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Title **HIV antiretroviral therapy: can franchising expand coverage?**

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Abbreviations

ART	Antiretroviral therapy (used here synonymously with HAART)
ARV	Antiretroviral drug
FHI	Family Health International
FP	Family Planning
HLSP	Health and Life Sciences Partnership
MSF	Médecins Sans Frontières
MTCT	Mother-to-child transmission of HIV
NAC	National AIDS commission or agency
NAP	National AIDS programme
NGO	Non-state organisation (not for profit, or for profit)
PCR	Polymerase chain reaction (test for HIV RNA or DNA)
PMTCT	Prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Plan or Paper
PSI	Population Services International
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SWAp	Sector-wide approach or programme (SWAP)
TB DOTS	WHO recommended strategy for TB [update: WHO/HTM/STB 2006]
VCT	Voluntary counselling and testing

1. Background

WHO estimates that 6 million people “urgently need antiretroviral therapy in developing countries” and targeted the delivery of antiretroviral therapy (ART) and related services for HIV/AIDS to 3 million by the end of 2005 [WHO 2003a]. By that date, however, only 1.3 million people were receiving therapy in developing and middle income countries [WHO 2006a]. Moreover, it has been suggested that 6 million may be a significant under-estimate, and that more like 12 million people may be in need now [England 2006a]. This is based on estimates of how many people actually fall within WHO recommendations for initiating first-line ART regimens in adults and adolescents ie. those with Stage IV symptoms or CD4+ T-cell counts < 200 cells/mm³ [WHO 2003b]. In fact, evidence is growing to support the initiation of ART at higher levels of immunological suppression than those currently recommended by WHO:

- before serious co-morbidities develop and where, typically in poorer countries, coverage of treatment for co-morbidities may be lacking [ART-LINC 2006], and
- to maximise the chances for CD4+ T-cell count to return to near normal levels [Keruly 2006].

Provision of ART by the public sector alone is not reaching even the 6 million figure, and is not likely to. Public sectors suffer from serious and worsening shortages and maldistribution of staff [WHO 2006b], and from chronic organisational weaknesses including poor management, labour rigidities, a lack of incentives and poor accountability. The result is that for many of Africa’s poor, and perhaps for the majority, the public health infrastructure is unavailable, difficult to access or severely understaffed by qualified providers.

Meanwhile, the private sector is growing in many, if not all, countries. There are often more health care providers in private sectors than public – although many may not be qualified – and they often have spare capacity. It is common to find 20% of doctors working exclusively in the private sector. In Nigeria, 78% of doctors and 25% of nurses work in the private sector [Jefferys 2004]. Moreover, many health workers work in both sectors. Total expenditures on health are now greater in private than public sectors in most poor countries, even for the poor. The lowest income quintile receives more of its health care services directly from the private sector than do higher income groups [Gwatkin 2000; Prata 2005]. For many of the poor, the choice of care is often not so much a choice between private and public, but between private and no care at all.

It is clear that the private sector offers huge potential to extend and maintain ART coverage. But the quality of care in private sectors is often low, and the challenge is to ensure that private providers achieve acceptable standards as well as coverage. Franchising may offer a way of achieving this in practice, thus maximising the prospects for universal access to HIV and AIDS services and associated prevention. This paper reviews the experiences of franchising and discusses the opportunities and implications for governments and donors of franchising for HIV and AIDS services.

2. What Is Franchising?

[Readers familiar with franchising in the health sector can skip to section 3]

Franchising aims to increase the supply of an established product or service by contracting a number of independent retailers in different localities to offer those products or services to consumers. It also aims to raise demand by allowing those retailers to sell an established brand.

In practice in health care, this means that private providers (franchisees) are contracted by a franchisor to offer consumers specified health care services (sometimes in conjunction with specified products) to specified standards and usually at specified prices. At the same time, the franchisor contracts to procure and provide a specified combination of training, drugs, commodities, advertising or branding and other support to the franchisees.

Franchisees participate because they gain access to a combination of drugs, training, laboratories, branding and referral networks that they can only have through the franchise. These inputs enhance their services and generate income that otherwise would not be available to them. If franchisees do not comply with franchise standards, they risk the loss of this income. Franchises can be purely commercial or more social in their motivation, both aiming to leverage the incentives of the private sector to increase the distribution of services and products, but with social franchising more concerned with improving access to, and quality of, services with public health benefits.

The success of franchising relies on advantages of branding, economies of scale and a balance of economic incentives between franchisor and franchisee. By harnessing the infrastructure, capital, human resources and incentives already available in the private sector, franchising offers the potential for more rapid and extensive coverage than would be possible by an organisation owning and running services itself. In poorer countries where most care is provided by private providers anyway (individual doctors, nurses, pharmacists, other formal and informal health workers, and shop and stall owners), franchising appears to offer a powerful way of improving the quality of services available.

Franchises are sometimes termed 'full' or 'fractional'. In a full franchise, franchisees are restricted to supplying products provided by the franchisor; in a fractional franchise they are allowed to stock and sell other products as well. Early franchises in the health sector provided products and services for family planning, and were little different from social marketing in many ways. More recently, franchises have included provision of primary care services and drugs. Annex 1 provides information on a number of franchises.

[For further discussion of franchising and other relevant private sector mechanisms, see HLSP 2004]

3. Does Franchising Work?

3.1 Evaluations and evidence

A number of reviews indicate that franchising can assure quality and coverage in a range of situations [Smith 2002; McBride and Ahmed 2001; Montagu 2002; Yamamoto 2003]. Annex 1 summarises what is known about the performance of a number of franchises for which some basic information is available.

The lack of external evaluations of operating franchises makes it impossible to draw firm conclusions about the cost effectiveness of this model for services delivery. We know that franchises have succeeded in extending service coverage and raising

quality whilst maintaining prices affordable to many consumers including many poorer consumers. But we do not know whether franchising has been the best way of achieving this given certain circumstances or whether other mechanisms would have produced more with comparable inputs.

We know more about the efficiency of conventional contracting arrangements under which non-state service providers are contracted with public finance to provide a specified range and quantity of services. There is no doubt that these can achieve value for money as well as extending services beyond those provided by governments [England 2004]. A recent review of evaluations of contracting examples where each satisfied basic criteria of measurement before and after, or against controls, indicates that contracting arrangements can work on a large scale, can be more cost effective than equivalent government services, and can reach poorer consumers [Loevinsohn 2005]. Another significant advantage of contracting is the speed with which coverage can be achieved by contracted NGO service providers. In Afghanistan, in less than three years, contracted NGOs are covering 75% of the population with basic health services.

The franchises reviewed in Annex 1 suggest the following.

3.2 Quality

Many franchises have been able to:

- achieve quality improvements in services and products over those available from government services and the un-organised private sector
- make services available to many more people
- increase the range of services offered, particularly in SRH
- raise continually the quality of their providers and attract growing numbers of consumers
- score well in consumer satisfaction surveys.

3.3 Costs, financing and sustainability

Most examples of social franchising have had high start up costs and received support from donors. Much of this support has funded setting up the franchisor. Unit cost data for services delivered is rare, difficult to compare with controls (eg. government equivalent services) and difficult to differentiate from the costs of the larger social marketing contexts from which franchises often originate. What little data we have appears to show that unit costs fall with the age of a programme, the level of diversification of the programme (number of products or services being sold) and the size of the population. So the lowest unit costs are seen in more mature programmes with a diversified portfolio of products and services, and serving larger populations (usually in large countries).

The franchises reviewed cover a wide range of circumstances affecting costs including:

- the degree of pressure on them to be self financing versus the degree of donor support
- the degree to which any inputs are provided free or subsidised (eg. family planning commodities)
- the size of the operation and the relative cost advantage obtained through bulk purchase of inputs passed on to franchisees.

Franchises will always struggle with the balance between financial sustainability and serving lower income groups (see section 3.4 below).

3.4 Scale, coverage and equity

Franchise operations have achieved a significant scale and coverage with services, often reaching populations with little choice of modern contraceptive methods, for example. Many have achieved rapid growth since start up. But how equitable they are depends on a number of factors. Without external subsidy, a franchise must balance its services and prices to at least break even financially. The natural tendency will be to serve income groups that can pay, and this means that franchising may not be able to serve really poor areas. A franchise may be able to achieve an internal cross subsidisation to cover some of the poorest consumers, but this cannot be a large part of its operations.

However, if ongoing external funding can be provided, then franchising may be an effective vehicle for targeting subsidies to poorer consumers. Demand side incentives, such as voucher schemes, may offer one way of doing this. Supply side support could be through subsidies to individual franchisees, or to finance the overhead costs and administration of the franchise system. The former risks creating perverse incentives for false reporting of numbers served or services delivered. The latter is less likely to skew incentives and cause dependence that could inhibit sustainability. Supporting the improvement of a centralised laboratory or referral service available to the franchise can also avoid perverse incentives. Similarly, supply side support could fund the initial extension of services into poorer areas, followed up with a voucher system to ensure access for the poorest.

3.5 External impacts

Impact on the public and other private providers

There is little evidence of how franchising has affected the public or non-franchised private sector, primarily because of the difficulty and expense of conducting baseline and follow-up comparison surveys. Anecdotal evidence exists that social franchise operations may cause competing private providers to improve quality and/or reduce prices. There are obviously dangers of introducing subsidised services and products into markets well served by private providers, but this is not usually the case for the poor for whom quality and affordability remain key issues.

Impact on government expenditure frameworks and relevance to PRSPs

To date, franchising has been conducted largely in relative isolation from governments. The most common model has been that of a non-profit NGO as franchisor, and for-profit entities (small clinics, individual health workers, pharmacies or shops) as franchisees. But franchising has the potential to allow government to expand healthcare provision using for-profit providers, and without the need for the high infrastructure costs required for direct governmental provision of care. India and, more recently, Pakistan are beginning to explore this potential.

3.6 Summary

Some very successful, long-established franchises indicate that this form of contracting can work well. But many franchises are relatively new and have not been evaluated at all. Practice does appear to support the theoretical advantages of franchising based on the balance of incentives outlined in section 2. Much depends on the motivation of the franchisor and/or on the ability of any aid funding agency to influence motivation. Table 1 summarises the characteristics of franchises and compares them with those typically found in government services.

Table 1: Potential advantages of franchises over government services:

	Franchised services	Government services
Quality		
incentives for quality	strong incentive for franchisees to attract and satisfy consumers - balanced by standards imposed by franchisor ¹	no incentive to attract and satisfy consumers; typically little quality control
staff capacity	spare capacity and often located in areas of high need where public services don't reach ²	staff shortages
Training and supervision	essential to maintain market – for franchisor and franchisee ³	less incentive and often neglected
Cost		
investment required to expand coverage	maximises use of existing private workers and infrastructure already providing some services ⁴	requires investment in new services and locations
efficiency	incentives to run an efficient organisation ^{5, 6}	not accountable for outputs, only inputs / expenditure
Scale / coverage		
	able to cover large numbers of consumers ⁷	able to cover large numbers of consumers subject to investment and staffing constraints
Equity		
	depends on subsidy to reach the poorest; can be self financing for non-poor consumers ⁸	based on total subsidy unless user fees are charged

Footnotes to Table 1:

¹ The greater the benefits to franchisees (income), the stronger the position of the franchisor to enforce standards.

² May include pre-existing community groups as franchisees. In Kenya, CFW has tapped into established church organisations to help find motivated entrepreneurs who are well respected by their communities. This could prove especially useful for ART patient support (and TB DOTs).

³ Where necessary to support the service provided, the franchisee should be able to tap into a referral system or other supporting service that provides supervision and a higher level of care.

⁴ Not such an advantage if there are few well-positioned retail outlets.

⁵ Including economies of scale that can be passed on to the retail outlet, thus increasing franchisee income and incentive to enter and remain in the franchise.

⁶ There are risks that franchisees will over-provide but see note ¹ above. Requires adequate marketing to ensure consumer awareness and trust in the product or service.

⁷ Subject to franchisor management experience to operate the network and to implement quality assurance programmes as operations expand.

⁸ Depends absolutely on sufficient consumers willing and able to pay enough to keep the franchise in business; this is greater for curative products/services, and creative ways need to be found to integrate prevention services.

4. Specific Issues with ART

This section summarises the principle technical issues of delivering ART. Section 5 looks at the possible implications of these issues for delivery through franchises. The issues of delivering ART are addressed under the following headings:

- identifying those in need of therapy
- providing therapy and related services
- integrating with prevention
- costs and sustainability.

4.1 Identifying those in need of therapy

HIV positive individuals will be identified by either voluntary counselling and testing (VCT), or presentation with symptoms, later confirmed by testing. Testing must be available, accessible and affordable. Rapid finger prick tests can be used by front-line care providers. The tests require no laboratory facilities, only a simple protocol and basic training. They require parallel testing with two different tests (eg. Determine™, Unigold™) and a tie-breaker (eg. Stat-Pak Rapid Test™) if results are discordant. If this cannot be done, suspected cases will need to be confirmed by laboratory testing. Routine 'opt out' testing (where the presumption is that all attendees will be tested unless they specifically opt out) should be available at reproductive health, antenatal, labour and delivery, and TB services.

But HIV antibody testing is not sufficient to indicate the need for therapy. WHO guidelines [WHO 2003b] recommend initiation at manifestation of certain clinical features of AIDS (WHO Stage IV and Stage III with CD4+ T-cell counts less than 350 cells/mm³) and when CD4+ T-cell counts fall below 200 cells/mm³. CD4+ T-cell counts require laboratory access, are expensive, around US\$25 per test, and could be required frequently (perhaps every three-six months) if therapy is to be initiated optimally. In reality, the necessary laboratory infrastructure is simply not available in rural areas of many, if not most, African countries. If large numbers of those in need are to be reached with ART, initiation for most will have to be solely on the basis of clinical assessment (Stages III and IV). In practice, most patients presenting at a clinic will do so because they have symptoms and are already at an advanced stage of the disease. ART programmes are demonstrating that, even with late presentation and without systematic CD4+ T-cell counts, excellent results are being achieved. Of 37,840 public patients who started ART in Malawi between January 2004 and September 2005, 77% were alive and continuing to receive treatment at the facility where they were first registered. Of these, 93% were fit to work. Less than 10% of patients who started therapy did so based on CD4 cell counts alone [Harries 2006].

Where laboratory services are available and reliable, it may be possible to detect some of those non-symptomatic individuals with low CD4+ T-cell counts, and to initiate treatment earlier. This could include many women whose HIV positive status was discovered in the course of antenatal care attendance.

Recent research indicates that total lymphocyte count (TLC) is an excellent prognostic marker for progression to AIDS in children. This test is much less expensive than CD4+ T-cell measurement and can be performed with an automated haematology analyser requiring little technical expertise [HIV Paediatric Prognostic Markers Collaborative Study, 2005]. Undoubtedly, research and new technological solutions will reduce the cost of measurement and monitoring, and will render these less dependent on expertise and support infrastructure [WHO 2005].

There are additional problems with infants and children of HIV positive mothers in that HIV antibody tests are not decisive until the child attains around 18 months of age. Definitive diagnosis before this age requires more expensive viral load testing (PCR). The significance of CD4+ T-cell count levels is also more complicated in children because they are not equivalent to those of adults.

4.2 Providing therapy and related services

The main aspects of this are:

- the complexity of treatment and adherence to therapy
- monitoring
- diagnosis and treatment of infections resulting from immune system suppression.

Complexity of drugs regimen and adherence to therapy

These issues were frequently cited as reasons for caution in initiation of therapy in poorer countries, but have largely been overcome. Generic fixed-dose combinations of lamivudine, stavudine and nevirapine (3TC/d4T/NVP), are available as a one tablet, twice daily regimen (Triomune, Cipla, Mumbai, India). Delivery has been pioneered by NGOs, and accumulating experience from around the world attests that these generic combinations are very effective and that adherence is excellent [Laurent 2004; Calmy 2006]. Generic fixed-dose combinations not only make adherence easy, but reduce the risk of resistance by making it impossible to take just one or two of the three active drugs.

Nevertheless, alternative first-line regimens are needed for those who experience severe adverse reactions, typically 6-7% of those starting ART using the above drug combination. Alternative first-line and second line drugs need to be stocked and made available at a small number of supporting health facilities. Efavirenz is commonly used to replace nevirapine which can cause hepatotoxicity and severe cutaneous rash, and zidovudine to replace stavudine which can cause peripheral neuropathy, for example. Second-line generic combinations based on protease inhibitors currently require a cold chain, but this situation will improve soon as new heat stable formulations are developed and approved, eg. Kaletra (lopinavir/ritonavir).

Monitoring

The main purposes of monitoring during ART are to confirm that viral load is decreasing sufficiently, that immune response is being restored, to identify adverse drug reactions before clinical symptoms appear or to confirm clinical diagnosis, and to detect emerging HIV resistance. Some of these tests are expensive: PCR for viral load can cost US\$100 a test. But several of the monitoring tests considered essential in richer countries will have to be dispensed with in practice in developing countries, and the frequency of tests reduced. Pragmatic guidelines have been proposed by WHO [WHO 2005]. The absence of these tests cannot be used as a reason to withhold therapy. In poorer countries they must be replaced partially with practical clinical guidelines, to help less qualified health workers identify adverse reactions for example, and with sample population testing for viral load and viral resistance.

Diagnosis and treatment of opportunistic infections

Suppression of the immune system by HIV results in many secondary infections. Commonly, these include tuberculosis, Cryptosporidium, Pneumocystis and fungal infections. The early initiation of ART can reduce this dramatically but, in practice, many patients present with advanced stages of HIV/AIDS and need general clinical diagnosis and treatment as well as commencing ART. Co-morbidity of malaria (500

million infections a year) with HIV presents significant problems for appropriate prophylaxis and treatment, for example [Brentlinger 2006].

4.3 Integrating with prevention

The availability of ART offers the potential to increase the effectiveness of prevention through raising VCT take-up rates and promoting behaviour change through associated counselling [Ehoile 2002; WHO/MSF 2003; Kasper 2003; Mukherjee 2003; Bill and Melinda Gates Foundation 2004]. ART service providers should capitalise on this and provide preventive services as an integral part of treatment services. This should include:

- primary prevention efforts including knowledge and behavioural change
- prevention of unwanted pregnancies to reduce MTCT
- detection and treatment of STIs (with referral)
- provision of condoms
- accessible VCT
- ART prophylaxis for HIV positive pregnant women (PMTCT).

4.4 Costs and sustainability of ART

The price of first-line ART drugs is under U\$150 a year, and can be expected to fall further as increases in aid funds raise sales, resulting in larger scale economies for producers, and encouraging local production and new entrants to the market. Nevertheless, these costs are more than many families can pay and substantial subsidy is required. Second-line generic combinations based on protease inhibitors remain expensive, currently eight-to-ten times those of first-line therapy. Moreover, consumers will not be able to or be prepared to pay for all preventive services, so their provision should be part of the general subsidised funding of service providers. The successful MSF programmes have dispensed ART free and it is claimed that this is a key factor in assuring patient retention in programmes, and in achieving successful long term immuno-virological response [Ferradini 2006]. But many people will be able to contribute to the costs of treatment and, with the limited experience of programmes to date, little is actually known about the price sensitivity of treatment. As always, the danger is that highly subsidised health services and products reach mostly the better off because they are easier to reach. There is much scope for innovation in cost contribution mechanisms like the 'Buyers Club' in Thailand in the earlier days of ART, assessing ability to pay, saving money for those already paying too much, and assisting those able to pay less than the best market price [Kreudhutha 2005].

Issues of costs and sustainability are not exclusive to franchising as an ART delivery mechanism: they apply to all delivery mechanisms. Given the relatively high costs of ARVs, diagnosis and monitoring, ART will only be available in poor countries on a sustained basis if there is continued substantial aid funding. As far as this paper is concerned, the issue is whether franchising can deliver ART to those who are not being reached by other means including government services, or at a better quality, or more cost effectively. This review indicates that there is that potential. Much will depend on local circumstances, but there are many situations where government health services are not reaching those in need and with a crisis in public sector manpower, it is difficult to see how they will.

By providing health workers with a better income, and one geared to their effort and success, franchising offers a chance of retaining those workers in countries that need them.

5. Implications for Delivering ART through Franchising

Although developed primarily for reproductive health services, more recently franchising has been adapted to offer general primary care. In Kenya, the CFW shops are selling high quality, price controlled, essential drugs to semi-urban and rural populations, using a model that combines micro-credit and franchise principles and that is focused on financial sustainability. Private community health workers staff the rural shops, whilst private nurses provide clinical services in the more populated areas.

Franchising is now being explored to address other health problems, notably tuberculosis (TB). A test project supported jointly by WHO and the Rockefeller Foundation in sub-Saharan Africa is planning to provide treatment for TB and other opportunistic infections resulting from HIV. *Green Star* in Pakistan is being funded to provide TB services through its franchising organisation, and is testing a mobile clinic model to target more rural populations. Franchising of TB services is also starting in the Philippines, and Population Services International (PSI) in Myanmar is exploring adding TB diagnosis and care to the existing franchise.

By extending coverage by trained providers, franchising may improve implementation of the TB DOTS protocol. Arrangements for diagnosis including the handling of (infective) sputum samples require good organisation and laboratory support. Other problems include how to deal with a patient's inability to pay. Some creative solutions are being tested to deal with this challenge including vouchers, community-financed bonds and/or patient co-payments that are refunded upon completion of treatment. To improve patient monitoring, community groups are being involved in supplementing the role of the healthcare provider in TB DOTS programmes. These groups, which may be religious groups, TB self-help groups or community volunteer groups, reduce the burden of daily monitoring for the health care provider, and encourage the patient to complete the full course of treatment.

Providing treatments for TB and opportunistic infections of HIV through franchises is possible in locations where there are private providers legally able to prescribe the appropriate drugs. By working with providers operating existing clinics, or creating incentives to open new ones, franchises can make use of existing or available capital investments in infrastructure and existing clientele. While a population of 5,000 (likely to generate say 25 TB cases a year) does not justify a new TB clinic, treatment could be added to the package of care already provided by a private provider.

Similarly, the reproductive health base of most existing franchises offers possibilities for integrating SRH and HIV and AIDS interventions. A pregnant woman attending antenatal care at a franchisee can be counselled for prevention and for an HIV test, and offered ART/PMTCT services, care and treatment, and contraceptive advice – all under one roof. Integrating these services could decrease stigma since it is not evident which services are being sought and utilised.

As far as is known, however, no franchise operation is providing ART as yet, although some have started offering VCT. The WHO/ Rockefeller Foundation support resulted in HealthSpot (see Box 1). Very recently, this has been taken over by FHI which now reports that it plans to start a franchise for ART in Kenya. The remainder of this review looks at what is known about the practicalities of doing this.

Box 1: what HFI stated it was doing**A Solution: Healthspot Franchise International**

The goal of the Healthspot Franchise International (Healthspot) is to utilize a private provider network model to deliver quality TB and HIV&AIDS care, following international and national standards, in sub-Saharan Africa. An international NGO will plan and organize the phased deployment of national franchises. In the first phase, limited franchises will be established in Kenya and shortly thereafter in Tanzania and then Uganda. When the treatment protocols, distribution model, incentive structure and management systems are honed, Healthspot will be expanded within those countries and other countries in the region.

The international NGO will contract to, or establish, a national franchise organization (NFO) at the country level. The NFO will be responsible for recruiting franchisees, enforcing clinical standards, delivering training, purchasing and distributing drugs and products, collecting data and marketing. The typical franchisee will be a mid-level provider such as a nurse or clinical officer with an existing private practice. This franchisee will be recruited by the NFO. Although the goal of Healthspot is to deliver quality care for TB and HIV&AIDS to the poor, most of the franchisee business will be general health services: family planning, fractures and headaches, and consultations and drug sales for malaria, diarrhoea, pneumonia and other common illnesses ie. the normal activity of these providers. But this will now be accomplished with quality-controlled drugs and quality-supervised protocols. In addition, the franchisees will also treat TB and opportunistic infections resulting from HIV. It is this integration of traditional general practice and public health services, targeting TB and HIV&AIDS that makes the franchise system unique and cost effective. ART will be added in coordination with guidelines of the National AIDS Committee (NAC), approximately 12 months after initiation of the franchise.

Cost Structure and Treatment for TB

For TB, the clients will pay \$0.50 for testing, and a National Tuberculosis Program-certified laboratory will do testing off-site. Once testing positive, the client will receive the full course of treatment drugs for free. The client will be charged an affordable fee, US \$4.00, for consultations provided by the franchisee. Payment in full will be upfront, and will cover all consultations throughout the course of care. The franchisee will dispense the medication over a 6 or 8-month period, notifying franchise outreach workers if the client fails to meet the treatment program. The franchisee will receive a \$15 bonus once the treatment is successfully completed, and the client will receive a completion bonus of \$4.00 making the full treatment free for those who complete the course of care.

Cost Structure and Treatment for HIV and AIDS

Using rapid tests on-site, HIV testing will begin as ART is rolled out through the franchise network. Irrespective of ARV availability and awareness of sero-status, patients with confirmed or suspected HIV will be given prophylaxis for OIs, counselling, and outpatient care at affordable rates – priced at the low-end of the for-profit market. In the first phase of introducing ART, franchise-employed consultant physicians will initiate therapy, and local community organisations and NGOs will collaborate on treatment support and compliance. In a second phase, the franchisees themselves will initiate ART with supervision from consulting physicians. In all cases pricing will be affordable, with first line ART drugs free, and consultations set at approximately US \$2.00 per month. A subsidy will be provided for those unable to pay, estimated to be up to 10% of the provider's total client base.

Local Governments

Healthspot is designed to make use of existing infrastructure and human resources in health services in sub-Saharan Africa that are normally beyond the control of national health services, but which nonetheless play an important role in providing care to the poor throughout the developing world. Healthspot will recruit from existing private providers only, will integrate their services into national public health programmes through government run training, alignment with government clinical protocols, and sharing of treatment and cure data with the appropriate government departments and national programs. Relevant government programs will be partners in providing oversight and regulation of private franchisees. In this way, Healthspot will formalise the status of private providers and integrate their services into the national public health structure.

It is neither desirable nor possible to create a franchise only to deliver ART. Franchisee providers could not make a living if ART was all they did, and ART delivery has to be built on services including at least counselling, HIV diagnostic capacity, primary care for diagnosis and treatment of opportunistic infections, and ideally some degree of immunological monitoring capability. HIV and AIDS interventions for prevention and treatment must become part of the normal, routine 'business' of relevant health services, whether they are franchises or conventional public sector delivery mechanisms.

Whilst the issues outlined in section 4 present some problems for delivering ART in a franchise, it should be remembered that they apply also and often more forcefully to delivery of services by over-stretched public sectors. There appears to be no intrinsic reason why a franchise cannot perform at least as well as public services in addressing these problems. These issues indicate that delivery of ART requires:

- maximum use of simple guidelines for use by front-line providers, including clinical guidelines to assist where laboratory based monitoring will be less than ideal
- training in the use of these guidelines and regular developmental supervision
- a degree of clinical expertise in providers and some higher level medical support
- ideally, a referral network able to provide more expertise and laboratory services.

There are many possibilities and variations in how this might be achieved in a franchise to meet national and local circumstances – see Box 2.

Box 2: Options for Social Franchising and ART

HIV testing could be performed by:

- franchisee providers using rapid test kits (based on protocols and backed up by confirmatory testing)
- more centralised services operated by the franchisor (to which either bloods or people can be sent for testing)
- services contracted from private or government laboratory services.

In order to maximise testing, it is desirable that it be offered by all franchisees either directly or by referral. It should be accompanied by counselling emphasising prevention and voluntary and sensitive contact tracing. Innovative payment systems for franchisees may be considered, such as payment for contact tracing leading to testing.

Franchisee providers could be:

- restricted to doctors
- extended to nurses and/or other health workers supported by focused training
- provided by a combination of health workers supported by a network of doctors or trained nurses (working as franchisees or directly for the franchisor).

All combinations require training of franchisee providers to maximise the treatment of opportunistic infections and the identification of symptoms and adverse drug reactions where laboratory testing capacity is minimal.

Monitoring for immunological and virological levels and adverse drug reactions could be provided by:

- centralised services operated by the franchisor (if the operation is large enough)
- private providers under contract to the franchisor, or by government laboratory services.

Detailed data on the experiences of ART delivery programmes and outcome are scarce to date. Research is much needed, including costing work on some of the programmes that have been working for several years.

The experience of the Médecins Sans Frontières group (MSF) is extremely valuable [Calmy 2004; MSF 2005]. MSF now covers almost 60,000 patients in 56 projects worldwide. The Chiradzulu District programme, for example, has been operating since 1997, having started at the district hospital [WHO/MSF 2004; Ferradini 2006].

From the end of 2002, the programme was adapted for scaling up. Essential elements of the adaptation are shown in Box 3. It now covers 3,000 people with ART. MSF employs five clinical officers, three dispensing nurses, seven counsellors, a pharmacy technician and a doctor, working with two clinical officers and nurses of the Ministry of Health. Clinicians focus on initiating ART and on patients who have just begun treatment. Dispensing nurses dispense the drugs and detect poor adherence, and also undertake triage for patients who have been stabilised. Patients are seen monthly by a clinician until they are stabilised, and the mobile team makes bimonthly visits to 11 sites in the district.

Box 3: MSF ART programme, Chiradzulu, Malawi

Adaptations of HAART programme towards scaling up:

- Disbanding of the previously established selection committee with immediate referring of the eligible patients to a counsellor
- Implementation of group HAART counselling sessions
- Because individual testing was not feasible, no systematic baseline CD4 count was done from 2003 and HAART was initiated according to clinical criteria only (WHO stage III or IV), as recommended by WHO when CD4 testing was not available
- Yearly CD4 count for all the patients as the only routine monitoring blood test undertaken; other tests (cell blood count, chemistries) done only at initiation or if needed
- Introduction of a fixed-dose combination (Triomune), which is known to facilitate adherence (one pill twice a day) and drug supply
- Running of the HIV clinic in the district hospital 5 days a week
- Decentralisation of HAART consultations through a mobile HIV clinic from the district hospital to the ten rural health centres and the peripheral hospital since early 2003
- Monthly follow-up visits by a clinician until stabilisation on antiretroviral drugs
- Bimonthly visits by dispensing nurses after stabilisation on antiretroviral drugs (for symptom questioning, antiretroviral prescriptions, and pill counts). A clinician was seen if symptoms were reported on questioning

Source: [Ferradini 2006]

In the early days of the programme when numbers were small, initiation was based on WHO recommendations of all those with Stage IV symptoms plus those with CD4+ T-cell counts below 200/mm³ [WHO 2003b]. As systematic CD4+ T-cell count testing became infeasible with larger numbers, from 2003 ART was initiated on the basis of clinical symptoms only (Stages III and IV). The availability of Triomune has been fundamental to the MSF programme since 2002, and to MSF programmes elsewhere [Calmy 2006].

Despite these compromises and the advanced stage of HIV and AIDS in patients presenting, a recent study shows that 74% of patients remain on ART at a median follow-up of 8.3 months, 91% of these on their original ART regimens, and 84% achieving viral loads of less than 400 copies per mL. Many lives are being extended and improved in quality using a quite simple but standardised vehicle for HIV and AIDS services delivery. The similar, simple approach to ART being implemented by

the public sector in Malawi is achieving comparable results [Harries 2006]. There is no reason why franchises could not replicate this and adapt it for particular circumstances.

A major challenge remains the earlier detection of HIV positive individuals in need of ART initiation. But franchised ART programmes should not be inhibited by the lack of this capacity. Public health priorities and equity issues demand that one standard generic fixed dose regimen of 3TC/d4T/NVP be extended to as many of those in need as possible as fast as possible [Harries 2006]. To do this, delivery mechanisms must keep this process as simple as possible so that relatively less qualified health workers can manage it: receiving presenting patients, counselling them, testing them, initiating standard treatment, ensuring adherence, identifying common side effects and treatment failure using protocols, and referring when necessary.

6. Implications for Governments and Aid Agencies

Franchising could help achieve HIV/AIDS goals

ART and related HIV and AIDS services could be extended to many more of those in need if they were provided by the many health workers who work as private individuals or in private clinics or shops. For ART services to be delivered successfully, these providers must be able to offer a range of basic health services and be supported with medical and laboratory services.

Franchise models offer the potential to raise the quality of health services by networking private providers and imposing common standards in return for enhanced income. They can extend services rapidly and in places where public provision is weak. They can provide competition for public services, thus creating incentives for inefficient government services to perform better to attract consumers and funding. They can also offer governments a vehicle for driving performance improvement: government bodies can themselves act as franchisor, thus creating an alternative to the human resource rigidities typical of the public sector and, for staff, an alternative to emigration to richer countries. For governments that are seriously seeking change, franchising could be a major driver for sector reform – public and private.

Without subsidy, franchises can only provide services to those consumers able to pay the economic cost of producing those services. But we know that many poorer people are already paying unorganised private providers and a major objective of franchising is to improve the relevance and quality of the services they buy. ART can be added to those services.

Should development agencies help?

Significant gains in universal access to HIV and AIDS prevention, treatment and care services require new approaches, including mechanisms that strengthen the private sector's contribution. The potential of franchises justifies significant funding to encourage the start up of new franchises by non-profit or for-profit groups, or by government itself, and the expansion of existing franchise networks to include ART services. These should be experiments on a significant scale including a rapid pace of growth, supported initially with technical expertise and monitoring and evaluation. They should provide broad-based health services built on primary care and/or SRH and aimed at integrating HIV and AIDS – and other vertical programmes – into routine health services.

Even if franchises are not able to focus on the poorest exclusively or immediately, agencies should be realistic and adopt a phased approach to their development.

Agencies could support start ups and expansion of franchises in localities with populations in need, then provide demand or supply side subsidy aimed at achieving access for the poorer eg. through voucher schemes (see section 3.4). They should incorporate externally performed operational research components to attempt to solve outstanding problems and improve cost effectiveness.

Next steps

Development agencies interested in promoting franchising should commission work to:

- determine specific locations with a combination of population in need and availability of private providers
- identify actual or potential franchisor organisations
- obtain government support in principle
- outline the nature and extent of the services to be provided.

More detailed work could then be undertaken on the structure of the franchise, the contract between the funding agency and the franchisor, specification of the services and standards to be provided, and costs.

Development agencies should ensure that this is coordinated with the plans of government and with other development agencies using participation in SWAp, NAC or NAP mechanisms. Where possible, these mechanisms should be used to act as intermediate fund managers and provided with technical support to do this and to ensure transparency and financial probity [England 2006b]. Private sector organisations can be appointed to handle arrangements and the release of funds to intermediate fund managers.

Through franchising, development agencies should promote the integration of HIV and AIDS interventions to become part of the normal business of health services, curtailing the vertical programme nature of much HIV and AIDS funding currently. SRH and MCH are two priority areas for this, and have already had successful experiences with franchising. HIV and AIDS interventions should not be achieved by adding on new dedicated staff or facilities but by training and development of existing cadres and incumbents. The considerable new HIV and AIDS funding should be employed to restructure and strengthen health services, including franchises, so that this integration is achieved and sustainable.

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Annex 1: Available information on known franchises

references cited in text are provided alphabetically in the References above

name of franchise	services delivered	quality	costs / financing	scale / coverage / equity
<p>Green Star Network Pakistan</p> <p>www.greenstar.org.pk</p> <p>Evolved from the Social Marketing of Condoms Project from 1985 and set up by PSI and others.</p> <p>Social Marketing Pakistan (SMP) set up in 1991 by PSI as local/NGO.</p> <p>Launch of <i>Green Star Network</i> in 1995.</p> <p>1. McBride J, Ahmed R. 2001</p> <p>2. Stephenson 2004</p> <p>3. HLSP 2004</p> <p>4. Montagu 2002</p> <p>5. Smith 2002</p>	<p>The social franchising part of <i>Green Star's</i> operation was established in 1995, offering a range of RH products:</p> <ul style="list-style-type: none"> ▪ 2 condom brands ▪ oral contraceptive ▪ 3 types of injectable ▪ emergency contraception ▪ a multi-vitamin ▪ RTI/STD services ▪ post-abortion care ▪ 'Destructurip' for disposing used needles ▪ Multiload IUD ▪ VSC ▪ antenatal and postnatal care ▪ a newly weds counselling service. <p>Franchising is 'fractional' ie. <i>Green Star's</i> products are only part of those offered by franchisees to the client.</p> <p>Urban and peri-urban customers served.</p> <p>12,000 trained private health providers:</p> <ul style="list-style-type: none"> ▪ male and female doctors in general practice 	<p>Franchise membership is associated with a significantly greater total client volume and a significantly greater family planning client volume.</p> <p>Franchised health establishments also have a significant positive association with the number of contraceptive method brands available.</p> <p>Clients in the higher monthly income groups had significantly greater odds of attending a franchised health establishment than those with incomes of less than \$60 per month.</p> <p>Attendance at a franchised outlet is significantly associated with reporting an intention to return to the same health establishment.²</p> <p>2001 <i>Green Star Cluster Evaluation</i> survey found that the majority of clients are likely to be from low income groups.</p> <p><i>Green Star</i> sees quality as a critical component in ensuring satisfied clients.</p> <p>Clients and others in the community perceive the technical skills and quality of care provided by <i>Green Star</i> franchisees to be nearly twice as high as other private providers.³</p> <p>70% of clients rated franchise quality as "high".⁴</p> <p>From the outset, SMP established a transparent process for franchisee selection using clearly defined criteria.</p> <p>Monitoring processes include internal</p>	<p>Original SM funding by USAID; KfW funding allowed start up of <i>Green Star</i> franchising.¹</p> <p>During 1997-2002, <i>Green Star's</i> cost per CYP declined by 46% (\$6.97 - \$3.78).</p> <p><i>Green Star</i> has lowest cost per CYP in a comparison of 60 international SM programs.³</p> <p>Clients rated service as follows:</p> <ul style="list-style-type: none"> ▪ "expensive"; 7% ▪ "medium" 72% ▪ "inexpensive" 20%.⁴ <p>The trend in total cost per CYP is downward, from US\$ 8.88/CYP in 1987 to US\$ 4.51/CYP in 2000. Increased costs in 1996 reflect higher expenditures for research, marketing and training related to the introduction of</p>	<p>In 2002, <i>Green Star</i> generated 2.0 million CYPs which represents 25% of estimated CYPs amongst all Pakistanis.³</p> <p>In its first five years (1995-2000), the <i>Green Star Network</i> grew to include more than 11,000 private health providers in more than 40 cities, receiving more than 10 million client visits per year.</p> <p>Pakistan has a population of 150 million (Population Reference Bureau, 2000).</p> <p><i>Green Star</i> has made family planning services much more geographically accessible to the target population of low-income urban Pakistanis. Fifty million people are within the network's area of coverage.</p> <p>An estimated 74 percent of <i>Green Star</i> clients are from low-income groups earning less than Rs 6,000 per month (SMP, 1998).</p> <p><i>Green Star</i> contraceptives are available in more than 30,000 retail outlets nationwide.</p> <p><i>Green Star Network</i> receives some 30 million client visits related to family planning each year. Assuming that each family planning client visits a <i>Green Star</i> outlet at least four times per year (for consultation or re-supply), PSI estimates the total number of clients to be approximately 7.5 million.¹</p> <p>300 female doctors in pilot; 2,000 female</p>

- chemists
- family health visitors.¹

IUDs, injectables and OCs.¹

doctors in substantive phase plus male doctors.⁵

Types of providers:

- GS1 – female GPs and paramedics able to insert IUDs
- GS2 – male and female doctors nor delivering IUDs
- GS3 – pharmacists
- GS4 – female junior paramedics.¹

An evaluation (Agha et al 1997) found:

- a doubling of the average number of FP clients at Green Star clinics within a six-month period (from 1.8 to 4 clients per clinic per day)
- a substantial increase in total clients at Green Star clinics during the pilot project period: average number of clients coming to Green Star Network clinics increased from 14 to 19 per clinic per day
- a steady increase in quarterly purchases of IUDs, injectables, condoms and OCs by Green Star clinics.
- prices for IUD and injectable contraceptive administration at Green Star clinics appeared to be higher than recommended
- overall, the availability of contraceptive supplies and counselling skills improved significantly; one remaining weakness was lack of a mechanism to follow up with individual FP clients.

Annual cost of marketing is US\$ 1.8 million.⁵

Preliminary results of a provider survey conducted by University of North Carolina (2001) show that members of the Green Star Network are nearly twice as likely to deliver FP services as their non-Green Star counterparts in the private sector.

In 1995, knowledge of any FP method was 90.7 percent among married women of reproductive age (Population Council, 1998). By 1997, two years after Green Star began, knowledge among these women had increased to 94.3 percent (NIPS/LSHTM, 1998). Particularly compelling is increased knowledge about the modern female controlled methods that Green Star promotes: OCs, injectables and IUDs. Among these women, awareness of OCs increased from 72.7 percent to 86.6 percent; of injectables, from 80.5 percent to 86.0 percent; and of IUDs, from 80.5 percent to

86.0 percent over the same two-year period (1995.97).

In the early 1990s, only 25-30 percent of married women of reproductive age in Pakistan who knew about the pill, IUD or injectable also knew where to get them (Pakistan DHS, 1992). By 1997, around 70 percent of these women knew where they could get contraceptives (NIPS/LSHTM, 1998).

A 1997 a media effectiveness study found unprompted awareness of Green Star to be almost universal: 94 percent recognised Green Star (AAL, 1997). The Green Star program is so successful that its name and logo are now synonymous with family planning.

A 1998 study of GS2 providers indicated that these doctors showed improved interpersonal skills, improved knowledge of contraception and greater willingness to promote family planning (Management Information Ltd, 1998).

A 1999 study found that GS3 providers were more knowledgeable about contraceptives, more alert to FP customers and their needs, more confident in providing info than untrained providers (Raasta, 1999).

According to the Pakistan Contraceptive Prevalence Survey 1994.95 (Population Council, 1998) and the Pakistan Fertility and Family Planning Survey (NIPS/LSHTM, 1998), contraceptive use increased by 34 percent between 1994 and 1996. The sales data translated into couple-years of protection are consistent with this estimate, showing a 40 percent increase in CYPs generated by modern methods.¹

<p>KEY social marketing (KSM), Pakistan www.key.org.pk</p> <p>The Green Key network is implemented by the Futures Group and was launched after Green Star.²</p> <p>1. Smith 2002 2. Stephenson 2004</p>	<p>Green Key offers training in birthspacing counseling and access to hormonal contraceptive products (Famila-28 and Nordette-28 oral contraceptives and Depo-Provera injectables) to physicians, paramedics, and pharmacists interested in expanding their family planning services.</p> <p>To reinforce trained service providers, Green Key has developed a referral network that includes private hospitals and clinics, and franchise members can refer clients to these hospitals for more extensive counseling and service support (Key Social Marketing 2002).²</p> <p>Providing a range of oral and injectable contraceptives to urban and peri-urban women and men, especially lower and mid-income groups.</p> <p>Use of targeted advertising, promotion and pricing.</p> <p>Franchisees are doctors, pharmacists, female health visitors and selected NGOs.¹</p>	<p>Franchise membership is associated with a significantly greater total client volume and a significantly greater family planning client volume.</p> <p>Franchised health establishments also have a significant positive association with the number of contraceptive method brands available.</p> <p>Clients in the higher monthly income groups had significantly greater odds of attending a franchised health establishment than those with incomes of less than \$60 per month.</p> <p>Attendance at a franchised outlet is significantly associated with reporting an intention to return to the same health establishment.² [NB. Green Star and Green Key were grouped together in this evaluation].</p> <p>Training and refresher training provided.</p> <p>Side effects managed through referrals to medical practitioners.¹</p>	<p>Funded by DFID.</p> <p>Budget is £7.04 million over 5 years.¹</p> <p>10,000 doctors in private practice 25,000 pharmacists 1,000 female health visitors Selected NGOs.¹</p>
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<p>CFW shops network, Kenya www.cfwshops.org</p>	<p>Established in 2000, offers basic essential drugs, at controlled prices, as well as a 'franchise operating system', that includes a protocol for counselling clients. Products are offered for diseases such as malaria, respiratory infections, pain and inflammation and worms.</p> <p>CFW shop franchisees are 'full', meaning that they only sell CFW products and offer CFW approved services.</p> <p>Peri-urban and rural customers served.</p> <p>Apart from donor funding needed for headquarters start-up costs, in the early years of operations there are no other subsidies in the system.¹</p>	<p>As a result of marketing campaigns and effective community outreach, HealthStore franchise owners are regarded by their communities not as simple shop clerks, but as health experts.</p> <p>To assure quality:</p> <ul style="list-style-type: none"> ■ standardization of aesthetics ■ business and clinical training ■ quarterly reports and analyses of progress ■ consistent regional support ■ regular monitoring ■ fixed drug prices. <p>Best-performing outlets (financially) in the evaluation were / had:</p> <ul style="list-style-type: none"> ■ clean ■ good stock of drugs ■ attractive arrangements of products ■ excellent customer care ■ effective promotional and outreach activities.² 	<p>Set up costs for each franchise unit are approx US\$1,700.</p> <p>The Individual HealthStore shops are available but core support will cost \$1 million annually to support 300-400 outlets.</p> <p>Net cost of less than US\$1 per patient served.</p> <p>Nurse-operated clinics can offer wider range of services than CHW-operated so they perform better financially</p> <p>Offers high quality drugs at below market prices.²</p>	<p>63 clinics and shops opened by 2005.</p> <p>The network serves an average of 40,000 patients per month.</p> <p>700,000 patients treated.</p> <p>In 2004, 177,256 patients treated; in 2005, number nearly tripled to 435,527 patients.</p> <p>Over next 3 years, aims to expand network in Kenya to 200 outlets serving up to 1,500,000 patient visits per year.³</p>
<p>Well-Family Clinic Philippines www.wfmc.com.ph</p>	<p>Established in 1997, offers family planning and maternal and child health services in urban areas.</p> <p>Franchisees are registered and practicing midwives; 205 clinics (as of October 2002).¹</p> <p>For detailed background, see Jones 2003.³</p>	<p>Franchisees are ejected from the network where they fail to conform to standards.¹</p>	<p>Fee is charged for additional training; a management fee of about US \$10 is charged per month and \$4 per delivery.¹</p> <p>Well Family Midwife Clinics charge wide range of prices for same service – some overcharging is taking place.²</p>	<p>210 clinics.</p> <p>75 clinics in Mindanao, 12 operated by Muslim midwives (USAID website).</p> <p>Clinics in 29 provinces of Philippines.¹</p> <p>Average of 5 clients per day served at each clinic.</p> <p>Mainly low-income clients served - 56% do not earn an income.²</p>

SDI, Philippines

¹. Smith 2002

<p>Provides services to middle-income urban areas through network of midwives.</p> <p>Targets women and children.</p> <p>Implemented since 1993.</p> <p>Franchisor is IMCCSDI – known as SDI.</p> <p>Franchisees are midwives – either existing SDI employees or independent midwives.¹</p>	<p>MCH/FP low and groups through midwives.</p> <p>especially women and children.</p> <p>since 1993.</p> <p>– IMCCSDI – known as SDI.</p> <p>are either existing SDI employees or independent midwives.¹</p>	<p>Quality control mechanisms:</p> <ul style="list-style-type: none"> ▪ SDI provides technical and admin training ▪ SDI provides regular monitoring, supervision, and further training as needed ▪ SDI sets prices for clients; mechanisms to provide services to poor.¹ 	<p>High initial costs.</p> <p>Flat monthly fee to franchisor.¹</p>	<p>In 1995 there were 49 franchisees and plans for expansion.¹</p>
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Foundation for Adolescent Development (FAD), Philippines

www.teenfad.ph

¹. La Vake 2003

<p>Manila: Teens (THQs): between various organisations.</p> <p>Provide information and sexual health and counselling.¹</p>	<p>Franchisees are Healthquarters (THQs): FAD and various organisations.</p> <p>Provide medical services, information on health and sexuality, education, and counselling.¹</p>	<p>Inconsistent monitoring/enforcement of standards.¹</p>	<p>THQs make no payment to FAD for services, only partial payment for products and materials.</p> <p>Funding received from UNFPA and David and Lucile Packard foundation</p> <p>Sustainability is a major challenge: payment for services and fee system is weak.</p> <p>When donor funding ends, may have to close down.¹</p>	<p>From March 2001 – 2002:</p> <ul style="list-style-type: none"> ▪ 4 THQs provided services to 7,000 youths ▪ 80% services fell into categories of IEC ▪ 1,400 clients seen for medical services ▪ 130 clients received FP services ▪ 6 received medical care for STIs.¹
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MEXFAM, Mexico

MEXFAM is the Mexican affiliated member of IPPF.¹

www.mexfam.org.mx

¹. Smith 2002

². La Vake 2003

Started social franchising with project to get private physicians to provide FP services in rural areas.

From 1990, delivers high quality, low cost MCH/FP services and information to low income peri-urban and urban communities through stand-alone doctors' practices, thereby establishing a network of financially self-sustaining clinics.

Targets women and children in these areas.

A package of MCH/FP services delivered according to protocols set by franchisor.

From 1994, Gente Joven (young people) project – 25 centres opened.²

Quality control mechanisms:

- franchisees receive initial training in FP
- franchisees use MEXFAM's own protocols
- monthly visits from franchisee coordinator
- periodic quality audits by MEXFAM's medical director and senior staff
- prices set in consultation with local community, with mechanisms to provide services to poorer groups.¹

Initial capital costs were high, and donor funded through franchisor.

Franchisees pay flat monthly fee for ongoing monitoring, use of franchise brand, and advertising.

Some franchisees could afford to pay higher fees to franchisor.

Has not yet demonstrated financial sustainability, but could.¹

In 1995, 290 doctors were franchisees, although a further 475 doctors had been community doctors in previous programme and left to become MEXFAM doctors.

25 youth centres opened from 1994 to 2002.²

ProHealth, Zambia

An NGO formed by PROSALUD, operating in Bolivia with PSI support, through ProHealth International.

Business format and operating systems franchised from ProHealth International.¹

¹. Smith 2002

Provides high volume, quality PHC at low to moderate fee levels in urban areas of Zambia through network of clinics.

Clinics provide FP, antenatal and obstetric services, baby and child health, preventive and curative health care, as well as diagnosis and treatment for STIs, TB, malaria and ARI.¹

Quality control:

- one clinic with training facilities will monitor technical standards at other clinics
- user satisfaction surveys to measure quality
- clinics will have at least one clinical specialist
- QA systems from ProHealth International.¹

Estimated cost for 12 clinics over 10 years is approx US\$ 10 million.

Sustainability through graduated user fees (dependent on ability to pay) and fee sharing with franchisees.

Annual subsidy of USD450,000

9-13 clinics each with at least one clinical specialist.¹

<p>Providing sexual health clinics for inter-city truckers, India</p> <p>Design of franchise being funded by DFID.¹</p> <p>¹. Smith 2002</p>	<p>Aims to provide STI diagnosis and treatment (syndromic), and promote condom use and education through social franchise network at major truck halt points to slow spread of HIV infection amongst intercity truck drivers.¹</p>	<p>Quality control:</p> <ul style="list-style-type: none"> ▪ franchisor to organise training for franchisees to required standards ▪ franchisor will hire doctors to supervise and monitor franchisees.¹ 	<p>Expected to cost £20 million in its full implementation phase, dependent on pilot phase.</p> <p>Targets up to 5 million truck drivers, their assistants and their sexual partners.</p> <p>Franchisees will be at least 300 doctors in private practice at or near truck halts.¹</p>
<p>Janani's Surya Clinic and Titli Centre Franchisees, India</p> <p>www.janani.org</p> <p>¹. Montagu 2002</p> <p>². Stephenson 2004</p>	<p>Started in 1996 in Bihar State, a two-level franchise consists of:</p> <ul style="list-style-type: none"> ▪ Rural Medical Providers (RMPs) branded as Titli Centres ▪ a smaller network of MD and MBBS doctors with private clinics (named Surya clinics). <p>Brand identification done through painting, posters, signage, and extensive advertising.</p> <p>Predominantly rural medical practitioners.¹</p> <p>SRH information and services for adolescents.</p> <p>Pilot will be tested with three types of youth organisation as franchisees.</p> <p>Youth organisations</p>	<p>Franchise membership is associated with a significantly greater total client volume and a significantly greater family planning client volume.</p> <p>Franchised health establishments also have a significant positive association with the number of contraceptive method brands available.</p> <p>No differences between clients satisfaction at franchised and private nonfranchised health establishments in Bihar.²</p> <p>RMPs are visited every 3 months by monitors. If RMP fails to score well on two consecutive visits he is replaced.</p> <p>66% of RMPs reported increases in overall clients are result of franchise.¹</p>	<p>60% of budget earmarked for communication.</p> <p>Janani is for RMP pays annual membership of \$12.¹</p> <p>As of March 2001, there were 8,756 Titli Centres in 42 districts, and 204 Surya Clinics.</p> <p>April 2002: there were 15,900 Titli Centres and 435 doctors in about 250 Surya Clinics.¹</p>
<p>IXCHEN, Nicaragua</p> <p>Franchisor is IXCHEN, a non-profit organisation; franchisees are existing youth organisations.</p> <p>Funded by DFID's Seedcorn Fund.</p>	<p>Quality control:</p> <ul style="list-style-type: none"> ▪ initially franchisor's staff will provide services and will train the youth organisations' staff ▪ franchisor's local clinic manager will make monitoring and supervision visits.¹ 	<p>Costs £200,000 for two years.</p> <p>In pilot stage, franchisor's costs will be met by donor funding.¹</p>	<p>Initially three franchisees.</p> <p>20 leaders and adolescents from each youth organisation will be trained to run IEC programme.¹</p>

premises used to make services accessible to adolescents.

Selected leaders and adolescents trained in basic admin to take over management and admin of services.

Fraction social franchise.

Provides IEC, FP, STI treatment, emergency contraception, antenatal care, med care, counselling and advice on relationships and family problems.¹

¹. Smith 2002

Sun Quality Health, Nepal www.psiwash.org/where_we_work/nepal

Started under USAID AIDSMARK project by PSI.

¹. PSI 2003-2004

². web site

SRH, HIV/AIDS prevention, and MCH.

Aimed at low income and vulnerable people.

Began early 2002.

Condom distribution strategy focusing on entertainment establishments in Kathmandu.

2004 launch of "OK" range of FP products with striking logo.¹

6 FP methods including three new technologies in Nepal: Multiload IUCD, one-month injectable, Postinor ²

22,125,603 condoms social marketed by PSI/Nepal and partners 2003-2004, an increase of 34% on condoms sold in 2002-2003.

328,781 CYPs generated by PSI/Nepal in 2003-04, an increase of 34% on previous year (three year average increase of 9%).¹

215,000 unintended pregnancies averted during 2005²

Social Marketing of health products in 75 districts.

Social franchising through 139 Sun Quality Health private sector franchise outlets spread over six districts. 255 private health providers.

Anticipated 400 outlets by 2006.¹

Expanded into the Terai (eastern and western regions) with establishment of 125 SQH outlets.

Total of 208 SQH outlets now operating.

Mobile service units provided services at 51 sites during past year, including 39 sites outside Kathmandu valley²

<p>TOP Madagascar</p> <p>1. La Vake 2003</p> <p>2. Ravindran 2005</p>	<p>Reseau, Developed by PSI from year 2000, private provider model focuses on youth. Three components: franchising, communication and research.</p> <p>Provides full range of services through GP physicians who display TOP logo.</p> <p>Services include diagnosis and treatment for STIs, FP counselling, pregnancy testing, immunisations, physical exams, breast exams, Pap smears.¹</p>	<p>\$1 million grant from Gates Foundation for four years.</p> <p>17 GP clinics in network.</p> <p>2,500 clients in first 2 years; 50% visits related to RH issues.¹</p>	<p>Franchisees pay modest membership fee to TOP Reseau, and show willingness to pay for more franchise services.¹</p> <p>In 2002, doctors from 56 existing private clinics were a part of this franchise²</p>
<p>K-MET, Kenya</p> <p>Private Providers Network of Western Kenya</p> <p>Founded in 1995 by Kisumu Medical Education Trust.²</p> <p>1. FHI YouthNet 2003</p> <p>2. Montagu 2002</p>	<p>Franchises private practices headed by a range of clinicians: OBGYNs, MBBS doctors, nurses, and clinical offices.²</p> <p>Supports numerous reproductive health networks in Western Kenya, and acts as an incubator for RH models and best practices.</p> <p>Assists innovative health programs in becoming "drivers." Includes peer education, PHC, MCH, nutrition, malaria prevention, home-based care for PLWHA.</p>	<p>Operates with revenues from franchise and individual membership fees, some donor and foundation funding.¹</p> <p>Includes 250 private clinics throughout W. Kenya.¹</p> <p>In mid 2000, network had 65 providers.²</p> <p>Clinics receive free contraceptives.</p> <p>Survey:</p> <ul style="list-style-type: none"> ▪ 14% of clients considered services to be "expensive" ▪ 73% "medium" ▪ 12% "inexpensive" ² 	<p>All providers trained in RH by team in Kisumu.</p> <p>45% of clients rated service quality as "high", 2% as low.²</p> <p>Training programs and curricula developed for variety of practitioners.¹</p>

K-MET has developed a collaborative community network of schools, churches, government agencies, NGOs, and private businesses — in parallel with its clinic network — that serves to market, publicize, sustain, and enhance the private providers franchise network.¹

Gold Star, Egypt

Not exactly a franchise: Government of Egypt is franchisor, and only government-owned or public clinics participate in programme.¹

¹. La Vake 2003

². Johns Hopkins 2006

Goal: "Maximizing access and quality of family planning and reproductive health services to enhance family health and quality of life."

Youth Services, FP, safe motherhood, RTI detection and treatment, early detection of cancer, services for older women.²

Clinics meeting quality standards receive a modest bonus or incentive.

Gold Star logo is sign of high-quality service.

Gold Star is essentially a quality-improvement program with an extensive list of standards that clinics must achieve. Each clinic is evaluated quarterly by the MOH. If the clinic fails to meet 100 percent of the Gold Star standards for two consecutive quarters, it loses its "gold star" and is put on an improvement plan.

Supervisors of the clinics must monitor that the nationally set clinic standards are being met and document the satisfaction of the family planning clients, according to the program's policies and procedures manual.

Other elements of this franchise include a standard referral system and a requirement for Gold Star clinic staff to attend three days of in-service training annually.¹

Increase in proportion of MOPH FP services from 30% of all FP users in 1992 to 40% in 1997.

Started in 1993 with USAID funding.

Involves 2,400 clinics, more than half of Egypt's 4,500 public RH clinics.

Services for unmarried youth are limited.¹

Revenue from fees charge at MOH clinics is collected and disbursed by district offices back to local clinics.¹

Increase in contraceptive prevalence from 47.9% in 1995 to 56% in 2000.²

High levels of exposure to campaign 8 months post-initiation, as reported by 87% of women ages 15-49 and by recognition of the Gold Star logo by 45% (Central Agency for Public Mobilization and Statistics-CAPMAS, Egypt, 1998); and high levels of understanding among women (70%) and men (90%) that the Gold Star represents high-quality services and well-trained providers.

The success of the Gold Star approach is also confirmed at the political and community level: State Governors increasingly wanted to be involved as keynote speakers at the high profile Gold Star certifications and ceremonies, and communities took action upon decertification of their local clinics.²

Biruh Tesfa "Ray of Hope", Ethiopia

Implemented in 2000 by Pathfinder International, funding from Packard Foundation.¹

1. Stephenson 2004

Franchisees are existing clinical community-based health care providers.

Franchisees receive training in delivery of contraceptives, STD prevention, HIV/AIDS counselling, post-abortion care, referral procedures.¹

Relative to private non-franchised services, franchise membership is associated with a significantly greater total client volume and a significantly greater family planning client volume. However, government health establishments are associated with significantly greater family planning client volumes.

Franchised health establishments also have a significant positive association with the number of contraceptive method brands available.

But clients at franchised outlets were less likely to report an intention to return to the service than clients at non-franchised outlets.¹

PPM DOTS (WHO PPM DOTS, 2004)

Not a franchise but an example of how private providers can be trained

20 PPM DOTS projects in 13 countries.¹

Evaluation data available for 16/20 projects.

These initiatives have uniformly achieved increments in TB case detection while maintaining high treatment success rates within the project areas.

Cost-effectiveness data from two projects indicate that PPM DOTS is as cost-effective as DOTS

In Bangladesh, 11,000 village doctors trained so far, contributed to diagnosis of 1,358 new smear-positive patients in 2002, and acted as DOTS provider in 50% of these cases with a cure rate of 94%.¹

Covers three regions: Addis Ababa, Oromia and Amhara, out of 11 regions in total.

92 clinics, 150 community health workers, 100 trained birth attendants, 48 marketplace providers, 120 workplace providers.¹

to provide a relatively complex service.

¹. PPM for DOTS 2004

Existing project evaluations indicate that PPM DOTS can improve case detection by 25–30%, while sustaining treatment outcomes which are far better than in the conventional private health care sector and on a par with those in the public sector (80–90%).¹

implementation in public sector.

An added benefit is that free or heavily subsidised treatment substantially reduces financial burden on patients.

In India, societal cost per patient cured was lower in PPM DOTS compared to private sector treatment.¹

(C) DFID Health resource Centre, 2006