Center For
Health Market Innovations
Primary Care Learning Collaborative

THE PRIMARY CARE

INNOVATOR'S HANDBOOK

VOICES FROM LEADERS IN THE FIELD

ABOUT THE CENTER FOR HEALTH MARKET INNOVATIONS

The Center for Health Market Innovations (CHMI) promotes programs, policies, and practices that make quality healthcare affordable and accessible to the world's poor. Operated through a global network of partners since 2010, CHMI is managed by the Results for Development Institute (R4D) with support from the Bill & Melinda Gates Foundation, the Rockefeller Foundation, and UKaid.

Details about more than 1,400 innovative health enterprises, nonprofits, policies, and public-private partnerships in low- and middle-income countries can be found online at **HealthMarketInnovations.org**.

R4D also manages the Center for Education Innovations at **EducationInnovations.org**.

RECOMMENDED CITATION

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TABLE OF CONTENTS

"If the challenges of implementing chains and franchises can be addressed, these models have potential to contribute to stronger health systems worldwide."

Dear Colleagues,

It is with great excitement that we are launching the Primary Care Innovator's Handbook, which is intended to start an ongoing conversation between leaders and implementers of primary care initiatives about concrete tools, approaches, solutions, successes, and failures, with the ultimate goal of helping these organizations to scale and to overcome challenges. The Handbook represents the culmination of a year of activities of the Primary Care Learning Collaborative, which facilitates knowledge sharing between chains and franchises working to provide high-quality primary health care in low- and middle-income countries.

As an initiative within the Center for Health Market Innovations (CHMI), the Collaborative supports CHMI's goal of enabling health systems around the world to better utilize private organizations to provide quality, affordable, and accessible healthcare, especially for the poorest and most vulnerable. Although the Collaborative targets a select number of organizations, its activities have the potential to affect the broader health ecosystem in several ways. It is our aspiration that others, both in private organizations and governments, will test and adapt the innovations and best practices identified through the Collaborative. In addition, the improvement and scale-up of promising private sector models that support the national goals of the countries in which they operate can play a central role in the development of strong health systems more generally.

Private health care providers are numerous in many low- and middle-income countries. While the private sector can be a source for innovation and responsive care, it is also largely unregulated, which means that the quality, affordability, and accessibility of care vary drastically. The government is in a unique position to regulate and help finance healthcare in the private sector, thus unlocking the private sector's powerful potential to contribute to national health goals and to improve health outcomes for the poor.

Chains and franchises offer promising ways to alleviate a major barrier to effective regulation, the private sector's high level of fragmentation. These models organize private providers and facilities into connected networks that can more effectively work with governments. When these networks grow in scale, governments can more effectively integrate a large number of providers into the broader health system, for instance linking them to public health financing schemes.

This Handbook is designed to support implementers of primary care organizations in improving their services. It is unique in capturing the experiences of leaders and implementers, reflecting on their learnings in their own voices. We hope that the Handbook will begin new conversations and encourage a culture of open and frank dialogue, allowing those working to improve healthcare for the poor to collaborate more effectively and push the entire field forward. If the challenges of implementing chains and franchises can be addressed, these models have potential to contribute to stronger health systems worldwide. We hope that you enjoy reading The Primary Care Innovator's Handbook.

Sincerely,

Komal Bazaz Smith

Komal Bazaz Smith
Senior Program Officer
Results for Development (R4D)
January 2015

"The recent growth of social enterprises and innovative business models around primary care is a very welcome development. As institutional 'laboratories' trying to address key challenges, these 'voices' may well hold (or may soon have) the solutions for many of the persisting gaps in our knowledge. The insights as well as opportunities offered by these practitioners as they continue to innovate in the primary care space hold **tremendous promise**, and the compilation of The Primary Care Innovator's Handbook represents one of the early documentations of this potential. This should, hopefully, **encourage many more innovations** in the space, more such 'voices' being heard, and much more food for thought in the global endeavor for strengthening primary care and attaining universal health coverage."

— *Somil Nagpal, Senior Health Specialist for the Global Practice on Health, Nutrition and Population at the World Bank**

*Views expressed are personal

INTRODUCTION

THE ORIGINS OF THE PRIMARY CARE INNOVATOR'S HANDBOOK

In recent years, primary care has garnered more and more attention from those working to improve health systems in low- and middle-income countries. As the first point of care for patients, primary care clinics and practitioners play a key role as a gateway to the rest of the health system, and they provide the basic preventive and curative care that saves the most lives. Consequently, interventions at the primary care level are crucial to improving health outcomes.

Recognizing that in many low- and middle income countries, the poor rely on private providers for a large portion of their care, many experts and innovators are exploring market-based solutions to improve primary care. As a result, in recent years the number of primary care chains and franchises has grown. These models show great potential for impact, but chains and franchises continue to face numerous challenges related to quality, affordability, sustainability, and scale.

Primary care leaders want and need practical know-how. They recognize that there are not always clear solutions to tough challenges, but they have found that there is value in sharing ideas and experiences, testing new approaches, and sharing the results to enable successful innovations to spread more rapidly between organizations and across geographies.

With this in mind, the Center for Health Market Innovations (CHMI) launched the Primary Care Learning Collaborative in October 2013 as a peer-learning network that enables knowledge sharing among participating organizations. Through the Learning Collaborative, members identify common challenges and gaps in knowledge, share experiences and ideas, and develop and test common solutions. The Learning Collaborative launched with five member organizations employing chain and franchise models to deliver primary health care in Kenya, Burundi, and India: Access Afya, LifeNet International, Penda Health, Ross Clinics, and Swasth India.

As organizations committed to creating change beyond their own organizations, the members of the Learning Collaborative felt that it was important to capture the knowledge, strategies, and innovations discussed within the group, so that lessons could be shared with and used by other health delivery leaders, as well as policymakers, funders and global health experts. This Handbook is designed to disseminate lessons and to create a further dialogue about innovations beyond the five members of the Learning Collaborative.

WHAT IS THE PRIMARY CARE INNOVATOR'S HANDBOOK?

For many of its members, the Learning Collaborative has been a unique opportunity to have frank and

Photo Above: Members of the Primary Care Learning Collaborative discuss site visits in Nairobi, Kenya. Photo credit: Alex Kamweru for CHMI

detailed exchanges about specific challenges. The tone of these conversations has been open and informal. Members of the Learning Collaborative are honest about their successes and failures. The Primary Care Innovator's Handbook is an attempt to recreate this experience in a way that anyone can benefit and participate, to make tacit knowledge explicit, and to encourage more conversations of this style among innovators working to improve primary care, so that the whole community can move forward together.

The Handbook is written from the point of view of people who are leading and managing primary healthcare organizations in low- and middle-income countries, and its primary audience is their peers – other managers of primary care organizations, or those who are hoping to start such organizations. Nevertheless, many others working in this field – policymakers, researchers, and funders – may find this piece useful in their work, as it sheds light on some of the day-to-day challenges and successes that primary care organizations encounter.

PEER COMMENTS

One of the goals of this piece is to create a conversation – not just to describe the experiences of one organization. Therefore, the Handbook includes a unique feature in the form of running comments that accompany each chapter. These comments come from peer organizations, both members and non-members of the Learning Collaborative, who are responding to the ideas and tools in that chapter – including commenting on whether they would like to use an idea in their own work, noting when they have tried a similar idea that was successful, or explaining why a particular idea may not work in their own context. Through this running commentary, the Handbook is working to capture the conversation around primary health care delivery, rather than a one-way presentation of ideas.

The Handbook is unique in that it is co-written by implementers themselves. Rather than trying to showcase generic lessons, it consists of reflections from members of the Learning Collaborative on their experiences running primary care chains and franchises, including concrete tools, thought-processes, and principles that they have employed in their work. The Handbook is in no way a prescriptive how-to guide for running these types of businesses and providing high-quality primary care, and it is not an academic piece offering unassailable evidence about what will work in every context. Rather it reflects what these organizations have learned from their experiences thus far, and is intended to leave the reader with ideas, tools, and inspiration, that they can then immediately test, implement, or adapt to their own work. It will hopefully also leave the reader with a desire to contribute to the conversation and share their own experiences and learnings.

The organizations that contributed to this Handbook are relatively young. They are the first to admit that they don't have all the answers and that there is much that they will continue to learn as they grow. However, as social innovators who want to work with others – rather than compete with them – to build this field as a whole, they are excited to contribute to this Handbook and to help launch a global conversation about what works and what doesn't work in sustainable primary care delivery. Their experience in the Learning Collaborative has shown that there is rarely a "one-size fits all" solution to a common challenge, but that hearing about how others have addressed a challenge and then reflecting on their own experience can be incredibly useful in identifying a solution that will work in their own context.

The Handbook starts with a chapter, written by leaders of primary care organizations in Kenya and India, on why primary care deserves our attention. The rest of the Handbook is divided into three sections: 1) Setting Up and Expanding Clinics, 2) Providing Care, and 3) Setting Up Effective Systems. Each of these sections is then further broken up into individual chapters in which an individual member organization tackles a key question related to the subject of the section. For example, in the Setting Up and Expanding Clinics section, representatives from Swasth India answer the question "How do you choose your clinic locations?" Similarly, in the Providing Care section, representatives from Penda Health reflect on the question "How do you improve patient experience?"

This Handbook should be considered a "living handbook." It is the start of a conversation and hopefully will grow over time with new insights and experiences. There remains much to be discussed, and many additional topics to be covered, such as: How do you ensure quality? How do you effectively work with governments? How can you ensure continuity of care for your patients through referrals? We hope that others will contribute to the development of this field by sharing their experiences with these and other questions.

If you enjoy reading this Handbook, and would like to contribute to the conversation yourself, please visit:

HealthMarketInnovations.org

BACKGROUND ON COLLABORATIVE MEMBERS

ACCESS AFYA | Nairobi, Kenya

Year launched: **2012**

Legal Status: **For-Profit**

Model: **Chain**

Target Geography: **Urban**

Number of clinics/outlets: **4**

Clients seen in 2014*: **3,500**

Access Afya is a primary healthcare social enterprise operating in Nairobi's slums, selling health services, diagnostics, products, and medication to low-income Kenyans. They use design, training, clinical protocols, operational processes, technology systems, and rigorous monitoring and patient care methods to ensure that their clients get consistent, quality service at any of their sites.

Authors »

Melissa Menke
Co-Founder and CEO

Jaclyn Boland
Healthy Schools Program Manager

Maggie Kiplagat
Human Resources & Talent Development

LIFENET INTERNATIONAL | Burundi

Year launched: **2009**

Legal Status: **Non-Profit**

Model: **Franchise**

Target Geography: **Urban, Peri-Urban, & Rural**

Number of clinics/outlets: **51**

Clients seen in 2014*: **850,000**

LifeNet International (LN) is a not-for-profit which uses a franchise model that includes nurse training, growth financing, pharmaceutical supply, business training, and marketing to improve the delivery of healthcare in Burundi.

Authors »

Stefanie Weiland
Executive Director & Burundi Country Director

Monica Slinkard
Former Medical Director

Aristide Mbonihankuye
Medical Program Manager

PENDA HEALTH | Nairobi, Kenya

Year launched: **2011**

Legal Status: **For-Profit**

Model: **Chain**

Target Geography: **Peri-Urban**

Number of clinics/outlets: **3**

Clients seen in 2014*: **24,000**

Penda Health is a for-profit social enterprise that aims to provide high-quality primary healthcare services for hard to reach populations in Kenya, with an emphasis on patient experience.

Authors »

Stephanie Koczela
Co-Founder

Nicholas Sowden
Co-Founder

Jessica Gross
Director of Health Services

ROSS CLINICS | Gurgaon, India

Year launched: **2011**
Legal Status: **For-Profit**
Model: **Chain**
Target Geography: **Peri-Urban**
Number of clinics/outlets: **9**
Clients seen in 2014*: **12,000**

Ross Clinics is a chain of multi-facility health clinics with a focus on delivering primary care. Ross uses family physicians, family dentists, and physiotherapists to provide personalized care for an entire family at an affordable cost.

Authors ❯❯

Devashish Saini
Founder & Family Physician

Naveen Vashist
Assistant Manager – Operations & Marketing

Nitin Ahuja
Assistant Manager – Operations & Supply Chain

SWASTH INDIA | Mumbai, India

Year launched: **2008**
Legal Status: **For-Profit**
Model: **Chain**
Target Geography: **Urban**
Number of clinics/outlets: **15**
Clients seen in 2014*: **100,000**

Swasth is a network of self-sustaining health centers providing quality primary healthcare services (Doctor, Diagnostics, Drugs and Dental) to India's urban poor at half the market rates. Supported by a Community Outreach Program and a referral network, each center acts as a "One Stop Shop" for health services.

Authors ❯❯

Sundeep Kapila
Co-Founder

Ankur Pegu
Co-Founder

Garima Kapila
Consultant

*Numbers estimated for December.

CENTER FOR HEALTH MARKET INNOVATIONS (CHMI)

The Center for Health Market Innovations (CHMI) is the central coordinator of the Primary Care Learning Collaborative. CHMI promotes programs, policies, and practices that make quality health care delivered by private organizations affordable and accessible to the world's poor. Managed by Results for Development, CHMI works through Regional Partners around the world and receives support from the Bill & Melinda Gates Foundation, the Rockefeller Foundation, and UKaid. Details on more than 1,300 innovative health enterprises, nonprofits, public private partnerships, and policies can be found in CHMI's programs database.

AUTHORS ❯❯

Komal Bazaz Smith
Senior Program Officer

Trevor Lewis
Senior Program Associate

Tricia Bolender
Consultant

BACKGROUND ON COMMENTERS

The following organizations, all of whom work in primary care and use a chain, franchise, or other network model, have contributed their own insights and experiences to the Handbook in the form of comments throughout the chapters.

Care 2 Communities | Haiti

Care 2 Communities (C2C), formerly known as Containers 2 Clinics, is a non-profit organization that saves lives by bringing sustainable primary health care to communities in the developing world. C2C's clinic model in Haiti offers high-quality, affordable care to low-income people and collaborates with the government to extend national priority programming for immunizations and family planning. C2C is building a network of primary care clinics across northern Haiti.

Allison Howard-Berry
Director of Global Operations

CARE Rural Health Mission | India

CARE Rural Health Mission (CRHM) is a not-for-profit organization funded by Care Hospitals' non-profit arm, CARE Foundation. CRHM specializes in delivering primary care and telemedicine solutions to rural communities by linking rural health workers in Maharasthra and Andhra Pradesh with doctors at a district-level hub and hospitals.

B. Girish Babu
Head of Operations

THE AUTHORS + COMMENTERS MAP

AUTHORS

1. Access Afya
2. LifeNet International
3. Penda Health
4. Ross Clinics
5. Swasth India

COMMENTERS

1. Care 2 Communities
2. Care Rural Health Mission
3. Rural Health Care Foundation
4. SughaVazhvu
5. Tiba Health Limited
6. Unjani Clinic
7. Viva Afya
8. World Health Partners

Rural Health Care Foundation | India

Rural Health Care Foundation's goal is to develop a chain of sustainable primary health care clinics across India targeting low-income groups, residing in the remotest regions, who are unable to access affordable quality primary health care services.

Anant Nevatia
President

SughaVazhvu Healthcare | India

SughaVazhvu Healthcare (SVHC) is a healthcare enterprise that works toward provisioning basic primary healthcare services to rural populations in India. SVHC focuses on managing chronic diseases for the community through multiple strategies that range from subscription-based payments to community involvement, demonstrating better outcomes and long-term compliance. SVHC is currently a network of nine clinics and has served over 70,000 patient visits through its network.

Zeena Johar
Managing Director and CEO

Aparna Manoharan
Head of Research & Advocacy

Tiba Health Limited | Kenya

Based in Nairobi, Tiba Health Limited is as a healthcare provider whose main goal is to promote quality primary, promotive, and preventive care sustainably to improve the quality of livelihoods of everyday people.

Fadhili Chacha
Managing Director and CEO

Unjani Clinic | South Africa

Unjani Clinic is a managed network of container clinics designed to provide primary health care services, at an affordable price, to under-served communities in South Africa. The fee-based service model enables sustainability and the empowerment of black women professional nurses through the use of a simple business model based on franchise principles.

Lynda Toussaint
CEO

Viva Afya | Kenya

Viva Afya is a primary health care company in Kenya that uses a "hub-and-spoke" model to serve densely-populated, low-income areas. In this model a main clinic (hub) is supported by several electronically connected satellite clinics (spokes).

Liza Kimbo
CEO

World Health Partners | India & Kenya

World Health Partners (WHP) is a not-for-profit organization that works to deliver quality healthcare services within walking distance to those most in need, by making markets work for the poor. WHP identifies and enhances the skills of pre-existing human resources within local health systems and develops linkages through the use of technology, creating networks of providers to deliver on a complete ecosystem of care.

Karen Pak Oppenheimer
Vice President

WHY PRIMARY CARE?

BY **DEVASHISH SAINI** (ROSS CLINICS) &
MELISSA MENKE (ACCESS AFYA)

PRIMARY HEALTH CARE IS THE CORE OF A HIGH-FUNCTIONING HEALTH SYSTEM. IT IS THE PROVISION OF COST-EFFECTIVE, QUALITY CARE FOR DAY-TO-DAY ILLNESSES TO INDIVIDUALS AND FAMILIES IN THE CONTEXT OF THEIR SOCIO-CULTURAL ENVIRONMENT.

Primary care providers serve as first points of contact for their respective communities and provide patient-centered care for a vast range of health issues, including preventive and promotive health services. They help patients navigate higher levels of the healthcare system when they need to.

Unfortunately, in recent decades, primary health care systems have failed to receive the attention and investment that they merit, both by country-governments and the international community. Below, we discuss why this is a mistake and why primary care needs to be the strongest component of a well-functioning health system.

Evidence suggests that communities and nations that invest in good primary care have consistently higher indicators of overall health than those that do not. For example, the 400 villages in India that are part of Jamkhed's Comprehensive Rural Health Project, which provides comprehensive community-based primary healthcare, have Infant Mortality Rates that are less than half those of other villages in the state. They have near 100% safe delivery and immunization rates, and malnutrition is less than 5% in under-5 children. These impressive results are not surprising, given that good primary care has health prevention and promotion at its heart and also empowers patients through health education and open information sharing.

Good primary care saves money for the family in the long run. Bad, inefficient or non-existent primary care results in small illnesses developing into catastrophic illnesses, resulting in much higher long-term costs for the same conditions. An absence of primary care can also lead to wasteful use of a low-income population's scarce resources because of self-diagnoses leading to inaccurate or substandard medicine.

Good primary care reduces the burden on secondary and tertiary care systems. As many of us can attest, a vast majority of the health care needs of any family are primary care needs. Secondary care needs are less common, and tertiary care needs are rare. With good primary care, the frequency of accessing secondary and tertiary care reduces, as most conditions are

Photo Above: A patient consults with a clinical officer at Access Afya's clinic in Kisii Village in Mukuru, Nairobi. Photo credit: Access Afya

identified and treated appropriately in early stages. Only those conditions that require secondary or tertiary care are referred on, thus ensuring appropriate utilization of these institutions. In addition, patients discharged from the hospital go back for readmission less frequently if they have access to primary care near their home. This then leaves secondary and tertiary care institutions free to develop unique specializations, procedures, protocols and efficiencies, as they were intended to. When primary care acts as a gatekeeper, the health system's resources are well-utilized to the benefit of all stakeholders.

Clearly good primary care can have incredible effects on the health of a community or nation. But the question remains: What does good primary care actually look like? A good primary care provider is multi-functional and able to provide comprehensive care. This is vital as primary care is a patient's first point of care, and the primary care provider must therefore be prepared for a wide range of potential conditions. The primary care provider is agile. He/she can quickly develop expertise in the most common illnesses seen. Also, the primary care provider is more flexible in tailoring therapy plans and changes to patients based on their individual concerns and uniqueness. Specialists and hospitals can find it difficult to be flexible on these fronts. Good primary care is responsive to context and is,

by necessity, much broader and more flexible in areas with weak health systems. A good primary care provider also understands the importance of care teams and sees his or her role as the start of a larger continuum of care.

context of the family, environment, and the patient's past history. Rather than offering episodic care, primary health care creates a continuous conversation about health outcomes and improvement. Good primary care institutions can and do deliver care to all

"A primary health care approach is the **most efficient and cost-effective** way to organize a health system."

— **Dr. Margaret Chan,** *Director-General of the WHO*

As many of us know, good primary care is complex. The primary care providers in organizations like yours and ours see a wide variety of illnesses, often presenting with poorly differentiated symptoms. They make a differential diagnosis, check for red flags, consider the patient's environment and background, counsel regarding health behavior, and coordinate care with other components of the health system. However, this complexity often goes unrecognized due to society's fascination with "life-saving" super-specialties. Communities and nations need to consciously spend more attention, energy, and funding on primary care as the backbone of the health system.

In a field where programs have traditionally focused on silos such as HIV/AIDS or TB, good primary care treats a patient as a whole, builds a long-term relationship with the family and community, and is able to provide curative and preventive services in the

socio-economic strata of the community, through the same resources, people, instruments, and buildings. Hence, health system spending on primary care can bring bigger improvements in happiness, disability-adjust lifer years (DALYs), quality-adjust life years (QALYs) and other health indicators, sooner than the same spending on secondary or tertiary care.

Good primary care is nimble and innovative. Primary health care clinics are logistically easier to set up, require less funds, and are generally faster to launch (from conception to first patient seen) than secondary and tertiary hospitals. This helps make primary health care a particularly flexible field that is ripe for innovation, whether through the creation of new models or the tweaking and adaptation of existing models. We are therefore excited to see innovations in the primary health care space, including private health care models that aim to increase access, improve quality, and reduce costs for patients.

Dr. Margaret Chan, Director-General of the WHO, summarizes this succinctly: "A primary health care approach is the most efficient and cost-effective way to organize a health system. International evidence overwhelmingly demonstrates that health systems oriented towards primary health care produce better outcomes, at lower costs, and with higher user satisfaction."

Given the importance of primary health care, the question arises of how, as practitioners and innovators, we can all make our own organizations more effective and efficient at providing quality health care to our patients. The following chapters outline key challenges and solutions we have found helpful in our own organizations.

Photo Above: Clinicians at a clinic in Burundi franchised by LifeNet International. Photo credit: Chad Bartlett

Setting Up + Expanding Clinics

"A ship is safe in harbor, but that's not what ships are built for."

— **John Augustus Shedd,** *American author and professor*

THERE IS NO SHORTAGE OF IDEAS FOR IMPROVING THE STATE OF HEALTH CARE DELIVERY GLOBALLY, BUT THE CHALLENGES COME ONCE THESE IDEAS "LEAVE THE HARBOR" AND FACE THE DANGERS ASSOCIATED WITH IMPLEMENTATION AND EXECUTION.

To overcome these challenges, an important tool in the innovator's toolkit is the idea of rapidly testing ideas and evaluating the results towards an organization's ultimate goal. The innovator can either make the decision to adopt this idea, adapt it based on learnings, or abandon this idea and learn from what did not work.

In this section, we hear from leaders in primary care organizations about how they grappled with initial decisions and trade-offs associated with setting up their clinics. These include identifying the market, service delivery, and clinical gaps, and developing an organizational model that best serves this segment's needs, choosing which services to provide, and deciding on clinic locations. The section closes with a reflection on developing an expansion strategy, considering both franchise and chain approaches.

What ties many of these reflections together is a focus on family- and patient-centric care. Indeed, successful organizations have learned the value of listening to patients and ensuring that all processes revolve around the question: "How can we best serve our patients and their families, based on what matters most to them?" In the following chapters, Access Afya discusses tools used to learn more about their customers and identify various current gaps in primary health care delivery; Penda Health, whose service model has evolved over time, discusses their processes for evaluating new services; Swasth, who has opened 21 clinics in Mumbai slums, reflects on their process to identify sites. The section closes with a reflection from LifeNet, who is currently expanding across country borders, on how they have developed their expansion strategy.

The following chapters provide inspiration and concrete tools that you can initiate and test as early as tomorrow in your own organization. *Don't wait, let's start now.*

FROM **ACCESS AFYA, KENYA**

What is the gap that your model is filling?

Peer Comments

Access Afya is a chain of micro-clinics located directly in the informal settlement of Mukuru in Nairobi, Kenya. This model has evolved and developed considerably from the original concept. We started with the basic idea of wanting to improve health access in urban informal settlements. Our research and experience showed a lack of qualified health providers in informal settlements and that patients didn't want to travel the longer distance to registered facilities when they had symptoms that they deemed to be minor, such as a fever. Therefore, the initial concept for Access Afya was a community triage point with a limited scope of service. The intent was for these easily accessible "health kiosks" to use cheap and easy-to-use diagnostics to diagnose illnesses, and then either treat the patient (if possible) or refer them on if their case was more serious.

SughaVazhvu (India): Community Triage or first-point of contact healthcare as a concept has been evolving within India. We've incorporated this into our model by pairing each of our physicians with a locally-hired health extension worker who serves as the first point of contact and carries out patient triage.

GATHERING COMMUNITY FEEDBACK

Before establishing these health kiosks, our team wanted to allow the community to participate in the design of the service, to confirm that this was the right model of care for the community's needs. We therefore engaged closely with the community health worker units in Kayaba and Kisii Village, two neighborhoods within the Mukuru slum in Nairobi, to hold focus groups with the local community. These focus groups were often run during and after health education sessions, co-run by our team and the local health workers, where community members would come to learn about topics ranging from nutrition for newborns to the effects of cheating in relationships amongst youth. This diversity of topics ensured a diversity of participants. The health education sessions served a central role in helping to build trust with the community and establish a level of openness. We were then able to pitch our ideas to the community members and receive frank and honest responses – and what we learned was crucial.

Unjani (South Africa): We also do this for Unjani Clinics before opening a clinic to ensure that we address the communities needs and expectations when we do open. A survey of 200 people in the community is completed.

WHAT WE LEARNED BY LISTENING

First, we learned that while the health kiosk concept was viewed as a needed service, it was not enough for our potential clients. They didn't want to come to our kiosks for a test, just to be immediately referred out into the existing health system. Focus group reactions to the kiosk concept illustrated a larger gap in their minds for an accessible clinic catering to a wider range of their needs. The model therefore evolved to offer the

Care 2 Communities (Haiti): Focus group dynamics are crucial to market research. Unlike individual interviews or surveys (which are, of course, important and complementary), in the focus group setting, there is often lively debate and negotiation about how the group of community members feels about or views a particular topic.

Photo Above: Access Afya staff and volunteers posing with the trash they collected after a community cleanup activity in the Jamaica Village neighborhood of Nairobi. Photo credit: Access Afya

fuller spectrum of primary care. Our clinics offer a wide range of services instead of focusing on a specific intervention, which many other programs targeting low-income communities do. We treat primary care as a first access point to the healthcare system and see it as the intervention most needed in a community with poor access to clean water, sanitary toilets, nutritious foods, and clean air. By focusing on holistic primary care, we focus on keeping patients well, rather than treating them when they are already sick, a type of care that generally isn't available in Nairobi's informal settlements.

The second key lesson that we learned from our focus groups was a dual lesson about drugs and medications. First, members of the community highlighted that they have a lack of trust in the chemists that they normally visit and in the quality of the drugs that they purchase from them. This is supported by studies on medication in Kenya that find up to one-third of the medicine, especially in low-income areas, to be substandard. Second, the community members confirmed that, when sick, Kenyans tend to self-prescribe and purchase pills, rather than see a doctor. We therefore try to fill these gaps by including pharmacies in our clinics and by having these pharmacies be street-facing. This latter point is particularly important because it helps deal with the problem of patients who self-prescribe.

For example, many customers will come directly to our chemist window asking for malaria medication. Our chemists, however, have been trained to explain to the customer that we offer malaria tests and they should consult with one of our doctors before receiving the necessary medication. This not only ensures that patients are receiving the appropriate medication, but it also gives our clinical officers a chance to speak with patients about how much medication to take, how often to take it, and at what time. Many of our patients say their regular chemists just give drugs without an explanation; the fact that Access Afya takes time to speak with the patient and follow-up makes the experience much more valuable to them. We are happy that the community is beginning to view us as filling in the gap of quality medicine that works but we know that this is not just about the quality of our medicine: good medication is the right medication taken at the right time and in the right way.

SughaVazhvu (India): The focus of Access Afya indeed seems to be making the transition from a reactive healthcare provider to a pro-active one. The WHO STEPS Manual has some excellent recommendations for community-based risk assessment methodologies, such as those that indicate individuals at high risk for diabetes and hypertension.

Care 2 Communities (Haiti): C2C has found that clients may want to purchase individual pills in an effort to save money; this compromises the quality of care if, for example, a full course of antibiotics is not observed. C2C mandates prescription sizes – ie: if 2 pills for 7 days is the recommended treatment, we only sell the 14-pill pack.

Swasth (India): Having a street-facing pharmacy has regulatory challenges in India so we do not do this. Therefore, to encourage better drug-purchasing behavior, we do not charge for a patient to just see a doctor. Charges occur only if drugs are required in some way or a procedure is done.

Photo Above: A clinical officer at Access Afya. Photo credit: Alex Kamweru for CHMI

A third key piece of feedback that we heard through our focus groups was the desire to have care that is accessible and at the community's doorstep. This let us know that it was important to be in the community and in the informal settlement. One reason that registered facilities are not found in the settlements is because the process of registering land and plot numbers is not easy. As a larger organization with plans to expand, we were able to form a relationship with the county health teams that ensured our clinics would be recognized and licensed. Another challenge is that these settlements are very dense and space is tight. Operating "kiosks" in this environment seemed relatively straightforward, but to fit full primary care clinics was more of a challenge! We spent time studying mobile clinics and other efficient spaces to fit our pilot model into a 12 foot by 15 foot room - an average plot in the slum.

One final gap that we aim to fill is access to information. Patients in slums often deal with temporary health outreach programs, chemists who have questionable training and motives, and low levels of internet access and skills for individual research. Patients have nowhere to go, then, to receive trustworthy information about health-related issues. We therefore put specific emphasis on marketing our clinics as places where patients can access necessary information about treatments and healthy lifestyles, and where they can always get nonjudgmental answers to scary or embarrassing questions.

The process of understanding community needs described above wasn't a quick one, nor is it over, but it was crucial: if we hadn't done this, we would have wasted time and resources implementing a model that may have been destined to fail from the start. For us, the value of hearing directly from our target community about the gaps they are facing, and then adapting our model accordingly, cannot be underestimated.

Care 2 Communities (Haiti): Yes, travel can be costly – both in terms of time and money – and it can also be dangerous. At C2C clinics, the client's alternative is usually a motorbike ride over bad roads to the nearest facility.

Unjani Clinic (South Africa): I agree - if education can form the basis of good primary health care and patients understand what they can do to prevent re-occurrence, the patient starts to take responsibility for their health and that of their families. Prevention is better than the cure, ultimately reducing the drain on resources.

Ross Clinics (India): Although it is important to understand the community needs before starting a clinic, it is also important not to delay too long. The best learnings can come once the clinic has launched. Therefore, it can make sense to start early with a basic setup, keep listening to the community and keep evolving the model.

FROM **PENDA HEALTH, KENYA**

How do you choose the services that you offer?

Peer Comments

The services offered by Penda have changed drastically since we first launched. It's a perfect example of how deciding which services to offer at a clinic is rarely a one-time decision, but more of an evolving process over the course of a clinic or organization's lifetime. There are a ton of factors that play into which services we offer, but overall we would say that it can generally be summed up in our patient-centric approach: we listen to our patients' requests.

PENDA'S EVOLUTION

Initially, Penda started focusing on women's health, primarily family planning with ante-natal care and then cervical cancer screening. We would see these women and start building a great relationship with them. Through this, we realized that women tend to be the decision-makers on health for their families in Kenya. These women would say, "I really trust this place. I trust it so I want to bring my kids here." And before we knew it, we were seeing whole families. We weren't expecting this, but it literally happened within a few months of us opening our first clinic. So now we run full primary care clinics.

> *Ross Clinics (India):* Similarly, we started with just medical consultation, medicines and lab tests, as this made sense from the 'provider perspective.' Now that we understand the 'client perspective' better, we offer more services that make sense from the family's perspective – dental procedures, vaccinations, physiotherapy, etc.

SATISFYING DEMAND

Our expansion into primary care was very natural, but primary care is still a pretty poorly defined arena. To decide which specific services and screenings we would offer, we first looked at what services were and were not being offered by the other health care providers in our neighborhood. This was actually fairly easy, and we found that other providers were more than happy to speak with us about the services they offer. We then combined this landscape analysis with a review of what we consider to be basic primary care needs (e.g. pregnancy tests) and used this to determine our initial service offering.

> *Ross Clinics (India):* Sometimes services choose us! We get a call from a dietician or a gynecologist who is willing to come in part-time or on-call basis, and we say, okay, let's try this out in the off-peak hours of the clinic.

Since then, we have added various other services. Many of these have come out of the follow up calls that we do with many of our patients. One of the questions that we ask on those calls is: "Is there anything that we could do better?" Often patients will suggest additional services that would help fulfill their needs, so we keep a running list of these. If there is a service that many people are asking for, we'll then head out into the community to get a better understanding of why they are asking for it: Is no one else offering this service? Or is the quality of existing

> *Viva Afya (Kenya):* The "Why?" follow up question is very important. Many times we have found that clients will make requests for additional services because they want to see you offer that service, but it is no guarantee that you will get sufficient demand to provide it at low cost. The additional research gauges actual business viability of new services.

services just not good enough? Or do people just want options? This helps us make an informed decision about whether it makes sense to add a service.

Photo Above: *A patient receiving dental services at Penda Health's clinic in the Umoja neighborhood of Nairobi. Photo credit: Penda Health*

FINANCIAL CONSIDERATIONS

Of course, with our focus on sustainability, there are always financial considerations when adding new services, although these tend to be pretty straightforward. Broadly speaking, services that we can charge for can be divided into five categories: consultation fees, drugs, labs, dental, and health promotion (e.g. cervical cancer screening). When considering the price of a service in any one of these categories, we take several steps. Our first step is a landscape analysis, which includes a competitive analysis of who else is offering this service and at what price.

Our second step is to explore the price-sensitivity of the service or test, referring to the degree to which a consumer's behavior is affected by price or not. We generally see that services that are commonly done (like malaria testing or the prescription of paracetamol) are price sensitive (meaning the consumer's behavior is heavily affected by the price), whereas services that are done more rarely (such as intravenous fluids or stitching services) are less price-sensitive. Using price-sensitivity as a consideration, we then explore the interplay of different services and how they can help off-set each other's costs (e.g. increase the cost of select labs to offset more price sensitive services). So for example, at Penda we are very firm that our consultation fees – which are price-sensitive – should be low (ours are 100 Kenyan Shillings compared with 500 Kenya Shillings at most other providers in our neighborhoods). This both supports our mission of making primary health care more accessible and gives us a comparative advantage compared to other providers.

Rural Health Care Foundation (India): We charge consultation fees since we believe that services provided for free are never valued and because we are looking to develop our clinics into self-sustaining units. However the fee charged from patients is very nominal. For a fee of Rs 60 (about US$1), the patient receives a diagnosis and a week long supply of medicine worth approximately Rs 300 (about US$5).

After that, we just need to make sure that we market our new services appropriately so that patients are aware of them and will use them. Our head of marketing and events will actually go into the community to advertise and let people know that we have new services. We are also able to send text messages to our current patient population to let them know when we are adding new services (or even running specials on current services).

EXPANDING A SERVICE INCREMENTALLY AND BUILDING REFERRAL NETWORKS

Recently, Penda added vision services at one of our medical centers, offering just vision screening. Within the first two weeks, we had 21 patients coming for vision screening, 18 of which were new patients. For now, we only offer vision screening and reading glasses. In the long-run we may hire an optician, so we can have a full range of vision services provided in-house, or develop a partnership that would allow us to offer these services through a monthly vision clinic. So, when we add a service, we'll often take this incremental "short-term, medium-term, long-term" approach, as makes sense for the service. This held true for our maternal health services, where first we were offering general ante-natal care services and only later added ultrasound.

However, expanding a service incrementally does add a moral question: Is it okay to screen a patient for something that you can't treat them for? Therefore, we have made it a priority to build a strong referral network, so that even if we can't treat the patient, we can send them to a trusted place that can. HIV is a perfect example. We do HIV testing, screening, and counseling, but we don't currently provide treatment options for our patients with HIV. We've created relationships with Ministry of Health facilities where patients can receive this treatment.

This type of **partnership** is really nice because it **decreases the burden** on the patient, allowing them to access all the care they require within their medical home.

We've also benefitted greatly from our partnership with Lancet Kenya – an internationally accredited pathology laboratory – although this works a little differently than a traditional referral. If possible, when a patient needs a test, we would prefer to run this test at Penda as opposed to sending the patient to several different places. Fortunately, our partnership with Lancet Kenya facilitates a better patient experience. For example, although Penda can't do basic blood chemistry tests in our lab, we can still draw that lab while the patient is there, and then Lancet Kenya will pick it up the same day and give us the results. Our providers can then work with the patient if they want to start treatment for high cholesterol. This type of partnership is really nice because it decreases the burden on the patient, allowing them to access all the care they require within their medical home.

Swasth (India): We have found running our own lab to be quite cost effective and it lets us control the experience.

STANDARDIZING SERVICES ACROSS CLINICS

Another question that has surfaced is whether we should have the same set of services at all of our clinics. Overall, we're aiming to have the same set of services across our facilities. However, there are a number

Photo Above: A Penda clinician organizes medicines at a community event.
Photo credit: Penda Health

of other factors to take into account. For example, we feel that it is always less risky to test a service at one facility, and then based on how successful it is, roll it out to other facilities, as we did with dental services. Similarly, some of our clinics are specifically designed to be more basic. We run one small clinic that could be called a "container clinic," so we feel comfortable with the fact that it offers a reduced set of services. Finally, especially in terms of things like pricing, we need to take into account the different clientele at our different clinics. Our clients in our Umoja clinic tend to be working middle class Kenyans, whereas those at our Kitengela clinic are lower down the economic ladder; so our prices in Kitengela are slightly lower than our prices in Umoja.

Care Rural Health Mission (India): We agree - we did a small pilot in 5 villages before scaling to 40 villages. Piloting is very helpful for learning before standardizing.

Swasth (India): Similarly, we have seen price dynamics to be very local and to differ in different parts of Mumbai. We have yet to offer different prices at different clinics due to operational complexity but we are intrigued by the idea.

BACK TO THE PATIENT

Which services to offer, where to offer them, and how to price them is a set of questions that we are revisiting every day at Penda. Clearly, as we've discussed above, there are a myriad of factors to take into account. Nevertheless, we feel that as long as we continue to listen to our patients and understand their needs and desires, they will continue to view us as their "medical home" and their first stop for healthcare.

FROM **SWASTH INDIA, INDIA**

How do you choose your clinic sites?

Peer Comments

Our experience has shown that the location of a clinic is a key ingredient for success. A poorly placed clinic will have slim hopes for becoming sustainable and viable. Nevertheless, our experience opening 21 clinics over the past three years (6 of which have closed) has indicated that clinic placement is a highly subjective decision, and there doesn't seem to be any hard formula to get it right in different contexts. Still, reflecting on our experiences, we are able to identify some important tips and guiding principles which I will share here.

Photo Above: One of Swasth India's clinics located in front of a local bazaar in Mumbai. Photo credit: Swasth India

BEING CLOSE TO YOUR "BASE POPULATION"

One basic learning is that we need to be close to where our target population lives. That may seem obvious, but we had originally thought that it would make the most sense to be at a key transit point where you have many different people passing through. Through this reasoning, we placed one of our first clinics near a railway station where hundreds of thousands of people pass through every day. Theoretically, this made

Access Afya (Kenya): We agree. We locate our clinics directly within where our target population lives, the slums. Our clinics are located next to fruit vendors and chapati sellers.

that clinic very public and easily accessible. However, there was no residential area within easy walking distance, so we found that we had no "base population." This really hurt that clinic's viability. By placing clinics near where our target population lives, we found that we could secure a regular client base while still being able to attract clients who are just passing through the area.

In addition to being near the residential areas, we learned that it is important to pick a spot with a sufficient catchment population. When we opened our first clinic, we were very hesitant to pay high rent, so we chose a location that was out-of-the-way in the corner of a slum. We thought that we would have an advantage because we were the only doctor in this area and therefore would have little competition. However, because we were in the corner, the immediate catchment was no more than a few households. Therefore, although we had great penetration in that market, we still only saw about 10 to 15 patients per day — well below our viability point of 30 patients per day. So we opened our third clinic in a location accessible to a much larger catchment area, and although the rent is at least three times higher, we're now seeing around 60 patients per day and are making a profit at that location.

We have found that assessing clinic locations doesn't always need to be an overly formal process and that we should avoid over-analyzing the situation. We actually mostly use the satellite view on Google Maps to look at the number of shanties, slums, and buildings that are in a particular area to get a sense of the population in the immediate vicinity. Our major focus is on ensuring that there is a sufficient flow of people in these areas. After that, we'll visit the street that we're considering in the evening and see the traffic of people. Based on the learnings I've described above, we have now developed a sense of intuition around this. As a result, we are personally involved in the decision-making process for every new clinic and normally make a decision about location within a day or two – or sometimes even on the spot!

Care 2 Communities (Haiti): Very interesting insight. This seems to differ from other urban models which often target transit/high-traffic locations and don't focus much on residency, since it can be fluid.

Unjani Clinic (South Africa): We agree - our residentially situated Unjani Clinics are our most successful. Generally, patients don't travel when they aren't feeling well, so they prefer to have a clinic within walking distance of where they live.

Care 2 Communities (Haiti): At C2C, we also solicit local opinions and perspectives about desirable locations within a community for a clinic, especially from community institutions with large constituencies (churches, community organizations, etc.)

> We have found that assessing clinic locations doesn't always need to be an overly formal process and that we should **avoid over-analyzing** the situation.

BEING NEAR COMPETITION

We have also learned that, at least in Bombay, it pays to be near competition. It's a cluster effect that isn't just seen in healthcare – you see businesses like restaurants and jewelers also clustering their shops. Although it seems a little counterintuitive, we have found that placing our clinics near other existing clinics is beneficial because people are already used to coming to that area to seek healthcare, so there are very few barriers for them to start coming to our clinic. Of course, for this to work, we have found that we need to communicate our value proposition and competitive advantage clearly so that we stand out from the other doctors. Therefore, we're very clear that our bundled services — where we offer clients all costs associated with their visit at a flat rate according

Rural Health Care Foundation (India): While this could be true for urban areas, it is probably not the same for rural areas. RHCF clinics in rural areas are only set up, where there is no government or primary health care facility within a 50 km radius. Moreover, competition from quacks has never had a cluster effect on our services.

Unjani Clinic (South Africa): This is a very interesting concept. In South Africa, we look for locations where we are a few kilometers away from the State operated clinics, but at least within walking distance of the nearest private general practitioner for clinic referral purposes.

to the severity of their condition — result in a cheaper visit, and that, since we offer lab tests and drugs, patients can access everything they need under one roof. As a result, we've found that patients will come to the area to visit their previous doctor but end up choosing us.

Photo Above: A nurse at a Swasth Health Clinic points to the newly opened Swasth Dental Care Clinic next door in the slums in Goregaon. Photo credit: Karen Dias for CHMI

BEING VISIBLE AND ON THE GROUND FLOOR

We don't open our clinics anywhere except on the ground floor. We're very clear that our clinics should be as visible as possible. To be visible, we make sure they are on the ground floor, they are facing the street, and the signage is prominent. In addition, we have found that it is important that the storefront should be unobstructed — we don't share storefronts with other businesses or choose locations hidden behind a tree. Our experience has shown that visibility is crucial.

EXPANDING: SPREADING VS. CLUSTERING

As we have expanded our network, we are often tempted to spread our clinics far apart so we can spread throughout Bombay faster. Spreading our clinics across Bombay would have many benefits. For example, we have received queries from some organizations, like taxi unions, about offering group enrollment to their members. However, when they found out that we are located in just one area of Bombay, they said that they couldn't work with an organization that couldn't serve all of their constituents across Bombay. So it is very tempting to spread fast to secure this large, regular client base.

On the other hand, we have identified several logistical advantages to keeping our clinics close together. As part of our system, we have several people on two-wheelers who visit all of our clinics twice a day to do things like collect blood samples and dental impressions and to deliver drugs and other products that are needed. As many people know, Bombay is a huge city with very bad traffic; so if our clinics were spread out too far from each other, collecting samples and delivering products would become a logistical nightmare.

Ultimately, we have found a nice middle ground between these two approaches. While our initial clinics were clustered very close together, we've now begun spreading them out a little further, using train stops as a basic measure of how far apart they should be spaced. Right now our goal is to try to get at least one clinic by each train stop. Only after we have spread out sufficiently across the city will we focus on gaining a deeper penetration around each stop.

Rural Health Care Foundation (India): This also helps make clinics more friendly towards the disabled.

Penda Health (Kenya): While we would love ground floor locations, Penda has 2 medical centers on a 2nd floor and 4th floor location. We've still seen great patient numbers though — around 1,000 per facility per month.

Tiba (Kenya): This is true for us too, although visibility can be a bit complicated in congested neighborhoods and / or informal settlements

Care 2 Communities (Haiti): In addition to logistical efficiencies, placing clinics closer together can also grow the "halo effect" of the brand. When a reputation for quality and value is established at one branch, other nearby branches benefit from that reputation.

FROM **LIFENET INTERNATIONAL, BURUNDI**

How do you develop your expansion strategy?

In developing an organizational expansion strategy, one big question is often around whether an organization should grow through franchising or through building their own company-owned chain of clinics. At LifeNet, we ultimately chose the "conversion franchise" model, which means we bring already existing independent clinics into the LifeNet franchise brand. Having started off with ten clinics and using this conversion franchise model, we now have fifty LifeNet clinics with a goal to reach sixty by year's end.

In considering whether to franchise or open company-owned clinics, one important element is assessing advantages and disadvantages of each in a local context and in terms of ultimately reaching one's goal – in our case, transforming primary care for Africa's poor.

OUR JOURNEY

We actually didn't start off with a conversion franchise model. We tested and tried some other models first. We tried running pharmacies within clinics, testing this model in a few different clinics. This ultimately didn't work out; there wasn't enough financial interest within the clinics themselves. We then tried the idea of mobile nurses. We envisioned a model with nurses who could visit individual households, diagnosing and training patients in their home. This structure ultimately didn't work either from a legal structure point of view. We would have needed to register as a commercial enterprise, but then taxes from that would have made sustainability very difficult.

We ultimately decided on the conversion franchise model after spending more time in clinics and repeatedly hearing, "What we need is training." We realized through speaking with clinic leaders that it's the lack of quality medical delivery and quality medical care that was killing people as much as the diseases themselves. This relates to IV complications, hygiene, and numerous other elements related to the care that is given at a facility. So we ultimately decided to develop training around quality. Once we had developed training modules to deliver and because we already had relationships within particular clinic networks, we decided to set up a conversion franchise model so that we could brand this quality training and quality metric tools.

Peer Comments

Tiba (Kenya): We currently run our own chains, which allows us to set standards and define quality measures necessary for patient satisfaction. However, for us, franchising is ultimately the way to go, as it allows for equity and efficiency on a large scale. We are moving towards a franchise model over the next 36 months.

Photo Above: Staff and clinicians in front of one of a clinic in Burundi franchised by LifeNet International. Photo credit: Chad Bartlett

THE CONVERSION FRANCHISE MODEL

A conversion franchise is different from a chain and also different from other types of franchises. As a conversion franchise, we work with partners who utilize our training and our branding. While we haven't yet progressed too far down the road of publicizing the brand, the first step is associating the LifeNet logo with each partner's clinic and giving them a banner to hang on their clinic as a LifeNet partner.

What we've found paramount in the success of a conversion franchise are our partners themselves. People make a big difference in independent outlets. Cultivation of partners is very important. Even though clinics may already have a network or some sort of affiliation amongst themselves, that doesn't necessarily mean that once you have one as a partner, you have them all. So it's very necessary to really do the work of cultivating these relationships as individual relationships.

We first identify potential partners in a number of different ways. Some of them are within networks that we are explicitly targeting (such as church partnership networks), while others come to us through word of mouth or referrals (right now in Burundi, at least half of the clinics on our waiting list of around twenty clinics have come to us directly to request a partnership). The first thing we do is just sit down and meet the leaders of a clinic. This tends to be informal; we will ask them questions about their clinic and why they are interested in this type of a partnership.

In evaluating potential partners, the first step is identifying whether the leaders of these organizations have the same mission, vision, and motivation as LifeNet. Even in more traditional franchise models, partnerships are key because it's a lot like looking for a business partner. There's got to be a click. You've got to have people who are trying to walk in the same direction and see value in one another. After the important elements of mission, vision, and motivation, we also look at other aspects when considering partnership. We want to find clinics with high patient volume because that results in greater impact for the work that we do.

Of course, government structures and legal frameworks are another important consideration. Legal frameworks that are beneficial to our work, for instance, include freedom for non-government clinics to make purchases of medicine and equipment as well as pay for training as they

Unjani Clinic (South Africa): While we are not a franchise, but rather a network of clinics founded on social franchising principals, we found that the use of a single brand (Unjani) is very powerful in that our patients recognize the value statement and offering that they identify with the Unjani brand.

Ross Clinics (India): This makes sense. Quality primary care requires patient-centeredness, community orientation and flexibility. We can try to instill them within our employees, but for franchisee partnerships, they must be present at the outset for the partnership to succeed.

Access Afya (Kenya): This is so important; if things like mission and vision are not explicitly talked about, we find an organization struggles to be effective. We spent two days this year doing this internally even!

see fit; freedom for non-governmental clinics to hire and fire (even if they are Ministry of Health staff); a speedy and simplified approval process of programs and memorandums of understanding (MOUs) with the Ministry of Health; imports of medicine and medical equipment exonerated from duties, etc. As we continue to expand to other countries, elements such as whether to charge a franchise fee and the ability to sell things like eye glasses differ depending on legal frameworks in that country. In Uganda where there is a requirement for continuing medical education (CME) for medical professionals, for instance, we plan to get certified as a registered provider of CME and then charge a monetary franchise fee for providing this CME.

Photo Above: *A clinician at one of LifeNet International's partner clinics records data. Photo credit: Chad Bartlett*

THE PARTNERSHIP PROCESS

Once the diligence process progresses beyond this first step of ensuring alignment in mission, vision, and motivation, we bring a nurse and a management trainer to the site. We utilize a checklist to do a quick assessment of number of employees, patient volume, and service offerings. We try to get as much basic information as possible. We then schedule a more in-depth meeting to sit down with the church leader (for those clinics that are part of church networks), clinic leader, and head nurse to walk through the partnership agreement and expectations from both sides. Assuming that there is a fit on both sides, we enter a contractual agreement to try it out, with opportunities for either organization to walk out in case it's not working.

We want to find clinics with high patient volume because that results in **greater impact** for the work that we do.

The first three months are really important. We conduct three trips and at least one quality assessment. We then sit down with our partner to review the various elements. This is their chance to say what their expectations were, for instance: "I thought you were going to be giving us medicine for free," and our chance to better explain our model.

World Health Partners (India): This is an interesting, though seemingly resource-intensive, way to onboard a franchisee, which allows you to weed out those who are not a good fit early on.

Photo Above: A village where one of LifeNet International's partner clinics is located. Photo credit: Chad Bartlett

This is usually the meeting in which there is a real understanding in the partnership and what we do. We then ask whether they would like to sign on for the next year and go from there. At this point, we have a waiting list of about twenty clinics.

Ultimately, the decision of whether to expand using a conversion franchise model, a traditional franchise model, or a chain model depends largely on organizational goals and the local context. In Burundi, there is a serious lack of capital, so it would be difficult for an individual to buy into a traditional franchise and start a new clinic. This would often require receiving money from outside the country to start a clinic. So in this context, the only way a traditional franchise might work is by having the franchisor also have a large fund to help establish the new clinics, with a way for franchisees to ultimately pay this loan back.

Unjani Clinic (South Africa): While we are a network and not a franchise, it seems that the benefits of a conversion franchise model over a chain model include an existing patient base, an established clinic (infrastructure) and an independent operator that does what is necessary to pay the bills every month.

THE COMPANY CHAIN MODEL

In terms of evaluating a franchise model versus a company chain one, we have found that one important distinction is the control of hiring and firing employees. Franchises do not have this power, though company-owned clinics do. As a company-owned chain, you can choose who your managers are. You can have a say in the recruitment process, while in our model, we don't. We can have influence – a soft kind of influence and influence by requiring reporting on performance, but ultimately as a franchise, we really can't choose our managers.

Another advantage of company-owned chains over franchises is the ability to standardize changes on a systems level. As a franchise, we're unable to say: "Patient flow would really work a lot better if we combined all payment systems at this particular point, so let's create one point of sale and rearrange the clinics accordingly. We can then cut these particular points in the process to create a much more efficient system." We're unable to make this type of change. We can suggest it, but we can't implement it. The only levers we have are access to the partnership and to particular loans.

It's an amazing thing to witness our partners internalize the learnings and trainings, and **watch them transform**.

OUR DECISION

Those are the primary areas where being a chain would help. On the other hand, based on our analysis and assessment of the local context, starting a company-owned chain would have been too expensive and capital intensive, with a much smaller impact given the investment. This would have required us to start brand new clinics or purchase existing ones. A company-owned chain model tends to open new clinics one at a time, so compared to a franchise model, growth can be limited with slower impact.

World Health Partners (India): Franchising is a good way to go when you are faced with limited resources, and you see that the existing resources can be leveraged and improved. It also takes advantage of the existing client loads of established clinics.

Photo Above: A clinician at a clinic franchised by LifeNet International.
Photo credit: Chad Bartlett

Photo Above: One of LifeNet's Nurse Trainers with a clinician at a franchised clinic. Photo credit: LifeNet International

At the same time, <u>a conversion franchise model allows us to work in partnership with local organizations, developing local leadership and local initiative.</u> It's an amazing thing to witness our partners internalize the learnings and trainings, and watch them transform. We've seen many examples of this through our partnerships. It's a different kind of trade-off, and one that we are happy to make.

Regardless of the actual model of expansion, one important element to keep in mind is the actual strategy for expansion. At LifeNet, we try to expand in units of ten clinics. We've found that running cohorts of ten makes sense in terms of making key hirings, such as a nurse trainer, a management trainer, and a driver for each group of ten clinics. As we vision out and plan how we will expand in other countries, it's always around starting with a group of ten clinics.

Managing by cohorts also has the advantage of training and quality improvement. Each time we report scores to senior leadership at a clinic, we report scores within the cohort, so they can see how their clinic is doing relative to others with whom they started. This serves as a great motivator for people, especially those clinics who are not doing well. Of course, we keep the actual names anonymous.

These are considerations for expansion that have worked well for us at LifeNet. The process of developing an expansion strategy is a very individual process, based on one's ultimate goals around impact and scale. We are using these lessons, as well as continuing to learn more, as we expand and grow beyond Burundi to Uganda, the Democratic Republic of the Congo, and beyond.

SughaVazhvu (India): This is indeed a very fascinating model. The concept of 'conversion franchise' has been implemented within healthcare in India in many single specialty and small 30-50 bedded hospitals. The core of training and other support services coupled with peer-learning through LifeNet's cohort based strategy sounds like the appropriate format for scale.

IDEAS TO TEST
FROM SECTION ONE

1 **Before opening a clinic in a community, understand the "status quo."** Where are families currently going for their health care needs, and why? Community outreach workers are incredible resources to connect with patients and better understand how they make their health care decisions. Once the current state is better understood, it becomes easier to build an organizational model and set up a clinic to meet these needs.

2 **Continually ask patients the question: "Is there anything that we can do better?"** Capitalize on opportunities to ask this question at the clinic as well as through follow-up calls. Develop a system to continually catalog, analyze, and evaluate these recommendations based on organizational goals and resource considerations.

3 **Choosing site locations for new clinics is often a subjective, but informed process.** Don't let "analysis paralysis" prevent you from making a decision and testing. A "perfect" site location seldom exists; so what is more important is developing learnings for your own organization. Broad themes include opening a clinic near your target population as well as considering opening near competition – thereby taking advantage of pre-existing "healthcare hubs".

4 **In considering whether to expand using a franchise or company-owned chain model, one important element is assessing the local context and assessing how each approach contributes to an organization's overall goal.** Franchises allow less control over hiring, firing, and managing employees, but can offer a faster path for growth in resource-constrained environments where capital to open new company-owned clinics may be lacking.

Providing Care

" People will forget what you said. People will forget what you did. But people will never forget how you made them feel."

— Anonymous

SECTION

2

PRACTITIONERS IN GLOBAL HEALTH KNOW THERE IS LITTLE TRUTH TO THE ADAGE, "IF YOU BUILD IT, THEY WILL COME."

Building a health care delivery organization is only the first step. The next crucial one is actually providing care that is high quality and affordable, which encourages patients to not only come, but to also convince their friends and extended family to come to your clinic for their care because of their experience — thereby building a strong customer base for your organization.

Successful leaders in this space focus on customers and the experience they provide them. Crucial in this customer experience are the providers themselves — a clinic staffed with unhappy providers is unlikely to yield happy patients. The chapters in this next section discuss tools to better understand patients' wants and needs, developing a relationship with patients throughout the continuum of care, and utilizing patient's feedback as a key input to improving quality.

Penda Health, recognized for their patient-centered care, discusses tools they have used to better understand patients' needs and desires. Ross Clinics discusses their use of "lean staffing," which employs principles of Lean Manufacturing to create more value for customers with fewer resources. LifeNet reflects on their approaches to instill change in provider behavior centered around improving quality of health care delivery.

FROM **PENDA HEALTH, KENYA**

How do you improve patient experience?

Patient experience is truly at the core of what we do here at Penda Health. By that we mean, at Penda we're not just interested in giving our patients the healthcare that they need, but also in giving it to them in the way that they want it delivered. Our goal is to make our patients healthy and happy. In fact, as a for-profit organization, we must stay focused on our patients. If the patient doesn't leave us both healthier and happier, they may not come back at all. Below, we are happy to share some of the approaches that we have used to determine patients' wants and needs, as well as insight into what we have found patient-centered care to look like in the Kenyan context.

Peer Comments

LISTEN TO THE PATIENT

For us, the key to creating a good patient experience is to listen to our patients and see them as partners in their own healthcare. We need to understand what matters to them and what they want, and then work hard to use that information to create their desired experience. This means that we need to constantly receive feedback from our patients. In this process we'll ask many questions and explore different areas of the patient experience, but the ultimate question that we are working to answer is: What is the one thing that would make a patient never return to Penda, and how can we avoid that?

We use five different methods to gather feedback: focus groups, feedback calls, follow up calls, a comment box, and feedback through SMS (text messages). We receive some of our most useful feedback during the focus groups. Focus groups are held once a month at each clinic with six to twelve people, including both current patients and others from the community. We generally cover topics relating to people's expectations of their healthcare provider, such as the services they want, how they like to be received, and the desired speed of their care. We sometimes cover specific issues that Penda is grappling with at that moment. For example, when we were thinking about different loyalty incentives that Penda could use, we held a focus group to help us think about how to design these incentives.

The feedback calls have also proved to be very useful, because it gives us a chance to ask outright about how their actual experience was and how we could improve it. We do about 10 feedback calls per week and ask three straightforward questions: how was your visit, how would you rate it on a scale of 1 to 10, and what could we do to improve your visit. These

Photo Above: A receptionist at one of Penda's medical centers. Photo credit: Penda Health

also help us get feedback on how our individual providers are performing on patient-provider interaction.

Similar to the feedback calls, we also try to conduct follow up calls with all of our patients within a couple days of their visit (we generally do this for about 80% of our patients), where we ask how the patient is doing and see if they had to go anywhere else to get additional care. Although these are more focused on following up on the patient medically, they are also greatly contribute to our understanding of the patient's experience with Penda. On the other hand, we have yet to find the comment box and the feedback by SMS (which is advertised in our waiting rooms) to be very useful for receiving meaningful feedback.

It is important to be conscious of the "black box" – the fact that many of our true wants and desires exist below the surface where we may not be able to truly verbalize them. This means that just asking what a patient wants may not be enough. One thing we've done to understand the black box is to make our focus groups not about Penda – we actually teach facilitators to not mention Penda. Instead we ask people about their behaviors. If you ask someone, "Is it important to you that you are attended to quickly?" they will undoubtedly say, "Yes." But if you ask them where they last went to seek healthcare, they'll say that they went to a government facility where they had to wait four to five hours. So instead, we ask questions like "If Facility X has a good doctor but you will need to wait three hours, and Facility Y has a doctor that is just okay but you could be seen right away, which would you prefer?" This type of questioning forces people to compare the importance of two different things that they say matter to them.

PATIENT-CENTERED CARE IN KENYAN CONTEXT

By gathering feedback through the previously mentioned methods, we have managed to identify a number of areas that we have found very important to invest in to improve patient experience. It should be noted that these were learned through our experience in the Kenyan context, but many would likely hold true in other contexts as well.

Access Afya (Kenya): We also find that patients sometimes prioritize their ailments and inform the clinician only of their worst condition due to fear of additional financial burden. So our follow-up calls have been a great opportunity to ask about unreported ailments and to encourage the patient to return to the clinic if needed.

Swasth (India): We definitely agree. We tried gathering feedback through SMS and through comment boxes and also found them not to be effective.

Unjani Clinic (South Africa): Interestingly, at Unjani Clinics our comment box is the most effective manner in which we receive feedback. We find that patients are reluctant to provide feedback through direct communication via telephone or in groups as it restricts confidentiality.

Care 2 Communities (Haiti): We whole-heartedly agree and have found the very same experience with our patients in Haiti: what they report that they value often does not align with what they do. Asking questions about behaviors, rather than desires, has been a much more effective way to gain consumer insight.

Investing in our clinics. Based on direct feedback from our patients themselves, we've determined that perception of quality is very important. One basic way that we try to display quality is by putting an emphasis on having physically attractive clinics. If you walk into our medical centers, they're clean, they're bright, and they're beautiful. The clinic that we just opened even has a skylight so the sunlight can pour in. We also employ full-time cleaners at our clinics and try to keep them as clean as possible for our patients.

Similarly, patients appreciate knowing that we have high quality equipment and that we are fully stocked with drugs. We therefore have put big windows in our pharmacy and lab so that patients can see our equipment and see all of the drugs that we have stocked on our shelves.

Unjani Clinic (South Africa): We found that because we are a private clinic (not a public facility), it is considered a "status symbol" for patients to be seen in our clinics. The look and feel of the clinic is extremely important.

Ross Clinics (India): We agree. We have glass walls (partially glazed for semi-privacy) for most of the rooms. This makes the clinic look more open, informal, and well-lit - and everyone in the waiting area can see that the doctor and staff are actually busy providing quality care!

In the end, we have found that it is the **small things** that really **make a difference** to our patients.

Finally, there are certain considerations that may seem small but that have made a big difference for patient experience. For example, although we deal primarily with outpatient issues, we will occasionally receive patients who are passed out or unconscious and are being carried in by their friends and relatives. We therefore purposefully put wider doorways at the front of our clinics so that it is easier to bring these patients to the procedure room. Another small but useful feature is that we have specifically avoided locks that require keys on both sides of the door to open (as is standard in Kenya). We have found that these keys often become lost, which means that the doors are effectively unlockable. We therefore exclusively install twist-locks, so that the doctor can always ensure patient privacy during a sensitive exam and not have staff or anyone else walk in on them.

Viva Afya (Kenya): Based on our experience, we do not lock consultation room doors at all, for the safety and comfort of our clinical staff and clients. We find the curtain screen is usually sufficient.

Investing in our services. Our patients like to have everything under one roof. When we first launched, we focused on women's health. However, we found that the women who came to us didn't want to go to one place for their own health and another place for the rest of their family's health. So we expanded to become full primary care clinics where they could access everything in one place (see our other chapter in the Handbook about how our services evolved over time, p. 19). Similarly, we have found that if we send patients away to buy drugs at another facility, they often won't come back. That was powerful information for us because it means that even if we have a great provider who sees the patient in a timely manner and gives them an accurate diagnosis, the patient may not come back if we don't have the drugs they require.

Ross Clinics (India): Clear communication of charges upfront also enhances patient experience. We encourage our dentists to clearly talk to the patients about the charges for each root canal and each crown separately before initiating the procedure.

Unjani Clinic (South Africa): This aspect is one of the "delights" that our patients at Unjani Clinics express most – "we get the medicines we need immediately, and we don't have to go anywhere else".

Investing in our staff. Our friendly and non-judgmental staff play a central role in making patients feel comfortable. We put a ton of energy into encouraging our receptionists to be friendly and focused on the patient because reception is a patient's first point of contact with the clinic. One example of this is that we give our receptionists the power to give patients discounts without approval from a manager. This absolutely opens us up to the risk of overuse — but it also gives our receptionist power to make the patients so happy!

Care Rural Health Mission (India): Our experience has been different: although having drugs is important we find that the quality of treatment by the doctor is a more critical factor having patients return in the future.

Photo Above: One of Penda's providers provides a health check-up during a community engagement event. Photo credit: Penda Health

We also spend a lot of time screening our providers to find doctors, clinical officers, and nurses who are non-judgmental. In particular, we offer free medical education trainings to non-Penda health professionals, and use those to help identify potential hires. We feel that simply by coming to these non-required trainings, these providers are showing an intrinsic motivation to provide high-quality, patient-centered care. We then also look specifically for providers at the trainings who are particularly engaged and ask particularly good questions.

We also invest a considerable amount of time and resources into making sure that our patient-centered culture is communicated to new employees and not lost as we bring on new people. One tactic for this has been to have new staff shadow current staff at all levels as part of their onboarding process. They'll shadow anyone from our cleaners to see how they open the clinic, to our receptionists to see how we greet patients, to our providers and laboratory technicians to see examples of how we prioritize our patients. It is crucial that our culture of focusing on the patient doesn't get lost with staff turnover.

Investing in the small "extras." In the end, we have found that it is the small things that really make a difference to our patients. I think the way we give balloons to children is a perfect example. It's a really simple act, but just blowing up a balloon helps people know this is a safe place and that we're going to take care of them. This is not something that patients will find at most other clinics.

The balloon is just an example, but we really try to give that something "extra" throughout the whole visit. When a patient walks in, our receptionists immediately drop what they are doing to attend to the patient. If there is a child coming in, they will give the child the balloon and pull out a child-sized chair for him or her. Our staff is trained in basic triage. For example, if someone has a fever, they're given paracetamol while they're sitting in the waiting room. Similarly, we've worked with our providers so that they don't just walk down the hall, pick up a file, and then scream the next patient's name. Rather, they walk out into the reception area, greet the patient by name, and then walk them back to the exam room. If the patient needs a test, our provider will walk them down to the lab and hand them over to the laboratory technician. We also prioritize recording each patient's history and not losing patients' records (the records never leave the clinic) because if we lose the patient's record and don't know their history, they'll feel like we don't know them and they'll stop considering us their medical home. All of the above really serves to personalize the whole experience.

Care 2 Communities (Haiti): Completely agree. During recruitment and hiring, we specifically look for clinicians who demonstrate an understanding that the C2C brand is not "business as usual" but represents a different sort of high-quality model.

Rural Health Care Foundation (India): While finding motivated professionals is central, one also needs to keep them motivated to keep working efficiently, especially in case of rural areas. Therefore, at RHCF, we provide our doctors with free boarding and lodging along with annual increments to their salaries.

Unjani Clinic (South Africa): We also found that having a "kiddies corner" with a few soft toys to play with made our little patients feel more at ease and just for a moment forget about how sick they were feeling!

Rural Health Care Foundation (India): We agree that this is important. In fact, we are working towards installing bio metric systems at our clinics to help maintain and track detailed medical records of each patient.

Another important aspect of the patient experience for Penda is the follow-up call. The follow-up calls are done by our providers who call back every patient after three days and ask them three things: "How are you doing? Are you feeling better? And have you had to go anywhere else to get additional care or medications?" These calls have three main benefits. First, our patients love it that we care enough to call and make sure that they're getting better. Second, the calls really build the relationship between the provider and the patient. And finally, the calls help us ensure that our patients actually are getting better and if they're not, we can bring them back in for a free follow-up consultation.

Photo Above: Patients receiving a typical Penda welcome with warm smiles and free pink balloon. Photo credit Penda Health

FINANCIAL CONSIDERATIONS

Of course, we can't ignore the financial considerations of investing in all of these extras. We work closely with our procurement officer to find the lowest possible price for the gifts and other items that we give patients. But we also feel that investing in the patient experience is part of doing good business. If we take really good care of our patients, not only are they going to come back, but they're also going to tell their friends about their experience. Returning to the balloon example, it is not as likely that a patient is going to go to his or her friend and talk about the sensitive details of their doctor visit, but when their child gets that balloon, that's something they'll talk about! And that helps make the whole investment more cost-effective. Ultimately, we're just looking for the little things that we can do to make our patients happy, and we're thrilled to see that these seem to be creating lasting impressions.

FROM **ROSS CLINICS, INDIA**

How do you staff your clinics?
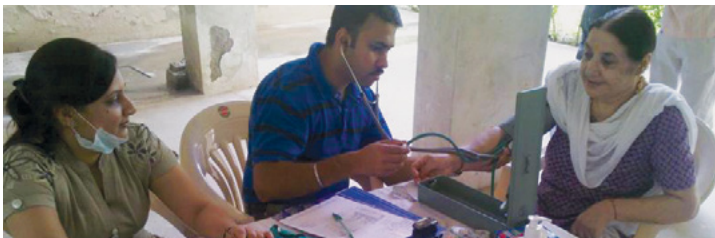
Peer Comments

Staffing and human resources don't always garner the most attention from those interested in the social enterprise space. Innovations in human resources are not necessarily that flashy or exciting. Nevertheless, our experience has shown that staffing has huge implications for a clinic, from its financial sustainability to the patient experience. Therefore, we at Ross clinics have invested considerable time in implementing and improving our lean staffing model – a model designed to maximize efficiency in human resources, ultimately leading to various benefits for the patients themselves.

LAUNCH AND EVOLUTION OF STAFFING MODEL

Initially when we launched, we thought that our clinics would have three primary staff: a clinic manager who would be in charge of the reception, stock management, and dispensing medicines; a nurse who would take vitals and provide some counseling to patients; and a doctor who would be the primary care doctor for the clinic. At first, we thought this was "lean," but over the course of time we have had to make it even leaner, largely due to issues of cost and our effort to be affordable for our patients. We realized that our clinic managers could actually takeover many of the activities which we assigned to our nurses, so now we have just a clinic manager and a doctor at each clinic (excluding dentists and other specialists who come in on a more ad hoc basis).

Rural Health Care Foundation (India): We agree. In order to cut down costs and make the RHCF clinics more affordable, one of the doctors at the clinic also doubles up as an administrator.

BENEFITS OF LEAN STAFFING

We originally began using the idea of lean staffing for financial reasons, but we have now seen several other benefits that have made it an

Access Afya (Kenya): Similarly, a key member of our clinical staff is a community health worker who supports the front desk, is responsible for maintaining the cleanliness of the clinic, and participates in outreach activities. We're considering expanding this role to include taking vitals while supporting the front desk.

Photo Above: A Ross Clinics clinician takes a patient's blood pressure.
Photo credit: Ross Clinics

attractive model. One benefit is that we are now able to use smaller clinics. This both decreases rent (which turns into savings that can be passed on to the patient) and allows us to be more flexible in where we locate our clinics as we expand.

In addition, having just one clinic manager has increased our personal relationship with our patients, because we have one single person who takes care of the patient from the time they pick up a phone asking, "When can I come in?" to when they actually arrive and are registered. The same person then assists the doctor with any procedures, dispenses medicines, collects lab samples, and collects payment. The fact that the patient is dealing with just one person – besides the doctor – really helps to increase their trust and build a long term relationship.

Nevertheless, being too lean can be restrictive in that a limited number of staff can only handle so many patients. Our one clinic manager, for example, can probably handle fifteen to twenty patients per day, but if we see a significant increase in patient levels, we would probably need a second clinic manager. As our clinics continue to grow, we'll have to explore and test to see how an additional staff member can best be incorporated to complement the clinic manager's current role.

> *Access Afya (Kenya):* Being too lean can also affect team morale and happiness. Balancing work and life is key for all staff members. Securing a locum pool is key in ensuring flexibility in scheduling to allow for days when staff request days off.

> The fact that the patient is dealing with just **one person** – besides the doctor – really helps to **increase their trust** and build a long term relationship.

PATIENT NEEDS VS. HOURS AND LEAVE

As we became more lean, we also reduced the number of hours that our doctors were working, so that rather than working from 8:30am to 8:30pm (which was a big financial burden for us), they are now working a 3 hour morning shift and a 3 hour evening shift. Not only did this not bother most of our patient since these were the hours when they were coming in anyway, but it strangely enough seems to have increased patient satisfaction. This is because, at least in our market in the Delhi or Indian context, we have found that patients believe that the doctor should be accessible but not too accessible. If the doctor is completely available, the patient begins to wonder whether the doctor has low demand because they are of low quality.

Another key staffing question is around leave. We've realized that, to fulfill our patients' needs, our clinics need to stay open seven days a week. It's not as if you can close on Tuesdays because patients don't get sick then. However, insisting that employees work every day of the week is unsustainable.

As a result, we have worked to optimize our clinic managers' and doctors' time in two ways. First, we offer our clinic managers flexible leave. Most of them have home towns that are about six to twelve hours away from our clinics. So rather than going home every weekend, many

Photo Above: The names of several physicians are prominently displayed in on of Ross Clinics' waiting rooms. Photo credit: André J. Fanthome for CHMI

of them prefer to work seven days a week for around a month and a half and then take fifteen days of leave all at once to go spend more time with their families. On the doctors' side, many of them are generally willing to work their shifts for all seven days a week, but for those who aren't, we'll get a locum (temporary) doctor who can fill in one or two days a week for vacations and emergencies.

RECRUITING

Recruiting is a central issue when it comes to staffing. When we first launched, we advertised on Naukri.com, a website for people looking for jobs in India. Putting job-postings there helped us to get our initial staff. However, more recently, we have been pulling more and more people from our own network. These new hires are sometimes people who were referred by our current staff; other times they are people who worked with some of our partner organizations (though we make it a policy to not actively poach these people).

The in-person interview is unsurprisingly a critical step in the process. During the interview, we focus less on clinical skills, because we believe clinical skills can be learned on the job. Rather, we use the interview to focus on questions like: Is this person excited about working in primary care? Are they self-motivated? Or will we need to be constantly following

Viva Afya (Kenya): We have found it too expensive to allow our clinicians two days off in the week, which they agitated for. So we give them one "rest day" in a week, and one other day they are out of the clinic, but 'on call'. The nurse will then attend to patients on those days, and call the clinician for telephone consultations or to come in if necessary.

Care Rural Health Mission (India): We generally give our clinicians Sunday off since it is a holiday with low patient workloads. We've also found that it generally isn't necessary to keep the clinician at the clinic round the clock during days they work. We've implemented a helpline to refer to nearby clinics for times when our clinics aren't staffed which has helped.

Care Rural Health Mission (India): We put greater emphasis on clinic skills. We view it as important to identify clinical strengths and emphasize continuous education to upgrade staff skills and improve the quality of treatments. We often train doctors before they even come on board, as well as do an audit of treatment and prescriptions.

Photo Above: A Ross Clinics' dentist in the dental room of one of their clinics.
Photo credit: André J. Fanthome for CHMI

up to see why they are not doing certain types of work? The person will be alone for most of the day, so it is quite important that they are highly motivated. Are they willing to learn? There is huge learning that happens in the first fifteen days. Are they able to handle multiple things at the same time? Are they good communicators and able to form strong relationships with patients quickly? We give these factors at least the same weight as a candidate's clinical skills, if not more, and we have been fortunate to find doctors and clinic managers who are eager to learn, have strong communications skills, and believe in the importance of responsible primary care that doesn't involve unnecessary tests or medicines.

In terms of the background and experience of our clinic mangers, after trying people with a number of educational backgrounds, we ultimately found that lab technicians with one or two years of experience working in a clinical setting are the best fit for the job. We of course provide them with additional training on things like the use of computers, patient handling, and stock keeping and dispensing. But we have generally found that they are very motivated to learn and that the lab-related (and other) skills that they bring are the right fit. We also found that people who are fresh out of school don't work very well. We tried a couple of people without prior work experience, but we think the expectations are just too high for them. But people who have had one, two, or three years of experience learn and work beautifully in this context.

On the doctor side, we have found two kinds of doctors who have worked out well for us. One model is the older retired doctors who want to continue working after retiring from their regular job but do not want the hassle of managing a clinic (being responsible for rent, etc). They want to come in for a few hours a day and get a comfortable income at the end of the month. The other kind of doctor that has worked well in our clinics is one who is studying for his or her post-graduation but is looking to earn some extra income during that time. Overall, we have quite a mix of young and old. Whatever their motivation, if they are excited about primary care and about providing high quality care to the people at affordable cost, then they will find that Ross Clinics is the right fit for them.

Access Afya (Kenya): We also believe it is important to hire clinical officers who believe in our mission and treat patients well. We even include a mock consultation as part of our interview process.

Swasth (India): We tried this same idea, but found Lab Techs did not want to work as an assistant at our clinics.

Rural Health Care Foundation (India): RHCF clinics mostly hire older retired doctors because they not only come with a great deal of experience but they also charge lesser than doctors who are in private practice. Instead they are happier with a regular income at the end of the month.

FROM **LIFENET INTERNATIONAL, BURUNDI**

How do you instill change in provider behavior?

Peer Comments

Changing provider behavior and instilling a culture of quality improvement is not easy. But it's at the core of what we do at LifeNet, so we've learned a lot along the way. We've worked to develop a model that's very interpersonal and interactive. This model rests on mentorship and training, ensuring that training is not just a one-sided data dump. Rather, we focus on building relationships between the trainers and trainees so that they build trust – and even a friendship – over time, and can truly be a resource to one another.

We're still learning a lot. In our experience so far, we have found three crucial areas to instill change in provider behavior: **(1) mentorship; (2) formal training; and (3) incentives**.

IMPLEMENTING CHANGE THROUGH MENTORSHIP

The success of our medical and business training is based on the trust we build with partner clinic staff, which leads to lasting behavior change and heightened capacity. Outside of medicine, we see mentor-mentee relationships as an important component of behavior change. Take Alcoholics Anonymous, for instance. Everyone in the program has a sponsor. It's a lot easier to undergo a major behavior change if you have someone on your side – who is not there to demean you, but to support you. Within medicine, there is a mentor-mentee relationship all through medical training. In nursing and medical school, you have your classes, but then you also have a clinical externship or residency where you're working with other people, and they are mentoring you informally or formally to become the provider that you become. This culture of mentorship continues outside of school, too. Clinicians learn from one another all the time. I think this is especially true in low-resource settings when people don't have access to the internet or many books. This peer-learning mentorship model is what we are trying to instill.

We have nurse trainers who are assigned a certain number of clinics that they visit every month. During this visit, they do a formal training for about two hours, but then they spend the rest of the day working with the clinical staff one-on-one or in small groups to make sure that all the

Penda Health (Kenya): We couldn't agree more. At Penda, the director of health services works with team leaders at each medical center to coach their providers on improving performance based on key quality metrics.

Photo Above: A clinician at one of LifeNet's partner clinics washing his hands, one of the basics of healthcare which is taught in LifeNet's curriculum. Photo credit: Chad Bartlett

information is understood and implemented, while building a rapport with providers. Beyond these on-site visits, our nurse trainers will also follow-up with regular phone calls.

This mentorship model rests on the understanding that people learn in many different ways. The model is meant to be individualistic and also supportive. We've worked with our nurse trainers to recognize different ways that people learn, and what different personality types need to encourage them to learn. While just offering information alone can work for some, it does not work for most. That's why we really try to leverage rapport and personal relationships that have been formed out of encouragement and trust.

Every month, we have a training of the trainers. Besides teaching new curriculum, these sessions also focus on role plays and practicing how trainers respond when a nurse is not doing something right. We build on the trainers' natural personalities – some of them use humor a lot and some are very gentle. We focus against having an attitude of shaming or anger. People don't say: "You're not washing your hands, you're disgusting." Instead, it's more like: "Let me help you with this; this is really important and worth doing, so let me help you." Doing things together – and not just talking about them – builds rapport. You see somebody hanging an IV in a way that's going to increase the risk of infection. You can go over and say, "I know a different way to do this that can be really effective; can I show you?" We encourage them to make it a comfortable interaction where people are more open to learning from them versus simply handing out negative criticism. At the same time, the trainers are still very direct: they identify any actions that differ from our quality protocol, point these out, and demonstrate the correct procedure.

FORMAL TRAINING

Of course, the mentorship model does not exist in isolation. We also provide formal training, which is linked with clear expectations and a transparent measurement system. In Burundi, nurses deliver 80% of all health care. So we work at the frontlines and deliver our medical

Access Afya (Kenya): Direct feedback on areas of improvement is key. Through chart reviews and calls to patients on treatment outcomes, we can identify gaps and determine corrective measures to include in training or external continuous medical education.

Penda Health (Kenya): At Penda, we provide a monthly educational intervention on two topic areas comprised of an online module, 1-on-1 discussion and a continuing medical education class, where our providers teach the content to other providers in the clinic vicinity.

training directly to nurses. We designed our curriculum for the local context and to align with the priorities of Burundi's Ministry of Health as well as the international community's Millennium Development Goals and Post-2015 Development Agenda.

The LifeNet curriculum is divided into five sections. Each section consists of about six months of training. The first module is about basic patient safety and hygiene. If you don't have the basics down, it's really difficult to move onto more complex work. The following modules focus on reducing morbidity and mortality for maternal health, child health, and neonatal and infant health, and then move on to chronic and non-communicable diseases. In each section, we pulled from local regional data to target the most common causes of morbidity and mortality, where the breakdowns are in the system, and where the breakdowns are in knowledge.

We use quality scorecards as an improvement tool, to see whether what we're teaching is actually being implemented and is making a difference to the patients. An important aspect of the quality scorecards is direct input from the patients themselves. For instance, we ask patients questions related to their experience of quality, such as: "Did you feel well-cared for during your visit?" and "Did the nurse ask you many questions about your problem today?" as well as quality audits, such as whether the nurse washed their hands before touching the patient and whether the medications they needed were available at the clinic. This patient feedback is an important input into the quality scorecard evaluations.

We are fairly strict with our new evaluation tools and use this as a measurement of whether to continue our partnerships. Our partners have two chances to pass and achieve over 80%, and then we have a conversation about whether we continue. If they don't hit the 80% mark, we view it as an indicator of their level of commitment to change and improving quality.

Access Afya (Kenya): LifeNet's scorecards are an interesting tool for evaluation. We also started with SafeCare standards, and used their cards to help create a structure for customized quality indicators.

This **mentorship model** rests on the understanding that people learn in **many different ways**.

THE USE OF INCENTIVES

There is a lot of discussion and debate over the use of incentives for instilling change in provider behavior. Although this has caused some cultural push-back, we think of incentives in a different way than straight cash through a per diem. We are trying to come up with more creative solutions than cash incentives that are more sustainable for the clinics themselves. We spend a lot of time visiting and listening to the providers at our partner sites. We have discovered that one of the big motivators for clinics that we partner with is more access to specialty care and specialists. So one incentive we have built in is specialty training. For instance, if the provider hits X% on their training module this spring, they would have access to a dental specialist to train the local staff. Bringing in specialists to teach specialty procedures often helps with income

Care Rural Health Mission (India): We see this as well. We have output-based incentives in our program, such as the number of people in the community being educated and the number of home visits, which help make delivery more effective in the community

generation, thus becoming an incentive to the clinics themselves due to their focus on sustainability.

At the clinic level, we have a series of incentives based in credit for purchasing drugs and equipment from us. Depending on which module they pass, the clinic receives a credit. For example, we have a pharmacy program where we deliver medicine to the clinics at close to cost. If the clinic passes one of the first modules, then they can get credit for this. They don't have to pay for the medicines when we bring it, but rather pay the following month. While credit incentives begin with medicines, these incentives progress to credit for equipment, which is something the clinics really value.

What we've found **does not work** in changing provider behavior is **shaming the provider** or being a burden.

On an individual level, we offer certificates for completion of each module. This helps keep people motivated individually, and is a way of holding people accountable for the information that has been taught. If they pass a written and practical exam, they get a certificate saying they have passed the module, as well as a small bonus incentive like a t-shirt or a pen that helps make people feel they are really part of a team working together.

So these are the areas that have worked for us. What we've found does not work in changing provider behavior is shaming the provider or being a burden. When you shame a provider in front of their colleagues, it breaks trust. It breaks their trust with you, and it may also break your trust

Ross Clinics (India): It is great that LifeNet has a formal standardized system for provider behavior change. We have seen some success with informal measures: communicating the mission, vision and values frequently, peer knowledge exchange sessions, easy availability of training material at desk, and specifically for providers, independent decision making.

Swasth (India): Agreed. We have also found "shaming" / criticizing to be better one on one and recognition in a group

Photo Above: Clinicians in the middle of a training at a LifeNet partner clinic in Burundi. Photo credit: Chad Bartlett

Photo Above: A clinician sees a patient at a clinic franchised by LifeNet International.
Photo credit: Chad Bartlett

with other people you're working with. It's not something that helps build a team. Sometimes this is counter-cultural, so it's something we have to work on together. We try to encourage our nurse trainers to be helpful and ensure that they're not being a burden. Instead of sitting there and reprimanding them in front of a patient, "Why aren't you washing your hands?" we encourage them to try to help instead. We've found this idea of "working together" to be crucial in both instilling and sustaining behavior change and quality improvement.

It's not easy to change behavior. It's a very individual process. Atul Gawande talks about this as well. He writes: "To create new norms, you have to understand people's existing norms and barriers to change. You have to understand what's getting in their way. So what about just working with health-care workers, one by one, to do just that?" He talks about a nurse's experience with her mentor. In the beginning, she felt that her workload was increasing through these visits. But then, she came to look forward to these visits: "She showed me how to get things done practically… It wasn't like talking to someone who was trying to find mistakes. It was like talking to a friend."[1] These are exactly the kind of one-to-one relationships we try to foster at LifeNet. And we are encouraged by the results we're seeing.

[1] *Atul Gawande, "Slow Ideas," The New Yorker, July 29, 2013.*

IDEAS TO TEST

FROM SECTION TWO

1 **Many of our true wants and desires exist below the surface, where we may not be able to truly verbalize them.** As Henry Ford said, "If I asked customers what they wanted, they would have said faster horses." Asking patients what they want is an important first step, but it's only a first step. Immersing staff in communities to more fully understand a patient's world is one way to overcome this barrier.

2 **Minimizing staff through maximizing efficiency provides one approach to creating more value for customers by using fewer resources.** It is important to test assumptions to see what mix of human resources is required in a particular clinic or model. Examining this from a patient's perspective, often patients want one point of contact, from contacting the clinic by phone to interacting face-to-face. The patient's desire for 24/7 accessible healthcare must be balanced with the needs of the provider staff themselves.

3 **There are three powerful levers for instilling change in provider behavior: (1) mentorship, (2) formal training, and (3) incentives.** In particular, mentorship provides a powerful incentive for change by fundamentally restructuring interactions from a culture of blame and "actively looking for mistakes" to one of collaboration and partnership, which develops a culture of learning. At the same time, it is important for trainers and coaches to still be very direct, identifying actions that deviate from quality protocol, pointing these out, and demonstrating correct procedure.

Setting Up Effective Systems

" There are no organizations without institutional habits. There are only places where they are deliberately designed, and places where they are created without forethought, so they often grow from rivalries or fear."

— **Charles Duhigg,** Author of *The Power of Habit: Why We Do What We Do in Life and Business*

SECTION

3

IN THIS FINAL SECTION, LEADERS IN PRIMARY CARE REFLECT ON THEIR EXPERIENCES IN BUILDING EFFECTIVE SYSTEMS, WHICH IS CRUCIAL IN SUCCESSFULLY EXPANDING ONE'S ORGANIZATION.

With one or two clinics, an organization can rely on the success of a particularly effective individual and on ad-hoc processes. However, as an organization scales, strong systems become necessary to maintain quality, rather than relying on an individual provider or manager for this.

While innovation tends to focus on developing the overall model itself, successful leaders have also found ways to innovate around seemingly mundane everyday tasks such as managing supplies, building an information system, and developing feedback loops within one's organization. These processes help organizations become more efficient, thereby better serving customers and supporting scale by systematizing key organizational functions.

While processes such as supply management, information systems, and internal feedback loops appear to be "back-end" services focused on the organization itself, reflections from leaders in the field show that they are crucial in providing high quality care to patients. Without a well-functioning supply management system and tools, patients may be unable to purchase medication that is needed for an illness. At the same time, organizational tools such as internal feedback mechanisms can help ensure that this family's needs and desires become inputs to organizational decisions and strategy, thereby helping the organization to grow based on insights generated by the patients themselves.

In the following chapters, Ross Clinics discusses principles around managing supplies and preventing stock-outs, while Swasth India – a leader in using information technology – reflects on their own journey of creating effective information systems. The section closes with Access Afya writing on feedback loops and their approach to continuous monitoring and evaluation.

FROM **ROSS CLINICS, INDIA**

How do you manage supplies and prevent stock-outs?

Managing supplies and preventing stock-outs is a key challenge for us, both organizationally and in making sure we offer the best care to our patients. As we have learned, stock management needs to be a very important part of operations, even if it's not the primary source of revenue. Otherwise, it has the tendency to become a primary source of loss for the organization.

CHALLENGES

The main challenge we face is on two fronts. The first is stocking too much, which results in expiration of items and general revenue loss to the clinic. The second is stocking too little, which leads to stock outs and the loss of patient satisfaction. Since these patients would need to go elsewhere to fill their prescriptions, it also leads to a revenue loss for the clinic.

Peer Comments

Penda Health (Kenya): We've found supply chain management to be equally challenging and important. When we ask our patients what factors would make them not return to Penda, "being sent away to purchase medications" is a top reason. Good supply chain management of drugs is core to our business.

Photo Above: Dr. Devashish Saini, founder of Ross Clinics, sees a patients in one of his clinics. Photo credit: Trevor Lewis for CHMI

Photo Above: Supply organization at Ross Clinics. Photo credit: André J. Fanthome for CHMI

There are a few major drivers that lead to these challenges. The biggest is variability. Since we are dealing with urgent care, there is large variability in patient footfall and sale of medicines. There is variability day-to-day: one day we might have thirty patients, while the next day we might have ten. There is variability in disease patterns as well. If we see a lot of patients with viral fever one week and decide to stock more of those medicines, there is no guarantee that we'll see any more viral fever patients the following week. Of course, there is also seasonal variability, where we see increased footfall of certain kinds and in certain clinics. There is also variability in the prescriptions of doctors themselves; some doctors have their own favorite antibiotics, antacids, and pain killers. However, for the most part, we can predict seasonable variability and variability in doctors' prescriptions. It's the day-to-day variability that is the most difficult to predict.

Besides inevitable variability, there are several other factors leading to supply challenges. The first is the issue of combination medicines. Instead of writing seven drugs in a prescription, there may be rational combinations that we can prescribe with only three or four medicines, which makes it easier for our patients and increases their compliance with the medicine regime. In diabetes, for instance, we need to keep five medicines in about fifteen to twenty different combinations, in order to cover the prescription needs of all our diabetic patients. This adds to operational challenges, as we need to understand and order each combination separately.

The second problem is that we are still not yet at the volume and size where we can source from pharmaceutical companies directly. Instead we have to talk to individual stockists, who are somewhere in the middle of the supply chain. What that means is there may be many changes in brand names. For example, with Ciprofloxacin we have had Ciprodac, Ciprobid, and Ciplox. All of these are generic brands of the same medicine as Ciprofloxacin, but sometimes when we go to purchase one, say Ciprodac, Ciprodac may no longer available at any of the stockists in the city. Then we just have to purchase whatever is available and instruct our clinic managers and doctors what brand is currently available.

A last issue is around pilferage. I keep hearing about pilferage in the context of supply management, but fortunately we have not encountered this problem at Ross. In reflecting on the reasons this has not historically been a problem for us, a few learnings come to mind. The first is we keep limited stock in our clinics and we don't overstock. We also don't stock many daily use items and cosmetics, which tend to be the items

Care Rural Health Mission (India): To help address this challenge of variability, we allow three drugs for each requirement in our drug formulary. Our doctors then prescribe within those selections, giving them flexibility while still allowing us to purchase at bulk pricing.

Rural Health Care Foundation (India): In order to minimize costs, we often procure near expiry drugs from pharmaceutical companies at cheaper rates.

Care Rural Health Mission (India): We have found that this challenge can be mitigated by having a drug formulary and approximating the necessary medical stocks. We have three accepted drugs for each requirement.

generally pilfered. Secondly, there is a lot of transparency and regular inventory auditing in our system. Lastly, we have a policy that staff can purchase medicine at cost for themselves and their family, so there is really no reason for them to pilfer the medicines.

PRINCIPLES THAT HAVE WORKED FOR US

We know there is no silver bullet to these challenges around managing supply and preventing stock-outs. However, there are five over-arching principles we've used to help in supply management. The first is developing a culture of shared responsibility in our clinics. Both our clinic managers and pharmacists are responsible for ensuring we don't have stock-outs. We have determined the stock-out, or reorder, quantity for our clinics. This is the quantity at which the clinic managers get an alert that they have to reorder a particular medication. We have a Google spreadsheet that keeps track of the reorder quantity for each item within each clinic. Once the current quantity falls below this reorder quantity, the spreadsheet highlights this in yellow. Clinic managers therefore get a visible alert and can call our head pharmacist to reorder more. Our head pharmacist also looks at this data on a daily basis to make sure we stay on top of this, particularly because we keep such a small amount of stock in each clinic. This has helped instill a culture of shared responsibility between our clinic managers and pharmacists: everyone needs to be responsible to prevent stock-outs.

Second, we ensure transparency in our systems. Our stock data and cash registers are available on Google Docs, and this is shared with all doctors, dentists, clinic managers, and senior management. Everyone knows that everyone else is looking at the data. Anyone can question the data, asking, "This doesn't look like the usual, so what happened in this case?" We are very open with our data. We have found that giving access to all the people who need to access the data helps build accountability within the organization. It also allows us to track medicines across clinics. We keep a tab on our near-expiry medicines and then transfer them within our clinics, so that they actually get used before the expiration date. Over time, we are getting better at predicting demand. We are starting to understand trends in patient footfall, doctors' preferences, the seasonal variations, and even the day-to-day variations.

Rural Health Care Foundation (India): RHCF works on a similar principle: we have a Daily Reporting system, where each clinic head reports to the Head Office on the number of patients treated that day, available stock of medicines, and requirements ahead.

We are starting to **understand trends** in patient footfall, doctors' preferences, the seasonal variations, and even the day-to-day variations.

Third, we focus on simplicity. We use a simple Google spreadsheet to track our supplies. We originally considered getting a proprietary stock management system, but in retrospect, this would have been too costly for us, from both a financial perspective and time to install and train our employees. We went with the easiest and cheapest solutions through Google Sheets, which has also helped with transparency across

Access Afya (Kenya): We have a different take on simplicity. For us, the elegance of the interface on our point of sale and inventory management turned out to be crucial to it working correctly. Some of our providers are less familiar with tools such as excel or Google docs, so we use Shopify for sales and Stitch for inventory.

Photo Above: A student helping Ross Clinics to set up their drug dispensing system. Photo credit: Trevor Lewis for CHMI

the organization. In disconnected systems with multiple clinics like ours, a tool like Google Docs is really helpful for improving day-to-day supervision and accountability.

The fourth principle is ensuring we are always looking for what's best for our patients. We use an ABC VED system to classify medicines according to their importance in terms of patient care and volume. ABC is categorized in terms of high, medium, and low sale-volume. VED stands for Vital, Essential, Desirable based on their importance to patient care. While there's more we can do with this, this framework has helped us to reorganize our stock and recognize the wide variability across different items.

Lastly, we focus on doing small things well. These may be considered "boring" daily stock-keeping tasks, but they are crucial to keeping the system running well. The most important element for us is effective planning. We look at all of our patient footfall and sales data and forecast based on this analysis. With this forecast, we can then purchase our medicines. Sometimes the data is limited, but it's still possible to forecast. We also ensure we have ongoing relationships with as many vendors as possible, so that we get competitive rates and are also not dependent on one single vendor. If they are stocked out of a medicine, you're also stocked out. Having multiple vendors is very important.

Swasth (India): Our integrated IT system helps with this by triggering an alert when stock is low. Central warehouse purchases are based on average consumptions, and we set cutoffs for each location based on need.

Lifenet (Burundi): We have found that these "small" things actually make all the difference for our partner clinics' stock management. Our partner clinics typically have high patient volume and quick turnover of pharmaceutical inventory. So if the day-to-day calculations are incorrect, they will order the incorrect amount of medicine the next month.

CONCLUSION

As a final word, I want to emphasize how important supply management has been for us, both from our patients' perspective as well as our organization's. Even if the pharmacy or the dispensary is not the primary source of revenue, we've found that it has to be treated as the primary source of revenue, in terms of the amount of time and effort that is spent on this. I've been asked my advice for organizations just starting out who may not have a lot of patient footfall and sales data. My advice would be to start with low amounts of stock, because when we are starting any new venture, we all tend to be very optimistic about what is going to happen. Also, it is important to expect variability; it will always be there. And to invest time and effort in stock management processes and systems, in order to provide high quality, consistent service to patients – which is a goal for all of us.

Care Rural Health Mission (India): Our experience finds the opposite: optimum stock needs to be there, as well as a reserve to cover for variability in demand. Especially starting out, trust for a pharmacy depends on ensuring 100% availability of drugs – even if this means stocking higher levels.

FROM **SWASTH INDIA, INDIA**

How do you create effective information systems?

My co-founder and I have fairly untraditional backgrounds for healthcare: we both have computer science degrees and were spurred to start Swasth to pursue our passion in the development sector. Given our technology backgrounds and our goal to rapidly scale effective health systems, we knew that technology and information systems would be the backbone of the company we built. Indeed, information technology is a very critical component of our work. However, at Swasth, we don't just build technology systems for technology's sake. We see effective information systems as crucial in both serving our patients well and scaling up our organization effectively; it helps us better analyze trends in our clinical data, and also sets up internal processes to keep things running smoothly. In this piece, I am happy to share more about how we've been able to do this and the types of key questions we asked ourselves in the process of building and maintaining effective information systems.

HOW INFORMATION SYSTEMS HELP US SERVE OUR PATIENTS WELL

Looking at this from a patient-centered approach, electronic medical records (EMR) are the backbone of our information system at Swasth. Our EMRs include a history of each patient and each of their visits to Swasth. Each family receives one physical card, and each family member has a unique ID to record each visit, the details of the visit, the lab results, medicine prescribed, and treatment done. All of this medical history is captured through the card. This system ensures that the doctor has an accurate patient history. At the same time, we provide hard copies of the consultation notes to our patients who prefer a physical record. However, patient notes can also get lost if there's only a paper copy. With EMRs, doctors are able to clearly see the patient history and compare any new lab reports to historical ones.

With the data that we collect, we are able to do different types of analysis to gain greater insight on the population we are serving. For instance, we do analysis around diagnosis, looking at which diagnoses we see most frequently and the expenditure per diagnosis. Right now we're thinking of how to best focus on chronic patients and figuring out how we might improve compliance.

Peer Comments

Tiba (Kenya): At Tiba, we currently use an open source system called Care2x, which allows us to provide holistic care through good data management and information systems that let us facilitate follow ups and manage appointments.

Penda Health (Kenya): At Penda, we still use paper patient files. We're currently identifying information we want to capture to inform targeted outreach, guide clinical care and measure provider performance.

Photo Above: A Swasth staff member uses the organization's back-end IT system. Photo credit: Swasth India

As we were developing this information system, one question we asked ourselves was whether to run this from laptops or other devices, such as mobile phones or tablets. This depends on an organization's priorities. For us, cost matters because we are focused on serving patients living in Bombay's slums. Tablets are more expensive than laptops; a basic laptop is cheaper yet more powerful. For us, operating in an urban slum, a laptop offered more flexibility than options like mobile phones, though a provider in a rural setting may find using mobile phones more beneficial. It all depends on the environment.

One big learning for us has been around building contingency plans. We originally thought of developing a system that was purely online. But in a place like Bombay, internet connectivity is always an issue. So now our system is offline and works without an internet connection, yet syncs up on the cloud once or twice a day, based on internet connectivity. We found this approach works well for us.

We monitor and evaluate our information system through an audit process. Basic details are audited by the doctor each day. A summary printout of the data entered is given to the doctor, who verifies it against the physical copy of the record. At the same time, the physical copy of every patient record comes to the central office every week. This information is checked against the data available online. In case of any errors, a scan of the physical copy is uploaded and a second auditor goes through the system and makes the final correction. Once this happens, the record is marked as audited and completed.

HOW INFORMATION SYSTEMS HELP OUR ORGANIZATION SCALE

Besides the electronic medical records, our Enterprise Resource Planning (ERP) solutions are integral for our organization as a whole. ERP helps us run and scale our business. To give you an example, when we were small with only one or two clinics, our staff was only about eight to ten people whose monthly salaries were processed manually.

Unjani Clinic (South Africa): We've also found a laptop to be most helpful: it acts as our server across our clinic network, is portable for security purposes, and the battery power ensures continued operation even during a power failure.

Care 2 Communities (Haiti): We found that having both an electronic and a paper system actually slows down the adoption of technology. While paper was naturally more comfortable for our Haitian clinicians, switching completely to an EMR system helped our staff gain confidence more quickly. We now have a tablet-based medical record system, which can also be accessed via a laptop.

So someone would sit one day each month and process payroll. Once we got to five centers, we realized we could no longer do this. There's a lot to keep track of — for example, how many days of leave were taken, computing salary based on the number of days worked, etc. So ERP helps us automate monthly payroll. Now everything is done through the IT system. For instance, everyone applies for leave online. We also track whether people are arriving on time through the system. The system continues to evolve and improve as we continue to grow.

Another example of how our ERP has helped us to grow and scale is through internal communication with our staff. Our staff is currently distributed across fourteen centers. Without the ERP system, it would be very challenging to communicate any announcements or changes in guidelines or processes. Now we have an internal messaging system that allows anyone to note any system breakdowns, whether it's as small as a light bulb not working or something much larger. We've had both EMR and ERP since almost the beginning at Swasth. This helps keep everything running smoothly.

CONSIDERATIONS AND LEARNINGS

For us, some of the major considerations of developing information systems have been the cost-benefit trade-off, the sequencing of EMR and ERP, and whether to build the systems in-house or use open source solutions.

Care 2 Communities (Haiti): This is an important decision-point for facilities considering EMR or ERP: custom software or open source? It depends on the unique needs of the operator/model. For example, C2C uses a customized EMR system on-site at the clinic, but we use an open source software platform for our Community Health Worker program.

With **one click**, I can easily generate a profit and loss statement of every Swasth clinic. That is **very powerful** information for me.

One question I often get is around the trade-off between the investment in time and money against the benefits that an organization receives through an information system. I can only speak for Swasth, but for us, investing in electronic medical records and an ERP solution has been very worthwhile. There are so many insights that come from the data. Our challenge right now is that we have more data than we can analyze, from both the clinical perspective and the business perspective. With one click, I can easily generate a profit and loss statement of every Swasth clinic. That is very powerful information for me. I know that one clinic is losing this much money each month, while this other clinic is generating this much profit – here is the gap, and here is our revenue per patient. I know the profit per patient that I'm making on regular consultations, on dental visits, on lab visits – and this is crucial to the sustainability of Swasth given our focus on low-income patients. This type of insight is crucial in prioritizing our investments in the business.

It also helps run the enterprise itself. I get 24 daily reports about operations at the clinic level. We can see whether a doctor came in late today, and if so, we call the doctor that day to ask them why. These calls aren't harsh or scolding, but it's enough to let everyone

Lifenet (Burundi): This is a challenge we face as well. Though we are collecting all data manually, we still have an overwhelming amount to analyze. We have begun using SalesForce to organize our clinical and management data.

Unjani Clinic (South Africa): In our clinics as well, ERP as opposed to manual systems, has allowed us to make quicker management decisions and better support our clinics. Clinic owners can focus on more patients and less on manual data capture. Clinics can also plan cash flow and expense management – using the manual system, this was an impossible task and owners were often surprised when the numbers were finally calculated.

Photo Above: A young nurse at the Swasth Dental Health Clinic in a slum area of Goregaon. *Photo credit: Karen Dias for CHMI*

know that someone is watching. Over time, this changes behavior because everyone knows it's not professional to be late. You don't have to tell them that; they know. The information systems we have allow us to get very micro in the level of detail and insight, which helps us run the organization at a macro level more effectively.

Another consideration is around whether to start with the EMR side first, or the ERP side. For us, it was important to integrate these two from the outset because to serve the patient well, these two systems have to be linked. Let me give you an example. Medicine inventory is something that needs to be integrated between both systems. Now when the patient's bill is created through the electronic medical records side, the medical stock are automatically deducted on the ERP side.

For us, a related question was whether to build these systems in-house or use existing open source solutions. When we embarked on this journey, we found very good ERP solutions and very good EMR systems. The challenge though was that they did not talk to one another, and it was difficult to customize them to do so. So that's why we ended up building our own systems in-house. The other primary reason was our need for both offline and online access. Ultimately, it is based on the needs of each organization, but we found this is what worked best for us.

> *World Health Partners (India):* Our experience was that our needs for the ERP changed over time. Our first attempt to build an ERP failed, but turned out for the better, because we realized we didn't actually really understand our own needs for the system early on.

THE HUMAN-SIDE OF INFORMATION SYSTEMS

As I conclude, I'd like to touch on one final important area, and this is the need to understand the human side of information systems. Information systems are only as good as the quality of the data entered. We've purposely kept the electronic medical records basic, and instead, worked with our staff to focus on improving the quality of data entry.

Information systems are only as good as the **quality of the data** entered.

In our experience, we've found that it's very important to understand the human psychology elements of information systems – both from the provider side as well as the patient side. One thing we were clear on is we didn't want our doctors to enter our data. This is because the doctors themselves did not want to do this, and the patients did not want the doctors to do this either. When we talked to peer organizations, we heard their patients complaining that the doctor was looking at the computer instead of paying attention to them.

We want our doctors to focus entirely on the patient, given they have skills that no one else has. Instead, we train others in the organization to enter in the data. Each clinic has two assistants; one manages the reception and enters all the information. We've coded the information and have given doctors diagnosis codes that are easy to remember. For instance, an upper respiratory tract infection is R1 (which is the most common respiratory tract infection), so the doctor just has to write R1 on his paper notes and the assistant enters this into the system. The notes themselves are a pre-carbonated set format, with one copy going to the patient and one copy remaining with us. That copy is audited after the data entry is done, so we are sure the data has been captured correctly. We do spend significant effort on this, but we don't disturb the doctor to do so. Sometimes it's easy for these types of considerations to get lost when building an effective information system, but we've found these types of considerations crucial to best serving the patient and scaling up effectively.

Unjani Clinic (South Africa): I completely agree – where possible, we have limited the ability to input data into our Patient Management System to the basics and ensure that much of the required data is not editable by the user to ensure that product codes, product descriptions, diagnosis codes, and treatment protocols are standard across our clinics for reporting purposes.

Access Afya (Kenya): We also believe a system should not be distracting to patient care. This is why we are doing a lot of work on developing visually appealing and easy to use interfaces, so when our providers do enter information, it does not take a lot of time and effort.

FROM **ACCESS AFYA, KENYA**

How do you continuously improve your model?

Our model is built to include constant monitoring and evaluation for improvement of our products and services in order to better serve our customers. Access Afya was founded with the belief that the healthcare industry was not treating patients like customers, meaning that the clients' needs and wants were not being taken into account. As a social enterprise, we are committed to putting client needs and wants at our core. Our social mandate drives us to care about designing a model that our patients actually value, and our enterprise structure means we need a lot of clients to perceive this value so that we can keep our doors open. We, therefore, put a specific emphasis on ensuring that our patients have multiple, ongoing avenues to provide feedback on our service, and we make sure that we use this feedback to continuously improve our model.

FEEDBACK FROM PATIENTS AND THE COMMUNITY

Peer Comments

One way we solicit feedback is through direct engagement with our current customers through weekly customer care calls. Originally, this was done on a quarterly basis. However, we were inspired by other members of the Primary Care Learning Collaborative, such as Penda Health, who do weekly customer calls. We now call a sample of our clients every week, which provides us with the most recent, relevant data.

Thirty patients are chosen at random (fifteen from each clinic) to call and discuss their customer experience that week at Access Afya. The customer care calls are completed by a member of the office team, not a clinician. Each client is assured their medical information is confidential and we do not have access to that information; our interest is in the experience the customer had at our clinic. First, we ask how the patient is doing and if they are improving. We then ask what they liked about our clinics, did not like about our clinics, and what they would like to see in the clinics. We then ask them to rate us on a scale of 1-10 (1 is low, 5 is medium, 10 is high).

Care 2 Communities (Haiti): These are interesting customer feedback loops. At C2C, we also conduct customer satisfaction surveys and we use the opportunity to ask not just for a satisfaction measure, but also what we could do differently that would improve the experience.

Another way we receive feedback is through direct engagement with the broader community. Our outreach team, comprised of both office and supportive staff, conducts weekly door-to-door marketing to understand brand awareness and use of Access Afya through qualitative feedback.

Penda Health (Kenya): Community engagement is extremely important to informing efforts to improve patient experience. Penda gathers this information through monthly clinic focus groups.

Photo Above: *One of Access Afya's clinics in the Mukuru slum in Nairobi. Photo credit: Alex Kamweru for CHMI*

Finally, we use our Brand Ambassador Program as a feedback loop to gain deeper insight about our brand and model. In this program, we specifically work with community health workers who are already referring to Access Afya, rather than trying to attract referrals through an incentive scheme so that our brand ambassadors truly believe in Access Afya and its value. We provide the brand ambassadors with special cards, t-shirts, and information on Access Afya's services so they can share Access Afya's products and services with fellow community members, neighbors, and friends. Over a monthly team meeting, we meet with our ambassadors to learn from their experiences in the field and hear what customers and community members are saying about Access Afya. The feedback, ideas, and opinions from these meetings are then shared with management and the clinics, and discussed at weekly staff meetings as opportunities to enhance or improve our services to better meet the wants and needs of the community.

INTERNAL FEEDBACK LOOPS

Our feedback loops aren't just patient facing; we also make sure to give our staff a chance to be heard. Our weekly clinical team meetings provide a central space where staff can bring up concerns, successes, questions and suggestions. On top of these clinical meetings, our clinical staff uses a Google Group on a daily basis to discuss and share new evidence, stories, policies, and challenging cases. This provides a space for staff to receive continuous feedback and input from their colleagues, which plays an important role in accurate treatment, teamwork, and quality improvement. This space serves a secondary purpose too. By seeing what clinicians do discuss, the management team can better respond to real needs. One example of this is when we were approached by a local health technology

Penda Health (Kenya): Penda also conducts weekly team meetings at our medical centers, which are core to addressing issues in real time and ensuring smooth facility operations. These meetings also build team morale, as each member offers appreciations for others' outstanding efforts over the previous week.

Swasth (India): These meetings are very useful. We hold them once a fortnight for administrators and once a month for doctors.

company that wanted to pilot remote clinical second opinions. When deciding on an ideal use case, we asked the clinicians what they were already discussing on Google Groups to make a decision on which types of specialists we might benefit from.

This encourages a greater sense of **ownership** and satisfaction among the staff in both **their own work** and in the **organization as a whole.**

As an organization, we come together multiple times each year. This simple act of reconnecting and spending time together is essential, especially with clinical operations that are "micro" and increasingly spread out. One example of an all-staff day was this summer's Vision and Value Day. Here, the full team had the chance to comment on, question, and agree on the vision of Access Afya, and then list and commit to its values. This encourages a greater sense of ownership and satisfaction among the staff in both their own work and in the organization as a whole.

INCORPORATING FEEDBACK

Creating continuous feedback loops isn't easy. It can be tempting to gather initial feedback for the design of a project, and then to just forge ahead. But we have found gathering feedback on an ongoing basis to be key to ensuring that our model is relevant and responsive. We also actively work to avoid the trap of gathering feedback, but then failing to incorporate it into our model in any significant way. We therefore put great value on this feedback and make sure that it is incorporated in a number of ways to improve our model and the services we offer. For example, we have found that great feedback comes out of our customer care calls. We find that patients like to tell stories and share their experiences, positive or negative. One comment patients make repeatedly about Access Afya is that other clinics in the area don't follow up with their patients. They feel we are special and they appreciate the time we take to make these calls.

Furthermore, patients ask for Access Afya to offer additional services such as x-rays, dental services, and ultrasounds for pregnant women. This feedback is then recorded in our customer care database, which we maintain in a survey format and use to track customers' comments, suggestions, and ranking of their experience, as well as to outline the patients' treatment outcomes and processes. This has led to the addition of several new services. For example, patients repeatedly requested that our clinics offer stool analysis for quick diagnosis and treatment of amoeba that cause diarrhea. Due to poor sanitation in the areas surrounding the clinics, water is often contaminated, and the prevalence of diarrhea is high. With this feedback, we have procured a microscope and are working to certify a new lab in order to perform this procedure.

Care 2 Communities (Haiti): This is an important approach for clinic models that are spread-out and expanding. Each clinic operates as a business unit, but there is so much to learn from each other. Creating that sense of support and comradery across work sites strengthens the brand identity internally, which is projected externally.

Photo Above: An alley, in the Mukuru slum, near one of Access Afya's clinics.
Photo credit: Alex Kamweru for CHMI

In addition, we have used the community surveys to obtain real data to design membership packages based on the wants and needs of the community. Questions on the survey form teach us about our target market, with questions such as: What savings methods do you currently use? What features would you value in a membership program? How do you teach others about health? This helps us to intentionally design products and services that meet exactly what our target community wants. For example, regarding the membership program, potential clients gave us great answers not only on the membership card features they liked, but also on how they currently use our clinic and on how they think the membership should be priced.

After analyzing feedback, we sometimes contact individuals to participate in focus groups to dive more deeply into the wants and needs of the community and how Access Afya is or isn't meeting these through our products and services. The information from these focus groups helps us to continually refine our competitive advantage and relationship as a health care provider in the community. One thing we heard a lot is that people associate Access Afya with a pharmacy, since most "clinics" in slums are actually medicine shops without

World Health Partners (India): Choosing which questions to ask and how to structure them in the right way is very important and very difficult! More of us should apply design thinking to create questions that produce the most useful responses.

Care 2 Communities (Haiti): This is so common: local misunderstanding about what the clinic offers. We try to get accurate information out through the channels we know are reaching people – for example, 30% of our patients hear about us through church announcements, so we focus on making sure that the church message is strong, accurate, and consistent.

Photo Above: A clinical officer at Access Afya examines their drug supply. Photo credit: Alex Kamweru for CHMI

doctors. Therefore, we've now created a new Access Afya "mascot" that is a mannequin dressed as a doctor that stands outside of each of our clinics! This is a funny attention grabber that also helps communicate that we are more than just a pharmacy.

We also incorporate qualitative customer feedback into staff performance reviews and evaluations. Using comments gathered from patients, we design training modules for clinical officers and clinical staff on how to maintain a high quality of care. Positive comments from the field are also shared and celebrated during weekly staff meetings, which is a great motivational tool for our staff.

We make sure to incorporate staff feedback, too. At a recent full-team meeting, it became clear to us that clinicians had lots of ideas about how to attract and retain clients. In response to this, we have decentralized part of our marketing budgets directly to the clinics to let the clinicians spend the money in ways that they deem to be most effective, such as free vaccination drives. One really popular outreach activity is "community clean-ups" in partnership with local community-based organizations. This was an idea by our office manager that our whole team liked, so we threw in team time and resources to make it happen.

Care 2 Communities (Haiti): This is great – Kind of a "360" approach to staff performance evaluation. It motivates staff to link customer satisfaction to their job performance.

SUPPORTING OUR VALUES WITH FEEDBACK LOOPS

Before opening our first clinic, and again this year after operating in Nairobi for two years, we came together as an organization to articulate and reaffirm shared values: empathy, quality, trust, discipline, commitment, honesty and respect. While we work every day to achieve these values, they are only as strong as the staff's and customers' perceptions of them. If a patient feels that we are not providing quality, then they need an avenue to let us know so that we can improve. Feedback loops are essential to living our values.

IDEAS TO TEST
FROM SECTION THREE

1   **Overarching principles to help with supply management include developing a culture of shared responsibility in clinics between clinic managers and pharmacists, ensuring transparency in systems, and focusing on simplicity.** Sometimes, even a simple Google spreadsheet to track supplies can be very powerful and can help with transparency across an organization.

2   **Effective information systems can be very helpful in scaling an organization and meeting patients' needs well.** Electronic medical records can help a provider in tracking a patient and family over time, as well as allow an organization to analyze trends in illnesses and medical conditions. An Enterprise Resource Planning (ERP) tool can help systematize organizational processes. Organizations must assess benefits and cost of these types of solutions based on their goals and available resources.

3   **It can be tempting to gather initial feedback for the design of a project, and then to just forge ahead, but gathering feedback on an ongoing basis helps to ensure that our model is relevant and responsive.** Both external and internal feedback loops are important. Customer care calls, door-to-door outreach, and focus groups can be useful for gathering feedback from patients. Internally, weekly staff meetings, Google Groups, and occasional "Value and Vision Days" can provide good opportunities for staff to provide feedback on the model.
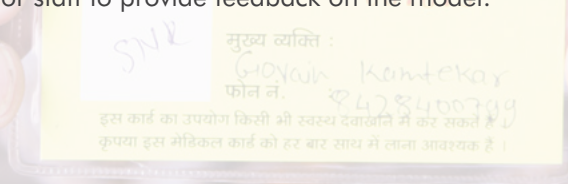
CONCLUSION

We hope that these reflections and learnings have provided you with concrete ideas and inspiration to test in your own primary health care facilities. And perhaps just as importantly, we hope that once you test these in your own sites, you continue the dialogue and let us know what did and didn't work for you. We see this handbook as a living document and a launching pad to greater collaboration and dialogue.

We know that we don't have all of the answers and that there is no "one-size fits all" solution for the myriad challenges we face every day, but we hope that hearing about our experiences with some of these challenges can inspire you to find and test a solution that will work in your context. We are committed to creating change beyond our own organizations, and developing this Handbook, full of reflections of our experiences running primary care chains and franchises, is our way of launching a global dialogue around this issue. We hope that policymakers, funders, global health experts, and other leaders of health programs – innovators like ourselves – will find this synthesis of knowledge, strategies, and innovations useful.

We realize this is just the starting point. Looking ahead to next steps, we hope to explore more common challenges together through an online platform, digging deeper around scaling up, achieving sustainability, and ensuring impact. Additionally, we aim to further explore the science of delivery, truly learning more of what works operationally and sharing this information globally.

Day to day, we may focus on supporting the growth of our individual organizations. But ultimately, with our focus on improving efficiency, capacity, and effectiveness, our collective goal is to build better functioning health systems and better primary care delivery.

» **Rather than see one another as competitors, let's see one another as what we truly are: partners in building better health systems globally. We invite you to join the dialogue.**

PHOTOGRAPHY

Captions and credits for photography appear along side their photo unless otherwise stated here.

Cover: Milind Sakarkar (age 4) gets a check-up with his mother, Lakshmi Sakarkar, at a Swasth Health clinic in the slums in Goregaon, Mumbai.

Pages 4: The Swasth Health Clinic in the Aarey Colony slum area in Goregaon, Mumbai. Photo credit: Karen Dias for CHMI

Page 11: A woman with her child at one of Swasth India's clinics in Mumbai. Photo credit: Karen Dias for CHMI

Page 14: A sale taking place at Access Afya's street-facing pharmacy. Photo credit: Alex Kamweru for CHMI

Page 32: The store room at one of Penda Health's clinics in Kenya. Photo credit: Alex Kamweru for CHMI

Page 33: A LifeNet Nurse Trainer trains clinicians at a clinic in Burundi. Photo credit: Chad Bartlett

Page 49: One of LifeNet's Nurse Trainers working with staff at a partner clinic in Burundi. Photo credit: Kristy Carlson

Page 50: A Clinic Manager at Ross Clinics. Photo credit: Trevor Lewis for CHMI

Page 66: Shilpakala Kamtekar, 48 with her Swasth Health Clinic card at the clinic in Goregaon. Photo credit: Karen Dias for CHMI

Page 67: One of LifeNet's Nurse Trainers provides a more formal lesson for clinicians at a partner clinic. Photo credit: Kristy Carlson

Page 68: Members of the Primary Care Learning Collaborative in front of one of Access Afya's clinics in Nairobi. Photo credit: Alex Kamweru for CHMI

RATHER THAN SEE ONE ANOTHER AS COMPETITORS, LET'S SEE ONE ANOTHER AS WHAT WE TRULY ARE: PARTNERS IN BUILDING BETTER HEALTH SYSTEMS GLOBALLY. WE INVITE YOU TO JOIN THE DIALOGUE.

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RESULTS FOR DEVELOPMENT

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