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What can social franchising bring to government health services?

by Rekha Viswanathan

Presentations delivered at the recent Global Conference on Social Franchising for Health suggest franchises have quite a bit to bring to the table. Several programs are already working creatively with the public sector to meet gaps in publicly managed care, and to spread government interventions for universal health and financial protection through private provider networks. Download the Conference Report to read brief summaries from the Conference sessions.

For this issue of the newsletter, I interviewed two health services programs that are using different approaches to engage the public sector. I wanted to learn how they work, how the government is involved, and what (if any) plans they have for sustaining these interventions over the longer term.

Profile 1: Alive & Thrive

Alive & Thrive (A&T) is a multi-country initiative to save lives, prevent illness, and ensure healthy growth and development through improved breastfeeding and complementary feeding practices. In Viet Nam, A&T conducts research to influence policies related to health and nutrition, conducts interpersonal communication and mass media efforts to address barriers to optimal infant and young child feeding (IYCF), and supports government owned commune health centers (public clinics) to apply social franchising principles to enable the provision of good quality infant and young child feeding counseling services.

The program was launched in 2009 with funding from the Bill & Melinda Gates Foundation. The governments of Canada and Ireland have since joined as donors. FHI 360 manages the program, Save the Children is the lead implementer, and the International Food Policy Research Institute (IFPRI) is the lead evaluation partner. GMMB supports this initiative with policy advocacy activities. The National Institute of Nutrition (NIN) in Viet Nam and the Alive & Thrive program team were co-franchisors until 2014, when the NIN assumed the role of sole franchisor.

I spoke to Nemat Hajeebhoy, Program Director of Alive & Thrive in Viet Nam, and Phuong Hong Nguyen, IFPRI Research Fellow.

Rekha: Why was the franchise program started?

Nemat: In Viet Nam the government services operate pretty well at the local level, so this was an opportunity we wanted to capitalize on.

We conducted an assessment of government health facilities at commune, district and province level to see how to move forward with the program through them. In the original assessment, we discovered

that midwives were not using a standardized approach to IYCF—one that was timed and targeted. At this point, the Government had already done work with Marie Stopes focusing on reproductive health, through their Blue Star and Tinh Chi Em programs, so we proposed franchising as a feasible approach to improving and standardizing IYCF counseling services. The government was receptive.

Rekha: Why would you characterize this program as a franchise?

Nemat: You know, that's a debate unto itself. The important thing is we are adapting social franchising principles for this program. Julie McBride (Population Services International) did a feasibility study and showed franchising could work in this space. What characterizes it as a franchise is the brand, the physical space, the willingness of providers to provide standardized services, the willingness of patients to pay, and the ownership and commitment of the program at the government level.

Rekha: You mentioned willingness to pay. Do people pay for this service?

Nemat: Technically, services to children under five years of age are provided free-of-charge; however, some provinces are looking at charges for this service. We are also investigating different revenue generation strategies in addition to user fees, like the sale of nutrition products, and compensation from the national health insurance program.

Rekha: This is a time-bound program. Did you have a transition plan from the outset?

Nemat: Yes, partnering with the National Institute of Nutrition at the outset and ensuring that the activities were in line with a variety of nutrition policies and strategies in Viet Nam was a key part of the transition plan from the outset. Over time, discussion and dialogue with the government at all levels enabled further elaboration of the sustainability plan for the 781 franchises already set up with project funding. In 2012, the Bill & Melinda Gates Foundation extended the program period by one year (from 2013 to 2014). This flexibility has allowed us to articulate sustainability and replication plans for each of the 15 provinces where A&T activities are implemented.

Initially, 781 franchise clinics were set up. In 2014, with co-investment from provinces, an additional 250 franchises were in fact set up. In 2015, there are plans for provinces to set up another 250+ using their own resources.

Rekha: What is the main ingredient for success at the province level?

Nemat: Human capital and leadership. Province by province, the implementation varies. Provinces with greater commitment and strong leadership have a greater likelihood of replicating and scaling up the program.

Rekha: Lessons learned?

Nemat: Setting up the brand (with such high standards for physical space) was so tedious. We have now developed a minimum brand package.

Rekha: Tell me how your program is able to leverage the national budget.

Nemat: The government of Viet Nam was already committed to IYCF, and it had an annual nutrition budget. Basically, we helped them do what they already committed to doing. To enable further investment from the government we did a costing study and used that information to advocate for the public sector insurance package to cover nutrition services. What we found was that if the government scaled up standardized IYCF services to 80% of its clinics, this would be a fraction of the nutrition budget.

As part of this process we had to undertake some important advocacy. First of all, malnutrition was not considered an illness so first we had to enable a change in this notion, and translate malnutrition services into three health services that could be costed and covered by health insurance: nutrition examination of the child, age-appropriate counseling, and treatment for children with signs of malnutrition.

The health insurance law was reissued recently. Unfortunately, we were not successful in getting these services included in the law, though we are working toward inclusion in sub-laws and sub-decrees. Also, as with other national target programs, the national target program for nutrition's budget will be cut by 65% this year.

Rekha: What implications does this have for the financing of the program?

Nemat: With minimal budget, we still have champions at the province level. Also, we have trained personnel in so many clinics and we expect them to sustain their improvements in care, and abide by the updated Standard Operating Procedures.

Rekha: What's your five year vision for the program?

Nemat: First, it's sustaining the current investment and ensuring the smooth operation of the 1200+ franchises. Then it's the expansion of the network in Viet Nam, both within the current provinces as well as to other provinces. Finally, we would like to see the program expand to neighboring countries. In Viet Nam we will continue to provide minimal technical assistance to NIN through mid-2016, and we will do an evaluation at that point to look at the sustainability of replication of the program in the country.

Additional reading and resources:

- Visit the WHO's Global Database on the Implementation of Nutrition Action to read a summary of the program's strategies and aims.
- Download Alive & Thrive's "Toolkit: Resources for infant and young child feeding counseling services in social franchise."
- Learn about the model applied by Alive & Thrive to deliver infant and young child feeding services.
- Learn about the program's methodology for evaluation.

To contact Nemat or Phuong, visit https://knowledge-gateway.org/sf4health and post a message.

Profile 2: BroadReach Healthcare

BroadReach Healthcare is a private company that offers strategic advice and consulting services to government and donor agencies, and operates health programs in various countries. Its portfolio includes a range of work in South Africa, including the development and management of a social franchise program in the North West Province. This program, also called the GP (General Practitioner) Programme, is intended to relieve the burden of patient care from the public hospital system by using private sector providers to manage the care of people that are living with AIDS.

The program was launched in 2005 with in-kind support from the North West Province Department of Health, and USAID grant funds.

I spoke to Shuabe Rajap, Senior Manager of Operations in South Africa, and Chandbi Tajeer, Project Manager, South Africa.

Rekha: How does the program work?

Chandbi: People living with AIDS are initiated on treatment at a public hospital, where they are stabilized for six months. They are then referred to a private GP or clinic participating in the BroadReach Healthcare franchise. If a patient acquires an opportunistic infection or requires treatment for another condition such as hypertension and diabetes, the GP will continue to provide treatment and care. Other conditions are referred back to the hospital.

Rekha: Tell me the history behind the launching of the program.

Shuabe: At the time (2005), there was an incredible need to get people on treatment —when there was no official national ARV program. The North West Province had a more progressive outlook, and they wanted a non-traditional approach—one in which they would be owners of any treatment initiative.

The local Department of Health (DOH) met BroadReach Healthcare at a conference, and subsequently contacted us. We promoted the concept of a PPP model. The DOH bought in, on the condition that it would provide ARVs and lab services. BroadReach Healthcare, with USAID funds, would pay for the consultation fees of the GPs.

Rekha: That was the genesis of the program. How has the program evolved?

Shuabe: Since then, there have been program changes to ensure sustainability. We are slowly withdrawing our input into the program.

For example, we used to have a peer outreach to trace clients that were not adhering to their treatment and management. Now, we have support groups and community structures involved in tracing patients. We also used to enroll patients into the program. Now, the DOH personnel enroll patients.

Rekha: Tell me about the practical challenges of transitioning BroadReach Healthcare's work to the DOH and others.

Shuabe: To be honest, we were nervous about the transition, as we had excellent program results. So, we closely reviewed standard operating procedures, and built watertight agreements with partners.

There are teething problems. So we continue to give technical advice and assistance where we see issues in implementation. For instance, we continue to give input to public hospital managers, as their buy in and commitment to this program is essential.

Rekha: I understand BroadReach Healthcare oversees and assesses quality of franchised services. Who will do this in the future?

Shuabe: We will continue to offer technical assistance to the DOH to get them to deliver these sorts of quality oversight and support services to GPs. Basically, we are looking at the gaps that the DOH has identified, and we are helping them resolve those issues.

For instance, we have a well-maintained disease management system in place. This involves the use of data management systems. However, our vision is to transition data management to the DOH. The challenge is that the public system is not as robust. So we are providing technical assistance to improve its efficacy. A major data transition at this stage would be risky.

Rekha: Why would you characterize this as a social franchise program?

Shuabe: Firstly, the programme does not have an independent branding with logo—the DoH and BroadReach logos are jointly used due to our longstanding partnership. Secondly, we do have a reputation that precedes us, by virtue of excellent results. Lastly, the model may be replicated at scale with other local DoH structuress owning the process.

Rekha: Are there membership fees?

Shuabe: No. We want to make the program attractive to GPs. And the consultation fees they charge under the programme are very affordable compared to private sector rates.

Rekha: Can GPs that participate in the network expect to make a profit?

Shuabe: We appeal to the social motivation of GPs. Under this program, they are paid ZAR 110 (Rand) for the health services they deliver. Normally, they would receive about ZAR 300.

Rekha: How do you make this program attractive to GPs? Tell me about the program's history of growth and membership.

Shuabe: It started by linking a Wellness Center (attached to a public hospital) with 5 GPs. Through marketing, we got 20 GPs to enroll and we extended the program to two other towns (with links to two other public hospitals). Now we have also created links from publicly operated primary health centers to GPs.

Our process of recruitment involves a process of localizing the program and getting buy in from the right people. When we first move into a town, we work with the local Independent Practitioners Association (IPA), and all private providers are networked into them. For the program to work, it is essential that the IPA buys in.

Also, the public sector, which provides the GPs with the necessary up-to-date training in the management of HIV/AIDS, are partners in this effort.

Rekha: This is an intensive process of localization and relationship-based marketing of an idea. What implications does this have for scale-up of the program?

Shuabe: Buy-in from all stakeholders is crucial, especially for localization and marketing.

We want to engage the National DOH, and that will be an important part of scale-up.

Chandbi: Also, we will continue to expand the basket of services to address co-morbidities commonly associated with HIV and AIDS, like hypertension and diabetes.

Rekha: What's your vision for the next five years?

Shuabe: Sustainability. We are transitioning day-to-day functions to the DOH. We also want the DOH to budget for the GPs' fees.

We will also strengthen the DOH data management system and move the data to their system. Lastly, as Chandbi mentioned, we will continue to expand services beyond ARVs.

Additional reading and resources:

Igumbor J, Pascoe S, Rajap S, Townsend W, Sargent J, et al. (2014) A South African Public-Private Partnership HIV Treatment Model: Viability and Success Factors. *PLoS ONE* 9(10): e110635. doi:10.1371/journal.pone.0110635.

To contact Shuabe or Chandbi, visit https://knowledge-gateway.org/sf4health and post a message.

SF4Health is a Community of Practice that includes agencies that support or operate social franchise programs in dozens of countries, social franchise programs from 40 countries, academic and research institutions and donor organizations.

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The Social Franchising Community of Practice is managed and convened by the Global Health Group at the University of California, San Francisco.