Public Policy and Franchising Reproductive Health: Current Evidence and Future Directions

Guidance from a technical consultation meeting

World Health Organization

USAID FROM THE AMERICAN PEOPLE

PSP-*One* PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

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Contents

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Section I

Introduction

The rapid growth of the private health sector in low-resource countries is widely recognized. Private providers commonly deliver a substantial proportion of health services in most settings, particularly outpatient primary care, that include reproductive health services. Whether the reason is convenience, proximity or the perceived higher quality and confidential nature of private healthcare providers, the fact remains that a considerable number of women turn to the private sector for their reproductive health needs. In many Asian and Latin American countries, the private sector – through clinics, hospitals, pharmacies or nongovernmental organizations – provides more than 50% of all contraceptives.[1] Recent evidence from sub-Saharan Africa indicates that approximately one third of all family planning methods are obtained through the private sector.[2]

In general, consumers spend a substantial amount of personal resources on obtaining services from the private health sector. For the poor, these expenses can be substantial, even catastrophic. According to recent estimates, resources spent on health care represent the largest share of out-of-pocket spending by households.[3] In sub-Saharan Africa, over 50% of expenditures on health are private, primarily out-of-pocket, payments by families.[4] Even the poorest households in Africa seek care from the private sector, demonstrating a willingness to pay for health services, particularly curative care. Approximately 49% of the poorest wealth quintile in sub-Saharan Africa who sought treatment for childhood diarrhoea did so from a private healthcare source.[5]

Although many governments, for a variety of reasons, have been slow to react to the expansion of the private health sector there is now widespread recognition of the need to engage the private sector in healthcare delivery. Implementing properly designed and financed public health policies with the help of the private sector can expand access to health and social services among low-income households. Implementing a public-funded health programme through the private sector (e.g. through an insurance programme, use of vouchers or direct contracting mechanisms) is operationally easier when private providers are organized into formal associations or networks. Governments need to carefully examine different policy options that facilitate the formation of such organizations and work with existing professional associations to develop private provider networks that benefit their members, complement the public sector's efforts, address health consumer needs and further national health goals, including ensuring equitable access.

Through public policy, governments and international donors can have substantial influence on increasing the private sector's involvement in reproductive health services. Although specific public policy efforts

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1 Winfrey W, et al. *Factors influencing the growth of the commercial sector in family planning service provision.* Washington, DC, USAID, 2000: (POLICY Project Working Paper Series No. 6).

2 Zellner S, et al. *State of the private health sector wall chart.* Bethesda, MD, Private Sector Partnerships-*One* Project, Abt Associates, Inc., 2006.

3 Financial resource flows for population activities in 2003. New York: UNFPA, 2003.

4 *The World Health Report 2005*; *make every mother and child count.* Geneva, World Health Organization, 2005. http://www.who.int/whr/2005_en.pdf (accessed on 27 August 2007).

5 Marek T. *Trends and opportunities in public-private partnerships to improve health service delivery in Africa.* HRH Global Resource Center. http://www.hrhresourcecentre.org/node/105 (accessed on 27 August 2007).

regarding the private sector will largely depend on individual country context, the following three broad approaches may be useful in guiding discussions:[6]

(i) Expanding healthcare access by engaging a range of private sector providers;

(ii) Harnessing and organizing existing private sector providers into a cohesive network to improve quality and ensure equity;

(iii) Shifting the burden of public financing of private healthcare sector among those able to pay for its services.

To assist policymakers and researchers to take advantage of lessons learned in the area of private-provider networks, particularly franchises, and to explore the types of policy options available to facilitate a greater role for the private sector, the World Health Organization's Department of Reproductive Health and Research, in collaboration with the United States Agency for International Development's (USAID) Private Sector Partnerships-*One* project, convened a technical consultation from 7 to 9 December, 2006 in Geneva, Switzerland. The meeting, entitled "Public Policy and Franchising Reproductive Health: current evidence and future directions", brought together experts in private-provider networks and franchises as well as in public policy. The consultation:

- Reviewed the evidence to date on the performance and impact of health networks and franchises in low- and middle-income countries;
- Explored public policy options that can facilitate and support the delivery of reproductive health through private-provider networks and health franchises in low- and middle-income countries.

This Guidance Note is based on the proceedings of the meeting and offers policymakers and researchers the latest evidence on private-provider networks and franchises, lessons learned in the field, and policy recommendations on how to mobilize private-provider networks and health franchises to help address reproductive health care needs in developing countries.

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[6] Harding A, et al., eds. *Private participation in health services*. Washington, DC, The World Bank, 2003 (Health, Nutrition and Population Series).

Section II

The case for franchising reproductive health services

Support for engaging the private health sector

Developing countries face many challenges in meeting the ever-growing healthcare needs of their populations. For example, by 2015, the number of contraceptive users in poor countries may grow by more than 200 million – driven by increasing demand and population growth.[7] Declining or unpredictable funding for some elements of a comprehensive reproductive healthcare programme may restrict access to priority healthcare services offered in public health facilities. During the past five years, the annual amount of donor funding for family planning services decreased dramatically – from US$ 723 million in 1999 to US$ 423 million in 2003.[8] In the same period, government funding for family planning services decreased by nearly 10%, while the overall support for reproductive health remained fairly constant, despite a growing demand. The funding shortfall for family planning varies from region to region, but it is particularly acute in Africa. Whereas US$ 270 million was required for family planning in Africa in 2006, donor funding and domestic resources combined totalled only US$ 200 million, resulting in a shortfall of US$ 70 million for that region alone.[9] The widening gap between insufficient donor and public funding and the rapidly increasing demand for family planning is but one reminder among many others for governments to develop effective policies and partnerships with the private health sector for reproductive health services. Such a partnership can increase the efficiency and sustainability of the overall healthcare delivery system, as well as respond to global calls for universal access to reproductive health services by 2015.

Defining the private health sector

The private health sector is comprised of a heterogeneous mix of both for-profit and not-for-profit entities operating outside the domain of government. The for-profit sector includes individual private practitioners (e.g. doctors, nurses, midwives, etc.), hospitals, clinics, pharmacies and chemist shops, labs and diagnostic facilities, pharmaceutical wholesalers, distributors and manufacturers, and private health insurance companies. The not-for-profit sector includes nongovernmental organizations (NGOs) and faith-based organizations (FBOs).[10] The commercial and NGO sectors, together with the public sector, comprise the total health sector.

The rationale for franchising reproductive health services

Private-provider networks are viewed as an effective business model because of their potential to rapidly expand the supply of health services, promoting universal access and contributing to national health goals. Networks can be constructed in organizational systems that are conducive to a number of interventions that have been shown to improve health outcomes, such as training, performance-based incentives, accreditation and financing mechanisms.[11]

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[7] *The unfinished agenda: meeting the need for family planning in less developed countries*. Washington, DC, Population Reference Bureau, 2004.

[8] Financial resource flows for population activities in 2003. New York, UNFPA, 2003.

[9] Cleland J, et al. Family planning: the unfinished agenda. *Lancet,* 2006; 368:1810–1827.

[10] Zellner S, et al. *State of the private health sector wall chart*. Bethesda, MD, Private Sector - Partnerships-*One* Project, Abt Associates, Inc., 2006. -

[11] Prata N, et al. Human resources and health franchising in Africa. *Bulletin of the World Health Organization* 2005;83:274–279. -

Private-provider network – an affiliation of health service providers (members) who are grouped together under an umbrella structure or organization (parent).

Private health networks offer the potential to improve the quality of health services and expand the scale of private practice, thus contributing to broad public health objectives. Unique aspects of such networks include the ability to:

- Organize often isolated private providers to offer standardized, quality health services;
- Benefit from economies of scale in training, capacity building, product procurement and distribution, and advertising;
- Rapidly expand service outlets and introduce or add new products and services, thus increasing access to priority health services;
- Negotiate financial reimbursement mechanisms, such as contracts for services with government, whereby the parent acts as the central point of contact.

Networks can take many forms but, in general, they can be considered as an affiliation of providers grouped together under a parent organization. One way to categorize private healthcare networks, based on stated objectives and ownership of service delivery points, results in three types of networks: social franchises, not-for-profit networks and for-profit commercial businesses.[12] There are different benefits to each type of these networks, but all aim to provide a degree of uniformity in the range and quality of health services provided, in addition to passing on savings or other benefits to its members in areas such as training, procurement of equipment and supplies, and advertising. With respect to promoting reproductive health, both social franchises and not-for-profit networks have been the most prevalent. While both types have a social orientation, a key difference lies in the ownership of individual service delivery outlets. Whereas, in a social franchise, outlets are owned by independent health practitioners, in a not-for-profit network, outlets are owned by a non-profit organization or nongovernmental organization. The range of network types is defined in Box 1.

Social franchising is a variant of the commercial franchise model, which is defined as "a contractual relationship between a franchisee (usually a small business) and a franchisor (usually a larger business) in which the franchisee agrees to produce or market a product or service in accordance with an overall blueprint devised by the franchisor."[13] In a commercial franchise, the range and quality of services are standardized and identified with a branded name (or logo); the overall arrangement is governed by a contractual relationship between the franchising organization and the providers. In commercial franchises the franchisee will commonly pay an upfront fee to "buy into" the franchise and pay periodic fees (e.g. royalties, membership) in return for receiving a tried and tested operating manual from the franchisor. The franchisee assumes a financial risk, which is mitigated by a proven track record in the franchisor's commercial viability and business plan.

In a social franchise the franchisor is typically a non-profit organization that bears most of the financial risk involved in establishing franchised outlets. Operational support is provided by the franchisor, and typically involves access to commodities, supplies and equipment at reduced cost, in addition to training in clinical and business skills and advertising. In return, the franchisees are often required to pay franchise fees, maintain certain levels of quality standards, and record and report on sales and service statistics. A key distinction of a social franchise lies in the objectives of the franchise,

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[12] Chandani T, et al. *Private provider networks*: *the role of viability in expanding the supply of reproductive health and family planning services*. Bethesda, MD, Private Sector Partnerships-*One* Project, Abt Associates, Inc., 2006.

[13] Stanworth J, et al. *Franchising as a source of technology transfer to developing economies*. Special Studies Series No. 7, London, University of Westminster Press, 1995; http://www.ac.uk/IFRC/07_paper.pdf (accessed on 27 August 2007).

which are based on social, rather than business, motives. In this sense, social franchises are akin to social marketing programmes, although the focus is on health ***services*** rather than merely on health ***products***.

"Social franchising is an attempt to use franchising methods to achieve social rather than financial goals, influencing the service delivery systems of the private sector similarly to the way in which social marketing has adapted traditional outlets for commodity sales." (Montagu, 2002)[14]

Box 1.

Types of private-provider networks

Not-for-profit network – Not-for-profit networks are fundamentally guided by social rather than commercial objectives and granted not-for-profit tax status, i.e. all profits are channelled to meeting the organizational mission and are not used for individual or commercial gain. Example: PROSALUD (Bolivia).

Commercial network – A business structure in which both the parent organization and members operate on a for-profit basis. The members typically comprise one or more of the following types of providers: hospitals, outpatient clinics, diagnostic centres, workplace sites and retail pharmacies. Generally, commercial networks take the form of a holding company whereby the parent owns all or part of the member entities. In other forms, the member entities are independently owned but contracted to operate within the network. Example: Total Health Trust Limited (Nigeria).

Commercial franchise – A system whereby a company (franchisor) grants to others (franchisees) the right and licence to sell a product or a service within a specified area and to use the business system developed by the company. The business system may also include a brand name or branded products sold exclusively by franchise outlets. Example: Subway sandwich shops (global).

Social franchise – An adaptation of a commercial franchise in which the developer of a successfully tested social concept (franchisor) enables others (franchisees) to replicate the model using the tested system and brand name to achieve a social benefit. The franchisee, in return, is obligated to comply with quality standards, report sales and service statistics, and, in some cases, pay franchise fees. All service delivery points are typically identified by a recognizable brand name or logo. Example: Greenstar (Pakistan).

Historically, social franchises have been tasked with assuring the availability and quality of services, and also assuring awareness and use of those services.[15] More recently, increased attention has been paid to ensuring the financial sustainability of social franchises, particularly in the light of reduced donor funding for reproductive health and the trend towards upstream funding mechanisms. In addition, social franchises are now challenged to move beyond the pilot stage and achieve economies of scale for making greater health impact. It is this shift towards sustainability and scale which opens the door to the potential for partnership with governments of developing countries, and which calls for evolving an appropriate name for this type of network to reflect a less subsidized model – health franchise.

[14] Montagu D. Franchising of health services in low-income countries. *Health Policy and Planning,* 2002; 17:121–30.

[15] Montagu D. Franchising of health services in low-income countries. *Health Policy and Planning,* 2002; 17:121–30.

The fact that private health care is largely unregulated has raised concerns about the quality of care provided by the private sector. In the absence of regulations, private practitioners may be tempted to practice inappropriately or opportunistically; for example, prescribing unnecessary treatment or not adhering to updated norms of care. Although increased oversight and enforcement of regulations may ameliorate these concerns, in reality, health ministries often do not have the necessary human or financial resources to adequately enforce regulations in the private sector, nor is direct enforcement necessarily the most effective means of ensuring adherence to regulatory guidelines. Organizing private practitioners into a cohesive network, such as a franchise, offers a potential solution to the regulatory challenge, whereby the franchisor shares the responsibility for oversight and enforcement functions.

Section III

Franchising reproductive health: experiences, emerging lessons and future directions

Experiences

Social marketing programmes for contraceptives are the best example of adopting the private sector to social goals of substantial scale, even though they do represent a variation on the franchise model and have several important distinctions that make social marketing operations somewhat exceptional among networks of private sector providers. In general, however, international experience with health franchises in low- and middle-income countries for reproductive health programmes is a fairly recent development and most franchised networks are operating at a relatively small scale. Currently, there are approximately two dozen social franchise programmes worldwide that provide reproductive health services, and most of them have been in operation only for a relatively short period. Each of these programmes has developed in response to specific conditions of the national healthcare market and each has a different configuration of services and varying business plans guiding its operations. As such, each franchise programme is unique and highly contextualized, making generalizations somewhat problematic. However, four broad approaches can be used to describe how health franchises and networks have adapted to the healthcare market and achieved greater scale, successfully segmenting their clientele from other private and public sector providers.

- Franchised networks are providing reproductive health services that government is not able to offer due to socio-political restrictions on public sector operations. The Sun Quality Health Network (Myanmar), RedPlan Salud (Peru) and FriendlyCare (Philippines) are providing family planning services in settings where the public sector has limited the range or availability of contraceptives.
- Social franchises are extending the reach of the public sector health system, reducing the backlog of accrediting providers for specific procedures.
- In many settings, private sector networks, including franchises, have been developed in response to the need to improve quality and ensure equity through social insurance programmes. In the Philippines, PhilHealth is partnering with FriendlyCare to provide family planning and other services to the poor, for which networked clinics are reimbursed by the national health insurer. Total Health Trust, in Nigeria, is working as a type of "preferred provider organization" (PPO) to facilitate the reach of the Nigerian National Health Insurance Scheme in order to expand access to priority health services, including reproductive health (as well as to create financial space for the PPO that is favourable to its long-term sustainability).
- Franchises have begun to develop partnerships with the commercial sector to expand people's access to care and ensure sustainability. RedPlan Salud negotiated a partnership with pharmaceutical companies and distributors, whereby the franchisor (INPPARES) purchases bulk quantities of brand-name oral contraceptives at a discounted rate. These are then sold to midwife franchisees at a marked-up price. As a result of its strategic partnerships, RedPlan Salud is able to meet its health objectives and has achieved financial sustainability. In the case of Kenya, Gold Star Network was created to improve and expand coverage of subsidized antiretroviral (ART) treatment services for HIV/AIDS patients within the private sector. Franchised physicians provide these services, for which they are reimbursed by their clients' employers and private health insurance companies.

Emerging lessons

The cumulative knowledge base on healthcare networks has produced some key lessons to guide future franchise efforts. In order to increase their viability and expand access to priority health services, the following conditions are essential:

- ***Supportive policy environment conducive to private sector provision of health services***. A prerequisite to the formation of a private-provider network is an adequate pool of private providers. Regulations that govern the licensing, accreditation and range of services offered by private providers are key factors in supporting or impeding the formation of a network.
- ***Adequate institutional capacity of both franchisor and franchisees***. Strong management capacity and sound business practices are prerequisites for viable private sector networks. These are particularly important features of successful social franchises because, historically, special franchises have operated with heavy donor support during the start-up phase, and have been particularly challenged to adapt to commercial practices when donor assistance is withdrawn. RedPlan Salud in Peru and FriendlyCare in the Philippines provide two examples of success despite donor withdrawal, in part due to business orientation of their leaders.
- ***Diversification of services beyond reproductive health***. The provision of reproductive health care will generally not generate adequate revenue to sustain a network, thus requiring cross-subsidization with more lucrative healthcare services. Indeed, the imperative of having diversity of services as a means of ensuring sustainability was highlighted in the discussions on how franchises have grown to scale. Some franchises mix widely diverse healthcare services in the process (e.g. lucrative executive physical examinations for large corporations with at-cost family planning services for the indigent). How best to achieve the right mix of cross-subsidized services is highly contextualized by local market forces and the business acumen of the franchisor.
- ***Diversification of funding and financial sources***. Donor-supported networks are increasingly diversifying their revenue to sustain themselves and to provide services to the poor. Developing partnerships with the public sector (and donor agencies) to obtain support for infrastructure, subsidized goods and commodities, or direct reimbursement/third-party payment mechanisms for the poor and needy patients are being used in many settings to expand access to reproductive health services through the private sector.
- ***Cost-effective monitoring and quality assurance mechanisms*** to protect the franchise's reputation while also containing costs. Assuring quality is particularly challenging as franchises grow to scale. Networks naturally optimize their economies of scale; however, quality assurance systems do not normally benefit from scale efficiencies, as the unit cost of visits to providers and ongoing supervision may not decrease. However, alternative mechanisms may help reduce the costs of quality assurance, such as partnering with a professional association to fold franchise services into its accreditation schemes, developing peer oversight or self-assessment mechanisms, or empowering consumers to respond to signs of high-quality service provision.
- ***Understanding of and responsiveness to evolving market conditions***. A keen understanding of the health care market (from the client and provider perspectives) and an ability to respond to changing market opportunities and constraints, as well as shifts in donor priorities and funding levels, are vital for a network to survive. This can be accomplished through market surveys, ideally prior to establishing the franchise. Such surveys should also be conducted periodically as well as a close watch kept of changes in the policy and political environment.

Underlying these lessons is the recognition that trade-offs exist between serving the poor, providing a full range of reproductive health services and financial sustainability of the franchise. The inherent tension between these goals underscores the importance of public sector support for private sector provision of public health goods, a clear understanding of franchise objectives by senior management of both public and private sectors, monitoring of the partnership over time, and adapting policy and operations in response to changing market forces and public policy goals.

Future directions for health franchises

The participants in the consultation shared their insights on the future of health franchising. These include:

- Continuing the evolution that has already begun – paying increased attention to management, relying on sound business practices and reorienting the franchise to be more cost-effective through simplification and reduced operating costs.
- Recognizing the importance of cross-subsidization – this applies to clientele as well as services and products. Realistically, it is not possible to serve only the poor while trying to sustain or grow a franchise. Thus, franchises must appeal to clients with ability to pay while also working with government to ensure access to reproductive health services by the poor. The concept of "socialized pricing" could be adopted whereby a franchisor or third-party payer could subsidize certain services or certain segments of the population. In a similar fashion, more lucrative services and products (typically curative) should subsidize preventive services and products (e.g. family planning). Offering products at various price points can broaden the appeal to a cross-section of the population. The rise in the availability of generic products (such as oral contraceptives) offers an affordable and more sustainable alternative to highly subsidized socially-marketed products. Franchises, which have in the past focused on reproductive health, may be wise to integrate HIV/AIDS and, potentially, TB services, in addition to general curative services. Where legal, emergency contraception and other services can be added to the basket of franchised products, and underserved groups such as unmarried women or adolescents can be targeted in the franchise's marketing strategy.
- Adopting various levels of providers and perhaps, in the process, de-medicalizing certain health services to expand coverage. Networks are able to expand their market and diversify their service mix when they include several levels of providers. All networks can identify a range of service delivery structures that are suited to their consumer market, especially if a network serves a differentiated clientele. Franchises lend themselves to establishing several levels (cadres) of providers that can be easily linked together through an internal referral system. Rural and urban consumers may benefit from access to a variety of reliable, high-quality products and services under a uniform brand, also ensuring continuum of care. Providers, on the other hand, may be motivated to join a network in the hope of attracting a larger client base.
- Transitioning the role of franchisor to a local entity. Such a transition would enable local oversight and ownership and increase operational efficiencies. For example, monitoring, oversight and ongoing training – functions whose costs are difficult to recover – may be gradually transferred to an existing local association already involved in these activities. Transferring the role of the franchisor to a local entity is an innovative concept currently under consideration by a few existing franchises.
- Narrowing down the list of quality indicators to a relatively few and then focusing monitoring efforts on these key indicators in an effort to save costs while still assuring quality.
- Devising ways to retain providers in the franchise. In order to do this, the franchisor must pay attention to the benefits of membership – if these are not sufficient, successful providers are more likely to abandon the network. Conversely, it is advisable to adapt the franchise model to allow for natural graduation of high-performing providers and concentrate on recruiting younger, less experienced providers into the network.
- Negotiating mutually beneficial partnerships with the public and/or commercial sector. Emerging experiences with these types of partnerships have begun to demonstrate that it is possible to develop win-win partnerships that meet both public health objectives and encourage sustainable provision of priority health services through the private sector.

Section IV

Public policy and franchising in reproductive health

Health franchises offer great promise in expanding access to priority health services. However, certain limitations on their ability to reach the poor, or to provide healthcare services of a public-good nature that generate limited profits, signal a potential role for increased public sector involvement so as to bring these initiatives to scale for a broader population impact. There are several government policy mechanisms that can guide the development and expansion of franchises providing reproductive health. Although a ranking of these policies in order of priority is problematic, financing policies are the most critical.

Financing

Reducing financial barriers to priority healthcare services is essential for the achievement of national health goals. A policy that guides financial support to social franchises is at the top of the list of priority policies for several reasons.

- Reducing financial barriers to health-care services of a public-good nature is essential for the achievement of national health goals. A policy that guides the operation of effective and efficient mechanisms for using the public sector's financial resources to promote universal access to reproductive health (as well as other public health programmes) is clearly important – both through the public and private sectors. Whether government uses its resources to finance its own operations to reach the poor, provides financial support to the private sector to reach underserved populations, or works towards some combination of public and private partnerships is an empirical question best answered by examining local conditions. The consultation meeting was not prescriptive on the mechanisms for achieving universal coverage even as it noted that having in place multiple and complementary financing arrangements is a feature of successful policy.
- Financial transfers of some type are essential if the private sector is to serve the health needs of the poor, as otherwise the poor will either be at risk of catastrophic expenses or simply not utilize needed health services. Additionally, without financial support for reproductive health services, the private sector will not be able to afford to provide unprofitable services and may not include many reproductive health services in its clinical practices. Subsidies are particularly important for social franchises that deliver reproductive health as this type of private sector network mandate is to reach both the poor and provide unprofitable public goods and services.

There are a number of mechanisms through which the public sector can provide financial support to the private sector. Many of the networks represented at the meeting have had successful experiences with one or more of these transfer mechanisms, which include the following:

- ***Social health insurance***. The expansion of social health insurance schemes in developing countries reflects important changes in government financial policy towards reducing out-of-pocket expenses in favour of pre-paid, pooled financing schemes.[16] The experience of

[16] Murray CJM, Evans DB. Health systems performance assessment: goals, framework and overview. In: *Health systems performance assessment: debates, methods and empiricism*. Geneva: World Health Organization, 2003, pp 3–18.

PhilHealth in the Philippines and the National Health Insurance Scheme in Nigeria are two examples discussed in the meeting of how governments are working effectively to implement public policy to reduce catastrophic health expenses and increase access to reproductive health through the private sector. PhilHealth is moving towards accreditation of the private sector (starting with FriendlyCare clinics) and provides financial support for family planning – in addition to other services included in a basic benefit package for the poor as well as all PhilHealth beneficiaries. The National Health Insurance Scheme in Nigeria has begun enrolling and contracting private sector providers, including the Total Health Trust (PPO) network, to offer a basic benefit package that includes reproductive health services. These examples demonstrate how participation as accredited members of an insurance programme is a practical means for gaining financial sustainability for the network, while also increasing coverage of reproductive health services.

- ***Contracting private health providers.*** Another mechanism for working with the private sector involves making direct payments to health providers through various types of contracting mechanisms. Evidence on contracting services by government to the private sector suggests that direct contracting can be effective in reaching underserved populations with reproductive health care in many settings.[17,18] Several participants presented their successful experiences in contracting: local government units in the Philippines purchase health benefit coverage for the poor through contracts with FriendlyCare; the Nigerian National Health Insurance Scheme contracts health maintenance organizations (HMOs) like Total Health Trust to provide basic health services, including those for reproductive health; and the Ministry of Health in Gujarat state, India, contracts private providers to offer maternal health services to poor women.
- ***Input subsidies.*** Governments have a long and successful history of providing subsidies for public health programmes delivered through the private sector, including NGO/not-for-profit networks. Most common are government-supported subsidies for commodities such as contraceptive methods, childhood immunizations, treatment for tuberculosis and, more recently, HIV/AIDS prevention and treatment.

In addition, the participants in the consultation offered several promising approaches in public policy that address issues of equity and financial sustainability, such as the following:

- ***Vouchers or output-based incentives***. Several donors have been experimenting with voucher programmes to encourage greater use of priority health programmes, including reproductive health in a variety of settings (India, Kenya, Nicaragua, Pakistan, Taiwan, Uganda). While the evidence is not conclusive on a large scale, vouchers have been shown to be practical methods of transferring payments directly to patients while also reaching underserved groups (e.g. commercial sex workers and adolescents).
- ***Liberalizing policies governing products.*** Since many provider networks and franchises depend heavily on products (e.g. contraceptives, ARVs, etc.), liberalizing policies and laws that regulate products, such as registration, importation and taxation, is another form of financial support to the private sector.
- ***Tax incentives.*** Some participants proposed that governments should explore income and other tax incentives as a means to encourage more private providers to deliver affordable services to target population groups.

Quality of care

Government's responsibility to ensure safe and good-quality health care (both services and products) is an inherent element of its accountability to its citizens. Public policy that structures interactions

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[17] England R. Experience of contracting with the private sector: a selective review issues paper – private sector. London: DFID Health Systems Resource Centre, 2004.

[18] Liu X, et al. *Contracting for primary health services: evidence on its effects and framework for evaluation*. Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates Inc., 2004.

between government and the private sector to ensure quality of health care and protection of consumers from fraudulent or harmful practices is a key function of its stewardship role governing the health-care system. Public policy towards quality of care in the private sector works through a legal-regulatory framework that customarily specifies licensing and accreditation requirements for personnel and facilities, conditions of provider negligence or medical malpractice, and an acceptable range of health outcomes/side-effects of drugs and procedures, among others. An effective policy includes both incentives and disincentives to ensure compliance and operates through a variety of state-controlled mechanisms, within both the health sector and other sectors (e.g. judiciary, trade and industry, civil service, etc.). These policy options are not specific to social franchises but are germane to all types of private sector networks. Hence, the discussion of public policy towards quality of care can become quite broad, blurring the boundaries between different types of private sector networks and health-care procedures, practices and products.

Regulating quality in the private sector is a challenge for developing countries. The participants acknowledged the public sector's central role in establishing the standards and ensuring quality for the entire health system. Yet, many ministries of health lack financial and human resources for monitoring and enforcement as well as tools, systems and capacity. As a result, many private sector groups have taken the initiative to implement their own quality systems in response to market demands by consumers for higher-quality services. The participants endorsed the following strategies to improve quality:

- ***Consumer education and advocacy***. Consumers also have an important role to play in monitoring quality and demanding safeguards, in part as a watchdog of government, but also in using their purchasing power to influence the private sector by switching from providers with poorer quality. Prompted by concerns for patient safety, several developing countries are pioneering consumer education and advocacy as a means to improve quality of services. The meeting's discussions drew upon the experiences of the India Consumer Act, the Uganda Health Consumer Group and the Philippines Seal of Approval as public sector initiatives to empower healthcare consumers. The challenge with the consumer education approach, some participants remarked, was educating consumers on what are truly quality health services.
- ***Medical councils***. In many settings, national professional councils often play a role in quality assurance through certification and accreditation. Some participants cited limited success with this model because it was often difficult for a professional association to monitor itself without giving the appearance of conflict of interest. Moreover, certification and accreditation tend to focus only on inputs and do not always measure provider performance or competency.
- ***Self-regulation***. Public policy can assist the private sector to develop a culture of quality through improving transparency and predictable application by government officials of regulations and oversight controls, i.e. restricting excessive discretionary authority. Government recognition and endorsement of the private sector's self-regulatory measures can also be instrumental. PhilHealth and Total Health Trust described their systems to accredit providers and facilities and assure quality which have been endorsed by the respective governments. In the case of Nigeria, private sector networks, like Total Health Trust, are authorized to certify their members to participate in national health insurance schemes and are reimbursed for their services. In the Philippines, PhilHealth issues 'seals of approval' of private providers, informing the consumers that they offer quality services.
- ***Provider payments linked to quality***. Others discussed how voucher programmes are another form of consumer-driven quality assurance where consumers can "vote with their feet" if they do not receive quality services from an accredited provider in the network.

These and other measures of ensuring quality in the private sector work best when the public sector has established clear leadership by articulating norms and standards of care. Tuberculosis control programmes have demonstrated strong leadership in these areas of supportive public policy towards quality in the private sector, and HIV/AIDS treatment programmes appear to be moving in the same direction during their early start-up phase of operations. Reproductive health also has strong

normative tools, but engagement with the private sector through concerted public policy actions is less systematic. Developing public policy for franchising reproductive health provides an opportunity to advance this area of work.

An important cross-cutting theme of public policy towards quality of care in the private sector concerns the timing of government involvement. Interventions work best before the enforcement stage: preventive medicine is preferable to curative. Relying upon sanctions from ministry of health or legal proceedings by ministry of justice are a last recourse and represent a failure of other policies. The means of moving the engagement of the public sector with the private sector to these more "upstream" functions requires strong public-private partnerships.

Action points

Key actions related to public policy towards reproductive health franchising include the following:

- ***Foster high-level support for working with the private health sector.*** Public policy in support of reproductive health franchises and other types of provider networks should be an element of a broader government policy towards the private sector in general. Ministries of health are encouraged to articulate explicit policies towards the private health sector through a position paper or a generalized framework that can guide the development of policies and operational mechanisms for constructive engagement with the private health sector in support of national health goals.
- ***Look for innovative solutions.*** Many private sector health networks are not familiar with the norms and standards governing reproductive health services, and they commonly rely upon pharmaceutical companies for updated technical information. A simple, low-cost solution to improving the technical skills of private sector providers would be to include them in donor-supported training activities targeted to the public sector. Another simple solution would be the public sector contracting the private sector to provide training to its service providers. Governments can also support continuing education through information technology and other easily accessible forms of Internet knowledge management tools that can be utilized by both public and private providers.
- ***Use multiple public policy options to improve the quality of care in the private sector.*** Social franchises require different types of support from the public sector in order to provide the poor with public health services. A first step is to recognize the franchise's contribution to addressing reproductive health needs, thereby opening the door for public sector support. A second step is to create a mix of public policies, such as commodity subsidies, insurance systems and contracting, that offer financial support along with steps to ensure a consistent, transparent application of regulatory frameworks that are clearly linked to established norms and standards of care. Once the policies are established, an independent intermediary/regulator can be set up that can simplify oversight and ensure prompt resolution of disputes.
- ***Remove legal and regulatory barriers to foster conditions for sustainability of the private health sector.*** Public policy to de-regulate and liberalize overly-restrictive policies governing licensing, accreditation, drugs and technologies will free up the market space for the private sector and need not necessarily create any risks to quality of care. Many reproductive health procedures can be provided by different health cadres such as nurses, midwives and paramedicals, and several commodities can be provided as over-the-counter medications. Liberalizing overly-restrictive policies will create opportunities within the formal health care market for the private sector to expand. Since many reproductive health services are product-dependent, relaxing restrictive policies on the registration, importation and taxation of essential commodities would facilitate the growth of the private sector and expand its coverage.

Section V

Implementing public/private partnerships to support franchising in reproductive health

Challenges to establishing public/private partnerships

Despite identifying a number of innovative public policy options for expanding access to and improving the quality of reproductive health in the private sector, the participants discussed many challenges to public policy supporting and partnering with the private health sector. These include the following:

- ***Minimal understanding of the private health sector.*** The private health sector is not as well organized as the public health sector. In many countries, there is limited information on private providers, such as the number of current private practitioners (doctors/nurses/midwives), what services they provide, and who do they serve. This problem is further exacerbated by the fact that the private sector does not report regularly to the public sector health information system.
- ***Lack of political will and support to include the private sector.*** The participants in the consultation commented on how both the public and private sectors mistrust each other. Limited information on the private health sector and limited contact between the two sectors further contribute towards this problem. Many participants lamented that there was no dialogue between the two sectors. The private sector is commonly not included in important activities such as health planning, revising and updating norms and designing new programmes, such as health insurance schemes, that will directly impact the private health sector.
- ***Unfair playing field.*** Donors and governments often expect high standards from the private sector. In many countries, the public sector imposes higher levels of quality of care standards than they expect from their own public health facilities. Also, the public sector and donors often believe that profit-making groups are not worthy of financial support, thereby requiring one to demonstrate and prove that working with the private health sector in reproductive health is a good investment of public/donor funds.
- ***Competition between the public and private health sectors.*** The participants stated that the policy dialogue between the two sectors was guided by the competition between them, and the public sector's fear of losing control if they included the private sector in the health-care delivery process. At times, however, competition between the public and private sectors was important to ensure value for money. Social franchises can be a more cost-effective way to reach the poor with reproductive health services, as demonstrated by the Greenstar network, which operates in urban and periurban areas of Pakistan, with a couple-years protection (CYP) cost of US$ 5, compared to the public sector cost of approximately US$ 30.

Factors facilitating public/private successes

The meeting identified several factors that helped address some of the constraints outlined above and contributed towards successful partnerships between the public and private sectors:

- ***Public sector supports private sector.*** For the public sector to become a willing partner, they must first recognize that the private sector has a positive contribution to make towards addressing public health problems and that the private sector can be a part of the solution. In countries where the public sector does not support the private health sector, there is a need for advocacy at high levels of government, both within and outside the ministry of health. Also,

the public-private mix-DOTS (PPM-DOTS) example illustrated that charismatic and committed individuals representing both sectors can be critical for creating the trust and dialogue needed to establish public-private partnerships.

- ***Transparency in rules governing the private sector.*** Setting clear expectations and transparent rules regulating the private sector is essential for successful partnerships. This is greatly facilitated when ministries of health widely disseminate and share norms and standards and establish clear rules for contracting, procurement and terms of payment. The example of the State Ministry of Health in Gujarat (India) demonstrates that when the public sector can negotiate a fair price agreed upon by both sectors and pays the private providers in a timely manner, it engenders trust among the private sector to participate in programmes that offer essential services to the poor.
- ***Accountability of all partners***. One of the main obstacles to public-private collaboration is the suspicion of each other. Creating a space in which both sectors can discuss and agree upon their respective roles and responsibilities is a first step. A second step involves documenting these agreed-upon roles in ministerial documents, such as national health plans or strategies, which lends credibility to the private sector's role. Lastly, monitoring and evaluation of how well each sector is fulfilling its respective role is an important tool to hold both the public and private sectors accountable.
- ***Foreign assistance to the health sector.*** Donors, lending institutions and major philanthropic organizations can have an important role to play in the formation of effective public-private partnerships. Tuberculosis control programmes illustrate how strong support from WHO can provide legitimacy for governments' public policy supporting quality PPM-DOTS programmes in the private sector. Using this same model of strong WHO support, HIV/AIDS treatment programmes appear to be moving in the same direction during their early start-up phase of operations.

Action points

Key actions related to public-private partnership formation include:

- ***Public sector consideration of the whole health system***. The public sector should recognize the private sector's contribution towards achieving public health goals. There is not enough information to measure this contribution and the private sector has a role in providing key information about the private healthcare markets. Additionally, the public sector can adopt a broad health system view that will help diminish the perceived competition between the two sectors. In considering the whole market, the public sector can better segment the market to understand the roles and responsibilities each can undertake towards reaching different target populations. Levelling the playing field by including the private health sector in policy processes that affect them and by uniformly applying the same standards in evaluating both the public and private sectors are important first steps.
- ***Foster greater communication and dialogue between the public and private health sectors***. The public sector can create opportunities to engage and communicate with the private sector. Ideas proposed by the meeting included establishment of policy forums to discuss public-private partnerships, holding workshops and training programmes to share reproductive health standards and norms, and private sector participation on committees to develop ministry of health plans and policies that directly impact the private health sector.
- ***Proactive private sector.*** The meeting suggested that the private health sector could actively propose or seek out public sector invitations to participate in forums and planning processes. Additionally, the private sector can benefit from the NGO experience by organizing themselves, using existing national professional associations (medical, nursing, hospitals and pharma) or international associations (e.g. International Federation of Gynaecology and Obstetrics). Private health networks need to be more proactive in demonstrating their added value to the national public health system through the generation of evidence suggested by this meeting.

- ***Demonstrate private sector commitment to working on public health objectives***. The private sector has an important role to play in fostering greater trust by demonstrating their contribution to and role in achieving public health goals. The private health sector can send a strong signal to the public health sector of their commitment by participating in government-sponsored programmes, such as social health insurance and voucher schemes, that serve the needs of the poor and other vulnerable groups. Moreover, they can demonstrate their willingness to adhere to government standards by conforming to public standards through self-regulation and other quality assurance mechanisms and by keeping records and reporting to public health information systems.
- ***Donor support for public sector engagement of private health sector***. Donors and multilateral organizations can play an important role in nurturing public sector engagement of the private health sector. A paradigm shift in donor policy that includes new terms and concepts redefining health systems to broadly include the private sector and other actors is a first step. Additional ideas for donor support of greater public-private interaction include: i) donors supporting the documentation and dissemination of best practices and successful examples of how to engage the private sector; ii) WHO regional offices raising awareness on successful examples of public-private partnerships and facilitating dialogue between the public and private actors within their region; iii) donors providing technical assistance to build the capacity of ministries of health to manage a pluralistic health system; and iv) donors seeking and investing in opportunities to create sufficient experiences in the private health sector.
- Multilateral organizations establishing new norms. Normative acceptance to working with and engaging the private sector to promote universal access to reproductive health needs to be vigorously communicated by key United Nations and other multilateral agencies, lending institutions and bilateral donors.

Section VI

Building the evidence base on franchises

Policymakers need sufficient evidence in order to guide their decisions on how to allocate scarce health resources. While franchises offer great potential to expand access to priority health services through organizing individual private practitioners, there is still much to learn about their impact on health care utilization, particularly among underserved populations. In general, the existing evidence base on franchises is limited.[19] As with other private-provider networks, franchises most commonly report data on client volumes, services provided, sales and profits and other process and output-level results. Evidence on quality of care is less frequently collected and, when it is reported, it principally uses measures of client satisfaction. Little empirical data exist on the technical or clinical quality of care provided by franchises, apart from anecdotal reports. Franchises are clearly committed to providing quality services, as otherwise their clientele would go to another source for care. However, the means of monitoring the quality of services is often informal and ad hoc, largely due to the inputs this function requires in terms of financial and staff resources.

Evidence on how franchises have made an impact on health coverage or outcomes is also limited. This, in part, is because few franchises have been of a large enough scale to create circumstances for a plausible correlation between their operations and changes in system-wide coverage or population-based health outcomes. Indicators of lower-level outcomes are appropriate to use and can provide evidence suggestive of improved health outcomes. For example, measures of service utilization (e.g. case-load) show changes in the source of care for institutional deliveries and family planning providers. However, this type of data is available for few of the existing franchises. Only a few rigorous impact evaluations have been conducted, and they have largely focused on provider- and client-level effects as opposed to population impact.

While there is some evidence which suggests that healthcare franchises have a positive effect for providers in terms of access to training and increased clientele, less is documented about the impact of franchising on client access to and utilization of quality health services. Franchises appear to have a positive effect on client perception of quality, but little evidence exists on observed technical quality of franchised providers.

Thus, while franchises have demonstrated promise in expanding access to priority health services and in serving underserved groups, the existing evidence base on franchises can be characterized as being at a *"proof-of-concept"* stage. Conclusions can be drawn about the feasibility of starting up reproductive health franchises and how to make them more sustainable, and suggestions exist on strategies to expand coverage. However, solid evidence on the effectiveness and impact of this type of private healthcare initiative is more elusive. Some of the larger and more mature networks are poised to yield evidence on how they are influencing the broader healthcare market and contributing to changes in population-wide health outcomes, but the data are not at that level of evidence yet. Collecting information on these indicators is a priority as franchises evolve and grow.

Evidence on effective resource mobilization strategies is a priority research topic. The challenge of reaching the poor with unprofitable/public-good services and running a commercially viable network

[19] *Issues in evaluating clinic franchising programs. Draft version: August 1, 2000. Prepared for the Advisory Board Meeting of the Clinic Franchise Evaluation Project, 7–8 September 2000*. http://www.cpc.unc.edu/projects/abm/papers.html (accessed on 27 August 2007).

is an inherent constraint for healthcare franchises. As a result, a franchise that promotes reproductive health and family planning services may require a more complex mix of funding sources than a purely commercial franchised network. The means through which successful franchises have achieved an optimal combination of financing to overcome funding gaps is important to understand – both to guide the development of new franchises and to enable existing networks to grow to scale in a sustainable way.

Creating a sustainable funding base also involves considerations of offering the right combination of services. Cross-subsidization from profitable services to those that operate at cost or below cost is a feature of successful health-care franchises. How best to achieve the right mix of cross-subsidized services is a research question that deserves further exploration. Likewise, evidence on what happens to reproductive health services as the franchise diversifies its products and services is also needed, in particular to answer the following types of questions:

- *Will family planning services enter into "competition" with other, more lucrative health services?*
- *Will provision of ART for treatment of AIDS compete with other reproductive health services?*

Understanding the dynamics of adding reproductive health services (and other priority healthcare services) to a commercially-driven network will advance the field of franchising for reproductive health and assist in defining an appropriate niche in the overall health market for this type of private sector network. Developing the evidence base on effective means of co-financing and cross-subsidization should necessarily be conducted within the context of increasing the franchise's capacity to monitor its operations and outsource specialized studies. Investments are needed to develop these essential skills within the franchise structure.

In addition to using research to improve the operation of social franchise programmes, evidence is required that responds to questions of the purpose and need for this type of private sector network. Moving beyond the *"proof-of-concept"* stage means, in part, showing that social franchises fill a niche in the health care market-place that is different from other types of private sector networks. Comparative studies are required that place the reproductive healthcare franchise within the context of other types of private sector health services or that provide a type of counter-factual against which the performance of the social franchise can be measured. This type of research will respond to questions by governments and donors about the comparative advantage of investments in social franchises as opposed to other types of private sector networks. Evidence on how utilization patterns/ access to different sources of reproductive health care are affected by the franchise will respond to this need.

Retrospective longitudinal studies are required to examine changes in market-place with the emergence and development of the social franchise. Additionally, evidence on what population groups are being reached by the social franchise will respond to gaps in understanding about whether these new forms of the private sector are growing the health market or simply changing the existing utilization patterns. Population-based measures are essential to providing both types of evidence, and should include mapping studies of health-seeking behaviours and the impact of measures to enhance financial protection of the poor.

Other types of comparative studies, such as cost-effectiveness and cost-benefit analyses, would also be useful. Little is known about which type of private-provider network, or which configuration of franchise elements, makes the most efficient conversion of inputs to output. Currently, the lack of standardized measures to assess the impact of franchises makes comparisons between franchises difficult. Additionally, behavioural studies of providers are called for that clearly identify factors that motivate providers to join and retain their membership within a franchise.

Action points

Key actions related to gaps in the evidence base include conducting research on the following topics:

- Evidence that goes beyond the *"proof-of-concept"* stage for reproductive health franchises. In addition to generating information on performance indicators, research that investigates the effects of a franchise on the total health-care market and changes in the health status of target population groups is required. Outcome indicators related to shifting patterns of reproductive health service utilization and new population groups being reached are among the priority subjects for demonstrating the potential of this type of private sector network to make a meaningful contribution to national health goals.
- Comparative studies of franchises with other types of health interventions (both private and public) can inform and influence decisions about resource allocation by government officials as well as donor agencies. Reaching a consensus on uniform indicators, e.g. CYPs or disability-adjusted life years (DALYs), could facilitate such comparisons.
- Evidence is required on how health-care provider behaviours are affected by the organizational reforms of franchises and on motivational factors for joining and retaining membership in a franchise.
- Cost-effectiveness and cost-benefit studies demonstrating how franchises convert inputs in health-care services to outcomes are lacking almost entirely from the literature. More information is required on how franchises are able to utilize financial support mechanisms to meet their stated objectives (e.g. providing priority health services to underserved groups and ensuring sustainable provision of reproductive health services).
- Operational research studies are needed that test the optimal mix of services, cross-subsidization of different services within a franchise, and diversification of funding sources for long-term financial sustainability.

Section VII

Conclusion

Health franchises are an important and unique form of private sector initiative. Many issues germane to their development cut across other types of private-provider networks clustered around individual private practitioners. The explicit goal of advancing universal access to public health services in general and reproductive health in particular, especially by underserved populations, sets them apart in many ways. Closer collaboration and cooperation with government is perhaps more essential for health franchises than for other types of private networks. There is a clear role for both government and the private sector to work together in partnership to promote increased access to reproductive health. While health franchises offer the promise to expand access to reproductive health and other priority health services, further evidence is needed to guide the operation of these franchises in the future and to assist in the formation of public policy to ensure quality of care, to advance equity and to secure long-term sustainability of this unique private sector network.

Annex 1

Technical Consultation Meeting
Public Policy and Franchising Reproductive Health:
Current Evidence and Future Directions

WHO Department of Reproductive Health and Research
USAID Private Sector Partnerships-*One* (PSP-*One*)

6–8 December 2006, Geneva, Switzerland

Agenda

09:00 - 09:30	**Welcoming Remarks** *Paul Van Look* *Director, Department of Reproductive Health and Research* *World Health Organization*
09:30 - 09:45	**Review of Meeting Objectives, Expected Outcomes, and Processes** *Dale Huntington* *Department of Reproductive Health and Research* *World Health Organization*
09:45 - 10:15	**Session 1** **Presentation: Private Provider Networks - Definitions and Evolution of Franchising Programmes** *Sara Sulzbach* *USAID PSP-One*
10:45 - 12:30	**Session 2** **Panel: Franchise Experiences - Adapting to the Market**
	Moderator: *Assia Brandrup-Lukanow* *(On sabbatical leave from GTZ)*
10:45 - 11:00	*Leni Cuesta* *FriendlyCare, Philippines*
11:00 - 11:15	*Peter Mwarogo* *Goldstar Network, Kenya*
11:15 - 11:30	*Nyo Nyo Minn* *Sun Quality Health, Myanmar*
11:30 - 11:45	**Commentator:** *Krishnamurthy Gopalakrishnan* *DKT, Viet Nam*
11:45 - 12:30	**Discussion**
14:00 - 15:30	**Session 3** **Panel: Franchise Experiences - Managing Scale**
	Moderator: *Jose Rimon II* *Center for Communication Programs*
14:00 - 14:15	*Daniel Aspilcueta* *RedPlan Salud, Peru*
14:15 - 14:30	*Larry Holzman* *Titli Centres and Surya Clinics (Janani), India*
14:30 - 14:45	*Oladipupo Awosika* *Total Health Trust, Nigeria*

14:45 - 15:00 **Commentator:** *Rehana Ahmed*
Greenstar, Pakistan

15:00 - 15:30 **Discussion**

16:00 - 16:50 **Session 4**
Moderator: *Roger England*
HLSP

16:00 - 16:20 **Presentation: Effectiveness of Social Franchising Programmes - Findings from the Alternative Business Model Evaluation**
Amy Tsui
Johns Hopkins University, USA

16:20 - 16:50 **Discussion**

16:50 - 17:00 **Orientation to Session 5 Working Groups: Understanding Franchise Programmes - Gaps in the Evidence**
Barbara O'Hanlon
USAID PSP-One

17:00 - 17:15 **Day One Wrap-Up**
Dale Huntington
Department of Reproductive Health and Research
World Health Organization

7 December 2006

9:00 - 10:30 **Session 5: Working Groups**

Working Groups: Understanding Franchise Programmes - Gaps in the Evidence

10:45 - 12:00 **Session 5: Plenary**
Working Group Presentations and Discussion

Moderator: *Ramesh Bhat*
Indian Institute of Management (Ahmadabad) India

12:00 - 12:15 **Orientation -- Round Table Talks**
Barbara O'Hanlon
USAID PSP-One

13:30 - 15:00 **Session 6**
Round Table: Public Policy and the Private Health Sector: Financing Approaches to Ensure Equity

Facilitator: *Peter Berman*
World Bank, India

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Godwin Ajakpo
National Health Insurance Scheme, Nigeria

Ruben Basa
PhilHealth Insurance, Philippines

Dominic Montagu
University of California San Francisco, USA
David Evans
Director, Department of Health Systems Financing
World Health Organization

15:30- 17:00 **Session 7**
Round Table: Public Policy for Ensuring Quality in the Private Sector

Facilitator: *Ariel Pablos-Mendez*
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USAID PSP-One

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Carlos Cuellar
PROSALUD, Bolivia

17:00 - 17:15 **Day Two Wrap-Up**
Dale Huntington
Department of Reproductive Health and Research
World Health Organization

8 December 2006

9:00 - 10:15 **Session 8 (part I)**

Working Groups: Public Sector Policy Options for Ensuring Quality and Equity in the Private Sector - Recommended Actions for Public and Private Sectors

10:45 - 12:00 **Session 8 (part II)**

Working Groups: Implementing Policy Options for Effective Public - Private Partnerships in Support of Franchising Programmes

14:00 - 15:30 **Session 9**
Working Group Presentations (Sessions 8, parts I & II)
Moderator: *Dana Hovig*
Marie Stopes International, United Kingdom

16:00 - 16:15 **Next Steps**
Dale Huntington
Department of Reproductive Health and Research
World Health Organization

16:15 - 16:45 **Concluding Remarks**
Marguerite Farrell
Senior Technical Advisor, Service Delivery Improvement
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Paul Van Look
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Annex 2

_T_echnical Consultation Meeting
Public Policy and Franchising Reproductive Health:
Current Evidence and Future Directions

WHO Department of Reproductive Health and Research
USAID Private Sector Partnerships-*One* (PSP-*One*)

6–8 December 2006, Geneva, Switzerland

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