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Launched in 2004, Amua is a fractional social franchise currently made up of 186 privately owned and operated clinics. Amua is implemented on behalf of the Government of Kenya by Marie Stopes Kenya with funds from the German Development Corporation (KfW). The goal of Amua is to employ the underutilized private sector to reverse downward trends in reproductive health and HIV/AIDS, as prioritized in Kenya's National Health Sector Strategic Plan, and to contribute to the achievement of the Millennium Development Goals.

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Case Study Series

Amua Network
Marie Stopes Kenya
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1 Executive Summary

Kenya's private for-profit health sector is wide-spread and developed, comprising 45 percent of all health facilities and employing 50 percent of all physicians in Kenya.^{1,2} Engaging the private sector to contribute to larger health goals is now seen as a national priority, with the Amua social franchise serving as an important model of such sector-wide collaboration for public health benefit.^{3,4}

The Amua social franchise

Launched in 2004, Amua is a fractional social franchise currently made up of 186 privately owned and operated clinics. Amua is implemented on behalf of the Government of Kenya by Marie Stopes Kenya with funds from the German Development Corporation (KfW). The goal of Amua is to employ the underutilized private sector to reverse downward trends in reproductive health and HIV/AIDS, as prioritized in Kenya's National Health Sector Strategic Plan⁵, and to contribute to the achievement of the Millennium Development Goals.

Amua 'franchisees' operate in peri-urban and rural areas of five strategically selected zones where Kenya DHS data indicates higher fertility and unmet need for family planning. Geographically, these project areas span parts of Nyanza, Western and Rift Valley provinces, all located towards Lake Victoria from Nairobi. The majority of franchisees comprise small, stand-alone medical clinics that are owned and operated by a licensed nurse and staffed by a few other health workers.

In essence, Amua franchised clinics enter an agreement with Marie Stopes Kenya to ensure quality provision of and access to a targeted range of services. Now in its second funding cycle (2008-2010), Amua is supporting an impressive range of reproductive health, safe motherhood and HIV services. Services include short and long-term family planning methods (as well as permanent methods through referral), cervical cancer screening, STI management, VCT, safe delivery, PMTCT, and post-partum hemorrhage management. Since 2004, Amua franchisees have directly provided Kenyans with roughly a quarter million couple years protection in family planning services.

Meanwhile, Amua membership signifies both benefits and obligations. As part of benefits, franchisees receive training, subsidized equipment, facilitative support visits from Amua and MoPHS teams, linkages to the national health system,

demand generation and promotions, and free family planning commodities. In return, they provide quality Amua franchise services within their service mix, avail themselves for training, submit monthly reports, and adhere to clinical protocols and other agreed terms stipulated in the Amua memorandum of understanding.

In addition to supporting quality services from franchisees on the supply side, Amua offers marketing, promotional and mobilization support to foster the demand side from clients. Once trained in the first module of quality service provision (comprehensive family planning), Amua franchised clinics are branded with the logo and painted in its colours. The Amua brand is on occasion marketed to wider audiences and promotional materials distributed, but demand creation is predominantly carried out by a pair of community health workers assigned to each franchised clinic who mobilize clients face-to-face. Franchisees serve lower to middle income Kenyans and are asked to abide by several recommended prices to increase accessibility and facilitate demand.

This Amua case study is intended for external experience sharing and to strengthen the body of knowledge on the model for social franchising. Amua's operations, challenges and lessons learnt are described within its contents.

Case study methodology

This case study was conducted using largely qualitative methods. The study has applied the standard template provided by the Global Health Group as adopted by an international consortium of social franchisors in November 2008. Qualitative inquiry was carried out in Rift Valley Province near Nakuru town by an external consultant. Three Amua staff, five franchisees, three community health workers and eight female clients were interviewed. No male clients were available. Franchisee interviews were conducted with four nurses and a clinical officer, male and female, in two peri-urban areas and three rural towns. In addition, a brief review of available program documents, service statistics and financial information was conducted.

Amua franchised clinics enter an agreement with Marie Stopes Kenya to ensure quality provision of and access to a targeted range of services.

1 Kenya National Bureau of Statistics. Kenya Facts and Figures 2007. Ministry of Planning and National Development, Kenya. 2007.

2 CSJS. Kenya: the Big Picture on Health. Center for Strategic & International Studies, 2009

3 Kenya Ministry of Health. Reversing the trends: The Second National Health Sector Strategic Plan (NHSSP II). 2005.

4 Ministry of Health [Kenya], Kenya Comparative Assessment of LAPM Activities: Final Report, Draft Report v. 0.9, April 18, 2008

5 Ibid NHSSP II 2005.

2 Context

Summary statistics ⁶	
Population (2006) ⁷	36,100,000
Percent urban/rural (2005)	42/58%
Gross national income per capita (Intl \$, 2004)	\$1050
Life expectancy at birth m/f (2004)	50/51
Probability of dying under five (per 1000 live births, 2004)	120
Total expenditure on health per capita (Intl \$, 2003)	65
Total expenditure on health as % of GDP (2003)	4.3
Percent of total expenditure on health that is private (2003)	61.3%
Percent of private expenditure on health that is out-of-pocket (2003)	82.6%
Maternal mortality rate - MMR (2005, adjusted) ⁸	560
Unmet need for family planning (2003) ⁹	25%
Contraceptive prevalence rate – CPR ¹⁰	46%
Contraceptive prevalence rate – modern methods ¹¹	39%
Total fertility rate – TFR ¹²	4.6
HIV prevalence (adults 15-64, 2007) ¹³	7.1%
Adult literacy (2000-2007) ¹⁴	74%

2.1 National population and health status

Population. In 2006, the country's population was estimated at 36.1 million, out of which 18.5 million are female including about 7 million currently of reproductive age. Population growth is estimated at 2.75 percent, down from 2.85 in 2004. People under 15 years constitute 44 percent of the population and those 15-24 form 22 percent. Youth is the fastest growing segment of the population and contributes to the high fertility¹⁵.

Fertility was highest in Kenya in 1979 when Total Fertility Rate (TFR) of 8 children per woman was recorded. In 1998, TFR was 4.7 and in 2003, 4.9 children per woman - the first increase since 1979. In 2008/9, it has again decreased to 4.6. The decline in fertility is partly explained by the increase in the use of FP methods and improved educational status of women. Fertility is not uniform across the country, ranging from 5.9 live births per woman in North Eastern to 3.4 in Central Province, and from 5.2 in rural areas to 2.9 in urban areas¹⁶.

Fertility preferences and unmet need for FP. Over 80 percent of all currently married women want either no more children (54 percent) or want to delay pregnancy for more than 2 years (27 percent)¹⁷.

A quarter of women who would like to either space or limit births are not using an FP method. Unmet FP needs are higher amongst rural women. Nearly 20 percent of births in Kenya are unwanted and 25 percent are mistimed (wanted later).

Current method preferences. The KDHS also indicates that long-term methods (LTM), in particular implants and IUCDs, remain amongst the least used modern methods of contraception, or by approximately 4 percent of currently married women. Trends over time include a decline in use of IUCDs since the 1980s, while the use of implants has slowly increased since the 1990s. Injectables have meanwhile become the most used method of FP¹⁹.

⁶. Unless otherwise stated, data obtained from WHO Country Health System Fact Sheet Kenya 2006

⁷. WHO 2008

⁸. UNICEF

⁹. KDHS 2003

¹⁰. KDHS 2008/9

¹¹. KDHS 2008/9

¹². KDHS 2008/9

¹³. National AIDS Control Council. Kenya AIDS Indicator Survey 2007. Republic of Kenya. September 2009

¹⁴. UNICEF

¹⁵. Kenya National Bureau of Statistics (KNBS). Kenya Facts and Figures 2007. Ministry of Planning and National Development P.O. BOX 30266, Nairobi, Kenya. 2007.

¹⁶. KDHS 2008/9

¹⁷. KDHS 2008/9

¹⁸. Central Bureau of Statistics (CBS) [Kenya]. Kenya Demographic and Health Survey 2003. Kenya Ministry of Health, and ORC Macro. Calverton, MD: CBS, MOPHS, and ORC Macro. 2004

¹⁸. Ibid KDHS 2003

¹⁹. Ibid KDHS 2003

HIV/AIDS. Of adults aged 15-64 years, an estimated 7.1 percent, or 1.42 million people, were living with HIV infection in 2007. In the same year, one in three Kenyan adults reported ever having been tested for HIV, up from one in six in 2003. Prevalence is higher among females (8.4 percent) and in urban populations (also 8.4 percent). In a national survey of 18,000 individuals, 60 percent of HIV-infected adults eligible for ARV therapy (CD4 count of <250 cells/ μ L) were not taking daily ARVs²⁰.

2.2 Health care system

Health care in Kenya is delivered through an expansive system of 5,170 health facilities operated by the government (41 percent), NGOs (15 percent), and the private sector (43 percent)²¹. The GoK has a dedicated agency for receiving and distributing medical supplies including FP commodities, known as the Kenya Essential Medical Supplies Agency (KEMSA), to all public and many NGO and private facilities. In further support of the health facilities, Kenya has nearly 67,000 health workers. This represents a low ratio of health workers to the population (2 per 1000) compared to Africa region, particularly in the case of physicians (1.4 per 10,000)²².

Health care is financed through a variety of means. Total expenditure on health is estimated at 4.3 percent of GDP with private expenditure accounting for nearly two-thirds. Of private expenditure, more than four-fifths is out of pocket²³. Public services are generally free at the point of care. In 2006, health was the sixth greatest area of national spending or about 7 percent budgetary allotment²⁴. The majority of national health coverage is paid for through tax revenues with donor funds contributing 15 percent to total health funding (2006)²⁵. In 2007, the GoK made contraceptives a line item in the budget and the same year procured a record 50 percent of FP commodities. The total budget for commodities was 6 million USD with funds from the GoK, USAID, UNFPA, DFID and KfW. This represents about 85 US cents per woman of reproductive age for FP commodities. All government-procured commodities must be free to clients regardless of the point of access.

2.2.1 The private health sector and regulatory framework

The private health sector is wide-spread in Kenya and used by all socio-economic levels. Engaging the private sector to increase its contribution to reaching public health goals is seen as a national priority²⁶.



Community Mobilisation at Keumbu Medical Clinic Kisii.

Professional associations (i.e., National Nurses Association of Kenya) manage licensing of both private and public sector workers. Membership with an appropriate professional association is therefore mandatory and providers must be relicensed every three years. Renewal fees and proof of continuous medical education are required as stipulated by the associations. Professional associations coordinate many of the courses available to private providers.

Private facilities are licensed with the Kenya Medical and Dentist Board following an inspection to verify clinic compliance with public health requirements. Inspection and renewal take place annually. Private facilities are required to report health service statistics to the district level Ministry of Public Health and Sanitation (MoPHS) on a monthly basis.

2.3 Franchisor relationship with the government

A formal contractual relationship exists between the Government of Kenya and Marie Stopes Kenya that distinguishes Amua from other social franchises. MSK was awarded the government contract to implement the social franchising project following a country-wide tender invitation, funded by the German Financial Cooperation (KfW).

Within the contract, the MoPHS designates MSK to execute social franchising services. The MoPHS is responsible on behalf of the GoK, while within the MoPHS, the division of reproductive health (DRH) is in charge of project coordination and oversight. The DRH/MoPHS signs off on Amua's annual financial forecast and work plan prior to submission to KfW, which disburses funds directly to MSK. The head of the DRH chairs a quarterly project management coordination group meeting comprised of representatives from the donor, professional associations and MSK that reviews project progress and agrees on ways forward. MSK reports Amua's outputs bi-annually to both KfW and the DRH.

The GoK requires the engagement of MoPHS district public health nurses and national curricula when conducting franchisee trainings. Training leads to certification in comprehensive FP service provision, which in turn allows franchisees to register for free commodity access from district GoK stores.

²⁰ National AIDS Control Council. Kenya AIDS Indicator Survey 2007. Republic of Kenya. September 2009

²¹ Ibid KNBS 2007

²² WHO Country Health System Fact Sheet Kenya 2006

²³ WHO Country Health System Fact Sheet Kenya 2006

²⁴ Ibid KNBS 2007

²⁵ CSIS. Kenya: the Big Picture on Health. Center for Strategic & International Studies, 2009

²⁶ Kenya Ministry of Health. Reversing the trends: The Second National Health Sector Strategic Plan (NHSSP II). 2005.

2.4 Market opportunities

The private sector is widely used in Kenya but tends to be biased towards curative care. According to the baseline for the second wave of recruitment, less than a quarter of private providers were offering any long-term family planning methods (LTM) prior to franchising. Amua staff feel that expanding preventative and promotive health services such as family planning (FP) in the private sector is an opportunity to better meet the Kenyan population’s needs.

Both clients and community health workers felt that there is demand for the confidentiality and attentiveness of private health care for services such as FP/SRH/HIV.

Meanwhile, commercial franchising (i.e., Kenchic, Bata, Nakumatt, Tusky’s) and modern marketing techniques are prevalent in Kenya, which suggests that the social franchising model is likely to be appropriate for the national environment.

3 Business Model

3.1 The model

Amua has adopted a fractional franchise model in order to increase availability of quality SRH services in existing private clinics. Franchisees receive training, subsidized equipment, facilitative support visits from Amua and MoPHS teams, linkages to the national health systems, demand generation and promotions, and free commodities. In return, they provide quality sexual and reproductive health services as part of their service mix, avail themselves for training, submit monthly reports, and adhere to clinical protocols and other agreed terms stipulated in the Amua memorandum of understanding.

3.1.1 The franchisor

Background. Founded in 1976, Marie Stopes International (MSI) is a UK-based nonprofit that works to prevent unintended pregnancies and unplanned births in 42 countries around the world. According to the country context, MSI delivers a range of services including FP, safe abortion and post-abortion care (PAC), and HIV/AIDS and STI services. MSI now runs a total of 9 social franchises that are marketed under the brand names of BlueStar, Suraj and Amua.

Marie Stopes Kenya (MSK) is a locally registered NGO operating since 1985 as a local affiliate to MSI. It is Kenya’s largest SRH and FP organization.

Initially, MSK focused on delivering services through stand-alone clinics called Marie Stopes Centres. 25 Marie Stopes Centres across Kenya currently offer quality services at subsidized prices. MSK has since broadened its approach to include social marketing

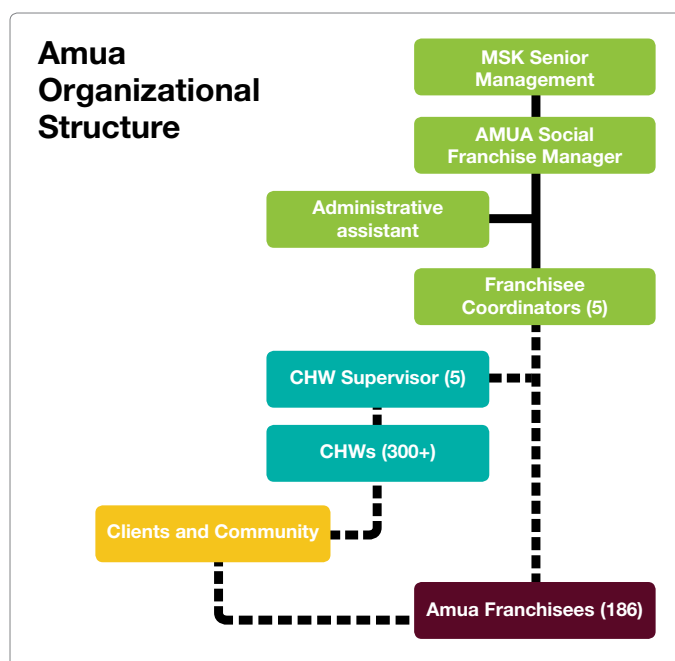
of commodities and 15 mobile outreach teams providing long-acting and permanent methods (LAPM) in hard-to-reach areas. In recent years, MSK mobile outreach teams have been providing over 60 percent of all LAPM services nationally.

The Amua social franchise, launched in 2004, is MSK’s most recent service delivery model to increase access to SRH products and services in the country. The goal of Amua is to employ the underutilized private sector to improve trends in reproductive health and HIV/AIDS, as prioritized in Kenya’s current National Health Sector Strategic Plan, and to contribute to the achievement of the Millennium Development Goals. Amua completed its first funding cycle in 2007 and is now in project phase two until 2010.

Amua administration. In total, 7 staff members are dedicated to running Amua. The Social Franchise Manager oversees the team of Franchise Coordinators in the five project areas and one administrative staff member.

Franchisee Coordinators are health professionals – mostly nurses. Each one is responsible for approximately 35-40 franchisee locations with support from the Social Franchise Manager. Responsibilities include selecting and recruiting franchisees, organizing training courses, conducting supervision and on-the-job training, delivering commodities and supplies as needed, collecting monthly reports and carrying out demand creation events.

MSK finance, marketing, ICT and monitoring and evaluation departments contribute to Amua activities. The MSK Deputy Director is the support manager at the central office for Amua and the MSI Global Social Franchising team provides technical assistance.



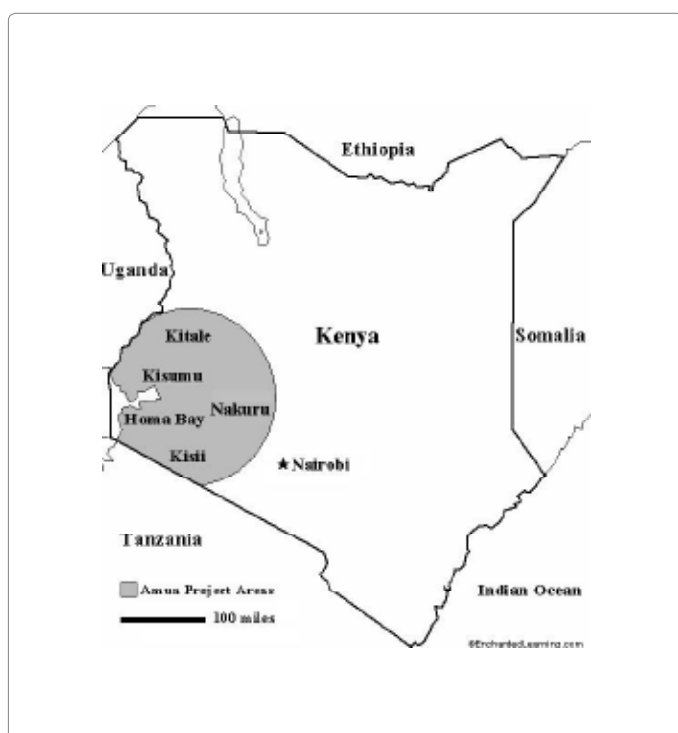
For demand creation support, each franchisee identifies two volunteer community health workers (CHWs) who are overseen by a CHW Supervisor in each area. The CHW Supervisors assist the Franchisee Coordinators to implement demand creation events. Neither CHWs or CHW Supervisors are Amua employees.

3.1.2 The franchisees

Amua is currently made up of 186 franchisee private clinics located in five strategically selected geographical areas of Nyanza, Western and Rift Valley provinces: Kisii, Homa Bay, Kisumu, Kitale, and Nakuru. Amua franchises the clinic itself rather than individual health providers, and the Amua brand name is added to the existing private clinic name.

About 80 percent of franchisees are small, individually owned and operated clinics, while 20 percent are larger maternity homes or multi-provider medical centers. Clinics are occasionally attached to other health services, such as a dentistry, or more commonly contain laboratories and pharmacies on the premises.

A typical small clinic has a waiting area containing a reception and a limited range of drugs for sale, and an additional room for both consultations and minor procedures. Small clinics are normally staffed by no more than two nurses and an assistant. Larger clinics might contain a laboratory, a consultation and minor procedures room, a delivery/PAC room and a recovery room with two or three beds. Larger clinics might be staffed by a clinical officer, several nurses, and a laboratory and pharmacy technician.



About three-quarters of Amua franchisee clinics are owned and run by nurses. The remaining majority are clinical officers (COs) as well as six medical doctors. Amua's phase one specifically sought to recruit doctors in order to roll out bilateral tubal ligations (BTL); however, getting doctors on board was found to be highly challenging. Amua now focuses on clinics run by nurses and COs who are better suited to provide the rest of the Amua service package.

Health professionals offering Amua services are equally male and female. Amua staff report that there is acceptability in Kenya associated with women attending male nurses for SRH needs or vice versa.

3.1.3 Target population

Amua aims to increase access to quality SRH services amongst poorer and hard-to-reach couples in underserved areas of Kenya. The five Amua target areas were specifically selected based on Kenya DHS data indicating lower than average contraceptive prevalence rates, lower use of LTM and higher fertility rates.

Interviewed franchisees reported serving a client base of small traders, cash workers and subsistence farmers, most of whom have a primary education. One franchisee was serving an area settled by IDPs following the post-election violence in 2008. Amua services are largely accessed by women.

Eight female clients were also interviewed at Amua clinics. Proximity and reputation were the most important reasons for selecting the franchisee. All reported that they have friends and family who use the same clinic. Most clients said that they do not attend any other facilities but rely on the franchisee's services alone. All, including one who was in labor, had walked from surrounding communities to reach the franchisee. Walking distance ranged from a few minutes to a few hours.

3.1.4 Services offered under the Amua franchise

Compared to other social franchises of similar maturity, Amua is rolling out an impressive range of ten SRH and HIV services in project phase two. This reflects Amua's close partnership with the GoK and the current national policy to integrate FP, SRH and STI/HIV/AIDS service delivery.

Most clinics – regardless of the cadre of health professional – were offering mostly curative services prior to Amua franchising. FP was generally limited to pills and injectables. All franchisees interviewed reported delivering both a wider range of FP services as well as receiving a greater share of FP clients as an outcome of franchising.

Amua services

Phase 1: April 2004 – March 2007

- ✓ FP counseling
- ✓ IUCD
- ✓ BTL or BTL referral

Additional services, Phase 2: Sept. 2008 – August 2010

- ✓ Condoms
- ✓ Pills (COC)
- ✓ Injectables (Depo-Provera)
- ✓ Implant (Jadelle)
- ✓ Cervical cancer screening (VIA/VILI)
- ✓ Safe delivery & PPH management (select franchisees)
- ✓ STI management, VCT and PMTCT (planned)

FP counseling. Franchisees must comprehensively counsel clients on FP methods to ensure the principle of choice. This includes counseling on methods that the franchisee may not directly provide, such as permanent methods.

Several franchisees said that they had greatly changed the way they counsel clients as a result of Amua. In the words of one, ‘I really learned not to look at my clients with pre-formed attitudes. Now I listen to them and help them to choose what will work best for them. I used to think I knew best.’

Permanent methods of contraception and referral. Just 6 franchisees currently provide BTL services, while the other 180 counsel and refer clients to Marie Stopes Centres or to scheduled Marie Stopes outreach events. The MoU stipulates that Amua franchisees should be able to refer at least 5 BTL clients per month. Actual referrals vary per franchisee but have averaged at 4.8 per month in phase two. Clients for vasectomy services are similarly counseled and referred.

Long-term methods of contraception. Amua prioritizes increasing access to LTM which are underutilized methods in Kenya. 100 percent of franchisees have been trained and equipped for LTM service delivery including IUCDs (Copper T) and implants (Jadelle™). According to the phase two baseline, about three quarters of new franchisees did not offer any LTM prior to franchising.

In interviews, franchisees reported LTM to be their biggest change since joining Amua and that these methods have brought them new clients. One franchisee said, “I was trained in IUCD in the past, but the difference is that I am now confident about my skills in insertion and removal.”

The Amua memorandum of understanding stipulates that franchisees should be able to provide at least 10 IUCD insertions per month to ensure they remain active in this service delivery. In reality, franchisees have delivered an average of 5.3 per month in phase two.

Short-term methods of contraception (phase two). As a mark of quality, all franchisees must also stock and provide injectables, oral contraceptives and condoms. Short-term methods were not supported franchise services during project phase. According to baseline data, all franchisees were providing some short-term methods when they joined Amua. In phase two, franchisees have been updated with training and linked with free GoK supplies to facilitate improved quality of service provision.

Cervical cancer screening and referral for PAP (phase two). Amua has trained 100 percent of its franchisees in cervical cancer screening using visual inspection with acetic acid/ Lugol’s iodine (VIA/VILI). Amua is the first service delivery channel in Kenya to make cervical cancer screening available to lower-income women and precedes the government’s roll out in public facilities. This is therefore a new service to all franchisees. VIA/VILI is cross-sold to clients who come for other services as many women are not yet aware of screening benefits.

Women with irregularities are referred to Marie Stopes Centres or public hospitals for further tests. Alternatively, franchisees can collect PAP smear samples and bring them to Marie Stopes Centre laboratories for analysis at subsidized rates.

HIV/STI services (phase two). In the first quarter of 2010, all Amua franchisees will be trained to provide additional services including 1) syndromatic management of STIs, 2) voluntary counseling and testing for HIV (VCT) using rapid kits, and 3) prevention of mother to child transmission (PMTCT). Franchisees will be accredited and thereby gain access to GoK supplies such as test kits and Neviraprine.

According to the baseline, many franchisees already offer these services (notably STI management and VCT) but they will continue to be strengthened through Amua training and support. Emphasis will be placed on reducing missed opportunities through the integration of FP and STI/HIV service delivery.

Post-partum hemorrhage management (phase two). Amua received additional funding in 2009 to train selected franchisees in PPH management and manage a revolving supply of Misoprostol. PPH management training, including a safe delivery refresher, was only extended to franchisees who attend deliveries on site (80 of 186 franchisees, or 43 percent). It is therefore not part of Amua’s standard service package.



Amua clinic branding.

3.1.5 Commodities and supplies offered under Amua

As Amua is operated by MSK on behalf of the Kenyan government, membership allows for free access to GoK contraceptive commodities (all methods) from district stores. Franchisees are registered with a service delivery point number to ensure access. Some franchisees already had SDP numbers at the time of joining and therefore this access cannot be seen as a unique benefit of membership.

Meanwhile, Misoprostol is not yet available from the GoK or KEMSA. Amua has therefore established a revolving fund to resupply the franchisees providing PPH management. Misoprostol is sold at cost and Franchisee Coordinators directly handle both payment and delivery. Alternatively, franchisees can send payment to the Social Franchise Manager through Kenya's mobile phone money transfer service, M-Pesa (by Safaricom).

HIV training and related accreditation will similarly allow Amua franchisees to access free rapid test kits and Neviraprine from the government. Amua does not anticipate involvement in the supply chain.

Drugs for STI management, acetic acid and iodine for VIA/VILI are privately purchased by the franchisees along with other consumables for Amua services (i.e., infection prevention consumables).

3.1.6 Scalability

Amua has already scaled up both the number of franchisees (from 141 to 186) as well as the number of services (from 3 to 10) when transitioning to phase two. The main priority of this scale up was to reflect national policy by expanding the range of FP method choice and integrating STI/HIV services with FP.

Franchisees were very positive about adding services and attending more training in phase two. According to interviews, this enthusiasm appears unabated. Meanwhile, MSI is unlikely to pursue service areas outside SRH as a result of close adherence to its mandate.

In the near term, Amua is drafting the proposal for a third phase (beginning in 2010) from KfW, during which time Amua will focus on ensuring increased efficiency and effectiveness in delivering FP/ RH services through the existing franchisee clinics and further integrating Amua into the national healthcare system. Amua and JHPIEGO have recently received collaborative funding through the Gates Urban Reproductive Health Project to increase access in 100 facilities located in poor urban settlements in five major urban centers.

3.2 Summary statistics

To date, Amua has generated a cumulative total of 557,749 couple years protection over phase one (257,613 CYPs) and phase two (300,136 CYPs so far), including the permanent method CYPs attributed to Amua franchisees through referral. Amua has generated a cumulative total of 212,239 CYPs through direct service provision alone (82,610 in phase one and 129,629 in phase two).

Total services and commodities provided by Amua - Phase II to date (June 08 – Oct 09)

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Total services	Total CYPs
FP consultation	6,800	7,082	9,992	12,501	29,212	65,587	~
IUCD (Copper T) insertion	2,051	2,465	2,946	3,240	4,169	14,871	81,791
BTL (referral)	3,714	3,220	2,051	2,460	2,145	13,590	169,875
Vasectomy (referral)	~	~	139	485	8	632	7,900
Implants	~	1,281	501	1,660	2,576	6,018	21,063
Injectables (3 month)	~	~	13,158	15,246	18,207	46,611	11,653
Pills (cycles)	~	~	9,336	20,946	12,975	43,257	3,089
Male condoms (pieces)	~	~	110,944	131,116	234,549	476,609	4,766
VIA/VILI	~	~	~	983	2,924	3,907	~

3.3 Service finances

3.3.1 Prices for commodities and services

Access to free government supplies means that franchisees can apply prices that reflect only consultation charges and the cost of other consumables involved in the service delivery (i.e., infection prevention materials such as gloves and chloride). Amua is positioned to offer services below private sector market prices by nature of the partnership with the government.

Amua prices

IUCD insertion	500 Ksh/ 6.75 USD
Implant insertion	500 Ksh/ 6.75 USD
VIA/VILI screening	200 Ksh/ 2.70 USD

To date, Amua has recommended prices for some franchised services, including IUCD, implant and VIA/VILI. All other services are priced at the franchisee's discretion.

Franchisees discuss and agree upon recommended prices at the conclusion of training sessions with guidance from Amua management. As a result, prices for IUCD and implant insertion have been set at 500 Ksh (about \$6.75 US) and VIA/VILI has been set at 200 Ksh (about \$2.70 US).

Amua management report that prices are fixed and should be displayed in franchisee clinics. However, none of the franchisees visited had posted prices, while all stated that they use sliding scales and communicate prices on a case by case basis. Some franchisees said that Amua prices were suggested 'as a direction only'. Most also said that they regularly reduce prices for poorer clients. Also, any fixed prices for implant insertion have been complicated by commodity insecurity. Franchisees explained that they have to adjust the price when implants are purchased during stock-outs of free supplies (i.e., adjusting from 500 to 800 Ksh).

All franchisees interviewed felt that their prices were fair or very fair compared to their local competitors, which was confirmed by the clients.

3.3.2 Subsidies

As a privilege of Amua membership, contraceptive commodities are accessed for free from government stores (while stock-outs do occasionally require franchisees to source commodities at cost). Franchisees named this a major benefit of franchising.

Amua offers equipment at subsidized rates, although owning all items on the required list is mandatory (i.e., insertion kits, autoclave, infection prevention set up, lamp and BP monitor).

In Amua's phase one, the subsidized price was offered at 50 percent of the real equipment cost and franchisees were given a year to pay off their share. However, very little of the money was recovered and this subsidy was effectively described as a 'bad debt' by Amua management. In phase two, the subsidy was adjusted so that franchisees pay just 20 percent of the real equipment cost. This was seen as extremely fair by franchisees so that payment has been much more easily recovered.

3.3.3 Pricing enforcement systems

Pricing for IUCDs, implants and VIA/VILI is collectively agreed upon by all Amua franchisees but not strictly enforced. Prices are monitored during supervision visits as well as through a mystery client survey implemented once this year. Evidence of overcharging is said to be reason for discussion with the franchisee, while punitive measures are not used.

3.3.4 Payment sources

Amua clients pay out-of-pocket for services. Franchisees serve peri-urban and rural areas where client inability to pay was said to be a recurring challenge. Some offer services on credit but reported that settling payments is problematic. Others reported that they feel compelled to offer services for free or at highly reduced cost when serving the poorest clients, which comes out of their own pocket. As one franchisee said, 'I am torn between operating at a loss and turning needy clients away.' Another franchisee estimated that one in four clients comes to her with no money at all, especially since IDPs moved into the area in 2007/8.

3.3.5 Insurance and vouchers

Insurance. Kenya has a national health insurance scheme (as well as many private insurance options) that is available to employees of the formal labor market and their families. Meanwhile, people living in Amua's peri-urban and rural communities predominantly work in informal labor markets. National health insurance covers inpatient cases and only about 10 Amua franchisees are registered (larger maternities offering inpatient care). These 10 franchisees can offer FP services under national insurance during post-natal care visits, while PMTCT is covered through antenatal care and safe delivery. The GoK is now piloting a new outpatient model for national scale up that would begin to cover more of Amua's service range. In light of this upcoming change, Amua is seeking to extend national insurance registration to its franchisees in the proposed third phase. Amongst interviewed clients, none had any type of insurance or knew of a scheme for which they might be eligible.



Clients wait for services from an Amua franchisee, Kisii

Vouchers. KfW and GoK have another initiative underway in Kenya that could offer a promising opportunity to reduce financial barriers for the poorest clients. This is called the Output-Based Aid voucher scheme, whereby community health workers sell FP and safe motherhood vouchers at highly subsidized rates directly to clients who fall under definitions of ‘deserving cases’. Clients can then claim services from their choice amongst the accredited facilities, of which there are public, NGO, FBO and private options (Marie Stopes Centres located in the pilot areas have been accredited, as well as 6 Amua franchisees). In turn, facilities are compensated for the services they have provided by returning the used vouchers and required documentation.

Accrediting more Amua franchisees to accept OBA vouchers could promote equitable access to services and allow franchisees to serve poorer clients without incurring a loss. Dialogue is ongoing about fostering links between OBA and Amua; however, for the time being both projects largely operate in different geographic locations.

3.4 Franchisee finances

3.4.1 Franchise operation costs

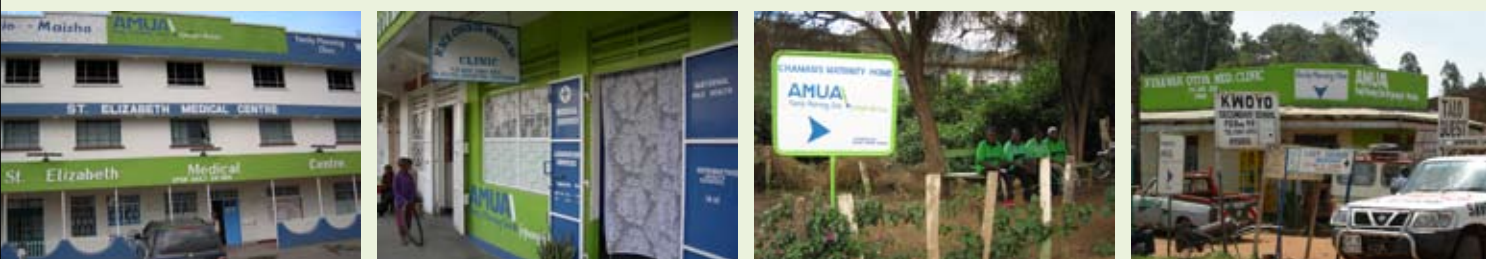
Amua first received a budget of 2,520,000 USD for the three-year phase one, and is currently operating from a 3.1 million dollar budget for the two-year phase two. Planned budgetary allotment for phase two includes 37 percent for marketing, branding and signage; 30 percent for training; 25 percent for project management, transport and remuneration; and 8 percent for equipment and supplies.

Over the first year of phase two (July 2008 until June 2009), Amua franchisees directly provided 89,768 CYPs with operation costs per CYP averaging at \$35.58 USD. When including the CYPs resulting from permanent method referrals (BTL and vasectomy), this figure reached 233,454 CYPs with cost per CYP averaging at \$14.40 USD. Phase two costs per franchisee averaged at about \$4,607 USD for the first year.

Amua operation costs - USD

Phase one April 2004 – March 2007	Cost/CYP (3 yr annual average)	\$7.40
	Cost/CYP (3 yr annual average, without BTL referral)	\$30.45
	Annual cost/franchisee (3 yr annual average)	\$5,950.50
Phase two July 2008 – June 2010	Cost/CYP (first year average)	\$14.40
	Cost/CYP (first year average, without BTL referral)	\$35.60
	Annual cost/franchisee (first year average)	\$4,607.30

The Amua brand and logo was locally developed by an outsourced consumer research and marketing agency. 'Amua' is Kiswahili for 'decide' and the brand name is followed by the motto, 'Jipangie Maisha', meaning 'plan life for yourself'. The brand has been consistently applied through signage and painting of franchisee clinics, while branded merchandise has been distributed to franchisees and to community health workers.



Compared to other MSI social franchises, Amua's cost per CYP is relatively high considering its 5 years of implementation. However, cost per CYP is not an ideal measure of Amua's cost efficiency since several of the franchised services do not or will not produce CYPs (i.e., VIA/VILA, HIV services, STI and PPH management). Also, Amua generates many referrals for permanent methods (in phase two, permanent method referral has generated 58.8 percent of all attributed CYPs), but the service delivery of these procedures is subsidized or paid in full by other Marie Stopes Kenya program budgets and does not incur cost for Amua.

Meanwhile, phase one generated a total output of 107,250 CYPs (direct provision) or 467,875 CYPs (direct provision and BTL referral) over the three year period, at estimated costs per CYP of \$30.45 or \$7.40 USD respectively. Phase one operation costs per franchisee averaged at about \$5,950.50 USD per year.

3.4.2 Cost-sharing with other activities or programs

Amua has a distinct budget from other Marie Stopes Kenya activities and programs. Some human resources are used to support the franchise from outside Amua's direct budget line, such as those within the MSK marketing, ICT, finance or monitoring and evaluation departments. For example, Amua has used the MSK marketing manager and BCC/IEC coordinator in development of key messages. The former M&E manager helped with many of the M&E initiatives.

3.4.3 Donors

Amua operates on behalf of the Kenyan government with funding from KfW. This is in line with Kenya's sector-wide approach (SWAp), whereby donors closely align programs with national goals. This means releasing funds to the implementing body (in Amua's case, MSK) based on financial forecasts and work plans that are pre-approved by the relevant government agency (the MoPHS/DRH).

In addition, Amua received a sub-grant from Venture Strategies to roll out PPH management in select franchisee locations. UNFPA has also contributed commodity donations to MSK that have benefited Amua franchisees.

Amua is now in its second major KfW funding cycle. An interim period between April 2007 and September 2008 was straddled by MSI maintenance funding. During this time, Amua activities were reduced to franchisees supervision visits, on-the-job training and access to free commodities to ensure continuity of quality service provision.

4 Franchise Operations

4.1 Franchisee relations

4.1.1 Franchisee selection

Amua has targeted five geographic project areas based on Kenya DHS data indicating lower than average contraceptive prevalence rates, lower use of LAPM and higher fertility rates in the areas.

Amua franchisee selection criteria: Summary

- ✓ Focus person is qualified & licensed with professional association
- ✓ Clinic licensed with MoPHS/GoK
- ✓ Located in target areas
- ✓ Focus person is full-time and fully private
- ✓ Facility amenities; equipment; cleanliness & appearance
- ✓ Affordability; client loads
- ✓ Willingness to provide Amua services and attend training

Professional associations were contacted to attain a list of all registered private practitioners in the designated areas. Franchisee Coordinators then located them on the ground and interviewed them using a baseline tool. The tool examined professional experience, service mix, and facility and equipment standards. Answers were scored to give quick indication of the intervention required to bring the clinic to Amua standards.

To reduce turnover, Amua's phase two put more emphasis on selecting locations where the full-time clinic owner or manager is willing to be trained.

Amua staff consulted MoPHS district-level public health nurses to know which private clinics regularly submit monthly reports, attend refresher updates and otherwise demonstrate professional activity in their area. This also served to double-check that clinics were registered with the MoPHS.

4.1.2 Franchisee recruitment

Following the selection process, recruitment involves invitation to a comprehensive FP training course including theory and practicum for LTM. Satisfactory completion of the course ends the recruitment phase and an MoU is signed with the new franchisee. However, if recruits do not 'make the grade' they do not proceed to signing the MoU with Amua. For example, ten out of 132 nurses and clinical officers trained in LTM during the first recruitment round were not extended membership.

Amua has undertaken recruitment at the beginning of each funding cycle as opposed to conducting rolling recruitments. The process is intensive, but has the advantage of training all new recruits at once. Amua will not recruit more franchisees before entering a new funding cycle.

Amua staff reported that phase one recruitment was difficult for two main reasons. Firstly, Amua was seeking to work with doctors whose professional agenda did not complement project goals, and secondly, there was little awareness of social franchising amongst health professionals. This required a lot of one-on-one discussion in order to convey the potential benefits involved with membership.

Challenges have been rectified in phase two recruitment. Demand to join was heightened by Amua's recognition in the project areas. In addition, the Amua service package and targeted cadres of health workers were adjusted to create a better win-win relationship.

During the second recruitment, 4 out of 5 clinics (67/82) invited to join Amua went on to do so, showing that the attraction to join is strong and benefits are clearly envisioned. Franchisee named various motivations. Three of five had not heard of Amua prior to joining but wished to expand services or gain access to products and training. They said that one-on-one conversations with the Franchisee Coordinator were key to making their decision. The other two had heard of Amua prior to joining and specifically wished to benefit from the same support they had witnessed in their peers' clinics.



An Amua franchisee receives a supportive supervision visit from the franchisee coordinator, Nakuru region.

4.1.3 Franchise contracts

Signed contracts have duration for the funding cycle (currently two years). The terms were developed in consideration of other contracts developed for Marie Stopes Kenya and similar social franchising contracts such as Greenstar's. The contract outlines expectations and stipulates that either party can retract from the agreement with three months prior notice.

Terms within the contract include franchisor responsibilities, franchisee adherence to quality measures – attending training, receiving supervision visits, following protocols – as well as membership fees and reporting. Minimum monthly service numbers are defined as 10 IUCD insertions per month and 5 BTL referrals.

Joining Amua incurs a fee of 2500 Ksh (roughly 35 USD) for smaller clinics and 5000 (70 USD) for large maternity homes, payable at completion of the recruitment training and signing. In the past, fees have been deducted from trainees' sitting fees. According to the MoU, this fee was suggested to recur annually; however, it has effectively only been applied as a one-time cost when joining. As a result, some franchisees did not remember ever paying to be part of Amua when asked in interviews.

Amua management said that the MoU would be revised in next project phase to reinforce quality requirements and to stipulate that franchisees cannot join other networks.

There were no reports of franchisee nervousness or hesitation to sign into the contract.

4.1.4 Requirements & benefits of enrollment

Amua requirements and benefits are extensively outlined in the Amua Franchisee Operations Manual. The manual is given to each franchisee at completion of the recruitment training.

When asked about membership benefits, franchisees most commonly named training, a wider range of services, increased client load and access to commodities and equipment. Promotional events, branding, signage and painting were not named. Meanwhile, reporting and adherence to protocols were most frequently cited as Amua requirements, while membership fees, active performance and supervision were not mentioned.

4.1.5 Franchisee retention

Over the 5 years, a number of franchisees have left Amua for personal reasons (retirement, translocation) or calamity (post-election violence, death), but none have done so out of membership dissatisfaction. Amua has not dissolved any contracts. On the other hand, over 20 franchisees were not invited to resign the MoU when moving from phase one to phase two. The great majority of these were not actively providing Amua franchised services and their places were offered to new franchisees.

Amua management expressed that expulsion has not yet been the line of thinking and direct discussion remains the primary means of addressing franchisee conflicts. The franchisor-franchisee relationship is far better defined as supportive rather than policing. Amua may become stricter - especially for any issues surrounding quality - now that the franchise is better known and clinics are keen to join.

None of the interviewed franchisees were aware of criteria or mechanisms in place for defranchising.

4.1.6 Level of commitment

Four out of five of the franchisees expressed strong commitment to Amua and saw membership as a distinguishing characteristic of their clinic. Reasons for commitment were associated with the list of perceived benefits (free supplies, training) rather than branding alone (i.e., the prestige of being Amua, recognition).

One franchisee was aware of PSI's recently launched franchise for long-term FP services and reported that she would not object to comparing potential benefits of membership.

4.1.7 Communication

The five Franchisee Coordinators serve as the major link between the Amua head office and franchisees. Site visits take place at least once a month in addition to regular phone calls.

Amua does not circulate a newsletter for franchisees nor are the franchisees ever assembled on a national level. However, franchisees in each geographic area come together during regional forums and trainings. Amua has ensured that they obtain area contact lists for direct collaboration.

Amua benefits	Amua requirements
<ul style="list-style-type: none"> ✓ Training ✓ Free commodities, subsidized equipment ✓ Branding, signage & painting ✓ Wider range of services; more clients ✓ Promotions & demand creation 	<ul style="list-style-type: none"> ✓ Training ✓ Supervision visits ✓ Adherence to standards & protocols ✓ Reporting ✓ Active in franchised services ✓ Membership fee

4.2 Promotions and marketing

The majority of Amua's promotional activities were carried out in phase one and then suspended during the 18 month interim period between funding KfW cycles. Promotional activities in phase two had not fully recommenced at the time of this case study.

Amua shares human resources for marketing with the rest of the MSK program. At the field level, Franchisee Coordinators are charged with coordinating demand creation events on top of clinical supervision and commodity support.

Overall, the community health worker component is the priority strategy for linking clients to Amua franchisees (see 4.7.3).

4.2.1 Branding

The Amua brand and logo was locally developed by an outsourced consumer research and marketing agency. 'Amua' is Kiswahili for 'decide' and the brand name is followed by the motto, 'Jipangie Maisha', meaning 'plan life for yourself'. The brand has been consistently applied through signage and painting of franchisee clinics, while branded merchandise has been distributed to franchisees and to community health workers. Amua merchandise has included pens, key rings, notepads, t-shirts, umbrellas, conference bags, headscarves, caps and aprons.

Signage is strategically placed on major roads or at intersections. Early in phase two, franchisee clinic exteriors and waiting areas were all attractively painted in green and blue Amua colors.

In addition, the MoPHS/GoK seal is printed on many Amua-branded materials and is a highly valued symbol by both clients and franchisees, according to Amua staff.

4.2.2 Media and demand creation events

Radio campaigns, road shows, market day shows and free camps have all been implemented at various points during Amua's 5 years of implementation. Overall, core messaging emphasizes the safety and benefits of LTM. During phase one, key messages were translated into the local vernacular and franchisees then identified a radio channel to best reach clients. After both phase one and two recruitment periods, launches were done using street performances (puppetry, music and megaphones) to inform communities about new Amua franchisees and services.

As the Amua is run on behalf of the Kenyan Government, recurring opportunities arise to combine MoPHS campaigns with Amua promotional activities, such as during local immunization pulses. The Franchisee Coordinator and CHW

Amua strategies used to date

- ✓ Branding
- ✓ Signage & facility painting
- ✓ Radio campaigns
- ✓ Road shows; market day shows
- ✓ Linking with MoPHS campaigns
- ✓ Free event days at franchisee locations
- ✓ Community health worker mobilization strategies



A larger Amua franchisee maternity home, Nakuru region

Supervisor take advantage of the congregations of mothers, either by erecting an Amua tent, using megaphones or carrying out street performances alongside the MoPHS campaign.

Amua also coordinates 'free camps' that are locally publicized as one-time opportunities for clients to access free services (especially IUCD services). This brings high volumes of new clients to the clinic and builds wider community relations with the Amua franchisee. During one such event, a franchisee reported inserting 48 IUCDs in a single day. Amua supplements free consumables while the Franchisee Coordinator assists to meet the high demand for services. However, franchisees are not paid for service delivery and free camps can incur some costs. As a result this strategy has not been uniformly applied and franchisees must express interest for free camps to take place.

Amua management considers marketing activities such as free camps or 'relaunch' road shows as a way to bring up service provision amongst the lower performers. A dip in service statistics might lead to such extra demand creation options being discussed with a franchisee. Therefore promotions are also carried out as retroactive measures.

Overall, promotional and demand creation activities have not been consistently carried out and were not named as membership benefits in franchisee interviews. Most franchisees referred only to the CHW strategy when asked what marketing or promotional support they receive. None referred to free camps or radio shows unless prompted and several had not benefited. Most said that they encourage word of mouth amongst their clients or offer free transport from the clinic to promote themselves.

It was suggested that Amua could be more aggressive in marketing, although most franchisees still felt that their FP client load had increased with franchising. Amua management expressed that greater attention will be directed to marketing strategies in coming months.

4.3 Logistics

4.3.1 Procurement and delivery processes

Amua has arranged that accredited franchisees can access free GoK FP commodities from district stores at their own convenience. All franchisees deemed this to be a good thing. However, the system is not trouble-free and stock-outs occur (especially for Jadelle and Depo-Provera). Some franchisees reported that public facilities are still given priority when accessing the district stores and also said they occasionally turn to their own private procurement sources. Franchisees appeared used to acquiring commodities through multiple means and only one expressed frustration with the available system.

Amua management must contribute efforts to ensure continuity of supplies, which essentially requires managing a small supply chain from time to time. When GoK district stores have stock-outs, Amua will turn to KEMSA, MSI or UNFPA for commodities and then redistribute them through the Franchisee Coordinators. The Franchisee Coordinators also manage and deliver a supply of Misoprostol for franchisees trained in PPH management. One member of Amua senior management was concerned that ad-hoc delivery can place an inefficient burden on work in the field.

4.3.2 Sales inventory and management

Amua does not require sales records but instead captures service statistics that indicate commodity volumes expended. Introducing an Amua-specific tool for sales inventory would add to the reporting burden franchisees already have towards the MoPHS, the Kenya Revenue Authority and Amua itself. Amua provides franchisees with a short course in simple book keeping and management, but franchisees use their own mechanisms to keep track of sales and inventory.

GoK stores and Amua management use the client volumes and monthly service statistics to determine the justifiable number of commodities for restocking. However, this might be slightly inaccurate as franchisees sell other FP commodities, such as PSI socially marketed brands (Femiplan).

4.4 Quality assurance

4.4.1 Quality

Across the MSI BlueStar Networks, quality is defined by six guiding principles listed below.

'Quality in family planning'²⁷

1. Range of services
2. Choice of methods
3. Information given to clients
4. Interpersonal relations
5. Technical competence
6. Mechanisms for continuity of care & appropriate constellation of facilities

Baselines were conducted prior to the two Amua recruitment phases. These were used to direct the selection process and to indicate private sector standards (for comparison post-Amua franchising, although this has not yet been done). At the baseline, quality indicators appeared weakest in the choice of methods and in technical competence relating to infection prevention. In addition, franchisees remarked that they had not been comprehensively counseling clients prior to franchisee-related training.

Range of services. In phase two, Amua is rolling out a wide range of integrated SRH and HIV services. This is a direct result of Amua's partnership with the GoK and reflects national policy. Non-provision of required services can be tracked through monthly reports. During the transition from phase one to phase two, non-provision of required services was the basis of dropping several Amua franchisees.

Choice of methods. Each franchisee is trained and linked to commodities for comprehensive FP service delivery, and five methods are directly available from all locations (condoms, pills, injectables, implants and IUCDs). All franchisees are required to at least counsel and refer for permanent methods.

Information given to clients. Comprehensive FP counseling is part of training and is a required service. FP consultations are tracked as a service statistic in franchisee monthly reports, and counseling is monitored through the Cliniscan tool and mystery clients (see 4.6).

²⁷ Bruce J, Fundamentals of quality of care: A simple framework, *Studies in Family Planning*, 1990, 21(2):61-90.

Interpersonal relations. The MoPHS contraceptive technology update promotes the rights-based approach when dealing with clients. Amua encourages franchisees to foster a respectful, customer-service oriented relationship and to think in terms of 'clients' or 'customers' rather than 'patients' or 'beneficiaries'. Amua has used mystery clients to provide feedback on the personal treatment they receive from franchisees.

Technical competence. Amua supports and assures technical competence through several mechanisms (see box).

Means of assuring technical competence

- ✓ Selection tools and process
- ✓ Recruitment training (CTU) with practicum
- ✓ Refresher & additional service training
- ✓ Provision of National FP Guidelines (MoPHS)
- ✓ Supervision visits and on-the-job training
- ✓ Access to subsidized, quality equipment and free, quality commodities
- ✓ 'Cliniscan' and QTA tools for monitoring

Franchisee adherence to clinical protocols for LTM is first directly observed during CTU training practicum. After this, one Franchisee Coordinator reported that clinical observation is difficult to coordinate. Technical competence is therefore most assured at induction to Amua, while the verification mechanism is weaker post-training.

Franchisees are required to own and properly maintain the required equipment, which is regularly checked during supervision visits.

Amua management expressed that failure to meet standards of technical competence will be increasingly connected to network expulsion. To date, this has not taken place.

Continuity of care. Amua has sought to work in hard-to-reach areas, but each project area has a Marie Stopes Center in the respective urban centre that franchisees satellite. Marie Stopes Centers is used for specialist SRH referral. Referral to GoK facilities is also common, while franchisee to franchisee linkages are less developed. Amua does not currently have a metric to capture continuity of care.

4.4.2 Training

Amua conducts the majority of trainings in conjunction with MoPHS district reproductive health trainers and uses MoPHS curricula. This ensures that the private sector franchisees adhere to national standards and protocols for service delivery without fostering parallel systems.

Franchisee focal points must be full-time private sector health workers. Sending employees to training by proxy is not permitted.

In order to meet particular concerns of the private sector, Amua has included training in basic book keeping and integrated service provision, encouraging the cross-selling of services for sustainability. Isolated trainings have been added in phase two to roll out cervical cancer screening (VIA/VILI) and PPH management.

Amua franchisee training to date

- ✓ Comprehensive FP, including LTM practicum (100% of franchisees)
- ✓ Book keeping, small business management (100%)
- ✓ VIA/VILI screening and PAP (100%)
- ✓ PPH management and safe delivery refresher (80/186, 43%)

Comprehensive HIV/AIDS and STI training is planned for all franchisees in the first quarter of 2010. It will similarly use the MoPHS trainers and curriculum. A comprehensive FP refresher is planned for the same quarter.

Interviewed franchisees underscored the value of attending the trainings linked to Amua membership, in particular clinical training. Some stated that training has led to increased range of services on offer and therefore greater capacity to draw revenue through the clinic. Others expressed that while they had been previously trained, they had lost confidence in their skills overtime and reduced the range of services accordingly. Alternatively, as one franchisee said, 'I was also offering most of these services 5 years ago. The difference is I am now sure in what I am doing.'

4.5 Support services

Amua Franchisee Coordinators are expected to carry out site visits to each franchisee on a monthly basis. The coordinator collects monthly reports, delivers supplies, checks in with the franchisee on technical issues and implements clinical assessment tools as required. On the job training is given to rectify any gaps in quality standards. Each has a motorcycle to reach the franchisees, which was said to be a challenge considering the large distances and seasonal weather conditions.

Franchisees reported being very satisfied with the support services they receive from the Franchisee Coordinator and appreciated the technical assistance. Site visits were not seen as a burden or intrusion.

Comprehensive HIV/AIDS and STI training is planned for all franchisees in the first quarter of 2010.

4.6 Monitoring and evaluation

Franchisee Coordinators are the key implementers of regular monitoring and evaluation activities.

Amua M&E tools

- ✓ MoPHS FP register
- ✓ Amua client record book
- ✓ Monthly franchisee summary reports
- ✓ Monthly CHW activity reports
- ✓ Consolidated monthly Amua report
- ✓ Baselines (phase 1&2), mid-term and end-term evaluation of phase 1
- ✓ Clinical compliance tools – Cliniscan
- ✓ Mystery client surveys

The primary monitoring tool for Amua is a duplicate monthly report form to capture franchise service statistics. The franchisee fills this out by referring to facility-based clinic records, such as the MoPHS FP register. The Franchisee Coordinator collects the original copy and compiles service statistics into a monthly regional summary.

Community Health Workers are similarly provided with a duplicate monthly report form to track demand creation activities, numbers of people reached with health education and numbers referred. The CHW Supervisor collects CHW forms to compile a monthly summary.

Summaries from the five geographic areas are reflected in a consolidated monthly performance report. Overall, this paper-based system poses a burden on staff who must try to cover the whole geographic area within early days of the month to collect forms. Amua is now exploring possibilities of collecting franchise service statistics by mobile phone (SMS).

For monitoring clinical compliance, Franchisee Coordinators have implemented the standard MSI Starscan/Cliniscan tool in each franchise location once this phase but data is yet to be analysed. Cliniscan examines branding, equipment, commodity stocks, record keeping and counseling, and concludes with an action plan for any outstanding issues. It should ideally be implemented every six months.

So far, Amua has completed MSI standard Quality Technical Assessments (QTAs) in 30 franchisee locations is currently analyzing the data. The QTA should be carried out annually and is designed to score franchisee adherence to clinical protocols, especially infection prevention. The QTA requires direct observation of clinical service delivery (i.e., IUCD insertion) and therefore poses logistical challenges in coordination.

Franchisees also keep a client record book that tracks client demographic data. Statistics were analyzed during the final evaluation of phase one to assess the effectiveness of demand creation activities.

Mystery clients occasionally visit franchisees to inquire about FP and report back on their experience, including professional greeting, quality of FP counseling, presence of Amua branding and prices offered. Mystery clients have been used once in phase two but data has not yet been analysed.

When any monitoring and evaluation activity indicates poor performance, the Social Franchise Manager works with Franchisee Coordinators to develop a remedial strategy. Poor performance relating to low service numbers might result in a re-launch or free camp organized at the franchisee clinic, while non-compliance with standards and protocols is cause for on-the-job training and increased frequency in supervision visits to overcome gaps.

As a general observation, the end-term evaluation of project phase one found that Amua data was being collected but not sufficiently utilized to assist in decision making and planning. Data collection continues to be stronger than analysis in phase two, possibly due to the fact that Amua does not have a designated M&E focal person. However, Franchisee Coordinators have recently begun to use service statistics to rank the franchisee's contribution towards Amua performance each month, which can be shared with the franchisee in order to show how he or she is doing compared to peers as well as overtime. This is currently the extent of sharing collected data back with Amua franchisees.



An Amua bicycle for community health workers to mobilize clients.

4.7 Network linkages

4.7.1 Client referrals IN to franchisees

Referrals to franchisee clinics largely stem from the mobilization efforts of Amua community health workers but the total number of clients referred is believed to be quite low (see 4.7.3).

In order to track the effectiveness of mobilizing clients with marketing and promotional strategies, Amua client register forms ask how the client learned about the franchisee. During the evaluation of phase one, compiled responses showed that word of mouth from satisfied clients is the most important influence. Informal referral and local reputation appear very important in Amua areas, while other sources of formal referral are not common. Eight clients interviewed for this case study said they had friends and family who used the same clinic. None could recall radio ads, but one had been referred by a CHW and another knew the franchisee from a joint MoPHS campaign. Only half said they had noticed the Amua signage when visiting but none could accurately describe what 'Amua' was. Clients felt that having positive word-of-mouth was the best way for the clinic to promote itself.

In terms of fostering linkages between franchisees, one said, "We used to be competition before, but now the other Amua franchisee 5 kilometers away has become my backstop. We can lend each other supplies if we run out, or even cover each other's practice when called away."

4.7.2 Client referrals OUT from franchisees

Amua management encourages referral between franchisees, to Marie Stopes Centres and to GoK facilities. The link to Marie Stopes Centres is particularly emphasized for any VIA/VILI cancer screening abnormalities. Referrals do not earn franchisees any payment.

Meanwhile, it appears that franchisees have not changed the way they refer since joining Amua and most reported sending clients directly to public facilities or other private clinics outside Amua. Rural and peri-urban locations are likely to present a logical order of referral that is not highly altered by franchise allegiance. Furthermore, Amua franchisees mostly offer a very similar range of services so that referral to another franchisee may not have added value for the client.

4.7.3 Community Health Workers

All types of health facilities in Kenya commonly engage community health workers (CHWs) to sensitize and mobilize clients for services. CHWs are Amua's main agents of demand creation.

Amua CHW strategy

- ✓ 2 individuals assigned per franchisee
- ✓ CHWs receive training in FP messages & community entry
- ✓ CHWs receive branded materials, pictorial aid, bicycles
- ✓ Monthly CHW activity reports submitted and summarized per area
- ✓ One CHW Supervisor per area
- ✓ Compensation/motivation is franchisee's role

According to the strategy, the Franchisee Coordinator and franchisee collectively identify two CHWs to act as volunteer liaisons between the community and the clinic, meaning that over 350 such volunteers are currently attached to Amua. Each geographic area has a designated CHW Supervisor who oversees their activities, collects individual monthly reports and supports larger demand creation events with the Franchisee Coordinator. CHW Supervisors receive a travel allowance, motor bike and casual retainer fee but are not employees of Amua.

Most Amua CHWs have had previous experience communicating RH/HIV related messages and connecting clients to health facilities. Three interviewed CHWs said they continue working for other facilities. Amua gives them a two-day refresher training in the GoK national community entry and mobilization strategy, including essential facts of FP/RH and HIV/STIs. Their skills are heightened to dispel common misconceptions that pose obstacles to service uptake. CHWs are given branded t-shirts and aprons to wear while mobilizing clients. Aprons with printed panels serve as pictorial teaching aides for health education and FP communication. A hundred bicycles were also distributed amongst CHWs during project phase one.

Amua therefore works to build CHWs' capacity for effective mobilization but does not directly compensate them for their time. The franchisees are instead encouraged to develop a motivation or compensation scheme. All interviewed franchisees reported either buying lunch or giving CHWs a small commission for referrals that result in certain services (i.e., IUCD or implant). On the other hand, three interviewed CHWs said that they are not often compensated for their efforts, especially since clients do not always mention when a CHW sent them for services. Amua management felt this might occur because clients do not think of these individuals as CHWs but rather as a neighbor or fellow church member. Therefore franchisees might underestimate the numbers of clients CHWs refer and fail to compensate. CHWs said that lack of compensation is discouraging. In one interview, a CHW explained that she might travel long-distances – pointing over the hills – to reach new clients for the clinic, but would often come home without fruits for her efforts.



Amua community health workers meet with their CHW supervisor.

In interviews, CHWs described reaching women of reproductive age (up to 60 a day) through targeting group membership, churches and marketplaces. The CHWs also reach out to men who they said harbor a lot of misconceptions about FP.

Franchisees gave mixed reports regarding the impact of CHW mobilization on client volumes. Most felt that they do not send many clients (estimates ranging from 2 to 12 a month) and that low motivation of the CHWs is a problem. However, during focus group discussions held for Amua's phase one final evaluation, a majority of clients said they first heard about Amua from CHWs in church, women's groups and home seminars, thereby indicating a more significant role.

4.7.4 Links to other organizations

Amua is run by MSK on behalf of the Kenyan government with funds from KfW. As a result, Amua's strongest link is with the MoPHS itself.

Amua was involved in the Family Health International-led comparative analysis to develop the national strategy on revitalizing long-term and permanent methods. As a result, Amua was named as a model for improving quality access to LAPM in the private sector²⁸.

Amua collaborated with Venture Strategies and a local NGO, KMET, when carrying out PPH training, and has occasionally collaborated with UNFPA. For example, Amua franchisees were used to facilitate care and training for sexual and gender-based violence cases during the post-election violence in 2008. Also, UNFPA has supported Amua (and all other MSK programs) with donations during national shortages of contraceptive commodities.

Looking ahead, a new urban reproductive health initiative with Gates funding will bring Amua and JHPIEGO together to improve quality SRH access in urban private and public facilities.

Three of the five franchisees interviewed said they had never benefited from initiatives with any other NGO, while the other two reported being previously trained under the USAID health services capacity development program, APHIA II (2006-2011).

5 Challenges and Opportunities

Since its launch in 2004, Amua has had several occasions to examine challenges and opportunities, including those identified during phase one mid-term and final evaluation.

5.1 Challenges

Recruitment. The biggest initial challenge was the inability to recruit medical doctors due to low interest in FP. This caused a disjoint between franchisee qualifications and the possibility of expanding access to BTL in the private sector as planned. In response to this challenge, Amua conducted a rapid assessment on the medical doctors' attitudes and motivations, and consequently decided to alter the franchise design to focus on lower level providers (nurses and COs). Nurses and COs are more engaged in FP and benefit more from Amua membership. BTL was therefore shifted to a referral service using MS Centres and outreach events. Program focus areas are now better matched to the franchisees' capacities and there have been no challenges integrating additional services.

Funding. Another challenge was the 18 month interim period between KfW funding cycles. MSI maintenance funds allowed for a minimal level of activities. However, no demand creation, marketing or promotion continued. The lack of sustained promotion is likely to have caused wastage of previous efforts.

Quality assurance. Amua staff reported having to provide significant support in order to bring franchisees up to quality standards, especially in the area of infection prevention. On-the-job training fell as a larger than expected burden.

Further to this is the ongoing challenge of monitoring clinical compliance post-training. Franchisee Coordinator supervision visits are not likely to correspond with IUCD or implant client visits, so that actual observations of franchisee clinical procedures are rare. The Quality Technical Assessment requires clinical observation; as a result, it has been conducted in just one in six franchisees. The QTA is supposed to take place in each franchisee location annually. The challenge of observing clinical procedures is likely to persist, and other social franchises have similarly reported it as a challenge.

Client inability to pay. Franchisees reported that client inability to pay private sector fees is the greatest challenge they face in their work. The effect on franchisees is significant and most reported offering services at a loss to the clinic in order to help such clients. The drought in 2008-9 noticeably reduced cash flow in communities so that three out of five franchisees reported not being able to charge regular service fees until people have enough money for food. One franchisee wished that Amua could develop a way to meet the costs for very needy

²⁸ Ministry of Health [Kenya], *Kenya Comparative Assessment of LAPM Activities: Final Report, Draft Report v. 0.9, April 18, 2008*

clients so that the burden didn't always fall on her small clinic. It was noted that 500 Ksh (6.70 USD) for LTM is a hefty price for many individuals in the communities.

Competition. Amua faces significant competition in Kenya. The government facilities offer a comparable range of services at no cost to the user, although clients report that queuing, provider bias and stock outs are a problem. The private sector is wide spread and almost all franchisees operate in range of other clinics. Meanwhile, PSI Kenya has launched another social franchise, the Tunza Family Health Network, which also supports LTM in small private clinics in similar implementation sites. Amua management felt that this new franchise is potentially leading to resource duplication, although it may also help to foster further growth of the market for LTM in Kenya.

All five franchisees reported struggling with competition in interviews, including GoK facilities, other private clinics, PSI-supported clinics and quacks.

Value propositions. Franchisees reported that Amua price-recommended services are sufficiently profitable, only that some clients cannot meet the fees. The exception is the Amua requirement of generating a minimum number of BTL referrals. One franchisee complained that this does not generate any revenue for the clinic to compensate for time spent counseling clients.

Meanwhile, Amua management said that they would begin to think of reducing costs while increasing outputs. This could be done by being more selective prior to extending training invitations, or potentially by increasing some franchisee cost-sharing for capacity building.

Fully integrating Amua into the National Health system. The GoK could go further to fully integrate the private sector into the national health system to take greater advantage of its potential. Amua management felt that the GoK might conceive of the social franchise as a project rather than an established service delivery channel with real advantages for achieving health impact. If the latter were more internalized, other MoPHS departments could also see opportunities for expanding access to essential services through Amua, instead of leaving it to the department of reproductive health alone. For example, Amua could provide excellent opportunities to achieving public health goals that fall under the departments for mother and child health, nutrition, and HIV&TB amongst others. There continues to be a need for advocacy with the GoK regarding Amua's potential.

5.2 Opportunities

The strength of Amua lies in the range of franchised services that directly reflects Kenyan government policy of FP/RH/HIV integration. This is a great opportunity for a private sector partnership to demonstrate close alignment with national health goals. Amua has already been acclaimed by the GoK as the model for increasing quality access to LAPM in the private sector²⁹.

With a full service package in place, the next opportunity is to bring up client numbers through marketing and demand creation activities. Amua management feels that franchisees are not yet operating at their full capacity.

An obvious opportunity, and one already under discussion, is to link the OBA voucher scheme to Amua so that franchisees are accredited. This would increase both equity and client volumes while reducing the burden of client inability to pay on franchisees.

Looking forward, Amua management feels that the social franchise model is the best way to bring access to RH/HIV services in remote areas of Kenya, such as North Eastern Province. This is due to the assumption that such populations prefer health providers from their own communities and that local clinics with improved quality and range of services would enjoy high acceptability from clients.

5.3 Lessons learned

- ✓ The strong relationship between Amua and the GoK has led to improved relations between franchisees and district level MoPHS staff. Franchisees were reported to think of the MoPHS as collaborative rather than authoritative as a result of Amua membership. This has been seen as positive by all stakeholders.
- ✓ Training is critical for overcoming provider bias and increasing uptake of LTM. Franchisees said that they greatly improved the way they counsel clients and all have widened the range of information and methods provided in their clinics.
- ✓ Amua has reflected on strategies to foster franchisee interest in FP services despite moderate profitability per service provided. To this means, it has been important to 1) work with lower cadres of health workers and 2) underline the value of cross-selling. Amua emphasizes that maintaining high volumes of satisfied FP clients helps lead to other opportunities. Franchisees reported that their overall sense of customer service has been improved with Amua.

The strength of Amua lies in the range of franchised services that directly reflects Kenyan government policy of FP/RH/HIV integration. This is a great opportunity for a private sector partnership to demonstrate close alignment with national health goals.

²⁹ Ministry of Health [Kenya], *Kenya Comparative Assessment of LAPM Activities: Final Report, Draft Report v. 0.9*, April 18, 2008

Glossary of terms

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral therapy
BTL	Bilateral tubal ligation
CHW	Community health workers
CO	Clinical officer
CPR	Contraceptive prevalence rate
CYP	Couple-year protection for contraception
FP	Family planning
GoK	Government of Kenya
HIV	Human immunodeficiency virus
IDP	Internally displaced person
IUCD	Intra-uterine contraceptive device
KDHS	Kenya Demographic and Health Survey
KfW	Kreditanstalt für Wiederaufbau
KSh	Kenya shilling
LAPM	Long-acting and permanent methods of FP
LTM	Long-term methods of FP
M&E	Monitoring and evaluation
MoPHS	Ministry of Health
MoU	Memorandum of understanding
MSI	Marie Stopes International (London)
MSK	Marie Stopes Kenya
PAC	Post-abortion care
PMTCT	Prevention of mother-to-child transmission of HIV
PSI	Population Services International
QTA	Quality technical assessment – MSI tool
SF	Social franchising
SM	Social marketing
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SWAp	Sector-wide approach
VCT	Voluntary testing and counseling for HIV
VIA	Visual inspection with acetic acid
VILI	Visual inspection with Lugol's iodine

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