Lightening Presentations
Session #3
BlueStar Ghana
Demand Creation Model

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Marie Stopes International  Ghana
November 2011
Community Challenge

• Population of women in reproductive age (15 - 49): 6.3 million +
• National unmet need: 35%
• Family planning misconceptions held by communities
• Low uptake of long term and permanent methods in urban and peri-urban areas
MSIG response

• Need to inform and educate community about long term family planning
• Men included in sensitisation depending on community
• Need that information to be directly linked to service delivery for immediate uptake

“DEMAND CREATION”
Demand creation team

- Demand creation champion
- Franchisor Clinical team (1 midwife, 1 nurse/midwife)
- Franchisee team (2 nurse midwives)
- Community based educators (4 CBES)
- Driver (1)
Demand creation services

- Implants
- IUCDs
- Recently added: Tubal Ligations – on scheduled occasions (by a surgeon)

All at the promotional price of 1 GHS/US 0.67
The monthly cycle

1. Community Entry
   CBE and referral management

2. Community mobilisation

3. Service delivery

4. Continued mobilisation

4. Continued service delivery
House to house sensitisation

Informing a small group of 5 at a compound house in North Kaneshie, Accra, on family planning methods and the up and coming promotional service delivery day for long term methods at a nearby BlueStar Clinic.
Applause!
About Drishtee

• As a social organization,
  – Drishtee works towards creating an impact in villages
  – By creating an ecosystem of microenterprises.
  – Led by Drishtee-trained entrepreneurs,
  – These enterprises aim to provide economic opportunities to the poor by facilitating access, generating employment and delivering affordable services; and reduce the role of the intermediary

• Provides a sound supply chain based platform for
  – Services such as Health, Education, Banking and Microfinance
  – Giving opportunities to provide market access and linkages for physical products such as eyeglasses, mobile phones, and agricultural products.
  – Has created a network of over 10000 rural entrepreneurs in remote rural areas.
  – A low cost, direct delivery rural supply chain network
Drishtee Health
First steps in 2004 (to 2006)
- Series of telemedicine initiatives – including partnerships with Escorts Heart Hospital to offer consultancy services
- In conjunction with Microsoft, began to offer telemedicine through kiosks in Bihar.

2007, established platform to focus on doctor consultations.
- Organized more than 350 weekly clinics in the states of Bihar and UP where a qualified doctor would attend to patients.

Initial success
- People showed great initial interest in these clinics
- Interest faded rapidly
Learnings

- Rural Indian community fails to relate to the technology based solutions, they prefer physical presence of the healthcare provider.
- Health interventions to be preceded by community mobilization and sensitization.
- The flag holders of the initiative should be part of the community.
- Same intervention cannot be replicated for different geographies.
- Issues of integrating with the existing village ecosystem of quacks.
Refined Model

- Rests on Drishtee's core supply chain model
  - for effective deliveries at optimum cost utilization.

- The health implementation strategies integrated with the **ecosystem of micro-enterprises** that Drishtee creates

- An integrated approach,
  - focuses on women health entrepreneurs
  - has components of basic diagnostics and basic pathology
  - support from qualified practitioners and back end support of local hospitals.

DHF offering diagnostic service
• **Linked at the Back-end**
  - A qualified Doctor who takes weekly rounds
  - A phlebotomist / Lab technician for weekly sample collection
Challenges and obstacles

• Limited understanding of 'good health' in rural areas
• Achieving desired behavioral change in the community
• Urban-rural divide
• Digital divide
• Existing quack ecosystem
• Difficulty in getting digital data from rural location
• High gestation period for establishing health model due to above listed constrains
Applause!
BlueStar Viet Nam
Working with Midwives

Le Thi Kim Yen
Mariestopes International Vietnam
November 2011
Introduction

Year of beginning: 2008

Number of delivery points: 300
(220 doctors, 80 midwives)

Number of provinces: 7/64

Franchised services: Safe abortion (MSP, MSMP), long-term FP method, short-term FP methods, FP counselling, RH care services
Country legal context (Vietnam)

- Only **OB-GYN** doctors are licensed by government to provide abortion, IUD insertion and other RH care services
- **Midwives**: permitted to provide only general medical services, such as giving injections, changing bandages etc…
- In **rural** areas: The public facilities (CHS) overloaded => rely on 2nd tier providers (midwives)
Local context

1. Public facilities overloaded
2. Very few OB-GYN doctors in the community
3. Clients come to Midwives based in the community
4. No legal support
5. Poor facilities
6. Limited professional training

Rural areas
Support activities to midwives

Before

Facilities support
Supply Infection prevention items
essential medical instruments
upgrade procedures room

After

Social Franchising for Health
innovate, demonstrate, replicate
Support activities to midwives

Capacity building

Training

On-job training

Quality control

Working with Midwives in BlueStar Vietnam
Performance of midwives

Baseline in comparison with service provision report

Note: After joining BlueStar, midwives have been trained on MA, and apply to the daily service delivery, before most of them had no chance to be trained on medical abortion, just informally.
## Performance of midwives

### Baseline and QTA report

<table>
<thead>
<tr>
<th>IP</th>
<th>Baseline</th>
<th>1st QTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>51.8%</td>
<td>87.5%</td>
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*Working with Midwives in BlueStar Vietnam*
ACTION:

Advocacy for policy change to extend the scope of service delivery of midwives (pilot in 2 provinces)
Applause!
Creating a value proposition for Social Franchising in Tanzania
Tanzania provider network
Access and Quality for FP Services

• 200 facilities in 10 regions
• All FP methods with a focus on LARC
• Communications and Branding on FP only
• Equipment, training, supplies, supportive supervision
Key Challenge: Winning owners' support

• FP Not a lucrative service
  – FP traditionally offered for free in all facilities in Tanzania as per government policy

• Perception of high costs associated with partnership
  - Creating more work
  - Making staff more likely to shift to the government (better pay)
  - Using more water and electricity
Programmatic activities to change perceptions

- Story sharing by owners
- Facility exchange visits
- Staff retention techniques
- Clarify government policy
- Change the social norm
- Invest in demand creation
- Introduce reward scheme for owners
- Expansion into safe motherhood / PAC / HIV integration

- Doing
- Verbal support obtained
- Going well

- Starting
- Developed messages
- Going well

- Starting
Defining a Value Proposition

PSI can really add value by

- Increasing number of clients
- Developing strong branding and marketing strategy
- Improving facility’s reputation in the community
- Investing in lucrative / new service areas
- Supporting owners to better operate their facilities
Way forward

• Develop an overall SF proposition that includes
  – Overarching network brand
  – Expansion into other services
  – Communication strategy and higher investment in demand creation
  – Capacity building in marketing
• Partner with strong local associations that can provide operational support and access to loans for QI
• Raise funding for expansion
Applause!
Clinic Level Quality Circle

Dr. Ashek Ahmed, MD, MPH

Smiling Sun Franchise Program (SSFP)
Quality Monitoring System of SSFP

Three tiers:

1. Central level
   - Clinical Quality Council (CQC)
   - Regular SSFP Monitoring
   - External Quality Audits
   - EmOC preparedness audit
   - Mystery Client
   - Quality week

2. NGO level
   - Quality Monitoring and Supervision
   - Monitoring of Clinic level Quality Circle

3. Clinic level
   - Clinic Level Quality Circle
Quality Circle

• Clinic’s quality is in the hands of clinical staff members
• Clinical staff members are proactive in day to day maintaining of clinical quality
• Clinic not depending on NGO HQ level for quality assurance, maintenance and improvement
Objective

To make the clinics capable and responsible for assuring, maintaining and improving the quality of their services
Structure

• All clinic staff are the members of Clinic Level Quality Circle
• Clinic Manager leads the circle
• Medical Officer acts as key person for clinical services
Principles

- Involving staff to develop ownership of quality
- Focusing on processes and systems rather than the individuals
- Encouraging continuous staff learning, development, and capacity-building
- Implementing continuous Quality Improvement works
Tools

• Self Assessment Guide

• Spot checklist (daily, weekly, monthly)

• Clinical meeting

• PDSA cycle

• Supportive Supervision

• Suggestion box and Exit interview
The PDSA Cycle for Learning and Improvement

**Plan**
- Objective
- Questions and predictions (Why?)
- Plan to carry out the cycle (who, what, where, when)
- Plan for Data collection

**Do**
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data

**Study**
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

**Act**
- What changes are to be made?
- Next cycle?

Source: *Improvement Guide*  p 60

IHI, 2006
Tangible Outcome

- Ownership developed among staff
- Responsiveness to improve quality developed
- Quality culture is taking its shape - anchored
- Leadership attributes are being formed
- Evidence of problem-solving in a better way using PDSA

Clinic level quality circle is an important legacy of SSFP
Committed to improve the quality of life of all Bangladeshis particularly mother and children through accessible, quality and affordable health services...Smiling Sun Franchise Program makes the difference.
Applause!
Mission:

“To measurably improve the health of vulnerable Malagasy with communications, products and services that are accessible and of high quality.”
Addressing population health needs

Caring for « Bako and Rivo » during their life cycle
Brand repositioning
DEMAND CREATION

MASS MEDIA

Mobil Video Unit

IPC

Network Services
Challenges

- Implementation of the integration (training, supervision)
- Pricing that allows both equity of service and incentive to providers
- Providing service delivery in rural areas
• Viewing provider as a target group
• Advantages to partnering with NGO clinics
• Performance-based financing: focus on both demand creation agents & providers
• Start small, and then grow:
  – Number of providers
  – Roll-out of new services
• Focus on one specific area (i.e. supply chain, marketing, service integration, research, etc.).
• Incorporate a programmatic success story—not just a patient success story.
• Teach the audience about what you have found works or does not work in your social franchise.
• Present a challenge your franchise is facing or has faced, and how and why you made a certain difficult programmatic decision.
• Tell a story related to one of the four goals of social franchising: quality, cost-effectiveness, equity or scale.
• Specifically, tell the group about how you measure any of these four goals.
Applause!
RedPlan Salud

From Peru. Health professionals from private sector as a network and social franchising, promoting access to services and products for Sexual and Reproductive Health
What is RedPlan Salud?

- A network of professionals to improve community access to quality products and services in sexual and reproductive health

- It began in 2002 organized by INPPARES, with initial support from USAID, Catalyst Project, Schering, and Pharmacia.

- Created as an alternative to the public sector that unable to meet the public demand for services and products
Mission:
Improving quality of life by facilitating access to them and their attention to their needs and demands in the field of Sexual and Reproductive Health, in a framework of respect for their human and reproductive rights, implementing and developing services quality that are accessible in terms of culture, geographic access, availability and cost.

Vision:
To constitute the main alternative, complementary to public services in the care of the SRH of individuals and their partners, through a network and social franchising of private sector professionals in the National Health System, with the technical, methodological and organizational support of INPPARES.
Who are affiliated in RPS?

- Health professionals with a private practice, 97% are midwives.
- They have studied the career of midwives at the university for five years (four years of undergraduate plus 1 year internship).
- Affiliates has an office in low-income areas.
- They have a municipal permit and operating license.
- Sign with INPPARES an affiliation agreement
RPS Components

- **Human resource development through training**, to develop competencies and skills in prescribing Contraceptives, infection prevention, promotion of SRH, social marketing techniques and development of quality services.

- **Creating and promote demand through awareness campaigns** and work in partnership and coordination with grassroots organizations in the community.

- **Supply of contraceptives** through the coordination work with pharmaceutical companies under the management INPPARES at a cost accessible to the low income population.

- **Monitoring and evaluation**, monitoring sales, services, impact on quality of life of people in SH - RH, performance of health professionals and customer satisfaction.
RPS Future

- RPS expand to more cities with low income population.
- Addition to our basket’s products affordable drugs for infections, painkillers, vitamins, and other products.
- Incorporate a strategy for early detection cervical cancer VIAA.
- Incorporate Primary Care at affiliated clinics
- Develop exclusive products for RPS: oral, HPV vaccines, monthly injections
- Expand to other segments of population with IPPF’s pill and EC
Applause!
BlueStar Uganda
Converting Voucher Schemes into Social Franchising in Uganda

Duncan Musumba
Marie Stopes International Uganda
November 2011
Overview of MSU Voucher Scheme

An **OBA** approach that finances agreed outputs for safe delivery, FP, STI treatment by:

- ✔ selling vouchers to clients at
- ✔ highly subsidised prices and
- ✔ by reimbursing the costs to the provider for
- ✔ the actual services provided.

- MSU role: Voucher Management Agency
The History

- Established in 2006 in four districts of Western Uganda and expanded to 20 districts in 2008.
- Supported by: Republic of Uganda
Core components

The MSU voucher scheme comprises of the following core components:

1. The funders (combination of GoU and donors),
2. The voucher management agency
3. Service providers
4. Voucher distribution and demand creation
5. Clients (or target beneficiaries)
6. The quality assurance system
7. Claims processing and reimbursement for services offered
Addressing supply-side

**Contract Model**
- Output-based contract with private providers
- Negotiated fee-for-service
- Accreditation before contracting
- Accredited providers must comply with service delivery contract to receive payment for voucher claims

**Marketing the Vouchers**
- Vouchers marketed to targeted clients
  - Radio talk shows/Adverts
  - Community mobilizations with film vans & health educators
  - Promotional materials
  - Branded signage at service providers
Connecting Vouchers & SF

• Harness existing infrastructure
• Provide a range of services as part of a single accredited network
• Aimed at increasing efficiency and sustainability of the health care system
• Aimed at ensuring access to quality healthcare
• Aimed at equitable access to healthcare services- emphasizing those most in need
The indispensable conditions for vouchers and SF

- Supportive policy environment conducive to private sector provision of health services.
- Adequate institutional capacity of both franchisor/VMA and franchisee/VSP.
- Diversification of services beyond reproductive health
- Diversification of funding and financial resources.
- Cost-effective monitoring and quality assurance mechanisms to protect the franchise’s reputation while containing costs.
Conversion is straightforward

Integrate SF into current voucher contracts

• Brand all existing facilities VSPs BlueStar
• Change the term from VSP network to BlueStar network
• Membership fees- introduced to VSPs
• Both cash and voucher clients accepted
• Standardized costs for all walk-in and voucher clients
• Educate all VSPs on BlueStar
• Exploit the synergy- common marketing and demand creation, HMIS
READY TO ROLL!!!!!!!!!
Applause!
LifeNet International

Global Conference on Social Franchising
Michael Spraggins, President
Pilot
Needs Driven Innovation

Smarter nurses and managers
Loans to grow operations
Medicines that make you well

LN Conversion Franchising
LN Growth Financing
LN Pharma
Hybrid structure

US 501(c)(3)

- Non-Profit
- For-Profit(s)
Conversion franchise for primary care clinics

- Nursing Training
- Management Training
- Pharmaceutical Consultancy
Conversion Franchising

**Recruit**
- Strategic relationships with church leaders
- Clinic site visits and preview training sessions

**Assess**
- 4 - 6 week assessment period
- Site visits, interviews, and data collection
- Custom Growth Plan

**Implement**
- Routine visits to implement training and franchise systems
- LN Quality ScoreCard measures impact on clinic operations
Applause!
Starting Up the First Social Franchise In Laos
Sun Quality Health Clinic In The Northern Region

Social Franchise In Laos
Social Franchise Network In Laos-What’s Different?

- **All** private doctors are government staff;

- **All** activities need to include government involvement;

- **All** projects need to get approval from government (MoH, MOFA);

- **All** Sun Quality Health clinics start with government-recommended TB clinics and;

- The Network will continue to integrate PSI Laos’ new health programs (TB, RH, Child Survival) through provider training and further clinic recruitment.
- There are 55 SQHs providing TB screening and TB DOTs treatment;

- There are more than 35 SQHs recruited for FP services

- More than 400 TB positives have been found;

- More than 114 IUDs inserted
Challenges of Social Franchise Network In Laos

- Sensitizing the government, providers and communities to what is a social franchise as this is the first Social Franchise Network in Laos;

- Slow results for TB program, which is the first program of the Network;

- Lengthy process of attaining approval from government;

- No Long term funding and;

- Take time to access SQH because of geographic area.
Applause!
New Service Ideas
Session #3
New Service??

Antenatal Care

Situation Analysis?
Provider Profile?
Client Profile?
Integration into existing service??

Pregnancy Test Kits
Iron, Folic acid and Calcium supplements
Clean Delivery Kits
Skilled Birth Attendant
Post partum IUCD
Misoprostol for PPH
Challenges

- Training & Motivation
- Monitoring & Supervision of providers
- Commodities & Supply
- Monitoring & Tracking clients
- Complications
- Demand Generation
Ultimate Franchise Picture

Existing Service

Antenatal care
Delivery care
Postpartum care

Quality
Equity
Scale

Promotion
Place
Price
Product

Cost
Thank You
Applause!
Technical Training Sessions
10:45–12:15pm

• Tips & Traps of SMS for Social Franchises- Baraza Room 2
• Business Training for Franchises- Baraza Room 1
• Quality Monitoring Tools- Fahari Conference Room
• Positioning and Branding - Baraza Room 3
• Positively Influencing Provider Behavior- Boardroom 1