“TINH CHI EM” (SISTERHOOD)

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I. EXECUTIVE SUMMARY

While the city of Da Nang, Viet Nam, has enjoyed overall improvements in its reproductive health and family planning (RHFP) programs, there remained room for growth. Working with Marie Stopes International (MSI), the Provincial Health Department of Da Nang created Tinh Chi Em (Sisterhood), a fractional government franchise dedicated to improving the quality and utilization of RHFP services at the level of the Communal Health Station (CHS). The pilot program implemented five basic components of membership: guided training, the use of fees in order to create a reward system for staff members, use of branding and social marketing to advertise the program, andmonitoring and supervision of staff and procedures.

While funding for the project was overseen directly by MSI Viet Nam, supervision of the entire program, including the disbursement of funds, was completed by the Project Management Board, which was made up of local health officers and a representative from MSI Viet Nam. The user fees applied through the program were fixed in order to cover operating costs and sustain project activities.

Performance monitoring and evaluation was one of the more outstanding features of the program. While the CHS staff and other stakeholders gave constant self-assessment and feedback, an independent group of evaluators also conducted midterm and end line assessments of the project. Because of these reviews, the achievements of the program were clearly highlighted at the program, staff and client level. Achievements included empowering the CHSs to mobilize resources to increase availability, creating strong teams of master trainers who effectively instruct CHS staff, and increasing service utilization and client satisfaction.

Still, while the program did seem to have several positive effects, implementation of the pilot was not without its challenges. Issues such as resistance to the adoption of new service fee and competition from other FPRH facilities need to be addressed and reevaluated before the program can grow further.

At the end of the trial period, most staff members showed strong commitment to the continuation and expansion of the initiative and ten additional CHSs were selected to join the franchised network with increased financing from Atlantic Philanthropies. Based on the success and lessons learned from Da Nang and Khanh Hoa, Atlantic Philanthropies continues to support three other provinces in Viet Nam, including Thai Nguyen in the North, Thua Thien Hue in the center of the country and Vinh Long in the South. These provinces will apply the Tinh Chi em model from 2009 to 2012.

II. BACKGROUND AND COUNTRY CONTEXT

Da Nang city is located in Central Viet Nam and is one of the country's four biggest cities. With a population of over 800,000 and a 92 km coastline, Da Nang is a major port city, boasting an international airport, well-developed road system and maritime line, and a railway connecting the North and South of Viet Nam. The city also attracts a wide range of immigrants due to its both industrial and agricultural economy.

Acknowledging a close connection between a population's health and its socio-economic development, the Government of Viet Nam has implemented two strategies over the past decade focusing on safeguarding public health: the National Population Strategy (2001-2010) and the National Reproductive Strategy (2001-2010). The general objective of the National Reproductive Strategy is to ensure the accessibility of reproductive health and family planning (RHFP) information and services for women, men and adolescents in an effort to reduce maternal and infant mortality. Closely following the national strategy, the Health Development Strategy of Da Nang (2005-2010) affirmed its commitment to the national objectives, stating that, "as of 2008, 100% of commune health stations (CHSs) have met the national standards". This means that skilled health workers such as doctors, midwives, nurses, traditional health officers and pharmacist are available at all CHSs. Furthermore, CHS health staff are mandated to receive refresher training on appropriate medical knowledge and professional skills, and all CHS facilities must possess the basic medical equipment necessary to meet the demand for RHFP services in the communities that they serve. The city has also focused on strengthening available resources in order to create conditions within the health system that are favorable to the implementation of RH care at the provincial, district, and communal levels. In addition, many international organizations, such as UNFPA, SCUS, UNICEF, and Cordaid, have supported the development of RHFP activities in selected areas of Da Nang city.

In recent years, reproductive health care in Da Nang has enjoyed significant achievements. The proportion of pregnant women who receive at least 3 check-ups prior to delivery has remained steady at 92-95%; the number of births attended by trained professionals has reached 98-100%; and malnutrition among children under 5 has gradually decreased, dropping from 25.9% in 2000 to 17.9% in 2005.

Despite these achievements, the city still suffers from reproductive health concerns such as continued maternal mortality and a prevalence of certain sexually transmitted infections. Furthermore, the quality of RHFP services in CHSs has not met the standards demanded by the people, often burdening the upper levels of the health system. Additional baseline assessments of the grassroots health system in Da Nang showed that only 11.7% of CHS staff received the mandated refresher training and only 3.3% of CHSs contained the most basic RHFP equipment. More alarmingly, only about 40% of medical staff at the district level and 26.7% at commune level believed that their professional knowledge and skills met the local need in term of RH care services. These figures showed that there was a significant need to strengthen and increase the uptake of reproductive health services in Da Nang's CHSs.

III. PROGRAM MODEL

a. Background

Social Franchising is the grouping of isolated service providers under a shared brand in order to form a network of practitioners that offer some set of standardized services. This approach enables the expansion of services by building upon existing expertise in poor or isolated communities. This model encourages greater RHFP service utilization, and improves provider knowledge and practices. Partial or fractional franchising describes the case where only specified services within an organization come under the franchise brand.

Marie Stopes International (MSI) uses fractional franchising to provide RHFP services in more than 500 clinics across Asia and Africa, emphasizing access, quality and equity of care. The primary advantages of franchise membership for providers include training, technical assistance, brand promotion, and subsidized supplies. For patients, franchising provides important quality assurance, as well as access to MSI's broad referral networks. Social franchising has been successfully employed in the private sector to bring small healthcare providers under a shared brand, but it has rarely been applied in the public sector and never using a fractional franchise model to network general primary care public clinics.

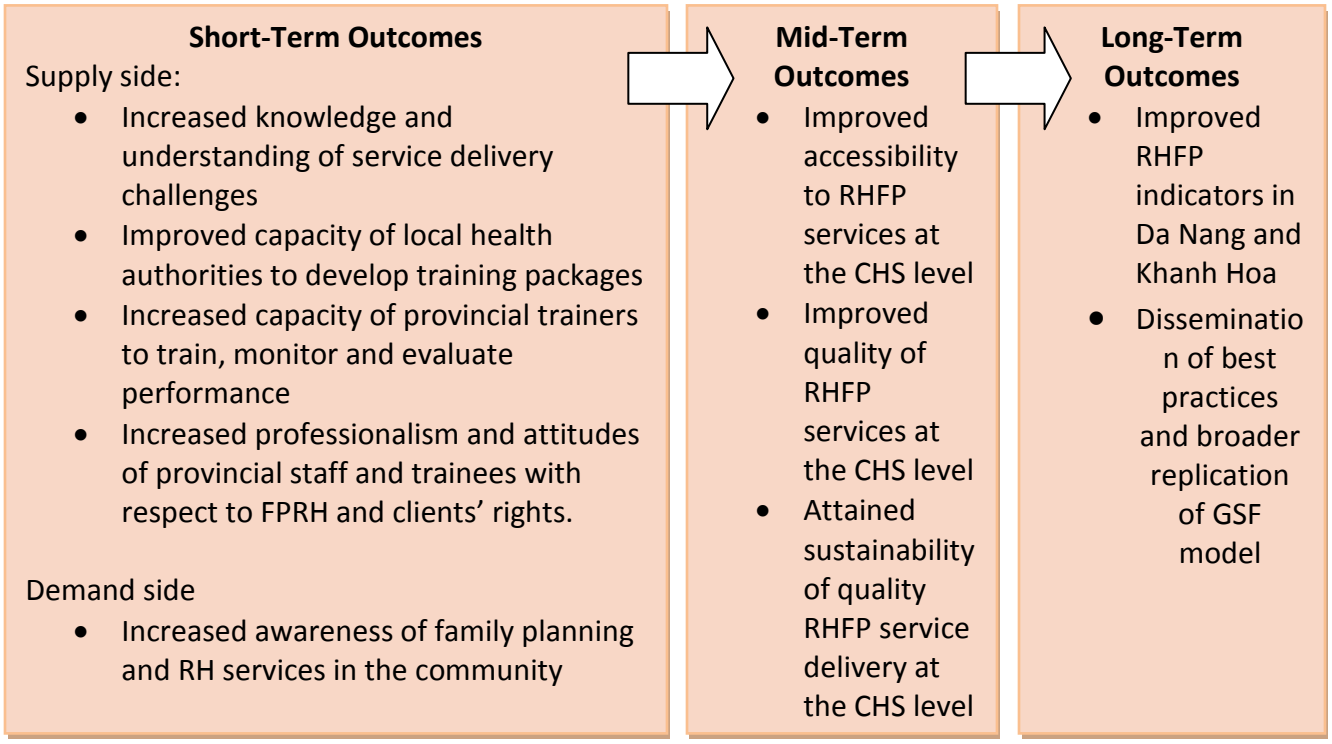
MSI Viet Nam, as a member of MSI Global Network, provides comprehensive RHFP information and services under the core philosophy of "Children by Choice not by Chance". It has extensive experience in working at the grassroots level to enhance the quality of RHFP services and promote equal opportunity in accessing care. Witnessing the myriad RHFP needs in Da Nang, MSI Viet Nam initiated the "Tinh chi em" (Sisterhood) model in 2005 under the project "Building the reproductive health capacity of the commune health network in Da Nang city and Khanh Hoa province". Atlantic Philanthropies (AP) provided additional funding for this project to support the renovation and construction of new commune health stations in the city.

Since its implementation, Tinh chi em has tested the extent to which a social franchising approach increases reproductive health care capacity in the public health care system of a developing country, a model that is hitherto referred to as Government Social Franchising (GSF).

b. Implementation Model

Tinh Chi Em is a fractional government franchise model principally implemented by the Provincial Health Department. MSI Viet Nam plays the role of project coordinator, provider of technical assistance and co-implementing agency.

The ultimate goal of the project is to improve the quality and utilization of RHFP services at the level of Communal Health Station (CHS) through the application of the Government Social Franchise (GSF) model, and contribute to the successful fulfillment of the National Reproductive Strategy of Viet Nam. The specific expected project results are demonstrated below:



The pilot project, implemented over a 3-year period from 2006 to 2008, included the following five key components:

- **Membership:** In order to build the franchise, as well as have CHSs meet specific criteria related to facility infrastructure, and to improve gographical location and human resources, CHSs were invited to join the GSF provider network. In the pilot phase (2006-2008), invitations were extended to 10 rural and semi-urban centres in Da Nang city and 28 in Khanh Hoa.

- **Training:** MSI Viet Nam provided training on social franchising and marketing techniques, quality assurance, customer service and clinical standards maintenance to all CHS staff. The targeted training curriculum was developed following a baseline survey in order to ensure that the training materials met the needs of both the clients and health care providers within the network. A group of provincial master trainers were instructed in competency-based methods to deliver training to all CHS staff. This training strategy helped reduce the cost of implementation and increase the project's log-term sustainability.

At the end of the pilot period, trainings were carried out for 79 individuals at 12 CHSs through a series of nine training courses, surpassing the initial target of 50 health providers in 10 selected CHSs.

- **Fee for services and reward system for health staff:** a reward system for staff in the CHSs was created that consisted of both tangible and intangible items. It was revised in order to encourage staff to perform higher quality services in the clinics. A fee for services was created for some clinical services in order to raise funds for the reward system.

- **Branding and social marketing:** Tinh Chi Em, which translates to "sisterhood" and carries the slogan "understanding, privacy and devotion in healthcare", is a fractional franchise model. Only the RHFP services at member clinics are offered under the "Tinh chi em" brand. Prior to adoption, the brand was extensively evaluated to ensure cultural relevance. Participating clinics were required to have a branded room devoted to the franchised services. Furthermore, a strategic plan for brand promotion included the recruitment of "brand ambassadors" to communicate franchise messages.

- **Monitoring and supervision:** The project was continually monitored and supervised by MSI Viet Nam and provincial teams. These groups also provided technical support and advice. Provincial monitoring team members were known as "buddies" of the CHS, which greatly helped GSF service providers to be open and receptive to their recommendations.

With these five key elements, the "Tinh chi em" (Sisterhood) model provided high-quality RHFP services, including gynecological examinations and treatments, safe motherhood counseling and reproductive health care for adolescents at affordable prices during convenient hours. Furthermore, the franchise has allowed the local population to access RHFP services at conveniently located CHSs, eliminating the need to travel to provincial hospitals.

IV. HUMAN RESOURCES

The Provincial Health Department formed the Project Management Board (PMB) to oversee the implementation of the "Tinh chi em" model. The PMB was created under the direction of the Da Nang People's Committee, a nine-member group that included officers from the local health sector and representative of MSI Viet Nam. The PMB was charged with managing all project activities, ensuring achievement of project objectives, and overseeing the disbursement of funds in accordance with government and donor regulations. The Board was also responsible for maintaining close collaboration with the MSI Viet Nam office and effectively mobilizing local resources to aid the implementation of project activities.

Ten local health care experts were called upon to work as provincial trainers, conducting outreach training for participating CHS staff and providing monitoring and supervision support at selected facilities to ensure quality of services. Additionally, three international experts and six supervisors from MSI Viet Nam were involved in the project implementation.

V. TARGET POPULATION AND OUTREACH

The "Tinh chi em" model was primarily developed to serve women between the ages of 15 and 49 (numbering approximately 200,000 in Da Nang city), as well as their families and partners. Participating CHSs and local partners undertook a number of activities to attract this demographic and promote the "Tinh chi em" brand, including, health festival, street events, community education sessions, and distribution of informational leaflets. A total of 49 communication sessions were organized in local CHS and other community venues, attracting 2,789 women and 172 adolescents. Furthermore, MSI Viet Nam partnered with the Grey Global Group, a leading communication company, to design the counseling rooms, develop a comprehensive marketing strategy, and engage in public relations. A dedicated website, available in both English and Viet Namese, severed as an effective tool to disseminate the project's activities to a wider audience.

VI. PERFORMANCE AND MONITORING

Monitoring and evaluation (M&E) appear to be an outstanding feature of the program. The on-going, supportive system was developed and implemented with the involvement of various partners and provided systematic qualitative and quantitative information on program activities as well as feedback from CHS staff and other stakeholders. The system tracked monthly client volumes, number of new patient visits, and types of service used. Client visits were monitored closely to ensure that all counts were accurate. The monitoring system was further tied to the project's management and financial arms in order to ensure that all funds were used efficiently. A monitoring and supervision team that included five persons from provinicial training team had established by Provincial Health Department mainly responsible for monitoring and supervision of project activities. One staff from MSI Viet Nam involved in the team. Due to team members also as members of Project Management Committee, all problems, issues, and concerns that arose during project implementation were documented and addressed in a timely manner.

An independent group of evaluators conducted mid-term and end-line assessments of the project. Data collection involved a desk review of project documents and mixed method primary data collection. Qualitative methods included: (i) key informant interviews and focus group discussions with project stakeholders (e.g., coordinators, provincial trainers, M&E team, and the head of member CHSs); (ii) focus group discussions with clients; (iii) semi-structured observations of CHSs; and (iv) intercept interviews with local residents in project sites. Interviews and focus groups were tape recorded and transcribed. Data analysis was conducted through the Atlas.ti software. Findings are presented in line with evaluation objectives.

The final project evaluation, performed after the 3-year pilot, revealed a number of noteworthy achievements:

At the programmatic level

- Raising awareness of service delivery challenges at the CHS level among provincial health authorities and garnering government endorsement for the implementation of the GSF model.
- Creating an effective partnership model involving close collaboration between an international NGO, the public health sector, and local government representatives in a developing country context.
- For the first time, successfully testing a GSF health care approach, which integrates a fractional franchise model into public service provision at the CHS level.
- Establishing a brand name for franchised RHFP services.
- Creating a strong team of provincial master trainers who are able to effectively instruct CHS staff in both social marketing/franchising and clinical services.
- Assembling a supportive monitoring system including a strong M&E team to monitor and support the participating CHSs on a regular basis.
- Achieving improved service delivery and utilization.

At the CHS and staff level

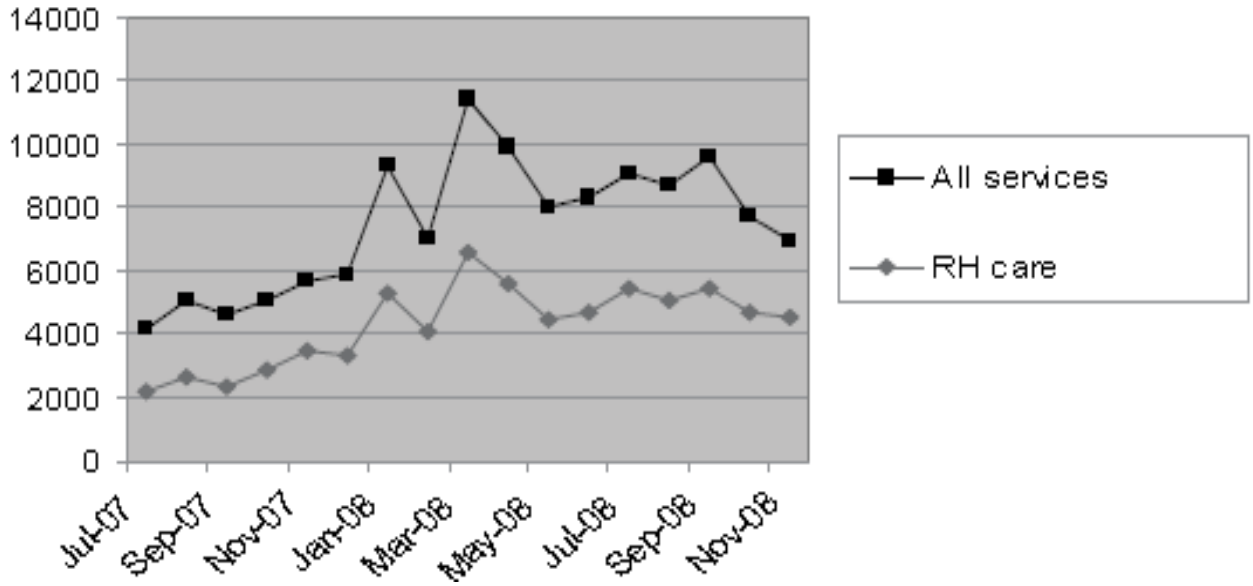
- Significantly improving the appearance and environment of CHS facilities.
- Empowering CHSs to mobilize resources in order to increase the availability of FP brands and RH services that better meets clients' demand.
- Strengthening staff clinical expertise and aiding the development of social marketing/social franchising know-how, including fostering promotional and communication skills.
- Producing a fundamental change in CHS staff attitudes toward integrating business approaches within a public health delivery system.
- Motivating CHS staff to provide high quality services by mandating compliance with brand commitments and quality standards.

At the client level

- Dramatically improving client perceptions of CHS reproductive health care service quality.
- Shifting clients' service utilization preference from other health facilities to their local CHSs.
- Increasing service utilization and client satisfaction.

Monthly reports of franchised CHSs showed the dramatic increases number of clients in CHSs.

Firgure 1. Service utilization in 10 CHSs in Da Nang from July 2007 to November 2008



CHS staff claimed that client volume increased between 20% and 50% during the project period. Although patterns of service utilization were not similar across all GSF clinics, most franchise members experienced higher visit counts for deliveries, gynecological check ups, and ultra-sound tests. Furthermore, many clients reported shifting from private or district level centers to their local CHS for RHFP services.

VII. CHALLENGES AND LESSONS LEARNED

Results of the final evaluation clearly outlined the challenges and lessons learned of project.

1. Challenges

- In Da Nang, consistent application of service fees has proven challenging due to an unequal distribution of medical equipment (i.e., some CHSs were better equipped than others), human resources (i.e., some CHSs were staffed by a full-time doctor while others were not), and differences in service availability. Furthermore, variation in clients' socio-economic backgrounds, financial status, needs, expectations, and willingness to pay has made the consistent application of fees difficult. Therefore, establishing fees for counseling services may have lowered utilization of the "Tinh chi em" branded room. At the beginning, managers and staff felt it was difficult to introduce fee for services to clients as they had been previously free of charge. However, day by day, clients felt

satisfy with higher quality of service and told each other and reputation of brand name Tinh Chi em was increasing.

- An inability to efficiently implement the planned staff incentive scheme resulted in a number of human resource challenges. In several cases, the lack of human resources reduced compliance with brand standards and commitments. CHS staff was often overwhelmed running other national health programs and attending numerous required meetings, resulting in an inability to be consistently available to clients. The human resources shortage was accentuated when CHS doctors left to work in hospitals or in private clinics.

- The second consecutive restructuring of the district-level health system caused a number of difficulties for project management. At the outset of the pilot, CHSs were managed by the District Health Center. During the pilot's second year, a newly established District Department of Health overtook CHS management, only to return management responsibilities to the District Health Center in the third year. This restructuring may have slowed the procurement of essential medicines and clinical equipment as CHSs were mandated to wait for approval from the constantly changing district managing body (e.g., District Health Center and District Department of Health).

- Several RHFP facilities in Da Nang city, including the Provincial RH Center, gynecology department of General hospital, Maternal and Child health department at District Health Center, were considered competitors of the franchised CHSs. Furthermore, the newly established Gynecological and Family Planning Clinic, one of eight reproductive health clinics established by the Reproductive Health Center and MSI Viet Nam, also became a competitor of the "Tinh chi em" franchise in the city. However, it is difficult to say how this competition affected Tinh chi em CHSs as there no data available.

2. Lesson learned

- **Recruitment of franchise members:** An important criterion for the selection of franchise members should be that the CHS has a self-motivated leader who shows strong willingness and enthusiasm to participate in the network. To accurately evaluate this criterion, clear communication about the benefits of joining the network is needed in order to avoid unnecessary misunderstandings. Furthermore, CHS selection should take into account its geographic location and the socio-economic background of its service area. Social franchise efforts appear less likely to succeed in communes located in the city center or near a hospital, areas where a large proportion of the population enjoys a higher standard of living. Therefore, priority should be given to communes with larger segments of lower-middle and upper-lower income residents who can afford to pay a small fee for RHFP services, but may not have the resources to pay for a high-end hospital.

- **Program design:** The development of GSF model has followed the 4Ps marketing principals (Produce, Price, Promotion, Place), integrating a business model in the provision of public health care services. Contributing to its success was a team of able and committed provincial master trainers who were well trained on competence-based teaching methods, able to design a needs based training program, and offer effective instruction. Communication and marketing efforts have addressed both the demand and supply side of RHFP service provision, a model in which staff service attitudes were considered equally important to their clinical or technical expertise. The adaptation of the social franchising and social marketing principles has taken into account the policy environment and socio-economic backgrounds of the target populations for appropriate adjustments.

- **Program implementation:** This project demonstrates that successful implementation of the GSF model requires effective coordination of project staff and collaboration among different provincial and commune-level stakeholders. In this regard, MSI Viet Nam not only provided technical assistance, but also played the leading role of project coordinator. At the CHS level, a close relationship between the CHS and commune authorities also appeared vital to the program's successful implementation. This was particularly true in the introduction of service fees, an undertaking that required advocacy and lobbying skills in order to gain the support of commune authorities. As noted earlier, implementation of the GSF model faced numerous barriers. Among these, the discord between the population health program supported by the Population Committee and the GSF model remains a significant challenge, one in need of a resolution before service fees can be applied. Last but not least, increasing CHS autonomy could result in better sustainability of the model.

- **Program sustainability:** The improvement in professional skills and attitude among health staff that resulted from supplementary training courses and supportive supervision activities played important role in sustainability of project. It brought with it the reputation of brand name and attracted more clients, and therefore increased income for CHSs. More over, leaders of health sectors had positive attitude toward this model and argeed to continue support to sustain and replicate of the model in the province. Procedures in development and implementation of GSF model was transfered from technical support organization to local partners contributed to sustainability of the model. Beside, provincial training team continue conducted training in the province for staff of CHSs and provided regular supervision, that contributed improve quality of care.

- **Monitoring and evaluation:** The program's success has in large part been due to an effective M&E system led by an M&E team that fulfilled dual functions: providing project supervision to foster CHS compliance with brand commitments and quality standards, and offering continual instruction on compliance with promised brand standards.

VIII. FINANCIALS

The pilot project's total budget was US$ 319,578, a sum directly managed by MSI Viet Nam. The project did not apply any kind of risk pooling, cross subsidization or voucher mechanisms.

Due to the fact that the government fully or partially subsidized many health care services at local CHSs, it was quite difficult to introduction user fees into the franchise as an additional source of revenue. User fees were eventually introduced in all 10 franchises in Da Nang in January 2007 and effectively raised CHS income.

The Tinh chi em service fees were mostly fixed to cover operating costs and sustain project activities. However, the initiative explored a number of fee-for-services arrangements that were adaptable to the local context, (e.g., economic status, availability and quality of health stations, and clients' willingness to pay).

Table 1: Total disbursement of the project

No.	Activities	1st Year	2nd Year	3rd Year	Total
A	**Management cost** (Administration, project personnel, office equipment, etc.)	**19,980**	**28,601**	**33,826**	**82,407**
B	**Fundamental activities** (Surveys, workshops, printing, trainings, M&E etc.)	**150,391**	**58,453**	**28,327**	**237,171**
TOTAL		**170,371**	**87,054**	**62,153**	**319,578**

IX. GROWTH PLANS (2009 – PRESENT)

Recognizing the increased number of clients visiting CHS to take advantage of the RHFP services, a number of CHSs have expanded their package of services to include screening for cervical cancer and counseling on new topics such as pre-menopause, pain relief during labor, and safe abortions.

Most staff of member CHSs strongly believed that they were able to sustain the "Tinh chi em" brand. Furthermore, provincial staff has shown strong commitment to continue and expand the GSF model to other communes. To support this expansion, the team of provincial master trainers has expressed willingness to provide continued training for staff at all newly selected CHSs.

After the completion of the pilot period, the Da Nang Health Department asked for support from Atlantic Philanthropies and Marie Stopes International to strengthen and expand the

Government Social Franchise network to the entire city, particularly, to the mountainous and remote areas not previously covered by the franchise. At the end of 2009, ten additional CHSs in suburban Da Nang were selected to join the GSF network, increasing the number of participating CHSs to a total of 20 in Da Nang and 76 in two provinces (Da Nang and Khanh Hoa).

The Expansion Phase that followed the pilot has focused primarily on: i) advanced training on quality RH care such as pre-natal care, deliveries, and post-natal care, counseling and communication, and management skills; ii) development of Information Education and Communication materials; iii) monitoring and evaluation; iv) upgrading the "Tinh chi em" counseling room; and v) further procurement of medical equipment.

The total budget for the expansion period is as follows:

a) Donor Funds:	about US$ 64,030 (VND 1,258,000,000)
b) Local contributions:	about US$ 32,070 (VND 630,000,000)

Furthermore, MSI Viet Nam has allocated an additional US$ 1,500 (VND 28,000,000) to all ten "Tinh chi em" member CHSs in order to promote the utilization of IUD contraception and help reach national utilization targets.

Based on success and lessons from Da Nang and Khanh Hoa, Atlantic Philanthropies continues to support three other provinces in Viet Nam, including Thai Nguyen in the North (25 communes), Thua Thien Hue in Central Viet Nam (25 communes) and Vinh Long in the South (20 communes). These provinces will apply Tinh Chi em model from 2009 to 2012. The same project management structure as in Da Nang and Nha Trang will be put in place in all three provinces, in which Provincial Health Deparments implement projects as role of franchisor and MSI Viet Nam provide technical assistant. In total in Viet Nam, there are 146 communes joined Tinh Chi em network.

ANNEXES

Sources of information:

1. Summary of project *"Building the reproductive health capacity of the commune health network in Da Nang city and Khanh Hoa province".*
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8. Interview Dr. Pham Thanh Nhan: Dean of Planning Section – Health Department of Da Nang city
9. Interview a team of project officers at MSI Viet Nam
10. Observation of Tinh Chi em Commune Health stations in Da Nang

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