

ORIGINAL RESEARCH ARTICLE

Does quality matter? An analysis of two-family planning delivery models on quality of care and client satisfaction of services provided in the private sector in Kajiado County, Kenya

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Abstract

There is evidence that good quality family planning (FP) services increases utilization. This was a facility-based mixed-method to compare the quality of care in the social franchised and non-franchised private health facilities in Kajiado County, Kenya. Quantitative data were collected from 586 FP clients' exit interviews and a facility inventory in 32 health facilities. Additionally, qualitative interviews were conducted with FP users and providers. The outcome variable was client satisfaction. Logistic regression findings show that clients in a social franchise were 2.2 times more satisfied than a non-franchise facility ($p=0.03$). Social franchises had higher numbers of trained providers on FP ($p=0.019$) and low contraceptive stock-outs. The satisfied clients had shorter waiting time ($p=0.002$) and clients with high school education were less likely to be satisfied (Adjusted Odds Ratio = 0.44, $p=0.001$). Improving contraceptives availability, health provider training and reducing clients' waiting time will increase client satisfaction and thus increase FP use. (*Afr J Reprod Health 2021; 25*[5]: 49-60).

Keywords: Family planning, quality, private sector, social franchising, Kenya

Résumé

Il est prouvé que des services de planification familiale (PF) de bonne qualité augmentent l'utilisation. Il s'agissait d'une méthode mixte en établissement pour comparer la qualité des soins dans les établissements de santé privés franchisés et non franchisés du comté de Kajiado, au Kenya. Des données quantitatives ont été collectées à partir des entretiens de sortie de 586 clients de la PF et d'un inventaire des établissements dans 32 établissements de santé. De plus, des entretiens qualitatifs ont été menés avec des utilisateurs et des prestataires de PF. La variable de résultat était la satisfaction du client. Les résultats de la régression logistique montrent que les clients d'une franchise sociale étaient 2,2 fois plus satisfaits que ceux d'une installation hors franchise ($p=0,03$). Les franchises sociales avaient un nombre plus élevé de prestataires formés sur la PF ($p=0,019$) et de faibles ruptures de stock de contraceptifs. Les clients satisfaits avaient un temps d'attente plus court ($p=0,002$) et les clients ayant fait des études secondaires étaient moins susceptibles d'être satisfaits (rapport de cotes ajusté = 0,44, $p=0,001$). L'amélioration de la disponibilité des contraceptifs, la formation des prestataires de santé et la réduction du temps d'attente des clients augmenteront la satisfaction des clients et augmenteront ainsi l'utilisation de la PF. (*Afr J Reprod Health 2021; 25*[5]: 49-60).

Mots-clés: Planification familiale, qualité, secteur privé, franchise sociale, Kenya

Introduction

Increasing the use of family planning (FP) services contributes to a reduction in maternal mortality. Studies have shown that up to 44% of maternal deaths could be averted by FP¹. A total of 270 million women have an unmet need for FP worldwide². The benefits of modern contraceptives to women's health outweigh the risks³. The current modern Contraceptive Prevalence Rate (CPR) for married women in Kenya was estimated to be

57.8% in 2020³, an increase from 53% reported in 2014⁴. The private health sector has become an essential provider of FP services in Kenya. In 2014, 34% of all FP clients obtained their services from private sector sources⁴.

The provision of quality of care in FP is necessary to enable improvement in contraceptive use. The relationship between the quality of contraceptive delivery and utilization has been studied with mixed evidence. Many studies indicate that good quality of services influences

contraceptive use positively^{5,6}. The availability of trained human resources, materials, and equipment was identified as key factors influencing the quality of FP services.

Another study on FP quality indicated that counselling services were essential in improving adherence to contraceptive use by enhancing clients' knowledge and satisfaction of services⁷. According to a recent report from Kenya's Ministry of Health (MoH), clients who choose to access health care from private facilities reported that they do so because they receive better quality of services defined by the experience of privacy and access to FP supplies and commodities than public facilities⁸.

A 2016 systematic review on the quality of care of FP services in sub-Saharan Africa showed that competent providers who had a good understanding of the clients' needs were associated with excellent quality service. Besides, other health system factors such as the level and numbers of staff, location of the facility, and health facility processes such as waiting time and the clients' counselling determined the quality of FP services offered⁵. A 2018 multi-country study covering Kenya indicated that FP quality in public facilities was associated with modern contraceptive use⁶.

However, based on the information provided above, there is limited evidence on quality-of-care differences between various private-sector delivery approaches. It is, therefore, necessary to examine the quality of care of FP services provided in private-sector delivery approaches, given that the private sector continues to complement public-funded FP programs in Kenya. In 2017, Kenya launched its national Costed Implementation Plan (CIP) for FP⁸. One objective included in this plan is to increase access and utilization of quality FP services by all population segments. This study provides additional evidence on the quality of care in the private health sector facilities that will be useful in advancing the objectives of the CIP.

This study focused on two leading private sector delivery models in Kajiado County in Kenya: social franchising and private health facilities or hospitals (non-franchise health facilities). Social health franchising uses commercial methods and organizes small private independent health care businesses into quality-assured networks to offer health

services through a network of certified private health facilities, who agree to provide harmonized services through a common brand⁹. Whereas the non-franchise private sector facilities are non-branded individually managed health facilities providing FP services in Kenya. These include major hospitals, private clinics, and some Faith-Based Organizations (FBO) facilities¹⁰. Studies on the quality of care in FP programmes have covered mostly public health facilities, with a limited number covering both the public and private sectors^{6,11}. This study assessed the quality of care and client satisfaction of services provided in the private sector in Kajiado County in Kenya..

Methods

Study design

This was a facility-based mixed-method study. The quantitative data were collected through a health facility inventory and a client exit interviewer-administered questionnaire to FP clients. In contrast, qualitative data were collected through focus group discussions (FGDs) and key informant interviews (KIIs). Data were collected between October 2019 to January 2020.

Study context

The study was conducted in Kajiado County, one of the 47 counties in Kenya. The county was selected purposively because most health facilities are in the private health sector (60%)¹⁰. Kajiado County has a total population of 1,117,840¹². Women of reproductive age (WRA) make up 27% of the total population, with a modern contraceptive prevalence rate (mCPR) of 45.2%⁴. Health care service delivery is decentralized in Kenya, where the counties are responsible for providing primary health services, including FP. The county has 253 health facilities with 170 private health facilities, including 18 social-franchised health facilities, including hospitals, nursing homes, health centres, clinics and dispensaries¹⁰.

Study population and sampling

The study population comprised WRA accessing FP services and service providers in 32 selected private

health facilities. For the health facilities to be eligible, they were required to be fully licensed and registered and have submitted FP service provision data through the Kenya Health Information System (KHIS)¹³ nine months before the study.

A purposive sampling approach was used to select the health facilities included in the study. All 18-social franchise health facilities that were operational in Kajiado were included. However, two facilities declined to participate in the study. Thus, data collection was done in the remaining 16 social franchise facilities¹⁰. To enable comparative analysis, 16-social franchised health facilities were matched with a similar number of non-franchised facilities to give a total of 32 health facilities. The matching criteria included selecting a similar health facility to the franchise health facility in terms of volume of health services, locality, type of health facility, catchment population, and the type/number of FP clients the facility served in the previous nine months of 2019. The sample size for the respondents in the facilities was determined using Diggle's formula¹⁴ for prospective studies, yielding 38 respondents per health facility. However, during the data collection, some facilities experienced low client numbers, and the target for 38 clients per facility was only attained in 40% of the total facilities.

Quality of care variables used in this study

The quality of care variables used in the study were based on a combination of the Donabedian framework¹⁵ and Judith Bruce's framework¹⁶ that measure FP quality. These included structural elements such as FP clinic equipment, infrastructure, availability of FP methods and policies. The key outcome was client satisfaction of FP services provided in the two private-sector delivery models. The independent variables included the client characteristics (age, marital status, education level and religion), and health facility level factors such as structural elements (FP clinic equipment, infrastructure, availability of FP methods and policies), and process elements (choices of contraceptives and the information provided during the client-provider interaction). The summative scores indicated in Table 2 in the results section were generated from the process structural elements generated in the regression

model using covariates derived from the FP clients' characteristics as indicated in Supplementary Tables S1 and S2.

Data collection

A pre-tested client exit interview tool and a facility inventory questionnaire were used for quantitative data collection. The client exit interview was administered to clients who had accessed FP services to assess their experiences on the quality of FP services provided, as adopted from the Kenya service provision assessment survey¹⁷. The information on the cost paid by the client to access the FP services was collected through the client exit interview. These included the amount they paid to access the services, including the cost of transport, the time in the health facility, and transportation time. This information was collected for each FP method the client received. The respondents were selected through a systematic random sampling approach. The exit questionnaire was administered in the clients preferred language (English or Kiswahili); it took about 30 minutes. Data were collected and entered electronically using the android phone - the Open Data Kit (ODK software). The health facility inventory questionnaire was administered to the health facility managers to collect information on infrastructure, staffing, services, and supplies.

For qualitative data, FGDs and KIIs guides were used. The FGD participants were selected through purposive sampling at the FP clinic, where they comprised eight participants. The data collection for qualitative and quantitative data did not happen on the same day, and therefore, FGD participants did not participate in the client exit interview. A total of 16 KII were conducted with facility managers. The guide covered topics on FP service delivery. Both the FGD and KII interviews were recorded.

Data analysis

Descriptive statistics were used to determine the client-level and facility-level variables. The difference in the quality of services in the social franchised and the non-franchised private health facilities was conducted using a t-test for continuous variables and a chi-square test for categorical

variables. Univariable and multivariable logistic regression analyses were performed where odd ratio (ORs) and their 95% Confidence Intervals (CI) were calculated to examine the difference between facility level and client-level factors associated with the quality and the client satisfaction with the services. The client's background variables in the univariable logistic regression analysis were adjusted for facility type, and then they were included in multivariable logistic regression analysis (age, religion, education level and marital status). Health facility-related factors were also included in the model to form an overall score; the elements consisted of FP clinic equipment, infrastructure, availability of FP methods and policies. The Statistical Package for Social Sciences (SPSS) Statistics for Windows, Version 25.0, was used to analyze quantitative data.

The open-coding style in ATLAS TI software¹⁸ was used to organize and analyze qualitative data. Inductive coding was done and supplemented with deductive approaches. Codes were assigned for each of the themes and patterns identified from the responses. The key themes identified were the importance of FP, access and availability, quality and cost of FP services.

Results

Socio-demographic characteristics of the study population

In total, 586 clients were interviewed who accessed FP services in 32 selected private health facilities. Due to missing data in five clients' records, 581 respondents' responses were used in the analysis. Majority were aged between 25-35 years at 52.5% (n=305), had completed high school level education - 50.6% (n=294), were Christians at 75.6% (n=439), and were married at 76.9% (n=447) [Table 1].

Quality of FP services – family planning methods provided to clients

The FP clients received a similar contraceptives method per the health facility delivery model as indicated in Figure 1, except for sayana press (subcutaneous injectable contraceptive) that was only provided in social franchise health facilities

and the emergency pill provided in non-franchised health facilities. For the non-franchise health facilities, 84.4% (n=200) clients received the FP method on the day of the study; out of this, 84.5% (n=169) were repeat users, while 15.5% (n=31) were new FP users. Also, 15.6% (n=37) of FP clients did not receive a FP method during the visit to the health facility. In the franchise facilities, a total of 89.0% (n=306) clients received FP services on the day of the study, which comprised 73.4% (n=223) repeat users and 26.6% (n=81) new FP users. Only 11.0% (n=38) of FP clients who visited franchise health facilities did not receive a FP method during the visit to the health facility. For social franchise health facilities, the most cited reasons for not receiving FP services were that the clients came for FP method check-up (28.9%) and lack of money (15.8%). For non-franchised health facilities, the common reasons for not receiving the FP method were the unavailability of the FP method (21.6%) and some clients were getting the FP method check-up (18.9%).

The health facility manager in a non-franchised facility pointed out the challenges of frequent stock-outs in providing FP services.

“Sometimes the FP methods are out of stock and for a long time, e.g., injectables, pills and emergency pill. The facility has never been supplied by the government with sayana press, and Mirena intrauterine contraceptive came and disappeared, and when it reappeared, it was very expensive. It is mostly preferred than copper-T according to the feedback from the clients”. (Respondent 3, KII).

Also, a health facility manager in a social franchised facility indicated that they have challenges with stock-outs of contraceptives:

“Sometimes we have a shortage of the long-term contraceptives like implants so when they don't supply from the government; we have to outsource from somewhere else” (Respondent 12, KII)

The structural quality of care aspects of health facilities

The assessment of the various FP methods provided in the health facilities used a composite measure.

Table 1: Socio-demographic characteristics of respondents by health facility type

| Profile | Social Franchise facilities | | Non-franchise health facilities | |
|-----------------------------|-----------------------------|----------------|---------------------------------|----------------|
| | Frequency (n=344) | Percentage (%) | Frequency (n=237) | Percentage (%) |
| Age (years) | | | | |
| 15-19 years | 7 | 2.0 | 9 | 3.8 |
| 20-24 years | 101 | 29.4 | 62 | 26.2 |
| 25-34 years | 178 | 51.7 | 127 | 53.6 |
| 35-40 year | 46 | 13.4 | 31 | 13.1 |
| 40-49 years | 12 | 3.5 | 8 | 3.4 |
| Marital Status | | | | |
| Single | 61 | 17.7 | 50 | 21.1 |
| Married | 275 | 79.9 | 172 | 72.6 |
| Divorced/separated | 4 | 1.2 | 11 | 4.6 |
| Widowed/other | 4 | 1.2 | 4 | 1.7 |
| Religion | | | | |
| Catholic | 63 | 18.3 | 62 | 26.2 |
| Protestant | 272 | 79.1 | 167 | 70.5 |
| Muslim | 3 | 0.9 | 7 | 3.0 |
| No religion/other | 6 | 1.8 | 1 | 0.4 |
| Educational level | | | | |
| Never attended school/other | 23 | 6.7 | 2 | 0.8 |
| Primary | 77 | 22.4 | 36 | 15.2 |
| High school | 167 | 48.5 | 127 | 53.6 |
| College | 61 | 17.7 | 60 | 25.3 |
| University | 16 | 4.7 | 12 | 5.1 |

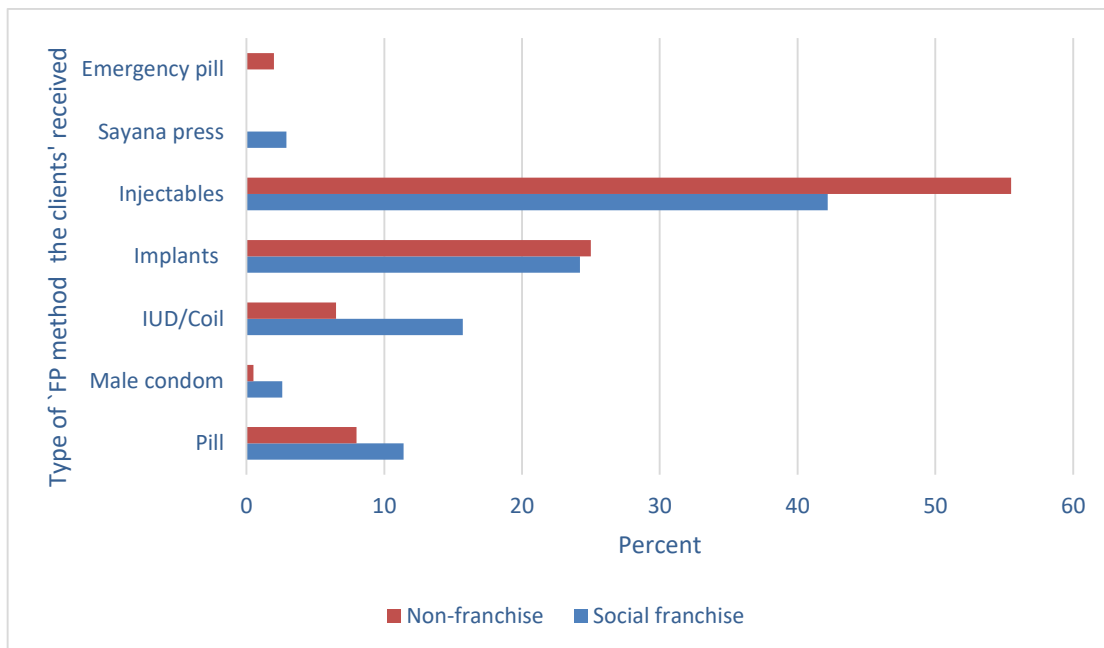


Figure 1: Family planning methods provided to the clients per health facility type

The results show that in all the 31 health facilities included in the analysis (one health facility was not included in the analysis due to missing data), the lowest number of FP methods offered was six, and

the highest number of FP methods was 13. The mean FP methods provided were 10.3 for non-franchise health facilities and 9.3 for social franchised health facilities (mean 10.3±2.1 SD

versus 9.3 ± 2.0 SD). There were no significant differences in the FP methods offered between the franchised and non-franchised health facilities ($p=0.206$). Regarding infrastructure, about 87% and 85% of required amenities were available in social franchising and non-franchising health facilities, respectively. There was no significant difference between the social franchising and non-franchising health facilities. There was a significant difference between the two health facilities on the level of FP stock-out situation in the past year, with social-franchised facilities having the lowest level of FP commodities stock-out. There was no significant difference in other areas examined (Table 2).

All franchised health facilities had a register where FP client's visits are recorded, whereas 92.9% of non-franchised health facilities had the same. Most health facilities had a quality assurance system (92.9% and 93.8% in social franchised and non-franchised health facilities). Internal quality improvement team was available in 57.1% of social franchised health facilities and 56.3% of non-franchised health facilities. A system to collect client opinion was available in 92.9% of social franchised and 93.8% on non-franchised health facilities. About 40.0% and 37.5% of social franchised and non-franchised health facilities, respectively, had the last supervisory visit by an external party (either a ministry of health official or a social franchised network supervisor) to the facility during the previous six months. The chi-square test of independence between health facility supervision arrangement and the health facility type showed that the relationship was insignificant. Regarding the availability of trained health workers on FP, social franchised health facilities had a significantly higher number of health providers who had received FP training in the last 12 months than non-franchised health facilities. The mean number of health providers with FP training in non-franchised facilities was 2.43, significantly lower than social franchised facilities, which was 3.93 ($p=0.019$).

Quality of FP services – process variables in delivery of services

A total of 94.1% ($n=546$) of the FP clients were satisfied by the services they had received. A Chi-square test was done, which showed a significant

association between the type of health facility and the client satisfaction of services (chi-square =4.921, $p=0.027$). Further analysis was done using binary logistic regression that showed that a client who visited a social franchise health facility is 2.2 times more satisfied with the health services provided than a client who visited a non-franchise facility (OR=2.2, $P=0.03$ 95% CI 1.1-4.4). There was a general consensus among the FGD participants on the good quality of care offered in the social franchised health facility as expressed below:

“They (social franchised) offer good quality services, and I also came here for a check-up; they are friendly also”. (Respondent 2, FGD 3).

“They (social franchised) are concerned with you, and they treat you well they want to make sure you are always comfortable”. (Respondent 6, FGD 4)

“They (social franchised) attend to you in a friendly and respectable manner”. (Respondent 7, FGD 3)

“I just love this place because they have good services and they serve clients very fast” (Respondent 1, FGD 1)

A composite variable was computed for counselling to compare the differences in the health facility type in terms of client interaction with the health provider with six binary indicators used: Whether the client discussed her reproductive health intentions with the health provider; whether the provider discussed her previous use of FP; whether the provider discussed all available methods; if the client was given a chance to choose her preferred method; whether the provider discussed on how the selected method works, and if the provider explained the advantages and disadvantages of the chosen method. Regarding client-provider discussion on reproductive health intentions, 83.4% and 78.0% in social franchising and non-franchising facilities respectively were informed on all available methods, and over 90% in all health facilities were given a chance to choose their preferred method. The bivariate analysis for the composite variables showed no significant difference in the counselling provided to the clients ($p=0.511$); the mean was 5.25 out of six counselling areas for social franchised health facilities and 5.17 out of six for non-

franchised health facilities. The association between the quality of counselling and client satisfaction was not significant overall. There was no difference in the number of counselling provided to either new or repeat clients in social- franchise health facilities; however, this difference was evident in non-franchise health facilities ($p=0.023$). The social franchise health facilities provided the same counselling level for new and repeat clients, but non-franchised facilities provided higher level counselling to new clients. The following feedback was provided by a FGD participant in the franchised health facility, supporting the view that the quality of care was good.

“The quality of service at this place is great, and they treat clients respectfully, and they are friendly”. (Respondent 2, FGD 4)

“My friends told me that this is a good hospital they offer good quality services and also in other facilities when you go to ask for some family planning methods, they don’t have, but here I normally get”. (Respondent 4, FGD 3)

“They offer good quality services, and they also allow one to use your insurance card” (Respondent 2, FGD 3)

Association between client satisfaction and the predictor variables used per the health facility type

The study assessed the various quality of care predictor variables to determine the association with the client satisfaction of services. One predictor variable used was the total client’s waiting time at the health facility before being attended by the health provider. Table 3 displays the findings. There was a significant association with the total waiting time at the health facility, with the satisfied clients having a shorter waiting time in both health facilities. The results showed a significant association with client satisfaction and waiting time in the social franchising health facilities ($p=0.002$). Another predictor variable used was the cost of services to the client. A chi-square test of independence was done to assess the client’s

satisfaction and perception of the cost of FP services received, which was statistically significant (chi-square =14.043, $p=0.007$). Most of the clients thought the services were affordable (96.6%). However, the difference between the health facility type on the service cost and client satisfaction was not significant. The following are responses from participants in a non-franchised health facility on how they feel about the cost of the services. There was mixed feedback with some clients indicating that the fee is affordable while others saying the cost needs to be reduced to make it affordable, as shown below.

“They (non-franchised health facility) have good services, and they are affordable”. (Respondent 1, FGD 4)

“There are no long queues compared to public hospitals, which have very long ones, and they are affordable. The cost is not too much even though it is a private hospital”. (Respondent 4, FGD)

“It is not affordable they should reduce the cost of the coil from 15 US dollars to 5 US dollars because some of us are not able to afford that”. (Respondent 5, FGD1)

Association between clients’ satisfaction and their characteristics - multivariable regression analysis

Of the 581 clients who accessed FP services, those between the ages of 25 to 49 years were significantly more likely to be satisfied with the FP services they received than those between 15-19 years, as indicated in Table 4. Compared with women with primary level education and below, women with high school education were significantly less likely to be satisfied with the services received (AOR= 0.44;95% CI:0.27,0.71). Similarly, there was a positive association between client satisfaction and overall health facility factors. The analysis showed no relationship between the client’s satisfaction with FP services received and the women’s current marital status and religion (Table 4).

Table 2: Summative scores of structural elements used in the study- bivariate analysis

| Variable measured | Mean±SD | Mean±SD | Mean±SD | P-value* |
|--------------------------------------|-----------------|---------------------|----------------|----------|
| | Franchise model | Non-franchise model | Average scores | |
| Infrastructure (0-19) | 14.0± 4.0 | 14.8±2.0 | 14.4±3.1 | 0.52 |
| Equipment (0-32) | 25.8±7.5 | 26.2±2.8 | 26.0±5.5 | 0.826 |
| Services provided in FP clinic (0-5) | 4.33±1.2 | 4.43±0.62 | 4.38±0.98 | 0.77 |
| Training materials (0-14) | 6.86±2.1 | 5.56±2.3 | 6.19±2.3 | 0.118 |
| FP method provided (0-14) | 8.66±3.0 | 10.25±2.0 | 9.4±2.6 | 0.10 |
| FP stock-out status in the past year | 2.26± 2.5 | 6.5± 2.7 | 4.45±3.38 | <0.001* |
| Overall scores | 68.6± 19.4 | 70.4± 8.8 | 69.5±14.7 | 0.734 |

SD - Standard Deviation *p-value significant at 0.05

Table 3: Client satisfaction of services provided and process aspects in social-franchising and non-franchised health facilities

| Variable | Franchised facilities | | | Non-franchised facilities | | |
|--|-----------------------|------------------------|--|---------------------------|------------------------|--|
| | Mean ±SD Satisfied | Mean ±SD Not satisfied | Significance level (bivariate) (p-value) | Mean ±SD Satisfied | Mean ±SD Not satisfied | Significance level (bivariate) (p-value) |
| Total waiting time at the health facility (minutes) | 16.4±23 | 36.7±38 | 0.002 | 15.0±20 | 20.0±25 | 0.316 |
| Total time spent with health provider (minutes) | 15.2±13 | 20.4±16 | 0.16 | 20.0±19 | 17.0±10 | 0.533 |
| The total amount paid for FP services ((United States dollars) | 1.8±3.1 | 1.7±3.5 | 0.80 | 3.1±4.1 | 3.6±6.9 | 0.567 |
| The total amount the client was willing to pay FP services (United States dollars) | 1.3±2.4 | 3.3±3.6 | 0.34 | 2.6±3.2 | 4.6±5.4 | 0.055 |
| The total amount paid for transportation to the health facility ((United States dollars) | 0.4±0.7 | 0.4±0.5 | 0.955 | 0.6±1.9 | 0.6±1.1 | 0.991 |

Key: SD-Standard Deviation, *p-value significant at 0.0

Table 4: Bivariate and Multivariable analysis of clients' satisfaction with FP services on selected covariates

| Variables | Univariable analysis | | Multivariable analysis | |
|--|----------------------|----------------|--------------------------|----------------|
| | COR (95%CI) | p-value | AOR ^a (95%CI) | p-value |
| Age category: Ref: 15-19 years | | | | |
| 25-34 years | 2.24 (0.0-3.20) | < 0.001 | 2.71(1.90-3.87) | < 0.001 |
| 35-40 years | 1.20 (1.52-9.48) | < 0.001 | 2.50 (1.71-3.65) | < 0.001 |
| 41-49 years | 5.75 (4.95-6.69) | < 0.001 | 8.79 (1.67-4.62) | < 0.001 |
| Education level: Ref: Primary and below | | | | |
| High school level education | 0.56 (0.44-0.71) | < 0.001 | 0.44 (0.27-0.71) | 0.001 |
| Collage level education and above | 1.64 (0.26-10.0) | 0.592 | 1.44 (0.19-10.7) | 0.719 |
| Religion: Ref: Catholic | | | | |
| Protestant | 0.74 (0.26-2.12) | 0.582 | 0.79(0.27-2.35) | 0.684 |
| Marital status: Ref: Married | | | | |
| Single | | | 0.69 (0.41-1.16) | 0.168 |
| Overall health facility factors | 1.01(1.00-1.02) | 0.001 | 1.01 (1.01-1.02) | < 0.001 |

Key: OR Odds Ratio, UOR -Unadjusted Odds Ratio, AOR- Adjusted Odds Ratio, 95% Confidence Interval *p-value significant at <0.05

^a Adjusted for clients' age, marital status, religion, education level and health facility factor

Discussion

This study sought to assess and compare FP services' quality and client satisfaction in the social franchise and non-franchise private health facilities in Kajiado County, Kenya. The factors that affect FP delivery quality were grouped into structural, process, client, and provider characteristics. This study shows that client, structural and provider-level factors were significantly associated with the quality of care and client satisfaction with FP services in both delivery models. For structural elements – most health facilities had most of the required amenities (such as availability of contraceptives, electricity, clean water source, adequate sanitation facilities, among other facilities), there was no difference between the social franchising and non-franchising health facilities in the overall structural elements of all the health facilities, except for the FP commodities stock-out status which was most common in non-franchised health facilities. The results from the study showed a higher level of unavailability of contraceptives in the non-franchised health facilities throughout the year; as a result, the client's method choice may not be fulfilled. Other studies have indicated that the availability of a wide range of FP methods is one of the key features of a better quality of FP services^{6,19}.

A demographic health survey analytical study in 2014 stated that Kenya Health facilities at both higher and lower levels of service delivery generally had inadequate infrastructure and supplies essential for providing good-quality services²⁰. This study seems to suggest that there has been an improvement in the structural infrastructural aspect of health facilities from previous studies conducted in Kenya, given that there were no significant differences between the two delivery models. A study conducted in Kenya on social franchising networks showed that the most important benefit of social franchising was training, counselling, and customer service, not structural factors²¹. The study results concur with this finding and provide additional information for non-franchised health facilities.

In this study, nearly all facilities had a system to collect clients' opinions and a quality assurance system, with over half having an

established internal quality improvement team. The only difference noted was the inadequate record-keeping of the quality assurance and management meetings in the non-franchised health facilities. Several other studies have indicated that structural health facility factors such as staffing levels, management, availability of materials and equipment were associated with the quality of care in FP services. This study was consistent with previous studies. The study suggests that the private sector health facilities have improved the availability of amenities needed to provide FP services.

This study documented a difference in the level of training received by health providers. The social franchised facilities had a significantly higher number of health providers who had received FP training than non-franchised health facilities. In line with our findings, other studies have documented that social franchising facilities advantages include the training provided to health providers, which in turn helps to improve the quality of services and increased utilization of services²². The study revealed that most clients received short term contraceptives, mostly injectable contraceptives. Some clients were not provided with an FP method during the visit to the health facility. The most common barrier that prevented them from accessing the service was the cost and unavailability of contraceptives. Contraceptive's stock-outs and irregular supply of FP commodities were identified as barriers affecting access to FP services in Kenya⁸. Other studies in Africa have identified the same challenge^{19,23}.

The quality of counselling has been identified as one crucial factor determining the client satisfaction of services^{5,24}. Appropriate counselling can improve health care utilization and outcomes. A recent study on the same subject covering Kenya indicated that the quality of FP services in public facilities was inversely related to contraceptive use and recommended assessing the quality of care in private sector facilities⁶. The findings from this study will add more evidence on this subject. This study showed no significant difference between the social franchising and non-franchising facilities on the level of counselling. Still, it showed that new FP users received significantly higher counselling overall in non-

franchised health facilities. This study suggests the need to provide counselling to all clients regardless of whether they are new or repeat users. Another study that was done in Senegal documented a similar difference. Other research studies have reported both negative and positive effects of counselling on client satisfaction^{11,25}.

Client satisfaction is an essential factor contributing to the uptake and continuation of family planning services^{11,26-28}. This study found that client satisfaction was high overall, similar to another study in Tanzania²⁶. The study found that those clients who received the FP services at the social franchised facilities had higher odds of being more satisfied than the non-franchised health facility. The availability of contraceptive stock could explain the higher level of client satisfaction at social franchised facilities and better training provided to their health providers and not from other structural and process aspects of quality of care. Other studies have reported similar findings^{24,25}. Another previous Ethiopia study found that repeat FP clients were more likely to be satisfied than new users¹¹. In contrast, our research found no difference in the level of client satisfaction among new or repeat users. This study showed a significant association between client satisfaction and the total waiting time at the health facility; the clients that waited longer in the social franchised health facility were not satisfied. This finding agrees with a 2016 systematic review of studies undertaken in African countries on factors determining the quality of care in FP services that suggested that client waiting time is an essential factor associated with quality of care in FP services⁵. The study showed an association between the client's satisfaction and older clients. This may suggest that older clients are satisfied with the cost of accessing private health services.

This study has some implications. It has demonstrated that social franchised and non-franchised health facilities have the required basic structural amenities to provide FP services; notable differences were on process factors. The study showed a need to improve counselling, improve the availability of contraceptive supply, increase the training of health providers on FP, and reduce the clients' waiting time in health facilities. All private health facilities should be supported to enhance the quality of care provided.

Limitations

This study's main limitation was the presence of a small number of social franchising health facilities - a total of 18 versus the 170 private health facilities in Kajiado County; hence, a small sample of the other non-franchised private health facilities was used to ensure a comparative study.

Conclusion

The findings from this study have demonstrated that there are no differences in the structural aspects of health facilities. The process and client-level factors influenced the quality of care in FP services in private health facilities. Reducing the client waiting time, availability of contraceptives, increasing the number of health workers with FP training and providing the same level of counselling for new and repeat clients were key factors affecting the quality of care in the health facilities. Appropriate interventions such as training more health providers in FP and reducing the clients' waiting time in health facilities need to be considered. The differences between the social franchised and non-franchised health facilities need to be addressed through policy interventions such as provision of standardize training in FP to all health providers in the non-franchised health facilities.

Competing interests

The authors declare no competing interest.

Authors' contribution

All authors wrote and approved the final manuscript.

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