In Homa Bay, a three-way partnership between the community, the government and a private sector agency has brought quality primary healthcare services closer to the community and promises to improve local maternal and neonatal outcomes. The Ubuntu-Afya Kiosks model demonstrates that embracing partnerships with communities and social enterprises can help counties to extend health services to communities and areas not covered by public and private health services.

Introduction

Homa Bay County in Kenya has one of the highest maternal death rates in the country. It is estimated that 583 mothers die for every 100,000 live births, compared to a national average of 362 deaths. The proportion of babies who die within the first 28 days of life is also high, at 26 children in every 1000 live births, compared to a national average of 22 deaths in every 1000 live births (KNBS, 2013; 2015). This situation is a result of inadequate access to quality essential health services. The available public health facilities are few, far apart and poorly resourced. Given the high rates of poverty, mainstream private sector healthcare providers do not find it commercially viable to set up in the remote rural areas. This leaves many poverty-stricken households in the hands of poorly regulated private practitioners, quacks and traditional healers. The majority of households struggle to pay for health care, sometimes forcing them to sell off household assets or make difficult trade-offs between spending on medical care or other basic needs like food and education.
Afya Research Africa (ARA), a Kenyan social enterprise, designed an innovative pro-poor healthcare financing and delivery model to address these challenges in Homa Bay. The model consists of a network of community medical centres, known as Ubuntu-Afya Kiosks, whose innovative co-ownership and cross-subsidisation enable them to thrive in areas previously considered too difficult or not profitable to reach with health service.

The Ubuntu-Afya model is a people, public and private partnership delivering health services to underserved communities whose cornerstone is active inclusion of the community in the business growth process of the kiosks thus promoting local ownership for sustainability. ARA mobilises communities to form self-help groups, and jointly set up a network of medical kiosks. The group contributes a building or land and labour to refurbish or build a structure, while ARA provides the initial set up and operation costs and facilitates appropriate equipping, stocking, staffing, and registration of the medical centre. ARA assists the community to secure county government participation in the network, where the county provides human resource and commodity support. The county government has helped in some cases to gazette the facilities and allocate them resources out of the county budget for kiosk operations. The community groups, with the support of ARA, also run supplementary businesses, such as motor-cycle taxis and mobile money services, whose income is used to subsidise the cost of care, generating extra revenue for the medical centres as well as earning dividends for the group members. A group member’s shares in the co-operatives are determined by their contribution. They also contribute to a collective savings and credit kitty from which members can borrow funds. The community group holds not more than a 49% share of the kiosk-enterprise unit jointly with the staff who run the clinics (clinical officers, nurses and community health workers). ARA retains a 51% stake in the enterprise, and its share of proceeds is reinvested towards growth of the kiosk and its associated business ventures. To enable interlinking and monitoring of the kiosks in the network, ARA implemented STONE-HMIS®, an in-house digital health information service that aids in monitoring kiosk performance including caseload, quality of care and revenue generation. STONE-HMIS also enables the feeding of data to the Ministry of Health’s district health information system (DHIS2) database, thus availing data to the county health management team for planning and oversight.

Through the support of the County Innovations Challenge Fund (CICF), an initiative of the UK’s Department for International Development, ARA operates 16 Ubuntu Kiosks in Homa Bay County (part of a network of 25 Ubuntu Kiosks in Kenya). The kiosks were set up in remote areas of the county which have poor health infrastructure, and on isolated islands in Lake Victoria. ARA aims to increase access to primary health care services, with a focus on maternal and neonatal health services for the communities that were hitherto underserved.
Results

ARA conducted an evaluation at the end of 2018 to assess the results achieved after implementing the Ubuntu Afya model in Homa Bay County for a period of two years. The evaluation used a ‘before and after’ survey design to measure changes in access to maternal and neonatal care, comparing with the status at baseline (June 2016). Within the catchment population served by the 16 Ubuntu Kiosks, 10 Community Units (CUs) were randomly selected as the clusters from which households were subsequently selected through consecutive sampling. Eligible participants were women of childbearing age living in the selected community unit. In total, 441 and 408 women were interviewed at baseline and endline respectively, using a standardized questionnaire.

The evaluation unveiled three overarching findings:

1) **Increased uptake of ANC services:** The proportion of women who attended four ANC visits during their previous pregnancy within the communities served by Ubuntu-Afya Kiosks rose from 64% to 71% in the study period (Ombech et al, 2018). This was higher than the county-wide average of 47% of women attending four ANC visits.

2) **Increase in uptake of skilled attendance at birth and neonatal care:** The evaluation found that there was a drop in the proportion of women delivering at home, from 17% in 2016 to 11% at endline, and a general increase in women delivering under a skilled birth attendant, from 85% to 90%. There was also a notable increase in the proportion of women whose babies received a medical examination within one day after delivery in the study community, which rose from 71% at baseline to 90% at end-line.

3) **Enhanced role of private sector providers:** The results showed a notable increase in women seeking care at private facilities (including the Ubuntu-Afya Kiosks), from 3% at baseline to 31%. Seventy-five percent (86 of 114) of the respondents who had been attended to in a private facility at end-line, specifically said that they had been attended to at Ubuntu-Afya Kiosks. The proportion of women giving birth at a private clinics rose from 3% to 16%, and those who sought postnatal care from private clinics increased from 4% at baseline to 41% at end-line. At the same time, a drop was observed in uptake of services at the county and sub-county hospitals; for instance, the proportion of women who reported delivering at county and sub-county hospitals reduced from 30% to 11%. This finding suggests that the model may have contributed to increasing demand for maternity care in lower level facilities and reducing pressure on referral facilities. However, caution is needed when interpreting these numbers as the end line evaluation period coincided with a prolonged health worker strike which affected access to services in public health facilities.
Conclusion & Recommendations

The **Ubuntu Afya model** has demonstrated the potential of community-based social enterprises to address inequities in the Kenyan health system. Thus stakeholders are encouraged to replicate such initiatives as a way of complementing services available through the public sector. Based on lessons from Homa Bay, the following recommendations could be useful to stakeholders, including county governments, wishing to adopt the model:

1) Develop local policies that encourage and support the establishment of people-public-private partnership models in primary healthcare, and which protect the investments by both community and businesses interested in social enterprises.

2) Support social enterprises in health to enhance their reach and impact by having guidelines on secondment of healthcare workers to such setups, providing supportive supervision and ensuring these centres are included in the distribution of essential public-sector commodities and supplies, especially those that come at no cost to the government.

3) Provide material support to fledgling social enterprises, to strengthen them and encourage communities to do more. Such assistance could include provision of land or existing facilities that could be refurbished to serve as a community health centre. It may also include waiving license fees for the supplementary businesses established by such outfits to raise extra revenue for the healthcare service.

4) Set up private-public engagement advisory teams to advise interested businesses on how to work with the county government in setting up the social enterprise. These advisory groups can guide businesses in identifying areas where their services would be most needed.

Footnotes


This project is funded by the UK government under the County Innovation Challenge Fund (CICF). The CICF invests in innovative interventions, products, processes, services, technologies and ideas that will reduce maternal and newborn mortality in Kenya.

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