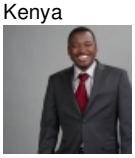
PatientPower: Transforming Healthcare Systems in Places of Extreme Poverty

Kenya



Kennedy Odede

Organization type:
nonprofit/ngo/citizen sector
Project Stage:
Idea
Budget:
$100,000 - $250,000
Website:
http://www.hopetoshine.org

- Community development
- Health care
- Health education
- Poverty alleviation

Project Summary

Elevator Pitch

Concise Summary: Help us pitch this solution! Provide an explanation within 3-4 short sentences.

PatientPower is an innovative model elevating standards of care in places of extreme poverty by bridging gaps between patients and the healthcare systems that serve them. By committing to 1) executive-level community control, and 2) integration of primary-care clinics with holistic services, PatientPower provides empowerment and infrastructure for communities to take charge of their own health.

About Project

Problem: What problem is this project trying to address?

PatientPower's pilot site is Nairobi's Kibera slum, the largest slum in Africa. Although 1.5 million people live in Kibera, the government does not formally acknowledge its existence and does not provide infrastructure: no roads, hospitals, schools, sanitation services or access to clean water. These deplorable living conditions and resource scarcity lead to the rapid transmission of disease. Kibera's child mortality rate is 4 times higher than in the rest of Kenya, and life expectancy is 20 years lower. Women face additional health risks: over 66% of girls trade sex for food to survive, and women are 5 times more likely to contract HIV than their male counterparts. The gaps in medical care are astonishing, summarized by residents as: prohibitively high costs, low-quality care, lack of trust in diagnosis and treatment due to limited time spent with providers, overuse of the same diagnoses, over-prescription of drugs, no room for questions or participation, long lines and inefficient systems, and lack of respect and dignity afforded to patients by caregivers.

Solution: What is the proposed solution? Please be specific!

In extremely low-resource areas, the educational, class and racial divides between medical professionals and their patients run deep—such that despite millions of dollars of foreign-aid, health outcomes remain dismal, and patients experience constant frustration and loss of dignity. To subvert the patient-provider divide endemic to the developing-world, the PatientPower model ensures that grassroots community leaders retain executive-level positions within their local healthcare organizations. By putting patients who have experienced health-care delivery first-hand in the pilot seat, PatientPower uniquely empowers individuals living in extreme poverty to take control of their own health—creating the space and the resources for change to come from within. Second, PatientPower integrates bio-medical primary-care clinics with holistic community services. Direct medical services are not enough to combat the full range of disease factors caused by severe deficits in sanitation, diet, clean water, and education. That's why in the Patient Power model, the clinic does not stand in isolation, but is tangibly linked to multi-faceted income-generating social services that serve to both alleviate sickness-inducing symptoms of poverty and ensure long-term organizational sustainability. In 2009, Shining Hope for Communities (SHC) initiated implementation of the PatientPower model in its pilot site: Nairobi's Kibera slum. I am the co-founder and Executive Director of SHC, and lived the first 23 years of my life as a resident and community leader of Kibera. I believe that PatientPower will not only transform my community, but by partnering with other grassroots leaders from other places of extreme poverty—this model can extend to communities like Kibera around the world.

Impact: How does it Work

Example: Walk us through a specific example(s) of how this solution makes a difference; include its primary activities.

SHC, an active community based organization in Kenya since 2004, has a proven track record of unparalleled grassroots credibility and social impact in Kibera. All of SHC's programs aim to combat inter-generational cycles of gender inequality and extreme poverty. Already we have provided community-run infrastructure such as a free school for girls, sanitary toilets, filtered water, vertical gardens, and literacy/computer training. Our impact has mitigated local deficits in education, sanitation, health, food security, and technological job skills. In the past year, our sustainable community services have reached 11,720 unique individuals. Malnourishment dropped by 98% among Kibera School for Girls students since opening, and rates of gender violence among female participants of our community programs were reduced by 75% in just the first year of operations. However, despite these important successes, without access to primary and maternal health services, residents of Kibera remain trapped in a cycle of poverty that makes poor health inescapable. As a result, for the past year we have actively engaged the community in broad dialogues to design a healthcare model that would meet their needs. PatientPower's 14-room pilot clinic was born out of these community focus groups and leadership meetings, and will provide high-quality primary healthcare for Kibera residents. Once the clinic is open, and the Patient Power model is complete, our impact in our pilot site will exponentially expand. This model has the potential to have tremendous impact to make healthcare more effective for 1 billion individuals living under $1/day across the globe.

About You

Organization:
Shining Hope for Communities

Section 1: You

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Your idea

Country and state your work focuses on

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Innovation

Do you have a patent for this idea?

Impact

Actions

From its inception, community experiences molded the vision and structure of the PatientPower model. We conducted focus groups with all sectors in our community—leaders, parents, and youth, asking: What are our healthcare needs? Where are the gaps in existing systems? This feedback, coupled with best practices, informed the underlying philosophy and program design of the clinic and social services.

First, ccommunity leaders played an active role in hiring a clinic staff possessing both the highest medical qualifications and a commitment to community-ownership. We assembled 20 local residents with traditional care-giving skills into a team of trained community health workers. The clinic blueprints themselves incorporated community input; full of color, books, and games, the structure fosters an environment of patient ownership and dignity. The clinic construction was overseen and completed by future clinic users. And finally, to ensure sustainability, we established long-term sources of subsidized pharmaceuticals, medical supplies, equipment, and an electronic medical records system, and set up the income-generating social services that are the core financial model.

Results

By committing to executive-level community leadership, exemplary standards of care, and provision of social services, we augment the impact of direct medical services. As clients utilize our preventative health programs, frequency of clinic visits and need for emergency care will be greatly reduced. At our clinic each client receives the individual attention they deserve, resulting in an increase in accurate diagnosis and decrease of unnecessary treatment. Our model makes patients empowered participants in their own care— improving treatment adherence. By linking bio-medical care with other social services (e.g. sanitary toilets, hand-washing stations, vertical gardens, and education), we tackle the root cause of much disease in Kibera: extreme poverty. When compared to well-matched controls—we expect PatientPower clients to experience significant decline in overall disease burden due to preventative care, as well as decreases in maternal mortality, infant mortality, STI transmission, disease transmission within families, and rates of unwanted pregnancy. Our clients will also report a significant improvement in subjective life-satisfaction, and control over their own health.

What will it take for your project to be successful over the next three years? Please address each year separately, if possible.

Year 1: With construction completed and the clinic fully-staffed, SHC's first priority will be to test operating procedures and educate the public about available services. Next, to ensure long-term executive-level community control and high-quality service provision, we will formalize systems for community input and governance. In addition to the executive leadership itself, we will institute a community advisory board to oversee daily operations and synthesize community feedback to relay to medical staff. In order to track the longitudinal impact of the PatientPower model, in Year 1 we will spearhead a participatory, community baseline health assessment. And finally, to lay the groundwork for long-term financial sustainability, the clinic will link with SHC's already-established income-generating service initiatives (IGSIs) such as the bio-latrine facility and vertical gardens. At the clinic, patients pay a nominal fee for services and medications because we know as a community that when patients make a monetary investment in their health, they are more likely to follow up their care. However, to ensure accessibility, clinic services must be subsidized beyond small user-fees. Thus the IGSIs provide two-fold support: these initiatives provide desperately needed (and otherwise unavailable) services to the community, and they improve health outcomes as well as generate profit to subsidize costs of clinic medications, supplies, equipment and salaries.

Year 2: We will continue to integrate both the advice from our community board and from clients into programs and protocols, altering them as needed. We will also spearhead a follow-up assessment to measure one-year impact and adjust our clinical programs if health and subjective targets are not met. IGSIs will expand also serve more people, increasing social service participation and further subsidizing the cost of high-quality clinical care.

Year 3: PatientPower will expand. Using the data collected and the refined systems we've developed in Year 1 and 2, we will be able to facilitate the adoption of the model at other health facilities operating in similar communities. We will facilitate the adoption of our model at other institutions and grassroots communities, consulting and disseminating information on how health systems can respond more efficiently to patient needs.

What would prevent your project from being a success?

1. Risk: Building both community and formal support. Communities in places like Kibera often do not accept foreign organizations. By the same token, community groups struggle to obtain institutional support—both are necessary for long-term success.
Mitigation: SHC's innovative leadership model recognizes the importance of strong ties to both grassroots communities and to institutions such as government. From my experience as a community leader in Kibera, I understand how to build unparalleled credibility at the grassroots level. I also know how to bring marginalized people together to leverage collective their power and establish strong ties with larger institutions.
2. Risk: Securing long-term financial support.
Mitigation: Outside SHC's broad donor base and extensive partner network, PatientPower's business plan utilizes IGSIs to ensure the program's long-term sustainability. Net IGSI profit keeps patient fees low- fees cover 28% of the clinic's operating costs, and IGSI profits provide the remaining 72%. Surplus IGSI profits fund the creation of IGSIs in replication sites. Providing necessary services that are otherwise unavailable ensures long-term community participation and thus program income.
3, Risk: Resistance to collaboration from health professionals. PatientPower implicitly challenges deeply entrenched power dynamics in the healthcare system. Significant gaps in education, class, and professional training often cause tensions, as skilled professionals may resist directives from inevitably less skilled community leaders.
Mitigation: PatientPower's structure shows how this tension can yield positive results. Using their experiences as patients, community members provide insight into the gaps in health delivery. This feedback informs overall healthcare delivery, impacting systems and shaping the clinic's philosophy. Next, community members play an active role in hiring highly qualified medical professionals with a genuine desire to implement

How many people will your project serve annually?

More than 10,000

What is the average monthly household income in your target community, in US Dollars?

Less than $50

Does your project seek to have an impact on public policy?

Yes

Sustainability

What stage is your project in?

Operating for less than a year

In what country?

Kenya, NA

Is your initiative connected to an established organization?

Yes

If yes, provide organization name.

Shining Hope for Communities

How long has this organization been operating?

More than 5 years

Does your organization have a Board of Directors or an Advisory Board?

Yes

Does your organization have any non-monetary partnerships with NGOs?

Yes

Does your organization have any non-monetary partnerships with businesses?

Yes

Does your organization have any non-monetary partnerships with government?

No

Please tell us more about how these partnerships are critical to the success of your innovation.

We have established external partnerships at every level to maximize impact and resource effectiveness. Our clinical partners include leading health professionals throughout Kenya who consult regarding protocol, best practice, technical support, and provision of care. We have also developed institutional partnerships with leading hospitals and specialized practices for our referral system and supply chain. Currently we are in conversations with the government ministry of health regarding receiving free supplies and support. Our government partnerships will also play a role in long-term plans for replication. We maximize funding through our established in-kind donation network. Hospitals and non-profit organizations from around the world have already donated thousands of dollars of supplies and made indefinite re-occurring commitments. Our financial partners include individual donors, foundations, and our IGSI program implementers. Without each partnership, our net would be cast too wide; with them, PatientPower ensures comprehensive and effective care for all patients.

What are the three most important actions needed to grow your initiative or organization?

In order to expand the PatientPower model at our pilot site and to replicate it in other places of extreme poverty, we will need to ensure that our model is continually meeting community needs at high standards. To do so, we need to take the following three critical actions: (1) ensure that the community remains satisfied by our programs and work with clinical staff to adjust systems and strategies to meet community demands, (2) bolster our financial model to ensure long term sustainability, and (3) document operating systems to enable model replication.
First, in order to maintain our commitment to community ownership of the programs, we will need to implement systems to formalize community involvement and governance. This will include establishing a community advisory board to formally oversee the health clinic and expanding our team of community health workers. In addition, we will initiate a rigorous, participatory controlled program evaluation to objectively measure program impact as well as solicit regular feedback from clinic users. We will take all of these strands of community input and work with the clinicians and other staff to re-think procedures so as to best meet patient demands. This might include implementing completely new clinic programs so as to better serve specific sectors of the community, or something as simple as putting different types of books and children's toys in the waiting-room.
Second, we will ensure that financial model continues to sustain the clinic. To do so, we will expand our social services beyond the bio-latrine center, and vertical gardens and clean water project to include additional service-initiatives that generate income. We are committed to investing in on-site income generating services, keeping low organizational overhead, and continuing to build our U.S. donor-base so that all of PatientPower's high-quality services remain accessible to even the most impoverished residents.
Third, in order to bring the PatientPower model to scale—we will need to document operating systems and leadership guidelines of the clinic and social services programs at our Kibera pilot site. This will enable other grassroots communities like Kibera to access the PatientPower model, adopt any and all procedures they find suitable, and request technical assistance.

The Story

What was the defining moment that led you to this innovation?

While living Kibera, I experienced firsthand the healthcare system available to the urban poor—a system that treated me, my family, and friends, as only a statistic. I have been forced to watch neighbors die in their homes because they could not afford treatment, had been misdiagnosed, or simply did not want to experience once again the indignity of the available healthcare options. I will never forget carrying my mother to one of Kibera's largest clinics run by a foreign NGO. I feared she might die, and I could barely afford the price of the clinic that only provides free care to participants in its research studies. We waited four hours for a doctor. I stood helpless as my mother's breathing came in gasps and she struggled not to fall off the packed bench. When we finally saw the doctor, he spent less than five-minutes in the room, and never looked my mother in the eye, and so she did not take her prescription correctly. Once I rushed a dear friend to a hospital aimed at Nairobi's poor. He was in dire condition---but the nurse said she couldn't treat him until we paid. The boy's father waved his money saying, "Please, we have it!!" She insisted that we first obtain a receipt. When we finally returned, receipt in hand, the nurse simply said, "I'm sorry, your son is dead." None of these tragedies are isolated incidents. They are frequent occurrences in facilities that provide healthcare to people living in extreme poverty.
Until I came to college in the United States I did not know that such experiences do not occur in the health systems of the affluent. I will never forget the first time I saw a doctor at college. He looked me in the eye, and asked questions that involved me in the process of my own health. For the first time I felt empowered to advocate for my own health. Sadly my mother, siblings, and community members do not have these options. Many avoid seeking healthcare unless it is an emergency. HIV, child birth, TB, and other diseases are destroying our community and claiming thousands of lives because people are not empowered to access information that would enable prevention, and suffer great indignities in the process of treatment. I can stand by and watch no longer, as I know communities like mine are capable of enacting solutions.

Tell us about the social innovator behind this idea.

I lived in Kibera for the first 23 of my 26 years of life. The oldest in a poor family of 8, I was responsible for my family at a young age. I often felt helpless, unable to pay my own school fees or those of my siblings. I saw my family and community suffocated by poverty. At age 7, I sold peanuts on the road to put my siblings and myself through school. Despite my efforts, 2 of my sisters had to drop out after becoming teenage mothers—one impregnated as the result of a gang rape. When she gave birth at sixteen, she almost died at home because we could not afford to pay for a clinic. I remember many times when I was sure that someone that I loved or even that I would die because we could not afford to see a doctor. Growing up I never felt in control of anything—especially not of my own health.
I saw many people's lives crushed and I dreamed of finding a way to change these devastating realities. After 23 years in Kibera, I intimately understand the challenges of daily life there. As one of the only person from Kibera to attend an accredited four-year college, I know what it takes to get out, and what is needed to transform my community. The first time I ever had extra money, 20 cents in 2005, I bought a soccer ball and started SHOFCO, the first youth group in Kibera founded and run by slum residents. I ran SHOFCO for 4 years with no money, but with faith in people's abilities to change their own lives. I expanded this group into one of the largest organizations in the slum. SHOFCO worked with 3,000+ people on AIDS education, female empowerment, microfinance, sanitation, and health. Because of my work as founder of SHOFCO, I am a respected community leader, often called the "mayor of Kibera." I'm in a unique position to implement this idea because of my life in Kibera combined with the skills I am gaining with a Wesleyan education. I can now combat the circle of poverty: I was born poor, raised poor and will return to help those who are poor like me to change our society.

How did you first hear about Changemakers?

Through another organization or company

If through another, please provide the name of the organization or company

Echoing Green

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