SHOPS PLUS

HANSHEP Health Enterprise Fund Research Study: Year 2 Findings

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About SHOPS Plus: Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is USAID's flagship initiative in private sector health. The project seeks to harness the full potential of the private sector and catalyze public-private engagement to improve health outcomes in family planning, HIV/AIDS, maternal and child health, and other health areas. SHOPS Plus supports the achievement of US government priorities, including ending preventable child and maternal deaths, an AIDS-free generation, and FP2020. The project improves the equity and quality of the total health system, accelerating progress toward universal health coverage.

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HANSHEP Health Enterprise Fund Research Study: Year 2 Findings

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Acronyms

ARA	Afya Research Africa
AOR	Agreement officer representative
B2B	Business to business
BoP	Base of the pyramid
DFID	Department for International Development
HANSHEP	Harnessing Non-State Actors for Better Health for the Poor
HHEF	HANSHEP Health Enterprise Fund
HMIS	Health management information system
LARC	Long-acting reversible contraceptive
IUD	Intrauterine device
SHOPS	Strengthening Health Outcomes through the Private Sector
USAID	United States Agency for International Development

Executive Summary

This report details the findings from Year Two of the Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) Health Enterprise Fund (HHEF) Research Study. This is a longitudinal study collecting data annually from a cohort of the original HHEF grantees—Jacaranda (a low-cost maternity center), Afya Research Africa (health kiosks located in urban slums), and Telemed (call center). The study examines how each component of the HHEF intervention influenced the grantees' efforts to increase access to family planning products and services and identifies other sources and types of support that have influenced the grantees' efforts, gaps that remain, and implications for interventions that seek to support the scaling of health enterprises. The study started in Year 2 of the Strengthening Health Outcomes through the Private Sector (SHOPS) Plus project and will continue through the end of project with check-ins annually.

In the first year of this study, the research team from the William Davidson Institute (WDI) at the University of Michigan identified a set of capacities that enterprises considered important in achieving increases in access to family planning. In the second year of the study, researchers traveled to Kenya and Ethiopia to conduct qualitative interviews with enterprise leaders. These discussions focused on better understanding how these enterprises integrate family planning into their business models and the contributions that family planning makes to the enterprises' strategy and performance. The research also sought to characterize the contribution that the HHEF made to participating enterprises' development relative to other types and sources of support and identify implications for the design of similar interventions in the future.

While all enterprises in the HHEF availed of the same support model, the research identified three distinct effects that the support had on the enterprises participating in the study—catalytic, broad, and focused. We relate these differing effects to the stage of development of the enterprise and the additional sources and types of support to which they had access. Future interventions can take account of this finding to more intentionally design support models that optimize for one or more of these effects.

The research also identified specific operational challenges with the integration of family planning into these business models and explored both the revenue and non-revenue benefits to the enterprises of providing access to these services. Provision of family planning, particularly LARCs, requires investments in physical facilities, staff training and certification, and proper handling of sensitive patient data. Service provision provides adequate revenue to cover the cost of service delivery, but also provides non-revenue benefits such as being eligible for inclusion in government programs such as the National Health Insurance Fund in Kenya, improves customer perceptions of the quality of the facility, and reduces the cost of customer acquisition by acting as a driver of attendance at health facilities.

These insights can help make the business case for greater private sector provision of family planning by identifying revenue and non-revenue value for the business and may provide guidance for more targeted support to these enterprises to help overcome the operational barriers they face in adding family planning to their business value proposition.

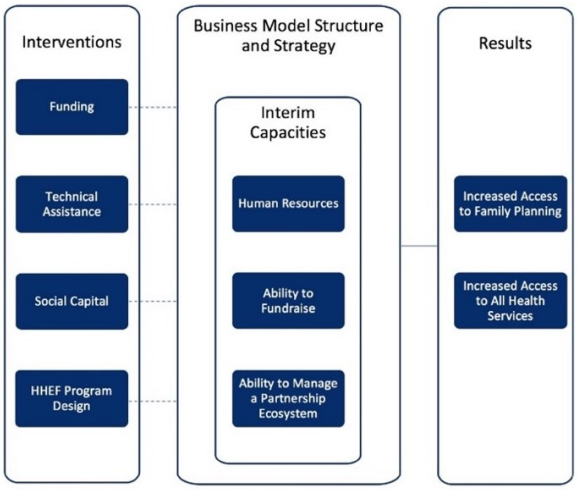
Introduction

The HANSHEP HHEF was implemented as part of the SHOPS project from January 2013–June 2015. The HHEF selected enterprises through a competitive, challenge fund style process, and provided them with grant funding, technical assistance, and facilitated connections to onward investors and other partners. The aim of these interventions was to increase the financial, knowledge, human, and social capital of the grantees, as a means of facilitating their transition to scale.

This study focuses specifically on how HHEF grantees have increased access to family planning products and services since the end of the project. With a better understanding of the enterprise capacities and strategies required to achieve this outcome and how they are developed, future interventions such as the HHEF will be better equipped to support enterprises in their efforts to achieve sustainability at scale and measure their progress towards this goal.

This study compiles qualitative and quantitative data from three enterprises, a subset of the original 16 grantee enterprises. Some data was submitted by the enterprises and captured in interviews during the HHEF, and some has been newly collected for this study. In the first year of this study, the research identified a set of capacities that participating enterprises considered important in achieving increases in access to family planning, and the elements of the HHEF that were important in developing these capacities as shown in Figure 1 below. Data will continue to be collected on an annual basis for the duration of the SHOPS Plus project to provide a longitudinal view of how these enterprises have increased access to family planning products and services based on the number of people served, the capacities that are important in achieving these results, and the evolving role of the support received as part of the HHEF in developing these capacities.

Figure 1. Conceptual model developed during first year of this study



With a better understanding of the ways in which the HHEF helped to support these enterprises, the second year of the study aimed to determine the relative influence the HHEF may have had vis-a-vis other support the enterprises received before, during, and after the program. As part of this analysis, we explore how family planning services have been integrated into these enterprises' overall business models and any specific barriers or challenges the enterprise has

faced in providing these services sustainably. We also we explore how the HHEF support model could have been enhanced, and what gaps remained. Together, this will provide insight into how the implementation of donor interventions to increase and sustain access to family planning, like the HHEF, can be improved.

Methodology

This study is based on data collected from three enterprises selected during Year 1—Jacaranda, a maternity clinic based in Kenya; Afya Research Africa, a network of kiosk clinics based in Kenya; and Telemed, a phone-based health counseling and information service based in Ethiopia. The enterprises are profiled in Annex A. Further information on the selection criteria is provided in the findings report from Year 1 (Fay, 2017).

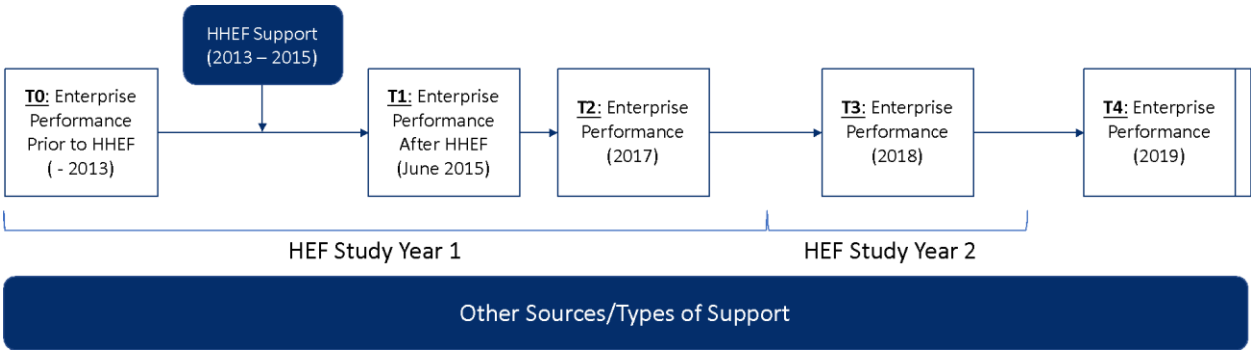
Data collection

Primary data collection—quantitative

This phase collected additional primary quantitative data in the form of service statistics on both the type and volume of products and services provided, covering the period from July 2017 (T2 in Figure 1) to June 2018 (T3 in Figure 1). These data were collected via a survey distributed to participating grantees for completion prior to qualitative interviews. Data for prior periods (T0–T2) was captured and reported on during the first year of this study.

This research study will continue to track these service statistics for future time periods, for the duration of the SHOPS Plus project.

Figure 2. Study timeline



Primary data collection—qualitative

Additional data was collected through in-person, semi-structured qualitative interviews with enterprise leaders and staff. The interview guide used by WDI researchers during these discussions leveraged the conceptual model from Year 1 of the study (Figure 1) and sought to identify the ways in which family planning is integrated into the enterprises' business models, the additional types and sources of support the enterprise received outside of the HHEF, and remaining gaps in the ecosystem of support available.

This research study will continue to conduct qualitative interviews with key informants from each of these enterprises, for the duration of the SHOPS Plus project.

Findings

Tracking increases in service statistics

All three participating enterprises provide a range of services that may include reproductive health, maternal and child health, HIV/AIDS, or services related to chronic conditions or general wellness. In 2013, the three enterprises provided services to a combined total of 3,227 clients. For the year ended June 2018, these enterprises were providing services to 59,401 people (see Figure 3), more than an 18-fold increase.

As detailed in Annex B (Figures 7–12), the drop off observed between 2017 and 2018 is driven by a substantial decrease in client interactions on the part of Telemed. This is due to a revision in the enterprise's strategy during 2018 to focus more on providing technology and patient communication management services to health facilities as an intermediary, rather than direct patient counseling, and to seek affinity partnerships with health insurance providers. The decision to stop directly marketing the Hello Doctor service to the public has resulted in an immediate reduction in calls (see Annex A for a more complete description of Telemed). In Figure 4 we factor out Telemed data and include just the service statistics from ARA and Jacaranda, which shows a continuous upward trend from 2013–2018.

Figure 3. Service statistics (all services across all three enterprises)

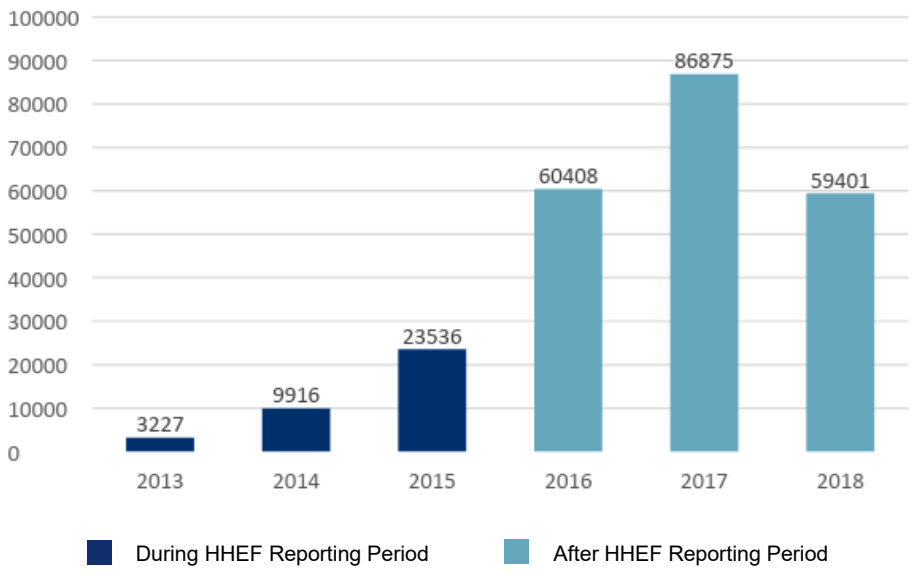
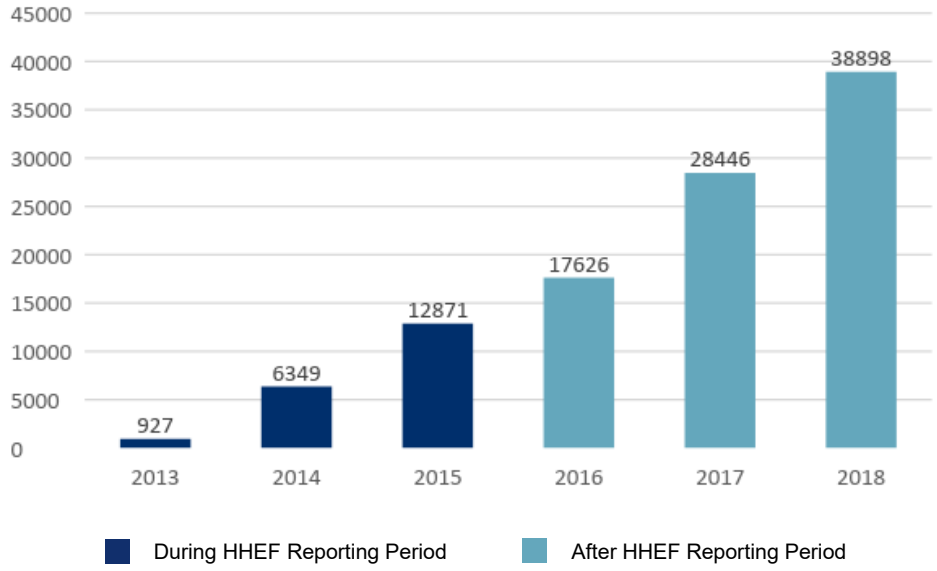


Figure 4. Service statistics (all services across ARA and Jacaranda)



Similarly, the number of people accessing family planning products and services also increased over the course of the HHEF, and this increase has continued in the years since. There were just 204 family planning clients in 2013, and now there are over 4,500—more than a 20-fold increase (see Figure 5). Despite the reduction in overall direct client engagement by Telemed, which also impacted the number of family planning clients it served, this decrease has been offset by increases in family planning clients served by Jacaranda and ARA. Figure 6 shows the number of family planning clients for just ARA and Jacaranda. Individual family planning service statistics for each of the three participating enterprises are included in Annex B.

Figure 5. Service statistics (family planning for all three enterprises)

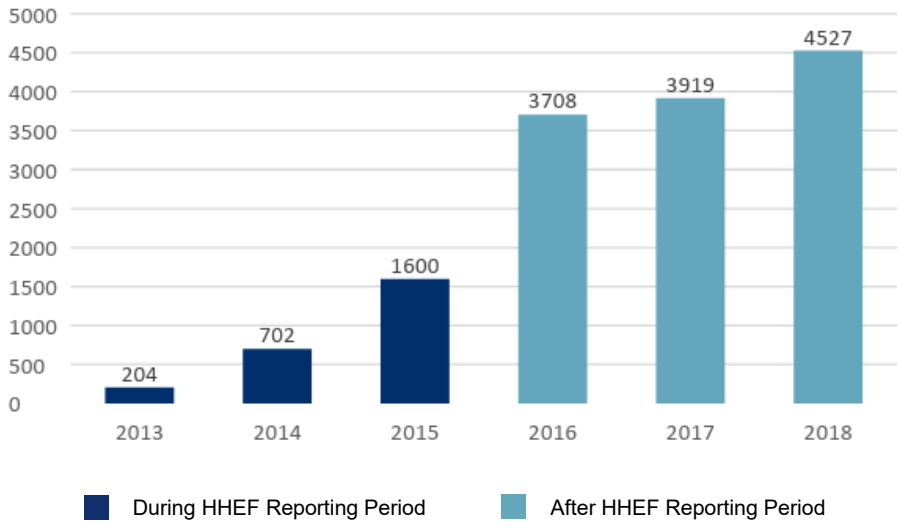
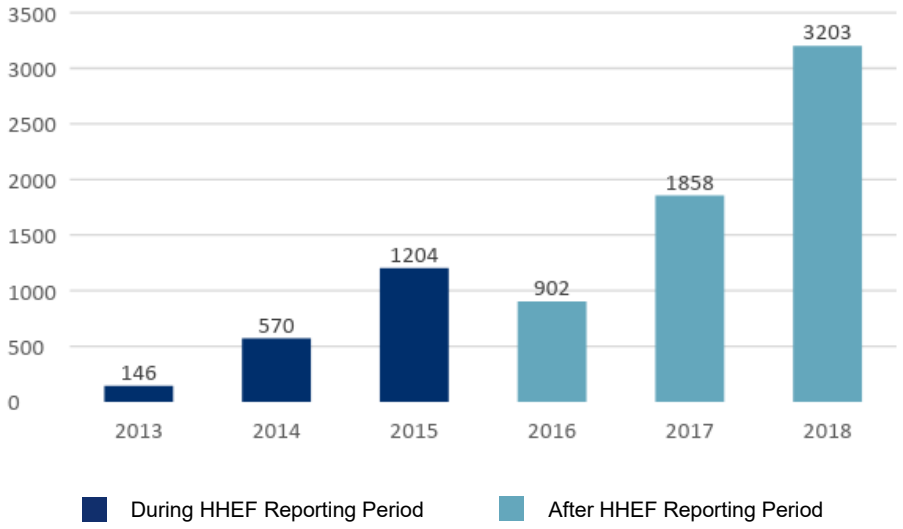


Figure 6. Service statistics (family planning for ARA and Jacaranda)



Note: ARA data was unavailable for the period July 2015–December 2015, resulting in underreporting of service statistics for 2016 in the graph above.

Qualitative findings

Integration of family planning into clinical business models

Two of the three enterprises studied provide clinical services and are based in Kenya, where family planning products and services are provided free of charge. These free commodities are accessed by all customer segments. Willingness to pay for these commodities is therefore difficult to determine. Without the administrative structures to limit which customer segments can avail of these free commodities, sustainable, scalable business models based solely on the provision of family planning services are unlikely to emerge.[1] If the private sector is to play a role in increasing access to these products and services, innovative approaches are required to integrate them into broader business models that can provide an appropriate platform.[2] All three enterprises included in this study integrate family planning into a broader suite of services. To better understand how to increase access to family planning it is important to understand how these products and services are integrated into the enterprises' operations, the strategies and resources that are required to deliver them, and the contributions they make to the overall economics of the business.

Operational implications

Provision of family planning products and services implies the facility has a minimum level of sophistication in a number of areas. This is particularly true for LARCs and permanent methods of contraception, however, neither ARA nor Jacaranda included permanent methods in their range of services.

[1] Cardno Emerging Markets (EA) Ltd. 2015. Diagnostic Assessment of Kenya's Family Planning Market. Palladium Group.
[2] Armand, F., O'Hanlon, B., McEuen, M., Kolyada, L. and Levin, L. 2007. Maximizing Private Sector Contribution to Family Planning in the Europe and Eurasia Region: Context Analysis and Review of Strategies. PSP One.

1. **Staff training:** specialized training and certifications are required for counseling and provision of LARCs by nurses.
2. **Facilities:** the facility must be able to provide sterile conditions, surgical facilities for the removal of implants, and the physical layout of the facility must enable patient privacy.
3. **Handling commodities:** facilities need to have the ability to source and store commodities. In cases where commodities are sourced from the government, additional processes may need to be put in place to provide the kinds of data and reporting that the government requires.
4. **Handling patient information:** There often are a number of social stigmas[3] associated with seeking family planning products and services. In addition to ensuring physical privacy for clients, information must also be protected via secure health management information systems (HMIS) and protocols regarding staff access to and handling of this information.

These operational implications represent barriers for enterprises to enter the family planning market, particularly with respect to LARCs. Better understanding these barriers may help to provide more effective support to private providers and incentivize greater inclusion of family planning in private sector business models.

Revenue

The Kenyan government provides family planning commodities free of charge through both public and private sector providers. As a result, there is low willingness to pay for contraceptives. Jacaranda and ARA are both service delivery organizations based in Kenya and generate service fees on the distribution of free government commodities. In most cases, this service fee just about covers the costs of providing the service. Therefore, neither enterprise is explicitly focused on growing family planning as a business line since the revenue generated doesn't contribute significantly to the sustainability of the business. When these enterprises do invest in growing family planning, it's focused on driving non-revenue benefits as described in the next section.

Telemed, however, generates the same per-minute charge per client interaction regardless of the health area, and family planning accounts for 20 to 30 percent of its revenues. As such, Telemed has developed a more strategic view around the growth of family planning business and is exploring new innovations in subscription payment models, automating elements of family planning counseling via interactive voice response, and bundling its services with the sale of pregnancy test kits.

Non-revenue benefits

In addition to the revenue generated by providing family planning products and services, both clinical service delivery enterprises also derive non-revenue benefits that provide an important contribution to their business.

[3] Mustafa, G., Azmat, S. K., Hameed, W., Ali, S., Ishaque, M., Hussain, W., Munroe, E. 2015. Family Planning Knowledge, Attitudes, and Practices among Married Men and Women in Rural Areas of Pakistan: Findings from a Qualitative Need Assessment Study. International Journal of Reproductive Medicine.

1. **Facilitates participation in government programs**

   To be empaneled for the National Health Insurance Fund, or to be registered on the master list of Kenyan health facilities, family planning is considered a minimum "qualification." In addition, the government operates a public-private partnership with some facilities, including some within ARA's Ubuntu network, to provide support for staffing, access to free commodities for immunization, HIV/AIDS, etc. Facilities taking part in these partnerships are expected to also act as channels for distribution of family planning commodities.

2. **Improves customer perception of the health facility**

   ARA has observed that customers consider the provision of family planning to be a sign of a quality health facility. If a facility does not offer family planning, customers consider the facility to either not be reputable nor of high quality. While clients may not avail of family planning directly, they consider it to be an indicator of the quality of a facility. Related to this is the idea that a facility is a 'one stop shop' for a customer's health needs, a factor that Jacaranda also acknowledged. While the customer may not avail of family planning services, there is value for them in knowing that the products and services are available if they do need them. This value comes about because there are costs associated to switching facilities or maintaining relationships with multiple facilities. All else being equal in terms of quality of care, price, etc., a customer will prefer to have all of their current and future needs met under one roof. Interestingly, in ARA's experience, this reluctance to maintain multiple relationships with facilities is more likely to occur with rural customers than with urban or peri customers. It may be that urban customers, who would typically have a greater number of alternatives to choose from, treat attendance at a clinic as being more transactional. These customers are more likely to attend the facility that provides the best service or experience in the area that they are seeking care and have less loyalty to the health facilities they attend.

3. **Reduces cost of customer acquisition**

   Participants reported that the provision of family planning products and services generates foot traffic into facilities, which may result in a client purchasing other products and services that have higher profitability for the business. This is particularly the case for short acting methods, where a client is required to return to the facility periodically. Additionally, this client interaction is an opportunity to build loyalty such that a client will choose that facility for his/her broader health needs. In both cases, the provision of family planning reduces the cost of customer acquisition for these enterprises.

   For example, Jacaranda provides standalone family planning services at its maternity clinic. While this doesn't generate significant revenue for the business, women that receive these services are more likely to then choose Jacaranda for maternity services when they do decide to have a baby. If the clinic were to stop offering family planning, it would likely have a significant negative effect on the enterprise. In 2017, 15% of Jacaranda's deliveries were with mothers who were past family planning clients.

Effect of HHEF support

Support provided by the HHEF was not provided in a vacuum. Each of the enterprises availed of support outside the HHEF, and, thus, the relative contribution of the HHEF support differed across enterprises. While the support model was the same for all enterprises at a high level, there were three distinct effects that the participating enterprises experienced that we

characterize as **catalytic**, **broad**, and **focused**. How the support provided by the HHEF affected each enterprise depended on the stage of the enterprise and the broader ecosystem of support to which it had access when applying to and during the HHEF.

Catalytic

For enterprises that experienced a catalytic effect, support provided by the HHEF unlocked resources in the future through awareness and reputation. Involvement with the HHEF put the enterprises on the radar of organizations with which it wouldn't otherwise have interacted. The legitimacy that the HHEF provided to these enterprises put them on a better footing with potential funders. The selection of these enterprises signaled to potential supporters that they had passed the due diligence process to get funding from DFID and USAID, which reduced the cost of the funder doing this due diligence themselves and increased the level of confidence in the enterprise. A catalytic effect may be most likely to occur with early-stage enterprises that have yet to secure any funding and lack the legitimacy that comes with it.

For example, ARA had received no funding when they applied for the HHEF. In fact, application to the HHEF was described as the first time that the organization had considered what it was doing as an enterprise. Selection by the HHEF constituted an implicit endorsement by USAID and DFID and led directly to further support from DFID through the County Innovation Challenge Fund. This funding facilitated the development of the Stone HMIS (formerly M-Afya) system, which ARA is currently aiming to spin off as a separate business to business (B2B) company serving health facilities. The clinic network, now branded as the Ubuntu network, was seeded by the HHEF and has grown from the initial nine clinics proposed in 2013 to 27 clinics in 2018. As a result of the HHEF technical assistance and mentorship support provided by the local business consultant, ARA became part of the Innovations in Healthcare network. This has led to further support from Open Capital Advisors, Excelsior, Pfizer, Grand Challenges Canada, and GE's Healthymagination program through the Miller Center for Social Entrepreneurship at Santa Clara University.

Broad

For enterprises that experienced a broad effect, support provided by the HHEF impacted multiple business areas and facilitated further investigation of the core value proposition of the business. This had a substantial effect on the enterprise, validating the value proposition and paving the way for future growth or informing a pivot or shift in the business model design, value proposition, or targeted customer segment. A broad effect may be most likely to occur with early-stage enterprises that have yet to fully develop their value proposition or where there are still some uncertainties about which customer segments to target.

For example, Telemed applied to the HHEF with a proposal to reinforce its call center, but also to establish an ambulance service that would bridge the gap between its phone-based counseling and the immediate need for ambulance services in emergency situations. Based on discussions with USAID and the selection committee, this proposal was revised to remove the focus on ambulance services and develop a platform for tracking HIV and TB patients that was integrated with the enterprise's call center. This revision to the proposal, and the subsequent support provided by the HHEF, had a significant impact on the enterprise's decision making and strategy in the following years. While not the only source of support the enterprise had, the HHEF support still had an important influence on Telemed's journey to develop its business. On reflection, the leadership of the enterprise acknowledged that this probably enabled Telemed to focus for longer than it otherwise would have been able to on efforts to make its call center

model sustainable. While more recently the enterprise has decided to pivot to operate as a B2B intermediary serving health facilities, it is able to do so because of the capabilities, particularly around technology and patient tracking, that were developed as a result of the HHEF investments and support.

Focused

For enterprises that experienced a focused effect, the support provided by the HHEF had a substantial effect on a single aspect of the enterprise. This helped to address a key question about the enterprise's business model that facilitated further growth. The support provided by the HHEF didn't directly lead to additional resources, but it was an important component of the business and contributor to overall performance and achievements. This focused effect may be most likely to occur with more developed or mature organizations where there are fewer uncertainties about the value proposition or customer segment.

For example, Jacaranda was supported by the HHEF to build an operating theatre based on the hypothesis that more women would be likely to deliver there if the facility could handle obstetric emergencies that might arise, thus strengthening the enterprise's core value proposition. This was proven to be the case and deliveries increased drastically from 20–30 per month in 2013 to over 100 per month in 2018. Outpatient attendances also increased as a result of the increased confidence and trust that Jacaranda was able to build with its clients. While other support was provided to Jacaranda in some areas such as health financing and National Hospital Insurance Fund empanelment, it was the support to build the operating theatre that was most significant according to interviewees at Jacaranda. Established earlier than ARA or Telemed, Jacaranda had a more robust ecosystem of partners that were providing support (predominantly focused on specific technical areas) both before and during the HHEF implementation.

The same support model was provided to all 16 enterprises. However, the enterprises' development stage and the other sources and types of support they received resulted in three distinct effects. Future interventions can take account of this finding to more intentionally design support models that optimize for one or more of these outcomes. Grouping enterprises into cohorts based on the three categories of catalytic, broad, and focused will allow for more efficient allocation of resources according to each group's distinct needs, along with placement of enterprises in groups that are substantially similar to each other and facilitate greater peer learning.

Remaining gaps in the ecosystem of support for health enterprises

Prior evaluations[4] conducted during and immediately after the HHEF concluded have examined how the design and delivery of individual interventions could have been improved. Because three years have passed since the HHEF ended, the enterprises have had time to reflect on what was delivered and how similar interventions could be improved moving forward. Below is a summary of findings to improve future interventions.

Creating market linkages

The HHEF focused on supporting individual ventures and innovations; however, support is also needed in developing market linkages, understanding customer segments, and gathering market intelligence. This is particularly important where enterprises are providing a product or service to the public sector and some advocacy may be required by the program, donor, or

[4] MacKay, B. 2015. HANSHEP Health Enterprise Fund (HHEF): Report of a Review for Abt Associates.

other organizations to develop the market opportunity. The market development lens also ensures that greater attention is paid to whether an addressable market exists for the proposed product during the selection process, and if not, suitable support is provided to the enterprise to develop that addressable market. Considering market linkages is one aspect of designing a health enterprise and innovation intervention that has a better understanding of and is more specifically tailored to the ecosystem that enterprises are operating within. This finding is consistent with the approach taken as part of the redesigned health enterprise and innovation activities under SHOPS Plus.

Greater public sector engagement

The public sector is a significant player in the provision of healthcare, from being a large and significant buyer of products and services to the regulations and policies that delimit the opportunity space for commercially viable business models. While some efforts were made to connect enterprises with relevant public sector entities, greater planning and structure may be required to deliver results from these engagements and develop the right partnership platforms (public-private partnerships, etc.). For example, ARA has a partnership with county governments in Kenya to ensure access to family planning commodities, and to receive support for staff salaries. However, this relationship is governed by a memorandum of understanding rather than by any legally binding mechanism, and is therefore less predictable for the enterprise and potential investors.

Implications and Next Steps

Implications of the findings

The findings from Year 2 of this study provide some important implications for the design of support interventions such as the HHEF.

Tailoring support to enterprises

While the sample size is small, the varying effects of the HHEF support suggest that future efforts to support health enterprises should take account of the stage of development of the enterprise, and whether the desired effect of the support provided is catalytic, broad, or focused. Based on the experience and outcomes for these three enterprises, the HHEF was most effective in providing catalytic support to ARA. ARA has succeeded in attracting significant resources and growing its business substantially because of the start that it received from the HHEF. The HHEF was successful in providing focused support to some aspects of Jacaranda's business, particularly the development of the operating theatre and the resulting growth of client numbers. However, other aspects of the support provided, such as the pre-programmed technical assistance curriculum, were less relevant to Jacaranda given their stage of development. Of the three types, the HHEF had more mixed results in providing broad support to enterprises. While the support Telemed received was helpful in developing the venture and attracting further resources, more attention was necessary to ensure the presence of a robust market opportunity for the enterprise, particularly with public sector clients.

Future programs to support health enterprises may benefit from selecting and segmenting enterprises along these lines by looking at the stage of development of the enterprise, other sources of support to which they have access, and the support they request. Building cohorts of enterprises that seek similar effects from the support being provided will allow interventions to

be designed to more optimally produce these effects, enable greater peer learning within cohorts, and thus make more efficient use of intervention resources.

Support Model Optimized for Catalytic Effects on Participating Enterprises:

- Applies to enterprises in early stages of development, including those that are pre-revenue
- Access to a standard suite of technical assistance that provides grounding in business fundamentals
- Focus on increasing visibility of enterprises, connecting with other sources of support and networks

Support Model Optimized for Broad Effects on Participating Enterprises:

- Applies to enterprises that have yet to validate their business model, where there are some uncertainties about the value proposition or customer segment
- Access to on-demand technical assistance, coaching, and mentorship to develop internal capacities
- Focus on helping enterprises to design and implement an experimental approach to test and refine their value proposition, build partnerships, and identify market opportunities that determine the robustness of their model

Support Model Optimized for Focused Effects on Participating Enterprises:

- Applies to enterprises that have validated their business model, but need support to achieve operational break even
- Access to specific technical assistance or connections to specific partners that solve a specific challenge or problem identified by the enterprise
- Focus on implementing and monitoring the performance of a specific intervention and understanding the impact on enterprise and health outcomes

While it may be possible to provide all three categories of support within a single program, a clearer recognition of and distinction between the categories may allow for more optimal selection of enterprises and design of support packages tailored for each cohort and, as such, constitute a more effective use of funding that achieves better outcomes in each category.

Business model design for integration of family planning

None of the three enterprises participating in this study operates a business model focused exclusively on family planning, nor were the proposals these enterprises submitted specific to family planning. However, as demonstrated by the service statistics collected as part of this study, the investments made as part of the HHEF have resulted in the development of integrated platforms that do have very tangible results in terms of increasing access to family planning.

In the case of ARA, investments made by the HHEF in improved HMIS systems have resulted in ARA developing the ability to provide high quality data to public institutions on the use of family planning products and services. Within the Ubuntu network, ARA is able to track family planning users across facilities to understand whether they are new users of family planning, or just new

to that facility—a capability that does not yet exist in national data of family planning use. This is particularly important for family planning because clients often move between facilities regularly because of the stigma associated with accessing these services.

ARA is also able to track patient information more holistically through these systems, thus improving the counseling and provision of family planning. For example, a holistic view of the patient allows consideration of how non-communicable diseases such as epilepsy or diabetes might influence family planning method choice, dosage, etc.

Understanding the rationale for why enterprises include family planning in these business models, and the effect it has on overall unit economics, also helps to make the business case for offering these services. Despite the limited revenue potential, family planning provides business value whether it is conforming to regulatory requirements, increasing customer perceptions of quality, or as a means to reduce the cost of customer acquisition. It is important also to understand the operational implications of providing family planning products and services, including how these might vary across method types, and the associated impact on provider strategy and behavior.

These insights can help motivate greater inclusion of family planning in private sector business models and make a stronger case for a strategic role for private health enterprises in the distribution of subsidized family planning commodities. The operational barriers and costs that private providers face in offering family planning may be addressed through more discrete interventions such as providing improved access to credit for investment in staff training, facilities, and data systems based on future revenue and non-revenue benefits that would accrue to the enterprise. These findings may also inform future efforts to promote increased private sector provision of family planning products and services. Rather than seeking to incentivize private health enterprises to scale up family planning as a single business line, more success may be achieved by increasing the number of health enterprises that integrate family planning products and services into their larger service platform, even if this is a small portion of their business. This may happen through broad support of integrated business models and innovations that provide new platforms that facilitate the provision of family planning products and services.

Year 3 research scope

In Year 3, the study will focus on barriers or challenges these enterprises face in scaling access to family planning and how USAID missions and their partners might address them. The outputs of this work will be a primer for USAID missions on the pathways by which scalable, sustainable health enterprises can contribute to increasing access to family planning, the business case for investing family planning funding in such enterprises, and approaches and models for how missions and their partners can best support these enterprises in reaching scale.

Annex A. Selected Enterprises

The participating enterprises selected during Year 1 of the study were:

Table 1. Selected enterprises

	Vision	Innovation Type	Health Focus	Target Population	Country
Afya Research Africa[5]	Improve access to quality healthcare and create wealth for low-income communities	Accessible and affordable health kiosks co-owned by the community	Family planning and reproductive health, maternal and child health, non-communicable diseases	Low-income populations in hard-to-reach areas	Kenya
Jacaranda[6]	Create a sustainable model that transforms maternal and newborn health outcomes in East Africa	Sustainable model that transforms maternal and newborn health outcomes in East Africa	Low-cost, high quality emergency obstetric care and caesarian sections	Mothers and children	Kenya
Telemed[7]	3 million users provided with timely medical advice and information	m-Enabled healthcare delivery that decreases barriers and improves quality of care	Maternal and child health, family planning and reproductive health, HIV and AIDS, tuberculosis	Rural residents	Ethiopia

Afya Research Africa

Rural populations in Kenya lack convenient access to health facilities, and the cost of seeking care is a substantial barrier for these communities. ARA applied to the HHEF[8] with the aim to launch a network of 12 kiosk clinics ('M-Afya' clinics, since rebranded to Ubuntu Afya) in rural areas in three counties in Kenya.[9] Ubuntu Afya[10] is a social enterprise which aims to provide

[5] Abt Associates. 2015. Afya Research Africa: Accessible and Affordable Health Kiosks
[6] Abt Associates. 2015. Jacaranda Health: Available and Affordable Emergency Obstetric Care
[7] Abt Associates. 2015. Telemed Medical Services: m-Enabled Health Care Delivery
[8] The M-Afya Kiosk Project: Devolving Basic Reproductive Health and Maternal and Child Health Services through Community Health Kiosks. Application to the HANSHEP Health Enterprise Fund in Response to RFA No. HEF-EK1-2013. May 3rd, 2013.
[9] By the end of the HHEF 9 clinics had been established. By July 2017, a total of 12 clinics were operational.
[10] http://www.afyaresearch.org/index.php?page=Projects&sph=121

affordable care to communities that are outside the catchment area of existing health facilities, and offer a range of health services including family planning, reproductive health, and maternal and child health services, including antenatal and well-baby assessments.[11] The clinics also provide care for non-communicable diseases, and sell medicines and other health products.

Ubuntu Afya clinics are a collaboration with the local community, and the community itself invests both labor and capital to help develop the physical infrastructure. ARA invests capital for additional startup costs for the necessary equipment and supplies, and ARA's own proprietary technology infrastructure for HMIS and Telemedicine. The clinic is staffed by a full-time clinician, and some clinics also have a trained community health worker or nurse. To offer these priority health services sustainably, each clinic also engages in additional revenue generation activities chosen by the community, such as provision of transportation or financial services. The clinics aim for full cost recovery, with excess revenue being redistributed to the community as a dividend. Sixty percent of Ubuntu clinics break even within the first 12 months.

Jacaranda Healthcare

Despite the Kenyan government's commitment to provide delivery services free of charge to every expectant mother in public sector facilities, Kenya's maternal mortality remains high at 488 deaths per 100,000 live births. In the private sector, the cost of delivery, especially in cases requiring emergency c-sections, can be very high.[12]

Jacaranda addresses this need through a network of low-cost, full-service maternity clinics that can provide for the full continuum of care, including care for obstetric emergencies, and provision of family planning services, including postpartum family planning. Sixty-two percent of Jacaranda's family planning clients choose LARCs.[13] Jacaranda aims to provide higher quality at lower cost through process innovations, more efficient use of resources including human capital, and through a variety of behavior change and consumer financing innovations that increase the number of touchpoints with their clients and increasing uptake of services such as family planning and antenatal care.

Telemed ("Hello Doctor")

Ethiopia's health workforce is significantly constrained, with just three doctors, nurses and midwives per 10,000 people.[14] Health infrastructure is similarly constrained, which makes it expensive to access healthcare, particularly for the 80 percent of the population who live in rural areas. This also results in limited awareness of the availability of health services.

Telemed implements the "Hello Doctor" health care platform, which makes information and medical advice from health professionals available to users over the phone, 24 hours per day, 7 days per week. The service also provides information on the location of the closest provider of health products and services, and has referral links to ambulance and home visit services. Users pay a per-minute fee through credit loaded on their phone.

[11] https://www.shopsplusproject.org/sites/default/files/resources/Afya%20Research%20Africa%20-%20Accessible%20and%20Affordable%20Health%20Kiosks_0.pdf
[12] https://www.shopsplusproject.org/sites/default/files/resources/Jacaranda%20Health%20-%20Available%20and%20Affordable%20Emergency%20Obstetric%20Care.pdf
[13] Jacaranda Health. 2017. Impact Report.
[14] https://www.shopsplusproject.org/sites/default/files/resources/Telemed%20Medical%20Services%20-%20m-Enabled%20Health%20Care%20Delivery_0.pdf

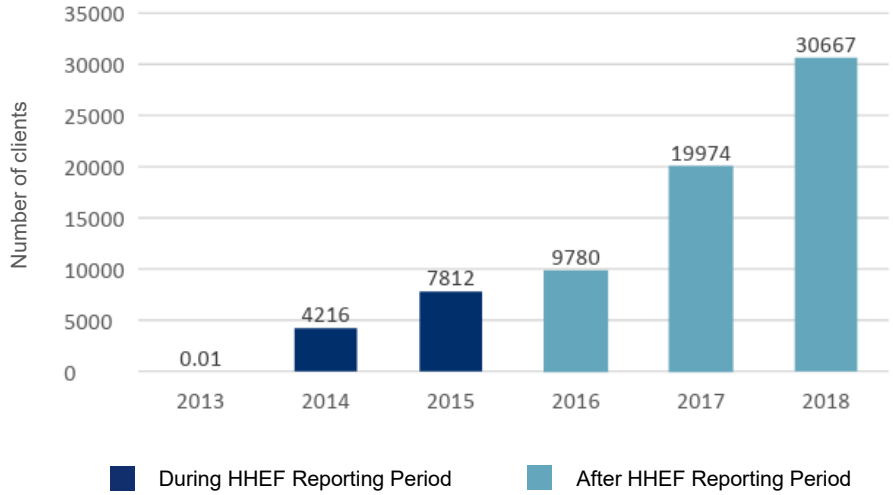
In addition to providing a low-cost option for accessing health expertise, the Hello Doctor platform also enables privacy, of concern for health areas that may have associated stigmas such as HIV/AIDS, or populations that experience discrimination such as young people. Indeed, a large portion of Hello Doctor's users are adolescents and young adults, who appreciate the privacy provided by the service.

As of 2018 Telemed has shifted its focus away from direct marketing of the Hello Doctor service to the public, and is seeking business to business (B2B) partnerships. These partnerships include bundling Hello Doctor with health insurance products and pregnancy test kits. Telemed is also seeking to provide its patient tracking and management platform as an intermediary service to health facilities.

Annex B. Enterprise Results

Afya Research Africa service statistics

Figure 7. Afya Research Africa service statistics (all services)



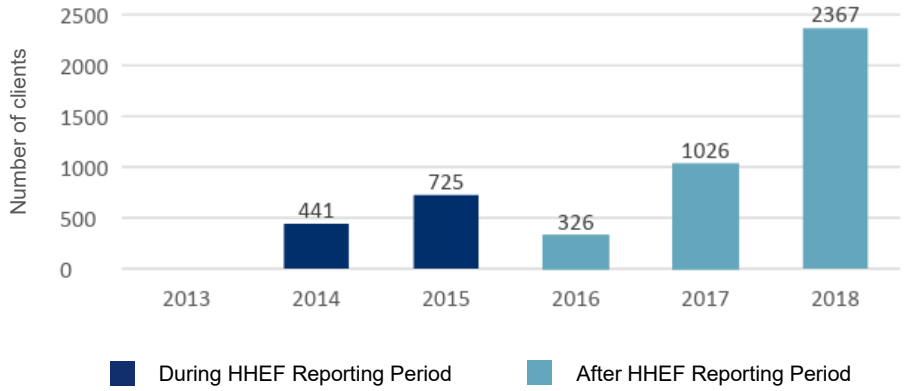
Note: Data was unavailable for the period July 2015–December 2015 resulting in underreporting of service statistics for 2016 in the graph above.

Family planning services

Ubuntu clinics provide family planning counseling and provide condoms, oral contraceptives, injectables, IUDs, and implants to clients on site.

Ubuntu clinics have also developed protocols to provide family planning products and services to groups that require more tailored care, such as those with epilepsy or hypertension, to ease access for these often-underserved groups.

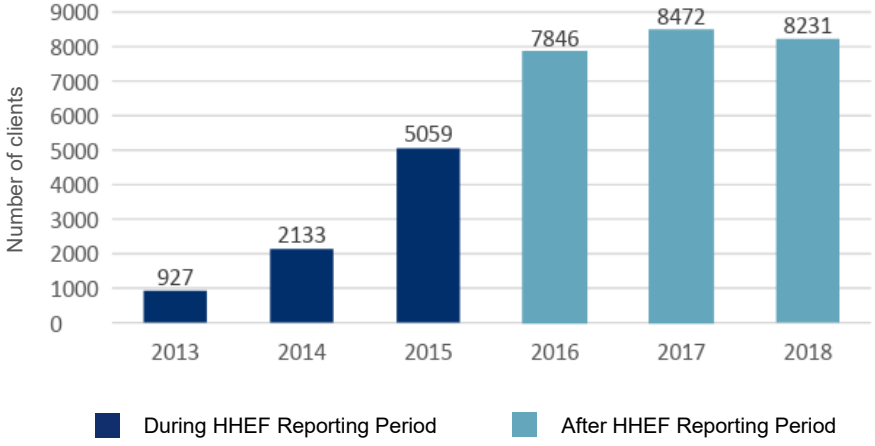
Figure 8. Afya Research Africa service statistics (family planning)



Note: Data was unavailable for the period July 2015 – December 2015 resulting in underreporting of service statistics for 2016 in the graph above.

Jacaranda service statistics

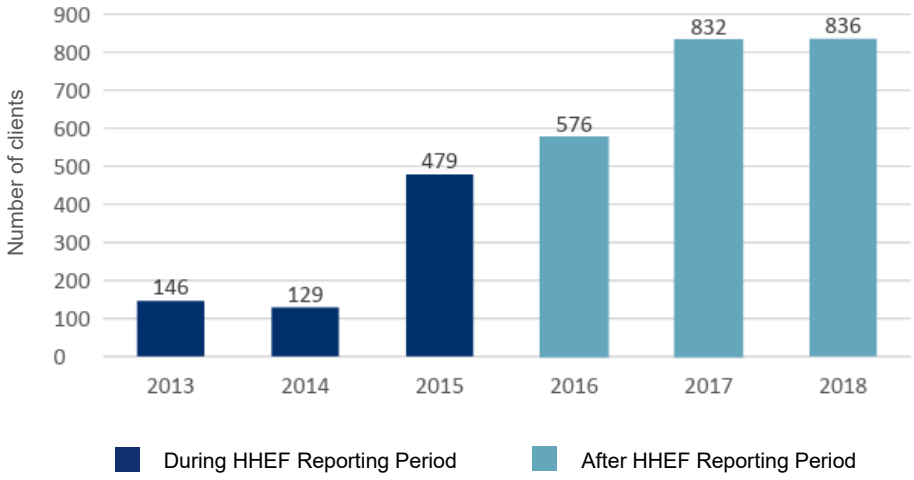
Figure 9. Jacaranda service statistics (all services)



Family planning services

Jacaranda provides a full range of short- and long-term contraceptive methods, with a specialty in postpartum family planning, which has a strong emphasis on long-term methods. Jacaranda facilities also provide standalone family planning services; however, this is low volume compared to postpartum family planning services.

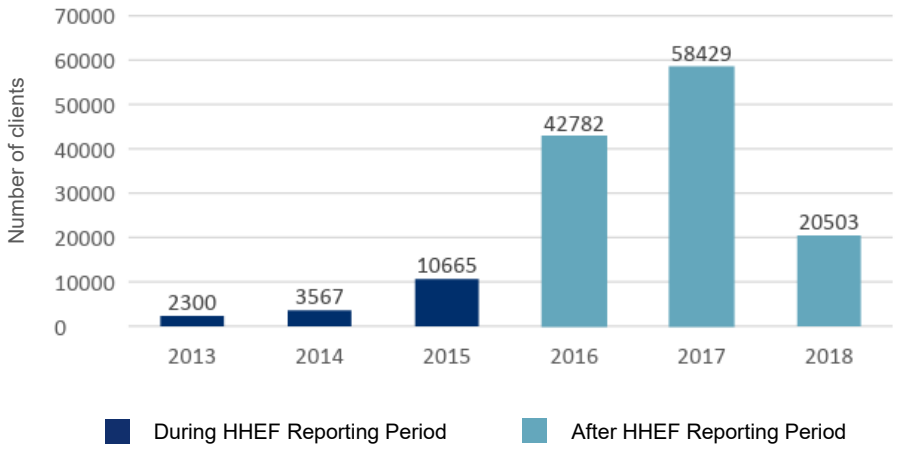
Figure 10. Jacaranda service statistics (family planning)



Note: Data collection during the most recent period identified an error in family planning statistics reported during Year 1 of this study. Jacaranda provided family planning services to 832 clients in the year ending June 30, 2017, not 424 clients as was included in the Year 1 report.

Telemed Service Statistics

Figure 11. Telemed service statistics (all services)

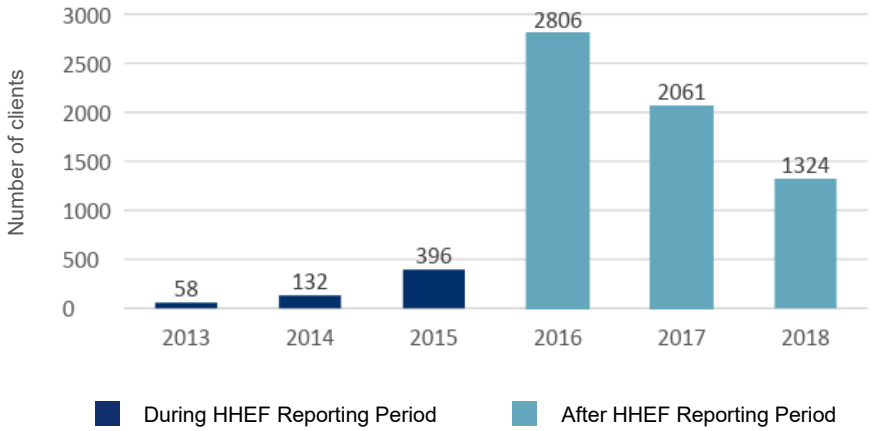


Note: As described above, Telemed's strategy changed in the period ending June 30, 2018 to eliminate direct marketing of the Hello Doctor service to the public in order to focus on B2B services and affinity partnerships.

Family planning services

Telemed provides family planning counseling to clients, answering questions about family planning methods, and recommending the most suitable methods for individual users. The service can also provide users with information on where to access contraceptive products and services. They have users that ask directly about family planning, and provide information and education in the context of discussions about reproductive health, STDs, emergency contraception and pregnancy testing.

Figure 12. Telemed service statistics (family planning)



Note: Family planning numbers for 2018 are estimates based on detailed analysis of one month of calls to determine the health area focus.