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Social Franchising as a Public-Private Partnership Model

Lessons Learned from the Merrygold Health Network of Uttar Pradesh, India

The Power of Innovations and Partnership

APRIL 2012

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FOREWORD

In 2005, the state of Uttar Pradesh, India's most populous state, had the highest maternal mortality in the country, the third highest infant mortality, poor uptake of modern family planning methods, and low use of institutions for deliveries. Furthermore, healthcare was accessed by the population largely through the private sector and studies indicated that out of pocket expenditure on reproductive and child health services in both government and private facilities was high. The combination of these factors imposed an enormous burden on the poor.

In response to this situation, the United States Agency for International Development (USAID), in collaboration with the Government of India and Government of Uttar Pradesh, focused its support on family planning and reproductive health services through the Innovations in Family Planning Services (IFPS) Project. In its second phase, the Project emphasized developing, designing, demonstrating, documenting and disseminating public-private partnerships (PPPs) for the provision of high quality healthcare services. Various consultations with stakeholders at the national, state and district level were conducted at the beginning of the program to identify potential models that could address local health needs.

Social franchising emerged as one of the models for consideration in Uttar Pradesh since it provided an opportunity for health managers to mobilize the private sector to provide consistent standards of care at affordable prices. International experience sharing and a state level workshop informed the design of this model to provide quality health services to those most in need. Sustainability through recovering costs from user fees and franchisee fees was one of the unique elements of this design.

The social franchising network in the state, branded as the Merrygold Health Network, has been able to demonstrate that the private sector can be constructively engaged to meet healthcare needs and supplement the public sector. Covering more than 35 districts of Uttar Pradesh, the model's network includes more than 430 private providers. Additionally, linking the model to various government schemes provides immense potential to reach out to larger populations with quality healthcare services.

It is hoped that this documentation of the social franchising model will provide insights to policy makers and program planners on how innovative models can be developed in partnership between the public and private sector to increase and expand the reach of quality healthcare services.

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This report was finalized by the ITAP team that included Shuvi Sharma, Dr A A Jayachandran, Sanjib Kumar Jha, Rajiv Ranjan, Heer Chokshi, Dr Utpal Das, Dr Ajay Misra and Ajay Patel. Dr Nimisha Goel and Priyam Bhasin have developed the case studies for the report. Tanya Liberhan has edited the report. This report draws on the previous documentation efforts of Dr Richard Pollard and a range of other published and unpublished reports.

This report has been reviewed by Dr Gadde Narayana and Dr Suneeta Sharma. Support from USAID for review of this document is acknowledged, especially Vijay Paulraj and Dr Ekta Saroha.

ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife
AYUSH	Ayurveda, Yoga, Unani, Sidha, Homeopathy
BPL	Below Poverty Line
CPR	Contraceptive Prevalence Rate
C-Section	Cesarean Section
FP	Family Planning
GoI	Government of India
GoUP	Government of Uttar Pradesh
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HIMS	Hospital Information Management System
IFPS	Innovations in Family Planning Services
IMR	Infant Mortality Rate
ITAP	IFPS Technical Assistance Project
IUCD	Intrauterine Contraceptive Device
JSY	Janani SurakshaYojana
L1	Level 1
L2	Level 2
L3	Level 3
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MGHN	Merrygold Health Network
MMR	Maternal Mortality Ratio
NABH	National Accreditation Board for Hospitals
NFHS	National Family Health Survey
NGO	Nongovernment Organization
OPD	Out-patient Department
PAC	Program Advisory Committee
PHC	Primary Health Center
PNC	Postnatal Care
PPP	Public-Private Partnership

RCH	Reproductive and Child Health
RH	Reproductive Health
RMP	Rural Medical Practitioner
RSBY	Rashtriya Swathya Bima Yojana
SBI	State Bank of India
SIDBI	Small Industries Development Bank of India
SIFPSA	State Innovations in Family Planning Services Agency
SRS	Sample Registration System
TAG	Technical Advisory Group
TFR	Total Fertility Rate
UP	Uttar Pradesh
USAID	United States Agency for International Development
USD	United States Dollar

EXECUTIVE SUMMARY

The Innovations in Family Planning Services (IFPS) project came into being as a joint endeavor of the Government of India and the United States Agency for International Development (USAID) in 1992. The project focus since 2004 has been to develop, test and document appropriate models of public-private partnerships (PPPs) to increase access to and use of integrated reproductive health (RH) and family planning (FP) services. Taking cognizance of the health requirements and stakeholders consultations on possible models, social franchising emerged as an innovative PPP mechanism that would help meet the health needs of the people of Uttar Pradesh (UP).

The objective of the social franchising project was to increase access to equitable, affordable and quality healthcare services for low income groups and the working class by engaging the private sector through sustainable partnerships and developing a network of franchised hospitals. Based on experiences from other international social franchising models and a design workshop involving major stakeholders, a model was evolved for UP. Salient features of this model were low cost, high volume to achieve financial viability, pricing at 50 to 60 percent lower than market price to drive volumes, comprehensive basket of services to cross subsidize preventive and promotive care, and revenue generation so as to be sustainable in the long run.

This USAID funded Network, launched in 2007, was managed by the State Innovations in Family Planning Services Agency (SIFPSA), and implemented by Hindustan Latex Family Planning Promotion Trust (HLFPPT) as the franchisor, with technical assistance provided by the IFPS Technical Assistance Project (ITAP). The private providers once enrolled as franchisees were responsible for providing quality services as per pre-determined quality and management protocols.

The social franchising network, branded as the Merrygold Health Network (MGHN), had a three-tiered 'hub and spoke' model. The first tier (Level 1 (L1), branded as Merrygold, comprised fully franchised health facilities. The second tier (Level 2 (L2), called Merrysilver, consisted of fractionally franchised facilities, and the third tier (Level 3 (L3) named Merrytarang was a referral network consisting of members at the community level. For each L1, it was envisaged that there will be 10 L2s and each L2 would have 15 L3s. Initially, there was no referral fee between the different tiers.

The MGHN expanded in phases and covered 35 districts of UP, with an objective of including 70 L1s, 350 L2s and 10,500 L3s into the network, over a period of three years.

Branding for the network was developed after audience segmentation and analysis, and the platform chosen was 'quality health services at an honest price'. The brand imagery, consisting of a marigold flower, leveraged on its auspicious and positive symbolism. A multi-pronged communication strategy was deployed with television spots, radio spots, newspaper advertisements, communication collaterals, and internal and external branding of facilities using the same branding for consistent experience for the consumer. Extensive branding and marketing of the network was a primary reason for private providers to join as franchisees.

Services at each level included:

- L1 Full Franchisees: Basic obstetrics care and C-section deliveries; normal delivery cases; antenatal care (ANC); counseling on contraceptive methods and distribution of contraceptives and related products including wellness products/over the counter medicines; advertising and promotional materials; and other additional services related to obstetrics/gynecology and pediatric care.The L1 facilities also offer ambulatory care, tie-ups with diagnostics facilities and pharmacies.
- L2 Fractional Franchisees: Basic obstetrics care; counseling on contraception methods; intrauterine device (IUD) insertions and distribution of contraceptives and related products.

Services were priced lower than the market rate to drive volumes. In addition, to meet the sustainability objective of MGHN, L1 facilities would pay Rs. 300,000 (about USD 6,000) as an initial franchise fee and three percent of revenues beyond that. L2 facilities would pay a one-time franchise fee of Rs. 1,000 (about USD 20).

Meticulously planned trainings for both L1 and L2 franchisees were conducted on standard protocols for the Network (430 doctors, 2000 paramedics and 475 non-clinical staff trained). These were supplemented with management development trainings, workshops with National Accreditation Board for Hospitals (NABH) on accreditation standards, newborn care, and trainings for L3 members. Recently, an e-learning program has been planned and is in the initial stages of implementation.

Quality standards have been established through protocols and guidelines. Franchisees are trained on these protocols and contractually obligated to follow them. Periodic medical audits determine whether franchisees are following the established standards or protocols.

Partnerships for pharmaceutical products, information systems, health insurance, diagnostics and financial loans from institutions were established. These partnerships proved cost efficient for franchisees and acted as a one stop RH facility for consumers. The MGHN health facilities were also linked with other existing schemes such as voucher system, FP sterilization scheme, Rashtriya Swasthya Bima Yojana (RSBY) and Soubhagyavati Yojana.

The project developed a computerized for system management of health information. A log-frame with indicators for increased demand for services; consistent and improved quality and range of products and services provided by franchisees; and enhanced capacity of franchisees to sustain a profitable practice was developed.

A total of USD 6.11 million was earmarked from March 2007 to February 2011 for the social franchising network.

The MGHN has expanded and is now operational in 36 districts across UP. It has been successful in bringing together more than 430 (67 L1s and 367 L2s) hitherto disaggregated private health service providers and nearly 10,000 community level workers into the folds of the network, making it one of the largest networks in India (Schlein, 2011).

From October 2007 till February 2012, the network has provided more than 756,100 antenatal checkups, nearly 133,900 deliveries, more than 10,600 sterilizations and nearly 38,200 IUCD insertions. In addition, with condoms and oral contraceptive pills, the network has generated more than one million couple years of protection (MGHN MIS, February 2012). Client satisfaction with the network was high. Thirty-eight percent of the women rated that they were 'very satisfied' and 53 percent as 'satisfied' (n= 66) with services they received at the network (Nielsen, 2009). Of all the women who knew about MGHN, 65 percent (n=474) reported they would visit the facilities again (presumably for a future birth) and 90 percent would recommend the network to a friend.

Medical audits conducted from September 2009 to August 2011 indicate that facilities have improved their quality of services with health facilities meeting more than 80 percent of the criteria.

A comparison of case load data for L1 facilities that have been in the network for two years indicated an increase in services uptake. On an average, normal deliveries increased by 20 per month, cesarean by nine per month, and ANC check-ups by 219 per month (Ernst and Young, 2011).

Over the implementation period, MGHN has demonstrated that social franchising as a model was capable of harnessing substantial private sector resources for health and could be rolled out and expanded very quickly. It had yet to prove that this could be done through a profitable franchise fee model.

A revised business plan has been developed for the network based on experiences from implementation. It has been suggested that recommendations from the plan and other studies be implemented in two phases: the consolidation phase and the expansion phase. The revised business plan indicates that with the suggested recommendations, the business model will break even in another four years.

The implementation of MGHN has demonstrated that a social franchise fills in a need for private sector by providing quality FP/RH services. It has worked extremely well within the contexts of the typical 'non-governmental organization (NGO)' model for such networks. Support to the model for another few years with a focus on revenue generation, while meeting its social objectives, will enable a sustainable network of health facilities in rural UP.

Chapter 1

INTRODUCTION

The Innovations in Family Planning Services (IFPS) Project came into being as a joint endeavor of the Government of India (GoI) and the United States Agency for International Development (USAID) in September 1992. The primary goal of the project was to assist the state of Uttar Pradesh (UP) in reducing the rate of population growth to a level consistent with its social and economic objectives, and to serve as a catalyst for GoI in reorienting and revitalizing the country's family planning (FP) services. The project was facilitated by the formation of a state health society, State Innovations in Family Planning Services Agency (SIFPSA), to guide the implementation of all project activities in the state. In the first phase of the project, SIFPSA had been engaged in various projects including nongovernmental organization (NGO) projects, reproductive and child health (RCH) camps, community-based distribution of Reproductive Health (RH) commodities, and several public sector strengthening initiatives.

The project first phase i.e. IFPS I, concluded in September 2004 and the project moved into its next phase (October 2004) with a shift in priorities. One of the key objectives of the new phase was to develop, test and document appropriate models of public-private partnerships (PPPs) to increase access to and use of integrated RH and FP services. Also initiated in the second phase, the IFPS Technical Assistance Project (ITAP) provided technical support for program planning, monitoring and evaluation, and to the IFPS Project in general.

One of the PPP models envisaged for UP was social franchising. Internationally, social franchising has come to be recognized as an effective tool in reconciling two key aspects —adequate profits with consumer affordability and standardizing quality of care with consumer trust in the brand—to serve as catalysts in health franchising.

The term 'social franchising' springs from the commercial franchising sector.'Franchising' generally refers to a franchisor that adapts a proven, small-business model and replicates it through selling the business plan, management systems, quality assurance, training, procurement and marketing services to a franchisee. The advantages to the franchise operators are that they replicate a proven business model and thus reduce the risks of going into business; they benefit from the bulk purchase of raw materials or commodities required by the business. As each franchisee operates in precisely the same way and offers precisely the same services, consumers come to trust the brand and repeatedly use the services, and as each franchisee operates under an identical branding, the whole network can be effectively supported through mass media and promotional activities. In return for these advantages and the reduced business risks involved in start-up, franchisees usually pay up-front fees and other operational and marketing fees on a permanent basis.

Franchises can be of two kinds – full franchises, where the franchisee only manages the business that is franchised, and fractional franchises where the franchise forms a part of a larger business.

Worldwide, there are about 50 projects in healthcare that refer to their activities as social franchising (Schlein, K., Drasser, K. and Montagu, D. 2011), and the numbers continue to grow every year. Franchises in 14 countries in 2003 have now increased to 31 countries in 2011. However, as these projects are initiated in the development sector and often dedicated to the provision of goods or services to low-income

groups or the poor, less emphasis is placed on the payment of franchise fees in almost all projects. However, since they are franchises, the other elements of commercial franchising are brought to play, such as branding, demonstrating trust in the quality of services, advantages of bulk provision of commodities or raw materials, and the benefits of joint sharing of the promotional spend through mass media.

Most franchises can be termed as social 'networks' in order to distinguish them from the few social franchises that do aim to recover costs by charging franchise fees and the franchisor intends to sustain the business through expansion and franchise fees.[1]

The social franchising approach has been applied in the context of UP, India, through the IFPS Project and this report documents the experience.

1.1 PURPOSE AND ORGANIZATION OF THE REPORT

This report has been prepared to contribute to the growing literature on social franchising and PPPs for reproductive, maternal and child health among the rural and urban poor. It explores the development, implementation and lessons learned of the USAID funded Merrygold Health Network (MGHN). This Network was managed by SIFPSA and implemented by HLFPPT with technical assistance being provided by ITAP. It is hoped that the experiences and lessons learned from the process described herein will help to inform the design and implementation of other such schemes in India and developing countries around the world.
Section 2 of this report analyzes the health scenario in UP and presents the rationale for seeing social franchising as a potential solution to the challenges. Section 3 covers the development process of the project. Section 4 describes the MGHN model in detail. Section 5 summarizes the total funds invested in the project and Section 6 details out the achievements. A discussion on insights from implementation is covered in Section 7. Section 8 covers the way forward for MGHN.

[1] Schlein K et al provide an alternate description of a social franchise as that which encompasses a network of private health practitioners linked through contracts to provide socially beneficial services under a common brand. The characteristics of a social franchise defined by them are: outlets are operator-owned, payments to outlets are based on services provided by client or other mechanisms, services are standardized, and clinical services are offered with our without franchise-branded commodities.

Chapter 2

UNDERSTANDING THE PROBLEM

RCH has remained an integral part of the Family Welfare program in India, since the time of initiation of the First and Second Five Year Plans (1951–56 and 1956–61), when the government took steps to strengthen maternal and child health (MCH) services. The National Population Policy adopted by GoI in 2000 reiterates the government's commitment to safe motherhood programs within the wider context of reproductive health (Ministry of Health and Family Welfare, 2000). Several of the national socio-demographic goals for 2010 specified by the policy pertain to safe motherhood. For instance, by 2010, 80 percent of all deliveries should take place in institutions, 100 percent deliveries should be attended by trained personnel, and the maternal mortality ratio (MMR) should be reduced to a level below 100 per 100,000 live births.

2.1 REPRODUCTIVE HEALTH IN UTTAR PRADESH IN 2005

UP is the largest and most populated state in India (population: 166 million, Census 2001).The Population Policy for the state, developed on the basic principles of the National Population Policy, was adopted in 2000 emphasizing on population stabilization and improvement of health status of the people, particularly for women and children. The intermediate objectives laid out in the Policy include reaching a replacement level of fertility of 2.6 in 2011; reducing in MMR to 394 in 2010 with a specific objective of increasing institutional delivery to 45 percent in 2011; and reducing in infant mortality rate (IMR) to 94 by 2011.The Sample Registration System (SRS) indicates maternal mortality at 440 per 100,000 live births (2004–06) and infant mortality at 73 per 1000 live births (2005) for UP.

According to the National Family Health Survey (NFHS–3) (2005–06), one-third of the women in UP did not receive any antenatal care (ANC) for their last birth in the five years preceding the survey, which was much higher than the national proportion of 23 percent. In the state, 43 percent of the pregnant women received ANC services from an auxiliary nurse midwife (ANM)/ lady health visitor (LHV)/nurse/ midwife and 23 percent received the services from a doctor. At the national level, doctors provided ANC services to more than half of the women (50%). Both mother's education and her wealth status were found to be associated with the ANC service uptake in UP as more than 94 percent of the mothers with more than 10 years of schooling, and 93 percent of the mothers who belonged to the highest wealth quintile accessed ANC services.

In the state, institutional deliveries constituted nearly 21 percent of all deliveries that occurred five years preceding the survey (NFHS–3, 2005–06). Of these institutional deliveries, more than 66 percent were catered to by the private sector, 32 percent by public health facilities and the rest (1%) by NGO/Trust sector. In urban areas, more than three-quarter (76%) of the deliveries took place in private sector health facilities while in rural areas it was 62 percent. The public sector accounted for 37 percent of institutional deliveries in rural areas and less than one-quarter (23%) of institutional deliveries in urban areas.More than 70 percent deliveries were attended by untrained personnel at home.

According to NFHS–3 (2005–06), the total fertility rate (TFR) for UP was 3.8. Nearly 44 percent of currently married women aged 15–49 years reported using any method of contraception in 2005–06 (NFHS–3), which had increased from 27 percent in 1998–99 (NFHS–2). The use of modern contraception was limited

to 29 percent. The contraceptive prevalence rate (CPR) was 17 percentage points higher in urban areas than in rural areas. However, the prevalence of female sterilization was almost the same among rural and urban women. Methods like IUD and condoms were more likely to be adopted by urban women than their counterparts in rural areas.

In UP, the FP services as well as supplies were provided primarily through a network of government hospitals or urban family welfare centers in urban areas, and primary health centers (PHCs) or sub-centers in rural areas. Private hospitals, clinics and NGOs also provided FP services. The public sector was the source of modern methods for 59 percent of the current users in the state. Nearly, one in five users received services from the private medical facilities. More than 90 percent of the female sterilizations were done in public medical hospitals whereas private medical sector and shops were the major sources of pills and condoms. A majority of IUD users (55%) obtained them from a private hospital or clinic/doctor in 2005-06 (NFHS 3).

NFHS data also indicates that the unmet need for spacing methods saw an increase from 9.1 percent in 1998-99 to 11.8 percent in 2005-06. The unmet need for limiting methods marginally declined from 13.4 percent in 1998-99 to 12.1 percent in 2005-06.

2.2 NEED FOR SOCIAL FRANCHISING IN UP

The National Health Accounts (2004–05) indicated that nearly 87 percent of the total health expenditure in UP was in the private sector. Out-of-pocket expenditure was incurred while availing services at public as well as private facilities. Break-up of expenditure on in-patient care among different components, for public as well as private facilities in 2004–05 in UP is presented in Table 1.

The private sector facilities, where a large portion of health services are being availed, are subject to self-regulation by their State Medical Councils under central legislation. In practice, however, this sector has relatively low levels of regulation and poor quality assurance controls (Planning Commission, 2008).

To summarize, UP has very poor health indicators with the highest MMR and third highest IMR in the country. Uptake of modern FP methods is low. Use of institutional facilities for deliveries is low, especially among the poorest. Out-of-pocket expenditure on RCH services in both government and private facilities is high with the healthcare systems imposing an enormous burden on the poor. The private sector, though available, unaffordable, highly unregulated and not many in the sector adhere to quality standards. Unmet need for FP and institutional deliveries is high, indicating a large gap with respect to service provisioning.

In the above context, PPPs have emerged as an important strategy for tapping the private sector while providing affordable, quality services to vulnerable populations. Social franchising, a PPP model emerged as an option that could tap the private sector for increasing access to affordable, quality RH and FP services in UP.

TABLE 1: COMPONENTS OF IN-PATIENT EXPENDITURE IN PUBLIC AND PRIVATE SECTOR (%)

Type of Hospital	Sector	Doctor's Fee	Diagnostic test	Bed, etc.	Medicine	Blood, etc.	Food
Private	Rural	21.72	7.42	18.72	46.98	1.32	3.83
	Urban	27.26	5.22	14.39	47.03	0.49	5.61
Public	Rural	12.83	13.70	10.64	54.00	3.65	5.18
	Urban	10.91	15.43	6.04	59.37	2.92	5.34

Source: National Health Accounts, India, 2004–05

Chapter 3

DESIGNING THE SOCIAL FRANCHISING PROGRAM

The USAID funded IFPS Project in its first phase from 1992–2004, concentrated on improving the access to and demand for quality RH services with particular emphasis on modern spacing methods and maternal health. Several innovative approaches were tried out in partnership with public and private sector agencies. Keeping in view the shift in program strategies at national level and key components of the RCH II program,[2] the focus of IFPS Project's next phase that commenced in 2004 was on PPPs to improve access to and improve quality of RH services.

During this phase of the project the main objective was to develop, design, demonstrate, document and disseminate PPP mechanisms in the health sector. In order to fulfill this mandate, a series of workshops and consultation meetings with stakeholders drawn from the public sector, NGOs, the organized sector, cooperatives, professional health associations, private providers etc., were conducted to share the concept of PPPs and explore partnerships that would be relevant for UP. Based on the deliberations in these workshops, social franchising emerged as a model that could be initiated in the state.

Since there was limited experience of implementing complex PPP mechanisms such as social franchising in the country, a workshop involving experts from different countries who had designed and implemented such mechanisms in the health sector, was conducted. The IFPS Project conducted two major workshops to inform design decisions.

3.1 LEARNING FROM EXPERIENCES: THE INTERNATIONAL SOCIAL FRANCHISING WORKSHOP

Social franchising leverages the vast network of service delivery units in the private sector to supplement the public sector delivery of services, especially in low resource settings. It has, therefore, come to be recognized as an effective tool in reconciling two key aspects in healthcare services—pricing for services with an eye on consumer affordability and standardized quality of care engendering consumer trust in the brand. The core task of social franchising is not so much to activate the delivery of services but to sustain the quality of services delivered within a larger mandate of social benefit.

Taking into account the success of social franchising in different parts of the world, a workshop on 'Social Franchising in the Health Sector' was organized on April 3–4, 2006 in Agra, and attended by about 100 participants. The international workshop brought together practitioners to share diverse experiences in social franchising and branded networks. The social franchising networks that were thoroughly explored were remarkably diverse, ranging from a pharmacy network designed to improve access to affordable drugs and commodities in Kenya to a clinic-based FP and MCH model managed through NGO networks in the Philippines to similar, but centrally owned and managed networks in Indonesia, Bolivia and Colombia. Among the Indian experiences, two fractionally franchised hospital models as well as a fully franchised model for eye care services were explored.

Most of the social franchising models—international and

[2] The second phase of the Reproductive and Child Health (RCH) program was initiated in April 2005 and has the main objective of bringing about a change in three critical health indicators, namely, reducing total fertility rate, infant mortality rate and maternal mortality ratio to meet the Millennium Development Goals, the National Population Policy 2000, the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India. RCH II is now an integral component of the National Rural Health Mission (NRHM).

national—showed the successful adaptation of franchising mechanisms in the FP and RH 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 and unserved populations. Bridging gaps in service delivery in rural or remote areas emerged as the main challenge for social franchising.

Consultative planning workshop to design a social franchising initiative, 2006

The primary recommendations that emerged from this first workshop were:

- Social franchising could certainly work. However, programs need to be founded on careful market analysis and sound business planning. To ensure viability of the venture, start with low hanging fruits (urban/semi-urban) before going to rural areas.
- Multiple services should be considered at the clinic or hospital level.There is a need to build in cross-subsidization into the model so that promotive and preventive services can be subsidized by curative services. This would help in making services affordable to the target population.
- The brand name for the network needs to be well-established.
- The model must be financially viable and attractive for the operator, both for the franchisor and the franchisee.
- Buy-in of all stakeholders, including communities, and enlisting their support for the model is essential for its viability.
- Targeting the poor and most vulnerable remains a challenge. Differential pricing mechanisms may be considered; linkages to insurance schemes and other similar programs should be considered.

During the workshop, it was emphasized that for social franchising to be successful, the idea that the business is franchising and not health needs to be understood.

3.2 CONSULTATIVE PLANNING WORKSHOP WITH STAKEHOLDERS

Following the international workshop, a three-day workshop titled 'Designing a Social Franchising Initiative in the Health Sector' was held from April 5 to 7, 2006, with about 40 participants. The participants included representatives from USAID India, Government of UP (GoUP), SIFPSA, local NGOs as well as national and international technical experts.The primary objectives were:

- to identify key elements of the design for a successful social franchising initiative in UP; and
- to prepare a roadmap for the initiative, aimed at augmenting public health delivery among the disadvantaged segments of the population.

At the end of the workshop the following steps were identified for evolving the social franchise. These included:

- Designing and conducting a market analysis to map existing providers, cost analysis studies, and the potential to develop referral mechanisms.
- Defining the target audience and segmenting that audience to ensure specific health service needs are met.
- Identifying the basket of services that must be delivered. The participants tentatively agreed that this should include FP services, maternal care, child care, reproductive tract infections, tuberculosis and malaria.
- Defining the modalities for delivery of these service mechanisms, including quality of care and monitoring standards.
- Understanding the legal aspects of establishing a franchise.

3.3 AWARDING THE CONTRACT

Based on inputs from the design workshop, experts worked with SIFPSA's Private Sector Division[3] and finalized the scope of work. A competitive bidding process involving release of expression of interest, the request for proposals being shared with shortlisted agencies, and evaluation of the three proposals received was undertaken by an expert panel, specially constituted for the purpose. The agencies also presented their technical proposals to the Technical Advisory Group (TAG) of SIFPSA based on which the HLFPPT proposal was selected.

The project was appraised by the Project Appraisal Committee (PAC) of SIFPSA, followed by a two-stage process of discussion and negotiation between HLFPPT and SIFPSA. A detailed cost benefit analysis was carried out and it was estimated that nearly USD 10 million would accrue as total household savings over three years to the franchise, clients as against what they would have paid in the private sector without the network. A final proposal was submitted by HLFPPT and finally sanctioned by the governing body of SIFPSA. The project was formally launched in August 2007.

3.4 SALIENT FEATURES OF THE SOCIAL FRANCHISE DESIGN

The social franchising model was designed with key objectives to develop a sustainable network of franchised RCH hospitals and clinics. The salient features that guided the network design were:

- ***Low cost, high volume to achieve financial viability:*** Increased volume and specialization of healthcare facility were expected to drive the costs down, with better patient outcomes. To achieve this, the fully franchised facilities were designed as a 20 bed facility.
- ***Pricing:*** The services were priced at 50 to 60 percent lower than the market price, with no hidden costs. This was appropriate considering the target population for the Network. However, the prices were determined by 'most frequent value' that the client was willing to pay rather than the lowest values. It was envisaged at the time that pricing will drive volumes and influence other private providers to reduce their service rates to remain competitive.
- ***Basket of services:*** In the past, fractional franchising initiatives for FP in the past clearly indicated a need for a basket of services for the network being designed (see Box 1). The facilities were designed such that a range of services—including obstetric care, gynecological care, FP, diagnostics and pharmacy—be provided, thus cross-subsidizing the low revenue generating services. This also ensured that the franchisor would receive adequate margins for running the franchising operations successfully.
- ***Revenue generating sustainable model:*** The model was designed such that services would be made available at a reasonable cost to the client. A detailed business plan was developed for the network. As per the initial projections, this continuous flow of revenue would ensure that the franchisee will break even in 18 months and the franchisor would be cash positive in four years, thus ensuring sustainability of the network, even after the initial funding period.

Services including gynecological care are provided at the facilities

[3] SIFPSA has 11 divisions which include public sector, private sector, contraceptive social marketing, training, information, education and communication, district action plans, research and evaluation, family planning information system, finance, internal audit, and human resources, administration and procurement. The social franchising project was managed by the private sector division.

BOX 1: VANITHA CLINICS: EXPERIENCE OF FRACTIONAL FRANCHISING IN ANDHRA PRADESH

Limited access to low cost provisioning of intrauterine devices (IUDs) with the private sector has been identified as one of the reasons for poor usage of IUDs in Andhra Pradesh. To meet this need, a fractional franchising program for IUDs, to assess the appropriateness of social franchising in enhancing use of IUDs, was developed. The project was initiated on April 8, 2001 and concluded after three years in December 2003. Branded as the Vanitha Clinics, the criteria for selection of clinics for the program were two-fold, one was location specific and other based on popularity of the doctor. The project franchised with hospitals that operated 24 hours a day and were owned by an obstetrician/gynecologist. Each franchisee paid Rs. 500 (USD 10) for registration for the first year only. The franchisees received payment for the services and products sold to the customers, and they in turn paid royalty to the franchisor. Initially, a model Vanitha clinic was set up in the Government Maternity Hospital, Hyderabad. A training center was also set up at this hospital to equip doctors to start such clinics in rural towns. To give these clinics a customized look so that clients identified with low-cost quality service, a uniform signboard was put up at each of the centers with the price board prominently displayed. Publicity was done extensively to popularize the clinics by placing advertisements in local newspapers and on Andhra Pradesh State Government buses. The Vanitha Clinics established a network with chemist shops, bangle stores, sari shops and beauty parlors to spread the word about their services.

Identified doctors underwent training on IUD insertion at Central Resource Center, Hyderabad. The paramedical staff at each clinic were trained in-house by a master trainer from HLFPPT.

The user charges for FP services were uniform across all franchisee clinics. Emergency contraceptive pills and urine pregnancy card (dipstick urine test) were introduced to meet the needs of the clients and help the clinics enhance revenue through their sale. Under the social franchising program, 57 Vanitha Clinics were set up in Andhra Pradesh. The project was evaluated by the Administrative Staff College of India, Hyderabad and the World Bank. According to the World Bank report, doctors reported that franchising had led to an increase in the number of people seeking FP services in their clinics.

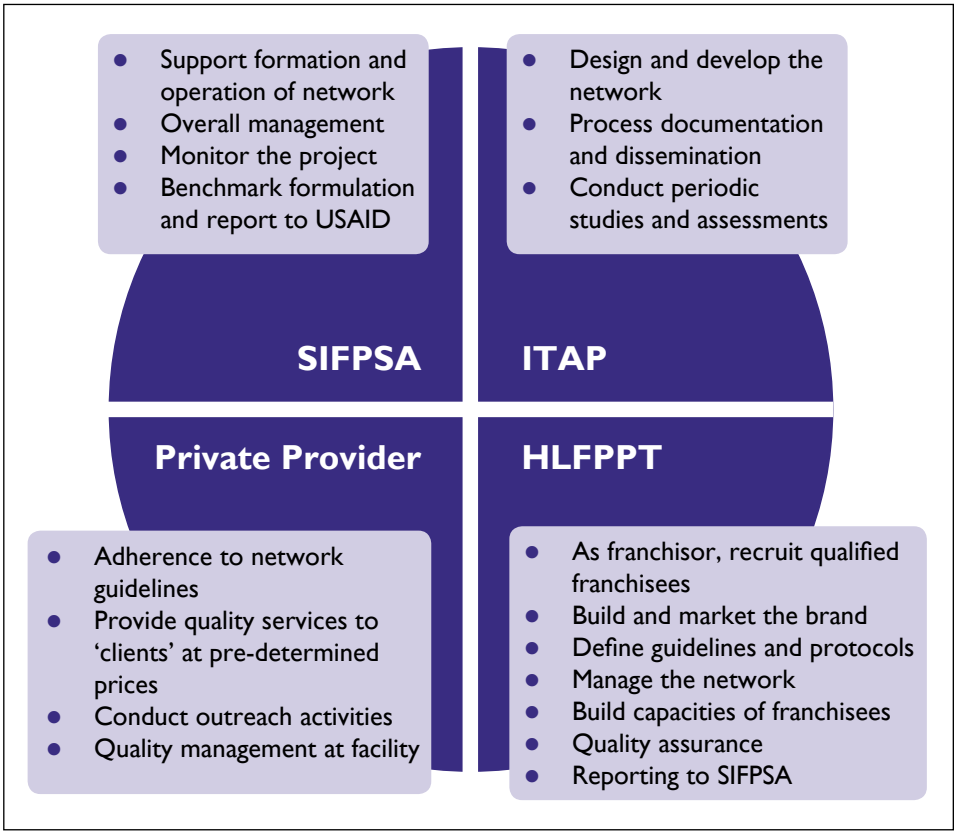
As the bouquet of services primarily included IUD insertion, emergency contraception and FP services, the sustainability of the franchise network beyond the period of funding was limited.

Source: Setting Up a Sustainable Network of Social Franchising Facilities for Working Poor, Hindustan Latex Family Planning Promotion Trust, March 2007

3.5 ROLE OF VARIOUS STAKEHOLDERS IN THE SOCIAL FRANCHISING NETWORK

Since there were many stakeholders involved in the establishment and management of the social franchising network, roles were clearly defined for synergies between them. The roles of partners are presented in Figure 1.

FIGURE 1: ROLES OF STAKEHOLDERS IN THE SOCIAL FRANCHISING PROJECT



SIFPSA for overall management

Based on the selection process, SIFPSA signed a contract with HLFPPT defining the terms of arrangement as well as pre-defined output indicators, called benchmarks, to be achieved by HLFPPT for release of funds. The Private Sector Division in SIFPSA was responsible for overseeing the implementation of the social franchising project. This included developing workplans with HLFPPT, monitoring their implementation, conducting regular field visits for verification, reviewing progress with respect to benchmarks, collating documentation for benchmarks, and qualitative and quantitative assessments of the network in collaboration with ITAP.

TAG the (SIFPSA) reviewed the project on a quarterly basis to monitor progress and provide inputs to strengthen implementation, discuss achievements and resolve issues.

ITAP for technical assistance and monitoring

ITAP as the technical assistance partner to the project provided support to SIFPSA as well as HLFPPT in designing and implementation of the network. This included conducting consultations for strategy development, review of protocols, periodic assessments by experts, field verification of the network in collaboration with SIFPSA, and process documentation and dissemination. ITAP was also part of the TAG (SIFPSA) and provided inputs during the review meetings.

HLFPPT as the franchisor

As the franchisor, HLFPPT's role was to establish and manage the franchise network. Specific responsibilities included recruiting and building capacities of franchisees, building the network brand, conducting outreach activities with the franchisees, establishing linkages with partners for specialized services, developing quality assurance systems and ensuring compliance to standards in the network, collecting and analyzing data for monitoring the network, and reporting to SIFPSA.

The franchisor had three offices to manage operations– the state office located in Lucknow and two regional offices in Varanasi and Bareilly.

Private provider as the franchisee

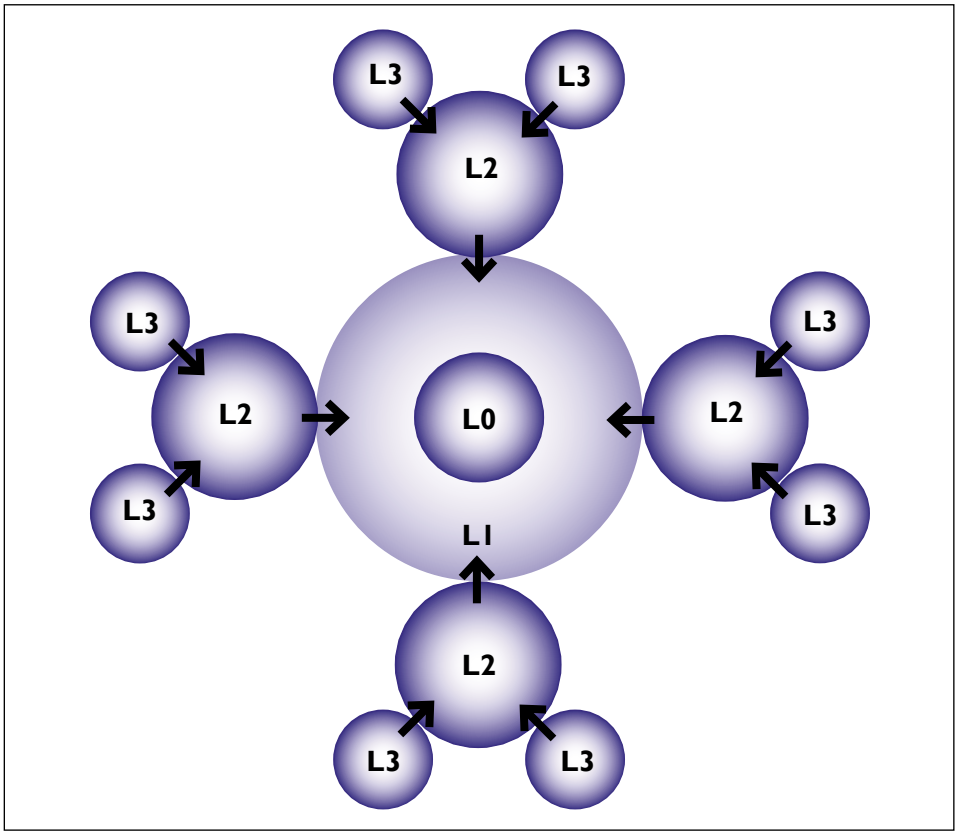
The private providers became franchisees in the network with the understanding that they would fulfill their contractual obligations to provide services as per quality standards determined by the franchisor, adhere to network pricing for services, support the franchisor in conducting outreach activities, submit reports as required by the franchisor, and pay the required franchise and royalty fee.

Chapter 4

THE MERRYGOLD HEALTH NETWORK

The MGHN was conceived to harness the potential of social franchising to establish a range of private providers in UP that would address the RH/FP needs of low income groups among urban poor and in rural areas.The aim was to create a social enterprise. The design of the social franchising model, which was a revenue generating model with a sustainability objective, was innovative and had not been tried in the country before. The model was first piloted in six districts of the state. During the course of its implementation, elements of the design elements were reviewed and revised in consultation with all stakeholders. Following sections present the original design along with the modifications made during the course of its implementation.

FIGURE 2: HUB AND SPOKE MODEL OF MGHN



4.1 NETWORK STRUCTURE

The MGHN was designed as a three-tiered 'hub and spoke' model for better rural outreach (Figure 2). It consisted of a mix of fully and fractionally franchised facilities that were connected to a network of community based volunteers. It was envisaged that each fully franchised facility would be a hub for 10–15 fractionally franchised clinics. These satellite fractional franchise clinics would be networked to the community based volunteer who will be trained in providing outreach and referral services.

Level 0 and Level 1: Merrygold facility – Fully franchised facilities characterize the network

In a franchising operation, it is common for the franchisor to have a fully owned facility for market seeding and serve as a model for other franchisees. HLFPPT had established two such facilities as model hospitals in Agra and Kanpur Nagar. These hospitals were 'test beds' for evolving and testing strategies, protocols, branding, staffing, pricing, services and procedures. Potential franchisees had the opportunity to appraise these models before committing to join the franchising network. These model facilities i were termed as Level 0 (L0) hospitals and were included in the social franchising operations.

The Level 1 (L1) facilities were fully franchised mirror images of L0 facilities. These facilities were planned as a 20 bed facility each within 6000 sq ft area, where a client could avail all maternal health related services under one roof. It was envisaged that an ambulance would be provided at each L1 facility and wherever feasible, laboratory diagnostic services would also be provided. The facility was designed to drive down costs while maintaining quality of services. The initial investment for a green field project by the franchisee was estimated to be approximately Rs. 4 million (USD 80,000).The franchisor identified commercial banks to facilitate loan approvals.

A doctor pays visit to a client at an L1 facility

These facilities were located in urban or peri-urban areas adjoining district headquarters and were standardized across facilities for a similar patient experience.

Level 2: Merrysilver facility - Fractionally franchised facilities increase reach

Each L1 facility was supported by a lower level facility consider 'operating in' the rural or peri-urban environment with less than 100,000 populations. These facilities were expected to be franchised to existing individual physicians, including traditional health practitioners. Since these providers were likely to offer a range of general services (beyond MCH services), they were included into the network as a fractional franchisee. They were termed Level 2 (L2) facilities.

Each L1 facility was serviced by about 10 L2 facilities in a 'hub and spoke' system. Each L2 facility was planned as a 5 to 10 bed facility and could perform normal deliveries. Complicated hospital procedures such as emergency obstetrics or cesarean births were to be referred to L1 facilities.

The primary differentiation between L2 and L1 facilities was that L2 facilities would not perform surgical services, notably C-section deliveries, and that they would be a substantial source of referrals to L1 facilities. Originally, L2 facilities were to be based at AYUSH (Ayurveda, Yoga, Unani, Sidha, Homeopathy)[4] providers and would primarily refer patients for C-section deliveries (or other complications or treatment) to L0 and L1 facilities.

Level 3: Merrytarang member – A grassroots referral network to drive volumes

A referral network of community based members at the village level was included in the design to mobilize community level participation. Each L2 facility would be linked to 15 Level 3 (L3) members. These L3 members support the outreach, rural communications, referral and demand generation for the network. Originally, it was envisaged that these members would be trained in simple diagnostic but non-invasive techniques to be able to ascertain the disease, give appropriate information to the client, counsel and refer to the nearest L1 or L2 facility. However, this was not implemented.

Recruiting the franchisees

Accreditation standards developed by the franchisor based on the modified NABH criteria for infrastructure, human resources, equipment and infection prevention among others were used for accrediting facilities at various levels.

[4] AYUSH is an acronym for non-allopathic system of medicine in India. These include Ayurveda, Yoga, Unani, Siddha and Homeopathy.

Expanse of the Network

The network was to be implemented in a phased manner to cover the entire state of UP— six districts in the first stage, additional 40 districts in the second phase and remaining 24 districts in the third phase. Each district was to have an L1 facility, totaling 70 such facilities in the state. The design imperatives of the hub and spoke required that the network have 700 L2 facilities and 10,500 L3 members.

Modification in the original design

- Coverage: While the network was originally designed to cover all districts of UP, it was realized after the first stage of implementation that resources being spread were too thin with only one L1, 10 L2s and 150 L3s in each district. To intensify the network in selected geographies, the coverage was reduced to 35 districts. With this modification, while the total number of L1s remained the same, the L2s were reduced to half. The network objectives were then redefined to 2 L0s, 70 L1s, 350 L2s and 10,500 L3s by August 2010.

Differential branding for various tiers of MGHN

4.2 BRANDING AND COMMUNICATION

HLFPPT conducted audience segmentation to develop the network branding. The target audiences defined for the brand were men and mothers-in-law who were value conscious, price-sensitive; and traditional. Consumer insights for this audience reflected that childbirth was a 'routine and common experience'. Rural medical practitioners (RMPs) were the first point for healthcare and were considered as 'friend and guide' by the target consumer. Moments of truth for these consumers in health facilities were unpleasant, as one villager shared:

"All hospital bills add up to more than you anticipate—there are hidden costs that the customer does not expect."

With these insights, HLFPPT branded the network as Merrygold Health Network. Marigold, used as the image for the brand, leverages the flower's positive and auspicious symbolism in the country.

To further differentiate the different levels of the franchise within the network, the L1 facilities were titled Merrygold, L2 Merrysilver, and L3 Merrytarang.

A key communication task for the franchising team was to position Merrygold on the platform of 'quality health services at an honest price'. The communication tagline of *Achchi-Sehat, Sacchi-Khushiyan* (good health, (for) true happiness) was thus developed. This was used as consistent communication across all media developed for brand promotion. The communication strategy developed for the project was multi-pronged with activities planned to strengthen brand equity, increase client load for franchisees and expand the franchise network by reaching out to new franchisees.

The tagline was used consistently across all television spots, radio spots, newspaper advertisement, communication collaterals, and internal and external branding for franchise facilities. A multi-media mix was used for reaching the target audience. Mass media included television, local cable, and newspaper advertisements. Outreach activities in the form of health camps, *godbharai* (baby shower) at health facilities, special day celebrations such as Mother's Day, community

health volunteer meetings, *saas-bahu-samellans* (mother-and daughter-in-law meetings) were organized. Reminder media was also used and included wall paintings, hoardings, tin plates and tree guards.

Each network facility was branded for easy recognition of Merrygold facilities. External branding included signage, pillar boards, brand posters, stickers and wall paintings. Internal branding was specified in the protocols and included painting of hospital interiors in a standard color scheme, and branding of reception area, waiting area and wards, stationery, rate cards and protocols.

Specific newspaper advertisements were released to invite potential franchisees. These along with sensitization meetings with potential franchisees were key to inducting the required number of franchisees into the network.

Communication between network members was also identified as a need. A newsletter for intra-communication within the network was launched. The newsletter provided project updates, general updates on health issues, experience sharing between franchisees, and management to the network members. This newsletter was very well received by the network members.

To reinforce Merrygold as a consumer friendly brand and network, a helpline was established in February 2010. The helpline responded to franchisee enquiries, information regarding provision of services from MGHN facilities, pricing, and counseling for FP and uptake of services.

Modification to the original design

Due to funding limitations, the budget for marketing and communications was limited in the original design. It was in October 2009 that a revised communication plan was developed that emphasized the need for a multi-pronged comprehensive communication strategy. An additional funding of USD 1.01 million was programmed specifically to strengthen the communication component.

4.3 REFERRAL FEE

Referral fee mechanisms are the preferred marketing tool of private sector health providers, payable to individuals who refer patients to them, and to other providers who refer for specialist services or treatment. This fee is often up to 30 percent of the service or treatment cost. Initially, while referral was a connecting link between the different tiers of the network, there was no standardized referral fee determined by the franchisor at any level.

With the introduction of Janani Suraksha Yojana (JSY)[5] for the private sector, the Merrygold franchisees were able to avail referral costs of Rs 600 (USD 12) per delivery through this scheme. In early 2009, this arrangement was discontinued by the government. As a result, many franchisees reported a steep decline in client loads. Subsequently, MGHN introduced a Rs. 300 (USD 6) referral fee payable to its present network of about 3,000 trained L3 Merrytarang referral agents.There was no referral fee established between L1s and L2s. While being interviewed for their suggestions, the franchisees felt that the referral fee offered (Rs. 300) was not a competitive amount and suggested increasing it to Rs. 600, i.e. at par with the JSY scheme.

Subsequently in 2011, the referral fee was revised at par with the JSY scheme and the L3 members received Rs 600 (USD 12) for each delivery.

4.4 SERVICES PROVIDED THROUGH MERRYGOLD HEALTH NETWORK

In broad terms, franchisees of MGHN offer the following services:

- **L1 Full Franchisees:** Basic obstetrics care and C-section deliveries; normal delivery cases; ANC; counseling on contraceptive methods and distribution of contraceptives and related products including wellness products/over the counter medicines; advertising and promotional materials; and other additional services related to obstetrics/gynecology and pediatric care.
- **L2 Fractional Franchisees:** Basic obstetrics care; counseling on contraception methods; IUD insertion;s and distribution of contraceptives and related products.

The L1 facilities also provide for ambulatory care, tie-ups with diagnostic facilities and pharmacy.

[5] Janani Suraksha Yojana (JSY) is a conditional cash transfer scheme launched by the Government of India under the NRHM. Under the scheme, pregnant BPL women who avail at least three ANC visits and have an institutional delivery in a public or private sector facility receive a specified amount of money.

COMMUNICATION MATERIALS AND ACTIVITIES

Brand Promotion		
Brand poster	**In-clinic board**	**In-clinic board**
		
In-clinic board	**Reception Backdrop**	
		
Booklet	**Merrygold facility board/hoarding**	**Hospital Branding in Waiting Area**
		

Local Media

Wall Painting

Hoarding

Mobile Van

POS/Print

Insurance/Jaccha Baccha Policy

MCH Card

Promotional Events

Godbharai Ceremony

Community Meetings

4.5 PRICING OF SERVICES

The pricing of services for MGHN were determined by a) internal costing of services; b) internal cross subsidization; and c) market prices. The franchisor identified the cost drivers, namely, hospital capacity utilization, initial investment, monthly fixed expenses, material usage and other expenses. To ensure overall sustainability without losing focus of the target group, MGHN design included private rooms and semi-private rooms in addition to the general wards for cross-subsidization. Preventive services were cross-subsidized by curative services. The franchisor benchmarked its prices at 30–40 percent lower than the prevailing range of market prices while ensuring that they are competitive and affordable for the target population. Existing compensation rates through JSY in the government set-up were also considered while determining the pricing.

It was envisaged that an increase in volumes for MGHN franchisees would result in bringing down prevailing market prices in their surrounding areas.

Revisions in pricing since inception

As per the initial business plan, the pricing of services were revised regularly to account for inflation. These revisions were incorporated based on rapid market assessments and in consultation with SIFPSA.

4.6 FRANCHISE FEES

To meet the sustainability objectives of the MGHN, it was decided that the franchisor would generate revenue from the franchising (licensing) fee and royalty fee.

The franchising fee, a fee at the time of signing the three year contract, provides the franchisee with the right to use the Merrygold brand name along with brand collaterals, project setting-up guidelines, cost effective procurement guidelines, manpower planning and business plan.

Royalty fee was designed as a percent of gross sales. This fee was charged by the franchisor for providing operational support, namely, clinical and administrative operating procedures, training of the franchisee and its staff, and marketing support.

HLFPPT established franchise fee levels at:

- **L1 Franchisees:** Rs. 300,000 (USD 6,000 approximately) as the franchising fee with an ongoing quarterly royalty fee of three percent of revenues.
- **L2 Franchisees:** Rs. 1,000 (USD 20) as the franchising fee with no quarterly royalty fees.

The rationale for the above was that, essentially, the operational 'profit' at L1 would be substantially influenced by the referral of patients from L2 facilities. These referrals would be for the most profitable 'clinical' services that L2 facilities would not supply. They would rely on income from the less profitable 'routine' health services. For these reasons, it was assumed that the

TABLE 2: REVISIONS IN PRICING SINCE INCEPTION

Procedure	Category	August 2007-August 2009 (in Rs.)	Aug 2009-December 2011 (in Rs.)	December 2011 till date (in Rs)
Normal Delivery	General Ward	1499.00	1999.00	2499.00
	Semi-Private	2499.00	2499.00	2999.00
	Private	3999.00	3999.00	3999.00
Caesarian	General Ward	4999.00	6999.00	7999.00
	Semi-Private	7999.00	7999.00	8999.00
	Private	11999.00	11999.00	11999.00
Hysterectomy	General Ward	5999.00	5999.00	7999.00
	Semi-Private	8199.00	8199.00	8999.00
	Private	12999.00	12999.00	12999.00
ANC/PNC/General/OPD		50.00	50.00	50.00
IUD		99.00	99.00	100.00
Sterilization		999.00	999.00	1500.00
Day Care Procedure		999.00	999.00	999.00

profit margins at L2 would not afford any realistic monthly franchise fee.

HLFPPT estimated that at this fee level and with the number of facilities that would be established, the franchise operation would begin to break-even, or earn a small profit from its operations in Year 4.

4.7 TRAINING

Induction training for L1s and L2s

The franchisor developed extensive induction training for franchisees. These were on-site trainings for doctors, para-medical staff as well as other non-clinical staff at the franchise facility. Trainings were designed to familiarize all staff with their job descriptions, medico-legal issues, discuss protocols with clinical staff, discuss and demonstrate steps for infection prevention and waste management, familiarize nurses with protocols for effective client care and management, and discuss and demonstrate different FP methods. The training modules elaborated on the following protocols: clinical obstetrics, FP and general hospital services personnel service, customer service, medication, quality of care, marketing, billing, budgeting and accounting, and material management. Sessions were designed to be interactive, encourage team building and included demonstrations for skill building. These trainings were conducted at L1 and L2 facilities and since inception of the network nearly 430 doctors, more than 2000 paramedics, and 475 non-clinical staff members were trained. These trainings were well appreciated by the franchisees and followed up with refresher trainings for L1 facilities in 2010 to re-orient the staff on important protocols.

Management development programs for franchisees

For strengthening the managerial and administrative capacities of franchisees, the franchisor organized a management development program at the Indian Institute of Health Management and Research, Jaipur in December 2008. The program covered topics such as roles of hospital administrators, planning and organizing for service provision in a hospital, nursing and ward management, hospital waste management and infection control, material management and inventory control, quality assurance, hospital information management system (HIMS) and medical records maintenance, legal aspects in healthcare, revenue cycle management, leadership and its styles, and team building. Thirty persons were trained in two batches.

Merrytarang members were imparted counseling skills during their induction training

Workshop on national accreditation board for hospitals

NABH is a constituent board of the Quality Council of India, set up to establish and operate accreditation programs for healthcare organizations. The franchisor facilitated a workshop for network franchisees with technical assistance from NABH in October 2009. This workshop oriented the network partners to 100 standards and more than 500 articles required for accreditation by NABH. This enabled the MGHN doctors to incorporate these best practices, thus ensuring commitment towards high quality care and patient safety. A self-assessment toolkit along with NABH guidelines was provided to franchisee partners. The workshop was attended by 29 participants.

Newborn care training

To sensitize and train hospital personnel on basic and emergency newborn care, trainings were conducted at Merrygold health facilities in Agra and Kanpur. Experts in the field of neonatology from premier institutions conducted these trainings in December 2007 and February 2008. The classroom sessions were organized only for qualified staff that could handle

Doctors demonstrating the standard resuscitation procedure on a mannequin

newborns. The training included modules on care at birth including newborn resuscitation, care in postnatal ward, care of small babies, and transporting sick babies. A separate practical session was also organized for assistants, nursing aids, ward boys etc. for better management of emergencies related to neonates.

Induction training for L3 members

Besides the clinical and management trainings conducted at L1 and L2 facility, an induction training was designed and conducted for Merrytarang members at L3. This training introduced L3 members to the MGHN, provided them with information on services available at MGHN health facilities, clarified their role, and imparted them with counseling skills. Frequent trainings at L3 had to be conducted to account for attrition of L3 members.

E-learning program

A recent innovation by the franchisor has been to evolve an e-learning program to meet the needs of continuous medical education for MGHN members. Envisaged as a comprehensive program to fulfill various training needs, this will reduce the need for classroom training and time away from the job. The e-learning program will be integrated into the ongoing training programs. The first module that covers basics for paramedics and advanced topics for doctors has been developed. This has the potential to evolve into a distance learning program for franchisees. This may well be the future for all training activities in the MGHN.

4.8 QUALITY ASSURANCE SYSTEMS

Accepting that the long range security of the franchise rested with consistent quality of care and standardization of patient outcomes across the network, the franchisor developed clinical and non-clinical standard operating protocols. These protocols were developed for general service, personnel service, customer service, medication management, quality assurance, marketing, billing, budgeting and accounting, materials management and operations. These protocols were guided by internationally recognized standards for quality systems and processes (ISO 9001-2000) as well as NABH standards. These included standards for structural, process and clinical care. Quality assurance was a focus area during the induction trainings and in line with the long term goal of attaining ISO 9001-2000 and NABH certification for different levels of MGHN facilities.

Accreditation of facilities at the time of recruitment into the MGHN was carried out by the franchisor to ensure minimum quality of services. Periodic medical audits, internal as well as external, were carried out to check adherence to protocols. Checklists based on quality indicators, namely facility readiness assessment, orientation of providers to client's rights, quality of clinical services, and infection and waste management were used for assessment. Medical audits were initiated in September 2009.

Quality improvement at a franchisee facility was achieved through the analysis of the QA checklists with the providers, capacity building of doctors and paramedical staff at the facility, and continuous follow-up on recommendations.

The MGHN also developed a protocol to provide personalized care to patients and their family members. The C.A.R.E.S protocol as it is called, emphasized on courteous, attentive, respectful, enthusiastic and safe customer experience.

All protocols were first established at the L0 facilities, validated at these facilities for practicality, and then scaled up to all facilities in the network.

4.9 PARTNERSHIPS

A range of innovative private sector linkages and partnerships were fostered over the course of implementation. It was envisaged that these partnerships would improve the efficiency of the MGHN by bringing in partners for managing specialized services. These partnerships are elaborated below:

- **Pharmaceutical services with Guardian Pharmacy** – to guarantee provision of quality commodities and pharmaceutical products at low costs.Taking cognizance of the target audience for MGHN, Guardian Pharmacy launched a low-cost rural brand, *Aushdhi* and established an outlet at the Agra L0 facility in December 2008. These outlets are operated by trained pharmacists. More outlets are envisaged for the next phase of expansion.

- **Information systems with WIPRO** – for providing IT services, notably HIMS software that was provided to L1 facilities in computerized form.

- **Health Insurance with United India** – to launch a customized maternity coverage insurance product called Merrygold *accha Bac*cha Policy. Benefits of the policy included compensation in the event of death of mother or child at delivery, expenses in the event of a cesarean delivery, complications arising during child birth and disability compensation in the event that there is a deformity or disability of child (excluding stillbirth). All benefits of the policy could be exclusively availed at a MGHN facility. The Merrytarang members were trained as agents for these policies and received a commission for every policy sold. Initiated in 2008, a total of 200 policies were sold.With an increase in prices of services, the insurance cover transitioned from micro insurance to a regular insurance product, and therefore the product had to be withdrawn.

- **Diagnostics with Metropolis** – a leading corporate diagnostics chain with global presence, for establishing laboratory services for routine tests related to MCH. The laboratory established at the Agra L0 facility in February 2009 was further networked to Metropolis's labs with sophisticated equipment where samples requiring specialized tests were sent. The test results were made available to clients at the Merrygold facility or on the Metropolis's website. The partnership, operational till December 2010, was discontinued due to an increase in their rates. These revised rates did not corroborate with MGHN's vision of provision of affordable health services. While local partnerships for diagnostics were facilitated to ensure seamless provisioning of services, the franchisor is currently in conversation with other diagnostics partners for future partnership.

- **Financial Institutions such as State Bank of India and Small Industries Development Bank of India** – for linking to potential banking and investment sources to support the establishment of each franchise operation. Issues of reduced risk in establishing a franchised business are well known. Tie-ups with State Bank of India (SBI) for greenfield projects and with Small Industries Development Bank of India (SIDBI) for financing requirements of existing facilities were formalized. Specific schemes, with financing nine percent at attractive rates and

Pharmacy outlets established at MGHN facilities were operated by trained pharmacists

repayment over longer duration, from both financial institutions were promoted among franchisees as a value addition.

4.10 LINKAGES WITH GOVERNMENT SCHEMES AND OTHER PROGRAMS

At the time of approving the MGHN proposal, the program advisory committee (PAC) had noted that since facilities under the MGHN cover all districts in UP and provide standardized quality services, these facilities could be accredited for government schemes. The PAC saw a potential for the MGHN to be a launching pad for government schemes such as JSY, social marketing of IUCDs, among others.

There are various national and state government schemes designed to tap the private sector for providing health services. The private sector is not very forthcoming to link with these schemes due to delays in reimbursement, lengthy administrative processes and follow up requirements. However, as part of the network, the franchisees had the option of availing these schemes with the franchisor liaising with the government departments to speed up processes and claims.

The schemes and programs routed through or linked with the MGHN were:

- Voucher System: A demand side financing mechanism was being operationalized in five select cities of UP for below poverty line (BPL) families. Eighteen Merrygold facilities in these cities were accredited under the voucher system and BPL families could avail cashless FP/RH services by redeeming their vouchers.
- Family Planning Sterilization Scheme: The franchisor supported franchisees in getting accreditation for the centrally sponsored scheme to compensate acceptors of sterilization for loss of wages. Sixteen Merrygold facilities were accredited in August 2011 and availed this scheme.
- Rashtriya Swasthya Bima Yojana (RSBY): A state implemented health insurance scheme for the poor, the RSBY provides Rs. 30,000 (USD 600) annual cover to a family. Thirty-nine Merrygold facilities were empanelled under RSBY by February 2012.
- Soubhagyavati Yojana: Another conditional cash transfer scheme specifically for the private sector is being revived in the state. Merrygold facilities that are not included under RSBY and wanting to be included in the scheme will be accredited and empanelled. This process was being facilitated by the franchisor at the time of writing this report.

4.11 HOSPITAL INFORMATION MANAGEMENT SYSTEMS (HIMS)

An elaborate and exclusive information system leveraging technology for collection, storage, retrieval and communication of data was developed for the MGHN. The HIMS was modular and integrated, had web enabled browser interface, and was designed with user-friendly interface that would enable client centric clinical decisions while ensuring quality of care. The HIMS included modules for registration, duty roaster, in-patient management, nursing station, operation theatre, management information systems, electronic medical and clinical records, billing, security and administration, pharmacy, housekeeping, laboratory, personnel, payroll, stores, and financial accounting.

The system was developed with a leading software developer, namely WIPRO. Consultations for identifying indicators for inclusion in the HIMS and establishing process flows resulted in the development of a comprehensive system. This system was pretested and then finalized for implementation with all the Merrygold franchisees.

The HIMS has been installed at all Merrygold franchisees.HLFPPT reports that, to date, 13 out of the 67 L0 and L1 facilities had established HIMS systems connected to a data processing unit at the HLFPPT office. The system is already functional and processing data.

4.12 MONITORING SYSTEMS

Performance of the franchisees was tracked on a monthly basis on four variables of volume, value, cost and profitability by the franchisor. Indicators for monitoring and evaluation of the project were agreed upon at the time of initiation. These included indicators for a) increased demand in social franchise services; b) consistent and improved quality and range of products and services provided by franchisees; and c) enhanced capacity of franchisees to sustain a profitable practice. Periodic reviews and assessments of the MGHN were conducted by the IFPS Project to assess progress of the network on these indicators. Some of

the external studies conducted for the network include:

- A post-launch review in December 2007
- A verification study of implementation components in 2008
- A quantitative mid-term assessment of franchise owners and consumers in 2009
- A qualitative mid-term assessment in 2009
- A brand image qualitative study of Merrygold facilities and its competition, in 2011
- An external proposal of a revised business plan for the Merrygold health network in 2011
- A verification study of MGHN in 2011.

In addition, monthly reports were submitted by the franchisor to SIFPSA providing details of L1s, L2s and L3s included in the network, number of marketing, training and field activities carried out, and service output data capturing ANC check-ups, deliveries and sterilizations, among others, conducted through the network.

Since the project was funded through the performance-based disbursement mechanism (see Section 5), the franchisor submitted the reports to SIFPSA against indicators related to franchisee numbers, office set-up, trainings conducted, as well as branding and on-ground communication activities conducted.

Chapter 5

FUNDING MECHANISM AND FINANCIAL STATUS

The social franchising project, like most activities under the IFPS Project, was funded through a mechanism of performance-based disbursement. A set of results, called benchmarks, were agreed upon by USAID and SIFPSA along with the amount required for activities to achieve the desired results. A total of 19 benchmarks were developed for the social franchising activities over the period March 2007 to February 2011. An initial amount of USD 5.10 million was approved and benchmarked for the project. Based on a strong need for intensifying branding and communication activities, an additional amount of USD 1.01 million was later programmed. Therefore, a total of USD 6.11 million was benchmarked and disbursed from USAID to SIFPSA. SIFPSA had, in turn, formalized a performance-based contract with HLFPPT, with benchmarks determined by those between USAID and SIFPSA. Funds were released once these benchmarks were accomplished.

The MGHN is a unique model that combines expansion with sustainability. Such a model was being implemented for the first time in India and required flexibility to revise operations and milestones while implementation. However, since development of benchmarks involved a long process, these revisions were difficult to formalize. This was a challenge for implementation, especially for a nascent model such as the MGHN.

A corpus was established with SIFPSA at the beginning of the project to meet operational costs of the network beyond the implementation period. With income generated from health services, collection from franchise fees and other sources, this corpus has grown to Rs. 31.5 million (more than USD 700,000) (HLFPPT, 2012). As the model matures, there is a need to shift the focus to a for-profit social franchise model while maintaining its focus of providing affordable, quality healthcare. A revised business planning exercise conducted in 2011 demonstrated that the MGHN could meet its operational costs and be profitable in another four years (Ernst and Young, 2011).

Chapter 6

MAIN ACHIEVEMENTS

Through the course of implementation, the MGHN has expanded and is now operational in 36 districts across UP. It has been successful in bringing together more than 430 (67 L1s and 367 L2s) hitherto disaggregated private health service providers and nearly 10,000 community level workers into the folds of the network, making it one of the largest networks in India (Schlein, 2011). Given its geographical spread and reach into rural areas also, the network has been able to provide comprehensive FP/RH services across districts.

Periodic reviews, assessments and surveys conducted for MGHN indicate that the network has made progress as highlighted in the following sections.

6.1 DEMAND FOR SOCIAL FRANCHISE SERVICES

For health services, Merrygold is a nascent brand as yet. Brand building and communication inputs were designed to reach the economically disadvantaged sections in rural, semi-urban and urban slum areas. More than 45 percent expenditure incurred by the network was on brand building and marketing, and this share increased to 58 percent with implementation of a revised behaviour change communication (BCC) budget (Ernst and Young, 2011).

From October 2007 till February 2012, the network has provided more than 756,100 ANC checkups, nearly 133,900 deliveries, more than 10,600 sterilizations and nearly 38,200 IUCD insertions. In addition, with condoms and oral contraceptive pills, the network has been able to generate more than one million couple years of protection (MGHN MIS, Feb 2012). The MGHN has been able to save many lives of mothers and children (See Box 2).

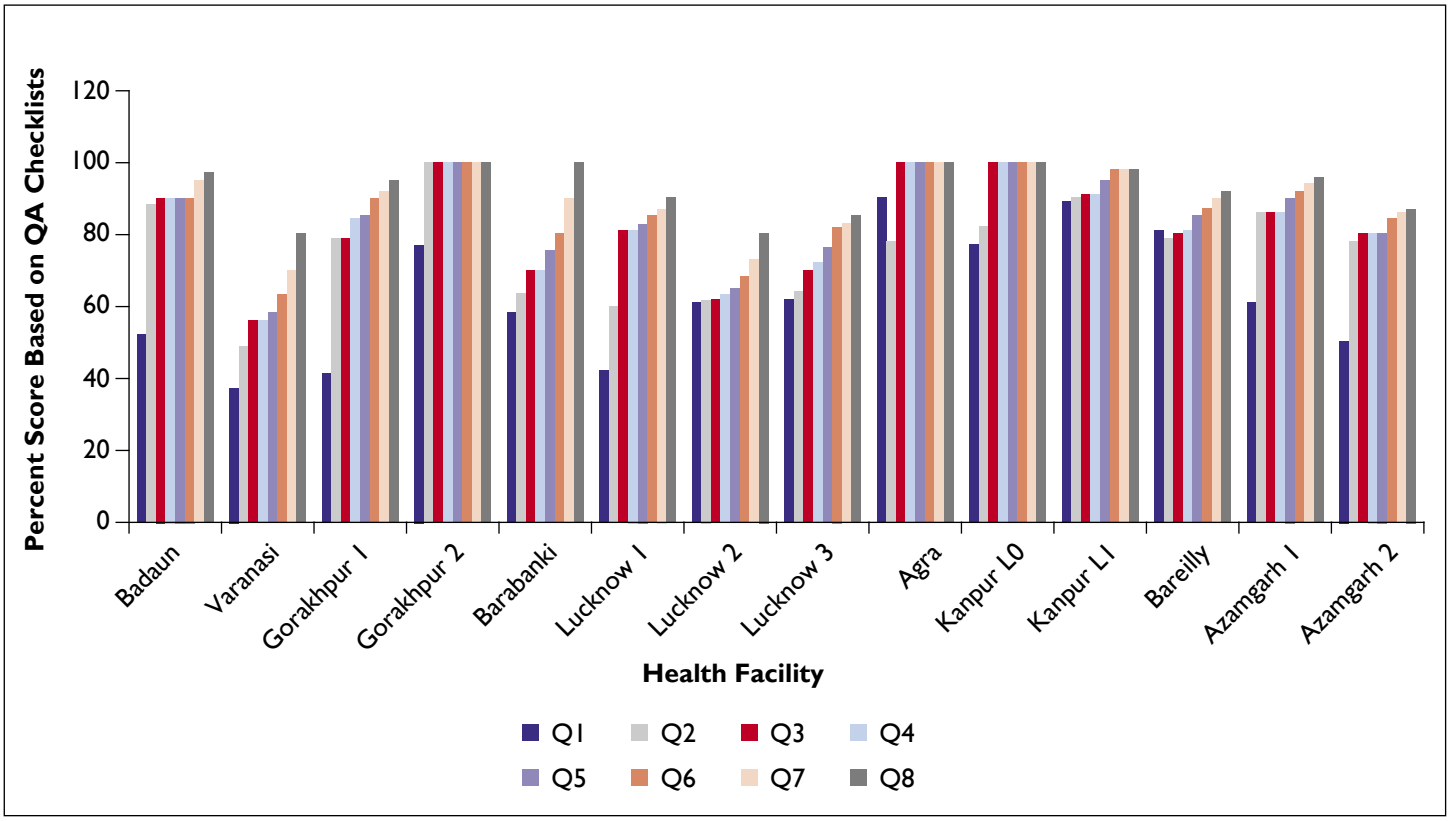
Studies revealed that of the women, mothers-in-law and husbands who had ever heard about MGHN, more than 78 percent eligible women (n=474), 75 percent of the mothers-in-law (n=114) and 84 percent husbands (n=100) had seen at least one promotional material of the MGHN. Of the women who had seen the promotional material, more than 79 percent (n= 370) also recognized the brand through marigold flower. Nearly 60 percent of the women (n=474), 76 percent of the mothers-in-law (n=114) and 52 percent husbands (n=288) were aware of at least two RCH services offered by MGHN. The primary services mentioned by the respondents were delivery, pregnancy care, PNC and FP services (Nielsen, 2009).

6.2 IMPROVED QUALITY OF SERVICE PROVISION

Client satisfaction with the network was high. Thirty-eight percent of the women rated that they were 'very satisfied' and 53 percent as 'satisfied' (n= 66) with services received at the network (Nielsen, 2009). Indicators for client satisfaction included convenient location of health facility, personal attention provided by health professionals and paramedical staff, technical skills and qualifications of providers, explanation of procedure, cleanliness of facilities, and duration of waiting time. Of all the women who knew about MGHN, 65 percent reported they would visit the facilities again and 90 percent would recommend the network to a friend.

Ninety-eight percent of the L1 facilities had a doctor available 24x7 for health related emergencies (n=59). Availability of a full-time doctor improved from 62 percent (n=28) in 2009 (Nielsen, 2009) to 81 percent (n= 59) in 2011 (NCorporate, 2012)

FIGURE 3: COMPARATIVE ANALYSIS OF QUALITY ASSURANCE SCORES FOR L1 HEALTH FACILITIES



(*not statistically significant*). Medical audits conducted from September 2009 to August 2011 indicate that there is a significant improvement in quality standards of facilities. The transition of facilities over eight medical audits to meeting more than 80 percent of the QA indicators can be seen from Figure 3.[6]

From the franchisee perspective, nearly 80 percent were satisfied with the quality of training provided to their staff and the QA system managed by franchisor (Nielsen, 2009). These aspects were also reflected through the findings of other studies (E&Y-2010-11, Brand Equity-2011) wherein the franchisor had agreed and valued their association with MGHN and its strong QA protocols due to which they have been able to upgrade their service delivery system.

6.3 ENHANCED CAPACITY OF THE FRANCHISEE TO SUSTAIN PROFITABLE PRACTICE

A comparison of caseload data for L1 facilities that had been in the network for two years indicated that services uptake had more than doubled. On an average, normal deliveries increased from three per month to eight per month, cesarean deliveries from two per month to four per month, and ANC check-ups increased from 20 per month to 75 per month (Ernst and Young, 2011).

"It has been a nice experience being part of the MGHN. The purpose of MGHN is good and it has helped to increase institutional deliveries and provided services to poor at a subsidized rate. We want to remain connected with this network."

Merrygold Franchisee,
Kanpur Nagar, UP

[6] Medical audit findings are presented here for 14 facilities that have been in the network long enough to have gone through eight rounds of medical audits.

BOX 2: MERRYGOLD HEALTH NETWORK: TOUCHING LIVES, MAKING A DIFFERENCE

Following are the stories of women and families whose lives have been impacted by the availability of quality and affordable healthcare facilitated by the MGHN. These families could not afford private healthcare that the network made available to them at highly subsidized costs.

- **Hemorrhage**: In a state of distress, 25 year old Kiran was admitted to a Merrygold hospital in Badaun district in Uttar Pradesh. In the final stages of pregnancy, she started to bleed heavily. Phulwa, a Merrytarang member, recognized the danger signs and accompanied Kiran to the nearest Merrygold health facility. Timely medical attention saved her life as doctors performed an immediate surgery and delivered an underweight baby girl. With continuous PNC, the child and the mother recovered their health. Kiran used the Merrygold service for regular medical checkups for her child, and went on to adopt a spacing method for FP.
- Shabnam was in the final stage of her pregnancy, when her own and her child's health were at risk. A village midwife told Shabnam and her husband that their child had stopped growing in the womb. In an hour of emergency, the couple decided to immediately seek medical help at a private nursing home accredited under MGHN, in district Badaun of UP. With access to timely medical attention, Shabnam delivered a healthy baby girl.
- **Premature Pre-labor**: Renu was eight months pregnant when she developed multiple complications that posed a risk to the lives of both her and the child. She could not afford private medical care and did not have a BPL card either, which entitles women to free ANC and delivery care under government schemes. Renu's family learnt from a neighbor about the benefits of MGHN available in Agra. They sought medical help at a Merrygold health facility where doctors took charge of Renu's situation and managed her complications. Within 24 hours, she prematurely gave birth to an underweight baby girl; the child was kept in intensive care for a week. The mother and baby were monitored in the hospital for eight days. Her medical bill was only a small percentage of what she would have paid for private health care, and importantly, did not put her family in debt.
- **Post-partum Hemorrhage at Home:** While Kaliya was delivering her fifth child at home, she suffered a hemorrhage. The bleeding went on for several hours.

(Continued on next page)

Her family sought help at a Merrysilver clinic where doctors referred her case to a Merrygold hospital for specialized care. Kaliya was transferred to the hospital by an ambulance sent to her house. The doctors diagnosed remnants of the placenta and treated it immediately. The Merrysilver and Merrygold facilities saved Kaliya's life.

- **Obstructed Labor at Home**: During home delivery, Kasmiri suffered labor pains for over 36 hours. A midwife and Kasmiri's mother, attending to her, were not aware that prolonged labor risked her life. Only after Suman, a Merrytarang volunteer intervened, Kasmiri was rushed to a Merrygold hospital in Gorakhpur. Doctors found the baby in distress, and performed immediate surgery. The child, born with breathing trouble, got medical attention at the hospital that put him on the path to recovery.
- **Cord Prolapse:** A highly common cause of infant deaths/stillbirths in India is chord prolapse. In Urmila's case, doctors at a Varanasi Merrygold hospital identified the condition in time, saving two lives. Urmila was admitted to the hospital with complications. As she went into labor, doctors apprehended the risk of a prolapsed cord and performed C-section. The newborn's health was monitored and Urmila was counseled by the staff on FP.
- **IEC leads to improved health-seeking behavior:** 22 year old Firdaus Jahan decided to get complete antenatal and delivery care, after she heard a radio jingle on Merrygold Health Network. She had seen women in her village suffer during home deliveries, but says she couldn't have availed private medical help without the subsidized care offered by MGHN. The facility was available close to her village in Amroha block. Firdaus availed complete ANC services at the facility and gave birth to a healthy child at the clinic.
- Sunita's mother-in-law influenced her to deliver at a Merrysilver clinic in their home town Mathura. This change in attitude of families to opt for institutional delivery has occurred as the Merrygold network gained popularity for offering affordable and quality medical care, especially for delivery and ANC. Sunita delivered at a Merrysilver clinic, where she plans to come back for her second child. She also received FP counseling.

Chapter 7

INSIGHTS FROM IMPLEMENTATION EXPERIENCES

7.1 ENGAGEMENT OF PRIVATE SECTOR

The project proved that within the context of provision of FP/RH services through the private sector to low income consumers in UP, the social franchising project was eminently feasible, even in peri-urban and rural areas. The private sector providers were certainly willing to invest in joining a franchise network that offered quality care at discounted prices offset by improvements to operational cost efficiency. Improvements in quality, continuous medical education and a strong brand that attracts customers have been the major attractions for the franchisees.

At the time of inception, it was envisaged that franchisees setting up green-field projects will be preferred as partners. The green-field projects initiated during the course took at least 2–3 years for completion of construction and initiation of service delivery. Social franchising was more effective with brown-field franchisees, especially those with nascent practice set up.

A need was also felt for a platform for interaction between the franchisor and franchisees. Regional Franchise Advisory Councils involving franchisor representative and franchisees could be formed in the next phase which would provide inputs for communication and resolve any disputes during operationalization.

7.2 SUSTAINING A FOR–PROFIT BUSINESS APPROACH

Proving that the social franchise could be sustained on franchise fees could not be accomplished over the duration of the project. A thorough analysis of the reasons for this was undertaken through periodic reviews, assessments and evaluations. Inputs from these studies were used to draft a revised business plan for MGHN. This plan suggested that with strategic and tactical revisions, the project had the capacity to meet its for-profit goals. It also emphasized ensuring timely fixed royalty fee payment by all the franchisees for achieving this objective. There was a need to first consolidate the network and then expand. However, it would be realistically feasible to achieve this aim within a period of three to four years.

7.3 BRAND IDENTITY–QUALITY AND PRICE

The social franchise brand identity built in the private sector cannot rely on a price advantage alone. A lower price is no predicator of quality. The premise must be built on the combined benefits of low price and quality, and be presented in an appealing, attractive and believable (rational) manner. The Merrygold franchise presented this correctly, as a combination of good quality and low price, but to get this across as a distinguishing factor appeared to have taken significant time. This may be because facilities were judged more by the reputation of the individual provider at any franchise facility as against a 'brand' promise per se. Thus, personal recommendation appears to be a crucial factor that can only be built over time, even when supported by significant mass media and a mass promotional campaign. Promotional strategies to enhance word of mouth recommendations should be put in place. A strategic plan to strengthen brand equity among target audiences also needs to be developed and implemented. A brand equity assessment has been conducted and will provide inputs for future activities.

7.4 PERFECTING THE BUSINESS MODEL

There is a need to balance moving to scale quickly so that the cost benefits

of scale may be realized with the issue of the need to test a viable business model before it is rolled out.

In this project, the model for L1 facilities was somewhat tested within the existing hospitals owned by the franchisor but the model for L2 facilities and their purpose as a driver of referrals to L1 hospitals, and the impact of L3 on demand equation could not be thoroughly tested before launch.

Essentially, the project was both testing out a business hypothesis and rolling it out at the same time. Such an approach could not take place in the commercial franchising sector. The commercial franchising sector adapts a proven business model, a model that may have taken many years to perfect, and then rolls it out. For MGHN, this may well have been unavoidable considering the demands placed on the project by the time-scale given to it. However, it added significant stress to the management of the project in allocating time and resources between meeting its roll-out goals and perfecting a complex business and operational model. This also affected the adherence to contracts by the franchisees.

The growth rate of the MGHN should be derived from the stage of development of the franchise package and testing. Where donor and project time-frames cannot permit a socially franchised business model to be developed through an extended pilot phase, very careful monitoring and evaluation is required so that problem issues can be identified and addressed early on.

While the MGHN was monitored periodically through the earlier mentioned reviews and assessments, indicators to review the business model were not included. Indicators such as income from franchise fees and steps towards attaining a profitable franchise operation need to be included in the monitoring system for subsequent phases of the network. In addition, revision of contracts to empower the franchisor and enforcement of these contracts is required without delay.Regular reporting from the franchisee to the franchisor using the HIMS will have to be mandatory under these revised contracts.

7.5 FAMILY PLANNING AND PREVENTIVE CARE

The lack of motivation of the private sector franchisees/providers to spend time on counseling for FP and preventive care needs to be addressed for MGHN. Recommendations for developing a broader package of services are yet to be implemented. Complete packages offering prenatal care through the first two years of the child's life, with payments made based on a predetermined schedule need to be developed and finalized. This would make the inclusion of counseling financially more attractive to the franchisee.

7.6 REFERRAL NETWORK

The hub and spoke model designed for MGHN, in which L2 facilities would refer complicated and cesarean cases to L1 facilities, did not mature as expected.The initial concept that L2 facilities would be based at AYUSH providers had been shifted to appointing MBBS or homeopathy private sector medical providers as required by GoUP directives. As a result, L2 providers were providing services, more or less, in the same manner as L1 facilities. Very few referrals, if any, were being made. C-section deliveries or other surgical services were being performed at the L2 facilities (if the personnel at the facility were qualified to perform those) even though they knew that this was not in accordance with their contractual arrangement under the franchise. Many L1 facilities looked at L2 facilities as a source of competition rather than a source of referrals. In addition, the existing referral system was well-established and deeply entrenched, with each private provider having their own operational referral network. It was therefore recommended that the referral system needed to be reworked with a single level of service facility (whether urban/peri-urban or rural-based), each with its own dedicated service area and served by a cohort of Tarang field-extension workers.

It was difficult to manage such a large force of more than 10,000 workers at the Merrytarang level. Issues of attrition, and repeated orientations and trainings increased the cost of operation of the network (Ernst and Young, 2011 and NCorporate, 2011). There was a need to consolidate the Merrytarang network as well as introduce a referral fee that is competitive in the market.

Chapter 8

WAY FORWARD FOR MERRYGOLD HEALTH NETWORK

Bearing in mind the lessons learned in establishing an extensive ambitious network such as the MGHN, a revised business plan was developed for the network. The plan developed in April 2011 proposes several variations and scenarios for the franchisor to strengthen the network. It has been suggested that recommendations from the plan and other studies be implemented in a phased manner– the consolidation phase and the expansion phase.

The plan suggests the following:

- Shift and re-focus the strategic direction of the MGHN to the original for-profit and sustainable social franchise model. The detailed business plan demonstrates that over a period of three, or at the most four years, the franchise should be profitable.
- Retain the present emphasis on 35 key districts in order to consolidate the system. However, it has been noted that an increase to 40 districts could be achieved without increasing the present franchisor's management costs.
- Consolidate L1 and L2 franchises into a single network. However, no referral mechanism between them is assumed.
- All new franchisees would pay a start-up franchise fee and all franchises will pay monthly or quarterly franchise fees. Periodic fees should be fixed according to the number of beds in the facility and rise over time, and not according to the percentage of sales (for account verification reasons).
- Any franchise can be a full or fractional franchise. MGHN needs to constantly consider expanding the health service offerings according to the respective size of facilities and qualifications of the franchisees and their staff.
- The value of Merrygold facilities as offering a combination of 'Quality plus Price' advantages over competition needs to be strengthened.
- Build an HIMS that can be 'sold' to the franchisees as a tool to improve the performance, including profit performance of their facilities.

The business plan offers convincing, external evidence of the intrinsic value of the franchise and its potential for success. It proposes that the franchise, suitably modified, should be able to obtain financial sustainability in about three to four years.

The implementation of the MGHN has demonstrated that a social franchise fills in the need for private sector providing quality FP/RH services. The project had demonstrated that social franchising, as a model, was capable of harnessing substantial private sector resources in health and could be rolled out and expanded quickly. Support to the model for another few years with a focus on revenue generation, while meeting its social objectives, will enable a sustainable network of health facilities in rural UP.

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Errata

Chapter 5, Page 22, Column 3

"A Corpus was established with **SIFPSA** at the beginning of the project to meet operational costs of the network beyond the implementation period."

should read

"A Corpus was established with **the Franchisor** at the beginning of the project to meet operational costs of the network beyond the implementation period."

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