



TECHNICAL BRIEF **APRIL 2015**

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**LEVERAGING THE POWER OF MARKETS FOR  
FAMILY PLANNING SERVICES: A LOOK AT PSI/  
MALAWI'S APPROACH TO SOCIAL FRANCHISING**

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## **MALAWI**

**POPULATION:** 15.9 million<sup>1</sup>

**POPULATION LIVING IN POVERTY:** 72%<sup>2</sup>

**POPULATION IN RURAL AREAS:** 84%<sup>3</sup>

**HUMAN DEVELOPMENT INDEX RANKING:** 170 of 180 countries<sup>4</sup>

**POPULATION UNDER THE AGE OF 15:** 46%<sup>5</sup>

**MATERNAL MORTALITY:** 460/100,000<sup>6</sup>

**UNDER-FIVE CHILD MORTALITY:** 83/1,000<sup>7</sup>

**MODERN CONTRACEPTIVE PREVALENCE RATE:** 42% among married WRA<sup>8</sup>

**TOTAL FERTILITY RATE:** 5.7 births<sup>9</sup>

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## THE CONTEXT

Despite a heavy burden of disease (e.g., malaria, HIV/AIDS and tuberculosis), high rates of poverty, chronic shortage and unequal distribution of health workers and vulnerability to climate conditions and changes, Malawi has made significant gains in critical health indicators in recent years. For example, maternal mortality declined from 807/100,000 live births in 2006<sup>10</sup> to 460/100,000 in 2012,<sup>11</sup> and under-five child mortality has fallen from 133/1,000 live births to 83/1,000 in 2012.<sup>12</sup> In addition, Malawi is on track to achieve five of its eight Millennium Development Goals, including those related to sexual and reproductive health.

Evidence shows that increasing contraceptive use and reducing unmet need leads to reductions in maternal and under-five child mortality.<sup>13</sup> In Malawi, recent achievements in expanding access to and use of voluntary modern contraception have resulted in a modern contraceptive prevalence rate of 42% among married women (2010), up from 28% in 2004. This is a remarkable increase, making Malawi one of the greatest family planning success stories of the last decade.

Among other factors, high-level political commitment, improved family planning policies and expanded product and service delivery approaches have contributed to these achievements. In 2006, the Malawi government embraced family planning as essential to attaining its health Millennium Development Goals.<sup>14</sup> More recently, as part of the global movement Family Planning 2020,<sup>15</sup> the Government of Malawi committed to raising the national modern contraceptive prevalence rate to 60% by 2020, with a major focus on youth.

From 2004 to 2010, Malawi's population increased from 12.5 million to 15 million. Despite recent declines in the total fertility rate, the country's population is projected to more than triple by 2040.<sup>16</sup> Growing population and demands for modern methods of contraception will require continued efforts to sustain the contraceptive achievements to date.

## DELIVERY OF FAMILY PLANNING PRODUCTS AND SERVICES

Contraceptive products and services are free in the public sector, which delivers 60% of the country's health services. Subsidized contraceptive products and services are available for a fee in the private non-profit sector, the second largest provider of health services in Malawi. This sector includes the Christian Health Association of Malawi which provides services to four million Malawians annually,<sup>17</sup> and Marie Stopes International's Banja La Mtsololo network.

Contraceptive products and services are also available in Malawi's commercial health sector. PSI/Malawi also works with a network of clinics in the commercial sector. Made up of private for-profit facilities, the commercial sector is relatively new and small, providing less than 3% of health services. However, many stakeholders believe that the commercial health sector is growing and will continue to do so. For example, PSI/Malawi reports that between 2008 and 2014, the number of for-profit drug shops more than doubled nationwide. As of 2014, the commercial sector includes an estimated 154 private, for-profit pharmacies and drug shops and 278 clinics nationwide.

Over the last decade, Malawi's policies on the distribution of contraceptive products and services have gradually moved toward broader access. For example, in 2008, PSI spearheaded advocacy efforts to persuade Malawi's Pharmacy, Medicines and Poisons Board to deregulate oral contraceptives. As a result, oral contraceptives are now considered "over-the-counter" products, which can be sold at drug shops and distributed by community health workers. Not long after this policy change, access to injectable contraception was also expanded when Health Surveillance Assistants (the lowest-level cadre in Malawi's public health system) were authorized to administer injectables at the community level. Health statistics in Malawi show an increase in both injectable and oral contraception. "Ever use" of injectables among married women, for example, increased from 41%<sup>18</sup> in 2004 to 61%<sup>19</sup> in 2010.

However, women who seek contraceptive services in the public sector still face challenges like long wait times and frequent product stock outs. In addition, across the country, there is limited access to long acting reversible contraception (LARCs), specifically, implants and intrauterine devices (IUDs), as well as to permanent methods. In 2010, only 1.3% of women of reproductive age in Malawi used an IUD or implant,<sup>20</sup> while 7.5% used female sterilization and less than 1% used male sterilization (these low figures are due in part to low demand as well as the result of limited supply).

## A GROWING PRIVATE SECTOR

The private sector as a whole has an important role to play in the delivery of health products and services. In a healthy market, free and subsidized products are targeted to those needing them the most, creating room for expanded private sector involvement in healthcare delivery. Markets that are overly reliant on free or heavily subsidized health services are less efficient and sustainable.

A small and growing private sector in Malawi presents

opportunities to maximize resources and create greater sustainability in delivering contraceptive products and services. However, a recent assessment of the private health sector in Malawi found a number of challenges and constraints. Private providers in Malawi are isolated and the sector is highly fragmented. Private providers have limited opportunities for networking and sharing information and few provider networks exist. In addition, there is limited supervision of private providers and services, and providers have little to no access to financing to assist in expanding or improving quality of services.

In 2011, PSI/Malawi developed a new reproductive health strategic plan. Analysis of the total market and growth of the private sector led PSI/Malawi to identify private sector social franchising as a way to add significant value to the overall health system. Based on a reproductive health landscape assessment, the plan also called for a renewed focus on youth as well as LARCs. Leveraging its existing relationships with private sector clinics already purchasing its social marketing products, PSI/Malawi concluded it could build a social franchise to improve access to LARCs and increase the availability of youth-friendly family planning services.

**SOCIAL FRANCHISING** creates a highly visible, branded network of existing, local health care providers. As a member of the network, each provider is contractually obligated to deliver specific health services in accordance with franchise standards. In exchange, the provider receives access to training, hands-on coaching and supervision, subsidized products and equipment, demand creation activities in support of his or her clinic and opportunities to engage with other network providers. As a result, social franchising improves individual providers' quality, productivity and supply line, while creating greater access to and demand for affordable products and services.

## PSI IN MALAWI

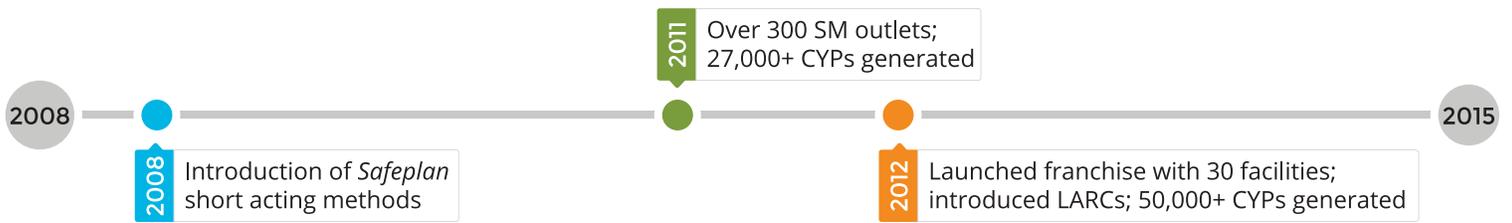
PSI/Malawi was founded in 1994 as a non-profit specializing in social marketing and behavior change communications for health. Today, the organization provides programming in family planning, HIV and AIDS, malaria, and water-borne disease prevention. The family planning product line consists of a robust range of short-acting and LARC methods.

In private sector clinics, pharmacies and drug shops, and through a network of community-based distribution agents, PSI/Malawi promotes and distributes male condoms branded Chisango, female condoms branded Care and oral contraceptives branded under PSI/Malawi's family planning umbrella brand, SafePlan. PSI/Malawi also distributes Safeplan injectables, emergency contraception, IUDs and implants to private sector sites with personnel who are authorized to sell and/or administer these methods. Each site sells the PSI products and services at a subsidized price affordable to the consumer, yet yields a slight

margin for those involved in the trade (i.e., the provider and the wholesaler, when appropriate). PSI/Malawi providers do not offer permanent method services but do provide interested clients with a referral to access the service in a non-governmental organization or public sector facility.

While much of PSI/Malawi's 18-year history has focused on product social marketing, in 2012 the organization launched the *Tunza* network of private sector social franchise clinics. This marked the introduction of clinical contraceptive services into PSI/Malawi's program and the beginning of a deeper connection between PSI/Malawi and many private sector providers it had distributed socially marketed products to for years.

With PSI/Malawi support and supervision, *Tunza* clinics offer the full range of short and long-acting contraceptive methods and services described above. In 2013, PSI/Malawi's *Tunza* network



consisted of 28 private sector clinics in five districts in Malawi's central region. By the close of 2015, PSI/Malawi expects to extend the *Tunza* network to 150 clinics, covering the country's central and northern regions.<sup>21</sup> A more thorough description of the *Tunza* social franchise program is provided on page 6.

In 2013, PSI/Malawi distributed socially marketed contraceptives through 28 social franchise clinics, 220 pharmacies and drug shops and 70 community-based distribution agents, while conducting interpersonal and mass media communications.<sup>22</sup> PSI estimates that in 2013 alone, its contraceptive products and services generated 171,735 couple years of protection (CYPs), averting 210 maternal deaths, 56,008 unintended pregnancies and 94,322 reproductive health disability-adjusted life years. Combined, PSI/Malawi's programs in malaria control, HIV/AIDS prevention, reproductive health and child survival averted a total of 7.77% of Malawi's total burden of disease in 2013.

## PROFILE

Nemezio Muria (above) is a Clinical Officer<sup>23</sup> and owner/operator of Chifundo Clinic in Malawi's capital, Lilongwe. Chifundo Clinic is one of the 28 clinics in *Tunza* Network in Malawi. Established in January 1998, Chifundo Clinic is located in Kawale, one of the commercial areas where both lower and middle-income people live.



Mr. Muria established the clinic in hopes of becoming financially independent and at the same time, serve his community by providing basic health care services. Mr. Muria provided basic health services including family planning counseling, *SafePlan* oral contraceptives and injectables. In 2012, Mr. Muria joined the *Tunza* Family Health Network.

As a member of the *Tunza* franchise, Mr. Muriya has benefitted from trainings provided by PSI Malawi including family planning counseling and service delivery, LARC service delivery, youth friendly health services, financial and business management, and quality assurance and quality improvement. Mr. Muria receives regular supportive supervision and mentoring provided by PSI clinical staff. PSI Malawi also supports the Chifundo clinic with mass media and demand creation activities carried out in the community through interpersonal communications agents.

In the two years since joining the *Tunza* network, Mr. Muria has provided family planning counseling and services to more than 3,500 clients; 139 opted to receive a LARC method. Mr. Mura has seen an increase in the sale of all family planning products and services provided in his clinic, a change that he attributes to increased demand in the community. "More people are aware of modern contraceptive methods now, especially after the interpersonal communication agents started to provide outreach in the community," Mr. Muria said. He values the support he receives from PSI Malawi and says that as a result of joining the *Tunza* network his clinic is now known in the community for its quality services, friendly staff and affordable prices.

## LAUNCHING THE TUNZA NETWORK

PSI/Malawi used many of the tools in PSI's Social Franchise Business-in-a-Box to prepare for the launch of the new franchise. Created in 2012 with USAID support under the Strengthening International Family Planning Organizations (SIFPO) project, the Social Franchise Business-in-a-Box is a series of tools structured around the four phases of the social franchise business process: (1) Pitch: assess acceptability and feasibility of a franchising approach as well as raising funds; (2) Design and Build: create the marketing, operating and financing plans necessary to launch and manage the franchise; (3) Validate and Prepare: select, train, support and monitor franchisees, and evaluate the franchise for expansion readiness; and (4) Growth: expand the franchise scale and/or scope.

**Pitch.** Since the funding outlook for a social franchising program was uncertain, PSI/Malawi developed a plan to maximize support from multiple donors<sup>24</sup> and internal sources to launch a small-scale franchise. PSI/Malawi hoped that even with a small number of clinics, it could provide evidence of the potential for social franchising in Malawi and eventually identify additional funding to build the pilot to greater scale.

**Design and Build.** PSI/Malawi modified the tools from Business-in-a-Box to develop a franchise business model tailored to Malawi. The figure below outlines the basic structure of the *Tunza* franchise, including the input flow throughout the system and returns from the client to the franchisee and from the franchisee to the franchisor.

In this model, PSI/Malawi is the franchisor, working with a network of pre-existing, commercial sector facilities and providers to improve their family planning services. *Tunza* franchisees are given access to subsidized contraceptives and equipment through PSI/Malawi, but are solely responsible for purchasing and stocking all necessary consumables, including cotton and gloves. In limited cases, PSI/Malawi supports the cost of modest clinic improvements necessary for providing high quality family planning services (e.g., an examination table for LARC insertions). In return for these benefits, franchisees agree to provide the outlined family planning products and services in accordance with franchise quality standards at a defined, affordable price.

By signing the *Tunza* letter of agreement, providers, as the franchisees, agree to:

- Offer family planning services, including counseling, short acting methods, LARCs
- Follow all applicable Ministry of Health and PSI family planning policies and procedures
- Refer gynecological complications to a higher level facility (e.g.,

## CURRENT STRUCTURE OF THE TUNZA FRANCHISE



- unexplained vaginal bleeding, complicated implant or IUD removals, HIV and sexually transmitted infection management services if care is not available at the facility)
- Notify PSI immediately of any adverse event
- Participate in trainings and annual provider meetings, as well as routine supervision and quality assurance visits
- Maintain and report client records on a quarterly basis
- Pay an annual network membership fee of MK8,000 (\$19 USD)<sup>25</sup>

In turn, PSI/Malawi, as the franchisor, agrees to provide the franchisees with:

- Training and certification to provide the health services outlined in the agreement
- Hands-on support and guidance to ensure that franchisees meet the network's minimum clinical and non-clinical standards
- Subsidized reproductive health commodities and equipment
- Assistance creating and/or expanding demand for the products and services offered

Once the basic structure and concepts of the *Tunza* franchise were defined, PSI/Malawi developed corresponding franchisee and franchisor operations manuals, including quality assurance and adverse event plans, again adapting many of the existing Business-in-a-Box tools. PSI/Malawi also developed an organizational capability plan outlining the staffing structure needed to both launch and manage the new franchise network.

## Validate and Prepare

**Identifying Clinics and Providers.** PSI/Malawi strove to identify providers, like Mr. Muria, who believe in the importance of offering family planning counseling, products and services; providers who would be committed to the objectives of the franchise network; and those who would adhere to the franchise's clinical and non-clinical standards and guidelines. Over the years, medical detailers working under PSI/Malawi's product social marketing programs collected large volumes of data from clinics selling *Safeplan* contraceptives. PSI/Malawi assessed this data using specific selection criteria to identify potential clinics/providers for inclusion in the social franchise network. Criteria included: geographic location and distance from other clinics offering family planning services; the clinic's current and potential volume of clients; type of provider at the clinic; provider training and certifications; quality of the clinic and desire/readiness to offer contraceptive services, including LARCs.

Through this process, PSI/Malawi identified an initial 30 clinics/providers. The 30 providers were invited to an orientation to learn about the franchise concept and agreements. All 30 opted to sign the letter of agreement and join the franchise.

**Assessing, Equipping and Training Providers.** PSI/Malawi performed a thorough LARC readiness assessment with each selected clinic/provider. The assessments found that many providers needed IUD training or refresher training as well as implant training. PSI/Malawi's LARC training consists of two days of theory and classroom work, including practice on anatomical models, followed by five days of training in a clinic setting. This includes observing client counseling and insertions and supervised insertion and removal practice. To be certified, each provider must perform three IUD and 10 implant insertions under supervision.<sup>26</sup> For the initial training, PSI partnered with a public sector clinic where *Tunza* providers conducted supervised insertions with support from PSI and Ministry of Health master trainers.

PSI/Malawi's initial LARC readiness assessments also found that many clinics needed equipment to perform LARC insertions and removals. PSI/Malawi purchased sterilizers and other equipment for inserting and removing LARCs.<sup>27</sup> This equipment was then sold to the *Tunza* providers at one-fourth of the purchase price. PSI/Malawi believes that provider contributions (i.e., paying a portion of the equipment costs) are essential to generating long-term commitment to the program.

**Creating Demand.** To generate demand for the family planning services at *Tunza* clinics, PSI/Malawi placed a dedicated interpersonal communication agent at each clinic. The agent works in the communities surrounding the clinic, providing

women and couples with family planning information and making referrals to the clinic. PSI/Malawi also began to advertise the *Tunza* clinic network through radio jingles, billboards and promotions during radio shows. Each *Tunza* clinic also received information, communication and education materials to promote family planning, including flipcharts, posters and method-specific pamphlets.

**Support and Supervision.** PSI/Malawi launched its on-going supervision and quality assurance activities immediately following the provider trainings. A team of two supervisors provided support to the 30 clinics, ensuring that each clinic initially received a supervision visit once every month. During this visit, the supervisor would review the family planning logbook, ask probing questions to uncover and address any provider concerns or challenges. Quality assurance staff also conducted quarterly assessments with each *Tunza* provider, developing action plans and offering hands-on coaching to address quality gaps.

*Below: Umoyo Clinic in Lilongwe*



**INTERPERSONAL COMMUNICATION.** Interpersonal communication is central to PSI's efforts to generate informed demand for contraception. Using a communication technique called Education through Listening, interpersonal communication agents use open-ended questions, affirmations and reflective listening to establish rapport with clients and identify myths or misconceptions about specific methods and contraception. The interpersonal communication agent plays a critical role in linking supply and demand for contraception by raising community awareness about available quality, affordable contraceptive products and services at the nearby *Tunza* clinic. The agent can distribute oral contraceptives and male and female condoms, but refers clients to the clinic for other methods, including LARCs.

**Growth.** Much of the “validate and prepare” stage is dedicated to testing, refining and assessing the franchise model in preparation to increase scale and scope in the growth stage. In 2014, PSI/Malawi began to expand the scale of the - franchise, with a goal of franchising 150 private sector clinics by 2015.

In terms of scope, *Tunza* is considered a partial franchise since PSI/Malawi supports only one of an array of services that the clinics/providers offer in their communities. In the future, PSI/Malawi may move beyond contraceptive services, building on the current franchise to strengthen providers’ services in other essential health areas, such as maternal and child health and HIV testing and counseling.

#### **A closer look at two key components of the *Tunza* franchise:**

**Quality Assurance.** Quality assurance is critically important in a clinic and franchise setting, not only for protecting client safety and rights, but also for creating client satisfaction and bolstering demand for services. PSI uses a formal quality assurance system that all social franchise programs must adhere to. The system has three principal components:

- Defined quality assurance standards (both clinical and non-clinical) and service delivery protocols;
- Provider training and regular supportive supervision and hands-on coaching; and
- Internal and external quality audits.

PSI/Malawi quality assurance standards include guidelines on infection prevention, informed choice and client confidentiality. These are shared in writing with franchisees and reviewed during orientation, clinical training and subsequent supervision visits. Adherence to the standards and guidelines is required per the letter of agreement signed by the franchisee and PSI/Malawi.

In September 2013, PSI/Malawi completed its first external quality assurance audit. An audit team organized by PSI headquarters, consisting of two clinicians (from PSI/Uganda and the U.S.) and one program staff member from PSI headquarters, spent two weeks in Malawi. The audit team evaluated a sample of individual providers, PSI/Malawi’s quality assurance and quality improvement systems and adherence to its own quality assurance plans. At the end of the audit, the audit team presented its findings to the PSI/Malawi team, including staff in charge of ensuring quality assurance. An action plan was created for addressing identified quality assurance gaps. PSI’s Global Medical Director subsequently reviewed the audit report and provided guidance on the action plan and established a timeline for addressing identified gaps. As standard practice, PSI’s global quality assurance team provides on-going support to in-country quality assurance teams to ensure that quality improvements continue, especially when a program expands its scope and geographic reach.

**EVENT DAYS.** Several months after launching the franchise, quality assurance staff reported that they could not observe LARC insertions during routine provider assessments due to lack of client demand for IUDs. Staff also noted that many *Tunza* providers were uncomfortable and reluctant to provide IUDs. To address this, PSI/Malawi introduced *Tunza* event days to raise awareness about *Tunza* clinics and services and create opportunities for providers to practice LARC insertions under supervision.

**Two weeks before an event, interpersonal communication agents begin mobilizing clients in the community by promoting the upcoming event day** and handing out an event day referral card to women interested in receiving services. The card entitles the client to any contraceptive product at half the regular *Tunza* cost. Clients that desire a permanent method are offered a referral to access the service in a non-governmental organization or public sector facility.

**Before the event, the quality assurance officer performs a pre-assessment of the host facility, ensuring that the site has sufficient consumables and is set-up to manage increased client flow.** Events typically last three hours. On average 20 LARC clients are seen, in addition to those who select short-acting methods.

**Among LARC clients, there is typically more demand for implants than IUDs.** During the event, an interpersonal communication officer facilitates family planning discussions and educational games for clients waiting to be seen. A training officer supervises the provider, assessing their technique and coaching and assisting as necessary. A quality assurance officer is also on-hand to observe services and evaluate adherence to cleanliness, waste disposal and infection prevention protocols.

**Event days have proven to be so successful that PSI/Malawi has started to invite multiple *Tunza* providers to a single event**– often inviting those who report the lowest LARC service delivery numbers in their own clinics. This allows hesitant providers to witness the actual demand for these services and enhance their competence and confidence providing LARC insertions.

**Youth-Friendly Services.** Youth between the ages of 15 and 24 represent 18% of the population in Malawi.<sup>28</sup> Numerous family planning stakeholders in Malawi have documented the challenges youth face accessing sexual and reproductive health information, products and services, including:

- Youth have few reliable sources for accurate sexual reproductive health information
- Providers often exhibit negative attitudes toward youth seeking sexual reproductive health services (e.g., unmarried youth are chastised for being sexually active, and young married women are discouraged from using contraception if they don't have children)
- Health facilities do not always cater to the needs of youth
- Youth often fear a lack of privacy and confidentiality at the clinic

Without access to accurate sexual reproductive health information and quality products and services, youth are left vulnerable just as they begin to experience their sexuality and make important decisions about sexual behaviors.

The government of Malawi recognizes the importance of reaching youth and has made youth ages 15-24 a focus under its Family Planning 2020 vision,<sup>29</sup> by introducing a country-wide initiative to increase youth friendly health services in the public sector. PSI/Malawi's reproductive health strategic plan, which is aligned with Malawi's national Family Planning 2020 vision, includes several initiatives to strengthen youth programming.

In 2013, PSI/Malawi identified 15 *Tunza* providers, including Mr. Muria, to participate in a week-long, youth friendly health services training led by PSI in partnership with IntraHealth. The goals of the training were to introduce global- and country-level definitions of youth friendly health services; explore providers' personal and professional values about providing sexual reproductive health care to youth; and to practically apply assessment and planning tools to strengthen the providers own youth friendly health services delivery.

Through role plays, mapping a day in the life of a young person, case study analysis and discussions with youth participants, the providers gained new understandings about youth, their hopes, aspirations and health needs. They learned about the many misconceptions young people harbor about contraception and conception and the devastating impact this can have on their health and ability to control the course of their lives.



*Above: "Youth Friendly Health Services" added to list of services provided at Tunza clinic*

Armed with this knowledge, providers used a tool to assess the youth friendliness of both their own and other *Tunza* clinics. Each participant then developed a strategy for improving youth friendly health services at their own clinic. As a result, several providers started youth sexual reproductive health clubs, while another added a youth library at his clinic. Yet another added "youth friendly services" to the sign outside his clinic, and many began advertising an short message service (SMS) hotline. Mr. Malola (pictured below), a Clinical Officer and owner of the Umoyo Clinic, is passionate about youth and is a strong proponent of the community's youth club. After the youth friendly health services training he dedicated a specific area of his clinic to youth and added a full-time youth friendly health services staff member.

*Below: Lemison Francis Malola, Private Sector Clinic Owner*



## RESULTS

**Health Impact.** PSI/Malawi's reproductive health programming delivered 171,735 CYPs in 2013. Of these, 10,742 were generated through *Tunza* clinics, where LARCs contributed 85% of the total CYPs. In 2010, only one out of every 50,000 women in Malawi was using an IUD, and one out of every 100 was using an implant.<sup>30</sup> Based on LARC uptake to-date in the *Tunza* program and the planned expansion of PSI/Malawi's *Tunza* network, including mobile LARC services, PSI anticipates that the next Demographic and Health Survey will show an increase in the national CPR for LARCs.

Data reveal that the majority of *Tunza* LARC clients seen from January through September, 2014, were under the age of 29: of the 1,725 implant acceptors, more than half (67%) were under the age of 29; likewise, 55% of 187 IUD acceptors were 29 or younger. Provider data reports that all LARC clients were married with at least one child. This data may be inaccurate and reflect cultural taboos and beliefs about who should use contraception. Unmarried clients may misrepresent their marital status to avoid provider judgment or mistreatment. Another possible explanation is that providers may have turned away unmarried clients and/or those without children. The initial youth friendly health services training took place late in 2013 and included only 15 of 28 *Tunza* providers. As youth friendly health services training and support continues, PSI/Malawi anticipates seeing an increase in LARC use by unmarried clients.

Two shortcomings of the data tracking system will be corrected in 2014, allowing PSI/Malawi to generate more complete health impact data. Currently, PSI/Malawi does not gather information on previous method used. Without this, it is difficult to ascertain the percentage of LARC clients who are new users versus those who are switching from another method. In 2014, this data will be incorporated into PSI/Malawi's management information system.

The other significant change is that PSI/Malawi will begin working with providers to track client data for all family planning clients, not just those who select a LARC. This will allow PSI/Malawi to more accurately assess clinic performance and to better analyze client data, identifying trends in method choice. This information can be used to strengthen both provider and consumer behavior change strategies and communications.

**Quality Client Perspective.** PSI/Malawi conducted confidential client exit interviews among 66 family planning clients at 18 *Tunza* clinics. The findings indicated that all clients were satisfied with the quality of service received and would recommend the clinic to a friend seeking family planning. A little more than half of the clients interviewed (56.1%) felt that *Tunza* staff were friendly.

When asked why they chose the facility, 80% of respondents indicated that it was close to home, while others (27.3%) cited the reasonable cost of services.

A high percentage of the interviewees (99%) indicated that the provider counseled them with accurate family planning information. The majority (68%) indicated that they had already selected a method before they visited the facility. Of those who reported that another person influenced their method choice, 72% indicated that their spouse influenced the decision, while 16% said other family members influenced them. Only 11% reported that the provider influenced the decision.<sup>31</sup> This underscores the importance of interpersonal communication and other non-clinic based initiatives to disseminate accurate family planning information when clients are choosing a method.

**Quality Audit.** As previously mentioned, in 2013, exactly one year after the launch of its social franchising activities, PSI/Malawi underwent its first external quality audit. The audit report showed that PSI/Malawi adequately met standards, with only minor issues flagged. An after-audit assessment conducted three months later found that all minor issues were adequately addressed.

**Equity.** Research conducted by PSI in 2010 indicated that 75% of the clients that visit PSI/Malawi-affiliated private clinics are in a low-income bracket.<sup>32</sup> Therefore, prior to introducing LARCs, PSI/Malawi conducted a market survey to develop a pricing strategy for both LARCs. Although most women reported that the recommended price of MK1,000 (USD \$2.50) per implant or IUD in a *Tunza* clinic was affordable for low income women,<sup>33</sup> PSI/Malawi intends to introduce a voucher system in 2014 to further subsidize the price for youth, for whom research has shown that price can be a barrier to access.

**Access.** In 2013, 52% of the *Tunza* clinics were located in areas classified as rural by the National Statistics Office. These clinics are located at a minimum of 5km away from the nearest facility (public or private) offering LARCs. Many clinics are located more than 5km away, with some in very remote and/or rural areas where the nearest facility is more than 40km away.

Through the *Tunza* network, PSI/Malawi is increasing the method mix available to women in Malawi. Of 28 clinics, none were offering LARCs before joining the network. Today, all 28 are providing LARCs on a routine basis. With the planned expansion of the franchise in 2014 and 2015, PSI/Malawi projects that the network will eventually reach over 180,000 women annually with the method of their choice, generating over 380,000 annual CYPs.

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**Cost-Effectiveness.** PSI/Malawi is not yet able to report on the cost-effectiveness of its franchise activities. In 2014, systems were introduced to enable tracking for all franchise-based expenditures. This addition, plus the collection of data on all contraceptive methods distributed through the clinics, will allow PSI/Malawi to determine the cost per CYP generated by the franchise. This cost can then be tracked and compared annually. It is anticipated that the cost per CYP will decrease over time because of heavy upfront investments in equipment, training and systems and of increased provider productivity over time.

## KEY LESSONS LEARNED

**Strengths.** The rapid launch of a small-scale franchise, leveraging multiple sources of funding and commodity support, allowed PSI/Malawi to demonstrate the potential of the *Tunza* franchise and to attract increased donor investments. This approach proved to be successful; without it, the *Tunza* network may have never gotten its start.

In taking a total market approach and assessing where PSI interventions could add the most value, the *Tunza* social franchise approach has shown a number of strengths:

- Greater engagement with private sector providers previously operating in relative isolation and with limited regulation
- Private sector providers strengthened their clinical skills and now offer new products and services previously unavailable
- Interpersonal communication agents in the clinics' catchment areas reinforce the critical link between informed demand and quality supply—essential to sustaining increases in contraceptive products and services use

Further, a unique strength of the PSI/Malawi franchise is that provider buy-in to the model was established from the start. This approach mitigated provider expectations that the franchisor should or would cover all costs associated with family planning delivery. It established a precedent for provider contribution and ensures that providers who join the franchise believe in its benefits, as well as the importance of contraceptive service delivery.

**Areas for Improvement.** In a franchise model versus a clinic ownership model, the franchisor has more limited control over the actions of the provider. For example, private sector providers in Malawi are not always accustomed to keeping client records. They often do not understand the importance of data collection and are reluctant to ask clients for the information requested by PSI. This is particularly true for numerous short-acting methods, when providers do not take the time to fill in demographic data for clients. As the franchisor, PSI/Malawi must continually seek new ways to incentivize accurate and complete provider data

collection and reporting.

Additionally, it is not yet clear what impact the *Tunza* franchise has on contraceptive access for the poorest and most vulnerable in Malawi—whether it serves those clients directly or affords them better access to public sector services by relieving some of the client burden on the public sector. USAID, through the SIFPO project, is funding a quasi-experimental study in Kenya to assess the impact of franchising on increased access to reproductive health services, and to provider revenue and volume. This study will help answer important questions about the role of social franchising in the market as a whole.

**Opportunities.** There are many opportunities to expand *Tunza's* reach. PSI/Malawi is currently identifying new clinics, with the goal of having 150 franchise members by the close of 2015. Each of these clinics can serve as a hub for increased community level activity. Interpersonal communication agents and mobile teams that use the clinic for product resupply and client referrals can expand the reach of family planning services beyond the walls of the actual clinic. Franchise clinics also offer opportunities to strengthen other critical health services, as well as to expand health services integration.

In 2013, PSI/Malawi launched a SMS hotline for sexual reproductive health. Despite minimal promotion, the hotline was flooded with over 50,000 text messages in the first month. Nearly all of the texts were sexual reproductive health related, and 95% were specific to family planning. The number of text messages greatly exceeded PSI/Malawi's expectations and overwhelmed the system. PSI/Malawi was forced to shut down the hotline until a better and less costly system can be identified. The demand for the hotline represents an opportunity. It could be an important channel for discretely conveying accurate sexual reproductive health information, particularly to youth. It could also serve as a driver of demand generation and referrals to *Tunza* clinics.

**Challenges.** PSI/Malawi must tackle several challenges in its franchise programming. The first is mastering franchise expansion without compromising quality. PSI/Malawi will need to balance the goal of rapidly achieving scale with the need to select clinics carefully. Furthermore, expanding from 28 to 150 clinics will require PSI/Malawi to more than triple the size of its interpersonal communications, supportive supervision and quality assurance teams. This will require careful planning, recruitment of highly capable staff and a thorough assessment of supervision systems required for each of these teams. Based on success to-date, event days will likely prove to be an important tool in scaling up training and allowing for hands-on coaching and mentoring new providers.

Increasing the availability of youth friendly health services is also a priority challenge for PSI/Malawi. Although 15 *Tunza* providers developed youth-friendly plans as part of the youth friendly health services training, not all have taken actions to implement them. Among those who have, several reported that youth clients cannot afford the cost of products and services and are turned away. In 2014, PSI/Malawi will hire a youth friendly health services officer to expand youth friendly health services training and work with clinics to implement youth-friendly plans. In 2014, PSI/Malawi will also pilot a youth voucher program and assess whether this improves access and uptake of *Tunza* services among youth.

Further, PSI/Malawi has noted that young, unmarried or nulliparous women rarely participate in interpersonal communication sessions at the community level. It is hypothesized that others in the community may rebuke these women for joining an family planning discussion. In an attempt to

address this challenge, in 2014, PSI/Malawi will pilot using youth interpersonal communication agents to target young married and unmarried men and women with contraceptive information and referrals. In addition, all interpersonal communication agents will talk at the community level about the importance of contraceptive information, products and services for youth.

The third challenge for PSI/Malawi will be overcoming provider discomfort with IUDs and bias toward other methods. PSI/Malawi will continue to implement event days focusing on those providers most in need of additional IUD practice. PSI/Malawi will also reassess its LARC communications and interpersonal communication strategies to determine what changes can be made to overcome consumer misconceptions and fears about the method, enabling clients to make an informed choice from a wide range of contraceptive options.

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21. This expansion is funded by KfW, with commodity support from USAID.
22. Funding and/or commodity support for this work came from five donor sources: KfW, the Dutch Government, USAID, UNFPA, and Norad.
23. The Clinical Officer is a member of a paramedic cadre established in Malawi to address the critical shortage of doctors in the country through task-sharing. This cadre undergoes three years of training with a one-year internship and the option to specialize in surgery, obstetrics and gynecology, ear, nose and throat, or ophthalmology, etc. Clinical officers provide similar services as doctors and are regulated by the Medical Association of Malawi, the same body that regulates doctors.
24. The Dutch Choices and Opportunities Fund (COF) provided funding support for the initial franchise launch, including IUD training and LARC insertion and removal equipment. USAID provided LARC commodity support. Funding from Norad supported training and communications to increase informed, voluntary access to affordable contraceptive implants through the Tunza network.
25. Though nominal, this fee is important for establishing provider commitment to the network and sets a precedent for other potential provider buy-in in the future.
26. During the initial training, removals are practiced on anatomical models only. Providers later receive hands-on supervision and coaching from a PSI/Malawi supervisor or trainer when conducting their first in-clinic removals.
27. PSI/Malawi leveraged sales revenue from previous FP projects to purchase approximately US \$30,000 in LARC insertion, removal and sterilization equipment.
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31. This is consistent with feedback from the *Tunza* network providers who report that most clients have decided on their method before reaching the clinic.
32. "Low-income" is defined by the response to survey questions that assess the possession of certain household items, rather than actual income earned.
33. Nearly all of the women interviewed were in the lower income category.





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