Part One: (B) Impact of Private Clinic Networks on Service Access

Amy Tsui

Dr. Tsui, of John Hopkins Bloomberg School of Public Health, discusses the findings from her research on private provider franchises in Ethiopia (Biruh Tesfa & Marie Stopes), India (Janani), and Pakistan (Greenstar). The presentation provides a definition of a social franchise and discusses the benefits of social franchising. The presentation also includes findings of her research study with a particular emphasis on the impact of these franchises on quality and access to reproductive health services.
RESOURCES: To access resources relevant to this subject matter, please select one from the box at the top right hand corner and click on view. This will take you to a PDF or a link where you can download the document.

To ask a question or post a comment, click the Contribute button at the top of this page. Dr. Tsui will answer your questions starting on November 16, until then, PSP-One's Senior Networks Advisor Sara Sulzbach will respond to all questions/comments

Denise Averbug
Nov 12 2006 7:58PM
Can you describe a little more the relationship between the franchisor and the franchisee? Does the franchisee have to pay the franchisor in order to be part of the network? If so, is this usually a flat fee or a percentage of revenue? What does the franchisor get in return? Are there any examples from other countries of networks that have been shown to successfully provide quality services in a sustainable way?

Sara Sulzbach
Nov 12 2006 8:22PM
Hi, my name is Sara Sulzbach and I'm the Senior Networks Advisor for the PSP-One project. I'm providing comments for all questions until Dr. Amy Tsui can respond on Thursday the 16th.
The relationship between the franchisor and individual franchisees is an important one, and is influenced by the type of agreement between the two entities, as well as by the benefits and obligations of franchise membership. In a typical social franchise, there will be some type of written agreement between the two entities that will outline both the requirements for membership in the franchise, as well as what benefits the franchisee can expect to receive in return. The written agreement will specify requirements for membership, such as training attendance, services which must be provided, quality standards which must be adhered to, routine reports on sales or service statistics, and any required fees. This agreement may also describe what the franchisor will provide to franchisee members, in the way of training and technical assistance, promotion, product procurement, assistance with information management systems. Franchise fees can range from one-time or annual membership fees, to fees to cover the costs of training, to royalties (paying a percent or flat-fee per specified services or sales).
In terms of examples of sustainable franchises, while many social franchises strive for both health impact and financial sustainability, achievement of sustainability (that is, less

reliance on external funding) has proven to be a challenge. There are examples of private provider networks that are making good progress towards financial sustainability (e.g. Janani in India, PROSALUD in Bolivia), but in both cases these networks have been in existence more than a decade, indicating that financial sustainability is not typically achieved overnight. A franchise of private midwives in Peru, known as RedPlan Salud, is reportedly self-sustaining after just a few years, aided by a partnership with two pharmaceutical companies which provide discounted commercial FP products.

Jeffrey Barnes
Nov 13 2006 7:19PM
Of the franchises which you mention as achieving some degree of sustainability, how good a job have they done in reaching rural and lower income consumers?

Sara Sulzbach
Nov 13 2006 8:42PM
Of the three networks I mentioned, PROSALUD in Bolivia has largely focused on urban and peri-urban settings. Janani, through its Surya and Titli networks, operates both in urban and rural settings. The Surya clinics are largely based in urban areas, whereas the Titli providers (rural medical practitioners) are populated in rural areas, where RH/FP needs are great. RMPs primarily provide non-clinical services, and refer to the Surya clinics for services they cannot provide. As for RedPlan Salud, this network of midwives began in urban areas of Lima, and then expanded into a few additional urban/peri-urban areas. Having achieved some success in these urban settings, the network is in the process of expanding into rural areas.

olayinka Ayankogbe
Nov 16 2006 1:04PM
Dear Dr Amy,
i was not able to hear your presentation properly . Your voice was breaking.I was not able to view the power point slides as well. But tell me one thing. These arrangements for private sec or involvement seem to me to mean foreign organisations setting up shop in developing countries.Can the in-country organisations be empowered to offer all these range of services that the foreign organisations definitely have more expertise in doing-Kind of knowledge transfer?
Thank you

Yinka

Doug Eisengrein
Nov 16 2006 8:06PM
Yinka,
I have answered the issues you are having with the multimedia presentation and the PowerPoints in an email directly to you. We hope this helps! Please let us know if you need further assistance.
Best regards,
Doug Eisengrein

iCohere Support

Denise Averbug
Nov 17 2006 5:13PM
Hello Dr. Tsui,
At the end of the presentation it is mentioned that government health facilities are the leading sources of health care in the study settings. Did you look at the trends for use of those sources over the study time? That is, do you have any information on whether there was a change in public/private sector share for RH services over time?"

Amy Tsui
Nov 17 2006 8:26PM
Dear Yinka,
Thank you for your question. The social franchise models all involved a partnership between the US funding source and an international organization with an in-country registered NGO office. The external funding source was hoping the concept would take off and be self-sustaining, obviously. So there was no interest on their part to fund a franchise network in perpetuity. Their motivation is to see affordable and quality RH services reach the targeted poor. The local registered NGOs, in turn, hope the networks can be financially viable by increasing their services and product mix to build the client base, while not losing sight of the original social mission. In a sense, these networks are capitated by local organizations with local staff and a program delivery experience that is very much locally owned and built through inevitable trial and error during implementation. The same could have been achieved if a local social entrepreneur had originated the concept, established the network and found initial financing for the franchise.
Regards,
Amy

Amy Tsui
Nov 19 2006 1:00AM
Thank you for your question.
There was no significant increase in the % of clients seen for RH at private compared to government facilities over time; however, there was an increase in the # of RH clients seen at private facilities. Since the total # of clients went up for private and government facilities, the % being seen for RH services did not. One noticeable change was in the # of clients coming to private facilities for child health and immunization care, most noticeably in Ethiopia. This may be related to the RH franchising efforts.