ADDIS ABABA UNIVERSITY,
COLLEGE OF BUSINESS AND ECONOMICS
DEPARTMENT OF MANAGEMENT
EXECUTIVE MBA PROGRAM

RESEARCH PROJECT ON

PROSPECTS AND CHALLENGES OF PRIVATE HEALTH CARE DELIVERY BUSINESS MODEL OF SOCIAL FRANCHISE: CASE OF MARIE STOPES INTERNATIONAL ETHIOPIA

FOR THE PARTIAL FULFILLMENT OF THE EXECUTIVE MBA
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Addis Ababa, Ethiopia

DECLARATION

I, the undersigned, declare that this study entitled "Private Health Care Delivery Business Model of Social Franchise Prospects and Challenges: Case of Marie Stopes International Ethiopia" is my own work. I have undertaken the research work independently with the guidance and support of the research advisor. This study has not been submitted for any degree or diploma program in this or any other institutions and that all sources of materials used for the thesis have been duly acknowledged.

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This is to certify that the Research project prepared by Akalu Zemene, entitled: Private Health Care Delivery Business Model of Social Franchise Prospects and Challenges: Case of Marie Stopes International Ethiopia is submitted in partial fulfillment of the requirements for the Degree of Executive Master of Business Administration in Management complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

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Advisor _____ Signature _____Date _____

ABSTRACT

Private health sectors working with Mariestopes International Ethiopia (MSIE) in franchising relationship are required to comply with new FMHACCA clinic standard requirements for middle level and higher clinic which potentially affect sustaining the relationship with Franchised Clinical network. Capability of access to financial resource, supply of FP commodities and trained manpower are constraints to the network, which are a challenge for MSIE to succeed with the objective ensuring sustainability of the service and increasing access for the underserved. This survey has an objective to assess the prospect and challenges of providing family planning and reproductive health services through social franchise network business model of private clinics for Marie stopes international Ethiopia (MSIE).

The purpose of this survey is to assess the prospect and challenges of providing family planning and reproductive health services through social franchise network business model of private clinics for Marie stopes international Ethiopia (MSIE)

A sample frame is prepared for collecting information about the challenges, prospects and strategy on the business model. The study has been conducted in franchised health provider networks that are located in the Addis Ababa City Administration, Oromya Regional State, Amhara Regional State, Tigray Regional State and south Regional State using a descriptive survey design method where the primary data was collected from randomly selected clinics through questionnaire. The study was conducted through a survey of key informant responses across the franchised Clinics, from a population of 535 clinics sixty (60) are purposively selected to represent the population due to similar standards followed by MSIE to operate with the clinics.

The result revealed that, there are many challenges the franchised clinics are facing, but the major challenges identified are lack of access to financing, branding and promotion of the clinics, exclusion of the private sector from the new health insurance scheme, demand creation activities, lack of incentive from government, stringent quality control and emphasis on more revenue generating clinical service than FP.

This survey indicated that, Prospects of the MSIE franchised clinics depend on their access to financial support and strong support provided by MSIE to continue in the business model in providing FP/RH Services.

Key words: Franchised clinics (Bluestar Clinics), Family Planning (FP), Reproductive health (RH) services, Supportive supervision, Quality audit and Health network.

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ACRONYMS

CPR: Contraceptive Prevalence Rate

CYP: Couple year of protection

EDHS: Ethiopia Demographic and Health Survey

EONC: Emergency Obstetric and Newborn Care

FMoH: Federal Ministry of Health

FP: Family Planning

GTP: Growth and Transformation Plan

HIV: Human Immune Virus

HSDP: Health Sector Development Plan

LAC: Latin-American Countries

LAPM: Long Acting and Permanent Methods

MDG: Millennium Development Goals

MMR: Maternal Mortality Ratio

MNCH: Maternal Neonatal Child Health

MOU: Memorandum of Understanding

MSIE: Marie stopes International Ethiopia

NHA: National Health Account

OOP: Out-Of-Pocket

PASDEP: Plan for Accelerated and Sustained Development to End Poverty

SAM: Short Acting Methods

SRH: Sexual Reproductive Health

SSA: Sub Saharan Africa

STI: Sexually Transmitted Infections

TFR: Total Fertility Rate

USAID: United States Agency for International Development

W.H.O: World health Organization

CONTENTS

CHAPTER 1
INTRODUCTION
1.1 BACKGROUND OF THE STUDY

Social franchising is a social business model which is a partial franchised business engaged by MSIE on the service provision of FP/RH. Marie Stopes International Ethiopia (MSIE) has established social franchise networks with private health service providers in five regional states. More than 535 MSIE franchisees exist across Addis Ababa City Administration, Amhara, Oromiya, South and Tigray Regional states. MSIE's social franchise (BlueStar) networks engage existing private providers to deliver high quality sexual reproductive health services in underserved areas. These franchisees are designed to increase accessibility to help meeting unmet need for effective family Planning (FP) and sexual reproductive health services. They are also established across the country where there are underserved communities and there is high demand for reproductive health and family planning service.

Social franchising provides a service delivery channel through which sexual and reproductive health organizations can significantly increase coverage of high quality and effective sexual reproductive health and family planning services. Private health providers represent a major source of health care in Ethiopia as it is true for the developing world and there is a strong likelihood of continued growth in the future. By engaging the private sector, social franchising enables sexual and reproductive health organizations to introduce services in underserved areas rapidly and cost-effectively. Social franchising also enables sexual and reproductive health organizations to increase the use of existing services by improving their quality or marketing them appropriately.

Social franchising was introduced to the Ethiopian private sector by MSIE on reproductive and family planning health service in August 2008.

The private network collaborating with MSIE in providing FP service are the major sources of contributors of Couple year protection (CYP), June 2016 performance of MSIE shows 50% results for CYP or family planning service is obtained from social franchised clinics.

The social franchised clinics outlet is the biggest channel through which major services of FP and RH services are provided. MSIE's investment to this sector is worth considering for future sustainable means of service delivery.

The Social franchise channel is a critical service provision channel for MSIE and investments made to ward maintaining and working with this sector shall be Management's focus area. Environmental factors, MSIE relations and policy environment that affect the prospect of this sector will directly also affect MSIE performance

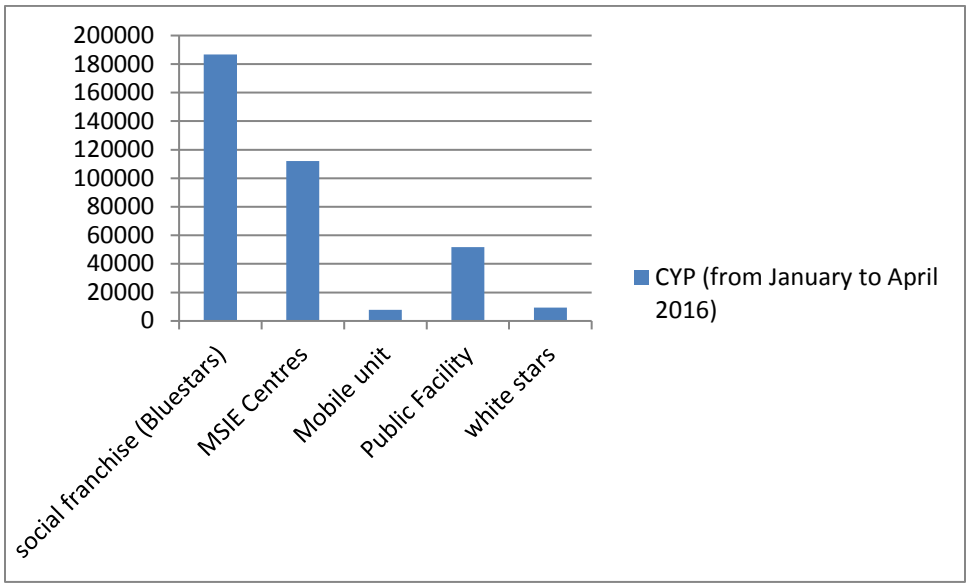

Figure 1: CYP (from January to April 2016)

MSIE performance Report on FP from January to April 2016 (MSIE first quarter report of 2016)

Social Franchising Ethiopia branded (BlueStar) is a fractional social franchise operated by MSIE. The goal is to expand and standardize Family Planning, sexual and reproductive health services in the private sector, thereby contributing to improved access to quality health care for Ethiopians. BlueStar currently supports family planning and Reproductive health services including HIV counselling and testing and sexually transmitted infection (STI) management services in many of the franchise project areas.

At this time, the franchise comprises 535 private clinics that who have all signed an agreement with MSIE to become members of the franchise network. As part of membership benefits, BlueStar franchisees receive training, on-site technical assistance, free or subsidized equipment, and at-cost or subsidized commodities with a free delivery service. In exchange, they accept routine monitoring visits, report monthly service statistics, and adhere to clinical protocols and other terms laid out in the BlueStar memorandum of understanding (MSIE Policy document, 2015).

This market is not limited to MSIE and Similar franchising business models pursued by other international non for profit organizations (INGOs) as a result of which some BlueStar franchises are departing MSIE and joining the new entrants and being de franchised by MSIE. This study identified factors that affect continued relationship of the franchised clinics with MSIE or pushing or motivating factors to look for other partners as a franchisee and suggested possible interventions required by MSIE.

1.2 STATEMENT OF THE RESEARCH PROBLEM

Marie Stopes International Ethiopia has introduced social franchise network system as new social enterprise business model with a purpose of increasing access to Family planning and reproductive health services for underserved. This business model is supported by technical capacity building and subsidized supply of family planning commodities.

The social franchising (SF) private clinics network will in addition supported by regular supportive supervision to help enhancing quality of service on SRH in general and particularly on different methods of family planning services.

The private health sector has increased to more than 6,000 in Ethiopia. Out of this Marie stopes has established a social franchise network relationship with 535 of the private networks by setting primary required standards and signed MOU.

As a result of this partnership MSIE serving thousands of clients through the network and wants to strengthen the continuity of the franchising network as a sustainable means of providing the service; while also MSIE would like to maintain its brand quality while providing the service through the network.

However; many INGO and local NGO like dkt, IPAS, engender health and FGAE are joining similar social enterprise market with similar franchising system and some partners with MSIE might have intention to working with other NGOs contravening with MOU signed with MSIE and new FMHACCA clinic standard requirements for middle level and higher clinic would potentially affect the maintaining of the Franchised clinics in the network.

Capability of access to financial resource is also believed to be another constraint to the network; these would be a challenge for MSIE to succeed with the objective ensuring sustainability of the service and increasing access for the underserved.

1.3 RESEARCH QUESTION

The following are the main research question of the Study:

I. What are the basic challenges to MSIE that will limit its level of expanding and maintaining the network members in the private health network?

II. What Interventions MSIE shall deploy to competitively be a choice of partner for the private health delivery service network

III. Can this outlet of service delivery will be best strategy to pursue and worth to consider

1.4 OBJECTIVE

GENERAL OBJECTIVE

The purpose of this survey is to assess the prospect and challenges of providing family planning and reproductive health services through social franchised business model of private clinics by Marie stopes international Ethiopia (MSIE)

The study determines the effect of current and prospective challenges on the overall organizational and operational performance objectives. It will then recommend direction MSIE shall follow to alleviate the challenge and explore the opportunities and determine the prospects of the clinics.

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SPECIFIC OBJECTIVES

The specific objectives of the research are:

I. To identify challenges and recommend solutions that helps to expand and maintain franchised relationship to ensure the continuity of the service access through this set up

II. To assess the effectiveness of a greed supportive relationship between MSIE and the franchised clinics and recommend solutions

III. To Identify major intervention areas of the MSIE to strengthen franchised private clinics in providing FP service

1.5 IMPORTANCE/BENEFITS OF THE STUDY

This research study will have the following benefits:

- This study will introduce a franchised social business model to the health sector of Ethiopia
- It provides an insight on the gap of franchisees expectation and technical support provided by MSIE.
- The study will also provide some basic information regarding the current contribution of the franchised clinics to the provision of FP/RH services
- It identifies the better and poor practices of the MSIE strategy to the quality, speed and flexibility employed during intervention with the franchisees
- It will explain government policy challenges to the franchisees and MSIE

Delimitations and scope

This research paper has focused on relationship of the bluestar clinics with MSIE on Family planning and Reproductive health technical support and commodity supply practices and intervention gaps which will impact its prospects. It would have been also a deeper and extensive coverage about the research questions under investigations, if the sample included more of the clinics under bluestar network, use an additional focus group interview and included customers' satisfaction survey questions. This research has purposively selected sample size of randomly selected 60 Bluestar clinics from Addis Ababa City Administration, Oromiya, Tigray, Amhara and South Regional States.

1.6 LIMITATIONS OF THE STUDY

Due to time, access limitation, the nature of the Bluestar clinics in each location, and shortage of related literatures review in Ethiopian context, the research has only concentrated on their Technical Managers/owners view of their relationship with MSIE, Impact of FMHACCA policy on their operations. This survey did not include MSIE Management's view and secondary data and limits the comprehensiveness of this study.

CHAPTER 2
LITERATURE REVIEW
2.1 OPERATIONAL DEFINITION

Social franchising is the application of the principles of commercial franchising to promote social benefit rather than private profit.

In the first sense, it refers to a contractual relationship wherein an independent coordinating organization (usually a non-governmental organization, but occasionally a governmental body or private company offers individual independent operators the ability to join into a franchise network for the provision of selected services over a specified area in accordance with an overall blueprint devised by the franchisor. Once joining the network, operators are given the right to employ previously tested incentives including: professional training, use of brands or brand advertisements, subsidized or proprietary supplies and equipment, support services, and access to professional advice. Members also gain beneficial spin-off effects such as increased consumer volume and improved reputation due to brand affiliation. Franchisees must adhere to a range of requirements including: providing socially beneficial services, meeting quality and pricing standards, undergoing mandatory education on provision of services, subjecting outlets to quality assurance mechanisms, reporting service and sales statistics, and occasionally, paying fixed or profit-share fees. Social franchises have been used for primary health services, pharmaceutical sales of essential drugs, HIV testing and counseling, and reproductive health services in the developing world.

As the naming has an effect in shaping the attitude of different stakeholders, the debate over the benefit of private health sector starts from the definition. Some observers referred to private health sector as " the nonstarter sector" and others as anything not public comprising of all providers who exist outside the public sector, whether their aim is charitable or commercial private. Understanding of the challenges and prospects of private sector in the provision of health services in general and FP in particular thus be tter pursued in relation to the type and composition that constitute the private sector. Defining the private health sector is thus an important first step to learn its potential role in addressing FP issues (Hazumi, laurafrost, 2008);Mills A, Brugha R, etal, 2002).

OXFAM mentions a more rephrased description of the private sector in pursuit of its advocacy of building up public health systems to primarily promote equity and quality of care through strengthening the public sector. While recognizing the influence of politics and economic factors, it described the make-up in low-income countries and apparent differences among them. Broadly, it denoted the private health sector to comprise for-profit and not-for-profit formal and informal providers[1] Bluestar is a brand name that represents the franchised clinics network working with MSIE; clinics identified by this brand are promoted by the name using the symbol assigned after the name.

2.2 RELATED WORKS

Formal for-profit providers are legally registered and recognized by governments are multinational and national companies and enterprises as well as private qualified individuals operating a range of large and small-scale health-care facilities and pharmacies for commercial gain. Informal for-profit providers are unlicensed and unregulated usually small-scale and include a wide range of individuals and enterprises including traditional healers, birth attendants and 'injectors' as well as drug shops and stalls. In many low-income countries, there has been a rapid increase in the number of unqualified individuals masked as health professionals to meet growing demands for modern medicine. Not-for-profit providers include faith-based organizations, charities, social enterprises providers and other non-government organizations that are referred as civil-society and offering a wide range of health services. While not motivated by profit, many organizations do still attempt to recover costs of services and their activities can be formal or informal, regulated or unregulated. Private and civil-society providers operate outside the public health system but are also increasingly being contracted directly by the state to deliver services on its behalf and Mariestopes international further contracted family planning and Reproductive health service to the private clinics (Bluestars). This is part of a wider trend that involves introducing market principles into health services on its behalf to increase access to areas that directly cannot be reached by MSIE through provision of technical support and

[1] (http://www.oxfam.org/policy/bp125-blindoptimism),

discounted commodity supply; this method of social franchising model is highly entered market by other civil service organizations[2].

Bluestar is a brand name given to the social franchised networks of clinics; those clinics identified by this name are benefited from promotions made by MSIE for the services of RH/FP.

The argument that prompted in this view is that, many private providers more prefer other new entrants to the market than MSIE or both at a time. Medium level clinics before the new FMHACCA policy standard will no more be applicable for the private clinics which have been a selection criterion in MSIE; this as well ignites the challenge of keeping the current members in the network.

> Literatures describe that the private sector in Low and middle income countries is the major manager of national health expenditure (up to 50%) to indicate its position as significant health service provider. Poor quality of care is not also unique to the private sector and might be endemic to health systems in less developed economies[3].

According to evidence from a multicounty studies, quality of care and provider competence is roughly equivalent in the public and private health sector. Other critics are also concerned about user fees charged by private health care providers, suggesting that such fees limit access to care among the poorest, consequently increasing disparities in health care utilization. The evidence here is also mixed in which some SSA countries charge for services in public facilities and there is no conclusive evidence that user fees in the public sector are lower than in the private sector In contrast, given health systems are often resource constrained, an alternative way to improve access to care can be to take on the opportunities and resources of an existing private health sector (Bulleting of the World Health Organization. 2002), (Milss A etal, 2002)
Taking into account the role of private sector in many low-income countries, public sector managers, who are expected to ensure access to care and protect the public, have started to understand and engage with these various players. More than 85% of 45 SSA issued official policy of working with the private health sector; however, the majority does not actually

[2] (http://www.oxfam.org/policy/bp125-blindoptimism)
[3] (www.ifc.org/ifcext/healthinafrica.nsf/Content/FullReport)

implement such policy and information exchange between public and private health sectors is weak (Marek T, etal, 2005)[4]. Dialogue between government and the private health sector is low; though, a growing number of countries is being (re-)initiated as a necessary first step. Regulations are also often inappropriate or outdated and enforcement is weak across the region to signify them as burden to the private providers and the inconsistent oversight perpetuates low-quality provision. In effect, effective engagement as well as setting roles and relations with the private health sector can prove difficult to realize. Even so, funds for health programs in general and working with private providers in particular is available from many international agencies, and need a wide range of approaches to influence consumers, providers and policy-makers. The scope of services targeted thus ranges from those for specific health priorities (e.g. HIV, tuberculosis, malaria, and reproductive health) to broader packages of essential services. As there are many efforts on a relatively small scale, however, they are undocumented that made the debate "rich in opinion and short on facts"[5], (Abt Associates Inc. July 2007),

Nevertheless, the stakes are already higher in regions like SSA that still lag far behind other world regions on measures of sexual and reproductive health. Being the home to only 15% of women aged 15 - 49 in developing regions, but SSA accounts for 63% of maternal deaths and 89% of HIV infections transmitted from mothers to infants in those regions. Deaths and disabilities are far high in that 183,000 women die in SSA from pregnancy- related causes, and 1.2 million newborns die in the first month of life whilst more than four in 10 women of reproductive age want to avoid a pregnancy. Accounting to a disproportionate 93% unintended pregnancy, more than half (55 million) are not using an effective contraceptive method. Every year, an estimated 63 million unintended pregnancies occur due to lack of contraception, and 19 million women resort to unsafe abortions to end unintended pregnancies paving the way around 82,000 women to die every year. The world is thus badly off-course to achieve the internationally agreed health MDGs. To get back on-course and achieve universal and equitable health care for all requires a massive expansion of health services as opposed to the failure will abandon hundreds of millions of people to an early death and illness. The critical question is how can be such a massive scale up achieved unless the private sectors either through social franchising model are involved? in addressing this concern, the argument in favor of role of

[4] http://www.ifc.org/ifcext/healthinafrica.nsf/Content/FullReport)
[5] (http://www.un.org/millenniumgoals/2014)

private sector as significant provider of health services, source of additional investment to public health systems. The argument further challenges the claim of better results at lower costs, outlets of superior quality, inequity of access as well as absence of evidence to typify a more responsive private sector than the public sector[6] (Private Sector Partnerships-One project, Abt Associates Inc. July 2007).

With these differing views however, there has been a noticeable interest among a number of donors and influential organizations to encourage and fund an expansion of health care and FP services by the private sector in low- and lower-middle-income countries. But, the focus on how the private sector can become more involved in health systems is blurred by the negative attitudes that stand a barrier in expanding collaboration between the public and private sectors.

As a result, the number of private providers and NGOs that deliver FP services and/or information in SSA are much smaller than in other regions of the world. Moreover, many of the NGOs are still quasi-state entities and more akin to professional organizations with limited incentives to engage in method supply or advocacy. With all these limitations, private sector in Asia and LAC operates about 50% of the total 46% and 47% regional CPR in 2012. In SSA, CPR increased by a twofold (13% to 26%) from 1992 to 2012 with an almost double growth in the share of private sector at 7.2%. Likewise, the share of public sector in Asia, LAC and SSA accounted to 25%, 25.7% and 18.9% respectively in 2012. In the three regions, LAPM covered about half of the modern method mix in Asia and LAC and less than one fifth (16%) in SSA. Except the gradient variations among the regions, SAM is estimated to largely dominate the method mix between 55% (in Asia and LAC) and 84% in SSA. The public sector remains the main provider of much of LAPM in larger proportion than SAM in Asia and LAC but the method mix by public sector in SSA exhibited a higher percentage of the SAM than LAPM[7], (Marie Stopes International, Reaching the under-served Global Impact Report 2012 – 2013, London, May 2013).

[6] (http://www.un.org/millenniumgoals/2014)

[7] [7](http://www.shopsproject.org/about/highlights/meeting-demand-for-modern-contraception-role-of-the-private-sector (2012 Global report),

The private sector plays an important role in the delivery of FP services and is a major source of FP services and methods in middle and lower income countries. Despite the positive role of the private health sector, much remains to be done to improve RH/FP services in SSA that has not experienced a significant decline in fertility. Consequently, it is thus imperative for SSA to re-double efforts to address the high unmet need of FP services and products. Engaging the private health sector is one strategy that can complement efforts of the public sector to satisfy many couples' FP needs. It presents opportunities to leverage private providers to support national health goals but significant challenges in quality and affordability. It is therefore essential to mitigate these challenges and harness opportunities through various forms of engagement mechanisms (outsourcing and franchising among others) that have been successfully used by many high income countries and a growing number of middle income countries. But governments in low income countries face significant constraints, (lack of information, weak capacity, and failing to set a high priority for the stewardship of whole health systems) which impede implementing such mechanisms. Any effort that envisions at promoting the role of private sector thus requires addressing such limitation so as to ensure wider coverage of health services in general and FP services in particular, and decreases the high unmet need for contraception (PATH and researchers from the Harvard School of Public Health, 2008).
In the literature, franchisee and franchiser relationship, specifically the context of MSIE working on RH/FP service is not assessed in regards to challenges in the franchisee relationship in providing technical support, supplies of FP commodities, equipment,FP training and business skill transfer and training are need to be assessed in the established franchising social marketing businesses.

Financial Capacity of non-governmental organizations (NGOs) to continuously extend their support for the franchised clinics are dependent on donor s which fluctuates based on international financial situation; and sustainability strategies are not clearly identified.

2.3 SOCIAL FRANCHISING MODEL

Although the private sector is relatively new, Ethiopia is signaling rapid development conducive to social franchising.
In the year 2000, Pathfinder International, trialed the social franchising model by implementing the "Biruh Tesfa" Health Network in Ethiopia. A 2007 review of the project concluded that the

current environment has since become much more favorable to private provider networks than that of 2000 when it started.

In addition, commercial franchising has grown in other areas such as fast food outlets and cafés. Meanwhile, the NGO DKT Ethiopia has been applying social marketing techniques to drive demand for FP commodities and other health products for about 20 years – and with considerable success. Between 2002 and 2007, DKT distributed about 75 percent of all condoms in the country. While the private sector has indeed been growing, private clinics have often remained limited in the range of SRH services on offer. Many Franchisee-supported services were previously available only in specialist, higher clinics frequented by high income clients of Addis Ababa and other big cities. The new Franchisee clinics, all located outside the capital city, are unique for making the range of services available to lower and middle income clients. Staff of the Clinics also feels the franchised clinics fill a strong market demand for confidentiality and privacy. Based on the experiences of running MSIE Centres, staff has observed desire for privacy from clients seeking SRH services and in particular those seeking safe abortion services. Franchised Clinics can provide clients far greater privacy, since walking through the clinic entrance does not reveal that any specific service is being sought (Clinical social franchising, Cynthia E, 2010)

2.4 MSIE FRANCHISING MODEL

A social franchise is based upon a model of franchising commonly used within the commercial sector. It typically involves the granting of a license by a social enterprise (the franchisor, often an NGO) to another person or company (the franchisee) to allow them to create demand using the branding of the social enterprise. The resulting franchise enables the franchisee to market the franchisors products or services from their own outlets. In turn, the franchisee must follow standard operating procedures following training and accreditation[8]

MSIE Social franchising in Ethiopia uses a fractional franchise model in order to increase availability of quality sexual and reproductive health (SRH) services in existing private clinics. Franchisees receive training, on-site technical assistance, free or subsidized equipment, and at-cost or subsidized commodities with free delivery service. In exchange, they permit routine

[8] (https://mariestopes.org/sites/default/files/Social-franchising-Innovations-FINAL.pdf)

monitoring visits, report monthly service statistics, pay annual membership fee and adhere to clinical protocols and other agreed terms laid out in the social franchising memorandum of understanding.

COMPONENTS OF THE BUSINESS MODEL

Resources

Private and franchised clinics are dependent on resources of trained manpower particular to FP and RH services from MSIE, Technical Support, Financing, supply of Contraceptive Commodity and Medical Instruments. Provision of FP Services by the Private Sector through Social Franchising is highly determined by the availability and quality of these resources supported by MSIE.

Policy

FMHACCA Policy and regulations (Standards, accreditation, Incentives) are another component of the business model which highly affects sustainability of the system as it is required to complied, MSIE play capacitating role to ensure the prospects of the franchise relationship between MSIE and the private sector are not challenged because of compliance. The franchised clinics are expected to comply with quality standards set by government and MSIE for licensing and franchised partnership respectively.

Quality Audits

Quality audits are conducted every quarter to ensure the requirements of MSIE and government are maintained to the standard set on guidelines. Quality must be met for the clinics to acquire their license and continue partnership of franchise relationship with MSIE

Performance Report

The franchised clinics are expected to make monthly performance report of the FP and RH services provided through the support of MSIE

CHAPTER 3
RESEARCH METHODOLOGY
3.1 RESEARCH DESIGN

A quantitative method is employed since it is the tool of collecting in depth information about the current practices and strategy on the business model. The study has been conducted in health provider networks that are located in the Addis Ababa city Administration, Oromya, Amhara, Tigray and South Regional States using a descriptive survey design method where the primary data was collected from randomly selected clinics through questionnaire.

3.2 DATA COLLECTION METHODS

Data was collected from the key informant of each selected clinics operating in Addis Ababa, Amhara, Oromya, Tigray and South Region using structured questionnaire that was administered by the researcher through a drop and pick technique after a week time.

3.3 DATA TYPE AND SOURCE

As per the selected research approach of this quantitative descriptive survey design, four part questionnaires have been filled by each of the randomly selected franchised clinic informants. The questionnaire had32 different questions which are adopted from MSI Standard survey questions.

The questionnaire was organized in line with the following main research questions: (1) Basic information of informants, (2) current franchising practices and Technical support by MSIE and (3) current operational Challenges and prospects. Then, a five point Likert Scale was used to assess these three types of questions which had a manageable number of questions under each section. The questionnaires had both closed ended and open ended questions.

3.4 TARGET POPULATION

Currently, there are 535 functional franchised clinics that are supported by MSIE across the country. The researcher has listed down 535 franchised clinics that operate throughout the country. This research has targeted randomly selected clinics in Addis Ababa City Administration, Oromya, Amhara, Tigray and South Regional States from the comprehensive list of the franchised clinics populations proportionally. The key informants include Clinic Managers or Technical Heads or their delegates.

3.5 SAMPLING METHOD AND SAMPLING SIZE

The study was conducted through a survey of key informant responses across the franchised Clinics in Addis Ababa, Amhara, Oromiya, Tigray and south Region proportionally. From a population of 535clinics in these regions, the researcher has purposively selected 60 (11%) of the clinics due to the fact that my constructs are common to the clinics. These are MSIE business model that applies to all clinics and EFMHACCA clinical quality standards that similarly affect all the clinics subject to this survey, which makes the population homogeneous. The 60 clinics are selected from each region proportionately taking the six regions as a stratum. The data were collected from 60 key informants of the functional managers/technical heads or their delegate by means of questionnaire. By entering the entire535 current franchised Clinics list in excel function for each region proportionately was executed so as to generate the random 60 clinics that were included in the data collection processes proportionally from each source. This is believed to give the most unbiased and the inferences can be generalizable among all the franchised clinics in the regions[9] (Palys,T. (2008).

3.6 TOOL OF ANALYSIS

The Statistical Packages for Social Sciences (SPSS 20) for windows was used to analyze the data that was collected from 60 questionnaires to measure and descriptive statistics, tables and graphs will be used to describe the variables.

3.7 DATA ANALYSIS TECHNIQUES

After the filled questionnaire collected, all the data completeness, relevancy and cleaning activities was performed by using different methods with an appropriate explanation. A total of 58valid responses were collected and analyzed to measure the study and research questions using figures and tables. The questionnaires have two basic parts such as the first is demographic information and the second is the study objective based questions. A total of 32 questions were categorized under the following four sections so that the research questions are addressed.

i. Basic information of the key informants

[9] (http://dissertation.laerd.com/purposive-sampling.php#homogenous), http://www.mathematik.unikl.de/mamaeusch),

ii. Current technical support provision

iii. Franchise practices

iv. Current operational Challenges & prospects

CHAPTER 4
DATA PRESENTATION, ANALYSIS AND INTERPRETATIONS

4.1 BASIC INFORMATION

Basic information such as, respondent's region, type of clinic, service year in the market, number of total clients served per month, type of family planning methods provided, share of family planning services compared to other medical services, occupational status of clients is presented in table 1.

Table 1. General characteristics

Characteristics	N	Percent
Regional State (N=60)		
Amhara Region	10	16.7
Tigray Region	10	16.7
South Region	11	18.3
Oromia Region	19	31.7
Addis Ababa	10	16.7
Type of the clinic as per the health facility standards (N=58)		
Medium Clinic	49	84.5
Primary	9	15.5
Service year in delivering health service (N=58)		
< 2 years	1	1.7
2 to 4 years	15	25.9
4 to 6 years	17	29.3
6 to 8 years	13	22.4
>8 years	12	20.7
Number of total clients the clinic provides with all health services (N=58)		
Up to 150 per month	18	31
151-250 per month	16	27.6
251-400 per month	17	29.3
>400 per month	7	12.1
Service year in the delivery of family planning services in collaboration with Marie stopes international Ethiopia (MSIE) (N=58)		
< 2 years	5	8.6
2 to 4 years	30	51.7
4 to 6 years	16	27.6
6 to 8 years	6	10.3
>8 years	1	1.7

Types of family planning methods the clinic delivers (N=58)		
Short Acting Methods	34	58.6
Long Acting Methods	6	10.3
Short acting, long acting and Counseling	18	31
Types of family planning service most commonly the clinic provides to clients (N=58)		
Oral contraceptive (OC)	2	3.4
Injectable	50	86.2
Implants	3	5.2
Intra Uterine Contraceptive Device (IUCD)	3	5.2
Share of family planning services from all health service delivery (N=57)		
<10%	15	26.3
11%-20%	21	36.8
21%-30%	11	19.3
31%-40%	8	14
>40%	2	3.5
Number of clients that the clinic provides with family planning services (N=58)		
<50 per month	13	22.4
51-100 per month	22	37.9
101- 150 per month	14	24.1
151– 200 per month	7	12.1
>200 per month	2	3.4
Occupational status of clients the clinic provides with family planning services		
Employed women of reproductive age	22	37.9
Self-employed women of reproductive age	14	24.1
Non-employed women of reproductive age	13	22.4
Non-employed housewives	2	3.4
Others	7	12.1

From Table 1, number of participants are from Amhara, Tigray and Addis Ababa 10 (16.7%) from each, Oromia Region 19 (31.7) and from south 11 (18.3%) were responded. From the table above 49 (84.5%) are medium clinics and 9 (9%) are primary clinics.

When we see the respondents in terms of their service year in health care; 1(1.7%) are less than one year 15(25.9%) served 2 to 4 years, 17(29.3%) served 4 to 6 years, 13(22.4%) served 6 to 8 years and 12(20.7%) served more than 8 years.

Looking in to number of clients served by the facilities 18(31%) serves 150 clients per month, 16(27.6%) served 151 to 250 per month, 17(29.3%) served 251 to 400 clients and 7(12.1%) served more than 400 clients.

Respondents are asked their experience in delivering Family planning (FP) service in collaboration or franchising relationship with MSIE; 5(8.6%) responded less than two years, 30(51%) said 2 to 4 years, 16(27.6%) responded 4 to 6 years, 6(10.3%) worked with MSIE from 6 to 8 years and only 1(1.7%) responded more than 8 years.

Respondents are also asked what type of FP services they are providing mostly; from the table above 34(58.6%) said short acting method, 6(10.3%) responded long acting method and 18(31%) said they provide all type.

When asked for specific family planning type they provide 2(3.4%) said oral contraceptive (OC), 50(86.2%) responded injectable, 3(5.2%) implants and 3(5.2%) Intra Uterine contraceptive Device IUCD.

From the respondents General characteristics, the majority of the respondents are from Oromiya Region followed by South Region and most of the clinics in franchised relationship are the medium clinics. When we see the service year in the market 72% are served for more than 4 years.

Majority of the clinics has been experienced for more than 2 years in providing FP/RH services, as opposed to method mix and emphasis on long term FP service focus of health bureau and MSIE the franchised private clinics are providing short acting family planning methods.

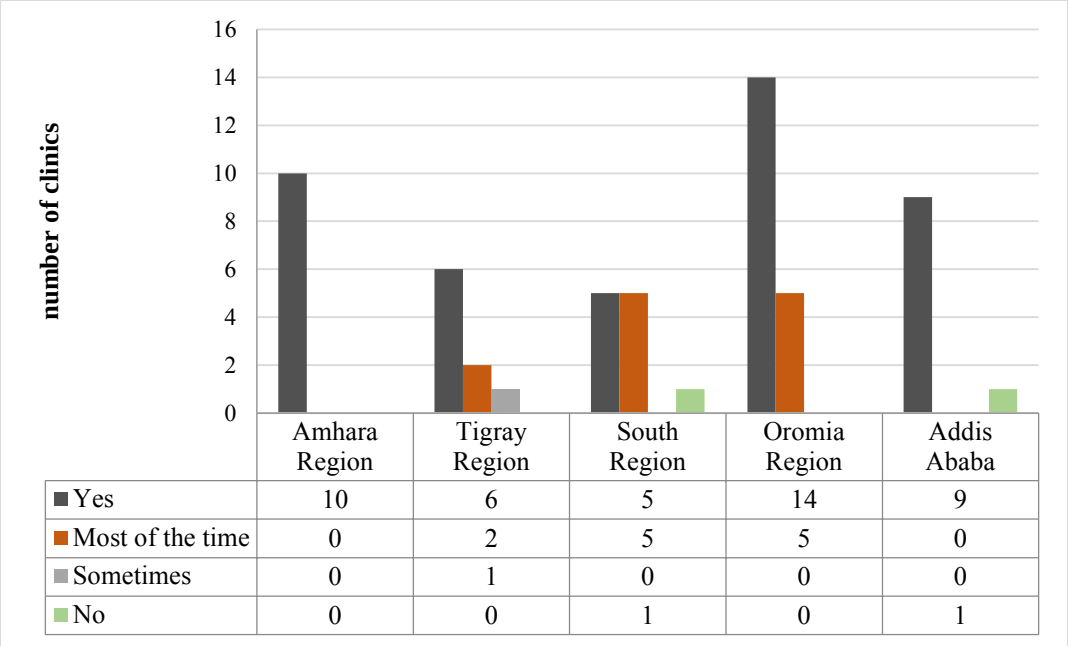
Injectable and oral contraceptives are widely provided service across the franchised clinics which are known for their short acting behavior.

4.2 RELATIONSHIP BETWEEN MSIE AND FRANCHISED CLINICS

As shown in figure 1, Respondents from all regions confirmed that they receive adequate support from MSIE as a supportive supervision; only two respondents from south region and Addis Ababa region are replied they are not receiving support. Twelve of the respondents (20%) said they receive supportive supervision most of the time

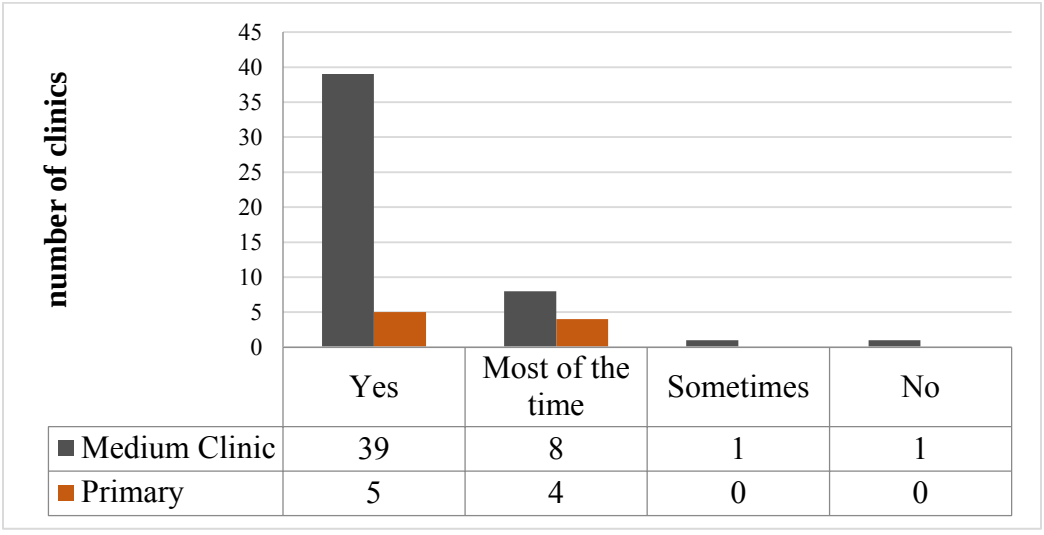
Respondents in Amhara Region are 100% happy in the provision of technical support from MSIE, South, Oromia, Tigray and Addis Ababa Region facilities require more follow up to improve satisfaction level of the facilities.

Looking into supportive supervision among other elements of intervention, MSIE moderately perceived good partner by the clinics, maximum satisfaction is a potential growth for MSIE to further strengthen the relationship.



	Amhara Region	Tigray Region	South Region	Oromia Region	Addis Ababa
Yes	10	6	5	14	9
Most of the time	0	2	5	5	0
Sometimes	0	1	0	0	0
No	0	0	1	0	1

Figure1. Regions that receive adequate technical support (supportive supervision) from MSIE



	Yes	Most of the time	Sometimes	No
Medium Clinic	39	8	1	1
Primary	5	4	0	0

Figure2. Type of facility that receive adequate technical support from MSIE

When compared by facility type, the medium clinics are the most recipient of the supportive supervision 47(78%) agreed that they receive adequate supportive supervision, two of the medium clinics said they don't receive; all the 9(15%) of the primary agreed they receive the support (See figure 2).

When compared between the primary and medium clinics, the mediums are those most benefited in supportive supervision conducted by MSIE.

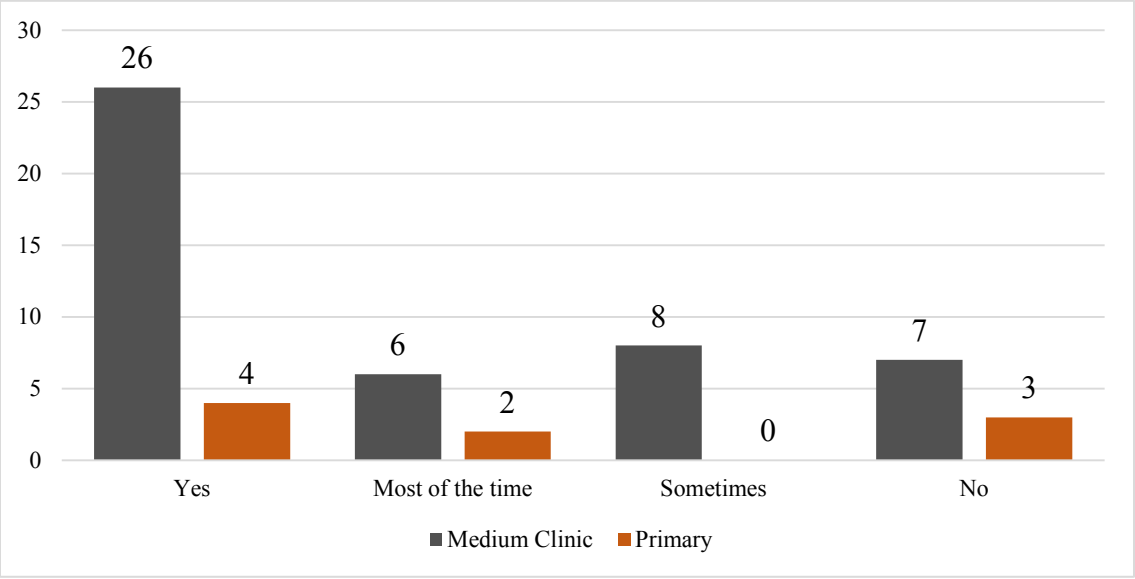


Figure3. Respondents that said branding and marketing support from MSIE is sufficient when compared to other NGO's

Branding and marketing supports provided by MSIE is confirmed sufficient by forty six respondents which is 78% of the total respondents, ten respondents (16.7%) replied there is no sufficient branding and marketing support from MSIE

From the ten respondents response of inadequate marketing support gives a clue that MSIE should work more on branding of the all clinics that are in the network, as this indicates there is a variation of Branding service to the clincs.

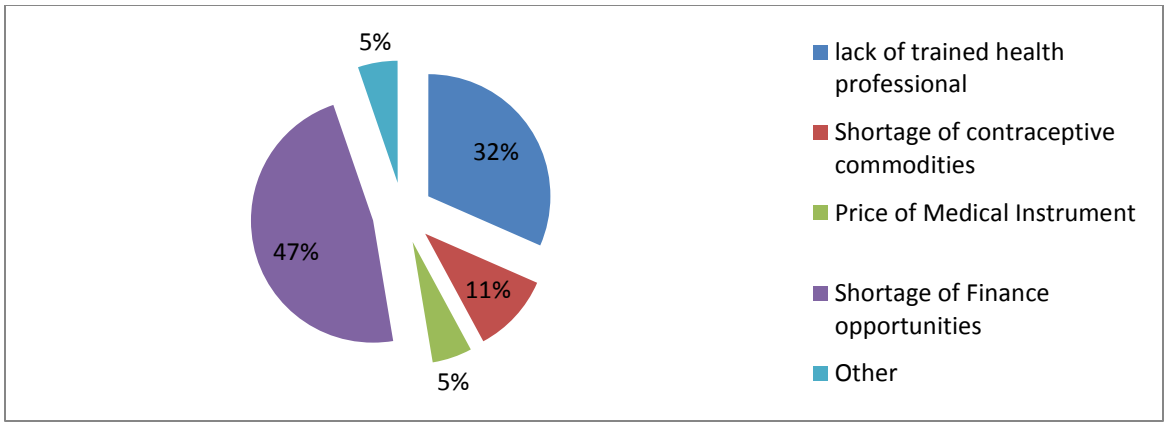


Figure4: Resources (inputs) supply affect role of the clinics most in the delivery of FP service

From the figure above 47% of the facilities responded lack of access to financial opportunities or the shortage of finance affected their provision of FP service, 32% said lack of trained health professionals, and 11% said shortage of contraceptive commodities.

From the response most of the facilities are having a challenge of access to financial resources and ability to retain trained manpower

In despite of health professionals are trained by MSIE for the social franchising clinics, it is yet the biggest challenge to the clinics because of high turnover of those trained employees.

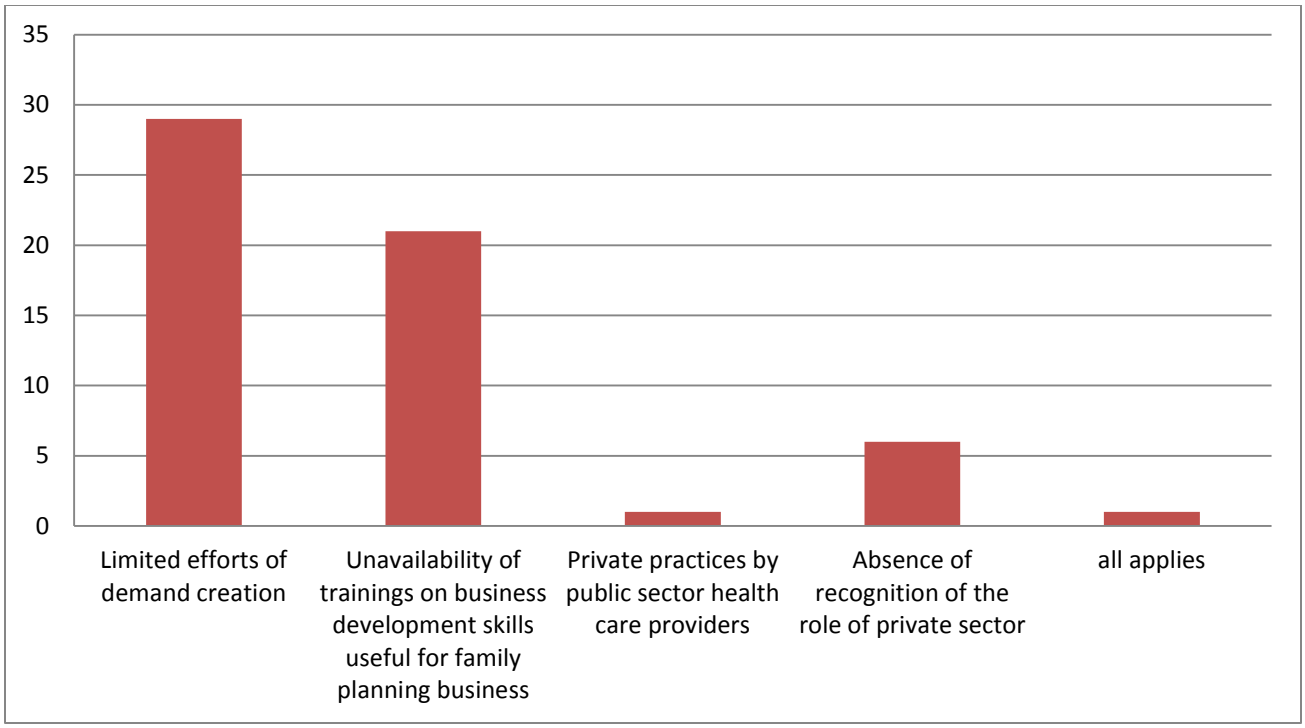


Figure5:Other constraints of the facility to provide improved delivery of FP service

The facilities are asked to select the most constraints to provide improved delivery of FP services and 29(50%) indicated limited efforts of demand creation by MSIE, 21(36%) said lack of business development skill training and 6(10%) responded absence of recognition of role of private sector by government

Inferred from this another basic challenge to the facilities is, limited efforts of demand creation and lack of business skill are indicated by the respondents.

In addition to demand creation activities skill and capacity, the franchised clinics are having gaps on business development skill.

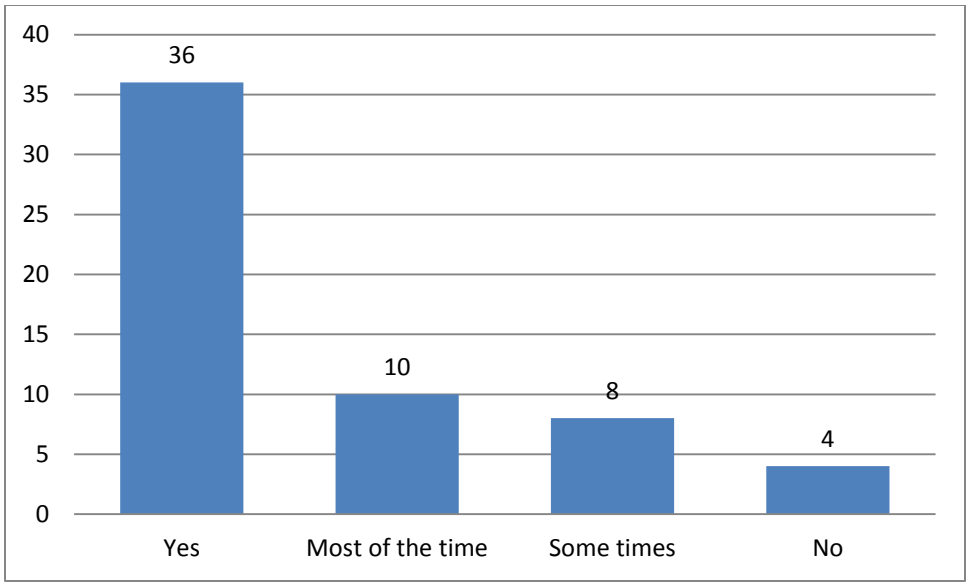


Figure6: Affordability of Medical supplies through MSIE

Respondents are asked whether supplies by MSIE is affordable compared to other suppliers and 36(62%) responded yes, 10(17%) replied most of the time, 8(13.7%) said sometimes affordable, only 4(6%) replied not affordable.

MSIE is considered strong partner in supplying affordable medical supplies when compared to others in the market for the supply of the commodities of the FP.

The Clinics are happy with the subsidized commodity supply from MSIE, this could help them to sustain in the provision of FP and RH service in the market.

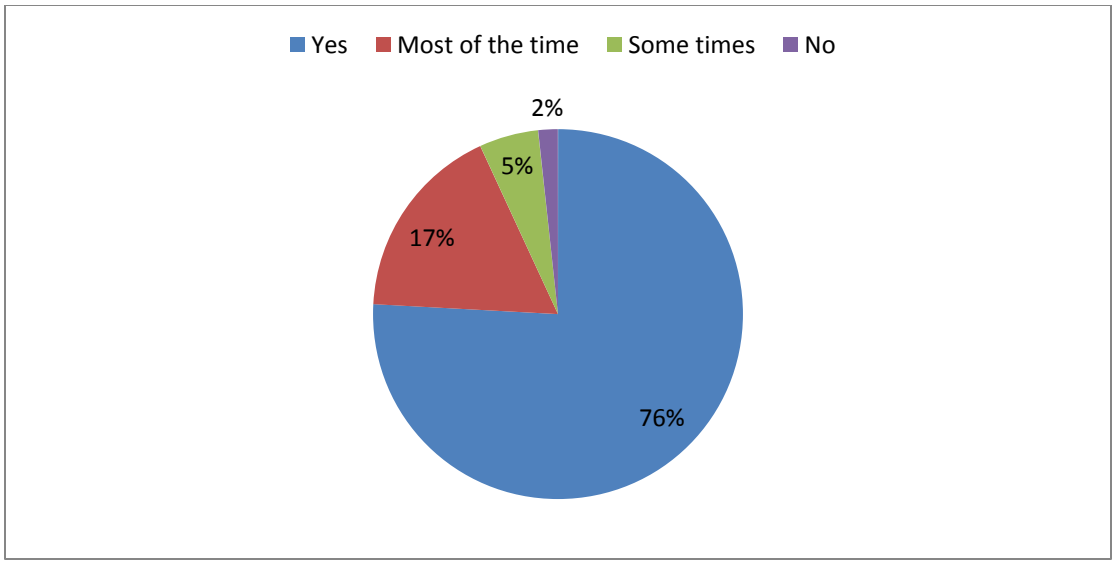


Figure7. Adequacy of Contraceptive commodities that are supplied by MSIE

Most of the respondents 44(76%) agreed that MSIE adequately supply the contraceptive commodities, 10(17%) responded most of the time, 3(5%) said sometimes and only 1(2%) replied not adequately supplied

Family planning commodity supply is the area where MSIE's strength in relationship with the franchised clinics according to the respondents to this question.

4.3 FMHACCA POLICY, QUALITY ASSURANCE, ACCREDITATION & INCENTIVE

From table below 30(51.7%) respondents rated quality of their setup is very good, 25(43%) rated Good, 2(3%) rated very poor. They are asked about how they ensure quality and 11(19%) replied through licensing upon establishment a nd a nnual r enewal o f l icense, 1 7(29%) s aid t hrough annual i nspection of t he g overnment, 21(36%) r esponded t hrough qua lity audit of B luestar (franchised clinics) network, 7(12%) replied by internal quality audit.

Most p ressing factors t hat h amper clincs delivery of qua lity FP s ervice has dr awn a ttention of 25(43%) a bsence of di alogue f orums be tween t he pr ivate s ector a nd government r egulators, 19(32.7%) excessive c linical qua lity requirement b y government, 7 12%) r eplied e xclusion of private sector from the social health insurance. Respondents are asked about affordability of the FP services and 38(65.5%) replied yes, 15(25.8%) said most of the time, 3(5%) replied and only

2(3.4) answered not affordable. For a question, whether social marketing activities under taken by MSIE attract more FP clients 32(55%) replied yes, 12(20.6) said most of the time, 11(18.9%) responded sometimes and only 3(5%) said no.

Forty eight (82%) o f th e f acilities a greed th at e xclusively me mbers o f Bluestar ne twork members, 4(6.9%) replied they are also a member with other NGOs.

The Respondents indicated that they ensure quality of their service provision through the quality audit of MSIE during the internal audit process and annual inspection of the government for licensing. Excessive clinical quality requirement by regulatory government bodies and absence of dialogue forum for information exchange are come out as a pressing factor that hampers their clinic in delivering FP services (see table 2)

Table 2. FMHACCA Policy, quality assurance, accreditation and incentive

	Medium Clinic		Primary	
	N	Percent	N	Percent
Rating of your clinic quality in the delivery of quality family planning services?				
Very good	26	53.1	4	44.4
Good	21	42.9	4	44.4
Very poor	1	2	1	11.1
Other	1	2	0	0
How does your clinic ensure delivery of quality family planning services?				
Licensing upon establishment and annual renewal	10	20.4	1	11.1
Through annual inspection of government	15	30.6	2	22.2
Quality audit of BlueStar network	16	32.7	5	55.6
Own internal quality- audit to comply with national family planning guidelines and protocols	6	12.2	1	11.1
Other	2	4.1	0	0
What are the most pressing factors that hamper your clinic in the delivery of quality family planning services?				
Excessive licensing procedures upon establishment	5	10.2	0	0
Excessive clinical quality requirements by regulatory Government bodies.	16	32.7	3	33.3
Exclusion of private sector from the social health insurance	6	12.2	1	11.1
Absence of/weak dialogue forum for information exchange between government and private providers	20	40.8	5	55.6
Others	2	4.1	0	0
Do you think the delivery of family planning services by your clinic is affordable to clients with low income?				
Yes	33	67.3	5	55.6
Most of the time	13	26.5	2	22.2
Sometimes	2	4.1	1	11.1

No	1	2	1	11.1
Do social marketing activities by MSIE dedicated to create demand for family planning benefit your clinic to attract more clients to your clinic?				
Yes	28	57.1	4	44.4
Most of the time	10	20.4	2	22.2
Sometimes	8	16.3	3	33.3
No	3	6.1	0	0
To which currently active association or Network is your clinic a member?				
Association of private health clinic owners at Federal level	2	4.1	0	0
Association of private health clinic owners at regional	3	6.1	1	11.1
BlueStar Network (MSIE)	41	83.7	7	77.8
Other NGO	3	6.1	1	11.1

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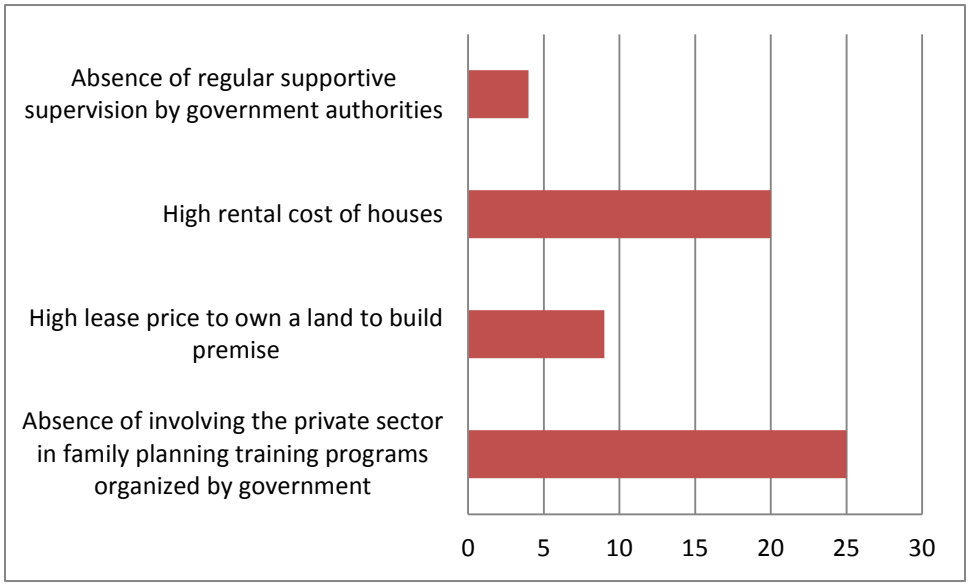

Figure8: Factors affecting private sector from playing active role in the delivery of quality FP service

From the chart 25(43%) responded absence of involving the private sector in family planning training programs organized by government, 20(34%) indicated high rental cost of house, 9(15.5%) replied high lease price to own a land to build premises.Lack of involvement in trainings organized by government, high cost of rent and lease price to own land are perceived the most challenging factors to provide quality FP services in the network.

MSIE shall facilitate a dialogue forum with public sector providers and government health agencies for the inclusion of the social franchised private clinics and to benefit from trainings provided by government (see figure 8).

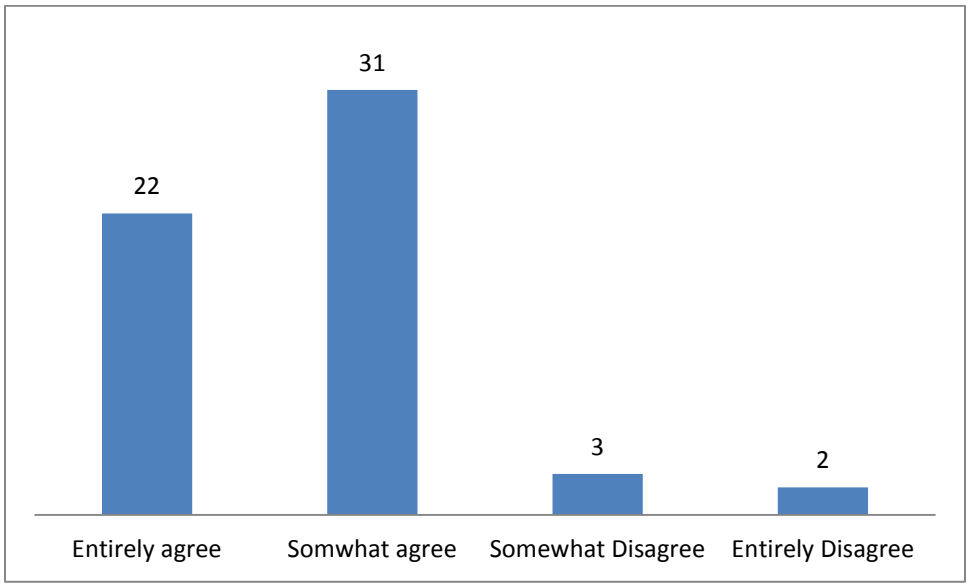

Figure9: Whether rules governing quality in private sector often more stringent than those for the public sector

Stringency of rules governing quality compared to public sector 22(37.9%) of respondents entirely agreethat it is stringent for the private sector, 31(53%) responded somewhat agree, 3(5%) replied somewhat disagree, and only 2(3%) entirely disagree.

The private health network of the Bluestar perceived that, rules and regulations that govern quality are more stringent when compared to public sector providers (see figure 9)

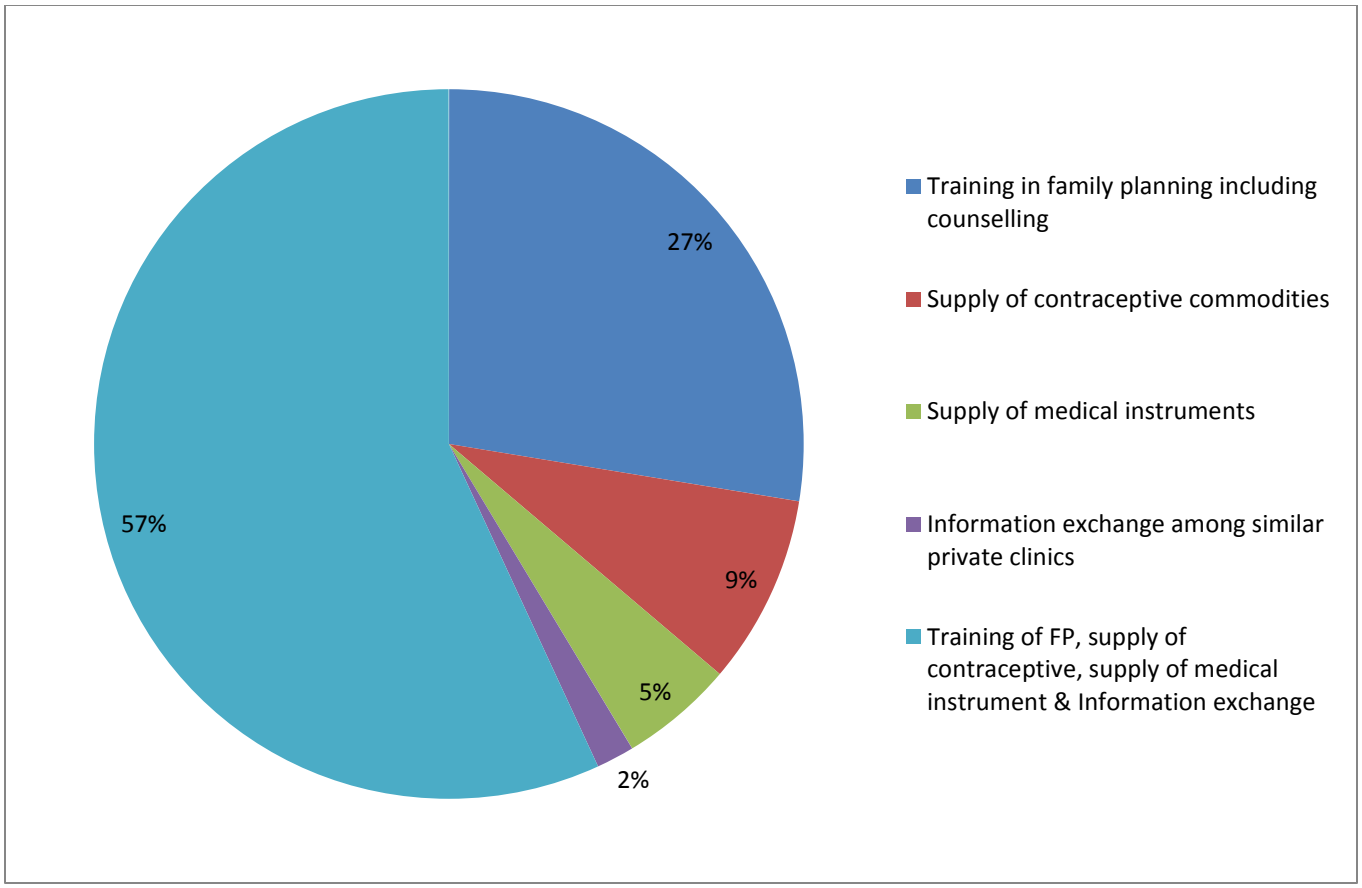

Figure10: Benefits of being Bluestar (social franchised) clinics membership

Respondents were asked benefits they are accruing from membership of Bluestar clinics network and 33(57%) responded Training on FP, Supply of contraceptive commodities, supply of medical equipment a nd i nformation e xchange, 15(27%) replied t raining on F P, 5 (9%) s aid s upply of contraceptive, 3(5%) r eplied s upply of m edical e quipment, and on ly 1(2%) r esponded information exchange.

There is a positive feeling of the relationship with MSIE is network benefit of Training on FP, supply of contraceptive commodity and information exchange from the Bluestar clinics network (see figure 10).

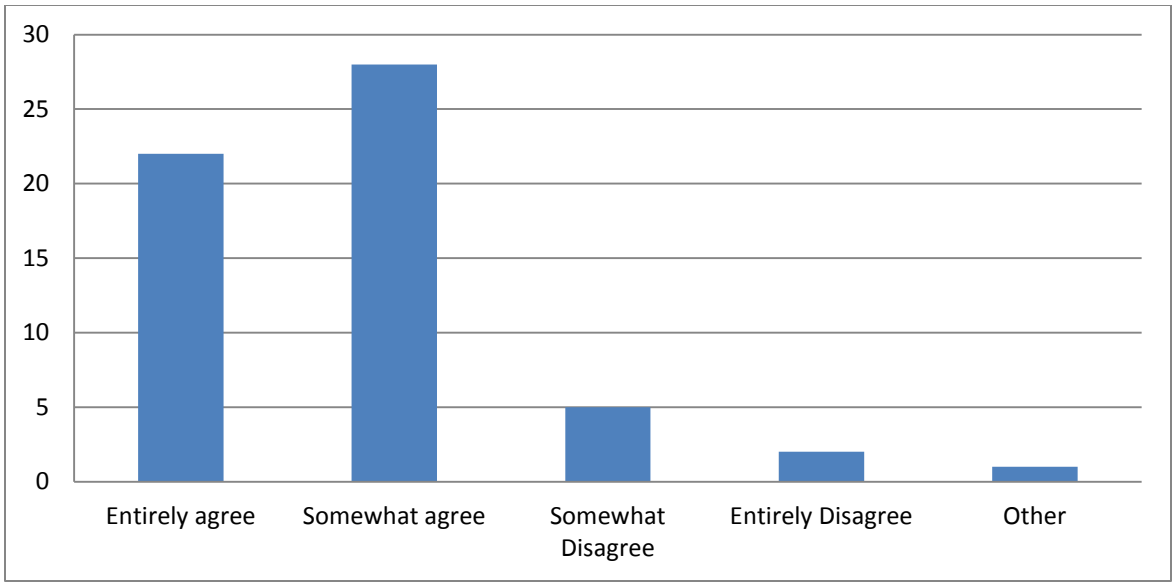

Figure11: Current policy environment supportiveness for active engagement of FP service

Respondents are asked their feeling toward policy environment for active FP service engagement and 22((37.9%) replied entirely agree, 28(48%) said somewhat agree, 5(8%) replied somewhat disagree, and only 1(2%) replied entirely disagree.

The facilities are agreed that the policy environment for provision of FP is supportive and encouraging (see figure 11).

4.4 PROSPECTS OF THE FRANCHISED CLINICS

From table below, facilities were asked whether the private sector can play an important role in the delivery of family planning services, 49(81.7%) replied entirely agree, 7(11.7) responded somewhat agree, 1(1.7%) said somewhat disagree and only 1(1.7%) replied entirely disagree. On provisions of incentives from government to the private sector 23(38.3%) replied entirely agree, 18(30%) said somewhat agree, 6(10%) replied somewhat disagree, only 1(1.7%) replied entirely disagree.

The facilities are asked whether the private sector can deliver quality family planning services if contracted through NGO sector and 39(65%) replied entirely agree, 12(20%) responded somewhat agree, 4(6.7%) said somewhat disagree, and only 2(3.3%) replied entirely disagree. They were also asked whether they are ready to provide FP services to lower income people and 27(45%) replied entirely agree, 22(36.7%) responded somewhat agree, 6(10%) replied somewhat disagree and only 2(3.3%) replied entirely disagree.

For the question whether the private sector can bring more resources in expanding reach and coverage of family planning services 27(45%) replied entirely agree, 27(45%) replied somewhat agree, 3(5%) replied somewhat disagree and only 1(1.7%) entirely disagree.

The private sectors in FP service provision would play a big role both in creating access and affordability if strategically supported by government and NGO sectors that are advocates of family planning access and choice, MSIE is the major player in provision of technical support and commodity supply when compared to the NGO sectors that are in the market of FP/RH service (see table 3).

Table 3. Prospects

	n	%
The private sector can play important role in the delivery of family planning services? (N=58)		
Entire agree	49	81.7
Somewhat agree	7	11.7
Somewhat disagree	1	1.7
Entirely disagree	1	1.7
The government should provide private clinics that deliver family planning services with incentive to expand coverage (N=58)		
Entirely agree	23	38.3
Somewhat agree	18	30
Somewhat disagree	6	10

Entirely disagree	10	16.7
Other	1	1.7
The private sector can deliver quality family planning services if contracted through the NGO sector (N=58)		
Entirely agree	39	65
Somewhat agree	12	20
Somewhat disagree	4	6.7
Entirely disagree	2	3.3
The private-sector at present is in a position to provide wider choices of family planning services to low income people (N=58)		
Entirely agree	27	45
Somewhat agree	22	36.7
Somewhat disagree	6	10
Entirely disagree	2	3.3
Other	1	1.7
The private sector can bring in more resources in expanding reach and coverage of family planning services (N=58)		
Entirely agree	27	45
Somewhat agree	27	45
Somewhat disagree	3	5
Entirely disagree	1	1.7
Prohibition of private practices by public sector health care providers contributes to affecting the contribution of private sector (N=58)		
Entirely agree	29	48.3
Somewhat agree	16	26.3
Somewhat disagree	9	15
Entirely disagree	3	5

CHAPTER 5
SUMMARY, CONCLUSION & RECOMMENDATION
5.1 SUMMARY

Evidences from analysis strongly suggest that supportive supervision, training, commodity supply and quality audit services that they receive from MSIE is to the expectation of the franchised facilities. Commodities or FP products supplied by MSIE is also perceived by most of the respondents that it is affordable; most of the facilities perceived that their quality of FP service is very good.

The respondents are indicated the benefits of being in social franchising relationship with MSIE is majorly for access to training of FP, supply of contraceptive commodities, supply of medical instruments, and information exchange.

However, cost of facility they are operating in, need for financial support to comply with FMHACCA requirements, Branding and promotion of their facility by MSIE when comparing to other NGOs, limited efforts of demand creation are come out as basic challenges to the success of the facilities to maintain the quality standards required to provide the services. The facilities are also perceived rules of governing quality from government side are more stringent to the private sector when compared to the public sector, absence of dialogue forums between the private sector and government regulators, excessive clinical quality requirements, exclusion of private sector from upcoming social health insurance, absence of incentive support from government are other major challenges for the private health facilities according to this survey.

Business skill development is one of the areas identified for intervention by MSIE to develop the capacity of the franchised clinics.

Most of the respondents in this research agreed that they are providing short acting FP majorly which contravene method mix and MSIE's interest to focus on long acting methods, this suggests that the clinics need to focus on method shift toward long acting FP service.

The prospect of the social franchise network on provision of FP service is dependent on their financial strength and ability to access loan; MSIE can play a great role in facilitating loan through the donors and financial institutions. The private network working in collaboration with

MSIE's prospect is dependent on their performance of FP service and willingness of donors support.

A strong support from NGO's like MSIE and government will help the private sector to grow and provide an access to RH and FP services; by its setup the private sectors are more accessible geographically to areas where underserved families are living. Social franchising approach for FP access is strategically plays a great role in contributing to family planning choices to the community.

5.2 CONCLUSION

Contribution of franchised private clinics in the delivery of FP service was low due to challenges with shortage of inputs, limitation on quality and affordability of FP services, access to finance and appropriate government support. By harnessing existing opportunities, active participation of private sector was foreseen to complement MSIE's efforts of sustaining the quality FP/RH services and sustaining the service in absence of donating organizations.

According to this study MSIE's franchising Business model is effective and required by the clinics in the network. It also identified gaps like lack of access to financing, lack of trained manpower, business skill, Demand creation activities and branding that are needed to be strengthened to maintain the strong relationship and ensure also sustainability of the network in the market of FP and RH services.

MSIE is perceived as strong partner by the franchised network of clinics in areas of technical support, commodity supply, and supportive supervision; while also there are specific recommendations that demanded further intervention. As the biggest service provision outlet and better option of creating access to underserved areas of the country the network of the clinics are strategic partner to the organization.

5.3 RECOMMENDATION

1. MSIE shall maintain its relationship with the Bluestar clinics by strengthening the technical and commodity supply support to sustain the performance results of the CYP.
2. For Medium and higher private clinics franchised by MSIE to provide quality and affordable FP services, MSIE shall look in to its current relationship effectiveness and follow an approach where the capacity of the private networks would be transformed permanently and enabling to support themselves in absence of continuous donor support; this determines the prospects of the social franchising network, a continued relationship with MSIE can be limited to commodity supply as a social marketing.
3. The Bluestar Clinics are requiring strong financial support to meet quality standards set by government and also to provide quality service to the clients; MSIE shall facilitate loan establishment through financial institution to enable an access to capital for Bluestar Clinics.
4. As a partner organization with Ministry of Health, FMHACCA and the Blustar clinics a dialogue forum shall be facilitate by MSIE to bridge the communication and partnering gap between the private clinics and government health institutions; also rectify through a dialogue mechanisms that Bluestar clinics can be involved in social health insurance service.
5. Demand creation activities are also a gap that is indicated by the Social franchising network; where they recommended MSIE to support more in the Branding and Demand creation activities by incorporating in to the marketing plan.
6. Business skill development is another area where MSIE intervention is required to develop the capacity of the franchised clinics through means of training and practical attachment.
7. From the quarter performance reports MSIE receives 80% results from 60% of the bluestars only; MSIE shall thus focus on fewer but more productive BlueStar clinics and also longer time supportive supervision and less frequent visit to the networks.

8. It is also recommended that the Bluestar clinics specific rewards in the form of community promotion and grading of clinics shall be introduced based on their achievement.
9. Branding the clinics is another recommendation to help promoting them and facilitate loan scheme for those better performing in terms of quality and CYP generation to ensure more sustainability in absence of MSIE and donor support.
10. MSIE shall further rectify or survey why most of the networks are focusing on short acting method FP service provision and device support mechanism to help them on method mix and long acting service provision.
11. The social franchising service outlet will continue to be best strategy of delivering service to areas where MSIE cannot reach by its own centres by addressing gaps identified in this survey and conducting further studies recommended here.
12. The franchised private sectors shall also be part of the new health insurance scheme to promote growth of the private institutions and also increase accesses to different areas of the country.

For future research, it is recommended that MSIE shall study and devise mechanisms where the active Bluestar Clinics can graduate to self-sustained grade level and they remain partners under social marketing; and replacement mapping strategies shall be developed for the graduating clinics. From Basic information there is an indication that type of FP provided are dominated by short acting methods only contravening to method mix policy of MOH; there shall a study why other methods are not deployed by the franchised private clinics

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ANNEX

Questionnaire

I am interested in your feedback about your Franchising relationship with MSIE its challenges and prospects, including FMHCCA standard impacts on your clinic, Technical supports you are receiving from MSIE. The out put of the survey will help to improve understanding of the prospects and challenges of MSIE's franchised private health providers. The primary purpose of the survey is for partial fulfillment of Executive MBA in Addis Ababa University for the researcher (Akalu Zemene)

For the sake of confidentiality, you are not required to write your name or your organization. Return this copy to the program officers of MSIE that are providing technical support to you.

My Many thanks for your time and Support!

Questionnaire

Please circle on your answer from the list

I. Basic information
    1. Regional State
        a) Amhara Region
        b) Tigray Region
        c) Oromia Region
        d) South Region
        e) Addis Ababa
    2. Type of the clinic as per the health facility standards.
        a) Hospital
        b) Specialty
        c) Medium Clinic
        d) Primary
        e) Other
           Specify _____
    3. Service year in delivering health service
        a) < 2 years
        b) 2 to 4 years
        c) 4 to 6 years
        d) 6 to 8 years
        e) >8 years
           Specify_____
    4. Number of total clients the clinic provides with all health services
        a) Up to 150 per month
        b) 151-250 per month

c) 251-400 per month
d) >400

Specify_____

5. Service year in the delivery of family planning services in collaboration with Marie stopes international Ethiopia (MSIE)
    a) <2 years
    b) 2 to 4 years
    c) 4 to 6 years
    d) 6 to 8 years
    e) >8 years

    Specify_____
6. Types of family planning methods the clinic delivers
    a) Short Acting Methods
    b) Long Acting Methods
    c) Permanent Methods
    d) Counselling
    e) Short acting, long acting and Counseling
7. Types of family planning service most commonly the clinic provides to clients
    a) Oral contraceptive (OC)
    b) Injectable
    c) Implants
    d) Intra Uterine Contraceptive Device (IUCD)
    e) Other

    Specify_____
8. Share of family planning services from all health service delivery
    a) < 10%
    b) 11% -20%
    c) 21% - 30%
    d) 31% - 40%
    e) > 40%

    Specify_____
9. Number of clients that the clinic provides with family planning services.
    a) < 50 per month
    b) 51 -100 per month

c) 101% - 150 per month
d) 151 – 200 per month
e) > 200
Specify_____

10. Occupational status of clients the clinic provides with family planning services
    a) Employed women of reproductive age
    b) Self-employed women of reproductive age
    c) Non-employed women of reproductive age
    d) Non- employed house wives
    e) Others
    Specify_____
11. Income of clients the clinic provides with family planning services
    a) < 500 Birr /Month
    b) 501-1000 Birr/month
    c) 1001-1500 Birr
    d) 1501-2000 Birr

II. Challenges

12. Do you receive adequate technical support (supportive supervision) from Mariestopes International Ethiopia (MSIE)?
    a) Yes
    b) Most of the time
    c) Sometimes
    d) No
    e) Other
    Specify_____
13. Are contraceptive commodities adequately available and supplied by Marie Stopes International Ethiopia (MSIE) whenever the clinic needs to replenish stock levels of the clinic?
    a) Yes
    b) Most of the time
    c) Sometimes

d) No

e) Other

Specify_____

14. Are m edical i nstruments s upplied b y M SIE c ompared t o ot her NGO's a re at affordable or subsidized price for your clinic?

a) Yes

b) Most of the time

c) Sometimes

d) No

e) Other

Specify_____

15. Is Branding and marketing support from MSIE is sufficient when compared to other NGO's providing similar support?

a) Yes

b) Most of the time

c) Sometimes

d) No

e) Other

Specify_____

16. Which of the resources (inputs) supply affect role of your clinic most in the delivery of family planning services?

a) Lack of trained health professionals

b) Shortage of contraceptive commodities

c) Price of medical instruments

d) Shortage of finance opportunities

e) Other

Specify_____

17. What other constraints the private sector has for improved delivery of family planning services?

a) Limited efforts of demand creation for family planning services

b) Unavailability of trainings on business development skills useful for family planning business

c) Private practices by public sector health care providers

d) Absence of recognition of the role of private sector

e) Other

Specify_____

III. FMHACCA Policy, quality assurance, accreditation and incentive

18. What is the rating of your clinic quality in the delivery of quality family planning services?
    a) Very good
    b) Good
    c) Very poor
    d) Poor
    e) Other

    Specify_____

19. How does your clinic ensure delivery of quality family planning services?
    a) Licensing upon establishment and annual renewal
    b) Through annual inspection of government
    c) Quality audit of BlueStar network
    d) Own internal quality- audit to comply with national family planning guidelines and protocols
    e) Others

    Specify_____

20. What are the most pressing factors that hamper your clinic in the delivery of quality family planning services?
    a) Excessive licensing procedures upon establishment
    b) Excessive clinical quality requirements by regulatory government bodies.
    c) Exclusion of private sector from the social health insurance
    d) Absence of/weak dialogue forum for information exchange between government and private providers
    e) Others

    Specify_____

21. What do you think are the factors affecting the private sector from playing active role in the delivery of quality family planning services?
    a) Absence of involving the private sector in family planning training programs organized by government
    b) High lease price to own a land to build premise
    c) High rental cost of houses

d) Absence of regular supportive supervision by government authorities

e) Other

Specify_____

22. Are rules/provisions governing quality in the private sector often more stringent than those for the public sector?
    a) Entirely agree;
    b) Somewhat agree;
    c) Somewhat Disagree;
    d) Entirely Disagree
    e) Other

    Specify_____

23. Do you think the delivery of family planning services by your clinic is affordable to clients with low income?
    a) Yes
    b) Most of the time
    c) Sometimes
    d) No
    e) Other

    Specify_____

24. Do social marketing activities by MSIE dedicated to create demand for family planning benefit your clinic to attract more clients to your clinic?
    a) Yes
    b) Most of the time
    c) Sometimes
    d) No
    e) Other

    Specify_____

25. To which currently active association or Network is your clinic a member?
    a) Association of private health clinic owners at Federal level
    b) Association of private health clinic owners at regional
    c) BlueStar Network (MSIE)
    d) Association of Nurses
    e) Other NGO

Specify_____

26. What benefits are accruing to your clinic as a result of membership?
    a) Training in family planning including counselling
    b) Supply of contraceptive commodities
    c) Supply of medical instruments
    d) Information exchange among similar private clinics
    e) Training in family planning including counselling, Supply of contraceptive commodities, Supply of medical instruments & Information exchange among similar private clinics
27. The current policy environment is supportive of active engagement of the private sector in the delivery of family planning services.
    a) Entirely agree;
    b) Somewhat agree;
    c) Somewhat Disagree;
    d) Entirely Disagree
    e) Other

    Specify_____

IV. Prospects

28. The private sector can play important role in the delivery of family planning services.
    a) Entirely agree;
    b) Somewhat agree;
    c) Somewhat Disagree;
    d) Entirely Disagree
    e) Other

    Specify_____
29. The government should provide private clinics that deliver family planning services with incentive to expand coverage.
    a) Entirely agree;
    b) Somewhat agree;
    c) Somewhat Disagree;
    d) Entirely Disagree

e) Other

Specify_____

30. The private sector can deliver quality family planning services if contracted through the NGO sector.
    a) Entirely agree;
    b) Somewhat agree;
    c) Somewhat Disagree;
    d) Entirely Disagree
    e) Others

    Specify_____

31. The private-sector at present is in a position to provide wider choices of family planning services to low income people.
    a) Entirely agree;
    b) Somewhat agree;
    c) Somewhat Disagree;
    d) Entirely Disagree
    e) Others

    Specify_____

32. The private sector can bring in more resources in expanding reach and coverage of family planning services
    a) Entirely agree;
    b) Somewhat agree;
    c) Somewhat Disagree;
    d) Entirely Disagree
    e) Others

    Specify_____

33. Prohibition of private practices by public sector health care providers contributes to affecting the contribution of private sector.
    a) Entirely agree;
    b) Somewhat agree;
    c) Somewhat Disagree;
    d) Entirely Disagree
    e) Others

Specify_____

Thank you very much for your time and interest to share us your opinion!!!