# SOCIAL FRANCHISING HEALTH SERVICES:

## *A Philippines Case Study and Review of Experience*

Well-Family MIDWIFE CLINIC
Affordable Quality Health Care at Your Convenience!

JSI

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## A Philippines Case Study and Review of Experience

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Barbara J. Jones
Richard V. Moore

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# I. INTRODUCTION

For over 15 years, John Snow, Inc. (JSI) has managed a number of public-private partnerships intended to expand access to family planning and other reproductive health services. JSI has been instrumental in establishing one such partnership in the Philippines—a so-called "social franchise," the Well-Family Midwife Clinic (WFMC) franchise. With funding from USAID/Philippines, JSI has worked with Philippine non government organizations (NGOs), midwives and the Department of Health (DOH) to adapt commercial franchising approaches for the provision of reproductive health services. This monograph describes that experience in an effort to contribute to a better understanding of the promise and pitfalls of social franchising as an approach for sustainable health service delivery. By relating the WFMC experience to that of social franchising schemes implemented elsewhere, policy conclusions and outstanding issues can be drawn for this nascent and complex approach for providing public health services.

The intended target audience for this publication includes policymakers and program managers in donor agencies, governments in developing countries, multilateral agencies (such as WHO), and technical assistance agencies working in public health. A secondary audience includes technical agencies working in other areas of social development interested in the applicability of social franchising to their work.

While this document is focused on the Well-Family Midwife Clinic franchise, and the USAID-funded TANGO Project under whose auspices the franchise was established, it is important to understand the theoretical framework of social franchising and to consider the experience of social franchises in other countries. The WFMC franchise, as well as other commercially oriented networks and franchises, offer valuable lessons and insights into the policy and programmatic implications for meeting public health goals, allocating public funds to achieve those goals, and capitalizing on the strengths of the private sector to offer basic health services on a sustainable basis.

**Section II, the main section of this monograph, is devoted to a description and analysis of the WFMC franchise. Lessons learned from the experience are included both within Section II and the final section. Section III, the final section, focuses on policy-programmatic conclusions, and recommendations presented in a Question and Answer format. An annex is also provided which lists and provides a brief description of the various studies, manuals, tools, and methods developed by the TANGO Project as part of the WFMC franchise scheme.**

## Social Franchising

As a form of public-private partnership, social franchising has until recently received relatively little attention by donors, governments, or the private sector. Like social marketing, social franchising applies accepted business techniques to provide "public goods" through the private sector. Whereas social marketing is largely used for product sales, however, social franchising is focused on the provision of services. Although social franchising may be used for any number of services that have broad social value, much of the global experience with the model has been for the provision of family planning and other reproductive health services.

Several comprehensive reviews of health care franchising in developing countries have been published in professional journals and by development organizations, and a multi-year evaluation of five health care networks utilizing various commercial business models is underway.[1] This monograph will not repeat the information in those sources except to provide a context for the present case study of the Well-Family Midwife Clinic franchise in the Philippines.

Social franchises share many of the characteristics of commercial franchises such as:

- Using a contract or agreement between a franchiser and franchisee that specifies the terms of the relationship;
- Franchisees are the owner-operators of their own business;
- Adhering to a standardized business format (i.e., the services to be provided and the way in which they are to be provided);
- Remittance of fees by the franchisees to the franchiser for rights to the brand and for services such as marketing, quality monitoring, and training;
- Return on investment and profitability as explicit and essential goals;
- Use of a brand to position and define the franchise market niche;

[1] Montagu, Dominic. Franchising of health services in low-income countries. Health Policy and Planning; 17 (2): 121-130. 2002.
Smith, Elizabeth. Social franchising reproductive health services. Can it work? A review of the experience. Marie Stopes International Working Papers, No. 5. February 2002.
Carolina Population Center, Alternative Business Model Project.

- Advertising and promotion; and
- Quality assurance.

*Unlike* commercial franchises, most social franchises are also characterized by:

- Financial subsidies from public resources provided by government or donors to establish and/or operate the franchise;
- An emphasis on services for the public good (e.g., maternal-child health, family planning, voluntary counseling and testing for HIV, immunization, nutrition, etc.); and
- Low-income groups as the intended consumers of franchise services.

## Comparing Social Franchising Schemes

All social franchising begins with a social agenda. The major difference among various social franchising schemes is the degree to which they incorporate a commercial agenda (i.e., profitability and financial sustainability) in addition to social goals.

Major social franchises for health are currently operating in a number of countries: Green Star in Pakistan, Janani in India, PROSALUD in Bolivia, and Well-Family Midwife Clinics in the Philippines, to name a few. All of these franchises share most but not all of the characteristics mentioned above and may have some unique features as well. All are fee-for-service systems, but achieving financial sustainability is a secondary objective for Janani, and for the Green Star network established by PSI, which views sustainability in terms of long-term health impact rather than financial self-sufficiency.[2] PROSALUD seeks to maximize cost recovery and increase the financial sustainability of its programs, while increasing use of low-demand family planning services that are provided free of charge. To ensure the long-term survival of PROSALUD, an endowment fund was set up by USAID. The following table provides an overview of attributes that are incorporated by the various franchising schemes.

As Table 1 illustrates, the various social franchising schemes incorporate different attributes in common with commercial franchising: Some more, some less. They represent a continuum of these attributes. What the table fails to convey, however, is how very different these schemes are in terms of their goals, strategies, and operational practices. While it would be

[2] Population Services International, Biennial Report, 2001-2002.

convenient to have "a" social franchising model, no such fixed model with fixed characteristics currently exists. For now, those interested must assess the objectives, strategies, and outputs of social franchising schemes in terms of the goals that the sponsoring donor or government wishes to achieve.

As shown in Section II, what sets WFMC apart from other social franchising schemes is the degree to which it has moved toward a commercial agenda. The challenge for WFMC is to find a viable balance between the original social goal of increased access to quality services and the commercial goals of profitability and sustainability. The issue of financial sustainability is particularly acute for the operations of the franchiser itself, and thus for franchise-wide functions such as quality assurance, training, marketing and advertising. The WFMC franchisees, for the most part, are financially sustainable, or are on track to become so within the near future based on sales and revenue. The franchiser, however, is dependent on the remittance of royalty fees by franchisees, which will need to almost double in number from the current 203 to cover the franchiser's costs.

The challenge for WFMC is to find a viable balance between the original social goal of increased access to quality services and the commercial goals of profitability and sustainability.

There are other important trade-offs for social franchising schemes depending on where they want to position themselves on the social/commercial goals continuum. These will be discussed in the final section.

**Table 1: Attributes of Various Social Franchising Operations**

| | Green Star | PRO-SALUD | Janani | WFMC |
|---|---|---|---|---|
| Contract between parent organization (franchiser) & clinics (franchisees) | Yes | Yes | Yes | Yes |
| Standardized business format | Yes | Yes | Yes | Yes |
| Brand | Yes | Yes | Yes | Yes |
| Marketing | Yes | Yes | Yes | Yes |
| Franchise fee | Yes | Yes | Yes | Yes |
| Quality assurance | Yes | Yes | Yes | Yes |
| Franchise operators own their business | Yes | Yes | Yes | Yes |
| Fee for Service | Yes | Yes | Yes | Yes |
| Financial sustainability as a primary objective | No | Yes | No | Yes |

## Policy Implications of Using Public Resources to Subsidize Private Sector Services

It is widely accepted that governments must ensure that basic health needs of the poorest segment of the population are met. Governments alone are not able to provide the "safety net" for even the poorest citizens. Yet, in many countries, public services are still widely targeted to and used by those with the means to pay for basic health care that is moderately priced.

**It is essential that public policy move toward a well defined "division of labor" between public and private sector health services** in terms of which sector will be responsible for which segment(s) of the population. To make such a division of labor possible, the public sector must stop competing with the private sector for consumers who can pay by providing free or heavily subsidized services. An exception to this might be preventive services that have broad social or public benefit, which might qualify for public support[3] under certain conditions. Even those services, however, have a demonstrated capability to recover a large percentage of their cost, even if they are not completely financially sustainable.

Some social franchising schemes seek ways to maximize health impact while optimizing revenues by selling packages of services or offering higher profit services in order to cross-subsidize less profitable ones. Whether such socially oriented business ventures can succeed, or whether they will become increasingly profit-oriented without continuous public subsidies, is not yet known.

There are several cases for which the use of public subsidies to provide essential health services through the private sector can be justified:

1. To ensure that all citizens, regardless of income, have access to and use goods and services which contribute to the achievement of public health objectives.

2. To encourage the private sector to provide services to poor and under-served populations if it can do so more efficiently than the public sector and at less cost to the public.

[3]By "public support" the authors include all financing or subsidies that originate directly or indirectly as public tax funds. Thus, funds which emanate from governments, foundations, or multilateral agencies are considered public funds.

3. To encourage private sector providers to serve those who can pay all or most of the cost of social goods, thus permitting the public sector to allocate most of its resources for services to the poorest and under-served populations.

There is strong justification for public resources to be used in all three cases. In the third case, however, private sector mechanisms such as social franchises should be able to contribute to public health goals and be financially sustainable. This is the hypothesis that USAID and JSI set out to test by creating the social franchise model called Well-Family Midwife Clinic.

# FRANCHISING REPRODUCTIVE HEALTH SERVICES IN THE PHILIPPINES:

# A CASE STUDY OF THE WELL-FAMILY MIDWIFE CLINIC FRANCHISE

## Country Context

With almost 80 million people, the Philippines has one of the fastest growing populations in Asia. With a young population and relatively low contraceptive use, the Philippines has a high annual population growth rate—2.36%—which increases the population by 1.7 million people per year. The contraceptive prevalence rate (CPR) for *modern* methods in 2002 was 32%, slightly higher than Malaysia (30%) but substantially lower than that of several other countries in the region (e.g., Thailand – 70%, Vietnam – 61%, and Indonesia – 55%).[4] There is also a high level of unmet need for family planning services, as demonstrated by the disparity in the total fertility rate of 3.7 and the desired family size of 2.7.

Inadequate access to health services for both the urban and rural poor, and gaps in maternal care contribute to a fairly high rate of maternal mortality (172/100,000 live births). Although 86% of pregnant women have at least one prenatal consultation with a health professional and 77% of pregnant women have three or more prenatal checkups, only 56 percent of births are attended by skilled personnel. [5]

In comparison with other countries in the region, the Philippines is in the middle of the ranking of per capita income ($4,220),[6] although the median household income is only $1,775.[7]

**The Philippines Health and Population Indicators[4]**

**Total fertility rate: 3.7**

**Infant deaths per 1000 live births: 37**

**Maternal deaths per 100,000 live births: 172**

**Births attended by skilled personnel: 56%**

**Contraceptive prevalence rate for modern methods: 32%**

**Per capita income: $4,220**

[4] Population Reference Bureau 2002 World Population Data Sheet

[5] National Health and Demographic Survey, 1998.

[6] PRB 2002 World Population Data Sheet

[7] National Census and Statistics Office

For decades the Department of Health (DOH) in the Philippines has operated a system of hospitals, health centers, and smaller health units to provide health care to all citizens. Services are provided free of charge or for very nominal fees, although patients might have to provide their own medical supplies such as bandages and sutures, and pay for medications. A program called *Sentrong Sigla* ("Center of Vitality," denoting a seal of quality assurance) Movement has been undertaken by the DOH to improve the quality of services in public health facilities. People with the financial means to do so, generally seek care from medical specialists in private clinics and hospitals—though no study has shown whether the quality of care is in fact better in the private sector than the public sector or whether individual health outcomes differ between the private and public. While typically, the general public cannot gauge the quality of clinical care, client interviews and anecdotal evidence suggest that DOH facilities generally do not provide satisfactory service in terms of convenience (hours of operation, waiting times), availability of supplies and medications, and client-provider interaction. Thus, even low-income clients are increasingly willing to seek health services from private providers who treat them more respectfully, have convenient hours of operation, less crowded waiting rooms, and provide more individualized attention.

**Segmenting markets and targeting health subsidies more effectively, the private health sector is being explored as a way to help meet health care needs in the Philippines.**

Segmenting markets and targeting health subsidies more effectively, the private health sector is being explored as a way to help meet health care needs in the Philippines.

It is not surprising that the Philippines DOH is unable to provide satisfactory health care to all given the burgeoning population and reduced resources from national and local budgets and donor organizations. At 3.3%, health expenditure as a percentage of total government spending in the Philippines is among the lowest in Asia. Expensive hospital curative services and care for the elderly absorb 58% of the health budget.[8] Thus, relatively few resources are available for preventive care. The Government of the Philippines has instituted a program of health reform that includes policy revisions and charging fees for service. The DOH and Local Government Units (LGU) recognize the need to augment their operating funds by collecting user fees—however, this is an unpopular strategy and difficult to implement in a country hard hit by an economic downturn since the late 1990s. At the same time, donor organizations are reducing assistance levels and pressing the DOH to reduce health care subsidies or at least to reduce the number of people who rely on subsidized health services.

[8] Asian Development Bank. 1999. Health Sector Reform in Asia and the Pacific: Options for Developing Countries. Manila

Acknowledging the need to segment the market, to target health subsidies more effectively, and to make more judicious use of public health services, the DOH, donors and technical assistance agencies are paying greater attention to the potential of the private health sector in helping meet health care needs in the Philippines.

There are many private health practitioners in the Philippines, particularly in Manila and other urban areas, catering to the upper and middle class who can afford to pay for care. Reproductive health care such as maternity and family planning services are generally the domain of private specialists (i.e., obstetrician/gynecologists), whose fees are far beyond the means of people in the middle and lower-middle class economic groups, the so-called "C – D economic groups." [9] C and D consumers have had to rely on the public sector for most primary health care including reproductive health services. People in the C and D groups, however, are able and willing to pay for health services available in the private sector if the services are moderately priced and are more satisfactory than those provided at public facilities. [10]

## Adapting Commercial Franchising for Primary Health Care and Family Planning

Since the mid-1980s, USAID and other donors in the Philippines have supported private sector initiatives to augment the national family planning program run by the DOH through its nationwide system of health facilities. Private sector initiatives for health and family planning have been undertaken by commercial, for-profit entities as well as by not-for-profit entities—non government organizations (NGOs).

**A successful health franchise requires trained providers, a population able and willing to pay, and demand for affordable quality health care.**

One such initiative was pioneered by John Snow, Inc. (JSI) and local NGOs, which adapted a commercial franchise model to the particular needs of clinic-based family planning (FP) and maternal and child health (MCH) services. The country has some of the ingredients necessary for a successful franchise: an excess supply of trained providers; a segment of the client population that is able and willing to pay for services; and demand for affordable quality health care.

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[9] The Philippine National Economic Development Authority (NEDA) divides the population into five groups, with group A at the highest income level and group E at the lowest.

[10] Cabegin, Emily Christi A. Willingness to Pay for WFMC Services in the Philippines. March 2001.

The foundation of a commercial franchise is normally an established business with an existing product or service and operating procedures. Leasing the rights to sell the product is a cost-effective way for the business owner to quickly expand the market and increase sales and revenue while sharing the financial risk with other investors. The investors, or franchisees, can enter the market quickly by using an existing product and business blueprint. Franchising has been successfully used by the food and hospitality industries for decades, but in the early-to-mid 1990s there was very little experience with the application of commercial franchising techniques to a social agenda of providing health services for low-income clients in a developing country.

**NGO franchisers business plans include financial projections, organizational structure, and the relationship between the franchiser and the franchisees.**

### 1. The Initial Franchise Model of the NGO Strengthening Project, 1993-1995

With funding from USAID for the NGO Strengthening Project, JSI worked on an initial franchise model with two large NGOs, the Institute of Maternal and Child Health (IMCH) and Integrated Maternal Child Care Services and Development, Inc. (IMCCSDI). Both NGOs owned extensive clinic networks that employed hundreds of service providers. The clinics, which were widely dispersed throughout the country, served very poor communities and were primarily funded by donor agencies. When the NGOs agreed to convert their clinic networks to a franchise, ownership of the clinics was transferred from the NGOs to service providers who had been NGO employees. The two NGOs became franchisers and their previously owned clinics became their franchisees. For USAID, JSI, and the NGOs, the objective was to increase the number of family planning users, to improve the quality of the services, and to decrease the operating costs of the clinics.

**Clinic franchisees business plans specify the franchise benefit package, menu of services, client and revenue targets, operating requirements and financial projections.**

Business plans for the franchisers included financial projections based on the number of franchisees and the remittance of franchise fees, the organizational structure of the franchise, and the relationship between the franchiser and the franchisees. For the clinic franchisees, the business plans specified the benefits package which they would realize as participants, the menu of services, client and revenue targets, operating requirements and financial projections. To upgrade the clinics and expand services, the project made loans available to the franchisees for clinic renovation and purchase or lease of equipment.

There were *similarities* between the two franchises:

- Both used written agreements to specify the roles of the franchiser and benefits that the franchisees would receive and franchise fees to be paid to the franchiser; and,
- Both instituted standardized services and operating requirements in their respective franchise clinics.

There were also significant *differences* between the franchises:

- IMCCSDI adopted a brand name (Family Care) for the franchise, and clinic ownership was transferred to midwife franchisees; and,
- IMCH clinics continued to operate with the IMCH name, and clinic ownership was transferred to physicians, nurses, or midwives as the franchisees.


An extensive program of technical assistance (TA) and training was undertaken by the Project for the NGO franchisers and the clinic franchisees. For the franchisers, the TA and training concentrated on business practices to prepare them to institute radically new (for NGO staff) business and management procedures and to develop more entrepreneurial and business-oriented attitudes. For the franchisees, training included family planning service delivery and counseling, and basic business skills.

The shortcomings of the initial franchise model began to surface 12 to 18 months after the franchise operations began. Some of the particular problems and related lessons learned include:

- NGO managers and staff did not adapt easily to business-oriented approaches and procedures essential for managing a franchise operation;
- Geographically dispersed clinics were difficult and expensive to support and supervise by the franchisers;
- Training in business skills was not well tailored to the needs of the clinic owners;
- Repayment of loans was poor;

- Franchisees resisted paying royalty fees to the NGO franchisers due to lack of technical services and support; and,

- The communities in which many of the clinics were located were too poor to pay even moderate fees for family planning and preventive health services.

In mid-1995, USAID directed JSI to cut back funding to IMCCSDI and IMCH for franchise development. Underlying the decision were legitimate questions about the Project based on the leveling off of family planning performance, as well as concerns about the effectiveness of the NGOs as franchisers. Despite these concerns, however, USAID and JSI still viewed social franchising as a viable mechanism for providing large numbers of family planning services and other needed health care.

At the time that funding was curtailed, the Family Care franchise had 47 clinics in operation, and IMCH had 45. Of those 92 franchised clinics, JSI believes that 52 remained in business as private practices, although this has not been validated. The other 40 clinics eventually closed, and the Family Care and IMCH franchises ceased to function when NGO staff responsible for franchise operations left the organizations. The NGOs themselves continued to run other programs that were not affected by the cutback in USAID funding.

Although the experience with the initial franchise model was only two years, the problems and lessons cited above were valuable in restructuring the franchise model that would be undertaken later.

### 2. The Restructured Franchise Model of the TANGO Project, 1995 to present

**Since the first clinics opened in 1997 to the end of TANGO in 2004, an estimated 220 clinic franchises will be in operation**

Reflecting the lessons learned from the initial franchise model, in 1995 USAID and JSI began work on a new project, "Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non Government Organizations," referred to as the TANGO Project. The Project, which ends in December 2004, is intended to improve NGO management capabilities and increase the availability of family planning in the private sector using a restructured model of social franchising.

The new venture was named the Well-Family Midwife Clinic (WFMC) franchise. The specific characteristics of the restructured franchise model include:

- A uniform business model based on commercial franchising that must be followed by all project partners;

- NGOs acting as area franchisers;

- Geographically concentrated franchise clinics affiliated with a designated NGO area franchiser;
- Uniform services and operating standards for all franchise partners;
- Clinics independently owned and operated by midwives as the franchisees;
- A unique "brand" used by all franchise partners; and,
- JSI as the *de facto* national franchiser until a local Filipino entity could be established as the national franchiser.

The restructured franchise model was intended to:

- Increase family planning use by stimulating provider productivity through clinic ownership;
- Increase the cost effectiveness of service outlets by using midwives, working primarily out of their homes, as the primary providers rather than more expensive nurses and doctors; and,
- Develop a profitable and sustainable service delivery mechanism that can function with reduced or no external funding.

**Those who can afford to pay moderate prices for health services are the logical customers for a social franchising program with public health, equity, and financial sustainability goals.**

The intended client beneficiaries of the franchise represented a significant change for many of the NGOs that traditionally served primarily very poor and indigent populations. As a business-oriented model, the beneficiaries of the restructured franchise are people in the middle and lower-middle income groups—the C – D groups—who can afford to pay moderate prices for health services in the private sector rather than relying on public sector health facilities. These groups are the logical customers for a social franchising program with public health, equity, and financial sustainability goals. 67% of clients of the Well-Family Midwife Clinic franchise report household income of $160 or less per month; only 11% of client households earn more than $319/month. [11]

[11] Cabegin, Emily Christi, Marilou P. Costello, ME Khan, James Foreit, Barbara Janowitz, Easter Dasmariñas, Gerard Suanes, Willingness to Pay for Well-Family Midwife Services in the Philippines. December 2001.

# Organization and Management of the Well-Family Midwife Clinic Franchise

### 1. Franchise Structure

In addition to USAID, the TANGO Project involves:

- JSI – provides project management and technical assistance on behalf of USAID and acts as *de facto* national franchiser;
- NGOs –as area franchisers;
- Midwives – the clinic owners (i.e., the franchisees); and,
- WFMC Partnership Foundation, Inc (WPFI) – a national franchiser established in 2002

#### a) TANGO Project Manager: John Snow, Inc (JSI)

JSI is the principal source of technical assistance and oversight for the TANGO Project. As USAID's cooperating agency, JSI is responsible for meeting objectives and disbursing and managing the funds in accordance with the Project design and the contract provisions. JSI oversees all project operations, and consults with USAID as needed in order to set and achieve the goals of the project. TANGO Project staff, located in Manila and various regions of the country, work closely with the NGOs and the midwives who make up the WFMC franchise network to strengthen their capabilities through training and assistance in business planning and management.

Although never referred to as such, JSI functioned as the *de facto* national franchiser in the absence of a single Filipino entity with the capacity and resources to establish and manage a nationwide network of clinics. JSI also developed functions that directly support the franchisees such as advertising and franchise-wide promotion, training, research and development, and monitoring for quality assurance.

**Once a franchiser, NGOs had to select targeted clinic locations and recruit midwives who were interested in owning and operating clinics.**

#### b) Area Franchisers: NGOs

IMCH and IMCCSDI, the two NGOs that experimented with the initial franchise model, and four new NGOs, were selected for the franchise in the early stage of the TANGO Project. Two more NGOs joined the franchise the following year, and at the end of 2002 there were ten NGOs participating as area franchisers.

To join the franchise, selection criteria required the NGOs to:

- Have an entrepreneurial orientation;
- Have the basic organizational capacity to implement a service delivery program;
- Have previous experience in family planning (FP) and maternal and child health (MCH) service delivery;
- Be willing to oversee activities in a specific geographic area; and
- Have the potential to become financially sustainable.

Unlike the initial franchise model, in which the NGOs had franchised clinics in widely dispersed locations, the restructured franchise model designated the NGOs as franchisers of clinics located in specified geographic areas. This targeted focus makes monitoring less cumbersome and more cost-efficient, and limits territorial overlap between NGO franchisers.

After being selected as area franchisers, the NGOs had two immediate tasks: Selecting clinic locations and recruiting midwives who are interested in owning and operating clinics. The NGO franchisers are responsible for providing technical support to their affiliated midwives for training, marketing, business planning, and the procurement and distribution of supplies and commodities. NGO supervisors make frequent supervisory visits to the clinics during the first 24 months of operation to offer on-site assistance in clinical practice, business management and marketing, and to assess the midwife's compliance with the WFMC operations standards. The NGOs also help ensure the collection, analysis, and submission to JSI of service statistics and other data needed for the management information system (MIS), used to monitor performance and improve services.

**The WFMCs work hand-in-hand with partner NGOs to manage and support the network. In a very real sense, the NGO partners function as "area franchisers" for the clinic network. In contrast to the donor-based model of service delivery, NGOs are held accountable for the business performance of their "franchise clinics." As one NGO executive said—**

***"Usually NGO projects are for free, but this was different from the beginning. We had to run it like a business, although it took us a while to figure out what we were supposed to do."***

**c) The Franchisees: Midwife-Owned Clinics**

The initial franchise model transferred ownership of the NGO's existing clinics to former employees. By contrast, the WFMC franchise uses clinics that are independently owned by midwives, who for the most part had no previous affiliation with an NGO. Whereas some of the clinics of the initial franchise were fairly large and offered an array of primary health services, the WFM clinics are small, often located in or near the midwife's residence, and offer a targeted menu of reproductive and maternal and child health services.

The six NGO franchisers recruited 90 midwives to join the franchise and open new clinics during the first year of the franchise. Since then new cohorts of midwives have joined the

**Midwives were initially skeptical of the idea:**

***"At first I hesitated – it was a huge gamble. But I really wanted something I could call my own."***

***" Me, a private practitioner? Can I handle this? I've always worked with a doc before."***

franchise every year, and as of June 2003 there were 203 franchised clinics in 29 provinces. By the end of the project in 2004, an estimated 220 clinic franchises will be in operation.

*Benefits and incentives.* Being part of the WFMC franchise provides various benefits and incentives for midwives, the most significant of which are greatly enhanced income and clinic ownership. Other benefits of joining the franchise include:

- Access to training and technical assistance;
- Quality Assurance upgrades;
- Technical assistance for business and clinical practices;
- Low-cost supplies;
- The support of a professionally designed marketing program;
- Opportunities for networking and peer support; and,
- A package of basic clinic equipment and instruments.

In addition, through the combined efforts of JSI and the USAID mission, the Development Credit Authority has recently approved a loan guarantee facility for the WFMCs. Current midwife franchisees will be able to access small loans for clinic facility improvement and replacement of equipment and instruments from a commercial bank via the national franchiser.

Professionally, WFMC franchise midwives enjoy greater autonomy than their peers employed in government-run clinics who usually work under the direction of a nurse or doctor. Midwives working in public clinics may be assigned to various services that do not utilize their training and skills in maternal health. A WFMC midwife, on the other hand, handles a targeted range of services that include MCH, family planning, and other primary care and gives individualized attention to her clients. In addition to increasing their competence as clinicians, WFMC midwives develop the business skills needed to run a clinic, including business planning, marketing, budgeting, bookkeeping, stock management and purchasing, and facility maintenance.

*Clinic "graduation."* When specific criteria are met, or 24 months after joining the franchise, whichever comes first, WFMC midwives are "graduated." At this point, the midwife and her clinic do not require such frequent supervision from the NGO area franchiser, and the midwife no longer receives technical assistance from the franchiser that is subsidized by the TANGO Project. Eligibility criteria for graduation are:

- The midwife has completed all WFMC required training and achieved competency;
- Marketing activities are being conducted;
- Technical support services for training, quality assurance, marketing, supply and commodities procurement, etc. are available from the franchiser and the midwife has the means to pay for the services as needed.
- Service statistics and other clinic data are being reported to the NGO franchiser for the MIS.

Graduated midwives continue their affiliation with their NGO franchiser but the TANGO Project no longer covers the cost of franchiser support functions. The midwife assumes responsibility for identifying the support she needs to maintain her clinic and for "buying" that support from an NGO or other accredited vendor with the particular expertise. Following clinic start up, most midwives need about 24 months of operations before they graduate.

**In the course of the program, a gradual transformation in self-perception has taken place among the midwives. From being "mere" volunteer midwives for the government, private midwives doing home deliveries, nannies (yaya) or caregivers, and domestic helpers, they have come into their own and have gained considerable confidence in their current status as owners of their own clinics.**
***"I am a professional midwife."***
**Such words never had that confident ring until spoken today by the Well-Family midwives.**

As of end June 2003, of 124 midwives who have graduated, 57% have achieved financial sustainability,[12] while 89.7% have reached operating profitability—that is, they are covering their monthly operating costs and earning enough profit to recover *some* portion of their initial investment and capital expenditures.

**d) The national franchiser: The WFMC Partnerships Foundation, Inc. (WPFI)**

With the TANGO Project ending at the close of 2004, JSI, in consultation with the NGOs and the midwives, determined that in order to be sustainable the WFMC franchise needed a national franchise entity to manage franchise operations. While all of the NGOs have improved their management capabilities significantly over the course of the project, there is no single NGO that could assume responsibility for overall franchise management. Not only does the role of national franchiser exceed the current capabilities of all the NGOs, the unique mission and governance structure of an individual NGO could be at odds in the future with other franchise partners or with the objectives of the franchise. It was clear that

[12] The TANGO Project defines financial sustainability at the clinic level as having earnings sufficient to recover investment and capital expenses and to cover monthly operating costs. The term "operating profit" refers only to the amount of income earned, net of recurring operating costs. The latter is monitored quarterly by the franchiser to ensure that the midwife is receiving enough profit to cover her living expenses, as well as her recurring operating costs.


**Purita Dantes**

About a decade ago, Purita Dantes, then in her 20s, had to keep two jobs at a time—as an assistant to physicians at a maternity lying-in clinic and at another hospital—to earn just P2000 a month.

Midwives are probably the least recognized in the hierarchy of the Philippines health care provider chain. Many end up working as assistants to physicians.

Purita learned of the Well-Family Midwife Clinics through a friend. She was offered the job of being a clinic manager herself, even though she knew little about the program. Armed with guts and faith in her capabilities, Dantes grabbed the opportunity. "I gave WFMC a try because it was my dream to have a clinic I could call my own. Before, that dream seemed impossible because I knew I had nothing and no one to financially support me," Dantes says. "But during the WFMC seminar, I learned that we would be receiving support from NGOs, so I was not afraid any more."

Dantes' WFMC is now one of the fast-earning Clinics in the country, generating an average income of P3,000 a day. Monthly, Dantes earns between P60,000 to 80,000.

The clinic, which is open from 8am to 5pm accommodates some 15 – 20 clients a day.

The midwife-entrepreneur's efforts have been amply rewarded. "Patients say that my clinic offers the best health care service in the community. They say that they are very well taken care of by my staff, and they are very satisfied with our services," says Dantes. "All of this contributes to my fulfillment as a midwife and entrepreneur."

*Excerpted from The Manila Times, page B5, October 24, 2002*

the long-term stability and growth of the franchise require an independent franchiser whose only mandate is the WFMC.

After consultations between the NGOs, the midwives, USAID, and JSI, the WFMC Partnerships Foundation, Inc., known as WPFI, was registered with the Securities and Exchange Commission of the Philippines in June 2002. The first National Assembly of the WPFI, held in November 2002, ratified the business plan and a Board of Directors was elected. The WPFI will gradually assume responsibility for oversight of the franchise prior to the expiration of the TANGO Project. Implementation of the business plan is underway, with technical assistance from JSI.

In addition to revenue generation and marketing the brand, the WPFI will maintain the following ongoing essential services and incentives for the WFMC network:

- Technical training updates;
- Monitoring and maintaining quality;
- Marketing and advertising;
- Facilitating access to credit via the credit guarantee facility;
- Providing access to low cost supplies; and,
- Sharing information on technical and WFMC matters of interest.

**The WFMC Partnerships Foundation was established in 2002 as a national franchise entity to manage franchise operations.**

In order to ensure the financial viability of the franchise, the WPFI will also need to almost double the number of participating clinics to about 385.

As WPFI develops capacity, it will assume all of the national franchiser functions previously handled by JSI, and will also assume most area franchiser functions done by the NGOs. These NGOs will gradually convert to providers of technical support services, carried out under contract to WPFI.

### 2. Management Information and Performance Monitoring

According to the agreements between the NGO franchisers and the TANGO Project, the franchisers are responsible for the performance of their affiliated midwife franchisees. Thus, both the franchisers and the midwives are under significant pressure to quickly establish clinics, attract clients, provide services, and generate revenue.

A management information system was developed to track inputs to and outputs of the NGO franchisers and the midwife franchisees. From the outset of the TANGO Project, an MIS has been used to monitor and improve the quality of services, the effectiveness and efficiency of the network, and the financial sustainability of the franchise. Initially, only quantitative service delivery indicators were used (e.g., couple years of protection (CYP) for family planning, the number of MCH services, and the number of referrals for sterilization). In 1999, new qualitative indicators, as well as additional quantitative performance indicators, were incorporated which included:

- Quality standards set for the project, including the number of supervisory-technical assistance visits;
- Business performance, including the preparation and implementation of clinic business plans and clinic marketing promotions;
- The completion of all legal and regulatory requirements for the clinic, such as business licenses, permits, and accreditation by government agencies; and
- Revenues earned by each clinic.

To track the growth of the franchise and the establishment of individual clinics, the NGO franchisers report activities such as clinic site selection, new midwife selection, completion of pre-service training by new midwives, clinic set-up, start-up marketing assistance, and promotional activities. In practice, the MIS data are passed on to the franchiser and to JSI, where the data are analyzed and used to coach the midwives in improving service delivery and in business planning. While it is a long term goal, at this point few midwives are interested or capable of using these data to improve their planning and decision making.

**_A performance- based payment mechanism_ was initiated that linked payment to the NGOs for technical support with outputs and benchmarks tracked by the MIS.**

To ensure that the NGO franchisers were sufficiently motivated to reach agreed-on benchmarks, the TANGO Project instituted a *performance- based payment mechanism* (PBPM) that links payment to the NGOs for technical support with outputs and benchmarks tracked by the MIS. The PBPM encourages the NGOs to be efficient and productive: the more outputs that are achieved at lower unit cost to the NGO, the greater the margin of earning. The PBPM has served not only the Project's need to make the clinics and the NGOs accountable for performance, but has instilled an awareness of the importance of performing efficiently.

PBPM benchmarks are established and updated annually by JSI and the NGOs and approved by USAID. On average, 80% - 90% of the benchmarks have been achieved within the annual workplan periods.

## Business Framework of the Well-Family Midwife Clinic Franchise

Many of the characteristics of commercial franchising were well suited to a social franchise such as the WFMC, although some adaptation was needed for WFMCs to achieve their objectives. Franchise elements incorporated and adapted for the WFMC include:

- Investment and shared risk;
- Setting standards for quality and performance;
- Use of a brand;
- The business format;
- Quality assurance;
- Economies of scale via bulk purchasing; and,
- Advertising and marketing.

As the WFMC franchise evolved, elements of the business framework were refined and strengthened to respond to the needs of the franchisees, to increase client demand and utilization, and to ensure franchise sustainability. Elements of the WFMC business framework and evolution of the franchise are described below.

### 1. Investment and Shared Risk

All WFMC partners have shared the risks inherent in an innovative endeavor such as adapting commercial franchising techniques for a network of primary health care clinics.

#### a) Donor subsidy for start up

With USAID funding, JSI has covered many start-up costs and provided technical assistance to refine the model and strengthen the franchise. Donor funding has been essential for establishing the WFMC franchise, and more recently for institutionalizing the national franchiser, WPFI. It is important to note, however, that from the outset the intended result of the TANGO Project has been to create a franchise service delivery system that would only need donor funding for an initial period in order to become financially self-sufficient.

### b) Setting up the franchise

Prior to joining the TANGO Project, participating NGOs were accustomed to receiving an installment of funds from a donor in advance of carrying out program activities. As WFMC partners, the NGOs had to use their own resources in order to conduct activities such as midwife recruitment, training, delivery of equipment to clinics, and supervisory visits, prior to receiving funds from the TANGO Project. Not only did the NGOs have to implement activities to receive funds, under the performance-based payment mechanism (PBPM), performance benchmarks for the NGOs were directly linked to results achieved by the midwife franchisees for service delivery and revenue.

*Clinic site selection.* Another aspect of investment and risk for the NGO franchisers was the selection of clinic locations. TANGO staff worked with the NGOs to develop a Rapid Market Appraisal for clinic locations, to determine the potential market niche of a clinic. The Appraisal takes into consideration the:

- Population density in the catchment area;
- Proportion of the catchment population in the C – D economic groups (representing potential consumers who could pay for services); and
- The availability of qualified midwives in the area who could set up and run clinics.
- The level of competition from other health service providers.

Despite the emphasis that the TANGO Project put on the necessity of attracting paying clients to the clinics, several NGOs located a few clinics in neighborhoods where very few clients could afford to pay. These sites proved to be inappropriate, given the need for the midwives to start providing services and generating revenue, and for the NGOs to show results in order to meet the performance outputs required. These clinics were closed and the midwives relocated to more appropriate sites. A Site Assessment Guide was developed to assist the NGOs in site and facility selection. With experience, the NGOs identified other criteria to consider in clinic site selection as well (e.g., easy access by public transportation, and proximity to competitors—be they other private providers or public health centers).

*Franchisee selection and deselection.* Employment options for midwives in the Philippines are fairly limited. Most midwives expect to be employed in government run clinics, although some go abroad to find employment. At the time that the WFMC franchise was being

instituted there were approximately 100,000 midwives in the Philippines,[13] many of them un- or under-employed, giving the NGOs a large pool from which to recruit. The NGOs determined their own strategies for midwife recruitment, but all selected the midwives according to criteria that included:

- Having a license to practice midwifery;
- Being interested in owning and running a business;
- Having funds to rent or buy a clinic and to make needed renovations;
- Being located (or willing to relocate) in the geographic area of the NGO franchiser.

Selecting appropriate midwives for the franchise proved to be both difficult and of critical importance. Selecting several midwives who turned out to be "wrong" for the franchise helped the NGOs learn how to better screen applicants. Midwives who could not maintain the quality service standards, or who did not achieve revenue targets, had to be "de-selected" from the WFMC.

Dismissal or deselection of midwives was expensive for the project. The costs associated with equipping a clinic and providing instruments, linens, record forms, signs, and information, education and communication (IEC) materials (approximately $2,700) were not necessarily lost if a clinic was closed since the equipment and other items could be used by another midwife. Investments in technical assistance and training, however, which cost approximately $3,500 per midwife, could not be recovered, and were lost to the project in the majority of cases. (Several midwives who resigned from the franchise of their own volition were hired as additional staff by other WFMC midwives.)

**Both the midwives and the NGOs learned the hard way that self-employment and risk-taking were not for everybody. From being simple service providers, the midwives had to learn how to run their clinics as business concerns. Some midwives had a difficult time making this shift. Thus, there were fallouts and deselections along the way, particularly when midwives received the mandate to upgrade their clinical skills and to meet increasingly stringent physical standards for their clinics. As one NGO executive described it,**

***"Before the standards, most deselections were usually for good reasons and often by mutual agreement. But after the standards issues became so important, there was a lot of hardship. We had midwives who had invested their hard-earned money, and who did good community work…they were doing what we had asked them to. But they simply had no way to meet the standards and ultimately had to be deselected. Some really hard choices had to be made."***

**c) Franchisee investment**

Perhaps the greatest risk has been borne by midwives who bought into the franchise. Midwives who opt to join the WFMC franchise do so knowing that they will not receive a salary from the NGO franchiser or the TANGO Project, since their net income is based entirely upon their ability to run a business that generates enough revenue to cover expenses and provide an acceptable income.

[13] JSI. Evolution of the TANGO II Project (1997– 2002), Revised Final Report. July 15, 2002.

**The average investment for a midwife to open a WFMC clinic is currently $7,800.**

Midwives were required to put up their own funds to rent or purchase clinic space and to renovate the space in compliance with the WFMC standards of size, layout, water source, and toilet facilities. Under present policies, new franchisees are loaned a basic set of FP/MCH equipment, which they are allowed to keep as long as they continue to be members of the franchise in good standing. In order to provide the full range of WFMC services, however, franchisees are required to purchase additional equipment with their own funds. The cost of replacement and re-supply of equipment or supplies initially provided by the TANGO Project is borne by the midwife.

The average investment for a midwife to open a WFMC clinic is currently $7,800. Midwives who joined the franchise in the early years of the WFMC had lower levels of investment because of smaller space and layout requirements for the clinics, and they were not required to purchase supplementary equipment.

*Access to credit.* One of the constraints to recruiting otherwise qualified midwives is that many of them cannot afford the relatively large start up investment. Moreover, even successful WFMCs who wish to upgrade or expand their businesses may need access to affordable credit. Unfortunately, in the Philippines, as is the case in many countries, small businesses find it difficult to get credit at realistic rates of interest or find it impossible to access credit at all because of collateral requirements. JSI has been successful at mitigating this problem through an agreement with the Development Credit Authority of USAID Washington and USAID Manila. Under this arrangement, the Development Credit Authority provides a credit guarantee facility provided through a local bank. The local lender is the Opportunity Microfinance Bank. The national franchiser (WPFI) acts as intermediary.

*"Before I had about 12 patients a day, but now it's up to about 30. I have three staff, working on shifts—we are open 24 hours a day. I have learned how to aggressively market with pamphlets, flyers, discounts and specials. Recently my clinic has been attracting new patients from adjacent barangays who have heard about us through word of mouth. I am very proud of that."*

**2. WFMC Business Format: Services and Standards**

Among other things, the business format specifies the "core" services that are included under the WFMC brand and are available at all WFMC outlets as well as how those services are to be provided. At the outset in 1997, the franchised services emphasized family planning, but also included maternal and child health services. Client demand for additional services, midwife capability to provide other services, and the need for integrated services to generate sufficient revenue, led JSI and the NGO franchisers to expand the menu of core WFMC services and specifically to include childbirth services. All aspects of the WFMC business format are covered in the WFMC Operations Standards Manual.

WFMC clinics are owned and operated by licensed midwives and some have clinic assistants as well as community-based marketing assistants. The clinics offer

a range of reproductive health and other basic preventive services but are restricted to those services that midwives are legally authorized to provide. The midwives, clinic assistants, *hilots* (traditional birth attendants), and volunteers conduct house-to-house visits for the purpose of clinic promotion, client follow-up, and product sales. WFMC core services are as follows with optional (non-franchised) services noted:

**a) Services**

*Family Planning:* Contraceptive methods including: condoms, combined oral contraceptive pills, progestin-only pills, injectables, and IUDs. Referrals are made for lactational amenorrhea method (LAM), natural family planning (NFP), and sterilization (male and female). Counseling about the benefits of family planning, available methods, and appropriate methods for an individual client based on medical history and personal preference is provided during antenatal and postpartum check-ups, and for new and repeat family planning clients.

**The WFMC service mix has been expanded to meet client needs, improve quality, and increase clinic profitability.**

*Maternity Care:* All WFMCs provide a full range of care for pregnancy and normal delivery. Services include antenatal check-ups, labor and childbirth, and postpartum check-ups. WFMC midwives attend deliveries in their clinics and, when requested, attend home deliveries. The midwives are trained to attend normal deliveries; in the event of complications the midwives are trained and equipped to stabilize and refer. All WFMCs have back-up physicians and designated referral facilities. Tetanus toxoid immunization, iron+folate supplementation, nutrition counseling, anemia screening, breastfeeding, and family planning counseling are done during antenatal visits. Immediate postpartum care includes initiation of breastfeeding, management of hemorrhage and referral if needed. Postpartum check-ups are scheduled at six weeks.

*Women's Reproductive Health:* Services include Pap smear, pelvic and breast exam, and pregnancy testing.

**The bulk of WFMC services are provided in the clinics but the midwives do attend home deliveries if requested.**

*Infant and Child Health*: Services offered for care of newborns, infants and young children include breastfeeding counseling and management, well-baby check-ups, vitamin A supplementation starting at 6 months, and de-worming. Immunizations for childhood illness are given by the WFMC midwives at the request of DOH officials during national immunization days. The vaccines are provided by the DOH and the midwives provide the service free of charge.

*Other Services:* Midwives offer blood pressure screening, ear-piercing for infant girls, and wound care. As an optional service, the WFMCs may sell over-the-counter medicines such as analgesics and antiseptics, and other products such as bandages, sanitary napkins, soap, and toothpaste.

The addition of labor and delivery to the menu of MCH services made a significant impact on the earning potential of the clinics, and was incorporated into the list of core services offered by all WFMC franchise clinics in 2000. While providing family planning is still key, labor and delivery services command higher fees and thus have helped the midwives generate more income. With a clear demand, the profit margin for maternity services is higher than for family planning. Providing a broad range of services—some more profitable, some less so—that meet the various reproductive health needs of women, has become a fundamental part of the WFMC's business plans. Over the course of the project various services such as Pap smear and routine pelvic and breast exams have been added to the WFMC menu to better meet the needs of the client population, improve quality, and increase clinic profitability.

Since the first clinics opened in mid-1997 through the end of 2002, the WFMC franchise has provided 1,302,363 MCH services and 234,897 CYPs.

**b) WFMC Operations Standards**

When the WFMC franchise began implementation in 1997, the various NGO franchisers set the clinical standards and business practices for their franchisees. Clinical standards and guidelines were generally consistent with those of the DOH but there were some variations among the NGOs of services offered or contraceptive methods available. There also was a variety in the appearance and layout of the clinics. An assessment of the WFMC facilities and clinical practice of the midwives led to the development of the WFMC Operations Standards Manual to standardize the key aspects of each clinic across the franchise. All NGO franchisers, WFMC facilities and midwives must comply with the Operations Standards Manual, which covers:

- Clinic functions and capabilities;
- Staffing requirements;
- Qualifications, functions, and training of the midwife;
- Qualifications, functions, and training of the clinic assistant;
- Resource requirements;
- Referral procedures;
- Waste disposal and infection prevention;

**Dulce Tamayo**

Dulce Tamayo runs the Well-Family Midwife Clinic in the Krus na Ligas community in UP Diliman, and on the second anniversary of opening the clinic, held a "Buntis Party" for expectant mothers. Dulce was nervous when she faced the 25 or so pregnant women seated outside the clinic. But when she began to talk about safe motherhood and the importance of taking care of themselves as pregnant women, she became more confident. She welcomed the women, some her clients, many simply neighbors who has heard about the event, and said she was glad they were interested in learning more about the importance of health services for pregnant women.

"Pregnant women need to have their prenatal check-ups," she explained. "At the check up, a health care expert can recommend proper diet, advise against unhealthy habits, suggest vitamins, and give counseling on personal hygiene, family planning, and perinatal care.

Dulce is a Registered Midwife and manager of the clinic. A former teacher who took up midwifery, and worked in a government hospital, she eventually got married and has two children. After attending the WFMC training, Dulce initially ran a clinic with her sister in Tandang Sora before setting up her own in Krus na Ligas. With a starting capital of about P100,000, a lot of loans, and a simple marketing campaign around the area, her clinic established a stable client base after only four months. Today, Dulce has about 178 family planning clients and about 90 clients who consult her for maternal and child health services.

By the end of the Buntis Party, after laughing over the parlor games, talks on breastfeeding and family planning, and giving away products from sponsors, it started to rain. Dulce had to wrap up the party and bid her guests goodbye. That night, as with any regular night, Dulce conducted her daily routine of counseling and check-ups until 7pm. If a pregnant client went into labor that night, she would go back to her clinic and deliver the baby, whatever time it was. It's all part and parcel of being the community's neighborhood midwife.

*Adapted from an article in The Philippine Star, July 13, 2003*

- Waiting time;
- Materials for home delivery;
- List of over-the-counter drugs that can be sold in the WFMC; and,
- Clinic design requirements.

The Operations Standards Manual is complemented by the Family Planning Clinical Standards Manual and the DOH Midwives Manual on Maternal Care.

### 3. WFMC Brand Advertising and Marketing

The TANGO Project conducted a market survey in late 1996 to better define the target market and understand needs and desired services. Data from the survey were used to develop a national advertising and local public relations campaign. In the process of designing the campaign, the franchise brand was established with the name of "Well-Family Midwife Clinic," and a tag line, "Affordable Quality Health Care at Your Convenience," as well as a logo and signature colors.

To attract and keep paying clients, the WFMC midwives understood that their clinics had to offer better services than their competitors, whether other private sector providers or the public sector. To segment the market, the WFMCs had to offer convenient hours and locations, quality services with a client orientation, and clean, comfortable facilities. The WFMCs distinguished themselves from government clinics by stocking commercial brand contraceptives rather than dispensing free commodities available from the public sector. As soon as they were earning enough money, many midwives made further investments in their clinics to improve the amenities or provide more services. Some of the midwives also cultivated good relationships with staff of the local government health centers (usually a Barangay Health Center, BHC, or Rural Health Unit, RHU) that are often willing to refer clients who can pay to the WFMC.

**In a rare display of both clinical skills and entrepreneurial ability, the midwives have charted the course of the WFMCs into important role models and the most concrete symbol of the TANGO II Project. One proud midwife declared that, "*People recognize the WFMC sign and tell their friends it is a nice place. It gives us credibility that we could never get on our own.*"**

When the project started, most of the NGOs already had an established presence in the region where they sponsored WFMC midwives. Since neither the midwife nor the WFMC brand had name recognition, the name and logo of sponsoring NGOs tended to overshadow the WFMC brand. TANGO staff encouraged the NGO franchisers and midwives to undertake local clinic

promotions to make the communities aware of the clinics, and to cultivate name recognition for the franchise while the product line of the franchise was being refined.

As franchisers, the NGOs were expected to undertake advertising and marketing of the franchise. Experience has shown, however, that the NGOs do not have the capacity to develop regional—let alone national—advertising campaigns, nor are they adept at marketing their affiliated franchisee clinics. Thus, JSI has undertaken much of the responsibility for developing marketing plans, advertising campaigns and promotions—functions that will be assumed by the new national franchiser, the WPFI. While some investment has been made in media efforts at the national level, considerations of cost-effectiveness and sustainability dictated the focus on local efforts.

**NGO franchisers and midwives increase community awareness and cultivate name recognition through local clinic promotions.**

Several years ago, JSI realized that one of the major problems to franchise growth was low demand and low utilization of clinic capacity, resulting in low income and reduced financial sustainability potential. It was also noted that there was a correlation between marketing efforts and the levels of clinic utilization. In response, JSI added a marketing professional to TANGO Project staff. A strategic marketing plan was developed to improve clinic-level marketing in order to expand client loads, improve family planning performance and increase clinic profitability. Key elements of the strategic marketing plan included:

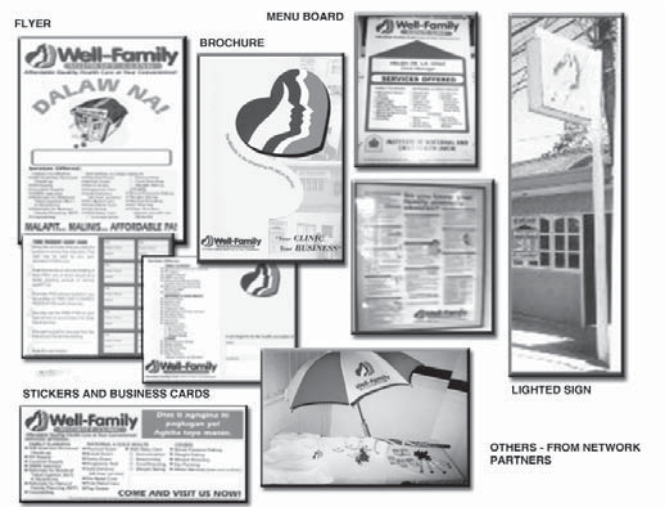
- Image building: Standardizing and upgrading exterior signage and maintenance; displaying DOH, JSI and NGO accreditation, affiliation and training certificates; displaying Local Government Unit (LGU) permits and licenses; introducing standardized clinic personnel identification tags and uniforms; introducing standardized curtains and linens with the WFMC logo; and developing, introducing and posting the midwife and WFMC Code of Ethics.

**The more entrepreneurial midwives have used creative marketing techniques to attract clients.**

- A new sales program: Establishing a client rewards and frequent user card program; packaging FP and MCH services; and fostering commercial linkages with pharmaceutical companies and institutional clients (schools, factories, etc.).

- A restructured sales force program: Recognizing high achievers by introducing The "Diamond Awards Program"; providing appropriate compensation for high achieving clinic sales representatives through a revised compensation structure; revising the old "volunteer" training program; and, recruiting and training new sales representatives with strong sales skills.

- New marketing communication tools: Developing sales materials (e.g., flyers, handbills, an omnibus WFMC poster, information leaflets and stickers); promoting public relations and publicity (e.g., press releases, giveaways and limited participation in special LGU and DOH events); and advertising (e.g., radio ads, corporate advertising support, and TV exposure).




The local clinic marketing is conducted by individual midwife franchisees; while some of these are aggressive marketers, many are not. The more entrepreneurial midwives—who are also the most successful—have used creative marketing techniques such as giving gifts or cash to clients for referring new clients to the clinic, using community marketing assistants for home visits and compensating them with commissions for recruitment of new clients and contraceptive sales, establishing contracts with local businesses and plantations to provide services to the employees and laborers, and using discounts or package pricing for multiple services. *Buntis* parties, hosted by the WFMC midwives for pregnant women, have also been a popular and successful technique to inform prospective clients about their services and attract new clients.

The WFMC brand is now widely recognized by people in the areas where the franchise is operating. This was achieved primarily through successfully implementing the "image building" interventions enumerated above.

Despite aggressive efforts to promote the WFMC brand and create brand recognition, questions remain about the actual demand created by these programs. Given the community-based nature of the WFMC clinics, the reputation of the individual midwife for personalized quality care will continue to be at least as important as marketing efforts. While marketing is essential to demand creation, it cannot substitute for a reputation for high-quality services at affordable prices.

### 4. Quality Assurance

Establishing a franchise of clinics and developing the capacity of the partners to maintain the quality of services and become financially sustainable requires numerous inputs by the donor and technical assistance agency. In addition to the WFMC Operations Standards

Manual, other tools developed by JSI for these comprehensive capacity-building tasks were developed and are being used in the clinics.

*Overview of the WFMC Quality Assurance Strategy.* Developing the franchise and protecting the brand have required substantial project investments to establish quality assurance mechanisms. The strategy for developing and maintaining a high level of quality assurance uses inter-related components and uniform standards. This QA strategy includes:

- Clinical and business training;
- Clinic rehabilitation and set up;
- Clinical backup and referral mechanisms,
- Reference materials, supervision;
- Deselection of midwives who chronically under-perform; and,
- The "WFMC Diamond Awards " recognition program.

These elements are reinforced by the individual franchisee business plans, as well as a comprehensive, evidence-based, monitoring system. The components of the WFMC QA strategy are summarized below.

**a) Clinical and Business Training**

Midwifery education in the Philippines includes didactic instruction in family planning but no practicum to develop clinical skills. In order to prepare the WFMC midwives for this essential service component, all midwives must attend and pass training sessions for Basic/ Comprehensive Family Planning, Family Planning Counseling, Interpersonal Communication Skills and Ambulatory Health Facility Management. Training in I.V. Insertion and Suturing of Perineal Laceration is also compulsory and provided by a hospital accredited by the Department of Health. With the exception of Ambulatory Health Facility Management, which is conducted by JSI, all clinical training is conducted by two of the NGOs that have extensive experience and capability in family planning training.

**All midwives must attend a competency-based Practicum to develop clinical skills**

For the WFMC franchise to be successful, the NGOs and the midwives also needed improved business skills. Training for NGO supervisors and managers included business and marketing to improve their own management skills and ability and to help them provide better support to the midwives. To support clinic-level business planning, TANGO staff developed business and management skills training designed specifically to meet the needs of the midwives as


**Flordeliza Raymundo**

Midwife Flordeliza Raymundo started a Well-Family Midwife Clinic in May 1996. Her first clinic was located in San Miguel Poblacion. She rented the space for P700 per month while her monthly income was about P8,000, much higher than the P3,500 she earned as a Clinical Instructor at the Dr. Yanga School of Midwifery.

In 2001, the WFMCs needed to upgrade their facilities. For Flordeliza, the prospect of expanding and renovating was an overwhelming challenge. She did not want to take the risk and was afraid of not being able to pay the rent or sustaining her operating expenses. However, according to Flordeliza, "JSI and my NGO have given me the needed 'encouragement' to believe in what I am doing."

Flordeliza moved into a bigger location, in front of the Marilao municipal office. At first she was hesitant about the location because she was afraid the city officials would oversee her activities. After again being given the needed encouragement, and understanding that her business operation was completely legal, she found that there was no reason to be afraid. Flordeliza has continued her operations, giving her best to her clients, and now earns about P30,000 per month—one month she even reached P50,000!

Because she is satisfied with the way things worked out for her, Flordeliza is planning to save up to buy her own lot in her native Marilao to put up another WFMC. Her advice to newcomers is to work hard, be dedicated and loyal to your work, and have lots of "tiyaga" (patience).

small business owners. Business planning and management, marketing, and costing and pricing services are included in the training.

**b) Clinic Rehabilitation and Set Up**

As the major contribution of the franchisee to her new business, midwives are required to provide the physical facility and meet the detailed standards for space, layout, hygiene, and color scheme specified by the franchise. The midwife must also purchase or lease equipment and instruments for MCH services. The franchiser provides the signage and, as noted earlier, the basic equipment, supplies, and instruments for family planning. The equipment and instruments are loaned to the midwife, and must be returned if she leaves the franchise.

### c) Clinical Backup and Referrals

All WFMC midwives have agreements with at least one, and in many cases two, physicians who provide backup in an emergency or for referral for case management outside the midwife's expertise or authorized function. Some of the WFMC midwives invite the physicians to spend several hours in the clinic on a given day for consultations on difficult cases. Having the physicians on-site on a periodic basis broadens the range of services available at the WFMC, thereby improving overall quality.

**Backup physicians broaden the range of services available through the WFMC, thus improving the ability of the clinic to meet a population's needs.**

Referral procedures are included in the WFMC Operations Standards Manual. All WFMC midwives identify appropriate facilities to handle emergency cases or services that cannot be provided in the WFMC such as voluntary surgical contraception (VSC) or necessary laboratory tests.

### d) Reference Materials

A complete set of technical, financial, administrative and other reference manuals and guides is provided to the midwife upon satisfactory completion of the training course. These materials also include forms for taking client histories, maintaining services information, supply management, referrals, and for financial management reporting. These manuals, guides and forms mirror the topics taught in the course, and are kept in the clinic.

### e) The Supervisory System

Working with the NGOs, JSI staff designed and implemented a system for supervisory support for monitoring quality, sustainability, marketing, and problem solving. The TANGO Project has Project Coordinators and Marketing Field Coordinators who work closely with the NGO supervisors and often make supervision visits together. The clinics are directly supervised by the NGO area franchisers. All NGOs have trained field supervisors who visit the clinics regularly to review business performance, recording and reporting, adherence to QA standards, and also assist in local marketing and promotional activities. The results of these supervision visits are included in the NGO quarterly reports submitted to JSI. In addition to these visits, the NGOs also conduct periodic meetings with the midwives and hold annual performance reviews. JSI staff also conduct periodic visits to the clinics for validation of reports and provision of technical assistance.

### f) Midwife Attrition

From the outset, the standards for midwives to join the franchise were set high. It also became clear that the standards to stay in the franchise had to be high. Thus, in addition to selection criteria, TANGO staff and the NGO franchisers established "deselection" procedures.

Inevitably, some midwives were not well suited to owning a small business or working on their own in compliance with franchise standards. In most cases, "de-selection" was done only after various remedial efforts were tried and failed. Three main reasons for deselection included failure to:

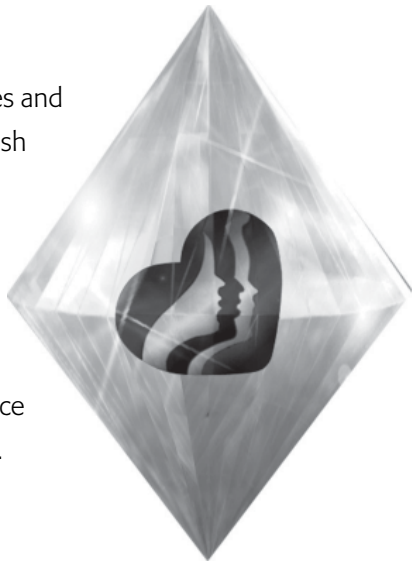
- Generate adequate income to sustain a clinic;
- Meet quality standards; and,
- Comply with reporting requirements and meeting attendance.

In order for the clinics to be sustainable they have to generate revenue and profit based on volume of sales (i.e., family planning and MCH services). If a midwife doesn't "sell" enough services, she doesn't make a profit. If she doesn't make a profit it is unlikely that she will be able to maintain the WFMC quality standards for clinic infrastructure and clinical practice, let alone stay in business. Thus, to protect the WFMC brand and ensure sustainability, a midwife who consistently fails to meet the performance requirements is deselected by the NGO franchiser.

Some of the midwives who were unsuccessful at meeting performance goals lacked the personal attributes to own and run a clinic. There were others, however, who were dedicated and ambitious but whose clinics were located in neighborhoods where there was not a sufficient population base that could afford to pay for services. This was more of a problem early in the project, before the NGOs had fully understood the necessity of attracting paying clients as the only way for a WFMC to become sustainable. These clinics were closed and the midwives relocated in neighborhoods accessible to C – D clients. In a number of cases, midwives decided to drop out on their own.

From 1997 through 2002, the total attrition rate for midwife franchisees (voluntary and involuntary dropouts) has been high, at about 46% of all midwives/clinics enrolled. Although this high attrition rate is regrettable and costly, JSI believes it essential to retain only those midwives with the capabilities and commitment to contribute to a successful franchise. Fortunately, as selection of midwives and support from the NGO franchisers improved with experience, the attrition rate has declined appreciably. Of clinics opened in 1997 and 1998, 68% subsequently closed; in 1999 the attrition dropped to 46%; in 2000 and 2001 only 20% of newly opened clinics were closed; and of clinics opened in 2002 less than 4% have closed.

### g) Recognition: The WFMC Diamond Awards for Excellence



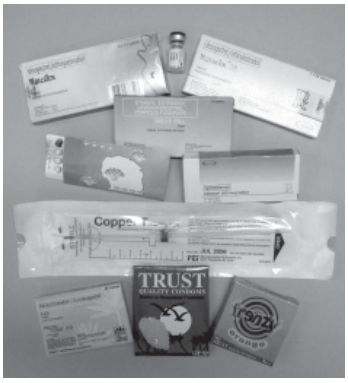
To motivate graduated midwives to continue providing quality family planning services and to strive for excellence, the TANGO Project instituted the WFMC Diamond Awards. Cash awards are given for excellence in patient care, family planning initiatives, leadership, business management, and collaborative activities for family planning advocacy and service. A trust fund will be set up to sustain the awards program following the end of the TANGO Project. JSI staff are negotiating with several private sponsors who are interested in underwriting the awards. Recognizing and rewarding outstanding performance and maintaining quality standards will help protect the WFMC brand once the midwives are no longer under the constant supervision of the NGO franchisers.

### 5. Competitive and Cost-effective Commodities Procurement

During the initial years of the WFMC franchise, the Department of Health gave the midwives free or subsidized contraceptives that they were legally required to provide to clients for free or at the subsidized price. These were the same commodities that the government clinics were providing free of charge, however, thus creating competition for clients with the same products at a different price. Moreover, using the government brands inhibited the WFMC clinics from creating their own niche and quality image.

**Using commercial brands reinforces market segmentation and strengthens the franchise's image as a private sector entity.**

Recognizing these problems, the NGO franchisers were encouraged to procure commercial contraceptives at discounted bulk prices that the midwives could sell at a profit. In addition to contributing to clinic revenue, use of commercial brands reinforced market segmentation and strengthened the franchise's image as a private sector entity. With the exception of the IUD, all contraceptives now available from WFMC clinics are commercial brands. IUDs are still received from DOH stocks because there is no commercial brand available in the Philippines that is affordable for C – D clients. Midwives charge for the service of IUD insertion or removal but not for the device itself.




Despite switching to commercial brands that offer their clients a wider selection of methods with better "shelf appeal" (packaging), WFMC midwives still face competition from government facilities and social marketing activities that offer free or subsidized commodities to those who can afford to pay. These unnecessary public subsidies undermine the policies of the DOH to shift consumers who can pay for commodities to the private sector. To supplement the commercial brands, the project recently concluded an agreement with the DKT social marketing group to supply WFMC clinics with commercial brands of injectables, condoms and contraceptive pills at wholesale prices.

USAID is planning to discontinue donations of contraceptives to the Philippines, and the Government of the Philippines seems unlikely to procure contraceptives given the opposition to family planning by political and religious groups. Developing and implementing an effective contraceptive security strategy will be essential to address the commodity needs of low-income consumers who will not have the ability to plan their families if existing low-priced commercial brands disappear from the market.

## Lessons Learned about the Business Framework

a) Designing and implementing the business dimensions of a social franchising project is a major challenge. Institutionalizing the business dimensions of the model includes the costing and pricing of services, location of clinics, target group analysis and marketing, selection of the franchiser and franchisees, and the financial relationship between the franchiser and franchisees.

b) The loan of basic equipment for start up has proven to be a good investment and a good approach. Access to commercial loans is essential to clinic start up and for expansion. By contrast, JSI believes that project-funded cash loans for clinic start up are not a prudent investment of donor resources, given TANGO's earlier problems with repayment. In addition, such loans might contravene the policies of some donors.

c) The payment of royalty fees to the regional NGO franchisers has been a hit or miss proposition for most of the WFMC franchise project. During start up, and before franchiser sustainability became a crucial issue, it seemed most important to focus on other dimensions of the model. As the end of donor support becomes more imminent, however, JSI is now focusing on this aspect of the business model. Based on this more recent experience, JSI has now developed some guidelines on how to proceed. These include:

    - Ensuring the regular payment of franchisee royalties requires a sensible balance of valued services from the franchiser, as well as strong sanctions for the chronic failure to pay. Undue emphasis on sanctions, however, will lead to unacceptable franchisee attrition rates. Even when both of the above mechanisms are done well, effecting regular and timely payments of royalty fees is difficult.

- After struggling to find the right basis for royalty fees, the new national franchiser—WPFI—will seek to base the fee primarily on childbirth deliveries, a high demand and high profit margin service.

d) Marketing.

Most social franchising schemes will need to focus on local and perhaps regional marketing, since concentrating at this level is more cost effective and more financially and managerially sustainable than national level marketing.

Increasing demand for WFMC services and achieving high utilization levels in the clinics are chronic problems that require aggressive, ongoing marketing and advertising, primarily at the local level.

e) Competition from free or subsidized government services is a major challenge, despite efforts to segment the market. The best approaches for minimizing the impact of public sector services is to maximize access for target populations, provide superior quality services, conduct aggressive marketing, and offer competitive pricing with the other competition.

## Laying the Foundation for Sustainability: Financial and Non-Financial

### 1) Financial sustainability

Achieving financial sustainability for the franchisees, the NGO franchisers, and for the WFMC franchise as a whole, has been a central objective of the TANGO Project from the beginning.

JSI believed that financial sustainability was a realistic goal for both the NGO franchisers *and* the franchisees. Experience has shown, however, that achieving financial sustainability for the franchisers is much more elusive than for clinic franchisees. The monthly "royalty fee" paid by the franchisees to the NGOs is inadequate to cover the costs of supervision, monitoring and other franchise services. This problem has been exacerbated by the inability of some franchisers to collect royalty fees on a regular basis, due in part to their franchisees' dissatisfaction with the services provided by the franchisers, and also due to the reluctance

of the franchisees to part with their hard-earned money. That the NGO franchisers have not been able to achieve financial sustainability, despite subsidies from the TANGO Project, is of particular concern for the new national franchiser, the WPFI, which will assume the franchiser responsibilities of JSI and the NGOs in 2004 with little, if any, assurance of future donor funding. In response to this challenge, the WPFI is using the experience of the NGOs to implement cost containment measures. In addition, WPFI is not relying solely on royalty fees, but is looking to other sources of revenue to support its operations.

In addition to the financial sustainability of the national franchiser, there are two other elements of franchise sustainability that will need to be addressed:

- The organizational sustainability of the WPFI; and,
- The willingness and ability of the franchise to continue to provide low-demand and low-profit preventive services, such as family planning when USAID no longer supports the franchise.

The latter dimension of sustainability will be addressed in the final chapter of this monograph. The present section on financial sustainability will focus on the sustainability of the franchisee clinics.

*"Earlier, it was sometimes hard to charge enough, especially when we knew that our patients were not that well off. But now I have learned how to do it tactfully, and I explain it from the first visit. I tell the new patient: "look, this is a nice clinic, much nicer than government clinics. But it costs me money – I am a businesswoman as well as a midwife. The fee is reasonable, and I'm sure you will get your money's worth. I will always be here to serve you and your family."*

**By offering an option to those who can pay for basic health services, the WFMC in effect complements the public health system by unburdening it of a significant number of clients, and enables government to save precious resources which can be used to provide for the needs of those who truly cannot afford to pay.**

**a) Franchisee revenue**

From the outset of the franchise, the WFMC midwives were expected to charge prices that covered the cost of services plus a margin of profit. By the end of 2002, 89.7% of clinics reported a monthly operating profit. Of these, 123 reported a total annual operating profit of Pesos (P)25,000 or more, while over 140 clinics are generating annual gross revenues of over P100,000. Net profit tends to run at about 48% of gross revenues. These results are particularly encouraging, given that 27% (54) of the clinics were opened only in 2002.

With the exception of midwives who were inappropriately located in poor neighborhoods, or who did not have the aptitude to run a business, many midwives quickly earned enough to expand their clinics by adding labor and delivery services and to hire additional staff. Nevertheless, there are wide disparities in earnings and profitability among the midwives that reflect, in part, the time that the different clinics have been functioning.

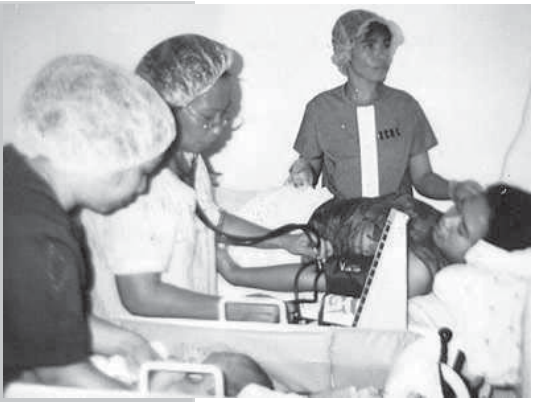
To put these income figures in perspective, a senior midwife working for the government earns between P6,000 and P14,000 per month—with most paid at

the lower end of this scale. It should be noted, however, that as government employees, public sector midwives invest no capital, take no risk, and can expect at least a modest retirement as part of their remuneration package.

For most of the WFMC midwives, their monthly earnings have been sufficient to cover their operating expenses and recover their initial investment. Indeed, the majority of midwives have made additional investments in their clinics, either to meet upgraded WFMC standards, or to make improvements to better serve their clients.

Many, but not yet all, WFMC midwives have benefited financially from their investment. As of the end of 2003, 57% of the 124 graduated clinics had achieved financial sustainability. Nearly all of the remaining clinics that have not yet achieved financial sustainability are expected to do so by the end of 2004.

**Marilyn Bermejo**



Within two years of having her own WFMC, Marilyn Bermejo has felt a significant change in her life. She feels fulfilled that she is able to practice all that she has learned in school and in her previous work; that she is able to help a lot of people. She has the respect and support of the people in her community who are so satisfied with her services that they give her recommendations and referrals. She is happy that she is able to earn enough without having to go abroad, where she worked for many years before the WFMC opportunity arose. She is able to help her community and be with her family at the same time.

Marilyn's daily activities include seeing anywhere from 10-15 clients a day, which translates to an average monthly income of P75,000 to 80,000. She considers herself a success because she was able to move from being an employee with a take home pay of P3,000 to her present situation where she is her own boss and can manage her time and resources as she sees fit. Her finances have never been better!

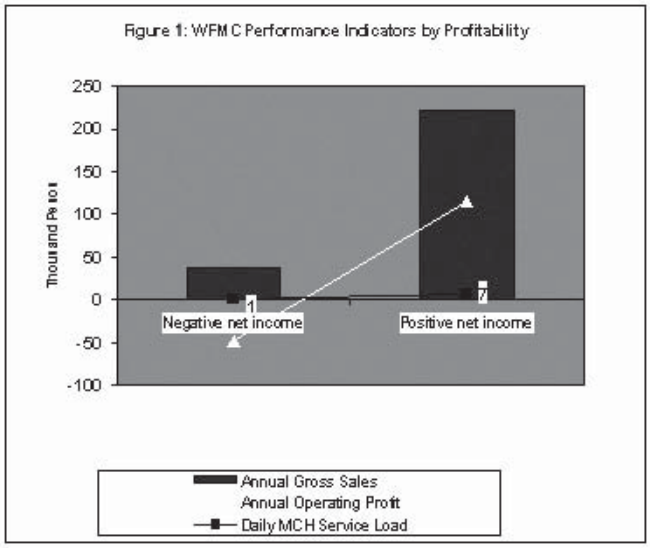
*Leveraging.* An important benefit of successful social franchising schemes is their ability to use donor assistance and public sector subsidies (such as free or subsidized commodities) to leverage private sector resources. The total income earned between 1997 and 2002 by the WFMC franchise was approximately P190 million (US$3.7 million). By the end of the project in 2004, it is estimated that WFMC revenues will total at least P312 million (US$6 million). This means that a large number of public services have been provided to the working poor on a largely self-financing basis. Even better, the public sector investment in

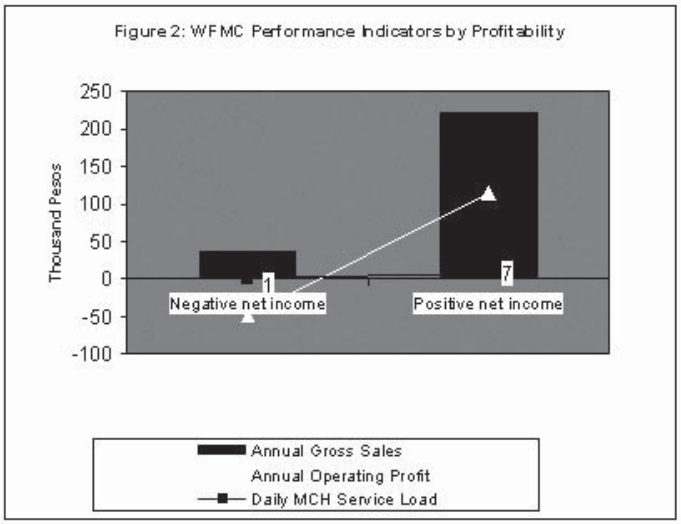
this scheme will continue to be amortized far beyond the end of the project as the services continue without additional public investment.

### b) Demand and Underutilization of Clinics

Despite the achievements noted above, the majority of WFMC franchisees are underutilized. A study conducted in 2002 showed that the number of daily client visits varies widely throughout the franchise, from a low of one client to a high of 57 per day; with an average of six visits per day.

Classifying WFMCs by sales and profitability outcomes provides interesting insights to their daily sales volume, as shown in **Figure 1** and **Figure 2**, below.



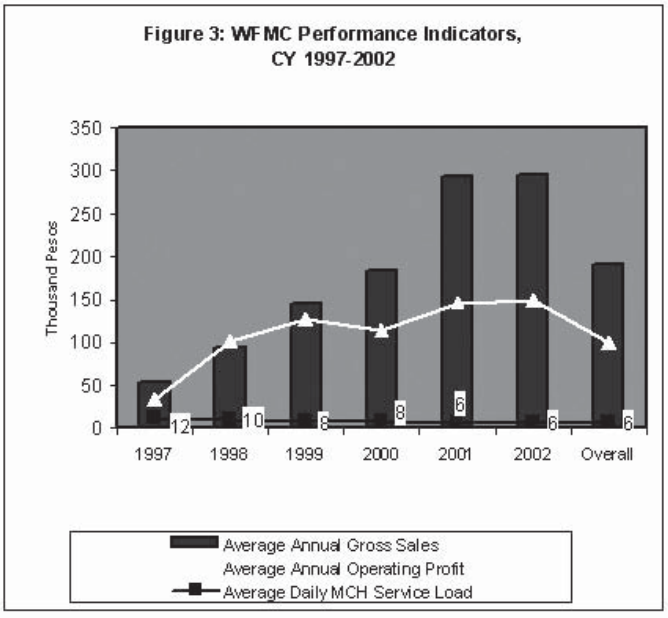



Two-fifths of WFMCs have monthly gross sales incomes of P10,000 and below, while more than half (53 percent) earn more than P10,000 per month in gross sales. **Figure 1** shows that by monthly sales category, an increase in daily MCH load leads to increases in gross sales income and operating incomes, with midwives earning monthly gross sales of P5,000 and below performing the lowest number of MCH services (two MCH services per day), while those earning more than P40,000 per month provided the highest MCH levels (17 MCH services per day).

In terms of profitability outcome, about 80 percent of WFMC midwives netted positive operating incomes, while only eight percent incurred losses. Those who presented positive operating outcomes have an average daily MCH service load of seven. On the other hand WFMC midwives who reported losses, performed an average of one MCH per day.

These two figures provide different perspectives on daily MCH service load. When WFMC midwives' MCH level is situated against their sales categories, it appears that six is the average daily MCH for midwives grossing P10,000 to P20,000 in monthly sales. These sales and MCH service levels represent minimum levels for more than half of WFMCs. Furthermore, relating MCH service levels to profitability outcomes indicates that about 80 percent of WFMC midwives have profitably utilized their clinic operations by performing an average of seven MCH services per day. Though not evident in the two figures presented above, MCH services comprise a host of services from pre-natal and post-natal services and well-baby care to clinic delivery or birthing services and immunization. This broad range of services carry varying service charges resulting in varying sales and profit outcomes.

The effect of such heterogeneity of MCH services offered by WFMC midwives is seen in **Figure 3**, which presents trends in WFMCs performance for the period 1997-2002, in terms of daily MCH service load, annual gross sales, and annual operating profit. The Figure shows that WFMC midwives' gross sales and operating income enjoyed a steady increase (except for operating income in 2000), despite declining MCH service load. Underlying this result is the conclusion that WFMC midwives' financial performance is not so much a result of MCH sales volume per se. Instead, the increases in sales and operating income are more likely the result of the fact that most WFMC midwives have provided a large number of high-



ticket, high-profit MCH services, particularly, birthing services, which increasingly account for their profitability.

As a caveat, it should be noted that aside from critical MCH sales volume in excess of operating expense, WFMC clinic utilization should also be evaluated in terms of a clinic's overall "carrying capacity," taking into consideration limits on clinic facilities and equipment, labor, clinic operating hours and adherence to quality of care standards.

Clearly, as a general rule, improvements in clinic utilization will translate directly into improved profitability of the clinics, and will improve their prospects for long-term sustainability.

**c) Costing and pricing practices**

In a commercial franchise the franchiser normally sets the prices for products and services based on market analysis and the cost of inputs. JSI and the NGO franchisers intentionally played fairly minor roles in setting the prices charged by the WFMC franchisees. As a result, there is wide variation in the price charged for the same service. Some of the variation is normal and reflects the geographic location of the franchisees. Although the midwives understand the importance of factoring in the cost of a service into the price charged for the service, they needed better information about what consumers in the catchment area are willing to pay, and about competitor prices. They also needed to be able to assess whether the prices charged for their services would generate sufficient revenue to cover their operating costs and enable them to become financially sustainable.

To respond to this need, in 2001 a financial sustainability and investment study was conducted. This study determined the minimum monthly income a midwife must earn to cover all fixed and variable operating costs, capital costs, taxes, loan interest. It also assessed the costs of the technical support services provided by the NGO franchisers that would eventually be the responsibility of the midwife to pay, rather than the project. The study allows the midwives to assess the cost of services and determine which services contribute positively or negatively to clinic operations. JSI has developed a tool to allow midwives and others to conduct such analyses.

*Profitable services.* Data collected from WFMCs in five geographic areas showed that childbirth deliveries in the clinic had the highest profit margins, followed by home delivery, Pap smear, IUD insertion, and IUD removal. In the national capital region (Metro Manila), in 2000, revenue from deliveries represented over 53% of total clinic revenues. A similar result is found in regions VII (Cebu and Central Visayas) and XII (Central Mindanao). The majority of

clinics perform 18-87 deliveries per year, for an overall average of 61 deliveries per midwife. The fee for deliveries ranges from P3000 to P5000.[14]

*Low-profit or unprofitable services.* Among family planning services, only DMPA injection and IUD insertion and removal generated a profit. Given the relatively low demand for IUDs in most locations, however, in practice IUD insertions are not an important source of revenues. It is interesting to note that, although condom and pill dispensing are a source of repeat business, they still do not contribute significantly to clinic income. On average, family planning services account for only 5%-7% of the total revenues of the WFMC clinics. Indeed, condom and pill dispensing have negative profit margins in some locations.[15]

"Bundling" or service packages were introduced in 2001 as a way to stimulate family planning use and increase the profitability of family planning services, as well as to meet multiple reproductive health needs of WFMC clients. Typically, WFMC midwives now offer family planning in a package price covering antenatal, delivery and postnatal care, for example. Or family planning and a Pap smear may be offered together. Although data are not available from the MIS to show the effect of such package pricing on family planning use, several midwives attributed increased family planning use to the service packages.[16]

It has become increasingly evident that childbirth deliveries have proved to be key for increasing the monthly gross earnings of the midwives. This realization has led to an increased emphasis on this service, as well as a re-thinking about how franchisee royalty fees are to be calculated. Suffice it to say that the inevitable differentials in profit margin between the low-demand preventive services, and the high-demand services, threaten to undermine the sustainability of the former over time.

**d) The effect of commodity costs**

The source of supplies and commodities, and whether they are purchased or donated, determine subsequent charges and profitability. There is no IUD commercially available at a cost that is affordable to the C – D clients of the WFMC franchise. For this reason, IUDs are provided free to the WFMC franchise by the DOH. WFMC midwives charge a fee for IUD insertion service but not for the device itself. Other contraceptives dispensed by WFMC

[14]Cost-Based Pricing Study on WFMC Services. TANGO II Project. July – August 2000.

[15] Cost-Based Pricing Study on WFMC Services. TANGO II Project. July – August 2000.

[16] Interviews with WFMC midwives by Barbara Jones in January 2003.

midwives are commercially purchased either directly by the midwife or by the NGO franchiser at a discounted bulk price. Condom and pill dispensing can contribute positively to WFMC income if some mark-up is added, although in practice, WFMCs are obliged to keep the price slightly below that charged in pharmacies.

**Bundling services in a package not only meets the RH needs of clients, but increases family planning use and profitability as well.**

**e) Willingness to pay**

A survey conducted in 2000 calculated the prices that WFMC clients were willing to pay for specific family planning and MCH products and services. The survey found that clients are willing to pay for amenities in the clinics as well, such as increased privacy, more comfortable waiting rooms, and air conditioning. The survey results showed that prices being charged for maternity services were as high as the market would bear. Family planning services and products were a different story; consumers reported that they could and would pay more for family planning than the WFMC midwives were charging.

To validate the study findings, additional research was conducted to determine the utilization of products and services in response to the price increases; to gain insight into the price-setting behavior of the service providers and role of the NGOs in setting prices; and to determine the implications of a more effective pricing policy.

Many midwives selected for the validation study were reluctant to increase their prices for fear of losing clients or because they didn't understand the price guidelines recommended for the study. Regarding the effects of price increases on demand, the study found:

| | |
|---|---|
| No effect on number of clients in: | 27 clinics (52.0%) |
| Decreased number of clients in: | 4 clinics ( 7.5%) |
| Increased number of clients in: | 17 clinics (33.0%) |
| No answer/not applicable: | 4 clinics ( 7.5%) |

Although the study showed that midwives could increase their prices for most services, the findings also indicated the numerous factors the midwives consider when they set their prices. Based on the results of this Willingness to Pay study, JSI recommended a price range with a minimum and maximum price per service for the various geographic areas rather than establishing standardized prices. The study showed that while price increases could increase clinic revenue, increasing the number of clients is a more effective way to increase revenue.

It is interesting to compare the experience of the WFMC franchise with the pricing strategies of franchise schemes in other countries. In 1991, the Green Star network in Pakistan sought to increase financial sustainability by raising the price of condoms; sales plummeted as a result.[17] PROSALUD in Bolivia, which provides family planning services free of charge but collects fees for curative services, has tried to improve the financial sustainability of the network by creating more demand and increasing the volume of services rather than increasing prices.[18] These various examples illustrate that the price elasticity of health and family planning services is quite sensitive for consumers with limited resources.

**f) NGO financial sustainability**

The NGO franchisers have had considerably less success in achieving operating viability or financial sustainability as a result of their participation in the WFMC franchise. Multiple strategies were employed to address NGO sustainability, which included improving institutional management, instituting business planning, and diversifying revenue streams. With the assistance of TANGO staff, many of the NGOs made considerable progress in streamlining and improving the efficiency of management functions, decentralizing operations, reducing excess staff and payrolls, and making more effective use of less expensive non-medical staff for supervision—all of which contributed to reducing operating costs and maximizing profit. The benefits of improved efficiency and more skillful management are not confined to the WFMC franchise but apply to all program activities of the NGOs.

Since the WFMC is now shifting to a national franchiser arrangement, the role of the NGOs as area franchisers will inevitably undergo major changes as a result.

**2) The sustainability of low-profit public health services.**

This is a fundamental issue that goes to the heart of decisions about adopting a more social or a more commercially oriented agenda for new social franchise programs. Some lessons learned about this issue in the context of the WFMC franchise include those offered below. The Conclusions section of this monograph will return to this issue.

**The benefits of improved efficiency and more skillful management are not confined to the WFMC franchise but have been realized by all NGO program activities.**

[17] McBride, Julia, Rehana Ahmed. Social Franchising as a Strategy for Expanding Access to Reproductive Health Services. Commercial Market Strategies Project. September 2001. Page 20.

[18] Cuellar, Carlos J., William Newbrander, Gail Price. Extending Access to Health Care Through Public-Private Partnerships: The PROSALUD Experience. Management Sciences for Health. Boston, MA. 2000.

- A major issue with using the private sector to deliver health services will be how to sustain the low-profit public health service, which lie at the heart of most social agendas, when donor funding expires. This dilemma will persist whether the model leans more toward social goals or more towards commercial ones. Maintaining these low-profit services may prove impossible with private sector providers in the absence of some form of continuing public incentives.

- In theory, the key to providing the largest possible volume of low-profit services, while maintaining good cost recovery, is to "bundle" these services with higher margin services, and market these as a "package." This approach has not been evaluated and documented, so the effectiveness in practice has not been demonstrated.

# POLICY-PROGRAMMATIC CONCLUSIONS, AND RECOMMENDATIONS

The WFMC franchise experience in the Philippines, together with limited information about other social franchising schemes, permits some conclusions and recommendations. As with the rest of this monograph, these conclusions and recommendations are drawn primarily with donors, policymakers, and program managers in mind. This Conclusions section uses a question and answer format, reflecting key issues to consider when seeking to understand, or to contemplate investment in, social franchising schemes for health.

## Policy and Programmatic Conclusions

The Well-Family Midwife Clinic franchise and other social franchises and networks raise a number of policy and programmatic issues, some of which can be addressed by the experience to date while others require further investigation. What was the WFMC initiative able to demonstrate with regard to certain key policy issues? These questions are addressed here.

### 1) Is it possible to maintain a workable *balance between the social agenda and the commercial agenda* in social franchising schemes?

This question may not be applicable to all social franchising schemes. Most social franchises operating today have downplayed the commercial agenda in favor of the social agenda. Each agenda has its own trade-offs that the donor, government, technical support agency, and franchiser must address and decide on during the design process.

Those schemes that focus on the social agenda should be much easier to design and implement than those that favor the commercial interests, or which try to seek a balance. The trade off will be, of course, that schemes heavily oriented toward the social agenda:

a) May require greater levels of public subsidy. That is because the franchisees may be less cost-effective service providers, in the absence of significant cost recovery goals.

b) May be less motivated and effective providers of services, in an atmosphere which downplays cost recovery, and which may reduce emphasis on an entrepreneurial mind

set and owner-operator self interest. There is some evidence from the U.S. and other industrial countries that, in employee-owned businesses, worker productivity is higher and the proportion of firms expected to continue through the next five years is higher.[19] There appears to be no comparable data for developing countries.

c) Have less need to struggle with the myriad dimensions of the business model, given their isolation from "the market."

d) Will be able to operate only so long as the subsidies last.

The schemes that tilt toward the commercial agenda, while seeking a balance between these two poles, may be more difficult to design and create, due primarily to the need for ambitious business plans. More importantly, such schemes are more likely, in the long run, to focus primarily on profitable services.

**What does a social-commercial balance look like?** Achieving and maintaining a balance between the *social agenda* and the *commercial agenda* means being able to continue to provide essential, low cost services to the working poor, and maintain an acceptable level of cost recovery and profitability (with or without public subsidies). As noted repeatedly, achieving and maintaining such a balance will be difficult. Despite this, we feel that—with care and attention—such a balance is possible, particularly where the public sector is able to subsidize those services and target groups not easily affordable in a fully financially sustainable social franchising scheme. The implications of imbalances in either direction may be summarized in the following lessons learned from JSI's experience in the Philippines:

- A primary or narrow focus on low-profit services (which includes most Primary Health Care services)—that is on social goals—results in low clinic utilization and inadequate income for the clinic owner.

- A primary focus on cost recovery and financial sustainability—that is, on commercial goals—makes it difficult or impossible to maintain the low-profit (social agenda) services, or to serve the poorest quintile, especially when donor support stops.

- A primary focus on those who cannot pay for services automatically means that the public sector has to pay most or all of the costs, and thus, financial sustainability cannot be a goal.

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[19] Marc Bendick, and Mary Lou Egan. "Worker Ownership and Participation Enhances Economic Development in Low-Opportunity Communities." Journal of Community Practice. Vol. 2 (1) 1995.

## 2) Is social franchising a good investment for public health program donors?

From the standpoint of investing public funds, the principal questions the policymaker must address are whether the private sector can provide a service that contributes to public health goals, and, if so, whether it can provide that service more cost effectively than the public sector. Issues which policymakers should address before investing public funds might include whether:

- The services to be franchised will contribute sufficiently to national public health goals (i.e., whether the services are needed and insufficiently provided to merit or justify the investment and risk).
- The target population for these goods should be eligible for public subsidies.
- The social franchising scheme can provide services as cost-effectively as alternative investments of public funds, including, particularly, the public sector itself.
- The Social franchising scheme permits the leveraging of significant private sector resources as part of the donor's "return on investment".

### Other Investment Considerations:

a) **The cost-effectiveness of franchise services versus alternative systems.** As noted, this is a key issue for determining the attractiveness of investing in franchise schemes. Unfortunately, at this point, there is no data with which to compare the unit costs of WFMC services with either the public sector or other private providers. These data will be gathered over the next year, and will be included in a second edition of this monograph.

b) **Goals.** Another investment consideration revolves around the financial sustainability goals of the donor and the proposed social franchising scheme. Whether a scheme is or is not financially sustainable is less important than the health problems it is designed to address, and the level of impact the scheme is likely to have. Social franchising schemes that rate positively on all or most of the above considerations are probably good investments of public funds, whether financially sustainable or not. The same is true of related schemes such as those that use social marketing techniques to distribute public health products.

**Thus, all things being equal, financial sustainability-oriented schemes are preferable to schemes that operate only as long as the public subsidy lasts. Unfortunately, all things and all social franchising schemes are never equal, and all social franchising designs involve trade-offs.**

The principal financial difference between sustainable versus non-sustainable schemes is that the former:

- Enable the source of the subsidies—the donor—to completely or largely cut off funding at some point, permitting the funds saved to be used for other purposes;
- Are less subject to termination or debilitating cutbacks resulting from economic downturns, shifting priorities, or donor fatigue;
- Continue to amortize the public investments long after the donor subsidies have been withdrawn, in effect increasing the donor's return on investment over time.

Thus, all things being equal, financial sustainability-oriented schemes are financially preferable as an investment to schemes that operate only as long as the public subsidy lasts. Unfortunately, all things and all social franchising schemes are never equal. As we have shown, all social franchising designs involve trade-offs.

c) **The public side of public-private partnerships.** A final and seldom considered dimension of these partnerships is the effect they have on the public sector. It is not enough simply to have the private sector keep its part of the bargain. The other side of the equation is the role of the host government under which a social franchise functions. The following questions should be considered when designing a social franchising scheme with the potential for large-scale operations, if for no other reason than to begin to get the DOH to look ahead. These dimensions revolve around whether and how well the public health system is able to take advantage of the benefits that the private sector offers. For example, is the DOH able to:

- Define its health goals well enough to identify needs and opportunities for investments in social franchising (or other private sector partnerships) schemes which can have the desired impact on public health goals, especially for the poor and underserved?
- Work with the private sector in a way that does not undermine its role of safety net provider to the medically indigent (that is by not competing with the private sector for clients who can pay)?
- Take advantage of the added service/product provider network to rationalize its own services delivery system and realize the cost savings?

- Move toward policies that enable and strengthen the ability of the private sector to act as an effective partner (e.g., through incentives, setting realistic standards, facilitating access to drugs and facilities in a constructive way)?

As we know, private providers will have little influence on the behavior of the public health sector in these areas. It is therefore important that the donors and multilateral health agencies seek to work with host governments to facilitate the most constructive behavior possible.

**3) How much does it cost to set up and/or subsidize a social franchising scheme, and what are the main variables affecting the cost?**

**In the first 7.5 years of the WFMC initiative, donors spent on average $4,082 to "graduate" a clinic. In addition, midwives franchisees spent an average of $7,800 each to open a clinic.**

Since data from other social franchising schemes are not available, the response to this question will focus on the WFMC experience in the Philippines.

Unfortunately, there is no simple answer to this question, given the large number of variables involved. The total donor input for setting up the WFMC franchise from early 1995 to 2003 —a 7½ year period—was $10.761million. This includes the costs of technical assistance and project management, setting up 203 new clinics, and initiating the establishment of a new national level franchiser organization. This comes to an average of about $ 4,082 to "graduate" a franchisee clinic. This amount includes the costs of inputs to the franchisee and to the NGO (and now national) franchisers, as well as all TA, training, management/ administrative, and advertising costs. Between 1997 and 2002, the cost per year to graduate a clinic varied from $ 3,077 to $5,225. Much of the variance is explained by the number of new-clinic startups in a given year, the resources now going into setting up the new national franchiser, the intensity of the marketing effort, and significant changes in the exchange rate.

It is anticipated that this cost will decrease as the initial start-up activities are completed. There are two major cost categories of the total donor investment in this project: Subsidies to the franchise, and one-time start up costs.

a) Subsidies to the franchise (WFMCs, NGOs, and the WPFI). This includes all direct support to these entities: equipment loans, salary and recurring cost/overhead support, grants, meetings. These subsidies came to $2.27 million, or 21% of the 7½ year total project cost.

b) "One-time start up costs." These are the costs to establish the franchise. They include: TA, training, monitoring and evaluation, initial brand creation, marketing and advertising, all survey and design work. Also included are the systems development work, such as:

setting and implementing standards and quality assurance systems, as well as the development of and training in WFMC reference materials, logistics, costing and pricing. The costs of operating the JSI office, direct and indirect costs are also included. All professional salaries and consultant inputs are (and are treated as) TA costs. These inputs constitute the remaining 79% of project funds, or $ 8.491 million.

The rationale for this allocation of costs is that, in a full-scale program, these costs will be supported by the increased revenue from a larger number of franchise WFMC clinics, and an on-going program won't have the one-time set-up costs.

Offsetting these investments are the leveraging of franchisee co-investment, and the amortization of the public sector subsidy. The franchisee investment in setting up a new clinic averages about P390k, or $7,800. Using this figure, the approximately 220 clinics which will be fully operational by end-of-project will have leveraged $ 1.72 million from these private sector providers.

In addition, the clinics have earned a substantial income. From 1996 to the end of the project, the clinics will have generated well over $6 million in revenues. Conservatively, assuming an income per clinic of between $7,000 and $8,000, the clinics will be earning a total of about $1.8 million per year, an income that will continue and grow as the clinic practices grow.

The major variables affecting the size of the public sector investment typically include:

- Whether the franchise was created from scratch—as in the Philippines—or was simply added-on to an existing set of private sector providers, an existing organization which could assume the role of national franchiser at a lower cost.
- The range and complexity of the services provided. It is reasonable to assume that creating the capacity to provide more and more complex high-quality services will require more time and money to create and maintain than those that offer fewer services.
- The cost recovery potential.
- The cost of equipment, and commodities.
- The other costs of operating in a given country or location.

- Service utilization. Although essential to have a health impact, more clients mean more cost, unless there is an offsetting cost recovery.

- The ability to minimize costs of franchiser functions, and to generate royalties to defray such costs.

**4) How effective are social franchising schemes? Can they provide large numbers of high-quality services to designated target groups?**

The answer to this question, most certainly, is yes. For example;

- The Green Star Program in Pakistan claims to have generated 935,000 Couple Years of Protection (CYP) over a six-year period through its thousands of providers, with 10 million client visits per year in 40 cities and towns.

- The PROSALUD Program in Bolivia provides a range of reproductive health and other services through its 33 clinics and one hospital to about half a million clients a year—accounting for 13% of the urban population of the country.

- The JANANI Program in Bihar, India provides basic services to a very large rural population through thousands of local providers and referral centers.

Between 1997 and the end of 2002, the WFMC franchise provided nearly 235,000 CYP and 1.3 million MCH services. By the end of the TANGO Project, the 220 clinics will be providing annually at least 36,000 CYP and 272,000 MCH services. These numbers should almost double when the WFMC franchise reaches its planned level of 385 clinics. Thus, even smaller social franchising schemes can meet local populations' needs with a substantial range of RH services. Moreover, all well-designed schemes will have the potential to expand to much larger scale operations.

These programs attest to the potential of social franchising schemes to work on a large scale, in terms of the numbers of services provided and the number of beneficiaries.

Factors affecting effectiveness

**a) Maximizing access.** Given the enormous variation in populations in rural versus urban catchment areas, the clinic location may have the greatest impact on the effectiveness of the franchise. Obviously, the ability to provide large numbers of services is all about maximizing access for large numbers of the target populations. As we have noted

elsewhere, all things being equal, the easiest and quickest way to create service delivery outlets is—where possible—to add services to pre-existing providers.

b) **Delivering high-quality services.** There could be a correlation between achieving and maintaining high-quality services and the range and complexity of the services provided. While it is possible for social franchising schemes to maintain high-quality services, even complex ones and on a large scale, more complex services present a greater challenge. These more ambitious services translate into higher costs to set up and will exact a higher recurring cost to the providers. On the other hand, such services may have greater cost recovery potential.

c) **Maximizing demand.** As noted earlier, for many—or perhaps most—social franchising schemes, achieving high and continuing levels of demand will require a well-designed and aggressively implemented marketing effort.

**The designers of social franchising schemes cannot simultaneously demand only low-margin services *and* expect significant cost recovery—or even high levels of demand and utilization.**

### 5) What kind of health services are best suited to social franchising schemes?

On the face of it, in any country with a reasonably well-developed private health sector, there should be little if any hindrance to social franchising schemes providing virtually any health service that the public sector is willing to subsidize. Just because social franchising schemes have so far focused almost exclusively on primary health services does not mean that they could not take on far more ambitious tasks. PROSALUD in Bolivia offers a broad range of curative and preventive services, and the WFMC franchise provides increasingly large numbers of safe delivery services. In addition, an international group is now laying out the design of a pilot social franchising-based scheme capable of managing the full range of tubercolosis (TB) services as well as anti-retroviral (ARV) services for HIV/AIDS patients.

The primary issue here (perhaps the only issue?) is the degree to which the sponsor of the social franchising scheme intends to pursue the commercial agenda—particularly issues surrounding cost recovery and financial sustainability of the franchise. As noted throughout this study, the designers of social franchising schemes cannot simultaneously demand only low-margin services *and* expect significant cost recovery, or even—in the face of competition from government outlets—high levels of demand and utilization. Where the public sector is willing to subsidize all or nearly all the costs of providing a service, a large choice of health services should be feasible in countries with a reasonably well-developed private health sector.

Even where the social franchising scheme is able to provide a mix of high- and low-profit margin services, the franchise will need to engage in clever bundling and marketing of

service packages in order to achieve significant utilization of these services, and remain profitable. JSI learned with the WFMC franchise, for example, that there was a large unmet demand for childbirth services, and that this was a high-profit service. By adding this service to the marketing effort, and bundling low-profit FP and immunization services into a package, the WFMC franchise was able to add substantially to its net income.

The other alternative is to cross-subsidize, helping to pay for unprofitable services via income from profitable ones. Although there has been much talk about cross-subsidization of low-profit services over the years, the documentation of cases where this has actually taken place is fairly scarce. One scheme that is said to use this approach is PROSALUD.

### 6) How long after start up do social franchising schemes need in order to "graduate" and become sustainable?

a) At the franchisee level

There are two levels of financial performance at the WFMC level; operating profit and financial sustainability.

- **Operating profit** is the amount of income earned (or revenues), net of operating costs. This is monitored quarterly to ensure that the midwife receives sufficient profit to cover her living expenses as well as operating expenses.
- **Financial sustainability** is the achievement of sufficient income to recover capital expenditures (for fixed assets and set-up investments).

Many of the latter costs were funded by the TANGO Project. Given their variability, TANGO does not include the midwife's income in calculating a clinic's operating costs—the major concern is only that this amount covers her expected minimum living expenses.

The average time required for a WFMC to achieve financial sustainability after commencing full operations is about 25 months, with about one-third reaching sustainability in under 24 months, and about one-third reaching that level only after 60 or more months. Of the currently operating clinics, 124 of the 203 clinics (61%) achieved financial sustainability—that is they have fully recovered their capital and recurring operating expenses. Given that 53 of the 203 current clinics (26%) opened only in 2002, this financial performance is gratifying.

**124 of the 203 currently-open clinics (61%) have achieved financial sustainability.**

**Given that 53 of the 203 clinics (26%) opened only in 2002, this financial performance is gratifying.**

The franchise "graduates" a midwife and her clinic after two years, regardless of whether the clinic is financially sustainable. During this two-year period, the midwife and her clinic

will have received the full complement of project support, equipment, training, marketing, MIS.

b) At the franchiser level

JSI has had concerns about the financial sustainability of the NGO franchisers almost from the outset of the project. Although the model has now shifted to a national franchiser approach, this has done little to settle these concerns. At the time of mandatory graduation of the WFMC franchise (at the end of the TANGO Project—end of 2004), financial analysis forecasts that the 220 clinics operating at that time will probably not produce sufficient income to keep the WPFI financially viable. According to that study, the break-even point for WPFI is approximately 385 clinics. Even with rapid growth, this number of clinics will not be achieved for one or two years after graduation. JSI will work with USAID and WPFI staff to seek bridge funding for this hiatus period.

Finances aside, following the full implementation of the JSI-assisted capacity building program, which will require about 18-24 months, the WFMC national franchiser will be able to assume its full responsibilities.

The authors lack information on how or whether the other major social franchising schemes graduate franchisees or franchisers.

### 7) How important is marketing and branding for sustainability and effectiveness?

The WFMC demonstrates that branding can create increase demand.

a) Local-area marketing is cost effective for a relatively small network of providers. National or even regional marketing is much more expensive and it is harder to determine the cost effectiveness of such large scale marketing.

b) There has been a measurable correlation between promotional schemes and demand/ utilization at the clinic level.

c) So far, it is not established whether WFMC brand recognition by clients is sufficiently strong to provide an inducement for the franchisees to pay their royalties and abide by franchise standards and other obligations. Even if the brand acts to increase and maintain demand, it is not automatic that the franchisees will recognize this link strongly enough so that it provides an inducement to remain in the franchise. After all, franchisees may believe (and may be right in believing) that the reputation of the individual midwife is the more influential factor in demand creation. The implication is that the franchiser

may be less attractive, and less able to generate royalties and maintain standards, if this potential incentive—branding—appears not to be significant.

### 8) Is it possible for a franchise to maintain a high level of quality services?

Yes. A common problem of working with health care providers in the private sector is the lack of mechanisms to achieve and maintain high-quality services. The experience of the WFMC—like that of other social franchising schemes—indicates that a franchise is an effective approach for assuring quality for the following reasons:

a) Applicants must meet specified requirements for joining the franchise and remaining a member in good standing. This may include completion of targeted training courses that may not be included in pre-service education and exams and continuing education requirements in addition to those needed for national licensure.

b) The franchise can establish compulsory operating and performance standards.

c) Franchisees are subject to periodic supervision and monitoring by the franchiser to verify adherence to standards and can be sanctioned, even dismissed from the franchise, for failure to comply.

The TANGO Project put considerable effort into creating a culture of quality for the WFMC franchise. Franchisees recognize that their clients expect and are willing to pay for a level of quality that is generally not available in public facilities. A menu of core services, required training, standardized layout of clinics, reference materials including technical standards available in all clinics, back-up support from physicians, periodic supervisory visits, and meetings with other franchisees all serve to reinforce provider competence.

Because USAID prioritized family planning services, considerable attention has been paid to ensuring their quality. Other services, such as antenatal and maternity care that are covered in-depth during pre-service midwifery education, have received less attention during the Project. Thus, beginning late 2003, the Project is undertaking a review of all WFMC clinical services and quality assurance mechanisms. Based on this evaluation, standards will be revised to comply with international recommendations, training updates will be organized, and ways to institutionalize quality assurance systems by the WPFI will be considered, as needed.

### 9) What has been learned about setting up a franchise?

While the lessons summarized below only reflect what has been learned from the WFMC franchise, JSI believes that they are likely to be widely applicable.

a) Technical assistance to and supervision of geographically dispersed clinics is difficult and expensive.

b) Technical assistance, marketing, and supervision skills—especially those related to commercial areas of a franchise—are hard to transfer to a novice franchiser, or to contract out.

c) Elaborate training activities are not cost-effective. During the initial NGO Strengthening Project, JSI implemented a rather elaborate and expensive training program for franchisees and franchiser NGOs as well. We learned that it is more cost effective to offer fewer, shorter courses, followed by refresher and on-the-job training.

d) Securing donor funding for the relatively long period needed to achieve effectiveness, quality, sustainability, and other project goals may be difficult. Few donors have programming horizons that exceed five years, while establishing a successful franchise can easily take longer. By the end of the TANGO Project, it will have taken 8 years (and over $10 million) to design, establish, and institutionalize the WFMC franchise. Even then, the new national franchiser—WPFI—will not be fully institutionalized. Perhaps three sets of factors were most influential in determining how much time was needed to bring the franchise to maturity. These include:

    - The need to create the model, tools, and methods from scratch;
    - The need to create the franchise from the ground up, rather than to use pre-established providers—the WFM clinics were created from scratch; and,
    - The belated realization that a national franchiser would eventually be needed in lieu of the NGO area franchisers.

It may be possible to shorten this gestation period as models are tested, lessons learned are disseminated, and tools and methods are shared. For this to happen, however, the quality of documentation and level of dissemination now extant in international public health will have to undergo a major change.

e) If the experience to date with the WFMC national franchiser—which is less than one year old at this writing—is any predictor, establishing a single, national level franchiser, with the human and financial resources required for managing a complex network of clinics, is likely to be a difficult, costly, and labor-intensive task.

f) The cost and reliability of commodity supplies has important implications for franchise success. While commercial brands may cost the WFMCs more, the supply line is reliable, and such commodities help to differentiate the WFMCs from government services. The advantages and disadvantages of donated commodities are, of course, the reverse.

g) WFMC has demonstrated that the franchise model can set and maintain quality standards in the private sector. What is less clear is whether the franchiser will be able to maintain these standards when the donor funding ends. This challenge will be especially acute where the services provided under the auspices of the franchise comprise only one part of the providers' services.

h) Identifying, accessing, adapting, and using *existing* tools and methods for managing a franchise has proven difficult and would be even more difficult for nascent social franchising schemes. This is because these models and information are widely scattered around the globe, because so far they have operated in relative isolation from each other, because few public health schemes are well documented or disseminated, and because there is no global entity currently acting as a repository and source of information.

## Recommendations

On the basis of only a single example—the WFMC franchise—the authors understand that making assertive recommendations would be rash. Nevertheless, some conclusions can be drawn from this and other experiences which do, in our judgement, permit putting the following ideas forward.

### General Recommendations

a) Despite the challenges, policymakers and program managers can feel some confidence that RH services provided through the private sector can achieve significant cost recovery. This is most likely to happen if:

- High-profit as well as low-profit margin services are provided,
- Services respond to consumer demand, and,
- Services are perceived to be of better quality than free or lower-cost services provided by public sector.

b) Donors should work with and encourage host governments to concentrate on serving the needs of the most economically disadvantaged. Clients who can afford to pay for primary care should be encouraged to utilize services available in the private sector, as long as the latter can serve their needs.

c) Public resources can and should be used to underwrite start-up or recurring costs for private sector services if those services contribute to the achievement of public health objectives at lower cost or more effectively than the public sector.

d) Interested donors and host governments should look into the possible benefits of social franchising approaches for the countries and services which they are interested in, where the basic conditions for successful social franchising schemes appear to be present. This should include the potential of these schemes to provide services not heretofore provided, such as TB and ARV drugs for those infected with HIV.

## Recommendations with Special Regard to Donor Investment Decisions and Project Design

a) When possible, seek out already functioning providers and potential franchiser organization, rather than create both components of the franchise from the ground up. This will likely be less and take less time.

b) Focus on establishing and sustaining priority, low-margin health services, which will become vulnerable at the end of the donor intervention.

c) Address the issue of market segmentation between the franchise and public providers. Learn about it, try to work with the government to make needed adjustments, and seek access and marketing mechanisms that will facilitate such segmentation.

d) Although it is necessary to work with the government policy-provider system, the franchise should be careful to avoid relying on the government for the most essential delivery or support services. If government support ends, the franchise could easily crumble.

e) From the outset, seek to define the social franchising model clearly, particularly including:

- Issues of what problem the franchise is intended to solve and for whom;
- Objectives;
- Targets;
- Time-frame; and,
- Indicators to be used.

This will be especially crucial in franchises, where the franchise-based services constitute only part of the total services offered—that is in a so called "fractional franchise."

f) Also from the outset, define and negotiate among all parties the business aspects of the model, including: services to be provided, quality standards to be met, income expectations, royalties due, costing and pricing, and the services or perquisites to be provided by the franchiser to the franchisees.

g) Plan for, create, and maintain high levels of clinic demand and utilization. Conduct local marketing and ensure high quality of care, good access, and competitive prices.

h) The donor should expect to provide inputs and effort long enough to have the desired impact, or reach the desired scale. The original design must be realistic about this.

i) The desired ultimate scale of the program should be planned for realistically in the original design. Most pilot projects never achieve scale because the issue is often not treated as a goal or as a strategic issue from the outset.

j) Pre-investment assessments by donors should carefully judge whether the pre-conditions for a franchise are present. These should include an assessment of at least the following pre-conditions:

- A supply of trained and capable service providers (preferably already in private practice) willing to become owner-operator franchisees;
- An organization, preferably local, which has or could develop the capacity to play the role of national franchiser;
- A sufficient population of potential, under-served C-D consumers to sustain clinics located in higher density urban and peri-urban areas;
- A capable (local or international) source of technical inputs to provide start up assistance;
- The possibility of avoiding excessive competition from the public providers for the same clients and same services;
- A "return" on the donor's investment which is attractive; and,
- An assured supply of commodities at an acceptable price cost to the donor, provider, and client.

# LIST OF ACRONYMS

| | |
|---|---|
| ARV | Anti-retroviral |
| CPR | Contraceptive Prevalence Rate |
| CYP | Couple Years of Protection |
| DOH | Department Of Health |
| FP | Family Planning |
| HIV | Human Immuno-deficiency Virus |
| HIV/AIDS | Human Immuno-deficiency Virus/ Acquired Immune Deficiency Syndrome |
| IEC | Information, Education, and Communications |
| IMCCSDI | Integrated Maternal and Child Care Services Development, Inc. |
| IMCH | Institute of Maternal and Child Health |
| IUD | Intra Uterine Device |
| JSI | John Snow, Inc. |
| LGU | Local Government Unit |
| MCH | Maternal and Child Health |
| MIS | Management Information System |
| NGO | Non Government Organization |
| PBPM | Performance-Based Payment Mechanism |
| PHC | Primary Health Care |
| PSI | Population Services International |
| QA | Quality Assurance |

| | |
|---|---|
| TANGO | Technical Assistance for the conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non Government Organizations |
| TB | Tuberculosis Bacilli |
| USAID | United States Agency for International Development |
| WFMC | Well-Family Midwife Clinic |
| WHO | World Health Organization |
| WPFI | Well-Family Midwife Clinic Partnerships Foundation, Inc. |

# ANNEX

# LIST OF TANGO II STUDIES, TOOLS, METHODS

## Studies / Surveys

1. Center for Economic Policy Research. 2000. "Cost-based Pricing Study on WFMC Services." A study to identify and determine relevant costs and expenses incurred by the WFMCs as a business enterprise, and to come up with a benchmark pricing schedule for WFMCs that incorporates both costs of clinic services as well as reasonable profit margin.

2. Center for Economic Policy Research. 2000. "Further Analysis of the Findings of the Cost-based Pricing Study on WFMC Services." Taking off from the "Cost-based Pricing Study", this study attempted to: (a) validate the aggregate impact of individual service profits determined in the earlier study; (b) present and analyze the actual dynamics of service mix, charges, and costs at the business enterprise level; (c) analyze the time utilization of WFMCs in terms of total time spent for service delivery vis-à-vis idle time, and service mix; and (d) identify number and type of FP services rendered per income classification of WFMCs.

3. Henderson, Clarence. 2002. "Evolution of the TANGO II Project." The story of the TANGO II Project from a donor-funded project that gave birth to the midwife-run Well-Family Midwife Clinics (WFMCs), to a franchise that will be managed by the WFMC Partnerships Foundation, Inc. (WPFI) who has taken over from JSI/RTI.

4. Espiritu et al. 2001. "Investment Analysis Study for the WFMCs." A study to determine the levels of operation, and quantitative benchmarks that will enable the clinics to attain operating and financial viability, thereby establishing the key financial success factors of a prototype WFMC and determining the potential of a clinic as an attractive investment proposition for the private sector.

5. Cabegin, Emily Christi A. et al. 2001. "Willingness to Pay for WFMC Services in the Philippines." The study estimates WFMC clients' willingness to pay for specific clinic services, and willingness to pay for amenities in midwife clinics including increased privacy, more comfortable waiting rooms, and air conditioning.

## Tools / Methods / Manuals

1. Que, Margaret O. and G. Dolorfino. 2001. "Cost Price Framework for NGO Service Packages." Tools and methodologies for cost and price analysis and computation, primarily designed to allow NGOs to continue providing the required support services to the clinics, and at the same time, generate revenue from the delivery of these services to the WFMCs.

2. JSI Research and Training Institute, Inc. (Philippines). 2000. "Handbook on WFMC Bookkeeping." Provides instructions on how to go about the various bookkeeping tasks as recording of income and expenses, recognizing expenses incurred in carrying out clinic operations, accounting and control procedures and the use of the Clinic Expense Book, and preparing the Clinic Monthly Performance Report.

3. JSI Research and Training Institute, Inc. (Philippines) and E. Canela. 2000. "Rapid Market Appraisal Manual for WFMC Prospective Franchise Holders." A business planning tool that would allow the midwife-entrepreneur to assess potential market areas, prospective clients and other such elements as demand information, supply, products and services among other things.

4. JSI Research and Training Institute, Inc. (Philippines). 2000. "Reporting and Monitoring Systems (modified) Manual." Includes the following topics, with sample forms and instructions on how to use the forms: (a) Recording and reporting processes; (b) WFMC-Records and Reports; (c) NGO- Records and Reports; (d) Field monitoring procedures, which are discussed extensively.

5. JSI Research and Training Institute (Philippines) and E. Canela. 2000. The Business Planning Manual: Materials and Handouts. This manual has three (3) parts, one each for its three audiences: (a) midwives; (b) trainers; and (c) NGO staff. Provides the methodology and steps in putting a business plan together, designed to allow for an understanding of the vital role of a business plan in the expansion and growth of the WFMC.

6. JSI Research and Training Institute (Philippines) and E. Canela. 2001. WFMC Growing Your Business Manual. Provides a system that a midwife can follow to allow her to better communicate and sell the WFMC services and in the process, increase the clinic's clients, consequently increasing the prospect of success of the WFMC.

7. JSI Research and Training Institute (Philippines) and J. J. Roces. 2000. WFMC Client Relations Manual for the WFMC Midwife. Imparts valuable information about the behavior patterns of customers, outlines the necessary processes to ensure the provision of excellent client relations and provides checklists that are easy to follow.

8. JSI Research and Training Institute, Inc. (Philippines). 2000. WFMC Operations Standards Manual. A reference book on the requirements and standards of the WFMC that covers: (1) functions; (2) capabilities; (3) staffing; (4) referral; (5) training; (6) basic resource requirements; (7) qualifications; (8) functions & tasks of trained assistants; (9) clinic hours; and (10) waiting time. Has three (3) parts: (a) standards for the FP clinic; (b) standards for the MCH clinic; and (c) list of materials for home delivery, Over-The-Counter (OTC) drugs, functional design requirements for the various rooms of the clinic.

9. Roces, Jose Jesus F. 2000. "WFMC Strategic Marketing Plan." Basically an action plan and map that outlines the different activities, steps or planned approach that the WFMC should take to gain a foothold in the health care market, directed at achieving improved gross revenue, which is critical to ensuring financial sustainability and the CYP performance through a more balanced Family Planning-Maternal and Child Health product mix.

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