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Social franchising reproductive health services
Can it work?
A review of the experience

Elizabeth Smith

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Elizabeth Smith: Consultant in Private Sector Participation in Health

Edited in 2001 by Dr Liliana Risi, Head of Research, Marie Stopes International.

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Acronyms

DFID	Department for International Development (formerly ODA)
ECU	European Currency Unit (now defunct)
FP	Family planning
GBP	Great British Pound
IMCCSDI	Integrated Maternal Child Care Services and Development Inc. (commonly known as SDI)
IEC	Information, education and communication
IUD	Intra-uterine device
KfW	Kreditanstalt für Wiederaufbau
MCH/FP	Maternal and child health and family planning
MEXFAM	Fundación Mexicana para la Planeación Familiar
NGO	Non-government organisation
PHC	Primary health care
PSI	Population Services International
PSPI	Population Services Pilipinas Inc.
SDI	see IMCCSDI above
SMP	Social Marketing Pakistan
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TL	Tubal ligation (female voluntary surgical contraception)
USAID	United States Agency for International Development
USD	United States Dollar
VSC	Voluntary surgical contraception

Abstract

Objectives
To provide an introduction to social franchising and examine its potential to help improve access to sexual and reproductive health (SRH) services in developing countries. To develop guidelines for social franchising in reproductive health.

Methods
A review of the experience of franchising in the reproductive health field, particularly two initiatives in Mexico and the Philippines funded by the United States Agency for International Development (USAID). The study evaluates various social franchises and compares social and commercial franchising in order to develop guidelines for social franchising in reproductive health.

Results
Social franchises in Mexico and the Philippines were visited and evaluated as part of the study. The two franchises exhibited advantages and disadvantages in common, but neither represented an entirely successful example of social franchising from which to build a model.

In terms of benefits, users received consistent standards of care at affordable prices, non-government organisation (NGO) franchisors were able to focus on financial sustainability and franchisees benefited (perhaps disproportionately) from subsidies and support in running their businesses.

Donors are attracted to franchising because it appears to:
- mobilise the private sector to provide reproductive health services
- control the quality of care provided within the private sector, and
- be sustainable through recovering costs from users and franchisees.

The two USAID-funded franchises examined in this study appeared to be successful on the first two counts. However, the social franchise designs were dependent on significant start-up funds from donors, ongoing technical support from US-based agencies and donor-subsidised contraceptive supplies for long term sustainability. In addition, the designs appeared to be too generous to the franchisees at the expense of the donor and, ultimately, at the expense of franchise sustainability. Nevertheless, the franchisors could reduce the impact of high franchisee costs by being more efficient in the management of franchisees, thus increasing their returns and those of donors.

Conclusions
The study found that social franchising has some potential to be used in reproductive health. Franchising can employ a wide range of skilled, semi-skilled and unskilled but trainable people in developing countries to expand access to good quality, affordable family planing and other reproductive health services in the private sector.

However, the sustainability of the approach is not yet proven; nor is its cost-effectiveness. Start-up and ongoing technical support costs of the franchises examined were significant and the attractive packages designed to retain franchisees might not be the best use of scarce donor resources and could jeopardise the prospects for long term sustainability. Careful consideration must therefore be given to costs and their implications early on in the design and appraisal phase of any social franchise.

Critical features in the design of a social franchise in reproductive health comprise:
- a tried and tested financial and operating franchisee model
- careful franchisee selection and recruitment
- an appropriate franchisor model
- franchisor identification
- a legal model to govern the franchisor/franchisee relationship.

However, it is important to recognise that there is no blueprint for a successful social franchise, nor is social franchising the sole answer to mobilising the private sector to provide family planning and other reproductive health services. Nevertheless, social franchising may, at a cost, provide a stimulus to raise standards for clients willing to pay and encourage private practitioners to deliver high quality reproductive health services for the first time.

Background

Social franchising

The current interest in social franchising
Franchising is a mechanism which has been long used in the private sector to enable rapid expansion in the distribution of products and services of a specified quality. Franchising harnesses unused capacity amongst entrepreneurs in the private sector to achieve this. These features of franchising: mobilisation of the private sector; control of quality of care; and rapid expansion of provision, make franchising an attractive mechanism for the delivery of SRH products and services in the developing world.

Private sector mobilisation
The private health sector is seen as being increasingly important in the delivery of SRH services in some developing countries. This is for three reasons:
- people in some developing countries already rely on the private sector[1] for health care to a large extent (and this is even the case for poor people: access to public services may be difficult for social, economic and geographical reasons)
- there is growth in private sector practice in general as increasing numbers of newly-trained doctors do not find employment within the public health system
- private practitioners may provide better access to health services (more convenient locations and opening hours and better client-provider relationships) than public or even NGO services. Franchising can use the spare capacity in the private sector to deliver SRH care services.

Quality of care
Interest in the private health sector is tempered by concerns about the absence of effective regulation and monitoring of standards, as well as the risk of financial exploitation. In addition, few private practitioners are adequately equipped or trained in the preventive aspects of SRH care, preferring to focus on curative care which is likely to be more lucrative. Social franchising can incentivise the delivery of preventive care and offer assurance that products and services are delivered to a consistently high standard and in a non-exploitative manner.

Rapid expansion of provision
The rapid growth in service delivery outlets, which franchising affords, offers donors and developing country governments the opportunity to expand SRH service provision relatively quickly, particularly if practitioners with established practices are recruited into a social franchise network.

Commercial franchising
Franchising is a term in common use; franchising is a dynamic sector in modern economies and a familiar part of our lives as consumers. Indeed, a survey in 1997 stated that franchising accounted for more than ECU 75 billion per year of retail sales in Europe[2] and its importance in the retail sector continues to grow rapidly. However, why franchising should be the favoured way of expanding a business is not generally understood; nor are the roles of franchisor and franchisee.

A broad but useful definition of franchising is:

> ***"an arrangement whereby a manufacturer or marketer of a product or service (the franchisor) grants exclusive rights to local independent entrepreneurs (franchisees) to conduct business in a prescribed manner in a certain place over a specified period."***[3]

In commercial franchising, profit drives the relationship: the end user of the product or service pays money to the franchisee for the product or services, from which the franchisor also receives a share.

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1 In some developing countries, for example in Pakistan, India and Bangladesh, it is estimated that over 70% of health care is privately purchased.

2 European Franchising Federation. European Franchising Survey; page 357. 1997.

3 Hoffmann R C and Preble J F. Franchising: Selecting a Strategy for Rapid Growth. Long Range Planning; 24, 4: 74-85. 1991.

In what market conditions is franchising an appropriate strategy?
Commercial franchising works when:
- there is sustained or growing consumer demand for a product or service
- the structure of the market can sustain new entrants, and
- there are trainable franchisees with skills and finance.

Why would an organisation choose to expand its business through franchising?
First and foremost, franchising removes the organisation's capital investment and its managerial and organisational constraints to growth. The franchisees provide the start-up capital and working capital and take on the day-to-day management of the business. This leaves the franchisor free to manage the franchisees with a small dedicated team and to promote the franchise brand. The franchisees who are selected are more motivated to succeed than employees of the franchisor would be (since the rewards are potentially greater) and bring local knowledge of the market to the running of the business.

Why would an entrepreneur choose to set-up a franchise rather than developing a business or buying a business outright?
The advantage for an entrepreneur is that he or she is provided with a business formula, incorporating the products, services and systems necessary for running a business and, most importantly, which has proven success. By buying into a franchised business, the franchisee lessens his or her business risk. The franchisee also benefits from training in all aspects of the business: he or she acquires skills in business administration and selling products or services to a specified standard.

How does franchising benefit the customer?
The benefit for the customers of a franchised business is the reassurance of a recognised brand or trade name and the associated assurance of good quality. The customer also draws comfort from the fact that a franchisee will have been trained and is equipped, supplied and monitored by the franchisor whose aim is to protect its brand or trade name. Prices are also often controlled by the franchisor.

The advantages and disadvantages for the franchisor, franchisee and customer are summarised in the Appendix (Table 1).

A significant feature of a commercial franchise is that while individual franchisees own much, if not all, of the physical assets of the business, it is the franchisor who owns the brand name and business format and has the right to determine and control how they are used. Franchisors therefore remain in strategic control of franchisees' businesses and take some of the revenue that is earned by the franchisees.

Franchisees, on the other hand, have greater financial incentive to work harder than would be the case if they were simply employed by the franchisor. The relationship between franchisor and franchisee is mediated by the franchise agreement which clearly spells out what each expects from the other, including the financial linkages between franchisee and franchisor. The franchisor has recourse to the contract in law to enforce its terms and to exercise control over the franchisee.

How the franchisor ensures that franchisees abide by the quality standards and procedures laid down by the franchisor is at the heart of current interest in franchising for SRH. In commercial franchising, franchisors use a variety of mechanisms to achieve this:
- regular monitoring visits to franchisee premises
- close scrutiny of financial and sales reports
- monitoring of sales of the franchisor's products or supplies to franchisees
- spotchecks and visits by mystery shoppers.

Types of franchising
Franchising falls into two main categories: first and second generation. The categories reflect the historical development of franchising; the difference between the two is the degree of prescription and control over the franchisees' operation. Both first and second generation franchising are relevant to social franchising in SRH.

First generation franchising is essentially a dealership arrangement, where the franchisor grants franchisees an exclusive territory in which to market and sell the franchisor's product or service. The franchisor allows the franchisee to sell under the franchisor's trademark to standards of service determined by the franchisor.

Second generation franchising adds a further element: the franchisee not only sells the franchisor's products or provides the service but does so in accordance with the franchisor's set of precisely laid down standards and methods or 'format'. This is in contrast to first generation franchising where the day-to-day running of the business may be of less concern to the franchisor. In second generation franchising, the franchisor wants to know exactly how the business is being run. It is second generation franchising which is most prevalent in the retail sector in Europe today.

Within first and second generation franchising, there are two types of franchise: a 'stand-alone', independently established and operated franchise (an independent business) and a 'fractional' franchise which is added to an existing business to create an additional income stream for the franchisee.

Social franchising
Social franchising is a development approach which applies modern commercial franchising techniques to achieve social rather than commercial goals; it is therefore analogous to social marketing which has been used to good effect in the promotion and distribution of preventive and curative health products.

Social franchising in sexual and reproductive health
SRH social franchising in SRH involves the targeted use of financial resources to establish and operate franchises offering SRH services, generally, but not exclusively, recruiting medical practitioners or paramedics as franchisees.

Social franchising lends itself to SRH care: longer acting family planning methods and other SRH procedures such as injectables, implants, male and female voluntary surgical contraception, safe motherhood services, safe abortion services and diagnosis and treatment of infertility, reproductive tract infections and sexually transmitted diseases all require trained providers and minimum standards of advice and care.

For social franchising in SRH, services can be defined into 'packages' with minimum standards for quality. Although no one franchise would be expected to deliver a full range of SRH care, each could provide a limited menu of services. Users would then benefit from the improved access to services and the assurance of quality afforded by a franchise.

Conversely, social marketing is ideally suited to SRH products (usually condoms and oral contraceptives), where information about the product can primarily be given through printed packaging or leaflets. Retailers may receive some training in the provision of product information but, generally, social marketing does not rely on this happening.

Is franchising an appropriate strategy?
Where the following conditions are present together, as is the case in some developing countries, social franchising can be an appropriate and attractive strategy for the rapid expansion of good quality SRH services:
- there is increasing unmet demand for good quality SRH services
- there are people who are prepared to pay (to an extent) for good quality SRH services
- there is limited access to services, especially in poor urban or rural areas
- there is a dearth of private practitioners who are adequately trained to provide preventive and curative SRH care
- there is a lack of suitably equipped facilities in the private sector
- there is under-utilised capacity amongst various cadres of medical practitioners
- there are difficulties for potential franchisees in the raising of start-up and working capital to establish their own practices.

In some developing countries, then, the preconditions for successful social franchising appear to exist: there is sustained or growing consumer demand; there is a pool of potential franchisees; and a market which can sustain new entrants. However, across developing countries, there is a wide variety of market types, each with different levels of supply, demand, capacity to pay for services, skills and experience of franchising systems as well as different legal systems. Each market needs to be approached on its own merits and the effects of these variables need to be accounted for in the detailed design of any social franchise. This will be demonstrated in the examples of social franchising below (see Results).

Social versus commercial franchising

There are five principal differences between commercial franchising and social franchising. These differences are critical in determining the structure and design of social franchises. In social franchising:

- there is no transfer of investment risk
- the market preconditions and franchising disciplines deemed essential for commercial franchising may not be present
- there is an additional stakeholder in the franchise: the donor
- the balance of experience between franchisor and franchisee is altered
- ineffective or inappropriate legal systems may undermine the franchise agreement.

There is no transfer of investment risk

In commercial franchising, there is a transfer of business risk from the franchisor to the franchisee. The franchisor remains motivated by profit but foregoes part of the trading profit in favour of the franchisee. Had the franchisor wanted to retain all of the profit, it would have continued to operate the franchise as a directly owned business. Instead, the franchisor chooses to pass the investment risk and the bulk of the profits to the franchisee, relying on an initial fee, management service fees or exclusive supply of goods for income.

In social franchising, the initial capital funding, which in commercial franchising is usually provided by the franchisee, is provided by the franchisor or another party - usually a donor - on a permanent, temporary or loan basis. The situation is therefore inverted: there is no transfer of investment risk. Working capital may also be provided by the franchisor or another party until the franchisee is financially self-sustaining.

The removal of the franchisees' financial risk alters the relationship between franchisor and franchisee. The risks of financial loss and failure, both of which are powerful driving forces for the franchisee in commercial franchising, may not be present or may be reduced; the franchisee may not be sufficiently motivated to make the franchise succeed, as he or she has little to lose.

Low motivation to succeed in franchisees can be a serious challenge in social franchising; it could result in difficulties in controlling franchisees and lead to high franchisee turnover. Common strategies to deal with these issues are careful franchisee selection and over-compensation of the franchisee (at the expense of users and the franchisor), even though these could jeopardise the long term financial sustainability of the franchise. This is evident in the first two case studies below (see Results; examples 1 and 2).

The preconditions for commercial franchising may not be present

In social franchising, the franchisor's motivation is not solely commercial; the franchisor is pursuing social interests as well. The franchisor is acting to stimulate provision in the private sector which market forces have failed to deliver. The franchisor may therefore not take as commercial and 'hard-nosed' an approach to recruiting and managing its franchisees as a commercial franchisor would. Equally, the market preconditions usually deemed essential to commercial business format franchising may not be present and franchising disciplines may not be the same or present or may be difficult to implement and control. This is evident in some of the case studies below (see Results).

There is an additional stakeholder in the franchise

In a social franchise, there is an additional stakeholder - the donor - who is totally absent from a commercial franchise. The presence of a third party - a donor with its own policy and programming agenda, providing finance for the franchise - may distort expectations of the success of the franchise. This may interfere with and adversely affect the relationship between franchisor and franchisee and the motivation of each to succeed.

The balance of experience between franchisor and franchisee is altered
In commercial franchising, franchisors prefer franchisees who have little or no experience of the franchisor's business; this strengthens the bond of mutual dependence between franchisee and franchisor. A further consequence of this is that customers visit franchised outlets because of the reputation of the franchisor's brand rather than the reputation of the individual franchisee.

In SRH social franchising, franchisees will usually have some medical training. There is a danger that the local reputation of the franchisee will be more important to clients than the 'pulling power' of the franchisor's brand, potentially weakening the bond of mutual dependence between franchisor and franchisee. If the franchisee decides to break free from the franchise arrangement and set-up independently of it, clients may feel more loyalty to the practitioner than to the franchise.

Nevertheless, it can be argued that while this may weaken the franchise, better quality SRH care is being provided; the ex-franchisee is likely to continue to provide better quality SRH care than would have been the case if he or she had not been part of the franchise at all.

Inappropriate legal systems may undermine the franchise agreement
Commercial franchising in developed countries is supported by a legal infrastructure which recognises and facilitates franchising. This centres on the status and enforceability of the franchise agreement: the contract which sets out the parameters of the relationship between franchisor and franchisees.

In developing countries, however, ineffective or inappropriate legal systems may undermine the effective use of the franchise agreement by the franchisor as an important means of control of the franchisee. Furthermore, franchising may not be recognised as a legitimate business mechanism.

In spite of these differences and the challenges they pose, social franchising appears to provide a stimulus to raise standards of quality for clients willing to pay for services and encourage private practitioners to deliver high quality SRH services for the first time. These outcomes presently conform to the needs and expectations of donors and developing country governments.

Methods

A review of the experience of franchising in the reproductive health field, particularly two USAID-funded initiatives in Mexico and the Philippines. The study evaluates various social franchises and compares social and commercial franchising in order to develop guidelines for social franchising in reproductive health.

The paper aims to provide an introduction to social franchising and examine its potential to help improve access to sexual and reproductive health (SRH) services in developing countries. The focus of this paper is the potential for franchising to ensure good quality advice and care in the private health sector as well as the sustainability of social franchising. The report draws from examples of social franchising projects funded by USAID, DFID and other donors to illustrate the scope and potential of social franchising in SRH.

An introduction to franchising and discussion as to why it is of interest in SRH is given; the concept of first generation and second generation franchising is introduced; and the essential differences between commercial franchising and social franchising for SRH are highlighted (see previous section - Background).

Two established SRH social franchises (USAID-funded) and some more recent examples of social franchising projects (DFID and other donor-funded), focussing in particular on the mechanisms for ensuring quality of care, are examined (see Results). The report goes on to discuss the limitations and advantages of the social franchising approach (see Conclusions).

Results

This section describes a number of individual sexual and reproductive health (SRH) social franchises, with emphasis on the potential for sustainability (both institutional and financial) and the mechanisms used to ensure that quality standards are maintained. The origins of SRH social franchising are traced and two established second generation social franchises in Mexico and the Philippines are described (see examples 1 and 2), leading to some conclusions about the use of social franchising in SRH. The report goes on to examine six more recent SRH social franchises (mostly DFID-funded), most of which are at the design or early pilot stage (see examples 3-8). Nevertheless, the wide variety of services offered and franchisors, franchisees and quality assurance mechanisms used, illustrates the breadth of possible uses for social franchising in SRH in developing countries.

Each franchise is described using the following format:
- objective and brief description of social franchise
- social franchise type
- status, donor and budget
- services and/or products provided
- target groups
- franchisor
- franchisees
- number of franchisees
- quality control mechanisms
- potential for sustainability

and a summary of all eight examples is given in the Appendix (Table 2).

The origins of SRH social franchising

It is perhaps not surprising that early experience of SRH social franchising arose from USAID-funded initiatives. Modern commercial franchising originated in the United States (US) and one third of all retail sales in the US are from franchised businesses. There is also some commercial franchising in the health sector in the US, including dental clinics, birth centres, kidney dialysis centres, optometrists and trauma centres. This experience has fed into the design of SRH social franchises in developing countries.

USAID-supported first generation SRH social franchises

A study of USAID-funded social franchising in SRH in 1995[4] reported that there was more long running experience of first generation than second generation social franchising. The USAID-funded first generation approach is typified by the project executing agency (the franchisor) recruiting private doctors or other medical practitioners into a network of franchisees authorised to provide particular SRH products or services. They are trained through local organisations (often NGOs) and authorised by the franchisor when they reach an agreed standard of knowledge and skill. A franchisee is provided with any necessary equipment and products are distributed either through existing distribution networks or by the franchisor. A local marketing company develops and promotes the franchise brand through mass media and widespread advertising. Products are usually provided to users at a price subsidised by the donor; alternatively, product manufacturers might make products available to the franchisor at a discounted price in expectation that the social franchise's promotion of their product will expand the market significantly. An example of this approach is described in the case studies below (see example 8).

USAID-supported second generation SRH social franchises

Second generation social franchising in SRH takes a more prescriptive approach and there are fewer examples of these arrangements. However, USAID have supported two NGOs, one in Mexico - la Fundación Mexicana para la Planeación Familiar (MEXFAM) - and one in the Philippines - Integrated Maternal Child Care Services Development Inc. (IMCCSDI, known as SDI) - which, with the prospect of a phased reduction in USAID financial support have developed second generation social franchises in an effort to work towards greater financial sustainability. It is instructive to look at these social franchises in more detail as they have both been in existence for some time and therefore provide useful lessons in social franchising (the MEXFAM and SDI franchises are summarised below; see examples 1 and 2):

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[4] Smith E. A Project to Develop a Blueprint for Franchising Family Planning and other Reproductive Health Services (for Marie Stopes International). Funded by DFID's Seedcorn Fund for sexual and reproductive health. 1995.

- both franchises confer benefits on users; in particular, the franchises provide SRH care at affordable prices, the quality of which is regularly checked and monitored by the franchisor
- both social franchises use cadres of medical practitioners who are either underemployed or unemployed and therefore motivated to join a network which gives advantages to a sole practitioner
- a major factor in the development of both social franchises was phased reductions in donor resources; the disciplines of franchising are helping the franchisors to focus on, and work towards, financial sustainability
- both franchises required significant start-up resources from donors
- there is evidence that in both examples, franchisees are significant beneficiaries of the system, possibly because franchisors fear losing franchisees once they are recruited and over-compensate them. It is questionable whether this is the best use of scarce donor resources
- neither franchise maximises its income from franchisees nor runs its operations at highest efficiency. Franchisors could increase their income from franchisees and reduce their own costs which would make the financial sustainability of the franchises more likely.

The remaining six examples of social franchising of the eight which follow, help to illustrate the range of possible applications of social franchising in SRH (see examples 3-8). None follows the precise pattern of the two second generation examples discussed above (and summarised in examples 1 and 2); most aim to add a franchised service on to an existing clinic, practice or organisation's activities, which is a less capital-intensive alternative. For examples 1-8, please see overleaf.

Example 1. Mexico - Providing maternal and child health and family planning (MCH/FP) through a social franchise

Objective and brief description of social franchise
- to deliver high-quality, low cost MCH/FP services and information to low income peri-urban and urban communities through stand-alone doctors' practices, thereby establishing a network of financially self-sustaining clinics.

Social franchise type
- a second generation, stand alone social franchise.

Status, donor and budget
- the franchise began its development in 1990 in response to a gradual withdrawal of donor funding to the previous 'Community Doctors Programme' which had been funded inter alia by USAID since 1984
- MEXFAM currently receives no external funding specifically for the social franchise but some overhead costs are funded by external donors.

Services and/or products provided
- a package of MCH/FP services, delivered according to protocols set by the franchisor.

Target groups
- women and children in low-income urban and peri-urban areas.

Franchisor
- la Fundación Mexicana para la Planeación Familiar (MEXFAM), the Mexican affiliated member of the International Planned Parenthood Federation.

Franchisees
- underemployed or unemployed doctors.

Number of franchisees
- in 1995, 290 doctors were franchisees, although
- a further 475 doctors had been community doctors in the previous programme and left to become 'MEXFAM affiliated doctors'.

Quality control mechanisms
- franchisees receive initial training in family planning followed by six-monthly refresher training
- franchisees use MEXFAM's own protocols for preventive care and FP
- a franchisee coordinator visits the franchises on a monthly basis and helps to draw up action plans
- MEXFAM's medical director and senior staff perform periodic quality audits
- MEXFAM sets prices for each franchisee in consultation with the local community that he or she serves; there are mechanisms to provide services to poorer groups within the target communities.

Potential for sustainability
- initial capital costs (donor funded through the franchisor) including developing and refining the franchise, recruitment, training, equipment and the operating subsidy were high
- franchisees pay a flat monthly fee for ongoing monitoring and supervision, use of the franchise brand and national advertising
- a financial evaluation showed that some franchisees could afford to pay higher turnover-related fees (rather than a flat rate) and that MEXFAM's supervision could be streamlined to reduce costs
- a financially sustainable social franchise, funded entirely by user fees, could then be attainable, although there would still be reliance on donor-subsidised contraceptive supplies.

Example 2. The Philippines - Providing maternal and child health and family planning (MCH/FP) through a social franchise

Objective and brief description of social franchise
- to provide MCH/FP services to low and middle-income groups in urban areas through a network of midwives, and
- to reduce the operating subsidy for an existing donor-funded project.

Social franchise type
- a second generation, stand alone social franchise.

Status, donor and budget
- the franchise developed in response to a gradual withdrawal of donor funding to an NGO-operated and managed MCH/FP clinic network initiated in 1984
- the franchise has been under implementation since 1993, with funding from USAID routed through John Snow, Inc. Research and Training Institute; the budget is not known.

Services and/or products provided
- an agreed package of MCH/FP services, delivered to a standard set by the franchisor.

Target groups
- women and children in low and middle-income urban areas.

Franchisor
- Integrated Maternal Child Care Services and Development Inc. (IMCCSDI, known as SDI).

Franchisees
- midwives - either existing SDI employees or independent midwives.

Number of franchisees
- in 1995 there were 49 franchisees and plans for the expansion of the network.

Quality control mechanisms
- SDI provides initial technical and administrative training in all aspects of the clinics' operations (clinical and business systems)
- SDI provides regular monitoring, supervision and further training as needed
- Department of Health officials perform quarterly inspections
- SDI sets prices for clients; there are mechanisms to provide services to poorer groups within the target communities.

Potential for sustainability
- initial costs of developing the social franchise concept, the business format and protocols and funding premises, renovation loans for franchisees, equipment, start-up supplies and training as well as technical assistance to SDI were high
- when the clinics become financially viable, franchisees pay a flat monthly fee to SDI to cover some of their costs
- franchisees generally earn significantly more than they would if they were employees of SDI, in particular through assisting with deliveries, which is not part of the franchise package
- the franchisor could expand the network of franchisees, take advantage of economies of scale in monitoring and supervision, charge franchisees a higher turnover-related fee (rather than a flat rate) and bring the social franchise to financial sustainability (although there would still be reliance on the contraceptive supplies which franchisees receive free of charge from the Department of Health).

Example 3. Zambia - Providing primary health care (PHC), including sexual and reproductive health (SRH) care, through a social franchise

Objective and brief description of social franchise
- to provide high volume, quality PHC (including SRH care) at low to moderate fee levels in urban areas of Zambia through a network of clinics, based on a similar initiative in Bolivia.

Social franchise type
- second generation, stand-alone franchised clinics, following a standard clinical and business format, combined with
- fractional sub-franchises for clinical specialists at selected clinics.

Status, donor and budget
- the franchise proposal is under appraisal by a donor
- DFID's Seedcorn Fund for sexual and reproductive health funded the feasibility study
- the estimated cost for 12 clinics over 10 years is approximately USD 10 million.

Services and/or products provided
- all clinics would provide: family planning services, ante-natal and obstetric services, baby and child health, preventive and curative health care, as well as diagnosis and treatment for sexually transmitted infections (STIs), tuberculosis, malaria and acute respiratory infection.

Target groups
- women, children and men in urban areas, with varying abilities to pay.

Franchisor
- PROSALUD, a NGO operating a well-established network of clinics in Bolivia with assistance from Population Services International (PSI), will form ProHealth International, a non-profit joint venture, and will franchise its business format and operating systems to ProHealth Zambia, a local non profit organisation
- ProHealth Zambia will operate the clinics under the franchise, employing local practitioners, and in turn act as franchisor to private practitioners who are medical specialists.

Franchisees
- ProHealth Zambia and
- clinical specialists.

Number of franchisees
- each of the 9-13 clinics will have at least one clinical specialist.

Quality control mechanisms
- ProHealth International's relationship with ProHealth Zambia will be defined and controlled by a franchise agreement. ProHealth International will control ProHealth Zambia though representation on ProHealth Zambia's board; this will enable the transfer of quality control systems and 'know-how'
- one clinic will have training facilities for all ProHealth Zambia clinic staff and for clinical specialist franchisees. The clinic will monitor technical standards at the other clinics in the network
- user satisfaction surveys will be used to measure the quality of care and services.

Potential for sustainability
- the franchise model is designed to work towards the achievement of long term financial sustainability through user fees (graduated according to ability to pay) and fee sharing with clinical specialist franchisees, however
- the franchise's financial model assumes that an annual subsidy of about USD 450,000 will be needed for the clinics to continue to operate after 10 years.

Example 4. India - Providing sexual health clinics for inter-city truckers through a social franchise

Objective and brief description of social franchise
- to slow the spread of HIV infection amongst inter-city truck drivers and their crews, in India, by providing STI diagnosis and treatment and promoting condom use though a social franchise network at major truck halt points; the network will be marketed under a common brand name or logotype.

Social franchise type
- a second generation, fractional franchise with
- stand-alone franchisees if needed.

Status, donor and budget
- the franchise model is being developed, tested and refined in the field, in anticipation of a nationwide launch
- the design of the social franchise is being funded by DFID as part of a larger project, prior to an anticipated substantive phase
- the overall project is expected to cost up to GBP 20 million in its full implementation phase
- the substantive phase is contingent on the success of a pilot phase.

Services and/or products provided
- a package combining treatment for STIs, based on the World Health Organisation and National AIDS Control Organisation (India) syndromic approach and necessitating only one visit to the provider, with condoms and educational materials.

Target groups
- up to five million truck drivers
- their assistants and
- their sexual partners.

Franchisor
- to be identified from a short list of private and non-profit organisations with a strategic interest in the initiative: a pharmaceutical company, a trucking company or a NGO with a commercial ethos.

Franchisees
- initially doctors in private practice at or near truck halt points
- the franchise may expand to include paramedics and may help to establish doctors in practice where there are gaps in provision.

Number of franchisees
- at least 300 doctors.

Quality control mechanisms
- minimum standards of care and the type of premises necessary for franchisees will be laid down in the contract between franchisor and franchisee
- the franchisor will organise training for franchisees; franchisees will only be approved if required standards are reached
- the franchisor will hire doctors to supervise and monitor franchisees: auditing premises and medical practices, retraining franchisees if necessary and replenishing stocks.

Potential for sustainability
- the potential for financial sustainability is good; initial studies indicate that the franchisor can cover its costs, give a margin to the franchisee and keep the package affordable to the target group (who have relatively high levels of disposable income), through the significantly discounted bulk purchase of drugs in the package
- the potential for institutional sustainability will be good if the selected franchisor is an existing organisation with a strategic interest in the sector and the franchisees are running existing viable businesses.

Example 5. Pakistan - Providing longer lasting family planning methods through a social franchise

Objective and brief description of social franchise
- to increase access to and use of longer-lasting family planning methods (especially injectables and intra-uterine devices (IUDs)) and referrals for voluntary surgical contraception (VSC)
- the social franchise is designed to overcome critical constraints to access to longer lasting methods of family planning: the lack of female doctors trained in FP counselling, IUD insertion and injectables within reach of female clients.

Social franchise type
- a first generation, fractional social franchise.

Status, donor and budget
- the pilot phase in two cities has just been completed and evaluated prior to a nationwide launch
- the marketing of clinical services is part of a larger social marketing and franchising project and is being funded by Kreditanstalt für Wiederaufbau (KfW); the annual cost of the marketing is approximately USD 1.8 million (excluding product costs).

Services and/or products provided
- primarily the multi-load CuT375 IUDs and injectable contraceptives, as well as
- oral contraceptives and condoms which are also being socially marketed through retail outlets and paramedics in the wider project.

Target groups
- low-income couples in urban and peri-urban areas.

Franchisor
- a joint venture between Population Services International (PSI) and Social Marketing Pakistan (SMP).

Franchisees
- currently female doctors in private practice (usually sole practitioners) or
- private clinics with female doctors
- to be extended to include male doctors.

Number of franchisees
- 300 female doctors in the pilot phase
- 2,000 female doctors in the substantive phase plus male doctors.

Quality control mechanisms
- the premises will be audited and altered as appropriate to meet the desired standard
- competency-based classroom and clinical training will be provided
- the franchisor will provide close on-site follow-up supervision and monitoring
- remedial training will be provided if standards fall below those required.

Potential for sustainability
- initial donor costs including the recruitment and training of franchisees, monitoring and supervision, demand creation, brand development and promotion and procurement of subsidised contraceptives were high
- the potential for institutional sustainability is good as SMP is a well-established local non-profit organisation and the franchisees are already running existing businesses
- the long term sustainability is dependent on: decreasing or eliminating subsidies on contraceptive supplies; charging fees for training and support; ceasing national advertising and relying on local promotional activities.

Example 6. Nicaragua - Providing adolescent reproductive health education and services

Objective and brief description of social franchise
- to increase access to and use of SRH information and services amongst adolescents in Nicaragua. The pilot will be tested with three types of youth organisation as franchisees and refined into a model; the model could lead to expansion of the social franchise within Nicaragua and elsewhere
- youth organisations' premises are used to make services more accessible to adolescents
- selected leaders and adolescents will be trained in basic administration and will take over the administration and management of services.

Social franchise type
- a first generation, fractional social franchise.

Status, donor and budget
- the social franchise is being funded by DFID's Seedcorn Fund for sexual and reproductive health
- the project cost is GBP 200,000 for two years.

Services and/or products provided
- information, education and communication (IEC), family planning, STI treatment, emergency contraception, ante-natal care, medical care, counselling and advice on relationships and family problems.

Target groups
- male and female adolescents.

Franchisor
- IXCHEN, an established non-profit organisation with eight years of experience of providing SRH services across Nicaragua.

Franchisees
- existing youth organisations.

Number of franchisees
- initially three, each a different type of youth organisation to test the social franchise model.

Quality control mechanisms
- initially, the franchisor's medical and educational staff will provide the services, and will train the youth organisations' staff and members to implement an IEC programme and manage the administration of the medical services
- subsequently, the youth organisations will become franchisees and then contract the franchisor's doctors for medical sessions
- the franchisor's local clinic manager will make monitoring and supervision visits.

Potential for sustainability
- for sustainability, 20 leaders and adolescents from each youth organisation will be trained to run the IEC programme
- the costs of providing services are marginal (as the infrastructure is already in place) and the cost of services will be within the users' ability to pay
- in the pilot stage, the franchisor's costs will be met by donor funding; subsequently, the franchisor will fund raise locally and charge a margin on supplies to franchisees to ensure the continuation of the programme.

Example 7. The Philippines - Providing female voluntary surgical contraception (VSC) through a social franchise

Objective and brief description of social franchise
- to increase access to female VSC - tubal ligation (TL)
- the pilot social franchise aims to work with private sector doctors who will add TL to their existing clinic service menu; this will keep set-up costs low
- the franchise will be aimed at low to middle-income women with some capacity to pay and will include a referral system to the franchisor's clinics for the very poor who need subsidised services. If successful, the social franchise will be extended to form a national network.

Social franchise type
- a second generation, fractional social franchise.

Status, donor and budget
- the project is at feasibility study stage and is being funded by DFID's Seedcorn Fund for sexual and reproductive health
- a donor for the pilot project is yet to be determined.

Services and/or products provided
- a complete Marie Stopes Ligation (MSL) package, including counselling, a low trauma procedure and follow-up care.

Target groups
- low to middle-income women who do not want any more children.

Franchisor
- Population Services Pilipinas Inc. (PSPI), an established NGO with experience in TL provision in static and mobile clinics, with technical assistance from Marie Stopes International (MSI).

Franchisees
- doctors who are already established in private practice.

Number of franchisees
- 12 doctors are proposed for the pilot project.

Quality control mechanisms
- the doctors and their clinical assistants will receive intensive clinical training in the Marie Stopes Ligation method of TL
- user satisfaction will be measured through exit questionnaires
- monitoring and supervision site visits will be carried out by PSPI's franchise manager.

Potential for sustainability
- institutional sustainability prospects are good: PSPI is an established local NGO and the franchisees will be selected from a list of doctors who are running existing viable businesses
- users will be charged fees which will cover the marginal cost of service provision and doctors' fees and will contribute to overheads
- PSPI will charge a margin on the supply of materials
- if the pilot is successful, flat annual fees will be paid to the franchisor by the franchisees in the substantive project.

Example 8. Pakistan - Providing injectable and other hormonal contraceptives through a social franchise

Objective and brief description of social franchise
- to increase the prevalence of hormonal contraception amongst urban and peri-urban women and men, especially lower and middle-income groups, in a financially sustainable manner through private sector channels
- the thrust of the project is to increase hormonal contraceptive use through targeted advertising, promotion and pricing. Participating private sector practitioners will display the project logo, indicating that good quality family planning advice and care is available. The project will coordinate its efforts with the PSI/SMP project in Pakistan (see example 5 above).

Social franchise type
- a first generation, fractional social franchise.

Status, donor and budget
- the project is being funded by DFID
- the budget is GBP 7.04 million over five years.

Services and/or products provided
- a range of oral and injectable contraceptives.

Target groups
- women and men in urban and peri-urban areas especially lower and middle-income groups.

Franchisor
- The Futures Group International, a US-based social marketing organisation.

Franchisees
- doctors
- pharmacists
- female health visitors and
- selected NGOs.

Number of franchisees
- 10,000 doctors in private practice
- 25,000 pharmacists
- 1,000 female health visitors and
- selected NGOs
- emphasis will be placed on recruiting female health workers into the network.

Quality control mechanisms
- all providers will receive training covering contraceptive methods, counselling, side effect management and quality customer service
- where standards are not met, providers will be offered refresher training
- side effects will be managed through referrals to medical practitioners.

Potential for sustainability
- the social franchise has been designed to be financially sustainable over the long term
- it is anticipated that the product manufacturers' expectation of an expanded market will result in their discounting wholesale product costs significantly, achieving affordability to the target group over the long term
- the franchisor's costs will be met by donors in the project's lifetime
- by the end of the project, the market for hormonal contraception is expected to have expanded sufficiently to sustain demand and the contraceptive manufacturers' involvement over the medium to long term
- the franchise is institutionally sustainable: manufacturers, suppliers and franchisees are all running existing businesses.

Conclusions

Advantages and disadvantages of social franchising

Advantages
For donors and developing country governments seeking ways to expand the provision of and improve access to sexual and reproductive health (SRH) care services, social franchising offers six key advantages:

- social franchising offers a mechanism for introducing SRH care into the private health sector; there is increasingly unutilised capacity in the private health sector in developing countries
- social franchising can improve the quality of care in the private health sector and can improve access to services even for poorer clients
- social franchising provides a means of making a wide range of SRH products and procedures, which rely on trained and equipped professionals for their delivery, available. In this respect social franchising offers a wider choice of SRH products than the social marketing of products through the retail network can
- social franchising confers benefits on users; they are reassured by the recognised brand name and assured that products and services are delivered to a consistently high standard and in a non-exploitative manner
- social franchising can be very effective in the targeting of SRH services. In the India social franchise case study above (see example 4) for instance, social franchising is being used to take services to inter-city truck drivers, their assistants and their sexual partners
- there is evidence that social franchising can be financially and institutionally sustainable. Ultimately, sustainability will depend on the users' willingness and ability to pay. The institutional sustainability of social franchising is greatly assisted where the franchise is fractional, that is, added on to an existing financially viable business.

Disadvantages
Social franchising does, however, have a number of limitations:

- the preconditions for social franchising - there must be sustained or growing consumer demand, a pool of potential franchisees and a market which can sustain new entrants - must be met. Of these, the second condition - a pool of potential franchisees - usually poses the greatest challenge; in some countries at present there is scarcity amongst particular cadres of medical practitioners or paramedics. However, in general, the private health sector is expanding in developing countries, and this limitation is becoming less of a hindrance
- social franchises require high levels of investment in the start-up phase. These costs can include: development and promotion of the franchise brand and business format, recruitment, the training and equipping of franchisees, the alteration and renovation of franchisees' premises to a minimum standard, product costs and the monitoring and supervision of franchisees. However, experience has shown that if franchising disciplines are followed, some social franchises can become sustainable through payments to the franchisor by franchisees or by the mark-up on supplies
- in the absence of continued donor funding, sustainable SRH social franchising relies on the willingness and ability of users to pay for the services that social franchising provides. However, there is increasing evidence that people are prepared to pay for good quality services. The poorest will always need a partial or total subsidy; social franchising can allow discriminatory pricing but this will diminish the likelihood of long term financial sustainability for the franchise.

Verdict

Although experience of SRH social franchising is fairly limited, there is evidence that it will be a useful and important mechanism in improving the supply of good quality SRH services in developing countries. Its potential is now being recognised by donors and developing country governments but is not yet fully realised in practice. Early signs are encouraging that social franchising can meet the challenge of providing good quality care through the private sector; evaluations of the more recent social franchises described in the examples above will be important in broadening understanding of the value and potential of this approach.

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Appendix

Table 1 - Advantages and disadvantages of commercial franchising

Advantages	Disadvantages
Franchisor	
• can expand the business more rapidly than if it had to fund, staff and manage all the outlets • can run the business with a small team of experienced managers • does not need to raise the capital for expansion - this is done by the franchisees • benefits from the franchisees' ownership, involvement and motivation - local people with local knowledge • passes on many of the day-to-day management problems to the franchisee.	• does not own the business assets or have a claim on the profits of the franchisee • does not have direct control over the franchisee business; control can only be exercised through the franchise agreement.
Franchisee	
• is provided with a proven business formula thereby reducing his or her investment risk • acquires the business blueprint containing all information and systems necessary for running a business • benefits from the franchisor's national advertising and promotion • benefits from the lower set-up costs for franchise businesses (as the franchisor will have minimised set-up costs through pilot operations) • has easier access to start-up capital because funders understand the benefits and reduced risks of successful franchises • may have access to discounted bulk purchase supplies.	• does not own the business format • has to pay continuing management service fees.
Customer	
• benefits from the assurance of quality afforded by the franchisor's brand and tradename.	• none.

Table 2 - Summary of social franchising case studies

Country	Funder	Target group	Franchisor	Franchisees	Services/Products	Francise type
Mexico	USAID	Women and children in low-income urban and peri-urban areas	MEXFAM	Doctors	MCH/FP services, delivered to standards set by MEXFAM	Stand-alone second generation
The Philippines	USAID	Women and children in low and middle-income urban areas	SDI	Midwives	MCH/FP services, delivered to standards set by SDI	Stand-alone second generation
Zambia	DFID has funded the feasibility study	Women, children and men in urban areas with varying abilities to pay	Pro-Health International (PROSALUD and Population Services International) and ProHealth Zambia	Pro-Health Zambia, local practitioners and clinical specialists	Reproductive health and PHC	Stand-alone and fractional second generation
India	DFID	Inter-city truck drivers, their assistants and their sexual partners	Pharmaceutical company, trucking company or NGO -yet to be selected	Doctors and paramedics	Treatment of STIs, condoms and educational material	Fractional and stand-alone second generation
Pakistan	KfW	Low-income couples in urban and peri-urban areas who want to space/limit births	PSI/SMP	Doctors	Multi-load IUD and injectable contraceptives, plus oral contraceptives and condoms	Fractional first generation
Nicaragua	DFID	Male and female adolescents	IXCHEN	Youth organisations	FP advice and services	Fractional first generation
The Philippines	DFID is funding a feasibility study	Low to middle-income women who do not want any more children	PSPI	Doctors	Tubal ligation	Fractional second generation
Pakistan	DFID	Couples in urban and peri-urban areas who want to space/limit births, especially low to middle-income groups	The Futures Group International - US based social marketing organisation	Doctors, pharmacists, female health visitors and selected NGOs	A range of hormonal contraceptives including Depo Provera	Fractional first generation

For further information:

Marie Stopes International
153-157 Cleveland Street, London W1T 6QW
Tel: 44 (0)20 7574 7400 Fax: 44 (0)20 7574 7417
E-mail: msi@stopes.org.uk www.mariestopes.org.uk
Registered Charity No. 265543 Company No. 1102208