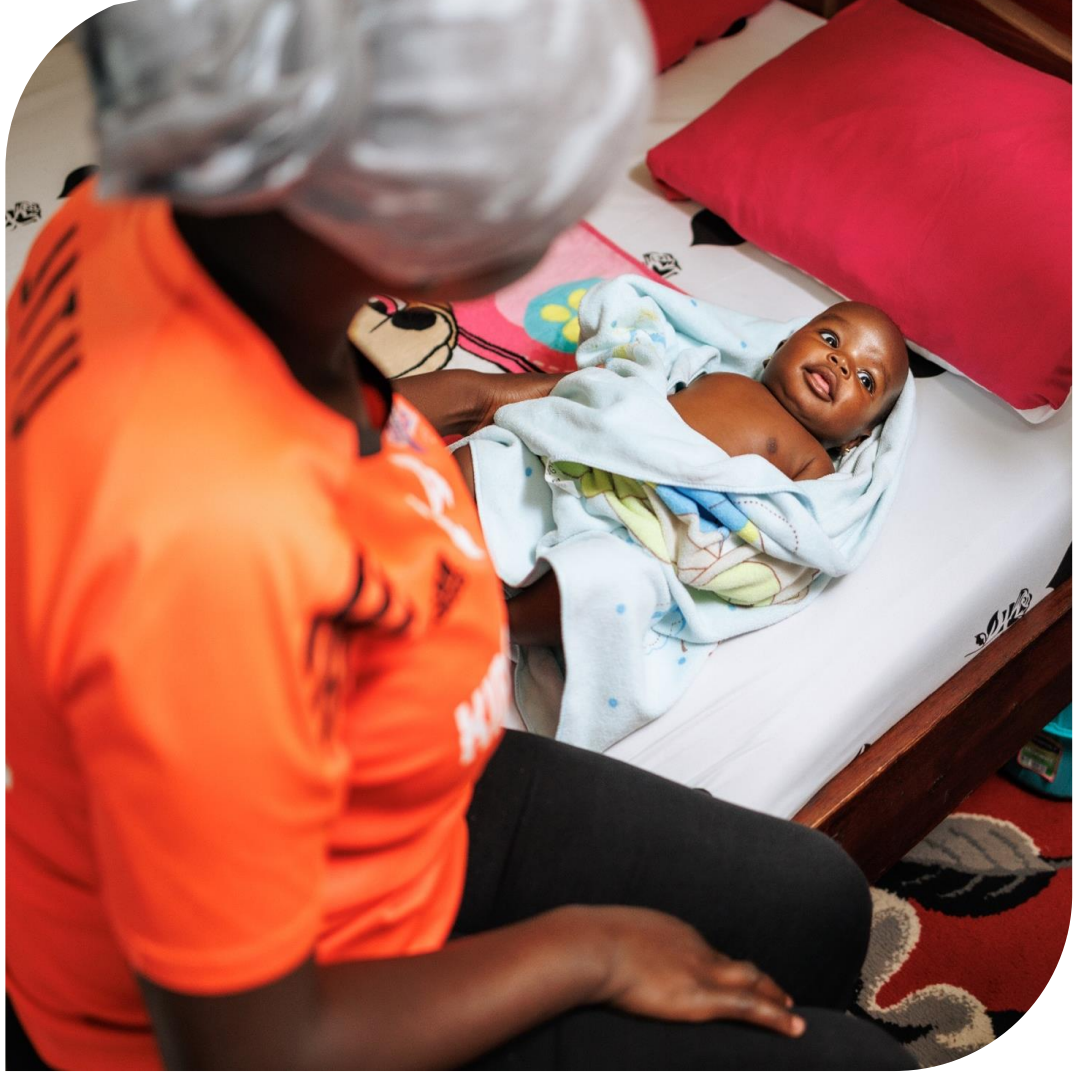
Tutunze Kakamega
Service Delivery Redesign (SDR)

Experiences and Lessons from SDR Implementation in Kakamega County, Kenya

9th July 2024

JACARANDA HEALTH
THINK WELL
rescue.co
ThinkPlace



Agenda

- ✓ SDR Background and Overview
- ✓ Experiences and Lessons Learnt
  - O Feasibility Assessment
  - O Design Phase
  - O Improvement and Implementation
- ✓ Kakamega County Reflections
- ✓ Summary of Successes and Learnings

Service Delivery Redesign Background

Kakamega 2021 Maternal and Newborn Health Statistics

97.6% 1st ANC Coverage

56.5% 4th ANC Coverage

72.6% Skilled Birth Attendance

41.6% WRA Receiving FP

82.6% Fully immunized children

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Overview for Redesign Model

Delivering care for **all** women in advanced facilities that offer definitive care for complications or in nearby affiliated birthing facilities.

High-quality antenatal and postnatal care in health centers and dispensaries

Our goal is to improve maternal and newborn outcomes in Kakamega county

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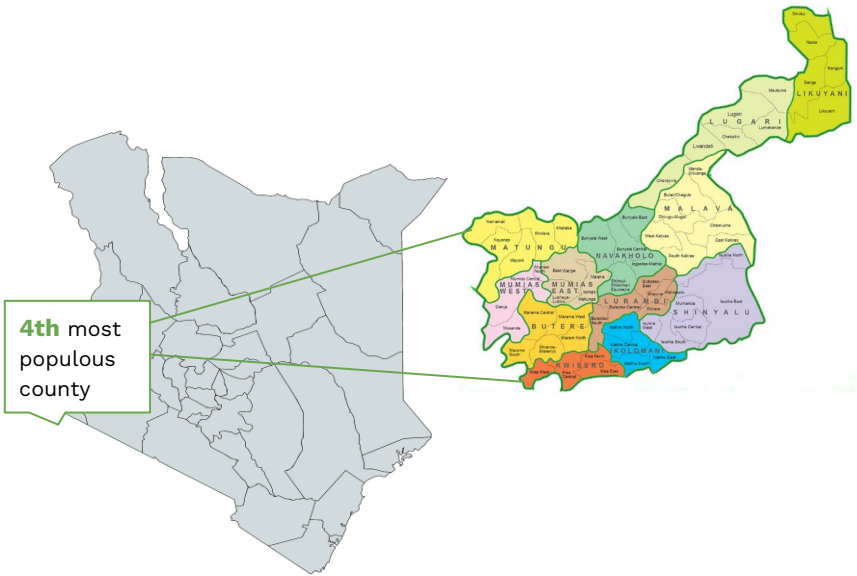
Feasibility Assessment

Feasibility Assessment Results and the need for Service Delivery Redesign (SDR)



85%

of facilities (174/205) conduct less than 30 deliveries per month

37%

of Kakamega births occur in a facility equipped to handle maternal emergencies

99%

of women in Kakamega live within 1 hour of an advanced hospital

>80%

(out of 151 respondents) supported Redesign

**Feasibility Assessment Results*

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The Plan for SDR Rollout in Kakamega

Feasibility Assessment

Collect and analyze data to **assess current system capacity** and gaps to close for redesign

Expected outcomes: Health system capacity map

Design Phase

Design locally-specific models and determine needed investments for redesign; design evaluation plan

Expected outcomes: Fully costed plan for redesign; evaluation plan

Improvement Phase

Implement **facility, community + non-health sector improvements** in preparation for policy change

Expected outcomes: Health system ready for redesign implementation

Implementation Phase

Implement redesign policy and roll out SDR in phased manner; evaluate redesign

Expected outcomes: Decreased maternal and newborn morbidity and mortality

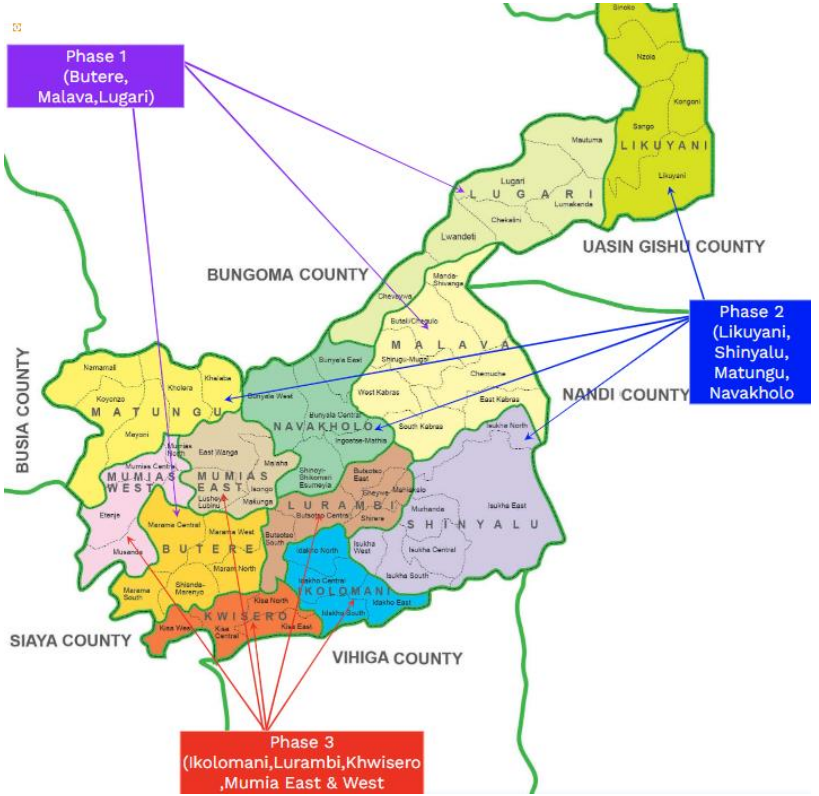
SDR Phased Implementation

The SDR initiative is being implemented in three phases:

PHASE 1 – Butere, Lugari and Malava Sub-Counties

PHASE 2 – Likuyani, Shinyalu, Matungu, & Navakholo Sub-Counties

PHASE 3 – across Ikolomani, Khwisero, Lurambi, Mumias West, and Mumias East Sub-Counties



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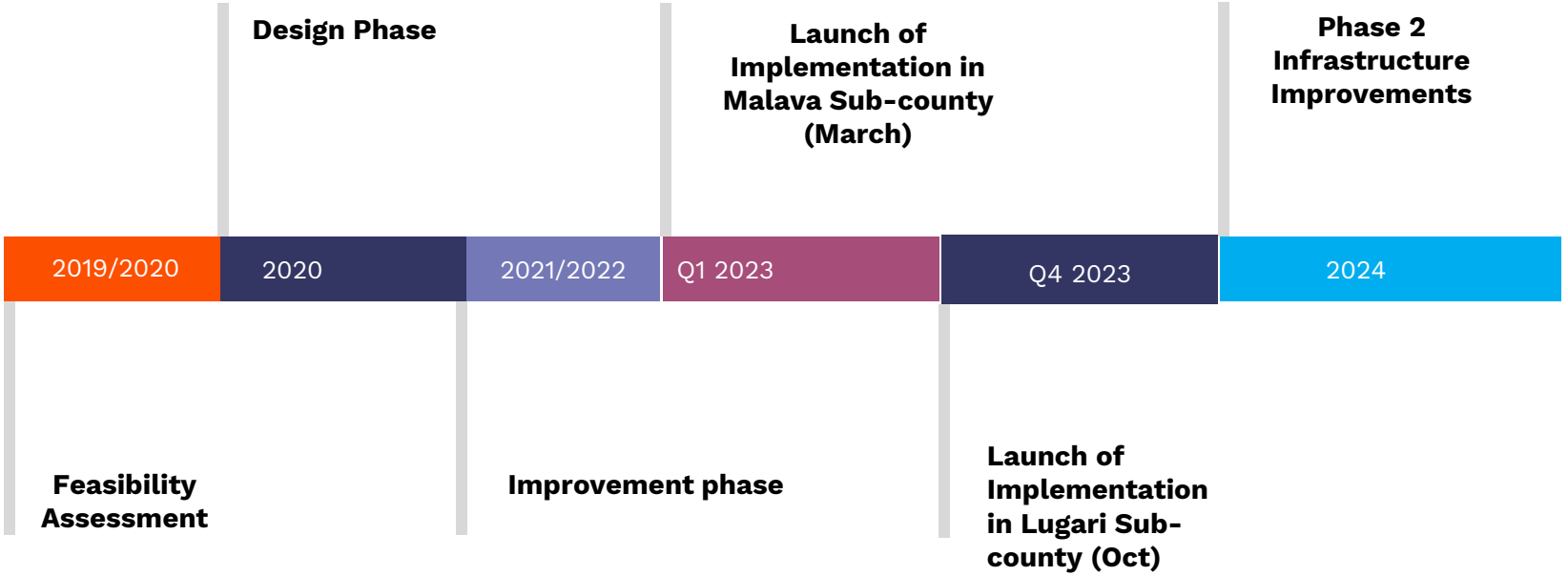
SDR requires a coalition of partners and strong coordination

JACARANDA HEALTH	- **Coalition Lead** - Partner to 20 County Governments - SMS digital health platform reaching 1.2M mothers - EmONC mentorship program with 200+ mentors, 10,000 providers trained - 50% Cost-Share with County governments
rescue.co	- Dispatch service that aggregates private and public ambulance network to respond to emergency services
THINK WELL	- Work with 30 county governments and national government - Track record of increasing revenue for MNH services and improved utilization of funds
ThinkPlace	- Human Centered Design expertise across a variety of domains - Deep experience in SRH/MNH patient journeys and trust-building
BUILDX MASS.	- Expertise in construction and project management consulting - Design with end-user in mind

Timeline of the Service Delivery Redesign



Design Phase

Design context - specific models and investments to reform the health system for definitive care

Incorporating the voice of health system stakeholders in redesign

Stakeholder Engagement

Engaged County leadership, health managers and community members to craft a shared vision of SDR

Research & Design

Targeted design research to identify potential levers and barriers to the system redesign and implementation

Co-design & Prototyping

Elements related to patient and provider definitions of quality of care, communication, transportation and safety management

ThinkPlace used Human Centered Design to gather insights to influence health reforms in Kakamega

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Stakeholder Engagement: Experience and Insights

Fears identified by stakeholders;

- ➔ Devaluing of L2/3 facilities
- ➔ Over-medicalisation of service accompanied with unnecessary c-sections
- ➔ Women already built trust in L2/3 care providers
- ➔ Increased workload

SDR Champions;

- ➔ Novel idea towards attaining UHC
- ➔ Staff motivation guaranteed
- ➔ Increases accountability and rational resource allocation
- ➔ Will increase mother and child survival

Stakeholders: Ministry of Health, Council of Governors, Kakamega County Health Management team Healthcare workers, Males and female of reproductive age, Local administrators, Political leaders, Masinde Muliro University

Lessons Learnt from Community Engagement

Multi-phased approach

- In-person participatory workshops
- Team building event
- Community dialogue sessions

Community dialogue sessions

- Address misconceptions
- Co-create messaging
- Build HCW relationships (hub-spoke)
- Increase ownership

Improvement and Implementation Phase

Facility, community and non-health sector improvements in preparation for policy change
Redesign policy and roll out SDR in Phased Manner, evaluate Redesign

Solutions that span through a Mother's pregnancy and postpartum journey

Improve prenatal/postnatal care
Scorecards
Equipment/Supplies

Infrastructure & Equipment, Provider skills improvement
Maternity construction/ renovation
Through In-facility Mentorship & Facility Assessments

Appropriate resources across the system
Finances, Staffing, Equipment, Infrastructure

Client engagement
SMS messaging + helpdesk service to empower mothers with information

Emergency Transport
Upgrade public/private ambulances
Train providers in referrals

Blood Availability
Identify existing sources of blood in emergencies

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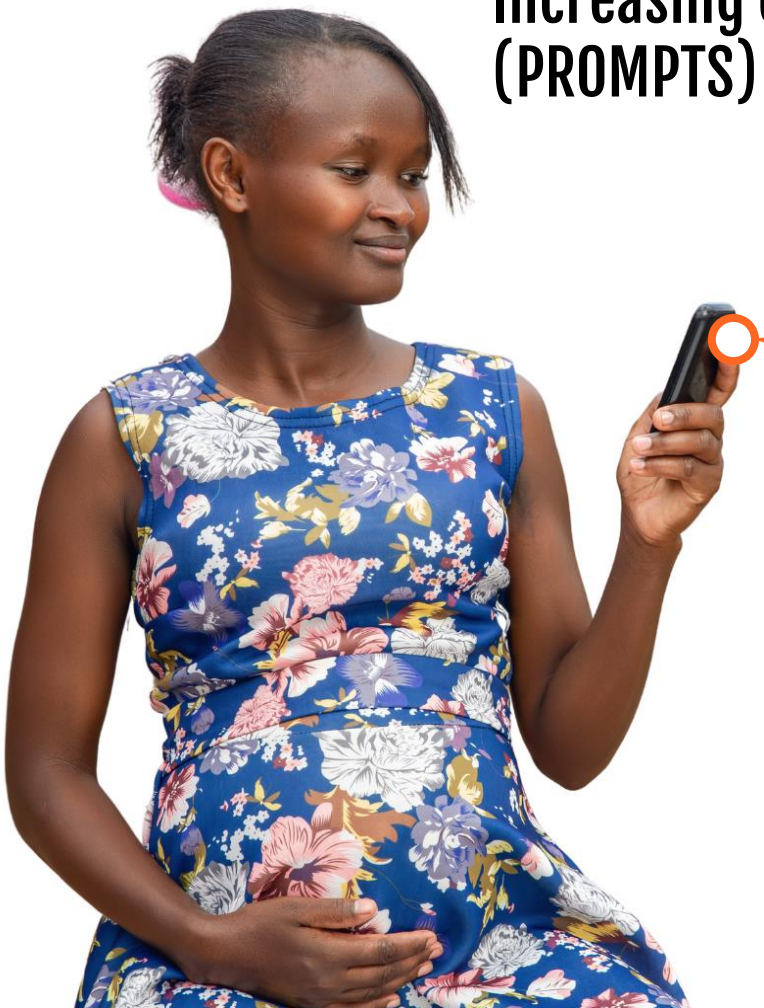
Increasing client engagement through digital health (PROMPTS)



160K expectant mums enrolled on PROMPTS

85% of mums in Malava Sub-county

100,844 questions received through our helpdesk.

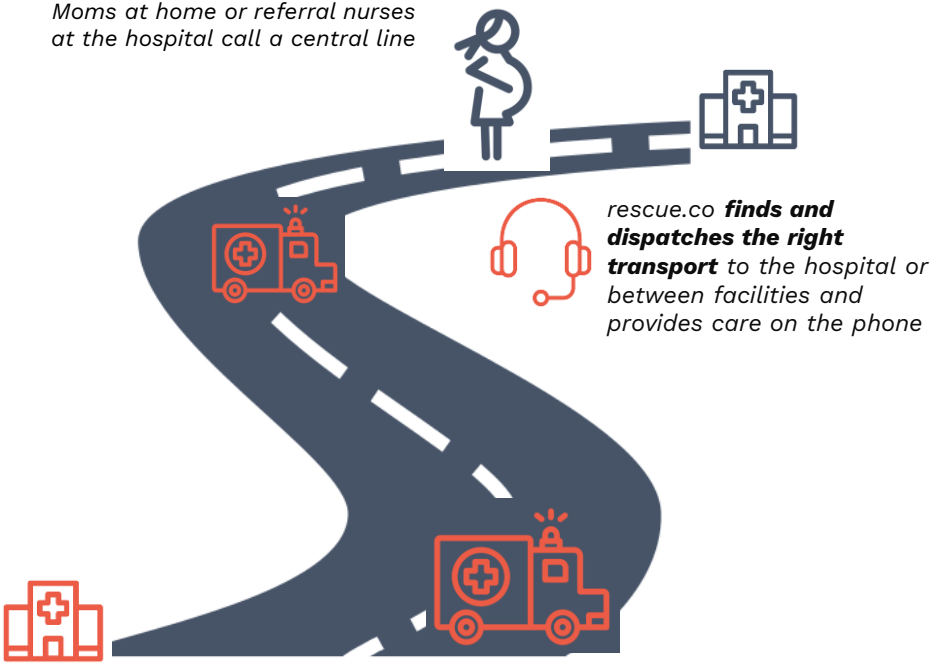
4.8% of the questions were classified as urgent and were resolved

2,400+ At-risk mums/babies evacuated

13.2% increase in PNC attendance from 33.4% in 2020

Improving access to high quality care through emergency transportation

Moms at home or referral nurses at the hospital call a central line



*rescue.co **finds and dispatches the right transport** to the hospital or between facilities and provides care on the phone*

*The ambulance moves the mother or newborn to the **right health facility** based on capabilities and availability tracked via the Flare platform*

Approach

- Non-emergency network of boda boda riders & medical taxis
- Ambulances

Access to toll free number:

- CHPs, Mamas & Babas, Healthcare workers
- PROMPTS to Ambulance service connection

Average response time reduced from **2 hrs to 27 mins**

8,699 evacuations through Rescue

86% pregnant women and 14% neonates

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Ensure that all providers have life-saving skills

Leveraged Jacaranda's EmONC Mentorship program which provides continuous in-person, in-facility training through government midwife champions (mentors)

100% EMONC curriculum completion in phase 1 L4 facilities

Increased **knowledge retention** among healthcare providers from 73% in 2022 to **93%** in 2023

5% decline from 23% in 2022 **in complicated referrals** from Malava Level 4 to County General Hospital Level 5

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Ensuring Blood availability for Maternal emergencies

Access to blood and blood supplies in an emergency situation is key to minimizing referral costs and saving lives

Previously Kakamega Blood Bank only collected **50%** of its target

Achievement: Kakamega County moved from collecting **700 units/month to 1,200 units/month**

County lacked a blood inventory tool

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Strengthening Quality ANC/PNC and Level 2/3 facilities

Building capacity and resourcing

- ANC/PNC management
- Adequate Equipment
- Data work planning and resource allocation
- Patient to staff ratio planning

Innovation around ANC care

- Ticketing: Address wait times, overcrowding, improve person centered care
- Point of care test kits for ANC profiling - Ensures access to timely ANC tests

High Quality People Centred Level 4 CEmONC Hospitals

New Maternity Theatre at Malava Hospital

- **HCD approach** in designing L4 facilities:
  Collaboration between designers, health managers, County engineers, contractors, health managers
- **Facility assessments** identified equipment gaps, quantities and specifications were provided
- HCWs trained on the use of the new equipment

Adequate Staffing of Comprehensive CEmONC Sites

Change in staffing numbers at Malava Hospital - **2022 VS 2024**			
Cadre	**Target**	**Nov 2022**	**Feb 2024**
Medical officers	8	6	5
Clinical officers	6	4	8
Anesthesia Clinical Officers	2	3	3
Nurses	50	42	60
Nurse Anesthetist	2	1	2
OBGYN	1	0	1
Pediatrician	1	1	1
Lab_Tech	10	5	8
Radiographer	2	2	2

30% increase in staffing numbers in L4 Sub-County facilities

Experience and Lessons Learnt

- Alignment and compliance with MoH staff norms and standards
- Negotiate with health managers to minimize rotation especially after recruitment or training.
- Staff motivation is equally critical to offer definitive care

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Health Financing: Increase funding and resource allocation for MNCH services

Technical support on evidence-based planning and budgeting

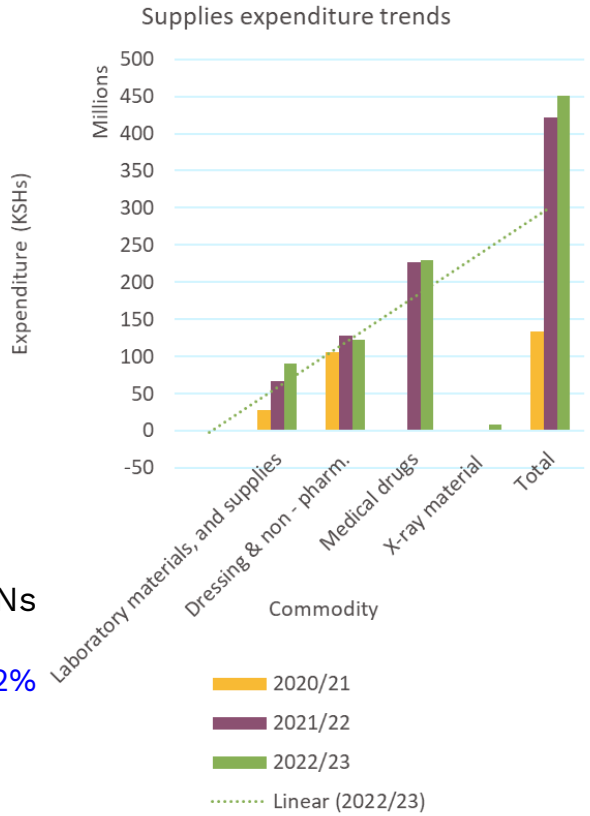
- Rational use of data to allocate key system inputs to improve delivery of MNCH services
- Allocation to essential supplies grew by 53% from FY 20/21 to FY 23/24

Facilities could not use funds collected → Institutionalization of facility autonomy → Resource allocation to improve the quality of MNCH services

- 7% revenue growth in year.
- Facilities used 27% of their own revenue to supplement plug in on commodity gaps

L2/L3 Devalued? → Alignment of SDR to the national reforms – PCNs and UHC reforms

- Increased direct financing to PHC facilities in the FY 2023/24 by 62% & 23% in L2 and L3 improving delivery of PHC services
- Increased proportion of poor women enrolled into NHIF's UHC scheme to reduce OOP while accessing PHC services



Post-Implementation

1 year after SDR Launch in Malava Sub-County

Progress Summary by Dec 2023

87%
of providers now pass their neonatal resuscitation tests (baseline 64%)

2x
bed capacity, from 40 to 84 beds in hospitals

50%
cost-share from government

85%
new and expectant mothers in phase 1 sub counties enrolled into PROMPTS

8,699+
mums/babies in need of critical care evacuated by via emergency dispatch

25 mins
time to reach facilities in emergencies

90%
fulfillment of blood needs through a tracker that locates blood across the county

High Quality People Centred Hospitals – Progress and Lessons

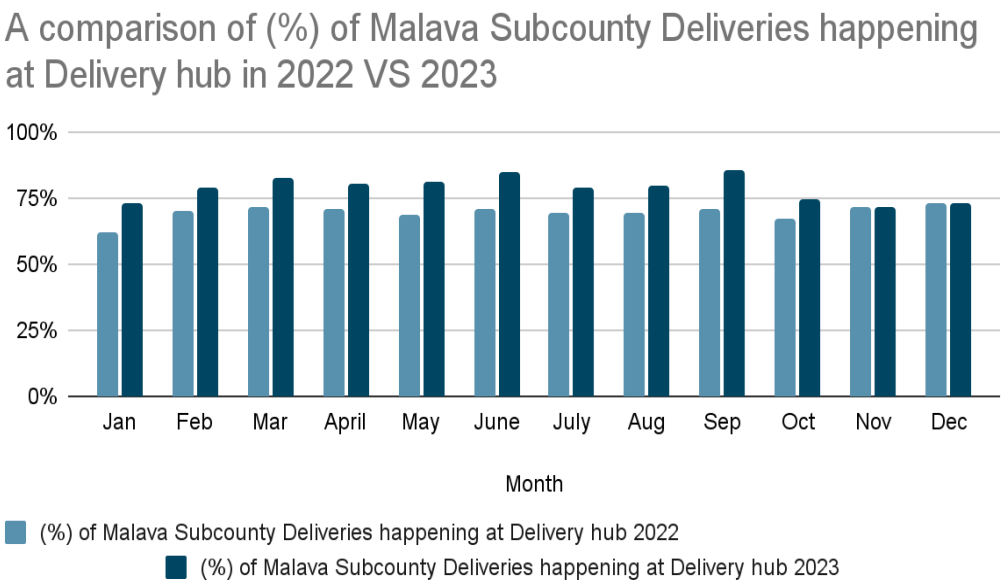
Approximately a 10% increase in hospital deliveries in Malava hospital with a reduction of home deliveries

Lessons Learnt

Planning for delays

- Political transitions last year led to phase 1 delivery shift delays.
- Delays in financing County commitments due erratic flow of funds.
- Rise in construction costs due to inflation

Insights from Malava Delivery shift



- In 2022, Malava delivery hub conducted **69% of expected deliveries,** whereas it now conducts **an average of 79% of expected deliveries** with the highest being in **Sept at 86%.**
- Malava sub county has recorded an **increase in 4th ANC** attendance from <70% between January to June this year to **85% in Aug**.
- Reduced neonatal referrals out of Malava due to NBU functionality
- More complex Difference-in-Difference analyses have corroborated this

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SDR sustainability and Government ownership

Implementation of Critical Health system policies

1. Kakamega Health Fund is currently under implementation
2. Referral policy under final stages of review - Set for Launch in Q1 2024
3. Waiver and exemptions policy at final review as well - Set for Launch in Q1 2024

County <> external partner cost share

1. For phase 1, County shouldered 50% of operating costs by providing HRH, commodities and service delivery costs
2. The plan is to increase County expenditure in phase 2 to progressively reduce dependency on external funding

Adoption low-cost sustainable innovations that improve MNH QoC

1. In 2023, Kakamega County piloted and scaled use of paper based tickets to ensure order in service delivery
2. To pilot use of point of care test kits for ANC profiling and how to leverage rotation of L4 lab services for ANC profiling in PHC facilities

SDR governance through County led TWGs

- Various project elements are currently being coordinated through county structures - TWGs including HRH, Finance, Referral, Supplies etc
- TWGs report into CHMT and a program implementation unit
- PMU reports to oversight team led by minister of Health with Biannual updates to the Governor for resource allocation and decisions

Key Lessons and Takeaways

✓ **Continuous Stakeholder engagement and Management - inception to implementation**

a) Need for continuous engagement via multiple channels to sustain SDR momentum
b) SDR doesn't occur in a vacuum: other reforms may disrupt the current system such as the delivery shift

✓ **Planning for delays**

a) Political transitions last year led to phase 1 delivery shift delays.
b) Delays in financing County commitments due erratic flow of funds.
c) Infrastructure improvements in Malava experienced a 6 months delay against plan

✓ **Balancing program strategy with political priorities for buy-in**

a) We have had to shift Matungu from Phase 3 to Phase 2 due to political considerations, but politics is an important factor for Champions
b) Our County engagements has been carefully crafted to stay within acceptable political boundaries

✓ **National and County level policy changes can have overarching impact on project implementation**

a) Case in point are recent changes in health financing and national insurance. SDR has to adjust to align with the changes

Reflections from Kakamega County Government

Experience

- **TWG approach of SDR governance** has enhanced structures in health system management
- Project implementation challenged our resource allocation approaches with heavy emphasis on data
- We have witnessed **increased uptake of skilled deliveries** in SDR sites.
- Project implementation has triggered documentation of best practices in policies for posterity i.e FIF, waiver and referral policies.
- SDR has opened up space for **innovativeness and creativity** among HCW e.g ticketing among others

Lessons Learnt

- **Health Policy** space in Kenya is dynamic and requires solid structures at County and hospital levels to adapt - We just adopted FIF and now we are transitioning to SHIF
- Service delivery can be enhanced by simple **innovations** - it just requires positive mindset among HCWs
- **Design for health care spaces** has evolved over time and the Government is keen on adopting lessons from designs by Mass in future expansions of healthcare spaces
- Lessons from **SDR's periodic checks on facility readiness** to offer definitive care will be emphasised in our programing moving forward

Acknowledgements

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Thank you