

GLOBAL HEALTH

Innovation Insight Series



Photo courtesy of Greenstar

A mother and child during a visit to a Greenstar clinic in Pakistan

PSI: Taking a Service Model to Scale

WASHINGTON, DC

ESTABLISHED 1970

KARL HOFMANN,
PRESIDENT AND CEO

THE PROBLEM/SOLUTION SPACE

Family planning involves the use of contraceptive methods to help women and couples plan and achieve their desired number of children, as well as the timing and space between births.¹ The need for family planning is particularly acute in developing countries, where an estimated 75 million unintended pregnancies annually place a significant burden on women, families, and society.² In these regions, pregnancy and childbirth are the leading causes of mortality among young women ages 15–19.³ Unsafe abortions add to the high rates of maternal death and morbidity.⁴ Unplanned births also limit women’s participation in income-generating tasks and community activities, and they contribute to high population growth in countries with limited resources.⁵

STANFORD
BUSINESS

GRADUATE
SCHOOL OF

Program in
Healthcare Innovation

STANFORD

CENTER FOR INNOVATION
IN GLOBAL HEALTH



Despite the great need for family planning, contraceptive use in most developing countries remains low. More than 220 million women in emerging economies have an unmet need for family planning services (meaning that they would prefer to avoid or postpone a pregnancy but are not using any contraceptive method).⁶ The reasons for this unmet need vary across regions and include cultural barriers, concerns about health and side effects, lack of access, and cost.⁷ One of the keys to potentially overcoming these obstacles involves offering women a full range of available contraceptive methods. Because only certain approaches may be acceptable based on cultural practices or religious beliefs, and as women may need both short- and longer-term options at different points in their lives, access to multiple contraceptive methods can help women find one that fits their individual circumstances.⁸



Photo by Aisha Talha, courtesy of Greenstar

Patients discuss family planning options with a healthcare provider at a Greenstar clinic

ABOUT PSI

Population Services International (PSI) was founded in 1970 as a nonprofit organization focused on improving reproductive health in developing countries, using commercial marketing strategies. Over the years, PSI broadened its mission to address the lack of family planning, the need for HIV and AIDS screening and treatment, barriers to maternal health, and major health threats to children under the age of five. Working in partnership with local governments, nongovernmental organizations (NGOs), and ministries of health, PSI now utilizes innovative communication and distribution techniques to increase the demand for, and the delivery of, health services and products.⁹

In 1995, as part of ongoing efforts to provide critical health services in developing countries, PSI sought to address the high unmet demand for family planning in Pakistan. “There were many Pakistani women, especially those on the lower end of the socioeconomic scale, who said they want to have fewer children but were not using a birth spacing or limiting method,” said Julie McBride, Technical Advisor for Sexual, Reproductive Health & Tuberculosis at PSI.¹⁰ Before developing a solution, however, PSI team members wanted to be certain that they understood the reasons for the discrepancy. “We didn’t want to assume that it reflected inadequate information and launch an educational campaign, or that the problem was access and could be solved by supplementing the supply chain to boost the availability of over-the-counter contraceptives,” said McBride. “For our solution to be effective, we needed to understand the barriers to family planning from the point of view of the consumer.”

After conducting field research and interviews, the team determined that the Pakistani women needed a greater variety of options. “In order for the women to be able to make changes or act on their desire to practice family planning, they had to have access to a whole range of family planning methods, including more clinical methods like the IUD [intrauterine device],” McBride stated. This realization refocused PSI’s investigation on health care providers. “Because they recommend and administer a number of the methods, they play a critical role in enabling women to actually use family planning,” McBride said.

Based on the organization's earlier work in Pakistan, PSI knew that the majority of low-income women sought healthcare services from the private sector. Yet, despite being better equipped than public healthcare facilities, these private providers were generally not delivering family planning services. To understand why this was the case, the PSI team applied its model of looking at "motivation, opportunity, and ability." "We learned that the private doctors were not motivated to provide family planning because they felt that it was the domain and responsibility of the public sector, even though the women

were coming to their private clinics for care," recalled McBride. "And they had little financial incentive, because family planning is a low margin service. Even more significantly, when we looked at their ability, we realized that few providers actually had the necessary training and skills to counsel clients, perform IUD insertions, or prescribe pills or injectables." McBride concluded, "Finally, because women didn't explicitly ask for these services, providers who might have been willing and able to deliver them did not have the opportunity to do so."

We learned that the private doctors were not motivated to provide family planning because they felt that it was the domain and responsibility of the public sector... and they had little financial incentive

Based on these insights, the PSI team developed a plan to identify community service-oriented providers who wanted to help Pakistani women with family planning, and then train them to provide a full range of clinical contraceptive services. "We felt that providing training to motivated providers who were already practicing in the private sector would be the fastest way to make family planning services more widely available," summarized McBride.

ONE CHALLENGE: TAKING A SERVICE MODEL TO SCALE

As a major NGO with a wealth of accumulated experience and significant resources at its disposal, PSI had the knowledge and ability to provide training to physicians. However, in order to educate enough providers to make a meaningful difference in a country with a population of more than 176 million, it would need to scale its training program quickly. This required devising a compelling business model with incentives to motivate qualified providers to participate. "We had to make providing family planning services both professionally and financially rewarding," said McBride. The second challenge to successfully achieving scale would be raising the awareness and visibility of the trained providers so that Pakistani women could find them. "We could identify providers who might have some motivation. We could build their skills by training them, but that led to another set of problems, which was, how would clients or potential clients, know which providers to go to for these services? Until we could solve that problem, there would still be a gap between supply and demand," explained McBride.

THE SOLUTION: BUILDING AND BRANDING A MOTIVATED PRIVATE PROVIDER NETWORK

To meet these challenges, PSI decided to leverage the idea of franchising. "We had this vision of a branded network of trained providers—a social franchise," described McBride. The operational mechanisms of the franchise model could be structured to incentivize the providers. By building the network from already established private medical practices, PSI could grow the franchise quickly and cost effectively. Importantly, the

franchise would also establish a recognized brand that patients knew and trusted, which was critical to achieving scale. “The branding was the key to helping patients find trained providers and feel comfortable about the quality of care,” said McBride. Before launching a nationwide undertaking, however, PSI needed to implement a pilot study to test and validate the social franchising concept.

To find doctors for a pilot study, PSI turned to its local affiliate “Greenstar” (formerly called Social Marketing Pakistan, an NGO that PSI formed in 1991). Among the organization’s staff were a number of healthcare providers, including Dr. Rehana Ahmed, a well-known and respected Pakistani doctor with deep connections in the medical community. Dr. Ahmed, who has since become known in the global health community as “the mother of social franchising,” was instrumental in helping to recruit highly-regarded providers for the initial study. Emphasizing the importance of this contribution, McBride noted, “If you want the program to work in the long run, you have to make the pilot work successfully. Recruit really good people, and you have a higher likelihood of success.”

More specifically, the doctors would have to meet certain essential criteria in order to become franchisees. While PSI could incentivize doctors with the promise of an increase in overall business, the team wanted to work with providers who were personally motivated to help women with family planning. “We wanted healthcare professionals whose personal values were aligned with PSI’s mission and wanted to deliver these services, not just capitalize on the brand,” explained McBride. Other criteria were tied explicitly to the local context. “In Pakistan, only qualified medical providers are allowed to do IUD insertions. So they had to be doctors. And they had to be female, because no Pakistani woman would go to a male doctor to have an IUD inserted.” A fourth important qualification was for the doctor to be the owner and operator of the practice in order to ensure both control and accountability for upholding high quality standards.



Photo courtesy of PSI

A Greenstar outreach worker explains family planning products to a client

With a handful of providers selected for the pilot, PSI focused on designing an operational framework for the franchise, which would become known as Greenstar Social Marketing. The framework set out both incentives and benefits that PSI would provide to the doctors, and the expectations and responsibilities of the providers as participants in the franchise. As PSI expanded its social franchising program in Pakistan, these responsibilities were clarified and documented in a manual. Across the years, as PSI implemented social franchises in other countries, the organization refined the business model further to make it even more comprehensive and robust.

Ultimately PSI’s social franchise model comprised four components. First, the franchisee operating system established standards for clinical quality and customer experience. The standards ensured that services were affordable and available to all clients. They also set productivity expectations and accountability for the delivery of franchise services. The second component was the franchisor operating system, which defined the selection criteria for providers as well as the support that would be provided to them in terms of training, facility development, and ongoing supervision. The third element encompassed

health financing, designed to regulate and motivate providers, such as providing wholesale equipment and commodities, which the providers could mark up and resell as appropriate. “We want providers in our network to feel an altruistic need. But they are also private sector business people, so we need to provide a financial incentive to make this an interesting and sustainable proposition for them,” said McBride. Health financing was also meant to remove barriers to care for clients. For example, it might promote a voucher system or partnerships with local health insurance companies.

The final element in the franchise agreement directly addressed PSI’s initial challenge of raising awareness of the trained providers so patients could easily find and access them. By branding and marketing the network, patients could readily identify facilities owned by trained providers and feel confident that they were receiving high-quality care. A good first experience was likely to lead the women to patronize the franchise providers

for other medical services beyond family planning. It would also encourage them to refer other women to the practice. PSI maintained specific guidelines to help ensure a positive patient experience and monitored franchisee performance. In exchange, it promoted the Greenstar network through marketing efforts that included mass media, signage, and interpersonal communications campaigns.

PSI evaluated the Greenstar pilot program in Pakistan based on its effectiveness in three key areas. As McBride described, “We looked at how being a member of the franchise affected the quantity of family planning clients that the facility received, as well as the quality of services that were being delivered by the providers. We also

looked at how it affected the overall client load of the facility, because we had promised providers that offering family planning services would increase their client base and revenues.” The pilot program delivered positively on all three measures. “Our research evaluation indicated that the quality of care being delivered was dramatically improved. It also showed that the number of family planning clients that the franchise facilities received doubled, and that there was a significant increase in the number of clients using other services as well,” McBride said.

Importantly, the pilot study revealed that the ongoing support offered to the providers by PSI was the most essential component in ensuring the success of the franchise. It also differentiated the franchise from other NGO interventions that focused only on training. Through monthly, in-person visits marked by open communication, the franchise support person (a Greenstar employee who is most often medically qualified) learned the needs of the franchisee and helped devise relevant solutions. This support ranged from ongoing coaching and mentoring to improve clinical skills, to operational support such as help with record keeping and customer relations, to supplying needed equipment. “The support and supervision helped detect potential problem areas and correct them in a timely and effective manner,” said McBride. “These partnerships were not only perceived as being valuable by the providers, but they became central to our whole business model.”

Reflecting on the development of the social franchising model, the PSI team believed that it was a mechanism for effectively providing patients with better access to higher-

Our research evaluation...showed that the number of family planning clients that the franchise facilities received doubled, and that there was a significant increase in the number of clients using other services as well

quality services. It also fostered broader social benefits. For example, by working with established providers rather than training new doctors and creating a parallel system, the franchise program helped strengthen the existing healthcare infrastructure. “Pakistan, like many developing countries, has a large but fragmented private sector, which the government is not fully equipped to regulate,” explained Nikki Charman, PSI’s Global Services Marketing Manager. “Not only does the franchise model rapidly improve the delivery of services, but it provides needed training and quality assurance. So at a very macro level, franchising is a fundamental way to help organize the private sector on behalf of the public health agenda.”

In Pakistan, and in 24 other countries around the globe as of March 2013, PSI demonstrated that social franchising can be a highly effective way to achieve scale by making a specific business strategy replicable. However, given the complexity of the model, McBride encouraged innovators interested in using the social franchising approach to start with the existing blueprints that PSI and others have already created based on best practices. From there, she stressed taking the time to carefully validate the business concept, then testing and refining it before going to scale. “There is a tendency, especially in the world of international development where there is pressure to quickly take projects to scale, to jump from the blueprint stage of developing a business to the scale stage,” she cautioned. “Once you are certain the business concept is really solid, be sure you understand the organizational capabilities needed to execute the strategy effectively, and make sure those resources are in place. Only after all those steps have been completed should the innovator consider going to scale.” She concluded, “Franchising is a great way to replicate a business strategy, but first you’ve got to make sure that your business is foolproof. We want to replicate success, not failure.” ♦

NOTES

- 1 “Family Planning,” World Health Organization, 2013, http://www.who.int/topics/family_planning/en/, (March 8, 2013).
- 2 Rachel Williams, “Breaking Down Barriers to Birth Control,” *The Guardian*, July 10, 2012, <http://www.guardian.co.uk/society/2012/jul/11/sexual-health-roundtable/print>, (March 9, 2013).
- 3 *Ibid.*
- 4 Lori Ashford, “Unmet Need for Family Planning: Recent Trends and Their Implications for Programs,” Population Reference Bureau, February 2003, <http://www.prb.org/pdf/UnmetNeedFamPlan-Eng.pdf> (March 9, 2013).
- 5 *Ibid.*
- 6 “Family Planning,” World Health Organization, Fact Sheet N°351, July 2012, <http://www.who.int/mediacentre/factsheets/fs351/en/index.html>, (March 8, 2013).
- 7 Rhonda Smith “The Faces of Unmet Need for Family Planning,” Population Reference Bureau, July 2012, <http://www.prb.org/Articles/2012/faces-unmet-need-familyplanning.aspx>, (March 10, 2012).
- 8 *Ibid.*
- 9 “PSI at a Glance,” PSI.org, <http://www.psi.org/about-psi/psi-at-a-glance>, (January 9, 2013).
- 10 All quotes are from an interview conducted by the authors in February 2013, unless otherwise stated.