

Innovation Uptake in Pro-Poor Health Markets

Private Sector Innovation
Programme for Health (PSP4H)

Prepared for

Department for International Development
(DFID)

September 2017

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1 Introduction

The Private Sector Innovation Programme for Health (PSP4H) was designed and funded by the Department for International Development (DFID) to be an action research project exploring the markets in which poor people pay for-profit providers for healthcare. This was a new area for DFID and its first solely dedicated Making Markets Work for the Poor (M4P) programme in the health sector. The overall objective of the PSP4H programme is to learn how a market systems approach might benefit pro-poor health interventions, to inform future programming.

Given its pioneer status and the programme's mandate, this narrative report captures the innovations discovered through the on-going course of PSP4H's implementation as it constitutes a significant amount of lessons learnt. This summary report will highlight the innovations that have worked in PSP4H's programming, what did not work and explore how these innovations have gone beyond their original interventions and been replicated in different health market areas and across country borders.

2 What is the innovation?

Innovation is the introduction of something new or simply a new idea, process, or device. However, often in today's modern world, the word 'innovation' is linked to technology and in its absence it is harder to justify the innovation. Beyond the technological innovation, there is the behavioural aspect that influences the use or adoption of a healthcare service or product by consumers.

In PSP4H's three years and ongoing implementation, the programme found that the actual innovation has been in the business model which is knowledge driven. The success or failure of an intervention is largely based on the business model adopted and how the business operates in the local environment. In the PSP4H context, adapting the healthcare service or product that previously did not exist locally to the local socio-economic environment is the innovation. The business model is simply the means and methods a firm employs to generate revenues and sustainably deliver health services and products to the mass market i.e. low –income population.

The business model innovation in PSP4H differs from conventional business wisdom for two primary reasons:

- > It goes against the notion that only financing can affect positive change in the healthcare system
- > It goes against the idea that innovation only concerns technology (something with a microchip or on the internet)

PSP4H's portfolio of interventions highlights the business model innovations and the factors that have made them successful causing them to be replicated across health segments whilst sustainably and profitably serving Kenya's working poor who are the mass market.

At this point, it is important to note that PSP4H engaged with some innovative companies manufacturing cutting edge health equipment that could greatly improve the quality of health services for Kenyans, however, the programme was unable to facilitate uptake in the local market. One such company was Mobile ODT (Optical Detection Technologies), an Israeli company creating smart medical devices using smartphone-based tools to provide cost-effective screenings in low resource settings. Similarly, Royal Phillips launched a tablet-size ultra-mobile ultrasound system in the Kenyan market to support maternal and infant care particularly in rural areas. Both devices would enhance the quality of diagnosis and treatment, but costs ranged between \$6,000 and \$14,000 each, which was out of reach for most private health care providers serving Kenya's low-income markets¹. PSP4H began facilitating a lease model for the network of private midwives, however, the cost was still not tenable. Beyond the lack of a suitable costing model, there were other infrastructural issues such as internet connectivity and integration with health platforms that inhibited the uptake of these innovative technologies. An interesting area to explore would be if M4P health programming can accommodate new innovative equipment and facilitate its uptake. While the M4P approach does not support purchase of equipment for market actors, in this case, private healthcare providers, it could provide facilitative support to encourage uptake through developing suitable financing models and marketing strategies for the target market.


¹ <https://techmoran.com/philips-unveils-the-visiq-ultra-mobile-ultrasound-system-in-kenya/>

3 What determines the success of the business model innovations?


Adaptation of the business model to the local socio-economic context

Market systems interventions are facilitative and as a result require partners to implement programmes. While the business model largely contributes to the success or failure of market interventions, how well the model is adapted to the local, social and economic fabric is an even bigger determinant of how successful the firm or organization will be in profitably providing healthcare services or products to the mass market. This largely explains why innovations brought to Kenya from Israel, India, South Africa and other places, are never 'copy and paste' and typically are not successful unless significant adaptations are made to consider the behaviours, cultural norms, societal values and economic profiling for the local market.

The City Eye Hospital (a PSP4H intervention partner) adopted India's Aravind Eye Care system business model and modified it for the Kenyan socio-economic context as is presented in the break out in the box shown below.



City Eye Hospital
quality and affordable eye care




ARAVIND
EYE CARE SYSTEM

Access to quality eye care services in Kenya is one of the areas where the working poor are currently underserved in addition to the lack of adequate skilled eye care personnel.

City Eye Hospital (CEH) is a commercial for-profit venture serving low-income communities by providing affordable, quality-assured eye healthcare to low income communities across Kenya. The founder of CEH was inspired to set up a facility to deliver eye care for low-income patients in Kenya and during his training in India he experienced the Aravind Eye Care System.

Aravind Eye care was established forty years ago as a not-for-profit and today has become the world's largest and most productive eye care provider in the world. The Aravind model has two components, the clinical part assembly-line cataract surgeries and the cross-subsidy model where those who can afford to pay more subsidise or even cover the whole cost of cataract operations and eye care for those who cannot afford; 70% of the surgeries are free or below cost and 30% are above cost.



City Eye Hospital in Nairobi has adapted the cross-subsidy model for Kenya even though the society is far different from India and they have done it within a commercial business entity and not an NGO like Aravind. Given the different social fabric in India, CEH had to figure out how the cross-subsidy model would sustainably work in Kenya by finding a suitable business model, thus leading CEH to partner with PSP4H.

Since CEH opening in 2015, like most private hospitals in Kenya, demand creation remains a systemic problem, especially facilities targeting the working poor who mostly pay-out-of-pocket since they do not have medical insurance covers. As a result, the ongoing intervention with PSP4H seeks to address the demand creation problem by working with CEH to:

1. Develop and test a financial model to model breakeven and potential profitability of outpatient/optical vs. surgery service lines and paid vs outreach patients with the objective of understanding the volume requirements behind reaching sustained profitability
2. Development and implementation of an outreach marketing plan with the intent of driving increased volume in non-surgery clients

As can be seen from the City Eye Hospital experience, it is evident that the implementing partner must have a solid understanding of the local business within the socio-political economy in order to develop and implement a winning business model.

Similar to the business model, the program design is equally adopted to the socio-economic context of the market. Any business model that is focused on the working poor must be designed from the bottom-up. Having a street level focus provides better market insight towards the behavioural economics and appropriate incentives for the healthcare business looking to provide healthcare services and products to lower income populations. A bottom-up approach brings the programme closer to the beneficiaries, so programming can better understand influencing behaviours of the target group. Often times, donors and development partners design top-down interventions and fall into the trap of creating solutions before fully understanding the problem faced by the target group. The programme, through its interventions, must incorporate these factors in its design.

4 What innovations have worked on PSP4H?

Quick intervention model

Traditionally, donor programs are designed with a top-down approach based on macro-analysis and insights gathered from the highest levels of government and policy makers which often times does not fully understand the needs of lower income groups. Given the M4P approach of conducting market analysis before intervening in the market, a lot of programmes have spent extensive time and resources carrying out baseline and market research studies which sometimes only add incidental value and unnecessarily delay programmes from getting to the implementation stage.

In the course of implementing M4P interventions in unserved or underserved health areas for the 'working poor', PSP4H has discovered that the quick intervention model can be just as effective as conventional interventions with several months and sometimes years of baseline research. The quick intervention model, which is based on direct market testing, is a better use of money to test a hypothesis based on knowledge gained. The emergence of the quick intervention innovation proves that testing the hypothesis with partners who are engaged as market players instead of doing more studies can provide development programmes with more evidence and impact the target beneficiaries in a shorter amount of time as well as better leverage for donor funds. The quick intervention model does not displace the importance of baselines as they are critical in measuring impact, however, it advocates for a shorter baseline information gathering period. It is important to note that the quick intervention model will not be suitable for all intervention types. Some PSP4H interventions like the Asthma Care intervention with Glaxo Smith Kline (GSK) required an extended baseline period to gather data to establish the current asthma situation in Kenya as there were no market studies available. However, there are increasingly more development programmes combining short baseline periods in order to get to implementation faster.

One of PSP4H interventions, which provides real insights to the quick intervention model is the Tanaka Nursing Home in Busia County in Western Kenya cited in the box below.



Private hospitals, particularly those serving the mass market, are frequently under-utilized and carry excess capacity even if they offer quality services at affordable prices. These hospitals struggle to create sufficient demand (volume) to recoup costs, much less earn a profit.

To address this problem, Tanaka Nursing Home (TNH) sought to identify effective demand generation strategies to gain operational efficiencies while maintaining quality care and affordability for the low-income rural population in its Busia catchment. Most of TNH's patients were covered by NHIF, however, due to the length of time it would take NHIF to disburse payments to private health facilities like TNH, a serious cash flow problem was constituted.

To reach the mass market, who typically pay out-of-pocket for healthcare as they have no insurance coverage, TNH in partnership with PSP4H designed an outreach programme focused on areas in and around Busia where substantial numbers of the target population reside or work. By definition an outreach program is an activity of providing services to populations who might not otherwise have access to those services or those not aware of where to access the services.

The objective was to create awareness among the target group that TNH services are accessible, affordable, and high quality. In order to increase the footfalls at TNH by the working poor, a quick intervention model was adopted which:

- Did not entail expensive market research
- Could deliver evidence in a shorter space of time

For four months, TNH staff and volunteers conducted outreach activities in the community, providing basic health checks as a way to promote their hospital and connect awareness to subsequent visits to TNH.

Results:

21% of the clients who participated in the outreach program returned to use TNH. Six months after the outreach programme, TNH saw demand for their services increase by 60%, total revenue increase by 20% and outpatient numbers increase by 51%. Based on the increase accrued from the outreach program, TNH was able to give the

hospital a face lift by renovating its buildings, increase its work force and are currently expanding the hospital building a 3 storey block to start a nursing school.



Figure 1: Outreach site at a Busia sub-county

TNH's experiment with community outreach and confirmed that innovative and creative marketing are needed to reach this often misunderstood and poorly researched population group. Community outreach, along with health camps, work with this target group given low knowledge levels on health issues and service availability. It was evident that personal contact supported with a regular one-on-one communication is critical to the non-traditional marketing approaches and is more likely to capture customers and bring them into a private health facility like TNH. In order to change socio-cultural perceptions that affect how the working-poor seek healthcare, communication through multiple channels about available services can make a positive difference.

Once again in this intervention, the innovation was solely in the business model to create awareness among the working poor about affordable health services.

Portfolio approach

In the course of implementing this action research programme, PSP4H learned that it is critical to have a diversified portfolio of market interventions, instead of having a fixed set of interventions from the onset, as only some of the interventions will succeed. In the portfolio, there are independent interventions addressing different systemic constraints, some of which will progress and mature and even in some cases scale-up organically, while others will die off. The flexible mix of interventions will minimize the risks and increase the chance for success also enabling the programme to have a diversity of partners and the opportunity to work with health businesses at different growth stages, all of which affect the success rate.

The portfolio approach is an iterative learning process where one learns from the successes as well as failures (fail fast, learn and act quickly) while remaining alert to major risks, using the information to design, adapt, scale-up and/or shut down market interventions as the markets evolve.

Starting at scale

Perhaps one of the most fruitful and innovative approaches explored by PSP4H has been starting at scale by engaging with existing aggregations. Scale-ups occur much easier when support extends to a group of partners with similar interests as opposed to working with individual enterprises and their associated value chains.

PSP4H's flagship intervention that tested this concept of starting at scale is *Pharmnet*. In Kenya, as with many other African countries, the pharmacy is the first point of call for medicines. Consumers can not differentiate between regulated and illegal/ unregulated pharmacies in Kenya and up to 30% of medicines in Kenya are said to be substandard with low income communities being at greater risk². The box below provides further information about the Pharmnet intervention.

² <http://www.nation.co.ke/news/Survey-reveals-poor-likely-to-buy-fake-drugs/1056-3071314-13jmdfpz/index.html>



PSP4H partnered with the Kenya Pharmaceutical Association (KPA), a professional association with 8,500 licenced members of which 4,000 of these own and operate community pharmacies, to network fully licenced retail pharmacies and drug shops owned or operated by their pharmaceutical technologist members. KPA members were already living and running their pharmacies predominantly in the low income neighbourhoods. Pharmnet delivers medicines under a common brand, owned by KPA, with the promise of assured quality. In creating Pharmnet, PSP4H assisted the network with brand creation and marketing, training on inventory management, cash flow management and customer care, conducting quality audit, establishing pooled procurement and advocacy. 250 pharmacies currently exist within Pharmnet.



The Pharmnet network serves as a self-regulation of community pharmaceutical market to improve access to medicines, alleviate the cost burden of medicines, reduce stock outs of medicines and fight the systemic problem of illegal pharmacy practices and illegal practitioners. The brand serves as a quality signal to the working poor consumer who have a wide array of unregulated chemists and medicine sellers all around. Networking improves confidence to patients and practitioners leading to better health outcomes.

Results of Pharmnet Impact study:

- 74% of the Pharmnet pharmacies showed an increase in monthly turnover
- The average monthly turnover increased by 21% with 6 pharmacies more than doubled their sales after branding
- 76% of the Pharmnet pharmacies showed an increase in monthly footfalls
- The average monthly traffic increased by 32% on average

In order to ascertain the impact and benefits of creating scale advantages through networks, PSP4H contracted an independent research firm to conduct an audit of 153 Pharmnet branded pharmacies from the 250-population sample across six regions. The branded pharmacies registered 32% growth in monthly footfall and 21% increase in monthly turnover within the second year of launching the business model.

It took PSP4H the same level of effort to support the initial 100 pharmacies as it would, if there were only five pharmacies willing to form a network. Creating scale advantages through networks represent the key to scale-up. As of September 2016 when the impact study was conducted, *Pharmnet* had reached 3.2 million low income Kenyan consumers with quality assured medicines.

PSP4H has been leveraging networks as a key to starting at scale and inherently, scaling up; This innovative model has since been replicated by five health networks in three countries. One of the first networks to replicate this model after Pharmnet was Labnet, a branded network of quality assured medical laboratories.

Showing that the network model is both replicable and scalable, in less than one year, Labnet expanded regionally into neighbouring East African Community of Uganda. Akin to Kenya, Uganda has a largely unregulated private sector with quack laboratories, drug shops and health providers. With the exception of the labs in large private hospitals, the small individual labs struggle to cover operating costs and the volume of clients they see is low.



Labnet Kenya

Similar to Kenya's pharmaceutical sector, access to reliable diagnostic testing facilities is a major healthcare challenge for low income Kenyans. PSP4H assisted the Association of Kenyan Medical Laboratory Scientific Officers (AKMLSO) to strengthen the private laboratory system by facilitating development of Labnet. The business model was drawn from the expertise gained from the formation of Pharmnet.

Labnet quickly adopted the franchise network model pioneered by Pharmnet and adapted it to its member independent private diagnostic laboratories.



Figure 2: Imani Laboratory, Eastlands, Nairobi

Labnet is a signal to consumers that the member lab is qualified and licensed; with branding in place, there is now a distinction between licensed and non-licensed practitioners in the market.

PSP4H assisted AKMLSO with the development of the network and the brand, marketing strategy and relevant business skills training.

90 laboratories currently exist in Labnet across 24 Kenyan counties and serving approximately one million patients. The Labnet network continues to grow given its financially self-sustaining design where members pay fees to join the network.

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USAID funded replication of Labnet Kenya in Uganda

Uganda has a largely unregulated private sector with quack labs, drug shops and health providers that operate outside of the health system. Lack of reliable laboratory services results in delayed and inaccurate diagnosis of disease, leading to avoidable mortality, drug wastage and high expenditure for government and individuals. In order to address the issues of weak governance, low barrier to market entry, weak enforcement of quality standards and unscrupulous practices in Uganda's lab sector, USAID's flagship private health sector program, Uganda Private Health Support Program decided to adopt Labnet's network model.

The Ugandan laboratory network drew on the experiences of Labnet in Kenya and AKLMSO agreed to share the Labnet name and branding with its Ugandan counterpart with a goal of achieving a uniform EAC wide identity for qualified labs. Similar to Kenya, Labnet Uganda comprises members of the Uganda Medical Laboratory who operate independent private labs.



Figure 3: UMLTA Medical Laboratory Technologists in Uganda

The shareholding structure has Labnet members in the majority, with minority shares set aside for the possibility of financial investors taking an equity stake. New members are also offered the opportunity to purchase shares. The organization is able to carry out trading activities based on its by-laws. Labnet charges fees to its members; revenues for the Labnet secretariat are driven by the membership fees and margins on pooled procurement of reagents, supplies and equipment. The pooled procurement system is being developed and will be the primary revenue driver and the key to long term sustainability. Labnet Uganda currently has 48 member laboratories with the potential of serving over a million Ugandans per year.

Labnet offers mass market consumers an identifiable place to obtain accurate diagnostic tests at an affordable price with opportunities for standardizing quality and overall better health outcomes for patients.

Given the success of the DFID funded Labnet initiative in Kenya, a USAID programme realizing the potential impact of improving access to affordable and quality medical diagnostic services by networking individual labs, replicated the same model in Uganda. Network synergies are the key to scaling up and networks overlap and can support each other. Labnet complements Pharmnet and it was only a matter of time before PSP4H and the Kenya Medical Association (KMA) began discussions to develop a similar network for consulting physicians called Docnet. Docnet closes the loop on affordable quality primary care from the private sector for low income Kenyans. The development of the Docnet network initially stalled due to transitional changes within KMA, however, the intervention has resumed and the modalities are currently being worked out with PSP4H.

All through PSP4H's implementation period of developing networks from existing aggregates of health professionals, PSP4H continues to share its learnings from pioneering this model with the donor and development communities. It was in one of such forums that the Swiss Agency for Development and Cooperation's (SDC) engaged with PSP4H to find out more about the network model. SDC is actively engaged in low and middle-income countries (in both stable and fragile contexts), as well as in transition countries. The SDC's support for health sector reforms in post war countries is deeply compelling. Its aim: to guarantee access to quality health services for the poorest. It was under this backdrop, the idea to pilot the development of a private sector network of medical doctors in Somalia over an initial period of 12 months was birthed.





SDC funded Caafinet (Doctors network) in Somalia

After the collapse of the Somali state in 1991 the private sector became the dominant provider of healthcare services. Although the international community has been supporting the re-establishment of functioning state institutions, progress is slow and the private sector continues to be the only provider of essential healthcare services. The health sector remains largely unregulated causing concerns over

the quality of care provided and the impact of out-of-pocket payment practices on poor and vulnerable groups. In an effort to alleviate this problem private primary health care providers needed to come together under one brand that offers value to both the consumer and primary healthcare provider. The branding of doctors' clinics is uniquely positioned to attract and signal consumers to access services, in the branded clinics that offer quality healthcare under the brand umbrella.



The 12-month pilot intervention is in the process of enrolling, training and branding 100 medical doctors into the Caafinet franchise network. These 100 doctors will serve an estimated 100,000 patients in the course of one year with access to quality, affordable primary healthcare.

Caafinet belongs to individual qualified medical doctors who are registered and licensed, members of the Somali medical association, operate private practices that serve low-income Somalis and are willing to abide by the network rules. Facility owners are required to pay an agreed membership fee in order to join the network and the fee will be used for various operational costs within the network and to ensure sustainability of the project.

The network increases the chances of business success because healthcare providers are associating with proven products and methods and also offering consumers the attraction of a certain level of quality and consistency because it is mandated by the Caafinet agreement. These changes will enable low-income Somalis to access quality healthcare services and provide better value for money spent on healthcare.

This network of its kind in Somalia, with a current membership of 59, started its operations in Mogadishu and Kisimayu and now it is attracting members from other regions within Somalia and Somaliland.

Beyond Pharmnet, Labnet and Docnet, PSP4H also supported the development of other existing health networks in Kenya- one within the PSP4H intervention portfolio and the other was replicated by a different DFID funded family planning program.

PSP4H's 2014 DFID Annual Review recommended the programme to establish partnership with at least one county government to develop a viable and replicable PPP approach which delivers value for the poor. PSP4H convened officials from eleven county health offices to see how best and in what areas PPPs could be pursued



and Kilifi County was one of the two that showed keen interest and shared mutual objectives. Top on the County's priorities was the improvement of its maternal and child health indicators (MNCH), particularly the increase in deliveries by skilled birth attendants. As a result, the Kilifi County health team decided to pursue community midwifery using PPP model which brought together individual privately practicing midwives providing maternal, newborn and child health services (MNCH) under a network called *Ukunga Bora*. The objectives of the network are to increase the number of women of reproductive age accessing maternal and child health services from

skilled private providers at the community level (antenatal care, delivery and postnatal care) and enhance sustainability of affordable services to lower income groups. PSP4H facilitated the provision of business skills training and follow-up for these midwives which is on-going, clinical training and supervision in collaboration with the County and the technical assistance required to set up a standardized network for midwives providing quality and affordable health MNCH services in Kilifi. *Ukunga Bora* has become a major player in Kilifi backing up the government systems during employee strikes and other shortcomings.



While the *Ukunga Bora* intervention implementation started late, towards the end of phase 2 of the PSP4H programme, a monitoring and evaluation assessment conducted three months after the business skills and emergency obstetric clinical training indicated a 63% increase in the number of general out patients seen while there were no significant changes in the access for the MCH services. The assessment also uncovered that drugs and employee salaries constitute over 80% of total expenditures of these private midwives. As a result, the private midwives under the *Ukunga Bora* network are working towards purchasing their supplies through a pooled procurement model, thereby bringing them cost savings which will enable them provide even more affordable service to the county residents and ensure business sustainability.

In addition to the network model being able to increase access to quality healthcare within a regulated system i.e. the franchise, this innovative model has also been used as a means to ensuring sustainability of private health businesses.



Networking ESHE's Integrated Health Kiosks-DFID funded

DFID's flagship family planning programme, the Enabling Sustainable Health Equity (ESHE) established 60 integrated health kiosks (IHKs) in selected rural sites across 19 counties with the intended impact of increasing the use of modern contraceptive methods.



The IHK is intended to be a 'low cost, high impact' model targeting rural women who previously had limited access to and choice of quality FP methods. The main objective of the IHKs is to increase FP access to rural communities that were underserved, the business model includes other basic healthcare services such as diagnostic, minor surgery and curative services alongside with FP to increase the potential number of clients and balance provider income such as family planning (FP) services alone are insufficient to sustain the business.

In reviewing the sustainability of the IHK business model, of the sample, less than half of the IHKs were moderately or substantially profitable with approximately 20% making a loss. To be sustainable beyond the end of the ESHE programme, overall the IHKs will need to earn higher profits than they are now in order to cover the incremental costs of marketing, training and facility maintenance. As a result, a sustainable business model for the IHKs to remain viable moving forward needed to be developed.

Figure 4: An IHK in Kakamega

Five common success factors amongst the most profitable IHKS were identified:

1. High footfalls (average number of clients/ month)
2. Product/service mix beyond FP (revenue diversification)
3. Marketing and demand creation activities
4. Location in busy marketplace
5. Operated by owner rather than employee

A comprehensive sustainability plan for the IHKs was developed revolving around organizing the existing IHKs into a franchise network to take advantage of synergies offered by aggregation. The business model design was drawn on expertise learned from PSP4H comprising:

1. Formation of the Afya Kwetu branded and registered health network
2. Development and implementation of a marketing strategy for Afya Kwetu

The latter is hoped to increase awareness of the branded IHKs and their acceptance in the community leading to improved up-take of family planning services. Adequate revenue driven by high footfalls would be supported by brand identity and consumer marketing while appropriate product mix both attracting patient volumes and providing adequate margins would be addressed by network operating standards, as would participation of the owner. Business skills would be upgraded through group training and follow ups are currently ongoing to ensure that trained skills are used/ implemented over the next months.

5 Sustainable and replicable development model at hand

Network effects are a route to scale and PSP4H's experience provided by overlapping healthcare networks is proving to be an effective value for money alternative to the conventional 'pilot and scale up' model that is commonplace but seldom actually achieves the desired scale. The figure below shows a map of the existing networks stemming from PSP4H.

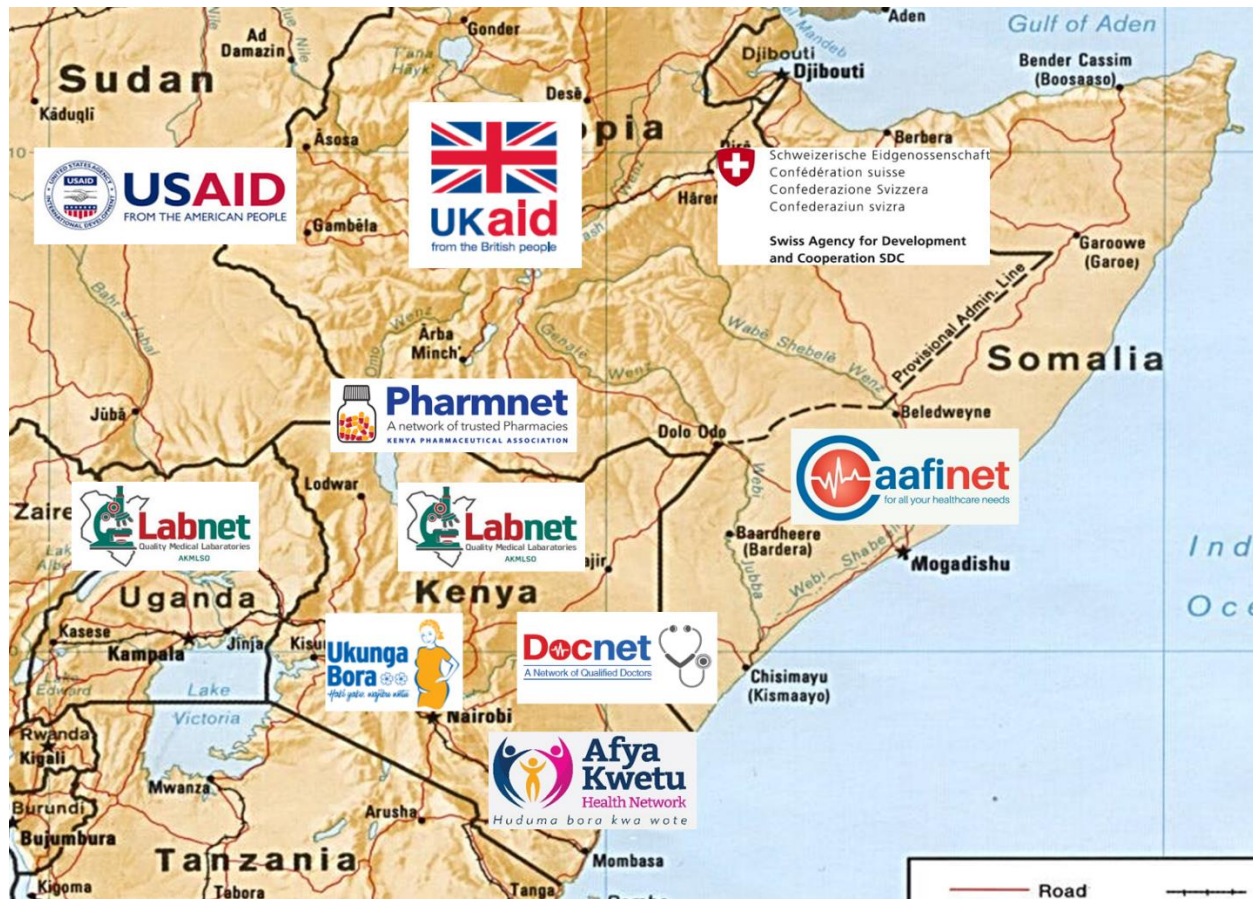


Figure 5: Private sector healthcare networks in East Africa stemming from PSP4H

From the network model replicated across health markets and countries and the interventions cited through the report, it is evident that PSP4H has a sustainable, replicable development model. Some leading private sector firms have even spent their funds to take on PSP4H pilots interventions. One notable example is the case of GlaxoSmithKline Pharmaceuticals Kenya (GSK), with a strong market presence in the pharma space, who used its own resources to size market opportunities identified by PSP4H and re-introduced the same asthma relief product with a better targeted marketing strategy for the target consumer market, Kenya's mass market/low income population.

PSP4H which started in 2013 as an exploratory two year research project with an initial £3.2 million budget through delivery exceeded DFID's expectations and grew into a 4½-year, £4.75 million programme. With the objective to learn lessons of how a market systems approach might benefit pro-poor health interventions, to inform future programming, PSP4H has developed and iterated varying business models which largely account for the innovations seen in the program. PSP4H's experience indicates that partner engagement is a key success factor and is fundamental to programmatic success as the partner create positive change by driving well beyond the research. In the absence of a motivated private sector partner with mutual objectives who desires to engage, invest, and share data, research and analysis alone will yield no results or lessons.

PSP4H's experience has prompted donor agencies, development practitioners, business organisations and governments to look differently at health intervention programming and apply market based approaches to influence health markets in order to harness private sector capacity to deliver pro-poor health services. Based

on the knowledge gained while implementing PSP4H's market-based interventions, donor programming can apply the learnings so more interventions will have the intended impact on the target audience and foster continued learning on how to apply market systems approaches in pro-poor health interventions.

Finally, it is important to note that effective dissemination is critical to innovation uptake. Presenting PSP4H's key programme achievements in compelling digital messages, written stories, blogs and articles to share with external stakeholders can be used to promote advocacy and influence decision-making and policy, shape thought leadership and foster pro-poor interventions. Ensuring learnings from PSP4H is effectively communicated using strategic global and local platforms will add value to the growing evidence that the private sector is a key partner to delivering good health outcomes for low-income populations in Kenya and beyond.