AHME Snapshot Overview

The African Health Markets for Equity (AHME) partnership aims to increase the use of quality essential health services by poor people in Nigeria, Kenya and Ghana by intervening on both the supply and demand side of the healthcare system, and integrating these into a single well-coordinated program. The AHME partnership is led by Marie Stopes International (MSI) with Population Services International (PSI), Population Services Kenya (PSK), Society for Family Health (SFH), PharmAccess Foundation (PAF) and the International Finance Corporation/World Bank Health in Africa Initiative (IFC/HIA) as collaborating partners.

Now in its fourth year of implementation, as the AHME partnership evolves, this is bearing encouraging results at a country level and important lessons as a whole. This snapshot series has been developed to capture the breadth of innovative AHME activities being implemented, to add to the evidence base for advancing Universal Health Care. Further snapshots will be developed and distributed between October – December 2016. A few selected snapshots will be selected for in-depth case study reviews.

Snapshot Structure

AHME has identified five key characteristics all of which are necessary and must be in place for the market to deliver quality essential health services to the poor (see Slide 2). The snapshots have been structured around these five key themes.
Market Conditions

5 conditions must be in place for markets to work for the poor

Poor Enrolled
Historically, coverage of the poor was not seen as a priority for NHI authorities, but this is starting to change with the advent of the Araya indigent scheme in Ogun State, Nigeria; the Health Insurance Subsidy Program (HISP) in Kenya; and the exemption of indigents from NHI fees in Ghana.

Primary Health Care Covered
Partners continue to work with NHI agencies to refine what is covered in their respective outpatient packages.

Facilities Contracted
Opportunities for small providers have been steadily improving in all three countries. Social Franchise networks have been facilitating empanelment but transparency remains an issue.

Quality Services Available
Networks in all three countries are strong and extensive, and improving quality by integrating PharmAccess’s SafeCare tools.

Viable Provider Business
Business skills and access to capital are improving through linkages to the Medical Credit Fund.
### Acronyms

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<th>Acronym</th>
<th>Description</th>
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<td>AHME</td>
<td>African Health Markets for Equity</td>
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<td>APN</td>
<td>Access Point Name</td>
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<td>DSF</td>
<td>Demand Side Financing</td>
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<td>GNHR</td>
<td>Ghana National Household Registry</td>
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<td>GPS</td>
<td>Global positioning systems</td>
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<td>Medical Credit Fund</td>
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<td>MEDS</td>
<td>Mission for Essential Drugs and Supplies</td>
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<td>MoGCSP</td>
<td>Ministry of Gender, Children and Social Protection – Ghana</td>
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<td>Marie Stopes Kenya</td>
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<td>PMT</td>
<td>Proxy Means Test</td>
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<td>SMAS</td>
<td>Survey Management and Analytic System – Ghana</td>
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<td>Virtualised Services Platform (VSP)</td>
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AHME successfully introduced an exemption strategy into the Ogun State Supported Health Insurance Scheme (Araya) to extend coverage to the poorest of the poor, free of charge.

This snapshot considers lessons learned from AHME’s work with Ogun State to integrate free health care coverage for the poor within its Araya health insurance scheme, including ways to finance the system through cross-subsidies. It discusses development of this demand side financing approach (DSF) as a model for other state-supported schemes.

Intervention

In Nigeria, out-of-pocket payments for health services are nearly double the sub-Saharan African average, constraining access for the poorest. To address this, in 2012 AHME undertook a study to consider potential strategies for extending healthcare coverage to indigent households. The study assessed multiple DSF mechanisms, weighed national versus state-based approaches, and included baseline health surveys, willingness-to-pay studies, and actuarial analysis. The results pointed to state-based approaches, which were already gaining traction in different parts of the country.

The study focused on six Nigerian states receptive to expanding equity in health care access, and found that Ogun State presented the best conditions for collaboration. The State’s Araya scheme was a nascent scheme in development, building on Ogun’s existing community-based health insurance programme, but with room for adaptation and input from AHME. There was strong political and financial commitment in Ogun, with money allocated from the State budget. The Health Commissioner and his team were very motivated and open to new ideas. Moreover, Ogun State met International Finance Corporation (IFC) criteria for transparency in the administration of health programs and the setting up of a risk pool that included the poor.

One element of AHME’s input into the scheme’s design focused on the proposed exemption strategy, including both the social and financial benefits associated with exempting individuals in the poorest quintile. AHME also addressed considerations of long-term sustainability and where AHME could have the highest impact.

With the Health Commissioner and his team, AHME delved into the financial risks and complexities of a scheme where costs of exempted beneficiaries would be cross-subsidized by non-exempted members.

The plan extended healthcare coverage to all populations in Ogun, so that the scheme would benefit from a wide, and thus sustainable, risk-sharing pool of beneficiaries. Expanded coverage was expected to drive up demand for healthcare services, providing health facilities with a regular income to invest in improving the range and quality of their care.

To ensure sustainability of the scheme, Ogun State planned to pass a bill embedding Araya into State legislation through the Health Financing Bill.
AHME successfully introduced an exemption strategy into the Ogun State Supported Health Insurance Scheme (Araya) to extend coverage to the poorest of the poor, free of charge

Result
Ogun State Government agreed to Araya design amendments which included the establishment of an equity fund that provided premium exemptions for the lowest quintile to ensure equitable healthcare access.

Examples and Evidence
“We have devised a program that will bring efficient healthcare within the reach of our people, who are hit hard when they incur bills as a result of ill health, or who may not even be able to afford care at all,”

Dr. Olaokun Soyinka, (formerly) Honourable Commissioner for Health, Ogun State

Lessons Learned
Although the Araya scheme design has changed since its original inception, it remains an important model for others looking to finance and institutionalise insurance exemptions for the poor.

Ensuring a full range of services for people living in the poorest areas remains a challenge, particularly among social franchise providers who tend to be more likely to serve indigent and rural populations.

Outlook
Ogun State was one of the first in Nigeria to implement a state health insurance scheme. The concept of free health insurance for the poor has now been embedded in the National Health Act of 2015. Araya thus can serve as an important model for other states looking to increase the scale and quality of public and private provider networks using demand-side financing.
Identifying poor households for social protection schemes presents numerous technical, social, political, and financial challenges. In Ghana, AHME collaborated with government institutions and partners in using an innovative approach to implement the Common Targeting Mechanism and select exempted poor beneficiaries for free registration into the National Health Insurance Scheme.

**Intervention**

Ghana’s National Health Insurance Agency (NHIA) initially had no formal system for identifying exempted indigents into the National Health Insurance Scheme (NHIS). The de facto approach was an informal community-based selection process, which was open to interpretation.

In 2012, the Minister of Gender, Children and Social Protection (MoGCSP), together with its partners, agreed on the Common Targeting Mechanism (CTM), which introduced the Proxy Means Test (PMT) as an objective means of identifying beneficiaries of social protection interventions. But as the PMT was paper based, the data validation required returning to the field, often months later, which was costly and presented difficulties retracing surveyed households in places with no addresses.

Under AHME, the IFC/World Bank Group Health in Africa (HiA) Initiative team introduced technology to increase usability and transparency by digitising the PMT tool onto a tablet device, linked to a secure cloud-based web service to give results in near real time. AHME modified the beneficiary identification methodology by using a household enumeration agency to systematically go door to door to identify eligible beneficiaries. The handheld tablet were fitted with mini-thermal printer. Households who qualified for NHIA exemption were instantly given paper receipts to register with NHIA for free.

Getting government consent to use the tool was initially a challenge. To address this the HiA (i) negotiated and transferred the management of the proposed conceptual change in process to the MoGCSP and the NHIA. This included all equipment to be used. (ii) A Project Advisory Group and a National Operations Team were set up both chaired by the NHIA and the MoGCSP. These operated as actual decision making bodies with only project compliance guidance from the AHME Country Leads. (iii) A live and interactive DASHBOARD with feed from the web-based operations portal were mounted in the Minister for MoGCSP and the Chief Executive Officer of NHIA’s offices to provide them with real time monitoring. (iv) A WhatsApp group was established on which all field enumerator and community mobilisation activities were communicated. Both the Minister and CEO led and participated. This approach allowed for high transparency and visibility on activities on the field. It also ensured that government was in control. This promoted mainstreaming and institutionalisation of the process.

Getting local political and civil society leaders buy in was critical to success. Community mobilisation was led by the NHIA and took into consideration deep sensitivities regarding issues of privacy and social stigma, government intrusion and politicisation of the project. Large community gatherings (durbars) were held featuring traditional leaders, District Heads, Members of Parliament, District Assembly Members, civil society leaders, and other dignitaries. Enumerators were carefully branded to represent and work under the supervision of the NHIA, not AHME.
Identifying poor households for social protection schemes presents numerous technical, social, political, and financial challenges. In Ghana, AHME collaborated with government institutions and partners to implement an innovative house-to-house process using a Common Targeting Mechanism to identify and select exempted poor beneficiaries for free registration into the National Health Insurance Scheme.

**Result**
Digitisation of the PMT and deployment through household enumeration has been successful with 109,282 households surveyed from Mar 16 – Sep 16, with 25,918 (24%) identified as exempt from NHIA registration charges and issued with paper receipts.

Independent validation of results and an analysis of cost effectiveness is currently underway.

**Lessons Learned**
Attempting to change public sector process that have become an inefficient and yet embedded process is naturally difficult. It required patience and systematic engagement and in this case took half of the two-thirds of the lifetime of the project to gain consensus. The main lesson here is that one cannot hurry to process of shifting norms and gaining acceptability to introduce changed.

The systematic engagement of governments by private sector oriented partners is an effective way of assuring governments that private sector innovative approaches to solving public sector challenges can yield positive results. However, the high-level buy-in from ministers and chief executives needs to be complemented with a equal effort at gaining local level political and community ownership of the proposed solutions.

**Outlook**
All data collected under AHME will be transferred to the Ghana National Household Registry (GNHR), ensuring effective and efficient targeting for more than one social protection intervention simultaneously.
The Survey Management and Analytic System (SMAS) provides real time monitoring of the identification of poor households eligible for the National Health Insurance Scheme (NHIS) in Ghana.

Data validation is one of the most costly aspects of survey implementation – accounting for as much as 40% of total expenditures. The SMAS is an innovative solution for validating and managing geographic targeting of poor households more efficiently, at lower cost, and with greater transparency than previous methods. This snapshot considers the implementation of the SMAS database and how the dashboard is being used to improve efficiency in programme operations.

**Intervention**

The SMAS technology was introduced by the Health in Africa (HIA) team of the World Bank’s International Finance Corporation (IFC). It applies a proxy means test (PMT) tool using a tablet that works with a secure cloud-based web service. The digitised tool was a response to paper-based methods applied in earlier programs that were too cumbersome, expensive, or error-prone to be usable.

In the field, enumerators ask each household 10 questions. The responses are loaded onto the tablet and synched to a central database that populates a dashboard in real time. The system instantly analyses the information and sends a response regarding the household’s eligibility for NHIS. It also flags potential errors, which are fed back to enumerators to be checked or corrected on the spot, greatly enhancing the data reliability. Additional materials (e.g., photos of houses) are also loaded into the system to validate the living conditions reported in the survey.

The SMAS tracks the location of each enumerator using GPS on the tablet, helping identify the location of people who qualify for NHIS in the absence of formal addresses. GPS data is also used to map the dispersion and density of poor households, benchmark district poverty rates, direct enumerators to target areas, and provide support if they become lost or stranded.

The SMAS is based in the cloud, with an operations site managed by the IFC HIA team. IFC also keeps a second dashboard for the National Health Insurance Authority (NHIA), which tracks details regarding NHIS registration. That system can disaggregate between new enrollees and those renewing with an exemption, for example, or keep track of those still waiting in the registration queue at the end of the day.

The ownership of the dashboard is being taken on by the Ministry of Gender, Children, and Social Protection. The HIA team still has privileged access, but SMAS is becoming embedded in the government system, and the Ministry features the dashboard prominently for advocacy purposes (showing work in the field in real time) and to support data-based program planning.

The potential of SMAS beyond its capacity as a reporting tool is just beginning to be recognized. The dashboard offers a dynamic platform for managing the full operation of social service delivery programs, from beneficiary identification, to program delivery and coordination. It is an innovative tool for mapping services to people, and across multiple service sectors.
The Survey Management and Analytic System (SMAS) provides real time monitoring of the identification of poor households eligible for the National Health Insurance Scheme (NHIS) in Ghana.

**Result**
Costs for enumeration and validation using SMAS average US$1.40 per person. Previous methods have ranged in cost from US$15.87 to US$95.44 per person, according to studies by Aryeetey et al (2011).

**Examples and Evidence**
The Minister of Gender, Children, and Social Protection prominently features a large screen in her office that displays the SMAS dashboard. It serves as a strong visual presentation for demonstrating the ministry’s reach and activities – showing how many people are in the field, and where, in real time.

**Lessons Learned**
The SMAS tool could be adopted across multiple countries and contexts. It saves costs compared to previous, paper-based versions and makes validation more rapid, accurate, and transparent. The tool also should be considered more widely for its benefits as an operations management system. It is a valuable planning tool and offers a method for mapping program activities to poverty levels across service sectors and geographic areas. Further work needs to be done to see if the SMAS can be linked to NHIA and other government data to improve coordination and beneficiary registration for social support services.

**Outlook**
The software used to identify and upload data to the dashboard in real time is open source, and can be easily replicated.

The IFC HIA program is in the process of formalising handover of the system to the Ministry of Gender, Children, and Social Protection, which is planning to use it for national household registrations.

The National Health Insurance Scheme of Ghana (NHIS) uses a biometric system to register beneficiaries, but lack of connectivity presents a major challenge for NHIS enrolment in remote areas.

This snapshot explores the challenges related to NHIS registration in areas that lack connectivity, along with some of the solutions AHME and its partners have implemented to address the problem.

**Intervention**

Ghana’s National Health Insurance Authority introduced biometric registration in 2014 as the standard national process for issuing cards to social health insurance beneficiaries. The process required that client authentication is done in real time before a card is issued to avoid data duplication. Although Ghana has a relatively strong data network, it fails to reach large parts of the country.

To address connectivity issues, most permanent district Scheme offices have set up Very Small Aperture Terminals (VSATs), which serve as a satellite ground station using a small dish antenna. However, these centres tend to be located at considerable distances from poor, rural communities.

Mobile NHIS registration is therefore constrained. Even were network is accessible connectivity is often unreliable. Long queues form, with people waiting up to four days to sign up. When registration closes in the evening, individuals pitch camp at the registration centres sleeping on benches. Those living in the vicinity mark their place in line with rocks, returning early the next morning to resume the wait. High daily temperatures, combined with lack of shade or seating, make the effort particularly uncomfortable.

There are various alternative solutions to this problem. IFC purchased Access Point Name (APN) identifiers to link the mobile registration sites to existing telecommunications networks. But weak signals persist which rendered them inefficient. AHME recommended using a Virtualised Services Platform (VSP) to create zones of connectivity benefiting from satellite connection. This was rejected as too expensive to be replicable.

AHME also looked at converting the fixed VSAT satellite dishes to the mobile ones particularly in areas that have now got good internet coverage. The VSATs are however set on concrete platforms, and there are issues of a proprietary nature which needs to be negotiated with the suppliers of the equipment to the National Health Insurance Authority.

Mobile VSAT units could be purchased for approximately $110,000 plus tax with an annual recurrent cost of $20,400 plus tax, but this is beyond the current AHME budget. It might be a good solution but the cost effectiveness analysis has to be done.
The National Health Insurance Scheme of Ghana (NHIS) uses a biometric system to register beneficiaries, but lack of connectivity presents a major challenge for NHIS enrolment in remote areas.

**Examples and Evidence**

An NHIS registration book observed in a remote area of Ghana’s Upper East region showed a difference of one person being registered on one day, with 263 registered the following day, due to connectivity issues. The recent AHME monitoring report showed that waiting times extended up to four days for persons showing up for registration. This is a common feature mainly due to technology challenges.

**Lessons Learned**

With poor connectivity, having the registration team travel in tandem behind the team enumerating households for free NHIA benefit as envisaged in the AHME project design is not feasible. The card as is currently does not carry any data for validation at the point of service access. The validation process that has led to the long queues serves little purpose other than for statistical accuracy. This can be corrected through delayed localised validation and synching. NHIA should consider the development of offline modules to allow for off-line registration. The data can sync to the central server when there is connectivity.

New policies are coming into place that will make NHIS registration cards valid for five years, reducing the burden of annual registration renewals. This is highly commendable.

**Outlook**

NHIS registration and renewal pathways should optimise both offline and online modules to maximise efficiency. A complete technology gap and cost effectiveness analysis needs to be undertaken to advise NHIA on next generation technology before AHME exits.
AHME seeks to link private health facilities in social franchise networks into universal health care schemes (UHC). Marie Stopes Kenya (MSK) has evolved the “network function” of the AMUA social franchise to broker franchisee empanelment into Kenya’s National Hospital Insurance Fund (NHIF).

The accreditation process for health facilities to qualify for empanelment into Kenya’s NHIF is complex and time-consuming, requiring 12 different steps. This snapshot highlights the processes and lessons from the field regarding the MSK experience of brokering NHIF empanelment of AMUA franchise clinics.

**Intervention**

MSK conducted an initial assessment of social franchise network members to evaluate their readiness for contracting with Kenya’s NHIF, quality performance, and geographic location, in order to ensure a focus on equity during the empanelment process. From the assessment, 50 of the 420 franchisees in the AMUA social franchise network were selected for the first round of intensive support to help them qualify for NHIF empanelment.

In collaboration with regional NHIF branches, sensitisation meetings for the selected facilities were held to walk them through the empanelment and accreditation process, which includes an NHIF checklist. The meetings also served to build trust between franchise providers and NHIF branch managers.

MSK and NHIF branch officers guided franchisees on compliance requirements, such as the need for a certificate of business registration, a practitioner license with the relevant medical board, employer registration with NHIF to obtain a compliance code, and formal application for inspection. MSK brokered the process to ensure that individual providers were not intimidated or overwhelmed.

MSK facilitated a pre-inspection of franchisee facilities as a ‘dress rehearsal’ for the NHIF inspection, using the NHIF checklist. In addition to the licenses, there is often a need to address infrastructure and documentation requirements. It can take health facilities 2–3 months to prepare for inspection once the pre-inspection has been completed.

The pre-inspection includes a set of minimum quality standards, and the facilities need to obtain a score of ≥60 to qualify for the inspection application. Those falling below the minimum score were supported to initiate a quality improvement process.

MSK guided facilities through the next step – completing and submitting the application form – by giving them a sample template of a completed form. Increasingly, MSK is encouraging clusters of clinics to submit group applications, as this reduces transaction costs for the NHIF and introduces economies of scale (e.g. streamlining inspections with close proximity, etc.).

Upon successful submission of applications, NHIF conducts unannounced inspections, the results of which are submitted by the NHIF branch manager to NHIF Nairobi. MSK tracked applications to reduce the waiting time through regular check-ins with the NHIF, as this process is currently not automated.

Once NHIF gives approval for contracting, it goes to gazettement at the Attorney General’s office, which falls outside of the NHIF and, to date, less straightforward to engage. Following approval, the provider is issued with a unique code, based on its capacity and range of services.

After successful empanelment, MSK continues to support franchisees with community mobilisation and contract monitoring, as it is important for providers to match the contract with their patient base and service capacity.
AHME seeks to link private facilities in social franchise networks into universal health care schemes (UHC). Marie Stopes Kenya (MSK) has evolved the “network function” of the AMUA social franchise to broker franchisee empanelment into Kenya’s National Hospital Insurance Fund (NHIF).

Result

MSK’s development of a “network function,” in which a franchise network is leveraged to engage with the NHIF and streamline the process, has yielded strong success. MSK convinced the NHIF to eliminate the payment fee for in-patient accreditation through policy change advocacy and feedback to the NHIF.

Furthermore, since introducing the network function in July 2015 MSK has provided intensive support to franchisees. The number of AMUA providers accredited into NHIF has doubled, increasing from 35 to 89 providers. AMUA providers now make up approximately 10% of all private providers empanelled in the NHIF (as of June 2016). Over 3,000 beneficiaries, on average, are enrolled with each AMUA empanelled provider.

Examples and Evidence

The development of the “network function” has strengthened MSK’s social franchise value proposition by streamlining the process for franchisees. One providers stated, “I have waited for four years to get accredited. MSK coming to assist us on this is a blessing” (Amua Franchise).

Lessons Learned

The inclusion of mid-level providers as part of strategic purchasing under national health insurance is critical to UHC, especially to ensure equity of access. But the high transaction costs around empanelling mid-level providers – both for the providers and the national health insurance scheme – can be prohibitive. This barrier can be overcome through brokering by social franchises.

Social franchises can also facilitate greater understanding to the NHIF of the differential rate requirements for private providers given that salary and medicines tend not to be covered through other funding mechanisms, such as budget support, as is the case with public sector and faith-based providers.

Outlook

Efforts will continue to focus on provider empanelment given the lengthy, labour intensive processes involved. However, providers and clients both need to benefit from the NHIF. This remains a challenging area to monitor as data needs to be extracted from individual providers. MSK has designed tools that are being used to collect NHIF data from empanelled facilities. This will inform risk mitigation measures in relation to the capitation model. Registration is still a paper based bureaucratic process. ICT and the transparency it would allow around empanelment is still a considerable gap in this process.
In Ogun State, PharmAccess collaborated with the government to institutionalise SafeCare standards within accreditation and empanelment into the state’s Araya health scheme

This snapshot describes the process used by AHME to consolidate the SafeCare quality assurance activities with those of Ogun State, build capacity for assessing and improving healthcare, and develop a sustainable model for healthcare quality improvement.

**Intervention**

From the start, AHME’s focus in Ogun State was to promote the long-term sustainability of healthcare quality assurance. In order to institutionalise SafeCare quality standards, AHME worked at the State government level as well as among public and private healthcare providers and franchise networks.

To engage with Ogun State’s health leadership, the International Finance Corporation (IFC) led meetings with the State Health Commissioner, followed by a workshop which brought together AHME partners and top state health stakeholders. The meetings and workshop featured discussions regarding the SafeCare quality improvement process, along with questions on how the standards and quality assessments could be aligned with the State’s existing system and the Araya scheme.

The State created a Technical Working Group (TWG), which included top leadership from the State Ministry of Health, including the Permanent Secretary, Department Directors, and Special Advisor to the Health Commissioner. AHME facilitated TWG meetings and brought in private-sector participation, including social franchise networks (SFNs), with representatives from private practitioner groups.

The TWG met for one year and prepared a recommendation document that included a roadmap to guide the state in institutionalising quality. By then, there had been a turnover in state leadership, but the new Health Commissioner was brought on board thanks to the momentum created by the working group and support from the Special Advisor to the Health Commissioner.

To curb standards fragmentation, the State instituted a Central Coordinating Unit for Health Standards within the Ministry of Health. AHME aided its development, adding private sector members, including SFN quality officers. The unit consolidated SafeCare standards with the State’s, creating an assessment tool that was manageably short while maintaining a robust set of criteria. The standards are used for accreditation to the Araya scheme.

To increase capacity, AHME began training SFN clinical quality officers to become quality assessors. The quality officers were linked to 30 of the clinical sites using WhatsApp groups to facilitate weekly technical assistance communications with providers. To harmonise activities at provider sites, AHME instituted quarterly coordinating meetings with the SFNs and PharmAccess/SafeCare.

The quality standards are now linked to provider empanelment with SafeCare quality improvement methodology increasing provider capacity to meet empanelment requirements of the Araya scheme.
In Ogun State, PharmAccess collaborated with the government to institutionalise SafeCare standards within accreditation and empanelment into the state’s Araya health scheme.

**Result**

Ogun State has adopted the SafeCare standards into its accreditation and empanelment system, and the recruitment guideline adopted by the Health Insurance Unit mandates that all providers be on the SafeCare quality improvement program. The SafeCare level determines the number of assigned clients per facility.

The state has increased transparency and can benchmark providers against those in five other African countries. Three more Nigerian states are looking to adopt the system.

**Examples and Evidence**

“PharmAccess’ support has greatly impacted the state, and quality improvement using the SafeCare method is seen as a must-have for the State”.

Dr Nafiu Aigoro, Permanent Secretary for Health, Ogun State

**Lessons Learned**

Key stakeholders should be engaged at the programme design stage to ensure buy-in. When developing a facility accreditation process for a nascent health insurance scheme, it is more efficient to modify existing tools than to design a new one from the ground up.

Maintaining open and regular communication with government helps to ensure continued engagement and builds credibility.

**Outlook**

AHME partners have worked with Ogun State to link quality standards with requirements for empanelment into the Araya scheme. AHME helped the state to develop recruitment guidelines for the state insurance system based on the SafeCare improvement process.

The integration of demand and supply is key to improving health care quality, and it is slowly gaining ground. Initially, there was no financial incentive for providers to improve quality from the demand side, particularly among public providers. Now quality assessments are determining accreditation and monthly capitations. Providers can be contracted into Araya when they reach SafeCare Level 2, and capitation payments increase as they continue to improve and reach higher levels.
Learning from Population Services Kenya (PSK) commodity supply chain model for its social franchise network, MSK applied the same approach. This snapshot looks at the approaches MSK used and lessons learned.

**Context**

Securing continued access to quality assured drugs and commodities is a key challenge for private clinics in Kenya. Population Services Kenya (PSK) have been successful in overcoming this barrier by linking clinics within their social franchise network to the Mission for Essential Drug and Supplies (MEDS), a non-for-profit organisation.

**Intervention**

In 2014, MSK’s internal quality audit scores in its social franchise network (Amua) continually showed a high percentage of clinics experiencing commodity stock outs or using non-quality assured drugs.

To overcome this challenge, MSK replicated PSK’s approach of linking franchised clinics within their network by brokering a contract with MEDS.

MEDS requires a minimum order value of KES 50,000 (US$500) which is not practical for smaller AMUA clinics. In response, MSK divided the network into 11 regions and identified one to two mid to large size facilities within each region to collect orders from smaller providers as part of a pooled procurement mechanism.

The contracted franchisees organise for transport of the drugs and commodities to their facilities and transfer the cost to the smaller facilities (an average of 10% of the commodity cost). This is still cheaper than obtaining drugs on the open market, and ensures that franchisees can access quality assured products in a cost effective manner. MSK picks up the drugs from contracted facility and delivers them to the smaller ones as part of the routine monthly visit.

**Result**

14 AMUA providers are now in contract with MEDS and pooling procurement for their regions. Since then commodity stock outs within the network have declined significantly, from high initial levels to only one stock-out reported in participating clinics in the past two years of operation.

**Lessons Learned**

A memorandum of understanding has been implemented following reports of conflicts on procurement fees and transportation costs between facilities.

The franchisor network value proposition can be strengthened by ensuring that franchised clinics receive essential drugs and commodities from an accredited and reliable supplier for the right price.

**Outlook**

Pooled procurement mechanisms can be an effective way to ensure access to quality commodities. MSK is looking into expanding the system to more AMUA franchisees.
Use of WhatsApp to support quality improvement in Nigeria

The PharmAccess Nigeria team introduced the use of WhatsApp to facilitate communications with AHME healthcare providers in franchise networks in Ogun State. The goal has been to improve efficiency and cost savings in technical support, while helping to establish a culture of quality improvement among the providers.

SafeCare is a stepwise quality improvement program for small-scale health providers, who offer care to most of the country’s poor. On-site technical assistance is key, but limited, due to the costs and time associated with working in remote areas. This snapshot considers how the PharmAccess Nigeria team used WhatsApp to streamline the quality improvement process, while creating a new community of (quality) practice.

**Intervention**

In Ogun State, the PharmAccess team provided business and clinical quality assessments for 60 small-scale private healthcare facilities. A baseline assessment was used to design tailored quality improvement plans for both management and service delivery. Providers then received technical support to help them adhere to their plans’ guidelines and recommendations.

The providers often had difficulty integrating the quality improvement activities within their practices. Quality facilitators were assigned to offer assistance on site. Because the providers were widely dispersed, the team searched for a way to compliment the on-site visits with remote interactions that could be conducted more frequently.

The team came up with the idea of using mobile technology as a simple solution that could be deployed quickly, easily, and at low cost. The WhatsApp platform was adopted to connect and communicate with providers on an informal trial basis.

Providers were invited to join a WhatsApp facilitation group, and those who self-selected to take part were trained to download and use the application. Two WhatsApp groups were formed, each consisting of 15 providers and a quality officer.

From August 2015 to January 2016, the groups conducted weekly WhatsApp meetings. Each one focused on a particular theme and set of quality improvement activities that were distinct and achievable, such as how to set up a standardized hand-washing system. The importance of each element was discussed, along with practical details on how to implement changes. Providers were expected to take up the quality improvement task and send a photo to the rest of the group.

The peer-to-peer aspect of the intervention drove participating providers to become more engaged with the weekly quality improvement topics, and with each other. The conversations engendered healthy competition among providers, spurring them to go even further with ways to apply quality improvements. The weekly discussions helped to make the on-site visits more productive, while cutting down on travel time and costs, which are the main cost drivers of the quality improvement facilitation.

Following the positive responses to the initial trial, the team has now launched a formal 6-month pilot of the WhatsApp groups. The pilot will include measurements of costs and benefits aligned with the SafeCare quality improvement process. Like the initial trial, it will include 30 providers, split into two groups, and supported by the quality officers.
The PharmAccess Nigeria team introduced the use of WhatsApp to facilitate communications with AHME healthcare providers in franchise networks in Ogun State. The goal has been to improve efficiency and cost savings in technical support, while helping to establish a culture of quality improvement among the providers.

**Result**
Anecdotal responses were overwhelmingly positive, and SafeCare assessments of six of the Marie Stopes supported health care providers found that three of them, which had been very active in the WhatsApp discussions, had risen from SafeCare Level 1 to a Level 2. Formal results remain to be tested in the follow-up pilot.

**Examples and Evidence**
“I feel delighted and more empowered about this quality improvement plan, in fact it has really touched me and has upgraded my facility – especially in the areas of hygiene, stock keeping, and waste management. Thanks for your support.”

Mrs. Popoola Janet Kehinde, Registered Nurse/Owner of Dabfek

**Lessons Learned**
WhatsApp is a cheap and effective way to connect groups remotely. It has been important in motivating providers and creating a culture of quality improvement through regular communications. The WhatsApp outreach provides a strong value-added and compliment to on-site facilitation, but cannot replace it entirely. Engaging providers is a process which requires work and time. It is critical for ensuring that quality changes are institutionalized and sustained over time.

**Outlook**
The initial trial was implemented as a stop-gap measure. The current pilot presents an opportunity to better define the WhatsApp component and how to combine it more formally with on-site facilitation for the quality improvement process. The pilot is set to measure the potential for improving access and efficiency in technical support, cost savings in terms of travel and logistics, and the development of a culture of quality improvement among small-scale healthcare providers.
More than 4,000 private health care providers in Ghana rely on payments from the National Health Insurance Scheme (NHIS) for 80% of their revenue, but it can take months for claims to be reimbursed. A receivable financing product from the Medical Credit Fund (MCF) is addressing the problem.

This snapshot looks at how the Medical Credit Fund (MCF) established a pilot receivable financing product to relieve cash flow constraints for private providers, and is moving to scale it up.

**Intervention**

MCF conducted a pre-pilot assessment which revealed that delayed reimbursements for services rendered under the National Health Insurance Scheme (NHIS) were pushing private providers out of business, towards microcredit and informal lending, or into charging patients covered by the national plan.

Responding to demand from health care providers, MCF created the receivable financing product. It played the role of intermediary, bringing together the banks, clinics, and the National Health Insurance Authority (NHIA), which manages NHIS. MCF recruited the participating clinics and trained providers on claims management. It offered training to bank officers regarding not only the financial product, but also how health care services operate within the health insurance scheme. MCF also managed the operational challenges that arose during the pilot roll out.

The receivable financing product was designed to provide a bank advance to the health care provider equal to 70% of claims owed by NHIS. When NHIS pays the claim, the provider receives the remaining 30% payment, less a 2.5% monthly interest rate accrued by the bank lender.

MCF has played a key role in brokering and building greater understanding between the health care and banking sectors, strengthening the providers’ ability to prepare and submit applications for the product. MCF has emphasised to the banks the low-risk nature of this transaction, which is not dependent on future performance, but on payment due.

Consequently, the banks have agreed to offer an interest rate for the loan that is lower than the rate of medical inflation, so that what the provider loses in interest payments is more than offset by prompt payment of the claim. The rate also is lower than the banks’ base rate.

A maximum of three monthly claims are eligible for financing per cycle. The oldest ones are financed first, with the expectation that they are most likely to be reimbursed soonest by NHIS. Once the NHIS payment is made, the clinic is able to apply for another financing cycle.

MCF conducted a six-month pilot of the financing product, which also included technical assistance to the health care providers in the form of SafeCare clinical and business support services. The pilot intervention was conducted across the country and targeted 15 providers. Each went through one or more cycles of claims processing and financing.
More than 4,000 private health care providers in Ghana rely on payments from the National Health Insurance Scheme (NHIS) for 80% of their revenue, but it can take months for claims to be reimbursed. A receivable financing product from the Medical Credit Fund (MCF) is addressing the problem.

### Result
45 claims worth 4.84 million GHS ($US 1.2 million) were financed, with an average loan cycle of 2.5 months. Total payments by NHIS were 3.9 million GHS (US$ 930,000), with 960,000 GHS ($US 240,000) outstanding. Providers report improved business continuity and health service quality.

### Examples and Evidence
“As I speak to you now, I am expecting the fourth receivable loan. I have applied for three, and the fourth one is currently being processed. And I will still apply for more soon. I am very interested, because it has really helped my organisation. I have even recommended the product to a couple of my colleagues.”
Director, Brite Life Clinic, Takoradi, Western Ghana

### Lessons Learned
Staff shifts do occur in partner institutions. It is important to establish broad and continuous engagement with key persons within partner organisations to increase product knowledge and maintain institutional memory.

The main challenge involved delays in claim submission, claims vetting, and the issuance of Letters of Best Endeavours. To counter this, an intra-NHIA process flow was approved to guide personnel and shorten turnaround times, in addition to assisting providers in submitting timely, accurate claims.

Demand for the product is high. Banks see it as low risk. But providers need support to submit well-managed claims.

### Facilities (Blue-Star Franchise – MSI)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Program</th>
<th>Bank</th>
<th>Disbursed per Cycle (GHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lebanon Community Clinic</td>
<td>AHME</td>
<td>uniBank</td>
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<tr>
<td>Brite Life Clinic</td>
<td>AHME</td>
<td>uniBank</td>
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<td>Anton Memorial Clinic</td>
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<td>uniBank</td>
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<td>Anton Memorial Clinic</td>
<td>AHME</td>
<td>uniBank</td>
<td>30,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>319,300</strong></td>
</tr>
</tbody>
</table>

### Outlook
The project is scaling up with the aim of reaching 40% of eligible clinics and addition of two more bank partners, Fidelity Bank and HFC Bank.

The receivable financing tool is meant as a stopgap until the financing gap regarding NHIS is resolved. MCF, through PharmAccess, participated in a technical review of NHIS instituted by the President of Ghana, which submitted its draft recommendations in September 2016, with the hope that it will result in bold financial decisions in 2017, following national elections.
In order to assist their empaneled franchisees with claims management, PSK are exploring the possibility of taking on an aggregator role.

**Intervention**

PSK works with members of its 400-strong Tunza franchise network to facilitate NHIF empanelment. PSK is developing its brokerage role further by establishing itself as a provider aggregator able to negotiate contracts on behalf of network providers with the NHIF. To this end, PSK is developing a roadmap which will address key questions:

- What gap could PSK address for both NHIF and providers so that the value proposition is compelling enough?
- How do we get NHIF and provider buy-in?
- How is revenue generated from an aggregator model?
- How viable is an aggregator model financially?
- What structural and legal considerations does the organisation need to address in order to perform this function?
- What investment is needed for infrastructure and personnel to perform this function?

Key outputs of the roadmap will be a thorough analysis exploring feasibility, desirability, and financial viability. This will include financial modelling.

**Challenges**

PSKs current relationship with providers in the network is based on a memorandum of understanding which is not legally binding.

NHIF terms and policies currently allow it to empanel only individual providers and not a representative organisation, due to experiences with fraud in the past. Aggregation could be politically sensitive, as it could mean reducing the revenue stream of the claims management department.
Population Services Kenya’s (PSK) Tunza franchise proposes to leverage its networking function to mitigate transaction costs between the Nation Health Insurance Fund (NHIF) and midlevel franchisee providers.

Examples and Evidence
Providers in the network have expressed appreciation for PSK’s role as a broker and shown interest in learning more about issues such as revenue sharing and how PSK’s role as aggregator could affect their business. Developing a roadmap and financial model will help to address some of their questions and concerns.

Lessons Learned
Restructuring PSK’s relationship with franchise providers into a contractual one where both parties share liability will require structural and organisational modifications.

PSK will benefit greatly from acquiring actuarial, risk assessment, management and mitigation skills. Developing a financial model will help PSK to identify where in the claims management process PSK could add most value.

A dedicated process owner is required at the NHIF to facilitate aggregation and foster engagement between the NHIF, the aggregator and franchise providers.

Outlook
PSK’s roadmap, due in early 2017, will outline benefits, challenges and key process milestones for aggregation. Whatever approach the aggregator takes has to be compelling enough for the insurer to bear an admin cost.