Social franchising of sexual and reproductive health services in Honduras and Nicaragua

MARIE STOPES INTERNATIONAL

PROVIDING CHOICES IN REPRODUCTIVE HEALTHCARE

viewpoint

contents

acknowledgments

This report outlines the findings of the external evaluations of the social franchising projects piloted by Marie Stopes International and its Partners in Nicaragua and Honduras. These evaluations were carried out by independent, locally based teams commissioned by Marie Stopes International. The final appraisal of the franchising models was carried out by the Centro de Investigaciones y Estudios de la Salud, part of the Universidad Nacional Autónoma de Nicaragua.

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This document outlines the outcome of three franchising projects implemented by Partners of Marie Stopes International (MSI) in Honduras and Nicaragua. The projects were designed to pilot full and partial social franchising models as part of an initiative to test and develop alternative forms of delivering quality sexual and reproductive health (SRH) services by a non government organisation (NGO).

This report:

- assesses the suitability of the models used for the provision of sustainable SRH services to the target populations in the project areas
- presents the major costs, benefits and risks to the franchisee, the franchisor and the donor agencies
- addresses the ways in which the viable elements of these social franchising models could be replicated successfully.

The MSI Partnership, which covers 38 countries strives to expand access to SRH information and services worldwide.

The latest research techniques and protocols are used across the Partnership to generate information which helps MSI improve and develop programmes in response to community demand. Research findings or methods which have particular relevance to the SRH sector in general are then disseminated.

The Marie Stopes International Partnership

MSI is a rights based, non government organisation, committed to supporting people's right to chose whether, and when to have children. The MSI Partnership forms a global network that spans 38 countries and aims to provide a range of high quality, affordable SRH services, information and behaviour change programmes for women, men and adolescents. All of MSI's work incorporates the philosophy of developing sustainable outlets of paid-for services that do not exclude people living on a low income or who are marginalised.

Sexual and reproductive health and franchising

The MSI Partnership is always seeking new and innovative ways of delivering high quality, sustainable, culturally appropriate services to the people with the greatest need. MSI has pioneered the use of social franchising to increase the reach of its SRH services into the community, whilst ensuring the high standards for which the Partnership is known are maintained. After five years of implementing three social franchising projects in Honduras and Nicaragua, MSI contracted Centro de Investigaciones y Estudios de la Salud, part of the Universidad Autonoma de Nicaragua to carry out a final evaluation of the four social franchising models utilised. This final evaluation was carried out between August and November 2005.

An overview

Franchising is a mechanism used in the private sector to facilitate rapid expansion, enabling the sustainable distribution of products and services of a specified quality. Commercial franchising is based on two main models: first generation franchising, where the franchisee purchases a branded product at one price from the franchisor and sells it at another, retaining the difference as profit; and second generation, or business format franchising, where a product or service is sold by the franchisee, who retains the whole profit margin less a royalty to the franchisor, usually based on sales volume. Franchise products compete in the market by either being products which are unique or which are made unique by a powerful brand name. In second generation, or business format franchising, the franchisee may own most or all of the equipment for the business, yet the franchisor, as owner of the brand name, determines how it is used. Businesses are attracted to commercial franchising as it removes the constraints to growth imposed by capital, managerial and organisational issues and franchisors provide the start-up and working capital of the business. In turn, the prospective franchisees are provided with a proven model for running a business and benefit from the support and expertise of the franchisor.

The success of franchising, using either of the models described above depends on the following elements:

- use of a successful business model
- full commitment by the franchisee
- use of a well known brand name which is secured by trade mark registration
- marketing support
- competitiveness
- continuity of supply of products
- proven profitability and financial stability of the franchisor
- a growth market.

Social franchising is a development approach that applies modern commercial franchising techniques to achieve social rather than commercial goals. In this way it is similar to social marketing, which is used to good effect in the distribution of preventive and curative health products. As in commercial franchising, initial funding is supplied by the franchisor, usually through a donor. Funding can be on a short or long term basis, or may take the form of a loan which must be repaid. In some instances, working capital is also provided by the franchisor until sustainability is reached. Thus, when applied to the health sector, social franchising attempts to harness the private sector delivery infrastructure for public health goals. In doing so, social franchising can expand the range of (primarily preventative) services offered in the private sector, improving the quality of these services and increasing the access that underserved populations have to them.

It has been argued that the availability of funding may reduce the franchisee's drive to achieve sustainability, as the capital investment is not provided by the franchisee. At the same time, social franchising can provide new stimulus to provide higher quality services and increase the number of clients who are willing to pay for them. Generating awareness of the quality of care offered can lead to an increase in the uptake of services, which generates further income for the franchisee. A market for social franchising depends on demand for the social service and people's purchasing power to pay for the service in demand, the delivery of which must in turn be adapted to local cultural and economic conditions.

Social franchising can provide higher quality services and increase the number of clients who are willing to pay for services.

Clients benefit from improved access to services and the guaranteed quality of the services or product provided through a franchise.

SRH services can be provided in "franchisable" packages of care, while training and service delivery protocols can be used to define minimum standards - standards which are monitored by the franchisor.

Social franchising of sexual and reproductive health services

Many SRH services lend themselves more to social franchising rather than to social marketing – permanent and semi-permanent family planning methods and other SRH services require skilled providers, making social marketing a less suitable delivery model. Clients benefit from improved access to services and the guaranteed quality of the services or product provided through a franchise. SRH services themselves can be provided in "franchisable" packages of care, while training and service delivery protocols can be used to define minimum standards - standards which are monitored by the franchisor. In developing countries, the unmet need for health services generates a growing demand, and in some such countries, where trained medical practitioners may be under-used, a pool of potential franchisees exists. In this context, social franchising for SRH services emerges in response to the health-seeking behaviour of clients for health services in general and SRH services specifically. In Africa, 60% of all healthcare services are delivered through the private sector; in Pakistan, the figure is 70% and in India, the figure rises further to 80%.

The first generation of SRH social franchising programmes began in the early 1990s in the Philippines, India, Bolivia, Mexico, Zambia and Pakistan. These programmes were delivered through a range of NGOs.
In Mexico, the franchise established was aimed at delivering high quality, low cost maternal and child health and family planning services and information to low income, peri-urban and rural communities. It sought to establish a network of financially self-sustaining clinics with a low initial capital investment and running costs. This franchise was taken by the IPPF affiliate, the *Fundación Mexicana para la Planeación Familiar* (Mexfam) which built upon an existing 'Community Doctors Programme' which had been funded by USAID between 1984 and 1990. By 1995, the end of the funding period, 290 outlets had been established. The franchisees in this model were unemployed or underemployed doctors who would manage viable private clinics that provided a reasonable income. Ownership of tangible and intangible assets remained the property of Mexfam as well as initial start-up investment in the case where the franchisee opted to hand over the franchise. Since the end of the funding period, Mexfam has received no external funding for the social franchise, although some overhead costs are funded in part by external donors.

Social franchising models across the world have provided a wealth of information for replication. One of the most successful models is that of Green Star in Pakistan, which successfully expanded access to

quality SRH services and products. In its first five years, the Green Star network grew to include more than 11,000 private health providers in more than 40 cities, attracting over 10 million clients each year. This model made a major contribution to increasing the national contraceptive prevalence rate from 17.8% in 1995 to 23.9% in 1999. As a result, the cost per couple-year of protection (CYP)[1] maintained a downward trend from US$18/CYP in 1995 to US$4/CYP in 2000. Important components of Green Star's success can be attributed to effective and efficient logistics management, the selection of the right healthcare providers/centres to operate the franchise (i.e. those who could be motivated to deliver SRH services; had underutilised capacity – and thus wanted to and could handle more clients – and which operated in low-income communities), constant training and high profile marketing. Of the 10 million clients that receive services through the Green Star programme each year, it is estimated that 20% receive SRH services. Most of these clients are women and the majority of the service providers are female.

Pilot projects have researched various models, including full and fractional (partial) franchising. In full franchising, a practitioner (established or unemployed) opens a SRH centre. Fractional franchising expands the service menu of an already existing medical practice to include SRH services under the brand name and quality standards of the franchisor. Initial funding for both full and fractional franchising is typically provided in the form of a loan or grant. It is essential for franchisors to develop realistic financial planning which is made clear to the franchisee in a written contract. Often, the franchisee is required to place some form of deposit with the franchisor to ensure that if sustainability or repayment is not achieved, initial funding is not completely lost. Such deposits may be made through a contract deposit on property, ownership of the franchise and/or equipment on the part of the franchisor or other loan return assurances. The so called *boilerplate* franchisee model includes financial assurances for the franchisor which include:

- the initial franchise fee payable by the franchisee to the franchisor
- on-going royalty, or management services fees
- mark up on sale of products.

It is within this global context that several international SRH agencies have piloted a number of social SRH franchise programmes. Projects piloted in Pakistan and Mexico that were subsequently evaluated before being expanded regionally and nationwide, focused on providing start-up assistance with the expectation of short term financial sustainability. Social franchising assumes that the franchisee lacks the credit to initiate service delivery. A franchisor can provide this credit through a donor, as well as ensuring the supply of materials and equipment, providing management assistance, establishing quality control and providing the marketing of a brand that will attract an increased number of clients who are willing to pay. Franchise clients are guaranteed quality care at affordable prices, and increased access to SRH services by qualified providers. The franchisees benefit by expanding their range of skills both as recipients of initial credit to establish the franchise and through their increased capacity to deliver services, which generate income. The franchisee also benefits from being part of a network that ensures and markets quality services and decreases supply costs, which again can increase profit.

[1]Couple years of protection (CYP) is an internationally recognised indicator of family planning performance. One CYP is the equivalent of one year of protection from unintended pregnancies for one couple.

Marie Stopes International and social franchising

MSI is committed to ensuring access to quality SRH services through sustainable, long term projects. The quality standards established and implemented by MSI, combined with a recognised brand name, business-like management, results orientation, and innovative marketing style, positions MSI as a natural franchisor in developing countries.

MSI has many characteristics which can prove beneficial for franchise success:

- it operates in many countries
- it is a well known global brand
- it has a great deal of successful experience in running cost recovery schemes
- it could naturally take the role of the trademark licensor, licensing the right to use its brand.

In 1999/2000, MSI began to explore various franchising models in a number of national contexts in Central America. With funding from the European Commission and the United Nations Foundation, MSI then began to pilot franchising models in Honduras and Nicaragua.

The overall context

MSI's development of four social franchise models within Nicaragua and Honduras was in response to a particular, serious combination of SRH problems within these countries and to the untenable funding situation within the region, identified by international donors. During the previous three decades there had been a significant increase in the use of modern contraceptive methods in Latin America and the Caribbean, with a consequent improvement in SRH indicators. However, those improved overall indicators disguised (and continue to disguise) the uneven distribution of SRH care within the region. Despite advances in the coverage of SRH services by Ministries of Health and NGOs, there remained a significant population who had little or no access to services.

In Honduras, traditional models for service delivery of SRH services failed to achieve the level of financial sustainability needed to create long term impact. With a Gross Domestic Product (GDP) of only US$745 per capita, Nicaragua was (and remains) the poorest country in Central America, with the exception of Haiti. At the inception of these social franchising projects, an estimated 75% of the Nicaraguan population subsisted on an income of less than US$1 per day. In both countries, the already poor socio-economic situation had deteriorated even further as a result of the devastating effects of Hurricane Mitch, which led to Honduras losing 80% of its public infrastructure and an estimated loss of US$2,000 million in economic terms. In Nicaragua, the destruction is estimated to have set the country back some 20 years.

While contraceptive prevalence among married women of reproductive age in both Honduras and Nicaragua exceeded 60%, existing State family planning services in both countries were far from efficient. The trend of rural to urban migration also placed considerable pressure on an already overburdened health service in the cities where these facilities were concentrated. Attempts to introduce models of socially and financially sustainable programmes had not met with great success, yet regional funding for SRH had decreased substantially, with major international funders withdrawing their support.

While earlier social franchising programmes in Mexico and Pakistan displayed both advantages and disadvantages in their base model, none represented an entirely successful example. It is the lessons learnt from these countries that have been used in establishing guidelines for the development of the second generation of social franchising programmes piloted by MSI in Nicaragua and Honduras. MSI first secured funding to pilot a full franchising model in Nicaragua and then was able to expand the pilot further by adding fractional models when further funding was secured.

Despite advances in the coverage of SRH services by Ministries of Health and by NGO's in Honduras and Nicaragua, there remained a significant population who had little or no access to services.

Franchise clients are guaranteed quality care at affordable prices, and increased access to SRH services by qualified providers.

The resulting three projects, which ran concurrently to form one overall pilot project, provided four different franchising models:

- full franchising in Nicaragua
- fractional franchising in Nicaragua
- full franchising in Honduras
- fractional franchising in Honduras.

These four models were implemented by local Partners, Marie Stopes Honduras (MS Honduras) and Marie Stopes International Nicaragua (MSI Nicaragua).

The specific context

The social franchising models were set within the context of the health sector reform programmes of the governments of both Nicaragua and Honduras; co-operative agreements between the national government and international donor agencies; and the policies and regulations for the provision of services set down by the respective ministries of health. The models were also set within the context of the guidelines established during the International Conference on Population and Development (ICPD),1994, ICPD+5 and the UNFPA Country Programme for Honduras, as well as the overall SRH policy of the European Union (EU).

Maternal and child health demographic indicators: Honduras

Variable	Indicator
Total population (millions)	6.9
Percentage of urban population	45.6
Total fertility rate	3.7
Contraceptive prevalence rate: all methods	62
Maternal mortality rate, per 100,000 live births	110
Child mortality rate	32
GDP per capita, US$	1,001
Human development index rating	116

Source: UNDP. 2005.

Maternal and child health demographic indicators: Nicaragua

Variable	Indicator
Total population (millions)	5.6
Percentage of urban population	57.3
Total fertility rate	3.3
Contraceptive prevalence rate: all methods	69
Maternal mortality rate, per 100,000 live births	230
Child mortality rate	30
GDP per capita, US$	745
Human development index rating	112

Source: UNDP. 2005.

Specific emphasis was placed on targeting young women who had no children and who did not regularly use contraception.

The projects

The three projects were designed to test and develop four new models for the delivery of SRH services through a network of financially sustainable, independently run franchised centres. The projects aimed at contributing to the expansion of sustainable service provision at a national level while contributing to the range of SRH services already offered through the public and the private sector. The service providers would benefit from the support provided by a NGO through credit and through branding.

1 *"A social licensing model for reproductive health services in Nicaragua"* was funded by the European Commission through budget line 6310 – reproductive and sexual health in developing countries. Through this project, **a network of four fully franchised SRH centres** was established, two in Managua, one in Jinotepe and one in Juigalpa.

2 Funded through a private trust, *"A pilot project to improve access to family planning and sexual and reproductive health services in low-income areas of Managua through social franchising of neighbourhood doctors"*, established **a network of 16 fractional franchises** to add family planning services to the service menu of independent general practitioners in Managua and Masaya, Nicaragua.

3 Funding for *"Social licensing of reproductive health clinics for the underserved in Honduras"* was provided by the UN Foundation through the UNFPA country office in Honduras. This project piloted two networks of full and fractional franchise models, with **a network of four full franchises** being established in Choluteca, Puerto Cortés, Tegucigalpa and Tela, and **a network of 20 fractional franchises** established across the north, central and western areas of the country intended to add family planning to general practitioners' service menu.

Overall, the projects ran from June 2000 to December 2005.

The project areas

In Nicaragua, the project areas encompassed low income, urban neighbourhoods in the cities of Managua, Masaya, Juigalpa and Jinotepe. In Honduras, the project areas encompassed low income urban neighbourhoods in the cities of Choluteca, Comayuagua, Danlí, Puerto Cortés, San Pedro Sula, Tegucigalpa and Tela, rural towns and the outlying communities in the central and western areas of the country.

The beneficiaries

Direct beneficiaries of all projects were the franchisees themselves and their clients who received services through them. The indirect beneficiaries were the partners and families of those receiving services.

The target populations

All projects had as their target populations low income women, men and adolescents of reproductive age residing and working within the project areas. Specific emphasis was placed on targeting young women who had no children and who did not regularly use contraception.

The models

Both the full and fractional franchising models provided through MSI Nicaragua and MSI Honduras featured training packages which included clinical management, client care and small business management, as well as updates in SRH issues and family planning (FP) practice. Information, Education and Communication (IEC) materials and marketing services were initially provided by MSI, along with guidance to franchisees on how to sustain such materials and marketing themselves. All franchisees were offered general follow-up support.

In Nicaragua, fractional franchisees had access to additional funds through interest-free loans for centre improvement and the purchase of equipment. Through MSI Nicaragua, full franchises had the initial investment costs of renovation of premises and equipment met, as well as the cost of franchise management provided through the project itself, with a soft loan to subsidise operating costs. The cost of rental, medical

supplies, etc. was channelled through MSI and the cost debited to the franchisees' loan accounts.

In the case of franchised clinics in Honduras, the donor (UNFPA) purchased medical equipment and MS Honduras distributed it to the franchisees, who had use of the equipment for the duration of the project. MS Honduras also provided a credit to both franchise types to cover clinic improvements, equipment and local marketing costs. A portion of this loan could be used for operating subsidies.

The models

	Honduras		Nicaragua	
	Full franchise	**Fractional franchise**	**Full franchise**	**Fractional franchise**
Soft loans (interest free) provided	✓ (capital costs only)	✓ (equipment and remodelling only)	✓ (includes operating costs)	✓ (equipment and remodelling only)
Loan limit	US$90,000	US$10,000	US$90,000	US$3,000
Loan guarantee type	Property and personal guarantors	Property and personal guarantors	Property and personal guarantors	Personal guarantors and goods
Grace period	24 months	6 months	24 months	6 months
Repayment period	5 years	18 months if >US$5,000 30 months if <US$5,000	5 years	6–18 months depending on loan amount
Branding	Full	Partial (signage, IEC materials, medical standards)	Full	Partial (signage, IEC materials, medical standards)
Local MSI brand	-	✓	✓	✓
International MSI brand	✓	-	-	-
Equipment	Purchased by franchisee and held in trust until loan repaid	Purchased through loans	Purchased by franchisee and held in trust until loan repaid	Purchased by franchisee and held in trust until loan repaid
Supplies	Purchased by franchisor and supplied on revolving credit	Purchased by franchisor and supplied on revolving credit	Purchased by franchisor as part of loan	Purchased by franchisor and supplied on revolving credit
Marketing	Materials and media	Materials and media	Materials and media	Materials and media
Information, education, communication (IEC)	Materials and media	Materials and media	Materials and media	Materials and media
Business support	Full	Registration as small business and filing taxes	Full	Registration as small business and filing taxes
Voucher system	✓	✓	✓	✓
Technical assistance/ training	✓ At least every 6 months	✓ At least every 6 months	✓ At least every 6 months	✓ At least every 6 months
Monitoring	At least bi-monthly	At least bi-monthly	Monthly	Monthly

Expenditure on health

Honduras, 2005	**US$**
Total expenditure in health sector	75,700,000
Expenditure on health per capita	10.97
Total expenditure on health through NGO sector	42,694,800
Per capita expenditure through NGO sector	6.18
Investment in SRH franchising by international donors through MSI	2,513,338
Per capita expenditure on SRH franchising through international donors/MSI	0.36
Per client expenditure on SRH franchising through international donors/MSI	16.00

Source: UNDP. 2003.

Nicaragua, 2005	**US$**
Total expenditure in health sector	127,711,312
Expenditure on health per capita	22.80
Total expenditure on health through NGO sector	44,698,959
Per capita expenditure through NGO sector	7.98
Investment in SRH franchising by international donors through MSI	1,216,662
Per capita expenditure on SRH franchising through international donors/MSI	0.22
Per client expenditure on SRH franchising through international donors/MSI	11.95

Source: UNDP. 2003.

As can be seen in the tables below, the projects took place during a period when SRH indicators changed for the better, in both Nicaragua and Honduras and it can be surmised that the services provided to clients through the franchising pilot projects played a part in this upward trend.

Sexual and reproductive health indicators during the project period: Honduras

	2000	2005
	Project inception	End of project funding period
Total fertility rate	4.4	3.7
Rate of contraceptive use	41.0	62.0
Maternal mortality rate per 100,000 live births	147.0	110.0
Child mortality rate per 1,000 live births	42.0	32.0

Source: UNDP. 2005.

Sexual and reproductive health indicators during the project period: Nicaragua

	2000	2005
	Project inception	End of project funding period
Total fertility rate	3.9	3.3
Rate of contraceptive use	60.0	69.0
Maternal mortality rate per 100,000 live births	160.0	83.4
Child mortality rate per 1,000 live births	45.2	30.0

Source: UNDP. 2005.

Reaching underserved populations

By the end of the project funding period, the networks of full and fractional franchise centres combined were supplying services to nearly 40,000 clients per year in Honduras and to approximately 25,000 clients per year in Nicaragua. Full and fractional networks reached similar numbers of clients in their respective countries over the project period. The user groups of the four models piloted were also very similar in profile. While the cost of services to the client in full franchise models proved to be generally lower than in fractional franchises, it was the willingness or ability of clients to take up SRH services, rather than their capacity to pay for them, which proved the principal difference between user groups. Fractional franchisees tended to provide more flexible working hours and as such, offered greater convenience for clients in the neighbourhoods in which they operated and for which these same clients were prepared to pay. Despite being generally more expensive to the client than services provided through full franchises, the fractional franchises were more effective in attracting clients.

The incorporation of a voucher system across all four models increased the accessibility of the franchised clinics to clients with limited or no capacity to pay for services. Vouchers entitling users to a free SRH service or package of services were distributed among potential clients in the poorest neighbourhoods served by the clinics. The number of clients to whom all franchisees could make vouchers available to was limited to 10% of their total client turnover. The vouchers led to high levels of service uptake when used in both the full and fractional franchise models, but failed to secure significant numbers of subsequent, paid-for visits by the same clients in either of these models. In a number of cases where voucher systems were not in place, some service providers were prepared to offer some subsidised services in order to attract clients, although again securing subsequent, paying clients proved difficult. Without external funding, neither of the franchise models offering SRH or general medical services in the project areas was able to reach populations with severely limited or no capacity to pay for services.

Cost-effectiveness

The table opposite provides a qualitative overview of the major elements of cost-effectiveness of each of the models piloted. This overview is based on experience over the funding period, interviews during the mid-point and final evaluations, project budgets and projections of usage rates at full capacity.

By the end of the project funding period, the networks of full and fractional franchise centres combined were supplying services to nearly 40,000 clients per year in Honduras and to approximately 25,000 clients per year in Nicaragua.

	Honduras		Nicaragua	
Cost-effectiveness parameter	**Full franchise**	**Fractional franchise**	**Full franchise**	**Fractional franchise**
Maximum number of users per service provider per day	30	30	30	30
Estimated maximum number of users seeking FP or SRH services per service provider per day	25	20	25	24
Services provided	SRH and FP with some general medicine	General medicine with some SRH and FP	SRH and FP with some general medicine	SRH and FP with some general medicine
Investment cost per clinic for franchisor	High	Low	High	Low
Maximum credit available per franchisee (provided by franchisor)	US$90,000	US$10,000	US$90,000	US$1,000–3,000
IEC costs to franchisor	Materials and media	Materials and media	Materials and media	Materials and media
Marketing costs to franchisor	Materials and media	None (doctors pay from their credit fund)	Materials and media	Materials and media
Overhead and franchise management costs	High	Medium (because of geographical distribution of franchisees)	High	Low

The full and fractional networks in both countries reached similar numbers of clients over the project period. When funds and human resources invested were compared to absolute client numbers in each model, the fractional franchise models proved more cost effective than the full franchise networks, with lower levels of investment and credit costs for the number of service users.

Comparative operating income to cost: full franchises
(income and expenditure figures were not gathered for fractional franchises)

	Honduras	Nicaragua
2003 – midway through funding period	98%	90.5%
2005 – end of funding period	146%	139%

Source: MSI quarterly statistics

Benefits and risks

The client

Through social franchising of SRH services the client gained access to a greater range of competitively priced services, offered by providers who complied with the quality of care standards upheld by MSI. While the full franchise model offered services at the most competitive rates, it was the greater flexibility of the fractional franchise model which appeared to be most beneficial to clients, allowing for more convenient opening times. There were no apparent risks to the client through social franchising.

The franchisee

Within the context of the models piloted, it is arguably the franchisees that derived the greatest benefit from social franchising. In addition to the provision of soft loans to expand and improve operations, franchisees received both clinical and business-focused training and support. They also benefited from the guaranteed provision of subsidised medical supplies and lines of credit through which to purchase these supplies. Through the provision of a brand which guarantees a high standard of care, franchisees were able to secure healthcare contracts with workers' unions and with local businesses for their employees. The various franchisees within the network offered a broad range of services and as such, were able to refer clients to other specialist service providers across the network and in turn, receive referrals. Risks faced by franchisees were limited to the possibility of having their assets stripped in the event of failing to keep up with repayments and to any adverse reaction encountered locally as a result of being associated with a SRH service provider.

The franchisor

As the franchisor, MSI benefited from achieving a greater recognition of its brand, through greater penetration of the market. This was achieved by establishing a network made up of service providers aligned with MSI's mission and goal and who complied with MSI's established standard of high quality service provision. However, neither the full or fractional franchise models allow a franchisor to recoup investment costs. Although a revolving fund to receive credit repayments was in place, as a finite resource, the support of the networks over the medium to long term was not possible without funding from external sources.

The donor agencies

The benefits to donors of supporting social franchising ventures were similar to those of the franchisor - principally, broad coverage of services and a resulting health impact achieved relatively quickly (and, in the case of supporting fractional franchises, at a relatively low cost). Franchise networks also allow donors to launch other, complementary projects that require an existing base of service providers of a demonstrated capacity and standard. Donor agencies must, however, be conscious that while they may not play a formal part in the legal loan agreement between franchisor and franchisee, they are likely to be implemented in any action required to recover loans.

Each of the three projects tested demonstrated elements of applicability, replicability and achievement of goals and purposes, which impacted positively on the SRH of the general population. When comparing a model and its equivalent in the neighbouring country, few differences emerged between those in Nicaragua and those in Honduras. Fractional franchising models attracted similar levels of clients in Nicaragua as they did in Honduras and, likewise, full franchise models attracted similar levels of clients in both countries. Both the full and fractional franchise models increased access to SRH for local populations, especially where the public service could not provide a full range of SRH services or where it did not provide the necessary quality of care. However, members of the fractional franchises displayed a greater potential for achieving broad financial sustainability than the full franchises.

The fractional franchises also appeared superior since their ability to offer SRH services in conjunction with general medical services showed the potential to recruit new family planning users who would not have sought these services if they were provided in isolation. In addition, clients who attended fractional franchises benefited from greater privacy as it was not obvious to others that they were specifically seeking SRH services. This may account for why the uptake of SRH services by male clients seemed to improve in fractional franchises. An added advantage of the fractional model was the opportunity to develop a more diverse range of services with lower levels of investment, making the potential payment of loans faster and more secure.

While both franchising models helped to build the skills of service providers, helping them to extend the range of services available to clients, the networks of fractional franchises enabled the greatest improvement in service availability for clients. However, full franchises provided a broader SRH programme, specifically focused on improving awareness of SRH issues as well as access to services, which in turn was better able to increase the perception of importance of SRH within communities. Given the stigma that SRH issues have among populations in countries with growing HIV/AIDS and unintended pregnancy rates, the importance of increasing the profile of SRH issues should not be underestimated.

Members of the fractional franchises displayed a greater potential for achieving broad financial sustainability than the full franchises.

The most successful franchises are those set up by doctors who are already known in the neighbourhood and who have an existing clientele.

Although both the full and fractional franchise models provided potential for replication, fractional franchising provided a particularly viable option for the rapid expansion of SRH services in a country, particularly where a culture of visiting a trusted private doctor in the area already exists. The fractional franchise models demonstrated the greatest cost-effectiveness from the donor perspective, with a high number of users and low investment and credit costs, although there remains a significant cost in credit and in network supervision. A full franchise model, however, requires greater investment costs over a longer period of time.

Lessons learnt:

- franchise models should be kept as simple as possible, particularly if they are exploring innovative ways to involve the private sector in service provision
- in order to implement a social franchise successfully, the franchisor needs to have an entrepreneurial outlook, backed up by sufficient institutional capacity
- the most successful franchises are those set up by doctors who are already known in the neighbourhood and who have an existing clientele. In areas without a high level of awareness of the franchise brand name, it is essential to select franchisees who are well known locally
- clear criteria should be established and maintained for the selection of franchisees. Potential franchisees should demonstrate that they are highly motivated to participate
- training on specific SRH topics must be provided to all care providers and community outreach workers. This proved a significant foundation for the development of a strong IEC programme, the only way in which a sustained impact may be had on cultural and belief-based misconceptions surrounding SRH
- franchise agreements and credit agreements should be separated and clearly defined, with linkages if appropriate (e.g. should the franchisee default on credit payments, s/he loses the franchise)
- operations manuals should only include essential information on the franchise norms
- monitoring systems should concentrate only on essential information to avoid unnecessary burdens for franchisor and franchisee
- it is important to identify target groups which fulfil the social objectives of the project without prejudicing the potential sustainability of the franchise. In order to be sustainable, franchised clinics must attract a segment of the market which is prepared to pay for services: this can cause conflicts with the social goals of projects which are aimed at low-income and under-served groups. Under-served groups with the capacity and willingness to pay are the most suitable target group for sustainable social franchising
- start-up loans should be given for capital costs rather than for operating costs, and steps should be taken to ensure that franchisees have a tangible asset and a viable business after paying off their loan, or if they withdraw from the franchise. Subsidies for operating costs should be provided as grants rather than loans
- interest should be charged on loans, however low. People take credit more seriously if they have to pay interest. Completely interest-free loans may also arouse suspicion. Low interest rates also provide an exit strategy for the franchisor should the organisation withdraw from the country before the debts are paid, as the credit portfolio could be passed to another micro-credit organisation
- the value of credit guarantees should be appropriate to the size of the loan. If guarantees cannot be given, the size of the loan may be too large for local conditions
- the franchisor must be aware that the legal framework governing franchising by not-for-profit organisations may be limited or non existent, and that even where legislation does

exist, its enforcement may be extremely difficult. Due to the financial exchange of franchising (specifically loans), a franchisor that is also a not-for-profit organisation may not be legally permitted to act as a loan agency, and so must consider sub-contacting this component to a third party. The franchisor must also be aware that defaults on the payment of loans must be dealt with – a situation which can change the public perception of a not-for-profit agency, especially one that has traditionally managed programmes that target the poorest sections of the population

- free, simply produced IEC materials that are easily understood and made easily accessible to existing and potential clients form an important part of increasing awareness both of the availability of services and of SRH issues
- IEC and marketing strategies should be clearly and separately defined, although there may be some overlap at activity level
- fractional franchises are more flexible and better able to adapt to local cultural and market conditions. In smaller towns, a fractional franchise may be feasible but the market for a stand-alone SRH franchise may be too small
- the cost structure of franchise norms for one-doctor clinics should be analysed and the norms adjusted if necessary to ensure that franchised clinics can be financially sustainable
- inclusion of the name of an international NGO or a donor leads clients to expect subsidised or free services, which are incompatible with a sustainable social franchise arrangement
- prices for services should be made sufficiently flexible to respond to local economic conditions. Marketing and publicity should be decentralised and adapted to the characteristics of each location.

Social franchising: future developments by Marie Stopes International

Having reviewed and evaluated the models piloted in Honduras and Nicaragua, MSI has been able to refine its franchise models still further.

In broad terms, a network of fractional franchise clinics should have the following characteristics:

- it should be located so as to target a particular client base, e.g. among low income areas in order to target low income clients
- the gender mix of its service providers should reflect the preferences of clients
- it should ensure service providers are motivated to provide IEC and counselling to men as well as to women, irrespective of the provider's gender
- it should ensure that clinic signage is service-neutral rather than focussed on SRH and FP, which in some countries tends to be associated with women's health
- small guaranteed loans should be made available for clinic improvements and equipment
- the monitoring system must be simple, using the purchase of family planning methods by the doctors as its principal indicator
- providers should be under-subscribed prior to joining the franchise and thereby have the capacity to add clients and generate more income.

As the franchising models are further refined, franchising networks can be integrated formally into national health strategies.

A network of fully franchised clinics should have the following characteristics:

- it should have simplified franchise operating norms to reduce the cost structure (primarily, low staffing and equipment requirements)
- its clinics should be established in franchisees' own properties to ensure that they have a tangible asset and an on-going business at the end of the project
- its franchisees must have a demonstrated entrepreneurial acumen
- guaranteed loans should be provided for capital costs, and grants provided for operating subsidies.

In both cases, the most successful franchisees were those who were already known within the community, who had an existing client base but whose businesses were not as successful as they could have been. An existing client base can be crucial in the absence of a high level of awareness of the franchise brand name among the target population. It is imperative that the commercial and legal relationship (including brand ownership and conditions of use) is clearly defined and understood by franchisee and franchisor. MSI also found that ensuring the financial and legal guarantees supplied by franchisees were properly in place was vital in order to recoup any portion of the initial investment costs, as was gaining full commitment from franchisees at an early stage.

As the franchising models are further refined, franchising networks can be integrated formally into national health strategies. Their inclusion within financing mechanisms such as national health insurance and SWAps (Sector-Wide Approach) would provide Ministries of Health with cost effective and structured mechanisms for collaborating with a large number of private sector providers.

Target populations should be groups who are willing to pay for services. This includes the poor, most of whom are prepared to pay even a small amount for service quality and convenience. In many instances, men (and adolescent and young adult men in particular) are an important, often overlooked target population who can be reached relatively easily through the use of a fractional franchise model. The target populations should be concentrated in geographical areas where the franchisor has capacity for monitoring and supervision.

MSI has now taken social franchising beyond Honduras and Nicaragua. In Bangladesh, our Partner, Marie Stopes Clinic Society, is integrating the lessons learnt from the Central American pilots into their Partnership Programme with General Practitioners, strengthening an existing network of 50 general practitioners (effectively fractional franchisees). In addition, they are assessing the feasibility of expanding the network further, with a view to providing, through the use of MSI standards that the service providers must adhere to, a government-approved accreditation system. Our Partner in Kenya, Marie Stopes Kenya supports a network of 120 franchisees to provide long-term and permanent family planning methods, with a view to supporting providers to expand their existing service mix to offer a broader range of SRH services. In both Ethiopia and Ghana, MSI is assessing franchising as a way of increasing access and coverage of high quality, sustainable SRH services by building the capacity of existing service providers to offer an improved range of SRH services.

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