



LA/PM Community of Practice Technical Consultation: Expanding Choice and Access to LARCs and PMs through Social Franchising

Meeting Highlights

**Washington D.C.
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Background and Meeting Objectives

Social franchising (SF) utilizes commercial-sector approaches to increase access, method choice, and service quality, working through networks of private providers who deliver services under a common brand, in accordance with franchise standards. In recent years franchise networks have emerged as a key delivery channel for increasing access to long acting and reversible contraceptive (LARC) and permanent method (PM) services for underserved populations, with more than 1.2 million LARCs and PMs delivered through Population Services International (PSI) and Marie Stopes International (MSI) franchise networks alone in 2013.

This was the third and final meeting in a series of technical consultations under the auspices of the LARC/PM Community of Practice (CoP) of Bringing Long-acting Reversible and Permanent Contraceptive Methods and Services Closer to the Client. The CoP aims to stimulate learning, foster an exchange of experience, and inform strategic thinking and programming within the FP community on LARC and PM service delivery. Aligned with the goals of the CoP, the objectives of the consultation were to outline the role of social franchising in the provision of LARCs/PMs, share research findings, discuss common challenges, and contribute strategic and operational solutions to these challenges based on participant experiences. Population Services International and Marie Stopes International SIFPO Projects organized the event, with support from USAID and Engender Health (the RESPOND Project).

The event was well attended with 55 participants from 20 organizations. This report provides highlights of the meeting, synthesis of plenary and working group discussions and links to presentations.

Executive Summary

Social franchising plays a growing role in market expansion and improvement of equity, quality, contraceptive prevalence rates and changing norms. Social franchising also helps to address many of the key challenges to making high quality, affordable LARC and PM services more accessible in the private sector, and supports USAID strategic priorities of ending preventable child and maternal deaths, an AIDS free generation and a focus on reproductive health in priority countries through workforce strengthening and demand creation. Over one million LARCs and PMs were provided through MSI and PSI franchises alone in 2013. The meeting highlighted the case of Uganda, where it is estimated that over one third of women choosing a LARC or PM in 2013 received it from an MSI or PSI franchisee. Five goals for franchising have been identified by the Social Franchising Metrics Working Group: Health Impact, Equity, Cost-effectiveness, Quality, and Health market expansion (e.g. providing services to those who would not otherwise receive adequate medical care). Available research on social franchising impact is inconclusive, with research gaps around equity and cost effectiveness, however new harmonized SF metrics and ongoing SF impact evaluations should improve the quality of information available.

Operational barriers to LARC/PM provision by franchisees include provider motivation and ensuring quality among privately owned clinics. Effective approaches to address these barriers include post-training mentoring to increase confidence in LARC and PM provision and provider behavior change communications designed to address other underlying obstacles. Maintaining high quality during expansions in the scale and scope of franchised services will require continual innovation, such as the use of third party accreditors and m-health supervisory tools.

In the context of a total market approach, SF promotes a healthy market and provides consumers with increased choice. As seen through voucher programs in Uganda and Cambodia and health insurance programs in the Philippines, SF utilizes different financing mechanisms to increase access to LARCs and PMs for the poor. Several outstanding questions still remain such as, is SF best placed to reach specific lower/middle income quintiles or, through links with health financing mechanisms, can it also be a viable channel to reach the poorest; what is the potential for redirecting subsidies to third party payments; how can we increase the value proposition of FP; and can we maintain high quality counseling and client choice?

Research and programming gaps that should drive the SF agenda moving forward include whether SF is reaching new LARC users; comparative cost effectiveness of SF and public sector investments; a better understanding of how well current health financing

mechanisms work and how they can be expanded; and a need for greater focus on PM provision by qualified franchisees.

Opening Remarks

Maureen Clyde, *Knowledge Management Team Leader, RESPOND project/EngenderHealth*, served as the chair for the technical consultation. In her opening remarks she emphasized the importance of social franchising and the role it can play in expanding access to LARCs and PMs.

Ellen Starbird, *Director, Office of Population and Reproductive Health, Bureau for Global Health, USAID*, welcomed participants to the meeting and spoke to USAID's support for social franchising. Social franchising is a valuable service delivery channel for increasing contraceptive access and choice, with PSI and MSI alone providing over 1.2 million LARCS through social franchises in 2013. Women and men already use the service delivery platform that social franchising builds on, thereby increasing the options available to them. Social franchising links to larger USAID priorities such as maternal and child deaths by helping meet the unmet need for spacing and limiting births and integrating family planning services into health service delivery. Social franchising addresses AIDS Free Generation priorities by offering HIV testing and counseling, ART provision and the prevention of mother-to-child transmission. It also increases method choice, uses a total market approach, creates demand and strengthens the capacity of providers in priority reproductive health countries. Ms. Starbird closed her discussion by encouraging participants to position social franchising as a critical component to achieve the FP2020 goal and post-2015 MDG goals. She ended by emphasizing that social franchising contributes to making a real definition of access that encompasses availability, affordability, accessibility, acceptability, quality and agency.

Setting the Stage

"Social Franchising within the Broader Health System and Private Sector Context"

Caroline Quijada, *Principal Associate/Scientist, Abt Associates* opened with a presentation of findings from the preceding technical consultation [*Expanding and Improving Access to LARCs and PMs through the Private Sector*](#), and the role of social franchising in helping to address some of the key challenges in this area.

Key findings were:

- Country policies play a critical role, especially in regards to regulating service provision.
- Private sector provision requires close attention to quality assurance mechanisms as there is no inherent supervisory structure particularly for small facilities.
- Expanded training is needed and must be tailored to the needs of private providers.

- Global Market Shaping initiatives have succeeded in greatly reducing the price of implants and IUDs, however, these have primarily benefited public sector and NGO supported programs.

Other key points of her presentation included:

- The private sector increases the number of available providers, increases consumer choice and brings innovations and new technologies.
- Engaging the private sector can be challenging as it includes independent providers, the scale and scope is unknown in many countries, and there are weak mechanisms for registering, regulating and monitoring these providers.
- Organizing the private sector is critical to achieving success in delivering LAPM services. Provider networks, such as social franchises, can be used effectively to address the challenges of delivering LAPMs through the private sector.
- Existing provider networks can be used effectively to provide trainings, monitor, market and link private providers to commodities. Professional associations as well as health insurance and or health financing schemes can provide an opportunity through which private providers can be accessed.
- In addition, Social Franchises can increase LARC and PM provision through the private sector by using commercial franchise principals in a public health service model.

“How Does Social Franchising Work?”

Goretti Masadde, Head of Social Marketing, PACE/Uganda laid the foundations for understanding what social franchises are and how they work. Social franchises saw a 60% growth between 2009 and 2012, expanding from 25 to 40 countries. Social franchises are networks of private sector healthcare providers who are linked to a franchisor through agreements, standards and protocols under one brand, to provide socially beneficial health services. Franchise outlets are owned by the operator, or franchisee. Franchises work by providing a business operating system to qualified clinic owners, along with the brand and support needed to be successful (training, marketing, supplies, access to credit and health insurance, etc.).

Benefits to the franchisee include promotion through a recognized and trusted brand, business training, continuous coaching and mentoring, equipment, supplies and financing. These offerings are highly valuable to the independent business owner because they significantly increase their chances of succeeding. However the benefits are conditional upon compliance with franchise standards and procedures, giving the franchisor the leverage they need to ensure that franchisees maintain a consistent standard of operation and care.

“Social Franchising’s Role in Expanding Contraceptive Choice”

William Nnyombi, Senior Manager, Social Franchising and Demand side Financing, Marie Stopes Uganda (MSU) discussed the role of social franchising in expanding contraceptive choice through a case study of MSU and PSI affiliate PACE franchises in Uganda. Social franchising as an intervention addresses many of the supply and demand

side constraints faced by private providers in offering a broad range of FP methods, including provider skills and confidence, equipment and commodities, and awareness of/demand for LARC and PM methods.

In Uganda, there is a high unmet need for FP, low CPR, and high discontinuation rate of short term methods. MSU and PACE have scaled up social franchising in Uganda, supporting 592 clinics, to address this. In 2013, an estimated 1/3 of all LARC/PM users in Uganda received their method from an MSU or PACE franchisee, with over 170,000 LARC/PM services delivered by the franchisees that year. Through a voucher system, MSU is ensuring that poor women can access franchisee FP services; in 2013, 40% of SF clients were new adopters of FP, and 61% lived under \$2.50/day. MSU has adopted several strategies to ensure full client method choice, including training on FP counseling and on all methods; referral pathways for PMs (and training on PMs for qualified franchisees); and mentoring to increase provider confidence on IUD provision, which has increased uptake.

The results suggest three main findings. First, equipping the private sector to offer a range of high quality FP services increases contraceptive choice and benefits the health system overall. Second, delivering LARCs is not just about product, but about addressing quality, and other supply and demand side constraints. Third, SF can increase access and choice for the poorest if the right financing mechanisms are in place.

“What Does Success Look Like and What Do we Know So Far?”

Nirali Chakraborty, PhD Reproductive Health Research Advisor, PSI first presented on behalf of the Social Franchise Metrics Working Group. The Social Franchising Metrics Working Group comprises various franchising implementors, donors and researchers. The objective of the working group is to agree upon the goals of social franchising, thereby creating a common definition of “success” and a means of measuring it in a way that is comparable across franchises, health services and feasible for all organizations. The group identified five goals for social franchising: health impact, quality, cost, equity and market expansion.

Measurements:

- Health Impact is measured through disability adjusted life years (DALYs). A DALY calculator will be available online in 2014.
- Quality is measured by the percentage of facilities complying with infection prevention protocols, percent of facilities with adequate supplies of tracer commodities, percent of facilities with evidence of ability to treat/refer clients with complications and percent of providers assessed yearly on adherence to national/global protocols. Pilot tests are underway to refine the tools, and to expand the concept of quality to include the client perspective.
- Cost effectiveness is defined as the organizational cost for delivering a service by health impact, and measured by cost per DALY.
- Equity is defined as the percentage of patients receiving franchised services that are within the lowest two national quintiles, and measured using a socio-economic index benchmarked to the national distribution. An [online toolkit](#) is available.

- The measure for market expansion is still under development and will be released in 2014.

Dr. Chakraborty also spoke about the current evidence supporting social franchising, and the scale of LARC and PM services provided by franchising.

- Research findings on social franchising are not conclusive, and limited rigorous research has been conducted. The majority of conducted studies have measured quality, but limited to family planning. Few studies have measured equity or cost-effectiveness.

Some Outstanding research questions include:

- Does franchising improve the quality provided by existing providers?
- Do franchises serve the poor, or allow for improved equity of service provision in the market?
- Does franchising increase access to services (SRH services) or shift use from other providers?
- Is franchising cost-effective?
- How do providers benefit from franchising?
- At least 2 current research studies are underway. AHME (African Health Markets for Equity) is conducting a five-year randomized controlled trial on franchising in Ghana, Kenya and Nigeria. Additionally, PSI is conducting a quasi-experimental study in Kenya, to evaluate population and provider components to franchising, including the added financial value for providers and how SF increases access to family planning.
- Based on available data on LARC and PM services in franchises, in 2012, seven million DALYs were averted by 38 programs that reported service provision numbers, the majority of which (78.4%) came from FP services. Of FP methods, 85.5% of the health impact attributable is due to LARCs.
- In 2013, MSI had about 3,500 franchise outlets, and provided LARC or PM services to over 600,000 clients. Similarly, in 2013, PSI had about 14,000 franchised clinics in 23 countries. The largest portion of PSI's 1.6 million LARC or PM services provided were through these franchised clinics.

“Understanding Provider Perspectives: SHOPS Philippines Case Study”

Robin Keeley, Family Planning Senior Analyst, SHOPS Project, Abt Associates discussed a recent case study by the USAID-funded Strengthening Health Outcomes through the Private Sector (SHOPS) project that looked at the case of the Philippines and whether it was feasible for private midwives to provide IUDs on a commercially viable basis. The presentation focused specifically on how some private midwives are able to provide a higher number of IUDs than others. Open-ended interviews were conducted with midwives from two franchise networks: Well-Family and Blue Star, which offer similar basic services including counseling and a range of family planning services, referrals for PMs, delivery, ante and post-natal care and newborn screenings. Midwives from both organizations receive similar initial support such as training, marketing support, connection to a range of

affordable commodities, assistance identifying clinic locations, and assistance with Phil-Health accreditation.

A summary of the findings are as follows:

- Although interviewed midwives from both organizations provided the same quantity of contraceptive services in 2012, midwives from Blue Star provided more IUDs while midwives from Well-Family provided more of other types of methods. Researchers identified three possible reasons for these differences:
- First, each network reported different selection criteria that they prioritize in their midwife recruitment. Blue Star reportedly looks for midwives who have a strong commitment to providing modern FP, are actively working in their community, and do not already have a clinic. This may engender a sense of gratitude in the midwives for the opportunity offered to them.
- Second, Blue Star introduces IUD skills early on in the training process and has a longer practicum with more required insertions. This may give the midwives more opportunity to become familiar with performing IUD counseling and services and make them more confident in recommending this method to their clients.
- Third, a large number of mid-level health workers increases competition and options for low-priced (yet unsubsidized), service prices, contributing to higher IUD provision. Blue Star caps their midwives IUD service charge at \$2.20 whereas Well-Family allows midwives to set prices based on market conditions, often charging \$11.00 for the service. This makes Blue Star IUD services more affordable, possibly contributing to higher service numbers.

“Provider Insights Exercise”

Mary Warsh, Deputy Director, Women’s Health Project, PSI and Goretti Masadde, Head of Social Marketing, PACE/Uganda began the breakout session by emphasizing the importance of the provider as a target audience and not just as a channel for service delivery. Participants were given pictures of franchise providers from around the world asked to step into the shoes of a provider and consider the many overlapping dimensions of their life from the moment they wake up until the end of their day. The purpose of the exercise was to gain insight into the provider's life -- both personally and professionally -- in order to learn more about provider motivations. What is important to him/her in life? What are their general hopes, aspirations, fears, concerns? What are their beliefs and attitudes about FP and how do these impact service provision? Each table was given a different picture of a provider and asked to provide insights regarding the provider.

Participants mentioned that one provider was a working mom -- raising several small children as well as working at the clinic every day in order to earn enough to send them to school so they could have a better life. Others mentioned that the provider seemed proud of her clinic -- she would enjoy learning new information and techniques that could build her reputation and that of her clinic. Other groups speculated that their provider may be inundated with patients or have strong attitudes regarding women or youth requesting FP services before marriage.

Challenges and Solutions for Effective Franchisee LA/PM provision

“Provider Motivation- Provider Behavior Change Communications”

Mary Warsh, Deputy Director, Women’s Health Project, PSI began by reiterating that LARCs and PM require the services of a trained provider -- clients cannot simply ask for the product and administer these methods on their own, as they can with oral contraceptives. Therefore, we not only need to focus behavior change efforts on demand creation but also on providers so that they are willing and capable to provide LARCs and PMs when clients ask for them. In order to do this, we need to convince providers that providing these more labor intensive methods is worthwhile not only for clients but for the providers themselves.

Key points presented include:

- Provider archetypes are descriptive narratives that include demographics and psychographics, taking into consideration provider insights and motivations to provide LARC services. Archetypes are used to create positioning statements for LARC services that are anchored in presenting the benefits of offering LARCs to the provider -- in essence, what's in it for the provider to offer these services.
- Interactions between NGO franchise staff and providers are designed to be consultative in nature to identify barriers to performing desired behaviors and solutions to overcome them. These interactions rely on 4 key pillars in order to achieve the optimal productive provider experience. The 4 Pillars of Provider Behavior Change Communication: Knowledge (provider needs and technical skills), Relevance (addressing specific provider needs), Balance (genuine focus on helping the provider) and Service (building productive and long lasting relationships).
- Using a simple Adoption Stairway to Behavior Change Framework, NGO franchise staff can strategically offer solutions to move providers through the steps to behavior change: Awareness> Interest> Trial> Adoption> Advocacy.

Solutions are delivered using value propositions. Value propositions clearly state the solution being offered to the provider, describes the benefit to the provider, provides evidence to the claim and explains the cost of risk involved with making the behavior change.

The Interaction model for PBCC follows a cycle: Plan > Engage > Deliver Solutions > Reinforce solutions > Evaluate.

PSI partnered with MERCK Fellows to create a Provider Behavior Change Communication Toolkit that addresses Organization & Structure, Communications and Material Development, Management & Coaching of Field Staff and Skills Building Curriculum for Field Representatives. Contact PSI for further information.

“Demand Generation- Branding, Consumer Interpersonal Communications Work”

Simon Mboyano, Director, Health Services Delivery, PS Kenya discussed the Tunza Family Health Network. Tunza is a fractional franchise network, started in 2008, with over 300 providers, 80% of which are nurses. Demand creation staff work with 300 Community Mobilizers, known as Tunza Mobilizers (TMs), to create demand for services. The Interpersonal Communication (IPC) objectives are to increase the percent of married women of reproductive age and youth who use modern FP methods to delay, space or limit child birth. The majority of TM's are from the local community, speak the local language and are women. IPC activities are carried out in small group sessions or through one-on-one communication. If requested, after each session participants are given follow-up and referral information. IPC messaging covers family planning, cervical cancer screening, HIV testing and counseling and management of childhood illnesses.

His main points are as follows:

- In 2013, Tunza shifted to provide mainly one-on-one sessions (70%). From their experience they found that outspoken personalities often dominated the group sessions therefore overshadowing women who may be hesitant to ask questions in a group setting.
- Tunza also began starting their meeting with information on LARCs instead of short term methods. They found that since knowledge around short term methods was fairly high, women had lost interest by the time the conversation shifted to LARCs.
- In 2013, Tunza's IPC had reached over 1 million participants, 80% of which were women. As a result in 2013 alone, over 100,000 women visited a Tunza clinic through an IPC referral. Of those who visited, over 19,000 women requested an IUD and over 25,000 requested an implant.
- 2014 quarter 1 data suggests that IUD and Implant demand has increased. Tunza has attributed this increase to the scale up of one on one IPC sessions and the change in messaging, to focus on LARCs and then short term methods.

“Strengthening Franchisee Quality. More than Access: Quality in SF Networks”

Brendan Hayes, Head of Social Franchising, MSI addressed how to balance expansion of scale and scope with attention to quality of service provision and quality assurance. He used an example from MSI to discuss how they were able to improve quality standards in facilities they do not own. MSI runs 620 clinics around the world and measures clinic quality through a standard audit tool that is also used for MSI clinical outreach and in the 3,300 franchise clinics supported by MSI.

A summary of his main points are as follows:

- Making quality improvement an explicit part of the franchise value proposition helps ensure that franchisees share our quality agenda.
- MSI is seeing sustained quality improvement in their franchised facilities overall. In 2013, SF scores were similar to the 2011 scores of MSI-owned clinics at 87%. Robust quality improvement is possible without facility ownership.

- Successful quality interventions draw on provider insights to understand behavioral determinants and create a value proposition for franchisees that can be leveraged for quality improvement.
- Structural determinants of quality are relatively easy to measure, but may not be the best indicators of quality of services. Expansions in the scope of franchised services and the scale of delivery will require continual innovation to identify better quality measures that are practical and cost-effective to routinely gather.

Balancing Equity, Access, and Sustainability- Approaches and Lessons

“Social Franchising in the Context of Total Market Approach”

Nirali Chakraborty, PhD Reproductive Health Research Advisor, PSI began by defining a total market approach. She noted that a total market approach should promote a healthy market by providing choices for consumers. The total market approach, in health services specifically, is very similar to health systems strengthening. Different sectors provide services/ products to different segments of a population in relation to their need. Reasons that the total market approach is relevant for social franchising include the high proportion of out of pocket expenditure on health, indicating that the private sector is a significant source of care, as well as the high percentage of FP services sought from the private sector.

Finally, Dr. Chakraborty offered questions to consider when applying a total market lens to social franchising, and for LAPM services:

- Should donors and implementers prioritize countries in which scaling up quality assured LAPM in private sector will assist the public sector? Will this relieve unmet need by allowing the public sector to provide additional services?
- Would equivalent investments in LAPM by donors into public vs. private sector delivery yield differential results?
- How would we assess improvements in the market for LAPM services? Is that the market which we should consider, or should it be more broadly defined?

“Vouchers in Three Parts: Addressing inequities in access to contraceptive services”

Ben Bellows, PhD Associate II, Population Council began by establishing that a significantly higher unmet need for family planning is found among the poor in 54 low- and middle-income countries. A practical strategy to reduce inequitable access in line with universal health care would be to target demand subsidies, or vouchers, to clients who could use these at a facility of their choice. The same strategy would reimburse accredited facilities that meet the contraceptive needs of poor clients at no cost to the client. This "voucher strategy" is intended for individuals who would have been unable to access their contraceptive method of choice in the absence of the subsidy.

In a recent literature review, 19 FP voucher programs were identified as operating between 1964 and 2012 with the majority of programs launched since 2005.

Dr. Bellows used a case study of a RH Voucher program in Cambodia in 2011 to discuss program impact on LARC use.

The main points are as follows:

- The program was designed to reduce barriers to utilization of RH healthcare services among disadvantaged women in nine operational districts who were enrolled in the national health equity fund (HEF) program. Vouchers included LARCs and short term methods, available at public and NGO facilities, with no user fees and a transportation subsidy.
- A quasi experimental evaluation of 2,200 women drawn from households in the catchments of voucher-contracted facilities and similar control facilities showed that vouchers significantly increased the use of LARCs over two years among postpartum women.
- It also showed significantly higher use of LARCs in voucher areas as compared to non-voucher study areas. There was an increase among all SES and education groups but it was most pronounced among women with no schooling.
- The results suggest that vouchers can benefit social franchising as they increase demand among those who wouldn't otherwise seek out or afford services. In fact, many franchises in the SF Compendium report using some form of demand side finance in their networks already.

From this, Dr. Bellows outlined several next steps to keep in mind. First, we need stronger systems to monitor performance metrics such as whether programs are bringing in new or repeat LARC users and how FP programs are performing. Better, standardized metrics facilitates comparisons of programs' performance. Additionally, transparent price signals help governments to see themselves as service purchasers, not simply service providers. Such a shift in perspective could help ensure the long-term financial sustainability of targeted demand subsidies within franchise networks and make progress toward universal, voluntary FP coverage as part of universal health care.

"Improving Health Outcomes through Health Financing in the Philippines"

Franklin Francisco, Project Portfolio Manager, Population Services Pilipinas Incorporated (PSPI) discussed linking PSPI's Bluestar social franchise with the National Health Insurance Program, PhilHealth, in the Philippines. PhilHealth addresses equity through sponsored programs for poor households, including a maternal and neonatal health care package covering pre-natal visits, delivery, neonatal care, post-natal care and family planning uptake. Over 114,000 cases had been reimbursed by PhilHealth as of 2013. Providers are paid per case and cannot charge more than the set reimbursement price.

A summary of the main points are as follows:

- PSPI has expanded FP choice and access by supporting franchised midwives to provide LARCs. BlueStar franchisees provided over 100,000 FP services to women in 2013, including 65,000 IUDs.
- Of 267 BlueStar facilities 179 are PhilHealth accredited. PSPI plays a vital role in linking franchised midwives to the PhilHealth health financing mechanism by supporting franchisees in their PhilHealth accreditation, providing a loan facility for accredited facilities to ensure cash flow when reimbursements were slow, and assuring quality.
- The result has been increased access to IUDs, especially among poor women, increased sustainability of franchises, greater client satisfaction, reduced poverty and inequity and greater number of services at a lower cost.
- PSPI is advocating for policy change to allow midwives to provide contraceptive implants as well as IUDs and short term methods. PSPI is also working to achieve accreditation for all franchisees and expand the overall franchise network.

Working Groups

Participants broke into four small groups to discuss the balance between equity and sustainability of social franchising in regards to LARCs and PMs. Specifically each group was asked to consider, what are the key challenges and possible solutions to balancing equity and sustainability? What roles can we play in these solutions? What can we learn from other sectors and what are the research and programming gaps?

Participants were broken into small groups for discussion. Each group had a pre-assigned facilitator. The main take away points from the small group discussions are as follows:

Key Challenges:

- Equity and sustainability for the entire system. We need to make sure SF is reaching those who really need it. SF seems to have a “quintile niche”
- Getting a seat at the table as a national priority
- Designing a business model that will lead to sustainability
- Increasing the value proposition of FP
- Addressing service gaps in the removal of LARC methods
- Providing counseling that targets the reproductive life cycle of our clients

Research and Programming Gaps:

- Conduct research to see if SF is reaching new LARC users.
- Compare cost effectiveness between the investments in SF vs. the public sector.
- Conduct case studies of the current financial schemes in order to uncover barriers.
- Document the social franchising model to help improve FP delivery such as strengthening social franchises to deliver FP services and national insurance schemes.
- Research barriers to PMs and actions that can be taken to improve such programs.

- Better understand how existing National Health Insurance schemes work.

Solutions:

- Decrease costs and maximize revenue. For example, find ways to decrease lab costs and optimize supply and commodities.
- Redirect cash flows, from donor funding through franchisors, to help create efficiency for higher profit margins.
- Increase the uptake of FP services through private funding.
- Redirect subsidies to third party payment.
- Improve branding & positioning of franchises to increase demand and help the supply side of program implementation.

Looking to the Long-Term: Options for Sustainable LARC/PM Provision

In her remarks on looking forward, **Maggie Farrell**, *Private Sector Team Lead, Service Delivery Improvement Division, Office of Population and Reproductive Health, Bureau for Global Health, USAID* remarked that USAID supports SF for LARCs and PMs because it can increase access by expanding method choice. Social franchising is an efficient way to improve equity, quality, contraceptive prevalence rates and changing norms. Social franchising can create knowledge and demand for contraceptive methods. The future of social franchising and how insurance and finance schemes will evolve is unclear but what is clear is that the private sector will play an important role.

In closing, **Elaine Menotti**, *Health Development Officer, Service Delivery Improvement Division, Office of Population and Reproductive Health, Bureau for Global Health, USAID* reminded participants that choice of provider as well as choice of method is important. She encouraged everyone in the global health community to share results and continue a dialogue. She noted that next steps are to work on the harmonization of metrics across organizations, improve integration of services and focus on not only insertions but removals as well. USAID is looking forward to seeing SF's role in market expansion, the value it offers providers, the role of vouchers and insurance, and the potential opportunity for PMs.