

ISSUES IN EVALUATING CLINIC FRANCHISING PROGRAMS
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Note: Figures 2 and 3 will be found in Tabs 4 and 5 of the meeting binder.

Introduction

Clinic franchising (CF) occurs when service delivery points contribute equity and resources of their own in exchange for the right to offer a defined set of health services and products of a franchisor for a perceived market advantage or to pursue a common social mission. Health clinic franchises, which have been growing in the U.S. as one form of response to managing high medical costs, are also being implemented in a number of less-developed countries. In the field of family planning service delivery, one of the first global efforts to establish a network of sites offering contraceptive information and services according to established standards is the International Planned Parenthood Federation (IPPF). Under this federation, over 150 family planning associations have been endorsed as the unique affiliates in their given country. Many affiliates supervise the quality of services provided in their own branch clinics within the country. As such, although IPPF affiliates and their local operations constitute a global network of service delivery points for standardized family planning and reproductive health care, they are not franchisees in a commercial sense.

Contraceptive social marketing (CSM) programs today lead in the application of the clinic franchise concept.¹ Social marketing programs create consumer demand through promotional media, the use of brand names and logos, and efforts to improve quality. They also work to improve and expand the supply of products through arrangements with local providers, pharmacies, pharmaceutical companies and governments, and through the effects of fee revenue and raised demand. The objectives of CSM programs include increased awareness of family planning, improved availability and accessibility of contraceptive supplies and services, and cost recovery from retailers and those clients who can afford to pay a small fee.² The effort to defray the costs of service delivery through pricing strategies for distributors and consumers sets CSM programs apart from other provider networks by integrating some financing and profit-making incentives found in commercial franchising models.

Generations of social marketing programs have centered on distributing contraceptive products, especially condoms and oral contraceptives. Clinic franchising in turn extends these principles to services, in what the Futures Group has referred to as *service marketing*.³ Clinical services support longer-term methods and broader reproductive health care and require the participation of trained providers. Networks of providers, or *franchisees*, are producers in the CF system; they create standardized and predictable services under a franchise name.⁴

The standardization and identification of services with the franchise name or logo, combined with contractual arrangements between providers and the franchising organization, distinguish CF from other social marketing programs that include provider training. At the same time, the social marketing version of franchising differs from commercial franchising in that franchisers and donors, instead of franchisees, bear the financial risk involved in setting up a site or establishing services.⁵

A variety of special programs and initiatives co-exist under the franchising concept. They involve different franchising organizations, different types of providers, and variations in contracts or other ownership arrangements. They also operate in a variety of contexts. While there is evidence of a growing market share for private sector suppliers of primarily non-clinical contraceptives, there is relatively little systematic evaluation of the impact and effects of CSM, let alone CF, programs *per se* implemented in developing countries.

This paper discusses some of the evaluation issues pertinent to identifying the net effects of contraceptive social marketing and clinic franchising programs. CSM style projects have been implemented throughout Asia, sub-Saharan Africa and Latin America, the oldest major one being the Nirodh social marketing program undertaken by the Government of India for condom distribution launched in 1968. A major source of financial support for CSM programs has been international bilateral, multilateral and private donors in the U.S., United Kingdom, and Germany, to name a few, which each year provide substantial funding annually to implement CSM and franchising programs in more than 50 developing countries. Efforts to evaluate CSM

and CF programs require information on the specific configurations of the CSM or CF components that produce successful results. Evaluating these programs crossnationally and systematically will help provide information needed to understand their effectiveness and efficiency within given resource, market and consumer demand environments.

For the purposes of this review, a CF program is defined as a network of service providers or outlets invited by a franchiser to practice that franchiser's program of service delivery, thereby earning the use of the franchiser's name and logo. In this review, we discuss variations in the franchising model and present a conceptual framework that can identify factors to be tracked and assessed in a comparative evaluation effort. We also briefly describe selected CF program examples in Bihar state, India; Pakistan, Ethiopia, and the Philippines. We review current efforts to monitor CF and CSM programs internally and the types of indicators used. Last, we discuss the issues involved in evaluating the overall effectiveness and cost-effectiveness of such programs in improving the delivery of family planning services and increasing contraceptive use.

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This review is limited to CF programs focusing on improved family planning service delivery and increased contraceptive use. The following sections describe variations in the franchiser, franchisee, and contract components of the franchising model, as well as contextual factors that may be significantly related to the effectiveness of a CF program.

Characteristics of franchising organizations

Goals, target populations and management

Clinic franchising programs were developed in the 1980s by non-governmental organizations

(NGOs), as well as by international donor agencies that selected these organizations to carry out program implementation. Local government agencies also played supporting roles. The goals of these entities and their interrelationships can influence the structure and success of franchising projects.⁶

The missions of franchising organizations and funders involve different balances of potentially synergistic or conflicting social and financial priorities. Social missions focus on improved contraceptive outcomes but may also include broader reproductive health goals, including sexually transmitted disease (STD) prevention, safe abortion care, and maternal and child health services. Efforts may be targeted specifically to poor or low and middle-income populations. Some organizations also limit their targets to urban and peri-urban areas, while others attempt to reach remote rural areas where cost-containment and income-generation can be more difficult.⁷

At the provider level, the level of commitment to the franchise model and to the traditionally private-sector entrepreneurial orientation can vary.⁸ Staff, for example, may hold a strong conflicting belief that family planning services should be free.⁹ Clinic proprietors may be recruited into a franchise network on promises of higher client volume for other services, in exchange for providing contraceptive products and services at low cost. Current CF programs are in various stages of development, with some organizations having the advantage of years of franchising experience, while others are discovering franchising as a new approach.

Franchising organizations have different levels of business and management expertise, and donors may or may not invest in these capacities.⁷ Organizations or funders generally conduct some level of market and/or operations research in the course of program development, implementation and monitoring. Ideally, market segmentation, specific target populations, service needs and preferences, pricing, and culturally appropriate brand design and communications are determined.¹⁰ Management styles range from active monitoring and control, or what Smith (1997) terms *second generation* franchising, to a more hands-off approach where

franchisers merely offer providers a territory and permit them to use the franchise name within their guidelines (*first generation*).⁴ Administrative costs and the importance of management efficiency may vary accordingly.

Provider selection and training

Considerable variation also exists in the requirements franchising organizations establish for providers to enter their networks. Though franchisers generally recruit those with some prior medical training, franchisees can range from being unlicensed rural practitioners to midwives and physicians. More than one type of provider may be utilized within one program, and different levels of providers may be linked by referral mechanisms in order to facilitate access to different levels of services.

Providers may be required to have existing practices that meet the franchiser's standards of quality, locational access, or target client populations. Some franchisers have also established preferred criteria for franchisee selection based on motivation, business skill, past business success, ties to the community and personal characteristics, all to improve retention and increase franchisees' chances of success.^{7,11} Relevant personal factors include gender, age, and socio-economic background.^{10,12}

All of the programs studied for this review have included training in order to enable providers to add or improve contraceptive and reproductive health services and standardize their skills, although different categories of providers within a franchise may receive different types of training. Rural medical practitioners and their female associates in a franchising program in Bihar, India are not medically certified and thus are not instructed to perform sterilizations; However, they are trained to counsel about all methods of family planning, sell oral contraceptives and condoms and conduct pregnancy tests. They are also trained to refer potential clients for long-term contraceptives to doctors in the franchise network.¹³ In the Green Star program in Pakistan, only female providers are trained on IUD insertion, as it is culturally

inappropriate for male providers to perform the procedure.¹⁴ Training for a provider's support staff, may or may not be offered.

Training components vary in number, style, duration and intensity among programs. In addition to technical skills, components may include counseling, quality control, business management, marketing, or some combination thereof. Technical skills training can also include STD treatment and other broader reproductive health care if the franchiser supports these services. Education about the franchise system itself, assessments of providers' needs prior to training, and evaluations of which training courses are valuable and which are expendable are occasionally part of the self-monitoring efforts.^{7,15}

Services

Expanding the range of services and choice of contraceptive methods, and introducing methods previously unavailable in an area, are means by which to increase contraceptive use and recover a share of service costs.¹⁶ Some franchise programs support STD treatment, safe abortion care, and/or other broader reproductive health services, both for their direct health benefits and for their potential to increase client volume and sustainability of provider participation.¹⁷ Integration with other valuable and often more profitable services helps to draw in clients and improve credibility of the health care package in the community.¹⁸ However, franchisers supporting integrated services at the same time encounter the need to keep providers from neglecting the less lucrative side of distributing family planning services.⁷

CF programs vary in their sales and distribution of medical supplies and equipment necessary to franchisees for clinical method care, e.g., IUD insertion and removal or surgical sterilization. Some have augmented their product line to offer such items as disinfectants, gloves, examination equipment, or antibiotics at reduced prices to franchisees. Franchisees enjoy the convenience of having their products, including contraceptives, often ordered at discounted prices, delivered directly to them, sparing them the need to travel to pharmaceutical or medical supply outlets

themselves. Other programs focus on increasing access to a particular method⁴ and provide training and sales distribution for only that method.

Franchisers have varied levels of investment in preliminary and ongoing market research used to guide service and pricing decisions. Organizations may establish systematic pricing systems based on their examinations of clients' willingness and ability to pay, local competition, opportunities for cross-subsidization, effects on utilization, and potential cost recovery. Some only suggest guidelines and leave pricing decisions to franchisees. Others, such as the Bihar CF program, advertise prices widely on billboards and in the print media to cultivate public awareness of their franchisee network and service prices, thereby constraining variance in fees charged by their franchisees. The use of voucher systems for those unable to pay is being adopted by some CF programs, including a Marie Stopes International proposed program in Mexico.

Demand creation

Franchising organizations commonly identify providers in their networks with their name, logo, or other marketing device. This marketing image may extend to clinic appearance, color schemes and even staff uniforms.¹⁹ Promotions are generally done by franchising organizations, enabling resources to be pooled and wider audiences to be reached.²⁰ Franchise programs may also be able to escape advertising restrictions and controversies that limit individual providers.²¹ Media outlets include television and radio commercials, clinic signboards, product packaging, and painted billboards and walls. Promotional offers have included coupons for a free first visit.¹⁰

The quantity and effectiveness of these promotions can obviously vary, as can access to different forms of media among target populations. In two cases at least, the Green Star Social Marketing Program in Pakistan and the Janani Surya Clinics in Bihar, India, local awareness of the logo and its association with family planning services is high--93-94% among respondents polled.

Franchisers using multiple forms of media can be quite effective, as messages can reinforce one another.²² Service marketing findings thus far indicate that word-of-mouth promotions may be even more important than media outreach, and CF programs that encourage providers to form ties with their communities and promote family planning among existing clients may have better outcomes.^{3,10,23} A franchiser's reputation and the specific messages and connotations associated with a logo are also factors to be considered.

A franchising organization's responsibility for demand creation for the purpose of maintaining product and service site awareness can not be underestimated. Most CF programs recruit single-operator providers, such as rural medical practitioners, village health workers, or pharmacists, at the community level, who have no resources for broad-based advertising. Without the franchising organization's continued advertising or interpersonal communication efforts, the prospects of increased client volume, often a key incentive for recruited franchisees, are marginal. As a consequence, provider commitment can wane quickly.

Quality assurance

In addition to increasing awareness of family planning services, franchising organizations attempt to create added value in such services so that clients are willing to pay for them. A perception of high quality of care is an essential component of this added value, which can result in greater service volume from returning clients and drawing clients in from greater distances.²⁴ While clients generally perceive both quality and convenience to be greater in NGO services than in government facilities, perceptions are dependent on a number of factors, including reliable supplies and choice of methods; cleanliness; counseling and examination privacy; staff competence and friendliness; follow-up mechanisms; and confidentiality.^{7,11,25}

As with variations in management style, franchisers have different levels of investment in and control over quality. Operating requirements for franchisees may specify standards for facilities, equipment, and range of services offered, as well as technical aspects of care. Some programs

conduct periodic quality audits, and some offer follow-up support that includes ongoing training for providers who fail to meet quality standards, or for all providers. Franchisers may also employ field supervisors and establish communication systems to facilitate quality improvements. One franchiser maintains a “blacklist” of network providers that have failed to meet performance standards. Another is considering termination of franchise agreements with franchisees that do not meet minimum grade standards.

As an additional measure, some programs have invested in information, education and communication (IEC) campaigns designed to ensure that target populations are able to judge the quality of services.⁷ Such efforts include the depiction of high quality facilities and client-provider interactions in available media, education on what to ask for in terms of treatment, and suggestions of ways to ask for it.²⁶

Cost recovery

The use of a franchising model may be motivated by an organization’s expectations for cost recovery and sustainability, and, in turn, by donor policies that encourage the same.⁷ Cost recovery prospects are strongly influenced by both contraceptive prevalence and prices.²⁷ Most social marketing programs, from which clinic franchising programs often evolve, operate on a cost-recovery basis through bulk purchases of contraceptives and discounted sales and distribution to wholesalers and retailers down the line. The central costs of packaging and marketing may be covered by sales profits or by external funds, from governments, donors or even cross-subsidization through profit-making enterprises operated by the social marketing organization. As franchisers, organizations may establish client volume or product sales quotas for their franchisees. They usually also invest in management information systems (MIS) to track utilization, costs and performance.

Clinic franchising programs in low-income countries tend for the most part not to be self-financed, let alone profitmaking. Donor funding of contraceptive and advertising costs has been

significant. In priority countries for Packard's population program, e.g., India, Ethiopia, Pakistan, and Nigeria, contraceptive prevalence is relatively low and private sector involvement in family planning care nominal. Franchising organizations are sensitive to the affordability of their services and the fragility of private providers' commitment to contraceptive service delivery. There is little reason to require high franchise fees or large purchases by franchisees of contraceptive stocks. In addition, franchise organizations price contraceptives low to make them affordable to both franchisees and low-income clients. As a result, contraceptives, unlike other pharmaceutical products such as antibiotics, tend not to generate a substantial share of a health practitioner's income.

Franchisers demonstrate varying levels of concern for, and monitoring of, the effect of prices on client demand and composition. Responses to price increases (price elasticity) are more significant among the poor; clients in less-developed countries are thought to be willing to pay only about one percent of their annual disposable income for family planning.^{25,28} Monitoring of client income levels may be an essential addition to cost-recovery efforts if franchisers are to avoid shifts toward service provision to middle or upper class clients.²⁹

The requirement of franchise fees in a low-demand setting may or may not work to the benefit of the franchising organization that is endeavoring to establish a large network of service delivery points or providers. On the one hand, such fees may not be paid regularly if the provider earns insufficient income from offering family planning services. On the other, fees encourage franchisees to identify with and develop commitment to the franchise. The Bihar CF program monitors fee repayment and has found the level to be 55% of its recruited rural medical practitioners. Among its social marketing distributors, approximately 65% order contraceptives repeatedly. Franchise fees also enable franchisors to recover some of the initial investment costs, such as training and local advertising, particularly from those franchisees that discontinue participation.

Though a franchise may be able to cross-subsidize sites with revenue from those that are profitable, it may not be willing to maintain franchisees who do not become self-sustaining. At the same time, while franchisers may remove franchisees from their networks if they fail to meet performance objectives, the cost of replacing a franchisee is high.⁷

Characteristics of franchisees

Backgrounds, capacity and prior skills

Franchisees are drawn from various backgrounds and have varying levels of skill and capacity for service delivery, outreach and management. They differ in their degree of connection to and credibility within their communities. Franchise providers may have existing practices to promote or establish new practices under the CF program. Franchisees often contribute equity of some kind, usually in the form of their facilities which may range from mobile "offices" of rural practitioners to fully equipped clinics. Their geographic coverage and overhead costs vary accordingly.

The distribution of these characteristics within a network is determined by the franchiser's criteria for provider selection and subsequent support, as discussed above. Providers may self-select on those factors relevant to their success, such as interest in family planning service provision, ability to work for what may be a minimal income, and willingness to take the risk involved in franchise practice. As participants in a CF program, they may add franchise services to their existing practice, in what Smith (1997) terms a *fractional* model, or provide only franchise-supported services in a *stand alone* model.⁴

Whether or not their practices are in place prior to becoming franchisees, providers enter a CF program with some amount of experience and reputation. Their social capital prior to recruitment into a franchise can be an important factor for their subsequent performance. Unlike product-centered social marketing, a provider's reputation can outweigh the reputation of the franchise name or logo.⁴ In addition to reputation, medical personnel and any support staff

working in a franchise clinic will vary in efficiency, affecting overall administrative costs.¹⁷

Objectives and expectations from participation

Franchisees enter a CF program with a range of objectives and social commitment levels. They may be motivated by opportunities for training; expectations of increased clientele and potential revenue; the opportunity to open, sustain, or expand a practice; the opportunity to provide needed services; or some combination of these factors. Joining a franchise can give providers access to new expertise and capital and allow them to replicate a successful model of service provision quickly. Participation also offers competitive benefits in that franchisers generally will not fund another franchisee in the same area.¹⁸ Providers and their staff may thrive in a entrepreneurial environment. On the other hand, they may lack familiarity or comfort with the franchise concept; and they may perceive the social ideals side of the franchise clashing with their financial motives.

Providers vary in their awareness of or ability to track the characteristics of the population they are reaching with their services; and recovering their costs may take precedence over expanding their services to harder-to-reach groups.

The sustainability of providers' motivations to remain franchisees no doubt invokes a clear cost-benefit calculation on their part. To the extent that the costs of participation, in the form of franchise fees, compliance with franchise standards and outlays for service delivery, remain lower than franchise-derived benefits, such as increased client volume and fee income, improved technical skills, and free advertising, franchisees are likely to continue to participate. Their willingness to participate primarily as a result of shared goals for social development, however, is not a clearly documented motivation. Franchising organizations, especially mature ones, are continually challenged to sustain provider participation with diversified and profitable product lines, new training opportunities, and active marketing strategies.

Characteristics of contracts

The CF programs included in this review involve more than a simple agreement by the franchisee

to distribute the franchiser's supplies. They involve transfers of technical expertise, operating, management and marketing systems, quality standards, and financial support. Most of these inputs have been discussed above. This section, therefore, focuses on financial arrangements. Two examples of clinic franchise agreements for an Ethiopian and Indian CF program are shown in Figures 2 and 3.

In order to facilitate a provider's participation in a CF program, franchising organizations may agree to provide funding in the form of business loans, or loans of facilities, office furniture and equipment. Franchisers contracting with providers who have existing facilities may also finance renovations and quality improvements. The Janani program in Bihar, India is in the process of painting the frontage of 14,000 rural medical practitioners' clinics to enhance their distinctiveness and visibility. Franchisors' support may be given outright, rent-free for a specified period or on the condition that franchisees eventually pay at least a portion of start-up costs back to the franchise. Alternatively, franchisees may pay in a percentage of their profits after achieving minimum levels of self-sufficiency. Loan repayments may be added to revolving fund in order to finance the start-up of other franchisees.

In addition to considerable start-up costs, the franchisor's administration of a network can be labor-intensive. Franchisers may request that franchisees pay flat or variable fees for ongoing training, supervisory, monitoring and promotional activities, and franchisees' willingness to pay will depend on the adaptability and perceived value of these services.⁷ Time periods for which support services are provided also vary. Input and feedback over a relatively long period of time may be necessary, as service delivery behavior is hard to change, and a simple start-up training is often not effective.³⁰ Contraceptive franchising programs often ask franchisees to maintain separate records on franchise-related services. In a fractional system, this involves nontrivial effort that busy practitioners may be unwilling or unable to make.

Reported TANGO III project findings in the Philippines divide contract types into *true*

franchises, in which franchisees collect fees and then make payments back to the franchiser in exchange for start up and support services, equipment and loans, and *hybrid* models in which franchisers pay franchisees a salary. Both are distinguished from large, integrated clinic models with clinics owned and operated by an organization, such as Marie Stopes International. The TANGO III project found that models where providers are dependent on clinic revenue did better financially.⁷ Potential profits are seen as an incentive for providers to increase their efficiency, quality, innovation, self-reliance and market capabilities.

The MEXFAM program in Mexico uses variations on these financing arrangements, with payments to providers being in the form of a short-term, partial performance-based stipend for the first two years.¹⁰ Performance-based payment systems can also be established by donors, who may tie franchise program funding to the number of franchisees an organization recruits or the number of support services it provides.⁷ A danger with profit-related objectives and unclear performance-based objectives, though, is their potential to bias both franchisers and franchisees toward more lucrative services and longer-acting methods.⁷

Contracts may remove franchisees who do not become self-sustaining, who fail to meet service delivery or quality of care objectives, or who otherwise violate contract terms to be removed from the program. In some cases, removal includes the confiscation of equipment and suspension of operations.³¹ Franchisees may also opt to drop out of the program, either before or after becoming sustainable, thereby decreasing the pool of services provided as part of the franchise. Alternatively, sustainable providers may maintain a link with the CF program as *affiliated doctors*.¹⁰

Contexts

Although the franchise concept has been replicated and adapted in different countries, individual franchise operations do not yet seem to have expanded globally beyond national or, in some

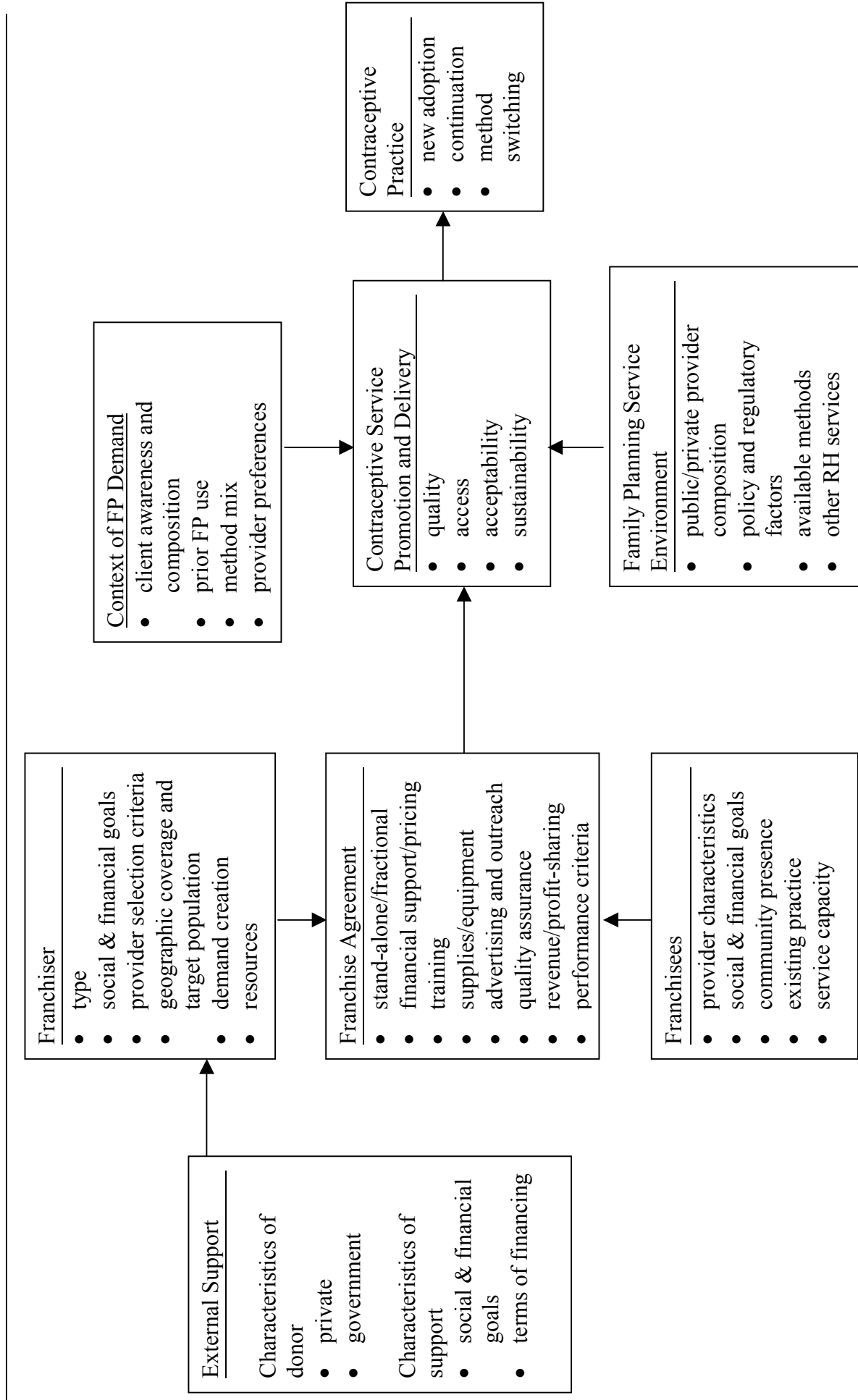
cases, sub-national boundaries. In contrast, within countries there may be more than one family planning clinic franchise operating, along side social marketing programs, such as in Pakistan, the Philippines and Mexico. In Pakistan there is both a Green Star and a Green Key franchise in operation, with similar contraceptive service models. Some health providers are members of both franchise networks. In these situations, programs may duplicate services and compete directly with each other, as well as with free or subsidized public sector programs. Regardless of the type of competition, franchise logos and promotions for CF services may impact negatively on providers *not* exhibiting the logo; and CF programs may attract patients from other providers, public or private, in addition to or instead of serving new clients.³² Market segmentation and coordination of programs, donors, and government agencies can address these issues.

Countries vary in the extent to which they support family planning, private sector participation, and franchise arrangements. Policy and regulatory constraints influence the types of family planning services provided, contraceptive supplies and equipment available, types of advertising, and pricing structures.²⁴ In an Ethiopian franchise program, the plan to recruit private sector physicians, market-based vendors, and community-based distributors, who would purchase contraceptive stocks from the government warehouse and sell them to clients, encountered reluctance on the part of the government to sell contraceptives at all. The government took the position that it receives contraceptives free through UNFPA donations, and its policy is thus to distribute them freely to all providers, public or private. In turn it requires second-tier providers to provide the methods free to clients. Franchise participants find their ability to charge client fees for contraceptive methods significantly restricted, even though they may charge for registration and consultation fees may be charged. With the financial incentives reduced, some franchisees, even after training, are referring lower-income clients to public clinics for completely free services.

Non-service delivery components of programs, including policy reform efforts and information-sharing, may become a necessary investment on the part of franchising organizations and

fundings, potentially drawing resources away from service delivery.^{7,33} Area and population characteristics, including geographic dispersion, levels of income and economic development, available media, and the size and structure of the family planning market can influence a CF program's success.²⁰ A favorable market is one with a growing demand for CF services among clients who can afford to pay, insufficient service delivery outlets, and a pool of underutilized providers.⁴ Provider availability is a crucial factor, as increasing the number of providers is much more difficult than procuring supplies, equipment, or facilities.¹⁷

Figure 1. Conceptual model of clinic franchising program influences on contraceptive practice



Selected Clinic Franchise Model Programs

The clinic franchise features of five family planning and reproductive health programs that will participate in the cluster evaluation are briefly described below. Their monitoring and evaluation efforts are discussed collectively in the next section. Table 1 provides an overview of the programs.

Green Star/Social Marketing Pakistan/Population Services International

The Sabz Sitara (Green Star) Program of Social Marketing Pakistan (SMP) is active in about 55 cities throughout Pakistan. Under the sponsorship of Population Services International (PSI), Green Star's program utilizes three main components: training of private providers, sale and distribution of brand-name family planning commodities, and local and mass-media advertising to serve a potential population of 50 million people in urban Pakistan.

Green Star provides up-to-date training in modern contraceptive technology, family planning counseling skills and infection control. To date, Green Star has trained 2,119 lady doctors (GS1); 4,258 male doctors (GS2); 2,586 pharmacists (GS3) and 2142 lady health visitors (GS4). An example of the terms of agreement between Green Star and recruited private practitioners (GS1) is given in Figure 2. All Green Star clinics receive a signboard for their clinic and extensive IEC materials featuring the Green Star logo. Other outreach activities promoted by Green Star include public billboards and community (Mohalla) meetings at networked clinics.

Methods provided through the Green Star program include a multi-load copper IUD (GS1s only), oral contraceptives (Nova pills), two-month injectables (Nova-ject), and two brands of condoms (Sathi and Touch). Green Star maintains an extensive purchasing and distribution network to supply methods at subsidized prices to their provider-network. Finally, Green Star employs a staff of trainers and doctors who make regular site-visits to monitor quality of care and respond

to special franchisee needs.

Janani/DKT International

The Janani Program of India focuses on providing quality family planning services and commodities throughout the northern Indian state of Bihar, population 102 million. Under the sponsorship of DKT International, Janani's program has created two networks of providers: Titli (Butterfly) centers of Rural Medical Providers (RMPs) and Surya (Sun) clinics run by certified medical doctors. Titli centers provide non-clinical contraceptives at the community level while also serving as a referral network to Surya clinics where clinical family planning methods are available along with other reproductive health and safe abortion services.

To date, Janani has trained 9,000 RMPs and 84 Surya clinic doctors. RMPs and their female associates (usually their wives) are recruited as a couple to become a Titli Center. The Titli Centers receive a signboard or have the façade of their clinic painted with the Titli logo; Surya clinics receive a signboard with the Surya logo. Both types of clinic receive personalized IEC materials and both benefit from Janani mass media activities including radio and newspaper advertising. RMPs must pay an annual fee of 500 rupees as well as purchase minimum amounts of contraceptive commodities quarterly. Janani provides fee discounts for strong performers as well as offers cash incentives for referrals to Surya clinics. Janani also requires Surya providers to honor its advertised pricing structure for services.

Reproductive health commodities and services provided by Janani include: oral contraceptives (Apsara and Mala-D), injectables (Depo-Provera), condoms (Mithun, Nirodh Deluxe and Trust), IUDs (Copper-T380A), sterilization (mini-lap and non-scalpel vasectomy), MVA kits (Liam) and pregnancy test strips (EasyPreg). Several of Janani's brands are renamed versions of government products including Mithun and Trust condoms and Apsara pills. Mithun, Apsara and EasyPreg are Titli center franchise products; these along with the IUD, injectable, MVA kit, and

sterilization are franchise products available to Surya clinics. The other products (Mala-D, Nirodh Deluxe and Trust) are distributed through Janani's parallel social marketing program. Janani also contracts with private individuals to manage six regional training centers, the sales and distribution of commodities to the marketplace and monitoring of providers.

Biruh Tesfa, Pathfinder International

The Biruh Tesfa program is a two-year project, that will begin late 2000, aimed at increasing access to high quality and affordable family planning services and products in selected areas of Ethiopia. Concentrating on the private sector, the program will promote linkages between clinic-based and community-based efforts. Clinic-based services will include private doctor clinics, nurse midwife clinics, and public-private clinics. Community-based providers, consisting of trained birth attendants (TBA), community health agents (CHA), market traders, and workplace providers, will be encouraged to refer to private clinics for clinical contraceptive methods and complications. The program will be implemented in Addis Ababa and four zones in the Oromiya and Amhara regions of Ethiopia, covering a total population of 10,373,394. The program plans to network 92 private clinics, 115 workplace providers, 150 CHAs, 100 TBAs, 6 rural medical practitioners, and 48 market traders into Biruh Tesfa by the end of the period.

A unique aspect of Biruh Tesfa is the important role coordinating NGOs will play. Using a decentralized approach, local NGOs will provide program oversight by hiring a coordinator, data collector and accountant for each zone. These staff will be the primary contacts for the health providers, and will report back to the central office monthly.

To date the program has trained 92 private providers and has identified market areas and villages (*kebeles*) in which to recruit market traders, CHAs, and TBAs. The 15-day training for clinic staff covers counseling, contraceptive technology (CT) update, Depo-Provera, IUCD and Norplant procedures, and for doctors, voluntary surgical contraception and post-abortion care

techniques. A five-day training program is planned for community workers and will include counseling, CT update, overview of OCs and condoms, and referrals. Efforts have been made to establish franchises in areas where family planning services have not previously been available. Private providers franchisees sign an agreement with Pathfinder International (see Figure 3) and must agree to offer reduced client registration/consultation and procedure fees, in addition to complying with quality standards. Community-based workers will enter into an agreement with the local NGO, establishing appropriate service fees together. Franchise clinics will be identified through large signs with the BT logo, while community workers will brandish common uniforms, bags and boxes with the logo. Biruh Tesfa will officially be launched in September 2000 with TV/radio ads, short films followed by panel discussions, and other promotional events.

Marie Stopes International, Ethiopia

Marie Stopes International/Ethiopia (MSI/E) has launched a project to address unmet reproductive health needs in the three regions of Oromiya, Amhara, and Tigre. This three-year project will establish clinics and community-based services in seven towns to improve awareness and access to reproductive health services, benefiting 600,000 women of reproductive age, 100,000 adolescents, and 50,000 children under the age of 5.

Well-equipped clinics will offer the full range of reproductive health services including clinical and non-clinical contraceptives (Microgynon OC pills, DepProvera, CuT380A IUCD, Norplant), sterilization (minilap and NSV) and termination of pregnancy (MVA procedure). Easily identifiable, clinics will be painted in blue and white with the "open door" logo clearly visible from the outside. Staff uniforms and materials will also share the blue and white theme.

Clinics will also provide the foundation for community-based education and distribution efforts including community-based distribution (CBD) agents, youth peer educators and workplace peer educators. Each clinic will staff a coordinating nurse and assistant to oversee community

outreach activities. Four CBD workers will operate within each clinic catchment area, charged with conducting home visits to generate clients, providing information and distributing contraceptives (pills and condoms), and referring to clinics for clinical family planning methods. Approximately 40 youth peer educators will operate in a similar manner, but will be based in middle or high schools. Both youth and workplace peer educators will form peer groups each month to discuss reproductive health issues in addition to distributing contraceptives and providing referrals. All community-based workers will be trained on family planning and reproductive health services, and will receive a monthly transportation allowance.

The MSI/E program is not technically a franchise, since the clinics will not be individually owned and operated. However, it has at least three important elements of a franchise model, which are 1) a market identity for its reproductive health and family planning services, 2) brand features of a logo and color scheme, and 3) self-financing status for each clinic within a few years after establishment. Because of these two elements, the project is included in the cluster evaluation.

Friendly Care, Inc., Philippines

To be completed

Issues in assessing program effectiveness

Monitoring services. Our review sought to identify the types of indicators CF or CSM programs have commonly used to monitor their performance. Our efforts are not exhaustive but for informational value, these indicators reported in the available literature on CF programs are shown in Table 2. There may not appear to be many in common but most likely our review has not captured the complete range of indicators in each program's management information system (MIS).

It is worth noting two measurement issues that may affect one of the indicators used by many CF and CSM programs -- couple-years of protection, a measure that converts contraceptive commodities sold or distributed at some level into theoretical years of protection provided to couples against unwanted pregnancy. For example, 13 cycles of oral contraceptives theoretically protect one couple for one year from unwanted pregnancy if used continuously. Alternatively, 13 cycles may protect 13 couples for one month from unwanted pregnancy. CYPs are imperfect measures of population-level pregnancy protection^{34,35} but are frequently used to present commodity distribution data in person-equivalent terms. Two issues are raised here regarding the use of service consumption or utilization data as a measure of CF program impact. First, the level at which contraceptive commodity distribution data are gathered are reported are not uniform across programs. Second, the conversion factors used can vary. For the first, some CF or CSM programs gather statistics at the point at which a wholesaler sells to local distributors, where the latter may be a community-based stocker or a retailer. Infrequently do CSM or CF sales data reflect actual client sales, which is not the case for government health statistics data. For the latter, public clinics usually report contraceptives provided directly to clients. Thus caution should be exercised in comparing contraceptive distribution or CYP data across different sources.

Second, different conversion factors may be used to calculate CYPs. Some CSM or CF programs may confer a couple with 12 years of protection for each voluntary female surgical contraception (VSC) procedure, while others confer 7 or 8 years of protection. The total CYPs provided by a program can be significantly influenced both by the number of VSC procedures performed, as well as the average age of female clients at sterilization. Younger sterilization clients generally benefit from more years of pregnancy protection, as compared to older clients. Variation in conversion factors used also exists for other contraceptive methods, such as IUDs, injectables and implants. Moreover, wastage is an important factor in the case of supply methods, such as the pill and condom.

Both of these measurement issues with the respect to the CYP indicator are mentioned for their relevance in comparing trends in performance data across CF programs.

Table 2. Types of performance indicators reported

Indicator	Program (s)
Client volume	Janani, Green Star, MSI
Services provided	MSI
Sales volume	Janani, Green Star
Profits	Ghana
Quality of care	Green Star
Client satisfaction	MEXFAM
Client rating of CF vs. competing providers	MEXFAM
Costs per acceptor	Ghana
Couple-years of protection	MSI
Financial performance by services provided	MSI
Effectiveness by provider	MEXFAM
Effectiveness by input	Green Star
Cost-efficiency/ 'pricing' of supervisory input	MEXFAM
Effectiveness of model	Green Star
Substitution	KB Mandiri

Program evaluation. CF programs can have a number of direct and indirect impacts on the FP/RH service environment and contraceptive practice. A small subset of these are of particular importance to their sponsors. These impacts fall into four categories: 1) increased contraceptive use, 2) increased service access for target populations, 3) improved quality of care, and 4)

improved efficiency in resource allocation and use. Evaluation of these intended impacts can include examinations of the relative effectiveness and cost-effectiveness of franchising programs, of Packard-funded franchising programs relative to other franchising programs, and of franchising programs compared to other forms of FP/RH service delivery. Ideally, the evaluation would also look at the net gain in contraceptive users and methods adopted over the implementation of Packard-funded franchising programs. While CF programs have been monitored and evaluated individually, the increases in contraceptive service provision and practice attributable to participation in CF programs have not been quantifiably measured in a comparative crossnational manner.

Sponsors of CF programs expect that the initial subsidization of the private sector providers' costs for participating in delivering contraceptive services will result in an expansion of the number of service delivery points. This expansion effect means reaching both new clients able to pay as well as, through affordable (discounted) pricing, new low-income clients. The expanded network of service delivery is expected to not only enable increased contraceptive use in the population but also enhance the sustainability of FP/RH service and supply systems within a given country. At the same time, because private sector providers are generally associated with better quality of care and, through CF program training, will learn adopt state-of-the-art standards of quality, CF program outlets are expected to be particularly competitive in this area of family planning care.

Within a family planning market, CF should have a net additive effect on contraceptive service provision. Alternatively it may draw business away from existing services, an issue referred to as *substitution*. This substitutive effect has been found among products in CSM programs in the past, and the KB Mandiri program has documented provider-switching from doctors and pharmacists to midwives following its promotional efforts in Indonesia.³² Simple increases in clinic volume, therefore, are not adequate evidence of overall increase in population served. Hence, the cluster evaluation design calls for surveying a range of FP service providers over time

on common output measures to track and model the net gains in contraceptive service provision.

Franchise programs may also instill competition in a market, potentially improving the quality and cost-effectiveness of services beyond those of the franchise itself; a benefit termed *expansion*. Such outcomes have been noted with NGO-owned clinic networks, which have had indirect effects on the prices of services among private sector providers, and on the practices of public and other NGO providers.³⁶ The long-term outcomes of clinic franchising are also worthy of consideration. Even if they are in the short-term less effective than other service delivery approaches, CF programs may continue to have some effect after subsidies are removed, as they do not require the ongoing payment of provider salaries and other recurrent costs to operate at some minimal level.

In terms of the fourth expected impact, the key question is whose resources are to be more efficiently allocated and used. At one level, it is the resources of the sponsor, whether this is an external donor or the franchising organization. Either may seek a redistribution of the responsibility of the total costs of family planning service delivery across existing public and newly eligible private providers. External donor funding often augments public funds that may have been used to support and enhance service provision, since public spending on family planning is often very limited in low-income countries. External assistance may substitute a high percentage of public spending, allowing scarce government resources for family planning to be directed towards especially needy populations or to other health services or social sectors.

At another level, efficient resource use will also involve the resources of the franchisee. Franchisors expect franchisees to shoulder a significant share of the financial risk for the new business. In the case of family planning CF programs, and especially for the ones involved in the cluster evaluation, there is in most cases minimal financial risk imposed on private providers participating in the networks. Front-end investments by franchisees of capital, time, and energy are limited, and most franchise operations recruit existing health care providers with the capacity

to serve a larger clientele.

Yet another set of resources involved in the consumption of family planning services is that of the client, i.e., the proportion of household income that might need to be allocated to contraceptive purchase for pregnancy avoidance. For this fourth impact, the questions of interest will be whether CF program services are being used by new or past consumers able to pay or with appropriate economic need.

Three specific questions will then be addressed in the cluster to assess the effectiveness of CF models:³⁷

1. What is the net effect of clinic franchising programs on the consumption of family planning and reproductive health (FP/RH) services?

The effects of interest are likely to be related to a) contraceptive use, such as changes in family planning client volume (new and return users), volume of other reproductive health services (new and return users), contraceptive method mix, client characteristics (social, demographic, economic), and client satisfaction; and b) consumer's cost of services, such as fees paid by clients for FP/RH services, economic affordability of FP/RH services, associated travel or time costs to obtain services.

2. What are the effects of clinic franchising programs on the provision of FP/RH services?

The effects of interest here are likely to be related to a) contraceptive service access (physical and geographic); b) quality of services (technical competence of FP/RH provider, information and counselling provided); c) acceptability and preferences for different FP/RH providers; and d) sustainability of provider commitment to FP/RH care.

3. What effects do clinic franchising programs have on recruited providers in their delivery of

FP/RH services?

Here the likely effects from participation are favorable shifts in: product pricing and purchasing; sales volume for non-FP products/services; technical skills for FP/RH service delivery; quality assurance (such as infection prevention, counseling); stock and inventory; advertising; revenues and profit; franchise/network interaction; and recordkeeping.

Thus far the specific issues to be established in a comprehensive evaluation of CF programs include assessing the 1) net gain in number of contraceptive service delivery points (expansion), 2) extent of improved quality of care, 3) net increase in contraceptive service utilization or consumption (volume), and 4) net increase in contraceptive prevalence.³⁸ Preferably the evaluation design would be experimental, rather than observational. For the cluster evaluation, however, the observational design will be used of necessity. A cross-sectional probability sample of FP/RH service delivery points, providers and clients served by those SDPs will be drawn for surveys at two time points, about four years apart. A subsample of the SDPs and providers at time 1 will be re-interviewed at time 2.

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- ³⁷ The cluster evaluation will not be able to integrate a household survey into its design, which would have enabled the measurement of impact at the individual user level.
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