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THE POTENTIAL FOR SOCIAL FRANCHISING AS A STRATEGY FOR INCREASING PRIVATE SECTOR INVOLVEMENT IN ADDRESSING HIV/AIDS AND TUBERCULOSIS IN ETHIOPIA

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavior Change Communications
CBO	Community Based Organisation
C&T	Counseling and Testing
CSM	Condom Social Marketing
CSW	Commercial Sex Worker
DACA	Drug Administration and Control Authority
DOTS	Directly Observed Treatment Short Course
FBO	Faith Based Organisation
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communications
IPC	Interpersonal Communications
MAPP	Medical Association of Private Physician Providers
NGO	Non-Governmental Organization
OI	Opportunistic Infection
PEPFAR	The President's Emergency Plan for HIV/AIDS Relief
PLWHA	Person Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
STI	Sexually Transmitted Infection
TB	Tuberculosis
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

Commercial franchising is a system where a larger company (the 'franchiser') typically contracts individuals or smaller companies (the 'franchisees') to operate commercial outlets on their behalf to pre-determined quality and business model standards. In most instances, the franchisee owns and runs the outlet, but works within set guidelines from the franchiser. Social franchising applies this extremely successful commercial approach to programmes with social objectives in order to improve the quality of services delivered by private providers, to standardize prices and to empower clients.

> *"Having explored the range of systems that have been tested for working with private providers, from contracting to vouchers to behavioral change and provider education, We conclude that franchising has the greatest potential for integration into large-scale programmes in Africa to address critical illnesses of public health importance"*
>
> Nodola Prata, Dominic Montagu, Emma Jeffery
> **Private Sector, human resources and health franchising in Africa**

For health services, where control of quality and ease of access are critical, social franchising provides an opportunity to improve quality and access to services, and set guidelines and prices with minimal government or donor investment.

This paper argues that social franchising or social franchising-like approaches have a strong potential role to play in Ethiopia to allow the private sector to support and complement the existing and future efforts of the public sector in the fight against HIV/AIDS and Tuberculosis, and presents models and examples where such methods have already been applied. Given an estimated 1.5 million people presently living with HIV/AIDS in Ethiopia, such assistance should be rapidly harnessed using international donor support, in order to bring more choices and a wider range of services to the most at-risk individuals, and their families suffering from the disease.

This paper identifies some of the areas where this approach can be effective, as well as highlighting some of its limitations, and where more research needs to be carried out. The two strongest potential limitations of the social franchising approach for HIV/AIDS and TB in Ethiopia include the relatively small number of private medical providers (The Economist magazine quotes the International Organisation of Migration, saying that there are more Ethiopian doctors in the city of Chicago alone than in the whole of Ethiopia), and the relative complexity and duration of care required with HIV/AIDS and TB related illnesses that does not immediately lend itself to private sector provision in a country that is among the poorest in the world.

However, while private sector franchising approaches can easily take on simpler services such as STI management, care of opportunistic infections and counseling and testing for HIV, it can also provide a crucial role in the provision of more peripheral but still vital services, including identification and referral of HIV/AIDS and TB cases, as well as subsequent follow-up and monitoring of drug use. Indeed, with a more conducive and welcoming private sector environment, more private doctors may be persuaded to remain in Ethiopia over the longer term to contribute to its development.

The 'business format' approach used in franchising can also be applied in franchising-like models, where the implementing agencies may be NGOs, CBOs, FBOs or other not-for profit organisations providing community based material, psychosocial and other forms of care to people living with HIV/AIDS who might otherwise be abandoned. These organisations and their clients would also benefit from more

professional, formalised, higher quality standards of care, with regular objective monitoring and follow-up training to ensure standards are maintained.

These groups should ultimately combine with both public sector and private sector providers to ensure a high quality continuum of care from HIV counseling and testing services, appropriate referrals to ART, PMTCT, TB DOTS and adequate post test services that will create a safety net, or 'smooth landing' for individuals and their families who may receive a HIV positive test result. If social franchising methods can be employed to the goals set out in this paper, they may truly make a difference to the health of millions of people in Ethiopia.

1. INTRODUCTION

This paper is a brief formative review of some of the options and issues that will need to be addressed by those wishing to introduce social franchising for HIV/AIDS and Tuberculosis (TB) in Ethiopia. Sections two to four are a literature review of current issues in social franchising, drawing heavily on the work of Dominc Montagu of the University of California in Berkeley; section five looks at identifying specific issues for HIV/AIDS and TB when it comes to franchising, and section six looks at available assessments of the potential for such models in the private sector in Ethiopia, and presents known positive and negative factors that will influence the success of franchising. No new research was conducted for this paper, though section six does provide suggestions as to next steps for defining what research questions still need to be addressed among stakeholders and potential franchise members, and in particular what the target groups might want or expect from health providers in Ethiopia. Three illustrative case studies are presented highlighting specific models for franchising in HIV/AIDS and TB related services that have been successful in other countries.

TB patients are often co-infected with HIV, with up to 70% of TB patients having HIV in some countries. In a country such as Ethiopia, a response is needed that will address the two diseases together, that can be quickly expanded and managed at a very large scale, that can assure quality, and that works through the channels where at-risk groups currently get care, or would like to get care. Most HIV/AIDS or TB related services are presently provided through the public sector, and while these services must continue to be upgraded to meet the needs of the poorest, there are other health care approaches, including those involving the private sector, that can contribute a significant support role and reduce the existing burden on the public sector.

In much of the developing world, including Ethiopia, private health care providers including doctors, nurses and pharmacies, are important sources of medicine and medical care and yet these providers are frequently not considered in public health planning. Private providers can potentially play a particularly important role among the poor, who are more likely to seek non-formal care and spend a higher percentage of their income on health care than the wealthy.

The private sector will often be attractive to patients, who may wish to avoid long queues, short opening hours, and low perceived or actual quality in the public sector. However, given significant asymmetries in knowledge between patients and providers, the private sector left to its own devices may not be able to regulate itself sufficiently to provide true quality advantages, particularly for diseases requiring long-term treatment. The activities of the private sector must therefore be carefully coordinated. When it comes to HIV/AIDS and TB care, unregulated and variable use of antiretroviral therapy and monotherapy treatment for TB in the private sector could lead to multi drug resistant strains of both diseases.

One strategy designed to address some of the market failings of the private sector and which has received significant attention of late is social franchising. Social franchising is an attempt to apply a successful commercial franchising model to achieve social rather than financial goals, influencing the quality and availability of service delivery systems of the private sector similarly to the way in which the social marketing approach has adapted traditional outlets for health commodity sales such as condoms.

Social franchising offers the potential for fast, low risk expansion through individual or private ownership, backed by a recognized brand with well-established attributes desired by consumers. Already, franchising has been used in a number of countries, including Pakistan, India, Madagascar, Zimbabwe, Cambodia and indeed Ethiopia to deliver reproductive health services to populations beyond the reach of government health programmes.

Montagu (2002) defines a number of key preconditions before any true social franchise model can be developed and ultimately be considered successful – measured in terms of increasing access, quality and use of services:

- There must be an existing and under employed private medical sector; this must be sufficiently large and widespread that it justifies the cost of building an umbrella franchise organization.
- The services being franchised have to have some potential to motivate private clients to pay for them. Most curative services will meet this criterion, but only rarely will people pay for preventative services or cures requiring long term treatment regimes; these latter, therefore, may not be suitable for delivery through franchise networks unless combined with curative care that offers franchisees the chance to diversify their income
- There must exist sufficient local capacity to build and mange a large organization, working in an effectively for-profit manner.
- The services being franchised must be sufficiently limited and definable that they can both be monitored and promoted with an assurance that quality can be maintained.

However, even where not all of these pre-conditions are in place, franchising-like approaches that take some but not all elements of the social franchising approach, such as the development, promotion and monitoring of a high quality business format, can still be applied effectively to non-profit organisations and other existing health providers. Alternatively some of the more complex HIV/AIDS and TB services that may not lend themselves immediately to a stand alone franchise approach may still be successfully added on to existing franchise models that do already provide services that are more appropriate and lucrative, such as family planning, STI management or other curative care.

Looking in more depth at these models, this paper will therefore discuss a range of potential areas where social franchising or social franchising-like approaches can be extended to the field of HIV/AIDS in Ethiopia, as well as highlighting some of the challenges and limitations that are evident in this particular country. A range of basic social franchising scenarios are discussed, though in reality, any service delivery model proposed is likely to provide a combination of these services to ensure a continuum of care to patients and clients[1]:

1. Counseling and testing centres for HIV

2. Tuberculosis diagnosis, referral and treatment through DOTS

3. STI syndromic case management

[1] Note the important distinction between 'clients' and 'patients'; a 'client' is an otherwise healthy (or asymptomatic) person who chooses to seek preventative care such as a testing or counseling service to help them remain healthy. A 'patient' is someone who has contracted a disease that needs curative or palliative care, and for whom the doctor will typically know 'what is best'. One of the challenges inherent in franchising with medical providers is that they do not distinguish between the two, and may treat the former as if they are 'sick', rather than healthy people seeking information and options. This matters because 'patients' are used to being instructed what to do by doctors; 'clients' on the other hand may be discouraged by such an approach, and may not feel they have been served well.

4. Opportunistic infection prevention and treatment

5. Post test care and support services, with a basic care and support package for PLWHA

6. Prevention of mother to child transmission (PMTCT) of HIV/AIDS

7. ART delivery through the private sector

Each of the above services would need to be targeted and carefully promoted to specific at risk groups who each have separate and identifiable needs. Such groups might include youth, commercial sex workers, factory workers, migrant workers and long distance transport workers, discordant couples and PLWHA.

Whereas public sector services may need to have the widest appeal to the 'average' person, franchised services can also be developed that target and appeal to these very specific at risk populations.

2. WHAT IS SOCIAL FRANCHISING?

Social franchising is an attempt to use existing and successful commercial 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 outlasts for commodity sales.

The most widely accepted definition of a franchise comprises a contractual relationship between a franchisee (usually taking the form of a small business) and a franchiser (usually a larger business) in which the former agrees to produce or market a product or service in accordance with an overall blueprint devised by the franchiser. As part of the contract, however, franchisers strictly regulate many of the activities of the franchisee - standardizing retail outlet design and colour, the range of goods and services offered, and acting to assure quality and prices.

Today, franchises are commonly divided into two types: traditional and business-format. In traditional franchises the rights to sell a product or service in a geographic area are sold to a franchiser, for example, a car dealership or a gas station. In business-format franchises a full set of advertising, service methods and delivery models are leased to a franchisee in a contract that allows for an ongoing relationship between the two parties - assuring quality and price controls to varying degrees. In reference to health care, the most relevant form of franchise is the business-format franchise

Most commercial franchises are stand-alone franchises. A stand-alone franchise, as the name suggests, exclusively promotes and sells the goods and services of the franchiser (e.g. McDonalds). A less common commercial variant, but the norm for social franchises, is the fractional franchise. A fractional franchise adds a franchised service or product to an existing business, creating additional income for the franchises and using existing business assets.

There is little doubt that there are significant economies of scale to be gained by social franchising programmes in expanding service delivery points through fractional franchises. In fractional franchise programmes, local franchisees contribute a large amount of pre-invested capital in terms of facilities, staff and pre-enrolled clients. This allows for large savings during expansion and a corresponding fast track to scale for beginning franchises. There are financial and non-financial costs associated with fractional franchising, including higher monitoring costs associated with supervising many providers, and potential brand confusion arising from parallel distribution of both franchised and non franchised goods and services, which may discourage potential clients. For a social franchise, these costs must be weighed against the potential benefits. A social franchise model therefore stands to benefit from:

- **Existing clinical infrastructure**: makes rapid expansion possible because the infrastructure, the providers and the client pool are already in place
- **Private providers**: serve smaller population areas, less mobile groups and marginalised populations
- **Standardisation of inputs, services and procedures**: allows a cost-effective and rapid expansion while assuring quality control. Contracts between franchiser and providers establish roles and responsibilities.
- **Profit motivation**: provides multiple levers of control. Providers participate because they may gain access to drugs, laboratories and referral networks that they can only have through the franchise. These inputs generate income which otherwise would not be available to them. If they don't comply

with franchise standards they risk the loss of this income. Central to franchising is the philosophy that providers are motivated by income. If they are also generous, well-intentioned and ready to work for the good of their community, that is a welcome and appreciated bonus, but the model does not require that to work.

3. THE ESSENTIAL ELEMENTS OF A SOCIAL FRANCHISING APPROACH

This section is a summary of the issues raised by Montagu (2002)

3.1 STANDARDIZATION OF SERVICES

Standardization of services is critical to franchises for a number of reasons. The clarity of a brand is a reflection of its immediate associations for consumers. Inconsistency, in advertising or in services, weakens the brand by clouding associations.

Within a branded set of services the goal of a franchise is to remove as much variability as possible. The poor performance of an individual outlet can affect the reputation of the larger group, sometimes significantly. The potential for disastrous incidents is high when franchises provide clinical medical services. Because of this, monitoring is crucial to medical social franchises, and the central tool of affordable, replicable monitoring is standardization.

A franchise must have a regular set of criteria upon which to judge the performance of members. In the for-profit sector, business format franchises place particular emphasis upon monitoring process indicators as well as outputs. Assuring that service standards are upheld is as, or more, important than products

One of the most difficult aspects of fractional franchising is the separation of franchised services from other provider-offered services that share the same facility. Often, this is impossible, both in practice because the branded and unbranded services share the same examination areas, equipment and providers, and in perception, because clients perceive the quality of the provider or the clinic, and do not differentiate between categories of services offered. This makes the selection of the providers critical to the parent organization and the monitoring of general service criteria - cleanliness, politeness of staff, sterilization techniques and appropriate time per client particularly important.

3.2 BRAND POSITIONING

Many years of experience with social marketing has demonstrated that family planning commodities, anti-malarial bed nets or vitamin supplements behave no differently in the market place than traditional commercial goods; products either succeed or fail based on branding which reflects market niches, positioning themselves as low cost or high quality, or targeting a particular age or ethnic group. Although the cumulative experience on the subject is still limited so far as franchising is concerned, there is no indication that this method of service delivery behaves in any way other than one would expect from the study of health commodity social marketing.

The trade-off between profitability and a focus on the poor can be avoided in instances where there is sufficient awareness of, and demand for, the services being franchised that an identifiable brand can have an impact on the number of patients visiting a provider. In this case, a well advertised brand and a rural or poor-urban focus has the potential to create enough demand quickly enough that member providers

will find the association beneficial and new providers will be enthusiastic to join the franchise. This situation is rare, however, particularly for the kinds of services most apt to be supported by social franchising programmes.

Brand positioning is essentially a decision about where to compete for clients. Competition is of particular importance to organizations attempting to franchise brands in developing countries. Poor legal protections for brand, slow or non- existent enforcement of legislation that does exist, particularly in rural areas, and the lack of enforceability of contractual agreements with suppliers and franchisees are all significant problems.

What competition can do is influence a provider's adherence to rules set by a franchising organization. If a franchise provides sufficient benefits to its member providers that there is competition on the part of medical practitioners to join, then many of the problems that arise from differential information between providers and clients can potentially be addressed by the franchising organization. The franchiser, with more information on which to judge providers than would be available to most clients, is in a position to demand quality of many sorts from members and to screen providers for membership. The franchise operates much like an accreditation agency, managing its brand through access to membership.

The ability of a franchise to become financially sustainable will, more than anything else, depend upon the target population it is hoping to serve and the corresponding positioning of its brand in the market. In most instances it is unlikely that services targeted at the poor and/or rural populations will ever be financially sustainable through franchising or any other market-based programme, due to a lower ability to pay among clients, and the higher costs of brand marketing and monitoring as geographic spread increases. In some cases urban programmes may have the potential to become financially sustainable over time, depending upon the market size, potential demand for the service and structure of the private medical sector.

3.3 BRAND COMMUNICATION

For normal consumer goods building a brand consists of identifying and communicating, through advertising, desirable attributes of your good. With less control over production, business-model franchises advertise both the goods available at outlets and the services provided.

When the brand represents a service, the advertising must highlight that and the monitoring of the programme must assure the quality of the service. The key to obtaining high perceived quality is to deliver high quality, to identify those quality dimensions that are importantant, to understand what signals quality to the buyer, and to communicate the quality message in a credible manner. But, beyond assuring the level of service at each outlet, the mass media communication must work to associate both the services and the brand name with the desired attributes.

Mass advertising will always be critical to the success of the franchise, and central to the value of the brand. Much rests on the franchisees appreciation of the benefits that they gain from their association with the franchise brand. Measuring and communicating franchise benefits is important; equally important will be having a long enough project duration that providers are given adequate time to realize on their own the value of the franchise brand.

With any franchise that operates on a large scale, there will always be a risk that the franchise will come into conflict with non-member providers. These could be government providers, commercial commodity retailers or other private practitioners, who may complain that adverts depicting the quality of the franchised services are indirectly accusing them of providing 'low quality' services. These sorts of

conflicts can be mitigated through involvement of the agencies affected (government ministries, public sector clinics, national medical associations) in the design or implementation of the network.

3.4 CREATING INCENTIVES FOR SERVICE PROVIDERS

The criteria for incentives to providers are that they be sufficient to assure compliance with the practice standards and to attract and retain new franchisees. The easiest way this can be achieved by adding new services to the franchisee's practice, or improving the quality of existing services, and then allowing franchisees to charge for the full cost of the services they provide.

However, since social franchising projects have social goals, a common aim is to lower the price to consumers through full or partial subsidy of goods or services to the consumer. This can create a number of challenges, including high costs, difficulty in verifying usage, potential for corruption at many levels and undercutting competing private providers of the focal good or service. Experience in social marketing programmes has shown convincingly that charging a price for services, however small it may be, is a critical component of a successful programme for tracking purposes, to assure use and to convince consumers of the products value.

The incentives offered to providers need not be solely, or even primarily, financial benefits from the franchised service. While data are limited, the experience of existing health franchises and other programmes working with private providers makes it clear that many providers place high value on opportunities for post-medical education, access to new medical techniques, and interaction with other medical professionals. Sole practitioners without a position in a medical institution are often isolated from their colleagues and welcome the opportunities to make contacts and exchange ideas that franchise membership may offer.

The indirect benefits of franchise affiliation are often difficult to value and may not be appreciated by members. Because of this, tracking of new clients, client volumes and income among franchised and non-franchised providers is highly desirable, particularly during the start up years of a franchise. This information can be used to provide feedback to member providers, demonstrating the benefits that result from their association with the franchise organization. Similar techniques are common in the commercial franchise sector.

3.5 QUALITY ASSURANCE

Medical professionals are particularly difficult to franchise. There is often a strongly held belief among medical practitioners that their clients are attracted by their skills, not by the brand of the franchise, as they may have gone through many years of training and invariably occupy a place of respect in their community. Convincing medical professionals to update and modify their practices, through training or through the imposition of mandatory procedural requirements, is always difficult, particularly so when the providers are operating without direct supervision in their own privately owned clinics. It is even harder to get them to submit to the necessary monitoring and supervision of their activities required by the franchiser to ensure quality of care is maintained.

The technical quality of services can be improved through:

- **Training**, to assure that providers are aware of best practices in the hope that practice will follow knowledge;
- **Encouragement**, by advertising quality standards (e.g. single-use needles for injections) at franchise clinics, regular feedback through cooperative monitoring or offering fee remissions and other

subsides to providers who adopt best practice procedures; and

- **Penalties** for providers who do not comply with franchise standards of care, including ultimately, expulsion from the franchise.

None of these solutions are likely to yield perfect compliance with desired practices. However, when benefits from membership are sufficiently valued by the member providers, a mixture of training, encouragement and penalties can together be used to assure that providers have an interest in improving quality.

Effective monitoring of quality of care is crucial to ensuring standards. The Bruce/Jain framework (1990) provides a model of attributes that compose quality services, Examples of these include establishing the provision, use and proper disposal of single-use needles, availability of sterilization methods, stocks of medicines and associated materials, cleanliness of consulting and operating rooms, the number of clinical procedures done each month and knowledge of potential side effects associated with the franchised services.

4. A TYPICAL FRANCHISE MODEL

4.1 THE FRANCHISER

This role can be carried out by a non-profit, non-governmental organization, or in some cases, could be contracted to a private commercial entity, particularly if it was considered that income generated through the franchise could grow over time. The franchiser contracts individual private providers, operating existing clinics, to operate under the brand of the franchise.

The services offered by the franchiser might include:

Recruitment, training & certification	• Recruitment of potential franchisees • Appropriate, well focused training courses, using modern training techniques and with an emphasis on quality (clinical, interpersonal) • Regular follow up training, focusing on areas identified during monitoring visits • Certification and re-certification of members on an annual basis
Business format development	• Clearly defined and well documented quality service delivery procedures in a manual, using international standards • Reporting and record keeping formats • Regular technical updates
Demand creation	• Branding & Promotion of services, through all appropriate channels effectively targeted at clients
Medical supplies	• Access to branded, high-quality health products and medical supplies possibly at subsidised prices, or using bulk ordering to obtain discounts for members. • Effective logistical delivery and ordering services
Business services support	• Small loans and other support for improving existing infrastructure • Facilitating franchisee requests to open bank accounts, develop independent funding proposal to banks or other donors • Business training – accounting, computer systems
Monitoring	• Continuous monitoring for compliance with business model standards, including o Supervisory visits o Mystery client surveys o Exit interviews with actual clients

4.2 POTENTIAL SOURCES OF FRANCHISER INCOME

Income for the franchiser could potentially be generated from charging the franchisee a fee to join the scheme, fees on the goods and services the franchisee provides, fees for training, and mark-ups on essential drugs and clinic supplies. However, it is likely that subsides from government or international donors will be required indefinitely.

4.3 THE FRANCHISEE

Potential franchisees can be recruited from a wide range of existing providers, though more commonly they will include basic medical doctors or nurses and clinical officers operating their own private practice, or private pharmacists. Franchisees must already have established facilities in order to reduce the investment required by the franchiser. High end 'specialists' will not typically be encouraged to join the network, as it is mid- and lower-level providers who usually already serve the poor, and who are used to charging lower fees for clients, and who may stand more to gain by joining in terms of reaching more clients and upgrading their skills.

The franchisee will be trained to deliver the services set out in the business format to an agreed standard, in addition to the normal medical services ordinarily performed. Existing services that lend themselves well to franchising include family planning and other reproductive health services, malaria treatment and STI management. For HIV/AIDS and TB, franchisee activities could include:

- HIV counseling and testing
- Referrals to other services, including care and support
- TB treatment and prevention
- HIV/AIDS Opportunistic infections - prevention
- HIV/AIDS Opportunistic infections - treatment
- Other infections - diagnosis, treatment and medication

4.4 POTENTIAL SOURCES OF FRANCHISEE INCOME

At start-up loans can be given to franchisees to cover some of the start-up costs including initial brand creation, marketing and advertising. Income for the franchisee could then come from a variety of sources, including:

- Fees for diagnosis of TB
- Fees for TB-related drugs
- Fees for HIV-related drugs
- Bonus for each verified successful treatment (from the franchise)
- Ancillary drugs, products and services for clients seeking treatment for TB, HIV and respiratory problems
- Fees charged to non-TB, HIV and respiratory clients for care and counseling (non-franchised services)

The franchise services may need to be priced very low, particularly for HIV counseling and testing (to encourage patients to come forward). Drug prices will be at or below market rate, but high enough to generate some income to providers, thereby encouraging them to join the franchise and comply with the franchise policies and standards. Ideally, fee levels need to be set at such a level as to encourage mid-level private providers to join the franchise for purely commercial reasons, though many providers may agree to offer a 'discount' on the fees they charge if they are confident the demand creation activities of the franchiser will increase their client load.

4.5 INTANGIBLE BENEFITS TO FRANCHISEES

Many franchisees will remain members of a network for other reasons than direct income generated out of the franchise services. Being a member of a franchised service can bring simple intangible benefits such as prestige within the community, and a feeling that they are responding to needs that they have previously recognised within the community but have felt powerless to respond to, such as the HIV epidemic. Experience from other countries shows that franchise members value belonging to a professional network that provides them with their only source of regular professional development, while at the same time, they may recognise the advantage of being a member of a network known for quality which will improve their patients confidence in the other, more lucrative services they offer. Where services are targeted at certain groups (for example STI services for youth) those outside the target group can be charged higher fees for the same service.

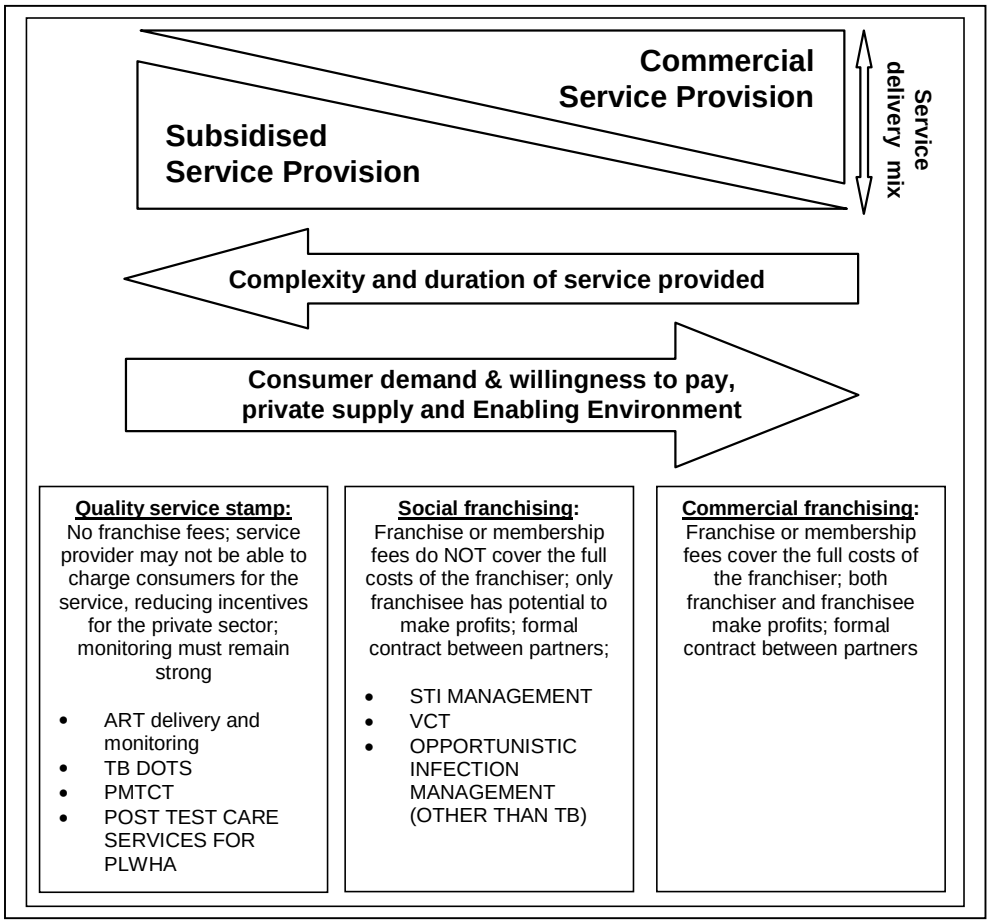
5. LIMITS OF SOCIAL FRANCHISING FOR HIV/AIDS AND TB INTERVENTIONS

Many HIV/AIDS and TB related services do not meet the parameters outlined above for franchising success, mainly for short term, affordable curative services, for which clients are more likely to be willing or able to pay. For a family planning service, the consequence of a client dropping out may simply be an unwanted pregnancy; for clients receiving ART the consequences and risks of dropping out of a franchised service that may no longer be affordable would be much more tangible and immediate, including public health risks of drug resistance and infecting family and community members.

The higher complexity of working with some HIV/AIDS and TB drugs raises another limitation not faced by reproductive health service franchising, that the main service providers will need to be qualified and trained doctors. Many reproductive health services can be effectively provided by nurses and other auxiliary staff, increasing the pool of potential franchisees available to work with.

However, there are still lessons to be learned from the franchising approach, and some HIV/AIDS related services may still benefit from a weaker form of franchising that might be closer to simple quality assurance through branding and promotion. The following scale shows where various services might fall in this scenario.

DIAGRAMME (I) THE 'FRANCHISING SCALE'



5.1 SERVICES WITH HIGH POTENTIAL FOR SOCIAL FRANCHISING:

The following services have a higher recognized potential for development into a franchise format, and may be quickly and effectively integrated into existing franchise formats that may exist for reproductive health services.

1. STI Management

2. Voluntary counseling and testing

3. Opportunistic infection management

These three services require relatively short interactions between provider and client or patient, and for STIs and OIs, involve curative services. Experience in other countries has shown that with VCT, which requires a minimum of one hour of client focused risk reduction counseling, there may be incentives for providers to cut corners to fit more clients into a single day. Models have developed where the franchisees might be NGOs or other non-profit organisations that do not face the same time constraints, or the franchiser itself may in fact set up a model VCT centre to act as a reference point to

franchisees, or even recruit counselors directly that will work in the private clinics of the franchisees so that parts of the service offered are more directly under the control of the franchiser.

Ultimately, a franchise may want to provide a combination of all three of the services described above in a single business format, therefore ensuring a comprehensive service to clients. VCT and STI management are particularly compatible; clients attending for STI services are strongly advised to go for VCT services, as they can be clearly identified as being at high risk of contracting HIV. Similarly, clients receiving counseling regarding protecting themselves from HIV may also benefit from additional information about preventing themselves from other STIs.

A model VCT and STI combined franchise is outlined in Annex 3.

5.2 SERVICES WITH LOWER POTENTIAL FOR TRUE SOCIAL FRANCHISING APPROACHES:

The following services have a lower recognized potential for development into a franchise format, but may still benefit from a social franchising-like approach.

1. ART delivery and supervision
2. TB DOTS
3. PMTCT
4. Post-test services and support
5. Basic care and support package for PLWHA

Services such as ART, TB DOTS and PMTCT involve expensive drugs that must be administered at critical times over long periods of time. The true cost is normally well beyond the reach of patients, and providers may be limited by national regulations in their rights to administer them. Patients may not even be able to afford the regular consultation fees that would be required to cover the amount of time taken by service providers to monitor drug use effectively.

However, franchisees can still be trained and certified in diagnosis, referral to government institutions and in the monitoring of the ongoing use of these drugs. In some countries private providers have been provided with drugs to administer directly themselves, once they have been certified through the franchise system (see Annex 1 for a description of a franchised approach to TB DOTS in Myanmar).

While PMTCT involves very specific and time bound contacts between providers and patients that might lend itself more to a fee based service, the timing issues around taking the drugs are so crucial that should a mother feel unable to pay to receive the service and declined, the consequences would be extremely severe. Again, a referral approach may offer more potential than direct service provision.

Post test counseling and basic care and support packages are two services that are less attractive to private providers, as they typically involve long term, non-medical material and psychosocial support to people with ever diminishing means of paying for them. Such services are typically supplied by NGOs, FBOs, PLWHA organisations and other volunteer community groups, and recipients would not be accustomed to paying for them.

However, the business model approach may still be applied to the volunteer groups providing the services by a franchiser that is working with a more conventional franchised network of service providers and is capable of providing the necessary technical support and monitoring. The purpose would be to establish a high quality referral support network for those who have tested positive and are benefiting from the other services provided through the network. Simple income generating schemes can be set up to distribute a pre-defined package of basic health care products at highly subsidised prices, though there may remain a significant amount of political pressure that such products should be made freely available to PLWHA.

Such an HIV "Basic Care Package" promoted by the franchise would enable HIV positive people to live longer and healthier lives whether or not they are on antiretroviral drugs. The care package is well-suited for poor settings because it builds on existing public health interventions to deliver high impact results at a much lower per client cost than ART. The package is a patient-managed, home-based care system that empowers HIV positive people to prevent opportunistic infections, delay the progression of HIV to AIDS and protect others from HIV. It could contain a range of products, including cotrimoxazole prophylaxis (a broad-spectrum antibiotic recommended by the WHO), long-lasting insecticide-treated mosquito nets, deworming tablets, condoms, water disinfection products and HIV/AIDS prevention and positive living materials (such as nutrition counseling).

Annex 2 outlines a post test service model being developed in Zimbabwe, integrated with a workplace HIV/AIDS and TB education programme and a network of franchised VCT centres.

6. FRANCHISING IN THE ETHIOPIAN CONTEXT

6.1 HIV/AIDS AND TB SITUATION ANALYSIS

Ethiopia has an estimated 4.4% national HIV/AIDS prevalence among adults estimated according to the National Sentinel Surveillance (NSS) antenatal survey data measurement from 2003. HIV prevalence is significantly higher among urban adults at around 12.6%, though this urban prevalence is thought to have steadied. Rural HIV prevalence is still thought to be rising, albeit from a lower level of 2.6% in 2003, and the Ministry of Health's 5th Report on AIDS in Ethiopia highlighted that in terms of absolute numbers, the major burden of AIDS in Ethiopia is increasingly falling on rural Ethiopians. Around 1.5 million Ethiopians are now thought to be living with HIV/AIDS; HIV prevalence among males is reported as being 3.8%, while among females it is reported as over 5%.

The Ethiopian government has committed itself to improving access to ART for those suffering from HIV/AIDS with support from a large number of sources, in particular the United States Government, and the Global Fund to fight AIDS, Malaria and Tuberculosis, and is currently implementing an ART programme roll out across major hospitals throughout the country. In order to identify those people that need to be on ART, Ethiopia needs to rapidly increase access to and demand for high quality HIV counseling and testing services. However, VCT use, while increasing, remains very low. Most of the existing service outlets for VCT or PMTCT are provided through the public sector, though there are around ten existing private sector VCT centres in Addis Ababa that charge between $5 and $30 per consultation, attracting people who are mainly middle and upper class. Despite these efforts, there is still a clear gap in counseling, testing and post test care services for rural, underserved populations. A number of national and international NGOs provide care and support services to PLWHA, though these are varied and disjointed efforts that do not meet the needs of the estimated 1.5 million PLWHA in the country.

The Ministry of Health reports that HIV accounted for 38% of TB case incidence in 2003, and expects that proportion to increase each year. TB and DOTS are presently managed exclusively through the public sector, while STI management through the WHO recommended syndromic management approach is more widely spread through both the private and public sectors, but still has inadequate coverage. The Ministry of Health, with support from the Centers for Disease Control (CDC) has recently revised its STI management protocols, and will soon expand and improve public sector availability of these services.

6.2 FRANCHISING SITUATION ANALYSIS

Ethiopia currently has a franchised network of reproductive health care providers, the Biruh Tesfa network managed by Pathfinder International since 2000. This network comprises of nearly 100 clinics, 150 community health workers, and 100 trained birth attendants, and operates in three regions, including the capital Addis Ababa.

However, there are presently no services that might be described as franchised HIV/AIDS or TB services. Consequently, a multi country study carried out in nine counties in sub-Saharan Africa including

Ethiopia in 2004 (Jefferies, 2004) collected important data that highlights some of the specific practical issues involved in franchising HIV/AIDS and TB services.

The follow section identifies some of the more important factors that will influence the success or otherwise of the uptake of social franchising approaches in a way that will meet pre-defined social goals. As well as wider environmental factors, it describes some of the legal areas surrounding private service providers, types of private outlets, and present fee structures.

It also identifies some new research areas that should be carried out to fill in some of the existing knowledge gaps regarding key stakeholders in the franchising process.

TABLE (I):

Factors supporting the introduction of social franchising for HIV services	Factors that may inhibit the introduction of social franchising services
The government sector faces constraints in terms of finances, human resources, weak logistics and a focus on tertiary and curative care. Health care quality and coverage is poor, with long waiting times, and long travel distances to facilities.	Small absolute numbers of medical providers, and within that, small numbers of independent private medical providers (eg just 13% of medical doctors and less than 1% of nurses are reported as being fully independent – Jefferys 2002)
Clearly defined national protocols for services such as STI syndromic management, VCT, PMTCT etc that give clarity to a franchiser defining standards.	Urban concentration of private providers; there are practically no nurses at work in the private sector in rural areas.
The Medical Association of Private Physician Providers (MAPP) is an active private medical association.	Three quarters of private providers in a survey of three regions in Ethiopia indicated their clinics are profitable; this may be a disincentive to enter a franchise.
Government staff can legally work in the private sector, and this is a common practice, increasing the potential number of medical providers that could join the network.	The government is the main provider of modern health care; the public is accustomed to attending the public sector for health care.
The government is actively encouraging the participation of the private sector and has included this in various policy documents, including the poverty reduction strategy and various health policy documents.	Low income levels and disposable income in the community, particularly in rural areas; low understanding of benefits of investing in preventative rather than curative care.
Franchising models are already in place for reproductive health services (MSI, Pathfinder)	Perceptions and expectations around quality of care are low among the general population. A lot of awareness raising will be needed to change this
Existence of experienced international and local NGOs capable of providing the franchiser role.	
Existence of high quality training and research agencies capable of providing monitoring and support to the franchiser	

6.3 LEGAL SITUATION FOR MEDICAL PROVIDERS:

There are no specific legal factors that are likely to inhibit the introduction of social franchising among private providers, apart from the restrictions on directly prescribing particular drugs. The following details were identified by Jefferys (2004):

- Anyone can own a private clinic, but only qualified medical providers can operate them. All practitioners require a license to practice, though renewal (required every 5 years) does not always occur.

- All qualified personnel can prescribe the drugs listed in the essential drugs list issued by the Drug Administration and Control Authority (DACA).
- Only government facilities can presently prescribe TB drugs, in line with DOTS programme.
- Only government and Red Cross facilities can presently prescribe ART, though there are plans to allow some private hospital facilities to dispense free ART in certain circumstances.

6.4 TYPES OF PRIVATE SERVICE OUTLETS

There are three main types of legal private clinic that a franchise network could contract with (Jefferys 2004); ranging from small clinics managed by a nurse to higher clinics managed by a doctor. However, there is no clear data on how many there are presently in each category, and further research would be needed for the appropriateness of each for entering into a franchising arrangement. Jefferys's study identified that only 195 of the 1,500 doctors recorded in the country are fully independent, however a significant number of the public sector doctors are likely to work part time in the private sector to supplement their incomes.

TABLE (II):

Clinic type	Description	Staffing levels
Small	Run by a health assistant or clinical nurse; general outpatient services offered.	Two staff minimum
Medium	Run by a health officer or general medical practitioner; diverse outpatient services offered	Three staff minimum
Higher	Run by at least one general medical practitioner or specialist; diverse outpatient services offered; could possess up to five beds for delivery and emergency services	Six staff minimum

According to recent MoH data, there are 311 pharmacists, 309 Drug Shops and 1,856 Rural Drug Vendors.

6.5 TYPICAL FEE STRUCTURE

It is also useful to consider the present earnings of providers in the private sector, to evaluate the kind of charges that might be made to a patient for a franchised service. While data is limited, Jefferys (2004) identified a range of illustrative charges for services ranging from 10-20 Birr ($1.10-$2.20) in urban areas to see a medical doctor or health officer, while a nurse would often see a patient for under 10 Birr ($1.10). Clients are not usually charged again for the consultation if they return for a repeat visit within 10 days. In rural areas, the client may pay 10-15 Birr ($1.10-$1.65) to see a doctor, though will more often receive a 'free' consultation but be charged extra for drugs prescribed. There are very few nurses operating in private practice outside urban areas.

The closer the agreed fee that a franchise member can charge for a franchised service to the present market rates, the more attractive the membership of the franchise will be to the provider. In practice, franchisees have often shown themselves willing to provide reduced rates to specific target groups, such as youth or PLWHA.

6.6 NEXT STEPS

Future research that may give a more detailed insight into the potential for social franchising could include the following:

1. Private sector care giver provider surveys: In depth interviews conducted with private providers (medical doctors, nurses, health assistants) to assess capacity and willingness to engage in franchised health service activities, including determining skill and service gaps, present levels of compliance with international standards, existing client flows etc.

2. Stakeholder assessment survey: In depth Interviews with key stakeholders including government, private sector and community and youth leaders to explore the potential and the demand for the franchising concept.

3. Pharmacy/outlet survey: To determine the current types of drugs and services being accessed directly through the pharmaceutical sector by people not visiting trained medical providers; in particular this will look at inappropriate antibiotic use among people seeking treatment for STIs and OIs.

4. Client based survey: A community based survey will look at the wider needs and demands of potential customers of franchised services, covering such aspects as service availability, location and branding preferences, and current health expenditure as well as willingness to pay for improved services among various target groups, including youth, PLWHA, migrant workers and other relevant groups.

GLOSSARY OF COMMON TERMS USED IN FRANCHISING:

Traditional franchise – also known as geographic franchise, this system gives a franchiser the sole right to sell goods in a demarcated area. Common examples include car dealerships and gas stations.

Business format franchise gains the rights to the product and the process of the franchise, and is usually required to follow certain service standards. This structure entails a close ongoing relationship between the franchiser and the franchisee. Examples include fast food outlets such as Burger King or Starbucks.

Stand alone franchise - a franchise outlet that only sells the products of the brand. Most business format franchises are of this nature.

Fractional franchise: a franchise outlet where only some of the goods or services provided from an outlet are part of the branded group. Traditionally rare in commercial retail because of the lower degree of control of the brand, some aspects of this exist in Post Office branches within local stores in the United Kingdom, or in the Ace Hardware network in the United States.

Social franchise: a franchise system, usually run by a non governmental organization, which uses the structure of a commercial franchise to achieve social goals.

ANNEX 1: CASE STUDY - FRANCHISED TB DOTS IN MYANMAR

In 2003, Population Services International (PSI)/Myanmar incorporated TB DOTS into its existing Sun Quality Health franchised network of private GPs that was already providing family planning, malaria, STI and other simple medical services. The TB service component was developed as follows:

- The franchiser (PSI) conducts a 3-day training sessions in TB DOTS for selected franchisees.
- On the basis of formative research, the franchiser developed a logo to "brand" TB DOTS. The logo was used as a central communications theme in designing and producing a range of communications materials, including two 60-second TV spots using a famous celebrity, aired on national television and mobile video units, as well as signboards, leaflets, posters, promotional items and forms. The same logo is used in both the public and private sectors.
- The National TB Programme (NTP) provides the franchiser with anti-TB drugs (fixed dose combination drugs) that are supplied free of charge by WHO's Global Drugs Facility. The franchiser in turn provides these drugs free of charge to franchisees who provide them free to patients.
- The franchiser developed a set of branded patient kits containing all the drugs and supplies needed to treat one patient: six kits were developed to cover the intensive and continuation phases of each of three categories of treatment.
- The franchiser worked with the NTP to train and accredit public and private laboratories so that they could perform sputum microscopy to required standards. The franchiser loans these laboratories a new microscope for the duration of the collaboration.
- The franchiser employs laboratory supervisors to support the accredited private laboratories, conduct continuous quality assurance tests, and pass samples of slides to the NTP for further checking.
- The franchiser negotiated a payment scale with the franchisees and laboratories. It was designed to provide some recompense for services provided while ensuring that cost would not be a barrier to low-income clients. Participating franchisees may not charge anything for dispensing the drugs or observing the treatment, but may charge the equivalent of $0.34 per substantive medical consultation, with up to ten consultations for the duration of treatment. In practice, it appears that most of the franchisees are waiving even this token fee and providing the service entirely free of charge to clients.
- The franchiser maintains a telephone "hotline" to respond to questions from franchisees on a daily basis. The questions raised and responses given are summarised in a monthly bulletin distributed to all providers.
- Record-keeping has been kept to the minimum necessary to monitor and evaluate the programme and report to NTP. Franchisees maintain a simple client history form that tracks treatment progress. Franchise supervisors complete a new TB record for each client during their regular visits to the franchisees. They visit each TB clinic weekly to register new clients into a management information system, and to track interrupters. The franchiser provides TB register data to the NTP and to each Township Medical Officer every quarter. Franchise service statistics are thus included in aggregate

data of the national programme.

- The franchiser conducts quarterly patient surveys on a random sample of patients to monitor costs and treatment progress. The franchiser also conducts mystery client surveys to participating laboratories to monitor compliance with free sputum microscopy and validate the provision of information on correct sputum taking.
- The franchiser employs outreach workers to assist franchisees with tracking of patients who have interrupted treatment.
- The franchiser recently initiated a pilot incentive scheme to reward up to 250 of the poorest TB patients with small cash payments at key points during the treatment provided they demonstrate 100% treatment compliance. Patients are selected by franchisees

From March 2004-August 2005, the main results were as follows:

- 223 medical providers and staff of 26 laboratories were trained in TB DOTS
- Over 20,000 clients referred by franchisees were tested at accredited laboratories
- Over 5,000 confirmed TB cases have been registered
- The cumulative treatment success rate is about 79%, which is in line with national targets for urban areas.
- The default rate is just 7%
- New cases are being registered at the rate of about 450 per month
- A client survey indicated 100% compliance by providers with the agreement to provide free TB drugs
- The majority of TB patients seen at Sun Quality Health DOTS clinics are from the lowest two income categories (66% of the patient survey sample).

Less tangible results have been impressive. The participating GPs have shown genuine enthusiasm for TB DOTS. In two cases, groups of GPs have spontaneously established funds to subsidise transportation costs and sick leave for TB clients who are especially impoverished. The attitude of the NTP has been positive throughout. The DOTS programme has served as an opportunity to bring together private and public sectors: for example, the first batch of trainees received their certificates from the Minister of Health.

The franchiser now plans to expand the programme to additional geographic areas.

ANNEX 2: CASE STUDY - POST-TEST SUPPORT SERVICE NETWORK, ZIMBABWE

Background

In June 2003, the franchiser, PSI/Zimbabwe took over an existing post-test service network from a previous USAID funded project. The project had four sites in two major urban areas, all of which were in proximity to existing franchised VCT centres also managed by the franchiser. The franchiser experimented with two different models, directly and indirectly managed sites. One of the conditions of the takeover was to create a new branded, quality approach, more focused on people affected and infected by HIV &AIDS. The new service was became part of a continuum of services between a workplace HIV/AIDS programme, franchised VCT services, and post-test support services.

Objectives

The new network was designed to address real needs and create a safety net or smooth landing for those who had just received a positive result, as well as for their families. The project aims to reduce HIV related stigma and discrimination, and ultimately to reduce further HIV transmission and re-infection. The psychosocial support, and referral linkages to care & support organizations, information services etc are further supported by the provision of affordable health products that can improve the lives of PLWHA.

Primary Services

1) Psychological support, given through Individual counseling sessions, couple counseling, including discordant couples, group sessions and Post-test club/peer support. These sessions lead to better acceptance of positive test results, a reduction in gender violence & HIV transmission, and better support for discordant couples.

2) Nutritional support through nutritional counseling, a nutritional booklet, and provision of high caloric, vitamin and micronutrient enriched food product known as "e'Pap". The nutritional package improves ART and OI treatment outcome in patients of national ART program

3) Comprehensive HIV/AIDS counseling with an emphasis on positive living; the centre works as a resource centre, with twice weekly HIV/AIDS Group Information sessions aimed at increased awareness, risk reduction, treatment literacy, and peer support through group discussions/disclosure. Information will generally be transmitted further than the support groups to wider community of PLWHA

4) ART adherence counseling, in collaboration with the Ministry of Health's national ART program. Patients are given preparation for ART before the actual treatment starts, a treatment readiness assessment, and adherence support while on treatment. Adherence assessment and monitoring is

carried out through self reporting and pill counts, in parallel with clinical and biomedical assessment for treatment failure.

The referral system

Each centre has a referral coordinator, who maintains a referral directory, organises stakeholder meetings with key HIV service providers, receives information on availability and quality of other HIV service providers, and maintains a register of clients referred to outside services, and follows up to monitor attendance.

Lessons learned

So far, the programme has identified that there is a high demand for quality post-test services in Zimbabwe, but that higher coverage of post-test centres is needed to meet this demand. The clients appreciate the tangible benefits offered by the post-test services, and the programme has so far experienced > 95% ART adherence based on self reporting and pill counts.

ANNEX 3: CASE STUDY - PROPOSED FRANCHISED NETWORK APPROACH FOR INTEGRATED VCT AND STI SERVICES FOR ETHIOPIA

This approach will create a franchised network of services, including STI syndromic management, STI treatment kits, and Voluntary Counseling and Testing for HIV/AIDS. The franchiser develops and pre-tests the concept, and contracts a network of private sector-based clinics, contracted to offer information, services and products to low-income target groups.

This concept comprises multiple channels of service provision:

1. The first channel involves an extensive **network of small primary health care centres**, recruited from existing private sector providers, including health NGOs. These centres will primarily provide improved services for the prevention and treatment of STIs using the syndromic management approach, following MoH and WHO guidelines.

2. The second channel will consist of a **group of network members who provide VCT**. This group will be recruited from the most successful of the centres established above or from those members who may already provide some level of VCT service. The franchiser identifies, trains and supports those network members who demonstrate the capacity to make the transition to offering high quality VCT. The new VCT providing network members will share standardized training, operating procedures, counseling and testing protocols, and monitoring and evaluation tools to ensure confidential and high-quality VCT service delivery.

3. The third channel involves **the establishment of a model stand alone VCT centre**, managed directly by the franchiser or an appropriate NGO. This VCT centre will be consistently branded with the centres described above and will also provide STI services of a comparable quality. This centre, in conjunction with other VCT services provided by the MoH and private sector VCT providers, will receive referrals from the network providers, and receive clients who walk in off the street. This model VCT centre will set service delivery standards that other providers of VCT will be able to aspire to, and will become part of a strong and supportive referral network into appropriate community care services and to government ART services, PMTCT, TB screening and family planning services. In subsequent years, a mobile VCT service can be added on to increase the project range to rural areas.

4. The fourth channel is a **network of accredited pharmacies and drug stores** that sell a range of branded STI treatment kits, receiving referrals from the medical providers. These kits provide a practical and effective aid to service providers in implementing the syndromic approach to STI management. The kits contains all the components, including drugs and IEC materials necessary to treat and to educate STI patients so that they complete their course of treatment, refer their partners, and adopt preventative measures in the future. These kits are only be available through the

franchise network. These sites could also refer clients to the VCT sites and provide IEC materials to encourage HIV testing.

All project components will be supported by a **comprehensive multi-media generic and branded communication campaign**. The campaign will address barriers to VCT such as fear of HIV-positive test results or lack of confidentiality. The campaign will also promote motivating factors for VCT such as 'peace of mind' and linking up with care and treatment programs. Promotions will also encourage prompt treatment of STIs by trained service providers and will raise brand awareness. Media outlets will include radio, television, and community events.

VCT through the project's stand alone centre will be affordable for low income people who cannot pay typical private sector prices, and network providers that agree to graft VCT services to their service delivery package will receive sufficient support, including salary support to counsellors and the provision of free HIV test kits that will enable them to keep their prices affordable.

An important component of quality STI treatment and VCT is referrals to other services according to patients need for PMTCT, ART, TB DOTS and other related care and support services. To strengthen the referral network STI centre staff will promote VCT among clients offered either by the individual service provider, if applicable, or by the most appropriate specialised VCT centres, including government centres.

Targeting

The network would target specific high-risk groups who are often the least likely to seek services from the public sector. STI treatment and VCT services offered through the clinic network, and STI treatment kits available in local pharmacies, would therefore target:

- Sexually active youth, particularly males, age 15 to 24;
- Symptomatic STI patients, particularly males, and their partners, who will seek out confidential STI services;
- Commercial sex workers and their clients/partners.
- Couples, especially discordant couples

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