Power of Networks: A Study of Health Franchises in Resource Limited Settings

by

Ramya Sankar

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Abstract

Billions of dollars are spent to develop drugs for infectious diseases in developing countries. How will these drugs along with clinical services be delivered to the patients who currently do not have access to them? Health franchises have been around since early 1990s, creating networks of shops and clinics that provide specialized care to low income individuals. This thesis attempts to understand the underlying mechanisms of successful health franchises. Two cases are taken into consideration, CFWshops in Kenya and Mi Farmacita Nacional (MFN) in Mexico. Both are pharmaceutical shops with small clinics attached to them.

The two cases were examined through a framework derived from successful commercial franchises and franchise theory. The elements that were addressed include operational structure, marketing strategy, product and service offerings, monitoring of businesses, and financial structure. CFWshops and MFN had some stark differences in how they addressed each of these elements. Unlike typical commercial franchises, health franchises aim to provide social benefits to the population. This goal requires franchises to not only create a business strategy to be financially sustainable and take advantage of networks, but also show health improvements in the community. The success of a health franchise is dependent on the health impacts it provides because its mission is not to generate a profit for the stakeholders but rather the value added to the customer by providing access that was not there before.

The comparative case analysis suggests several key recommendations. Health innovations in resource limited settings should create networks with other public and private health groups to leverage existing knowledge and best practices. This reduces cost and time of learning and allows businesses to utilize existing channels to provide access for drugs and services to individuals who currently are not receiving them.

Thesis Supervisor: Anjali Sastry
Senior Lecturer, Operations Management/System Dynamics
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1. Introduction

Health care delivery is a relatively new science aiming to understand and find solutions to the problem of access of care especially in resource limited settings, using a systems approach (Jain et al. 2008). This is not limited to developing countries. Developed industrial nations such as the United States have also struggled with the issue of delivering care. The problem presents unique obstacles for the health industry due to the ethical and public interest of health care as an essential service.

Access can be broken down into four dimensions as illustrated in figure 1. Geographical accessibility, acceptability, financial accessibility, and availability all describe the type of access needed to provide adequate care. All four of these dimensions must be met in order to provide quality service to the patient.

Figure 1. Various dimensions of healthcare access adapted from source (Peters et al. 2008).
Accessibility is broken into two subcategories of financial and geographical access. This means creating health facility infrastructure in remote areas as well as making existing services more affordable. Availability refers to the capacity of providing services such as the number of healthcare workers in the area as well as the consumers demand for that service. Finally, the acceptability of services focuses on the patient’s approval of the care being provided. Value-based care hopes to improve the healthcare system as a whole by encouraging providers to compete for business based on the patient’s level of satisfaction (M. E. Porter & Teisberg 2006). This aspect of access is too often neglected since many health markets are so fragmented and options are limited that there is not enough competition to compete on value.

Privatization

There has been a trend towards privatization of healthcare systems in many developed and developing countries (Brugha & Zwi 1998). Privatization of healthcare has very serious affects on the public health system as well as advancing the quality of care. As more physicians and nurses opt to work in the private sector, the quality of care in the public sector declines (Aiken et al. 2004). Private care is desired due to ease of access, shorter wait periods, flexible hours, and quality of service. While this trend creates an incentive to provide better quality care and helps generate innovation in the healthcare system, it undoubtedly disenfranchises those who cannot afford to seek private care.

What is the best way to both incentivize workers as well as the market to provide access to affordable healthcare to low income communities? While one size does not fit all regions or even
communities, it is appropriate to evaluate a model that has made an impact on a community and analyze how it can be successfully reproduced.

1.1 Motivation

The Bill & Melinda Gates Foundation has promised to increase spending on global health in 2009 to $3.8B (AFP 2009). The World Health Organization’s (WHO) budget for 2008-2009 is proposed to be $3.745B (2008). These figures do not account for the money spent by governments to tackle the issue of health in the population. With all this money pouring into research and programming, what is the mechanism by which this translates into care for individuals? How does innovation in technology and programming generate the outcomes desired?

Healthcare as a market is unique from other consumer goods and services. Willingness to pay for service is sometimes overshadowed by ability to pay. This means that while one might be willing to pay a lot for treatment, they will not be able to afford the service. The market does not capture the positive externalities of obtaining treatment. A good example of this is in the market for vaccines. As more individuals get vaccinated, the greater the benefit to the public. Traditionally governments take it upon themselves to induce a demand to create a supply for vaccines. According to the WHO, in 2007 over 70% of expenditures for vaccines were spent by governments (WHO 2008). Understanding this unique market allows those in the healthcare industry to better target and provide services. This leads to a need for sound health policy on the part of national governments to help regulate and maintain a thriving market for both consumers and producers.
Healthcare is often subsidized through public spending in order to provide equity and efficiency lacking due to market failures. Efficiency is created by capturing externalities that the market did not address and equity is the goal of public spending (Castro-Leal et al. 2000). Unfortunately many public healthcare systems are failing in providing quality care for their citizens and often times public subsidies disproportionately help higher income individuals. According to an International Finance Corporation report, “in Mauritania, 72 percent of hospital subsidies benefit the richest 40 percent of the population” (International Finance Coporation 2007). Many private systems of care are neither accessible nor affordable by the poor. Is there a way to create a business model that tackles this issue that can be scaled to provide care to those who lack services currently?

The issue at hand is not to create a profitable market on the premise of catering to the poor but rather to create a self-sustaining model to provide access to quality services and products. This is of great interest to me personally because the medical research industry has over the years poured millions of dollars into finding vaccines, cures, and developing drugs for chronic illnesses and infectious diseases. The goal of providing healthcare is the act of actually delivering these products and providing services to patients. Studying the mechanism by which this is achieved will give greater insight on how best to deliver care.

*Resource Limited Settings*

The focus of this thesis is on delivering care to populations in resource limited settings. This refers to individuals who fall under low-income status with respect to the country they reside. This was used instead of an absolute level of income because it frames the problem as a
disconnect from the main health delivery system rather than a quantifiable poverty metric. This means that the interest lies in why there is a lack of access to care rather than issues of poverty. This captures three of the dimensions of accesses listed above: availability, financial accessibility, and geographical accessibility. Within the scope of these limited resources, what type of innovation can break through the barriers to create access?

1.2 Disruptive Innovation

Disruptive innovation is a term introduced by Clayton M. Christenson describing technologies that target low-end users and eventually over time innovate to capture the entire market. This is done by constantly squeezing out the traditional market which currently ignore the low-end users because they are not as profitable. Figure 2 illustrates this concept by showing how, over time; disruptive technologies can enter the market from low-end users to the mainstream.

Figure 2. Graph of disruptive innovation infiltrating market (Christensen et al. 2000)
Traditionally, healthcare systems have been resistant to change and regulations help maintain sustaining innovations (Christensen et al. 2000). Since sustaining innovations provide for the more profitable market, disruptive innovations are greatly needed in order to start penetrating the low-end, and in the case of healthcare, those who require basic care. This means not just providing care for more complex, expensive illnesses, but rather providing basic care for easily treatable ailments. This excludes treatment for chronic illnesses such as cancer and diabetes.

A good example of this in healthcare in the United States is the retail MinuteClinic chain. MinuteClinics are housed within pharmacies and stores that are attended by nurse practitioners or physician assistants. They provide basic services such as flu vaccine shots, treatment for ear infections, allergies, poison ivy, etc. (Richard Bohmer 2007). MinuteClinic is just one of a handful of in-store clinics in the United States that aim to provide primary-care services at low cost and structured to be consumer-driven. This also means that the type and number of services provided is limited. This is where this type of disruptive innovation is limited because it is unlikely that this model can take over a more complex health system.

1.3 Franchising as a Model

Franchises seem to provide a model that has been able to penetrate areas where services previously have not been present or not as high quality (Ruster et al. 2003). This can be used as a disruptive innovation to provide basic, low-end services, which are often ignored or too costly in large scale hospitals and clinics. The model inherently serves as a mechanism of being replicable. A business model is established and then replicated using guidelines and standards which maintain homogeneity in services and quality. This homogeneity is the hallmark of a
franchise. The shortcomings of this model which will be discussed in detail are limited in their scope of service. Franchises cannot provide comprehensive care but are limited to very specialized services. What they lack in scope, they make up in scale. As the number of businesses in a franchise increase the marginal cost to service each decreases. This means that the strength of a franchise is in its network of businesses.

As a model, franchises are very narrowly defined and very much top down which prevents variability, helping to maintain standards and high quality. Pharmacy franchises are in a good position to sell their high quality brand in countries with poor regulation due to the associations with branding. This establishes an automatic stamp of approval. Once the infrastructure is present it is easier to add on unique components such as small clinics or internet access. There are many different ways to create a franchise contract, outlining the rights of using brand and services. Franchises are organized as a contractual agreement in which a franchisee pays (in accordance with the contract) to obtain rights to sell products, use a process, or more generally operate under a trademark or brand name (Lafontaine 1992).

A business format franchise is the most common type of franchise in practice. Franchisors create a business model that is given to franchisees which includes the business plan, marketing strategy, training manuals, as well as the products and services required to run the business. In this type of franchise, the franchisee is provided with everything to run the business and given support through training (Lafontaine 1992). This type of franchise can have two variations, the most commonly used type, stand alone, means that the business only sells brands that the
franchisor provides the individual business. A fractional franchise allows franchisees to sell products that might not come from a set distributor.

All of the franchises discussed in this document will be of the business-format where rights given to business owners are outlined by product and service provisions as well as how the business is run.

**Social Franchise**

Social franchises use traditional commercial franchising tools to promote a social goal. The business can be non-profit or for profit venture; however, the common theme is that it strives to achieve a socially positive end. Figure 3 illustrates the feedback loop associated with the three targets of social health franchises, promoting quality, access, and use. Increased use of products and services provide a positive feedback in creating quality and access to the goods and services. A franchise must be able to maintain all three components in order to be successful. Providing access is the ultimate goal but social franchises strive to maintain high quality which promotes use of service (Montagu 2002).

It is important to understand a model’s strengths and weaknesses so that it is used appropriately within context. What follows is a list of some of the benefits and limiting qualities of general franchise models. This will help shape the discussion of how to evaluate franchising in a health context.
1.3.1 Benefits of Franchising

*Quality Control*

Each franchised unit of the business has an automatic signaling mechanism to its customers about the quality of their goods and services. A successful franchise maintains a visible brand name that is easily recognizable and therefore provides its franchisees with a means to assure quality standards. This also means that the enterprise must be careful in the monitoring of the business in order to maintain reputation and assure compliance. Signaling theory suggests that franchisors can signal quality by creating high royalty fees and investing in stores themselves (Lafontaine 1992). As a health franchise in a developing country with poor regulation, it is very important to provide quality assurance both to franchisees as well as potential customers. This
creates an advantage over local products and services provided which do not have the same branding.

_Proven Business Model_

Those wishing to start a franchise business have the benefit of a proven business model. Instead of worrying about the higher level operations (marketing, branding, organizational structure, training guides, etc.), franchise owners can take more care into the daily operations of the business. This frees franchisees up to concentrate on improving customer satisfaction in local service rather than working operations of the business such as marketing.

_Highly Specialized Care_

The quality of service can be high because franchised business specializes in one area. This is done in order to maintain standards and to ease ability of replication. This allows businesses to easily monitor and evaluate their franchises as well as to provide a quick channel to investigate and implement changes. Over time, this leads to specialization and expertise in one area. Specialization provides the costumer with a level of quality assurance as well as confidence in the service being provided. This provides the business with learned knowledge and expertise in the area.

_Replicable_

All these reasons allow franchises to be so easily replicable. They provide those wishing to own their own businesses a proven formula without all the overhead worries that are present in owning a business. The purpose of a franchise model is to create many businesses in order to
drive down inventory and managerial cost that the franchisor must incur to service each franchise in the network. As a model, franchises’ success relies on how many businesses are in their network.

### 1.3.2 Limitations of Franchising

*Highly Specialized Care*

While specialized services allow businesses to become experts in the area, it can also be a limitation, especially in health care. If care cannot be provided, there must be mechanisms and channels present in order to refer individual to treatment that is needed. Health franchises are not a means to tackle comprehensive care; they are limited in their scope and provide access to niche needs. This limitation must be acknowledged and addressed in order to effectively create a franchise ready business model. It should be noted that while these franchises should not be a substitute for a primary care provider, in many resource limited settings they assume that role because no other facility exists in the area.

*Maintaining brand*

While franchises depend highly on branding, they must be concerned with maintaining that brand. One store that is poorly run can have an effect on the brand and in turn all the franchisees. This is why businesses must be very careful in giving out franchising licenses as well as assuring compliance of standards. A good example of this is the case of Jack in the Box and E. coli outbreak in 1993. This greatly hurt Jack in the Box chains outside of the Washington area which was being affected by the incident. Management as well as foresight of potential problems is key to maintaining a standard and brand (Ulmer & Sellnow 2000).
Dependence on distributor

In order to assure quality of products, franchises rely on the businesses distribution channels. This means that they are dependent on these distributors for their supplies and are usually not allowed to purchase from other sources. This is done to ensure proper order and delivery but also to protect quality of service and products.

Top down

Unlike other businesses, franchises are very top down oriented. This means that changes in operations, marketing, branding, etc. are made by the franchisor. This prevents any big changes to be made in individual businesses. Yet again, this allows the franchise model to be able to maintain quality and brand, but limits local growth in business.

Given the strengths and weaknesses of the franchise model as seen in traditional commercial franchises, a framework was created to evaluate health franchises. This framework is intended to provide a lens by which to look at current existing health franchises to understand what has been working well and what lessons can be learned to further the impact of health franchises in resource limited settings. There are some unique aspects of health franchises especially those tackling issues of access in developing countries that were discovered after examining many operating health franchises including the power the partnerships and the value of measuring health impacts in the public.
2. Proposed Framework for Healthcare Franchises

The essential elements that are required to create a successful franchise include a well defined list of product and service offerings, effective marketing, clear operations structure, adequate funding, and proper monitoring. These five elements strengthen a social franchise to reach its goal as well as become successful businesses.

Starting with a survey of the literature and an extensive study of health franchises the five core elements were chosen as the basis of my framework to explore what successful traditional franchise business might teach us about health franchises. Before turning a business into a franchise, each of the areas mentioned must be addressed in order to provide adequate support to franchisees and to create a solid foundations for the business. It is hypothesized that if these core elements are met, the social franchise will meet the goal of use, quality, and access and serve its social mission.

Each element in this framework interacts with the other components in a way that either highlights the benefits of a franchise or its limitations. For example, Quality assurance is done through monitoring of all the individual business. The better the franchise is at maintaining inspections, the easier it is to market the stores as providing quality products and services. Conversely, poor monitoring can lead to non-compliance which may hurt the reputation of both the individual store as well as the brand.
Each of the five elements of the framework are presented in figure 4 as they relate to each other. At the center is the operations piece because this is what keeps all of the other elements together and outlines how each is formulated. Label “1” indicates the positive relationship between increased marketing efforts and increase in customers due to visibility. Label “2” illustrates the two-way relationship of monitoring and menu of offerings. The products and services that are offered is limited by how well they can be monitored to ensure quality. Subsequently a stronger structure for monitoring can lead to expansion of products and services. Finally the relationship between marketing and monitoring is indicated by label “3.” Proper monitoring mechanism assures brand quality and serves as a marketing strategy for the business.
Each of these elements is described below and example of an operating health franchise in resource limited settings is used to highlight how these pieces are crafted within the business. Some are successful while others are still tweaking the model to perfect the formula.

2.1 Menu of Offerings

The key element of a franchise is that they are standardized. This means that the customer always knows what they are getting when they step into the store. Changes in what is offered do not occur as quickly as in other businesses because approval needs to come from the franchisor. In health franchises, this menu of offerings must be crafted to meet specific needs of the community or ones that the business specializes in.

Franchising is not appropriate for comprehensive care but rather targeted list of services. A successful franchise is able to understand its own strengths and what value added they can bring to the community. There must be a balance between what the community needs and what can be standardized. Many of the franchises that are to be explored aim to provide services and products that are limited by what area of healthcare they wish to tackle. Many of the health franchises in operation today address reproductive health including several fractional franchises started by Population Services International. Many of them provide counseling and contraceptive products as well as surgical procedures.

It is important to make sure the business is able to manage inventory and skilled labor for the products and services being provided. A well defined menu of offerings allows businesses to be
more easily replicable and take advantage of scale by buying inventory in bulk. Examples of franchises below address the issue of scope in the operations of the business.

### 2.2 Marketing

Marketing refers to both marketing the business to potential franchisees as well as to the customers. This is often done through strategic branding of the business. Many health franchises use word of mouth and local community outreach events to market health services. Recruitment of franchisees is often done the same way unless there are resources to produce more sophisticated marketing techniques such as through trade publications and conventions.

Sehat is a subsidiary of the Medicine Shoppe pharmacy chain which was first established in St. Louis, Missouri. Sehat utilizes the pharmacy chain in India, especially highly populated urban areas to provide affordable, quality healthcare to the urban poor. This is done by creating a payment scheme through the pharmacy in which the patient is reimbursed for the clinic visit if pharmaceuticals are purchased at the Medicine Shoppe. The clinics are staffed with fulltime physicians.

Currently eight Sehat clinics have opened. Through various iterations, it has become clear that placing clinics in the slums instead of the surrounding area increases foot traffic. Referral teams were also created to increase marketing of services. This includes a core group of women in the community who would visit each household and refer sick members of the family to visit the clinic.
The clinic is operated as an arm of India’s largest pharmacy franchise, Medicine Shoppe. As a business model, Sehat takes advantage of the Medicine Shoppe franchise that has a large market already established. There are currently over 130 stores across the country. The goal is to create 1000 locations by 2010 and open up 350 Sehat clinics within the next 3-4 years (2007). The low cost stems from capturing a market of customers that would not have otherwise visited the pharmacy. More than an innovation in clinical access, it is a marketing tool for the pharmacy which has health benefits to the public. Locating the clinics in the slums allows individuals for easy access and creates a community around the establishment.

Marketing for Sehat is done through a lot of word of mouth campaigns. Since the clinics are located in slums, the presence is immediate to their customer base. Special promotions of services are used when clinics first open to start getting business.

2.3 Operations
The operations of a franchise refer to supply chain of both goods as well as the organizational structure of the business. This element sets the foundation and dictates how all the parts of the organization interact with each other. Important pieces to consider include the training manuals, guidelines for opening up new franchise stores, franchise contracts, and contracts with suppliers. The structure must also outline how inventory will be accounted for and distributed to various locations.

VisionSpring, formerly known as Scojo Foundation, sprung from the idea that many individuals in developing countries could benefit from non-prescription eyeglasses. Dr. Jordan Kassalow and
Scott Berrie teamed up to create Scojo Foundation and Scojo New York, a reading glasses company to provide funding for the foundation. The name changed to VisionSpring once Scojo New York was sold in 2008.

![Figure 5. Value chain for glasses sold through VisionSpring entrepreneur (Clemminck & Kadakia 2007)](image)

Figure 5 shows the flow of money for each pair of glasses sold. The low cost for each pair of glasses is maintained by economies of scale. Readymade glasses are manufactured in bulk and sent in kits to district coordinators and partner organizations. VisionSpring uses local “vision entrepreneurs” (VE) to sell their eye glasses. This leverages the expertise of the locals as they are the first point of contact for potential customers. This often produces a higher rate of sale than the wholesale channel because it is more immediate contact with the buyer.

Figure 6 illustrates the supply chain of the glasses as well as the hierarchy of the organization. Not all VEs work directly with district coordinators, whereas some work with partner organizations which report to the main office. Glasses are bought in bulk from manufacturers in China which avoids the cost of individual offices buying their own supply. This cuts the cost dramatically allowing VisionSpring to become competitive.
The franchise works by creating a model of mobile shops. VEs are given a kit and trained by local VisionSpring partners to educate and screen the public on common eye conditions as well as sell glasses. Marketing is done either through community meetings or individual door to door sales by VEs. The network created by VisionSpring allows for low cost distribution of their products. The supply chain provides direct dissemination from partner organizations in the region who receive kits directly from manufacturers. The local partnership organizations and district coordinators are in direct communication and contact with VEs and therefore keep track of all sales and progress. Each VE undergoes a three day training in vision testing, marketing, and sales.

While Scojo Foundation received 5% of pre-tax revenue from Scojo New York, the business is not currently self sustaining. The goal is to break even on the entire business venture by 2010 which will require an increase in volume of eyeglasses sold (Clemminck & Kadakia 2007).
2.4 Funding/Financing Structure

The financing arm of the business ensures that it has sufficient funds for operations. Many health franchises are outside-funding driven, either by private donors or governmental subsidies. Groups such as Population Services International, Marie Stopes International, and DKI International are all non-profits that have started reproductive health related franchises in various countries. Donor funded franchises have different financial structures and funding concerns than those that are self-sustaining.

Janani, a non-profit program that works with reproductive health in rural India, is a part of the DKT-International charity headquartered in Washington D.C which promotes family planning and HIV/AIDS prevention through social marketing (Anand). Services are franchised to Surya Clinics which are headed by Janani administrators. Rural health care workers are trained to be liaisons between the clinics and those in the community. They interact with the women in the households to educate them on contraception and the services provided by the clinic. They are also licensed to sell non-clinical products and over the counter tests from Butterfly Centers, which are franchised pharmacies. Butterfly Center staff and the healthcare workers may refer patients to Surya Clinics for other products and services. The Butterfly Centers get commission for referring a patient to the Surya Clinics.

The organization was built upon the idea that many social marketing programs failed to reach individuals in rural communities. As most of India’s population lives in rural areas, the program was established to serve a two-fold purpose. It addressed both the lack of access of reproductive health services in the remote areas as well as the high cost of products and services. Currently the
program is not sustainable since it does not generate enough revenue for its operation. Funding sources include Indian Tobacco Company and Tata Steel for running two Surya Clinics (Janani 2008). Grants from the Indian Government also help pay for procurement of contraceptives and marketing. As a public-private network, the organization is able to sustain operation but cannot currently be self-sustaining.

A plan has been set in place to become self-sustaining and not have to rely on outside donations and grants. The five step plan includes (Janani 2008):

1. Streamlining process in order to reduce costs.
2. Outsourcing public reproductive health care to Surya Clinics.
3. Developing partnerships to help cover costs.
4. Investing in other revenue-generating activity related to mission.
5. Partnering with institutions that will start running clinics will help recoup cost from capital investments.

Funding for franchise

While individual franchised businesses generate a profit, there is an upfront cost which needs to be accounted for in the initial investment. Various mechanisms for this payment are used. Some require the full funds upon requesting to become a franchisee; others highly subsidize the fee or set up loans for startup cost. The Indian Government reimburses $35 for the cost of sterilization services. This cross subsidizes injectables and IUD services (2008). The government also pays for IUDs, pills, and condoms.

Payment by customers
In low income developing countries 60% of health spending comes through out-of-pocket payments as compared to only 20% in higher-income countries (Peters et al. 2008). Method of payment by customers should be addressed in order to maintain revenue stream by the franchise owner.

Many health benefits are highly subsidized by the government in public facilities but also in the goods provided to private care (such as vaccines). In order to create evidence-based practices, several groups have been set up to manage vouchers to create demand-side subsidies. This would allow individuals to choose where to receive services from. The voucher scheme allows the patient to drive the quality of service as the provider must compete for quality. An example of a successful voucher program is one set up by The Central American Health Institute. The institute gives vulnerable groups (sex workers, clients, and their partners) vouchers to be redeemed at select clinics (Sandiford et al. 2002). This forces the clinics to provide the best quality care at affordable costs. This scheme is well outside the realm of franchise models but one that has been used and still in the process of being improved to appropriately allocate shared funds.

2.4 Monitoring of Franchisee Outlets

The strength of a franchise is in utilizing a proven business plan. In order for franchises to maintain brand and high quality, a monitoring mechanism must be in place to make sure that franchisees are compliant with the rules and regulations set forth in operation manual.

CareShop Ghana, founded in April 2002 by Ghana Social Marketing Foundation, is a transformational franchise. The goal is to transform established pharmaceutical stores, also
known as licensed chemical sellers (LCS) under the CareShop brand (Segrè & Tran 2008). This is done to unify the various LCS stores and provide one cohesive brand to sell quality drugs.

CareShop used to send supervisory team to strictly monitor each store with a 52 item checklist each month (Segrè & Tran 2008). This proved to be too costly to pay personnel and therefore cut back on monitoring tasks to when deliveries were being made. Monitoring mechanism is needed to make sure that compliance is taken place with regards to contract made between franchisor and franchisee. This includes stocking shelves with CareShop approved drugs and standards set on cleanliness of store. Standards must be met in order to increase customer satisfaction and more importantly assure quality associated with brand.

3. Methodology

3.1 Why a Case Study Method

In order to analyze the franchise model, two franchises were studied in depth to understand the core elements of the business as well as where obstacles had to be overcome. Many health franchises exist specializing in their own field. CFWshops in Kenya and Mi Farmacita Nacional in Mexico were chosen because they were two franchise models that provided more varied services than the majority of the other organizations that were found. Both franchises are pharmacies that provide clinical care. The most common health franchises provided reproductive health services, but this was too narrow of a scope to understand the mechanisms of a health franchise business. These two cases were also chosen because they were relatively comparable since they provide similar services. An in depth comparison cannot be made since the context of the environment where each is located have too many variants to make a valid comparison.
Case studies of CFWShops and Mi Farmacita Nacional were used to evaluate the success and failures of franchising and what can be done to improve them. The information on the businesses stem primarily from literature found in previous case studies, news articles, journal articles, and primary source interviews. This provided both a historic as well as future picture of the businesses. This multi-method approach also creates greater validity in content as well as evaluation through proposed framework.

3.2 CFWshops

Healthstore Foundation, a nonprofit started by Scott Hillstrom, created a franchise of pharmacies and small clinics in Kenya called Children and Family Wellness Shops (CFWshops). The stores are located close to the community in which it serves. Location of store is determined by the foot traffic that can be generated with respect to market centers. The buildings are either owned or rented by the franchisee. The common barriers to access that CFWshops address are distance, price, product quality, diagnostic quality, and consistency of supply. Since the stores are located within walking distance of members in the community, they are more likely to use the stores instead of going into city centers where most health facilities are located (Fertig & Tzaras 2005).
Country Profile

Unemployment in Kenya has been estimated to be as high as 40%, while 75% of the population consists of agricultural laborers (Central Intelligence Agency 2009). Health expenditures make up 4.6% of GDP. An infant mortality rate of children under 5 years of age is 12.1% (World Health Organization 2006). The leading causes of death of all ages include HIV/AIDS, lower respiratory infections, and diarrheal diseases (World Health Organization 2006). The health workforce is very scarce, averaging one physician for a population of 10,000 in the entire nation. Individuals spend 80% of all health expenditures out of pocket and therefore the burden of payment is borne mostly by the individual (World Health Organization 2008).

Competitive Advantage

The competitive advantage of CFWshops has is in its low-cost of drugs. This is due to the central wholesale of drugs by Sustainable Healthcare Foundation (SHF). There is also a central management of political and regulatory issues that do not have to be dealt with by the individual business owners. Having many locations also provides for sharing of best practices and taking advantage of scale. As a central unit, SHF provides the stores with these services and serves as an advocate for the stores in dealing with government as well as drug suppliers (Fertig & Tzaras 2005). This frees up resources for the individual shops, allowing them to concentrate on daily operations.
Figure 7. CFWshop store front in central Kenya can be seen with logo on top\(^1\).

### 3.2.1 Menu of Offerings

The drugs that are sold at a typical CFWshop are set by the central organization. These are limited to drugs on the WHO essential medication list (Starbird 2009). These drugs are chosen because they comprise the treatment of some of the most common causes of deaths in Africa (Starbird 2009). The variants in the products sold in the store are seen in hygiene products such as brand of body soap. These variants depend on the local market where the store is located. The services provided by stores owned by nurses are strictly limited by the list found in Appendix 1.

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\(^1\) Photo courtesy of Catherine Casey
This is done so as to avoid nurses from providing services for which they do not have adequate resources.

These lists of products and services are not permanent but rather feedback is taken from franchisees on what their customers are asking for and if it would be possible to include those services on the menu of offerings (Starbird 2009). One of the most common requests is to do lab testing which some franchisees have referred their patients to local labs in the community.

### 3.2.2 Marketing

Franchisees are found through local advertising and word of mouth from current franchisees (Starbird 2009). The store itself is branded through their logo that is painted visibly on the store fronts and also on uniforms for staff. Marketing campaigns include outreach campaigns and promotions of new products (Fertig & Tzaras 2005).

### 3.2.3 Operations

There are three entities that comprise the network of clinics. At the highest level is the HealthStore foundation which is a US 501(c) (3) nonprofit corporation located in Minneapolis Minnesota. This group is simply a decision making body concerning the foundation and its operations. A subsidiary of this group is a NGO in Kenya, headquartered in Nairobi, Sustainable Healthcare Foundation (SHF). SHF is responsible for communication and operations with local franchise owners.
Ties to Public Health System

There are no formal networks with the public health system or other private providers. There are several informal connections between nurses and the healthcare system. Some nurses refer their patients that they cannot treat or services they cannot provide, such as lab tests, to other facilities (Casey 2009). Nurses also work with the Ministry of Health regarding vaccine availability. NGOs also work with SHF as a distribution channel.

As franchisees, there is a degree of freedom that is allowed in referring patients and informing them of other services provided locally but there are strict rules on services and products

Figure 8. Structure of entities in the CFWshop franchise.
provided by the business. This prevents deviation from the standards of operation and maintaining brand of the franchise.

3.2.4 Funding/Financing Structure

SHF purchases the drugs wholesale and therefore is able to maintain low prices. The stock consists of 150-250 government approved tested products. The upfront cost of owning a franchise is $1700 (Fertig & Tzaras 2005). The franchising fees are captured in the pricing of the drugs when they are sold to the shops. This is the only fee the franchisee sees. Delivery, training, and other operation fees are subsidized by SHF. All the revenue generated by the stores is taken in as profits minus the cost of purchasing the products that are sold in the shops.

This allows for the individual businesses to be self-sustaining while the HealthStore foundation, currently, still relies on grants for its operations. The organization is currently going through many organizational changes in order to create more sustainable for profit organization in the country. The goal is to create for profit entities which support the franchisees in the country while still maintaining a nonprofit in the United States. The procurement of drugs will also be changed to reflect this by outsourcing buying and delivering of drugs to Surgipharm Ltd.

3.2.5 Monitoring of Franchisee Outlet

As figure 8 shows, there are two field offices in Kenya, one in Kisimu and one in Embu, servicing the west and central parts of the country respectively. These field offices are in charge of clinics that are in their area. Most shops are in rural areas with the exception of two in Kibera slums near Nairobi. Each staff member is responsible for 20 clinics and provides the monitoring,
assistance, and delivery to these shops. Franchisees directly report to the field office which then reports to SHF.

Currently, each clinic is monitored twice a month during delivery, but this schedule will be changed once procurement is outsourced. Non-compliance with franchise standards results in revoking of franchising license. Since the franchisee owns or rents the physical building, the shops cannot be turned over to another franchisee. So far there has been only one case of revoking of franchisee licensing (Starbird 2009).

3.3 Mi Farmacita Nacional

The mission statement of Mi Farmacita Nacional (MFN) is “"to bring medicines and special services to the regions of the most necessity in the Mexican Republic and to provide health, well-being, communication and accessible prices to the majority of homes." This business was created to specifically target the low-income neighborhoods and therefore location is key and is evaluated carefully before approving franchise. The first shop which was built in Tijuana serves a community that has high rates of individuals who try to cross the border but fail and cannot afford to go back home. This influx of people creates high rates of poverty in the city creating a need for affordable health services (Coronado et al. 2007).

Country Profile

20% of Mexico’s population lives under the poverty line and there is a 4%-5% unemployment rate. 63.9% of Mexicans in 2004-2005 did not have access to healthcare through employment. Since healthcare is decentralized there is not regulation on quality of physician standards. Over
“2 to 3 million households spend more than a third of their income on healthcare each year.” (Barraza-Llorens et al. 2002). Prior to 2005, there were very few restrictions on selling pharmaceuticals. Physicians were required to prescribe both the brand name as well as molecular name of drug. The Generic drug market is estimated to be $2.2Billion. Legislation passed in 2005 required all drugs that are commercialized in Mexico must show proof of bio-equivalency by 2010 (Business Monitor International 2007). This legislation was created in hopes to drive away competition from black market drugs that are prevalent in poorly regulated countries.

**Competition**

Pharmaceutical market in Mexico is highly fragmented and competitive. Since the regulation of pharmaceuticals is very poor the barrier to entry is very low. MFN’s largest competitor is Farmacias Similares, which sell “similar” drugs, which are not bio-equivalent certified (Hayden et al. 2007). MFN is allowed to price so competitively due to its unique partnership with drug manufacturer and distributor. Since the level of competition varies from region to region, the franchise owner is allowed to modulate prices according to demand in their market. In a lot of cases if MFN stores are not able to be competitive in price they leverage their accessibility as well as the cleanliness of their stores. Accessibility is a critical issue since the nearest public hospital/pharmacy is further away than MFN stores. Some franchise owners try to increase foot traffic by providing additional products and services such as Internet booths and hygiene products (Coronado et al. 2007).
First Mover Advantage

The first mover advantage refers to capturing gains in a market by being the first to enter or make significant gains which makes it more difficult for competitors to share the market. In most developing countries, there is a large market for counterfeit pharmaceuticals, especially in areas where there is not any regulation or enforcement. These drugs are popular because they are often times cheaper than those sold at pharmacies. Counterfeit drugs and those found in the black markets are the largest competitors for pharmacies in highly dense urban areas in developing countries.

Pressures from multinationals have made Mexican officials to crack down on sales of pharmaceuticals that do not adhere to bio-equivalency standards. Legislation passed in 2005 requires all new drugs to show bio-equivalency in order to be sold in the market by February 2010 (Business Monitor International 2007). This came with great opposition from "similares" drug sellers, which infringe patents on pharmaceuticals. The legislation is in hopes to keep these drugs off the market. Since Farmacias Similares are the largest competitors for Mi Farmacita Nacional, the new legislation will allow MFN to capture greater market share once the regulation is enforced and Similares pharmacies must invest in resources to fulfill regulation.

This is not usually the case in developing countries since the health industry is not well regulated. Regulation is not usually enforced and therefore it is difficult to ensure quality products and services. Establishing a brand and standard allows for creating a market base that can permeate the industry.
3.3.1 Menu of Offerings

Drugs that are sold at MFN stores are not set like CFWshops. The market determines the most popular drugs and ones common in the localities of the store dictate what medicines are offered (Krasovsky 2009).

Figure 9. Mi Farmacita Nacional shop in Morelia, Michoacán. Clinic can be seen adjacent to the pharmacy shop\(^2\).

Mexican law prohibits clinics inside pharmacies and therefore clinical services are provided in an adjacent building which employs a physician. There are no set of services that limit what the physician can provide. This is often dictated by resources of the separate clinic (Krasovsky 2009). Figure 9 shows a store location in El Rielto area in Michoacán’s capital of Morelia.

\(^2\) Photo courtesy of Guillermo Krasovsky
3.3.2 Marketing

Marketing for franchisee opportunity is done through trade shows and traditional advertising methods (online and print). MFN uses its logos on all promotional items to create brand. The logo contains the image of the doctor and the two pills as seen in Figure 10. Franchisees are encouraged to use the logos for marketing material they design for their business. Promotional items are marketed through individual store locations.

Figure 10. Mi Farmacita Nacional logos outside of store in Tlalnepantla\(^3\).

\(^3\) Photo courtesy of Guillermo Krasovsky
3.3.3 Operations

The pharmacy chain was established in Tijuana, Mexico, in 2003 and is co-owned by Grupo Farmaceutico (Pharmaceutical distributor) and Laboratorios Collins (manufacturer of generic medicines). This unique partnership allows for MFN to provide the franchisees with low priced drugs and dependable distribution to all its stores. Figure 11 shows the flow of goods. Drugs manufactured at Laboratorios Collins are delivered to the franchise stores through Grupo Farmaceutico distribution channel. The distributor is required to be used for products ordered from other vendors as well. The main office for MFN is housed inside Grupo Farmaceutico’s office in Tijuana.

Figure 11. Operational structure for Mi Farmacita Nacional

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Dashed line in illustration refers the virtual monitoring through data collected from the inventory system.
3.3.4 Funding/Financing Structure

Franchisee

Potential franchisees apply to start a shop for which the location is carefully reviewed by MFN. Once the application is approved, franchisee puts forth the start up cost for opening up a store. The franchise fee is an upfront cost as well as a monthly contribution of 3.5% of revenue.

MFN allows entrepreneurs to start pharmaceutical franchise businesses. As a franchise, the business model rewards quality products and services to customers, which is generally good for sales and growth. Franchisees are recruited through the Internet, magazine advertisements, and franchising tradeshows. Franchise owners are from middle and upper socio-economic class since the startup cost is $50,000. MFN is currently trying to work with local banks to provide loans for starting franchises (Coronado et al. 2007).

As store owners, franchisees are given a range of freedom in operations unlike other franchises. They are allowed to purchase drugs from other suppliers but must use the franchise’s distribution provider (Grupo Farmaceutico). One store owner decided to offer a micro-insurance scheme which helped fund a clinic that uses MFN pharmaceuticals. As seen in CFWShops, clinical services increase foot traffic. Some stores are staffed with part time physicians who receive $364/month and 5% of store revenue for their services. Studies have shown these stores experience greater number of costumers (Coronado et al. 2007).
3.3.5 Monitoring of Franchisee Outlet

An electronic system called eMaksimus is used to manage inventory data as well as to view sales across all franchises. Non-compliance with franchise rules and regulation result in loss of license and turn over in ownership of shop. Infractions are documented inspections and a “three strike” policy is used to break contract (Coronado et al. 2007). In the past there have been low incidents of turnover or closure of shop (Krasovsky 2009).

4. Analysis of Franchise Organizations

While both cases (CFWShops and MFN) had franchise models designed to address all the elements of the proposed framework, each had their own shortcomings. Table 1 summarizes how each organization addresses the elements and the distinct difference between the two. The elements were determined as core components of franchises as established by successful commercial franchises but those are not enough to create successful social franchises. As stated earlier, social franchises have a goal of providing services to further a social objective. In order to achieve the social objectives, in addition to the elements examined in this thesis, franchises must be able to provide valuable feedback regarding health impacts. Feedback, coupled with a strong financial structure, allows franchises to expand their reach.

The last column in table 1 highlights the distinct difference between CFWshops and MFN. Overall the franchisees that are a part of MFN tend to have more freedoms than those who own CFWshop outlets. The financing structure of MFN is more self-sustaining than that of CFWshops.
## Comparison of Franchise Elements

<table>
<thead>
<tr>
<th>Elements of a Franchise</th>
<th>CFWshops</th>
<th>Mi Farmacita Nacional</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Offerings</strong></td>
<td>Strict list of drugs that are sold dictated by essential drug list. Clinical services are also limited to an approved list.</td>
<td>Initially a standard set of drugs and services is prescribed but once business is established, franchisee is able to decide what inventory is appropriate for location.</td>
<td>CFWshops is a lot more prescriptive and franchisees do not have freedom in product or pricing.</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td>Franchisees get direct support from SHF. SHF and HealthStore foundation collaborate in making high level decisions.</td>
<td>Franchisees get direct support from headquarters which is located within Grupo Farmaceutico (GF). Laboratorios Collins provides drugs for the stores. GF is the distributor for all approved purchases.</td>
<td>MFN operations are streamlined because most everything is done in house through the partnership with manufacturer and distributor. CFWshops is tiered with 3 levels of staff. Procurement and distribution are outsourced.</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Currently HealthStore foundation is non-profit and donor driven. The donor funds are used to heavily subsidize some of the capital costs for franchisees. Start up cost of a franchise is $1700. Franchising fee is added to the price of drugs so all revenues are taken as profits minus the cost of inventory.</td>
<td>Start up investment cost for franchise is $50,000. Franchise fee is accessed by collecting 3.5% of monthly revenue. Physicians are paid $364/month and an extra $91 if they consult 50+ patients.</td>
<td>MFN financial structure is more closely like a commercial franchise with percentage revenue taken as franchise fee where as CFWshop collects it at the point of sale of products.</td>
</tr>
<tr>
<td><strong>Marketing</strong></td>
<td>Franchise is promoted through word-of-mouth from community members. HealthStore generates marketing material for the franchises. Discounted items and outreach events are also encouraged to increase visibility.</td>
<td>Franchise is promoted through trade magazines and internet ads. Promotional items use the MFN logos and franchisees are free to create their own material.</td>
<td>MFN's marketing to potential franchisees is more formulaic. CFWshops relies mostly on community to recommend potential franchisees. Promotion of products and services are similar.</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Each outlet is inspected on regular bases by field office staff.</td>
<td>Inventory is monitored via eMaksimus, commercial database system. Outlets are randomly inspected for contract infractions.</td>
<td>MFN has a monitoring system that is more streamlined.</td>
</tr>
</tbody>
</table>

Table 1. Comparison of CFWshops and Mi Farmacita Nacional with respect to core elements of a franchise.
The strength of MFN lies in its unique partnerships as well as streamlining of operations from collecting digital inventory data to monitoring of outlets and marketing campaigns that are highly targeted. These strengths allow MFN to provide its franchisees with more freedom in how they operate their individual outlet.

_Growth as a Goal_

Successful businesses are those that are sustainable and stick around for years without continually being in debt. Successful franchises expand until they hit a saturation point. This means that, unlike traditional businesses, franchises must be able to grow and expand in order to maximize gains. All of the core elements are interdependent and are strengthened by growth. As marketing effort increases and there is more awareness of the brand, the more attractive it is to own a franchise which in turn grows the network. As the network grows, the economies of scale drive down prices for products that need to be delivered to individual stores/clinics. Both organizations had a strategy for growth and have opened outlets at a comparable rate.

_Financial Structure_

The financial structure of the franchise must be created to adequately sustain operations through licensing. In an attempt to become fully for-profit, CFWSHops has outsourced their inventory and delivery of drugs to Surgipharm Ltd., a large distributor of pharmaceuticals in Africa. Previously, they had been receiving discounted drugs from a non-profit wholesaler, MEDS (Mission for Essential Drugs and Services), but Surgipharm allows them to have an external distribution chain which cuts down on services they have to provide internally. MFN does not
have the similar funding issues as CFWShops since it is entirely for-profit run and there are no subsidies incurred by the franchisor.

*Health Impact Metric*

Cost effectiveness is often used to evaluate health programs (Montagu 2009). The World Health Organization uses Disability Adjusted Life Years (DALY) to obtain a metric for the improvements made by an intervention. A DALY is used as a measurement to evaluate and compare intervention when calculating cost effectiveness. This methodology is used to provide feedback for the organization as well as donors and governmental institutions on the progress of the program. This gives decision makers at all levels a metric both to fund and continue successful programs and to reevaluate unsuccessful programs. This element is crucial in being able to effectively sustain a program that is providing health benefits.

Providing health impact studies is especially important to organizations and programs that depend on outside funders or public funds and are held accountable for the impact they make in public health. CFWshops currently does not produce a cost effectiveness report but rather keeps a collection of data on patients served and revenue generated at each location. Table of revenue generated in 2008 can be found in appendix 2. As a business, they are currently in the process of shifting their model from a non-profit, relying on grants and outside funding in order to subsidize some of the franchise costs, to an entirely for profit model. One of the problems in relying on outside funding is not only this need to allocate resources for impact studies but also stipulations from outside donors that might not align with operations of the business. MFN does not conduct impact studies either so it is not clear how the shops have improved public health. Fortunately,
MFN is not dependent on outside funding so their accountability on this issue is less than that of CFWshops.

Aid funded health franchises must especially be able to provide data on the health impacts of the business in order to continue receiving funds. Profit generating franchises do not have this concern of donors but should they still be accountable for the health impact of their business? If the mission is to create access to quality drugs and clinical services, it is important to qualify what quality means. This is also what makes the business competitive and easily marketable. This positive feedback would suggest that understanding the health impact of the business will be of benefit to them.

Franchises are supposed to be a disruptive innovation because they are consumer-driven. This means products and services are tailored around patient needs. In order to really infiltrate the market, the business must prove that its presence in the “low-end user” sector is in fact making a difference. This difference is not just in customer satisfaction but the public health impact of the business.

Partnerships
Financing and health impacts as goals of improving a franchise business can be achieved through partnerships. MFN was able to expand and provide consistence service to all the franchisees because they had solid foundation of the pharmaceutical business from their partners. The strength lies in being directly attached and even being housed within a pharmaceutical distributor. While franchisees can purchase products from other vendors, they are required to use
Grupo Pharmaceutico as their distributor. This helps them monitor the shipments that each store is receiving. MFN currently has frozen their expansion efforts due to recent events with increased violence in major cities. Especially in Tijuana and the larger cities, there has been a decrease in business since the target customer base is through foot traffic (Krasovsky 2009). Expansion has traditionally been franchisee driven without a real goal from headquarters to create shops in a year. This means that the trade shows and marketing for franchisees is important in creating more stores.

MFN has the resources to accurately track inventory and sales through their use of commercial software unlike CFWShops, which relies on paper inventory slips. Using digital tools cuts down on personnel resources and can help with documentation of products and services provided. While it is not feasible for all organizations to rely on digital tools, it is still important to keep reliable records of progress. Financial metrics are not enough since these franchises aim to improve health. Unlike other business models, the metric must include the impact the intervention is making in public health. This is needed in order to ensure its sustainability since profitability is not the aim of most of these businesses.

Regulation

Regulation and policies from governmental entities has both helped and hurt these businesses. In Kenya, nurses are required to retire at age 55 (Ndetei 2008). This creates a whole pool of potential franchisees for CFWShops since many of these retired nurses still feel they can earn an income (Casey 2009). They are attracted to the franchise model because they can grow professionally by learning business skills as well as being their own boss.
MFN is able to take advantage of regulations especially in pharmaceuticals because their supplier manufactures certified generic drugs. This partnership streamlines the process of acquiring drugs for the shops and not having to deal with regulatory issues themselves.

5. Recommendations

Understanding the two case studies through the lens of the proposed framework provided an analysis of the success and failures of health franchises. What follows is a set of recommendations for various stakeholders of health franchises in order to learn from previous implementations. Many of these recommendations stem from the analysis of CFWshops and MFN and the lessons learned from each case.

5.1 Entrepreneurs

Entrepreneurs who wish to start health franchises must be deeply rooted in the communities in which they wish to serve. This means having networks in surrounding areas to ensure support. Since social franchises aim to provide access to services that were not present before, it is essential to understand the needs as well as the context for interventions. This requires thorough market research of how to attract customers and provide both easy access and satisfaction in service. Sehat provides a good lesson in this as they initially opened clinics outside of their target area and realized that it did not receive much foot traffic due to social barriers.

It is also necessary to understand the goal of the franchise business so as to tailor all the elements to achieve that goal, especially the services being provided. The goal also determines how the
business is structured as evidenced by the distribution networks in the franchises described above. The success of the overall business will be determined by the impact it makes on public health and therefore the goal must be well defined to provide meaningful insight on impact.

Finally, the financial structure of the franchise should address both relationships with franchisee as well as funds to maintain complete system. This means how franchisees will be accessed fees and how the franchisor will recoup cost for franchise-wide maintenance. Like in any other business, cash flows should be closely monitored in order to ensure that all franchises are generating profits.

5.2 Governments/Regulators

Since national governments have a vested interest in public health, it is essential to work with private entities to strengthen overall health system. Instead of creating competition, public private partnerships should be created to bring together strengths to form collaborative efforts in providing care. Since the private sector is able to create distribution networks, it would be to the benefit of governments to use these channels to distribute large scale purchases such as vaccines and essential drugs. This was seen in the case of informal partnerships in Kenya with CFWshop nurses.

In many developing countries, poor pharmaceutical regulations lead to sales of counterfeit drugs. While regulations may be in place, lack of enforcement prevents them from being effective. Since many of these franchises are not making a huge dent in the healthcare system other regulatory issues do not have direct effect on them. In the United States, MinuteClinic has come
across pressure from medical associations to demand more regulation. This is not the case in the franchises that were studied in developing countries since they have not generated a large impact but rather well tailored to their niche market.

The public health sector should collaborate with the private sector in general but also should consider franchises in particular to partner with national programs. Franchises make it simpler to create collaboration since creating a partnership with the franchise creates many more partnerships and networks with all the outlets.

5.3 Investors

As investors, it is important to evaluate if franchising is the best strategy for the business being pursued. Not all health interventions lend themselves to the franchising model.

- Is there an unmet demand for the service?
- Are there individuals willing to become franchisees?
- There is a large barrier of entry in terms of capital investment to start individual businesses.
- Is access limited to urban poor and rural populations?
- Are there enough individuals willing to pay for services and is there a mechanism in place for those who cannot pay?

If the business seems appropriate for a franchise, it is important that all the core elements mentioned earlier are present. Additionally, as a social franchise, evaluation of the businesses health impacts in the community should be addressed. The investment in a social franchise is two-fold, both providing initial capital funds for the entrepreneurs as well as investment in public
health. Investors should be weary of business plans that do not include both metrics in progress reports.

Finally, businesses in health should utilize the expertise in both public and private systems. This means creating sound partnerships with local networks. Partnerships are indicators for success because they allow the franchise network to grow and provide support, spreading the business risk. Partnerships are signaling mechanisms which indicate to investors that there is interest and support for the business.

6. Conclusion and Future Works
Can market forces help drive better quality care and access for those who currently lack services? Can these businesses provide access while still making a profit? To answer the first question, it is evident by the increase of private sector in health to say that market forces can create quality care where public services are not sufficient. Whether these entities should generate a profit is beyond the scope of this thesis but traditionally have they and can they feasibly generate a profit is questionable. Many of the franchises that were examined as part of background for this study are driven by subsidies and focus on using the money more efficiently rather than a self sustaining model. MFN has been one of the few businesses to be sustainable on its own through the profits they generate. MFN’s success can be attributed to the strong partnerships generated between Laboratories Collins and Grupo Farmaceutico. This partnership provides a strong foundation for the model to build on.
Successful non-profit social franchises have well established partnerships that provide them with a solid foundation. Their goal is not to become profitable but rather use funds provided by governments and donors to effectively provide care to as many people as possible. Partnering with local organizations and working with local governments allows them to leverage expertise from local groups as well as established networks. While there have been many successful health franchises, it must be noted that it is essential to provide feedback and create a measurement and evaluation system in order to improve the business. This also allows the intervention to be replicable as tangible positive results create an instant marketing tool for expansion.

All of the franchises that were examined, especially CFWShops and MFN provided key insights on the special need of social health franchises. Not only must the basic elements of a franchise be met, but partnerships, finance structure, and performance metrics must be established to ensure sustainability and growth. Franchises are desirable because they leverage economies of scale. This can only happen if they are able to grow their network. For social health franchises growth is intertwined with the ability to provide health impact evaluation not simply profit measures.

Future work in the area should include assessing how these businesses can better integrate themselves with complimentary providers (creating referral networks). This can help strengthen networks as well as increase impact of their presence in low-income areas. It would also be good to access the customer satisfaction of the services being provided and how that feedback can be integrated to the business model. The insights gained from the research done for this thesis have come exclusively from the experience of franchisors. A complimentary piece would include a
survey of franchisees as their experiences owning the businesses and their gains from the model.

Finally, the hope for future study in health franchise models is to create a collaborative knowledge bank of different businesses and organizations. It is through this collective that lessons can be learned and models adapted to form successful interventions in health delivery. Tackling health issues should be a collaborative effort, leveraging expertise from both the public and private sectors. Neither can solve the access problem alone. Currently, health franchises are making progress within the communities they operate but have not reached the scale of traditional commercial franchises. Perhaps the interventions should be more local but the franchise networks creates this collective learning model that benefits all stakeholders involved. This network learning effect of franchises should be harnessed and should be emulated by creating networks to bring together public and private sectors to improve the overall health of the population in resource limited settings.
Appendix 1: Products and services provided by CFWshops

<table>
<thead>
<tr>
<th>Diagnosed and Treated by Clinics:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Injuries: burns/cuts/sprains/fractures</td>
</tr>
<tr>
<td>Upper respiratory tract infections</td>
<td></td>
</tr>
<tr>
<td>Skin disorders</td>
<td>Dematias, worms</td>
</tr>
<tr>
<td>Ear infections</td>
<td></td>
</tr>
<tr>
<td>Opportunistic infections associated with HIV/AIDS</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Services Performed:</th>
<th></th>
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<tbody>
<tr>
<td>Medical check-up (consultation)</td>
<td>Application of crepe bandage (in case of sprains)</td>
</tr>
<tr>
<td>Rapid diagnostic tests of HIV, malaria</td>
<td>Counseling (general)</td>
</tr>
<tr>
<td>Wound dressings</td>
<td>Growth monitoring for children</td>
</tr>
<tr>
<td>Blood pressure check</td>
<td>Weight check</td>
</tr>
<tr>
<td>Suturing cuts and dressing</td>
<td>Community outreach</td>
</tr>
<tr>
<td>Removal of stitches</td>
<td>Health education and promotion</td>
</tr>
<tr>
<td>Immunization (For the future, eventually all of the nurses will be registered with the government EPI program)</td>
<td>Family planning services (male condoms, pills, and Depo injection)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Injections:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sell and promote the following preventive and hygiene and retail items:</td>
<td></td>
</tr>
<tr>
<td>Antiseptic cream and liquid</td>
<td>Lotion</td>
</tr>
<tr>
<td>Baby powder</td>
<td>Lozenges</td>
</tr>
<tr>
<td>Bar soap</td>
<td>Mouthwash</td>
</tr>
<tr>
<td>Bed nets</td>
<td>Multivitamins</td>
</tr>
<tr>
<td>Bleach</td>
<td>Petroleum jelly</td>
</tr>
<tr>
<td>Bottled water</td>
<td>Ribena</td>
</tr>
<tr>
<td>Cod liver oil</td>
<td>Sanitary pads</td>
</tr>
<tr>
<td>Cotton wool</td>
<td>Sticking plaster bandages</td>
</tr>
<tr>
<td>Dental cream</td>
<td>Tissue paper</td>
</tr>
<tr>
<td>Diapers</td>
<td>Toilet soap</td>
</tr>
<tr>
<td>Ear buds</td>
<td>Toothbrushes</td>
</tr>
<tr>
<td>Effervescent salts</td>
<td>Toothpaste</td>
</tr>
<tr>
<td>Energy drinks</td>
<td>Toothpicks</td>
</tr>
<tr>
<td>Glucose powder</td>
<td>Washing powder</td>
</tr>
<tr>
<td>Gripe water</td>
<td>Water purifying liquid</td>
</tr>
<tr>
<td>Lip balm</td>
<td>Water purifying powder</td>
</tr>
</tbody>
</table>
### Appendix 2: Profit generated from CFWshop outlets in 2008

<table>
<thead>
<tr>
<th>Summary Unit Performance</th>
<th>Median</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>USD @ 70 / 1 KSH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales</td>
<td>4,278</td>
<td>5,209</td>
</tr>
<tr>
<td>Cost of Goods Sold:</td>
<td>1,604</td>
<td>1,752</td>
</tr>
<tr>
<td><strong>Gross Profit:</strong></td>
<td>2,674</td>
<td>3,457</td>
</tr>
<tr>
<td>Gross Profit % of Sales</td>
<td>63%</td>
<td>66%</td>
</tr>
<tr>
<td>Less Expenses</td>
<td>1,100</td>
<td>951</td>
</tr>
<tr>
<td>PROFIT</td>
<td>1,574</td>
<td>2,506</td>
</tr>
<tr>
<td>Patients reached</td>
<td>6,928</td>
<td>6,099</td>
</tr>
<tr>
<td></td>
<td>1,961</td>
<td>2,993</td>
</tr>
</tbody>
</table>
### Appendix 3: Summary of franchises discussed.

<table>
<thead>
<tr>
<th>Country</th>
<th>VisionSpring (Scojo)</th>
<th>CFWshops (Healthstore)</th>
<th>Mi Farmacita Nacional</th>
<th>Sehat (The Medicine Shoppe)</th>
<th>Janani (DKT International)</th>
<th>CareShop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>India, Bangladesh, Mexico, Guatemala, El Salvador and Ghana</td>
<td>Kenya, Uganda, Rwanda</td>
<td>Mexico</td>
<td>India</td>
<td>India</td>
<td>Ghana</td>
</tr>
<tr>
<td>Demographic Area</td>
<td>Rural</td>
<td>Various rural and peri-urban areas in central Kenya</td>
<td>Mostly urban and small cities</td>
<td>Urban</td>
<td>Mostly rural</td>
<td>Mostly urban</td>
</tr>
<tr>
<td>Area</td>
<td>Eye glasses</td>
<td>Drugs and clinical services</td>
<td>Drugs and simple clinical services</td>
<td>Clinical services</td>
<td>Health clinics and health product outlets (specifically family planning and reproductive health care)</td>
<td>Pharmacies</td>
</tr>
<tr>
<td>Reach</td>
<td>65 locations comprised of 17 drug outlets and 48 basic medical clinics throughout Kenya</td>
<td>57 franchises in over 15 of 31 states of Mexico</td>
<td>8 locations in Mumbai</td>
<td>40,000 rural health providers, has established 620 franchisee medical clinics, and is delivering its products through 31,000 shops in 3 Indian states: Bihar, Jharkhand, and Madhya Pradesh (eventually reach Chhattisgarh, Uttar Pradesh, Uttranchal, Rajasthan, Orissa, West Bengal, and Assam)</td>
<td>270 shops have been integrated to network</td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td>Visits to shops during delivery</td>
<td>Inventory management system</td>
<td>Customer-driven health clinic business based on direct connect between patients and MBBS doctors</td>
<td>Conventional social marketing program (management system with strict financial and inventory controls), field personnel used to distribute products by scaling from high to low populated areas</td>
<td>Regular visits to shops by inspection team</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 3: Summary of franchises discussed. (continued)

<table>
<thead>
<tr>
<th>Fee Payment</th>
<th>VisionSpring (Scojo)</th>
<th>CFWshops (Healthstore)</th>
<th>Mi Farmacita Nacional</th>
<th>Sehat (The Medicine Shoppe)</th>
<th>Janani (DKT International)</th>
<th>CareShop</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-refundable deposit of Rs. 500</strong></td>
<td>Non-refundable deposit of Rs. 500</td>
<td>Built into drug cost</td>
<td>Upfront franchise fee, monthly contribution (3.5%)</td>
<td>Part of pharmacy chain</td>
<td>Process of creating more streamlined structure, but currently much of it is subsidized.</td>
<td>$15 initial fee and payment of renovation and training.</td>
</tr>
</tbody>
</table>

**Partners**

- Bangladesh Rural Advancement Committee aka BRAC (Bangladesh), Freedom from Hunger (Ghana), Fundación Paraguaya (Paraguay), Corporate Social Responsibility Dept. of Vendanta Resources (India)
- Management Sciences for Health aka MSH, USAID, Oswald Family Foundation, Procter & Gamble, ExxonMobil Foundation, International Finance Corporation, Acumen Fund, Rockefeller foundation, David Weekley Family Foundation
- Grupo Farmacéutico, Laboratorios Collins
- Acumen Fund, Medicine Shoppe, Inc.
- DKT-International
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