BILL & MELINDA GATES foundation

UKaid from the British people

AHME AFRICAN HEALTH MARKETS FOR EQUITY

AHME support to Kenya's Linda Mama free maternity programme through social franchising – what did we learn?

Prepared by Gabrielle Appleford, Consultant

MARIE STOPES INTERNATIONAL
Children by choice, not chance

psi Healthy lives. Measurable results.

PharmAccess FOUNDATION

Acknowledgments

African Health Markets for Equity (AHME) is funded by the Bill & Melinda Gates Foundation and UK Department for International Development. The project aims to deliver high quality primary health care, particularly to the poor, through the private sector in Kenya and Ghana. The AHME partnership is led by Marie Stopes International in collaboration with Population Services International and PharmAccess Foundation. For more information on AHME, please contact ahme.management@mariestopes.org.

This work was led by Gabrielle Appleford (Consultant) with the kind assistance of Edward Owino (Marie Stopes Kenya) and Rita Mwachandi (Population Services Kenya).

Recommended citation: Appleford, G. April 2019. AHME support to Kenya's Linda Mama free maternity programme through social franchising - what did we learn? African Health Markets for Equity, Marie Stopes International.

This case study has been funded by the Bill & Melinda Gates Foundation and UK aid from the UK government; however the views expressed do not necessarily reflect the official policies of these bodies.

Photo: Tunza client receiving post-natal care services in Nairobi, Kenya. Credit: Population Services International.

Contents

List of acronyms

AHME	African Health Markets for Equity	PNC	Post-natal care
ANC	Antenatal care	PPFP	Post-partum family planning
CHV	Community health volunteers	PSI	Population Services International
KII	Key informant interviews	PSK	Population Services Kenya
MoH	Ministry of Health	SME	Small and medium sized enterprises
MSI	Marie Stopes International	TBA	Traditional birth attendant
NHIF	National Hospital Insurance Fund	TM	Tunza mobiliser
PAF	PharmAccess Foundation	UHC	Universal health coverage

Introduction

Figure 1: AHME theory of change

The African Health Markets for Equity (AHME) programme, funded by the Bill and Melinda Gates Foundation and the UK Department for International Development, aims to deliver high quality primary health care through the private sector in Kenya and Ghana. The six-year programme seeks to improve the functioning of the health system in terms of quality, access, security of supply, sustainability and equity in ways that benefit the poor. The AHME partnership is led by Marie Stopes International (MSI), with Population Services International (PSI) and PharmAccess Foundation (PAF) as sub-contracting partners.

The AHME partnership identified five conditions that must be met for markets financed through national health insurance schemes to work for the poor. These five conditions underpin AHME's intervention strategies (Figure 1):

1. **The poor are enrolled**
2. **Key primary healthcare services are covered.**
3. **Accessible facilities are contracted.**
4. **Accessible providers offer quality services.**
5. **Providers run viable businesses.**

This case study describes the experiences and perceptions of MSI and PSI social franchises and healthcare providers in their networks who participate in Kenya's Linda Mama free maternity programme, managed by the National Hospital Insurance Fund (NHIF). The case studies and the experience of private sector participation in government-initiated pro poor schemes is relevant to other organizations and governments seeking to overcome obstacles in linking private providers into a universal health coverage (UHC) scheme.

Background

The goal of the Linda Mama programme is to *"achieve universal access to maternal and child health services and contribute to the country's progress towards UHC"*.[1] The scheme is publicly funded through the Ministry of Health (MoH) and provides a package of antenatal, delivery and post-natal health care services targeting women on the basis of need, and not ability to pay.[2] The scheme therefore caters for women not covered under the National Hospital Insurance Fund (NHIF) or other form of insurance.

The scheme was introduced in phases:

- Phase 1, from April 2017, commenced with the faith-based and private sectors
- Phase 2, from July 2017, included the public sector
- Phase 3, from March 2018, saw the addition of antenatal care (ANC) and post-natal care (PNC) services to the benefits package

Under Linda Mama, reimbursement rates are tiered by level of care and provider type. Public sector tariffs are lower as these are considered additional to line-item budgets that cover facility operations and maintenance, health worker salaries, consumables and other costs. Private sector tariffs are slightly higher. For both sets of tariffs, it is unclear how they were arrived at and why they are significantly lower than those provided for under the NHIF national scheme, also known as Supa Cover. For example, reimbursement for normal delivery under Linda Mama ranges from Ksh 3,500/USD 35 to Ksh 6,000/USD 60 while the NHIF national scheme reimburses Ksh 10,000/USD 100 irrespective of level of care or provider type. Table 1 provides an overview of Linda Mama tariffs by level of care and provider type for ANC, delivery and PNC.

Table 1: Linda Mama tariffs

Facility level	Normal delivery	Caesarean section	ANC (per visit)	PNC (per visit)
Private health centres and maternity homes (level 3)	Ksh 3,500/USD 35	N/A	1st visit = Ksh 1,000/USD 10 2nd - 4th visits = Ksh 500/USD 5	1st-4th visits = Ksh 250/USD 2.50
Public health centres and dispensaries (level 2 and 3)	Ksh 2,500/USD 25	N/A	1st visit = Ksh 600/USD 6 2nd - 4th visits = Ksh 300/USD 3	1st-4th visits = Ksh 250/USD 2.50
Private hospitals (level 4)	Ksh 6,000/USD 60	Ksh 17,000/USD 170	1st visit = Ksh 1,000/USD 10 2nd - 4th visits = Ksh 500	1st-4th visits = Ksh 250/USD 2.50
Public hospitals (level 4 and 5)	Ksh 5,000/USD 50	Ksh 5,000/USD 50	1st visit = Ksh 600/USD 6 2nd - 4th visits = Ksh 300/USD 3	1st- 4th visits = Ksh 250/USD 2.50

Purpose and methodology

The purpose of the case study was to generate learning on:

- Participation of providers under the Linda Mama programme
- The support provided to providers for the Linda Mama programme
- The experiences and perceptions of providers of the Linda Mama programme
- How to improve performance of the Linda Mama programme

The case study drew on primary and secondary data sources. Secondary data included Linda Mama programme documentation as well as published studies. Primary data was collected through key informant interviews (KIIs) with:

- Six MSI and six PS Kenya social franchise providers located in three counties, Uasin Gishu, Nakuru and Kilifi
- Two NHIF branch officers in two of the three counties
- Two MSI and three PSI technical team members supporting the respective social franchise networks

Data was collected over the period November 2018 to February 2019. A grounded approach to data analysis was used, whereby all data was reviewed, and codes iteratively introduced. Findings have been organised around key themes related to provider participation, perceptions and experience with Linda Mama as well as social franchise support. Counties have not been referred to by name but have been coded as A, B and C counties in order to protect the anonymity of the providers.

Above: Tunza client receiving post-natal care services in Nairobi, Kenya. Credit: Population Services International.

Findings

Social franchise providers in the Linda Mama programme

Not all social franchise providers are able or willing to participate in the Linda Mama programme. In the first instance, private facilities must be accredited in the NHIF to be part of Linda Mama. There are significant barriers to entry for private sector providers, particularly those that are small and medium size (SME) facilities. Linda Mama also has specific eligibility requirements, for which a separate contract is issued. Even when facilities are eligible, some private providers have chosen not to participate in Linda Mama, largely due to the low tariffs: in both franchises only about a third of NHIF-accredited facilities have taken up the offer. Table 2 provides an overview of NHIF accredited social franchise facilities and those participating in the Linda Mama programme.

Table 2: Social franchise provider accreditation

Description	MSI (Amua social franchise)	PSI (Tunza social franchise)
Total number of franchised facilities	340	415
Total number of NHIF-accredited facilities	173	208
Number of NHIF-accredited franchise facilities providing maternity services	77	207
Number of NHIF-accredited franchise facilities participating in Linda Mama	61 (79%)	84 (40.5%)

Social franchise providers that participate in Linda Mama are recognised by the NHIF for their contribution to programme performance. This contribution has addressed supply - delivery of the Linda Mama package - and demand - recruitment of expectant women on to the scheme. On the supply side, MSI and PSI social franchise facilities represent almost half of the private providers in the programme, given the low uptake of Linda Mama writ large by the private sector (while not explored in this case study, there also appears to be malaise with the programme in the public sector). Currently, NHIF estimates that only 299 private providers are active in Linda Mama (defined as those providers making monthly claims).

Social franchise support to the Linda Mama programme

AHME support to social franchise providers has facilitated their contribution to the Linda Mama programme. Support has aligned to the five conditions necessary for national health insurance schemes to work for the poor as presented in Figure 1. This support has been tailored by partner, based on the value proposition and investment of the respective social franchises. There have been two main areas of support; increase Linda Mama client flow and reduce the transaction costs of participation in the scheme.

Increase Linda Mama client flow

The social franchises have supported Linda Mama public education as well as client identification. There has been more investment in this area by PSI given the additional resources that they have through another project on safe motherhood. The PSI social franchise has also engaged NHIF branch offices and Tunza Mobilisers (TMs) to support client recruitment, as part of Tunza outreach and event days. In contrast, MSI has not engaged the NHIF branch offices on outreach and event days, which tend to involve MoH personnel. However, MSI has oriented the community health volunteers (CHVs) to create public awareness on the scheme.

MSI and PSI staff and social franchise providers reported that knowledge on the Linda Mama programme remains low, despite the scheme having been in operation for almost two years. Knowledge gaps within communities also extend to client eligibility given that the NHIF is associated with membership fees, or ability to pay, and not entitlement, based on need. This may also be reflective of the limited exposure of communities to other forms of social protection.

Community mobilisers are enlisted to provide support with client identification and recruitment. This support emanates from the social franchise and/or is initiated by individual providers.

- **Support is more systematic through PSI, which uses TMs.** TMs are CHVs trained on how to map clients, the use of NHIF job aids, and provided with a reporting tool, which they use to check registration against the Tunza facility register to verify if clients have attended for ANC, delivery and PNC. If there is a discrepancy, the TMs trace the woman in the community. Given its intensive nature, this level of support is provided in a sub-set of Tunza health facilities, which are rotated on an annual basis, as part of a broader support package. TMs receive Ksh 2,000/USD 20 stipend per month, Ksh 100/USD 1 per client registered to Linda Mama (or the NHIF national scheme), Ksh 50/USD 0.50 for each ANC visit and Ksh 100/USD 1 after a client delivers. There is no incentive provided for PNC. Tunza providers may also increase the base amount provided to TMs through their own resources.
- **Support is more organic through MSI, which uses the government community structure.** The social franchise and franchise providers tend to work with CHVs from their catchment areas and may provide a small incentive for their mobilization efforts, with MSI providing support on event days (Ksh 1000/USD 10). Incentives vary from one provider to another but are in the range of Ksh 200/USD 2 - Ksh 500/USD 5, which is given after a woman delivers at the facility. In some instances, where home deliveries are common, providers may also work with traditional birth attendants (TBAs) and engage them as birth companions. In two instances, MSI social franchise providers also indicated that public dispensaries direct clients to their respective facilities. This level of cooperation with public health facilities was not reported by other MSI or PSI social franchise providers.

Box 1. Provider frustrated to serve rural community

While the providers visited were selected because they were already participating in Linda Mama, one Tunza provider was interviewed as she was actively seeking accreditation with the Linda Mama scheme. This older woman, running a rural clinic, is accredited for the NHIF out-patient contract. She requires Linda Mama to serve women in her community who are poor and now go to the public facility which is operating under Linda Mama. As a result, she has seen her deliveries drop from twenty a month to almost nil. Since 2017 when she was advised that she was ineligible for Linda Mama with no explanation provided, she has continued to request accreditation. In every interaction with the NHIF, she is told to 'go and wait'. Implicit in these interactions is the expectation of personal gain for bottlenecks to be removed.

Reduce participation transaction costs

The social franchises have brokered engagement between providers and the NHIF in order to reduce transaction costs. This support has been provided to Tunza social franchisees through PSI business development officers, embedded in regional teams. In contrast, support from MSI has been centralised in a single AHME health financing officer, who works through the social franchise coordinators based at regional level as well as directly with social franchise providers. Through these channels, the social franchises have brokered:

- Accreditation in the NHIF for in- and out-patient contracts as well as Linda Mama[3]
- Orientation of providers to the various schemes and contractual obligations
- Practical advice on claims and reimbursements
- Facilitation of peer-to-peer support through social media (i.e. regional WhatsApp groups) that includes the NHIF's Linda Mama programme manager

Providers in the franchise networks tend to be mid-level providers - clinical officers, nurses and midwives - who run SME facilities, such as level 3 clinics and maternity homes. Atomized, their voice has had limited weight and is under-represented, even within private sector alliances.[4] Through aggregation, challenges are presented and brokered with the NHIF, facilitated by the social franchises. This has been most successful at county level where process delays have been experienced.

Not all transaction costs are experienced equally by social franchise providers. There is evidence that providers located in the same counties, working with the same NHIF branch offices, are not treated equally. Within county eco-systems there appears to be a tendency to prioritize larger facilities, many of which are male owned. In contrast, the smaller clinics and nursing homes, often owned and operated by female providers, reported more incidences of delayed or frustrated NHIF and Linda Mama accreditation and processing of reimbursement claims. Box 1 provides an example of one provider's frustration in seeking accreditation on to the Linda Mama programme. Table 3 provides a summary by provider of Linda Mama deliveries and reimbursement experience. This suggests that more Linda Mama deliveries are occurring in level 3 facilities while these same facilities are the ones experiencing greater delays in reimbursement. This situation works at cross purposes to the aims of Linda Mama.

Table 3 : Social franchise provider deliveries and reimbursement experience

County	Franchise provider	Provider sex (M/F)	Linda Mama deliveries	Reimbursement experience	Remarks
A	Tunza 1 (level 3)	F	N/A	Not able to enroll in scheme	
A	Tunza 2 (level 4)	M	Staff not able to verify	No delays cited	Very few claims being generated
A	Tunza 3 (level 4)	M	3	No delays cited	Very few claims being generated
B	Tunza 4 (level 3)	F	12	Major delays cited	She reported not having been paid since May 2018
B	Tunza 5 (level 4)	F	40	Delays cited	She reported delays of three months
B	Tunza 6 (level 4)	M	4	No delays cited	
B	Amua 1 (level 3)	F	30	Delays cited	She reported delays of three months
B	Amua 2 (level 3)	F	15	Major delays cited	She reported not having been paid since May 2018
C	Amua 3 (level 3)	M	>100	Delays cited	He reported not having been paid since Oct 2018
C	Amua 4 (level 3)	F	16	Major delays cited	She reported not having been paid since Aug 2018
C	Amua 5 (level 3)	M	30	No delays cited	He reported having been paid in Oct 2018 and in Jan and Feb 2019
C	Amua 6 (level 3)	M	20	Major delays cited	He reported not having been paid since Sep 2018

Smaller social franchise providers are least able to absorb transaction delays with Linda Mama. Some female providers reported challenges paying staff and suppliers as a result of delayed Linda Mama reimbursements. One indicated that she was having to send in-patient clients away as she could not afford to stock medicines and consumables as a result of the delays. Delays on Linda Mama may also be compounded by delays from other NHIF contracts, such as capitation for the national out-patient scheme. Furthermore, providers reported a contraction in cash clients due to increased NHIF enrollment, reducing their cash buffer.

"They [NHIF] strain us."
[Tunza 1 provider, County A, female]

"I don't have anything."
[Tunza 4 provider, County B, female]

Perceptions of Linda Mama

Despite frustrations with Linda Mama, most providers are supportive of the programme. While the rates are considered low, some providers indicated that they wanted to serve poor women in their communities. NHIF branch managers have also picked up on this theme, framing Linda Mama as corporate social responsibility. Providers in two of the counties were very insistent that the rates were too low, particularly those operating in SME level 3 facilities, where reimbursement for normal delivery is Ksh 3,500/USD 35. There was comparison made to the NHIF in-patient scheme, where reimbursement is much higher. In the third county, where providers were more rural, there was a more conciliatory view of the reimbursement rate. One provider indicated that he had pegged his delivery rate to the sale of a goat (estimated at Ksh 2,000/USD 20) as this is what women used to do before Linda Mama when they wanted to deliver in his facility. Given this, he found the reimbursement of Ksh 3,500/USD 35 for normal delivery to be fair. Other providers indicated that the rate would be more acceptable if they were reimbursed in good time.

"If using the same facility and same staff, then why should you discriminate? For sure you cannot break even, this looks like Red Cross work."
[Tunza 6 provider, County B, male]

"If they do as they [NHIF] say, that is fair."
[Amua 2 provider, County B, female]

"This was not meant to be a meant to be a profit-making activity."
[NHIF branch manager, County B, male]

The addition of ANC and PNC to Linda Mama has made the package more attractive to providers and women. This package is intended to provide a continuum of care, for mothers and their babies up to six weeks post-delivery. All providers reported that they are seeing mothers for ANC and PNC however these services do not operate in lock-step with deliveries, for a variety of reasons, such as mothers not opting to do the four visits or seeking care from the public facility. The reimbursement rates for these services were also viewed as fair but 'tight' for ANC 1, given the number of tests required. Almost half of providers indicated that they offered post-partum family planning (PPFP) free as part of PNC, particularly where the commodities were availed through the public sector. Providers recognised the need for free PPFP given the socio-economic status of their communities while one provider indicated that he was "passing on the subsidy" provided to him from participation in MSI event days.

There is recognition that other NHIF schemes can complement limitations with Linda Mama. Ideally providers have all three contracts - the national scheme out-patient and in-patient contracts and the Linda Mama contract. For example, those providers with in-patient contracts can admit Linda Mama mothers and their infants should there be a complication or illness, not covered under the free maternity scheme. Similarly, ultrasound scans can also be charged through the in-patient contract. While providers reported paying out-of-pocket for emergency referrals to higher level facilities, a new contract between the Kenya Red Cross Society and NHIF for ambulatory services will be available to support emergency cases with prior notification.

Right: Amua client receving post-natal care services in Juja, Kenya.
Credit: Marie Stopes International

Lessons learned

The Linda Mama programme is more attractive to SME providers, but they face the highest barriers to participation. There appears to be greater congruence between Linda Mama and SME providers, serving poorer, more rural communities. However, these providers also reported greater barriers to participation in the scheme, which start with empanelment into the NHIF. This was self-reported more frequently by female providers than by their male counterparts.

The Linda Mama programme is more viable for providers when they have the NHIF in-patient and out-patient contracts. Given the narrow margins of Linda Mama, some concessions have been made by the NHIF to cater to illness or complications (beyond caesarean section) on the in-patient contract. However, SME providers are less likely to have this contract in place and are unable to benefit from these concessions.

Inconsistent and unpredictable disbursement of funds threatens the viability of provider businesses. This situation has made it difficult for facilities to plan, and is a substantial challenge for SME facilities, dependent on the reimbursements for operating costs and the livelihoods of providers. A reduction in cash paying clients - largely due to the success of NHIF enrollment - has changed the business landscape of providers. While providers are ready to embrace this change - as demonstrated by the existence of and desire for multiple contracts with the NHIF - this comes with significant risks.

Social franchises can play a valued intermediary role between purchaser and provider. There was demonstrated appreciation by providers of this function, which has undoubtedly strengthened the social franchise value proposition to providers. This function plays out in small and larger ways, ranging from more formal engagement (training for example) through to smaller interactions, via social media, that are both motivating and practical. These interactions also include some NHIF staff, who are reported to be active in the groups. This interaction is assisting to clarify procedures and address challenges experienced by providers.

Recommendations

The private sector, including SME providers, have a role to play in UHC in Kenya. Their participation in purchasing arrangements, such as the NHIF and Linda Mama, can facilitate client choice, particularly where physical access and quality in the public sector may be constrained. In order to stimulate greater participation of the private sector in the Linda Mama programme the following recommendations have been made for consideration by the NHIF.

Standardize the reimbursement rate for normal delivery in the private sector. Currently this ranges from Ksh 3,500/USD 35 to Ksh 6,000/USD 60. It is recommended that a single reimbursement rate of Ksh 6,000/USD 60 is used for all level 3 and 4 private health facilities. This would signal to providers an intent to promote quality at all levels of care, which may be constrained through a tiered tariff model.

Provide greater procedural clarity for providers. There is need for more proactive and consistent management of providers so that procedural delays can be reduced for all providers irrespective of age, gender, location and facility level. This is acutely needed for claims processing and reimbursement delays. This should also extend to how complications and illness are managed, as well as ambulatory care. Currently, Linda Mama contracts are not precise, open to interpretation and do not align with the policy intent of Linda Mama.

Reinforce the inclusion of PPFP within the PNC package. Consider a separate reimbursement, or a top up to one of the PNC visits, to cater for this service. The effective inclusion of modern PPFP in Linda Mama would allow Kenya a viable strategy for improving its uptake, which is estimated at only 16% at six months, despite an estimated 64% of women delivering in health facilities. This suggests a missed opportunity for post-partum mothers.

Provide greater procedural clarity to communities. There remains low public awareness of Linda Mama and some confusion related to eligibility. More concerted effort to address gaps in understanding would facilitate greater access for poor and marginalised women who need Linda Mama the most. This should be spearheaded by the NHIF and county departments of health and include the private sector.

Below: Tunza client receiving antenatal care in Thika, Kenya. Photo credit: Population Services International.

References

[1] http://www.nhif.or.ke/healthinsurance/lindamamaServices (Retrieved: 23/2/2019).

[2] Detailed guidance on specific benefits under these packages is available on the NHIF website: http://www.nhif.or.ke/healthinsurance/lindamamaServices.

[3] See a complementary case study: Appleford, G., Therui, I. and Owino, E. January 2018. Brokering Accreditation in Kenya's AMUA Social Franchise Network, African Health Markets for Equity, Marie Stopes International.

[4] The Kenya Private Sector Alliance (KEPSA) is dominated by large private providers and other players such as the pharmaceutical sector, represented by the Kenya Healthcare Federation (http://khf.co.ke/about-us/).

[5] Avenir Health, 2017. Opportunities for Family Planning Programming in the Post-Partum Period in Kenya. Avenir Health, Connecticut, USA.

Marie Stopes International
1 Conway Street
Fitzroy Square
London W1T 6LP
United Kingdom

T + 44 (0)20 7636 6200

info@mariestopes.org
www.mariestopes.org

Registered Charity No.
265543

Company No.
1102208