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YouthNet

Applying Social Franchising Techniques to Youth Reproductive Health/HIV Services

Steven D. LaVake

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Introduction

In a commercial franchise, a company offers a blueprint of how to sell its product, and a local business buys the right to use the blueprint, usually in a particular geographical area under certain rules. The public health field has begun to draw on the tools and techniques of commercial franchising, giving birth to the term "social franchising."

In the 1990s, the U.S. Agency for International Development (USAID) began funding social franchising programs in order to expand markets for clinical family planning services beyond public health hospitals and clinics to private-sector doctors, pharmacies, and private outreach efforts. Now, social franchising has begun to move beyond a strict franchise approach to one that involves community partners; this more fluid model may appeal to program planners trying to meet the reproductive health and HIV prevention needs of youth.

This Youth Issues Paper examines what role social franchising might have in expanding reproductive health and HIV services for youth. Steve LaVake, who coordinates private-sector programming for YouthNet, developed this paper based on a review of the literature on social franchising, visits to five programs that involve some aspect of social franchising for youth, and conversations with experts in the field.

Chapter 1 addresses how social franchising techniques might be applied to meeting the needs of youth. Chapter 2 summarizes the research available in the still-new field of social franchising. Chapters 3 through 6 describe four types of social franchising models for youth: joint venture, community, private provider, and governmental. The models overlap and are not mutually exclusive. Case studies of the five programs visited by the author illustrate how these models have been put into practice. Chapter 7 offers observations and suggestions for next steps in the field of social franchising and youth.

We hope this paper will be useful in your work. We welcome your comments as YouthNet continues to explore ways to expand services for youth and how techniques drawn from social franchising and other private-sector approaches might be useful in expanding reproductive health and HIV prevention programs for youth.

— Dr. Nancy E. Williamson, YouthNet Program Director

Chapter 1. Social Franchising Techniques and Youth Programs

Social franchising draws on commercial franchising techniques to increase access to and use of socially beneficial services, and to improve the quality of these services. "Franchising is a mechanism for replicating a proven business strategy," explains Carlos Cuellar of Abt Associates, an expert on social franchising.[1] In franchising, a company offers a blueprint of how to sell its product, and a local business buys the right to use the blueprint, usually in a particular geographical area under certain rules.

The social franchise model has traditionally created networks of private medical practitioners (doctors, nurses, midwives, pharmacists) that offer a standard set of services at lower costs under a shared brand name. Franchise members are normally offered training, brand and commodity advertising, inter-franchise referrals, a branding that shows high-quality standards, and other benefits. "Stand-alone" franchises exclusively promote and sell the goods and services of the franchisor; "fractional" franchises, in contrast, are businesses that add a franchised service or product to its existing operations.

Franchising efforts in the reproductive health field vary significantly in size, governmental involvement, profitability or cost-recovery, and the nature of the franchise itself, especially as multipurpose community organizations add a franchised service to their existing programs. Social franchises often share data and referral systems, logos, brand positioning, quality standards, marketing, and training. Traditionally, franchisees own much, if not all, of the physical assets of the business, and the franchisor owns the brand name and business format. The franchisor receives a percentage of the revenue earned by the franchisee and remains in strategic control of the franchisee's business. What works in one country does not necessarily work in another, due to variations in social, cultural, economic, and political variations such as buying power, number of private health providers, and access to services.

Social franchising has successfully expanded family planning services for adults in some countries utilizing private-sector providers (see Chapter 2). However, the needs of adults and youth are different. While adult clients seek clinical services of good quality, youth often are not seeking or using clinical services. Youth under age 24 comprise about half of all new HIV infections, and a growing number of young people are sexually active for more years prior to marriage than ever before, resulting in more unplanned pregnancies, sexually transmitted infections (STIs), abortions, and need for contraception. Pregnant adolescents need prenatal, delivery, and postpartum care. As youth become a higher priority for policy-makers and program planners, can social franchising techniques help expand the services these young people need?

Youth need accurate information, education, counseling, and skills in human relationships. Programs for youth need to promote abstinence, delayed sexual initiation, and reduced number of partners. Sexually active young people need access to condoms, negotiation skills in using them, and diagnosis and treatment of STIs. Sexually active youth may also need emergency contraceptive pills (ECPs), voluntary HIV counseling and testing (VCT), post-pregnancy care, and choices in contraception.

Providers of all these services — from teachers to doctors — need to have youth-friendly skills, while programs need to adopt policies and services that appeal to young people's needs. Involving youth in the design and delivery of these services is likely to improve responsiveness to young people's needs.

Many youth programs attempt to address the very same goals that social franchising programs pursue: to increase access to, use of, and quality of services. Some programs serving youth are using social franchising techniques, even if they do not use that term, do not think of themselves as being part of a franchise system, or have never heard the term "franchising."

An inherent tension exists in social franchising between achieving social goals and reaching revenue targets for private providers. This tension can be even more pronounced with youth programs, given young people's limited ability to pay for services. Consequently, many social franchising projects focus little attention on youth services.

Methodology

No global review or analysis exists of social franchising for youth reproductive health and HIV programs in developing countries. This Youth Issues Paper attempts that task, building on information from a literature review, consultations with experts, and five case studies. Few programs combine reproductive health and HIV prevention, a franchise relationship among private providers (nongovernmental or for-profit), and an emphasis on youth (10 to 24 years of age). Finding all three of these components in a single program is challenging.

Five programs were identified that met these criteria and that also reflected all regions of the developing world. In varying degrees, the programs highlighted in this study employ social franchising techniques, are sensitive to youth involvement and youth-friendly services, and combine private-sector and community involvement. The five programs, all visited in 2002, are:

- Foundation for Adolescent Development, Teens Healthquarters, the Philippines
- Gold Star Project, Egypt
- K-MET Private Providers Health Franchise Network, Kenya
- Mexfam, Gente Joven, Mexico
- TOP Reseau Youth-Friendly Social Franchise Project, Madagascar

Each program was reviewed with regard to its use of social franchising techniques, including the number of clinics involved, the number of clients and youth served, the number of community organizations involved, the type of community involvement, efforts at making services youth-friendly, and the structure and extent of youth involvement. The case studies are based on interviews with stakeholders, personal observations, and review of program documents. No formal quantitative research was undertaken.

The case studies address only the aspects of the organizations relating to social franchising techniques and youth services. Most of the five organizations have wide, diverse programs. The descriptions, observations, and findings do not apply to the overall program.

The case studies are presented through four models of social franchising for youth:

- joint venture
- community
- private provider
- governmental

It is important to note that the models have overlapping characteristics, such as community involvement, and are not mutually exclusive. Some of the programs have elements of several models.

Franchising Youth Services

How can social franchising help address the needs of youth? The answer to this question requires viewing social franchising in a different way, looking at not just the standard approach of franchising clinical services. Instead, this paper looks at applying social franchising techniques in the broader community context in which youth reproductive health and HIV prevention needs are met — clinics, schools, youth centers, clubs, sports teams, faith organizations, and other groups.

Table 1. Application of Social Franchising Techniques, Case Study Programs

Techniques	TOP Reseau	Mexfam	FAD	Gold Star	K-MET
Promotion					
Marketing/Media	x	limited	x	significant	
Logo/Branding	x	x	x		
Training					
Technical	x	x	x	x	x
Youth-friendly services	x	x	x		x
Management	x				
Quality Assurance					
Technical	x	x	minimum enforcement	extensive	x
Youth-friendly services	x	not written			not written
Information Sharing/ Referral Mechanisms	x	x	x	x	x
Cost Recovery Mechanisms					
Charge fees	x	x	x	x	x
Centralize purchases	x			some	
Franchise Contract					
Franchise or membership fees	x				x
Franchise agreements	x	x	x		

As projects for youth have begun to draw on aspects of social franchising, researchers and analysts have identified six franchising techniques that youth programs can most easily utilize. Franchise packages for youth services that draw on these techniques are now being developed (see box, page 7). The summaries below include some of the key findings from the case studies (see Table 1, above).

1. *Promotion and Marketing*. Logos, signs, branding, and media promotion can help position and link services in a way that appeals to youth and their supporters. Most of the programs reviewed in these case studies use a logo (some developed by youth through a logo design contest) and a variety of marketing and communication techniques to advertise a brand. Targeting a product to a market niche, such as an age or ethnic group, is important for youth social franchising projects. Selling a product or service depends on branding and marketing. Many of the programs combine marketing with education or "edutainment" in the form of traveling dramas performed by youth, call-in or discussion programs on the radio, or mobile vans with audiovisual presentations and materials (particularly useful in reaching rural areas). Word-of-mouth through community networks and youth-serving organizations that collaborate with the social franchising program can also help to create demand quickly enough to satisfy member providers and attract new providers. Underutilized promotion techniques in these programs were print advertising, television, and spokespersons from sports or music.

2. *Training*. In theory, the franchisor trains staff, youth promoters, and volunteers, ideally with a certification program and an emphasis on quality of service. However, not all providers currently receive training in youth-friendly services or in administering a franchise system. Training in technical issues and youth-friendly services is a significant incentive for providers involved in the programs reviewed. Likewise, peer educators, youth outreach volunteers, and youth center activity managers highly value the training they receive through the franchise system. The franchises often collaborate in providing technical

training with hospitals, the Ministry of Health, and others. They provide their own recruitment and training programs for youth. Only TOP Reseau has developed a curriculum and handbook specifically for training providers on youth-friendly methods, which the providers said they valued highly. TOP Reseau also monitors the program to ensure responsiveness and quality. A youth-friendly services training curriculum specific to a social franchise should be adapted and applied to similar projects.

3. *Quality Assurance and Standardization of Services.* Young people, who often hesitate to seek services at all, are encouraged by predictable service quality on three key matters: confidentiality, provider competence, and provider sensitivity. Except for Gold Star and TOP Reseau, the programs reviewed do not apply or enforce quality standards in a systematic way. They do provide training to ensure that providers are aware of and follow "best practices" regarding youth reproductive health and youth-friendly services. Some advertise quality standards within the franchise. Detailing these standards and expectations in a contract or other formal agreement at the outset, reinforcing best practices with appropriate training, and establishing an ongoing system for monitoring and evaluation could help assure quality standards. Some of these steps were taken, which contributed to high client and staff morale and increased the number of youth clients in some programs. The status of belonging to a well-respected franchise appeared to be the most significant motivator to a provider for adherence to quality standards. Gold Star is essentially a quality assurance project that uses penalties and rewards to enforce adherence to a detailed set of medical and reproductive health standards. Only Gold Star and TOP Reseau have actually removed a provider from the franchise due to lapses in standards.

Some programs serving youth are using social franchising techniques, even if they do not use that term, do not think of themselves as being part of a franchise system, or have never heard the term "franchising."

4. *Information Sharing and Referral Mechanisms.* Since youth rarely have all of their needs met at one location, a referral system can assist youth in getting a full range of services. Referral forms are used in most franchises to direct clients to resources both within the franchise and to hospitals, laboratories, or other organizations that provide more specialized services such as HIV testing. This type of networking serves specific client needs and also expands links of collaborative community groups. All five of the programs reviewed in this study use standardized data collection, information sharing, and referral forms and procedures, which enable them to better respond to the specialized needs of youth.

5. *Cost Recovery Mechanisms.* Many youth, especially those most at risk for HIV infection, cannot afford services. Economies of scale such as centralized purchasing and fee schedules can reduce the cost of services. Charging a fee, no matter how small, is important in order to have the client value the service, to monitor client use through financial records, and to provide for cost recovery to the extent possible. Most of the programs charge fees on a sliding scale based on the client's ability to pay. In some cases, a modest initial or annual "franchise membership fee" is also charged to the provider. Despite these fees, most programs fail to recover costs and are significantly subsidized. In some cases, depending largely on clinic location, providers are partially subsidized by the franchisor, and doctors volunteer their time. Centralized bulk purchasing of equipment and supplies that results in lower unit costs to individual clinics can also assist in cost recovery. However, unless networks are large enough, franchises are unlikely to benefit from these economies of scale. The costs of fixed overhead, brand advertising, and training can be reduced by spreading them over a large number of service sites. Only a couple of the programs visited apply bulk purchasing or achieve any economies of scale although most supplement their revenues through cosmetic supply sales, cyber cafes, dental care, and other services, often linking these services with reproductive health and HIV educational videos.

6. *Franchise Contract.* Formal business agreements can clarify goals and directions for the franchise, thereby helping to expand and sustain programs. Three of the reviewed programs do have some form of standard written agreement outlining the respective obligations of the franchisor and franchisee. However, enforcement of the terms of these agreements varies significantly, as do the methods of screening the candidates, preparing the candidates for membership, and training members on procedures in the agreement. In some cases, inappropriate contract formats were used, such as commercial franchise agreements in English. More culturally appropriate, relevant, and mutually understood formats coupled with an interview or screening and preparation program, including a business plan, would improve application of this technique.

Expanding Youth-Friendly Services

Providing youth-friendly services is a challenging issue that affects social franchising efforts. "The reality is that clinics are not usually the first choice for most young people — especially unmarried youth — when they need reproductive health information and services," explains the end of program report from FOCUS on Young Adults (1995-2001), a global project funded by the U.S. Agency for International Development (USAID). "Nonetheless, public-sector clinics need to become youth-friendly because these clinics remain necessary for some services that youth need such as STI diagnosis and treatment, pregnancy tests, pre- and postnatal care, and secondary prevention."[2]

Programs have begun to develop guidelines, checklists, training materials, and assessment tools to help make services work best for youth. "Simply stated, services are youth-friendly if they have policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their youth clientele for follow-up and repeat visits," explains Judith Senderowitz in a literature review of the topic.[3]

FOCUS on Young Adults developed a tool to analyze and score clinics on the quality of their services to youth through the use of 21 indicators, divided into these four categories:

Sample Franchise Package for Youth Services

- Market Research in Potential Site
- Physical Improvement and Set Up
  - standard physical layout, color, signs for branding
- Basic Furniture and Office Equipment
- Manpower Recruitment
  - medical provider, community relations officer, health volunteers
- Training and Skills Development
  - orientation on franchise and adolescent sexuality and reproductive health
  - skills training programs on peer counseling, group facilitation, and franchise operations
  - staff accreditation courses
  - training in other areas including STI management, teen immunization, social marketing, and quality services
- Operation of Medical Services
  - reproductive health – pregnancy test and counseling, pre- and postnatal care, Pap smear examination, responsible parenthood consultation, and others
  - nonreproductive health – dental care, skin care, ear piercing, drug counseling and referral, weight management
- Operation of Information, Education and Communication (IEC) Services
  - counseling services, educational classes
  - film, video showing
  - Web site, "e-mail-a-friend" program, library
- Administrative and Logistic
  - transportation
  - office supplies, forms
  - medical supplies and drugs
- Operational Systems Installed
  - management information system (MIS)
  - financial, inventory, security, referral systems
- Establishment of Network Referral Agencies
  - family planning, STI/HIV counseling and diagnosis
  - substance abuse, domestic violence, sexual abuse
  - legal aid, educational support, other
- Marketing Plan
  - public relations, promotion
- Strategic Business Plan
- Continuing Technical Assistance
  - promotion and marketing, IEC development
  - skills training, MIS analysis
- Process Evaluation by External Agency

The package of items above is based on the Teens Healthquarters Franchise Package, provided through the Foundation for Adolescent Development in the Philippines.

- the facility itself, including operating hours, location, and privacy
- provider attitudes and performance, including respect shown to clients, confidentiality, and adequate time for interaction
- administrative procedures, such as whether fees are affordable and whether drop-in clients are welcome
- how youth perceive the clinic's services[4]

A few countries have begun to develop their own youth-friendly standards. In South Africa, a National Adolescent-Friendly Clinic Initiative (NAFCI) has sought to make public clinics more youth-friendly, working with the Ministry of Health and loveLife, a national project funded by the U.S.-based Kaiser Family Foundation. Through a series of meetings and consultations with specialists on quality assurance, NAFCI defined 10 standards by which clinics are to be judged on the quality of their services to youth. The program seeks to develop an accreditation system, beginning in pilot clinics, based on the NAFCI standards. The clinics themselves determine how to make their services more youth-friendly, using the standards and guidelines.[5]

Three rigorous evaluations have been conducted on programs that sought to make services more youth-friendly. None of them found an association between the establishment of youth-friendly services and an increase in service utilization by youth, but all showed some progress. A study in Ecuador found an increase in the number of returning clients,[6] and a Zimbabwe study showed improved attitudes among clients and staff.[7] In Zambia, with interventions in eight clinics and two control clinics, the project trained peer educators as well as health care providers and included a community outreach component to increase acceptance. Changes in community attitudes resulted, which led to an increase in services in both the clinics trained to be youth-friendly and the control clinics.[8]

Youth Involvement Can Help Increase Services

Community and youth involvement can help increase the use of reproductive health and HIV services for youth. "If the community is not invested in the reproductive health of youth, it will be much more difficult for youth to seek appropriate services for themselves," explains a paper presented at a 2003 World Health Organization (WHO) consultation on providing services to youth. "A new paradigm needs to be supported: one that considers youth as not just clients but as integral resources in the design, implementation, and evaluation of a program."[9]

Youth "should be involved from the start as full and active partners in all stages from conceptualization, design, implementation, feedback, and follow-up," advises WHO.[10]

Youth involvement in local programming includes peer education projects, youth-led clubs and sports teams, and membership on management boards. Some studies indicate youth involvement helps youth to increase the use of services, especially regarding peer educators, but more research is needed.

In Peru, a peer program in six cities resulted in improved knowledge and attitudes, a reduction in the proportion of sexually active males, and increased contraceptive use at most recent intercourse.[11] A peer program in Cameroon resulted in improved knowledge about contraception and symptoms of sexually transmitted infection, and increased condom use.[12] The West African Youth Initiative in Nigeria and Ghana, where youth worked as reproductive health peer educators and in other related activities, resulted in a significant increase in use of modern contraceptives (from 47 percent to 56 percent) and a willingness to buy contraceptives in the intervention area.[13]

The Mathare Youth Sports Association (MYSA), in a slum area of Nairobi, Kenya, offers reproductive health education while operating football teams, garbage collection, and other community projects. "One of the keys to MYSA's success is that it treats the skills and ideas of youth as its strongest resource," explains a report on MYSA.[14] The International Planned Parenthood Federation now has a substantial number of youth on its board of directors. Applying social franchising techniques to youth programs has the potential to expand a small sports or peer education program to a network of such programs that cover far more young people.

Chapter 2. Research Results on Social Franchising

Commercial franchising techniques work best with sustained or growing consumer demand for a service or product, a market structure that can sustain new enterprises, and the existence of trainable franchisees with skills and financing. For a franchising system to be successful in the health field, three rules of thumb apply, explains Dr. Dominic Montagu of the University of California, an expert on the topic. The private sector should provide at least 25 percent of the health care services; a concentrated market with weak services should exist to provide a clear value-added niche; and potential for market growth for the preventive or curative health service should exist.[15]

In the 1990s, a demand for clinical family planning services existed, methods became more available, and private-sector providers were available for franchises. Donors funded pilot projects in India, Mexico, Pakistan, the Philippines, and other countries. These programs sought to draw on the largely untapped potential of the private sector to increase access to services while providing more uniform quality. Social franchising held the potential of assuring clients of consistency and good quality in a recognized product or brand name. Program planners also hoped the approach would lay the groundwork for a sustainable system.[16]

Although donors had worked with the private sector through social marketing programs for condoms and other commodities, social franchising represented a new type of involvement. "While generations of social marketing programs have centered on contraceptive products (such as the pill or condom), clinic franchising extends these principles to services, i.e., service marketing," explains Dr. Rob Stephenson of Johns Hopkins University.[17]

Research Finds Benefits

In Pakistan, Population Services International (PSI) and its local affiliate, Social Marketing Pakistan (SMP), had developed a successful social marketing campaign selling condoms through private-sector outlets. But social marketing could not meet the growing need for other contraceptives and clinic-based services. Turning to the franchise approach, they launched the Green Star Network of family planning service providers in urban areas of Pakistan.

In 1995, Green Star trained 300 doctors and paramedics in two urban areas as a pilot project, based on a curriculum used in Indonesia to train private-sector providers in family planning delivery. Advertising over local television and radio generated demand, and clinical services increased dramatically.[18] The project responded, training more providers throughout the urban areas of the country. In its first five years, the project grew to include some 11,500 private-sector health providers, including pharmacists and junior paramedics, in more than 40 cities, with some 10 million client-visits per year. Contraceptive prevalence rates jumped from 18 percent to 24 percent, with dramatic rises in use of oral contraceptives, injectables, and intrauterine devices. The project demonstrated the "capacity for social franchising to support a very rapid scale-up in the delivery of health care services. On the opposite side of this coin are the great difficulties encountered in monitoring outlets and managing information from a large number of franchises brought on board quickly," concluded

an analysis of the project by Commercial Market Strategies, a USAID-funded project.[19]

In other countries where marketing conditions were well suited for franchising, projects have also been successful. In an evaluation of survey data from some 14,000 clients from nearly 2,700 health facilities in Ethiopia, India, and Pakistan, Dr. Stephenson of Johns Hopkins University concluded that "franchising positively influences family planning and reproductive health client volume, staffing levels, and the number of family planning brands and reproductive health services available. Client satisfaction is higher at franchised than other types of health establishments."[20]

A franchise has the potential to increase access to services and provide assurance of consistency and quality through a recognized brand or trade name. An analysis of client choices among private providers in Kenya, Pakistan, and Bihar State in India found an association between high estimation of quality and the use of franchised services. The study concluded that service quality was an important factor for clients in choosing services.[21]

A review of social franchise projects in the Philippines, Mexico, India, Nicaragua, and Zambia found that the approach could help mobilize the private sector to provide reproductive health services and help standardize the quality of care provided. "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 planning, and other reproductive health services in the private sector," the study concluded. However, sustainability and cost-effectiveness were a concern. "Start up and ongoing technical support costs of the franchisees examined were significant, and the attractive packages designed to retain franchisees might not be the best use of scarce donor resources and could jeopardize the prospects for long-term sustainability."[22]

A number of social franchising operations have emerged in Asia, including the Blue Circle and Gold Circle programs in Indonesia, the Blue Star clinics in Bangladesh, and a social marketing and franchising program called Janani in two large states of India (Bihar and Madhya Pradesh). Janani, unlike most franchisees, uses a two-tiered system to promote referrals between rural areas and clinics where doctors have more training. The franchise consists of sites branded as "Titli Centres" in rural areas where providers can, when necessary, refer clients to franchised "Surya Clinics," which are part of a smaller network of private doctors in regional towns. The overall project promotes branding at both levels, with signs, posters, and extensive advertising for the brands, the network, and the local outlets.

A recent evaluation of Janani, along with Green Star in Pakistan and the Biruh Tesfa franchising system in Ethiopia, found that these franchises provide more services than do other private providers, almost as many as governmental clinics, and substantially fewer than nongovernmental organizations. The Carolina Population Center, a U.S.-based research center, did the analysis as part of a project, Evaluating Alternative Business Models for Family Planning Service Delivery,

funded by the David and Lucile Packard Foundation.[23]

Projects in Zimbabwe, Nicaragua, South Africa, and other countries have used some social franchising techniques in youth programs. In Zimbabwe, the Ministry of Health and Child Welfare began implementing a national VCT network in 1999, with funding from USAID and technical assistance from PSI. The network, dubbed New Start, has grown to 12 centers, 10 of them in existing health services, with an emphasis on quality in counseling and testing. About six of every 10 clients are 20 to 29 years of age. With an HIV infection rate of 34 percent among those ages 15 to 49, Zimbabwe had built-in demand for this kind of franchised service. The success of the campaign has prompted PSI to pursue VCT social franchising approaches in other countries.

In Nicaragua, Instituto Centroamericano de la Salud (ICAS), the franchisor, developed five franchisees, working with community-based nongovernmental organizations (NGOs), an evangelical group, and a university, using technical assistance from Marie Stopes International and funding from the United Kingdom Department for International Development. ICAS trained staff and youth promoters in sexual and reproductive health issues; attempted to establish a clinical infrastructure; and used information, education, and communication (IEC) campaigns to reach youth in the community. Although services addressing medical and psychological needs expanded, achieving functional franchisees was more challenging. "The organizations need to devote staff time and resources to training in service management and eventually in managing the IEC work and the services themselves. These resources were often not available," concluded a Marie Stopes International analysis.[24]

In 1999, the loveLife project, with a multimillion-dollar, multiyear budget from the Kaiser Family Foundation, launched a large campaign in South Africa using billboards, television, community mobilization, a hotline, and other approaches. In 2000, it began to add a service delivery component by creating youth centers, working to make existing clinics more youth-friendly, and supporting peer education and other outreach projects. The loveLife branding achieved significant name recognition throughout the country. A survey of 1,000 people found that more than half had heard of loveLife and that more than 90 percent of those aware of the project identified it as a symbol of hope and communication about sex, sexuality, and HIV/AIDS. Analysts are watching closely to see if the massive funds invested in the project are effectively expanding services to youth.[25]

The level of donor support is a key factor in determining the appropriateness of pursuing a franchise approach. A donor may bring its own conditions, priorities, and expectations for success of the franchise, which may influence the relationship between the franchisor and the franchisee, including the motivation of each to succeed. Franchising is attractive to some donors because of its potential to mobilize the private sector to deliver reproductive health services, control the quality of care, and offer some hope of sustainability through use of fees to recover some costs. Balancing sustainability with meeting social goals is challenging, however, and involves issues such as capacity building, organizational strengthening, and business management skills training.

Chapter 3. Joint Venture Model

In this approach to social franchising for youth, a central organization (the franchisor) works to create a joint enterprise with private providers or other NGOs (the franchisee). Ideally, the franchisee has the capacity to reach youth in schools and through community outreach, as well as to provide clinical services. The franchisor may rent equipment, provide training and supplies at subsidized rates, and offer other support, including branding for the overall program. The Gente Joven (translated "young people") project of the Mexican Family Planning Association (Mexfam) is attempting a joint-venture franchising approach, particularly in its work in economically depressed and semirural areas.

Mexfam, Gente Joven

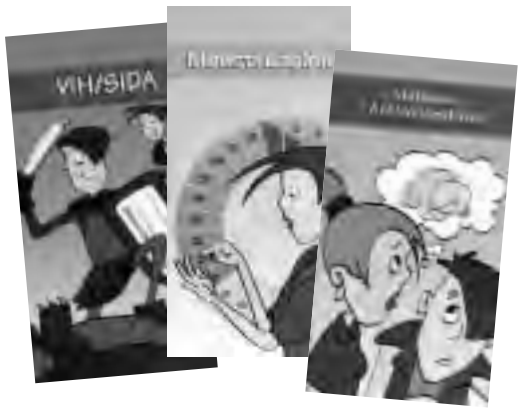
Mexfam began its first social franchising effort in the 1980s with a project designed to get private physicians to provide family planning services in rural areas.[26] In the 1990s, Mexfam joined 475 community doctors with another 290 private doctors to form a new franchise system focusing on maternal and child health and family planning services in low-income urban areas. The franchise system has mobilized the private sector and controlled the quality of care provided, but it has not yet demonstrated financial sustainability.[27]

In 1994, Mexfam initiated Gente Joven, which has grown into a system of centers throughout the country working through clinics, schools, and community outreach. About 25 Gente Joven centers provide clinical services. As funding by USAID and other donors has diminished, Mexfam has had to support Gente Joven centers with private donations, foundation grants, and fees.

Mexfam is seeking to make many of the 25 centers self-sustaining within the next few years, establishing what can be thought of as a joint-venture franchising approach. Mexfam hopes to pass administrative and financial responsibilities for Gente Joven centers to private doctors and NGOs who administer the centers. The potential strengths and challenges involved in this step were made clear during site visits to Gente Joven programs in Mexico City and the nearby city of Puebla. The visits included schools, community outreach sites, and NGOs collaborating on Gente Joven activities.

The franchising techniques that appeared to be the strongest assets for this transition were:

- marketing and logo branding of the Mexfam and Gente Joven name
- sharing of information between Mexfam and Gente Joven centers on all aspects of service delivery
- training and quality assurance of technical services, notably the involvement with peer educators, schoolteachers, and other community groups



The power of branding was evident at a public bus stop, where passengers recognized and warmly greeted a group of Mexfam youth wearing matching T-shirts with Mexfam logos. The youth were traveling from one community theater event to the next at a public school.

The involvement of the youth helps to build community support for the project, adding strength to the franchising approach. Youth play a key role at Gente Joven by serving on youth management committees, developing programs, and acting as promoters. The promoters work with youth in schools and community settings to provide information, counseling messages, and in some cases, condoms and oral contraceptives.

"We have only four paid staff but about 25 youth promoters who do outreach activities, talks, and demonstrations that bring in an average of 390 youth per month," said Dr. Juan Manuel Yee González, coordinator of the Gente Joven Puebla clinic. "The youth run the Internet café and cultural center including youth art expositions and sales, which is almost self-sustaining. They want to begin a condom shop." The Puebla clinic has a youth-friendly atmosphere with food, photography, guitar classes, and basketball.

Some youth centers provide clinical services. The centers visited appeared well equipped to provide a wide range of contraceptive methods, but few youth used the clinic, a situation typical of many youth center clinics. In contrast, young people do seem to be using a new youth-only clinic established at a metro station in Mexico City, where private physicians and Mexfam health care professionals provide services. A youth committee helps manage the clinic, where hours are flexible and services are mostly provided during after-school hours. The minimal fees are often waived or paid in installments, depending on the individual circumstances of young clients.

In addition to its own Gente Joven centers, Mexfam promotes the Gente Joven program through clinics already owned by a private party, where costs and income from fees are split with Mexfam, and with community clinics, where the owner rents equipment from Mexfam. In community clinics, Mexfam provides contraceptives, educational materials, logos and signage, and some advertising, and in return uses the clinic as an intake and referral site for youth. These clinics are often located within poor neighborhoods, putting them within easy reach of youth, including a large population of married young people who may be comfortable visiting the clinic. Gente Joven also collaborates with hospitals and other providers, using the familiar logo as an attraction for youth. At a hospital outside of Mexico City, for example, bright Gente Joven posters on the wall guide youth to a special youth-friendly service area. The hospital staff provides the services. "We are delighted to

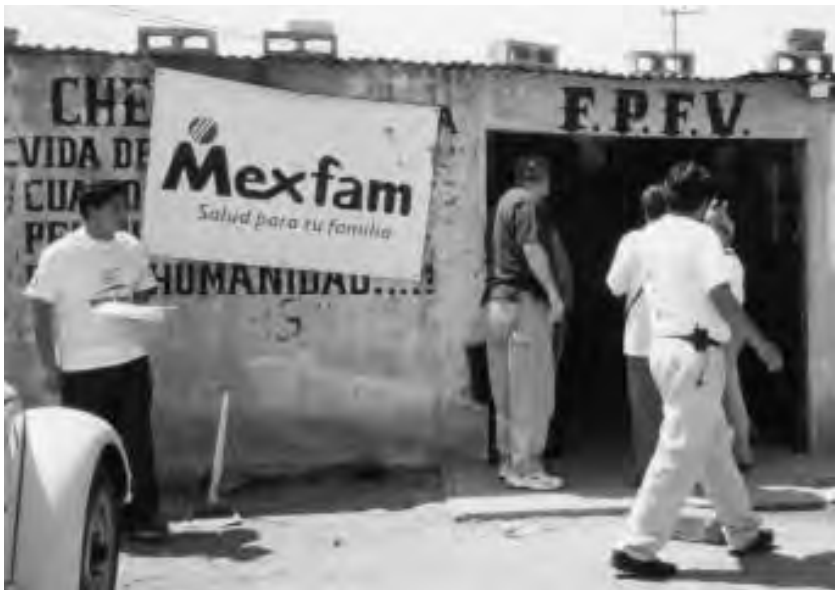
Determining the best way to reach youth with clinical services is a challenge in Mexico, as it is throughout the world. Youth services that are integrated into adult programs, both at Mexfam centers and private clinics, seem to be reaching more youth than do clinics at Mexfam youth centers.

A Gente Joven peer educator leads a demonstration of correct condom use with a group of young people.

have Gente Joven's assistance in promoting these youth services," the hospital director said.

Findings and Observations

Determining the best way to reach youth with clinical services is a challenge in Mexico, as it is throughout the world. Youth services that are integrated into adult programs, both at Mexfam centers and private clinics, seem to be reaching more youth than do clinics at Mexfam youth centers, with the possible exception of the new youth clinic at the metro station. At these adult clinics, several providers have usually been trained in youth issues and counseling techniques, and offer services to youth as needed during the day.



Meanwhile, many youth receive condoms and sometimes oral contraceptives through Mexfam's community outreach and youth promoters. This approach increases youth access to contraceptives but has limited quality control. Youth promoters are often not able to provide adequate counseling on the pill or offer follow-up services to ensure continuation or correct use.

Mexfam's strength appears to be its educational services, such as providing information on condoms and training on decision-making skills, which are conducted by a Mexfam/Gente Joven staff member. Collaboration with schools is particularly strong. Mexfam provides curriculum development, pedagogical and communication materials, class demonstrations, and teacher training. "Links with teachers and other institutions enable us to offer a training class with very young kids (ages 8 to 13)," said Dr. Juan González at the Puebla clinic. "This is an important program for shaping values and promoting abstinence."

Mexfam has not established community-wide quality standards for youth services in its Gente Joven programs. Providers follow their own organization's standards, which may or may not be tailored to youth. Gente Joven is developing such standards and planning to introduce them through the network. Ideally, standards for youth-friendly services and youth participation, as well as a uniform certification or review process, should be established and enforced for community organizations participating in the collaborative network.

In moving toward a more independent status for the Gente Joven centers, Mexfam plans to provide training in program and financial planning. To help them achieve sustainability, Mexfam also hopes the centers can develop diversified funding sources and private-sector involvement. Believing they lack some of the skills and training for functioning more independently, local clinic staff and the youth committee at the new youth-only clinic appear concerned with the approaching deadline to become self-sustaining franchises. More training in budget and management operations for the centers is needed, as well as support in diversifying funding. This will also involve decentralizing budgeting and other management functions to regional managers.

Chapter 4. Community Model

Small NGOs focusing on youth often seek to develop collaborative community networks, including clinics, schools, churches, local governments, media outlets, private businesses, hospitals, pharmacies, and other NGOs. The community model uses social franchising techniques to structure a strategic alliance between providers of services and community groups involved with youth, such as educational programs. This alliance aims at reaching youth more effectively than a single NGO can do alone. This collaborative approach might be called a "community franchise," which departs significantly from the classic social franchising model, yet retains many of its key elements.

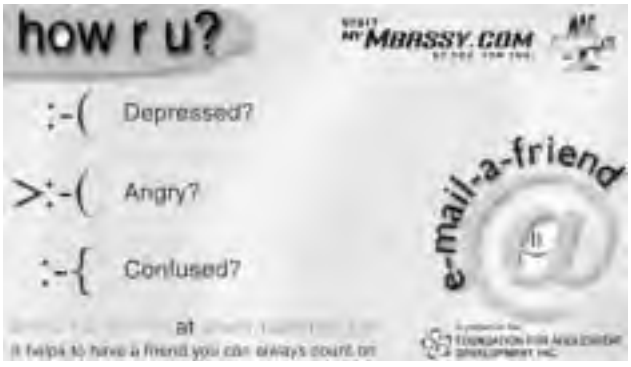
FAD, Teens Healthquarters

In 1988 in Manila, the Philippines, advisers to a youth center launched a small NGO called the Foundation for Adolescent Development (FAD). They wanted FAD to be a multiservice program for youth that provided information and services on health and sexuality. "We focus on sexuality as a vital concern in the development stage of adolescence," says Aurora Silayan-Go, a FAD founder and now president.

FAD began with a community center and has expanded to include a campus-based program to mobilize student leaders and peer facilitators, a telephone hotline that provides counseling, an extensive referral program, a Web site that provides frank information on sexuality, and entertainment for educational programs using videotapes and other techniques. A life-planning educational and vocational skills training program consisting of nine modules targets disadvantaged teens.

A key aspect of the community model is working with multiple supporters outside the strict franchises. FAD works extensively with a variety of community organizations such as schools, youth centers, and other NGOs that display the franchise logo and host demonstrations, theaters, counseling, and educational events.

To help spread these types of services to more areas of the city, FAD began a franchise system, with the franchisees referred to as Teens Healthquarters (THQs). The THQs are partnerships between FAD and various types of organizations, including NGOs and a municipality. Each of the four THQs now operating is designed as a community-based center that provides a comprehensive and holistic approach to youth development and sexual and reproductive health. The centers provide medical services, information, education, programs on forming values, counseling, and referrals. At each site, youth-friendly professionals and peer educator volunteers administer the services. FAD seeks to standardize operations, training, promotion, monitoring, and evaluation. FAD has also sought to involve the private sector, primarily through fundraising and joint sponsorship of events.



This business-card advertisement of the "e-mail-a-friend" project provides a handy way to tell clients using the THQ franchises about another FAD service.

All of these activities earned FAD recognition from the Philippine Commission on Population for "pursuing innovative approaches and strategies" and for "networking with the corporate world." Funding sources include UNFPA, the David and Lucile Packard Foundation, and other private companies and foundations. FAD has obtained in-kind contributions, donations of promotional products (t-shirts, audiovisual tapes), endorsement by celebrity spokespersons, newsletter publication, and other forms of collaboration from companies such as Levi Straus, Coca-Cola, Sara Lee, Proctor and Gamble, and Avon. However, collaboration has often been centered on short-term special events rather than the development of long-term relationships.

A key aspect of the community model is working with multiple supporters outside the strict franchises. FAD works extensively with a variety of community organizations such as schools, youth centers, and other NGOs that display the franchise logo and host demonstrations, theaters, counseling, and educational events.

Findings and Observations, THQs

Visits to two THQs demonstrated the potential for franchising the FAD model. In both sites, the THQ makes no payment to FAD for services and only partial payment for products and materials received from FAD. The THQs share an eye-catching logo, a youth-friendly branding strategy, as well as information, referral mechanisms, staff training, and ideas generated from FAD's core services. Quality standards exist on paper, but monitoring or enforcement of these standards — notably those related to youth involvement — was inconsistent.

The THQ Santa Rosa site is a joint program of FAD and a partner NGO, Responsible Parenthood-Maternal and Child Health Association of the Philippines. Located near an industrial park, it markets the program to employers in the park using slick, colorful materials. "Together, we can make your industrial employees productive and responsible members of the working community," reads the bright, trendy brochure.

In contrast, the Dosmarinas THQ, a partnership with the municipality of Dosmarinas, is based in an impoverished refugee resettlement area outside of Manila. This THQ provides counseling, educational classes, and some medical services. As part of the franchise arrangement, FAD is willing to offer provider training at the sites in quality-of-care issues.

From March 2001 to 2002, the four THQs provided services to about 7,000 youth; about 80 percent of the services fell into the categories of information and education, including outreach efforts. For the 1,400 clients seen for medical services, the THQs mostly provided primary care, such as blood pressure monitoring, dental care, and pre-employment screenings. Only 130

The THQ clinic provides a range of services, summarized on this billboard outside.

clients received family planning services, and only six got medical care for STIs. The Santa Rosa THQ saw the most youth, but the Dosmarinas THQ saw far more youth under age 15. The four sites also saw substantial numbers of adult clients seeking medical attention, about half the number of youth clients, especially at the Dosmarinas THQ.

FAD utilizes social franchising techniques, especially promotion through marketing, logo, and branding. It also shares program information and referral systems, trains staff for technical areas and youth-friendly services, has a franchise agreement, and uses a client fee system. FAD has quality assurance guidelines for technical areas but enforces them only minimally. It lacks management training, centralized purchasing, membership fees, and guidelines for what constitutes youth-friendly services (see Table 1, page 5).

Sustainability of the THQ franchises is a major challenge for FAD. The payment for services and fee system is weak, to some extent, because the THQs operate either in low-income areas or target youth with minimal ability to pay. Thus, some communities lack the demand and revenue to sustain the franchise when donor funding ends. In addition, FAD has not focused sufficiently on such franchise management issues as sustainability. Even so, FAD has been innovative in pursuing opportunities for support and involvement from private industry. More such efforts are needed to help FAD sustain its franchise approach. Links with livelihood projects that generate revenue among youth may be needed in some THQ communities before fees can realistically be expected to help build sustainabilty.

In terms of its services, the franchise system could be strengthened through greater integration of FAD's wide array of services into all THQs, including its hotline, campus-based program, and entertainment for education.

A group of young people with their "Sexters" t-shirts, one of FAD's projects emphasizing "Socially, emotionally, sexually responsible teeners."

Chapter 5. Private Provider Model

The classic social franchising model used in family planning and other reproductive health projects expands the access to and use of services to additional clinics, hospitals, pharmacies, or other locations. This is typically done by the use of logo branding, training of the new franchisees, monitoring of quality, and other techniques through a formal franchise arrangement. Some social franchising projects, such as the Green Star project in Pakistan, grow from a successful social marketing program that is then replicated or extended from commodities to services. The commercial provider model may begin on a small scale, involving only 15 or 20 clinics, but then usually expands in number and territory similar to a commercial franchise.

While this model of social franchising is perhaps the most widely known, it generally has not focused on the specific needs and interests of youth, and has sometimes intentionally avoided youth. In order to meet strict business and sustainability goals, some franchises have had to exclude serving youth. In 2000, a project began in the coastal area of Madagascar using the private provider model of social franchising to focus on youth. Also, in western Kenya, a project using social franchising with an extensive provider network for other reproductive health issues is now addressing the needs of youth.

TOP Reseau, Madagascar

TOP Reseau is a project of PSI, the world's largest social marketing organization (see page 9). In many countries, PSI has expanded the traditional social marketing of condoms through advertising and private-sector sales outlets to include counseling, newspapers, and more broadly based community activities, especially when focusing on youth. In Madagascar, PSI developed TOP Reseau, meaning "top quality, cool network," as a franchise system that involves youth in program design and development. Launched in 2000 with a $1 million, four-year grant from the Bill and Melinda Gates Foundation, the project consists of three well-integrated components: franchising, communication, and research. Based in the port city of Tamatave, the project has expanded to the surrounding rural areas and plans to expand to the capital city and other regions.

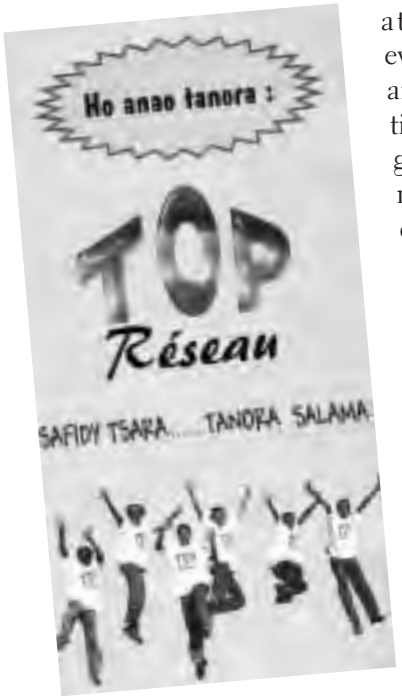
At the 17 clinics currently in the network, doctors and other staff receive training, educational materials, and support services from the core TOP Reseau/PSI staff. The clinics were invited to join the franchise after interviews and evaluations. A detailed contract specifies the franchise arrangement. Extensive and continual training is provided in technical skills and management issues, with an emphasis on youth-friendly services. PSI has created and refined an impressive training manual on youth-friendly services, as well as other operational manuals, curricula, client kits, and flip chart visual aids for providers and youth clients (primarily 15 to 24 years of age). "The most important part of the franchise is the youth-friendly training provided for counseling and treatment of youth," said Dr. Jean-Marie Andriamanonga of the Beryl Rouge Clinic, a franchise member.

In Madagascar, the clinics in the network generally provide a full range of services through general practitioner physicians. The clinics, all of which display a matching

TOP Reseau logo, benefit from marketing and media promotion on television and radio, and from referrals from other components of the project coordinated by PSI. For example, PSI sponsors a mobile communication program that travels to different communities showing videos and distributing educational materials, and an active peer education program that refers clients to the clinics. All of these franchising tools appear to have drawn more youth clients to these clinics. "My business has increased 25 percent since I joined the franchise, and 60 to 70 percent of my clients are now youth," said Dr. Andriamanonga.

Diagnosis and treatment for STIs draw many of the youth. While the HIV prevalence rate is less than 1 percent nationwide, the STI rate is as high as 30 percent in some areas, a concern for many youth. Other services include family planning counseling, pregnancy testing and counseling, as well as general services such as immunizations, physical exams, breast exams, and Pap smears. The providers currently pay a modest membership fee to TOP Reseau but indicated a willingness to pay more for franchise services as their business continues to increase.

Another aspect of the program that builds the client base is the work of peer educators in the schools, as well as at community events, workplaces, and other locations where youth gather. At one meeting outside of school, a peer educator distributed literature, discussed reproductive health issues, and led a condom demonstration for about 25 youth, ages 15 to 19. Unlike many programs, TOP Reseau peer educators are paid. They receive U.S. $150 per month and must lead at least 40 such sessions per month, as well as get at least one group to come to the office for a video presentation and discussion. Currently, the peer educators are paid with donor funds through PSI.



A TOP Reseau peer educator leads a demonstration of correct condom use as young people gather outside.

Findings and Observations

In the first two years of the project, the 17 clinics have provided services to some 2,500 clients, with about half of the visits related to reproductive health issues. (The franchise has not yet developed data broken down by age.) In addition, peer educators have conducted about 520 sessions. Working with the clinics, PSI has begun to track clients served by sex, area, religion, marital status, age, type of service, and other variables and plans to use the data in ongoing research and monitoring activities. Such data can help in addressing key questions such as whether the addition of franchising techniques is associated with an increase in youth seeking clinical services.

Project leaders envision the individual clinics eventually taking over more responsibility for the project themselves, thus ensuring long-term sustainability. They have established a committee of clinic physicians to provide overall project oversight and to extend community relations and support. Eventually, revenue from membership fees will go to the committee as it assumes

greater responsibility for the project. Such a committee might have even greater potential if it included youth members in substantive roles.

"The most important part of the franchise is the youth-friendly training provided for counseling and treatment of youth."

Dr. Jean-Marie Andriamanonga,
Beryl Rouge Clinic,
TOP Reseau franchise member

TOP Reseau offers well-developed franchise techniques, including excellent training on youth-friendly services, a valuable referral system throughout the franchise network, and effective media and branding images, which collectively could be considered "best practices" for reaching youth. However, project costs are high, and some practices will be difficult to replicate on a large scale, such as the amount paid to peer educators. Careful attention is needed to ensure sustainability and expansion, including these steps:

- Develop relationships with the private sector and other community organizations — perhaps through a parallel support network or a collaborative community network.
- Document the impact of franchising techniques. Program monitoring should document the number of youth seen, the types of services received, and the cost-benefit relationship to the franchise services used. The program could examine how many more youth are coming to clinics as a result of the logo and media promotion.
- Explore ways to diversify funding and generate revenue.

K-MET, Kenya

Begun as an indigenous NGO in 1996, K-MET has developed and now supports numerous reproductive health networks in western Kenya. K-MET operates the "Private Providers Health Franchise Network" as an incubator for reproductive health models and best practices. It builds effective community collaboration and involvement and creates support networks including strategic partnerships with community leaders and organizations. The network has grown to include some 250 private clinics throughout western Kenya.

K-MET operates with revenues from franchise and individual membership fees, through fees from its two small private clinics, and with some donor and foundation funding. It functions with only a four-person staff, plus extensive volunteers. "In K-MET we want everybody to be a driver," says Executive Director Monica Oguttu. "We don't want any passengers."

K-MET works throughout the region to assist various types of innovative health programs in becoming these "drivers." With a holistic community development approach, these programs include peer education, primary health care, maternal and child health, nutrition, prevention of malaria and waterborne diseases, community networking, and home-based programs for people living with AIDS. K-MET uses the social franchising techniques of sharing information, developing referral mechanisms, training staff on technical issues and youth-friendly services, and charging franchise membership fees. K-MET hopes to develop more emphasis on youth through a collaborative community network with schools and other youth-serving NGOs and to integrate this youth focus into its existing provider network.

The K-MET sites visited had developed training programs and curricula for a variety of practitioners from doctors to midwives to peer educators, and many involved traditional healers. K-MET has consistently pioneered new techniques and models in community outreach and networking, training of peer educators, training of adult volunteers in home-based programs, research, and policy development. USAID/Kenya has used some of the K-MET training methodology and community involvement practices.

Findings and Observations

K-MET has developed a collaborative community network of schools, churches, government agencies, NGOs, and private businesses — in parallel with its clinic network — that serves to market, publicize, sustain, and enhance the

private providers franchise network. In this way, K-MET functions as much in the community franchise model as in the private provider model. K-MET now has an opportunity to improve and scale-up its existing social franchise to include a "youth component" for a comprehensive reproductive health and HIV/AIDS prevention program. K-MET hopes also to develop revenue-generating activities, which could help sustain the network.

Some youth groups and community groups are helping to broaden K-MET's franchise efforts. For example, staff from the K-MET clinics, a collaborating hospital, youth and community volunteer groups, and public officials attended the first K-MET annual youth network and festival, which featured a parade of some 100 youth through downtown Kisumu, the main city in the region.

To continue to develop this franchise, K-MET should consider these steps:

- Develop a logo to enhance the franchise, perhaps sponsoring a design contest to get more youth invested in the project.
- Utilize the media more and feature youth role models and spokespeople throughout the community network.
- Package and document models and innovative practices so that training can be systematized.
- Emphasize management and business planning, including research on costs and benefits, financial diversification, and greater earned income or revenue generating activities for both K-MET and related youth organizations.

K-MET, which provides clinical services itself (left), is building interest in youth among its community franchise network. For example, they used a festival (above) where youth peer educators paraded through downtown Kisumu, Kenya.

Chapter 6. Governmental Model

Governments themselves may also operate social franchises in the reproductive health field. While not involving the private sector, these efforts by ministries use social franchising techniques, especially quality standards, logos, training, and referrals, as well as incentives and subsidies. When performance is successful, private-sector franchises are rewarded with profits. Similarly, governmental clinics through a franchise approach are rewarded by incentives and subsidies.

Gold Star Project, Egypt

Although operated entirely by the government, in many ways the Gold Star project in Egypt reflects the traditional social franchising model. The success of the project has grown to involve some 2,400 clinics, more than half of Egypt's 4,500 public reproductive health clinics, according to the Ministry of Health (MOH). The clinics are generally publicly owned and locally operated. The government of Egypt, through its MOH, is the franchisor, and only government-owned or public clinics participate in the program.

The Gold Star project started in 1993-94 with USAID funding, which is now declining. Governmental funding has grown and, as an incentive, is tied to performance by individual clinics. Unlike traditional franchises, revenue from fees charged at MOH clinics is collected centrally and disbursed by district offices back to local clinics. Gold Star clinics meeting quality standards receive a modest bonus or incentive.

Youth-friendly services have no apparent emphasis in the overall program, although discussions about a youth initiative appear in planning documents. Many young married women under age 24 are being served, but services for unmarried youth are limited. A visit to a Gold Star clinic in Giza, a suburb of Cairo, reflected this treatment pattern. The clinic reported serving about 150 clients per day, about 60 percent of whom were under age 24.

A clinic official said that they saw very few unmarried women. It would be "too shameful" for them to come to a clinic in their neighborhood, he said, and so they go to a clinic outside of the area. This explanation suggests that unmarried women from other areas might be coming to the Giza clinic, but there was no evidence of or discussion about such visits. Given the local culture, providing youth-friendly reproductive health services for sexually active, unmarried youth is particularly challenging in Egypt.

Gold Star logo and signage were prevalent at the Giza clinic, as were detailed charts with client and community information such as the number of pregnant women and the number using contraceptive methods. The Gold Star logo has come to be known as a sign of high-quality services; this association is probably the most important accomplishment of this franchise system. Television spots, promotional and educational materials, and an attractive gold star trophy emphasize that the logo is a sign of quality. The program stands as a testament to the power of status and recognition as a primary incentive to maintain quality standards.

Gold Star is essentially a quality-improvement program with an extensive list of standards that clinics must achieve. Each clinic is evaluated quarterly by the MOH. If the clinic fails to meet 100 percent of the Gold Star standards for two consecutive quarters, it loses its "gold star" and is put on an improvement plan. Supervisors of the clinics must monitor that the nationally set clinic standards are being met and document the satisfaction of the family planning clients, according to the program's policies and procedures manual. Other elements of this franchise include a standard referral system and a requirement for Gold Star clinic staff to attend three days of in-service training annually. Other than referrals, there appears to be little communication among clinics.

Findings and Observations

The community outreach efforts of the Giza clinic were limited to "healthy worker" seminars provided at a nearby concrete block factory. The factory apparently benefited from the seminars in the form of reduced absenteeism and increased productivity. Nevertheless, the seminars generated no revenue because payment for these services from the factory was deemed inappropriate by clinic staff.

Although concerned with sustainability after donor funding ends, Gold Star shows only marginal interest in revenue generation, earned income, or private-sector involvement. It has undertaken a study on revenue generation, which may stimulate greater private-sector initiative. Although perhaps constrained for political reasons and as a public clinic, the Gold Star franchise could benefit from compensation for services provided to commercial enterprises, such as the concrete factory in Giza. Such fees for services could help strengthen and sustain franchises. Without greater private-sector involvement, Gold Star remains essentially a quality improvement program for public health with limited potential for private-sector linkages.

Although there is a declared interest in a "youth initiative," there are no visible signs or plans to develop distinct services for youth beyond the brochures and information currently available. Increasing contacts with community groups that have contact with youth offers one opportunity to reach more young people.

Staff members of the Gold Star clinic in Giza.

Chapter 7. Lessons Learned, Observations, and Conclusions

Many projects are just beginning to apply social franchising techniques to youth services in a systematic way. Sensitivity to providing youth-friendly services and involving youth in substantive roles is also growing. The case studies and the review of the literature on other emerging projects provide some clues as to which aspects of social franchising might assist in meeting the reproductive health and HIV prevention needs of young people.

Lessons Learned

Of the six primary franchising techniques most easily adaptable to youth programs (see Chapter 1), referral mechanisms and promotion and marketing are the two techniques used most often among the projects visited. Programs promote franchises through logos, branding, creation of market niches, and use of promotional posters, community theater plays, drama and skits, mobile communications vehicles, and radio programs. The least used techniques are quality assurance through standards and enforcement, especially for youth-friendly services; developing franchise agreements with pricing strategies or sustainability planning; and training in business management skills. Most of the projects promoted youth-friendly services through training and community outreach, but few had formal quality standards established for the franchise.

Social franchising is traditionally designed for clinical services, and adapting these techniques to more community-based approaches to meeting youth needs is challenging.

TOP Reseau in Madagascar employed the most social franchising techniques (see Table 1, page 5). Gente Joven in Mexico and FAD in the Philippines used aspects of all six techniques, but neither provided training in management, utilized centralized purchasing, or charged franchise fees. While Gente Joven is in the process of developing quality assurance standards for youth-friendly services, FAD has not yet taken that step. Gold Star in Egypt, a strong franchise model in many respects, has not developed youth-friendly quality assurance standards, and due to the centralized governmental structure, does not have a franchise agreement or charge membership fees. K-MET in Kenya has not developed or promoted a franchise approach but uses the other franchise techniques to varying degrees.

Generally, the more active and successful projects use more youth-friendly practices and focus more on involving youth as peer promoters and volunteers and, in some cases, as equal partners in the decision-making process. Some projects have youth members on committees that deal with budgets and other management decisions.

Table 2 (see page 25) provides a summary of 10 youth-friendly services and youth involvement parameters, based on observations during the project visits. The parameters fall under the four categories of youth-friendly services discussed in Chapter 1 (see pages 7-8); the fourth category, youth perceptions, is adapted to include youth involvement. All of the projects appear youth-friendly to some degree in the indicators for the facility (separate space for youth, appearance appealing to youth) and for administrative procedures (sliding fees, flexible hours, and welcoming atmosphere).

In terms of provider/staff attitudes and performance, all but Gold Star include training in youth-friendly services, and all provide confidential services. Only FAD and TOP Reseau include training for youth in business management and technical issues, although Mexfam and K-MET do conduct training for peer educators. Only Mexfam includes youth in governance or management committees.

Observations and Conclusions

Social franchising techniques may be useful to programs focusing on reproductive health and HIV prevention for youth, but more research is needed. Social franchising is traditionally designed for clinical services, and adapting these techniques to more community-based approaches to meeting youth needs is challenging. Even so, lessons learned from traditional social franchises may be valuable when looking at how selected franchising techniques are applied to youth services. For example, an analysis of the Green Star project in Pakistan (see page 9) revealed several important lessons: field-test franchise operations before expanding, develop support from key stakeholders, define clearly the franchise services, establish a franchise dues system, establish a system of monitoring control between franchisor and franchisee, use branding, and motivate franchisees.[28]

The observations and conclusions that follow are based on site visits, a research and literature review, and consultations with experts, as synthesized in this paper. While they echo many of the points found in analyses of traditional social franchising projects, they also address other issues specific to services for youth.

Because the reproductive health and HIV services that youth need range from educational and life skills to clinical services for contraception and HIV testing, identifying the types of services being franchised is critically important.

1. *For a social franchise to be successful and sustainable, there has to be sufficient demand for, and use of, the services that are being franchised.* Because the reproductive health and HIV services that youth need range from educational and life skills to clinical services for contraception

Table 2. Application of Youth-Friendly Practices, Case Study Programs

Practices	TOP Reseau	Mexfam	FAD	Gold Star	K-MET
Health Facility					
Separate space	some	x	x	some	x
Appearance	x	x	x	some	some
Provider/Staff Attitudes & Performance					
Youth-friendly services training	extensive	some	some		some
Confidentiality	x	x	x	x	x
Administrative Procedures					
Sliding fees	x	x	x	x	x
Flexible hours	most	some	some	some	some
Welcoming to youth	x	x	x	x	x
Youth Perceptions/Involvement					
Demonstrations to peer educators	x	x	x		x
Youth partners, governance, or committee		one exclusive youth clinic			
Youth training (business/technical)	some		some marketing		

and HIV testing, identifying the types of services being franchised is critically important. Often, youth cannot pay for clinical services, which may limit the traditional franchise system of clinical services for youth. However, community collaborations with educational services for youth can also utilize a franchise system, as shown in several case studies, although issues of cost and sustainability require more attention.

2. *Social franchising techniques have the potential for increasing the number of youth using clinical services.* Community outreach volunteers and communication activities targeted at young people with the greatest need for services can help create demand and link youth to services. Franchise training in youth-friendly services can also help attract and retain youth to services as clinics gain a reputation for being friendly to youth. Because additional financial investments may be needed for these purposes, questions of cost-to-benefit analysis, commercial viability, sustainability, and expansion should be considered, as is the case with the TOP Reseau project.

3. *Tensions exist between private providers' interests in profit and public health programs' commitment to social goals.* For many of the smaller NGO franchises visited, the primary social goals of the organization take clear priority over commercial franchising techniques. All the projects examined require donor funding, and many of the smaller franchises are concerned about what they will do when donor funding ends. Operations research projects need to assess the economic viability and sustainability of franchise models, particularly among projects intending to increase services to low-income youth.

4. *The associations among quality of services, youth-friendliness of services, and the number of youth accessing these services are not clear.* Given the lack of evidence, operations research needs to examine whether youth-friendly services in a franchise system are more effective than traditional services from independent clinics.

5. *Providing franchisor and franchisees with training in business management skills and building the capacity of those NGOs involved may contribute to the success of social franchising.* To provide the planning, supervision, and management support needed by franchisees, the franchisor needs to have supervisory and management skills and other organizational capacities. Through skill training, the franchisor could foster a more efficient business relationship and respect for contract terms; develop business plans and strategies including enforcing minimum standards to protect brand equity; and provide better financial accounts and records. In this way the franchisor also helps support the morale that is particularly important to smaller NGO franchises that pay or employ the franchisee staff (for example, see community model, Chapter 4).

In the Philippines, FAD promotes its "Socially, emotionally, sexually responsible teeners" (Sexters) project in schools.

6. *Existing franchises can add a focus to youth.* Franchises can provide training to franchise members on how to provide youth-friendly services or involve youth in programming. Or they might add workplace interventions in areas that can reach youth employees as a way to expand the franchise market. Using existing franchises to reach more youth may be easier than starting a new franchise working with one provider at a time.

7. *Social franchising for youth may be most successful when building collaborative community networks.* Most social franchising models focus on a private provider network. But projects with minimal donor investment, strong potential for sustainability, and larger numbers of youth clients might reach more youth by developing parallel networks — a franchise network for private providers and a collaborative network with community groups — i.e., combining the provider and community models presented in this paper. This community collaboration could assist with promotion, publicity, volunteers, and in-kind or financial support, and provide opportunities to reach more youth at churches, schools, workplaces, and other NGOs. Mexfam, K-MET, TOP Reseau, and FAD all rely on relationships with community organizations to support the franchise network, and some provide logos to these organizations and consider them franchise members.

8. *Linking youth reproductive health/HIV services with livelihood development projects may help sustain franchises and attract youth.* Some franchises have started linking reproductive health/HIV with income-generating activities such as cyber cafés. Some of these activities have been developed by the youth themselves. Expanding such activities may help franchises with sustainability issues when faced with reduced donor funding. Youth livelihood projects linked with a franchise may also help attract youth to the franchise and thus increase demand for services. The first priority of most youth interviewed was earning money, not reproductive health or HIV services. Small business activities enable youth to acquire business planning and management skills that could be applied to the franchise. Young people have many creative ideas for small, informal revenue-generating activities but lack the seed funds to get started.

9. *Involving youth in substantive decision-making roles may enhance the success of the franchises in several ways, including attracting larger numbers of youth.* Mexfam's Gente Joven project uses youth promoters to work in schools and the community, and involves youth leaders in decisions that affect local centers and clinics in the franchise network. With a youth representative on the Community Committee and a standing Youth Committee of the Board of Trustees, TOP Reseau and Mexfam, respectively, give youth a voice and provide a meaningful role for young people in project management.

10. *Socioeconomic, political, cultural, and commercial contexts affect the ability of a franchise system to work.* The ability of clients to pay is a critical component, and social franchising may be most effective in lower middle class or middle class areas rather than the poorest areas. Political factors play a role in various ways. Mexico, for example, is providing more authority to local districts in a decentralization process of governance. This reinforces the efforts of Mexfam to encourage local franchises to take responsibility for their own sites and become self-sustaining. Social and cultural factors, economic infrastructure, and national policies affect the success of private providers in a social franchise system.

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