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Evaluating the African Health Market for Equity (AHME) Initiative in Ghana and Kenya

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Yes

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Abstract

Sub-Saharan Africa accounts for 24 percent of the global burden of disease. While private clinics are the first source of care for many Africans, the quality of care offered in private facilities is inconsistent and often weak, and the private healthcare sector faces a wide host of challenges. In this study, IPA-affiliated researchers from UC Berkeley and UCSF will evaluate the impact of a multi-pronged private healthcare initiative on healthcare utilization, quality of care, clinic financial outcomes, and child health outcomes in Kenya.

Policy Issue

Sub-Saharan Africa accounts for 24 percent of the global burden of disease,^[1] yet it only has 11 percent of the world's population. The health care systems of the countries in the regions are facing numerous challenges at once, including lack of training and organization, insufficient standards and quality monitoring, and high out-of-pocket expenditures. While

many efforts to address problems in the health care sector have focused on government clinics and hospitals, private providers are in fact the first source of care for many Africans. Though millions of people rely on private clinics, regulation and enforcement of quality care in private facilities is generally weak, and the private healthcare sector is not structured to ensure either quality or affordability.^[2] These issues have impelled governments and NGOs to turn their attention to improving care in private facilities. Thus far, many programs have aimed to solve individual constraints to providing high-quality health care, but few have intervened on multiple fronts simultaneously. A multi-faceted approach has not been tested. This research will fill this gap by testing an initiative that addresses multiple health challenges in the region at once.

Context of the Evaluation

Ghana, Kenya and Nigeria, the countries participating in the African Health Market for Equity (AHME) initiative, all have large populations, a high disease burden, high out-of-pocket payments for healthcare, and they are all working to expand the reach of their health insurance programs. The initiative was designed and is being implemented by Marie Stopes International, Population Services International, PharmAccess Foundation, Grameen Foundation, the International Finance Corporation, and Society for Family Health.

AHME is a multi-faceted initiative that aims to improve both the supply and demand for private healthcare among the poor. Supply-side interventions aim to ensure high quality of care, while demand-side interventions aim to reduce barriers to accessing high-quality care. Evidence suggests that grouping private providers under a franchised brand with a social goal could improve both access to and the quality of some clinical medical services. Such “social franchising” entails creating a valued brand for goods or services, with a social goal, and extending the reach of that brand by leasing the right to use it. A social franchise model serves as the basis for the AHME initiative. In addition, the initiative includes training in basic clinical management and strategic planning for quality improvement and access to credit to implement improvement plans. AHME will also facilitate government registration for clinics. Finally, clinic personnel will use information and communication technology (ICT) to improve operational efficiency.

Details of the Intervention

Researchers Paul Gertler (UC Berkeley) and Dominic Montagu (UCSF) will use a randomized evaluation to evaluate both the effectiveness and cost-effectiveness of the AHME program at improving quality of care, service utilization, access to high-quality care, and health outcomes. While the initiative is taking place in Ghana, Kenya and Nigeria, the initiative is being evaluated only in Ghana and Kenya, and the randomized evaluation is occurring in Kenya only.

In Kenya, the researchers will randomly assign private clinics that meet criteria for selection into the AHME program to either a treatment or comparison group. Clinics in the treatment group will be invited to participate in AHME immediately, while clinics in the comparison

group will be recruited into AHME after the evaluation is complete.

Clinics participating in AHME will receive five interventions:

1. **Social franchising:** Private providers will be trained and certified to deliver standardized care under a franchised brand. The brand aims to signal to the client that the clinic offers high-quality services. Local and national marketing for the brand aim to build demand for the franchised services.
2. **SafeCare:** The program provides participating clinics with a standardized assessment of facility quality, support in developing quality improvement plans, and incentives for clinics to improve quality of care.
3. **Medical Credit Fund:** The fund provides strategic planning support tied to performance-based financing to eligible SafeCare-participating clinics.
4. **Demand-side financing:** AHME will facilitate registration with Kenya's National Health Insurance Fund for SafeCare-participating clinics that meet a minimum standard of quality.
5. **Information and communications technology (ICT):** Mobile phones and other technology will be utilized to enable clinic personnel to, among other things, collect data and directly reach clients.

Data will be collected over a four-year period at both the clinic and household level to measure healthcare utilization, quality of care, clinic financial outcomes, and child health outcomes.

The impact evaluation in Kenya will be a collaborative effort between Innovations for Poverty Action and researchers from the University of California, Berkeley, who will lead the overall evaluation, and the University of California, San Francisco, who will lead the accompanying qualitative evaluation.

The qualitative evaluation will take place in Ghana and Kenya over the same four-year period to complement the quantitative findings. The qualitative evaluation will explore provider and client attitudes towards quality of health and options for care and will describe the AHME operation processes and their effects on the overall markets and institutional environments in which they function. Members of the research team will conduct in-depth interviews with providers participating in AHME and their clients and carry out focus group discussions in communities surrounding AHME facilities. The researchers will also conduct key informant interviews with AHME partner organizations and other key project stakeholders.

Results and Policy Lessons

Results forthcoming.

Sources

[1]UNEP. "Global Shortage of Health Workers." http://www.unep.org/training/programmes/Instructor%20Version/Part_2/Acti...

[2]Prata, Ndola, Dominic Montagu, and Emma Jefferys. "Private sector, human resources and health franchising in Africa." *Bulletin of the World Health Organization* 83, no. 4 (2005): 274-279.

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