



# International Workshop on Social Franchising in the Health Sector

## Workshop Proceedings

**NOVEMBER 2006**

This publication was produced for review by the United States Agency for International Development. It was prepared by Constella Futures.

**CONTRIBUTOR**

Shuvi Sharma

**EDITED BY**

Aditi Bam

ITAP is a three-year project funded by United States Agency for International Development under Contract No. GPO-I-01-04-00015-00 beginning April 1, 2005. The project is being implemented by the Futures Group International in partnership with Bearing Point, Sibley International, Johns Hopkins University, QED, Urban Institute and Association of Reproductive Health Professionals (ARHP).

*For further information contact:*

**Constella Futures**

1D-II, Parkwood Estate

Rao Tula Ram Marg

New Delhi - 110 022

**ITAP**



CONSTELLA FUTURES

# **International Workshop on Social Franchising in the Health Sector**

## **Workshop Proceedings**

**NOVEMBER 2006**

**This publication was produced for review by the United States Agency for  
International Development. It was prepared by Constella Futures.**

# CONTENTS

<b>Foreword</b>	<b>vii</b>
<b>Abbreviations</b>	<b>viii</b>
<b>Executive Summary</b>	<b>x</b>
<b>Inaugural Session</b>	<b>1</b>
<b>Opening Remarks</b>	<b>3</b>
<b>Importance of Social Franchising</b>	<b>4</b>
<b>Inaugural Address</b>	<b>5</b>
<b>Session I : Introduction to Social Franchising</b>	<b>9</b>
<b>Overview</b>	<b>11</b>
<b>Franchising as an Economic and Social Development Tool</b>	<b>12</b>
Introduction	12
Franchising	12
Reasons for Success of Franchising	12
Franchise Components	13
Fees in Franchising	13
Breadth and Importance of Franchising	14
Economic and Social Value of Franchising	14
Social Franchising	16
Conclusion – Why Franchise?	16
<b>Using a Commercial Franchise Approach for Improving Access to Primary Health Care and Essential Drugs - the example of CFW shops in Kenya</b>	<b>17</b>
Introduction	17
What is ACCESS?	17
Why Essential Drugs in CFW shops?	18
Beginning of CFW shops	18
CFW shops is a Private Organization	20
Core Principles of CFW shops	20

CFW shops Franchise System	21
Scaling up of CFW shops	21
Health Promotions	22
Health Promotion Outcomes	23
Conclusion	23
<b>Panel Deliberations</b>	<b>24</b>
Key Observations	24
<b>Session II: International Experiences in Social Franchising for Health</b>	<b>27</b>
<b>Overview</b>	29
<b>Social Franchising Experiences in Pakistan</b>	30
Introduction	30
Background – Greenstar Social Marketing and Social Franchising Program	30
Social Franchising – the Pakistan Experience	30
Greenstar Model for Social Marketing and Franchising	31
The Greenstar Program	33
Lessons Learned	33
Greenstar Results	33
Benefits to Government	34
Sustainability	35
Challenges	35
<b>Well-Family Midwife Clinic – Social Franchising FP/MCH Services in Philippines</b>	36
Introduction	36
What is Unique about WFMC Model?	36
Philippine Setting – the FP/MCH Market	36
WFMC Franchise Model	38
WFMC Partnerships Foundation, Inc. (WFPI) – the Franchisor	42
Accomplishments	43
Lessons Learned	44
Conclusion	45
<b>Branded Networks as Alternative Business Models – Serving the Market, Expanding the Market</b>	46
Introduction	46
First Set of Questions	46
Business Models	46
Is the Brand Important?	50
Conclusion	50
<b>Panel Deliberations</b>	<b>51</b>
Key Observations	51

<b>Session III: Essential Success Factors for Social Franchising in India – Learning from International Experiences</b>	<b>55</b>
<b>Introduction</b>	57
<b>Recommendations of Group Presentations</b>	58
Key Messages from International Experiences in Social Franchising	58
Lessons Learned to Quicken and Improve Readiness and Acceptance of Social Franchising	59
Specific Takeaways for Success of Social Franchising in India	60
<b>Panel Deliberations</b>	62
Key Observations	62
<b>Summing up: Day One Proceedings</b>	64
<b>Session IV: Social Franchising in India</b>	<b>65</b>
<b>Overview</b>	67
<b>Self-sustaining Social Enterprises – World Class in India</b>	69
Introduction	69
Existing Paradigms in Healthcare Delivery	69
Developing Social Franchising Models	70
PROSALUD Case-Study	70
Indian Model – Aravind Eye Care System	72
Conclusion	75
<b>Experiences of HLPPT in Social Franchising – Public-Private Partnership in RCH</b>	76
Introduction	76
Why Public-Private Partnership in Social Franchising?	76
Social Franchising – Creating the Middle Path	77
HLPPT Model	78
Viable Venture	81
Roll out Plan	81
<b>Franchising for Health – the Apollo Experience</b>	82
Introduction	82
Motivations for Franchising – Changing Face of Healthcare	82
Apollo Health and Lifestyle Limited	83
The Apollo Clinic	83
The Apollo Clinic – Positioning	85
Franchising: the Business Format	86
Learning	86
Conclusion	86
<b>Panel Deliberations</b>	87
Key Observations	87

<b>Session V: Indian Experiences in Social Franchising</b>	<b>91</b>
<b>Overview</b>	93
<b>Experiences of PSI in Social Franchising</b>	95
Introduction	95
Social Marketing Programs	95
PSI Model for Social Franchising – Network	96
Key Clinic Network	98
Summing up	101
<b>Social Franchising – the Janani Experience</b>	102
Introduction	102
Janani	102
Lessons from Franchising Experiences – Surya Clinics Phase -I	104
Mutual Benefits	105
Impact	106
Conclusion	106
<b>Social Franchising a Way to Healthy Jharkhand</b>	107
Introduction	107
Jharkhand Health Status	107
Conventional Approach Cost-intensive	108
Bridging Gaps – Social Franchising	108
Developing Social Franchising Models in Jharkhand	110
Conclusion	113
<b>Panel Deliberations</b>	114
Key Observations	114
<b>Session VI: Relevant Experiences for Scaling up of Social Franchising in India</b>	<b>117</b>
<b>Introduction</b>	119
<b>Recommendations of Group Presentations</b>	120
Key Messages	120
Success Factors	120
Who could be the Franchisee?	121
Identification of Franchisees	122
Quality Management System	122
Sustainability	123
<b>Session VII: Panel Discussion – Way Forward for Social Franchising in India</b>	<b>125</b>
<b>The Way Forward – Key Recommendations</b>	127
Social Franchising – One of the Tools	127
Government Roles	127

Innovations in Public-Private Partnership – Shared Risks	128
Social Franchising as a Business Model	129
Models	129
Differences between Social Franchising and Commercial Franchising	129
Franchisor Identification	129
Avoiding Duplication with Shared Resources	130
Sustainability	130
Franchise Viability	131
<b>Annexures</b>	<b>133</b>
<b>Agenda</b>	<b>135</b>
<b>List of Participants</b>	<b>138</b>



**USAID | INDIA**  
FROM THE AMERICAN PEOPLE

## FOREWORD

Uttar Pradesh, with an estimated population of 170 million, faces several serious challenges in the health sector. As per the National Sample Survey Organization estimate, nearly 91 percent of health care seekers depend on the private sector for services with only nine percent opting for public sector health services. In addition, the private health sector is growing at a faster pace than the government health sector. Of the total 47,567 registered allopathic doctors in the state, only 6,766 are in public sector. The large number of vacancies in all government health institutions, coupled with slow expansion of health delivery facilities have resulted in high dependence on private sector health care. The private health sector is complex, ranging from unqualified individual practitioners to tertiary hospitals offering services at high costs that a vast majority cannot afford. Health expenditure is one of the main causes of poverty and hardly three percent of households have health insurance coverage.

The Ministry of Health and Family Welfare, GoI, recognizing these realities, has developed a strategy of encouraging public private partnership mechanisms in the health sector as part of the National Rural Health Mission. Social franchising is one such mechanism that helps to create a large network of private health institutions, assures uniform quality of health care, creates demand for services and substantially reduces costs involved. Social franchising is a business model that, is self-sustaining. USAID-funded social franchising networks in several countries have achieved significant results.

In order to understand the issues and challenges in implementing social franchising in the health sector, USAID-funded IFPS Technical Assistance Project (ITAP) conducted an international workshop in April 2006. Experts from several countries and within India presented thought-provoking papers and engaged in intense discussions that helped to identify critical key elements integral to social franchising in the Indian context, with particular focus on Uttar Pradesh. This volume, which is a compilation of the workshop deliberations, will be of immense help in disseminating this important information amongst a wider audience.

I would like to take this opportunity to congratulate the ITAP staff for their effort to publish and disseminate this volume. In collaboration with the Government of UP and other private and public-sector partners, USAID hopes to take these social franchising efforts forward by designing and implementing a phased-in social franchising project in Uttar Pradesh.

Robert Clay  
Director

Office of Population, Health and Nutrition  
USAID

U.S. Agency for International Development  
American Embassy  
Chanakyapuri  
New Delhi 110021

Tel: 91-11-24198000  
Fax: 91-11-24198612  
[www.usaid.gov/in](http://www.usaid.gov/in)

# ABBREVIATIONS

AHLL	Apollo Health and Lifestyle Limited
ANM	Auxiliary Nurse and Midwife
AWC	Anganwadi Center
AWW	Anganwadi Worker
AYUSH	Ayurvedic, Unani, Sidha, Homeopathy
BPL	Below Poverty Line
CBOs	Community-based Organizations
CFW shops	Child and Family Welfare shops
CHCs	Community Health Centers
CPR	Contraceptive Prevalence Rate
CYP	Couple Years Protection
DFID	Department for International Development
EmOC	Emergency Obstetric Care
FH	Family Health
FP	Family Planning
HLFPPT	Hindustan Latex Family Planning and Promotion Trust
IFA	Iron and Folic Acid
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
INGOs	International Non-governmental Organizations
INR	Indian Rupees
ISMPs	Indian System of Medical Practitioners
IUCD	Intrauterine Contraceptive Device
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
NACO	National Aids Control Organization

NGOs	Non-governmental Organizations
NRHM	National Rural Health Mission
OT	Operation Theatre
PPCP	Public-Private Community Partnership
PPP	Public-Private Partnership
PSI	Population Services International
RCH	Reproductive and Child Health
RH	Reproductive Health
RMP	Registered Medical Practitioners
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WFMC	Well-Family Midwife Clinic
WHO	World Health Organization

# EXECUTIVE SUMMARY

## **SOCIAL FRANCHISING**

Social franchising in the health sector is an innovative approach strengthening partnerships between the public and private sectors for improved delivery of health services. In developing countries, the growth of health franchising programs as alternate business models has emerged in response to the numerous challenges faced by public health systems. Effective health management for meeting the health needs of both rural and urban populations is a key policy concern of governments worldwide.

Over three-fourths of healthcare services in India, as in other developing countries, are privately procured. This indicates the availability of vast service delivery resources in the private sector. Social franchising leverages these resources to supplement the public sector delivery of services, especially in low resource settings. This mechanism provides opportunities to deliver health services to poor segments by integrating with other public-private partnership models such as community insurance and vouchers.

Social franchising, therefore, has come to be recognized as an

effective tool in reconciling two key aspects in healthcare services – adequate profits with consumer affordability and standardized quality of care engendering consumer trust in the brand. However, the core task of franchising is not so much to activate the delivery of services but to sustain the delivery of quality services within a larger mandate of social benefit.

This motivation has emerged as the key premise in the difference between social franchising and commercial franchising. The scale of interventions ensures that quality benchmarks integrated in social franchise models influence not only the public – but also the commercial sector, which, consequently, expands the availability of regulated quality of services. Despite this benefit that it triggers, however, a downside of social franchising is that such ventures can encounter difficulties in attaining self-sustainability if not implemented properly.

## **SOCIAL FRANCHISING WORKSHOP**

Taking into account the success of social franchising in different parts of the world, the IFPS-II Technical Assistance Project (ITAP) in collaboration with USAID, SIFPSA

and Sibley International convened a workshop on ‘Social Franchising in the Health Sector’.

The Workshop aimed at converging diverse international experiences in social franchising and branded networks operational in various countries such as Pakistan, the Philippines, Indonesia, Colombia and Kenya with the social franchise networks in India, to promote better understanding on relevant experiences and enhanced learning for scaling up social franchising in India.

With the active participation of government representatives and delegates from the Indian states of Uttar Pradesh, Uttaranchal and Jharkhand, the Workshop combined public sector participation with international and national participants from academic institutions as well as developmental (INGOs, NGOs and donors) and civil society organizations.

Most of the social franchising models – international and national – featured at the Workshop, showed the successful adaptation of franchising mechanisms in the family planning and reproductive health sectors. The cross-cutting theme across the international and Indian experiences was the economic and social value of franchising and its suitability for health initiatives to increase availability and accessibility among underserved or unserved populations.

Bridging gaps in service delivery in rural or remote areas, however, still remains a considerable challenge across most models. This is reflected in the case studies of the

Greenstar Network of Pakistan, the Well-Family Midwife Clinic Network of the Philippines and the Apollo Clinics of India that are largely based in urban and peri-urban locations. On the other hand, the Child and Family Welfare Shops model of Kenya, the Janani Network in Bihar, Jharkhand and Madhya Pradesh, and Population Services International’s experiments in Uttaranchal and a few southern states of India, represent experiments in adapting social franchising models in rural locations. The integration of both rural and urban health needs indicate new dimensions in social franchising models, which are being initiated by Hindustan Latex Family Planning and Promotion Trust in India.

Besides the challenges of effectively positioning social franchising models in rural locations, the design and implementation of the business dimensions of a social franchise network are major concerns. Furthermore, in most developing nations there is the challenge from free or subsidized services such as free availability of contraceptives or subsidized sterilizations, promoted by government health program. The self-sustainability of social franchising models, therefore, poses a significant challenge across countries and models.

This is particularly significant for India, since social franchising is new in the country. It requires a sustained time period for experimentation and support and collaboration with multiple partners, i.e. the government and donors, before social franchising initiatives can be effectively scaled up in the larger public domain.

## **PUBLIC-PRIVATE PARTNERSHIPS IN INDIA**

Government response to social franchising in India has been encouraging, as also reflected in the interest of the state governments of Uttar Pradesh, Uttaranchal and Jharkhand to adopt social franchising models to improve health service delivery. There is a growing recognition within government circles that the State needs to explore alternate models to address infrastructural gaps in the public health sector that are less cost-intensive and offer more flexibility. There is a clear understanding that the public sector alone cannot bridge these structural gaps without private sector partnerships.

Social franchising offers a new approach in health services provision through networks of private providers ensuring socially beneficial services. For governments, being responsible for providing equitable opportunities to the disadvantaged, social franchising mechanisms offer means of providing services that are more affordable and accessible and which could also change the mindset of consumers, converting them from beneficiaries into customers. This change requires a concurrent change in mindsets of public sector providers from that of serving beneficiaries to meeting the needs of customers, as customers are more demanding of health services than passive beneficiaries. Thus, in order to improve service delivery and ensure demand generation, beneficiaries need to be encouraged to become proactive customers.

However, the status of public-private partnerships in the health

sector in India show that a majority of the existing franchising arrangements in the country are primarily business models, operating without the government and located primarily in the high-cost specialized or corporate sectors. This highlights the need for establishing authentic public private franchising partnerships with a rural orientation.

## **SUCCESS FACTORS FOR SOCIAL FRANCHISING IN INDIA**

Some key successes highlighted in the Workshop indicate that certain prerequisites are essential for the successful implementation of social franchising. These include conducive policy and legal frameworks for social franchise models; systematizing financing procedures; standardizing quality benchmarks and ensuring accountability and transparency.

It is also evident that social franchising in India requires a long-term commitment with a phased approach in planning interventions. This approach is important to monitor the impact of innovations in the delivery of health services, especially in view of the geographic and demographic diversities in India requiring different operational strategies to comprehensively address health needs.

In terms of sustainability, the twin factors of adequate resources and diversification of services are important. A combination of financial resources (donor and government funds) and human resources (qualified and committed service providers) are essential

to facilitate a diversified basket of health products and services.

## **THE WAY FORWARD**

Social franchising, while one of the many options before government for improving the delivery of public health services, has the potential to build various levels of networks that provide linkages from the bottom-up, integrating the health needs of the grassroots or rural with the urban population. India, with its wide variety of health practitioners, from community recognized health providers to AYUSH workers and qualified doctors, besides health associations, CBOs, NGOs and ISMPs, has the depth and diversity of resources that can be tapped to support public health services.

It is critical to combine social objectives with business fundamentals in social franchising initiatives. Ensuring economic viability and financial sustainability entails developing shared risk models with in-built components of cost recovery. One such approach would be initiating voucher schemes, which would widen the outreach among poor clients. The potential for different price and subsidy combinations in social franchising models is a unique feature, which boosts its

potential as a tool of public-private partnerships.

While the goal of most social franchising models is self-sustainability, it need not become an imperative when the initiative is directed towards poor, rural populations, who warrant an even greater helping hand.

The Indian Government has many positive ways to engage with social franchising. Even if franchising models are currently predominantly in the private sector, the State can provide direct financial support or help finance support services such as technical support. Alternatively, it can adopt social franchising in its overall program strategy to focus its activities in specific areas.

The key to moving forward in India is to recognize that there are varying levels of complexity and diversity, and large populations requiring quality health services, which demand the employment of diverse approaches and models. Future strategies for India, in particular, indicate piloting possible models over a reasonable period of time. The need is to employ different tools in different situations and build a broad portfolio of interventions reflecting the diverse facets of social franchising.



# INAUGURAL SESSION

## INAUGURAL SESSION

### Opening Remarks

*Donna Sibley, President, Sibley International*

### Importance of Social Franchising

*Randy Kolstad, Division Chief – Reproductive Health Division, USAID*

### Inaugural Address

*Nita Chowdhury, Principal Secretary – Health, Uttar Pradesh*

*Shivendu Shukla, Secretary, MoHFW, Government of Jharkhand*





# OPENING REMARKS

*Donna Sibley*

**M**s. Donna Sibley addressed the Workshop participants stating that if franchising had emerged as the marketing phenomenon of the commercial sector for the latter half of the last century, then it was possible that social franchising would perform the same role in the social sector in the first part of this century. She emphasized that the need was to transfer the lessons learned in the commercial sector to the social sector to achieve similar rapid growth in penetration of the target market. She shared her belief in self-sustaining distribution networks and that franchises could be built using public-private partnerships through which the donors and governments could address issues such as water supply and health services more

effectively, especially among needy populations.

She appreciated the fact that the Workshop facilitated the gathering of some of the most experienced practitioners in the relatively new field of social franchising. Sharing their experiences offered the opportunity to examine pertinent issues of social franchising in detail before developing a plan for the family health franchise for the state of Uttar Pradesh.

She mentioned the partnership of Sibley International – a key institution involved in the field of social franchising for the past 16 years – in this initiative and looked forward to working with the Workshop participants throughout the week.

# IMPORTANCE OF SOCIAL FRANCHISING

*Randy Kolstad*

**M**r. Randy Kolstad elaborated on USAID's involvement in public and reproductive health in the state of Uttar Pradesh in the last decade. He indicated that in the last ten years, USAID's work in Uttar Pradesh had been both successful and challenging.

In 1992, the USAID initiative in Uttar Pradesh was known as 'The Innovations in Family Planning Services Project', which subsequently led to the second phase. Mr. Kolstad stated that in both periods the emphasis was on innovations, though much of the progress has been on just one type of innovation. It was time, therefore, to move towards the next type of innovation, and he suggested social franchising to be the key feature for the next generation of innovations.

Mr. Kolstad further stated that the focus of the day's discussions was to explore how best to address the

reproductive and child health needs of the populations of Uttaranchal, Uttar Pradesh and Jharkhand which formed a large part of north India, and how best to use the next generation of innovations for this purpose.

Summing up, Mr. Kolstad stressed the need to utilize the immense international experience present at the Workshop to explore new ideas in working together. He concurred with Ms. Donna Sibley that public-private partnerships offered a tremendous challenge and despite the different cultures between the two sectors, he felt that it was crucial to collaborate in order to best serve health needs.

He concluded his address by welcoming all the participants and urging them to apply the lessons and experiences shared in the Workshop to the local realities in their states of operation.

# INAUGURAL ADDRESS

*Nita Chowdhury*

**M**s. Chowdhury expanded on the elements of public-private partnership expressed by Mr. Kolstad. She emphasized that in public-private partnerships it is important to define the theme precisely. She mentioned the Government of India's Seventh Five-Year Plan in the mid-80s, when the Government first suggested public-private partnership. She recalled that at that time the general perception about public-private partnership was that the government would make available public goods such as land, concessional rates for electricity, water supply, etc. and extend grants, in the hope that such a package would lead to a sea change in the working of the social sectors such as education, health etc. Yet, over the years, the results had not been exactly as expected.

She cited the example of the Delhi Government health sector, which was among the first to extend huge concessions to big private sector partners such as the Apollo Group. However, in the last five years, public interest litigation indicated that the partnership between the public and private sectors had not delivered according to expectations. While the government expectation had been an increase in the availability of

best medical services to all sections of patients, in actuality, the best facilities became available primarily to the middle class.

The implementation defeated the very purpose for which the partnership was intended, and it was only after a protracted struggle with the help of court intervention and social awakening that out-patient facilities were made available to a small section of the intended beneficiaries. The government was informed that it was not possible to ensure treatment to all sections of the population, most notably the poor patients.

The rationale offered for not extending services to the poor sections was that (a) poor people did not fit into the private sector service providers scheme of things, (b) poor people did not generate the type of profit desired and (c) even public health partnerships needed to work for profit, since the private sector had to repay expenses incurred on service provision such as loans. Consequently, despite the best of intentions, the public-private partnership had not yielded the intended results. She mentioned that such experiences had caused much distress to the public and influenced rethinking in the government.

On the other hand, Ms. Chowdhury also acknowledged the government's shortcoming in this scenario. She stated that the government had been making grand institutions as far as buildings were concerned. Presently, Uttar Pradesh has 3,460 primary health centers, 386 CHCs, and over 160 hospitals in the government sector that together provide over 3 lac beds. However, the low utilization of such government health facilities raises concerns regarding public perception about the government as a provider of quality health services. This remains the key concern facing the public health sector.

In view of such government experiences in public-private partnership, Ms. Chowdhury suggested that the Workshop move beyond conventional thinking on traditional roles of the government as the giver and the private sector as the taker. She questioned whether it was possible to view this relationship differently and explore partnership situations wherein the services of all could be used together.

In this context, the first issue is to recognize that in some cases the private partners might extend better services, while in other cases the government might have better services to offer. But in cases where there are gaps, the efforts of both the sectors could be pooled to enhance results. The other issue is to explore a different style of

functioning. In this context, she appreciated the efforts of USAID that had facilitated the development of initiatives according to the local needs. She emphasized the need to continue in this manner instead of making a model that fits all parts of Uttar Pradesh.

Citing her professional experiences of working in various parts of Uttar Pradesh, Ms. Chowdhury pointed towards the differences between different areas, such as western and central regions of the state. In view of geographical as well as other socio-economic variants, she emphasized the need for exploring different types and models of partnerships for different areas. She remarked that such an approach would probably require much more handholding in certain areas in comparison to others.

She urged the participants to view the Workshop as an opportunity to come up with different types of innovations suited to different states. She was also hopeful that inter-state partnership in this direction, for example between Uttar Pradesh and Jharkhand, could trigger off planning for better delivery of health services.

In conclusion, she thanked the Workshop organizers for inviting her and expressed happiness at being part of this process. She hoped that the Workshop deliberations would present some ideas for her to work on and offer something that she could implement.

# INAUGURAL ADDRESS

*Shivendu Shukla*

**M**r. Shivendu Shukla shared certain models of public-private partnerships initiated by the Ministry of Health and Family Welfare (MoHFW), Jharkhand. Presenting the government's experience in such partnerships, he recounted similar experiences in Jharkhand as in Uttar Pradesh. He mentioned that the Jharkhand Government had also extended concessions to the private sector in view of certain expected results that had not matched the government expectations, despite a long period of 25 years. This had led to rethinking in terms of new models in public-private partnership to achieve the desired goals.

## **ISSUES OF CONCERN IN PUBLIC-PRIVATE PARTNERSHIPS**

Mr. Shukla stated that one dimension of public-private partnership is the coming together of two mindsets and building enterprises in collaboration. It also points to the role of the government in deciding how to use public resources. He raised the issue of whether resources for the public good should be channelled only through the public sector. He felt that the public sector itself need not create all the facilities but could outsource some of them, at the

same time ensuring the provision of services to the most needy sections of the population. He elaborated on this alternative proposition by sharing an example whereby a hospital is set up by a private enterprise and the government buys out the services. Such an arrangement ensures that instead of creating a facility or hospital, the government uses those funds to buy out services.

Furthermore, the key issue in public-private partnership is about informational asymmetries. Mr. Shukla emphasized that it was easier to control informational issues while working within the government sector. However, in public-private partnerships, the adverse selection issue had emerged of importance in view of the past experiences in private service providers contracted in such collaborations. Consequently, it is crucial to ensure that information asymmetry issues remain an integral part of such partnerships.

Another important issue in public-private partnerships is of mechanisms to monitor the quality of services being provided. Mr. Shukla stated that the issue of quality service is extremely important in healthcare because

it is easily perceptible. Yet, it is difficult to measure quality objectively, and even more difficult to define it in contracts with private service providers. This raises two important issues – how to address such concerns in a public-private partnership contracts and how to enforce public-private contracts in practice – to ensure that desired outcomes are realized from such partnerships.

### **JHARKHAND EXPERIENCES IN PUBLIC-PRIVATE PARTNERSHIPS**

In view of the above concerns, Mr. Shukla shared one of the models tried in Jharkhand in the field of family planning. Referring to the Government of India scheme in which 20 percent of the services are provided free to poor patients, and which also gives cash incentives to private health providers for family planning operations, he mentioned the modifications in the scheme introduced by the Government of Jharkhand. These modifications had been prompted by difficulties in assessing client eligibility for the scheme and constraints in measuring whether 20 percent of services had been provided free of cost. Instead, the Jharkhand Government pays the difference in the costs to the private practitioner for every family planning

procedure performed, irrespective of the client being poor or rich.

Mr. Shukla rationalized that this approach presented a simplified way of enforcing contracts between the private providers and the government, as it only entails an announcement to the client by the private provider that a particular family planning procedure costs a reduced amount. He further stated that such initiatives would also create a manifold increase in the demand for health services due to increased affordability with the reduction in costs. Such experiments could ensure cheaper or subsidized services in the private sector for the local population, particularly those sections that were unable to incur even small health expenditures, while giving them the option of availing such services free of cost at the government hospitals.

He also stated that the Jharkhand Government was working on a strategy to increase the total services for the Surya clinics, franchised by Janani, and also to improve public facilities so that the poor people could directly access such services from government hospitals.

# SESSION I

## INTRODUCTION TO SOCIAL FRANCHISING

Chairperson

*Birte Sorenson, Senior Public Health Specialist, The World Bank*

### **Franchising as a Social and Economic Development Tool**

*Michael Amies, Consultant, Sibley International*

### **Using a Commercial Franchise Approach for Improving Access to Primary Care and Essential Drugs – the example of CFW shops in Kenya**

*Denis Broun, Country Director, UNAIDS, India*

Discussant

*Sheena Chhabra, Division Chief, Health Systems, USAID*





# OVERVIEW

The first session of the Workshop introduced the participants to the concept of social franchising, as widely understood worldwide. Building on the key premises and conceptual framework of franchising, the session also highlighted the distinctive aspects of social franchising. With the key focus on initiating deliberations on franchising, the session comprised two presentations on various ongoing approaches and models in social franchising operational in different parts of the world.

‘Franchising as a Social and Economic Development Tool’ is a paper that encapsulates the process of franchising from its beginnings in medieval Europe to the contemporary world of social franchising. Drawing linkages between business or commercial franchising and social franchising,

it profiles the unique features as well as the wide scope and potential of franchising. The paper traces the connections between social franchising and its role as an effective conduit for humanitarian aid initiatives reaching a wide section of the population.

The paper on ‘Using a Commercial Franchise Approach for Improving Access to Primary Care and Essential Drugs’ with the example of Child and Family Welfare Shops (CFW shops) in Kenya represents the potential of commercial franchising with a social purpose. The successful experience of the CFW shops franchise, operational in a private sector environment, demonstrates the possibility of improving the access to health products and services that are better adapted, in closer proximity to people, more affordable and yet of high quality.

# FRANCHISING AS AN ECONOMIC AND SOCIAL DEVELOPMENT TOOL

Michael Amies

*In the common interpretation, franchising implies “The developer of a business concept licenses others – the franchisees – to operate that concept, for an agreed period of time, within a specified territory, using his/her system and the ‘brand’ (usually) in return for financial considerations.”*

## INTRODUCTION

The beginning of franchising dates back to 1066 AD in medieval Europe with the innovations of William the Conqueror in France. He franchised large parts of the country to barons and they ran those parts on his behalf and paid a royalty to the king.

In the interim centuries, franchising has seen a lot of development and particularly so in late 20th century, when franchising came to dominate the retail and service sectors in western markets. Currently, more than 50 percent of the retail trade in the United States is through franchise outlets and in Western Europe the figure is around 38 percent.

## FRANCHISING

There are several definitions of franchising. In the common interpretation, franchising implies “The developer of a business concept licenses others – the franchisees – to operate that concept, for an agreed period of time, within a specified territory, using his/her system and the ‘brand’ (usually) in return for financial considerations.” There are also instances of franchises without any fee structure.

Despite the current wide prevalence of franchising, it is not a magic

formula with an answer for everything. However, its unique feature is that ‘one can be in business for one’s own self, but not by one’s own self.’

Franchising in the commercial sector has largely followed the business format franchise, which has come to be recognized as the most common and successful form. In this format the franchisee receives not just the rights to distribute products or services but also helps in operating the business. This is a point often missed in social franchising program – that for the franchisor, it is the franchise which constitutes the business and not the end product or the service that is delivered. It is about developing the franchised network and supporting the franchisee. The social franchisor needs to recognize that it is no longer operating a single clinic but a franchise network of independently-owned businesses (clinics).

## REASONS FOR SUCCESS OF FRANCHISING

Various factors have contributed to the success of franchising. Franchising allows very rapid market penetration, generally leading to market dominance. The McDonald’s model is a classic example of rapid growth and market domination via franchising.

In a typical business-franchising model, rapid penetration is ensured because many persons with small amounts of money, who then become entrepreneurs running their own businesses, rather than becoming mere employees, share the risks of capital investment.

In addition, the development of a brand and brand recognition is a key reason for the success of franchising.

## **FRANCHISE COMPONENTS**

The key components of a franchise comprise the following.

- Proven product or service.
- Operating system tested and documented that establishes ability of the franchisor to run the business.
- Legal framework that defines a relationship between the franchisor and franchisees.
- Registered brand and logo that is protected against misuse by others.
- 'Sovereign' territory where the franchisor guarantees not to put any more franchisees within the same territory so that there is greater synergy among franchisees and less competition.
- Training and support.
- Marketing programs run by and with the franchisor and franchisees.
- Equipment and supply chain that provides economies of scale if processed centrally by the franchisor.

In addition to these components, the success of the franchise is ensured because the customer comes to trust the brand.

Lastly, this franchise system depends on the inter-dependence of the franchisor and the franchisees. The franchisor needs the franchisees to expand and provide an income, while the franchisees need the franchisor for access to business systems, the brand, continuous training and development of products and services.

## **FEES IN FRANCHISING**

There are diverse fee systems in franchising. In some systems, fees are optional. In a standard franchise system there is a provision for initial payment or franchise fees that accords the right to the use of the name (brand) and the system.

Usually, there is also the ongoing payment system that is termed the royalty or management service fees, which is frequently a percentage of the total sales volume. There are other methods, such as fixed royalties based on projected volume of business.

Lastly, there is often a small amount of the total sales volume that contributes to the central marketing program. These are the most common features of franchise fees.

Alternatively, another example of operating systems is of the franchisor supply chain, where the franchisor takes margins on the product supplied and does not charge a royalty. An apt example of such a case is Baskin Robbins – the franchisor simply charges the franchisee for the ice cream purchased and makes its profit from that alone.

## **BREADTH AND IMPORTANCE OF FRANCHISING**

The extent of franchising is illustrated by its wide outreach in more than sixty market sectors. It is not just limited to 'fast food' but is growing rapidly in the service sector. This is partly because it is one of the cheapest sectors in terms of capital investment for the franchisee to get into. Often there is no retail site involved and there is scope to develop what has come to be termed as 'low cost franchises', sometimes also called 'blue collared franchises'. In such franchises, the franchisee operates the business by himself or herself and does not employ other people, for example, plumbing repair. There is a very wide range of investment levels in franchises that range from US\$1,000 to US\$100,000 and more.

The scope of franchising allows virtually any product or service that needs to be distributed to multiple customers through multiple distribution points, to be franchised.

McKenzie encapsulates the importance of franchising as *"Franchising is a world's ambassador of free trade. The world's wealth ends up in the retail and service sector. Franchising is the high-tech retail and service side of the equation. It helps to bring economic security to nations."*

The key feature of franchising is the mutual dependence of the franchisor and the franchisee and remains the vital feature of the franchise relationship.

## **ECONOMIC AND SOCIAL VALUE OF FRANCHISING**

The value of franchising in economic development is immense due to its role in various market sectors. It helps in promoting successful economies based on many small businesses and not a few very large enterprises. The small businesses create a 'middle class' of business owners. They tend to be small in the way they behave and tend to favor the democratic society, which has laws that people follow. However, franchising can create many small businesses very quickly through the replication factor and franchises have a very high success and survival rate.

Studies in America and Western Europe have demonstrated that an independent business generally has an 80 percent chance of going bankrupt in three years and only a 20 percent chance of success. However, with franchising these figures can be reversed, and the purchase of a franchise that is operating properly assures an 80 percent chance of success. Therefore, the success rate in franchising is very significant.

Another promising aspect that is good for emerging economies is that franchises tend to operate in the formal sector and are thus revenue generating for the state. They also have an effective start-up and expansion strategy. A good franchisor helps the franchisee to start the business. A good franchisor plans development in relation to the size of the territory that can support the business. Apart from the blue-collar franchise, which is in

**McKenzie encapsulates the importance of franchising as "Franchising is a world's ambassador of free trade. The world's wealth ends up in the retail and service sector. Franchising is the high-tech retail and service side of the equation. It helps to bring economic security to nations."**

itself a job, most of the franchisees train their employees so that skills are developed as part of the franchise. Training is an integral part of the franchise for facilitating skill development and quality improvement. Job creation is thus an additional asset.

Franchising helps to introduce new products and services that improve the infrastructure and also lead to quality improvements. The franchisor typically imposes standards for the products or services supplied with which the franchisees must comply and forces quality requirements back up the supply chain.

All these factors cumulatively impact foreign and local investments, since both are encouraged by success rates. In the United Kingdom, the National Westminster Bank has a franchising department, which pre-approves franchises. It looks at the franchises operating and decides whether they are any good or not, and a new franchisor is expected to submit a business plan that is reviewed by the Bank. Thereafter, the Bank is happy to make loans for approved franchisees for that franchise. Lending institutions have more confidence in franchises than in independent 'start-ups'. This is primarily due to the evident difference in the success and failure rates of these two business systems.

### **Franchising and Finance**

Finance in franchising is applicable to both commercial and social franchising. The high success ratio of franchising makes it attractive to lending institutions. For example, banks are more likely to invest in

or lend to franchises due to easy review of existing units and financial appraisal of operational units, to assess whether the business is working or viable. The business proposition is always the same and the franchisor has a vested interest in the success of the franchisees. It is attractive to financial institutions since franchising is not just one little business but also a network of businesses. In addition, leasing programs can be introduced in sectors with significant capital investment. In the social franchising market this is often the case, an example being the Greenstar Network in Pakistan, which entails the development of large health clinics requiring large investments in equipment.

Franchising helps to produce a macro effect from micro effort. Donor agencies usually like this factor because if an investment is made in the development of a business as a franchise, it automatically expands each time new franchisees join the franchise, thereby reducing the unit cost of development. In contrast, experience has shown that quite a lot of business service centers developed under donor programs, especially in the former Soviet Union that operated on one to one basis, were extremely high cost and usually failed.

### **Franchising in the Micro Sector**

Franchising in the micro sector is not a fully developed system as yet. The businesses in the micro sector are usually very 'simple' in concept. They do not require much business or operating systems and are less dependent on 'how to run the

business' aspect of a franchise. The inter-dependent phase may be of short duration, unless supply based. In such cases, some kind of a short-term franchise agreement may be more appropriate, generally of one-two years or five years.

In this franchise system, the franchisor is more akin to an incubator since it operates within low level business market where the franchisor passes on expertise to enable people to run their business efficiently. At the same time, there is also recognition that the learners will be free once they have learnt how to run the enterprise successfully.

Although these types of franchises do not ensure brand development to the same extent as commercial franchising, rapid business development and multiplication is possible. Occasionally, however, such operations produce speedy establishment of the brand image.

Franchising in the micro sector has proved to be an efficient business system, despite rare cash and inventory control. This approach can provide a path to upgrade from micro to medium sized businesses and integrate micro business into the formal sector.

### **SOCIAL FRANCHISING**

Social franchising differs from commercial franchising primarily in its motivation, though franchisors in commercial franchising as well often expound social objectives.

In social franchising, inter-dependence between the franchisor

and franchisee is needed and like commercial franchising, it also benefits from having a sound business system and the creation of the brand or the image. But it must still be economically viable in the long-term, unless donor support is guaranteed.

Social franchising can equally benefit from a commercial attitude, implying that it needs to attract customers and provide necessary services, as well as look for referrals and repeat customers. It also benefits from a uniform approach so that customers recognize that they have consistent services and products. The standardized package in social franchising helps to regulate the quality of services. However, social franchising can have difficulty in moving towards self-sustainability.

### **CONCLUSION - WHY FRANCHISE?**

Franchising offers several advantages. No other distribution system offers rapid market penetration without massive 'central' investment. It also helps to provide uniformity of experience to the customer. In addition, franchising leads to the creation of many small, independent businesses and acts as an effective conduit for humanitarian aid initiatives reaching a wide section of population. And if not franchising, what else is there to try that has not already been tried?

In conclusion, franchising can be a model for making quality health service available to vulnerable sections of the society, which allows for rapid expansion with limited investments.

*Social franchising can equally benefit from a commercial attitude, implying that it needs to attract customers and provide necessary services, as well as look for referrals and repeat customers. It also benefits from a uniform approach so that customers recognize that they have consistent services and products. The standardized package in social franchising helps to regulate the quality of services.*

# USING A COMMERCIAL FRANCHISE APPROACH FOR IMPROVING ACCESS TO PRIMARY HEALTHCARE AND ESSENTIAL DRUGS

## THE EXAMPLE OF CFW SHOPS IN KENYA

Denis Broun

### INTRODUCTION

The commercial franchise model of Child and Family Welfare (CFW) shops in Kenya aims at improving access to primary healthcare and essential drugs. Operating within a small set up of less than 70 outlets, it presents one of many approaches prevalent in health franchising worldwide.

### WHAT IS ACCESS?

Access to primary healthcare essentially implies access to essential drugs. However, access to care and to medicine remain elusive in practice. In this context, the CFW shops franchise in Kenya has been trying to observe whether franchising has improved access, and concurrently trying to delineate the methodology required to measure both access and the progress towards access.

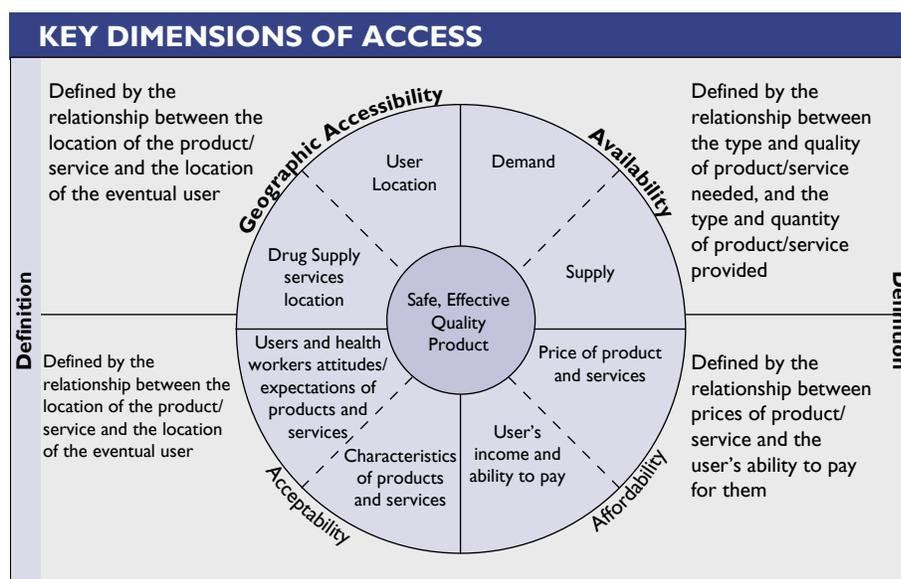
### Key Dimensions of Access

There are five key dimensions of access.

- Geographical accessibility refers to the location or proximity of services to people or users. If the distance to health services is reduced, it leads to an

improvement in accessibility.

- Financial dimension of accessibility refers to affordability; a product is more accessible when it is cheaper and affordable.
- The availability dimension implies the easy availability of health products and services. It is common in some countries, as in India, that availability and accessibility are limited. For example, the presence of doctors and free availability of drugs in a primary health clinic or the public health sector is



*The key premise of setting up CFW shops in Kenya was to develop a franchise in a private sector environment with focus on improving the overall quality of access to health products that were of high quality, better adapted to the needs of the people, in closer proximity to people, and cheaper or more affordable for the target population.*

established. However, the non-availability of both doctors and drugs signifies gaps in practice, thereby indicating the absence of any real availability or access.

- The acceptability dimension captures whether the products are acceptable to the people for whom they are designed. If the products do not match the aspirations of the people, the target population is unlikely to avail of them, resulting in minimal uptake. In effect, adversely impacting accessibility.
- The quality dimension of accessibility denotes the need for quality products and services.

### **WHY ESSENTIAL DRUGS IN CFW SHOPS?**

The CFW shops were initiated with a focus on essential drugs. In many African countries, availability of and accessibility to essential and safe drugs remain difficult since the incidence of spurious drugs is quite high. Therefore, the key premise of setting up CFW shops in Kenya was to develop a franchise in a private sector environment with focus on improving the access to health products that were of high quality, better adapted to the needs of the people, in closer proximity to people, and cheaper or more affordable for the target population.

### **BEGINNING OF CFW SHOPS**

The CFW shops were set up in the year 2000 with virtually no money. In the six years of its operation, the Network has received about US\$800,000 in financial support. This remains in stark contrast to the monetary support received by franchises in Asian countries such

as Pakistan and the Philippines, that receive start-up funds of millions of dollars. But since this is not the case in African countries, from the very outset the concern has been to develop a commercially oriented and viable system that generated its own money or resources. This approach has emphasized the need for reducing costs and enhancing gains from economies of scale, and serves as the key feature of the CFW shops franchising model.

On the other hand, the CFW shops have gathered additional resources in terms of renowned technical experts to advise on essential drugs as well as provide technical guidance on the management of the franchise. In terms of effective business management, the Franchise Advisory Board based in Minneapolis, United States provides business advice to the CFW shops franchise. Legal support has also been available from legal experts at the International Franchise Association.

All these inputs and resources have helped the CFW shops to evolve as a commercial franchise with a social purpose.

### **Start-up Concerns**

#### ***Profitability and cost recovery***

The primary concern of CFW shops franchise was how to be profitable. Financial management of a franchise is an important factor in its development. This involves professional management of the franchise outlets and developing basic record-keeping and accounting systems.

The franchise is based on cost-recovery basis. People in Kenya are

used to paying for health services due to the weak public health sector. Therefore, starting on the premise that people paid for health care, the concern for CFW shops was to ensure that people received quality products and services and their money's worth.

### **Quality products and quality services**

Quality has been the driving force of the franchise. But in the African context, with the huge inroads of spurious drugs, the franchise was concerned about how to make a distinction between a genuine and a fake drug when they had the same brand name. The clients solved this problem, as people were quick to realize which drug worked and always returned to the outlets when they were satisfied with the quality of drugs.

Besides quality products, regularized training programs are a prerequisite to ensure quality of services. This process has to be able to identify the training needs of the franchisees and ensure that training is targeted towards areas of weakness.

In this context, developing standards to be achieved should be clearly established, explained and measured. Similarly, monitoring by teams of expert supervisors who provide handholding and guidance to the franchisees has been promoted.

In sum, all these aspects are important to keep the franchise together, since franchisees need to be responsible towards the brand and feel a sense of pride in the brand. The shared sense of brand

ownership towards maintaining brand quality, by both the franchisor and franchisee is crucial.

### **Developing full franchise model**

The CFW shops have been developed on the full franchise model to ensure optimum control on the operation of franchisees. The full franchise model approach was considered important to institutionalize minimum standards of quality, common across the various franchisees, to ensure high performance.

### **Franchisees' access to credit**

Developing a franchise network with African franchisees without large amounts of money to invest in the business was another challenge. The franchise had to explore access to capital and micro finance for the franchisees.

In Kenya, ensuring such a facility for the franchisees posed a considerable problem. The minimum investment required to open a CFW shop or outlet was about US\$1,500. This amount was too large for credit and too small for bank loans; therefore the franchise developed new financing mechanisms with support from Kenyan micro-credit organizations. The development of a strong franchise system is incumbent upon providing for good credit mechanisms for the franchisees.

### **Subsidies versus procurement**

Since the beginning, the CFW shops franchise did not adopt the subsidy approach. In view of the devaluation of CFA Frank in 1994, many African countries decided on a list of essential seasonal drugs

that would remain subsidized in the public sector only. However, what actually happened was that many such essential drugs disappeared from the public sector but promptly reappeared in the pharmacies and drug stores in the private sector, which were then purchased at market prices by consumers.

The CFW shops franchise, therefore, decided against subsidies and tried to build its operations on excellent procurement. Excellent procurement in Africa implies procurement of high quality products at a very low cost. The Medical Essential Drug Service (MEDS), an eminent organization in Kenya, providing services of high quality control, supported the franchise in this effort. The CFW shops franchise established a procurement arrangement with MEDS, which ensured that the franchise only purchased products from MEDS and was able to retail or sell them at good prices. This has earned the franchise a reputation of having the lowest retail prices but still with enough margins for its franchisees to make a quality living from their business.

In the recent past, however, the franchise has adopted a subsidized approach in one of its operations for distributing anti-TB drugs in a region close to Nairobi, accessing the subsidized products from the government.

### **CFW SHOPS IS A PRIVATE ORGANIZATION**

The franchise is a private organization. It has incentives that are typically of the private sector although there are also elements of

partnership with the public health system or the government, as in reporting to the health department, setting up clinics on government request and so on.

The relationship of the franchisor with the franchisee is that every outlet is inspected and accredited. Every outlet is regularly visited and the franchise provides a report to the district health officer every month with details on the number of patients that have received services, etc. The franchise is also involved in an alert system, issuing forewarnings of any health disasters or epidemics.

In terms of direct partnership with the government, the franchise plays an implementing role in supporting the government in setting up health facilities in new districts. In the past, the franchise has been asked by the government to open franchised clinics in different areas, although it is sometimes difficult to match the criteria for opening a franchised site and a government site, as they might not be the same.

### **CORE PRINCIPLES OF CFW SHOPS**

The CFW shops ensure that health workers own and operate their own small clinics or shops. In the beginning, the brand consisted mainly of shops, though the franchise is now changing to more of primary care clinics. Therefore, the brand is still associated with shops.

These shops distribute essential drugs and provide basic healthcare services. In order to promote greater affordability of essential drugs by the poor, the franchise has

*The relationship of the franchisor with the franchisee is that every outlet is inspected and accredited. Every outlet is regularly visited and the franchise provides a report to the district health officer every month with details on the number of patients that have received services, etc. The franchise is also involved in an alert system, issuing forewarnings of any health disasters or epidemics.*

adopted a unique approach. All the prices of the drugs are set by the franchisees, creating uniform and standard prices across all the CFW shops. This has ensured controlled prices and enhanced affordability for the poor clients.

To lend greater sustainability to the model, one basic principle of operation has been to ensure that each outlet provides a living income for its owners.

### CFW SHOPS FRANCHISE SYSTEM

The efficiency of the CFW shops franchise system is based on the twin strategies of tight franchise controls and standardization of operations.

- Tight franchise controls and regulations are implemented through stringent operational standards. These include:
  - ◆ Rigorous, uniform systems and training.
 

*The franchise provides an initial training of six weeks, followed by a refresher training of two weeks in the same year to the franchisees. In the successive years, other training sessions of one week are organized based on individual needs. Most of the training is on strengthening the business management approach, rather than health management. The trainees meet all the training costs themselves. The franchise offers no subsidy. This aspect has strengthened the commitment of the franchisees.*
  - ◆ Careful selection of locations and operators.
 

*The franchise has stringent*

*franchisee selection procedures. At most times, the franchise's operator list has 200-250 people waiting to be franchisees.*

- ◆ Control over products and prices.
- ◆ Quality of service delivery monitored by regular inspections.
- ◆ Loss of franchise opportunity due to non-compliance with operational standards.
 

*The franchise remains particularly vigilant to any deviation from adherence to the quality standards by the franchisees. Any non-compliance by the franchisees results in their exit from the franchise.*
- Scale and standardization are catalysts to improve efficiency of the franchise system. These include:
  - ◆ Leverage the combined buying power of the full network to obtain quality medicines at the lowest possible cost; strictly controlled prices at retail.
  - ◆ Scaling up the enterprise to over 300 locations will reduce the cost of access to essential drugs to less than US\$1 per person per year.

### SCALING UP OF CFW SHOPS

Beginning with 11 outlets in the year 2000, the network of CFW shops has expanded to 65 outlets today. This expansion has also seen a progression in the services offered by the franchise. In the initial period, the franchisees only sold essential drugs, which limited the financial viability of the franchise,

## CREATING TRUE ACCESS TO PRIMARY CARE AND ESSENTIAL DRUGS

- + Reasonably Close (within 1 hour's walk)
- + Consistently in Stock
- + Affordable to the majority in poor communities
- + Quality & Freshness
- + Accurate Diagnosis and Treatment
- + Outlet & Products are Known & Accepted by Patients
- + Sustainable Outlet Economics

**= Truly Accessible Medicine**

as the turnover remained low. The key reason for the franchise's limited financial viability was the high investment of the franchisor in organizing training resources and trainers as well as procurement, delivery and supervisory teams. On the other hand, the franchisee functioning as a retailer was able to recover costs rapidly and enhance profits individually.

This led to greater introspection within the franchise and the model expanded its basic services by recruiting nurse franchisees. Beginning with the testing of primary care clinics operated by nurses in 2003, the franchise presently has 36 such clinics. This change has increased the training input of the franchisor, since regular training of nurses is a requisite need for enhancing quality services. The franchise has provided for one-month training courses on Integrated Management of Childhood Illnesses (IMCI) and standardized antenatal and postnatal care procedures.

By 2006, the CFW shops franchise has expanded to 65 operational outlets, with 36 clinics and 29 shops. It operates in ten districts of Kenya

with regional offices in central and western parts of the country.

The growth strategy of CFW shops has focused on increasing inflow of clients in each outlet. In this direction, the single most important change in the franchise model has been to transform more shops into clinics, with emphasis on increasing outreach and preventive healthcare services. Consequently, CFW shops network has been progressively involved in health promotions to attract more clients and expand outreach.

### HEALTH PROMOTIONS

The health promotion initiatives have helped to target the community through primary school children, provide basic health screening, share information with community members, hold demonstrations for key health practices and successfully market the local CFW shop.

Regular health screening activities with focus on de-worming of school children and growth monitoring of infants and young children under the age of five, in the various operational districts, have been some of the particularly successful interventions. In addition, the facilitation of malaria

## EXPANSION OF CLINICS



- ◆ Have a wider range of products and services
- ◆ Record higher average patient visits at 900/mth
- ◆ Able to run various types of out-reach activities
- ◆ Yet average sale per patient is affordable at US\$0.4

field days with support of the Ministry of Health (MoH) improves stakeholder relations and assists franchisees in community outreach. All these multi-pronged approaches have cumulatively resulted in greater penetration of franchise products and services and thereby enhanced the business.

### **HEALTH PROMOTION OUTCOMES**

Health promotion initiatives have made a strong impact on outlet performance and sustainability. They indicate that a commercial franchise approach can improve the performance of a public health facility.

By 2005, the relatively small network of 65 outlets under the CFW shops franchise recorded about half a million patient visits (including school screening and

growth monitoring activities) at a rate of about 45,000 clients seen per month.

This has resulted in a significant increase in sales – about 60 percent higher in 2005 than in the previous year, and greatly increased motivation among the franchisees.

### **CONCLUSION**

Despite being a relatively young franchise with the oldest outlets only six years old, the CFW shops network has developed into a stable and profitable business for all the outlets. The future direction for the franchise is towards expansion of its health promotion activities that have generated greater visibility of, and accessibility to, the franchise products and services. The CFW shops network is committed to strengthening its mechanisms of primary care management.

# PANEL DELIBERATIONS

The panel deliberations presented below summarize the key observations made by the Chairperson, discussants and Workshop participants on the introduction to social franchising concepts.

## KEY OBSERVATIONS

### Importance of Social Franchising

- Social franchising is an important vehicle to improve the quality and accessibility of products and services in terms of geographical access, availability, affordability and acceptability.
- It has extensive impact.
- It is possible to increase efficiencies in franchising through economies of scale.

### Key Elements of Developing Social Franchising Models

Some of the recommended elements in developing social franchising models are the following.

- Exploring public-private partnership:
  - ◆ Defining objectives and goals of the partnership with focus on (i) technical capacities of the available franchisees, (ii) size of the network and (iii) the economies of scale.
  - ◆ Recognizing the marketing

challenge from existing providers and therefore establishing stringent adherence to quality standards by the franchisees to ensure competitive edge.

- ◆ Balancing the products or services provided with impact on overall public health.
- ◆ Assessing the available options in products and services to be delivered through the franchise.
- ◆ Financial attractiveness for the franchisee, as the franchisee is a commercial and not a social entity.
- ◆ Quality assurance of franchise products and services.
- ◆ Quality standardization and monitoring.
- ◆ Franchises need a long-term commitment to perfect the system – an average of six-years can be required to successfully develop a franchise, with the minimum of a decade if the franchise is required to cater to low income, poor and vulnerable segments.
- Strong market analysis: The importance of strong market analysis is to ensure that the private system can

support the primary healthcare needs of the target population. Therefore, an assessment of the following factors is crucial:

- ◆ Defining the package of services that the franchise is to deliver.
- ◆ Identifying the range, quality and commitment level of existing providers and the market competition. *Especially in the context of franchises targeting rural populations, it is important to check the possible reluctance of health providers to stay in rural areas, and to find mechanisms to overcome such constraints.*
- ◆ Assessment of demand for services.
- ◆ Costs and financial evaluations – providing better than the existing service through a franchise mechanism, for the same expenditure, is essential.
- ◆ Examining regulatory issues regarding licensing, willingness to pay, etc.
- ◆ Financial viability of the franchise.
- Training appraisal:
  - ◆ Training needs assessment of the franchisees.
  - ◆ Matching franchisee training with the cost of participation vis-a-vis loss to business during training period of the franchisee.
- Assessing both supply and demand sides of social franchising:
  - ◆ Balancing behavioral change of providers (supply) with awareness generation of the target population (demand).
  - ◆ Cross subsidization of services so that the poor segments of the target

population find the services affordable, and thus maximise public health impact.

- Developing strong business plans:
  - ◆ It is important to recognize that franchise sustainability is possible only if it is a good business proposition for both the parties – the franchisor and franchisee. *The franchise should ensure enough profitability to the franchisee to make a decent living and this remains fundamental to any franchisor-franchisee relationship.*
- Financial performance:
  - ◆ Profitable social good: profitability of franchisees coupled with social good.
  - ◆ Improvising a long-term sustainability approach. *Beginning with some level of public subsidy but minimizing public subsidies as volumes increase and the model develops.*

### **Stimulating Government Interest in Social Franchising**

- Developing successful social franchise demonstration models to catalyze government’s obligation to expand outreach to the poor and vulnerable groups in difficult to reach and remote areas.
- Exploring possibilities of channelling government outlets for basic health services through franchise models.
- Recognizing limitations of franchise systems but facilitating reciprocity between the government and private franchise systems so that quality standards developed within franchise systems can impact on government provided health services.



# SESSION II

## **INTERNATIONAL EXPERIENCES IN SOCIAL FRANCHISING FOR HEALTH**

Chairperson

*Randy Kolstad, Division Chief, Reproductive Health, USAID*

### **Social Franchising Experiences in Pakistan**

*Rehana Ahmed, Greenstar Network*

### **Well-Family Midwife Clinic in Philippines**

*Easter Dasmarinas, Former CEO, Well-Family Midwife Clinic*

### **Branded Networks as Alternative Business Models**

*Juan Carlos Negrette, Senior Technical Advisor, Johns Hopkins University – Center for Communication Program*

Discussant

*Mridula Sinha, Secretary, Science and Technology, Government of Jharkhand*





# OVERVIEW

The second session of the Workshop focused on the international experiences in social franchising for health. The experiences from Pakistan and the Philippines illustrate the challenges in the practice and implementation of social franchise models in different countries. In addition, case studies of business models of branded networks in Indonesia also provide key learning for the development of social franchise models.

The paper on the Greenstar Network on ‘Social Franchising Experiences in Pakistan’ captures an Asian perspective. It offers details on developing a public-private partnership model for social franchising and social marketing of female contraceptives within a larger package of family planning and reproductive health services. The paper also elaborates on the different stages in the implementation of the Greenstar social marketing program, its key components, results and outcomes, as well as the lessons learned and the ongoing challenges.

The Well-Family Midwife Clinic paper discusses the social franchise model of midwives delivering family planning and maternal and child health services in the Philippines. It indicates

that the unique difference between a social franchise and a commercial franchise is that the former has a social agenda or motivation. The key challenge for the Well-Family Midwife Clinic franchise is to reconcile the commercial motivations of the franchisees and the social objective of the franchisor. The Philippine experience shows that competition from free or subsidized services is a constant challenge. The paper also highlights that although designing and implementing the business dimensions of a social franchise network are a major challenge, creating a network is not as daunting as sustaining it.

The paper on ‘Branded Networks as Alternative Business Models’ indicates that though branded networks fulfil many requirements of a social franchise, they do not necessarily need a social franchise framework for implementation in the health sector. Successful examples of branded networks, however, do provide important insights and learning for the development of social franchises. The case studies of branded networks in Indonesia and Colombia present business models that move away from traditional approaches in health service delivery to provide useful references for franchising interventions.

# SOCIAL FRANCHISING EXPERIENCES IN PAKISTAN

Rehana Ahmed

*The focus of social franchising is to make up the shortcomings in the public sector by transferring private sector efficiencies to it.*

## INTRODUCTION

In the past decade, a growing number of health franchising programs or alternate business models for health management have emerged in developing countries. These programs provide support to private health providers thus helping to increase access to, and improve quality of, services such as family planning (FP), maternal and child health (MCH), etc. Some of these programs have increased their scope to include various components such as family health (FH), disease prevention and treatment.

The Greenstar Social Franchising model of Pakistan is a successful venture in this direction.

## BACKGROUND - GREENSTAR SOCIAL MARKETING AND SOCIAL FRANCHISING PROGRAM

Social franchising emerged in Pakistan in response to government programs, which needed to address the twin issues of the low contraceptive prevalence rate and the very high total fertility rate in the country. Concern about under-utilization of the public health sector services raised the issues of exploring the reasons for this as well as for client preference for private health services. The focus

of social franchising is to make up the shortcomings in the public sector by transferring private sector efficiencies to it.

In keeping with such concerns, Greenstar Social Marketing company has spearheaded the Greenstar Social Marketing and Social Franchising Program in Pakistan.

## SOCIAL FRANCHISING - THE PAKISTAN EXPERIENCE

Pakistan has a total population of 146 million and its annual population growth rate is 2.1, implying that the population will double by 2035.

In view of the projected scenario, the Pakistan Government has promoted two strategies that have been successful in decreasing total fertility and increasing contraceptive prevalence. The rural strategy involves trained community health workers from local villages who counsel and distribute condoms and pills. The second strategy has been to encourage social marketing and social franchising in the urban setting.

### Situation Analysis

The low public health expenditure in Pakistan has clearly impacted life expectancy, which is equivalent to the life expectancy rates of the West more than 100 years ago.

The lack of available public health services is also reflected in the high maternal mortality rate (MMR).

Another constraint in Pakistan is the small number of paramedics. The doctor-nurse ratio is 4:1, but all doctors are not employed in the public health sector and the country has a large private health sector.

### **Milestones in Social Franchising**

Social franchising in Pakistan has been synonymous with the emergence of Greenstar in 1995, although social marketing of condoms began in 1986 with USAID support. However, within a few years USAID withdrew support due to Pakistan's nuclear policy. This gap was filled by support from the German Government through its development arm KfW for a five-year period starting in 1995. They not only supported the condom social marketing operations but also funded the launch of new products and services to expand choices to couples using contraception. Greenstar was appointed as the executing agency.

The German program added IUCD as a female contraceptive product. This remained a considerable challenge for Greenstar due to the negative image of IUCD in Pakistan. To add long-term contraceptives such as IUCD, the project had to include a major component for the training of medical providers in counseling and administering contraceptives, including management of side effects. The scope of these training activities was not only innovative in the Pakistani context but also helped to create a virtually new paradigm

worldwide, by building a large network of private sector health providers offering FH/RH services and products.

Since 2000, Greenstar has received funding from diverse sources such as the Department for International Development (DFID) and the United Nations Population Fund (UNFPA) with a revival of USAID funds in 2003. This has enabled Greenstar to expand its portfolio to various other products and services including family health and disease prevention.

### **GREENSTAR MODEL FOR SOCIAL MARKETING AND FRANCHISING**

The development of the Greenstar Model for Social Marketing and Franchising required research in the initial period, which first focused on identifying the provider in the private sector to be responsible for insertion of IUCDs. Secondly, Greenstar had to offer quality family planning choices that extended beyond a single product, which was done by promoting counseling on various contraceptives in addition to IUCD. This was possible since KfW also funded hormonal contraceptives and condoms presenting an array of products. The research involved focus group discussions and in-depth interviews to assess the prevalent knowledge, attitudes and practices in the private health sector.

The research analysis helped to design and produce products, services and the Greenstar brand. In order to strengthen the supply side, Greenstar had to identify and profile private sector female health providers who undertook insertion of IUCDs. Those identified were

***The government has about 1,500 family welfare centers and the Network has added 14,000 private doctors, female paramedics, chemists and male doctors. This represents the largest reproductive health network in the private sector worldwide.***

registered doctors, nurses and lady health workers, and Greenstar provided training to them on cross-cutting issues such as counseling skills, infection and prevention management, as well as training on modern contraceptive methods. In addition they were provided with product samples.

In the pilot phase, the project was initiated in two cities of Pakistan. Greenstar began its operations with 300 outlets, 150 in each city. Simultaneously, a communication campaign in the local media for clients and service providers was launched. Within a year the pilot project proved to be a success, as the first evaluation demonstrated that the client ratio, on an average, had increased from one to four in each clinic. This achievement allowed Greenstar to expand into 200 cities of Pakistan.

The success prompted Greenstar to explore how to expand the outreach of female health providers and local doctors in the community. They identified local chemists as the crucial link between the community and the health providers, since the chemists are a good source of health information in the community. This led to the second round of training and orientation to paramedics, male doctors and chemists, enabling them to talk to the local communities about family planning and to refer them to the nearby Greenstar clinics. The process also helped to increase the information network.

Today, there are 14,000 trained private sector health providers enrolled in the Greenstar Network

across the country. The government has about 1,500 family welfare centers and the Network has added 14,000 private doctors, female paramedics, chemists and male doctors. This represents the largest reproductive health network in the private sector worldwide.

### **Franchisees and Benefits to Franchisees**

Doctors, focusing largely on female practitioners, paramedics and chemists are the primary franchisees. They have received various benefits from Greenstar. The foremost benefit has been the large-scale advertising in the electronic and print media about the services of Greenstar clinics and improved mass marketing of the brand and services. This directly resulted in an increase in the client numbers.

The second benefit has been the continuing medical training and education as well as professional development of the private sector health providers. This support in the world of changing health information has made a lot of difference in attracting people into the Network. This also reflects an important part of the program, which has been commended by external evaluators.

The increase in referrals to the Network partners has been an added benefit. For example, the increased referrals to private practitioners by chemists have resulted in a marked increase in their medical practice.

In addition, the Network also offers non-monetary incentives as well as the facility of bulk purchases of

contraceptives through the sales promotion offices at reduced prices to the franchisees.

### **Impact on Family Planning**

The overall impact of the government and the social marketing and franchising programs in Pakistan in the last ten years has resulted in the decline of the total fertility rate from 6.2 to 4.1, with further decline in progress. The contraceptive prevalence rate (CPR) has increased from 9 percent to 38 percent with an uptake of modern methods by 30 percent and IUCD no longer has a negative image. The CPR is expected to double in the next five years if investments continue to be made in the private sector and are extended to the rural areas.

### **THE GREENSTAR PROGRAM**

The key components of the Greenstar program are:

#### **Condom Social Marketing**

Social Marketing of SATHI condoms is the focus of the program. It also includes a wide range of other contraceptives such as one-month, two-month and three-month injectables, emergency contraception pill packs as well as the IUCD. In addition, it also includes a nutrition product for pregnant mothers and girls of reproductive age. In response to the high incidence of neonatal tetanus among infants, Greenstar has also introduced a small and clean delivery kit with a blade and thread for tying umbilical cord. These products are full recovery items and not every product is subsidized; only the core products are subsidized.

### **Social Franchising**

The Greenstar Network integrates products and services addressing FP, HIV/AIDS, MCH, and other public health disease management. The Network keeps on adding antenatal and postnatal care components and training of the service providers. At present, Greenstar alone has about 21 products and services of which the private provider can avail.

### **LESSONS LEARNED**

Some of the key lessons learned in the Greenstar experience have been encouraging.

- Engaging the private sector is making a substantial contribution to family planning and reproductive health.
- There is potential for private providers to make an even greater difference in reducing Pakistan's burden of diseases.
- Greenstar has the lowest cost per couple per year protection. It is important to remain within a certain cost.

### **GREENSTAR RESULTS**

Greenstar has achieved considerable results in several areas.

#### ***Expanded access to health services and products***

There has been a great expansion in access to health services and products across the country through the 14,000 trained private sector health providers enrolled in the Greenstar network.

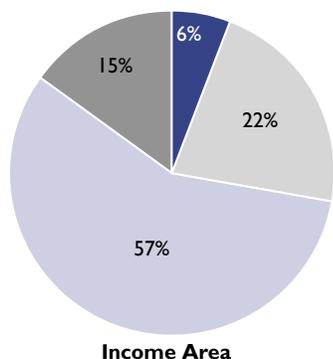
#### ***Improved quality of care***

The quality of care is reflected in the enhanced client satisfaction with franchisor services, seen in Pakistan, Ethiopia and India. There is increased evidence to show that

## EQUITY AND TARGETING THE POOR

### Focusing Greenstar efforts towards low income areas

Sample of 404 Greenstar Clinics



Source: UNC/Carolina Population Center, 2001

clients of franchise facilities are 41 percent more likely to return to that facility than clients of commercial/non-franchise facilities to theirs.

#### **Increased CYPs and CPR**

The benefits of social franchising have helped to establish the need for multiple players in the health sector. The government public health sector is the biggest player in family planning in Pakistan. The Greenstar Network follows at the second level, with additional contributions by the commercial and NGO sectors.

#### **Increased reproductive health client flows**

The alternate business models cluster evaluation points to one important finding for Greenstar; namely that the female franchise clients are younger, lower parity and less educated than clients at other private sites. These younger and low parity clients are important because they significantly contribute to transition.

#### **Equity and targeting the poor**

Greenstar efforts are focused towards low-income areas. The Greenstar clinics are located in or near the urban slums. Only those clinics with at least 50 percent poor clientele qualify to be in the Network. Thus, Greenstar has been successful in expanding its services and outreach among poor people in lower income areas.

#### **Cost and cost efficiency**

Greenstar has one of the lowest costs per couple years protection (CYP) in the world of social marketing and franchising. Between 1995-97 during the pilot phase of the project, the cost of CYP was

US\$9.3, which reduced to US\$1.87 by 2003. However, this estimation did not include the fees paid by the client for the quality services received from the service provider, in most cases the NGO. In order to monitor the costs, Greenstar plays an advisory role in recommending the service charges to the provider. Currently, the overall program costs remain at about US\$3.66.

Expansion of the Greenstar Network among more resistant sections of the community who still need to adopt family planning, requires consistent communication and advocacy. This entails additional costs to meet the communication expenditure, increasing the overall costs to about US\$5 per CYP.

#### **BENEFITS TO GOVERNMENT**

The Greenstar Network has benefited the government in several ways.

#### **Better organized private sector**

The 14,000 strong franchisees organized with the Greenstar Network are a strong force of well-trained service providers. The government can contract these, through Greenstar, for providing quality health services.

#### **Performance based contracts possible**

Under the Greenstar franchising model, partnerships are formed between Greenstar (the franchisor) and the selected private sector providers (the franchisees) with an agreement that requires the providers to integrate a package of health services to be delivered in accordance with quality standards established by Greenstar.

### **Franchisor responsible for quality control and standards in the franchise network**

The franchisor is responsible for quality and standard of services and products. Protocols and standards of practice have been developed, which can be monitored and regulated. The defaulters (the franchisees) can be removed from the partnership.

### **SUSTAINABILITY**

Greenstar is an indigenous institution of Pakistan with a strong managerial capacity and a team that can contribute towards improving health in the long-term. Although it receives technical assistance from external partners and international NGOs, being a local institution adds to its sustainability.

The private sector service delivery norms are established and can be enforced. This has led to tangible changes in the private sector health practices and in the process enhanced business viability, as an increase in clients directly impacts the business of these providers.

Another important facet of sustainability is the local production and market segmentation for the products, such as contraceptives, oral pills and injectables. Some of them are cost recovery products and some of them are subsidized through donor support.

In terms of financial self-reliance, Greenstar considers that it would be really sustainable when the government funds the franchise operation.

### **CHALLENGES**

Despite the success of the Greenstar Network, it is faced by various challenges.

- Further strengthening of the provider involvement (franchisor-franchisee relationship) is a key concern for sustainability of the Network.
- Maintaining provider skills and managing a growing network is an ongoing challenge. Over the years, Greenstar has decentralised and expanded its service and product portfolio. It has a subsidiary company called GoodLife that manages new products such as Glucose D, Pure tablets for water purification, and Sprinkle for child food.
- Expanding rural coverage is difficult, since about 80 percent of the doctors' practice is in urban areas. It remains a challenge that needs to be aggressively addressed.
- Enhancing sustainability through consistent advocacy for public sector commodity supply for social marketing and franchising is an important step for diversification in the future.

# WELL-FAMILY MIDWIFE CLINIC SOCIAL FRANCHISING FP/MCH SERVICES IN THE PHILIPPINES

*Easter Dasmarinas*

## INTRODUCTION

The Well-Family Midwife Clinics (WFMC) is a social franchise model delivering family planning (FP) and maternal and child health (MCH) services. Tapping into the vast resources of skilled midwives in the private sector, the franchise has created an effective franchisee network of midwife-owned clinics to bridge gaps in quality delivery of healthcare services. Leveraging the support of NGOs as partners in the selection and training of midwives, as well as in the organization of the clinic-franchise system, the model has an in-built mechanism for strengthening franchisees and expanding the network.

This paper gives a brief background of the FP/MCH market in the Philippines linking it to the key principles in the WFMC franchise model, its structure and business operational components. It also documents the key accomplishments and lessons that have emerged in the implementation of the franchise.

## WHAT IS UNIQUE ABOUT WFMC MODEL?

In the mid-90s, the Philippines had a large brain drain of healthcare professionals, but even so, the country had a vast pool of service providers – the midwives. There

were approximately 100,000 midwives and only 14,000 of them were in the public sector. The remainder either worked as domestic help or storekeepers, while many of them just waited for suitable positions in government facilities. Most of the midwives were not trained as entrepreneurs, although there were some midwives practising in the private sector.

This was the premise on which the Well-Family Midwife Clinic program was initiated in 1997. The WFMC model assists midwives to become independent owners/operators of fully sustainable family planning and maternal and child healthcare service facilities. This is done via:

- An NGO-based franchise model
- Rigorous application of business tools and methods

The model utilizes NGOs to recruit and provide technical assistance to midwives. In addition, intrinsic to the model is the vigorous application of business tools and methods.

## PHILIPPINE SETTING – THE FP/MCH MARKET

### Demand Indicators

The FP/MCH market in the Philippines is quite similar to other developing countries. In

2003, the National Demographic and Health Survey indicated that the population in the Philippines was close to 82 million, with 14 million women of reproductive age, of whom only 37.9 percent gave birth in health facilities or had institutional deliveries. One in every six pregnancies ended up in unplanned abortions.

The population growth rate averaged 2.36 percent. The total fertility rate (TFR) was at 3.5 and there was a one child gap between desired and actual fertility. The contraceptive prevalence rate was about 49 percent, the maternal mortality rate (MMR) was 172 per 100,000 and infant mortality rate (IMR) was 29 per 1000 live births.

Knowledge on family planning was almost universal, with a majority of the population having information on FP methods. In addition, the majority of the family planning acceptors were willing and able to pay for health services.

### **Supply Indicators**

Studies in the country in 2002-03 revealed that the location of health facilities or service providers was largely determined by proximity to the market, with most of them situated in urban or peri-urban areas, with the rural areas remaining mostly under-served. In the traditional sources of family planning services, the government had a majority share at 67 percent, while the private sector stood at about 30 percent. Pharmacies were a significant source of contraceptives such as pills and condoms.

In terms of maternal and child health services, almost 60 percent deliveries were attended by doctors, midwives or nurses and about 38.5 percent were attended by traditional birth attendants.

### **Demand-Supply Gap**

The gap between the demand and supply of FP/MCH services was indicated by several factors:

- Insufficient government funds to sustain quality service delivery.
- Lack of resources – middle-income groups competing with lower-income groups for government services.
- About 40 percent of public sector clients had the ability to pay.
- Unmet reproductive health needs of the youth.
- Over 25 percent of married women wanted to delay their next delivery for two years.
- Difference between actual and desired family size.
- High fertility rate and low contraceptive prevalence rate.

The key reasons for the gap were:

- Lack of awareness of private sector alternatives for the middle market.  
*While there were visible private providers/practitioners for the upper market segment, they remained inaccessible to the middle income groups due to the prohibitive cost of the services.*
- Lack of differentiation between private and public sector providers.
- Inadequate information and education to dispel misinformation.
- Lack of co-operative arrangements between the

***Studies in the country in 2002-03 revealed that the location of health facilities or service providers was largely determined by proximity to the market, with most of them situated in urban or peri-urban areas, with the rural areas remaining mostly under-served.***

private and public sectors involving appropriate cross referrals.

### WFMC FRANCHISE MODEL

The development of Well-Family Midwife Clinic served as the response to the existing opportunity in the FP/MCH market in Philippines in the late 90s. WFMC model is a community-based enterprise with a full franchise approach that incorporates the core values of professionalism, ownership and empowerment combined with principles of economic development. The goal of the model is to increase the availability of services in the private sector by significantly increasing the number of midwife-owned clinics that provide family planning and basic maternal health services.

The business objectives of the model are to:

- Increase family planning use by stimulating provider productivity through clinic ownership.
- Increase cost efficiencies of service outlets by using midwives rather than nurses and doctors.
- Develop profitable and sustainable service delivery mechanisms that can function with reduced or no external funding.

Initially, WFMC tried to explore the possibility of a conversion model but because the objective was to expand the number of midwife-owned clinics rather than increase the volume of services for the existing healthcare providers, a full franchise model was adopted. Therefore, the focus is on increasing the number of services rather than stimulating the existing facilities.

## WFMC MENU OF SERVICES

### SERVICES OFFERED

#### Family Planning

- ◆ Counselling
- ◆ Pill Supply
- ◆ Condom Supply
- ◆ IUD Insertion/Removal/Check-up
- ◆ DMPA Injection
- ◆ Referrals for Bilateral Tubal Ligation (BTL) & Vasectomy
- ◆ Referrals for Natural Family Planning

#### Others

- ◆ Blood Pressure-Taking
- ◆ Growth Monitoring
- ◆ Wound Dressing
- ◆ Ear Piercing
- ◆ Other Services

#### Maternal and Child Health

- ◆ Physical Exam
- ◆ Breast Exam
- ◆ Pelvic Exam
- ◆ Pregnancy Test
- ◆ Normal Spontaneous Delivery
- ◆ Pre-natal Care
- ◆ Post-natal Care
- ◆ Pap Smear
- ◆ Well-Baby Care
  - Deworming
  - Cord Dressing
  - Weight-Taking
- ◆ Newborn Screening

WFMC thus functions as a specially designed outlet for the efficient and effective provision of family planning and maternal and child health services. It provides the means for couples to space and limit the number of children to their desired family size. It also helps women to reduce health risks to themselves and their children. This is an ambulatory health facility that provides an entry point for patients availing of healthcare services including normal deliveries. Therefore, the midwives are expected to know how to assess their patient's condition and provide proper referral. In case of simple illnesses, the clinics provide appropriate management.

## Franchise Structure

The present franchise structure has changed from the initial structure. In the beginning, the franchisor JSI/ RTI Incorporated served as the de facto franchisor. Currently, the franchisor is the Well-Family Midwife Clinic Partnership Foundation. The partner NGOs function as area developers, with specific territories to develop a portfolio of clinics. The franchisee is the midwife who is the owner and manager.

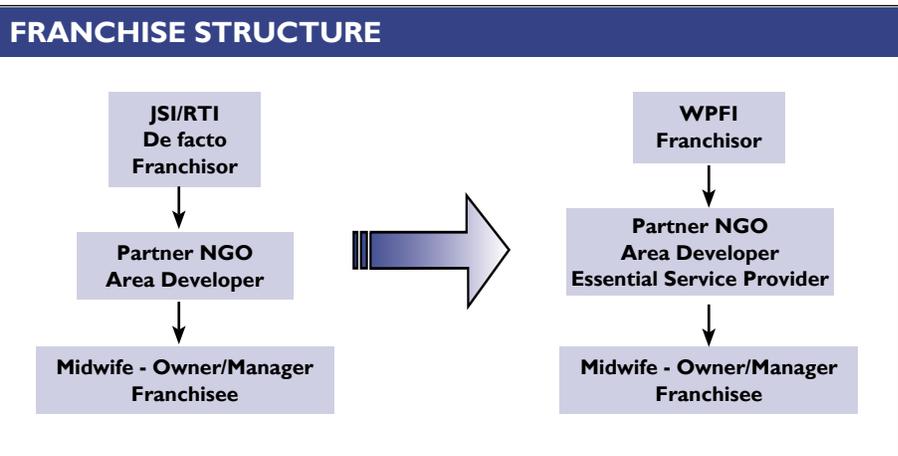
In this structure, the NGOs role as area developers has been strengthened with management training, which helped to build their capacity to oversee the delivery of FP/MCH services by the portfolio of clinics within their area. They are accountable for the business performance of clinics under their supervision. The midwives, as franchisees, invested a small but significant amount of funds to set up their clinics and were provided free clinical training and marketing support to empower them to manage a successful business model.

## Business Framework

The business framework of the WFMC franchise model includes six key components.

## Investment and shared risk

One of the key differences between a social franchise and commercial franchise is that the start-up of a social franchise is usually subsidized by a donor agency or some kind of public funds. In the WFMC case, a USAID subsidy provided the initial funds for start-up. However, from the



outset, the objective was to create a franchise service delivery system that would only need funding for the initial period thereafter becoming self-sufficient.

The monetary investments in the beginning were largely from USAID, amounting to about US\$13 million. The NGO and franchisee counterparts also contributed their funds, adding up to about US\$2.7 million. The midwife capital investment was small, but significant, since it funded the initial operating costs of the clinics, such as rentals and local marketing/ advertising. Regarding non-monetary resources, the franchise leveraged the infrastructural resources of the NGOs. The present support from USAID to WPFI is a small sum of US\$200,000 for two years, to cover a portion of the operating cost of the Foundation.

The technical assistance was provided by JSI, to strengthen business development and skills of the partner NGOs and the franchisees and improve clinical skills of midwives, placing strong emphasis on developing quality assurance standards within clinics.

It also provided support for marketing and promotions, both for the network and the local clinic, including development of promotional materials and collateral. Furthermore, it promoted the development of a management information system for the franchise model to mainstream recording and reporting of service delivery and performance at all levels – franchisor, area developer and franchisee.

### ***Setting standards for quality performance***

The menu of services and products provided by WFMC are standardized across all the network clinics. The entry point for the franchise was family planning services. Initially, WFMC faced difficulties in diversifying to another product line. But after two years of operation, it was evident that the clinics or franchisees were not earning enough from family planning products alone. Secondly, there was under-utilization of the midwives' skills. Therefore, combining both these concerns, WFMC diversified into the product line of maternal and child health. This diversification has proved very successful for WFMC, since 90 percent of the total income at the clinic level is currently generated by the maternal and child health services and provides sustainability for the franchisees. Additionally, the clinics have further expanded their services to include over the counter drugs, cosmetics, toiletries, etc.

Another key feature of quality standardization in WFMC has been the integration of stringent selection criteria for both area

developers or NGOs and the franchisees or midwives. The important requirements for NGO eligibility comprise entrepreneurial orientation, previous experience of delivering family planning and maternal health services, and basic organizational capacity to administer a clinic franchise-type program using midwives. In addition, a key concern also is the willingness of the NGO partner to concentrate operations in selected geographic areas in order to focus on larger clusters of midwife-owned clinics and to reduce the costs per clinic established and serviced. This aspect is significant because certain locations such as clinics on islands with a sparse population prove to be resource-intensive and raise concerns of cost-effectiveness.

The franchisees or midwives selection criteria is based on several rigorous parameters, but the most important qualification is the willingness of the midwife to put up money and pay for clinic capitalization inclusive of clinic set-up, rentals, renovation cost, etc., continuing education and training; and franchise and royalty fees. The franchise only provides the initial training but for continuing education, the midwives need to take the initiative and personally incur all the costs of training. This aspect of franchise charges is very important as well as challenging for any franchise with some element of a commercial agenda and needs to be considered from the inception. Whether franchise fees or royalty charges are to be levied by the franchise needs to be clearly defined at the outset.

### **Facility requirements**

In terms of facility requirements, the clinics are required to be clean and located in a safe environment. To ensure adequate business, the clinics need to be situated in densely populated areas with a reasonable level of economic activity. The clinics are also required to pass the WFMC rapid market appraisal standards. This includes an assessment on the rationale for setting up a clinic in a certain area, such as market evaluation in reference to existing providers and competition, scope for adequate business volume to sustain the clinic operations, etc. In addition, the clinics have to meet the Health Department licence norms.

Similarly, there are benchmarks for services and products offered in each of the clinics, to differentiate WFMC from other providers. These comprise the facilities in the delivery rooms, the equipment and instruments used, etc. Standardised service delivery protocols are maintained at all the clinics to ensure both product and service differentiation of WFMC from other private as well as public providers.

### **Brand advertising and marketing**

The WFMC brand name and logo is consumer-based with a unique marketing proposition about affordable quality healthcare as per the client's convenience. The franchise is also involved in promoting the clinics at both the network and clinic levels. Marketing WFMC as a network includes promotional activities such a participation in health

### **WFMC BRAND NAME AND LOGO**



related national celebrations, advertisements in print and electronic media, press releases, etc. At the clinic level, the marketing strategies are directed towards strengthening relationships with the clients through home visits, social events for pregnant women, etc.

### **Quality assurance**

WFMC is committed to incorporation of quality standards that ensure quality assurance for all the franchise clients. In this direction, the franchise is involved in promoting clinical and business training of the area developers (NGOs) and the franchisees (midwives) to build their capacity in various relevant areas such as business planning and development, costing and pricing of services, public relations, interpersonal communication, etc.

WFMC also ensures clinical and back-up referral mechanisms so that each clinic has a back-up physician and a referral facility for emergencies and complications. To systematise these arrangements, a memorandum of agreement between the franchisee and the referral facility is mandatory.

To maintain the quality of the network, WFMC even follows

## ATTRIBUTES OF THE WFMC FRANCHISE

	WFMC
Contract between parent organization (franchisor) & clinics (franchisees)	✓
Standardized business format	✓
Brand	✓
Marketing	✓
Franchise fee	✓
Quality assurance	✓
Franchise operators own their business	✓
Fee for service	✓
Financial sustainability as a primary objective	✓

profitability for both the franchisor as well as the franchisees. Since the franchisees are able to receive drugs and other supplies at discounted rates, in comparison to market prices, there is an increase in their profit margins.

### **Management information and performance monitoring**

The WFMC-MIS tracks inputs and outputs of NGOs and midwife franchisees in terms of quantitative (referrals; MCH services; revenues from FP, MCH, etc.) and qualitative (quality standards; marketing promotions; business performance, etc.) indicators. Functioning as a performance assessment and monitoring system, it ensures in-built checks and balances within the WFMC model.

### **WFMC Partnerships Foundation, Inc. (WFPI) – the Franchisor**

In 2002, WFPI was registered as a non-profit, non-stock foundation with the government. This changed the franchisor from JSI to WFPI, though in the new arrangement the trademark is still owned by JSI but has been licensed to WFPI authorizing the Foundation to use and license the use of the marks to its franchisees in the Philippines.

### **WFPI essential services**

As a franchisor, WFPI provides essential services to the franchisees. This includes technical training updates (continuing education program); monitoring and maintaining quality; marketing and advertising; facilitating access to credit and providing access to low-cost supplies; providing accounting

a de-selection process for non-performing franchisees. In cases of any clinical malpractice, non-compliance with clinic facility standards, mismanagement of clinic equipment and instruments or clinic bankruptcy, WFMC terminates its contract with the franchisee.

Conversely, WFMC also recognizes valuable franchisee performance and has instituted the 'WFMC Diamond Award'. This award is the foremost and pathbreaking recognition program in the country that honors excellence in midwifery, entrepreneurship and partnerships in serving the Filipino family, and making a difference in the way Filipinos view the midwifery profession.

### **Economies of scale via bulk purchasing**

WFMC has developed a centralized procurement system for selected clinic commodities to obtain economies of scale via bulk purchasing. This ensures

and legal services, and sharing information on technical and WFMC matters of interest.

## **ACCOMPLISHMENTS**

The WFMC franchise model has been successful in creating impact in diverse areas.

### ***Designed and implemented a new, innovative and sustainable model for franchising health service delivery***

WFMC has developed a concept of providing fee-based FP and MCH services through creation of opportunities for private midwives to become health entrepreneurs and private FP/MCH service providers. Concurrently, WFMC has helped evolve the NGOs as service providers or area franchise agents.

### ***Created networks of viable 151 midwife clinics***

The model has developed a large network of clinics of which 130 clinics have achieved operating sustainability and 124 clinics have achieved financial sustainability. This has resulted in an increased provision of FP services by the clinics. Between 1997 and 2004, WFMC extended CYPs services to 283,771 couples and MCH services to 169,6315 people, especially those belonging to the under-served segments, resulting in an income of US\$ 6,073,167.

### ***Created the technical tools/ systems to implement this new model***

The franchise has integrated diverse mechanisms and systems to develop a robust model of health service delivery. At the clinic level, the quality control systems and

capacity and business development procedures have strengthened the model. At the NGO level, the same has been achieved through a performance-based management system complemented by capacity building and business development training.

### ***Cultivated a paying market for the clinics – provided an option for the healthcare consumers from C & D classes***

The model has successfully introduced a viable pricing system for clinic services to achieve cost-recovery and profit maximization. It has also promoted public awareness of the network and encouraged trial usage of services and products offered by the clinics to maintain continued patronage of the clinics.

### ***Empowered midwives***

The model has singularly empowered the midwives, transforming their role from ordinary healthcare providers to entrepreneurs with their own clinics. This has definitely contributed to enhanced personal self-confidence and professional status of the midwives, leading to a marked increase in their social and economic status within the community. It has also created opportunities for long-term financial security and social mobility for the midwife as well as her family.

### ***Influenced government policy on recognizing midwives as one of the professional healthcare providers***

WFMC model has helped the midwives to gain recognition as alternate service providers for the

low-risk package of Philippine Health Insurance Company.

### LESSONS LEARNED

The implementation of the WFMC model has resulted in considerable achievements as well as offered diverse lessons for improving the franchise approach for delivery of FP and MCH services. Some of the key lessons have been summarized below:

- Designing and implementing the business dimensions of a social franchise network is a major challenge. Creating a network is not as daunting a challenge as sustaining it. This gains additional importance during expansion of the network and the challenges of protecting the brand while ensuring quality of services.
- There is a paying market among the C and D economic segments; however, clients are always seeking lower prices on an ongoing basis.
- Low contribution margin of family planning services can impact on sustainability of clinic operation. Increasing demand for FP services and achieving high utilization levels in the clinic require aggressive, sustained marketing and advertising, especially at the local level.
- Competition from free or subsidized services is a major challenge, despite efforts to segment the market.
- Mainstreaming service networks into the commercial private sector is beset with challenges from government regulatory agencies. This is a typical challenge in franchising,

since coinciding the timing of government regulations with business expansion can be a difficult proposition. For example, delay in obtaining government licences for commercial operations essential for any clinic start-up could conflict with business expansion plans and timelines.

- Branding goes behind the name and logo. The brand needs to be more than just the franchise trademark and should be linked to the total experience of the consumer while accessing services.
- In addition to the above, there are other pre-conditions in designing an effective social franchise model:
  - ◆ Supply of trained and capable service providers willing to become owner/operator franchisees.
  - ◆ An organization preferably local, which has or could develop the capacity to play the role of national franchisor.
  - ◆ Sufficient potential population or under-served consumers to sustain clinics located in higher density urban and peri-urban areas.
  - ◆ A capable source of technical inputs to provide start-up assistance.
  - ◆ The possibility of being able to avoid excessive competition from public providers for the same clients and same services.
  - ◆ A return on donor investments which is attractive.
  - ◆ An assured supply of commodities at an

***Branding goes behind the name and logo. The brand needs to be more than just the franchise trademark and should be linked to the total experience of the consumer while accessing services.***

acceptable price to the provider and client.

## **CONCLUSION**

Balancing the achievements and successes of WFMC with the lessons that have emerged in the implementation of the franchise model poses considerable challenges

in evolving improved mechanisms for delivery of FP and MCH services. A key consideration for the future is strengthening the midwife clinics within the newly formed independent WFPI and effectively building the full franchise model, combining commercial concerns with social objectives.

# BRANDED NETWORKS AS ALTERNATIVE BUSINESS MODELS

## SERVING THE MARKET, EXPANDING THE MARKET

Juan Carlos Negrette

### INTRODUCTION

**B**randed Networks fulfil many requirements of a social franchise, but they do not necessarily need or require a social franchise framework for their application in the health sector. However, successful examples of branded networks do provide important insights and learning for the development of social franchises. The case studies of branded networks in Indonesia and Colombia present business models that move away from traditional approaches in health service delivery to provide useful references for franchising interventions.

### FIRST SET OF QUESTIONS

There are two broad areas that need attention with regard to social marketing.

- As markets become more sophisticated, are traditional approaches in social marketing still relevant? Are interventions that were applied successfully 15 years ago still applicable in today's world?
- Where in the 'real world' (as in *private commercial sector*) is there a business model where more success leads to more losses; therefore, increasing the need for more subsidies?

### BUSINESS MODELS

The answers to these questions are available from examples of business models from two opposite sides of the world – Indonesia and Colombia.

#### The Indonesian Case – Bold Visions, Bold Results

In 1986, the Chairman of the Indonesian Family Planning Board envisioned that in the next 20 years, 80 percent of the family planning services would be provided by the private sector and 20 percent by the government, with the latter serving only the poor.

Indonesia worked towards this objective through a self-reliance movement (KB Mandiri) leading to the emergence of the 'Blue Circle Program'. The three key elements of the Program comprised:

- A Branded Network of private practising providers – tapping into the existing private providers extending health services for a charge or fee.
- Branded products
- Partnership with private commercial sector

This implied that the all services/products of private providers in the network became branded as Blue Circle. All of the private providers in the Network got acknowledged

or recognized in the market as Blue Circle.

This approach was a departure from the traditional or existing subsidized social marketing models in family planning services.

### **Private sector participation in Indonesia**

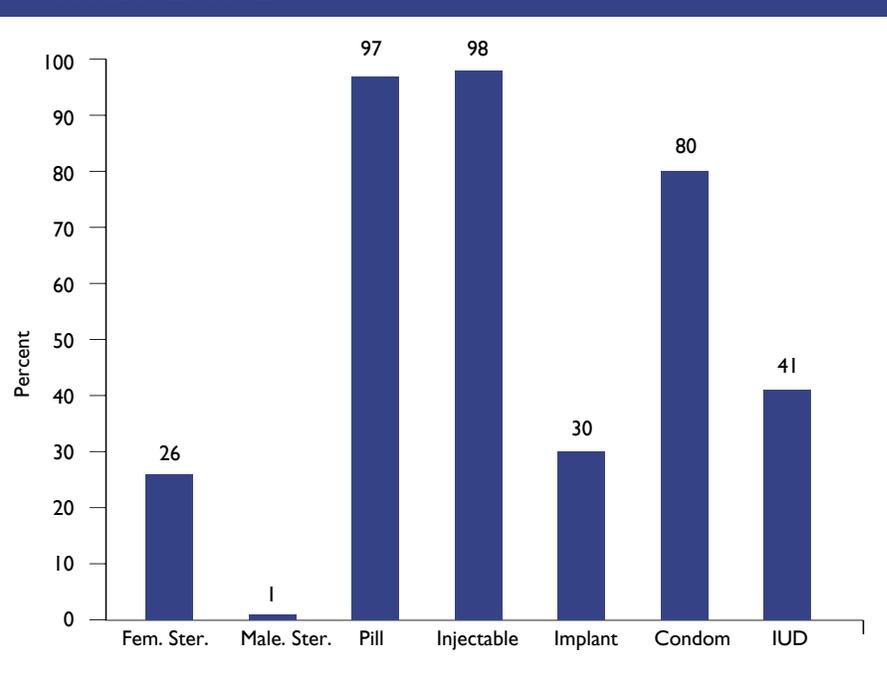
By 2003, the result of the Blue Circle Program was visible in Indonesia with the dominance of the brand in the market. Private sector providers were providing almost 70 percent of all the family planning services, with a share of about 80 percent in the total injectables and pills supplied to the clients.

The success of the Program could be perceived from the high percentage of the population paying for contraceptives.

An assessment of the price of some of the family planning methods in Indonesia presents an interesting picture. The difference between the private and public sectors in terms of prices is almost negligible. In the public sector, an injectable is priced at Indonesian Rupees 10,418, while the private sector charge by a *bidan* or midwife is Indonesian Rupees 10,450, implying a minuscule difference of 0.3 percent. The same is evident in the prices of pills, with the public sector cost at Indonesian Rupees 4,041 and private sector cost at Indonesian Rupees 4,704, or 16 percent higher. This disparity is too small to create market segmentation between the private sector and public sectors.

In contrast, the picture of some of the long-term family planning

## PERCENT OF INDONESIANS WHO PAY FOR CONTRACEPTIVES



methods is more varied. An IUD at a government facility is priced at Indonesian Rupees 8,309 while the same services by a private doctor cost Indonesian Rupees 28,629, indicating more than a 300 percent difference. In the case of female sterilization, the cost in a public health facility is Indonesian Rupees 74,701, while at a private hospital the charges are more than double at Indonesian Rupees 198,116, though the same service by a private doctor is provided at Indonesian Rupees 70,295.

This model of service delivery, despite the creation of the Blue Circle brand – with its own set of prices and private providers trying to privatize family planning services – does face sustainability issues. This raises the second set of questions related to sustainability.

- Can this business model weather a devastating economic crisis?

- Is it just a matter of surviving or actually thriving?

**Private sector participation's impact on contraceptive prevalence rate (CPR) in Indonesia**

A comparison of a private sector market share against the CPR in Indonesia indicates that the higher the private sector participation, the higher is the CPR. Despite the devastating economic crisis in Indonesia since it became a branded nation, the fully private family planning services continue to grow.

Such a situation leads to the third set of questions.

- What is the competitive advantage for private and public sectors in terms of products/ services versus social economic segmentation (SES)?

In the case of Indonesia, it is clear that the price differentiation between the public and private sectors in terms of family planning

methods of injectables and pills is minimal, thereby achieving a part of the government objective of increasing private sector share in family planning services. In contrast, the public sector needs to focus its attention on long-term family planning methods of IUCDs and female sterilization, where the price differential with the private sector is substantial.

**Changing Roles of Government in Health Services**

In the changing world, the role of a government in expanding availability and access to health services is faced with two options – either to empower supply or empower demand.

In terms of empowering supply, the government interventions are focused on funding of public facilities for service provision, which has been its traditional role. Alternatively, in terms of empowering demand, government interventions have focused on enhancing consumer choices with social insurance schemes.

Empowering demand increases the power of choice among the consumers, enhances competition and cumulatively leads to quality improvement.

**Colombian Health Sector Reform**

For years, there was a huge debate in Colombia about health insurance and improving coverage of health services. To facilitate health sector reform, the Colombians introduced a twin-track approach.

- Contributive plan, financed by mandatory employee-employer



contributions – intended to cover 70 percent of the population.

- Public social funds, financed by national and local taxes and government contributions (VAT, other contributions) – intended to cover 30 percent of the population.

### **Social security health system**

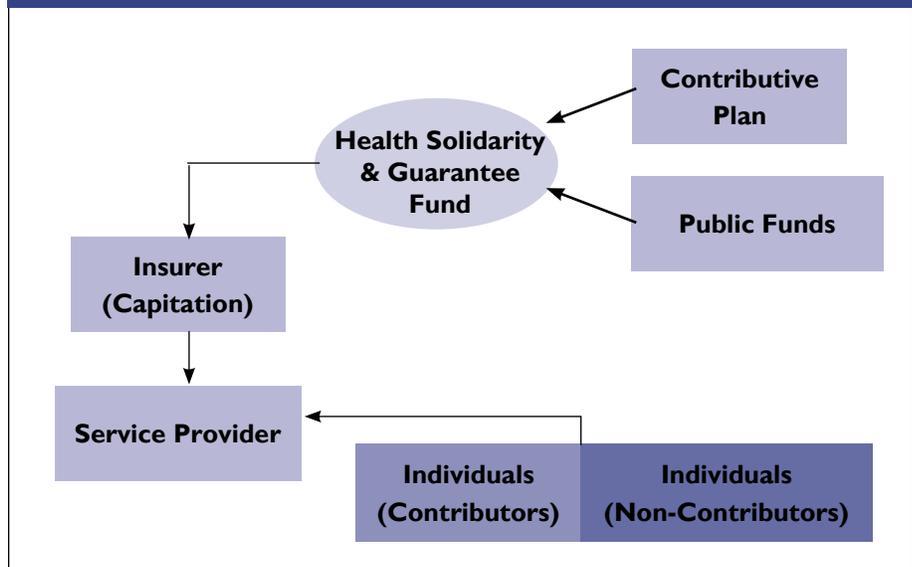
The twin-track approach aimed at ensuring 100 percent coverage for all Colombians in all health matters. It integrated the health needs of non-contributors, as in the poor segments who could not afford to pay for any health services with the contributors or the paying sections of the population.

The Colombian health sector reforms helped to increase the health social security plans coverage from 18 percent to 69 percent of the total population, between the period 1993 and 2005. This also contributed to a change in family planning. In 1999, the CPR was 66 percent, which increased to 78 percent by 2005.

### **Branded network – a challenge in Colombia**

Profamilia is a branded network in Colombia that has played an important role in the health sector. The Network emerged from a phase of ‘non-sustainable monopoly’ to self-sustaining entity’ between 1991 and 2005. In 1991, despite a market share of 60 percent, about 50 percent of the income of the Network was from international donors, making it a highly unsustainable network. This changed by the year 2000 with a reduction in donor income to almost 12 percent.

## **SOCIAL SECURITY HEALTH SYSTEM: HOW IT WORKS**



Presently, though Profamilia’s market share is estimated at 20 percent, it is a successful enterprise.

### **Profamilia’s sustainability**

In the 90s, Profamilia lost almost US\$2 million per year that was covered by donor funds. This has changed in the present decade with the expansion of services by the Network. Profamilia now sells preventive services such as breast self-exam, pap smears, etc., to the insurers, offering a wider range of health services, marking a shift from family planning to reproductive health.

The improvement in Profamilia’s sustainability level has been a result of complementary strategies.

- Anticipating change – set up professional team to study legal and operational perspectives.
- Learning how to manage ‘financial risk’.
- Widening its supply of services including more and more of reproductive health services but strengthening its source of

*The Blue Circle Brand has paved the way for the government to charge royalties from private service providers using the brand, implying that the commercial sector pays brand royalties to the public sector.*

- competitive advantage: family planning.
- Taking advantage of its previous ‘social investment’ because of its community program and solid brand equity.

### **IS THE BRAND IMPORTANT?**

The Colombian health sector reform improved access to health coverage. It also encouraged competition, but most importantly, it has tested the staying power of brand equity.

This raises two important questions:

- Is brand and brand loyalty a key factor in sustainability?
- Do brands have actual value?

### **The Branding Challenge**

For Profamilia in Colombia, the health sector reforms paved the way for establishing brand equity while in Indonesia it has been the

reverse. The Blue Circle Brand has paved the way for the government to charge royalties from private service providers using the brand, implying that the commercial sector pays brand royalties to the public sector.

The strength of brand equity is that it facilitates:

- ‘New’ ways to relate with the customer.
- A paradigm – from ‘service delivery’ to brand loyalty.

### **CONCLUSION**

Branding offers immense potential for improving the health sector. The emergence of branded networks as alternate business models is also an important tool in social marketing. A crucial key to this approach is engaging the private sector in the processes of change.

# PANEL DELIBERATIONS

The Chairperson, discussants and Workshop participants delineated the key highlights of international experiences in social franchising in the health sector, as presented below.

## KEY OBSERVATIONS

### Standardizing Approaches in Social Franchising

- Need for application of a standard approach in social franchising with implementation through a customized approach – implementation is a considerable challenge and requires a consistent effort.

*It is important to recognise that behind the scene most franchises operate with similarity in operations and standards. However, there are differences from region to region and country to country regarding the interface with the customer and the needs of the customer. While it is the needs of the customer that should drive the menu, the rules of service delivery, whatever the menu, should remain the same.*

- Changing mindsets from that of serving beneficiaries to meeting the needs of customers, as customers have a strong stake in health transactions compared to passive beneficiaries.

Therefore, all beneficiaries need to be encouraged to become proactive customers in order ensure demand generation and to improve service delivery.

*The beneficiary approach reflects the passivity of the health system, while a more aggressive commercial approach helps to attract or win over customers and influence their attitudes. The latter is important, particularly with regard to preventive programs, since it requires educating the clientele, which is also a key factor in the success of any health system.*

### Franchise Economic Viability – Public Sector Free Services versus Private Franchises Paid Services

- The economic viability of franchises with paid services is likely to be challenged by the problems encountered in cost recovery due to the free availability of similar services in the public health sector.
- This is an important challenge in the Indian context. Therefore, the situation demands co-existence of many kinds of possibilities and different kinds of models. Consequently, the approach in India, and Uttar Pradesh, in particular, calls for the piloting

of certain possible models on a smaller scale and evaluating them to see what works.

### **Developing Different Franchising Models**

- There is a broad portfolio of working interventions in franchising; one may be appropriate in one setting while another may be appropriate in a different setting. Therefore, the need is to engage different tools in different situations, since no single approach or specialised tool can address all concerns.

### **Brand Equity is Integral to Franchising**

- Building brand name as synonymous with quality of health services is a central part of franchising.

### **Government and Private Sector Partnerships – Concerns in the Indian Context**

- The private sector is one of the most unregulated sectors in India and requires standardised licensing. Therefore, in the context of public-private partnerships in health services delivery in India, the question remains whether through franchising, an accessible and affordable private sector that offers quality services can be established? Also can government programs be channelled through such networks?

*There is a sizeable private sector presence in the health arena. On an average, about 70 percent of the services accessed by people across India are provided by the private sector. Therefore, it is*

*very important to explore the kind of partnerships between the government and the private sector that can be built if franchising models are put in place, and the kind of policies and interventions that are required to facilitate such processes.*

- In India, franchise networks have greater potential for success if they provide a bundle of health services or a basket of services, instead of single service such as family planning. However, donor funds are generally limited to specific interventions, limiting the possible strategies available with governments to engage in such partnership networks with the private sector.

### **Challenges to Expanding Outreach of Qualified Medical Personnel in Rural Areas**

- Need to address the issues of accessibility and availability of health services in rural areas of India. The complexity of the Indian rural situation is exacerbated by lack of appropriate understanding among the rural population about the meaning of health and health practices. Therefore, the challenge is to educate the rural population to create the requisite demand or market for franchising.
- The Indian Government's policy of barring the practice of untrained doctors or barefoot doctors that serve as the first referral point for a large section of the rural population, needs to be reviewed. This issue gains importance in the light of a huge pool of traditional birth

attendants in rural India who have been trained to conduct safe deliveries, but are largely illiterate, and also lack the skills of the Philippine midwives to leverage their practices into clinics. Integrating the services of such rural health providers' needs to be considered as a catalyzing agent for rural health services. They can be the channel to reach those qualified

nurses and paramedics who are deputed to the rural areas.

- Poor living conditions in rural and remote areas have impacted the outreach of public sector and private sector health providers. It is therefore critical to devise means to make health practice and service delivery in rural India attractive for the service providers.



# SESSION III

## ESSENTIAL SUCCESS FACTORS FOR SOCIAL FRANCHISING IN INDIA - LEARNING FROM INTERNATIONAL EXPERIENCES

Chairperson

*Shivendu Shukla, Secretary, MoHFW, Government of Jharkhand*

### Break-out Groups - Takeaways of International Experiences

Discussants

*Rehana Ahmed, Greenstar Network, Pakistan*

*G. Manoj, CEO, HLPPT, India*





# INTRODUCTION

The third session of day one of the Workshop was designed as break-out group work among the participants for capturing specific takeaways or learning from international experiences essential for success of social franchising in India.

In this process, the Workshop participants worked in four separate groups under the coordination of a group Chairperson. All the groups deliberated on a set of three questions followed by group presentations. The presentations summarized the discussions in the groups and focused on the key strategies identified in response to:

- Key messages from international experiences in social franchising.
- Lessons learned to quicken and improve readiness and acceptance of social franchising.
- Specific takeaways for success of social franchising in India.

# RECOMMENDATIONS OF GROUP PRESENTATIONS

## KEY MESSAGES FROM INTERNATIONAL EXPERIENCES IN SOCIAL FRANCHISING

- Social franchising is a comprehensive concept that can provide a different option for delivery of healthcare services in developing economies. *Social franchising is the need of the hour. It essentially requires involvement of the private sector to promote effective delivery of health services. Social franchising should cater to the concepts of affordability, accessibility, acceptability, availability, and most importantly, accountability.*
- Transition of clients from beneficiaries to customers is an important paradigm shift – an increase in social franchising in the health sector will mark a significant shift in the nature of populations accessing health services, from being beneficiaries of the health (largely public health) system to customers. *This will also change the government approach in treating patients or clients in the public sector, viewed so far as beneficiaries. At the same time, change in the customer's self-perception will, in turn, lead to diverse demands on the system.*
- Branding is important for the success of social franchising. *Integration of branding with market analysis, identification of specific areas of interventions and defining specific roles of stakeholders, are key components for success.*
- Networking is crucial to the success of social franchising. *It is essential to explore partnerships of mutual benefit to both franchisors and franchisees.*
- Diversified basket of products and services is important for sustainability. *A holistic package with bundling of health services is crucial for the success of the social franchising model.*
- Capacity building of service providers is a prerequisite to ensure quality of health services. *The Philippines and Pakistan experiences establish the need for regular training and capacity building of service providers. Continuing medical education and advanced training is crucial to maintain the quality of private sector service providers. The possibility of trainees themselves bearing the training costs for advanced training or continuing education programs is an important factor in cost-efficiencies.*

- Standardizing quality assurance in social franchising models needs to be continuously supported by monitoring on quantifiable quality assurance parameters.  
*Continued quality assurance to be an important focus area. Regulatory protocols to be systematized and government monitoring should take place within either a legal or policy framework.*
- Moving from reliance on external funds to sustainability or possible sustainability should be envisaged from the inception of the social franchising model.  
*It is possible to shift from great reliance on external funding to less reliance and gradual self-reliance as the programs develop, as exemplified in the Colombian experience with Profamilia. However, in the initial phases, need for government subsidy for social franchising might be expected.*
- Long-term commitment and phased planning required for social franchising.  
*For sustainability and profitability of the social franchising model, it is essential to explore both short-term and long-term situations and developing a phased approach in planning interventions. This approach is crucial to review the impact of such initiatives on the overall populations, and their stake in new processes of health services' delivery, apart from the stakehold of the customers, financiers and donor agencies. This is important to ensure mutual benefit for all the partners.*
- Start small and then scale-up.

## **LESSONS LEARNED TO QUICKEN AND IMPROVE READINESS AND ACCEPTANCE OF SOCIAL FRANCHISING**

- Social franchising can augment accessibility to health services.  
*Evidence-based support for developing social franchising models is essential for facilitating adoption of social franchising. Furthermore, social franchising can help expand the existing public health services and streamline quality norms. The private provider should be encouraged to play the role of an implementer supported by the government in the role of a facilitator.*
- Systematizing accountability – developing a system or model that is more accountable and transparent.  
*A key lacuna in the public health system that has impacted its performance and efficiency has been the lack of accountability. Therefore, developing systems of accountability is critical to create social franchising as models with a difference. For this purpose, an accreditation system for the franchisees to monitor their functioning against quality benchmarks is essential.*
- Need for a conducive policy framework.  
*The policy framework would need to spell out regulation, standardization and accreditation of the service providers.*
- Community participation essential for success of social franchising.  
*Developing community trust, faith and confidence in the private as well as public sectors is critical for*

***A key lacuna in the public health system that has impacted its performance and efficiency has been the lack of accountability. Therefore, developing systems of accountability is critical to create social franchising as models with a difference.***

**Presently, Government commitment is conducive to social franchising with the launch of National Rural Health Mission. There is a need to mobilize capable human resources, build capacity of service providers and identify financial resources to support and subsidise the program.**

*any initiative on social franchising in health.*

- Participation of women as key partners in social franchising is important.  
*Engendering women's participation, not only as stakeholders but also as central partners in the overall process and system of social franchising.*
- Developing clarity in the market on the potential of social franchising.  
*Need to develop clarity at the outset, as to what social franchising can do and what it will try not to do. This is important to avoid unrealistic expectations.*
- Availability of financial resources is a prerequisite.  
*Suitable availability of funds and finances and the role of donor agencies are the pre-conditions, which will determine the extent and the kind of social franchising models adopted.*
- Need for regular training of pharmacists and paramedics in addition to doctors, as complementary service providers in health franchises.  
*Affordable prices, quality of services and easy accessibility promote social franchising.*
- Successful pilots or demonstration models of social franchising.  
*Under-utilized services of private sector for public health.*
- The present approach of private sector health providers, in urban slums or rural areas, focuses only on curative care. However, public health has important preventive aspects that are ignored by the private sector, leading to under-utilization of the private sector resources.

## **SPECIFIC TAKEAWAYS FOR SUCCESS OF SOCIAL FRANCHISING IN INDIA**

- Franchising Policy with a framework for phased implementation would be essential for the success of social franchising in India.  
*Presently, Government commitment is conducive to social franchising with the launch of National Rural Health Mission. There is a need to mobilize capable human resources, build capacity of service providers and identify financial resources to support and subsidise the program.*
- Strengthening of private and public sectors essential for success of social franchising model.  
*Both sectors are complementary and neglect of either is inimical to any progress towards social franchising. Mutual respect and collaboration between both the sectors is important to develop a comprehensive and holistic approach to delivery of health services. Recognition within the sectors that they are complementary to each other is required to ensure mutual help to sustain social franchising interventions. An innovative approach is to make the public sector infrastructure and facilities accessible to the private sector for better service delivery.*
- Monitoring and evaluation essential to ensure accountability and transparency.  
*Monitoring and evaluation should be participatory with members of the community. There should be informal interviews with customers to assess their health needs and views on social franchising. There is a need to ensure accountability*

of health services' delivery by all stakeholders. This would require systematic quality standards and benchmarks.

- Availability of capable franchisor and private providers is important.

*The service providers need to gain comprehensive understanding of social franchising to be not only willing but also capable partners.*

- Synergy between health and education is crucial to ensure quality of service providers. *In developing countries, adequate literacy is a concern among the majority of the populations. This gap is particularly apparent among private health providers in rural areas such as dais (traditional birth attendants or midwives). To engage such*

*segments of health providers in constructive interaction and deliberations on social franchising requires a minimum level of understanding on the subject.*

*Therefore, such private providers should be educated upto the level of Class VIII or X, but a potential constraint is the lack of adequate numbers of providers who can match the criteria of franchisee eligibility or the quality benchmarks of the model.*

- Market analysis is paramount to determine the needs of the customers as well as the products and services already being offered by existing providers. *Innovations will be important for developing different solutions to suit different regions.*

***The service providers need to gain comprehensive understanding of social franchising to be not only willing but also capable partners.***

# PANEL DELIBERATIONS

The deliberations by the discussants and Chairperson on the group presentations carried forward the key issues raised by the participant groups on the success factors in social franchising. The critical issues of franchising were discussed along with the role of government and innovative suggestions for healthcare provision. These are summarized and presented hereunder.

## KEY OBSERVATIONS

### Critical Issues for Franchising

- Selection of right franchisees. *Selection of appropriate franchisees is a key factor for sustainability. It is important to tap young service providers, motivated to comply with the quality standards of the franchise as well as willing to invest time on their clients for family planning counselling. Providers who already have a busy practice do not have the time for the concerns of public health.*
- Failures possible in two dimensions – price and quality standards, and process standards prescribed by franchisor but not implemented by the franchisees.
- Fixing prices with quality assurance. *This is likely to remain a key challenge – how to ensure quality*

*at the same time ensuring that the prices of services and products are lower than the current sector prices. The franchising model will have to pay special attention to the aspect of quality of care, which is quite variable in the private sector. In such a scenario, the franchise model ensures standardization, beginning with training of service providers and setting standards. In addition, the operations manual or quality standards manual serves as an important tool to monitor the services being delivered. The providers who do not follow the standards of service delivery, need further or refresher training. Therefore, an integral part of social franchising is to bring about uniformity in the services delivered by the providers.*

- Sustainability – linkages with financial institutions. *In exploring a sustainable model for franchising, a primary concern is of revenue. Therefore, it is important to tie-up with possible financing institutions for providing start-up capital at low rates of interest. The foremost requirement for any franchising model is of demand creation. Therefore, though financial self-reliance is desired, it is more important to address acute problems and health concerns in situations that require immediate*

attention. In such a context, the approach is to take funds from donors or financial institutions to begin work and in the process try to build financial-self-reliance.

- Synergy between social marketing and social franchising. Most of the programs across the world have successfully integrated social marketing and social franchising, where the products are delivered through the social marketing channel and services through the social franchising channel. Developing the right synergy among them is crucial in the long-term and provides learning for franchising in India.

### **Role of Government in Social Franchising**

Social franchising represents a new approach in provision of health services. It symbolizes networks that provide socially beneficial services. For governments, as institutions responsible for social outcomes, the social franchising mechanisms offer alternatives in providing services to people, that ensure increased affordability and accessibility, and in the process convert the hitherto beneficiaries into customers.

In India, the majority of the existing franchising arrangements are primarily business models, operating without the government and mainly located in the high-cost specialized or corporate sector, such as the Apollo hospital franchise. This raises concerns as to whether the government can utilize such institutions for social franchising purposes. Such institutions are also more likely to be interested in the curative rather than the preventive aspect of medicine, while the latter happens to be the government's priority.

### **Cost Reimbursement Models**

The large presence of NGOs in the health sector in India has facilitated mechanisms of health service delivery that are essentially cost reimbursement models. However, such models lose out on an important aspect of private business – of ensuring least cost solutions or cost-efficiencies.

An alternative approach would be to buy out services of big providers and retail them at a particular price to the people whom these services should be reaching.

*An alternative approach would be to buy out services of big providers and retail them at a particular price to the people whom these services should be reaching.*

# SUMMING UP: DAY ONE PROCEEDINGS

The day's proceedings highlighted the common ground between all the presentations and experiences shared by the speakers. The discussions reflected that all presentations had approached similar problems from different directions to reach similar conclusions about how health could be delivered through social franchising or quasi-franchising programs, signifying the thinking that franchising is one of the ways of moving forward towards improving the provision of health services.

The key points common across the various presentations indicate the following:

- Focus on demand-led rather than supply-led solutions.
- Commercial franchising approach offers important lessons in terms of improving coverage and quality of coverage in delivering health programs.
- Proper market research is fundamental to future growth to understand which is the target market, where it is located, how it is organized, how it gets its information and what it can afford.
- Government commitment is vital to the success of franchising in the health sector, both in terms of involvement and cooperation, and simplifying any existing bureaucratic constraints, to create a system, which is workable and simple for both the franchisees and clients to access.
- To develop a franchising system within a public-private partnership model requires both the public and private sectors to cooperate and complement each other, not to compete. The model also needs to be adaptable to different situations and particularly, would need to address at some stage the differences between the urban and rural provision of services.
- Ensuring sustainability in the shortest possible time scale – though achievable at the franchisee level – remains challenging at the franchisor level and may need to be addressed in terms of long-term support, either through donor or government funds.

# SESSION IV

## **SOCIAL FRANCHISING IN INDIA**

Chairperson

*Denis Broun, Country Director, UNAIDS*

### **Self-sustaining Social Enterprises – World Class In India**

*Kaushik Madhavan, Associate Director, KPMG*

### **Experiences of HLPPT in Social Franchising – Public-private Partnership in RCH**

*Anant Kumar, Head – Social Franchising, HLPPT*

### **Franchising for Health – the Apollo Experience**

*Sudhir Bahl, Vice-President, North, Apollo Health and Lifestyle Limited*

Discussants

*Loveleen Johri, Senior Reproductive Health Advisor, USAID*

*Sanjay Pandey, Executive Director, Jharkhand Health Society*





# OVERVIEW

The first session on the second day of the Workshop shifted from international experiences to social franchising in India, with some specific examples and learning from three Indian experiences in franchising models. The papers demonstrate the significant diversity of existing models - commercial franchising, full franchising and partial franchising.

'Self-sustaining Social Enterprises – World Class in India' is a paper comprising two case studies of successful social enterprises in healthcare, one in Bolivia and the other in India. The central proposition is that commercial businesses offer considerable lessons to social enterprises. The innovations across various sectors of commercial business reflect multiple examples of combining low cost with good quality and profitability, the key tenets of social franchising. In a country like India, only about 13-14 percent of the population has health insurance to cover corporate hospital care. Therefore, even in the private health sector, the real challenge is to provide quality healthcare that is comparable to big corporate hospitals such as Apollo and Escorts, but at affordable or low costs. The Aravind eye care system operating in Tamil Nadu, serves as

the perfect example of a low cost, quality driven and self-sustainable healthcare model.

The paper on 'Experiences of Hindustan Latex Family Planning and Promotion Trust (HLFPPT) in Social Franchising – public-private partnership in RCH experiences' encapsulates the initiatives of the organization in developing a healthcare model with full as well as partial franchising components. Envisioned as a nation-wide network for delivering quality reproductive and child health (RCH) services, the model comprises 'for-pay' reproductive and child health hospitals and clinics that deliver accessible, quality and affordable healthcare services to lower and middle income families in semi-urban areas. Integrating innovative approaches in public-private partnership, the HLFPPT model caters primarily to two categories of patients. Those who can afford to pay an insurance premium are linked to community health insurance schemes, while those belonging to families living below poverty line (BPL) or people who cannot afford to pay the basic insurance premium are linked to government health schemes.

'Franchising for Health – the Apollo Experience' introduces franchising

experiences in the corporate healthcare sector. Apollo Health and Lifestyle Limited (AHLL) is a subsidiary of the Apollo Hospitals Group with expertise in franchising and setting up a chain of day-to-day healthcare clinics across the Indian subcontinent named the Apollo Clinics. While government focus has mostly been on basic healthcare, the day-to-day healthcare involving specialists' consultation, diagnostic facility or a pharmacy, all under one roof was a

gap bridged by the Apollo Clinics. The Clinics therefore function as a one-stop destination for all day-to-day healthcare needs and signify the first concentrated effort to provide standardised service in this segment. Launched in 2003, there are currently 47 Apollo Clinics operating in the country. Conceived within a 'for profit' model but with a larger social service approach, the Apollo Clinics deliver family-focused primary healthcare services.

# SELF-SUSTAINING SOCIAL ENTERPRISES WORLD CLASS IN INDIA

*Kaushik Madhavan*

## INTRODUCTION

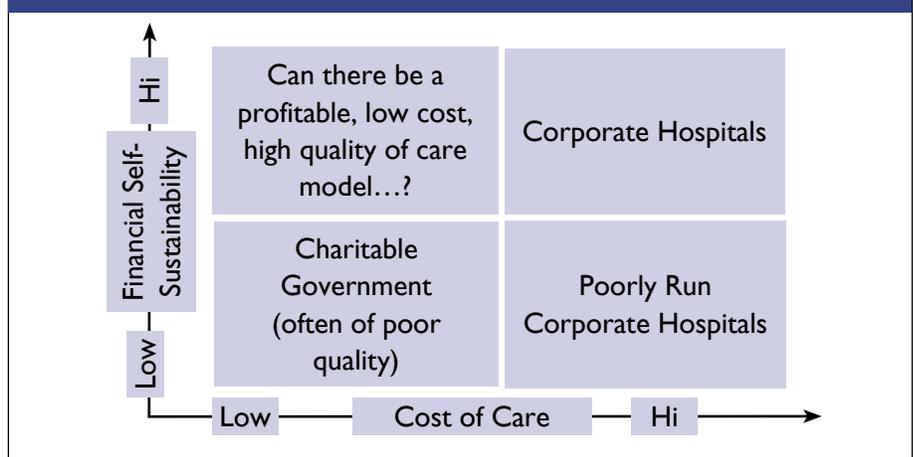
There are several examples of successful models in social franchising and social enterprises worldwide. These have provided significant learning for development and expansion of healthcare initiatives in India. This paper focuses on the key components to develop a profitable, self-sustaining, low cost yet a high quality and socially accessible model of healthcare.<sup>1</sup>

## EXISTING PARADIGMS IN HEALTHCARE DELIVERY

The framework for healthcare delivery points to two key aspects is of healthcare. One aspect that the cost of care has to be low enough to help the masses or the people at the bottom of the pyramid, who are unable to access healthcare. The other aspect is that the entity (whether person or business) delivering the service needs to be commercially viable in order to be sustainable.

The healthcare delivery framework indicates two options. One side presents the low cost of care characterized by low financial sustainability, while the other side presents the high cost of care that has better potential for self-

## THE EXISTING PARADIGMS IN HEALTHCARE DELIVERY...



sustainability. The challenge lies in finding a low cost, high quality, yet a profitable model of healthcare. Within this framework fall the charitable institutes or even government run facilities that extend a major portion of the free care or low cost care, but lack sustainability from the financial viewpoint. In contrast, the corporate hospitals perform excellently from the shareholders point of view. They are extremely profitable and can function as successful stand-alone businesses. However, the downside is that the high costs restrict accessibility to services to only those people who can afford to pay.

<sup>1</sup> The paper comprises case studies of two successful social enterprise models in healthcare – Prosalud in Bolivia and the Aravind eye care system in India. Both provide significant takeaways and learning for franchising models.

In a country like India, with low penetration of insurance, only about 13-14 percent of the population has health insurance to cover corporate hospital care. Therefore, the real challenge is to have quality of care that is comparable to big corporate hospitals such as Apollo and Escorts, with a much reduced fee structure.

### **DEVELOPING SOCIAL FRANCHISING MODELS**

The above premise has served as the motivating factor within KPMG to develop social franchising models in India for self-sustainable and fairly low cost reproductive and child health (RCH) clinics targeting the peri-urban and semi-urban populations.

Synthesizing information from multiple sources in developing the desired business models, KPMG has followed various levels of analysis. It has initiated primary research on understanding the existing private service providers. In India, private practitioners deliver 70 percent of the healthcare. The research focused on determining the reasons for the profitability of private sector providers, the key features of their business models and drawing lessons to integrate in the social franchise business model. Similarly, secondary research on case studies of successful international social franchising models was undertaken. This helped to extrapolate the relevant information to the Indian context. Some of the relevant case studies with specific takeaways are presented below.

### **PROSALUD CASE-STUDY**

Commercial businesses offer a wide range of learning to social enterprises. The innovations across

various sectors of commercial business reflect multiple examples of combining low cost with good quality and profitability. This was evident with the secondary research on the case-studies of successful international business models. The Prosalud case-study is a case in point that offers key takeaways for constructing a model in India.

### **Prosalud Profile**

Prosalud is a USAID funded healthcare delivery model working in Bolivia. It is funded and sustainable to the extent that 80 percent of its costs are recovered. During 2002, it targeted about 400,000 people in the urban and peri-urban areas of six regions in Bolivia.

Prosalud Health Systems Support Organization has been involved in health services that range from well baby clinics to reproductive health, laboratory facilities, physical rehabilitation as well as eye and dental care, through a network of 33 centers. It functions within a polyclinic kind of a model where multiple services are provided as a basket to its clients.

### **Takeaways from Prosalud's Experience**

The many challenges faced by Prosalud and the approaches adopted to address them, serve as important lessons in developing franchise models.

### ***Garnering community support and winning over existing health personnel***

Any new entrant setting up a new business, not just in the healthcare business, but even in a commercial organization, is faced with the

challenge of obtaining community consent. This is particularly pronounced in health service, which is characteristically a very private interchange. Therefore, community consent remains a critical success factor for any health facility.

To address this challenge, Prosalud identified their market through intense market analysis. It assessed the health needs, market competition, and most importantly, whether Prosalud could make a differentiated value proposition in the existing markets, so that the community gained some value out of the Prosalud clinic. In this process, it conducted constant interaction with the key stakeholders in the community, essentially the cooperatives, women and youth, to engage them in better awareness about Prosalud centers, its operations and value-added services.

### **Financial sustainability**

Another key challenge for Prosalud was financial sustainability. The organization adopted a fee-for-service kind of a model where everyone had to pay, with an element of cross-subsidy in it. The cross-subsidization system included free preventive services supported by the government such as immunizations, while curative services typically were paid for. This approach generated footfall into the Prosalud clinics. Once people started coming in for free services and gained first hand exposure to the quality of services offered, it promoted the cross selling of other revenue generating services. In addition, Prosalud followed a twin-track approach; it charged clients who could afford to pay and

subsidized clients who could not pay for their services.

In this process Prosalud developed a network of 33 health centers. Though all the centers had varied levels of financial performance, having a network facilitated the organizational strategy of performing centers supporting non-performing centers.

On the cost recovery side, Prosalud adopted various strategies for financial sustainability that remain relevant to the Indian context. For example:

- Incentive systems for workers
- Risk sharing schemes
- Economies of scale
- Diversification of services to build the centers as a one-stop shop and pharmacy.
- Strengthening a portfolio of services rather than focusing on a single product.
- Establishing strong tie-ups with companies and groups so that it emerged as a model suitable for variety of clients, such as corporates, who wanted a network of facilities such as health screening for staff members. This increased the client volume at Prosalud centers.

### **Quality control in the face of physicians resistance**

Quality control is a critical factor in under-utilization of public services in India. A survey by the World Bank has highlighted that the quality of services has a very strong impact on people using the facilities. Even people who cannot afford are willing to pay for quality care, signifying the importance of quality perception

*A survey by the World Bank has highlighted that the quality of services has a very strong impact on people using the facilities.*

among people. This finding is particularly relevant in the Indian context since a key lacuna in the Indian healthcare system, especially public healthcare system, is the low quality perception among people. Poor quality perception is thus a key that drives poor utilization of facilities.

Prosalud has also remained vigilant to quality perception among its clients and institutionalized a proper quality assurance mechanism whereby the quality perception has been maintained at par or above of what is available through a private practitioner.

#### ***Attracting doctors to the network***

Being a charity offering low cost service, Prosalud had to address the issue of paying doctors to work in rural areas. It adopted a profit sharing approach with more incentives for doctors performing emergencies. Thus, better performance of the outlet meant increased incentives for doctors to perform better.

#### ***Setting prices for services***

Pricing various services in such a way that it is not a very high cost proposition for the patient while simultaneously providing the necessary financial cushion to manage the health facility, is a key element in developing any franchise.

### **INDIAN MODEL - ARAVIND EYE CARE SYSTEM**

#### **Background**

Aravind eye care system started as an eye hospital in the town of Madurai in Tamil Nadu in 1976. Beginning as an eleven-bed private clinic, its mission has been to eradicate needless blindness. Needless blindness is

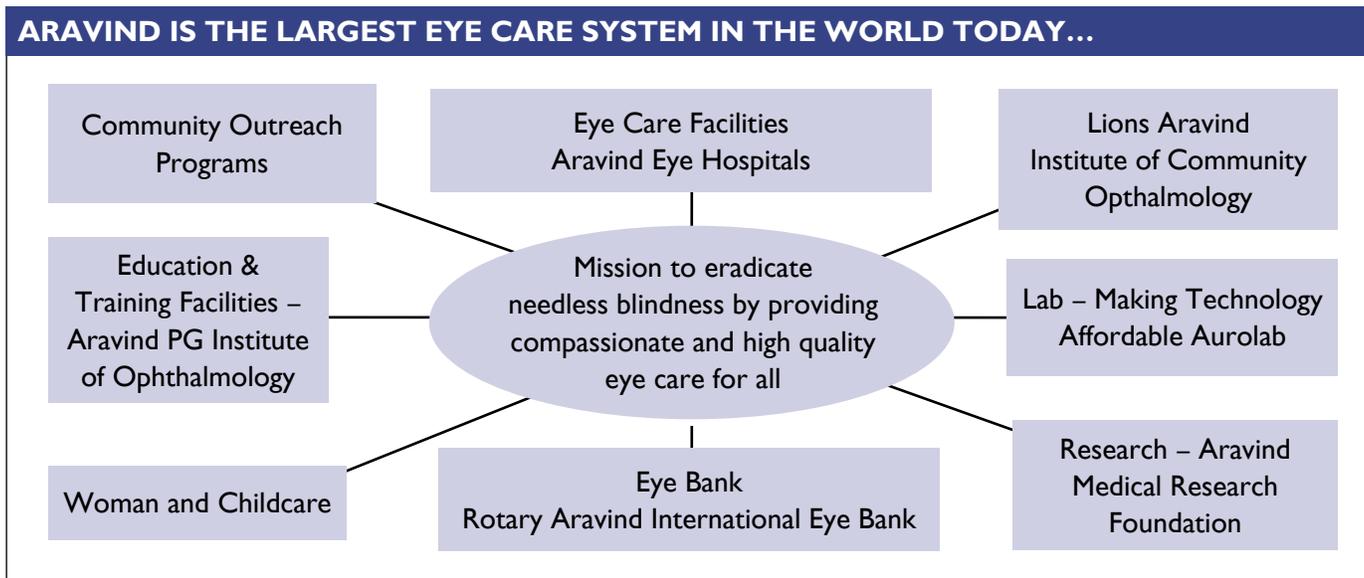
estimated among 45 million people worldwide and is found among 9 million people in India.

The Aravind eye care system hospital presently has five hospitals, located in the cities of Madurai, Pondicherry, Coimbatore, Theni and Tirunelveli, in southern India. The Madurai clinic has expanded into a 1,500-bed hospital, performing 190,000 surgeries per year, recorded as the highest number of surgeries performed anywhere in the world and 45 percent of all surgeries in Tamil Nadu. Nearly five percent of all eye surgeries in India are undertaken through Aravind eye care system. It is recognized as the largest eye care system in the world today.

#### **Facilities**

In the last 30 years, the driving force behind its expansion has been the vision of eradication of needless blindness by providing compassionate and high quality eye care for all. The Aravind eye hospitals provide various kinds of eye care facilities. They have integrated modern technical systems in eye care and one such example is the manufacture of affordable foldable lenses. In this direction, the hospital has established an 'Aurolab', which is involved in pharmaceuticals and intraocular lenses. The hospital also has a strong research wing under the Aravind Medical Research Foundation. The Aravind Post Graduate Institute of Ophthalmology is recognized as a center for excellence in doctoral programs, and receives a multitude of students from across the country as well as international students who are actively involved in research

## ARAVIND IS THE LARGEST EYE CARE SYSTEM IN THE WORLD TODAY...



projects. The Aravind International Eye Bank is a premier part of the institution. The hospital is also diversifying in women and childcare with emphasis on education and training. Aravind eye care has developed from a single hospital providing just cataract surgeries into a system that is well integrated and horizontally diversified to provide a holistic health delivery model today.

### Key Aspects of Aravind Eye Care System

#### Free services

One of the key aspects of Aravind eye care system is that it provides a wide range of free services. More than 50 percent of the surgeries and 50 percent of outpatient visits in the Aravind eye care system are without any cost. This is a significant proportion compared to international norms and specifically important since it does not charge a premium to paying customers. The paying clients do not have to incur any high or additional expenses to subsidise the 50-60 percent of the population that receives free surgeries.

#### High quality standards

The Aravind eye hospitals maintain high quality standards of services. Aravind eye care has one of the best performances in the world. A comparison of Aravind eye care with the Royal College of Ophthalmologists (UK) indicates comparable results. Therefore, free provision of services has made no impact on the quality of services delivered at the Aravind eye hospitals. In fact, their quality is considered superior to even NHS, UK performances.

## ARAVIND HAS ONE OF THE BEST PERFORMANCES IN THE WORLD...

Aravind Eye Care compared with Royal College of Ophthalmologists					
Adverse Events during Surgery			Adverse events within 48 hours of surgery		
Event	Aravind, CBE	UK National Survey	Event	Aravind, CBE	UK National Survey
Capsule rupture & vitreous loss	2.0%	4.4%	Corneal Edema	8.0%	9.0%
Iris Trauma	0.3%	0.7%	Weak leak/rupture	0.67%	1.2%
Wounds	0.3%	0.25%	Retained lens material	0.87%	1.1%

### ***Financial independence***

The Aravind eye care system is financially independent of donors, and has been consistently generating surpluses. In 2001-02, the institution recorded an income of INR 388 million, and had a surplus of INR 210 million. The salaries paid to the doctors, a central component of health facilities costs, are competitive with the market. The Aravind eye hospitals have established that they have the lowest costs in the market, even for paying customers, and still generate a surplus, a key indicator of a sustainable model. This clearly indicates that Aravind eye care system has developed into a low cost, self-sustainable provider of healthcare.

### **How is all This Possible?**

Several critical factors have contributed to the success of Aravind eye care system.

### ***Efficient work flow combined with high doctor productivity***

Aravind eye care hospitals have focused on work flow innovations leading to high doctor productivity. An Aravind eye care doctor performs around 2,600 eye surgeries per year against the national norm of about 400. This is akin to 5-6 times the productivity of a regular, well-qualified doctor. The main reason for increase in productivity is an efficient work flow system developed at Aravind. For example, the operation theatre for cataract surgeries has multiple operating tables on which doctors operate simultaneously.

### ***Trained paramedics complement doctors***

The hospital invests substantial time and effort in training nurses and

paramedics to take care of all the non-critical activities of eye surgery, thereby ensuring that the doctors' attention is focused on conducting operations. The related work such as preparing the patient and post-operative preparations in terms of cleaning up, bandaging, etc. are undertaken by the support staff. Therefore, the surgical procedures have an assembly line approach, the doctor moves from one operating table to the next, while the trained paramedics take care of the other procedures.

The work flow is designed in such a manner that the doctor's time is used for the most crucial aspect of the surgery, while the well-trained paramedics handle all the non-critical aspects. This is a key work flow innovation that Aravind has developed.

This has also been possible because chances of cross contamination amongst patients are quite low in eye surgeries. It may not be so for all aspects of surgery but wherever there are low chances of cross contamination across patients, such models offer an important learning.

### ***Backward integration***

Aravind found that imported intraocular lenses were quite expensive and raised the costs. To address this concern, the hospital adopted the 'backward integration' strategy. It was able to organize a technology transfer for intraocular lenses, adapt it locally in India and in the process save a lot of costs.

### ***Incentives for doctors***

Retaining doctors in any health facility is very crucial. At Aravind,

the doctors are taken as residents and on completion of the MBBS program; they earn a two-year postgraduate program, which serves as a motivation for their retention. In addition, there is a strong focus on doctor development. There are many interactions, weekly meetings and peer review among doctors. There are other opportunities for knowledge enhancement through presentations, seminars, research and tie-ups with other institutions.

### **Strong emphasis on selection and training**

Aravind lays strong emphasis on selection and training of its health personnel. Interviews for paramedics are conducted jointly with the family to ensure family commitment in order to retain the people in the system.

### **Volume generation through outreach activities**

Aravind eye care hospitals make intensive efforts in expanding outreach activities with focus on rural health programs.

## **CONCLUSION**

The case studies of Prosalud and Aravind eye care system clearly indicate that it is possible to provide very high quality healthcare at low cost within a self-sustaining system. Both the models provide key learning for franchising initiatives:

- Look for business model innovation – to achieve high volume and low cost operations. *The Prosalud business model represents a network that provides cross-subsidy and scale economy, whereas Aravind has generated*

*work flow and training innovations leading to much higher productivity than normal.*

- Each stakeholder should benefit. *A one-sided business model does not function. The key stakeholders such as the doctors and paramedics need to be paid competitive market salaries. The Aravind model establishes the payoffs of inputs such as training and doctor development that lend value addition to the health personnel through the system, and cumulatively impact the retention of health providers.*
- Offering ‘one-stop shop’. *A diversification in services increases patient volume and utilization of services, and therefore facilitates financial viability. Focusing too much on a single service might be dysfunctional from a financial standpoint.*
- Financial sustainability can be ensured by quality assurance. *Good quality of care has a twin positive impact. It attracts paying clients and thereby favorably impacts financial sustainability*
- Effective information, education, communication and outreach services increase awareness leading to increased utilization of services.

This aspect is particularly important in countries like India, where people take illness for granted and hesitate to access health services. About 40 percent of the illnesses remain untreated because people do not think they need treatment. In such situations, outreach services can convert a large segment of potential or target clients into active clients.

***A diversification in services increases patient volume and utilization of services, and therefore facilitates financial viability. Focusing too much on a single service might be dysfunctional from a financial standpoint.***

# EXPERIENCES OF HLPPT IN SOCIAL FRANCHISING

## PUBLIC-PRIVATE PARTNERSHIP IN RCH

Anant Kumar

### INTRODUCTION

The experience of Hindustan Latex Family Planning and Promotion Trust (HLPPT) in social franchising began with the implementation of a fractional franchising project – ‘Vanita clinic project’ – in Andhra Pradesh around 2002-2003. In this initiative, the organization was providing family planning counselling and IUCD (intrauterine contraceptive devices) services through a chain of hospitals and clinics.

During the implementation process, the organization became concerned about the long-term sustainability of the model; post the project’s termination. Consequently, HLPPT collaborated with KPMG to develop a model that met HLPPT’s requirements and ensured sustainability.

This paper focuses on the development of public-private partnership in the social franchising model adopted by HLPPT, with specific reference to the context, components of the model design and achievements recorded in implementation so far.

### WHY PUBLIC-PRIVATE PARTNERSHIP IN SOCIAL FRANCHISING?

#### Context

The healthcare scenario in India is comprised of two dominant players – the public and the private health sectors.

The public health sector accounts for the majority of the health infrastructure in the rural areas, including primary health centers, community health centers, etc. that essentially provide free service. However, their users often perceive the services rendered by the public health facilities as being of low quality. On the other hand, the private health sector, motivated by profit maximization and maximum value to its shareholders, is largely unaffordable to the poor. Another key aspect of the private sector is that it is unregulated.

In India, the healthcare expenditure statistics reveal that more than two-thirds of healthcare spending is out of the user pocket. Only one percent of the population has any medical insurance. Employers’ contribution is about 15 percent and government spend is about 20 percent, while the household

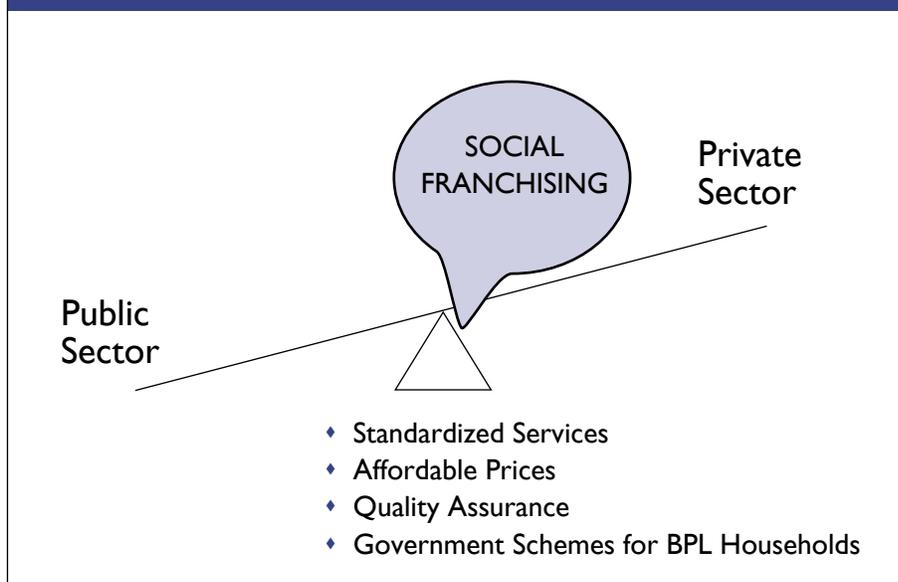
directly incurs 64 percent of the healthcare expenditure.

In terms of healthcare expenses by provider category, the user incurs health expenditure on several kinds of health providers. The private sector leads with private practitioners' share of about 40 percent and mid-market private hospitals with 42 percent. The upmarket private hospitals attract about 7 percent of the health expenditure. In contrast, the charitable hospitals have a small share of about 11 percent. An assessment of the size of the private facilities indicates that 84 percent of the private hospitals are less than 30-bedded, mostly belonging to the mid-market category.

In rural areas as well, the private practitioners provide 56 percent of the healthcare. The predominance of the private sector is indicated in the data on institutional deliveries. For instance, in Uttar Pradesh, the private sector providers' conduct close to 69 percent of the institutional deliveries.

In terms of the nature of services provided by the two health sectors, there is a clear distinction. The private sector offers a relatively small share of preventive services but takes care of a large portion of curative services. It offers only 10 percent of immunizations, 40 percent of prenatal care and a little more of institutional deliveries, but takes a majority share in hospitalization and outpatient care. However, despite performing a substantial portion of institutional deliveries, the numbers of infant

## CREATING THE MIDDLE PATH



and maternal mortality rates in the private sector remain high.

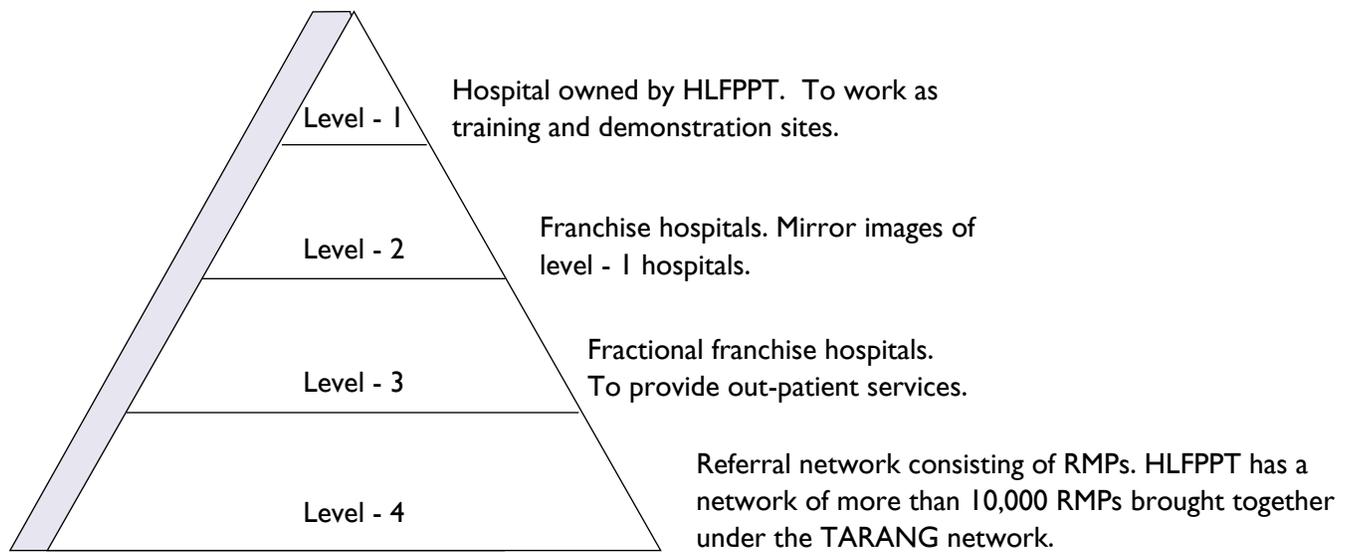
Therefore, HLPPT identified that the challenge was to shift the focus of services provided by the private sector. It observed that if the private sector started to focus on preventive and promotive care; the entire public health scenario in the country could change.

### SOCIAL FRANCHISING - CREATING THE MIDDLE PATH

HLPPT began to explore whether it was possible to take the private sector towards the promotive side and consequently defined its task as 'engaging the private sector in quality RCH service provision at affordable prices'.

The model planned by HLPPT focuses on creating a middle path between the private sector and the public sector. The role of HLPPT is to provide standardization of services at more affordable prices

## LIFESPRING NETWORK



(in comparison to the private sector) with strong quality control and quality assurance to ensure that quality is not compromised at the cost of price. In addition, HLPPT has also tried to link government schemes for households below poverty line.

Social franchising has been effective in strengthening public-private partnership for creating access to quality RCH services worldwide. Social franchising is harnessing private sector strength in addressing critical public health issues through standardised quality service delivery mechanisms at affordable prices within a preventive and promotive healthcare focus.

### **HLFPPT MODEL**

The HLPPT social franchising model of public-private partnership for RCH service delivery is envisioned as a nation-wide network. It comprises 'for-pay' reproductive and child health

hospitals and clinics that deliver accessible, quality and affordable healthcare services to lower and middle income families in semi-urban areas. This initiative has been planned to significantly contribute towards reducing maternal and child mortality and provide demonstration models for replication.

The HLPPT model is structured like a pyramid with four layers. The top layer, or level one, comprises of hospitals directly owned and operated by HLPPT. These hospitals work as training and demonstration sites as well as serve as quality assurance sites. The second level comprises of the franchise hospitals and exemplifies a full franchising model. The level two hospitals function as mirror images of hospitals in level one but are managed by a third party – the franchisee. HLPPT provides the technical know-how and competence to such hospitals but is not directly involved in their

management. On the third level is the fractional franchising model. This comprises of already existing hospitals, where HLPPT just adds its services. At the bottom of the pyramid is the fourth level that functions as a referral network of registered medical practitioners (RMPs). HLPPT has a strong network of more than 10,000 RMPs brought together under the TARANG Network. The network partners provide referral services as well as undertake family planning counselling.

The HLPPT model caters primarily to two categories of patients -  
- those who can afford to pay insurance premiums and are linked to community health insurance schemes, and those living below poverty line (BPL) or people who cannot afford to pay the basic insurance premium. These are to be linked to government health schemes.

### **Franchisor-Franchisee Relationship**

HLPPT functions as a franchisor managing the entire model. The franchisees are the Jeevan Dhara Network and Life Spring Network. The Life Spring Network denotes full franchising where the doctor or an entrepreneur invests the entire money for setting up the hospital. Alternatively, the Jeevan Dhara Network represents fractional franchising.

As a franchisor, HLPPT provides the franchisees with the products and/or services as well as training and technical know-how. For these inputs, the franchisees pay certain licensing fees and royalties to

the franchisor. Strengthening the linkages between the franchisor, franchisees and the clients/customers is a strong quality control and a customer feedback system.

### **Role of HLPPT**

HLPPT typically helps the franchisees in all the practical aspects of setting up and scaling up the business, for example, through support in equipment procurement. In this context, HLPPT has developed a national network of vendors over the last one year. The vendor network is projected to leverage supply of equipment to the franchisees. The vendor database, developed as part of the vendor network initiative, lists suppliers from all parts of the country and ensures competitive market prices of equipment for the franchisees.

The organization is also involved in regulating quality assurance systems, pricing and marketing mechanisms. HLPPT has partnered with teams of finance and marketing professionals/experts to integrate the best available expertise in its social franchising efforts. In terms of capacity building and training of franchisees, HLPPT is also building a database of doctors who can serve as resource persons or master trainers.

With regard to developing innovative approaches in franchising, HLPPT is also in the process of leveraging telemedicine facilities for its franchisees. Similarly, the organization is actively engaged in a dialogue with the Government of India for creating national schemes for BPL families.

### Role of Private Providers

From the franchisee side, the model expects the private provider to broadly adhere to three guidelines. One is to provide services according to HLPPT protocols. The organization has developed stringent protocols for standardization of services; for example, emergency obstetrics care (EmOC) procedures have to be institutionalized by the franchisees offering such services.

The other two aspects relate to charging prices fixed by HLPPT and emphasis on quality assurance audits.

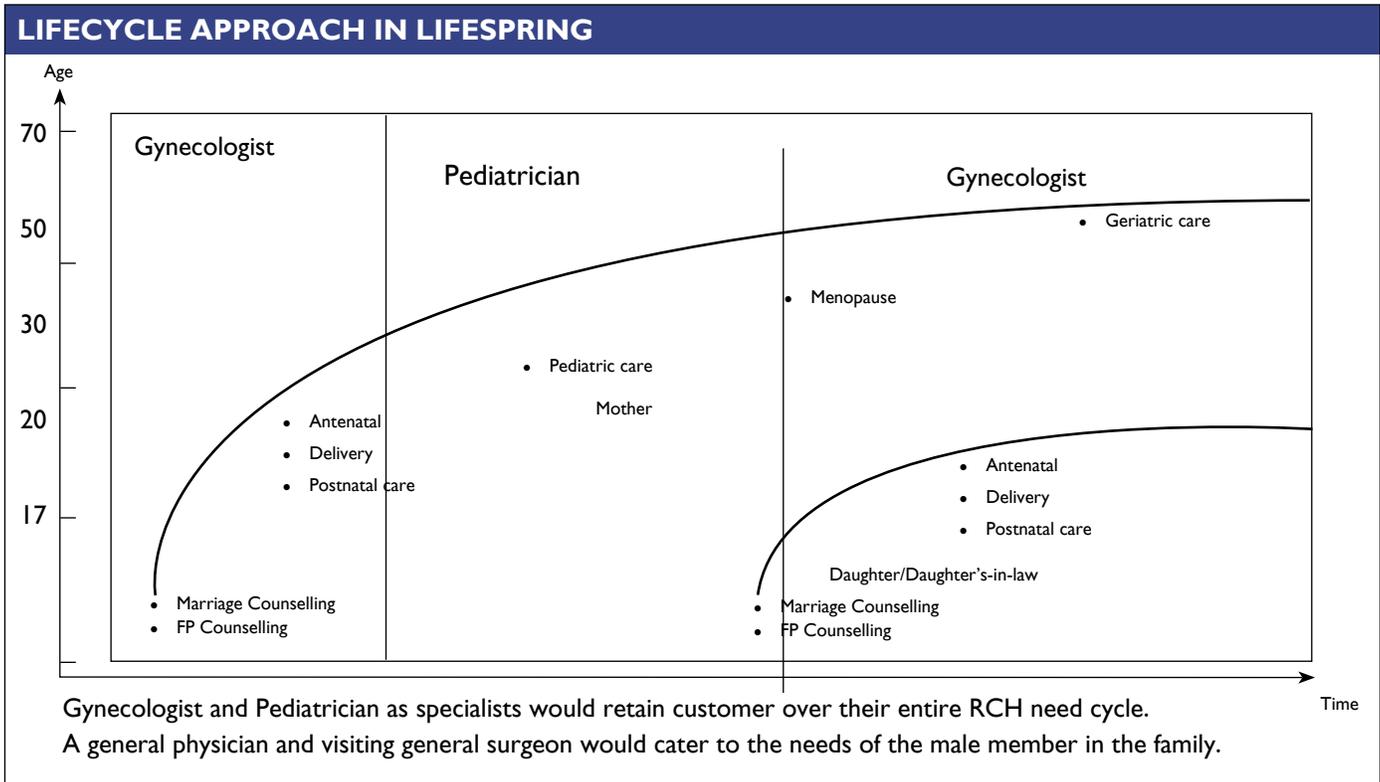
### Customer Care - Lifecycle Approach

The HLPPT franchising model identifies three critical customer values or propositions. The first is of affordable services to the patients,

second of quality medical care and third of personalized care.

Personalized care is an innovative addition by HLPPT, built on the premise that generally when a patient walks into a hospital, he or she is subjected to an impersonal and clinical approach to the entire process of service delivery. However, HLPPT research has proved that a patient expects a lot of personal attention rather than just information about the disease. This understanding has led to the development of a complete personalized care protocol adopted by hospitals currently operating within the model.

This principle is part of HLPPT's lifecycle approach model in healthcare. It includes services, starting from marriage counselling to family planning counselling,



supporting the client through antenatal, deliveries and postnatal care, and then advancing to paediatric care and onto guidance during menopause. The gynecologists and paediatricians, as specialists, are expected to provide these services for the mothers and children to help retain the clients over their entire RCH need cycle.

The RCH basket of services contained in the HLPPT model also extends to cover the needs of the entire family through general surgical, diagnostics, in-patient, and general physician services.

In terms of financial value to the customers, the HLPPT franchise hospitals are comparatively lower priced than other private hospitals. For example, the franchise hospitals in Hyderabad, Andhra Pradesh, charge only INR 1,200 for normal delivery of patients admitted in the general wards while costs in other private hospitals range between INR 4,000-12,000. Similarly, the costs of caesarean delivery in HLPPT franchise hospitals are INR 4,900 whereas the market prices can range from INR 8,000 to 25,000.

### **VIABLE VENTURE**

The HLPPT model in its last five months of operation has been able to cover 70 percent of its expenses. Cost recovery has been facilitated by the maximization of cross-subsidization within the system, the higher earning services supporting the less paying to balance the equation.

Viability of the model is closely linked to the financial planning of the franchise. Though heavily dependent on seed capital to initiate the set-up, develop the infrastructure and establish the brand, HLPPT is optimistic about its sustainability. The model is planned with cost recovery for franchisees projected from the second year of full operation.

In terms of revenues and expenses, the key sources of revenue identified are institutional deliveries and pharmacy and diagnostic services, while the main areas of expenditure are manpower and materials. Despite being a low cost model, the salaries of doctors and paramedics compare with the best in the industry.

### **ROLL OUT PLAN**

In the first phase, HLPPT is setting up three hospitals as training and demonstration sites across India. Two are operational in Hyderabad and Kanpur, while the third hospital in Agra is being developed. The second phase of building the franchisee network is in progress. About 160 franchisees have been identified and processes of franchisee screening have been initiated.

In conclusion, HLPPT hopes to integrate the passion of franchisees with the vision of the organization, to strengthen its model for increasing access to quality healthcare with focus on improved RCH services.

***HLPPT is optimistic about its sustainability. The model is planned with cost recovery for franchisees projected from the second year of full operation.***

# FRANCHISING FOR HEALTH

## THE APOLLO EXPERIENCE

*Sudhir Bahl*

### INTRODUCTION

**A**pollo Health and Lifestyle Limited (AHLL) is a subsidiary of the Apollo Hospitals Group. The Apollo Hospitals are a large healthcare network in south Asia. The AHLL is a wholly owned subsidiary of the Apollo Group with expertise in franchising and setting up a chain of day-to-day healthcare clinics across the Indian subcontinent named the Apollo Clinics. There are currently 47 Apollo Clinics in operation.

The Apollo Clinics represent an integrated healthcare delivery network. This paper traces the inception of the franchising business and the experiences in developing the model.

### MOTIVATIONS FOR FRANCHISING — CHANGING FACE OF HEALTHCARE

In the last few years there has been growing awareness about preventive healthcare, also marked by a sharp increase in competition in the corporate healthcare sector. An industry overview of healthcare in 2000-01 indicated a significant finding on the increasing expectations from the 'quality' aspects of health. Despite the commendable achievements of the Indian healthcare facilities, the

measurement of quality has been missing.

A key constraint experienced by any patient considering a doctor or a medical facility is the lack of a rational framework to make an informed decision. Most people rely on word of mouth or peer advice to seek information on which medical facility to visit. This fundamental precept served as the motivation for building a rational framework within Apollo.

In addition, a major reality in healthcare business was that the day-to-day healthcare segment represented a large opportunity for expansion. In the natural lifecycle of a human being, being admitted to a hospital accounts for less than 5 percent, on an average. While government focus has mostly been on basic healthcare, the day-to-day healthcare involving a doctor's consultation, diagnostic facility or a pharmacy, all under one roof was missing. Consequently, the goodwill enjoyed by Apollo as an excellent healthcare provider served as the incentive to enter into this segment. Additionally, the initiative also offered immense opportunities to leverage Apollo's expertise and brand equity.

Therefore, the Apollo Clinic model was conceived within a 'for profit'

model but with a larger social service perspective, and with a focused shift from illness to wellness. Healthcare provides the opportunity to do good and do it well.

## **APOLLO HEALTH AND LIFESTYLE LIMITED**

The Apollo Health and Lifestyle Limited (AHLL) is a 100 percent subsidiary of the Apollo Hospitals Group, incorporated to deliver family-focused primary healthcare services. The Apollo Clinic functions as a one-stop destination for all day-to-day healthcare needs and signifies the first concentrated effort to provide standardised service in this segment. The first clinic was launched in 2003.

### **Business Model and Strategy**

The Apollo Group chose franchising as the business model for two reasons. Franchising exploits entrepreneurial potential offered by individual franchisees, which is very critical to rapid market expansion. Secondly, the scalability of the business model is ensured in terms of quick progression (increasing the number of clinics) and product expansion.

The cornerstones of the business strategy adopted in development of the Apollo Clinics were primarily (i) the economy of scale and (ii) the network effect. Both these dimensions, along with high volume and low cost have served to build sustainability and profitability of the enterprise. Though an assessment of the capital cost of the franchise might appear high in comparison to other public-private partnership models, the business volume signifies its success.

## **THE APOLLO CLINIC**

### **Concept**

The Apollo Clinic is a nation-wide network of franchised day-to-day health care clinics. It comprises branded retailing of healthcare services.

The predominant difference created by the Apollo Clinic is of convenience. It has established convenience on three parameters – specialists' consultations, diagnostics and pharmacy. The thrust on integrating specialists' rather than general practitioners was an informed decision to cater to the lack of specialists' availability in private health practice. The objective was to combine specialists' expertise with very advanced diagnostics facilities and pathology and integrate the latest technology and standardization. Advanced diagnostics is the backbone of patient care, since the lack of correct diagnosis impacts the entire treatment cycle. In addition, 24-hour pharmacy services lend a supportive arm to the Clinic.

This conceptual approach was considered crucial to ensure consumer/client benefits as well as assist in maximizing revenue.

### **Design**

To facilitate the development of client friendly clinics, the Apollo Clinics were designed with a different outlook. Shifting away from a clinical approach, the foremost concern was on developing the right ambiance for the customers. Non-clinical spaces of Apollo Clinics lend warmth and reassurance to clients that they are in safe hands.

*The Apollo Clinic functions as a one-stop destination for all day-to-day healthcare needs and signifies the first concentrated effort to provide standardised service in this segment.*

In designing functionally efficient clinics, the Apollo Clinics have an edge due to the vast pool of available clinical personnel of the Apollo Hospitals Group. This has helped to create efficient work flows and systems to comprehensively address customer needs.

The global relevance of the Apollo Clinics design is indicated by similar clinics found in other parts of the world, such as Qatar. The replicability and modular aspects of Apollo designs have also led to greater cost-efficiency in terms of creating easily maintainable clinics.

### **Technology**

Installing appropriate equipment is a foremost concern in the Apollo Clinics. The approach has been to use the best technology possible within the confines of the seed capital.

This has led to the establishment of some of the best technical services available in clinics in the country. An assessment of the recently launched Apollo Clinics, in the cities of Gorakhpur in Uttar Pradesh and Bhatinda in Punjab, has earned them the distinction of having the best-automated diagnostics labs. Such achievements have been facilitated by the policy of periodic review of technology and equipment to keep the Clinics updated on the market changes and advances.

Use of modern software has played a critical role in managing the Clinic work force and ensured

customer satisfaction. Today, the Apollo Clinics have created such a desirable niche in the market that the moment a new Apollo Clinic is opened, all the insurance companies, banks, and others in the employment sector approach it for empanelment. The key reason is that each and every system runs through software where no report can be changed and is made available within the time allotted by the corporate entity or bank. This has created a visible difference in terms of transparency and delivery of healthcare.

The Clinics maintain electronic records of each patient for a certain number of years. This has led to increased convenience for patients seeking insurance as well as ensured greater productivity. The systematic work flow is improved by effective software. The source code of the software is not shared with the franchisee. This remains within the control of the franchisor and is one of the key controls in franchise operations.

### **Service Quality**

Quality of services is the hallmark of Apollo Clinics. In pursuance of ensuring 'quality' aspects of health and efficient measurement of quality, the franchise has been exploring concerns such as '*what is the actual patient time*' as in the average time each patient spends at the Clinic from check-in to check-out. Due to the lack of any existing standard procedures or statistics to make this assessment, the franchise has developed some in-house plans and formulas that are refined through service quality audits.

Some of the key challenges faced in delivering quality services are the following:

**People: selection and recognition**

As in any industry, people and resources are a big challenge. Work in a franchised model is heavily dependent on the motivation of the franchisees as well as other personnel. Although the Clinics do not face any shortage of qualified doctors, employing efficient customer care executives (CCEs) to manage the reception, the first level of interface between the customer and the Clinic is challenged by the call center industry, largely because the health franchise pay scales cannot compare with those offered by the call centers. However, the Clinics have striven to maintain quality and tried to recruit people with a different kind of passion.

**Training: operational and behavioral**

A mandatory 15-day structural training program for every employee follows every Clinic launch. In addition, the directors of every franchise Clinic have to undergo a two-week training course at the Indian Institute of Management, behavioral (IIMA). Apollo has developed a specific program on healthcare from a business perspective run by IIMA, especially for franchise directors.

**Ongoing audit and benchmarking**

Systematic ongoing audit and benchmarking processes are integrated into the functioning of each Apollo Clinic. The benchmarking procedures introduced by Apollo face some competition from other franchises

in India, which has led to increased examination and further refining within the system to enhance results.

**Communication: patient empowerment**

To strengthen patient empowerment the model has a structured feedback system. Each clinic is equipped with a suggestion box for feedback from customers. These cannot be opened by the franchisee and only operations managers from Apollo are authorised to conduct regular checks and audits.

**Pricing**

The Apollo Clinics pricing mechanism is based on value for money. The franchise undertakes an intensive city analysis before any clinic launch to determine market prices of health services. In addition, Apollo has also been focused on communicating and generating public awareness that corporate health facilities such as Apollo are not over-priced. For example, the standard benchmark for pricing within Apollo laboratories is 20 percent less than other private laboratories. Therefore, the key premise within Apollo is profit driven by volumes, rather than margin.

**THE APOLLO CLINIC – POSITIONING**

The Apollo Clinics are positioned to offer reassurance to the middle class that healthcare is affordable. This is the target clientele for Apollo since 70 percent of the business opportunity is identified with it. It also advocated for addressing the ‘family as a unit’.

*The franchise undertakes an intensive city analysis before any clinic launch to determine market prices of health services. In addition, Apollo has also been focused on communicating and generating public awareness that corporate health facilities such as Apollo are not over-priced.*

Apollo has been trying to promote the prevention aspect of healthcare. However, the existing Indian mindset takes health for granted. Therefore, there is a strong need to shift this attitude towards the concept of prevention. At the inception of the model, Apollo had estimated generation of about 30 percent of the revenues from health checks but the current return is only about 10-11 percent. Consequently, consistent effort is required to build the prevention side of the business.

Nonetheless, equating Apollo with quality, non-premium pricing, value-added services and a family orientation have come to be recognized as the Apollo USP.

### FRANCHISING: THE BUSINESS FORMAT

The Apollo franchise model is based on developing the entrepreneurial spirit and exploiting entrepreneurial potential. The business approach has to recognize that healthcare is not only about money. It has to incorporate an inherent element of passion for delivering the right service, and sensitivity towards the patients or customers.

These characteristics inform the franchisee selection. The typical Apollo franchisee profile includes entrepreneurial spirit with the ability to motivate and train people, coupled with financial acumen and full-time commitment to the business.

### LEARNING

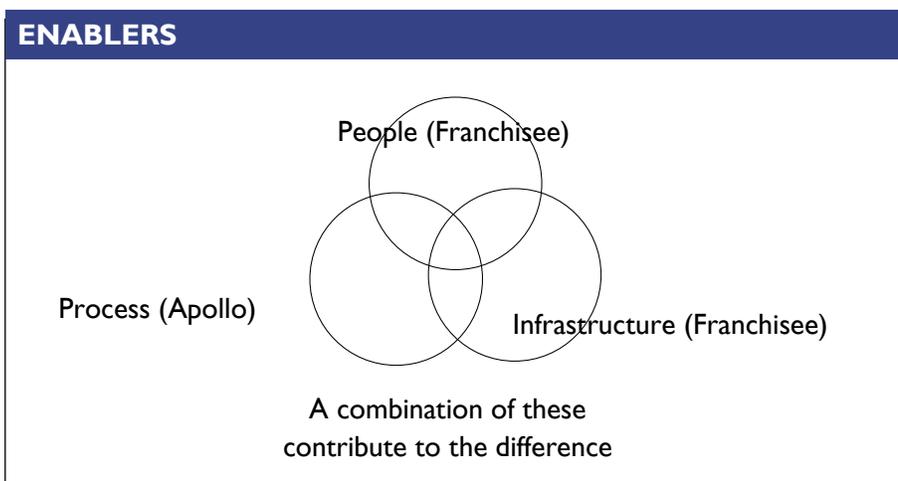
The key learning that has emerged from the Apollo Clinics model has been the importance of identifying the right franchisees. The lesson has been to involve people with entrepreneurial spirit as well as passion and sensitivity for serving patients.

Another key learning is of empowerment of the franchisee, since after the creation of the model; it is operated entirely by the franchisees. As a franchisor, Apollo's control is mainly in terms of conducting periodic monitoring and audits.

The need for greater sensitization towards providing quality is an ongoing concern.

### CONCLUSION

In the Indian scenario, while the number of Apollo Clinics is growing, from 47 already operational to a further 20 clinics to be opened in 2006, franchising in the health sector is still developing and there is a lot to learn about the industry.



# PANEL DELIBERATIONS

The key observations by the discussants and participants during the first session on Indian experiences in franchising provide substantial learning about the variety in existing models, from examples of full franchising to partial franchising to commercial franchising. The important points are summarized below.

## KEY OBSERVATIONS

### Exploring Innovations in Franchising Models

- Develop some innovative models on private-public partnership and social franchising that can be adapted for the three states of Uttar Pradesh, Uttaranchal and Jharkhand.
- Build on existing best practices within the country, from good, working examples such as the Aravind eye care system, to best combine the talents from the public and the private sectors.
- Draw lessons from the HLPPT model with combination of full and partial franchising components that serves as a good model integrating several levels of service providers, a strong linkage with the community health service providers and linkages with private practitioners.
- Explore whether the range of private practitioners available in India, such as fully qualified medical officers in ayurvedic and unani schools of medicine, can also be used as resources. If so, there is the need to provide some kind of training to doctors in the private health sector outside the allopathic system – such as training the unani and ayurvedic doctors in simple procedures like inserting IUCDs, to increase their potential to partner in the franchising networks.
- Address challenges in initiating franchise models by facilitating local solutions, such as adding incentives to salaries to attract providers.
- Develop sustainable and low cost models for health clinics – cross-subsidization and sustainability.  
*Cross-subsidization of services, wherein the revenue from curative care subsidizes preventive care, raises concerns on managing sustainability issues of health models. However, pairing these aspects is possible through efficiencies without having to pass on a higher charge to paying customers. In addition, in the*

*Indian context, the government largely funds preventive care such as immunization. Therefore, provision of such services in the private health sector is one of the strategies towards attracting footfalls. Routing existing government subsidies to generate extra footfalls helps balance cross-subsidization.*

### **Key Challenges in Mainstreaming Social Franchising Models in India**

- How to put the last person in the last village, the last household and the last vulnerable family as the 'first' in any social franchising strategy, and to add another dimension to public-private partnership (PPP), which would be to develop public, private and community partnership (PPCP). *There is a need to review the resources available in rural areas and specifically identify the needs to be addressed, for example, possibilities of developing communication and transportation networks to ensure a patient's ability to reach a semi-urban area or tehsil level town. This would be especially relevant to address the issue of maternal mortality in rural areas, which is aggravated by the lack of doctors and infrastructure at the village level. Two existing networks – the rural ASHA network and the PCO or telephone network could be used for furthering this purpose. ASHA could take control of the situation and telephones in the villages could be used to quickly arrange to take a patient to a higher care institution.*
- Identifying mechanisms in social franchising that can

lead to the empowerment of the community involved in the partnership. Community empowerment in terms of involvement in the decision-making process and ownership of the franchise unit requires that control and command in the relationship between the franchisor and franchisee are more equitable. This requires developing a different model of social franchising in India where the community is at center stage.

- Analysis on the cost of care and financial self-sustainability to integrate the third dimension of benefit.
- Integrating the technology component in social franchising in the health sector to reduce costs.

*Examples of franchising by private enterprise in other sectors provide important learning for social franchising in the rural health sector. Indian Tobacco Company (ITC) is experimenting with a 'e-Chaupal' kind of a model in Uttar Pradesh and Madhya Pradesh. They have been able to penetrate to the extent of about 4000 points in Uttar Pradesh and 5000 points in Madhya Pradesh for outsourcing commodities, by investing about INR two lakhs to create an Internet infrastructure. In a similar manner, Hindustan Lever is trying to innovate on a model for product distribution through self-help groups in Andhra Pradesh. Both these examples are of commercial enterprises trying to leverage the huge demand for products and services in rural India. These models have overcome the first aspect of the challenge, which*

*is distribution or outreach and can provide important lessons in leveraging technology for social benefit.*

*Therefore, technology solutions can provide innovations to structure a healthcare provision model. An example is a Chennai-based telecommunications organization working on wireless local loop access technologies. One of its pilot projects is trying to use wireless systems in local loop access technology to provide some kind of a telemedicine interface. This is particularly important in the rural context, since for chronic ailments, people do not mind travelling distances, but in non-chronic situations such as advice on certain infections or an*

*epidemic, immediate access is crucial. Therefore, such commercial models combined with technology facilitation through telemedicine provide initiatives in the right direction.*

*Rural healthcare can benefit from elements of these commercial models like ‘e-Chaupal’ and technological innovations such as telemedicine, and in the longer-term undertake infrastructure augmentation to overcome the problem of accessibility.*

- Integrating the governance dimension in social franchising by partnering with the public sector.
- Identifying whether networking is the path for replication and scaling up.



# SESSION V

## INDIAN EXPERIENCES IN SOCIAL FRANCHISING

Chairperson

*Beth Fischer, Country Director, Intra Health*

### Experiences of PSI in Social Franchising

*Tim McLellan, Country Director, PSI*

### Social Franchising – the Janani Experience

*Nita Jha, Deputy General Manager, Janani*

### Social Franchising a Way to Healthy Jharkhand

*Shivendu Shukla, Secretary, MoHFW, Government of Jharkhand*

Discussants

*DK Saxena, Government of Jharkhand*

*Deoki Nandan, Principal, Agra Medical College*





# OVERVIEW

The second session on day-two of the Workshop continued with the Indian social franchising experiences. Two of the papers related to social franchising models facilitated by development organizations, while the third described the progress made by the Government of Jharkhand in promoting social franchising in the State. A common theme across the three papers is the potential for expanding social franchising models in rural India with the objective of improving availability of, and accessibility to, healthcare services in remote locations among low and middle income populations.

‘Experiences of PSI in social franchising’ reflects the organization’s focus on exploring social franchising as a model for solving health problems and its role in impacting behavior change. The paper discusses social franchising as a key part of social marketing, supported by the essential component of communication. The combination of social franchising with social marketing is fundamental to recognizing that the former is not a stand-alone approach. PSI has been utilizing this approach in HIV/AIDS and reproductive health programs in building franchise networks in various states of the country,

targeting the under-served rural communities. Since social franchising is new in India, it needs time, support and significant collaboration with various partners, especially the government and donors. It requires a sustained period of experimentation to develop its strengths, to build partnerships with a variety of providers and try out different iterations.

‘Social Franchising – the Janani Experience’ signifies the role of social franchising in leveraging private sector resources to supplement the public sector delivery of services, especially in low resource settings. The Janani program with its three networks of shops and markets, the Titli (butterfly) Centers network of rural practitioners and the Surya Clinics network of qualified MBBS medical doctors as franchisees, establishes the integrated approach in health services’ delivery, linking the rural clients to modern facilities in the states of Bihar, Jharkhand and Madhya Pradesh. Initiated within a social marketing structure for delivery of contraceptives such as condoms and pills, the Janani program has diversified to deliver clinical services to rural as well as urban clients within an infrastructure to provide cost-effective services

to the poor. The Janani experience indicates that the core challenge for social franchising is not so much the creation of service delivery networks but to sustain the delivery of quality services in the networks.

Government commitment to strengthening public-private partnership in health services delivery is illustrated in the paper on ‘Social Franchising a Way to Healthy Jharkhand’. The Government of Jharkhand’s intention to address the large infrastructural gaps in the public health sector has led to the State’s interest in alternative models

incorporating private sector participation. The Jharkhand Government has adopted the social franchising strategy to help address the various constraints related to availability, accessibility, acceptability and affordability of health services. It considers that social franchising ‘gives people choices’, to select their service providers. The State has introduced two schemes – Janani Suraksha Yojna and Sarva Swasthya Mission – the former as a maternity benefit scheme and the latter as an innovative health insurance plan to extend healthcare support to impoverished and BPL families.

# EXPERIENCES OF PSI IN SOCIAL FRANCHISING

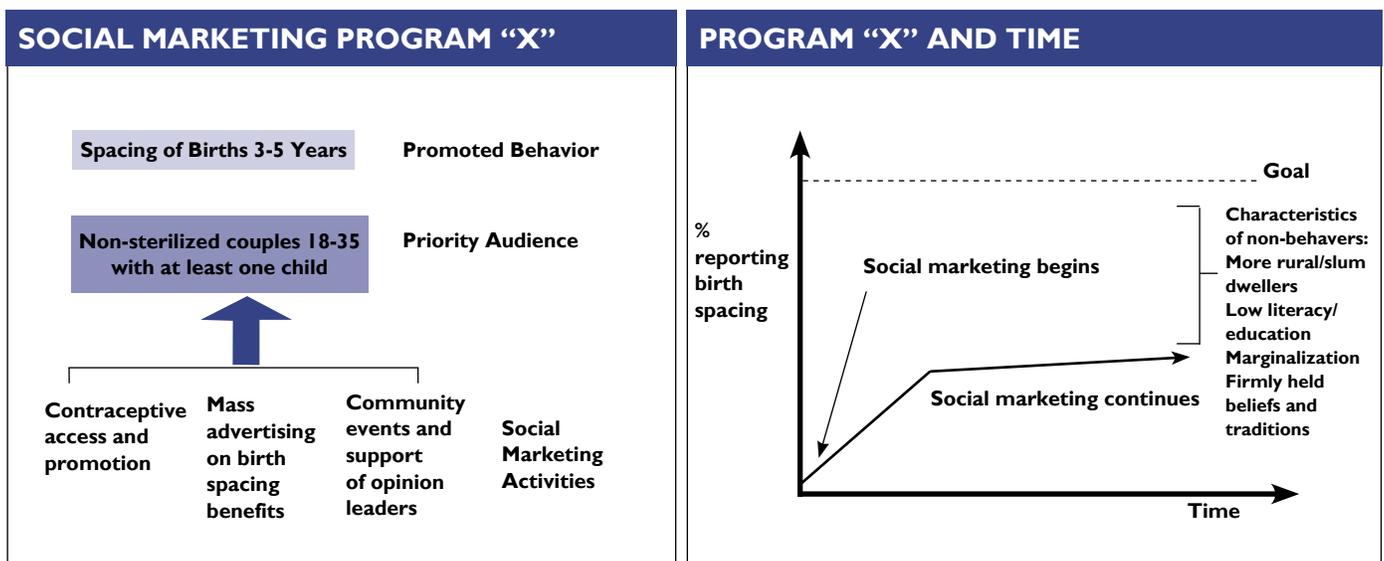
Tim McLellan

## INTRODUCTION

The paper on experiences of Population Services International (PSI) in social franchising conveys three key messages. With the background of PSI in behavior change, the focus of the organization is to explore social franchising as a model of solving health problems among target populations and its role in behavior change. The second message is about the importance of integrated implementation, products and communications, which are crucial components in pursuing social franchising. The third message is of the challenges encountered in sustaining social franchising efforts.

## SOCIAL MARKETING PROGRAMS

Social marketing is a strategy for bringing about behavior change with focus on trying to promote a specific behavior. Typically social marketing activities for spacing would comprise a combination of mass advertising on spacing benefits, contraceptive access and promotion, and some community events for garnering support of opinion leaders. The integrated social marketing package designed would need to justify the program and the behavior promoted, and to fit into the overall infrastructure of the community.



Experiences of many social marketing programs in India indicate that the projects make a fairly good start in the first few years but gradually reach a state of stagnation, or plateau, indicating no further increase in the percentage of people reporting change in behavior or the 'promoted behavior', making it harder to get behavior change over time. This indicates certain 'gaps' in social marketing programming.

In social marketing terms, these gaps relate to the priority audience that remained un-reached by the outreach activities and are generally characterized as the 'non-behavers', or those pockets of the target audience who have not adopted the desired or promoted behavior. Such groups typically comprise the more rural, slum dwelling and marginalized populations, having low literacy and education levels, and often, entrenched beliefs and traditions.

### **Challenge of the Gap**

Addressing the existing gaps in social marketing programs presents considerable challenges. An appraisal of the remaining audience or the 'non-behavers' signifies people with high barriers to change. To alter perceptions of people with barriers requires substantial investment of time and does not respond to mass communication outreach activities but instead mandates a different approach of personalized, individual level interactions to build confidence and trust. Such individualized communication is both time and resource intensive and changes the entire expense dimension of any activity. This is one of the reasons

why a large number of social marketing programs start to flatten out over time.

Furthermore, it is daunting to address the concerns of huge populations that are left out of the initial activities. Generally, the non-behavers represent large, dispersed populations. In a behavior change program, the challenge is to target specific groups within larger populations.

### **How Private Providers can Help**

Private providers can help to meet some of the challenges, and their role becomes even more important in view of their standing with the target audience. Often, the providers themselves are already part of established healthcare disseminators for the target audience, and, therefore, they are already in some way acceptable and are relatively known and trusted. Thus, their relationship with the target audience may make them effective instruments for behavioral counselling.

In addition, integration with other multiple services, such as family planning with maternal and child health issues could more efficaciously influence specific behaviors.

Lastly, private providers represent independent health services, reducing the need to set up any program-owned clinics.

### **PSI MODEL FOR SOCIAL FRANCHISING – NETWORK**

In the context of the gaps in social marketing initiatives that

lead behavior change programs to plateau, PSI perceives social franchising to be one of the ways to address that obstacle and continue the progress.

The development of the PSI model of social franchising includes the following components:

- Identify providers that are used by target groups.  
*This involves ensuring that the identified providers are credible to promote the desired behaviors.*
- Train, support and motivate the providers to provide good services.
- Brand clinics, and position them to encourage the behavior to be promoted.
- Advertise with multi-media to generate public awareness about the providers in the target community.
- Establish quality standards and ensure periodic monitoring.

PSI has been utilizing this franchising model across HIV/AIDS and reproductive health programs. The Saadhan Network was a reproductive health program implemented for over a year (December 2003-March 2005) in Uttaranchal State. The Key Clinic Network is a focused activity for HIV/ AIDS prevention, operational in the four states of Maharashtra, Andhra Pradesh, Karnataka, and Tamil Nadu.

### **Saadhan Network**

The Saadhan Network was situated in 164 slums covering a population of about 2.6 lakh. The program selected 98 Indian system of medicine practitioners (ISMPs). The key areas of training and intervention revolved

around the central strategy of counselling on issues of maternal and newborn care, birth spacing, child nutrition and immunization, as well as prevention and management of diarrhoea.

The program promoted the training and capacity building of ISMPs and developing their referral linkages with 26 qualified obstetricians and pediatricians. The other activities focused on increasing access to and promotion of low cost products such as contraceptives, iron folic acid, ORS, clean delivery kits, etc.

In terms of product promotion, the program initiated concerted mass communication. One of the start-up activities was to introduce the providers to the idea of a network and also PSI. This was undertaken as part of a mass communication campaign for several months to build a relationship with the providers and create excitement among them for being a part of a big and substantial network that would also promote them in their community.

After the project was launched and the providers were in place, the focus turned to creating demand for the clinics. This comprised a range of neighborhood and local media events such as street theatre, magic shows and games, focused on integrating social messages on all the different areas of behavior that impacted reproductive and child health issues such as birth spacing, ORS intake, clean water and safe storage of water.

Similarly, community mobilization initiatives included identification

*One of the start-up activities was to introduce the providers to the idea of a network and also PSI. This was undertaken as part of a mass communication campaign for several months to build a relationship with the providers and create excitement among them for being a part of a big and substantial network that would also promote them in their community.*

of more than a hundred peer workers who made home visits and interacted with women's groups emphasizing the same messages used in the mass communication events.

### Social Franchising in Uttaranchal Program

In terms of promoted behavior, the Uttaranchal program integrated two issues – birth spacing and other MCH behaviors – among the priority audience of low-income parents in slums with children under the age of five years. To facilitate promoted behaviors among the target audience, the social franchising approach offered value addition at two levels – first, of trained providers and second of personalized counselling and support, products and services and then referrals on to the higher level – cumulatively resulting in depth of reach, unique to social franchising.

Traditionally, social marketing initiatives with their mass advertising

and community events do not bring a program up to the level of instigating behavioral change. In contrast, the social franchising approach brings to the target audience a depth of reach. The target audience comes to the trained providers because they have been promoted as safe destinations ensuring quality care, and so their word regarding behavioral change is likely to be taken more seriously.

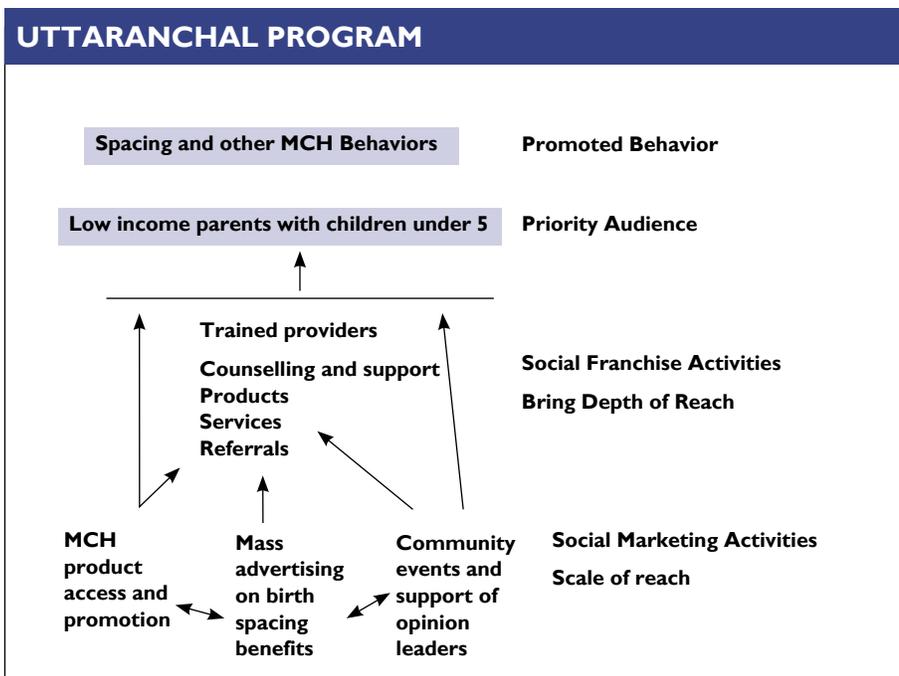
### Results of Uttaranchal Program

PSI was able to measure tangible behavioral changes as an outcome of program interventions. The results of the Uttaranchal program measured against its logframe deliverables showed an increase in all the indicators. Contraceptive use had risen, the use of clean delivery kits promoted for home deliveries had recorded more than a 25 percent increase, tetanus toxoid immunization promoted alongside government programming had a slight increase, and ORS usage had recorded a substantial three-fold leap.

This was equally reflected in the marked increase in the sales of products such as contraceptives (condoms and the pill), ORS packets, IFA tablets, etc. A large percentage of the products' sale was unrelated to the clinics or trained providers, which indicated the positive impact of communication campaigns spread over a considerable period of time.

### KEY CLINIC NETWORK

The Key Clinic Network (KCN) is a franchise that focuses on sexually transmitted infections (STIs). Its



operations are in the HIV-high prevalence states of Maharashtra, Karnataka, Andhra Pradesh and Tamil Nadu. The program functions as a part of larger behavior change activities of the Avahan program. The Network targets clients of sex workers with the objective of motivating them towards timely and correct STI treatment seeking behavior, and to improve the quality of STI treatment delivered.

### **PSI's Challenge**

The key challenges faced by PSI in improving STIs treatment were:

- Find clients of sex workers across a huge area.  
*The clients of sex workers do not fit into any specific profile, such as being associated with any particular occupation. They can be professionals, office-goers, rickshaw pullers or truckers. Therefore, one of the problems was identifying men who visited sex workers, across the large geographic spread of the four states.*
- Raise knowledge and risk perception about STIs.
- Increase access to good syndromic management.
- Targeting the right segment is especially hard.  
*The Network focused on about 5 million clients spread across 100 cities covered in the program but at a point in time less than one percent of them need STI treatment, making targeting considerably difficult.*

### **Consumers**

The promoted behavior among the consumers is to encourage them to seek quality STI treatment immediately. Consequently, the availability of quality service is

an important factor in facilitating promoted behavior. However, the target audience or clients of sex workers perceive the availability of good STI services to be low, which, in turn, prevents them from seeking out such services. PSI, too, discovered this lack of quality services, as well as the low knowledge of, and practical experience in, syndromic management. This lack of knowledge was evident even among qualified MBBS doctors, despite the wide publicity and promotions on STIs by NACO and WHO.

STI treatment is particularly constrained by two factors – (i) myths on STIs causation and (ii) underestimation of the severity of STIs. As a result, many men self-medicate initially, and only seek the services of qualified medical practitioners, such as MBBS doctors, when it starts to really hurt. A hurdle to seeking qualified medical advice is that the MBBS doctors are generally perceived to be harsh and judgmental.

### **Key Clinic Network**

The KCN comprises 875 MBBS providers located across 100 cities and towns in the four program states. The selection of towns is based on risk behavior and prevalence profile. Therefore, clinics are located in places with very high prevalence and very high-risk behavior to ensure the best access to men who are clients of sex workers, thereby increasing proximity to relevant locations. The providers were selected based on evidence of already existing client load, as also experience of dealing with STIs treatment.

## Key Clinic Package

The Network integrates a composite set of interventions.

- Provider recruitment, training and motivation  
*Training on syndromic management to improve practice among providers is a key target area. This is complemented by counselling and supportive care to alter the harsh attitudes of doctors. Support visits and network development are strategies that ensure all the Network doctors visit various physicians to develop a strong community of providers.*
- ACT-I  
*Pre-packaged kits for urethral discharge, and counselling aids, which can be used by the providers for demonstration in counselling sessions with clients to enhance behavior change.*
- Communications  
*Communication is essential to educate and motivate consumers, and promote the use of Key Clinics. The program uses all forms of*

*media to increase client inflow to the clinics. The program engages in periodic field interactions with the target audience to inquire about incidence of STIs and whether they visited a Key Clinic for treatment. This monitoring exercise is geared towards influencing about 50 percent of the target audience who, at the end of the project, can acknowledge the value of and need for Key Clinics.*

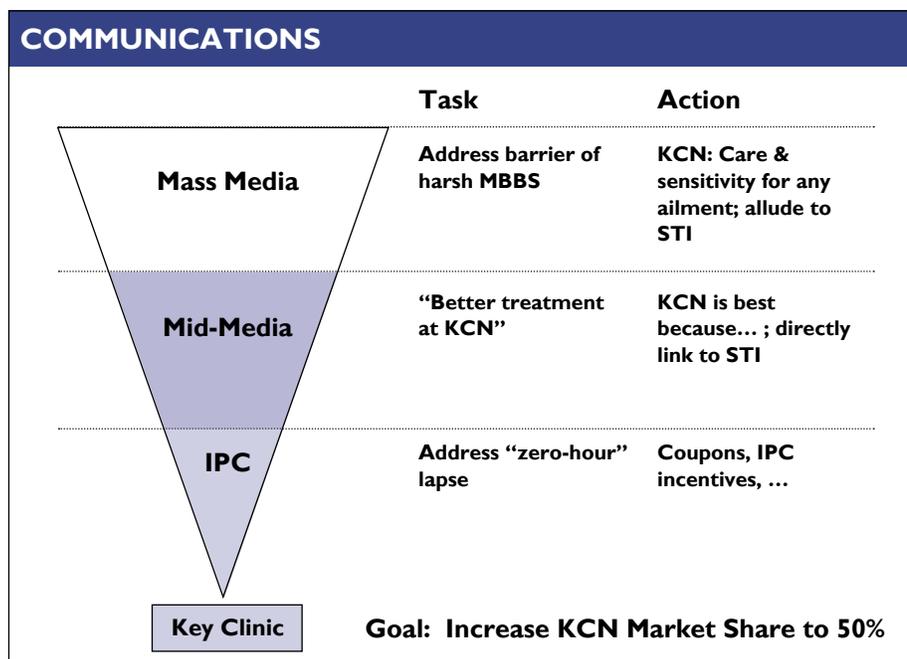
## Progress

It is still early to assess the impact of the KCN after two years of its operation. However, the Network has developed an effective strategy for program implementation and is moving towards scaling up.

The baseline survey undertaken indicates about 7 percent market share as of December last year. The communication activities are in the process of being scaled up for phase-2 but the doctors have already started to report an increased number of clients. The walk-ins estimated for the month of March 2006 were about 350. There is an increased awareness about Key Clinics. The program research shows that it is difficult to find people 'who do not know KCN'.

The Network is increasing in scale and quarterly tracking of the client flow indicates that overall the Network has attracted about 15,000 men to the Key Clinics for STIs treatment as of January 2006.

Quality is the focus of KCN. The Network clinics emphasise quality in the key areas of correct prescriptions, counselling and advice



on condom use, and advice for partner treatment, and serve as strong links to behavioral change indicators of the program.

## **SUMMING UP**

Franchising in the health sector is inextricably tied to consumer focus. Social marketing and social franchising approaches direct a strong focus on the specific people to be reached. The service providers are the first targets of behavior change and concerted efforts are required to consistently motivate providers to deliver quality services.

Social franchising is a part of social marketing and should be supported by products and communication; the latter being an essential component. It is fundamental to understand that social franchising is not a stand-alone approach but must be combined with, and supported by, social marketing.

Social franchising offers considerable potential for diversification of activities. It presents potential platforms for integrating other health services if the relationship with the providers is strengthened and providers perceive benefit in that relationship.

In addition, the present networks could be leveraged to integrate malaria and other MCH interventions in the case of Saadhan, and voluntary counselling and testing linkages and anti-retroviral therapy and tuberculosis management in the case of the Key Clinics.

Furthermore, to ensure that this technique grows and becomes a part of public health, it is important to agree on certain expectations. PSI considers social franchising as a way to impact under-served populations in a cost-effective manner. In this context, it may not always be possible to ensure financial self-sufficiency, especially if the goal is to serve the poor or work in rural areas; therefore, support programs are essential for a significant period of time.

In conclusion, since social franchising is new in India, it needs time, support and significant collaboration with various partners, especially the government and donors. It requires a sustained period of experimentation to develop its strengths, to build partnerships with a variety of providers and to try out different iterations.

***Social franchising is a part of social marketing and should be supported by products and communication; the latter being an essential component. It is fundamental to understand that social franchising is not a stand-alone approach but must be combined with, and supported by, social marketing.***

# SOCIAL FRANCHISING

## THE JANANI EXPERIENCE

*Nita Jha*

### INTRODUCTION

Service delivery in the health sector is primarily through two providers – private and public – with the NGO contribution rated at a minuscule 0.7 percent. Over three-fourths of healthcare in India, as in most developing countries, is privately procured. About 80 percent of Indian clients access the private health sector, indicating the availability of vast service delivery resources in the private sector. Social franchising leverages these resources to supplement the public sector delivery of services, especially in low resource settings. In India, this signifies a huge potential with about 450,000 doctors, 12 million shops, and 1.25 million rural practitioners, implying the availability of a huge network of private practitioners that can be used for delivering health services.

There are two broad areas that need to be addressed in order to bring the private sector into the social franchising framework.

- How to reconcile the private sector's quest for adequate profits with the poor consumers' need for getting services at an affordable price?
- How to bring the private sector or resources, which are mostly unorganized, within a

management framework so that quality of services and quality of care can be ensured?

The private sector is largely motivated by economic concerns, working for profit and consequently tends to move away from the poor. Therefore, leveraging the interest of the private sector is possible by either bringing in subsidies or through economies of scale. Janani plays the role of an intermediary in this process, of redirecting the energies of the private sector and leveraging its support to deliver health services at affordable prices to ensure benefit to poor clients.

### JANANI

Janani is an organization working in the three states of Bihar, Jharkhand and Madhya Pradesh with an outreach among about 190 million people. Functioning as an affiliate of DKT International, it started within a social marketing structure for delivery of contraceptives such as condoms and pills, but over the years has shifted to deliver clinical services to rural as well as urban clients within an infrastructure to provide cost-effective services to the poor.

The target segment in the Janani programs comprise people belonging

to low and middle-income groups who cannot afford the full costs of private services but can make part payment. People below the poverty line are still ignored, as they cannot afford to pay anything for the services. Presently Janani's focus is on low and middle segments by lowering prices through means of subsidies and a large volume of services.

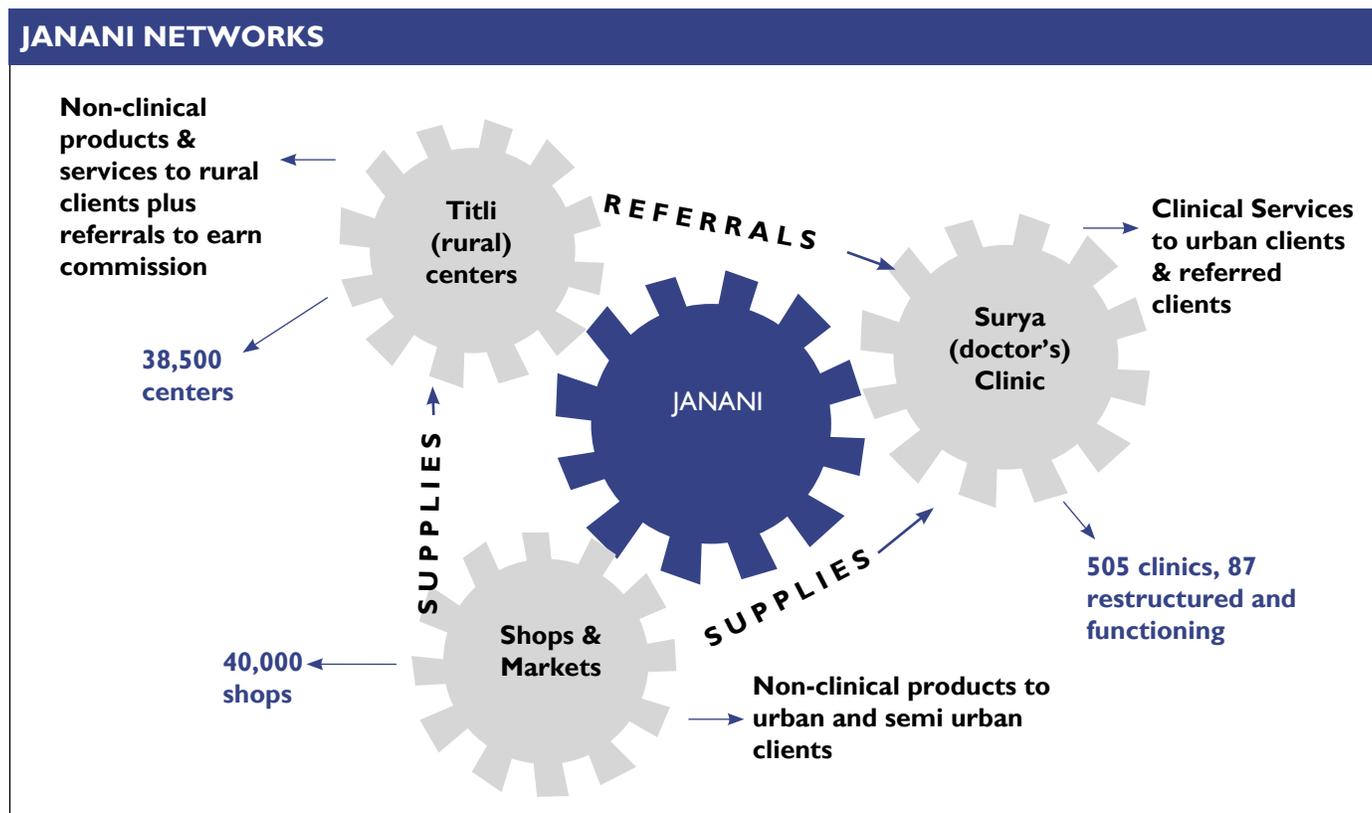
### Janani Networks

The Janani structure comprises of three networks – shops and markets are part of one network, the second network is of rural practitioners called the Titli (butterfly) Centers, and the third network is of Surya Clinics with qualified MBBS medical doctors as franchisees. The large outreach of Janani can be assessed from its expanse in the states of Bihar and Jharkhand. In these states there are 40,000 shops that mostly sell pills

and condoms and also some clinical items such as iodine. The rural network with 38,500 Titli Centers provides counselling services, non-clinical products as well as referrals to Surya Clinics. The Surya Clinics provide all the clinical services to rural and urban clients. All the three networks are inter-linked and function as service providers at different levels offering different kinds of services.

### Services

The shops deliver products in urban and semi-urban areas and also replenish all the supplies of the other two networks. In the Titli Centers at the village level, a couple is trained on how to counsel on family planning and provide contraceptives such as pills and condoms, undertake routine examinations such as pregnancy tests, haemoglobin and blood pressure checks, antenatal and



postnatal check-ups and if the client needs any clinical services, make referrals to the Surya Clinics. The approach of involving the husband and wife together as service providers at the rural centers is to facilitate female client inflow, since rural women are more comfortable sharing their health problems with females. Each Titli Center pays a membership fee of INR 300 per annum. To further strengthen the role of women in healthcare services, the program is also providing advanced training to the women service providers in basic clinical skills on abdominal examination, detection of different pelvic discharges, etc. to facilitate better referrals of women clients to Surya Clinics.

The Surya Clinics Network of qualified private doctors provides a range of family planning, reproductive health as well as general health and other curative services. The focus is on enhancing the surgical skills of providers and paramedical services. The program regularly updates the knowledge of the doctors and integrates modern technologies to advance skills.

In clinical franchising, Janani considers its responsibility to ensure good quality and standardized services at all Surya Clinics. To achieve this objective, Janani has established norms that are mandatory for each clinic. An indication of the quality benchmarks is reflected in a survey that proved 88 percent of the clients in Janani's Surya clinics come through recommendations of satisfied clients.

## LESSONS FROM FRANCHISING EXPERIENCES - SURYA CLINICS PHASE - I

The second phase of the Janani program has been developed based on the lessons learned from the first phase of the franchising experience with Surya Clinics.

During the first phase of the program, Janani was primarily involved in clinical franchising and had a franchisee strength of 505 Surya Clinics. However, the franchise had not systematized any franchisee fee or control over the doctors. This led to poor quality of services in the absence of any quality standardization norms. In addition, the focus of the network was only on family planning. Thus, in the second phase of the program, Janani has reduced the franchisee network of Surya Clinics to 87 clinics following restructuring.

The key lessons from the experiences in the first phase were:

- Franchise norms can be enforced only if the program goes beyond vertical family planning strategy. *This was an important lesson, particularly since the doctors were not generating enough income to sustain either their interest or services, thereby posing sustainability issues within the network. Consequently, Janani expanded its services beyond family planning to reproductive and general health to ensure increased income for the franchisees.*
- The huge demand for sterilizations and IUDs can only be met if operation theatres (OTs) are strengthened.

Initially, the doctors were mostly involved in OPD procedures, but with the increase in client load as well as growing instances of minor surgical procedures, the need for operation theatres at franchisee clinics emerged as a felt need. This also pointed towards developing holistic operational strategies incorporating paramedics' support for doctors so that they could concentrate on surgical procedures.

- Uniform spread of clinics. The first phase of the program lacked any uniform spread of clinics and sometimes a location had four or five clinics.
- Rural referrals need to be strengthened.

### **Changes in Phase-2**

Building on the lessons gained from the first phase of Surya Clinics, Janani has adopted stringent franchisee norms in the second phase.

#### **Franchisee norms**

Doctors have to conform to norms including prices determined by Janani. In addition, all the Surya Clinics have to look identical and each clinic has an administrator appointed by Janani to ensure quality of care. While there were no franchisee charges in the first phase, a franchisee fee has been introduced in the second phase whereby each doctor pays an annual membership fee of INR 45,000. These funds are utilized to cover the administrator's salary. The administrators' tasks are divided between the clinic and rural centers. Each administrator spends three days a week at the clinic to oversee the administrative work and the remaining three days in the field, visiting the Titli Centers to

streamline referrals to the clinics, thereby maintaining inter-linkages between rural and urban networks.

#### **Quality of care**

Quality of care is a key focus area in the present phase of the Janani program. Both technical and non-technical quality norms have been institutionalized in the Surya Clinics. Non-technical quality of care indicates the physical and emotional quality of the services provided at the Clinics. Medical quality determines the technical aspects of services, such as adherence to antiseptic measures for clients, OT sterilization test, and use of disposable syringes and needles for all clients, etc.

Non-technical quality norms include adherence to reporting systems as per Janani formats and strict compliance with charges or prices fixed for Surya Clinics. The franchisees have to maintain all the consent forms signed by the clients. In addition, all clinics have to maintain efficient waste disposal systems.

#### **MUTUAL BENEFITS**

The doctors in the Surya Clinics Network are part of a mutually beneficial relationship with Janani. The program provides the doctors with training, ensuring regular updating of their understanding and knowledge of medicine. It further extends advertising support as each clinic is heavily advertised by hoardings, banners and other publicity aides. In terms of increasing business, the clinics receive rural referrals that are financially attractive to the doctors. Each Surya Clinic is linked to about 200 Titli

*The program provides the doctors with training, ensuring regular updating of their understanding and knowledge of medicine. It further extends advertising support as each clinic is heavily advertised by hoardings, banners and other publicity aides.*

**COST TO CLIENTS IN RUPEES**  
**(OBJECTIVE TO KEEP ABOUT 50% OF COMMERCIAL)**

Procedure	Surya	Market Rate
Tubal ligation	499	850 to 2,000
Vasectomy	149	500 to 800
Appendicectomy	1,199	2,500 to 5,000
Abortion	399	600 to 5,000
Inguinal hernia	1,499	3,000 to 5,000
Gall bladder operation	2,499	5,000 to 8,000
Delivery	699	2,000 to 5,000
Hysterectomy	2,599	6,000 to 10,000

*Medicines and bed charges, if required, are extra.*

It is particularly important to note that Janani provides quality services at costs even lower than DKT. The DKT cost per CYP is US\$3.25 while the Janani cost is US\$2.7. The cost-efficiency of Janani is further demonstrated by a comparative study with the public sector services. The public sector sterilization cost in the state of Chhattisgarh is INR 6,300 and in Uttar Pradesh it is INR 10,000, while the Janani costs, despite utilizing private sector doctors, is considerably lower at INR 1,040.

Centers and they refer all the clients to this clinic, thereby ensuring a certain volume of business for the franchisees. In addition, all the clinics receive support services such as commodities and supplies at low or reduced prices.

In return, the Clinics have to ensure service delivery as per Janani norms and in the process, create facilities providing services at affordable prices that are about 40-50 percent less than the market prices.

**IMPACT**

The growing impact of Janani is discernible in the program areas. Janani currently delivers 21 percent of family planning services in the program states and has protected 6 million couples and averted 2.9 million pregnancies at a low cost of US\$2.76 per couple year protection (CYP), which is equivalent to the actual Janani cost of US\$2.7. This signifies the cost-efficiency of the program.

**CONCLUSION**

Specifically for Janani, it is evident that vertical family planning programs are not sustainable, and the need is to move beyond family planning to include other reproductive health services. The diversification of the program by including a basket of services lends itself to substantial reduction in costs and coupled with improved quality of services can ensure greater outreach among clients.

The Janani experience has led to many lessons that have enriched the program but at the same time posed considerable challenges. The core challenge for social franchising is not so much the creation of service delivery networks but to sustain the delivery of quality services in the networks. Although, the process is management intensive, there are huge entrepreneurial energies, even in poor resource settings, just waiting to be tapped.

# SOCIAL FRANCHISING A WAY TO HEALTHY JHARKHAND

*Shivendu Shukla*

## INTRODUCTION

The Government of Jharkhand has been actively pursuing development goals in a direction similar to social franchising. The Government's focus is on exploring and developing strategies, mechanisms, programs and projects that can further strengthen the State and energise the buying capacity of the poor. In this direction, the Government of Jharkhand is committed to leveraging the support of the private sector to channel public health resources and services towards the poor and improve accessibility among vulnerable populations.

In Jharkhand, about 80 percent of the health services being accessed by the people are provided by the private health sector. This is particularly important in view of the fact that 54 percent of the population in Jharkhand is poor, according to the definition of families (with five members) with an annual income of less than INR 15,000. For such families, an expenditure of INR 200-300 on private health facilities is a big expense that they can ill afford. In addition, in Jharkhand, malaria is the biggest killer among impoverished communities, followed by tuberculosis. However, the big and highly efficient hospitals focus more

on "big" diseases and rarely address a commonly occurring illness such as malaria.

## JHARKHAND HEALTH STATUS

Jharkhand is a predominantly rural state with about 78 percent of the population residing in rural areas. The health status of the state is much below the national average on the key reproductive health parameters. The state faces huge infrastructure gaps in the public health sector, reflected in the abysmally low numbers of basic health institutions such as sub-health centers, primary and community health centers, as well as sub-divisional and district level hospitals. In addition, poor facilities for mobility available to the health service providers substantially reduce the availability and accessibility of health services in remote locations.

### HEALTH STATUS

Item	India	Jharkhand	Best Performing State
Full ANC	18.6%	10.5%	66% (Kerala)
Institutional Delivery	46.9%	21.6%	95.7% (Kerala)
Safe Delivery	62.1%	31.1%	97.2% (Kerala)

Source: RHS - 2002-03

## **CONVENTIONAL APPROACH COST-INTENSIVE**

Creating extensive public sector structures has been the conventional approach in government planning of health services for poor populations. This has been a cost-intensive and expensive proposition with the creation of stand-alone hospitals that essentially encompass all the facilities under one roof, such as nurses and doctors residences, pathology, OPD, etc., all provided for by the government.

In terms of costs incurred for making government health facilities available, there is a common misnomer in equating cost of service with price of service. While the price of service in most of the government hospitals may be free or very low, the cost of these services to the society, however, is not free. The government incurs the cost of creating free or subsidized health services, through the taxes collected from the public, thereby indirectly passing on the costs to the public.

The enormity of the public health sector costs is indicated in a survey undertaken in Jharkhand to assess the costs of OPD consultations in various government hospitals. The findings indicate that cost per OPD consultation in the public sector varied from as low as INR 15 to as high as INR 1,000, amplified by examples of facilities in which four doctors might attend to only 8-10 patients per day on an average.

Therefore, the cost appraisals of public sector health services tend to be myopic in focusing only on the prices paid by the people or

consumers and overlooking the indirect costs borne by the society.

## **BRIDGING GAPS – SOCIAL FRANCHISING**

The challenge of addressing infrastructural gaps in the public health sector has led to rethinking towards less costly and more flexible models. It is clearly understood that the public sector alone cannot solve the structural deficiencies in the health sector, with a consequent need for private sector participation.

This recognition is validated by the large presence of the private sector in the health arena, as well as the felt need to involve local communities for increased participation and ownership, engendering social empowerment. This approach necessitates the development of community and system based effective monitoring mechanisms.

The Jharkhand Government concluded that adoption of the social franchising strategy would help address the various issues related to availability, accessibility, acceptability and affordability of health services. Social franchising 'gives people choices, especially to the low income population, by transforming a beneficiary into a customer. Most impoverished communities lack the resources to access private health services, in effect reducing their 'choice' or selection of health services and increasing their dependence on public health services, which, in turn makes them beneficiaries of the public system, rather than customers.

Within the social franchising approach, the Jharkhand Government is also keen to promote a 'bundle' or comprehensive package of services for the communities.

### **Objectives and Principles of Social Franchising in Jharkhand**

The key objectives of social franchising in Jharkhand are:

- Protecting the poor from indebtedness and impoverishment.
- Improving the access with dignity, by the community to healthcare services
- Encouraging health-seeking behavior.
- Encouraging private sector health facilities to be established in remote and rural areas.

These objectives need to be coupled with adequate demand for private sector health facilities in the rural areas, so that these units become economically viable and receive the required caseload or clients for profitable operations. In this direction, the Jharkhand Government is committed to certain key principles for social franchising in the State.

The key principles for social franchising in Jharkhand are:

- Government – as a key facilitator, and not a provider.
- Leadership – initiated by the private sector.  
*The first task is to create or identify a private entrepreneur willing to invest and take responsibility.*
- Empowerment – participation and ownership.  
*Empowerment of both the*

*community and the private provider is crucial for enhanced government partnership with the private providers.*

- Sustainability – financial, quality of healthcare and differential cost regime.
- Equity – intra- and inter-generational.  
*Promote equitable access to services by all – not just the rich, but also the poor – and create sensitivity among providers for this.*
- All inclusive social protection – rights based approach.

### **Features of Social Franchising**

The key features of the social franchising model envisaged in Jharkhand comprise the following.

- Reaching out to the poor through active private sector initiatives.
- Complementary to the public health system.  
*Leveraging the strength of the private sector to provide services to larger populations more efficiently and at cheaper costs.*
- Setting up standards for primary and secondary healthcare systems.  
*Development of quality standards for service delivery by network providers might encourage better adherence to standards and protocols of service delivery by other health providers outside the network due to increased business competition, leading to increased compliance with standardization of services within the overall health system.*
- Co-payment for the services (not free services).
- Differential subsidy regimes – for different income groups.

***Empowerment of both the community and the private provider is crucial for enhanced partnership with the private providers.***

- Cashless healthcare services to poor.  
*Developing identity cards for poor to access health services without any payment.*
- Strong community and private sector participation in management and service delivery.

### **Roles of Government and Private Sector**

In this model, the key roles of the government will be of an initiator and facilitator of the process. It will provide conflict resolution in cases of any conflict between the customers and the private sector providers and promote an enabling environment for public-private partnership.

The government will also develop an appropriate policy framework and extend supportive supervision as well as provide resources and ensure simplified procedures for strengthening public-private partnership. Furthermore, the government will promote accreditation of facilities and standardization of procedures for increased equity.

The foremost role of the private sector is to take risks and lead as a major stakeholder in public-private partnership. It should also develop its own strategies for strengthening the partnership processes. In addition, the private sector has to play a crucial role in the standardization of the quality of healthcare and promote transparent processes for providing comprehensive healthcare services.

## **DEVELOPING SOCIAL FRANCHISING MODELS IN JHARKHAND**

### **Janani Suraksha Yojna**

Janani Suraksha Yojna is one of the models launched in Jharkhand in January 2006. It is a maternity benefit scheme, launched as a health voucher scheme in the State, which aims to reduce the maternal mortality ratio (MMR). Its relevance is indicated by the fact that despite a large investment in reproductive health, the MMR in India remains close to 540, indicating the poor performance of the public sector in maternal health.

The scheme is designed to benefit pregnant women from impoverished families through registration at the village-level *anganwadi* centers (AWCs), and provide incentives to improve their health-seeking behaviors. The objective is to increase the demand for health services by the poor and promote their access to health services. The scheme enables pregnant women to avail of maternity services, including antenatal services, immunizations and institutional delivery. It provides choices to poor clients to select service providers, such as, if the woman wants to use a private hospital, the health vouchers cover expenses for the delivery in any of the accredited facilities in the State.

The scheme helps to increase the buying or purchasing power of the poor, which the government envisions will positively impact the private sector in rural areas. Some progress in this direction has been made with the interest shown by

NGOs to set up institutional delivery facilities and gain accreditation from the government.

### **Implementation process**

The scheme provides four types of vouchers to pregnant women that are designed to take care of the health needs of the mother and newborn through pregnancy, delivery and post delivery.

The first health voucher is a cash payment of INR 100 when a confirmed pregnant woman from a below poverty line family is enrolled by the *anganwadi* worker (AWW) at the *anganwadi* center. After the registration, the AWW hands over the money to the pregnant woman and gets a signature or thumb impression on the voucher. The cash is to encourage the pregnant woman to regularize her antenatal check-ups, tetanus injections and IFA consumption. The AWW tracks these basic pregnancy precautions among the registered women.

The second health voucher is given in the third trimester of pregnancy as a coupon to cover institutional delivery expenditure. The AWW provides a voucher of INR 700 to the pregnant woman, which has no cash value but can only be used for an institutional delivery in either

an accredited private provider or a public sector facility. This offers multiple choices to the pregnant woman. She can choose to access a private sector hospital such as a Surya Clinic, with a charge of INR 699 for institutional delivery. The voucher ensures reimbursement to the private provider from the government. Alternatively, if the pregnant woman chooses to access any other private provider with higher institutional delivery costs, for example, INR 900, then she just has to pay INR 200, while the voucher will cover the remaining amount. In the other option, if the pregnant woman opts for a government hospital, then the voucher is handed over at the hospital and INR 700 is reimbursed to the government hospital management society. The scheme emphasizes the role of hospital management societies in utilizing such reimbursements for improving the services at government facilities. It has been observed that government health facilities lack flexible managerial mechanisms to enhance service delivery. The Government of Jharkhand believes that such flexibility can be facilitated through the creation of hospital management societies, which can utilize available funds to improve health services in the government or public sector.

## **HEALTH VOUCHER SCHEME**

- Four Types of vouchers
  - ◆ → Early Registration - Rs. 100 to the expectant mother. To encourage the ANC/TT/IFA consumption.
  - ◆ → Rs. 700 coupon for institutional delivery – given in the third trimester.
  - ◆ → Rs. 300 to mother, after full immunization.
  - ◆ → Rs. 100 cash to AWW as performance based incentive.
  - ◆ → Rs. 100 cash to ANM as performance based incentive.

The third voucher is again a cash payment of INR 300 provided by the AWW to the mother on seeing full immunization certification of the newborn. This includes completion of a full 10 weeks of immunizations covering up to DPT 3, polio and BCG. Jharkhand faces a huge challenge in terms of immunization and this aspect of the scheme is envisioned to act as an incentive. In 2000, the immunization percentage was as low as 9 percent. This has improved to about 45 percent in 2006, but the State aims to increase the proportion to 70 percent in the next two years.

The fourth voucher comprises two sets of payments of INR 100 each for AWW and ANM as performance based incentives. The medical officer in charge (MOIC) at the primary health care center disburses these incentives.

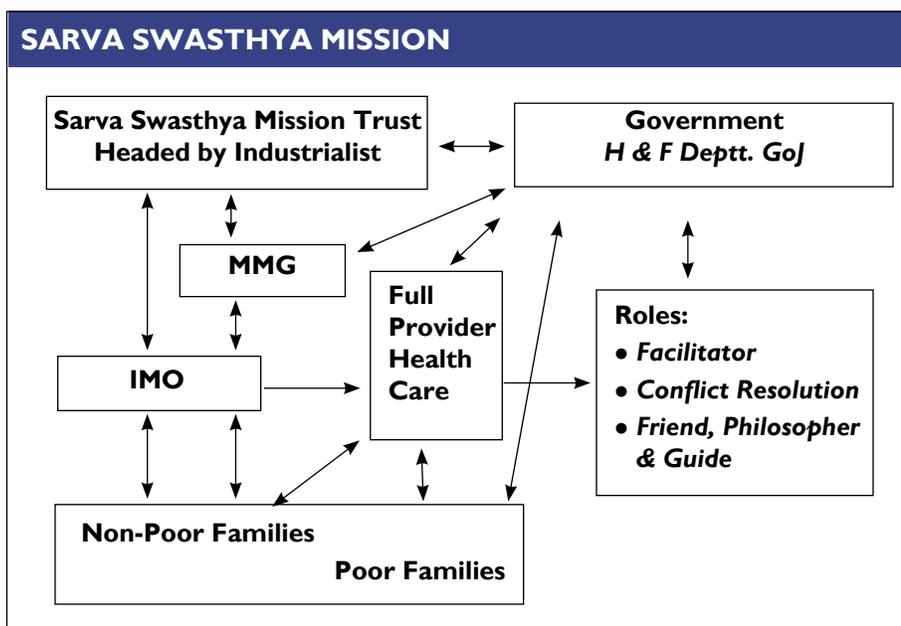
### Sarva Swasthya Mission - Health for All

The Sarva Swasthya Mission (SSM) is a program introduced in Jharkhand

in August 2005. It is an innovative health insurance scheme being developed in partnership with a corporate partner, the Tata group of companies.

The SSM program is planned under the jurisdiction of the Sarva Swasthya Mission Trust, to be chaired by the industrialist Mr. Ratan Tata. The Trust will create two organizations – the Mission Management Group (MMG) and Insurance Management Organization (IMO). The MMG will comprise a group of professionals responsible for designing the insurance plan, while the IMO is to function as an insurance company responsible for implementation of the insurance plan. These two organizations are to be supported by ‘Full Provider Healthcare Units’ to extend health services to the target population. The targeted beneficiaries are of two categories – people living below the poverty line (BPL) and others. The Trust will cover all the BPL premiums while non-BPL families will pay their own premiums. This aspect is the first innovative feature of the program.

The private sector health providers are to be part of the Trust. The program envisions a network of private health facilities linked to the Trust, which will ensure the quality of service and set the standard protocols of treatment, as well as provide a mechanism for the clients to shift from one facility to another. This is designed to combine the resources and benefits of the private sector with the promotion of healthy competition among the providers in the network. Additionally, the program supports



this idea to facilitate greater choice for the clients to select their health provider and reduce dependency on a single provider, irrespective of the quality of service. Therefore, the lock-in period is designed for only a year, after which the beneficiary will have the option to shift from one facility to another. This facility for the clients is the second innovative aspect of the program.

The program design is geared to utilize the efficiency of the private sector and market competition among providers, to develop an alternative to public sector healthcare. In this program, the role of the government is limited to that of a facilitator and arbitrator

for conflict resolution. The financial resources for the program depend entirely on private sector funds and the revenue generated from the premiums of the paying clients.

## **CONCLUSION**

The Jharkhand Government's effort in facilitating social franchising in public health service delivery is a crucial step in the direction of strengthening equity, empowerment and social protection mechanisms at the community level. It signifies a shift in the government role as a key facilitator in public-private partnerships for provisioning of health services, especially targeting the weak and poor sections of the rural populations.

***The Jharkhand Government's effort in facilitating social franchising in public health service delivery is a crucial step in the direction of strengthening equity, empowerment and social protection mechanisms at the community level.***

# PANEL DELIBERATIONS

The discussions by the panelists and participants on the second session on Indian experiences in social franchising raised important concerns with reference to the provision of healthcare services in rural India. The key observations point to critical areas that require further strengthening and focus in refining franchise models for delivery of rural health services.

## KEY OBSERVATIONS

### Targeting Social Franchising in Rural India

- Social franchising can be a very effective tool in Indian states with poor resource settings, especially in view of high poverty levels and the dependence of impoverished communities on the public sector infrastructure to cater to their health needs.
- Improving the efficiency of delivery mechanisms of government programs and schemes for rural masses through public-private partnerships is essential to ensure increased accessibility to healthcare services by target populations. This could be achieved by combining social franchising with vouchers and other mechanisms of demand side financing.
- Developing different models for delivery of health services to rural and urban populations is important because of the differences between rural and urban settings. Lessons drawn from past experiences show that adaptation or replication of urban models in rural areas has mostly failed.

### Sustainability of Rural Franchises

- Sustainability of models developed for rural areas are incumbent on identifying sources of funding – donor agencies, government or the private sector – since target groups are resource poor.  
*Health is not a priority among impoverished and vulnerable populations fighting for daily survival in resource poor settings. Therefore, demand generation for health services in rural areas needs to be balanced with adequate resources for ensuring the economic viability of franchises.*
- Identifying the ‘nature’ of the franchisor – whether corporate groups, NGOs or development groups – in social franchising is crucial for long-term sustainability.
- The management and sustainability of any health

program is inextricably tied to the funds generated by the program since financial resources remains the primary tool for managing franchise networks.

*The case of the Janani program is a point in reference where the program has striven to increase its financial resources by introducing certain changes such as charging a nominal amount of INR one for client follow-up, whereas earlier such services were rendered without charge.*

- For enhanced sustainability of health services in social franchise models designed for rural areas there is a need to incorporate preventive and curative services for rampant diseases such as malaria and diarrhoea, rather than just the 'rich class' illnesses such as cardiac diseases.

### **Monitoring Mechanisms and Measuring Change**

- Integration of monitoring procedures in franchises is crucial to ensure quality standardization as well as to facilitate assessment of the impact of the services delivered. *For example, in-house personnel need to undertake regular monitoring of the franchisees such as the system followed in the Janani program, where the Clinic Coordinators or administrators are responsible for monitoring of Surya Clinics and submitting monthly reports to Janani. In addition, an outsourced verification team back-checks 25 percent of all the work and reports whether all the Networks are performing in accordance with the Janani quality benchmarks and norms.*

- The impact of program deliverables need to be captured at the individual/household level. For example, in addition to the distribution figures for preventive care services delivered such as IFA tablets; the percentage of the target population that actually consume the IFA tablets received by them needs to be assessed

### **Communication for Behavioral Change and Program Transparency**

- Expanding partnerships with local communities, especially local co-operatives or groups in rural areas, are ideal to enlarge the outreach of healthcare services. The franchisee groups can interact with the local communities through such local or people's organizations to influence behavior change.
- In developing communication campaigns for improving healthcare demand in rural areas, recognizing the distinction between inter-cluster communication and intra-cluster communication is essential, as health practices often differ between different clusters. Intra-cluster communication is more effective than inter-cluster communication. Hence, developing different behavior change strategies to target social influences within various clusters of community groups is crucial to enhancing the impact of the communication.
- Developing gender sensitive communication strategies as part of the franchise outreach and awareness generation activities is important.

*In this context, the example of the gender sensitive communication strategy undertaken in working with sex workers and their clients for improved STI treatment as part of the Key Clinic Network provides valuable insight. The communication program was subjected to a number of gender screenings in terms of how the messages were received by the people. PSI often checked the communication messages with a specific target group to avoid stigmatizing sex workers. Similarly, even while addressing men separately, particularly clients of sex workers, PSI found that the messages did not stigmatise the sex workers or their clients.*

- Mass media communication helps to create public awareness about the franchise, the franchisee clinics, the brand and the services offered. This in turn, also has a valuable spin-off in terms of transparency – public transparency on the charges for the various health services provided by the program, since the rates of all the clinical services are also heavily advertised. This ensures added pressure on the provider for adhering to the advertised rates, negating any possibilities of over-charging.

# SESSION VI

## RELEVANT EXPERIENCES FOR SCALING UP OF SOCIAL FRANCHISING IN INDIA

Facilitated by

*Carol Rosener, Facilitator*

*Donna Sibley, President, Sibley International*

*Michael Amies, Consultant, Sibley International*

### Break-out Groups' Presentations





# INTRODUCTION

**G**roup presentations on 'Relevant Experiences for Scaling up of Social Franchising in India' focused on specific recommendations by participants on – key messages, success factors, franchisee selection, quality management system and sustainability.

To facilitate group work, the workshop participants explored these issues in four separate groups, coordinated by a Chairperson.

# RECOMMENDATIONS OF GROUP PRESENTATIONS

## KEY MESSAGES

- Social franchising is a continuous behavior change process.
- Convergence between public and private sectors is important for the success of franchising.
- Need for clarity on what (a) public sector can offer (b) private sector can offer.
- Social franchising – why and for whom – identify and prioritize the target population.
- Understanding the customers needs and see if there are providers to provide the services.
- Start with low hanging fruits (urban/semi-urban) before going to rural areas.
- It should include an expanded basket of integrated products and services most relevant to the target population.
- Well-designed selection of franchisees – including franchisee identification based on community needs with community involvement and participation.
- Develop various levels of networks (for example Janani) – linkages between the grassroots level, middle level and top level.
- Effective networking and referral system.
- Quality of services and maintaining quality of service delivery is important – strong monitoring mechanism for quality of services provided.
- Effective training – continued capacity building processes for improving self-sustainability.
- Entrepreneurship is the main deciding factor for expanding the social franchising network.
- Economies of scale need to be worked out for franchisor and franchisee.
- Single unit has to be viable before it can be up-scaled – only proven/existing models should be up-scaled.
- Work place management for improved overall efficiency.
- Financial viability and sustainability is crucial – tap into existing resources for franchising.
- Social franchising can be made sustainable by taking cues from private sector operations.
- Understanding the limitation of social franchising – recognizing that it is just one aspect of a strategy for public-private partnerships and that it might be suitable in some situations but not in others.

## SUCCESS FACTORS

- Focused objective and clear goals of social franchising – need to define realistic objectives.
- Recognizing that social franchising is only one tool in a large toolbox for improving

delivery of health services.

- Enabling environment created by government – consistency with government policy on how to expand services.
- Market analysis and a sound business plan – need for market analysis and intelligence.
- Basket of services – multiple services provided by one comprehensive unit.
- Establishing the brand name (branding) – ensures delivery of quality health services.
- Good communication and marketing strategies – to establish the services among the people.
- Optimization of productivity of health providers – ensuring the existence of a minimum pool of qualified practitioners.
- The availability of standard operating procedures (SOPs) and quality protocols.
- Assuring quality through stringent and effective monitoring and evaluation techniques.
- Managerial ability and organizational work culture.
- Long-term commitment to training and capacity building.
- Financial viability – attractive economic model for providers.
- Buy in of stakeholders – making sure that the community is also supportive of the franchise, in addition to the franchisor, the franchisee, the government, the donor, all the key stakeholders in social franchising models.
- Voucher scheme (as the Janani Suraksha Yojna – maternity benefits scheme of Jharkhand) very useful for the rural population.
- Some level of social awareness and social motivation among providers – warm and respectful

treatment accorded to the clientele.

- Client satisfaction, efficiency and effectiveness of health services integrated with behavior change communication.

## WHO COULD BE THE FRANCHISEE?

- The franchisee to be identified based on the objective of the program and services that need to be provided.
- Franchisee selection must ensure that providers are trained and licensed to provide the services that they deliver. For example, registered medical practitioners (RMPs), Graduate doctors (MBBS), etc.
- Stratification and function-based franchisees – model can be multi-tiered – such as Janani network with certain kind of service providers in rural areas or outreach sites, combined with more developed services in urban or peri-urban centers.
- Different types of providers/ franchisees for different types of services – associations such as IMA/FOGSI/IAP/VHAs.
- Networks of NGOs/hospitals/ ISMPs/CBOs/corporate bodies/ faith based organizations, etc.

For example:

### Rural Areas

- ♦ AYUSH (Ayurvedic, Unani, Sidha and homeopathy) workers /NGOs.
- ♦ Rural medical practitioners – community recognized health providers – for referral services.

### Urban Areas

- ♦ Private hospitals/clinics/ nursing homes.

**Recognizing that social franchising is only one tool in a large toolbox for improving delivery of health services.**

- Market players (such as pharmacists) or entrepreneurs.
- Providers with technical competence and capability of delivering service.
- No overlapping of geographical and operational areas – an important aspect for the business model.

### **IDENTIFICATION OF FRANCHISEES**

- Comprehensive market analysis based on a business model – to determine both the supply side and the demand side.
- Community needs assessment to identify local needs/behaviors as well as for matching the franchisees with the needs of the target population – assessing accessibility of franchisee by local people as well as recognition and acceptance of providers in the community.
- Technical expertise – minimum qualification/experience in the area of services.
- Working experience in the defined geographical area.
- Entrepreneurial and managerial skills, and capacity building ability.
- Financial ability (risk-taker) – to be able to sustain the organization.
- Fulfilling regulatory requirements.
- Commitment to, and passion for, quality healthcare, and treatment protocol for long-term sustainability.
- Capable of social mobilization.
- Dedication/leadership qualities of the franchisee – willingness to learn and improve performance.

### **QUALITY MANAGEMENT SYSTEM**

- Defining quality standards with well defined “dos and don’ts” – standard treatment protocols, SOPs, pathways, measurable indicators, monitoring and feedback systems.
- Setting quality protocols on three levels:
- Functionality of the institution – assessing whether the franchisees’ equipment, etc. is up to the quality standards.
- Providers level – to measure their skills and ability to handle post service complications.
- Client level – number of clients using the services satisfactorily.
- Quality management has to be systemic and process-oriented.
- Training and support systems contribute to quality augment system – regular training of providers on quality assurance.
- Supportive supervision and coaching of franchisees – to ensure quality improvement and standardization of franchisee performance and services.
- Responsibility of the franchisor to ensure ability of franchisees to meet quality standards.
- Process and outcome-based HMIS by facility (internal) and community (social audit).
- Systematic quality audits – formation of in-house and external process auditors (quality improvement circle).
- In-house grievance redressal forum and feedback mechanism coupled with strong supportive supervision to address disputes – also useful as a monitoring tool.
- Random quality cross-check in the facilities.

- Services and prices on offer – widely publicized.
- Community participation/ monitoring as a mechanism of accountability – to ensure demand side accountability of the providers.
- Client satisfaction measured through exit interview.
- Financial incentives/recognition for quality maintenance.
- De-franchising of non-performing franchisees.

## SUSTAINABILITY

- Franchisor needs to have financial stake in the business – shared risk model between the franchisee and franchisor.
- Sustainability at two levels – franchisee and franchisor levels:

### Franchisee level

- ♦ Access to commodities at a lower than market price.
  - Increased business through
  - Referrals
  - Upgraded technical skills
  - Upgraded facilities

### Franchisor level

- ♦ Cost recovery built in from the beginning
- ♦ Fee structure for franchisees
- ♦ Other sources of revenue generation through:
  - Government/ donor support – for commodity procurement or providing other types of subsidies, or for facilitating behavior change communication, demand generation, medical education for the franchisees.
  - Other partnerships in terms of making services

and products more accessible and available–

- Transportation links
- Pathological lab links for diagnostic facilities.

- Donor or government or investor can make an upfront investment – for covering costs of recruiting, establishing quality standards, initial marketing, etc. – for setting up the system.
- Developing corpus fund and linkages with financial institutions.
- Operating expenses need to come from the revenue generated through the franchise – therefore, franchisees and franchisor operations have to be sustainable/profitable.
- Well-defined business plan and relationship for “win-win” situation.
- It is not possible for all schemes to be fully self-sustainable, especially those for poor and rural populations. Therefore:
  - ♦ Differential price and subsidy regime (dynamic) in social franchising – cross-subsidization of services between units can add to sustainability.
  - ♦ Synergy and linkages amongst various schemes (vertical) for optimal use of the facilities – creative examples like voucher system need to be leveraged.
  - ♦ Community health insurance for a kind of financing mechanism that could be linked to the service delivery mechanism.
- Influencing effective demand for sustainability.
- Social marketing (diversified basket of products)

**Community participation/monitoring as a mechanism of accountability – to ensure demand side accountability of the providers.**

complements social franchising.

- Sensitization of private and public sector stakeholders.
- Sensitization of political leadership – develop policy

framework for promotion of social franchising.

- Inculcating the 'we' feeling – sense of ownership among all the stakeholders.

# SESSION VII

## **PANEL DISCUSSION - WAY FORWARD FOR SOCIAL FRANCHISING IN INDIA**

Chairperson

*Peter Berman, Lead Economist, The World Bank*

Discussants

*Randy Kolstad, Division Chief – Reproductive Health, USAID*

*Shivendu Shukla, Secretary, MoHFW, Government of Jharkhand*

*Michael Amies, Consultant, Sibley International*





# THE WAY FORWARD

## KEY RECOMMENDATIONS

*Peter Berman, Randy Kolstad, Shivendu Shukla, Michael Amies*

**A**s the concluding session of the workshop, this session highlighted the critical issues and important points to be borne in mind as we move forward with social franchising in the country. The key recommendations of the panelists have been detailed in this section.

### **SOCIAL FRANCHISING - ONE OF THE TOOLS**

Social franchising in India offers substantial potential for addressing the health needs of the underserved and vulnerable populations – the poor and the urban slum dwellers. However, the suitability of social franchising for very remote and underserved rural areas needs to be examined. There is the need to recognize that social franchising is just one of the tools in a wide arsenal of methods for health improvement. Therefore, it is unrealistic to expect one tool to serve each or every health need across the diverse spectrum of populations.

Developing realistically defined objectives and outcomes of social franchising is crucial. It is important to decide what social franchising is to accomplish, and at the same time acknowledge what social franchising will not attempt to deliver. This

makes it easier to consider other tools for those areas where it is recognized that social franchising is inappropriate.

### **GOVERNMENT ROLES**

The government role should remain as that of a facilitator and instead of providing cost reimbursement models, the focus should be on facilitating models that provide services. This distinction is particularly important in the Indian context where there is a significant level of experience in public health delivery through NGOs, based largely on cost reimbursement models. If the government is committed to reaching health services to poor people, then social franchising by itself will not be able to do so, though to some extent it can make these services available as Janani's experiment with the Titli centers indicates.

Social franchising can be explored to help the private sector diversify and enhance its services to address a wider segment of the healthcare market and deliver much more. The government can support such initiatives by –

- Using it as its own delivery mechanism by supporting or involving itself directly in that mechanism – the government

*Developing realistically defined objectives and outcomes of social franchising is crucial. It is important to decide what social franchising is to accomplish, and at the same time acknowledge what social franchising will not attempt to deliver.*

programs can be converged with the private sector providers to reach health services to poor people. Additionally, the issue of limited access to health services by poor people due to the absence of adequate buying capacity can be addressed by targeting subsidies to those sections of the population.

- Distinguishing between the segments targeted by private providers and taking responsibility to focus delivery of public health services in areas that are considered geographically or economically very difficult to service. An example of the latter activity is the voucher scheme in Jharkhand.

### **INNOVATIONS IN PUBLIC-PRIVATE PARTNERSHIP – SHARED RISKS**

Targeting of government subsidies needs to be systematized to ensure their reach and benefit to the intended beneficiaries. The Jharkhand Government has carried out some initiatives in this direction. In Jharkhand, some government facilities or hospitals such as the community health centers (CHCs) are under-utilized with bed occupation rates of less than 10 percent. To ensure better uptake of public health services, the Government of Jharkhand has undertaken a different approach, encouraging private entrepreneurs to take over such facilities on a long-term lease and instead of giving money to employ doctors, the government will buy their services. In this approach, the government buys health services in bulk and then asks the private providers to

retail them to the poor at prices determined by the government. For example, diagnostic services such as an X-ray may cost INR 50 but to subsidize the service for the poor people at INR 10, the government covers the difference in the retail and the cost price. However, the government does not invest in the purchase of equipment or cost of technicians.

The Government of Jharkhand is also making similar efforts in health facilities set-up in impoverished villages by trusts, churches and mission organizations that are under-utilized. This lends an added value to public-private partnership, wherein not only do private firms manage public property but also the reverse is possible, in that private properties are supported by public funds to enhance utilization of existing services by target or underserved populations.

This is an area with huge potential for innovation and creativity, provided that all the government capital is not risked on a single model. There is a need to share risk, encourage private entrepreneurs to take the lead and for the donor agencies and government to play the role of developing concepts and bringing all stakeholders together for interaction.

Interactive deliberation processes such as workshops with participation of private entrepreneurs and government representatives as well as discussions on mutual concerns, needs and the interest in partnerships, is a way forward. Such interactive workshops need

to be organized at state and district levels.

## **SOCIAL FRANCHISING AS A BUSINESS MODEL**

There is a need to recognize the business part of social franchising. The use of the term 'social' in franchising largely reflects the social objectives, otherwise like any other business; health too is a business. Therefore, in social franchising, the policy makers need to explore business models. It needs to be perceived from the perspective of private entrepreneurs who invest money to make money. Governments need to be vigilant to such concerns in order to facilitate proactive involvement of private participants.

Hence, social franchising implies the marriage of a business orientation to a public service orientation in providing healthcare. Social franchising promotes the nurturing of the entrepreneurial spirit of service providers with the desire to experiment and continue learning with new activities in health service delivery. This aspect is very important and also indicates one of the benefits of social franchising.

## **MODELS**

Social franchising today has a number of models. The way forward in India might possibly lead to the creation of yet another model, and may perhaps result in different models in different states, as each state might be inclined towards developing a customized model.

Despite developing customized models specific to different regions, there are strong possibilities of

substantial similarities between them. Therefore, they do not necessarily have to be brand new models. There is tremendous scope for learning from among the existing models and building on the similarities.

## **DIFFERENCES BETWEEN SOCIAL FRANCHISING AND COMMERCIAL FRANCHISING**

A commercial franchising model starts with a successful business entrepreneur wanting to expand rapidly, who, instead of approaching the bank for capital, finds somebody (as in a franchise) to run the business and in return pay a fee or royalty to the entrepreneur. Hence, the start of such an initiative is usually from an existing unit.

In contrast, social franchising begins from the ground up and in the health sector it essentially entails conversion franchising. This typically implies operating with practitioners already in the marketplace. Most health franchises build on partnerships with health providers already from the market, as they are recognized in the market. The franchising processes help to train, improve and brand them, thereby integrating individual providers in a bigger business system. In this regard, social franchises remain different from a commercial start-up.

## **FRANCHISOR IDENTIFICATION**

In exploring social franchising models for India, it is crucial to determine – who is going to be the franchisor and who is going to set up this network. It can potentially be the government or a private entrepreneur. These alternative

*Social franchising implies the marriage of a business orientation to a public service orientation in providing healthcare.*

scenarios are important because they define the type or design of the network and determine the kind of relationship that will be developed between the franchisor and the franchisee.

In a private network, the capital can be sourced from private enterprise or donor agencies. On the other hand, the government can be the franchisor and provide a set of standard services. Or the government can support private franchisors, such as in the HLFPT model, where the government, to some extent, supports the setting up of certain facilities through monetary contribution to the franchisor while the franchisees put in their money to set up those facilities.

### **AVOIDING DUPLICATION WITH SHARED RESOURCES**

There is a growing need for some kind of association of social franchisors operating in the health field. For example, PSI with operations in about 64 countries has created a generic center for franchise manuals available for all their units worldwide. It helps to bring the magnitude of work being done into focus, offers potential for strengthening and puts a lot of work in the public domain. Therefore, multiple projects should share a common library or resource to exchange experiences and learning as well as to ensure that work does not get duplicated.

### **SUSTAINABILITY**

In the context of India, the social franchising approach essentially points to aiming for self-sustainability from the inception. Working with franchisees that are willing to pay

for training will demonstrate their commitment, and the need might be to start small and then scale up, as others are attracted by the benefits of belonging to the network.

It is crucial to emphasise that social franchising models need to undergo a gestation period in small networks or as pilot projects in order to optimize their development and establish their efficacy and sustainability.

### **Piloting Social Franchising Models**

While piloting any social franchising model it would be critical to realize that economies of scale increase the efficiency of a social franchising model. However, experience in some countries indicates that social franchising programs are killed at the pilot phase because they prove to be uneconomical. It needs to be recognized that this is a pilot phase and the economies of scale have not been able to come into play due to the lack of sufficient clinics or facilities.

This aspect makes the issue of critical mass especially important for social franchising. In commercial franchising, the cost of supporting and training franchisees turns positive for the franchisor because the royalty flow is more than the franchisor spending, whereas in social franchising program that happens less frequently because the franchisor is often subsidized.

The standard development process for a successful franchise entails piloting one unit in year-I, increasing to perhaps two franchisees in

the year-2, and developing to 10-15 franchisees in year-3, with the potential to expand rapidly after that. During that period, the franchisor has to extend training and support, and administration services for the franchisees, before receiving any income from them. This generally implies a long period of investment and it is rare for a franchisor that starts from one successful unit to break even by year-3 from royalties.

Consequently, it is emphasized that social franchising models require a long-term commitment – minimum term of about 3-5 years – before being subjected to any performance assessment.

#### **FRANCHISE VIABILITY**

There is a general perception that some form of long-term funding from the government or donor may be necessary at the franchisor level, though, it is important to recognize that this is determined by factors such as market strategy, economic

debt and geographical breadth of service delivery.

Business norms dictate that ‘deeper’ the outreach, the less there is to take from the market, in terms of cash, while the cash flow in a market system is the lifeblood of the system. Therefore, if too little cash is available the franchisee cannot succeed, and, consequently if there is not enough cash flowing back to the franchisor, the franchise is not viable on a purely commercial basis. Endemic cash flow constraints reduce the ability of the franchisor to support and innovate. It also needs to be emphasized that the franchise should earn its revenues from the royalties rather than from the franchisee fee.

Given these endemic constraints, it needs to be recognized that social franchising is a delivery mechanism that might work, only if there is clarity on the model and the kind of products and services to be franchised.

***It is emphasized that social franchising models require a long-term commitment – minimum term of about 3-5 years – before being subjected to any performance assessment.***



# ANNEXURES

**AGENDA**

**LIST OF PARTICIPANTS**



# AGENDA

## SOCIAL FRANCHISING IN THE HEALTH SECTOR

APRIL 3-4, 2006

AGRA

### Day One - April 3, 2006

0900 – 0930	Registration
0930 – 1030	<p><b>INAUGURAL SESSION</b></p> <p><b>Opening Remarks</b>  <i>Donna Sibley, President, Sibley International</i>            Importance of Social Franchising  <i>Randy Kolstad, Division Chief – Reproductive Health, USAID</i></p> <p><b>Inaugural Address</b>  <i>Nita Chowdhury, Principal Secretary – Health, Uttar Pradesh</i>  <i>Shivendu Shukla, Secretary, MoHFW, Government of Jharkhand</i></p>
1030 – 1100	Tea Break
1100 – 1300	<p><b>INTRODUCTION TO SOCIAL FRANCHISING</b></p> <p>Chairperson  <i>Birte Sorenson, Senior Public Health Specialist, The World Bank</i></p> <p><b>Franchising as a Social and Economic Development Tool</b>  <i>Michael Amies, Consultant, Sibley International</i></p> <p><b>Using a Commercial Franchise Approach for Improving Access to Primary Care and Essential Drugs – the example of CFW shops in Kenya</b>  <i>Dennis Broun, Country Director, UNAIDS, India</i></p> <p>Discussant  <i>Sheena Chhabra, Division Chief, Health Systems, USAID</i></p>
1300 – 1400	Lunch Break
1400 – 1600	<p><b>INTERNATIONAL EXPERIENCES IN SOCIAL FRANCHISING FOR HEALTH</b></p> <p>Chairperson  <i>Randy Kolstad, Division Chief, Reproductive Health, USAID</i></p> <p><b>Social Franchising Experiences in Pakistan</b>  <i>Rehana Ahmed, Greenstar Network</i></p> <p><b>Well-Family Midwife Clinic in Philippines</b>  <i>Easter Dasmariñas, Former CEO, Well-Family Midwife Clinic</i></p> <p><b>Branded Networks as Alternative Business Models</b>  <i>Juan Carlos Negrette, Senior Technical Advisor, Johns Hopkins University – Center for Communication Program</i></p> <p>Discussant  <i>Mridula Sinha, Secretary, Science and Technology, Government of Jharkhand</i></p>

1600 – 1630	Tea Break
1630 -1800	<p><b>ESSENTIAL SUCCESS FACTORS FOR SOCIAL FRANCHISING IN INDIA - LEARNING FROM INTERNATIONAL EXPERIENCES</b></p> <p>Chairperson <i>Shivendu Shukla, Secretary, MoHFW, Government of Jharkhand</i></p> <p><b>Break-out Groups – Takeaways of International Experiences</b></p> <p>Discussants <i>Rehana Ahmed, Greenstar Network, Pakistan</i> <i>G. Manoj, CEO, HLFPPPT, India</i></p>
1800 – 1810	<p>Closing Remarks for the Day <i>Carol Rosener, Facilitator</i></p>
1930 onwards	Dinner

## Day Two – April 4, 2006

0900 – 0915	<p>Recap of Day One Proceedings <i>Carol Rosener – Facilitator</i></p>
0915 – 1100	<p><b>SOCIAL FRANCHISING IN INDIA</b></p> <p>Chairperson <i>Denis Broun, Country Director, UNAIDS</i></p> <p><b>Self-sustaining Social Enterprises – World Class in India</b> <i>Kaushik Madhavan, Associate Director, KPMG</i></p> <p><b>Experiences of HLFPPPT in Social Franchising – Public-private partnership in RCH</b> <i>Anant Kumar, Head – Social Franchising, HLFPPPT</i></p> <p><b>Franchising for Health – the Apollo Experience</b> <i>Sudhir Bahl, Vice-President, North, Apollo Health and Lifestyle Limited</i></p> <p>Discussants <i>Loveleen Johri, Senior Reproductive Health Advisor, USAID</i> <i>Sanjay Pandey, Executive Director, Jharkhand Health Society</i></p>
1100 – 1130	Tea Break
1130 – 1300	<p><b>INDIAN EXPERIENCES IN SOCIAL FRANCHISING</b></p> <p>Chairperson <i>Beth Fischer, Country Director, Intra Health</i></p> <p><b>Experiences of PSI in Social Franchising</b> <i>Tim McLellan, Country Director, PSI</i></p> <p><b>Social Franchising – the Janani Experience</b> <i>Nita Jha, Deputy General Manager, Janani</i></p> <p><b>Social Franchising a Way to Healthy Jharkhand</b> <i>Shivendu Shukla, Secretary, MoHFW, Government of Jharkhand</i></p> <p>Discussants <i>DK Saxena, Government of Jharkhand</i> <i>Deoki Nandan, Principal, Agra Medical College</i></p>
1300 – 1400	Lunch

1400 – 1530	<p><b>RELEVANT EXPERIENCES FOR SCALING UP OF SOCIAL FRANCHISING IN INDIA</b></p> <p>Facilitated by  <i>Carol Rosener, Facilitator</i>  <i>Donna Sibley, President, Sibley International</i>  <i>Michael Amies, Consultant, Sibley International</i></p> <p><b>Break-out Groups' Presentations</b></p>
1530 – 1600	Tea Break
1600 – 1645	Group Presentations
1645 – 1715	<p><b>PANEL DISCUSSION - WAY FORWARD FOR SOCIAL FRANCHISING IN INDIA</b></p> <p>Chairperson  <i>Peter Berman, Lead Economist, The World Bank</i></p> <p>Discussants  <i>Randy Kolstad, Division Chief – Reproductive Health, USAID</i>  <i>Shivendu Shukla, Secretary, MoHFW, Government of Jharkhand</i>  <i>Michael Amies, Consultant, Sibley International</i></p>
1715 – 1730	<p>Vote of Thanks  <i>Manoj Agarwal, State Representative – UP, ITAP</i></p>

# LIST OF PARTICIPANTS

S.No	Name/Designation/ Organization/Address	Phone no.	Email ID
	<b>Ministry of Health and Family Welfare</b>		
	<b>UTTAR PRADESH</b>		
1.	Ms. Nita Chowdhury Principal Secretary (Health)	0522-2616088	
2.	Shri M.K.S. Sundaram District Magistrate-Jhansi	0510-2470556	
3.	Mr. Amrit Abhijat District Magistrate-Allahabad	9450961777 0532-2250400	
4.	Ms. Aneeta Chatterjee District Magistrate-Unnao	0515-2820201 2820400 9415330866	
5.	Dr. S.K. Patwar Joint Director	9415112186	
6.	Ms. Neena Shukla UP-HSDP	0522-2328489	
7.	Mr. Vijay Srivastava CTO-Unnao	0515-2820564 (O) 0522-2422067 (R) 9450021383	
8.	Dr. Shamsher Singh Nagar Swasthya Adhikari Agra	9927082683 9319406034	
	<b>UTTARANCHAL</b>		
9.	Dr. Kalpana Gupta Director-Health and Family Welfare Government of Uttaranchal	0135-2710200 9412052639	Gupta_kalpana@gmail.com
10.	Dr. Usha Ramola CMO-Uttarkashi Government of Uttaranchal	9897349705	
	<b>JHARKHAND</b>		
11.	Dr. Shivendu Shukla Secretary-Health Government of Jharkhand	9431129333 9431129302	
12.	Dr. Mridula Sinha Secretary, - Science and Technology, Government of Jharkhand	9431129302	

13.	Mr. D.K. Saxena Joint Secretary, Health Government of Jharkhand	9431671224	Dinesh_986@sify.com
14.	Dr. P.N. Pandey Civil Surgeon - Bokaro Government of Jharkhand	9431127724	
15.	Dr. V.S.N. Singh ACMO - Palamu Government of Jharkhand	9431135278	
16.	Dr. Dharmendra Kumar RDD - Ranchi Government of Jharkhand	9431371331 0651-2545764	
17.	Mr. Subir Kumar State NGO Coordinator Government of Jharkhand	9334425445	Sbr_kmv@yahoo.ca
18.	Dr. Elvina Sheetal Deputy Director - Health Government of Jharkhand	9431361698	
19.	Dr. Sanjay Pandey Executive Director - JHS Government of Jharkhand	9431103513	spandeyjhs@yahoo.com
<b>UN &amp; DONOR AGENCIES</b>			
20.	Dr. Denis Broun Country Coordinator UNAIDS	41354545	bround@unaids.org
21.	Ms. Birte Sorenson Senior Public Health Specialist The World Bank	9899872232	bsorensen@worldbank.org
22.	Prof. Peter Berman The World Bank	9871387191	pberman@worldbank.org
23.	Dr. Rakesh Jha State Facilitator ECTA	9835062977	drrakeshjha@sify.com
24.	Dr. Davendra Verma Program Advisor ECTA	9868301919	verma@echfw.com
25.	Dr. J.N. Srivastava State Facilitator-UP ECTA	9415110706	jnsrivastava@gmail.com
26.	Dr. Randy Kolstad Chief-Reproductive Health Division USAID		rkolstad@usaid.gov
27.	Dr. Lovleen Johri Senior RH Advisor USAID	9899805554	ljohri@usaid.org
28.	Ms. Sheena Chhabra Chief-Health Systems Division USAID	011-24198564	schhabra@usaid.gov

29.	Dr. Anchita Patil USAID	011-24198000 Ext. 4564	apatil@usaid.gov
30.	Ms. Moni Sinha Sagar Project Management Specialist USAID	011-24198000 Ext. 8524	msagar@usaid.gov
<b>CO-OPERATING AGENCIES AND IMPLEMENTING AGENCIES</b>			
31.	Dr. Bitra George Deputy Country Director FHI	9818342422	bgeorge@fhiindia.org
32.	Mr. G. Manoj CEO HLFPPT	011-24618157	gmanoj@hlfppt.org
33.	Mr. Tim McLellan Country Director PSI	9810155582	tim@psi.org.in
34.	Ms. Carmen Chan Program Director – Family Health PSI	011-26278375	carmen@psi.org.in
35.	Ms. Beth Fischer Country Director Intra Health International	9811431255	bfischer@intrahealth.org
36.	Ms. Sonalini Mirchandani Country Director Johns Hopkins University - CCP	9820211749	sonalini@jhuhcpindia.org
37.	Mr. Anand Verdhan Sinha Country Director Abt Associates	011-41669566	anand@psp-one.net
38.	Ms. Saswati Banerjee PSP-One Abt Associates	41669566	sashwati@psp-one.net
39.	Dr. Sanjit Naik Population Foundation of India	9818286426	sanjit@popfound.org
40.	Mr. Sudhir Bahl Vice President Apollo Health and Lifestyle Limited	9810214068	sudhir_bahl@theapolloclinic.com
41.	Mr. Juan Carlos Senior Technical Advisor Johns Hopkins University, CCP Baltimore, USA	(410)6596300 (410)2231876	
<b>NGOs</b>			
42.	Mr. T.H. Khan Gramin Mahila Kalyan Sansthan Kanpur	9415480549	
43.	Mr. Naseeb Alam Siddiquie Sarvjan Kalyan Samiti Allahabad	9415307140	naseeb@hotmail.com
44.	Mrs. Sundaram NIRPHAD Mathura		

45.	Dr. S.B. Agarwal Chief Medical Superintendent Baldev Hospital, Varanasi	69415810294	
46.	Dr. Vijay Tondon Jawaharlal Rohatagi Eye Hospital Sarvodaya Nagar Kanpur	9415051753	jlrhospital@hotmail.com
47.	Mr. Deepak Kumar Director St. Paul Charitable and Educational Society Jhansi	9839776346	stpaulcharity@yahoo.com
48.	Mr. U.C. Pandey President AWARD Delhi	9415041774	support@awardinternational.org
49.	Mr. A.K. Shome Manager FPAI Lucknow	9415026607	
50.	Ms. Shipra Shukla AAYUSHI (NGO) Happy World College Sector-D, Aliganj Lucknow	9839214525	
51.	Mr. S.K. Sinha Director, Vinova Sewa Ashram Shahjahanpur	9838910940	
52.	Dr. Rahul Bansal Head Community Medicine Subharti Medical College Meerut	9837277055	Rbansal2003@yahoo.co.in
53.	Ms. Anjana Mohan PCDF Lucknow	98 39010907	anjanatul@hotmail.com
54.	Dr. E.B. Sundaram Director Swarn Jayanti Hospital Mathura	011-23932280/55442770/ 32900487	
55.	Mr. C.M. Kachru CRSM Indian Oil U.P.& Uttaranchal	9415019125	
56.	Mr. Aditya Murthi Project Director Sri Ram Murthi Smarak Trust Bareilly	9412293353	
57.	Dr. Vijay Tandon Hon. Secretary & Administrator Rohatagi Eye Hospital, Kanpur	0512-2350627/2304486/ 2297247/2297605	

58.	Mr. Pradeep Kumar Project Director Indo Gulf Jan Sewa Trust Hospital Sultanpur	05361-270032	
59.	Mr. Prabhat Agarwal General Secretary KUTUMB Lucknow	9415005513	prabhata@hotmail.com
60.	Mr. Sunil Sah Manager-Clinical Franchisee Janani, Bihar	9431015038	sunil@janani.org
61.	Ms. Nita Jha Deputy Manager Janani, Bihar	9431015036	nita@janani.org
62.	Mr. Murli Aggarwal Co-ordinator NIRPHAD Mathura	2825341	
63.	Dr. Sanjay Deputy Director NIRPHAD Mathura	2431164	
<b>PROFESSIONAL BODIES/ORGANIZATIONS</b>			
64.	Mr. Jitendra Jain President Pharmacist Association Agra	9412485693 2302020 3297739	
65.	Dr. O.P. Tiwari General Secretary-IMA	09415201999	droptewari@sify.com
66.	Dr. Mohan Prakash CEO Muzzafarnagar Medical College Muzaffarnagar	9810077248	mohan-prakash@hotmail.com
67.	Dr. Deoki Nandan Principal SN Medical College Agra	9412257725	dnandan51@yahoo.com
68.	Dr. Usha Sharma President (FOGSI) Principal LLRM Meerut	9837020407	ushadr@hotmail.com
69.	Ms. Sujata Tomar Nurses Association Agra	9412170664	
70.	Dr. Kusumlata Srivastava Head-Pediatrics KGMU Lucknow	2480060 (R) 9415016634	

71.	Dr. B.D. Bhatia Head-Pediatrics BHU Varanasi	9415812139 2570721	Baldev-bhatia@rediffmail.com
72.	Prof. Rukma Idnani Gen. Secretary FOGSI & Prof. of Obst. & Gynae., LLRM Meerut	9837001109 0121-2762422	
73.	Dr. Uday Mohan Gen. Secretary IPHA & Prof. Community Medicine, KGMU Lucknow	0522-2257343 (O) 0522-2237571 (R)	drudaymohan@yahoo.com
<b>SIFPSA</b>			
74.	Mr. H.S. Chugh GM (HAP) Lucknow	0522-2235618/19/20/21	hschugh@upgovt.com
75.	Dr. Brijendra Singh GM (Pub.) Lucknow	0522-2235618/19/20/21	brijendrasingh@sifpsa.org
76.	Mr. Azad Singh GM (DAP) Lucknow	0522-2235618/19/20/21	azadsinghonline@gmail.com
77.	Dr. S. Krishnaswamy GM (Pvt.) Lucknow	0522-2235618/19/20/21	skswamy123@gmail.com
78.	Ms. Shaheen Khan APC (Pvt.) Lucknow	0522-2235618/19/20/21	Shaheen19@rediffmail.com
79.	Ms. Geetali Trivedi PC (IEC) Lucknow	0522-2235618/19/20/21	geetalitrivedi@yahoo.co.in
80.	Ms. Savita Chauhan DGM (Pvt.) Lucknow	0522-2235618/19/20/21	chauhansavita@rediffmail.com
81.	Dr. Sulbha Swaroop DGM (Pub.) Lucknow	0522-2235618/19/20/21	
82.	Ms. Humaira Bin PMU, Agra	2885835	
<b>ITAP</b>			
83.	Ms. Donna Sibley President Sibley International USA	202-8339588	dsibley@sibleyinternational.com
84.	Mr. Michael Amies Consultant Sibley International United Kingdom	(44) 1386501326	maa@pershore.wyenet.co.uk

85.	Ms. Carol Rosener Consultant/ Facilitator Sibley International USA	1-561-731-2189 USA	Crosiel9@aol.com
86.	Dr. Easter Dasmariñas Former CEO Well-Family Midwife Clinics Philippines	+ 639177945070 (632) 6873530	edasmariñas@yahoo.com
87.	Rehana Ahmed Formerly of Greenstar Network Pakistan	+254-734-660957	
88.	Dr. G Narayana Director Futures Group	9810192840	gnarayana@futuresgroup.com
89.	Ms. Shuvi Sharma Technical Officer Futures Group New Delhi		shuvisharma@futuresgroup.com
90.	Dr. V. Jayachandran Operations Research Manager Futures Group New Delhi	9810383291	vjayachandran@futuresgroup.com
91.	Mr. Ajay Pandey State Operations Research Advisor -UP Futures Group	0522-2238907 9839994226	apandey@futuresgroup.com ajayiips@hotmail.com
92.	Dr. Manoj Agarwal State Representative-UP Futures Group	9839476644	magarwal@futuresgroup.com
93.	Mr. Ashok Singh Manager Capacity Building-UP Futures Group	9412057115	asingh@futuresgroup.com
94.	Mr. Avindra Mandwal State Representative-Uttaranchal Futures Group	9334787075	amandwal@futuresgroup.com
95.	Dr. Prakash Narayanan State Operations Research Advisor- Jharkhand Futures Group	9839912344	pnarayanan@futuresgroup.com

*Content, Design and Printing*

New Concept Information Systems Pvt. Ltd.

Tel. 011-26972743, 26972748, email: [nc@newconceptinfo.com](mailto:nc@newconceptinfo.com)



**US Agency for International Development**

American Embassy

Chanakyapuri

New Delhi – 110 021

INDIA

Tel: (91-11) 2419 8000

Fax: (91-11) 2419 8612

[www.usaid.gov](http://www.usaid.gov)