotherapy machines to offer treatment to women found to have positive lesions. Due to the good relationship several government agencies provide Huduma Poa outlets and field activities with technical support, equipment, stationary, drugs, commodities, laboratory reagents and other consumables.

8.0.0 NETWORK MEMBERSHIP AND TYPICAL OUTLET

There are 80 Huduma Poa outlets spread out in 15 counties that comprise of the former Nyanza, Western and adjacent areas of the Rift Valley provinces. Most of the franchisees are middle level health workers (nurses and clinical officers) operating standalone medical clinics that operate during the day. Though most providers are female, this is not intentional and there is no indication that the health seeking behaviour of the population is biased to a specific gender.

Ownership of Huduma Poa Outlets segregated by cadre

<table>
<thead>
<tr>
<th>Qualification/Cadre</th>
<th>No. clinics owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>28</td>
</tr>
<tr>
<td>Clinical Officers</td>
<td>14</td>
</tr>
<tr>
<td>Doctors</td>
<td>12</td>
</tr>
<tr>
<td>CBOs/NGO</td>
<td>9</td>
</tr>
<tr>
<td>FBO</td>
<td>8</td>
</tr>
<tr>
<td>Company Limited</td>
<td>4</td>
</tr>
<tr>
<td>Non-Medical Persons</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total Franchise Facilities</strong></td>
<td><strong>80</strong></td>
</tr>
</tbody>
</table>

Most of the providers of the Huduma Poa services work exclusively in the clinics but are not necessarily the proprietors. Collectively the Huduma Poa clinics have 18 medical doctors; 168 nurses and clinical officers; and 19 pharmaceutical technologists. A typical Huduma Poa outlet is made up of a reception and three additional rooms, the staff comprise the provider an assistant and occasionally a lab technician. Some nursing homes franchise out the MCH wing to Huduma Poa. Within the network are also outlets that are run by NGOs and community based organisations.

Prior to joining the network the providers did not offer the full range of Huduma Poa services and those being offered were at a much lower scale. Auxiliary services like infection prevention and commodity management were also not well practised compared to after joining the network.

The franchisor intends to grow membership to 200 outlets in the next three years.

8.1.0 Clinic Selection

As indicated earlier the first batch of Huduma Poa clinics were willing participants from a loose network of providers who had been working with KMET and PharmAccess foundation on other health interventions.

Recruitment of additional members was done from a list of recognised and licensed providers in the local MoH registers. The program officers initially map out the clinics to ensure there is no overlap of catchment populations and that clinics serve the targeted populations. Potential members are then approached and to join the network must meet the following criteria:

i. Are duly licensed and the providers are registered
ii. Willing to join the network and abide by its regulations, they should not belong to another franchise

iii. Meet the minimum standards on infrastructure, personnel, range of service offered, documentation practices and IP practices. Those that do not meet the standards and are interested in joining can be given time to improve and are re-evaluated at a later date.

- **Clinics meeting initial criteria**
  - **Launch of clinic and marketing, providers are issued with starter kits for FP**
  - **Continued on-job training and support supervisions**
  - **Branding after provider has acquired proficiency**
  - **QAO organize training to bridge knowledge gaps, and assist in development of quality improvements plans**

- **Identification recruitment and training of CHWs**
  - **KMET and Owner sign MOU**
  - **Clinics meeting initial criteria requesting to join**

- **Mapping of clinics by Program and Quality Assurance Officers that meet initial criteria**

- **Mapping of clinics by Program and Quality Assurance Officers**
  - **Assurance Officers that meet initial criteria**
  - **Bridge knowledge gaps, and assist in development of quality improvements plans**

SF Case Study Series Kisumu Medical Education Trust (KMET) — SF Case Study Series Kisumu Medical Education Trust (KMET) — SF Case Study Series Kisumu Medical Education Trust (KMET) — SF Case Study Series
Providers that meet the criteria sign an MOU with the franchisor; the quality assurance team visit them to further evaluate the clinic with the aim of identifying gaps and needs in training, equipment and systems. From this evaluation a training plan and an action plan are formulated to assist the provider attain the Huduma Poa standards.

The providers then undergo a series of training in the order identified by the QA team subject to training opportunities and are given starter kits to set them off. Once the providers are back in their facilities, the marketing team promotes their facility through organised facility based event days. These provide the requisite volume of clients that allow providers to gain proficiency and confidence in provision of LARM; interpretation of VAA/VLI results and HTC.

These event days are also opportunities for the QA team to assess the competence of the provider and offer on job training. Only when the QA team is satisfied that the provider is competent does the franchisor brand the clinic.

From clinic identification to branding takes on average two months with facilities that are mission owned taking longer as their decision making process is longer. Of the clinics mapped during initial recruitment 73 were found ineligible to join the network, 80 clinics currently in the network. Sixty nine (69) clinics were actively sought and recruited while 12 requested to join the network and were granted having been found eligible to join the network citing the requirement to have met the recruitment criteria.

8.3.0 Contracts

There is a well spelt out Memorandum of Understanding that is signed between the franchisee and franchisor that states the contractual obligations of each party. All the providers encountered felt it was fair and easily enforceable. None of the members recruited had expressed any misgivings with any of the clauses. No registration nor membership fee was collected, this was to get the buy in of the initial members.

8.4.0 Benefits of enrolment

- Preferential access to MCF for facility improvement. This was cited as the best benefit of membership by the providers visited.
- Capacity building – through training and support supervision.
- Improved relations between the facility and MoH officials.
- Improved range of services and service delivery systems (integrated one stop visit)
- Having CHWs attached for demand creation and clinic specific promotional events
- Support with subsidised or free commodities and supplies including stationary through the KEMSA and NASCOP channels or the KMET buffer stocks and starter kits
- Access to appropriate IEC materials
- Facility branding that has given clinics feasibility

8.5.0 Drawbacks of enrolment

- The members encountered pointed out that the partial loss of autonomy that comes with joining a network was a minor drawback.
- Increased documentation and required reports especially associated with HIV services and free commodities.
- Increased workload from the HIV services that are nonetheless free or close to free.

All providers encountered however were of the opinion that the benefits outweigh the drawbacks. Doctors were reluctant to join the network citing the requirement to offer affordable services.

8.6.0 Membership Attrition

Of the 80 current network members 69 were actively sought and the rest approached KMET for consideration. Many applicants did not meet the minimum criteria and were turned down. At the time of writing 8 members had been asked to leave. This represents an attrition rate of 10%.

Failure to meet the minimum network quality standard was one provision after 6 months of engagement, and capacity building, led to disfranchising. Some providers who fail to adhere to an affordable costing of network services thereby rendering null the demand creation messages had also been disfranchised.

Considerable effort is made by KMET to ensure recruited franchisees stay in the network. Only 2 of the 8 disfranchised members had been branded and plans were underway to erase the branding. The facility CHWs are also withdrawn on termination of contract. However equipment that had been initially donated IEC materials on site and commodities are left in the clinic.

8.7.0 Network Linkages

Some of the Huduma Poa outlets are better in terms of size and range of services and act as referral for their colleagues. Additionally network members refer their clients to large public hospital in their catchment population.

The franchisors meet in their regions quarterly for performance review meetings and share their experiences, challenges and possible solutions. These KMET sponsored events are opportunities to reinforce the networks commitment to quality.

Kisumu Poa clinic owners and their staff are eligible to join the KMET Sacco, a savings cooperative movement of franchisor staff that is an additional avenue for getting personal credit.

Communication between clinics and KMET is carried out through mobile phone, email and physical visits. There is at least a once monthly data collection visit. Visits are responsive to the clinic needs new or struggling providers receiving closer attention compared to old and proficient hands.
**9.0.0 THE MEDICAL CREDIT FUND (MCF)**

Established in 2009 the MCF is a pioneer in provision of health care financing that is linked to technical assistance to improve quality of care to clinics and dispensaries in Africa. Huduma Poa outlets fit the profile of clinics targeted by the fund. They are unable to progress for lack of capital, and have no access to the conventional financing schemes due to high cost of credit, and their dependence on out of pocket payment which leads to an unpredictable revenue stream and poor qualification for loans.

KMET and PharmAccess foundation have partnered to assist franchised clinics access financing through the MCF. The MCF is not exclusive to KMET and other non-network clinics may also access it, however Huduma Poa outlet are better placed for financing.

The MCF bridges the gap by provision of access to capital and technical assistance that makes the providers optimize the financing in achieving quality health care provision. Prior to capital provision, the clinics are assessed; findings are used to prepare a quality upscale plan in consultation with the owners. Providers undergo training on financial literacy and the health care upgrade and come up with a business plan that will then be financed through participating banks.

The MCF has a revolving fund that partly finances the loans and has negotiated with two banks as implementing partners; Chase bank and K-REP bank. There are two types of loans, the entry loan and 2nd or subsequent loans. The entry loan is a smaller loan given to participating clinics and is to be paid within six months, the fund for this loan is entirely from MCF and no collateral is required. When the clinic defaults MCF absorbs the loss. Completion of the entry loan is one of the eligibility criteria for the bigger second loan which is equally financed by the MCF and the implementing bank, it requires the clinic to provide a collateral, it has a longer repayment period of up to five years.

Interest is charged on both loans at prevailing rates by the banks guided by financial market forces. At the time of this case study Chase bank charged annual interest at 16% while K-REP charged 19% both at reducing balance with monthly payments. The higher K-REP interest rates are due to it being a community based institution and thus had higher risks. Interest proceeds are equally shared by MCF and the implementing banks, MCF ploughs back its earnings into the revolving fund. It is possible that other banks may join the scheme in the future.

According to regulations from the central bank of Kenya (CBK) which regulates financial management in the country all loans that have not been serviced for a period greater than three months are declared in default. The MCF has a default rate of approximately 2% with some of the clinics eventually paying up.

A semi-annual evaluation program assesses and confirms the franchisee’s compliance with the SafeCare quality standards and the initial business plan is conducted by MCF and SafeCare teams as participating franchisees service their loans in compliance with the implementing banks.

Loans provided by MCF are exclusively for facility improvement, however there is a possibility that once given the clinic owner may divert the funds for other non health related activities. MCF guards against diversion of funds by matching loans to facility improvement plans guided by quotations of equipment to be acquired or bills of quantities (BQs) for construction etc. After funds have been disbursed enquiries into its use is made during supervision. However some clinics still divert the funds and it has been observed that these are the clinics that tend to default on payment.

Of the 81 clinics in Huduma Poa, 18 have been financed so far and others are undergoing consideration for financing. So far KShs 43.4 million ($10,000 USD) had been disbursed to Huduma Poa outlets with the largest amount to a clinic being KShs. 22M ($260,000USD) and the lowest is KShs. 200,000 (2,400 USD). The highest funded clinic at the time of the case study had also completed the SafeCare standard accreditation process and was certified. Thirteen clinics had completed their loans while 5 are still servicing either the entry or second loans. Two clinics defaulted, and one loan had to be written off as a bad debt, a loss that MCF absorbed, the other clinic made late but full payment of the capital sum. Outside of Huduma Poa the highest loan ever disbursed was KShs 35 Million (412,000 USD) and applications in excess of KShs 100 Million had been received and were under consideration.

Providers consider the interest rates to be high, there are financial institutions that offer lower rates, however most of the clinics would not be eligible for these and the rates offered in MCF are close to the market average. The payment duration mirrors what other financial institutions pay.

**10.0.0 TARGET POPULATION**

The Huduma Poa network targets the urban and rural poor, and other populations that are underserved due to poor road network, and inadequate health facilities. The 15 counties that comprise the area of operation of Huduma Poa Health network, coincide with the country’s region that have some of the worst health indicators in reproductive health, HIV, child survival and cervical cancer, pointing to a greater need for intervention.

Clinic selection, event organisation and marketing, is biased towards the network distribution serving the target population.
11.0.0 SERVICES AND COMMODITIES

11.1.0 Family Planning

Huduma Poa providers are trained to offer FP counseling and the full range of the reversible methods of contraception. Emphasis is made on the LARCs of IUCD and implants. The prevailing method mix betrays low uptake of these efficacious methods.

A baseline survey carried revealed that only 1.5% of the targeted clinics were offering the full range of FP prior to joining the network. Most of the facilities only offered the short term methods; thus they needed support to offer LARCs. KMET biases its support to LARCs in order to address this gap. Provision of quality and comprehensive FP which includes the LARCs is considered the flagship Huduma Poa service, and all recruited clinics offer this service. Care is taken not to compromise client choice.

11.2.0 HIV Counseling, Testing, Care & Treatment

Huduma Poa outlets have providers who are trained to offer HIV counseling and testing using the rapid kits as prescribed by the NASCOP curriculum. Those who are identified to be HIV infected are linked to facilities that offer comprehensive care and treatment services. Testing of pregnant women and PMTCT is also offered in the outlets. Some select Huduma Poa outlets offer care and treatment these facilities meet the following criteria:

- Have more than two clinical staff members one of whom must have been trained in ART provision and treatment of common opportunistic ailments. There should also be a counsellor on adherence to medication.
- Have a laboratory for performance of baseline and monitoring tests during HIV care, these include CD4 counts. Provision is also made for these facilities to be specimen collection points with samples being transmitted to a central laboratory.
- Are recognised by the local MOH officials and NASCOP as care and treatment centres and are thus provided with the drugs, test kits and requisite reporting stationary.
- Are willing to offer services at affordable rates and keep all the requisite reports.

Offering HIV care and treatment services was listed by the providers encountered as the most laborious and unrewarding of the services. This is due to increased record keeping that comes with provision of ART and the strict timelines for submission of monthly and quarterly reports, failure to comply would lead to withdrawal of ARVs from the site. Nonetheless those who offered it considered it a key service in their clinics.

11.3.0 Integrated Management of Childhood Illnesses (IMCI)

Huduma Poa clinics offer outpatient treatment of children under 5 using the IMCI strategy as adopted by the MoH. The IMCI offers simple and efficacious methods to comprehensively manage the leading causes of childhood mortality. The providers are trained on the algorithms in the IMCI manual and assisted to redesign or set up their units to be responsive to this approach. This includes setting up of an oral rehydration therapy (ORT) stores and a counselling room. The IMCI treatment facilities are also given the requisite IMCI attendance stationary and limited range of medicines from the government stores.

11.4.0 Cervical Cancer Screening with VIA – VILI

The KMET Huduma Poa outlets offer cervical cancers screening using VIA/VILI and interpretation of findings. Clients who are found to have pre cancer lesions or lesions suspicious of overt cancer are referred to pre selected facilities usually public level 4 facilities, for cryotherapy, or other suitable treatment.

Many Huduma Poa clientele referred by the facility CHWs if patients with complicated ailments or in emergency. Though the waiting time is long, they are offered transport. The franchise intends to introduce supplemental training on life support and medical emergency management.

12.0.0 SCALABILITY

The KMET Huduma Poa Network is on track having achieved its target of 80 outlets by the end of 2014. KMET aims to expand to 200 Huduma Poa facilities in the next three years. Network expansion will be done gradually with concurrent expansion of KMET staff; this will ensure new recruitment is not at the expense of support offered to old network members. All members will be encouraged to grow in capacity and offer the full range of Huduma Poa services.

13.0.0 QUALITY ASSURANCE OF HUDUMA POA

In keeping with the network’s name and positioning statement, the Huduma Poa brand promises high quality services; several mechanisms are in place to ensure the minimum standards that guarantee quality are maintained. The quality assurance plan is modelled on the FP aspect but tailored for other Huduma Poa services.

13.1.0 Quality Assurance Strategy

The technical competence of providers is assured through:

- Careful selection of registered clinics with approved and licenced staff.
- Formal training on the basis and use of the Huduma Poa SOPs. These are derived from MoH standards and training is done by MoH staff and approved trainers. They comprise of documented best practices.
- Provision and use of protocols.
- Facilitative supervision with continuous on job training. Event days are organized to increase confidence, experience and proficiency.
- Semi annual assessments with a checklist to assure retention of skill, equipment and adherence to best practices.

Client safety is assured by:

- Use of commodities that are approved and provided by the MoH and adherence to the SOPs and training guidelines.
- Adherence to the universal precautions on IP. Huduma Poa outlets are encouraged to have autoclaves, currently it is estimated that 65% have autoclaves.
- All facilities have incident management protocols that have been approved by the GAOs. They also have a referral strategy with well displayed phone numbers to call in case of an emergency. Though the franchise does not cover for cost of treatment for the complications that arise from network services, KMET readily offers transport.
- The franchise intends to introduce supplemental training on life support and medical emergency management.
emergency management.

Client Choice – though Huduma Poa marketing in FP is biased to the LARMs, client choice is respected, client choice is guaranteed through:

- Non biased comprehensive counselling that assures informed client consent for her choice
- Commodity safety – providers are required to have all the temporary methods of FP in stock at all times.
- Neither the CHWs nor the providers are given any incentives for referrals if the client opts for a particular Huduma Poa service
- Providers are encouraged to refer for services not available in their facility

Continuity of care - the clients is assured by ensuring that at all times all the requisite Huduma Poa services commodities and reagents are in stock, through linkage to the County MoH team, KEMSA and NASCOP. KMET also maintains a buffer stock where supplies are sold to providers of friendly prices.

Respect for client privacy and confidentiality is assured by providing one on one consultation in a room that affords adequate visual and auditory privacy. Additionally documents with client confidential data like the HTC registers are securely stored.

Documentaion – Providers keep accurate records and all requisite registers and other data entry stationary, that are checked on a monthly basis. These registers are also used to determine quantification for supplies.

Accuracy of HIV test results is assured by:

- Following the protocols as prescribed by NASCOP for HIV testing that calls for confirmation of all positive results.
- Proper storage of test kits, and use of only the approved kits
- External quality control by submitting 10% of all specimens, and all specimens that have discordant results to the reference laboratory as required by NASCOP.

13.2.0 SafeCare - Basic Health Care Standards

Most of the healthcare services in Africa and other resource poor settings are offered by dispensaries, health centres and small private outlets. These “bottom of the pyramid” facilities struggle with maintaining health standards. Moreover guidelines on standards and accreditation are often lacking.

Three organisations: - PharmAccess foundation, JCI (Joint Commission International) and Council for Health Service Accreditation of Southern Africa (COHSASA) jointly founded SafeCare as a custodian of internationally recognised standards that are applicable in resource poor settings.

SafeCare is a think tank that leverages its knowledge on the causes of bad healthcare to design methods that address deficiencies in health systems. KMET is a collaborating partner and uses the SafeCare approach to help bridge gaps in quality in the Huduma Poa outlets. SafeCare uses an incremental and stepwise manner while focusing on 13 areas of operation in the outlets. Not all the outlets have all the SafeCare aspects these are

1. Management and Leadership
2. Human resource management
3. Patient and family rights and access to care
4. Management of information
5. Risk and incident management
6. Primary healthcare services (outpatient)
7. In patient care
8. Operating theatre and anaesthetic services
9. Laboratory services
10. Diagnostic imaging services
11. Medication management
12. Facility management (buildings and machinery)
13. Support services (laundry, housekeeping etc)

Performance in quality improvement can be tracked until the Huduma Poa outlets attain full accreditation based on the International Society for Quality in Health Care (ISQua), it also allows for rating and benchmarking and can form a basis for performance based payouts.

SafeCare is collaborating with NHIF to include its standards in the funds accreditation system which will put Huduma Poa outlets in a good position to tap into the insurance market.

At the time of this case study the process of accreditation was voluntary amongst the Huduma Poa outlets, but the intention was to eventually have all the clinics included. Twenty two clinics had initiated the process, one – Sleeam had completed and was certified, and 4 were at advanced stages of accreditation awaiting final assessment. The accreditation process takes on average 18 months if the clinic meets the set improvement goals when due and are assessed in time. However some well performing clinics meet standards ahead of schedule and invite the SafeCare auditors early and thus complete the process quicker. Linkage of the SafeCare standards to the MCF is an additional incentive for clinic owners to adhere and maintain quality standards.

14.0.0 MARKETING

14.1.0 Marketing Strategy

The marketing of the Huduma Poa services uses a strategy that has been designed by the Health Communication and Marketing officer. It is implemented by his team that comprises the 4 demand creation officers and the community health workers.

None of the service commodities in use by the franchise is branded therefore most of the promotional communication is generic and promotes the Huduma Poa services without insistence that they must be sought in the clinics. The network is yet to conduct surveys that determine the impact of each marketing strategy on service provision. The marketing strategy includes:

- Use of CHWs – this is the main strategy.
- Wall branding of the clinics and erection of light boxes that advertises the Huduma Poa outlets.
- Huduma Poa days – these are done in the Huduma Poa outlet to advertise it to the catchment population. Clients are attended to in the outlet by the franchisees with support from MoH and KMET staff, and therefore the provider gains from the event.
- Community health days – Unlike facility based Huduma Poa days, these are done away from the facility in areas that are underserved or hard to reach. KMET Huduma Poa services are promoted, and people advised to seek further care in the nearby outlets. Providers from the nearest Huduma Poa clinics are always in attendance.
- The Huduma Poa days and Community health days provide the community an opportunity to voice
their health concerns and in concerted effort with health workers identify barriers to accessing service. They are also a good opportunity to meet men who usually shun visits to the clinics.

- KMET has introduced Huduma Poa radio adverts in local dialects where listeners can call in, they are conducted in local dialects for a wider reach.
- Use of street banners and posters,
- Distribution through the clinics and CHWs of brochures, leaflets and other printed IEC materials
- Design and distribution of branded merchandise like T-shirts, doctor coats, umbrellas, bags, pens etc. These are given to the providers, the staff, CHWs and clients as gifts during promotional events

14.2.0 The Huduma Poa CHW Strategy

This is the main Huduma Poa promotional strategy, as indicated earlier there are two CHWs attached to each Huduma Poa outlet. They are sourced from the local community unit and linked to the clinic. They are trained on the key messages on the Huduma Poa services and mobilisation skills. They work under the supervision of the demand creation officers and CHWs. Their work as defined by the franchise coincides with what the MoH expects of them thereby minimising conflicts

- Their main task is to create and sustain demand for high quality health services as provided by the franchisee they use their training in social behaviour change communication.
- They equip the target community with accurate and reliable knowledge on FP and other Huduma Poa services; they demystify RH, dispel myths and misconceptions, and act as Huduma Poa brand ambassadors.
- The community is thus made aware of the available FP methods and services, benefits of LARCs; importance of male involvement in RH; child nutrition and breast feeding amongst other key health messages.
- They do this through door to door visits in the community, and holding educational talks during community events and meetings.
- They mobilise potential clients and community members to turn up for community health days and Huduma Poa days. During these events they give health promotion talks.
- During mobilisation for community health days, MoH staff and other non KMET affiliated CHWs are involved thus increasing community acceptance of the Huduma Poa clinics.
- When they meet eligible potential clients they refer them to the Huduma Poa clinics using slips provided by the network management.
- The number of successful referrals to a clinic and the success of an event day are some of the parameters used to gauge the performance of CHWs. They also maintain a daily activity register; their community work is expected to lead to increased client flow in their facilities.
- The CHWs are volunteers and are not paid by the franchisor nor the government. Some providers however provide a stipend to their CHWs in recognition of the role they play.
- However during trainings and event days KMET provides an allowance to them, all CHWs encountered said the allowance was little but were appreciative.
- They are additionally provided with promotional items like umbrellas, bags, T-shirts which is appreciated.

15.0.0 LOGISTICS

KMET assists facilities within the Huduma Poa network to be included in the Master Facility List (MFL) that is maintained by KEMSA. A clininic needs approval from the local MoH to be included in the list. Once included, these facilities are provided with some commodities from the KEMSA stores free of charge. These include contraceptives, HIV test kits, and some of the medication used for the IMCI protocol like Vitamin A, Zinc, ORS, de-worming tablets etc. However to maintain the supply, the facilities are expected to give accurate returns.

When deliveries from KEMSA are delayed or inadequate, the QAOs liaise with local MoH officials to source from the county or sub county stores. The requisite stationary are also obtained from the local MoH stock.

Anti-retroviral therapy (ART) drugs and related stationary are obtained from nearby government level 4 hospitals that act as the mother institution for numerous satellite private and public clinics.

As a safety net KMET procures and warehouses Jadelle and IUCDs to maintain a buffer stock, on the occasion a franchisee cannot access commodities from KEMSA or the local county stores, they can be acquired from this stock. Most commodities procured are already subsidised and KMET passes this subsidy to the providers, only recovering the cost of the logistics. The head quarter buffer stock has a computerised inventory and orders from the field are quickly dispensed, with allowance for the franchisees to pay using mobile money.

Some of the drugs in the IMCI protocol and non-pharmaceutical commodities like gloves and laboratory glassware are not provided by KEMSA or KMET. It is expected that the provider recovers costs and a margin from the clients.

None of the supplies used for the Huduma Poa services are considered to be of high value or sensitive and meritorious of tracking. There have been no reported cases of diversion of commodities to non-network outlets; expiry; nor of damage of commodities in the buffer stock and clinics.

Stock outs have been documented, but these are usually due to delays and unpredictable delivery of the KEMSA supply chain. Modules on commodity management are included in the training on contraception and on provision of ART.

Sustainability of commodity safety hinges on KEMSA improving its systems, fortunately with devolution of healthcare and its consequent decentralised procurement of drugs has led to improved efficiency at KEMSA.
16.1.0 Huduma Poa Sky Teledicine

In partnership with World Health Partners (WHP), KMET introduced into the Huduma Poa franchise a teledicine project that improves access to health care in marginalised areas. It is modelled on WHP’s social franchising and marketing models. A similar project has been successfully implemented by WHP in India with runaway success, and forms the largest teledicine franchise in the world. It has over 5000 service providers remotely connected to 16 virtual doctors, in its initial 5 years it has had over 110,000 tele-consultations.

The Sky project has been running for three months, it has 7 participating facilities of which are Huduma Poa outlets while 2 though non-franchised are being considered for recruitment. These facilities also known as Sky Centres are remotely connected to a Central Medical Facility (CMF) at the Kisumu KMET Corkran clinic that is manned by a medical doctor and nurse counsellors.

Criteria for recruitment into Huduma Poa Sky:-

- Willingness and interest to participate in the program
- Possession of a computer or laptop with prescribed minimum specifications
- Reliable source of electricity and internet connectivity
- Basic computer literacy
- Training

Each Sky Centre has 6 CHWs whose task is to market the centre and identify clients in need and refer them to the Sky Centres.

Each Sky Centre has 6 CHWs whose task is to market the centre and identify clients in need and refer them to the Sky Centres. However in situations where referral is not possible due to distance or patient reluctance, the CHW, all of whom have mobile phones, calls the CMF and speaks to a nurse counsellor or the doctor. The staff at the CMF would then recommend a plan of action that may include investigations and/or medication. In case of investigations the client is advised to visit a Sky Centre, however, if an prescription can be sent to the CHW through a coded SMS, the CHW decipher it and writes it out for the client to collect medication at the Sky Centres or at any other drug shop.

The Sky Centres have computers that have been installed with the Remote Medical Diagnostics (ReMeDiTM) software that has an interface for clerking of patients and clients. It allows for creation of medical records; tracking of patients; and the dissemination of results and training materials to both providers and patients. The provider uses the software to connect over the internet with a doctor at the CMF by video or audio link. The provider also has the WHP provided Medical Data Acquisition Kit (ReMeDiTM kit) that comprises of: ECG leads, chest component of the stethoscope, pulse oximeter, thermometer probe and blood pressure cuff. This kit is connected to the computer and allows the doctor at the CMF to remotely examine the patient in addition to details gleaned over the video link.

The cost of the software and use of the ReMeDiTM kit, plus the attendant marketing is covered at inception by an enrollment fee. The patient pays a consultation fee to the Sky Centre and for each tele-consultation the Sky Centre pays KShs. 20/- (~ 0.25$) the funds are ploughed back into the project for sustainability. The Sky Centre covers its own costs of internet, and chooses its internet provider.

The Sky Centres and CMF operate daily from 0800 hrs to 1700 hrs, and coordinate with each other to ensure that patients get the prescribed drugs. In the future a revolving fund will be put in place to ensure availability of prescribed drugs and the program will be extended to include specialists in Nairobi and New Delhi cities. The Sky program intends to expand to 10 facilities with 60 CHWs. Occasionally doctors from the CMF conduct in-reaches to the Sky Centres and review patients who had been previously seen remotely. A similar WHP App that uses android smart phones mDOC is available but has not been deployed in the Huduma Poa network.

In the first three months there had been 291 tele consultations, the sky management targets having 300 per month.

The ReMeDiTM software can run in low bandwidth (32kpbs) and is highly stable, challenges faced so far are attributable to poor internet connectivity, and due to this some consultations are done via audio mode alone or with support of the phone. There are many positive responses from satisfied clients who have been saved a long trip to access a doctor. The Huduma Poa Sky telemedicine thereby allows advanced care to be extended virtually to franchise patients.
17.0.0 SERVICE RESULTS AND FINANCING

The Huduma Poa Network is managed by KMET with funding from USAID through APHIAplus channelled through the HCM consortium. The lead partner in the consortium is Ps(K). The total fund is slightly over 1.7 million USD to be used over a five year period.

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<th>YEAR</th>
<th>IUCD</th>
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<th>IMPLANON</th>
<th>E - PILL</th>
<th>DINPA</th>
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*excludes condoms

*http://www.cpc.unc.edu/measure/prh/indicatprhprh_fu/condoms

Other Huduma Poa service numbers

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<th>Year</th>
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<th>HMO consults</th>
<th>HIV</th>
<th>VIA</th>
<th>CYPs attained*</th>
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*http://www.cpc.unc.edu/measure/prh/indicatprhfu/condoms

17.1.0 Supply Side Finances

The Huduma Poa program is considering reviewing all results into DALYS as an additional measure of performance and cost effectiveness.

The cumulative cost per CYP seems to follow the expected pattern, being higher at the inception year when FP trainings were done for all the reporting franchisees and taking into consideration big one time purchases like project vehicles and other equipment. It is instructive to remember that family planning is a method mix that is in keeping with the national picture, the three month injection is the most popular followed by the implants, with the three year implant being preferred. There has been a significant increase in IUD uptake.

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The cumulative cost per CYP may also not be an accurate measure of cost effectiveness as there are other aspects of the program that are not FP, however it can provide insight into trends. The Huduma Poa program is considering reviewing all results into DALYS as an additional measure of performance and cost effectiveness.

It is expected that cost per franchise should be higher at inception when project initiation involves a lot of trainings and purchases that include project vehicles and operational costs that are in some instances 10 times the Huduma Poa recommended maximum charges.

The expectation to charge affordable user fees stems from the following provisions:

- Network membership is free
- Trainings, both formal, OJT and supportive supervision are free
- Most of the commodities are provided by the MoH
- Marketing of the facility and branding is at no cost

Some of the aspects of Huduma Poa that are not exclusive to the social franchise like the MCF and SafeCare project are funded separately. The buffer stock for contraceptive is also sourced from a revolving fund within KMET.

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All the providers encountered during this case study, confirmed that since joining the Huduma Poa network, their workload and patient flow had increased with consequent improved profitability. The increase in patients was for both network and non network services. They however point out that the non network services were more profitable. Nevertheless they partially attributed their increased profitability in the non network services to membership in the Huduma Poa Network.

### 18.0.0 HUDDU MA POA NETWORK PARTNERSHIPS

- **Ministry of Health** – As demonstrable in various aspects of network management and program implementation, the government through the ministry and its officials on the ground are the biggest partners
- **Population Services Kenya (PSK)** – They are the leading organisation in the A2P3lacus HCM consortium. PSK operates the Tunza network of clinics, Tunza collaborates with KMETs Huduma Poa in the organisation of trainings in FP.
- **PharmAccess Foundation** – Are key partners in the SafeCare standards and MCF components of the project.
- **World Health Partners (WHP)** – A US based organisation that is assisting in rolling out Poa in the organisation of telemedicine project.
- **Goldstar** – This is a network of clinics that provides HIV diagnosis and treatment as a network service. They are part of the HCM consortium and partner with KMET.

### Huduma Poa network in building the capacity of staff and network members in provision of ART and PMTCT services.

KMET is also a member of the association of Social Franchising for Health in Kenya

### 19.0.0 PROGRAM EVALUATION

Service data from each of the Huduma Poa outlets is collected on a monthly basis for all the services and translated into CYPs and other performance indicators. The number of field days conducted and CHW referrals is also monitored. A comprehensive evaluation of the KMET Huduma Poa franchise against the objectives that were set at inception will be done at the current phase of implementation approaches end. But it is worthwhile noting the following:

a) **Health Market expansion** – The HMKT Huduma Poa franchise has ventured into areas that had no health facilities offering the Huduma Poa services. This has been complemented by the inclusion of Huduma Poa Community days where the network offers services as outreachs in far flung rural areas. Even in areas that were well served with both public and private clinics there is evidence of improved health seeking behaviour due to the Huduma Poa marketing. with women accessing services that they would have previously not have sought.

b) **Quality of service** – In the Huduma Poa outlet has remained consistently high as shown routine and in semi annual assessments and is improving year on year.

c) **Equity** – The Huduma Poa network started in the 6 counties that are from the former Nyarans provence. These are also the counties that are leading in HIV incidence. Other reproductive and child health indices in the Huduma Poa area are spending points to the high need for mitigating health programs. Even within those counties Huduma Poa network clinics are sited to target under served areas and pockets of population that have comparatively higher disease burden.

d) **Health Impact** – The number of clients and patients accessing Huduma Poa services through the network clinics are recorded and well kept. It is possible that KMET can translate these into DALYs ascertained as a measure of impact in addition to CYPs that the network uses to measure FP services.

e) **Cost effectiveness** – As is expected the current cost per franchisee and cost per CYP appear high. Case studies of other programs show the high cost will be sustained until the network grows to its full scale after which it is expected to progressively reduce. Indeed some of the benefits of the network will cultivate the project duration. Other program case studies in the country have found an average two year cost per CYP and cost per franchise to be USD 35.95 and 23,371.1 respectively. And a three year average of USD 7.40 and 5,950.5 respectively. However cost comparison can only be made after provision is made for difference in franchise design and exchange rate variation [19,20].

### 20.0.0 CHALLENGES

- **High staff turnover** – In many instances the trained providers are not the outlet proprietors, after training the skill acquired makes them more marketable and some of them leave the clinics. The franchise management addresses this by preferentially recruiting and training clinic owners and having more than one person trained in each outlet to guarantee continuity of service. On job trainings and CMEs are also encouraged.

- **Screening for cervical cancer and HIV testing and diagnosis identifies those who will be diagnosed and need treatment. However none of the franchisees outlets has capacity to treat pre cancer lesions and few of the clinics offer comprehensive treatment of HIV. Clients are thus compelled to visit other public health facilities after diagnosis. KMET intends to acquire a few cryotherapy units and train more providers on ART.

- **Whereas the CHWs are known to be volunteers many of them expect KMET to provide remuneration for services rendered. As they are not franchise staff, KMET is limited in terms of administrative supervision, and some leave when they get employment opportunities. With loss of the investment made in their training and capacity building.**

- **Slow disbursement of funding** – On some occasion the program had to slow the pace of implementation to match the pace of donor remittance of support.

- **High franchisee expectations** – Many people in Kenya associate trust like KMET with financial abundance and “freebies.” Some franchisees thus joined the network with higher expectation than what was offered.

- **Some of the popular private providers in the community, and who are in the list provided by the local MOH officials end up being impostors and quacks.

- **Commodity safety – Total reliance on KEMSA and the MOH channels for ensuring commodity safety leads to frequent stock outs.**

- **Community resistance – there is widespread misconception and myths against network services. There is low uptake of IUD and low male involvement. The KMET area of operation is dominated by disempowered women and low male involvement in reproductive and child health issues.**

- **Competition – Though opportunities are still available, there are other franchisees in the field wooing the same pool of private providers.**

### 21.0.0 OPPORTUNITIES

- **There is still a large unmet need for quality health services that can be partially addressed by social franchise expansion in size and range of service.**

- **The adapted devolved system of managing health that makes private public partnerships possible.**

- **A large population of private providers, some of whom have shown willingness to join the network.**

- **High mobile network penetration and a rural electrification drive that will allow for expansion of web and mobile based innovations.**

### 22.0.0 LESSONS LEARNED

- **The community strategy when well harnessed is a good method of mobilisation and demand creation.**

- **More men are willing to support their spouses in reproductive health, if approached and armed with accurate information.**
• Community events like Huduma Poa days and community health days provide good opportunities to engage men in RH issues.

• Satisfied IUCD users are good method ambassadors and are effective in instilling confidence amongst potential users.

• Service data suggest that many clients find it easier to change from Depo to implant compared to other change in methods.

• The legitimate use of MoH provided commodities, personnel and system lends the project credibility in the eyes of potential providers and public.

• When using the MoH supplies, a franchisor is better off having a buffer stock to secure commodity safety and fill gaps in supply chains.

• Care should be taken at project inception to thoroughly vet providers to avoid impostors and quacks joining the network.

VIGNETTES, ANECDOTES AND TESTIMONIES

"the chest part of the stethoscope is at the Sky Centre while the ear piece is at the CMF, and they are connected over the internet" Akhlesh Sharma the Technical Advisor Sky Program while explaining how the project works.

"Previously in some areas clients had to hire motorbikes at great cost to access services that they now get for free at a nearby Huduma Poa outlet" Amos Onderi KMET Huduma Poa coordinator

"Life has become hard, the farm does not produce enough like it used to, so we have to be wise." Judith Aoko’s grandmother in support of her granddaughter’s decision to use implants for prevention of pregnancy.

For its leadership and courage in advocating for RH rights, KMET in 2004, was awarded the Margaret Sanger Award by Planned Parenthood Federation of America and is the first organisation in Africa to get the award.

"They knew what they wanted and why, they just had no access to comprehensive contraception services, that is what Huduma Poa has availed" Mr. Abok Barnabas a Huduma Poa QAO describing part of his target community.

"Her worry was the cost of contraceptives, but when I gave her a Huduma Poa referral card, she only had to pay KShs 100/- (1.2USD) for a long term FP method" Jacinta a CHW on a client she referred.

"Moving facilities to the next level needs funding. Thanks to MCF we can now do this" Dr. Omboga, proprietor, Nyamira Maternity and Nursing Home.