INCLUSIVE INNOVATIONS

Bringing Healthcare to Low-Income Women through Franchising

Networks of private providers are increasing access to good-quality reproductive health services

HIGHLIGHTS

- Women's health franchisees operate under the common franchise name, meet the franchisor's quality standards, and follow its operating procedures.
- Health services include family planning, treatment for sexually transmitted infections, abortions and postabortion care, and the sale of contraceptives.

Franchised Tunza Family Health Network providers after a training

Summary

Poor women in South Asia, Southeast Asia, and particularly Sub-Saharan Africa lack access to good-quality reproductive health services. To address the problem, a growing number of women's health clinics are offering reproductive health services based on a commercial franchising model. Each of these franchises reach thousands of women, meeting a critical need.

Development Challenge

Every day more than 800 women die of pregnancy- and childbirth-related complications—most of which are preventable (WHO n.d.). Especially in Sub-Saharan Africa and South Asia, millions of women die unnecessarily because public health systems are weak and serving poor populations is not attractive to private providers. Where the private sector does serve the bottom of the pyramid, the quality of care is often low and services often unaffordable.

The global incidence of neonatal death has fallen dramatically in the past 25 years, from 47 per 1,000 live births in 1990 to 19 in 2015 (UNICEF n.d.). But even at this rate, 2.7 million babies a year still die in the first month of life.

One way to address these challenges is through women's health franchises—social franchises based on conventional commercial franchising models. These models deliver good-quality reproductive health services to poor women, reducing both maternal and neonatal mortality. Services include family planning, safe motherhood care, treatment for sexually transmitted infections, abortion and post-abortion care, and the sale of contraceptives and other products.

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This series on Inclusive Innovations explores business models that improve the lives of those living in poverty. Editors are Elaine Tinsley and Natalia Agapitova. Written and researched by Endeva and Ashley Insight.

Business Model

Components of the Model

Franchising depends on the ability to standardize the provision of a service, something that is not possible for many types of health care. Areas in which standardization is possible include primary, eye, dental care and family planning and reproductive health, where training and monitoring are relatively straightforward (World Bank 2003; KfW 2010).

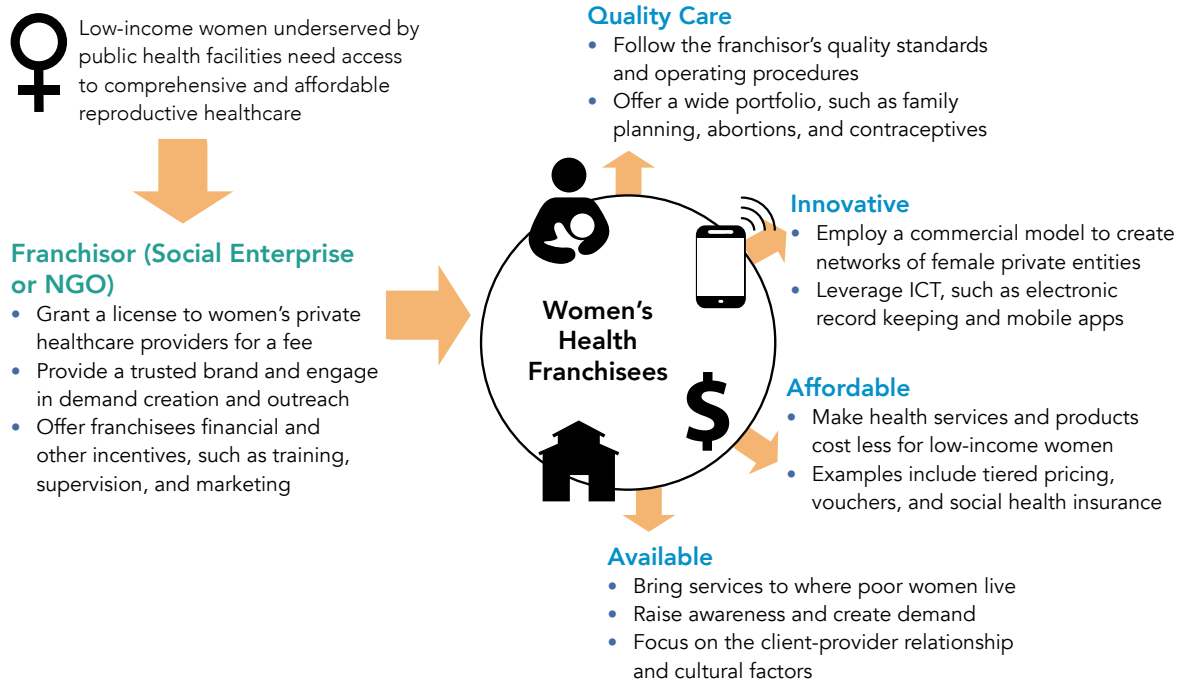
Women's health franchises are based on conventional commercial franchising models. Typically, the franchisor grants a license to a network of private healthcare providers (the franchisees), usually in return for a fee. The franchisees operate under a common franchise name and are required to meet the franchisor's quality standards and follow its operating procedures when providing services.

The franchisor provides a trusted brand and builds demand through outreach to potential patients. It also provides a range of financial and other incentives, including training, supervision, marketing, and in health products at below market rates. In Pakistan, for example, Greenstar provides its franchisees with monthly visits from its doctors, who consult on difficult cases, share advances in clinical practices in reproductive health, and conduct one-on-one training in areas of need (Center for Health Market Innovations n.d.).

Fractional (or partial) franchise models are very common in women's health. Under this model, franchisees are preexisting private health care providers that remain free to offer services not supported or standardized by the franchisor. Fractional franchises are often associated with international NGOs, such as Marie Stopes International (MSI) or Population Services International (PSI), which contract with private providers through their nationally registered affiliates.

Some franchises, such as the Merrygold Health Network in India, use a mix of both fractional and full franchising. Its network includes fully franchised hospitals and fractionally franchised clinics in rural areas.

Figure 1. Features of women's health franchises model



Cost Factors

The main cost factor is setting up the franchise, which involves developing standard operating procedures, branding, and setting up patient tracking and administrative systems. These costs can be high, but they help reduce the costs of individual franchisees.

Revenue Streams

Franchisors earn revenue from franchisor fees, the sale of technical and program assistance to franchisees, the sale of commodities (such as contraceptives and medicines), and fees for affiliated services (such as labs). Franchisees earn revenue from a mix of sources, including payments from patients and vouchers, subsidies, social health insurance, and national insurance payments from the government (Table 1).

Table 1. Revenue sources and pricing of selected women's health franchises

Network	Parent organization	Sources of revenue / Pricing comparison
BlueStar (Ghana)	MSI	65 percent out-of-pocket payments by patients, 35 percent vouchers and subsidies
BlueStar (Vietnam)	MSI	65 percent out-of-pocket payments by patients, 35 percent vouchers and subsidies
Jacaranda Health (Kenya)	—	National health insurance, prepayment, package pricing, complication insurance Price of comprehensive maternity care is about a fifth the price charged by other private hospitals.
LifeSpring Maternity Hospitals (India)	HLL Lifecare Ltd.	30–50 percent below market rates (a two-day maternity stay, including medicines and a baby kit, that costs about USD 150 in a private ward, costs USD 42–USD 85)
Merrygold Health Network (Rajasthan, India)	Hindustan Latex Family Planning Promotion Trust (HLFPPT)	40 percent out-of-pocket payments by patients, 30 percent vouchers, 10 percent social health insurance, 20 percent unreported
Merrygold Health Network (Uttar Pradesh, India)	Hindustan Latex Family Planning Promotion Trust (HLFPPT)	Majority out-of-pocket payments by patients, rest insurance and other means. Priced 50–60 percent below market prices
Sabz Sitara (Greenstar) Network (Pakistan)	PSI	92 percent out-of-pocket payments by patients, 8 percent vouchers and subsidies
Tunza Family Health Network (Kenya)	PSI	Majority out-of-pocket payments by patients, rest vouchers and subsidies

Sources: Viswanathan, Schatzkin, and Sprockett 2014, networks' websites, and personal communications with Merrygold and Tunza representatives.

Financial Viability

Franchisees are generally able to generate profits. In contrast, franchisors are often donor dependent, although some networks have achieved profitability for both franchisors and franchisees (Table 2). One example is Merrygold, which was set up with seed funding provided through a grant. Its franchisees can expect to have a positive cash flow after 18 months of service, according to the company; franchisors (in operation in five Indian states) typically become profitable within about four years.

Table 2. Sources of funding and operating costs of selected women's health franchisors

Franchise/country	Sources of funding	Annual cost to operate (2013 dollars)
BlueStar (Ghana)	Donor funding and franchisee fees (USD 70 a year for clinics, USD 50 a year for pharmacies, and USD 30 a year for chemical shops (shops that provide basic health provisions)	353,000
BlueStar (Vietnam)	Donor funding and franchisee fees (USD 70 a year for clinics, USD 50 a year for pharmacies, and USD 30 a year for chemical shops (shops that provide basic health provisions)	353,000
Merrygold Health Network (Rajasthan, India)	Donor funding and franchisee fees	693,000
Merrygold Health Network (Uttar Pradesh, India)	Donor funding and franchisee fees	254,000
Sabz Sitara (Greenstar) Network (Pakistan)	Donor funding and sales of products	10,820,000
Tunza Family Health Network (Kenya)	Donor funding and franchisee fees	6,855,000
Well Family Midwife Clinic (Philippines)	Franchisor fees, sales of technical and program assistance to franchisees	11,000

Sources: Viswanathan, Schatzkin, and Sprockett 2014, networks' websites, and personal communication with Merrygold and Tunza representatives.

Partnerships

Most franchisors are nonprofit organizations, such as a nationally registered affiliate of an international NGO (BlueStar, Greenstar, Tunza) or a national social enterprise or NGO (Merrygold, Well Family). Franchisors typically provide franchisees with standards, training, certification, supervision, performance monitoring, quality assurance, products, and links with financial institutions. Training often includes technical and clinical skills as well as management and customer care. Greenstar's quality assurance and performance monitoring include monthly site visits, four internal audits a year, and provider surveys and mapping studies. Franchisors analyze data quarterly and feed it back to franchisees. They also engage in brand marketing and awareness-raising to increase demand for affiliated services.

Franchisees are typically preexisting private health providers, ranging from one-person practices (run by doctors, nurses, or midwives) to larger clinics, maternity homes, and hospitals. They typically adopt specific standards and procedures set out by the franchisor, regularly report to the franchisor, and usually pay a franchise fee. Franchisees deliver reproductive health services and products to women, typically charging them 50–60 percent less than market rates. Where clinics have yet to be established, franchisees often require support in building up a health facility. Franchisors link prospective franchisees to financial providers to help them secure loans.

Many women's health franchises are funded primarily by donors, although they use a range of additional revenue-generation strategies. In 2013, the top donors (other than parent agencies) were the U.S. Agency for International Development (USAID), anonymous donors, the U.K. Department for International Development (DFID), the Bill & Melinda Gates Foundation, and the Norwegian Agency for Development Cooperation (NORAD) (Viswanathan, Schatzkin, and Sprockett 2014).

The Well Family Midwife Clinic franchise, with 85 outlets in the Philippines, is funded primarily by revenues from the sale of technical and program assistance to franchisees and franchisor fees (Viswanathan, Schatzkin, and Sprockett 2014). LifeSpring, an Indian franchisor, is a 50-50 joint venture owned by HLL Lifecare (a government of India enterprise) and the Acumen Fund (a US-based social venture capital fund).

Several models employ community outreach workers to raise awareness and provide health information and referral services. Greenstar, Tunza, Well Family, and others each employ several hundreds of outreach workers (Center for Health Market Innovations n.d.). Some models use a multilayered outreach model. BlueStar Vietnam conducts community outreach with both salaried employees and people who receive commissions for referrals. Clinic-based outreach is also part of their strategy (Viswanathan, Schatzkin, and Sprockett 2014).

Implementation: Delivering Value to the Poor

Awareness

Women's health franchises use a range of communication mechanisms to create awareness and increase demand, including conventional advertising (through television, radio, billboards, leaflets, and posters) and community outreach and events. The Well Family Midwife Clinic in the Philippines organizes health events on clinic anniversaries and the owner's birthday.

MSI-affiliates hold demand-generation events, such as offering free services for a day (Marie Stopes International 2011). Tunza, in Kenya, has dedicated staff ("Tunza Mobilizers") whose job is to build demand. Three hundred volunteer community-based outreach workers cover one clinic each, providing awareness-raising, health information, and referral services.

Efforts to build awareness are sometimes coupled with financial incentives to create demand. The Merrygold Health Network in Rajasthan, India hosts outreach camps and baby showers for expectant mothers to raise demand for its services. In Pakistan community health workers hand out referral tokens to women in poor communities for use at Greenstar's franchised clinics.

Acceptance

Women's health franchises increase their appeal by providing good service, being sensitive to cultural factors, and leveraging information and communications technology. Patients cite the client-provider relationship as their main motivation for using private franchised providers.

All franchises use female outreach workers. Greenstar employs "lady health visitors" and ensures that women have separate sessions with female franchisee representatives to discuss their health problems, including domestic issues. Given that men are a key determinant of women's health, Jacaranda Health in Kenya is examining ways to increase men's involvement, particularly regarding labor and delivery choices.

Accessibility

Women's health franchises increase accessibility by bringing reproductive health services closer to where poor women live, particularly in rural and peri-urban areas. They are particularly important in areas underserved by public facilities, which are often understaffed and experience frequent stock-outs. To tailor its services to women's needs, Jacaranda sends satisfaction surveys to clients. Jacaranda also uses mobile phones to send appointment reminders and input patient data.

Affordability

All women's health franchises aim to make services and products affordable to poor women, with some aiming to reach the bottom wealth quintile. Merrygold's cross-subsidy model enables it to charge 50–60 percent below market prices to its low-income patients, who make up more than 70

percent of its patients. Several franchises, including Greenstar in Pakistan, use voucher schemes. Jacaranda, in Kenya, addresses affordability barriers through a mobile prepayment service it developed, to help clients prepay for delivery costs to spread the financial burden of a large bill.

Task-shifting, whereby less skilled workers take on the more mundane tasks of more skilled personnel, keeps costs down. At Jacaranda nurses provide all clinical care, nurse aides provide nonclinical care, and community health workers manage home visits and client education (Center for Health Market Innovations n.d.).

Results and Cost-Effectiveness

Scale and Reach

Some women's health franchises have reached significant scale. Greenstar, the first major women's health franchise in the world, has more than 7,500 clinics (Table 3). Since it was established, in 1991, it has served about 650,000 women, in more than 3.5 million visits. BlueStar has 304 clinics and maternity homes in Ghana and 299 in Vietnam. Tunza, in Kenya, has registered 710,000 visits since 2008. The Merrygold Health Network has performed more than 890,000 antenatal checkups, 170,000 deliveries, 42,000 intrauterine contraceptive device insertions, and 11,000 sterilizations. MSI's social franchise networks in the Philippines inserted 23,000 intrauterine devices in the first eight months of 2010, just two years after it was launched (Marie Stopes International 2011).

Table 3. Number of outlets of and patient visits to selected women's health franchises

Franchise/country	Parent organization	Number of outlets	Number of visits
BlueStar (Ghana)	MSI	304 clinics and maternity homes	208,000 since 2008
BlueStar (Vietnam)	MSI	299 clinics and maternity homes	758,000 since 2008
Jacaranda Health (Kenya)	None	2 clinics	Care provided to more than 5,000 women and more than 500 babies delivered since 2012
LifeSpring Maternity Hospitals (India)	HLL Lifecare Ltd.	12 clinics	30,000 babies delivered since 2005
Merrygold Health Network (Rajasthan, India)	HLFPPT	26 clinics and maternity homes, 12 pharmacies	12,000 since 2013
Merrygold Health Network (Uttar Pradesh, India)	HLFPPT	240 clinics and maternity homes, 2 pharmacies	145,000 since 2007
Sabz Sitara (Greenstar) Network (Pakistan)	PSI	7,543 clinics and maternity homes, 99 standalone laboratories, 12 health kiosks	3,529,000 since 1995
Tunza Family Health Network (Kenya)	PSI	316 clinics and maternity homes	710,000 since 2008
Well Family Midwife Clinic (Philippines)	None	85 midwife clinics and maternity homes	52,000 since 2002

Sources: Viswanathan, Schatzkin, and Sprockett 2014, networks' websites, and personal communication with Merrygold and Tunza representatives.

Models focus on both the bottom and middle quintiles, covering both rural and urban areas. The majority of Tunza's patients come from the bottom two quintiles; a quarter come from the middle

quintile (Viswanathan, Schatzkin, and Sprockett 2014). Some franchises focus exclusively on urban or rural area; many serve both. Greenstar operates 4,822 outlets in urban and 2,832 outlets (37 percent) in rural areas. BlueStar Vietnam has 195 outlets in urban and 586 (75 percent) in rural areas.

Improving Outcomes

Patients are receiving services and products they might otherwise have been unable to access. As a result, maternal mortality has fallen significantly. Women also benefit from shorter waiting times and better-quality care.

Private franchises have increased patient satisfaction. In a study conducted in Ghana and Kenya, women cited the client-provider relationship as the main reason for choosing a franchise facility. They described providers as caring, respectful, and considerate and reported high levels of satisfaction, thanks to the high quality of medical care, short waiting times, facility cleanliness, and staff attitudes (Sieverding, Briegleb, and Montagu 2015).

Cost-Effectiveness

Taking care of women's health improves their ability to stay productive, both directly and indirectly, as their families' main caregivers. Healthier women increase the productivity of other household members and reduce the risk of catastrophic expenditure.

There is evidence that the presence of franchised facilities puts downward pressure on prices. According to the CEO of Merrygold, private service providers that had been charging exorbitant prices had to revise their price structure to stay in business (personal communication, May 19, 2015). As a result, privately provided health services became more affordable to wider parts of the population.

Scaling Up

The number and size of women's health franchises has soared in recent years, and the focus has broadened from family planning to women's health and even family health. This trend may reflect client needs as well as franchisees' desire to diversify their sources of revenue.

Standardization and focus are key to making women's health franchises work. Other important factors include providing extensive technical and clinical training; ensuring a high level of quality of care through ongoing monitoring and evaluation as well as refresher training; reflecting local circumstances in the pricing structure; facilitating loans for prospective franchisees; and cutting costs where possible without compromising quality.

In Ghana and Kenya, brand recognition does not appear to be an important factor, particularly on the demand-side. In contrast, it has been a key determinant of engaging providers as franchisees in the Merrygold networks (Sieverding, Briegleb, and Montagu 2015).

A major factor for growth is the availability of underemployed health providers whom franchisors can recruit into their networks. Network size allows for economies of scale and bargaining power in procuring products, supplies, and equipment. It is also associated with increased brand recognition, making it easier to recruit additional franchisees. Rising income levels in the target population should also build both demand and supply.

Challenges

The ongoing need for subsidies and donor funding raises questions about both sustainability and scalability. Merrygold franchises in several Indian states require substantial initial investments before becoming profitable. Even NGO-backed franchises, such as Tunza in Kenya, are aiming to achieve financial sustainability and thus beginning to experiment with various revenue streams. Other constraints include the high cost of producing good-quality health services at a price women are willing and able to afford.

Role of Government and Policy

Governments and donors can seed and co-finance privately provided health services that lack incentives to cater to the poor. Social franchise networks, particularly as they scale up, constitute a useful entry point for governments to engage with and integrate private providers.

- *Policy and regulation*: Governments could address registration requirements for franchised networks and legal provisions for franchising. Other policy barriers include difficulties in procurement of drugs, commodities and supplies by private actors; and accreditation.
- *Alignment and harmonization with the national health system*: Governments benefit from working closing with private clinics to improve provision but also data collection for oversight of the country's health demands and needs. Tunza's clinical guidelines and protocols are based on the protocols of the government of Kenya and the World Health Organization; Tunza regularly shares data with the government. It provides regular training to franchisees through accredited providers, enabling franchised providers to maintain their practice licenses. It also links franchisees to government services that provide products for free. This linkage facilitates government regulation and oversight.
- *Public-private partnership and demand-side financing*: Governments can engage with women's health franchises through contracting, establishing a voucher scheme, or accrediting them to participate in the national health insurance scheme if one exists. In 2004 MSI Kenya established AMUA under a contract with the government of Kenya. AMUA franchisees are eligible to obtain some free commodities from the government; the AMUA network provides products to clinics in case of government stock-outs (Sieverding, Briegleb, and Montagu 2015). Greenstar, the second-largest provider of family planning services in Pakistan after the government, partners with the public sector and donor agencies to implement voucher schemes that provide subsidized access to healthcare for mothers.
- *Principles of fractional franchising for the public sector*: MSI has helped the governments of China and Vietnam apply the principles of fractional franchising to the public sector. Under this model, services are standardized and marketed under a single brand. Each facility is refurbished, and public sector employees at each facility receive training on social franchising and marketing, financial sustainability, quality of care, branding, and customer service. Public facilities do not pay an annual fee, and they do not necessarily receive products from MSI (Marie Stopes International 2011).
- *Monitoring*: The monitoring built into franchising may be attractive to governments interested in establishing partnerships with small-scale providers close to communities that lack the capacity to oversee their own operations. Public actors need to consider the subsidies required by a franchise network and measure them against alternative mechanisms (such as subsidies) to boost women's health.

Table 4. Selected women's healthcare franchises

Company/country	Website	Description
BlueStar (Ghana)	http://www.marystopes.org/	Clinical social franchise aims to improve access to and quality of family planning and reproductive health services provided by the private sector.
BlueStar (Vietnam)	http://www.bluestar.org.vn/	Clinical social franchise aims to improve access and quality to family planning and reproductive health services provided by the private sector.
Jacaranda Health (Kenya)	http://www.jacarandahealth.org/	Fully self-sustaining and scalable chain of clinics provides affordable, good-quality maternal and child health services to poor urban women.
LifeSpring Maternity Hospital (India)	http://www.lifespring.in/	Network of hospitals provides reproductive and pediatric healthcare to low-income people in urban and peri-urban slums.

Merrygold Health Network (India)	http://www.merrygold.org.in/	Network of private clinics provides low-cost, good-quality maternal and child healthcare services.
Sabz Sitara (Greenstar) Network (Pakistan)	http://www.greenstar.org.pk/Sabzsitara-Clinic.html	Franchise network works through private and public channels, marketing family planning products and services; training health care professionals; and providing mother and child health services, vouchers for safe delivery, and detection and treatment services for tuberculosis.
Tunza Family Health Network (Kenya)	www.psikenya.org	Network recruits and trains private practitioners to provide contraception; promotes uptake in the community; and provides access to affordable health services, including screening for cervical cancer and sexually transmitted infections, HIV counseling, and childhood diseases.
Well Family Midwife Clinic (Philippines)	http://www.wfmc.com.ph/	Network provides family planning, maternal and child healthcare services, and basic health services of a midwife.

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Profile: Merrygold Health Network

Private health service providers provide low-cost, high-quality reproductive health services through social franchising in Uttar Pradesh, India

Challenge

Uttar Pradesh, India's most populous state, has a high unmet need for family planning: 25 percent of women who want to postpone pregnancy or avoid getting pregnant do not have access to family planning (World Health Partners). Despite significant progress, the number of maternal deaths per 100,000 live births (292) is among the highest in India.

Thousands of community health workers support Merrygold's networks of midwifes and doctors, like this gynecologist in Uttar Pradesh.

Innovation

Launched in 2007, Merrygold Health Network (www.merrygold.org.in) is a social franchise (similar to a commercial franchise, a social franchise is the replication of a social enterprise model linked through agreements to provide goods or services under a common franchise brand), implemented by the Hindustan Latex Family Planning Trust (HLFPPT), an NGO promoted by HLL Lifecare Limited, a public enterprise of the government of India. The network employs a three-tiered model of fully franchised hospitals, fractionally franchised clinics (relying on the state's extensive network of licensed private healthcare providers), and community outreach workers to provide affordable services to lower-income populations. Its services include antenatal, perinatal, and postnatal care as well as related maternal and child health services and family planning. Its Uttar Pradesh network consists of 280 health facilities, 280 doctors, 1,540 nurses and midwives, and about 9,500 community outreach workers.

Franchised hospitals and clinics generate revenue through a low-cost, high-volume strategy that allows them to price services at 50–60 percent below market prices. All facilities accept health insurance and make services affordable through tiered pricing and the cross-subsidization of preventive and curative services. Merrygold ensures that general ward patients account for at least 70 percent of its patients; the other 30 percent pay higher fees in the semi-private and private wards. Franchisor revenue is generated through a franchising fee of about USD 6,000 for hospitals and USD 20 for clinics, plus a royalty fee for hospitals of 3 percent of revenues. Community workers provide outreach, particularly in rural areas, and generate demand for the network. They receive a monthly performance-based reward from Merrygold.

Impact

In its first seven years of operation, the network conducted more than 890,000 antenatal check-ups, delivered 170,000 babies, performed 11,000 sterilizations, and inserted 42,000 intrauterine devices. It provided more than one million "couple years of protection" (a measure used by family planning services that indicates the estimated protection from pregnancy provided by contraceptive methods during a one-year period) and saved 14,157 disability-adjusted life years (Viswanathan, Schatzkin, and Sprocket 2014). Price pressure from Merrygold forced some private service providers to revise their price structures to stay in business.

Scaling Up

The network has been enormously successful in ensuring equitable access to good-quality health services. Impressed with its results, the government of India asked it to expand to all 75 districts of Uttar Pradesh, up from 25 districts.

Merrygold was set up with the goal of financial sustainability. During its first four years of operations, it relied on donor funding to establish the network, its branding, protocols, and software and to build caseloads. Since 2011 revenues have provided about 85 percent of its funding. It plans to become fully sustainable by about 2017 or 2018.

Merrygold's experience indicates that an exclusive focus on family planning limits the prospects for profitability: Offering additional services, such as maternal and child health services, was necessary to render the model sustainable. Ensuring equitable access to quality services in rural and remote areas remains a challenge.

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Profile: Tunza

Network of franchised providers offers high-quality health services to women in urban and rural areas in Kenya

Challenge

Despite improvements over the past several decades, about a third of women in Kenya who would like to avoid pregnancy do not use contraception, with poor married women being affected almost twice as much as women from middle- and higher income groups (Smith 2014). Lack of access to contraceptives increases the number of unwanted pregnancies, high-risk deliveries, and fatal pregnancy-related complications.

Tunza trains existing private sector health care workers, like these men and women in Kenya, to provide family health and other services. Source: www.pskenya.org

Innovation

Population Services Kenya (PS Kenya, www.psikenya.org), an affiliate of Population Services International (PSI) launched the Tunza Family Health Network in 2008. This social franchise network engages private sector clinics as franchisees that provide family planning and wider family health services—including long-term family planning methods, maternal and child care, voluntary male circumcision, and HIV/AIDS testing and counseling—in Kenya.

Tunza has 316 clinics in its franchisee network, making it the largest social franchise in Kenya. About 60 percent are in urban and peri-urban areas, with the remaining 40 percent in rural areas. Each clinic serves and treats about 15 patients a day, for a total of 5,000 visits a day.

PS Kenya empashizes alignment and harmonization with the national health system, using clinical guidelines and protocols that are based on those of the government of Kenya and the World Health Organization. It facilitates integration of the public and private sector by providing regular training to franchisees by providers accredited by the Ministry of Health. It links franchisees to government services that provide essential commodities free of charge, facilitating regulation and oversight by the government. Tunza quality assurance officers supervise franchised clinics, 70 percent of which have just one or two providers.

Three hundred community health workers (known as “Tunza mobilizers”) generate demand for services. Each mobilizer covers a single clinic, raising awareness and providing health information and referral services. Tunza mobilizers work part time, receiving USD 30 a month from PS Kenya. Some very profitable clinics top up the mobilizers' salary, rewarding them for referrals.

The franchisor encourages franchisees to keep service prices low, but pricing is at the discretion of each provider. Patients generally pay USD 2 per consultation, far less than the private sector fee, which can be as high as USD 75. Most payments for health services are out-of-pocket, although some are paid for through a voucher subsidy scheme introduced in 2011 that benefits low-income women.

Like many other social franchises, Tunza traditionally focused on family planning. In response to demand, it now also provides integrated management of childhood illness, HIV testing and counseling, voluntary male circumcision, and treatment of noncommunicable disease. It thus affects the whole

family and changes the way in which family members, particularly men, engage with women's health issues.

Impact

Tunza has provided 311,000 couple years of protection (the protection provided by family planning services during a one-year period) and averted 250,000 disability-adjusted life years (DALYs). The program has also improved the lives of its franchisees, 300 of whom are female nurses and midwives.

Scaling Up

Harmonizing its approach to fit within the government system and maintaining close relationships with key government departments have been key drivers. For training, Tunza teams collaborate with various divisions of the Ministry of Health, ensuring that Tunza franchisees receive certification recognized by the ministry and adding credibility to the franchise. To select providers, the Tunza network ensures that facilities have government's registration and are licensed by the relevant bodies,

To avoid accrediting providers with invalid certificates. The franchisor links its network of health providers to the government in order to receive essential commodities. PS Kenya is responsible for ensuring the quality of franchisees, but the government regularly checks to ensure that providers are registered and comply with standards. The Tunza team also conducts joint supervision visits with Ministry of Health officials. PS Kenya recently extended its links with the government, where it sits on the Technical Working Group for Reproductive Health. These links increase its ability to influence government policy.

In scaling up the Tunza model, integration of services that target the whole family was key. Particularly important was it efforts to encourage men to get involved in family planning.

Franchisees are profitable, but Tunza is 100 percent donor funded. Achieving sustainability is an explicit goal. PS Kenya has started developing the Tunza 2.0 model to render the program financially sustainable within the next five years. PS Kenya plans to generate revenue through the mass procurement and subsequent sale of commodities, training packages, brokerage fees for affiliated services (such as labs), an increase in franchise fees, and the introduction of royalty payments for high-income franchisees.

Identifying and motivating providers remains a challenge. Existing providers, many of whom previously worked in the public sector, are typically not business oriented and need considerable guidance to run a private clinic as a business.

The franchise model provides limited oversight to the franchisor; ensuring quality and respect of protocol can therefore be difficult. To address this challenge, the franchisor uses rigorous retention criteria to ensure that providers not abiding by the requirements are removed from the network.

Reference

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http://www.prb.org/pdf14/kenya-unmet-need-contraception.pdf