CASE STUDY:
“SURAJ” - A PRIVATE PROVIDER PARTNERSHIP

Marie Stopes Society, Pakistan

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ABOUT I&B

i&b Consulting is a management and organizational development consulting services firm that provides organizational development and technical assistance centered on strengthening the capacity of nonprofit organizations, government agencies and corporations.

Some of the services that i&b provides are: Organization and Management Development; Program and Project Management; Strategic Planning; Monitoring and Evaluation; Impact Assessment; Human Resource Development; SWOT Analyses; Gender Integration and Mainstreaming; Communication Skills; Retreats; and Capacity Building (including Training of Trainers) through participatory, hands-on, interactive workshops.

Our consultants have several years’ experience in the private and NGO sectors. Clients have included donors agencies and local and international NGOs such as DFID, Swiss Development Corporation, the Aga Khan Foundation, the Aga Khan University, Marie Stopes Society, Aahung, the National Committee for Maternal and Neonatal Health (NCMNH), Shirkat Gah, Enterprise and Community Development Institute (ECDI), Mercy Corps, and the World Population Foundation.
1. EXECUTIVE SUMMARY

In Pakistan, the private sector makes a significant contribution to the provision of family planning services. Contraceptive prevalence is at 30 percent, and unmet need for contraceptives is 25 percent, meaning that one out every four Pakistani women would either like to stop having children, or would like to wait two or more years before having another child, but are not using any method of family planning.

One of the objectives of the new draft of the Population Policy of Pakistan is to increase family planning use to 70 percent by the year 2025. Approximately two-thirds of Pakistanis live in rural areas, which often tend to be remote and difficult to access.

Programs such as Suraj can therefore play a significant role in expanding access to family planning services, since the providers under this program are primarily located in rural areas where other health facilities are missing.

The Suraj Private Provider Partnership

Marie Stopes Society’s Private Provider Partnership, known as Suraj (an Urdu word meaning ‘sun’) aims to increase demand, access, and choices and provide improved quality services for Family Planning and Reproductive Health for underserved and poor communities through building an integrated network of service delivery outlets. MSS launched Suraj, a Private Provider fractional social franchising initiative, as a pilot project from 2008-2012.

This initiative is one of the main components of the organization’s National Expansion Project and is a partnership between MSS and private local Health Service Providers in rural areas.

In each intervention district, MSS has established a center for provision of reproductive health services. Within a radius of 10 km of the MSS center, community based distribution (CBD) field workers conduct door-to-door visits to provide counseling, distribute contraceptives, and make referrals for clinical services to MSS centers for injectables and IUCDs. The referrals include referrals for vouchers to clients who qualify for them based on a poverty assessment tool used by MSS. In the areas beyond the 10 km radius of the MSS centers, where access to qualified and trained health providers is severely limited, the private providers provide services to clients.

There are currently 100 providers operating in 18 districts in the provinces of Sindh and Punjab. In 2009, a total of 77,736 clients have been served, with an average of 777 clients per outlet.

The Suraj private providers are trained and accredited by MSS and provide family planning services to clients referred to them by the field workers marketing referral vouchers. The field worker marketing conducts door-to-door visits to market the Suraj brand and services, mobilizes the community, generates referrals and distributes vouchers to potential clients.

The partially franchised facilities provide basic family planning services under the

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1. Pakistan Demographic and Health Survey, 2006-07.
2. Pakistan Demographic and Health Survey, 2006-07.
Suraj logo, namely, supply of birth control pills and condoms, administration of injectable contraceptives, and insertion and removal of IUCDs (Inter-Uterine Contraceptive Device).

Case Study Methodology
This case study was conducted using primarily qualitative methods. The study applied the standard template provided by MSS to the external consultants developing the case study. The consultants interviewed one senior member of the MSS team for information about the franchisor. They also traveled to four field sites identified by MSS and interviewed four private providers and twelve clients, using the questionnaires provided by MSS. The consultants referred frequently to other MSS staff to address queries that arose through the development of the case study.

In addition to the interviews, a literature review was conducted of background materials on the Suraj Private Provider Partnership. Additional materials, such as the Pakistan Demographic and Health Survey 2006-07 and other relevant documents, were consulted for data as needed.
2. CONTEXT

2.1 National Population and Health Status

<table>
<thead>
<tr>
<th>Summary Statistics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>180 million³</td>
</tr>
<tr>
<td>Percent rural</td>
<td>65%⁴</td>
</tr>
<tr>
<td>Percent urban</td>
<td>35%</td>
</tr>
<tr>
<td>Gross national income per capita (int.$ 2004)</td>
<td>US $ 2300⁵</td>
</tr>
<tr>
<td>Life expectancy at birth m/f (2004)</td>
<td>64.6 years⁶</td>
</tr>
<tr>
<td>Under Five Mortality Rate (per 1000 live births, 2004)</td>
<td>94⁷</td>
</tr>
<tr>
<td>Percent of public expenditure on health (% of GDP)</td>
<td>0.4%⁸</td>
</tr>
<tr>
<td>Percent of private expenditure on health (% of GDP)</td>
<td>1.8%⁸</td>
</tr>
<tr>
<td>Maternal mortality rate - MMR (per 100,000 live births)</td>
<td>276⁹</td>
</tr>
<tr>
<td>Unmet need for family planning</td>
<td>25%¹⁰</td>
</tr>
<tr>
<td>Contraceptive prevalence rate – CPR</td>
<td>30%¹⁰</td>
</tr>
<tr>
<td>Contraceptive prevalence rate – modern methods</td>
<td>22%¹¹</td>
</tr>
<tr>
<td>Total fertility rate – TFR (2005)</td>
<td>4.1¹²</td>
</tr>
<tr>
<td>Percentage of births attended by a skilled birth attendant</td>
<td>31%¹³</td>
</tr>
<tr>
<td>Percentage of one-year olds immunized against measles</td>
<td>78%¹⁴</td>
</tr>
<tr>
<td>Percentage of one-year olds immunized against tuberculosis</td>
<td>82%¹⁵</td>
</tr>
<tr>
<td>Adult literacy rate</td>
<td>55%¹⁶</td>
</tr>
</tbody>
</table>

⁵ World Development Indicators 2007. World Bank.
⁷ Pakistan Demographic and Health Survey 2006-07, p. 90.
⁹ Pakistan Demographic and Health Survey 2006-07, p. 177.
¹⁰ Pakistan Demographic and Health Survey 2006-2007, page 81.
¹¹ Pakistan Demographic and Health Survey 2006-07, p. 56.
¹² Pakistan Demographic and Health Survey 2006-07, p. 42.
¹³
**Population.** Pakistan is considered to be the sixth most populous country in the world with a population of 180 million. If the population grows at the current rate, it is estimated that it will reach 459 million by the year 2050. Even if the total fertility rate declines to two births per woman, it will be 335 million by 2050.\(^{17}\)

**Fertility.** The Total Fertility Rate (TFR) in Pakistan is 4.1 per woman. It is important to note that for Pakistan, the fertility rate takes into account all women between the ages of 15 and 49, regardless of whether they are married or not. Given that in this country most births take place within marriage, it is also important to look at marital fertility, which is 6.6.\(^{18}\)

**Fertility preferences and unmet need for FP.** 25 percent, or one out of every four women, say that they would like to stop having more children or wait two or more years to have another child, but are not doing so at present.

**FP and current method preferences.** 22 percent of currently married women are using a modern method of contraception; 8 percent are using a traditional method. Knowledge of family planning in Pakistan is widespread; 96 percent of ever-married and currently married women age 15-49 know of at least one method of family planning. It is important to note that the most popular family planning method is female sterilization (8 percent), followed by condoms (7 percent), withdrawal (4 percent), and the rhythm method (4 percent). The IUCD, injectables, and pills are each used by 2 percent of married women.

Use of male sterilization and implants is negligible.

**Safe motherhood and abortion.** In Pakistan, one out of every three pregnancies is unplanned. According to a national study on abortion conducted by the Population Council in 2004,\(^{19}\) 890,000 induced abortions take place in Pakistan every year, most of which are performed in an unskilled environment, or by unskilled providers, or both. About 200,000 of these induced abortions end in complications and unsafe abortion is considered to be a significant contributor to maternal deaths in Pakistan. The current abortion law, amended in 1990, states that pregnancy can be terminated if carried out in good faith during the early stages of pregnancy in order to save the life of a woman or to provide ‘necessary treatment’. Many providers are unaware of the law, with the result that many women resort to unsafe abortions.

It is also important to note that most women who opt for an abortion are age 30 or above and have completed their desired family size, indicating that if they had been able to plan their families, they may have avoided having an abortion which could potentially be unsafe.

### 2.2 Healthcare System

Pakistan has 71,000 nurses and midwives, 19,000 other health service providers and 126,000 physicians. For every 10,000 people, there are 5 midwives, one other

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\(^{18}\) http://www.unicef.org/infobycountry/pakistan_pakistan_statistics.html

health service provider and 12 hospital beds.

70 percent of healthcare is provided through the private sector. The public sector is large but does not work efficiently. Problems occur with supplies and staffing, and facilities often tend to be poorly maintained. Frequent changes in government also lead to frequent changes in staff at all levels. Salaries within the government health sector tend to be low and private practice is much more lucrative and hence preferred by most providers. Therefore, access to healthcare tends to be very expensive for the average Pakistani who relies on private sector facilities.

Greenstar Social Marketing, one of the leading organizations in Pakistan for social marketing of contraceptives, plays a significant role in providing access to family planning services for the poor; however its outreach tends to be primarily urban and semi-urban.

There are several associations for private providers such as the Pakistan Medical Association, the Pakistan Nursing Council, the Pakistan Society of Obstetricians and Gynaecologists, and the Midwifery Association of Pakistan.

There is little interaction between private and public providers; however, due to recent efforts by the NGO sector, especially through advocacy with the Ministries of Health and Population Welfare, both at the federal and provincial levels, this picture is slowly changing. Many private providers who are also engaged in the NGO sector have begun interacting with senior people within these Ministries to advocate for policy change and implementation.

Nevertheless, the relationships that are being developed between the private and the public sector are largely individual-driven; for example, the current Health Secretary is supportive of public-private partnerships as are several senior people within the Population Welfare Ministry. If any of these individuals are transferred, there is no guarantee that their successors will be interested in continuing to build these relationships; thus, at present, public-private relationships are being developed, rather than institutional public-private partnerships.

Regarding health financing, total expenditure on health is estimated at 2.1 percent of GDP and private expenditure on health is 83 percent of total expenditure on health.

General government expenditure on health as a percentage of total expenditure on health is 17.5 percent and general government expenditure on health as a percentage of total government expenditure is 1.5 percent. Per capita government expenditure on health is approximately US $ 9.20

Given that only 31 percent of births are attended by skilled birth attendants, the number of available healthcare providers is low and is concentrated mostly in the urban areas, which are home to a minority of the population.

While public health facilities are free or very low cost for the poor, they tend to be poorly staffed, managed and equipped, and even though the services may be provided

20 http://www.who.int/whosis/database/core/core_select.cfm
free of cost, patients and their families generally have to bear the cost of all supplies and medications.

The Lady Health Worker (LHW) program, which has around 100,000 LHWs across the country based mostly in peri-urban and rural areas, has played a significant role in expanding access to family planning. LHWs report to the Ministry of Health and while their primary mandate is advocacy for and provision of family planning services, they are often required to work on other campaigns such as polio and immunization.

2.3 Regulatory Framework for Private Providers
Registration bodies for private providers exist, such as the Pakistan Medical and Dental Council, which requires registration from all providers upon completion of medical studies, and the Pakistan Nursing Council, which has similar requirements for nurses. However, enforcement of these regulations is relatively weak; many unqualified personnel run clinics that are not monitored in any way, and do not face restrictions in opening or running these clinics.

Drug regulation is similarly weak and many unqualified providers disburse ‘home made’ medication and remedies. Over the counter medication is easy to obtain since no prescription is required, which further facilitates practice by unqualified providers. A Drug Regulatory Authority exists, but does not function efficiently and drug distribution is not rigidly regulated.

2.4 Market Opportunities
Given the above situation of a large population, high marital fertility, and the fact that the majority of the population lives in rural areas where service provision is relatively low, it is apparent that there are significant market opportunities for the private sector. In an earlier assessment of the Suraj Private Provider Partnership conducted in late 2009, several of the clients interviewed revealed that the Suraj providers were the only healthcare providers in their areas that were easily accessible and were therefore a popular choice.

While Greenstar Social Marketing provides family planning services to a large population, their outreach, as mentioned earlier, is mostly urban and semi-urban. Thus there is significant potential to work with previously untapped healthcare providers in rural areas and to expand provision of services and products through the Suraj Private Provider network.

The number of private providers is on the rise, primarily due to the growing population and their accessibility. There are significant market opportunities for the private sector, since, according to the providers interviewed, the quality of the services provided by the government is poor. The target population is also increasing because many women who previously lacked awareness or access to family planning are now being reached through mechanisms such as the MSS Field Worker Marketing.
3. BUSINESS MODEL

3.1 The model

3.1.1 Franchisor

Marie Stopes Society (MSS) was registered in 1990 as a non-profit, social enterprise to provide reproductive health and family planning services to the people in Pakistan. MSS is a global partner of Marie Stopes International (MSI), a UK based organization with partners in 43 countries around the globe.

In addition to providing franchising services, MSS provides reproductive health services including family planning and provision of safe post abortion care through its MSS centers and clinics as well as outreach programs for communities near the centers. They have a website on adolescent sexual and reproductive health (www.srhmaters.org), to which people can submit queries. They also have a nationwide toll free confidential helpline with trained telephone counselors who answer questions and provide referrals if needed.

MSS operates in 73 out of 126 districts in Pakistan and is one of the leading private reproductive health service providers in the country.

3.1.2 Franchisor relationship with government

MSS has several formal relationships with the government. 36 MSS centers are registered with the government, and the government contracts out to MSS for running Tubal Ligation services.

In addition, MSS has signed separate MoUs (Memorandums of Understanding) with the Provincial Population Welfare Departments in Punjab and Sindh for mobile outreach services.

MSS also frequently engages with the Ministry of Health as a consultative partner, and the MOH actively supports the organization’s work. The Managing Director of MSS is also a board member of NATPOW, the National Trust for Population Welfare, which is a subsidiary of the Population Welfare Ministry.

3.1.3 Franchisees

There are 100 franchisees in 18 districts in Sindh and the Punjab, with an average of five franchisees per district, which includes Lady Health Visitors; nurses, doctors and midwives. They are referred to as Suraj providers, and all accept vouchers.

The voucher scheme is an Output Based Aid (OBA) voucher scheme launched by MSS for IUCD insertion, follow-up and removal through its accredited private providers. The voucher concept has both demand and
supply innovations in financing healthcare by subsidizing clients directly and reimbursing providers only after services are actually delivered. The target population for the MSS OBA voucher scheme is poor married women of reproductive age (MWRA) in need of family planning methods in selected areas of intervention. This OBA scheme contains a comprehensive guideline for voucher development and printing, distribution, redemption, validation and reimbursement to ensure accountability and transparency at all levels. To determine compliance and detect potential fraud, an external firm has been engaged to conduct annual validation of a sample of redeemed vouchers.

Suraj facility staff is female and usually have the provider and one MSS Field Worker Marketing (FWM). Prior to becoming a franchisee, providers offered basic out-patient services to women and children such as treatment for minor illnesses, treatment for coughs and colds, etc. Some providers were already providing basic family planning services, albeit with very low client volume.

### 3.1.4 Target population

The target population for the franchisees is rural poor, mostly married women with children. The target population is the same for all franchise services, including those provided by voucher. The market rate for IUCDs in the area in which the franchisees operate is Rs. 400-500, which is at least five times the cost of short term methods such as pills, injectables and condoms. Therefore, those who qualify for an IUCD through the voucher system because they meet the poverty criteria are able to have access to long term family planning methods.

Franchisees who were already providing services in family planning prior to the inclusion in the franchise operations report an increase from 2-3 clients per week per provider (verified by the base-line reports) to 20-22 clients per week per provider (as per the operational data of MSS Pakistan).

Additionally, the providers note that even those women who have fewer children but would still like a gap are coming in for family planning services. Clients also state that free commodities are an incentive to them to visit the clinics and avail the services provided. In addition, clients find the staff to be friendly and personable, say that the Suraj clinics are cheaper than others, and appreciate the flexible hours.

Providers say that clients who would not be able to afford an IUCD feel comfortable coming in with a voucher because they do not feel as though they are asking for charity. Providers try to ensure that all clients are treated the same way.

### 3.1.5 Services offered under franchise

Suraj Providers currently provide basic contraceptive services. In addition, they provide family planning counseling, free insertion and removal of IUCDs for OBA voucher holders, and referrals where required. MSS also plans to introduce post abortion care services at private providers’ clinics.

The Field Workers Marketing who are placed at each provider’s clinic do door-to-
door marketing; provide referrals to Suraj Clinics; and distribute OBA vouchers using the poverty ranking tool. The Poverty Ranking Tool is a participatory assessment using nine self-reported indicators to determine whether a client qualifies for a voucher for an IUCD. The indicators include average number of meals per day, type of housing, average income, number of earning members in a family, number of dependants in a family, access to clean drinking water, access to reproductive health services, etc. (see Annex 1 for details). The poverty ranking tool and voucher distribution is also verified by the Senior Field Supervisor.

<table>
<thead>
<tr>
<th>Suraj Services</th>
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</thead>
<tbody>
<tr>
<td>Family planning counseling</td>
</tr>
<tr>
<td>Contraception oral pills</td>
</tr>
<tr>
<td>Condoms</td>
</tr>
<tr>
<td>Intra Uterine Contraceptive Device (IUCD) Insertion</td>
</tr>
<tr>
<td>Intra Uterine Contraceptive Device (IUCD) Removal</td>
</tr>
<tr>
<td>Injectable contraceptives</td>
</tr>
<tr>
<td>Emergency Contraceptive Pills</td>
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</tbody>
</table>

All franchisees offer the services mentioned above, with IUCDs forming the majority of the client load. In 2009, 39 percent of the client load came from IUCD vouchers. Some of the franchisees were also offering these services prior to joining Suraj, but say that they were under-utilized; the marketing provided under Suraj has helped increase utilization of the services. Family planning awareness in the communities where they work has increased and they feel that the quality of their work has improved since they are now following formal infection prevention protocols.

MSS has selected these services because of the relatively low contraceptive prevalence rate (30 percent) and high unmet need (25 percent) in Pakistan. Vouchers have been offered for IUCDs because many women want a long term family planning method such as the IUCD but cannot afford it since it is significantly more expensive than short term methods such as oral pills, injectables and condoms. A few of the providers interviewed said that approximately 80 percent of their clients use the voucher services since the clients in the areas where they operate have low socioeconomic profiles. The clients interviewed said that they found the voucher scheme extremely useful and helpful for accessing long term family planning.

### 3.1.6 Commodities offered under franchise

Under the Suraj franchise, MSS sells condoms, oral contraceptives, injectables, intrauterine contraceptive devices, pregnancy test strips, and two disinfectants (Savlon and Unicon) to the Suraj providers. MSS offers the providers different short-term and long-term contraceptives, so that they can provide these products to their clients. The pregnancy test strips are marketed to them to help with their provision of FP services. To improve infection prevention standards, MSS offers the providers two high quality disinfectants, which are not available in their local markets.

They are also looking for new products to distribute to the providers that will help improve their clients’ lives and are currently exploring different health products to introduce in the future.
3.1.7 Scalability

The current model is very scalable. The requisite systems are in place but there is a need for funding in order to expand. As part of a study that MSS is conducting for the Research and Advocacy Fund (RAF), they will be setting up 30 additional providers.

In the pilot phase, Suraj has established 100 franchisees since its inception in November 2008 and the plan is to scale up to 500 franchisees in all four provinces of Pakistan by December 2012, contingent on adequate funding and support.

At scale, the franchise will contribute significantly to national service provision for the foremost long-term contraceptive method available in Pakistan, the IUCD.

Introducing a new service or commodity into the existing network would be fairly straightforward. If it was a simple product (e.g. a fast dissolving infection prevention disinfectant tablet), then the field teams could brief the providers and distribute it. If it was a service, MSS would need to plan, coordinate, and conduct training sessions for franchisees. All the franchisees interviewed said they could immediately introduce a new product or service. The main challenge for MSS when introducing a new component would be in ensuring that it was being used properly in the initial phases after introduction. For example, when the disinfectants were first introduced, it took some of the providers some time to learn how to mix them properly.

The voucher scheme is an integral part of the Suraj franchise and also has many systems in place for running it, so it would be possible to scale this up quite fast. The future sustainability of the voucher scheme depends on donor support. MSS is exploring ways to broaden the number of donors supporting the scheme, and in the longer term, it seems like a feasible mechanism for the Government of Pakistan to take over.

Franchisees report that they could easily integrate a new service or commodity into their existing practice – awareness for this would need to be raised by the Field Worker Marketing, fliers, etc. They also say that they could comfortably increase the number of clients per day from 6 (at present) to about 8-12.

3.2. Summary statistics

3.2.1 Number and types of franchisee outlets

There are 100 outlets across the provinces of Sindh and Punjab. All outlets are stand-alone clinics with one franchisee per outlet. All outlets have the contraceptive commodities mentioned earlier and any equipment required. This includes syringes for administering injectable contraceptives and the equipment required for insertion and removal of IUCDs such as an examination bed, sterilizing equipment, proper facilities for waste disposal, cotton, gauze, alcohol swabs, and relevant medical instruments.

There are no different categories of franchisees, nor is there any tiered structure. 65 percent of the franchisees are Lady Health Visitors who have undergone basic reproductive health training provided by the government; 20 percent are...
midwives and the rest are nurses and qualified doctors.

Franchisees say that since becoming a Suraj provider, they have more clients, are given more respect, are appreciated more because they now provide free services, and they value the association with an established organization such as MSS.

3.2.2 Number and types of commodities and services provided

In 2009, 56 percent of total family planning clients availed IUCDs for long term family planning services and 44 percent of clients chose short-term family planning methods. Of the total long term family planning users, 61 percent of clients paid out of pocket and 39 percent used vouchers.

Excel based dashboard tools are developed to summarize commodities and services both on a monthly as well as a cumulative basis. The cost per CYP (Couple Year of Protection) is approximately US $ 3\(^{21}\) and in 2009, MSS generated 243,674 CYPs.

Franchisees make daily diary entries for services provided; and there is also weekly reporting and a bi-monthly check of commodities.

3.3 Service Finances

3.3.1 Prices for commodities and services

Suraj providers purchase subsidized commodities from MSS for about Rs. 3 per unit – for all long and short term family planning methods except condoms, which cost Rs. 0.50. Prices are standardized for all Suraj centers. A price list (given below) is prominently displayed in all clinics. However, based on the discretion of the provider, an informal sliding scale is in place for charges for commodities, depending on how much the clients can afford to pay.

Franchisees charge a service cost from voucher and non-voucher clients, which includes the cost of the commodity.

Providers feel that they have an advantage in the market over other, non-Suraj providers due to the fact that they provide free services, which not many people are doing; in fact, other private providers charge large amounts of money for similar services.

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\(^{21}\) Note: US $ 1 = Rs. 86
### 3.3.2 Payment sources

All voucher and non-voucher clients pay out-of-pocket for services depending on what they can afford. Franchisees also said that clients’ inability to pay is a constant challenge since they serve mostly low income populations. As a result, an informal sliding scale is in place, as discussed above.

A few franchisees also said that they feel compelled to offer services for free or at highly reduced cost when serving the poorest clients. Clients who qualify for vouchers for IUCD insertion receive the IUDs free of cost and do not have to pay any charges. Clients who do not qualify pay the full amount of Rs. 200.

As a few of the franchisees remarked, ‘The low cost items like injectables, pills and condoms are mostly distributed free because the clients are too poor to pay for them.’ The poverty is clearly highlighted by an example that one of the franchisees gave: ‘One client wanted an injectable. She inquired about the cost and left before I was able to inform her about the sliding scale. The woman then tried to save up enough money to pay for the injectable but by the time she was able to do so, she was already pregnant.’

### 3.3.3 Subsidies

There are commodity-specific subsidies for franchisees and commodities are provided to providers and clients at below-true prices. Subsidies are implicit, i.e., franchising education and support are given free or at minimal cost. The value of the subsidies is communicated to franchisees during orientation.

### 3.3.4 Pricing enforcement systems

MSS requires standard prices for all items and services across all locations. Providers cannot charge more than these prices for any commodity or service. Each provider has a price list available in her clinic and the
Field Worker Marketing states the prices to clients when she goes on her door-to-door visits.

There is no formal sliding scale in place but there is an unofficial/informal sliding scale through which prices may be adjusted based on the providers’ subjective assessment of their clients.

Quality checks take place on a regular basis to ensure that a standardized pricing system is in place; there is also a 24-hour call centre where issues can be reported. In addition to accepting complaints, the call center also provides: client counseling, information on what services are available and where they can be availed; and back-up support to clients, private providers and field workers in case of emergency. If a provider charges above the standard price, she is first given a warning and is then de-accredited from the Suraj partnership; however, franchisees tend to follow the pricing system and have not been observed over-charging their clients.

Clients are given a voucher worth Rs. 200 for each IUCD. This is below the market rate for this commodity, which is generally priced at about Rs. 400-500. Vouchers are reimbursed at below market rates. Pricing has been determined through a mapping exercise and through assessing the amounts that clients indicate they are willing to pay. Clients do not report paying additional fees.

### 3.4 Franchise Finances

#### 3.4.1 Country operation costs - overall and breakdowns

MSS’s total budget for 2009 was US $ 8.2 million, of which the total budget for the Suraj initiative was around US $ 560,611. A breakdown of expenditure under the Suraj initiative is given below:

<table>
<thead>
<tr>
<th>Item</th>
<th>Breakdown (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Expenditure</td>
<td>10%</td>
</tr>
<tr>
<td>Training, Accreditation, Monitoring &amp; Evaluation</td>
<td>25%</td>
</tr>
<tr>
<td>Management Information System</td>
<td>1%</td>
</tr>
<tr>
<td>Survey And Research</td>
<td>3%</td>
</tr>
<tr>
<td>Marketing</td>
<td>21%</td>
</tr>
<tr>
<td>OBA Vouchers</td>
<td>8%</td>
</tr>
<tr>
<td>Administrative Cost (overheads [13%], personnel cost [19%], etc.)</td>
<td>32%</td>
</tr>
</tbody>
</table>

Since the initiative’s inception there have not been any significant changes in total cost, although changes have occurred within budget heads.

#### 3.4.2 Cost-sharing with other activities/programs if any

Suraj is widely advertised; 21 percent of the total budget is dedicated to marketing the initiative. MSS does not cost-share with other activities or programs.

Community Health Workers are utilized as part of the National Project. They are not directly part of the Suraj program, but in areas where they are present, they provide guidance to the Field Workers Marketing on where to locate potential clients who are
not being served by government health centers.

MSS’s Field Workers Marketing (FWM) mobilize communities on reproductive health/family planning through door-to-door visits in selected areas. These FWMs are MSS employees and in addition to community mobilization, they refer clients to Suraj outlets; distribute vouchers; and help in voucher validation.

### 3.4.3 Donors

The project is funded by an anonymous donor. It does not receive any financial or in-kind support from the government. The annual commitment for Suraj is approximately US $ 560,611.

### 3.4.4 Cost subsidy per unit

The Suraj cost is about US $ 3 per CYP. The total cost subsidy per voucher is Rs. 200, of which Rs. 150 is for the provider to insert an IUCD, Rs. 20 for follow-up by the provider and Rs. 30 for IUCD removal by the provider.

“**A partnership between MSS and private local Health Services Providers to increase demand, access, choices and quality services of Family Planning & Reproductive Health for underserved and poor communities through building an integrated network of service delivery outlets.**”
4. FRANCHISE OPERATIONS

4.1 Franchisee Relations

4.1.1 Franchisee selection

At present, Suraj is targeting the two most populated provinces in the country, Sindh and Punjab.

The selection criteria to select franchisees are that they need to be female, be formally qualified, be well-known in the community, be willing to provide family planning services and adhere to the protocols established by MSS. Providers’ interpersonal skills and enthusiasm for their work also play an important role in selection.

<table>
<thead>
<tr>
<th>Franchisee Selection Criteria Summary</th>
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</thead>
<tbody>
<tr>
<td>Owned or staffed by a female</td>
</tr>
<tr>
<td>Formally qualified</td>
</tr>
<tr>
<td>Located in target areas</td>
</tr>
<tr>
<td>Well-known in the community</td>
</tr>
<tr>
<td>Interested in providing SRH services</td>
</tr>
<tr>
<td>Willing to attend training</td>
</tr>
<tr>
<td>Willing to keep records &amp; report</td>
</tr>
<tr>
<td>Willing to adhere to protocols estab-</td>
</tr>
<tr>
<td>lished by MSS</td>
</tr>
</tbody>
</table>

4.1.2 Recruitment

Franchisees are recruited by the Regional Executive- Private Provider Partnership, and the Field Operations team (District Project Officer, In-charge Field Operations and Senior Field Supervisor). Franchisees are not currently being actively recruited; however, recruitment needs to be done when occasionally franchisees are de-accredited and there is a need to fill their slots.

All providers are approved for vouchers.

4.1.3 Contracts

After potential franchisees have completed their training, they are assessed by an external consultant, undergo a written test, an oral assessment, and are observed for IUCD insertion. Once they clear this process, they are internally accredited by MSS and a partnership is developed through a formal contract. They are also charged a nominal Annual Network fee of Pak. rupees 150, which is about US $ 2. Contracts are enforceable and are actively enforced; members sign them willingly, without any trepidation. There is no different contract relating to voucher scheme participation.

The contract outlines the rights and obligations for both MSS and the franchisees. Franchisor responsibilities include regular training on family planning and business management skills, ensuring a regular supply of low-cost contraceptives, distribution and reimbursement of vouchers, providing materials for branding and marketing, providing facilities for microfinance, and conducting regular monitoring and evaluation.

Terms within the contract also include franchisee responsibilities, such as adherence to quality measures, attending training, maintaining and reporting accurate records of services provided and commodities distributed, ensuring prominent display of the Suraj brand, maintaining stock records, honoring vouchers for redemption by MSS, paying an
annual membership fee, and following protocols established by MSS.

The contract also states that either party can retract from the agreement with one month’s notice.

4.1.4 Costs/benefits of enrollment

Providers benefit when the Field Workers Marketing create a demand for the FP services through their community-based marketing since providers profit when non-voucher clients seek family planning services. Providers also benefit from the voucher scheme when they reimbursed Rs. 200 on each voucher service cycle.

Trainings and ongoing support are regularly provided to the franchisees and different teams from MSS also visit the franchisees on a regular basis to address any issues that may arise and provide support. Franchisees are given the option of purchasing commodities from MSS or elsewhere. For products purchased directly from MSS, the cost is deducted from their monthly reimbursement for vouchers. Providers are not required to contribute towards marketing of the program, products or services, but are welcome to do so if they wish.

Start-up loans are available to franchisees and MSS has signed a Memorandum of Understanding (MoU) with the largest micro-finance bank in Pakistan to provide loans to eligible private providers for upgrading their health centers if needed. However, no providers have availed this micro-finance facility yet. The most likely reason is that the interest rates are relatively high. MSS is exploring a commercial loan arrangement with several banks that will provide more competitive interest rates.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Training</td>
<td>• Receiving supervision/monitoring visits</td>
</tr>
<tr>
<td>• Subsidized commodities &amp; free</td>
<td>• Adherence to standards and protocols in</td>
</tr>
<tr>
<td>equipment</td>
<td>service provision</td>
</tr>
<tr>
<td>• Technical assistance</td>
<td>• Record keeping and reporting</td>
</tr>
<tr>
<td>• Guaranteed supply availability</td>
<td>• Annual membership fee</td>
</tr>
<tr>
<td>• Branding, signage &amp; painting</td>
<td>• Appropriate use of Suraj logo</td>
</tr>
<tr>
<td>• Wider range of services</td>
<td>• Training</td>
</tr>
<tr>
<td>• More clients &amp; revenue</td>
<td></td>
</tr>
<tr>
<td>• Demand creation</td>
<td></td>
</tr>
<tr>
<td>• Microfinance facility</td>
<td></td>
</tr>
</tbody>
</table>
4.1.5 Ongoing membership fees

There is an annual membership fee of Rs. 150 (approximately US $ 2) obtained through a cashless monthly deduction.

4.1.6 Franchisee retention/attrition

MSS selects, trains, and accredits providers, after which the organization enters into an agreement with them for one year. At the end of the year each private provider’s performance is reviewed and MSS decides whether to renew the agreement with the provider. In 2009, 14 private providers left out of a total of 100. Of these, four were de-accredited due to poor performance and lack of adherence to agreed commitments, and ten left due to personal reasons.

Regular monitoring visits by a variety of teams from MSS improve provider satisfaction and service quality. A 3-tiered monitoring system (district, regional and support office level) is in place for Suraj centers in which operations and technical teams visit the centers. In addition, a third-party voucher validation takes place once a year and there is also an annual quality services audit.

4.1.7 Loyalty/level of commitment

Most franchisees appear very enthusiastic about the program and have made it a significant part of their practice. They appear conscientious about completing all paperwork, filling out the required forms and registers, etc. Franchisees also state that they greatly value the training that MSS has provided and find that it has significantly enhanced their knowledge and skills.

4.1.8 Communication

Communication with providers is maintained through site visits by various teams from MSS, including the Quality Assurance department, Internal Audit department, Organizational Development department, and Communications and Marketing department.

The Senior Field Supervisors are district based and visit the franchisees on a weekly basis. They in turn report to the District Project Officer (DPO) who schedules a visit to the franchisee locations every fortnight. The main link between the MSS Head Office in Karachi and franchisees in the three regions are the Regional Executives (RE) who perform quarterly visits. Additionally, the district and regional teams are in routine contact by phone and text messages with the franchisees, which is an inexpensive way of maintain contact. This form of supervision is quite cost effective and is easily scalable as the system is already in place and the addition of new services would be demanding in terms of time and not expense.

4.2 Quality Assurance

4.2.1 Quality

Quality Assurance is rigorous and extensive. Providers are evaluated for six parameters through a Monitoring Checklist which is completed by staff teams that visit providers as well as by external auditors on a regular basis. The parameters are:

- Client Focused Centers, which relate to the overall condition of the centre,
hygiene, availability of an examination bed, etc.

- Supplies from MSS, which verifies the availability of contraceptives and assesses the efficiency of the supply system.
- Instruments and Equipment, which assess the condition of the instruments and equipment including availability and use of sterilization equipment.
- Counseling, which assesses the quality of the family planning counseling given by the providers to their clients.
- Procedure, which assesses providers’ knowledge of insertion and removal of IUCDs.
- Infection Prevention, which assesses providers’ awareness and knowledge of infection, use of appropriate gloves, sterilization of equipment, appropriate disposal of waste, etc.

MSS is particular about addressing any quality issues that may arise. For example, an external audit conducted in 2009 using this checklist revealed infection prevention as a relatively weak area. In response, MSS took measures to ensure that proper waste disposal methods were in place.

4.2.2 Training

All providers go through a five-day training upon selection, which includes three days of theoretical and practical training on reproductive health and family planning, counseling, quality of services, and IUCD insertion and removal, and two days of business training that focuses on developing basic skills in budgeting, record keeping, stock management, cash flow planning, branding, marketing, the OBA voucher scheme and business development plans.

They are also provided with annual refresher trainings which highlight the project objectives and address the findings of the internal quality assurance department as well as third party quality audits. The refresher trainings also incorporate areas of improvement identified during monitoring visits by the operations teams.

Additionally, the Quality Assurance department, which consists of trained doctors, facilitates and provides on-the-spot training when non-compliance to standards is observed.

Franchisees appreciate the training and say that it has significantly improved the quality of their services, which has helped to increase their client base.

4.2.3 Managing adverse events and complications

A referral plan, reporting and follow-up protocols are in place and regularly adhered to so that adverse events and complications can be managed effectively in a timely manner.
4.2.4 Monitoring and evaluation

There are several layers of monitoring and evaluation on an operational level which are conducted by the field teams. Vouchers are initially validated by the Senior Field Supervisor and the MSS Internal Audit team also conducts site visits to perform voucher validations as well as to evaluate the quality assurance standards. The MSS Quality Assurance team facilitates the maintenance of quality standards. In addition to that, external third party Quality Assurance and Voucher Validations are conducted on an annual basis.

Some franchisees also collect feedback from clients on the quality of their services. Franchise reporting requirements include reporting on a weekly basis to the Field Worker Marketing and a register is maintained by providers for record keeping.

4.3 Logistics

4.3.1 Procurement and delivery processes

MSS purchases commodities bi-annually. These are stored in a central warehouse and delivered to district offices on a quarterly basis. The private providers purchase the commodities from the district offices every month, based on their need. Procurement is done regularly and efficiently, and providers did not report facing any shortages in supplies. Providers can purchase commodities from the market or from MSS. According to the operational data of MSS, 70 percent of private providers were buying contraceptives directly from MSS whereas 30 percent were procuring them from other sources in the local market.

4.3.2 Sales and inventory management

Sales and inventory management is done manually at the private provider level; at support office level MS Excel-based templates are used. The providers use stock reports which they generate bi-monthly, and data sharing is done on a monthly basis.

4.3.3 Voucher claims processing & systems

Providers receive reimbursements for vouchers by check on a monthly basis within 15 days of submission. The cheque is issued from the Support Office and is
delivered through the District Project Officer/Senior Field Supervisor.

4.4 Network Linkages

4.4.1 Promotions/marketing

The total budget for the Suraj initiative for 2009 was around US $ 560,611 of which 21 percent was dedicated to marketing.

Marketing is done through field visits done by the Field Worker Marketing, posters, wall paintings, leaflets, etc. The Suraj logo, which is displayed prominently in Urdu outside all clinics, is also another means of effective marketing. In addition, large branded posters detailing the available services in Urdu are displayed prominently in some of the centres.

The clients said that the best means of marketing was the Field Worker Marketing, since she was from their community and therefore known to them, and because she brought the information to their homes.

<table>
<thead>
<tr>
<th>Promotions and Marketing Strategies used to date</th>
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</thead>
<tbody>
<tr>
<td>Branding</td>
</tr>
<tr>
<td>Signage</td>
</tr>
<tr>
<td>Mohalla (community) meetings</td>
</tr>
<tr>
<td>Field Worker Marketing mobilization strategies</td>
</tr>
<tr>
<td>Suraj Friends (Key stakeholder )</td>
</tr>
</tbody>
</table>
4.4.2 Client referrals IN to clinics

Clients are referred ‘into’ clinics by the Field Worker Marketing who conducts door-to-door visits. Franchisees also have clients who were coming to them prior to becoming Suraj providers, and informal networks are in place such as word of mouth. The franchisees’ public relations skills and local reputation appeared to hold considerable weight. Several of the clients interviewed reported that they came to a particular provider because of her attitude and the empathy she displayed. Very few clients said they had noticed the Suraj logo prior to visiting the clinic for a service because women’s mobility is quite restricted in most of the areas that the franchisees serve, due to conservative sociocultural norms.

4.4.3 Client referrals OUT from clinics

Franchisees can refer clients to MSS health centers for permanent contraceptive methods (tubal ligation and vasectomy) and post abortion care (PAC) services.

In some instances, in larger cities where Community Health Workers are present, the MSS Supervisor and the Field Worker Marketing meet with the Community
Health Workers (CHWs) 2-3 times a week. The CHWs guide them on where they can access clients who cannot be serviced by the government’s BHUs (Basic Health Units) due either to issues of access or because the BHUs do not provide urgent service, which MSS does. These potential clients are taken to either MSS centers (Behtar Zindagi) or Suraj, depending on proximity.

4.4.4 Outreach workers

A female Field Worker Marketing (FWM) is assigned to each Suraj private provider, and she visit households in the Suraj franchisee’s catchment, raises awareness about the range of family planning methods available with the Suraj provider, reinforces the Suraj brand image, uses the poverty assessment tool to screen potential clients for eligibility for the IUCD voucher, distributes vouchers, and makes referrals to the Suraj clinic for FP products and services. The FWMs are paid a basic salary by MSS, and they do not currently receive incentives.

4.4.5 Links to other organizations

Several MSS health centers are registered with the Ministry of Population Welfare (MoPW) as RHS (Reproductive Health Services) “B” centers. For outreach activities, relationships have been established with the district level Ministry of Population Welfare offices to coordinate camps, and they also link with Lady Health Workers (LHWs) for outreach follow up. Through MSS’s membership in the Pakistan Alliance for Post Abortion Care (PAPAC), they are connected with a range of NGOs trying to ensure post abortion care in Pakistan.
5. CHALLENGES AND OPPORTUNITIES

5.1 Internal Challenges

5.1.1 Establishing product mix

MSS has not faced any challenges in establishing the product mix or in integrating new products. Since the providers in the Suraj network are already well-established, it took some time for the marketing agents who work with the providers to get members of the communities to start identifying the providers’ centers as Suraj clinics. Two of the main operational challenges are trying to ensure quality standards and to monitor widely dispersed Suraj providers.

5.1.2 Supply chain exclusivity

MSS has a well-organized supply chain system for ensuring that the providers have the products it offers. Different brands of some of the products (e.g. pregnancy test strips) are available in the local market at a cheaper price, and in some cases, the providers opt to buy these products. MSS tries to encourage the Suraj providers to buy the products they offer by emphasizing their quality.

5.1.3 Organizational receptivity to change

Overall, MSS is very receptive to change. The organizational culture supports innovation, and if it can successfully pilot an initiative and have adequate funding, then the initiative is scaled up.

5.2 External Challenges

5.2.1 Competition

There is competition from the government, the private sector, and other NGOs for the reproductive health products and services that MSS offers. With specific regard to social franchising, Greenstar is one of the largest social franchising organizations in the world. However, they operate in urban areas, and MSS franchisees are in rural areas. In urban areas, there tends to be more competition where there are more private providers and where the public sector generally functions better. In rural areas, there tend to be fewer providers, and there are many gaps in public sector service provision, which reduces competition in rural areas.

5.3 Opportunities

5.3.1 Stimulating consumer demand

Preliminary results suggest that Suraj is significantly stimulating consumer demand and addressing unmet need for family planning. For example, a rough calculation shows that the number of IUCDs inserted on average by a typical Suraj provider in a year represents 14 percent of the contraceptive prevalence rate (CPR) of the population in her catchment area, which is much higher than the 2.3 percent share that IUCDs represent in the national CPR (2006-
07 PDHS). MSS believes that client demand can be increased by revisiting clients who may not have been interested in FP services or not been available during an initial visit and by extending the population catchment area covered by each FWM.

5.3.2 Reformulating value propositions to franchisees

The organization is always looking for ways to increase the value for private providers to remain part of the Suraj network.

The addition of difference products and services can increase the profitability of the franchisees, and they are very interested in this.

MSS is testing introducing Femplant branded Sino II implants, which are high cost/low volume products, to selected providers and will see how it impacts their profitability.

5.3.3 National Health Insurance Scheme

There is no National Health Insurance or Social Health Insurance program in Pakistan at the current time.

5.4 Lessons Learned

5.4.1 Franchisor

The FWM marketing has been key for generating demand for franchisees’ services, and the OBA voucher has helped increase access to family planning methods for poorer, underserved members of the Suraj providers’ communities.

5.4.2 Franchisee

Franchisees say that they would like to see more counseling for family planning and awareness regarding prevalence and prevention of illnesses such as Hepatitis B and C.

Franchisees also said that social marketing strategies and door-to-door visits from Field Workers Marketing will help improve women’s contraceptive use. In addition, family planning programs need to target myths and misconceptions regarding family planning and provide adequate information about side effects to address fears concerning contraceptive methods and improve contraceptive use.

5.4.3 Client

Low cost and ease of access are significant reason for clients visiting the Suraj providers. Other reasons cited were that providers are friendly and often have personal relationships with their clients, as well as the fact that the providers are female.

Clients say that commodities, especially injectable contraceptives, should be provided free of cost. Some also requested that maternity services and general medicine be made available at franchisee locations.
Glossary of Terms

CBD  Community Based Distribution
CPR  Contraceptive Prevalence Rate
GDP  Gross Domestic Product
IUCD  Intra Uterine Contraceptive Device
LHW  Lady Health Worker
MoU  Memorandum of Understanding
MSS  Marie Stopes Society
MWRA  Married Women of Reproductive Age
NEP  National Expansion Program
OBA  Output Based Aid
OOP  Out of Pocket
PPP  Private Provider Partnership
Acknowledgements

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