Lessons for Future Health and M4P Programming

Private Sector Innovation Programme for Health (PSP4H)

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PSP4H
PRIVATE SECTOR
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1 Introduction

Governments and development partners increasingly recognise the importance and potential of businesses in addressing the health challenges facing low income populations in East Africa. Instead of seeing the public and commercial health sectors as opposing forces, there is growing interest globally in how one can complement the other. Yet there is little evidence on how best development agencies can work with the for-profit sector to improve the health of low-income segments of the population. Among the United Kingdom Department for International Development's responses to the situation is an action research programme in Kenya to foster better understanding on how the private for-profit health sector can benefit the health of Kenya's working poor.

The Private Sector Innovation Programme for Health (PSP4H) – implemented by Cardno Emerging Markets and consortium partners – utilises a market systems approach known as Making Markets Work for the Poor (M4P). Using the M4P approach, PSP4H works to strengthen the overall healthcare system, increase the private for-profit health sector's capacity to reach the poor1, and measure improved access and quality services for the poor gained through its interventions. The main objective of the programme is to share evidence and lessons learnt with both Kenyan and international health stakeholders on the benefits of this approach for pro-poor health programme design. The programme works on a broad range of health topics, seeking to understand health areas underserved for the poor, namely diagnostics, healthcare finance, low-cost delivery models, maternal health, non-communicable diseases, pharmaceutical supply chain and Public Private Partnerships.

PSP4H reaches the end of its three-year first phase in September 2016. This paper, published shortly beforehand, is the last of three papers capturing lessons learned from the programme's first phase. The first paper 'Lessons Learnt by the Private Sector Innovation Programme for Health – Midterm Report' captured the top ten lessons learned at the programme's midpoint (PSP4H, 2015c). The second paper 'Successes and Failures in Health Market System Interventions: Learnings from PSP4H in Kenya' (PSP4H, 2016a) focused in more detail on what has worked, and has not worked, in the interventions which PSP4H has so far initiated. The current paper focuses on what future M4P-in-health programming can achieve, learning from and building on PSP4H's work so far.

The next chapter is primarily intended for readers unfamiliar with the M4P approach. The chapter explores how an M4P approach can improve poor women and men's health in Kenya. It also explains how M4P programming is different to other development partnerships with private healthcare providers.

Chapter 3 summarises progress to date in action research pilots started by PSP4H, and suggests how future M4P programming could build on each of them. We explore ways that future M4P programming could further strengthen the sustainability of the changes, raising the likelihood that Kenyans benefit from them for decades to come. We also explore opportunities to improve and expand the impact of these changes, so that hundreds of thousands of low-income households across Kenya – perhaps millions – can benefit.

Chapter 4 explores new intervention areas which future M4P programming might address further. The ideas in this section draw on PSP4H action research, wider research on Kenya's health sector, and global M4P experience.

The final chapter shares lessons from PSP4H which can be applied across interventions in a future M4P programme. The lessons in this chapter will interest health specialists, but also M4P programmes working in other sectors.

[1] PSP4H's primary target group involves the 'working poor', the informally employed who have nominal disposable income and largely pay out-of-pocket (OOP) for healthcare expenses. This target low income group comprises more than 83% of employment in Kenya (Muiya, B & Kamau, A. 2013. *Universal Health Care in Kenya: Opportunities and Challenges for the Informal Sector Workers*, International Journal of Education and Research, Vol. 1, No.11)

2 Why an M4P Approach to improving low-income Kenyans' Health?

This section explains why PSP4H has used an M4P approach in its action research, designed to improve health outcomes among low-income Kenyans. The section is structured around three headline premises. The first premise is that businesses make important contributions to poor Kenyans' healthcare. Secondly, market failures prevent businesses from contributing better to poor Kenyans' healthcare. Thirdly, unlike most donor support to private health providers, M4P programmes are designed to address the market failures which make most difference to poor women and men.

2.1 Businesses in Kenya make important contributions to poor Kenyans' healthcare.

Until recently, development agencies' efforts to improve and expand Kenya's health facilities focused almost exclusively on the public and non-profit sectors. Commercial providers of healthcare to low-income Kenyans had been largely ignored or unrecognised.

Yet even for Kenyans living in poverty, commercially-run health facilities play an important role. In Kenya, private hospitals and clinics provided 17% of all outpatient services and private pharmacies another 13% in 2013. People living in rural areas tend to depend more on public facilities for outpatient visits, however private and faith-based healthcare providers play still a very important role (MoH, 2014a, p. 17f). For over 60% of Kenyans, the first point of care remains a kiosk, chemist or pharmacy to purchase drugs for self-medication (PSP4H, 2014b, p. 3).

Low-income Kenyans' usage of private health facilities will surprise some health experts. Particularly as government-owned primary care facilities offer free consultations, whereas for-profit health centres usually charge consultation fees. This raises an important question: why do so many low-income Kenyans make their outpatient visits to private chemists, private clinics and hospitals?

Research by PSP4H and others reveals four main reasons: willingness to pay, hidden costs of "free" consultations, indirect costs of consultations, and perceived differences in quality. Below we explain each of these in more detail.

Many Kenyans are accustomed to paying for healthcare. Together, households' out-of-pocket and insurance payments fund 40% of Kenya's total healthcare expenditures, contributing more than the government (34%) and donor funding (26%) (MOH, 2014b, p. 12). Whilst some of this money is spent by wealthier Kenyans and expatriates buying premium health insurance, detailed qualitative research shows that Kenyans living in poverty also often pay for healthcare (Zollmann and Ravishankar, 2016). PSP4H research finds the same, the poor spend significant amounts of their scarce incomes on health care (PSP4H, 2014c).

Even at Kenya's government-run health centres, hidden costs are common. A 2014 PSP4H survey found that, whilst consultation fees have largely been eliminated, government primary care facilities often charge patients informally for consumables like cotton wool and gloves. Equally, public facilities often run out of medicine and patients are forced to acquire the medicine outside the public facility (PSP4H, 2014d, p. 17).

For low-income Kenyans, the indirect costs of healthcare often matter even more. In some areas, the transport and opportunity cost[2] to reach the nearest government health centre is higher than the consultation fee charged by nearer, commercial sector clinics. Families may therefore opt for private clinics to save money and time. Other common reasons include shorter waiting times, longer opening hours, better customer care and access to medical supplies unavailable in public facilities[3] (PSP4H, 2014d).

[2] Opportunity costs such as losing incomes during waiting time or the duration of illness.

[3] According to Zollmann and Ravishankar (2016), 'The perception of high costs of care – along with the opportunity costs of long waits and indirect costs like the cost of transportation – come through in a 2014 study led by the Strengthening Health Outcomes through the Private Sector (SHOPS) Project as the most important reasons that informal sector workers earning USD 5–15/day in Nairobi were forgoing care. More than 70 per cent of their 359 respondents reported the costs of care as a key barrier to accessing healthcare, more than 60 per cent cited long waiting times, and more than 40 per cent reported transport costs as a barrier (Munyua, 2015). The KHHEUS found that 86 per cent of patients incurred some kind of transport cost for their facility visits, with the average round trip cost being Ksh. 143, often more than the cost of treatment

A final factor, mentioned often, is quality. Patients opt for private providers if they perceive that these providers offer better advice or access to medicine. Kenyans generally rate private health providers higher than public ones, in terms of satisfaction with service and facilities (IHME, 2014).

The research on patients' preferences reveals an important lesson: to successfully serve low-income Kenyans, private health facilities must complement public sector health providers. Unable to compete on price with government-run primary care, independent healthcare providers must instead compete on quality or specialise in filling specialisation gaps in public provision[4].

In doing so, independent healthcare providers contribute towards Kenya's universal health coverage objectives. They also help to relieve congestion in government health facilities.

Until now we have focused on the businesses which operate healthcare facilities serving low-income Kenyans. Businesses in Kenya also play a range of other roles in Kenya's health sector. For example, Kenyan and international companies manufacture and distribute medicines and medical equipment, offer health insurance, train health workers and operate laboratories. In other words, Kenya's commercial sector not only directly provides healthcare; Kenya's businesses also supply products and services which support government, civil society and other firms to deliver healthcare.

2.2 Market failures prevent businesses from contributing better to poor Kenyans' healthcare.

The last section described how the commercial sector delivers and supports healthcare to low-income Kenyans. This section describes how Kenya's commercial healthcare could improve, benefiting Kenyans on low incomes. We also describe how business providing vital support services such as health worker training and medical insurance could improve.

Our findings in this section are based primarily on research by PSP4H, triangulated where possible with other sources. As part of its research, PSP4H conducted focus group discussions with 509 working poor men and women, and health workers. The programme also interviewed health officials, health facility managers and other sector experts.

Below we outline several of the major health system-wide constraints identified which prevent private healthcare providers and support services from serving poor Kenyans better (PSP4H, 2014d).

Lack of business and financial management skills: Many operators of small, independent practices lack the basic tools and skills to manage cash flow or analyse costs or profits. This can prevent them from accessing credit to operate and expand their services. Meanwhile, poor stock control can lead to wastage and to medicines becoming locally unavailable. Many providers also report that they lack marketing skills, meaning that prospective patients remain unaware of the type and quality of services they offer.

Crowding out by donor subsidies. Donor subsidies can create unfair competition. Free products are frequently "dumped" on the market, leaving the commercial sector unable to sell unsubsidised stock. Subsidised medical supplies and grants for capital expenditure are also routinely given to favoured private providers. Here, well-connected healthcare providers are the ones which prosper, even if others would perform best without the unfair competition.

Lack of information. There are persistent problems of poor communication and information sharing. On the public sector side, the Ministry of Health struggles to motivate the private health sector to regularly report its activities to the ministry's health management information system. On the private sector side, key constraints include exclusion from government policy and planning processes, and exclusion from clinical training organised by government agencies. The latter makes it harder for private healthcare practitioners to update and improve their medical knowledge.

Counterfeit drugs. In March 2011, the Kenya Association of Pharmaceutical Industry (KAPI) estimated that counterfeit medicines accounted for approximately Ksh 9 billion (USD 100 million) in sales annually. This

itself. IHME's survey reported much less frequent spending on transport, with only 45 per cent reporting transport spending, with a similar average spend of Ksh 164.'

[4] The *2010 Service Provision Assessment* also found that private health providers tend to provide narrower, more targeted services; whereas their public sector counterparts tend to offer more often comprehensive service packages. (NCAPD et al., 2011, p. 32)

figure corresponds to between 20 - 25 percent of the total legal commercial pharmaceutical market (Daily Nation, 2011).

Access to finance: In general, larger hospitals and pharmaceutical manufacturers have access to formal credit. However, smaller facilities and solo practitioners – the private provider group most likely to serve the poor – cite access to finance as a major constraint. This, in turn, is partly caused by one of the constraints cited above – their lack of business and financial management skills (Calvert Foundation & Duke University, p. 15). Lack of access to credit limits private provider capacity to expand services and invest in quality improvements.

High regulatory costs. To operate legally, pharmacies and health centres require multiple licenses and must negotiate a myriad of government departments to get them. Private pharmacies and health centres also receive inspections from several different regulatory agencies. The system creates confusion and is costly and time consuming. Private providers also complain of government inspectors seeking bribes.

Weak enforcement of government rules: Quality in the private health sector, still a major concern, can be significantly improved through a combination of better enforcement and incentives. The Ministry of Health has many of the instruments in place but has underinvested in capacity to enforce standards and norms.

Competition with informal providers. The Kenyan Pharmaceutical Association estimates that there are 12,000 unregistered pharmacies in Kenya, three times more than registered pharmacies. Registered pharmacies consistently reported that unlicensed facilities and/or illegal workers in the informal sector represent one of the most difficult areas of competition. Such facilities offer lower wages, and often lower prices, than licensed pharmacies which employ qualified personnel.

2.3 M4P programmes prioritise the market failures which make most difference to poor women and men's health

The last section described major constraints which prevent businesses from contributing better to poor Kenyans' healthcare. This section describes the advantages of addressing these constraints using an M4P approach.

Inclusiveness: recent private-sector-in-health programmes have attracted criticism as they treated private provision as an end-goal neglecting the pro-poor focus of service provision (Oxfam, 2014). PSP4H is different – the programme has worked with healthcare providers that are already committed to serving Kenya's working poor. Partnerships have focused on improving providers' performance in areas which have demonstrable benefits to poor women and men.

This is consistent with M4P guidance. To choose where to intervene, M4P programmes generally start by understanding which constraints within the system (in this case, the health sector) have the most impact on poor women, men and children. Next, M4P practitioners diagnose the root causes of these constraints, looking for viable opportunities to make the (health) system work better for the poor (Springfield Centre, 2015).

Improving performance across the health sector: most private-sector-in-health programmes have focused on the problems and performance of individual healthcare providers or franchisors. This limits their impact. With development agency support, an individual provider or single franchise network may expand or improve their performance. It appears very rare, however, that support limited to individual providers improves performance in the wider health system[5].

In contrast, M4P guidance recognises that innovations rarely spread automatically or accidentally from one business to another. So, after helping a particular business to test a new innovation, M4P programmes should

[5] We are unaware of any systematic review of development agencies' support for individual social franchisors, health commodity distributors, or healthcare providers. One study – 'Strengthening health systems in developing countries through private investments' – mentions that 'it is hard to find [any business model] at scale' and 'For innovations focused on serving rural populations, we haven't seen many scalable / viable business models; we don't see many pan-country models with large impact' (Calvert Foundation and Duke University, 2015). In addition, the authors of this paper have consulted with several health and market development experts working in East Africa and beyond on this topic. Feedback consistently supports the idea that innovations rarely spread beyond the businesses receiving direct programme support, unless a conscious effort is made by the programme to do support the diffusion of such innovations. Where programmes give grants or technical assistance to businesses operating within the health sector, it is worth remembering that these businesses have disincentives to help their competitors to adopt the innovations they have introduced with programme support.

actively support and persuade other businesses to adopt it (Springfield Centre, 2015). This focus on sector-wide, systemic change helps to make competition fairer and gives consumers greater choice. More importantly, if several companies improve how they serve the poor, instead of just one company, the impact will be much greater. This impact is also likelier to last; the innovation introduced no longer depends on a single business to keep it going.

Partnering with government and business to make the health system work better. M4P programmes achieve more when they recognise the roles played by governments, as well as businesses and civil society, in making sectors work better for the poor. This is equally the case in Kenya's health sector; national and county governments play important roles. Firstly, under Kenya's devolved constitution, county governments are healthcare providers. Secondly, governments also perform a range of other roles which affect how well independent healthcare providers serve low-income Kenyans. For example, government agencies can remove counterfeit and sub-standard medicines from the market, promote adherence to public health guidelines among private providers, and provide information which helps patients to make informed choices about their healthcare.

To make the overall health sector better, an M4P programme can assist government agencies to strengthen their performance of these roles. Indirectly, there is a potential for M4P programmes to help government health centres and hospitals to perform better. An example in the next section from Kisii shows how an M4P programme can support public hospitals to use commercial advisory and training providers to improve customer service and staff satisfaction.

Sustainability: A common mistake in health programmes is to view problems simply as either a lack of funds, or a lack of capacity. M4P programmes assess partners' capacity, but also their *incentives*, to take responsibility for adopting, continuing and investing in changes introduced. M4P programmes are expected to monitor interventions' progress towards sustainability and adapt interventions if things go wrong.

Flexibility in how to intervene: As described the last section, a county's health system can face different constraints. These constraints can lead businesses to underperform in a wide range of ways. Whereas many programmes only have one type of instrument to deal with the multitude of constraints (e.g. a programme only gives grants, or only gives technical assistance), M4P programmes typically tailor their choice of intervention activity to the problem they seek to address.[6]

Consistent with this view, the constraints in Kenya's health system which PSP4H has encountered have been caused by a wide range of factors. Where the programme has succeeded, it is partly by using intervention tactics that fit the type of market failure they are addressing[7].

The next section gives more detail on the action research interventions which PSP4H has pursued. A separate PSP4H paper examines comprehensively the successes and failures of the first phase; the next section focuses on the interventions which PSP4H wishes to take forward. We analyse and suggest what could be done to build on these interventions, with future M4P-in-health programming.

[6] As well as grants and technical assistance, other options include market research and analytics; introducing organisations to each other and brokering and mediating partnerships between them; persuading organisations to try new ways of working by presenting evidence; organising visits to places where the desired change is already underway; mentoring; seconding staff to a partner organisation; partially guaranteeing loans to a partner organisation; and investing directly in the organisation through a bond or equity.

[7] For example, to address information and skills shortages, PSP4H has commissioned market research, guided business modelling, offered mentoring, or advised on marketing and strategy, as appropriate. Where relationships have been lacking, programme staff have brokered and fostered relationships among businesses, or between businesses and government agencies.

In contrast, programmes which only offer grants can usually only sustainably address market failures caused by the risk arising from temporary uncertainty over the success of a new innovation. Even then, grants are only appropriate in some circumstances – such as when sharing the cost of "learning by testing" a new business model offers better value for money than additional market research or technical advice for business model design. More often, however, programmes give grants to private enterprises for other reasons, such as a desire to spend the budget they have been allocated. In such cases, grants almost always fail to sustain change. This is because the underlying reasons why the grant recipient did not make the desired change before receiving the grant remain unaddressed

3 Advancing Existing Interventions

This chapter summarises progress to date in six action research pilots started by PSP4H, and suggests how future M4P programming could build on each of them. We explore ways that future M4P programming could further strengthen the sustainability of the changes, raising the likelihood that Kenyans benefit from them for decades to come. We also explore opportunities to improve and expand the impact of these changes, so that hundreds of thousands of low-income households across Kenya – perhaps millions – can benefit.

3.1 Introducing health insurance and savings products to Kenya's informal sector

Summary of progress so far: Unable to access enough cash when needed, many low-income Kenyans delay or forego essential healthcare. Whilst waiting to gather enough cash for treatment, millions of Kenyans see their health deteriorate; many thousands die8.

There are opportunities to change this. Kenyans could save for, or insure against, future healthcare needs before they arise. Yet the uptake of health insurance and savings schemes is low; only 17% of all Kenyans are covered9 and coverage of the poorest quintile remains extremely low at 2.9 percent (MOH, 2014a, p. 54).

Informal sector workers are particularly unlikely to buy health insurance. They cite cost, complicated registration procedures and past experiences as key reasons. Many also feel that the state's national hospital insurance privileges formal sector workers (Zollmann & Ravishankar, 2016, p. v).

PSP4H has helped to launch a health insurance and medical savings product which seeks to overcome these barriers. Both the product's design and its marketing are tailored to the needs of Kenya's informal (Jua Kali) sector. The product, AfyaPoa (Cool Health) is marketed by Jawabu Empowerment Holdings, a Kenyan firm specialising in financial services for Kenya's informal sector workers10.

AfyaPoa also allows Jawabu and PSP4H to test a research hypothesis. Recent research has suggested that low-income Kenyans are reluctant to set aside money to cover likely, future health needs; poverty instead leads low-income Kenyans to prioritise immediate, definite needs (Zollmann & Ravishankar, 2016). If AfyaPoa were to attract large numbers of customers, it would challenge this hypothesis. It would though make the case for health insurance being an appreciated and demanded risk mitigation strategy of the poor.

Initially, Jawabu is targeting AfyaPoa at a specific sub-set of informal workers: market traders on low to middle incomes in densely populated commercial zones. Market traders buy insurance premiums which cover their costs of inpatient treatment. One year's premium costs Ksh 5,000, with a waiting period of one month before a customer is eligible to claim. To enhance affordability, customers pay just 20% of the total premium up-front. The remaining Ksh 4,000 is paid in daily instalments of Ksh 40. Customers can also add family members to their insurance policy for an extra annual premium of Ksh 1,000 per person.

The new insurance product is linked to a voluntary savings scheme, which customers can use for outpatient health services. The idea is that whenever a customer or family member suddenly falls sick, they have money set aside for treatment.

Acquiring the insurance is easy. Jawabu chooses well-known Jua Kali artisans in target marketplaces and trains them to sell the insurance package to their peers. If a customer wants to subscribe, the sales agent will open a client account by mobile phone and link the customer to a mobile money platform, through which the client will pay the instalments, store savings and register claims.

[8] In the 2013 Kenya Household Health Expenditure and Utilization Survey, 12% of sick people reported not having sought treatment when needed. The number of Kenyans with unmet health needs however vary significantly among different districts. Other studies mention significantly higher numbers of Kenyans with unmet healthcare needs, particularly when taking into account those who delay treatment. In the 2012-2013 *Kenya Financial Diaries* study, 59% of urban Kenyan households and 29% of rural Kenyan households reported not seeing a doctor or taking medicine when needed, at least once during the past year (MOH, 2014a / Zollmann and Ravishankar, 2016).

[9] The 17% figure is from Republic of Kenya Ministry of Health (MOH, 2014a). During the course of the Kenya Financial Diaries study, only 15 per cent of households had any kind of health insurance coverage. (Zollman & Ravishankar, p. 18).

[10] The programme conducted market research to inform product design, trained sales agents involved in the pilot, and helped to train staff from participating hospitals in how to administer insurance claims.

Furthermore, Jua Kali associations and their members play a key role in the distribution network. Although they are in the informal sector, Jua Kali groups are well organised and offer access to up to 8 million Kenyan workers (PSP4H 2016b).

Jawabu began to test AfyaPoa in December 2015, in a marketplace in Nairobi which hosts about 3,000 traders; 817 policies were sold in the first five months, exceeding expectations11. When traders' family members are included, these policies cover 2,438 individuals. Jawabu now plans to introduce AfyaPoa in marketplaces across Nairobi. For this expansion, the company will engage further relationship managers to train and manage community sales officers and agents in each of these new marketplaces, to educate informal sector workers on insurance as a risk mitigation measure, and to promote its health insurance. Jawabu targets selling 15,000 AfyaPoa policies in 2016. Meanwhile, Jawabu continues to work on product improvement, and is taking steps to further reduce its risk exposure12.

If demand for AfyaPoa successfully grows, complementary PSP4H pilot interventions will help Jawabu to serve its growing customer base. Several programme partners (Pharmnet pharmacies, Labnet medical laboratories and Docnet primary care practitioners could offer AfyaPoa customers access to their ready-made healthcare provider network. Afya Poa has already set-up partnership with Pharmnet and Live well clinics.

Opportunities to build on the action research: as Jawabu tests AfyaPoa on a larger scale, the insurer will need to monitor and continue to understand its customers' satisfaction and loyalty. Jawabu can take steps to improve customer loyalty, by ensuring that claims are promptly addressed, clients clearly understand the terms of the insurance and that they continue seeing value in the insurance even if they do not have claims (e.g. no-claim benefits)13. A future programme could potentially help Jawabu to succeed in these areas, with advice and support.

If AfyaPoa proves successful, Jawabu might also benefit from technical assistance in adding optional features to the insurance. For example, for an extra fee, AfyaPoa customers could in the future gain insurance coverage for emergency optical or dental treatment.

To benefit Kenyans on a large scale, a future programme may need to assist Jawabu in finding additional working capital to finance its expansion. New staff will need to be hired to manage a growing network of sales. Jawabu may also need to invest in its capacity to forge partnerships with additional clinics and hospitals, helping new and more rural business partners to set up systems to submit claims.

If Jawabu succeeds commercially, a future programme could play an important role in persuading other insurers and brokers to start offering similar products. New health insurance offers would give low-income Kenyans greater choice. The number of informal workers able to access micro-insurance might grow faster too, as new entrants target different counties and under-served groups.

Finally, a future programme would add value by monitoring the Government of Kenya's plans to enrol more informal sector workers in the National Hospital Insurance Fund (NHIF). A rapid growth in the uptake of this publicly subsidised health insurance could reduce demand for private health insurance among informal sector workers. At a minimum, it would force private insurers to differentiate their offer to low-income Kenyans. For example, insurers might start selling supplemental coverage to NHIF policyholders, giving them access to health services not covered by their NHIF policy (Slootweg, 2016). Conversely, a rapid uptake of AfyaPoa might put pressure on the NHIF to upgrade its offering to stay competitive.

3.2 Improving independent clinics and pharmacies' management and marketing

Summary of progress so far*:* PSP4H's action research with low-cost pharmacies and clinics has revealed useful insights into what prevents them from better serving more low income Kenyans.

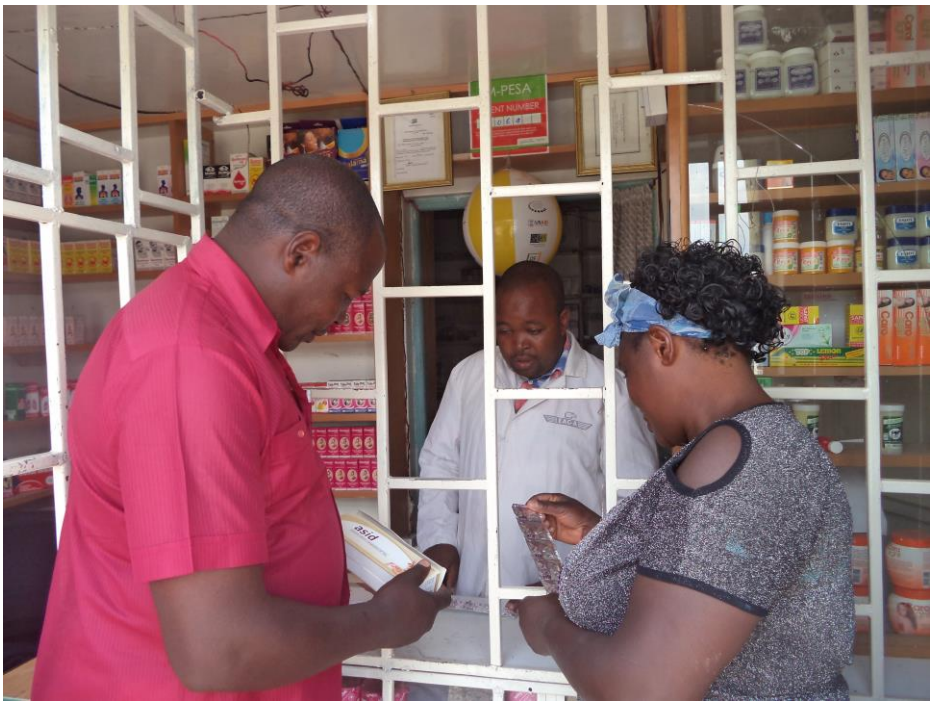
PSP4H, in its interactions with clinic and pharmacy staff across Kenya, has consistently found a shortage of business and management skills. Micro, small and medium health businesses often experience difficulties in

[11] Jawabu had targeted 10% market penetration for the pilot.
[12] Jawabu is looking into improving the technical side of the insurance transaction (the mobile application) as well as the policy side, to perfect its business model. Furthermore, ideas around further enhancing the product are developing, for example add-ons to current insurance policies.
[13] Low levels of understanding about insurance, and mis-selling of products by agents, have been major hampered other ventures selling insurance to low-income households. See for example Craig Churchill and Michal Matul (eds.) *Protecting the poor: A microinsurance compendium, Volume II*. Geneva: International Labour Organisation

managing cash-flow and inventory, marketing, financial planning, and in offering adequate customer service. In Kenya, past efforts to provide management training to healthcare professionals have tended to be donor-dependent and unsustainable[14].

PSP4H therefore trialled clinic and pharmacy managers' willingness to pay to improve their business and management skills. PSP4H found that many of targeted operators of independent pharmacies and clinics value business skills training enough to pay for it[15]. By trialling business skills training, PSP4H also confirmed its relevance and applicability to such businesses. In a follow-up survey, 80% of trainees reported applying learning from the training to make improvements in their businesses (PSP4H, 2016a, p. 12). Meanwhile, most clinic and pharmacy owners found other management courses available in Kenya too costly, impractical and academic.

Among the business skills most in demand among independent healthcare providers is marketing. PSP4H's consultations with micro, small and medium health providers reveal that most struggle to cost-effectively market their services to low-income households very challenging. Facility managers have little knowledge about developing and implementing marketing strategies and have very limited funds to test such.



PSP4H ventured into supporting a few marketing strategies pilots tailored to different types and sizes of businesses, targeting the Kenyan mass market to increase footfall[16]. Whilst the results of these pilots are mixed, they give good insights into which marketing models might work in future, how to develop effective marketing strategies and tactics, and gaps in healthcare providers' business models inhibiting effective marketing to low-income customers.

Opportunities to build on the action research*:* PSP4H has demonstrated the need and demand for business skills training among Kenya's low-cost independent health providers. The programme has started to look for interested suppliers. AMREF Health Africa, which is opening a training institute targeting Kenya's independent midwives, is one. AMREF, which intends to run the training institute as a sustainable business, is working with PSP4H to adapt and add the business skills curricula to its offer[17]. Brainland Consultants, which delivered the initial course on behalf of PSP4H, has also expressed an intention to continue offering the course, as a business.

If these interested service providers do commercially offer management training for independent clinics and pharmacies, a future programme would probably want to monitor how well they perform. Short-term programme assistance might be needed, to help these service providers improve how they market and deliver their courses. Equally, a future programme would probably add value by finding further institutions willing to

[14] A list of health management courses offered in Kenya, in recent years, can be found in Jacinta Nzinga, Lairumbi Mbaabu and Mike English. 'Service delivery in Kenyan district hospitals – what can we learn from literature on mid-level managers?' *Human Resources for Health*, 2013, 11:10.
[15] The training focused on cash-flow management, inventory management and customer relationship management. With the help of a trainer, on completion of the training participants prepared individual business work plans, applying classroom learning to their businesses.
[16] See also following interventions: LiveWell, City Eye Hospital, Jacaranda Health, Tanaka Nursing Home, GSK: http://www.psp4h.com/interventions/
[17] AMREF intends to achieve commercial sustainability by offering courses which nurses willingly pay for.

deliver the curricula PSP4H developed, or similar content. For example, medical professionals' associations might be interested in offering business skills short-courses to their members.

A future programme could also add value by sharing PSP4H's lessons on marketing health services to low-income Kenyans. Ideally, business skills trainers could then teach pharmacy, clinic and laboratory owners these lessons, as part of their courses. In the long-term, this will be more sustainable than if a future programme gave marketing expertise directly to independent healthcare providers[18].

To support the emergence of suitable training providers, the programme may have to test further which types of trainer are best suited to offering business skills courses for clinic and pharmacy managers. Trainers will need to offer a service that is affordable; appropriate for adult education; relevant to the healthcare sector; available in convenient locations; and available at times convenient for clinic and pharmacy managers. As well as classroom based short courses, the programme could explore distance learning options – often the cheapest form of capacity building and the most appropriate for providers working in remote areas.

As a second step, the programme could provide temporary, catalytic assistance to training providers, to expand the number and diversity of business skills courses on offer to clinic and pharmacy managers. Only if a sustainable, commercial supply of business skills training emerges, will clinics and pharmacies across Kenya access the business skills and knowledge they need to serve their customers better.

Thirdly, a future programme could look at the feasibility of including healthcare management content in the diploma and degree curricula for different clinical disciplines; see the next chapter on health skills and education for further reflections on this.

3.3 Improving independent midwives' services through their inclusion in county hospitals' midwife training

Summary of progress so far: In Kilifi County, 31% of births happen without a skilled midwife, delivered by traditional birth attendants, family and friends, or mothers alone. The number of stillbirths and deaths of new-born children in the county remains high. Kilifi's county government is trying to change this, targeting an increase in the proportion of births attended by a skilled provider from 69%[19] to 75% by 2017.

Community midwives are doctors, clinical officers and nurses who help mothers give birth safely in areas or circumstances where hospitalisation is not an option. Recognising community midwives' importance, leaders of Kilifi's county government and its main hospital wanted to work closer with community midwives. County health managers wanted to supervise the quality of deliveries, antenatal visits and postnatal care by these independent midwives. Moreover, county officials wanted community midwives to contribute to their data gathering around maternal and child health, to be able to monitor the county's progress towards reducing unskilled deliveries.

PSP4H has helped Kilifi county government to start negotiations with a local network of private community midwives committed to improving their skills and service. The community midwives network was willing to expand outreach and engage in dialogue with the public sector to improve maternal and child health (MCH) services. PSP4H brokered the link between the county hospital and the midwife group and supported the county to formulate a collaboration package that is appealing to the midwife group. The package includes:

- Inviting private midwives to the public sector's clinical training. Until now these clinical trainings have only been available to midwives working at County-run hospitals.

[18] The UK aid-funded Kenya Markets Assistance Programme has trialled a similar approach with agro-input retailers. The programme persuaded marketing experts to sell their expertise to agro-input retailers. The programme initially shared the costs of hiring local marketing experts with interested agro-input retailers. In pilots, agro-input retailers which hired marketing expertise improved customers' experience, and this had a positive knock-on effect on sales. Nonetheless, other agro-input retailers' willingness to pay for marketing expertise remained modest. One hypothesis is that many of these small, independent businesses were only aware of the full value of marketing expertise after receiving it. A second hypothesis is that a shortage of working capital was the biggest constraint that these enterprises faced; paying for marketing expertise would drain their working capital. So that, even if they attracted more customers with improved marketing, they would lack the working capital needed to buy extra stock to serve these additional customers. A third hypothesis is that the retailers were aware that many non-governmental organisations offer free training sessions periodically. So, enterprise owners were waiting for a free training session, instead of paying to receive advice immediately.
[19] This data is from the county hospital Kilifi. However, the KDHS 2014 mentions that only 52 % of skilled births are assisted by skilled midwives.

- The midwives network gaining a seat on the Maternal and Child Health Stakeholder Committee at the county's main hospital.
- County hospital midwives supervising and conducting quality assurance of community midwives.
- Community midwives accessing equipment, supplies and medicines for pregnant women via the county hospital.
- County hospital and community midwives conducting combined medical outreach programmes.

PSP4H has supported the community midwives to respond to this offer from the county government. With technical assistance from the programme, the community midwives have clarified the mission, vision and procedures of their group. The group aims to become a countywide network, with all members adhering to minimum professional standards. To maintain the functioning of the group and standards, the association has introduced a membership fee, which twenty eight Kilifi midwives have so far paid. PSP4H has contracted a marketing agency to create a brand and logo for the association. A clear brand should make it easier for pregnant mothers to differentiate between skilled and unskilled midwives. Finally, PSP4H funded an initial round of business skills trainings for members. Whilst there is a risk of this creating dependency, the programme hopes to demonstrate the value of such training so that midwives are willing to pay themselves, in future.

Opportunities to build on the action research*:* next, the programme will verify if Kilifi County Hospital does start including independent midwives in its clinical trainings, and budgeting for this accordingly. Equally, the programme will monitor if the County Hospital's midwives conduct the supervisory activities planned[20].

Over time, it will be important to monitor midwives' satisfaction with the training, as well as with their association's standards and services. Likewise, a future programme should gauge county officials' satisfaction and intent to continue their partnership with independent midwives. The programme can then use this feedback to understand the partnership's sustainability gaps.

The county government, with programme support, can assist the midwives network to expand within Kilifi. Initially, the training will take place at Kilifi's referral hospital. Some Kilifi community midwives will find the transport costs of reaching this training venue prohibitive. Thus, county health officials are considering using sub-county hospitals much more in the collaboration with the midwives. For example, sub-county hospital staff could: train community midwives and use sub-county hospitals as venues, to bring the training closer to midwives across the county; take responsibility for collecting data from independent midwives; and supervise community midwives in their catchment areas.

A longer-term objective would be for the County Government to include Kilifi's traditional birth attendants in its partnership. In Kilifi County, traditional birth attendants deliver 11% of babies, whilst an even bigger proportion is delivered by family and friends (MOH, 2014a, p.131). Training from qualified nurses and doctors could improve their practices, and raise the likelihood of them identifying pregnancy complications which require a hospital referral.

Finally, a future programme could also advise on how independent midwives can best share data with county health officials. Being able to receive data from remote areas of Kilifi was an initial driver for the County Government to partner with community midwives. However, midwives' remoteness and dispersion will require technological solutions and training, to make data collection reliable and timely.

If the pilot described above succeeds, a future programme would naturally consider how the model can be adopted on a larger scale, in counties beyond Kilifi. Currently, there is no national association representing the interests of private midwives. The programme would need to consider who is best suited to form midwives' associations in counties where they do not already exist. To avoid creating dependency on the programme, this might be a role taken up by county governments. Alternatively, by businesses which supply midwives with ancillary products.[21]

[20] Given that the County Government's trained midwives are already busy performing their existing duties, the County may need to allocate extra resources to make the supervisory visits possible.

[21] This model has been pioneered by the for-profit arm of DKT. In Indonesia DKT serves more than 6,000,000 couples with a wide range of family planning alternatives. Its core distribution network involves 40,000 midwives that it trains to deliver affordable contraceptive and reproductive health products. DKT has business franchise agreements with more than 4,100 of the midwives; franchisees are supported with additional information and promotional materials to increase their service quality and delivery.

A future programme could also use learning from the pilot to explore where else Kenyans' health outcomes could be improved, if public and private sector healthcare providers share training resources.

3.4 Improving customer service in public hospitals by involving professional trainers

Summary of progress so far: Customer care and patient treatment is often poor in Kenyan's public hospitals (Abuya, 2015). Incidences of verbal and physical abuse and patient neglect have been increasingly reported in recent years (KTN Report, 2013 and 2015).

In 2014, Kisii county leaders were concerned about the performance of the county's main hospital. Kisii's County Health Executive and managers at the County's Teaching and Referral Hospital experienced daily complaints about patients' treatment and customer care.

Overhauling customer service at the hospital would be a major task, however. The Kisii Teaching and Referral Hospital serves a catchment area of 1.5 million people and sees two hundred new admissions and four hundred outpatients every day.

PSP4H is helping Kisii County Government to attempt to transform customer service at the hospital. Instead of intervening directly and unsustainably, the programme has sought to create a sustainable solution: local customer service experts offering professional advice to county governments' health services. If successful, this model could cost-effectively drive continued improvements in hospitals' customer service, across Kenya.

PSP4H first commissioned research with hospital staff and patients, to understand the root causes of the hospital's bad customer service. The research revealed a lack of motivation, caused in part by staff feeling unvalued and gaining little recognition when performing well. Customer service skills gaps were also identified.

PSP4H hired Brainland Business Consultancy Ltd, local specialists in business skills training. Brainland developed one and two-day training courses, as well as a customer service manual for the hospital. The hospital invested in-kind, by covering staff costs to attend the training and by organising staff schedules to keep the hospital running whilst the training took place; 617 hospital staff and managers have been trained.

Importantly, PSP4H and Brainland are also assisting hospital managers in developing a customer care policy for the hospital. The policy is expected to lead to several major changes in how the hospital is managed. These include the creation of forums for staff to give feedback to managers, an employee reward and recognition system, follow-up customer service training, and better processes for gathering patient feedback. The hospital has set up a taskforce to oversee progress, with the power to allocate further resources[22].

Opportunities to build on the action research*:* Part of the learning from this pilot will be to understand what works and does not work in improving the public hospital's customer service. Early, informal feedback from clients, staff and management is positive about the effects of the training on customer service; PSP4H plans to conduct more interviews to verify this.

If the pilot demonstrates that local consultancy advice can improve hospitals' customer service, a future programme could help firms like Brainland to expand their commercial offer to other counties' public facilities. For example, a future programme could encourage other counties' health departments to invest in customer service expertise, share the cost with the first few willing counties. This will provide an opportunity to test counties' own willingness to pay for customer service expertise, which is necessary for their access to this expertise improvements to become sustainable.

A future programme could also examine, more broadly, the markets for other support services to public hospitals. This would mean identifying the areas in which large numbers of public hospitals tend to underperform, then assessing which of these tasks hospitals could perform better by accessing expertise from local businesses and universities. A future programme could also monitor the implementation of reward and recognition schemes and their effects on hospital efficiency and customer service.

[22] During the implementation phase, the hospital's board of directors decided that the management and corporate governance structures were suboptimal, leading to high costs and a shortage of consumables. A Chief of Administration was hired, working alongside the CEO. It is expected that this change will support the implementation of the customer service policy and further increase the hospital's overall efficiency.

3.5 Helping Kenyans to avoid unqualified pharmacists and fake medicines

Counterfeit drugs are thought to be widespread in Kenya. So too are pharmacies and drug stores with unqualified staff. Experts estimate that about 12,000 informal pharmacies exists, three times more than official ones[23].

One reason why counterfeit medicines and unqualified providers continue to thrive is that customers find it hard to differentiate between genuine and fake pharmaceuticals, and between qualified and unqualified pharmaceutical personnel. Unqualified drug shop staff, and vendors of fake medicines, can take advantage of this information failure, offering lower prices to price-conscious Kenyan consumers.

PSP4H is helping the Kenya Pharmaceutical Association (KPA), which represents Kenya's pharmaceutical technologists, to introduce a brand and set of services called 'Pharmnet', which could change this[24].

To participate in 'Pharmnet', pharmaceutical technologists must fulfil certain criteria. Their qualifications and the pharmacy they operate must both be government-recognised. Members should also adhere to Pharmnet's own quality guidelines; KPA has started inspecting Pharmnet member pharmacies to verify compliance and plans to inspect each on an annual basis (Kenya Pharmaceutical Association, 2016).

Pharmacies that meet these criteria can use the 'Pharmnet' brand on their shopfronts. With programme support, a Pharmnet logo has been developed and adopted. The Pharmnet brand is intended to help consumers identify a pharmacy that stocks genuine medicines and is staffed by qualified professionals.

As of May 2016, 323 pharmacies have joined Pharmnet and paid franchise fees. So far, 250 of these have invested their own funds, alongside PSP4H support, to pay for their shops' re-branding. KPA expects 150 more pharmacies to be branded by September 2016[25]. The investments made by pharmacy owners show that many are optimistic about the brand. If customers see the Pharmnet brand as a sign of high quality medicines and medical advice, Pharmnet members hope that more Kenyans will choose them over unlicensed providers.

KPA is also piloting a pooled procurement system for Pharmnet members through a for-profit subsidiary, Nairobi TechPharm. One aim of this pooled procurement is to help member pharmacies to source pharmaceuticals from trusted sources. Pooled procurement was also intended to reduce prices, although at the time of writing the volumes being procured were too small to achieve savings. In May 2016, 70-100 pharmacies had begun buying pharmaceutical through KPA's pooled procurement system.

Some distributors see Pharmnet's bulk procurement operation as competition. Whereas before, distributors sometimes supplied pharmacies directly, Pharmnet is encouraging pharmacies to order through them – and asking manufacturers and distributors to offer KPA medicines at lower prices. This price reduction allows Pharmnet to make a small margin to cover the cost of its bulk procurement operations whilst offering pharmacies the same medicines at the same price or lower.

Pharmnet and PSP4H hoped that distributors and manufacturers would be willing to sacrifice margin and collaborate on logistic infrastructure in order to widen their distribution channels and sell higher volumes, as Pharmnet's brand increases their sales of genuine medicines, displacing fake medicines. Whilst 'one or two' distributors continue to supply medicines through Pharmnet, and other firms have expressed interest in manufacturing drugs which could be supplied through Pharmnet, certain distributors appear sceptical or critical of Pharmnet's approach. These distributors have sought to undermine Pharmnet.[26] [27]

Opportunities to build on the action research: more can be done to fast track Pharmnet's commercial viability and growth prospects. KPA developed detailed forecasts and analysis of Pharmnet's future revenues and cost structures up to the year 2017. The initial financial projections, however, were not achieved owing to failure by KPA to invest sufficient capital in the business. A future programme might support Pharmnet to

[23] Interview with KPA and PHARMNET leaders, Elo Mapelu and Jesse Kirowo, 23.06.2016
[24] PSP4H has provided extensive technical assistance to the Kenya Pharmaceutical Association. This includes helping to design the network structure, and covering training costs. KPA leaders acknowledge that without PSP4H's support, they could not have started Pharmnet.
[25] As an introductory offer, PSP4H and KPA offered to pay for the re-branding of the first 100 pharmacies to join Pharmnet.
[26] As KPA's bulk distribution arm grew, one distributor began to perceive KPA as a competitor. The distributor was already selling to some of these pharmacies. The distributor offered KPA above-market prices, prices that were not competitive. The distributor was also undercutting KPA by approaching Pharmnet members directly with better offers than what they were offering to KPA.
[27] Some distributors insisted upon KPA's bulk procurement arm acquiring their own distribution license and investing in logistics, while knowing that KPA's bulk procurement arm, as a start-up, could not afford this.

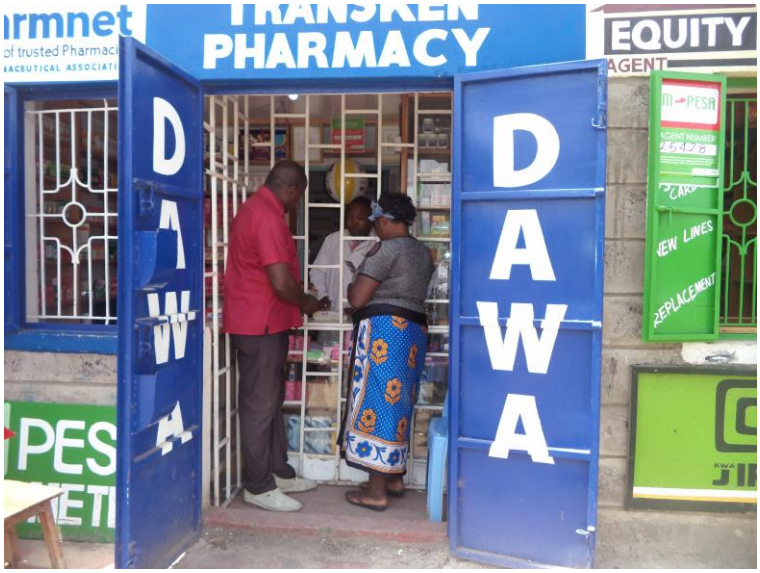
review its projections and adapt its business model accordingly. Up-to-date projections would help KPA to raise more working and investment capital.

One area needing investment is Pharmnet's pooled procurement operations. Two interns, introduced by PSP4H, manage Pharmnet's distribution of medicines. Orders are consolidated in a spare room and delivered to pharmacies through public transportation systems. The current, "lean" structure has kept costs low. However, for Pharmnet's pooled procurement to become sustainable and grow, Pharmnet will need to hire full-time staff and eventually make infrastructure investments[28].

A number of activities have been conducted to raise the profile of the brand among the Kenyan public. Advertisements in 'matatu' buses ran in Nairobi and Mombasa to raise consumer awareness during August 2015 and January 2016. Other low-cost marketing materials in the form of fliers, brochures and branded merchandise, and radio spots were produced Pharmnet[29]. However, further investment in promoting the brand will be needed.[30]

This is because making the public in all Pharmnet counties aware of the network brand, and what it stands for, is essential to Pharmnet's sustainability. Kenyan consumers must understand what 'Pharmnet' means, in order to choose Pharmnet-branded pharmacies over others. Only then will pharmacies value their Pharmnet membership enough to renew it.

Pharmnet members realise this; they have invested in re-branding their shops, but now they need KPA's help with marketing so that the public knows what the brand stands for. They cannot do that alone; most work long hours in their pharmacies, and feel that they cannot spare time for marketing[31].



Pharmnet's managers may need future programme support in clarifying their commercial strategy. For example, they will need to decide what proportion of medicines pharmacies must buy from Pharmnet, in order to remain as members. If Pharmnet members continue buying medicines from outside the network, they may unintentionally stock counterfeits, damaging the Pharmnet brand. To mitigate this risk, Pharmnet will require a quality assurance process which is both cost-effective and credible. KPA may need programme assistance in designing this process, and finding the working capital to finance it.

A future programme could also generate useful evidence on how well the Pharmnet brand changes consumer behaviour. Equally, it will be worth verifying if any changes in consumer behaviour lead to better health outcomes. For example, if and why consumers switch from unlicensed to licensed pharmacies; if Pharmnet pharmacies stock significantly lower proportions of counterfeit medicines and give appropriate consultations; and if Pharmnet clients experience faster recovery compared with other licensed and unlicensed pharmacies.

If Pharmnet can demonstrate commercial viability and value to its members, it has great potential for expansion. More than 90% of Kenya's 3,500 registered community pharmacies are operated by KPA

[28] KPA envisages an asset-light warehouse system, which would allow Pharmnet to grow without requiring KPA to own large warehouses. However, to supply pharmacies beyond Nairobi and its surrounding area, whilst avoiding uncompetitive long lead times, KPA will probably need to hold stock in regional warehouses, or pay local distributors to do so on its behalf. Even within the Nairobi area, as Pharmnet grows, ICT upgrades will be needed to log, aggregate and track orders, manage delays and complaints, and manage liquidity.
[29] PSP4H supported these activities considerably given that KPA lacked sufficient resources to test marketing operations at such an early stage in the *Pharmnet* initiative.
[30] Based on feedback from pharmacy owners interviewed in April 2016 about customers' brand awareness and the change in their customer numbers over time.
[31] Interviews with Pharmnet member pharmacy owners, Nairobi, May 2016

members[32]. The potential is even greater if Pharmnet could find a way to collaborate with the informal sector (see next chapter).

A future programme could also support other organisations to perform similar roles. Industry experts and insiders are aware of large private medical distributors who perform better than others in avoiding counterfeit medicines[33]. Yet these reliable distributors do little to advertise their trustworthiness. Through a marketing campaign, and by co-branding the pharmacies which buy from them, reliable distributors could help Kenyans to find the genuine medicines they supply. Potentially, reliable pharmaceutical manufacturers could do the same[34].

The emergence of several quality-focused pharmacy brands would benefit Kenya's health sector in several ways. It would give pharmacies greater choice and power over which reliable supplier to buy from. As these leading brands compete for market share, the number of pharmacies participating would also grow faster. Finally, if several quality-focused pharmacy brands emerge, Kenyan consumers would no longer depend on one particular organisation to access reliable medicine.

Indeed, there are other similar initiatives trying to establish quality standards in pharmacies and clinics through branding in Kenya. These include the Pharmaceutical Society of Kenya's Green Cross initiative and the Child and Family Wellness (CFW) clinics. Future efforts would benefit in depth systematic collection of lessons learnt from these similar initiatives.

Finally, a future programme could also help government bodies clarify, streamline and strengthen their efforts to raise public awareness around substandard and counterfeit drugs. The government's efforts would also benefit from closer collaboration with quality-focused health businesses, such as Pharmnet.

3.6 Improving knowledge and uptake of asthma inhalers

Summary of progress so far*:* an estimated 4 million Kenyans suffer from asthma. Conventional pressurized inhalers, reported to be the most effective and fast relievers of asthma, are too expensive for low income consumers in Kenya (PSP4H, 2015a). So when the British pharmaceutical company GlaxoSmithKline (GSK) introduced a low-cost inhaled asthma reliever medicine to Kenya in 2013, its prospects seemed high.

Initially, sales were low. PSP4H-funded market research prompted GSK to reconsider its marketing strategy to better serve the mass market. The research uncovered reasons why so few Kenyans with asthma were buying the reliever medicines: few asthmatics were aware of the product; few pharmacists were aware of the new product; and low-income households were deterred by the up-front cost of the asthma inhaler.

GSK is now changing how it promotes and prices its inhalers based on a renewed marketing strategy, developed with technical assistance from PSP4H. The inhaler is now on sale at a much lower price (Ksh 20, £0.14) and the capsules can be bought individually at Ksh 7.

As part of the marketing strategy, GSK will raise public awareness and train health care providers and community health workers on asthma care. To achieve this, GSK plans to collaborate with professional associations, Government (both National and County level), other non-governmental organisations and healthcare providers targeting the mass market in Kenya[35]. Initially, these multi-stakeholder efforts will be coordinated by PSP4H. The programme hopes that GSK will take over responsibility for coordinating consumer education by internalising this function in the future; if more Kenyans are aware of asthma, GSK's reliever medicines sales are likely to increase.

[32] Interview with KPA and PHARMNET leaders, Elo Mapelu and Jesse Kirowo, 23.06.2016
[33] Some pharmaceutical distributors have been reportedly supplying substandard and counterfeit medicines. A future project would have to perform a careful due diligence of potential partners.
[34] If the co-branded pharmacies attract more customers and sell more medicines, the distributors/ pharmaceutical manufacturers would benefit too. Firstly, they would sell more medicines to these co-branded pharmacies. Secondly, co-branded pharmacies' loyalty to the distributor would grow, as the distributor's brand adds unique value to the pharmacy. Thirdly, the distributor could use the offer of co-branding to persuade additional pharmacies to start buying their medicines from the distributor.
[35] GSK already had plans for initiatives to train frontline health workers about diabetes and asthma diagnosis and treatment. GSK's investments in raising Kenyans awareness of asthma are therefore not fully attributable to PSP4H's support. See for example GlaxoSmithKline (2015)

The asthma education campaign is expected to start in June 2016. Partners will start by focusing on Nairobi County. To leverage network synergies, other PSP4H partners, including Pharmnet and LiveWell clinics[36], will be involved. If successful, the public awareness campaign could be rolled to all counties in Kenya by 2018.

Opportunities to build on the action research*:* If monitored well, this pilot can generate insights into how well a pharmaceutical manufacturer can contribute to raising public awareness of a non-communicable disease. Lessons from the pilot would have value beyond Kenya; the World Health Organization (WHO) predicts that the global burden of non-communicable diseases will rise by 27% between 2013 and 2023. By 2020, the WHO predicts that non-communicable diseases will cause seven out of every ten deaths in developing countries (WHO, 2013).

If successful, the pilot could also help a future programme to persuade other pharmaceutical companies to invest in improving low-income Kenyans' understanding of (chronic) diseases as a way to better market their medicines. It will be important to gauge over time how much GSK is willing to invest in asthma health education; and equally, how satisfied the company's leadership team is with their investments.

A future programme could also investigate other interventions to improve the health outcomes of asthmatic patients. Notably, whilst relievers give asthmatics short-term reprieve during attacks, asthma controller treatment is essential for long-term management of asthma. In Kenya, this is still only affordable to a few, mostly wealthy asthma patients. A future programme could support pharmaceutical firms to research and market low-cost asthma controller medicines.

[36] Livewell Clinics have also been a partner of PSP4H. They run and advise a set of clinics within their Livewell network in and around Nairobi.

4 Further Opportunities for future M4P-in-Health Programming

The last section described several action research interventions which PSP4H has started, which a future programme can learn from and build on. This section focuses on new intervention areas which a future programme could scope further.

The intervention ideas presented in this section draw on PSP4H's action research, wider research on Kenya's health sector, and global M4P experience.

4.1 Improving the performance of unlicensed health providers

A large proportion of Kenya's health providers are unlicensed. Some of these 'informal' providers possess training in a health or pharmacy-related field but not enough to qualify for licensure under current laws, while other operators are wholly untrained (WB, 2008, p.5)[37].

Informal providers are used particularly frequently by low-income Kenyans when buying medicines. The Kenyan Pharmaceutical Association estimates that there are 12,000 unregistered pharmacies in Kenya, three times more than registered pharmacies[38].

Maternal care is another area where Kenyans continue to rely on the informal sector. Although the number of births attended by skills midwives is growing, an estimated 38% of births in Kenya are delivered by an unskilled, informal provider (MOH, 2014a, p. 121).

Studies show that informal healthcare providers account for sometimes significant numbers of healthcare interactions, depending on the country, the disease, and the measurement method (Sudhinaraset, 2013). Price and non-price factors such as lack of knowledge and education, shortage of medical supply with the public sector, proximity etc. are reasons for why low-income households refer to informal providers (McCabe, 2009). Interventions that improve health services in the informal sector could potentially have the biggest impact on the Kenyans' poorest.

A future programme could start by reviewing existing research on Kenya's informal health sector, and lessons from elsewhere in improving the performance of informal health providers (Bloom, 2011; Mackay, 2008; Benavides S. et al., 2013; Minzi, O. M. and V. S. Manyilizu, 2013). Key questions are likely to include:

- Why do so many poor Kenyans continue to choose unqualified and underqualified providers? Can patients easily differentiate between qualified and unqualified providers? How do patients perceive the difference in quality of service between qualified and unqualified providers?
- Do patients only choose unqualified providers when qualified providers are distant, or unavailable? Or, do the prices charged by formal providers, or the uncertain quality of services they offer, lead many low-income Kenyans to prefer informal providers?
- What incentives and disincentives do unqualified and underqualified providers have to gain formal qualifications? What incentives and disincentives do unregistered pharmacies have to register their businesses? [39]
- To what extent is the registration and licencing process a problem of unclear or overly burdensome procedures or standards?

[37] Businesses can be 'informal' in different ways, leading some experts to talk of a 'sliding scale' between formality and informality. For example, a kiosk selling medicines may be staffed by a qualified pharmacist, but not be registered with Kenya's pharmaceutical governing bodies. Even if the kiosk and pharmacist are registered with relevant health authorities, they may not be registered for tax. Even if they are registered for tax, they may be under-reporting profits. Or knowingly buying and selling sub-standard medicines. In this section, by 'informal' we mainly refer to unqualified health workers practicing vocations which Government of Kenya policy states they require qualifications to practice. By 'informal' we also refer here to health workers who are not registered with their relevant professional body, as required by Kenyan law.
[38] Interview with KPA and NTP leaders, Elo Mapelu and Jesse Kirowo, 23.06.2016.
[39] Bloom argues that to find appropriate strategies to include the informal sector, there is a need to look at providers' technical knowledge gaps, but also more broadly at providers' sources of knowledge, their livelihood strategies, and the institutional settings within which they operate.

- What can be done, sustainably, across counties, to incentivise unregistered pharmacies to register?
- What trade-offs could arise from efforts to increase registration, and how would these affect these informal providers' customers?

The purpose of this research would be to inform intervention design. Depending on the findings, one set of interventions might facilitate the emergence of more affordable, accessible training courses which allow unqualified providers to gain qualifications. Potentially, another set of interventions might seek to change providers' incentives and capacity to register their businesses with health bodies. This might require a future programme to invest in political economy analysis and public sector reform expertise – helping counties to remove disincentives to formalise such as corruption among health inspectors. However, interventions will be strongly influenced by the officials' interest and willingness to consider informal actors as crucial healthcare service providers within the health system (Bloom, 2011).

4.2 Informing the Kenyan public about health topics

The more that people understand about their health, the likelier they are to get their health problems properly diagnosed, choose appropriate treatment, and adhere to the medical advice they receive.

In Kenya, there has been notable progress over the past two decades in educating citizens on some important health topics. For example, education campaigns have succeeded in increasing HIV awareness, uptake of HIV testing, use of methods to prevent HIV transmission, and HIV treatment. As a result, HIV prevalence and mortality have fallen in Kenya (National AIDS Control Council, 2014).

Kenya, like most countries, also faces widespread misunderstandings about important health concerns. For example, few Kenyans are aware of diabetes. The International Diabetes Federation estimates that only a quarter of the 700,000 Kenyans living with diabetes are diagnosed (IDF, 2014).

Meanwhile, when many Kenyans get a fever, they incorrectly self-diagnose and buy malaria medicine. Often, their fevers have other causes. In a 2012 study, Kenyan adults who purchased malaria medicine were later tested for the disease; 75% did not have malaria[40] [41].

There are several reasons why these serious gaps in the public awareness of health issues remain. Firstly, whilst Kenya's Ministry of Health, through its Division of Health Promotion, informs the Kenyan public about health matters, research suggests that the Division has limited capacity and resources (Kei, 2012).

Meanwhile, there is a growing trend of businesses in Kenya supporting health education campaigns. Pharmaceutical firms in particular are contributing funding, marketing expertise and infrastructure. However, their efforts are understandably constrained by regulations that prohibit direct advertising of prescription medicines to the public (MOMS, 2010).

Whilst in some cases, companies are motivated by short-term Corporate Social Responsibility objectives, in some cases they have commercial incentives to do so. The Asthma Care Improvement Programme (ACIP) is a good example. ACIP is a multi-stakeholder taskforce, which PSP4H is helping an asthma medicine manufacturer to establish, fund and lead. ACIP will help to coordinate efforts to educate health workers and the public on asthma. Whilst the emphasis is not on promoting a specific product, if greater asthma awareness leads more of Kenya's asthma sufferers to seek treatment, sales of asthma medicines are likely to grow.

A second example is the insulin manufacturer Novo Nordisk, which is working with Kenya's national government, civil society and other businesses to raise public awareness of diabetes. To improve low-income Kenyan diabetics' access to insulin, the company firstly distributes through faith-based organisations in twenty seven counties. Secondly, Novo Nordisk limits distributors' and pharmacies' mark-ups which keeps consumer prices relatively low (Novo Nordisk, 2014).

[40] Misdiagnosis led these adults to miss out on the treatment they actually needed and to waste scarce cash on medicines they did not need. Studies in Tanzania have also found frequent misdiagnosis, including among children. The following study in Tanzania found that 46% of people treated for malaria actually had malaria (Reyburn et al., 2004 / Abdul Latif Jameel, 2012).

[41] In Kenya, hospitals and health centres are increasingly offering rapid diagnostic tests for malaria. The UNITAID-funded Private Sector RDT Project is attempting to strengthen the demand for and supply of these tests in Kenya. It is expected that rapid diagnostic tests, alongside greater public awareness of the declining prevalence of malaria and greater public awareness of other causes of fever, will reduce the incidence of misdiagnosis of fevers in Kenya.

A future programme could explore the potential to establish similar partnerships to address other national health education priorities. For example, could public-private partnerships go further in raising awareness among Kenyans about diabetes? Equally, could health education campaigns increase interest in micronutrient powders?

A future programme could also try to persuade Kenya's low-cost private sector health centres and pharmacies to invest more in educating patients on health matters. At present, few include health education in their marketing strategies. Yet many have incentives to do so: by providing health-related information which the public values, healthcare providers can demonstrate their expertise to potential customers, strengthening their reputation for quality and customer service.

For a future programme, a third, related opportunity is to work with the mass media. Radio stations and television channels provide the Kenyan public with large amounts of information[42]. Competition for listeners and viewers is fierce[43]. A future programme could commission market research to gauge how much unmet demand there is among listeners and viewers for high quality, health-related content. If there are gaps in the market, the programme could work with leading radio and television producers to expand and improve their coverage of health topics.[44]

4.3 Combatting fake and sub-standard medicines

Estimates of the prevalence of counterfeit and sub-standard medicines in Kenya vary, but all signal a widespread problem. In a 2015 report by the Kenya Association of Manufacturers, the judiciary and others, an estimated 30% of total medicines sold in Kenya were fake. Kenya's Pharmacy and Poisons Board, which is responsible for tackling the problem, believes that prevalence is lower (Daily Nation, 2016a). Meanwhile, according to Pharmaceutical Society of Kenya President Paul Mwaniki, '*at least 10 per cent of medicine supplied to the Kenyan market is either counterfeit or sub-standard.*' The market can not sufficiently be controlled partly because Kenya has only sixty pharmacy inspectors, for over 10,000 pharmacies, he observed (Daily Nation, 2016b).

As well as staff shortages, efforts to tackle fake medicines are hampered by corruption. PSP4H interviews with pharmaceutical technologists reveal that many have encountered inspectors, more driven by financial incentives than by removing counterfeit medicines (PSP4H, 2014d, p. 39).

Whilst efforts to improve enforcement would be laudable, new technologies could make it easier for patients and pharmacy owners to avoid fake drugs. In Chapter 2 we discussed opportunities to help patients to find reputable pharmacies, by supporting Pharmnet and other controlled, branded supply chains. A future programme could look further at recent innovations in supply chain management which can be used to combat counterfeits (Cruikshank, 2014).

A future programme could also explore partnerships with manufacturers of genuine medicines. Firstly, a future programme could help manufacturers to make their genuine medicines easier to differentiate from fakes. In Nigeria's pharmaceutical sector, and Kenya's seed industry, some companies combat counterfeits by adding SMS verification codes to their products' packaging[45].

[42] A 2011 survey found that 99% of Kenyans aged 15+ had listened to the radio at least once in the past four weeks; 71% had watched television; 48% had read print media; 16% had consumed media on the internet. For more information, see Synovate Kenya (2011).
[43] In 2010, Kenya had 107 radio stations and 15 television stations. Source: Synovate Kenya (2011)
[44] Lessons can be learned from the FIT-SEMA programme, which used similar research to persuade Uganda's radio stations to sustainably offer programmes to develop and broadcast informative and audience-responsive programming for the small businesses, farmers and rural enterprises.. The radio stations have a business motivation to drive up listenership – more listeners, more money from advertisement. Previously, donor agencies and other companies just delivered content around certain topics to the radio stations to be broadcasted. However, these messages were not interesting to listeners nor did the radio station have ownership over the content. FIT-SEMA capacitated radio stations to develop programmes that are important to listeners and hence drive up listenership. These programmes are now common in Uganda, having reached roughly seven million small business owners (Anderson & Hitchins, 2007).
[45] Companies inscribe unique codes on the product's packaging. The consumer scratches off the code, and sends it as a text message to a dedicated phone number, which automatically verifies whether the product is genuine or not. For more information on its use in Kenya's seed industry, see http://www.standardmedia.co.ke/business/article/2000162647/kenya-seed-company-launches-sms-technology-to-fight-counterfeit. More information on the technology's use in the pharmaceutical industry can be found on the website of technology provider Sproxil, at www.sproxil.com.

Secondly, a future programme might persuade manufacturers to do more to educate pharmacy owners on what their own packaging looks like, and how to distinguish it from fakes. Similarly, pharmacy owners could do more to show customers how to differentiate genuine medicines from and fakes. Reputable pharmacies could increase their sales by doing so; when customers shop around, and opt for cheaper but fake medicines, reputable pharmacies lose out.

A third area to explore is Paper Analytical Devices – a new, emerging technology for pharmacovigilance and post-market surveillance. Paper Analytical Devices are low-cost test cards which pharmacists can use to quickly determine whether a drug tablet contains the correct active pharmaceutical ingredients. Whereas at present, pharmacy owners would require laboratory equipment to test medicines, which they lack, the Paper Analytical Device requires no additional equipment. A future programme could investigate the market for Paper Analytical Devices among pharmacies in Kenya, and whether programme support is needed to spread their adoption among pharmacies (BBC News, 2015).

4.4 Improving how county governments work with businesses to deliver healthcare

Government-run health centres and hospitals can procure both clinical and non-clinical services from the private sector. When things go well, government-run health facilities can benefit from private sector expertise, particularly in non-clinical areas such as staff training, logistics and procurement. The quality of these "back-office" services makes a significant difference to how well health centres and hospitals serve their patients. Yet PSP4H's experience suggests that county governments often struggle to design and manage private sector engagements, missing opportunities to improve service delivery, as described below.

PSP4H consulted with eleven counties on their interest in starting new healthcare-related public-private partnerships. The programme invited proposals from counties which felt that they had viable ideas, but required technical assistance from PSP4H to set up the partnership. Several counties submitted concepts, which varied from contracting a business to operating an oxygen plant to outsourcing ambulance services. PSP4H engaged with two counties on pilot projects.

The proposals were insightful in several ways. Firstly, they revealed widespread interest from county governments in working with the private sector to achieve health objectives. Secondly, they demonstrated that counties were interpreting 'partnership' with business in many different ways. Often, county officials had unrealistic expectations about businesses' willingness to invest in joint ventures, without clear commercial incentives. Equally, a general lack of capacity in conceptualising partnerships, planning and contracting was evident.

A future programme could explore sustainable routes to improving county governments' capacity to engage private sector service providers. Whilst other development agencies already plan training and capacity building for county officials on public-private partnerships, a future programme could explore ways to make this capacity building available to county government officials on a sustainable, long-term basis. PSP4H's engagement with county government revealed a widespread interest, and need, to learn more about public-private partnerships and how to manage them (PSP4H 2015b). It may be worth investigating what prevents Kenya's civil service training organisations from responding to this need.

5 Lessons Learnt

This chapter shares four key lessons from PSP4H which can be applied by future M4P programmes across interventions. The lessons in this chapter will interest not only health specialists, but also M4P programmes working in other sectors. Readers of this section may also be interested in Chapter Four of the first lessons learned paper, which details an additional six lessons (PSP4H, 2016a), as well as the programme's midterm report (PSP4H, 2015c).

5.1 Partnering with associations and networks offers scale, but also challenges

Working with networks and associations has been popular among development agencies, enabling programmes to access large numbers of people quickly. In some of its interventions, PSP4H has followed this approach. Instead of working with individual pharmaceutical technologists, or single laboratories, PSP4H has engaged with their respective professional associations[46]. Working through professional associations has given PSP4H access to larger numbers of pharmacies and laboratories than the programme would have got, if it had tried to work with these businesses individually.

In working with associations, PSP4H has largely avoided common mistakes made by development agencies. One such mistake is for development agencies to encourage and fund associations to take on new functions without adequately considering their capacity and incentives to continue these functions in the future. When association are unable or unwilling to perform their new functions sustainably, the benefit to members is temporary at best. At worst, previously functioning associations become indebted, divided and dysfunctional.

A second common mistake is for development agencies to set up new associations, without understanding the reasons why stakeholders failed to form their own association in the first place. Here, it is rare for members to see the associations as "theirs" – these groups typically fall apart when donor support ends (see for example Stewart, 2014).

Aiming to avoid the mistakes mentioned above, PSP4H has employed three tactics. Firstly, PSP4H has assessed partners' capacity and incentives before and during interventions. This has enabled the programme to make better choices about which associations to partner with. PSP4H's monitoring of partner associations' incentives and capacity has also allowed the programme to modify or exit partnerships, where the programme's expectations of an association's capacity and incentives have not been met.

Secondly, PSP4H has only partnered with existing associations, where members have already demonstrated their willingness and ability to work together. Thirdly, PSP4H has sought to avoid partner associations becoming dependent on the programme. PSP4H has refused to give grants to business associations, to avoid them seeing the programme as a "customer" and leaders losing their focus on members. Instead, PSP4H's support has mainly been in the form of technical assistance.

PSP4H's experience in partnering with associations and networks offers other lessons too.

Firstly, careful business planning is essential, before programmes encourage associations to start selling new services to members in exchange for fees. Programme and association managers should understand what capital investments and human resources will be required, to continue and expand the new service beyond the pilot. When setting up Pharmnet, PSP4H and KPA created a partnership agreement, laying out each organisation's activities, responsibilities and required investment for implementation. This document helped to ensure timely implementation during the set-up phase.

Secondly, before encouraging associations to begin lines of business, programmes should pay careful attention to the association's financial and operational capacity[47]. For example, in the case of Pharmnet, the association's telephone and public transport-based procurement and distribution systems are likely to hinder expansion of the association's pooled procurement arm. A second, long-term challenge is implementation of

[46] The Kenya Pharmaceutical Association (KPA) and the Association of Kenyan Medical Laboratory Scientific Officers (AKMLSO).
[47] For example, association leaders must often be skilled in advocacy and member engagement. Whilst these skills may be transferable to the business arena, other skills are also needed to run a business, such as financial planning and marketing are not always found among association leaders.

the marketing strategy; KPA will need to invest more in creating and maintaining Pharmnet's brand value, doing more to sensitise the public. Otherwise, members are unlikely to continue paying KPA to use the brand.

Thirdly, programmes can achieve some sustainable impact at scale by collaborating with a single association, but this does not guarantee that they will influence the wider health system. An association can usually only manage a limited expansion in its membership and outreach with the resources and capabilities it has. For example, PSP4H has supported a private midwives' self-help group in Kilifi to expand county-wide. However, the association's current members have limited incentives and capacities to expand the association beyond the county boundaries.[48]

5.2 Analysing partners' ability to match increased demand with supply

Some smaller businesses struggle to cope with rapidly rising demand, if marketing campaigns are successful. Additional demand usually requires extra working capital. Investment capital may also be needed in order to serve more customers, such as when businesses need to expand facilities or hire extra staff. Businesses which fail to raise this additional capital can suffer a decline in their service quality – patients having to wait longer to see a nurse, for example. Declining service quality can do long-term damage the business's reputation.

Some of PSP4H's partners faced such difficulties (PSP4H, 2016a). This demonstrates the value of future programmes, when assisting smaller enterprises to improve their marketing, to think through various scenarios of future demand. After forecasting future demand, programmes can help partner businesses to foresee and avoid operational bottlenecks which would arise if demand rises. For example, a partner business may wish to delay a marketing campaign until expansion plans are complete, to minimise the risk of being unable to cope with a surge in demand.

5.3 Avoiding grants

PSP4H has made a great effort to avoid giving grants. This tactic has proven helpful in avoiding partnerships with businesses that would have been motivated mainly by the opportunity of getting a grant; PSP4H has instead sought partners who are committed to trialling new ways of working.

PSP4H has largely succeeded in finding such partners. This is evident from the investments which partners have made, alongside PSP4H, in new ways of working. For example, Kisii Teaching and Referral Hospital has dedicated considerable management time, and made 617 of its staff and managers available for training, to improve its customer service. Meanwhile, Jawabu, an insurance broker, hired a dedicated team to develop and roll out its new health insurance product, and commissioned an Actuary Report, among other investments.

However, even when PSP4H has leveraged in-kind contributions from partners, such as those mentioned above, partners may still be unwilling or unable to continue investing in a change process. If a partner business makes no cash investment when setting up a new business model, the risk is greater that the partner will not or cannot invest later on, when cash is needed to continue, expand or improve the business model. Therefore, when partners' contributions to pilots are in-kind, programmes should conduct extra due diligence, looking out for financial, operational or management issues which could prevent the partner from making cash investments, if needed later on (PSP4H, 2014a)[49].

Even when offering technical assistance only, programmes need to think about who will provide technical assistance in future, if it is a recurrent need. Whilst many programmes overlook this, making their capacity building interventions unsustainable, PSP4H has anticipated this. In Kilifi, for example, PSP4H is currently

[48] So far, the programme has avoided temptations to push Kilifi's midwives' association to expand beyond its members' willingness and ability. Sensibly, as development impact often ends when programmes push for rapid, large scale outreach, ignoring the cost this has to sustainability. To benefit midwives and pregnant women beyond Kilifi, the programme will instead need to influence midwives' associations and governments in other counties, using learning from its pilot intervention.

[49] Co-financing in cash is often a problem for associations. Even if they have large numbers of members, associations often have small cash reserves. In the case of Pharmnet, PSP4H overcame this by helping the Kenya Pharmaceutical Association to find low-cost solutions to get bulk procurement started. Pharmnet was launched without require grant funding from PSP4H (only technical assistance and staff time were provided). However, there are signs that KPA may struggle to raise the capital needed to expand its bulk procurement operations, for example in acquiring extra warehouse space and installing an ICT system capable of managing large order volumes. Learning from PSP4H, a future programme may wish to give grants, only if the partner is showing commitment, and a temporary capital shortage is likely to undermine the testing of the innovation. As an alternative financing mechanism, to help partners to raise capital for short-term needs, a future programme also consider partial loan guarantees.

negotiating with county hospital managers to include training for nearby private midwives in their next annual training budget.

5.4 Networking and relationship building among health-related businesses

The success of new innovations often depends on collaborations between businesses. Equally, the absence of collaboration can undermine innovations' success. As part of its role as a facilitator, PSP4H has actively helped like-minded businesses to collaborate in testing new innovations.

For example, PSP4H partner Jawabu was looking for health clinics and pharmacies to serve customers buying its health insurance product. Meanwhile, LiveWell and Pharmnet were partnering with PSP4H on separate interventions – testing new marketing, branding and distribution methods. PSP4H introduced the three organisations to each other. LiveWell's health clinics and some Pharmnet chemists are now registered to serve customers of Jawabu's new health insurance product.

PSP4H's asthma intervention is a second example of collaboration between partners who began working with the programme on separate interventions. GlaxoSmithKline has established a multi-stakeholder group, including Pharmnet and LiveWell clinics, to raise awareness of asthma, as part of its marketing strategy.

These collaborations are not accidental; the programme has deliberately created opportunities for interaction between partners. The programme organised a 'partners summit' where partners were exposed to each other's businesses and encouraged to explore networking synergies. PSP4H has sent frequent newsletters to stakeholders, detailing its various partnerships and the innovations they are testing. At times, this has spurred partners' interest in other areas of the health system. The programme has also organised frequent presentations and events about innovations by its partners, followed by networking opportunities.

PSP4H's ability to nurture collaborations among partners has useful lessons for M4P programmes. One reason why PSP4H's networking efforts appear to have succeeded is that the businesses invited had four key features in common: they were all interested in improving Kenya's health system; they were all willing to test new business models; they all had an interest in products and services which benefited low-income households; and they have not been swamped with donor money. These common features may have helped partners to have more substantive conversations with each other than might otherwise happen at networking events.

A future M4P-in-health programme would probably continue to play this networking function for some years. In the long-run, if interest grows in innovations to improve to low-income Kenyans' health, the programme could help a Kenyan institution to play this convening and brokering role without donor funding, perhaps its partner the Kenya Healthcare Federation. Perhaps in a similar way that iHub does for Kenya's technology sector[50].

5.5 A brief summary of lessons learned

PSP4H is among the first development programmes to use an M4P approach in the health sector. By taking this approach, the programme has differed in two important ways from most programmes that engage with health-related businesses in Africa. Firstly, with a budget of GBP 4,190,277 over three years, PSP4H's value addition has not been in handing out cash. Instead, the programme has used in depth market research, networking events and technical assistance to influence and support changes and innovation in Kenya's health landscape. Secondly, the programme has encouraged private sector partners to better target Kenyan's 'mass market', the low income households. The programme has helped firms to adapt their business models and supported innovations, so that these different market segments can benefit from improved quality and access to health services.

[50] For more information on iHub and how it is funded, see Toby Shapshak, 'Kenya's iHub Enters a New Chapter', *Forbes*, March 11th 2016.

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