

Empowering Women Health Providers through Social Franchising

Stories from Kenya and Uganda



Summary

While social franchising interventions were designed to achieve positive health outcomes and were not intended to improve gender equality, franchisors in some countries target primarily female cadres such as midwives. As a result, social franchising may unintentionally help women providers overcome gender-related barriers. SHOPS Plus visited social franchisees in Kenya and Uganda to better understand how social franchising has affected the lives of women franchise owners. This brief analyzes the findings from interviews with women providers using the Social Franchising Empowerment Framework. It finds that social franchising empowers women providers, specifically within their ability to make and implement decisions and perform tasks as well as in their self-confidence. Based on the findings, the brief concludes with recommendations on how social franchises and the private sector overall could take a more intentional approach to improving women's empowerment outcomes.

Keywords: Africa, family planning, gender, networks and franchising, private provider networks, provider access to finance, provider networks, provider quality, quality assurance, quality improvement, social franchise, sub-Saharan Africa

Photo: Julius Caesar Amooti Kasujja

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CENTRES IN REPRODUCTIVE
HEALTHCARE

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Kenya

Introduction

Women health workers bring tremendous value to health service delivery globally, yet little is known about what factors contribute to their performance, satisfaction, and empowerment, particularly within the private health sector. Women not only make up the vast majority of health care workers globally (High Level Commission on Health Employment and Economic Growth 2016), but their contributions to health care are economically significant—accounting for 5 percent of global gross domestic product or approximately \$3 trillion (Langer et al. 2015). At the same time, they tend to be on the lower end of health workforce hierarchies in terms of status, pay, and decision-making authority. Cadres of nurses, midwives, and community health workers are almost entirely female, while cadres of doctors, directors, and managers are predominantly male (WHO 2008).

The experiences of women in the health workforce are largely shaped by cultural norms and power dynamics, such as assumptions about men and women as leaders or caregivers (Newman 2014). These norms and dynamics can affect morale, salaries, performance, promotion, safety, access to credit, training, and other factors of success in the public and private health sectors. Given women’s predominant role in the health workforce and persistent shortages of health care workers, it is

important that global health leaders understand how to help women unlock their full potential as providers, support staff, leaders, and owners of health care businesses.

Literature documents the many challenges women face in the health sector globally. A commentary by Constance Newman in *Human Resources for Health* (2014), which presents research from Kenya and Uganda, notes that gender influences pay disparities, promotion opportunities, workplace safety, and quality of life for women working in the health sector. Evidence shows the health sector in Kenya and Uganda, as well as elsewhere, reflects high levels of both vertical (women concentrated in lower-level positions) and horizontal (women concentrated in specific provider cadres) gender-based occupational segregation. Occupational segregation implies that individuals within the health system are constrained from making free choices about their career paths (Newman 2014).

In-depth qualitative research has illuminated these gender dynamics in the health workforce. One study gathered life histories of health workers in Cambodia, Zimbabwe, and Kenya. The study found the occurrence of “gendered decision making” and that women have to make difficult choices regarding taking advantage of education and training

opportunities when their children are young. The study found that training and higher educational opportunities are more difficult for women with young children to participate in—particularly those which require them to be away from home for long periods of time—and that women in these countries are expected to follow their spouse and sacrifice career opportunities as a result (Dhatt et al. 2017).

Although important investigations of gender and the global health workforce are relatively recent, some literature also captures promising approaches to advancing health outcomes alongside gender equality. Krubiner and colleagues (2015) specifically looked at how nurses and midwives can be empowered through different health interventions. They note that while most examinations of empowerment in the health sector have focused on clients, there are “significant opportunities to contribute to the dual goals of improved health and women’s empowerment through investment in the female health workforce” (Krubiner et al. 2015). They identified 94 programs that included “hallmarks of empowerment” by addressing access to credit, access to training, promotion of autonomy, and building self-efficacy of providers, among other elements. The study found that social franchising was one of four interventions that contributed substantially to empowerment, because of its investment in provider training, supply chain enhancements, technological improvements, and supervision. The authors went on to argue that “greater attention is required to have explicit commitments to empowerment within [health] programs and to systematically track how well these different types of inputs translated into empowerment goals” (Krubiner et al. 2015).

The private sector can be attractive to women providers because it offers flexibility and a path to leadership that may be denied to them in the public sector. Yet in many countries, the private health sector is fragmented, with many providers operating independently of any central authority, complicating efforts to support provider performance and ensure business success. Private providers who operate independently are often not fully integrated into the broader health system. Social franchising offers a way to address this issue. It is defined as “a network of private sector health care providers that are linked through agreements to provide socially beneficial health services under a common franchise brand” (High Impact Practices in Family Planning 2018). Social franchises offer many benefits to the providers in their network, which can vary but often include: clinical skills training, business training, branding, commodities, and quality assurance mechanisms. These benefits often result in increased client volume and business growth (High Impact Practices in Family Planning 2018).

Social franchising is important to expanding access to family planning in the private sector. Various studies have looked at the impact of social franchising (Chakraborty, Mbondo, and Wanderi 2016; Beyeler, De La Cruz, and Montagu 2013; Munroe, Hayes, and Taft 2015); however, there is very little information on whether or how female and male health providers may benefit differently from participating in these networks. Even the most basic data about the number of male and female social franchisees are unavailable in many countries. While social franchising interventions were designed to achieve positive health outcomes and were

not intended to improve gender equality, in some countries, franchisors target primarily female cadres such as midwives. As a result, social franchising may unintentionally help women providers overcome gender-related barriers by building their access to resources and changing power dynamics in their homes or communities.

In 2018, the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project conducted visits with social franchisees in Kenya and Uganda to better understand how social franchising has affected the lives of women franchise owners. This

report analyzes the findings from interviews with women providers using the Social Franchising Empowerment Framework (see Methodology section), and seeks to prompt further examination of gender, women's empowerment, and social franchising. The objectives of this report are to:

- 1) Illuminate whether and how women franchisees are empowered through social franchising; and
- 2) Help identify interventions through which the private health sector might more intentionally and consistently improve both gender equity and health outcomes.



Social franchises, such as Tunza, may unintentionally help women providers overcome gender-related barriers by building their access to resources and changing power dynamics in their homes or communities.

Photo: What Took You So Long

Methodology

Life history approach

Because the effect of social franchising on women owners is a new area of inquiry with little existing sex-disaggregated data, SHOPS Plus adopted an ethnographic approach, capturing the life stories of women franchisees through in-depth interviews. Collecting the histories of women franchisees facilitates an examination of their perspectives on any changes that may have occurred in their lives as a result of joining a social franchise.

Selected interviewees had been franchise owners for at least five years, and health providers for at least 10 years. All interviewees gave written consent to use their names, stories, and images for this report. An institutional review board conducted an expedited review of the protocols for protection of human subjects and granted approval prior to the start of the interviews. SHOPS Plus staff asked interviewees to draw a timeline of their life to help them reflect on formative moments, and note any changes that may have occurred due to their participation in franchising. Using the timeline and an interview guide as a prompting tool, the semi-structured interviews explored factors in the interviewee's decision making, changes in their relationships and wellbeing, and perceptions of their economic and social status. Interviewees also reflected upon the benefits of social franchising that had the greatest value in their lives. The SHOPS Plus team also interviewed social franchise program staff to provide

context to each program. A desk review of literature examining gender and the health workforce and social franchising benefits underpinned and complemented the interviews.

SHOPS Plus conducted 14 life history interviews in Kenya and Uganda. These countries were selected based on the following criteria:

- They are among the USAID family planning priority countries.
- They have more than one social franchising program with different franchisee benefits and requirements.
- Population Services International (PSI)—a SHOPS Plus partner and the largest social franchising program globally—has a presence there.
- They are English-speaking.

SHOPS Plus conducted interviews with female owners of facilities affiliated with five social franchises in Kenya and Uganda (Table 1). In Kenya, SHOPS Plus interviewed the female owners of three Population Services (PS) Kenya Tunza brand facilities and three owners of Marie Stopes Kenya (MSK) Amua brand facilities. In Uganda, the team interviewed three owners of PSI Uganda ProFam facilities, three owners of Marie Stopes International (MSI) Uganda facilities, and two owners of facilities associated with Reproductive Health Uganda (RHU).

Table 1. Franchise facilities visited

Kenya	Uganda
PS Kenya: 3 Tunza facilities in Nairobi, Muranga, and Embu	PSI: 3 ProFam facilities in Kampala
MSK: 3 Amua facilities in Nairobi, Kajiado, and Machakos	MSI: 3 facilities in Masaka
	RHU: 2 facilities in Kampala

Social Franchising Empowerment Framework

The team analyzed interviews using the Social Franchising Empowerment Framework (Table 2), which expands upon the four dimensions of empowerment originally proposed by Jo Rowlands (1997). The framework looks at four dimensions of empowerment—power over; power to; power within; and power with—to identify how they might manifest in social franchising.¹

Table 2. Social Franchising Empowerment Framework

Aspect of Empowerment	Description	Application to Social Franchising
Power Over	An individual's ability to influence others	<ul style="list-style-type: none">• Increased ability to direct others in workplace decisions• Increased status in community• Creation of gender-equitable work environments
Power To	An individual's power to make and implement decisions	<ul style="list-style-type: none">• Increased professional capacity• Increased ownership and control over resources• Increased access to credit• Increased access to insurance
Power Within	An individual's understanding of possibilities for change	<ul style="list-style-type: none">• Enhanced self-esteem and self-efficacy
Power With	An individual's power to expand influence through collective action	<ul style="list-style-type: none">• Meaningful participation in professional networks• Creation of new outlets for collective action

¹ The Social Franchising Empowerment Framework was developed by Mary Beth Hastings of Iris Group, expanding upon the widely used framework by Jo Rowlands and adapting it to the context of social franchising. Original source: Rowlands, J. 1997. *Questioning Empowerment: Working with Women in Honduras*. Oxford, UK: Oxfam. For more discussion see: Hillenbrand, E. et al. 2015 "Measuring Gender-Transformative Change: A Review of Literature and Promising Practices." CARE USA.

Limitations

The purpose of this activity was to shed light on the experiences of women franchisees and not to conduct an in-depth research study. There were a number of limitations to the activity. As this was not a research activity, the sample of interviewees was quite small and may not be representative of all women franchisees. The women whom SHOPS Plus interviewed were selected by the franchisor, introducing the possibility of selection bias. SHOPS Plus also only interviewed current franchisees and not providers that either exited the network or chose not to join a network. In some cases, franchisor staff sat in on the interviews to interpret or clarify questions for the interviewee, but only after confirming that interviewees were comfortable providing frank answers in front of franchisor staff. The activity also did not seek to compare the extent of empowerment resulting from different social franchising models nor did it seek to compare the experiences of women and men.



A social franchisee from PSI Uganda's Profam social franchise network.

Photo: Julius Caesar Amooti Kasujja

Context

Kenya

The government of Kenya recognizes 24 cadres of health professionals. While many cadres are dominated by men, the majority of Kenya's public sector health workforce is female (23,531 compared with 18,050 male) according to data from 2014 (MOH 2014). Nurses and midwives, who are often the main providers of family planning, are primarily female (15,428 compared with 4,943 male) (MOH 2014). Sex disaggregated data on cadres in the private sector are not available.

Recognizing the need to address human resources for health (HRH), the government of Kenya developed a strategy for 2014-2018 that outlined plans to address HRH issues throughout the country (MOH 2014). One of the guiding principles that went into the development of this strategy is gender responsiveness. The plan notes, "Gender responsive approaches will be adopted to ensure gender equity in the training, recruitment, deployment, development and management of the health workforce." Additionally, one of the strategic objectives in the plan regarding improving staff wellness and welfare is to develop a gender sensitive and responsive policy. However, the plan does not go into further detail.

The private health sector in Kenya is an important source of care. According to recent estimates, 39 percent of facilities (4,292) are privately owned and

operated, 48 percent are operated by the Ministry of Health (5,279), 9 percent (1,004) are operated by faith-based institutions, and 3 percent are operated by NGOs (328) (Kenya Master Health Facility List). Data are not available on the share of social franchises in the private sector. Doctors, nurses, midwives, and clinical officers are the only cadres allowed to own practices in the private sector (Mugambi 2018).

Social franchises in Kenya

Population Services Kenya

has operated the Tunza social franchise network in Kenya since 2008. Tunza is the largest network of private providers in Kenya (Chakraborty et al. 2016). Its primary objective is to support distribution of family planning through networked providers, with a focus on increasing access to long-term methods. The brand promises "friendly, quick, affordable and quality services." The network has a wide geographic presence with 413 facilities covering 40 of the 47 counties in Kenya (Waita 2018; Population Services Kenya 2018). The majority are owned by nurse midwives (76 percent), followed by clinical officers (23 percent), and doctors (1 percent) (Waita 2018). A franchise manager noted that nurses tend to venture into the private sector more than any other cadre and are often based in low-income communities where the need is the greatest. Although the numbers were not readily available during the first interview, the manager later reported



that 216 facilities (52 percent) in the network are owned by women (Waita 2018).

According to staff, PS Kenya recruits approximately 30 providers to join the Tunza network every year. PS Kenya initially recruited providers using TV advertisements. Now, providers express interest in joining the network because they have heard about it through other colleagues and recognize the brand. Using a selection tool, the PS Kenya evaluates potential candidates that are already licensed. Upon completion of the evaluation, the facility signs a memorandum of understanding (MOU) with PS Kenya to officially join the network.

Marie Stopes Kenya operates non-independent static facilities as well as a social franchise network. MSK has operated the Amua Social Franchise since 2004. There are currently 343 clinics in the network. The majority are owned by nurses. The facilities are primarily mid-sized and consist of about two to three rooms with approximately five staff (Mugambi 2018). Potential Amua franchisees must be willing to provide a range of health services including family planning, labor and delivery, malaria, tuberculosis, nutrition, and diarrhea management services (Center for Health Market Innovations 2019). They are identified by MSK primarily through referrals. Similar to PS Kenya, Amua providers are selected by a social franchise coordinator who evaluates the provider against a selection tool. Providers must not be within five kilometers of another Amua facility to avoid competition. After an evaluation that includes visits from a business advisor and quality assurance advisor, MSK and the provider sign an agreement and the provider pays a subscription fee of 5,000KSH. After a few months, MSK brands the facility (Mugambi 2018).



The National Health Insurance Fund (NHIF) is a government-sponsored insurance scheme that is

being implemented as one way to achieve universal health coverage in Kenya. Approximately, 50 percent of Tunza facilities are empaneled with the NHIF (PS Kenya 2018). Amua facilities are also increasingly contracted by the NHIF with support from the Africa Health Markets for Equity initiative. Becoming empaneled providers for the NHIF allows providers to have access to a stable client base.

Uganda

As with many countries, Uganda's health workforce is largely dominated by women; a 2017 HRH study conducted by the Ministry of Health reported that 54 percent of public health workers are female while 46 percent are male (MOH 2017). However, the female workers are not often in management positions. The ministry states this is because of the large numbers of nurses and midwives, who are mainly female (MOH 2017). Estimates from 2012 show that men occupy well over half of senior and middle management positions (Newman, Mugisha, and Matsiko 2012). The ministry has prioritized addressing sexual harassment in the health sector and is in the process of developing a sexual harassment prevention and response system with support from partners (MOH 2018).

Social Franchises in Uganda

Population Services International Uganda

operates two social franchising models: ProFam and Tunza. There are currently 158 facilities in the ProFam network that are mainly owned by midwives (40 percent). Program staff estimate approximately 37 percent of ProFam owners are female (Muttu 2018). Providers must attain a minimum score of 80 percent on the facility mapping tool to join the network. High-performing ProFam facilities can transition to the Tunza social enterprise model. Tunza facilities receive increased inputs from PSI in terms of technological and business support,



and providers contribute to these inputs through revenue sharing. Three facilities now operate as Tunza, and the goal is to increase this number to 22 by 2020.

Marie Stopes International Uganda

operates health care centers as well as a network of approximately 156 social franchise facilities under the BlueStar network. Most of the facilities are operated by clinical officers, and staff estimate that about a quarter of all facilities are owned by women. MSI Uganda recruits mid-level providers who are licensed to practice medicine and operate a clinic. The providers and their facilities must be located far enough from other MSI static clinics and BlueStar clinics and close to target populations. The providers must also be willing and able to offer a range of health services with a youth-friendly



and respectful approach. In addition to benefits commonly offered to franchisees, the network facilitates access to vouchers, which allow low-income clients to access services free of charge while providing franchisees with a source of reliable payment for their services.

Reproductive Health Uganda

is an affiliate organization of International Planned Parenthood Federation. In addition to operating static clinics, RHU has a small network of 18 social franchise facilities that are funded by the SheDecides project. RHU extends benefits such as commodities, skills and business trainings, and quality assurance to its franchisees. Facilities are not currently branded, but there are plans to offer this in the future.



The owner of Josma Health Services, part of the MSK's Amua social franchise network in Kenya, stands with team members.

Photo: Marie Stopes International



Reflections

Social franchising empowers women providers. Across the two countries and five franchises, women franchisees reported positive changes as a result of franchising that correspond to the four aspects of empowerment (Table 3). The most commonly cited effect of franchising was in the “power to” and “power within” categories—particularly the ability to offer an increased array of services demanded by their communities, and the self-confidence in knowing that they were able to perform these services well. For example, one woman franchisee noted that she never offered family planning before because she wasn’t trained in it, but she now proudly considers herself “a guru” for voluntary IUD insertion and removal. For one nurse, when her husband—a doctor in the clinic—passed away she felt that people weren’t sure she could meet their needs. She said that joining ProFam and participating in their training gave her significant confidence in her skills.

“I owe a lot to Marie Stopes. You can be passionate, but not know where to put it. They help to narrow you down and direct your energies.”

—Phyllis, MSI Amua



Photo (above): Intissar Sarker



“There is great change...
Before ProFam, I was nothing!”
—Mary, ProFam Uganda

Photo: Intissar Sarker

Table 3. Examples of each aspect of empowerment as reported by the health providers

Aspect of Empowerment	Reported Changes
Power Over <i>Influence in workplace and community</i>	<ul style="list-style-type: none"> • ‘What a provider looks like’ changed for the community • Former staff seek advice on their own businesses from women providers; members of the community seek business and health advice • Trained women providers model good provider behavior, train public sector providers, prioritize quality • Women facility owners report creating more family-friendly workplaces
Power To <i>Ability to make and implement decisions, perform tasks</i>	<ul style="list-style-type: none"> • Women increased their ability to provide quality services with training and supplies (such as IUD insertion and removal) • Women providers who had access to business training reported improvement in business skills, increasing income for themselves and to reinvest in their business • Interviewees reported increased autonomy to make household purchases, often investing household funds in school fees to improve educational options for their children, or rental property to build household income further
Power Within <i>Self-Confidence and Efficacy</i>	<ul style="list-style-type: none"> • Interviewed providers all reported increases in self-confidence • Women providers demonstrated self-confidence by offering new services, taking out loans, expanding their facilities, leaving government employment, overseeing work of senior-level medical staff (including doctors)
Power With <i>Ability to make changes with peers</i>	<ul style="list-style-type: none"> • Networked women providers report sharing skills and experiences with other providers in the network, and lending staff when needed, for example, on special clinic outreach days

Of the different aspects of empowerment, “power with” was the one that social franchising does not appear to contribute substantially to. While social franchising helps women providers to problem solve with peers, networking does not harness their collective power to create structural or systemic change.

All women interviewed were already empowered to some extent before they became franchisees, as they each had the ability to open and run a private practice. One franchisee in Kampala, Uganda, had moved from the garage she first operated out of to a new site, which she purchased and expanded with loans that she obtained herself before becoming a franchisee. Yet even those who demonstrated relatively high levels of empowerment pre-franchising also increased their empowerment post-franchising. A midwife in Kenya, for example, was a high performer who purchased a site and was operating her own clinic, but continued her work in the public sector at the same time. She reports that it wasn’t until she joined Tunza and participated in their trainings that she developed the confidence to fully invest herself in her own business. Another said, “I was always bright, but my confidence has increased.”

Key inputs of social franchising and their effects on empowerment

While SHOPS Plus did not seek to compare the precise impact of various benefits of social franchising, franchisees pointed to several benefits as being particularly important for their empowerment.

Technical skills training: In most interviews, women providers mentioned skills training as a key benefit of franchise participation. Not only did this training allow them to expand their services to reach new clients and better serve existing clients, it increased their confidence and expanded their influence within their community and with other providers. Many providers mentioned that they had no or limited access to in-service training before joining the franchise. Several interviewees mentioned IUD insertion and removal in particular as key skills that have benefited their practice. A ProFam provider—one of many interviewees who reported never having seen an IUD prior to participating in a franchise—said that she routinely performs IUD insertion within the context of informed choice and a wide range of contraceptive options.

“I used to only attend to mothers [for pregnancy and delivery]. Now I can give them family planning as well, and that brings in more clients.”

—Vicentia, MSI BlueStar Uganda



Photo: Intissar Sarker

Business training and support: While the extent of franchise-sponsored business training ranged from very basic instruction on supplies and income management to more in-depth support in accessing loans, orienting these women providers in business practices appears highly relevant to their success and to their understanding of themselves as business owners. Moreover, none of the providers interviewed had been able to access such training outside the franchise network. For many women, understanding themselves as business owners in addition to health providers was critical to unlocking their entrepreneurial creativity, as they better grasped their need to diversify and advertise their services. Particularly where franchisors facilitated access to credit or registration with health insurance schemes, women reported a high impact on their success and self-confidence.

Quality assurance: Many women attributed their greater attention to quality of care to their participation in the franchise, which in turn contributed to their success, influence among other providers, and self-confidence. Several said their attention to infection prevention in particular had improved greatly. One provider said she learned through MSK to provide the same high quality service in her town as a client would find in the capital. Another said that while sometimes her clients in a poor neighborhood in Kampala complain about the fees, they know that they get better quality of care than in a public clinic or hospital.



“I saw myself as just a nurse.
Now I see myself as a CEO.”
—Elizabeth, PS Kenya Tunza

Photo: Intissar Sarker

Participation in peer networks: While there are not strong examples of franchising bolstering women’s *power with* other franchisees to create change together, the women interviewed discussed how important networks were to their personal empowerment and success. Franchising reduces the isolation that providers would normally face in private practice, linking them with peers who may otherwise be seen as competitors. For many of the women interviewed, this networking provided important opportunities to hone their skills. As one provider said, “I might not be as good in a method as someone else. We show each other how to do things and visit each other to build up practical experience.” Franchising also can alleviate short-term staffing shortages, as franchisees loan out staff when another clinic needs additional support for mobilization events. “It’s a family,” one woman said of her franchise network.

Box 1. Gender-related barriers

Through a focus on women’s paths to becoming successful providers and business owners, the interviews revealed a great deal about gender-related barriers to overcome. One example is the perception—enforced by gender norms and expectations discouraging women from risk-taking—that women should avoid loans. One provider wanted to expand her clinic, but she said, “I don’t know where I can get the money.” When asked about getting a loan, she said she was worried about how she would pay. Other providers, particularly in Uganda, where interest rates are high, said similar things.

Women’s experiences as employees in the private or public sector also point to significant barriers. One woman worked in a private clinic whose owner sexually harassed many of his female employees. When he propositioned her, she refused him and decided it was time to find new employment. Many of the women mentioned the inability to get days off to take care of sick children and the lack of a clear pathway to advancement as key factors in leaving the public sector. Running their own businesses promised flexibility in taking care of children, and more than one woman started out operating her clinic out of her own home.

While most of the women interviewed reported that their husbands were supportive, some of them had to overcome initial opposition from their spouse. Faced with the financial burden of starting her own business, Phyllis in Kenya said her husband looked at the bills and said, “See, this isn’t working!” The husband has now warmed to the idea and even helps out fixing her clinic’s equipment. Shortly after getting married, the husband of one midwife in Uganda forbade her to work. She stayed home for eight years, asking herself, “why did I waste my time going to school?” Finally, she asked him if she could return to work and he allowed it.

Outcomes of franchising and empowerment

To varying degrees, all of the women interviewed had converted the inputs received from franchising into gains for their businesses and themselves. Women providers who were able to build their clinical and business skills invested that training into their businesses. All had added staff since joining the franchise, and all but one of the providers interviewed spoke of continued plans for physical and staff expansion of her business in the future. Physical expansion plans ranged from the modest—adding a room or two for examinations or recovery—to the very ambitious, with one provider in the process of purchasing a large two-story building with space enough to offer a full range of inpatient and outpatient services.

“When you are empowered,
you realize the potential you
have and you go for it.”
—Ann, PS Kenya Tunza



Photo: Intissar Sarker

Along with physical expansion, many of those interviewed had added and/or were actively seeking to add new services to their offerings. Several of the women had added dentistry, pediatrics, and outpatient surgery, and others had doctors on staff or on contract to perform emergency obstetric care. Some already had x-ray and other more expensive equipment, while others were saving up to make these purchases so they could add additional services demanded by their communities.

Box 2. Unlocking women's entrepreneurial potential

When Ann, a Tunza franchisee, heard from women in her community that they wanted the option of a more private and comfortable atmosphere for childbirth, she looked around her existing space—already filled with delivery, recovery, lab, and examination rooms—and imagined the future in a space with two stories. Months later, her vision was becoming reality—she had added one private suite with separate reception area and had started on two more. The suites feature separate bathing facilities and television.



The private birthing room Ann built.

Photo: Intissar Sarker

Franchised providers said their client flow had increased substantially as a result of their participation. In part, this was because of the greater range of family planning methods and other services they were now able to provide, as well as community confidence in the quality of their care. In some cases, access to insurance or voucher payments made a significant difference in driving up client flow. Free service days sponsored by the franchise also helped build brand awareness and establish trust among the community. These increases in client flow improved women's income, which then allowed them to invest back in their businesses.

As a result of improvements generated by franchising in their income levels and self-confidence, women said they had more influence in their households. Women used their increased income not only to invest in their businesses, but in themselves and their families as well. Most of the women pointed to payments for improved and advanced schooling for their children as the clearest examples of the benefits of this income. Some purchased vehicles for themselves, or land as a rental investment. Several women said that their higher income had given them more weight in making household spending decisions, with a couple of the women saying they could make spending decisions on items for themselves without consulting their husbands.

Franchised providers indicate that their success as business owners and providers has increased their status in their communities. In some cases, franchising is a very direct contributor to increased status and influence. One provider said that she is sought out as a trainer by other providers and the Ministry of Health, primarily because her franchise is known for having high-quality skills on the newest family planning methods. Several providers said they shared their knowledge and leadership in different ways with their communities, including providing business advice to former staff, discussing the importance of family planning in their churches, or volunteering to provide health care in marginalized communities. Nearly all the women said they act as mentors to younger staff or their children who've entered the medical field.

“I wasn’t really confident before—now I can talk to anyone.”

—Ann, MSI Amua



Photo: Intissar Sarker

Box 3: Social franchising’s boost to women’s self-confidence is key

Social franchising clearly can contribute to building women franchisees’ confidence in a transformative way. Training and support gives them the opportunity to learn and expand their skills, and allows them to compare themselves with peers. Private practice can be very isolating for those moving from a public sector hospital, so these learning spaces meant a lot to women interviewed. As Elizabeth in Kenya said, “When you’re alone, you never know how people outside are doing. You may think you’re doing really well, but you may then realize you’re not and you have to ‘pull up your socks.’” Now, Elizabeth considers herself “a professor in my own way” because she’s called on to train others, including by the Ministry of Health. “People ask if I can teach them because they know Tunza is the first to get skills, and they are known for quality.” This confidence boost has meant a tremendous amount in how she views herself and her business. “I didn’t have a dream before. Now I have a dream every day.”

External support contributes to empowerment

The conversations with women providers revealed that several factors external to franchising affected their process of empowerment. For example, most of the women had supportive husbands and families. In fact, several women included their husbands in their businesses in some capacity, in roles such as construction, equipment repair, administration, or board member. Only one woman interviewed expressed that her husband was not fully supportive of her work, but even in that case, he was reportedly glad of the additional household income. One woman had a very unsupportive husband who, before his death, kept her from practicing for many years and required his permission before she could return to her profession.

Access to credit and insurance are also critical to women's empowerment. Kenya's national health insurance program and its relatively low interest rates were both key factors for women providers' success before and after their entry into franchising. By contrast, Ugandan providers (with one exception) seemed much more reluctant to seek out loans. The lack of national health insurance in Uganda means that these providers rely solely on client payments and their savings for cash flow—except for MSI Uganda franchisees, who had access to voucher programs.

Box 4: External support contributes to empowerment

Ann, a nurse operating a BlueStar franchise in Kajiado, Kenya, knows well the importance of both a supportive husband and health financing. Before joining BlueStar, her business had fallen on tough times. Her business relied on cash payments from clients, but few in the community could afford to pay for services. When it became so bad that she wanted to close her doors, her husband took action. While she staffed the clinic, he went to the local office for the national health insurance program and registered her clinic to receive reimbursements. That made a tremendous difference, because as Ann reports, the surrounding flower farms have 5,000 people covered by the program. Ana has since joined the government's reimbursement program, Linda Mama, which enables her to offer maternity care free of charge to the client.

Recommendations

Women providers are critically important for the effective provision of family planning services globally, including in Kenya and Uganda. The women and program staff interviewed agreed that family planning clients often seek women providers because they don't feel as comfortable discussing reproductive issues with male providers. Several staff also mentioned that women tend to be more mission-driven to provide quality family planning, and aren't in business to solely make money. In fact, most of the women spoke passionately of their commitment to serving the community, to influencing others to see family planning as positive, and to helping women avoid negative personal and health care experiences they or their family members and friends had in the past. As a result, according to some program staff interviewed, they may tend to stay in social franchising commitments longer than male providers.²

As suggested by these interviews, the empowerment of women providers also contributes more broadly to gender equality. The women providers interviewed show a commitment to empowering

the women in their care through the provision of quality family planning and other services. They use their income to improve their children's education and provide for their households. They are eager to share their business and technical skills with others, including with the young women they mentor and employ, and they break stereotypes in their communities around what a typical business owner and skilled health provider looks like.

Lessons for social franchisors

Based on these interviews and the analysis using the Social Franchising Empowerment Framework, it is clear that social franchising can strengthen the empowerment effect it has among women providers, by taking a more intentional approach to gender integration. As noted earlier, social franchising has not been designed specifically to empower women. By adding gender-sensitive interventions or slightly modifying existing interventions (Table 4), social franchising may be able to significantly improve both health and women's empowerment outcomes.

² Length of participation in social franchising by gender was not analyzed by gender as part of this study.

Table 4. Gender-sensitive interventions to improve health and women’s empowerment outcomes

Aspect of Empowerment	Intervention or Modification
Power Over	<ul style="list-style-type: none"> Publicly highlight the work of women providers as both businesswomen and skilled health providers Consider requiring franchisees to implement anti-sexual harassment and family-friendly workplace policies and practices as a criteria for selection into the network
Power To	<ul style="list-style-type: none"> Continue skills training and use women trainers where possible Continue/expand business training, especially as it relates to accessing capital, and highlight successful women franchisees Consider a women-specific business training and coaching program that targets gender barriers, such as risk-aversion related to credit and external factors such as family and community Work with lending institutions or organizations to facilitate access to finance for franchise owners Recommend that women franchisees have a separate bank account for earnings to ensure they are able to separate personal expenses, monitor business income, and substantially grow the business (and engage with husbands in advance to mitigate any unintended consequences like intimate partner violence) Train women in computer literacy including computer-based recordkeeping
Power Within	<ul style="list-style-type: none"> Include peer-to-peer sharing of expertise in trainings and other events Facilitate opportunities for women franchisees to share their stories and experience outside of the network
Power With	<ul style="list-style-type: none"> Increase networking opportunities specific to women franchisees Provide opportunities for franchisees to work together to advocate on national or local policy issues that affect family planning and health service provision

To understand and learn from these interventions, social franchisors should also consider the following changes to their monitoring, learning, and evaluation practices:

- **Collect data on the sex of providers to track applicants, franchisees, participation in trainings, access to credit, and attrition.** Currently, these data are not readily available. Knowing not only how many men and women own franchises, but also how many men and women apply for and leave franchising will help franchise organizations better understand where their current practices might be creating gender-related disparities.
- **Collect and analyze data on franchisees’ perceived benefits of franchising and disaggregate by sex.** Some franchisors collect data on the perceived benefits of franchising, but none of the programs included here disaggregate the responses by sex. Such disaggregation can lead to a deeper analysis of how social franchise programs may be benefiting men and women differently.



A ProFram social franchisee discusses implants with a client.

Photo: Vanessa Vick

- **Develop and track indicators of empowerment.** Social franchisors could highlight and build on their existing and new work that empowers women providers by creating and tracking indicators of empowerment, potentially using the Social Franchising Empowerment Framework. Examples could include tracking the number of women franchisees who mentor younger women, the percentage who invest in expanding their businesses, the percentage who report increased self-confidence, or the number who engage in advocacy for policy advances on family planning or maternal health.

Lessons for the non-franchised private sector

The private sector outside of social franchising, through provider associations and other networks or interventions, can also apply important lessons from this analysis. With targeted investments, the systemic weaknesses, isolation, and gender-related barriers to success that women providers encounter outside of social franchising can be addressed.

- **Offer skills and business training.** Both skills and business training are important for the success of private clinics and the empowerment of the women who run them. Some women interviewed indicated that they had received skills training from midwives or other professional associations, but that these associations had weakened in recent years. No woman indicated that she was able to access business training outside of franchise networks. Business skills are particularly important for women providers because of social norms that equate business acumen with masculinity.

- **Address gender-related barriers to credit and technology.** Having the ability to expand physical space and improve efficiency is vital to private sector clinics, but women owners often face barriers to credit and technology that men do not. Women tend to express greater fear of taking out loans than their male counterparts. Similarly, women may have learned through societal norms that technology is easier for men, and as a result, the use of computers or mobile apps may seem too daunting. Women-specific trainings can address these gender barriers.
- **Create spaces for collaboration and joint action.** The women interviewed were proud to be on their own, but were also grateful for opportunities to collaborate with other franchise owners, particularly other women. Reducing the isolation of private practice by creating opportunities to act together—whether to advocate on a policy issue that affects their practice or to refer clients to each other when needed—may contribute to provider performance and satisfaction.



A franchisee from RHU stands in front of a list of services offered by her clinic.

Photo: Intissar Sarker

Conclusion

Capturing the life stories of women providers involved in social franchising illuminates how they empower themselves when they can access training, finance, insurance schemes, and supportive supervision. At the same time, these stories suggest that the private health sector has much to gain from more deliberately addressing the gender-related obstacles to empowerment and business success that women providers commonly face. The private sector has an important role to play in unleashing the potential of such a sizeable portion of the health workforce, benefiting both women providers and the communities they serve.



Photo: What Took You So Long

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