Liverpool School of Tropical Medicine

Franchising mechanisms in Uttar Pradesh, India: Working for the poor people? Equity and quality aspects

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Master is International Public Health

July 2010

This dissertation has been submitted in partial fulfilment of the requirements for the award of Master in International Public Health

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To Maria Josefa Rodriguez Berea, “Pepita”

In memoriam

Acknowledgments

To Cecilia, my wife, my friend, my supporter. For her patience and her encouragement. Just because she was always there.

To my mum. She told me for many years to go to study to the UK. Here there is.

This dissertation would not have been possible without the help of many people, especially in India. I will always remember the people from Shayogh Office in Lucknow: Annu, Pravesh, Ankita, Ekta, Sunil, Rashmi, Molly, ... made my time in India pleasant and enjoyable. Thanks to all of them. Thanks very much also to Paula in Lucknow and to Anita in Delhi for making my India experience easier.

I am especially grateful to Anchita, my translator and research assistant. She guided me through a new and complicate setting with patience and competence.

Tank very much also to CHSJ, especially to Dr. Abijit Das. He had the idea of this research, and he is always thinking in how to advocate for the poorest people in India. A great and hard job.

Special thanks to my friends than came to Liverpool to visit me, making this year in Liverpool “shorter” and, obviously, funnier. Thanks to all my family, because I know they are always there.

I would also like to give special thanks to my supervisor, Prof. Xiaoyun, for his advises and suggestions during all the dissertation process. He was especially useful reading the draft and making invaluable comments even when time was running out.

Finally, to all the anonymous women of India, and specially Uttar-Pradesh. This research is dedicated to them.

Acronymus

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
ARV	Anti-retroviral
ASHA	Accredited Social Health Activist
BPL	Bellow poverty line
CHSJ	Centre for Health and Social justice
FGD	Focus Group Discussion
HIV	Human immunodeficiency virus
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HPS	High Performing States
JSY	Janani Suraksha Yojana
LPS	Low Performing States
LSTM	Liverpool School of Tropical Medicine
MHFW (	Minsitry of Health &Family Welfare)
NHRM	National Health Rural Mission
MMR	Maternal mortality ratio
OT	Operation theatre
PLHIV	People living with HIV
Pps	public-private partnerships
RHS	Reproductive and Health Services
SIFPSA	Family Planning Project Services Agency
SRH	Sexual and Reproductive Health
UP	Uttar-Pradesh
USAID	United States Agency for International Development

Executive Summary

Background and rationale of the study

The role of public-private partnerships in India became a major debate last years. Several types of contracting-out mechanisms have been popularized, even sometimes there is not enough evidence supporting these practices. Social health franchising is one of these types of public-private partnership not deeply evaluated yet. Therefore, the research aimed to evaluate the impact on equity and quality among poor people of a reproductive health social franchising mechanism in Uttar Pradesh, India.

Objectives

The main aim of the research was to evaluate the impact on equity and quality of a reproductive health social franchising mechanism in Uttar Pradesh, India. Other objectives were the description of the studied franchising network and to examine the impact on access and utilization of franchising providers compared with other public providers. Perceives quality and satisfaction among users of both types of facilities also was compared.

Finally, the research also aimed to draw suggestions and recommendations to improve both the franchising network and the public providers' service delivery.

Methodology

A comparative study among different providers (franchisee and public provider) was carried out. Field data were collected between April and May of 2010, while data analysis was carried out on June and July 2010.

Mixed methodology (both quantitative and qualitative) was used, to open the scope of the research and to enhance its quality. Qualitative data, mainly semi-structured interviews, secondary data and a focus group discussion were carried out to describe the studied franchising network and to evaluate services' utilization. Quantitative

methodology, based in exit-interviews, was used to analysis access, perceived quality and satisfactions of services.

Quantitative data were collected in a paper basis and later introduced in a EPI-INFO form. Both EPI-INFO and SPSS software were used to analyze quantitative data. Univariate logistic regression analysis was used to compare satisfaction with SES and other factors theoretically related with satisfaction. To describe general characteristics of users T- student was used to compare means. To compare socio-economic groups and utilization (% of poor population using each facility) Pearson chi-square was also used.

Results

The studied franchise network is not increasing utilization of services, according the generalized view of franchisee health managers . Quantitative data also shows show socio-economic status populations and scheduled and other backward casts are more likely to attend public facilities than franchising facilities ($p < 0.05$). Results show higher perceived quality among users of franchising mechanisms than those attending public facilities in terms of inter-personal relation (both with medical and non-medical staff) and infrastructure. Patients attending public facilities are also more likely to be unsatisfied than those attending franchisee outlets.

Conclusions

The studied franchise network is not increasing utilization of services and is not addressed to the poorest people, although users perceive higher quality and are more satisfied than those attending public facilities. This can be explained because the “high competitive” environment in India for the poorest. Governmental sector is strongly subsidizing institutional deliveries through a conditioned-cash programme. This means *in practice* poor people are going to choose public facilities when care-health-seeking to get the associated benefits (*cash*). Therefore, middle and high socio-economic status populations are the big beneficiaries of the franchising programme.

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Chapter 1- Introduction

1.1. Rationale of the study

Enthusiasm about public-private partnerships is extremely variable according to values, interests and views of authors and others stakeholders involved. Probably the major tendency strongly supports public-private partnerships as a necessary, efficient and essential way to achieve public-health related goals in developing countries (Montagu, 2002; Raman& Björkman, 2006). Prata, Montagu& Jefferys (2005) also support public-private partnerships arguing that poor people choose between going to a private provider *vs* not seeking health care when sick. In the other side, authors like Widdus (2001) even suggest that public-private partnerships have to be seen just as "social experiments".

Bustreo, Harding& Axelsson (2003) highlight the importance of describing, monitor and evaluate these public-private partnerships (*ppp*s) initiatives (especially those related with sexual and reproductive health) before spread them massively. Perrot (2006) also emphasizes that public-private partnerships are just tools to achieve pre-determined goals and not an end in itself, so they have not to be considered as a *panacea*. Nonetheless, the role of private sector into public health policies and strategies is still a major debate (Hanson *et al.*, 2008)

Franchising has become a popular type of public-private partnerships (Patouillard *et al.*, 2007). Social health franchising consists in grouping private health providers under a franchised brand to offer same set of services at the same price and quality (Montagu, 2002). However, researches about franchising mechanisms don't show conclusive evidences yet, especially among poor people, as showed a recent Cochrane systematic review (Lagarde & Palmer, 2009). Liu, Hotchkiss, Bose (2007) also pointed out the widespread of social franchising networks has been developed in the absence of robust evidence of its effects).

There are several gaps in research about franchising mechanisms. A study about quality and perceived satisfaction of different types of providers (franchises, Governmental, private non-profit and private for profit) carried out in Pakistan showed similar levels of satisfaction and quality among providers. However, they found higher

proportion of poor clients using franchise facilities than government clinics, and cost-for patient seemed to be also lower in the franchise facilities (Bishai *et al.*, 2008). Cost-effectiveness of franchising mechanisms is also not enough studied. Potential conflicts of interest between the stakeholders involved in the public-private partnerships are also not deeply researched (Walt, Brugha & Haines, 2002) Finally, Patouillard *et al.* (2007) also concluded after a systematic literature review that there is not enough evidence on the impact of public-private partnerships on quality and/ utilization of health services by the poor. Peters, Mirchandani. & Hansen (2004) also pointed out after an extensive literature review that most part of the studies about public-private partnerships in the area of SRH are descriptive or theoretical.

Therefore, the scope of this research will include franchising network utilization and access to services, users' perceived quality and users' satisfaction, as identified aspects where gaps in research are bigger. Reasons of private outlets to join the franchising network will also be studied to analyze sustainability of the initiative and how it can be improved.

1.2. Study area

1.2.1. India Health system

Private sector plays a major role in health service delivery in India (Gov. of India, 2007). Private sector include several types of providers, delivery models and stakeholders, including profit and non-profit organizations, traditional healers, TBAs, pharmacies, trusts, insurance companies, stand-alone specialist services, *quacks* (unqualified doctors), small laboratories,etc (Raman, 2008). Therefore, it becomes difficult to authorities and researchers to get complete and reliable information about the private sector because this sector fragmentation and the wide range of providers.

However, one of the majors constrains of using private sector facilities in India is the cost, especially among poor people. Almost 50% of patients admitted in hospital wards have to sell assets or borrow money to pay the hospital bills, and 25% of farmers fell down below the poverty line because of the cost of the health care in

private facilities (Sengupta & Nundy, 2005). It is also described the inefficient use of resources by the private physicians, e.g., not using standard recommended treatment regimes (Bhat, 1993).

Table 1. shows India's expenditures in health:

Table 1: India's expenditures in Health

Area	Total expenditure on health as % of gross domestic product		Government expenditure health as % total expend		Private expenditure health as % total expend		Out of pocket expenditure as % of total private expenditure		External resources as % total expenditure on health	
Year	**2000**	**2006**	**2000**	**2006**	**2000**	**2006**	**2000**	**2006**	**2000**	**2006**
South-Asia region	3.6	3.4	28	33.6	72	66.4	88.7	88.3	2.4	1.9
LICs	4.2	4.3	33.3	36.2	66.7	63.8	89.9	85.4	11.7	16.9
India	**4.3**	**3.6**	**21.8**	**25.0**	**78.2**	**75**	**92.1**	**91.4**	**0.6**	**1.0**
Global	8.2	8.7	56.6	57.6	43.3	42.4	51.5	49.3	0.3	0.4

Data source: (WHO, 2009)

It is showed private expenditure on health as % total expenditure in health is 75%, much higher than the regional average. This expenditure is mostly based in out-pocket payments rather than in insurances schemes, so likely poor populations' access to service is low in terms of affordability.

Due to this importance of the health private sector in India, public-private partnerships are often suggested as a solution to increase access to health care (Goel, Galhotra, & Swami, 2007). As it is argued that franchising mechanisms can increase access and utilization of health services among poor people (Montagu, 2002), franchising

mechanisms are one of the types of *pps* selected by the Government and donors to expand SRH services. Specifically franchising mechanisms as a way to deliver services have been explored in India since 2000 (Wexler, 2008)

In the other hand, public sector facilities are under the management of Ministry of Health and Family Welfare. Under the MHFW, the National Rural Health Mission (NRHM) has the mission of “provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure” (NRHM, 2005). Uttar Pradesh, the selected State where the franchising network is developing its activities, it is included in the scope of the Mission

Public sector facilities in rural and semi-rural areas of India are organized in a 3-tier system, as follows (figure 1), to try to assure high coverage of services.

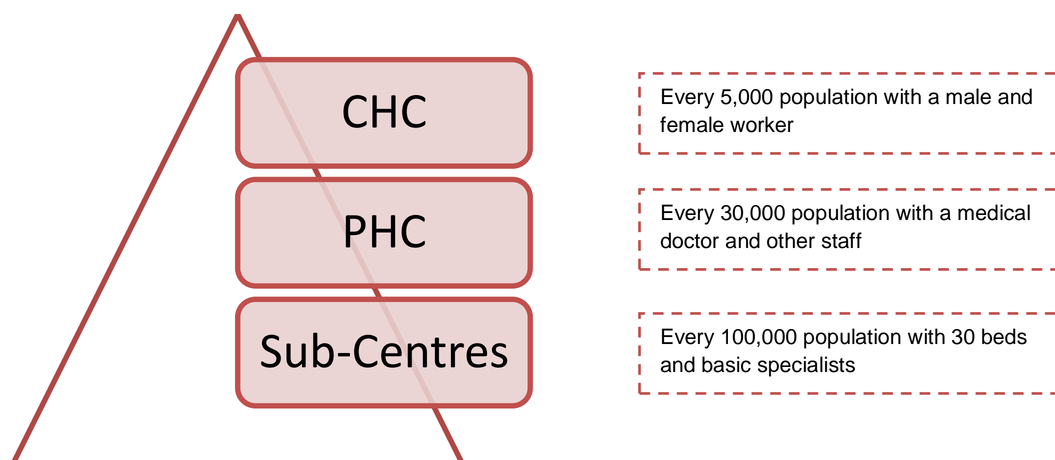


Figure 1: India Public Sector 3-tier system (WHO, 2007)

This extended offer of services including public facilities and several types of private providers makes difficult to study health seeking behaviour of poor people, especially when attending informal or non registered providers. It is described among women from urban areas in India a clear preference for health private providers for ANC and delivery, just limited in practice for lack of economic resources for paying, especially among those from lower socio-economic status. Suggested reasons for this preference are proximity, staff’s behaviour, shorter waiting time and more inter-personal communication (Neena Shah *et al.,* 2009).

More et al. (2009) also found through a birth surveillance system in urban India a significantly higher use of private facilities for delivery among better-off women than those from lower socio-economic status, and that they were five times less likely to deliver at home that poorest women. Therefore, this research will include in both franchisee facilities and Governmental clinics analysis of utilization and access to services among poor people.

1.2.2 Sexual and reproductive Health in Uttar-Pradesh

Uttar Pradesh is one of the largest States of India. Its population arises to 166 million, and total fertility rate is almost the double of India's average (3.8 *vs* 2.6). Most part of Sexual and Reproductive Health indicators are worst than the national average, so their improvement is a priority to achieve the health related Millennium Development Goals (MHFW, 2010b)

Table 2 shows main UP demographic indicators compared with the national ones. Figure X shows where is UP situated in India. Table X lists main SRH indicators in Uttar Pradesh.

Table 2: Selected Indicators. India and Uttar-Pradesh State

. No.	Item	Uttar Pradesh	India
1	Total population (Census 2001) (in million)	166.20	1028.61
2	Decadal Growth (Census 2001) (%)	NA	21.54
3	Crude Birth Rate (SRS 2008)	29.1	22.8
4	Crude Death Rate (SRS 2008)	8.4	7.4
5	Total Fertility Rate (SRS 2008)	3.8	2.6

6	Infant Mortality Rate (SRS 2008)	67	53
7	Maternal Mortality Ratio (SRS 2004 - 2006)	440	254
8	Sex Ratio (Census 2001)	898	933
9	Population below Poverty line (%)	31.15	26.10
10	Schedule Caste population (in million)	35.15	166.64

Source: MHFW, 2010

Figure 2: Map of India and Uttar Pradesh (India National Family Health Survey, NFHS-3)

Table 3 shows UP selected Sexual and Reproductive Health indicators:

Table 3: Selected Sexual and Reproductive Health indicators. Uttar Pradesh State

Indicator	
Maternal care	
Percent of women received ANC check-ups	57.8
ANC check-up at home	10.3
ANC check-up in first semester	22.0
Three of more visit for ANC	24.6
Two or more TT injections	69.5
Adequate iron folic acid tablets	8.7
Full ANC check-up	4.4
Awareness of RTI/STI and HIV/AIDS	
Percent of women who have heard of RTI/STI	29.1
Family Planning	
Current use of any FP method	35.6
Current use of any modern FP method	26.2
Current use of female sterilization	14.4
Current use of male sterilization	0.2
Percent users who received follow-up services any modern method	17.3

Source: DLHS-RCH, 2002-2004 (ISPII, 2007)

1.3. The client and the franchising network

The topic of this research was suggested by CHSJ (Centre for Health and Social Justice). CHSJ is an Indian-based NGO focused in promoting human development, gender equality, human rights and social justice, specifically in their health related-aspects. Stated objectives of the Organization are building evidence on the impact of existing health policies and programmes; to identify priorities to increase access and

quality of health care for women and other marginalized people; advocacy; and to develop leadership and capacities for improve of quality and access to health care services (CHSJ, 2010).

CHSJ works in partnership with several NGOs and CBOs, including Sahayog in Uttar Pradesh. Sahayog works mainly in gender equality promotion and women's health from a human rights framework. Main activities are advocacy and strengthening partnerships (SAHAYOG, 2010). Sahayog was the host of the research team and led the process to get the key actors involved in the study.

In the other hand, the franchising network was launched in August 2007, with the collaboration of SIFPSA (Family Planning Project Services Agency) and with USAID as main donor. Hindustan Latex Family Planning Promotion Trust (HLFPPT) is the implementer of the franchising initiative. HLFPPT is a non-profit organization which implements "innovate initiatives" to face main health problems in India, specifically Maternal and Child Health (HLFPPT, 2008). One of these initiatives is the Social Franchising Project called "Merrygold". Merrygold is a franchising brand grouping private providers of Uttar-Pradesh which provide Sexual and Reproductive Health services at the same price and standardized quality. HLFPP as implementer had the role of selecting and managing the potential outlets to be franchised. It is supposed also that quality of services will be assured by protocols and periodic quality audits. The network stated also that it is committed with the more underprivileged populations (Press release, 2007)

1.4. Overview of the research

As seen above, the role of public-private partnerships in India became a major debate last years. Several types of contracting-out mechanisms have been popularized, even sometimes there is not enough evidence supporting these practices. Social health franchising is one of these types of public-private partnership not deeply evaluated yet. Therefore, the research aimed to evaluate the impact on equity and quality among poor people of a reproductive health social franchising mechanism in Uttar Pradesh, India.

A comparative study among different providers (franchisee and public provider) was carried out. A research team was conformed, including main researcher from LSTM and a research assistant from Uttar-Pradesh. Field data were collected between April and May of 2010, while data analysis was carried out on June and July 2010.

Mixed methodology (both quantitative and qualitative) was used, to open the scope of the research and to enhance its quality. Qualitative data, mainly semi-structured interviews, secondary data and a focus group discussion were carried out to describe the studied franchising network and to evaluate services' utilization. Quantitative methodology, based in exit-interviews and a checklist, was used to analysis access, perceived quality and satisfactions of services.

Finally, the research also aimed to draw suggestions and recommendations to improve both the franchising network and the public providers' service delivery.

Chapter 2: Literature review

This chapter reviews main issues related with the objectives of the research: private-public partnerships and franchising mechanisms; perceived quality of health care ; and users' satisfaction

2.1. Search strategy

For making the literature review, a comprehensive, iterative search of published literature in English was made. For each topic different terms were introduced in OVI-SP, through Global health database. Google scholar was also used. Table 4 shows searched items.

Table 4: Literature review: searched items

Topic	Searched terms
PPPs	• "Public-private partnerships" • "Contracting-out" • "Private provider"
Franchising mechanisms	• Social franchising
Perceived quality	• Health care + perceived quality • "Health care quality"
Users' satisfaction	• "Patients satisfaction" • "Users' satisfaction" • "Clients satisfaction"

2.2. Public-private partnerships

It is strongly argued that contracting with the private sector is an effective and rapid way to improve and extend health service delivery and achieve MDG related goals in low and medium income countries, especially Reproductive and Health Services (Loevinshon, & Harding, 2005; MSI, 2006). Shaikh *et al.* (2010) even argued

contracting with the private sector is “in an efficient, effective, superior and fair manner” of service delivery.

It is also often argued that public-private partnerships can increase the coverage and quality of health services. Public-private partnerships as a strategy to be implemented in low- and middle-income countries to improve maternal health and safe motherhood is largely encouraged as well (Brugha & Prietze-Aliassime, 2003)

Rosen (2000) describes four types of public-private partnerships in Reproductive Health services: outsourcing (the Government pay a provider to deliver services), contracting in (private sector is contracted to manage public services), subsidies, rental and privatization of services. However, other more comprehensive classification is provided by Patouillard *et al.* (2007), who identify seven types of public-private partnerships:

- Social Marketing
- Voucher schemes
- Pre-packaging
- *Franchising*
- Accreditation
- Regulation
- Trainings
- Contracting-out

Palmer (2000) highlighted that even if it is argued that contracting out with the private sector can both improve accountability and efficiency of public funds and mobilize private resources towards public health goals, evidence is not strong enough to support this arguments. A systematic review about effects of contracting-out (Liu, Hotchkiss, & Bose, 2007) also pointed out even access to services seems to improve when contracting-out there is not enough evidences about the effects in equity and quality of services neither efficiency aspects. They also highlighted that not negative or wider health system effects of contracting out are enough studied. Other aspects

related with public-private partnerships, as managerial processes, are also not studied (Nigenda & Gonzalez, 2009).

Goals that private-public partnerships can achieve are described by Donika *et al.* (2009). It includes reduction of fragmentation of providers; change provider incentives and increase monitoring; subsidize of targeted populations; education of patients and reduction of asymmetries of information; and the use technologies that improve quality. Franchising mechanisms can achieve, at least theoretically, most part of these described goals, as seen later.

Finally, one Cochrane systematic review reviewed the effectiveness of contracting out healthcare services and in improving access to care in low and middle-income countries. The review was not conclusive, showing the need of deeper and wider research about the topic (Lagarde & Palmer, 2009)

2.2.1. Franchising mechanisms

Franchising is a type of public-private partnership, as seen above. Several definitions of social franchising are suggested. England (2006) provides a wide definition of franchising as a system which ”aims to increase the supply of an established product or service by contracting a number of independent retailers in different localities to offer those products or services to consumers”.

CGD (2008) identify some common characteristics of a network of providers to be considered as a social franchising network: outlets have to be operator-owned, payments are based on services provided and standardized services have to be offered. This definition excludes, e.g., non-profit networks who offer free of charge clinical services. Other authors prefer to indentify “models” of social franchising mechanisms. Lavacke (2003) identifies four models of franchising mechanisms: joint ventures, private provider model, community model and governmental model. Table 5 summarizes main features of the suggested models:

Table 5: Franchising mechanisms models

Model	Characteristics	Main techniques
Joint venture	A central organization (the franchisor) creates a joint enterprise with private providers or other NGOs	• marketing and logo branding • training and quality assurance
Community model	It uses social franchising techniques to develop strategic alliance between providers of services and community groups	• Promotion (marketing/logo) • Trainings • Minimum quality assurance
Private provider	Clinics and Hospitals are engaged into a branded network (the franchising network) to increase access.	• marketing and logo branding • training and quality assurance • Franchise contract
Governmental	Government can use social franchising techniques into governmental clinics and hospitals	• marketing and logo branding • training and quality assurance • Incentives and subsidies

Some of the social franchising techniques and procedures, such as cost recovery schemes or referral mechanisms, are common to all the models. These models are also not mutual exclusive, so a particular franchise network can have features of two or more different models.

Other classification of franchising models is summarized by McBride & Ahmed (2001). They identify *stand-alone franchises* and *fractional franchises* models. Stand-alone franchises model is based in a franchiser who provides infrastructure and equipment to the providers (franchisees). This model can be useful when health providers have scarcity of resources (as infrastructure). It also permits the franchiser monitor closely quality and services provided.

Instead, in the fractional franchises models new services like SRH services are added to the “basket of services” of an existing health provider. Advantages of this model are that is easily replicable and sustainable, and it strengths health providers’ capacities. However, quality control can become a constrain

2.2.2. Franchising theoretical framework

Montagu conceptual framework (Montagu, 2002) is often used to explain *how* and *why* franchising mechanisms are achieving their goals and objectives, specifically increasing access and improving quality. Figure 3 shows the suggested logical chain of events leading to the expected results.

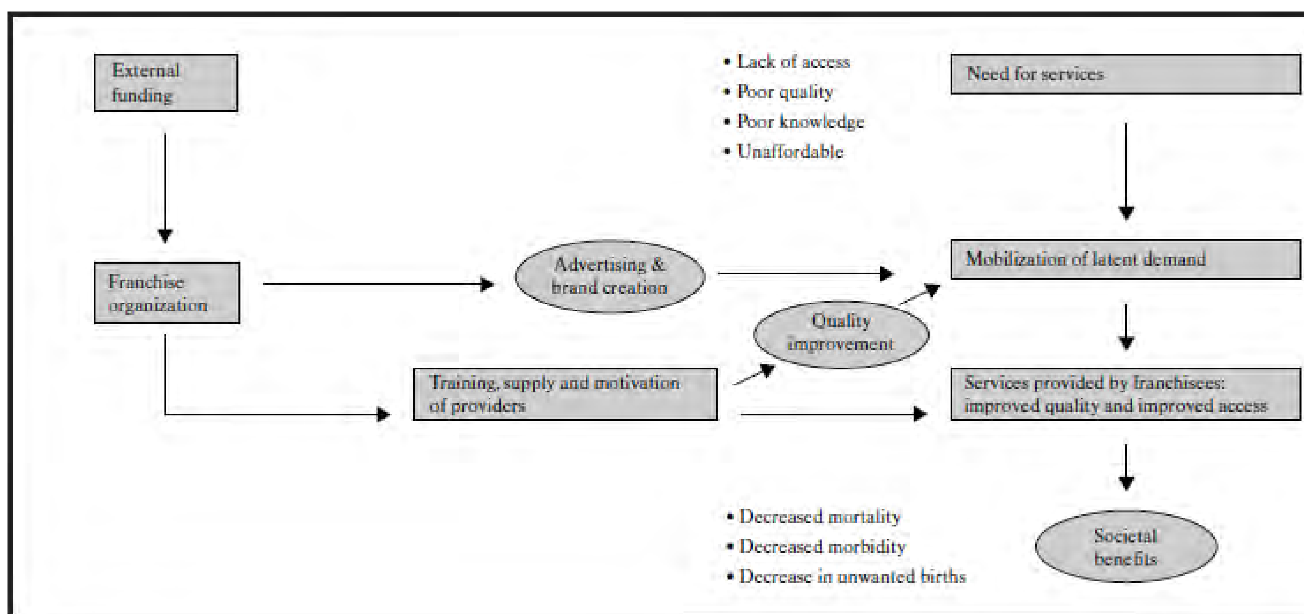


Figure 3: Health franchising mechanisms framework (Montagu, 2002)

Basically, Montagu theoretical framework suggests three ways with which franchising networks are improving quality: advertising, trainings and motivation of providers. Then, these quality improvements will mobilize potential users to attend the branded network. Therefore, two main outcomes will be produced: quality improvement and increased access.

However, Koehlmoos *et al* (2009) examined the evidence that social franchising has on access to and quality of health services in low- and middle-income countries.

Review was not conclusive, showing the need of testing the framework under “real field conditions”, with comparable measures and procedures.

Other authors also argued limitations of the framework. Lonnroth *et al.* (2007) pointed out limitations of branding and marketing. Their findings show main reasons identified for visiting a provider were that the clinic was the usual point of care and distance to the clinic. Marketing had limited effects in poor people health-seeking behaviour.

Relations between franchising and quality and satisfaction have been also studied, showing mixed conclusions. A descriptive multi-cluster randomized study of three franchising networks in different settings showed an association between clients' satisfaction and franchise membership. However, in one case this association was positive (clients of franchise network were more satisfied than clients from other providers) but in other case association was negative, so conclusions were not conclusive (Stephenson *et al.*, 2004). Agha *et al.* (2004) found in one quasi-experimental study higher satisfaction among clients of a franchising network than those visiting control clinics. Curiously, this satisfaction was not associated with higher awareness of the franchising network. Therefore, association between franchising mechanisms and higher satisfaction among users in not yet enough studied.

Finally, some results are suggested to study franchising social networks in comparable basis. CGD (2008) suggested volume and access, cost-effectiveness, quality and equity as expected results to be measured, because it is argued than those are the common goals of franchising networks.

2.3. Quality of care

Donebedian (2005), the most known “guru” of health quality, highlights quality of health care is an especially difficult concept to define. Reerink (1990) also pointed out the difficult that researchers have found to define health quality since Ancient Egypt and Rome. Therefore, there is no consensus about the definition of health care quality, although several definitions and frameworks have been suggested. Health care can be defined as “being composed of health care systems and actions taken

within them designed to improve health or well-being" (Campbell, Roland & Buetow, 2000). Feld (2007) defines quality of health care as ""the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Steffen (1988) also defines quality of health care relating capacities (inputs) with goals (outcomes) as "is the capacity of the elements of that care to achieve legitimate medical and nonmedical goals". In general, definitions moved from the notion itself to *evaluative approaches*, where dimensions of health care and categories to be measured are the central point (e.g., by comparing actual health care with pre-defined or standardized criteria) (Reerink, 1990)

Wilde (1993), *e.g.*, describes four dimensions of perceived quality: the technical competence of the health care providers; infrastructure; the attitudes and actions of the staff; and the socio-cultural atmosphere of the service delivery provider. Rao, Peters& Bandeen-Roche , 2006) describe five dimensions of health care quality when designing a survey to measure it: availability of medicines, medical information, non-medical personnel attitudes to the patients, medical personnel attitudes to the patients, and hospital infrastructure. However, Lee& Jones (1993, cited by Donebedian, 2005) suggested the most popular 8 dimensions of health care quality: technical competence, access to services, effectiveness, interpersonal relations, efficiency, continuity, safety and amenities, as show the figure 4

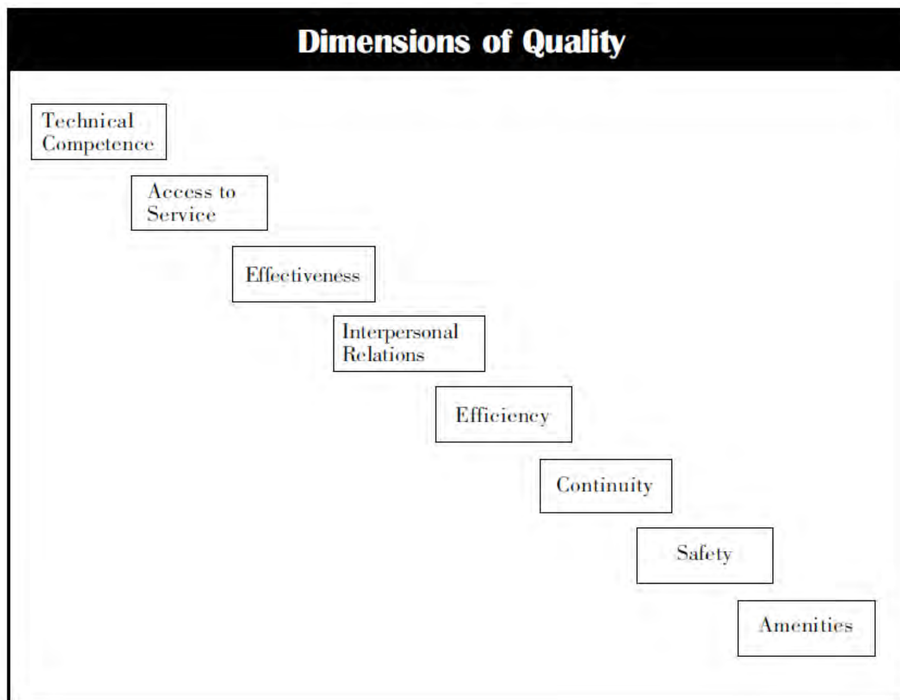


Figure 4: Dimension of quality according Lee& Jones (1993), refered by Brown *et al.*, 1998

Beyond the described dimensions of quality, quality of health care used to be classified as observed quality and perceived quality. Observed quality relates pre-defined standards of quality with the services delivered. It is focused mainly in process and structural aspects. Instead, perceived quality refers to the views and perceptions of the patients about the health care that they received (Baltussen *et al.*, 2002). Objective quality can be measured in different ways, as check-list of infrastructures or checking reported procedures. Barber, e.g., (2006) used retrospective reports of selected prenatal care procedures to measure quality among public and private SRH providers. Perceived quality can be measured both with quantitative methods as surveys and questionnaires and qualitative methods, as interviews and focus groups discussions (Donebedian, 2005)

Finally, some reasons are stated to support importance of measuring perceived quality of care. It is suggested that quality improvements can lead to increase in service utilization and higher revenues (Øvretveit, 2002). Quality assessments and related operational research activities also can be used to improve quality of care (Boller *et al.*, 2003).

It is also widely suggested that perceived quality is related with health service utilization. Andaleeb (2000) highlights patients' perceptions of quality of care are driving users to private facilities instead to public health services. Akin & Hutchinson (1999) also explain phenomena like "bypassing" (when patients avoid a nearby health facility to go to other alternative facility, often private and costly) because of low perceived quality of public free facilities. Yip, Wang, & Liu (1998) includes perceived quality in their analysis of patients' choices of health provider, together with insurance, disease pattern and other socio/economic variables. Therefore policymakers and health providers may benefit of a deeper understanding of patients' perceptions about quality of care.

2.4. Users' satisfaction

There is a growing interest in patients' satisfaction among donors, researchers and policy-makers (Staniszewska & Henderson, 2005). Health system reforms are often under this interest (Mira *et al.*, 1998). It is also argued that patients' needs and wishes should to be a central point of a humane health system (Cleary et al., 1991). Thompson (2006) also suggests measuring and monitoring users' satisfaction increase public accountability and lead to quality improvements. Andaleeb, S. S., Siddiqui, N. & Khandakar, S. (2007) argue that satisfaction can be used as a competitive tool by health providers, increasing utilization of services; it can increase patients' quality of life; and it could be also used a tool for health providers to detect problems and face it. This includes to identify patient needs, developing standards, and to design services, systems and processes. Finally, it is also argued satisfaction (and dissatisfaction) can have also an impact in patients' behaviours about their treatment and illness (Hudak & Wright, 2000)

Following this growing interest, research was focused last years in both in *what* is patients' satisfaction and *how* can be measured it. Hawthorne (2006) identified 5 groups of theories regarding users' satisfaction, based in an extensive literature review. These theories are summarized by Gill &White (2009):

Table 6: Theories about patients' satisfaction

Theory	
Discrepancy and transgression theories	Patients satisfaction depends on congruency between patients' healthcare orientations and provider conditions of care
Expectancy-value theory	This theory relates satisfaction with beliefs, values and prior expectations
Determinants and components theory	Personal preferences and expectations influence patients' subjective satisfaction
Multiple models theory	This theory highlights the social perception of health
Healthcare quality theory	Interpersonal process of care is seen as the key factor related with users' satisfaction

There is also no consensus about determinants or factors associated with health care patients' satisfaction. Mendoza-Aldana, Piechulek, & Al-Sabir (2003) highlighted that patients' satisfaction is more related with users emotional needs such as provider's behaviour towards the patients or waiting time that with provider's technical competence. Others authors (Newman *et al.*, 1998) suggest patients' satisfaction is associated with level of training of health providers, confidence in the providers and shorter waiting times. However, Andaleeb, S. S., Siddiqui, N. & Khandakar, S. (2007) found service orientation of doctors as the key factor related with patients' perceptions of care, even they identify a several factors that can be related with patients' satisfaction, as reliability, responsiveness, assurance, appearance of the physical set-up, communication and report, cost, access and availability. Marcinowicz, Chlabicz, & Grebowski (2009) also point out doctor-patient interaction as a key component of patients' satisfaction, although they recognize satisfaction is a "multidimensional concept". Other identified factors are gratitude, equity, loyalty and even luck (Staniszewska & Henderson, 2005)

As theories about what it is users' satisfaction and which factors are related with it are not under consensus, measuring users' satisfaction becomes also a challenge. Hudak & Wright (2000) define satisfaction measures as "any measure that seeks patients' evaluations or affective responses to distinct dimensions of the health care experience". However, a lthough measuring users' satisfaction is becoming widespread in the health sector, Gill& White (2009) pointed out that there is a lack

conceptual and theoretical development of patients' satisfactions concept, frameworks and models.

Quantitative methodology was used classically to measure users' satisfaction (Radovilsky, 1993; Matis, Birbilis, & Chrysou, 2009; Bernhart et al., 1999) through standardized questionnaires and surveys. However, Williams (1994) has questioned quantitative methods for measuring users' satisfactions. He argued that patients may have a complex set of values, beliefs and perceptions about health care that difficulty can be embodied in questionnaires. Therefore, quantitative methodology could lead to a poor analysis of health care service and can misrepresent patients' views and perceptions Even he recognized questionnaires can increase health services accountability, he argues qualitative methodology could be more appropriate to measure patients' satisfaction, because can explore the views, terms of expression, expected quality and beliefs of users about health care.

Marcinowicz, Chlabicz, & Grebowski (2009) also highlights quantitative methods are based in "a priori" ideas and concepts about satisfaction of researchers, so they suggest the use of qualitative methods for measuring users' satisfaction. Therefore, the debate about which methodology is more suitable for measuring users' satisfaction is still open.

Chapter 3- Study design and methods

3.1. Aims and objectives

The main aim of the research was to evaluate the impact on equity and quality of a reproductive health social franchising mechanism in Uttar Pradesh, India. Table 7 shows the objectives of the research:

Table 7: objectives of the research

Objectives
O.1 To describe a reproductive health social franchising mechanism implemented in Uttar Pradesh, India
O.2 To examine the impact on access and utilization of a health franchisee provider compared with other providers (public providers) in Uttar-Pradesh, India
O.3 To assess the effects on quality of a health franchisee provider compared with other providers (public provider) in Uttar-Pradesh, India.
O.4 To suggest policy options to address quality and equity (access and utilization) aspects in a health social franchising mechanism in Uttar-Pradesh, India.

3.2 .Study design

The title of the research is "*Franchising mechanisms in Uttar Pradesh, India: Working for the poor people? Equity and quality aspects*" The collection data period was from April to May 2010. Data analysis was carried out until June 2010. This dissertation was submitted on 16th July 2010.

The study area was Lucknow District (Uttar Pradesh, India). Lucknow District was selected purposively, according accessibility for researcher. A health franchising mechanism was evaluated in this study. It was compared with other type of health provider (public provider).

Table 8 shows methods used to carry out the research, matched with the objectives:

Table 8: Objectives and methods

OBJECTIVE	METHODS
O.1. To describe a reproductive health social franchising mechanism implemented in Uttar Pradesh, India	• Semi-structured interview with general manager (s) of the franchising network • Secondary data (reports,…)
O.2 To examine the impact on access and utilization of a health franchisee provider compared with other providers (public providers) in Uttar-Pradesh, India	• Secondary data (Description of geographical location of facilities, list of prices; policy documents) • Semi-structured interviews with health managers of facilities • Perceived quality exit-survey: socio-demographic characteristics
O.3 To assess the effects on quality of a health franchisee provider compared with other providers (public providers) in Uttar-Pradesh, India.	• Perceived quality exit-survey
O.4 To suggest policy options to address quality and equity (access and utilization) aspects in a health social franchising mechanism in Uttar-Pradesh, India.	

3.3 Research questions

Each objective aims to answer highlighted questions to increase the understanding of the studied franchising network. Table 9 shows main questions addressed by the research:

Table 9: Main questions addressed by the research

Objective	Questions	Method to answer it
O.1.	• Which are the goals of the health franchising mechanism studied? • Which mechanisms they implement to get their goals? • Is there any policy/strategy addressed to poor people?	• Interview to HLFPPI manager

O.2	• Which is the socio-economic status of people using franchising *vs* public facilities? • How long users wait for doctor/nurse? • How much users spent in their last visit? • How users pay for the services (are they insured? Voucher scheme? Out-of-pocket expenditures?) • How long the physician/doctor spent with users? • How are distributed the facilities (are reaching the poorest communities?)	• Data from exit interviews • Secondary data
O.3	• How users do perceive the quality of services? • How is the "objective" quality of the different providers (franchising *vs* public)? • Which are the reasons leading people to use public *vs* franchising MCH services?	• Data from exit interviews • FGD
O.4	• How franchising mechanisms and public health providers can satisfy better the client's expectative, if needed? • How franchising mechanisms and public health providers can increase quality of care, if needed? • How franchising mechanisms and public health providers can increase equity (access and utilization)?	Analysis of both quantitative and qualitative data and comparing emerged data with "standards" of quality (Desk work)

3.4 The research team

The research team was integrated by the main researcher and a research assistant. Profiles, background and approaches (views) to the research are summarized in table 10 :

Table 10: Composition of the research team

Team Members	Profile	View
Main researcher	• Trained in qualitative/quantitative research • First time in the country. • Experienced in health sector • No knowledge of Hindi/ Urdu	Outsider
Research assistant	• Not previous trainings in qualitative research, so a short training in qualitative research (2 days) was necessary. • Not research experience • Both English and local language • Social academic profile	Mainly outsider/ Insider

3.5 Contribution of the student to the research

Research´s topic was suggested by the client (CHSJ). Aim, objectives and methods to carry out the research were developed by the student, under supervision of his tutor. Guidelines for semi-structured guidelines were also developed by the student. Perceived quality and client' satisfaction questionnaires are adapted from Rao, Peters& Bandeen-Roche (2006).
International Institute for Population Sciences SES classification (IIPS, 2007) for socio-economic status was added to this questionnaire.

For collecting the data, the student moved onto the study area (Lucknow District, India) for 6 weeks. A research team was created, including the student (main researcher) and a research assistant, as seen above. Main researcher´s (the student)

tasks included lead the team, to carry out the semi-structured interviews, selection of the interviewees, random selection of the facilities to be visited, supervision of the research assistant and to obtain permissions. Research assistant´s tasks included to carry out the exit-interviews, transcription of semi-structured interviews under supervision of main researcher and to act as translator and facilitator of the main researcher.

Finally, the student carried out the data analysis, under the supervision of his tutor. Discussion, conclusions and recommendations emerging of the findings were also identified and elaborated by the student.

3.6 Study population

The franchising network includes more 70 hospitals and more than 700 primary health centres in 5 districts. A District of Uttar-Pradesh (Lucknow District) was selected purposively, because offered better access to the facilities to the researcher.

Health facilities to be assessed were chosen randomly after have been stratified (secondary/primary and matched (franchisee/public facility). One secondary level franchisee facility refused to entry in the study, so was substituted by other one, although was of primary level care because no more franchisee secondary level facilities were available (see table 11).

Table 11: Facilities visited according level of care and type of provider

	Primary level	Secondary Level	**TOTAL**
Franchisee facility	4	2	**6**
Public facility	3	3	**6**
TOTAL	**7**	**5**	**12**

Distribution and names of the facilities were provided by health authorities and the franchising network. Respondents of semi-structured interviews were the health managers of the selected facilities.

Respondents to exit interviews will be selected outside of the facilities, according they were leaving the facilities. Inclusion criteria were :to be a female 18-50 years old and to have been attended in the facility this day (including OPD services, ANC services and discharged from the hospital).Exclusion criteria were patients that are workers of the hospital or relatives of them.

FGD' participants were selected purposively among community members of a selected health facility's catchment area.

3.7 Sampling strategy

Different sampling strategies were used for both for quantitative and qualitative research.

For sampling size of perceived quality questionnaire, WinEpiscope software was used. An adapted from Rao, Peters& Bandeen-Roche (2006) perceived quality and satisfaction questionnaire was filled Adapted from Rao, Peters& Bandeen-Roche (2006) questionnaire is based in a five-item Likert item for each question (16 questions). Assuming a total population unknown, and an expected absolute error of 0,5 (expected mean 3 in a three-item Likert item 1 to 5), 62 questionnaires will be needed (2 standard deviations, Confidence Interval 95%).

Number of health facilities (12) and therefore number of semi-structured interviews (12 health managers + manager of franchising network) is chosen taken in consideration constrains on time and access to the facilities of main researcher.

3.8 Data collection methods

Mixed methodology was used to carry out this research, including both quantitative and qualitative methods. Mixed methodology can be helpful for different reasons. It is suggested that news researches have to be aligned with previous published researches in terms of methodology (Silverman, 2005). Studies about users'

perceptions use to be quantitative (based in questionnaires) and qualitative. It is also suggested that quantitative methodology can contribute to measure phenomena (e.g., physically accessibility), so combining both methodologies “will offer a powerful resource to inform and illuminate policy or practice” (Ritchie& Lewis, 2003). Flick (2007) also suggests the use of pragmatic approaches to evaluations, including both qualitative and quantitative methods, because allow *triangulation* (cross-check qualitative and quantitative data) and *facilitation* (each approach provide hypothesis and pathways, so the research scope will be wider).

The methods used were:

Quantitative

1. Exit interviews. Exit interviews questionnaire is based in from Rao, Peters& Bandeen-Roche (2006) questionnaire. They carried out a research to determine patients’ satisfaction in Lucknow, Uttar Pradesh, including tertiary, secondary and primary facilities. This questionnaire includes 3 satisfaction questions and 16 perceived quality questions. It is based in a 5-items Likert scale, where respondents have to agree or not with each statement, ranging the answers from strongly disagree to strongly agree. Rao, Peters& Bandeen-Roche (2006) questionnaire was complemented with socio-demographic questions. Respondents’ socio-economic status classification was based in International Institute for Population Sciences SES classification (IIPS, 2007). Exit interviews were carried out in Hindi language to patients leaving health facilities, according inclusion criteria, as seen above.

Qualitative

2. Secondary data. Collected reports, *powerpoint* presentations, available website information about the franchising network and list of facilities provided by the MoHFW and the franchising implementation agency are considered secondary data.

3. Semi-structured interviews. Interviews enable the researcher to obtain a systematic knowledge about a selected topic (Kvale, 2007). 14 interviews were made

to key informants and other selected stakeholders. Table 12 summarizes number and type of respondents to the interviews. Managers were fluent in English, so this language was used in the interviews.

Table 12: Number and type of respondents to the semi-structured interviews

Respondent	Number of semi-structured interviews
Franchising network manager	1
Representant of Ministry of Health	1
Managers of franchisee facilities	6
Managers of public facilities	6
TOTAL	14

4. Focus Group Discussion. FGD can be useful to encourage participation of people reluctant to be face-to-face interviewed (Barbour, 2007). Therefore, one FGD was carried out with low socio-economic status women from a community in order to explore their views and perceptions about health care providers and their care-seeking behaviour.

5. Field notes. Field notes are notes took meanwhile the research was on-going by the researcher (Gibbs, 2007). These notes helped the researcher to organize and summarize emerging data, and they kept impressions of the interviews and Focus Group Discussions.

3.9 Data analysis

Qualitative and quantitative data needed different type of analysis, although results were later triangulated.

Qualitative data

Qualitative data analysis includes secondary data, semi-structured interviews and one FGD. Interviews were carried out in English language, so no translation was

needed. FGD was carried out in Hindi and English languages, so translation was necessary. A framework analysis was used to interpret and sift data. Table 13 shows framework analysis´ phases.

Table 13: Qualitative data framework analysis´ phases

Phases	Steps	Description
Phase 1	1- Familiarisation	Main researcher and researcher´s assistant read every transcription of FDGs and semi-structured interviews carefully. Comments and perceptions of interviews key points were shared
	2- Thematic framework	A thematic framework emerged from transcriptions. Research team members seek behavior patterns, common experiences and beliefs that were categorized.
	3- Coding	NVIVO software was used for coding to increase transparency of analysis´ process.
Phase 2	4- Charting	Charts and models were elaborated to simplify and explain patterns and identified themes.
	5- Interpretation	Most important themes and patterns were analyzed and interpreted, and co-related with existing literature. Qualitative data were triangulated with quantitative data to give coherence to the findings.

Explanatory analysis includes generalizability of emerged data. Generalizability is not an aim *per se*, but could be reached through different strategies. Some described strategies that were used in this research are combination of quantitative (survey) and qualitative methodologies, purposive sampling and developing an analytical model, as Silverman (2005) suggested.

<u>Quantitative data</u>

Quantitative data were collected in a paper basis and later introduced in a EPI-INFO form. Both EPI-INFO and SPSS software were used to analyze quantitative data.

EXCEL was also used. Different analysis will be carried out. Univariate logistic regression analysis was used to compare satisfaction with SES and other factors theoretically related with satisfaction. To describe general characteristics of users T-student was used to compare means. To compare socio-economic groups and utilization (% of poor population using each facility) Pearson chi-square was also used.

3.10 Quality assurance

Different procedures were used to ensure quality of data and enhance the trustworthiness of the research. Trustworthiness was checked both during collection of data and analysis process.

During collection of data, some procedures were taken to enhance the quality of the process. Main points emerging from semi-structured interviews were summarized to respondents to check researchers´ understanding. Health managers also chose language of interviews (usually English), so they felt comfortable. When local language was chosen, the research assistant led the interview. Interviews were also made in a quiet and private environment, usually the own desks of health managers. Research team composition (leaded by a foreign researcher but including a local national research assistant) was also crucial to extend researchers´ understandings and to cross-check views and perspectives of emerging topics.

During the data analysis, some quality procedures were also taken, as triangulation. Triangulation is defined as taking different perspectives to answer a research question by using different methods or approaches (Flick, 2007b). Therefore, qualitative data (secondary data and data from semi-structured interviews) were cross-checked with quantitative data emerging from exit interviews . Transcriptions if necessary were validated by main and assistant researchers. Exit interview questionnaire was already validated in the same area. Reflexivity among main researcher and research assistant was also encouraged, doing diary meetings and questioning main emerged issues.

3.11 Ethical considerations

The ethic approval for this research was obtained from the LSTM Ethic Committee before starting the data collection

Confidentiality and privacy

Names of respondents of exit interviews were not collected. Interviews were made without the presence of health personnel of the facilities, to avoid interferences or coercions in the answers.

Semi-structured interviews respondents' names were coded, so confidentiality was assured. Interviews were carried out in the office of the health managers, so privacy also was taken in consideration.

Filled questionnaires, printed declarations and transcriptions and collected data were stored in a safe place in the office of the client. Electronic copies of data had double protection. Data were store in the personal computer of the main researcher, under password access.. Backup of electronic data was kept in a USB disk also under password access.

Consent

Informed consent for exit interviews was asked orally. Respondents were informed about aim of the study, the purpose of the research and about the lack of consequences of no answering. It was asked in Hindi, as most part of respondents doesn't speak English.

Consent for semi-structured interviews and focus group discussion was also asked orally. After consent was given, interviews were recorded.

Dissemination of results

At the end of the field work findings were shared with the client which suggested the research, and with the different health providers involved in the research. The franchising network managers and managers of health facilities were also informed about the results, when e-mail addresses available.

It is also expected that main results will be shared with communities, health authorities and policy makers by the client.

3.12 Limitations of the research

In terms of the research design, important factors related with access to SRH services, like available commodities (Rao. & Dhruba, 2006) were excluded of this research. Effectiveness, costs (medical costs; cost by patient) and sustainability of the franchising network are also not in the scope of this research.

Care-seeking behaviour itself was also outside of the scope of this research, even some related aspects were discussed and analyzed

Limitation factors of data collection were time, access to the facilities and authorizations to carry out the research, which were delayed because of administrative processes. Therefore, study area of the research was limited to District level instead State level. Time was also a limitation for data analysis.

Chapter 4- Results

Qualitative results

Qualitative data have been collected from semi-structured interviews, focus group discussion, field notes and from secondary data, as policy documents. These data relate objectives one &two (to describe a reproductive health social franchising mechanism and to examine access and utilization of the franchising network). Results related with *Objective one* came mainly from secondary data and a semi-structured interview to the implementation agency (HLFPPT) State Manager. *Objective two* findings emerged from semi-structured interviews to health managers and community members, although are triangulated with other emerged data when necessary.

4.1 Description of a Reproductive Health Franchising Network

Merrygold is a fractional (partial) social franchising network who provides Sexual and Reproductive Health Services. Therefore, private outlets joined to a branded network to offer new services (SRH services) under some pre-determined conditions (a standard package of service, with standard quality and fixed prices). Emerged themes from interviews are grouped as shows the following table (table X.). HLFPP state manager (acting as a key informant) highlighted main key points about *what* is expected from the franchising network, *how* the network is working and *why* is going to be successful. Other emerged sub-themes are challenges of the concept and future of the network. Results are complemented with data provided by the network

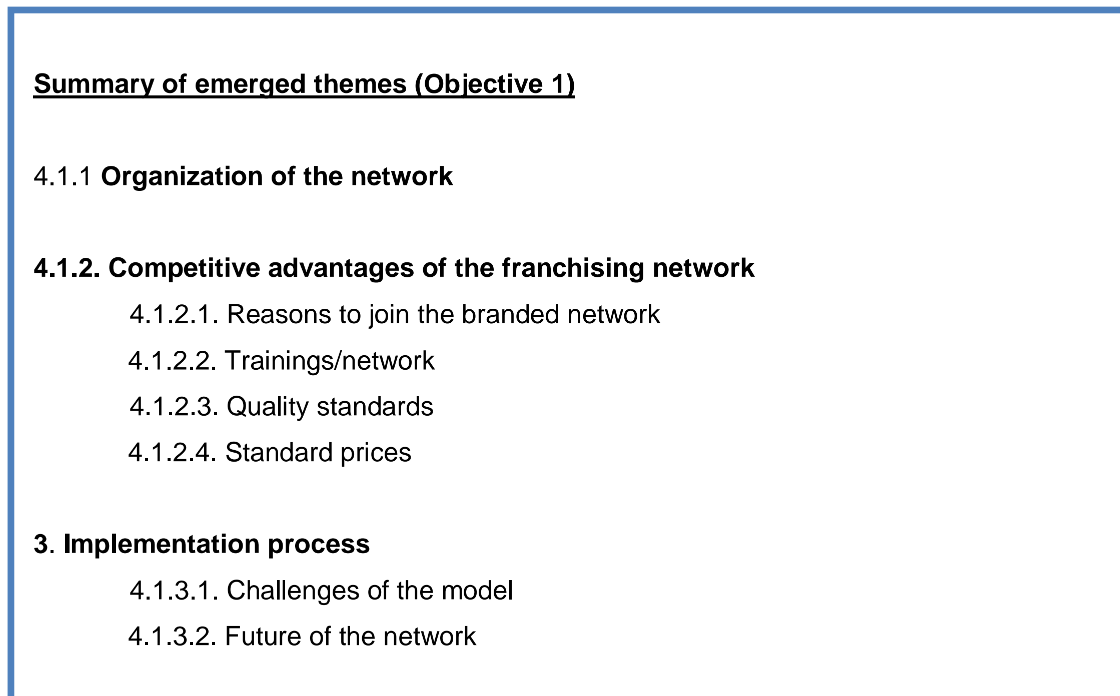


Figure 5: Summary of emerged f qualitative indings (Objective one)

The Merrygold network is organized as a "pyramid system". It has to be composed, according their roll-out strategy (Gopalakrishna, 2010) by 2 references Hospitals (L0), seventy - 20-bed *Merrygold* Hospitals (L1), 700 *Merrysilver* clinics (L2) and 10,500 health motivators, called *Merrytarang Ayush* partners (L3) across the State of Uttar Pradesh. The research couldn't get the exact number of Hospitals and health motivators at the time of the study. (see figure 6)

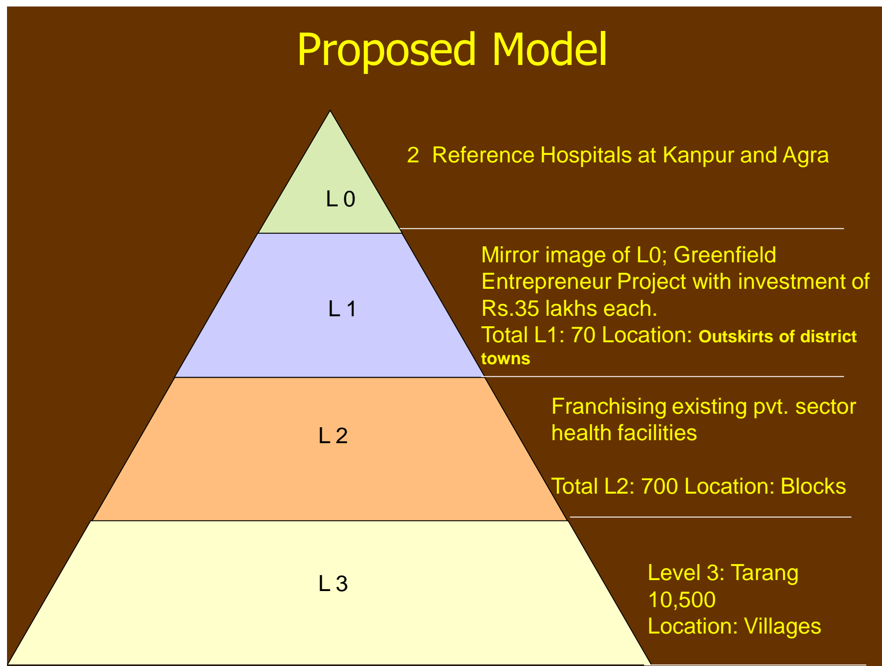


Figure 6: Merrygold proposed model (Gopalakrishna, 2010)

Merrygold hospitals provide maternal and child health services, and emergency obstetric care facility. The *Merrysilve*r clinics provide basic obstetric care, family planning services, counselling and immunization services. Health motivators (*MerryAYUSH* or *MerriTarang*) provide health-counselling, condoms, Oral Contraceptives, Oral Rehydration Salts and Iron and Folic Acid tablets, and act as links between the communities and the health facilities (both second and third level).

In Uttar-Pradesh District (the study area), there are 3 associated Merrygold hospitals to the branded network and 16 Merrysilver clinics. The secondary data provided by the implementer of the network didn't include the exact number of health motivators. Likely this number is registered, but data didn't seem to be easily accessible. Merrygold hospitals are settled in urban areas, while Merrysilver clinics are spread between urban and semi-urban areas.

Table 14: List of Merrygold associated outlets in Uttar Pradesh District

List of MerryGold (L1) Partners			
S.No.	**Block**	**Name of the Institution**	**Area**
1	Lucknow	Shri Ram Maternity Centre	Urban
2	Lucknow	Saraswati Hospital and Research Centre	Urban
3	Lucknow	Ankertie Sewa Sansthan	Semi-urban
List of MerrySilver Members			
S.No.	**Block**	**Name of the Institution**	
1	Bakshi Ka Talab	Muzaffar Hospital	Semi-urban
2	Krishna Nagar	Chandra Prabha Nursing Home	Semi-urban
3	Lucknow	Jeevan Hospital	Semi-urban
4	Lucknow	Goel Hospital	Urban
5	Lucknow	Dr. Neerja Singh	Urban
6	Lucknow	Khadra Nursing Home	Semi-urban
7	Lucknow	Aman Hospital	Semi-urban
8	Lucknow	Bhargava Nursing Home	Semi-urban
9	Lucknow	Hazarilal R.V. Nursing Home	Semi-urban
10	Lucknow	Shree Mankameshwar Hospital	Semi-urban
11	Lucknow	Satyam Nutrsing Home	Semi-urban
12	Lucknow	Vatsala Hospital	Semi-urban
13	Lucknow	Indu Nursing Home	Semi-urban
14	Lucknow	Fatima Medical Centre	Semi-urban
15	Lucknow	Raj Poly Clinic	Semi-urban
16	Lucknow	Relief Hospital	Urban

As shown in the list, majority of outlets are set-up in Lucknow Block, the capital of the District. Just two outlets are covering other blocks (Bakshi Ka Talab and Krishna Nagar). The HLFPPT State manager argues that this inequitable distribution of the facilities among urban/rural areas is not representative of the whole distribution of the franchising network in Uttar Pradesh State:

> **Implementer Agency manager:"** *Lucknow shouldn't be a represe*
> *you want to understand what Marigold is all about. Lucknow is the upmarket and the most developed town in UP*"

However, this is not a shared view among public providers:

> **MoHFW representant:** "*most of the times they* [Merrygold] *are located in the urban areas*"

4.1.2. Competitive advantages of the franchising network

4.1.2.1 Reasons to join the branded network

Reasons of private outlets to join the franchise brand are based in two reasons, according the network perceptions: advantages of economies of scale and current changes in provision of services in the health sector:

Advantages of scale economies

> **Implementer Agency manager:":** "*we showed this to the private sector doctors. If you work for this price, if you will promote this hospital under this brand name, and if you will maintain these quality standards, you will still be earning even if you will provide low cost services*"

> **Implementer Agency manager:":** "*my challenge as a franchiser comes that if I have motivated my franchisee to work at 30% of the market price, I should be giving him more volumes of work*"

> **Implementer Agency manager:":** "*it's completely business model, there is no subsidy. If high volumes are coming to the hospitals, then the franchisee would be making a profit*"

Changes in provision of services

Implementer Agency manager: "*why private sector doctors are coming to us? The private sector doctors also feel that the changes that are happening in the market place (...) they are also interested in their ma the community*"

4.2.2.2 Trainings/networking

The access to trainings and information updates is one the classical reasons argued by private outlets to join a network. Main part of private providers pointed out this reason to join the network:

Franchising health manager, I. 8: " *I am interested in Marigold only for the guidelines*"

Franchising health manager I. 12: " *they* [Merigold] *are trying to pass on information; they are trying to upgrade our knowledge*"

Franchising health manager, I. 8: "*So by joining the network I used to have certain guidelines also and criteria also according to the WHO, SIFPSA, USAID. So I can provide quality services after joining this network.*"

However, perceptions about trainings are not uniform. Some of them are positive:

Franchising health manager, I 8: "*The L-three workers trainings have been done 2-3 times in a year and their benefits are being seen*"

Most part of them negative

Franchising health manager, I 4: "*Since the time I have joined this hospital, Marigold has not given any trainings.*"

Franchising health manager, I 11: "*Single training they have given us regarding the family planning. They told us that they are planning to give us aanganwadi one, but they have not given us the exact date about t*

4.1.2.3. Quality standards

In terms of quality standards provided by the network, it is supposed that outlets' quality of services is monitored each 45 days by the quality officers of the network.

> **Implementer Agency manager:** "*we have a quality assurance team which goes to each facility every 45 days. So, our quality assurance is based on a standard checklist, as to what all facilities" they have an*

> **Franchising health manager, I.8 :** "*Not every 45 days, but two to three quality audits have been done in a year*"

However, there are different views among the managers about the effectiveness of these check-ups, ranging from positives views:

> **Franchising health manager, I.3:** "*Marigold is good in maintaini they provide us training and keep on checking whether we are maintain the standards or not"*

To negative views:

> **Franchising health manager I 5:** "*what they are going to achiev quality are they going to achieve. (...) They co clean or not. The owner of a hospital would n*

Users' views and perceptions about quality are also taken in consideration, more by the franchising brand rather than by the outlets' managers. Just one visited facility have a "complain box" (personal notes). No franchisee provider stated community participation in management of the facility or "active" looking for users' feed-back.

> **Implementer Agency manager:** "*Once the client is discharged, about 30-40% of them should be talking to our people on the phone, to give their feedback on their treatment and suggestion if any. (...) We get di"rect fee*

> **Franchising health manager I 11:** "*if you have any problem you can put it in the complain box or you can meet to the administrator or the manager for any kind of query or problem you have faced in this hospital."*

4.1.2.4. Standard prices

Prices are standardized among the outlets associated to the network. Services are offered in "under-market" price. Therefore, high volumes of patients will be necessary

to guarantee the sustainability of the services. Prices are not subsidized by the donors or the Government.

> **Implementer Agency manager:** "*Merrygold patients are charged at 50-60% of the private sector prices. Merrygold argues that specialization on SRH and high volume of clients will ensure sustainability of these sub-market prices*."

> **Franchising health manager, I 3:** "*The prices are very reasonable, anyone can afford them*"

> **Franchising health manager, I 12:** "*The prices are too low*"

4.1.3. Implementation process

4.3.1 Challenges of the model

Network identified key challenges are to enhance high volumes of patients (so prices can be kept low) and market development.

> **Implementer Agency manager:** "*that is a real challenge to work on the volumes, to tell the people that this is the clinic and you can go there and avail the services*"

> **Implementer Agency manager:** "*the challenges are more as the market is not mature. There is a market where you have to invest; we get the clients from that 4 million market also, from the home deliveries section. So we have to tell them, we have to convince them about the institutional deliveries*."

Low utilization of services is analyzed in Objective two results section (access and utilization of the franchisee services)

4.1.3.2. Future of the network

There is a duality in the perception of the outlets' managers about the franchising model. Although they assume the idea is good, their view is the franchise is not achieving his goals, so they are not getting benefits of being franchisees:

> **Franchising health manager, I 9:** "*It is very nice on paper* [how franchising has to work], *very beautiful* (…) *but nothing is happening*"

Franchising health manager, I 12: " *It is an excellent concept* [franchising model] *but the only thing is the wheel has not started rolling well*"

This mismatching between the idea (and model) of the network and the reality about how is implemented is a major issue for most part of providers. Therefore, outlets managers' views about the future and evolution of the brand are diverse, and likely are related with the analysis of the interviewees about the causes of the detected limitations and challenges.

Very negative view

Franchising health manager I4: "*I think they* [Merrigold] *are going to collapse, that is my personal feeling*"

Conditional view

Franchising health manager 5: "*It* [Merrigold] *has to improve a lot.*"

Positive view

Franchising health manager I8: "*It* [Merrigold] *is going to grow*."

Implementer Agency manager: "*these one or two years are tough when these facilities will start having more patients*"

4.2 Access and utilization of a franchising network (qualitative findings)

Objective two of this research aims to evaluate access and utilization of the franchisee SRH services, especially among poor people. Qualitative data regarding this topic are therefore analyzed. Emerged themes from the interviews are close inter-related. First, views about utilization of services are reported. Then, causes underlying the low utilization of services emerged (social market strategies and competition with other pro-poor schemes).Advantages and disadvantages of both public and franchisee systems were also analyzed by respondents. Some solutions to address low utilization rates were proposed by the interviewees. Perceptions about access to the services also emerged from the interviews. Finally, interviewees were asked about how they are tackling with HIV/AIDS.

Summary of emerged themes (Objective 2)

4.2.1. **Low utilization of services**

- 4.2.1.1. Marketing strategies
- 4.2.1.2. Referral system
- 4.2.1.3. Competition with other pro-poor schemes (JSY scheme)
- 4.2.1.4. Advantages and disadvantages of both public and franchisee systems
- 4.2.1.5. Suggested solutions

4.2.2. **Access to SRH services**

4.2.3. **Response to HIV/AIDS**

- 4.2.3.1. HIV/AIDS related services
- 4.2.3.2. Integration of services in national policies
- 4.2.3.3. Few number of cases
- 4.2.3.4. HIV/AIDS related stigma

Figure 7 Summary of emerged qualitative findings (Objective two)

4.2.1. Low utilization of services

Reasons because clients (users) are attending the franchisee clinics are the own concept of franchising and a "*market point of view*", according the implementation agency manager

> **Implementer Agency manager::** "*The pricing would be uniform, the quality would be uniform, and the client will have the same kind of experience*"

Implementer Agency manager:: "*So, if from a market point of view, we see the institutional delivery as a product, these 4 million people are seeing this product of institutional delivery for the first time in p going there, they are not satisfied with the product. When the second delivery happens in the same family, when they have already seen the basic product in the public health facilities, now they want the q people who have been coming for these 1400 rupees and institutional delivery would be converting into Marigold in about 2 years.*"

However, it is a generalized perception among outlets managers that membership of the network is not providing "extra-patients". In other words, the brand name is not increasing the number of clients of the associated outlets:

Franchising health manager I9: "*The concept with Marigold is v why they are not successful. Concept is fantastic, doctors are working very hard, but the patients are not coming*"

Franchising health manager I 11: "*They [patients] are [just] coming by the name of the hospital*"

Franchising health manager I 11: "*we haven't received any patie months*"

Franchising health manager I 12:" *Right now, we are not getting even for the OPDs we are not getting any cases*"

Franchising health manager I 11: "*They* [Merrigold] *asked us to write down every patient. So we have written here. Till now we have treated only 2 or 3 patients for marigold.*"

Main reasons of this low use of services suggested by providers are the failure of the marketing strategies, the weakness of the reference system and competition with other pro-poor schemes.

4.2.1.1. Marketing strategies

Most part of franchisee providers agree marketing strategy is not working properly. Different reasons are suggested about *why* these marketing strategies are not

achieving their goals. These include lack of publicity, advertisements addressed to "wrong" target populations, campaigns not enough spread across the catchment area of the facilities and finally even the negation of marketing strategies as causes of low utilization of services.

> **Franchising health manager I 11**:" *I think there is a lack of publicity because not a single banner of the Marigold we have seen. Not a single banner I have received from Marigold*"

> **Franchising health manager I 3:** "*I think if the Marigold is going to advertise more for middle class and upper class people it will be*

> **Franchising health manager I 5:** "*They never came and organized camps over here*"

> **Franchising health manager I 12:** "*it is publicized well. The publicity part is good but how to make it work, that working part has not come out well. The webbing has to be closer. Like the registration. Someone should be there who are working in the marigold or in the outskirts.*"

4.2.1.2 Referral system

Other main reason argued by the outlets' providers to explain the perceived lack of new patients attracted by the brand is the weakness of the reference system. Most part of providers agree that heath motivators are not referring patients to the upper levels (Marisilver and Merigold):

> **Franchising health manager I 11:** "*They* [health motivators] *haven't referred t case in Marigold*"

> **Franchising health manager I 8:** "*the referral service is not properly running, so I have a referral column in my register which is empty right now*"

Suggested reasons behind this lack of referred patients from the health motivators are that they are poor incentivized, competition with other providers, gaps in the communication system and lack of "commitment" of the health motivators.

> **Franchising health manager I 5:** " *they* [motivators] *want incentives for each and everything*"

Franchising health manager I 4: "*the problem is with the motiva*
bring patients (...) Though our hospital is prov
why they are taking the patients to other places"

Franchising health manager I 11: "*I am very sorry to say from our motivators we*
haven't received any patient in the last 3 to
gap between us and them. They come and collect all the data we provide. We extend
our work to them, we do all the paper work, we maintain registers but in the end we
are not getting any kind of patient with their motivators"

Franchising health manager I 8: "*Regular camps may be not in 20 villages but in*
just 5 villages, but regular camps. (...) Neither
effort"

Franchising health manager I 9: "*The ASHAs are thieves, they do*
and they just want money (...) They are supposed
more, the commission. Its like, you give me more or else I am going to the other
hospital. Yes, yes this is exactly what happens."

Health motivators' performance and therefore the poor links between communities and health facilities are even considered as the main problem of the network in achieving his goals.

Franchising health manager I 12: "*That is the biggest drawback of this organization*
that the links are not motivated enough to for
cases from any level (…) *the grassroots level, level 3, level 2, level 1, the flow of*
patient is not there"

Franchising health manager I 4: "*The motivators are the weakest link in the*
franchisee"

4.2.1.3 Competition with other pro-poor schemes (JSY scheme)

Qualitative data about the JSY (*Janani Suraksha Yojana*) scheme have emerged from both secondary data (Governmental policies and documents) and the semi-structured interviews.

Governmental policies state that JSY scheme vision is "to reduce overall maternal mortality ratio and infant mortality rate and to increase institutional deliveries in BPL

families” (MHFW, 2006a). This scheme target BPL pregnant women, both of rural and urban areas, offering conditional cash assistance for institutional delivery.Table 15 (MHFW, 2006).shows amounts to be paid by check for every institutional delivery:

Table 15: *JSY* scheme conditional cash incentives

Category of States	RURAL AREA			URBAN AREA		
	Assistance Package to mother	Package for the Accredited Worker	Total	Assistance Package to Mother	Package for the Accredited Worker	Total
LPS	700	600	1300	600	200	800
HPS	700	NIL	700			

Uttar Pradesh is categorized as a Low Performance State (LPS), so even women from urban areas can benefit of the scheme. In Low Performance States there are not also limitations in the number of deliveries of a particular woman to receive the assistance (MHFW, 2006b)

Among most part of interviewees JSY scheme is described as successful, and it is associated by health managers (especially of public facilities) with higher utilization rates. It is also associated with the decrease of maternal mortality ratio (MMR)

> **MoHFW representant:** “*They* [patients] *use Janani Suraksha Yojana (JSY) the most. Nowadays, most of the deliveries are conducted in the hospitals, free institutional deliveries*”

> **Public clinic manager, I 6:** “*it* [JSY*] is a huge success*”

> **MoHFW representant:** “*It has come down* [maternal mortality] b*ecause 30-40% of institutional deliveries are being conducted i*

Perceptions about *why* the scheme is being successful are based in economic reasons. Both pregnant women and ASHAS are getting incentives if institutional deliveries are carried out.

> **MoHFW representant:** “*the NRHM under this scheme is providing 1400 rupees to each beneficiary so that they come to the hospital and get an institutional delivery done*”

MoHFW representant: "*ASHAs are getting good amounts of money from the government hospitals. They also take money from the patients*"

Public clinic manager 6: "*The sum of 1400 rupees is a lot of money to these people.*"

In the other hand, franchise providers highlight that women are moving from the private providers to the public facilities for delivery reducing their benefits and increasing competence, even they recognize some women (especially those from higher socio-economic status) still prefer deliver in private/franchisee facilities.

Franchising health manager 5: "*with such an initiative from the government* [JSY] *it's very difficult for a private doctor to s Janani Suraksha Yojana, earlier we used to ear that much money*"

MoHFW representant: "*They* [women from higher income groups] *would not like to come over here to the CHC and the PHC. They go the private facilities. They do not get any benefit of the JSY over there and have to pay further*."

Franchising health manager 5: "*the government has introduced Janani Suraksha Yojana, so they get paid from the government services, but there are many patients who don't want to go, they" say that we will c*

Health motivators and ASHAS also highlight the important role of the programme among poor-people. In contrast, they show a limited knowledge of the franchising programmes.

FGD1, R1: "*We don't make people aware about private available here only then why would they go to the private provide*

FGD, R2: "*They are very poor so if we take them there, then a lot of money is saved and the women get money also if we take them there. They get 1400 rupees for the Janani Suraksha Yojana. The ASHAs get 600 rupees. We also go with them but we don't get any money. We get 1700 rupees for t UNICEF*"

FGD, R1: “*I tell the women about it but I don’t tak (...) They give better care and f they take 999 ies as the rupees for delivery*”

However, when the providers analyze deeply the scheme, they also found some concerns and limitations of the model, as living in rural or remote areas, nomadic behaviour, non-interest in public sector facilities and satisfaction

> **Public clinic manager:** ”One of the reasons could be that they are still not aware of the schemes as majorly the population is living in the rural areas. Some of the patients are only interested in getting it done from the private doctors. Thirdly is the nomadic population who keeps on going from one place to the other.”
>
> **Public clinic manager 6:** “now due to these 1400 rupees, people have started to come out of their houses and get the deliveries done in the hospitals (…)the difficult thing is how to maintain it. As you know 1400 rupees is a big amount of money to these poor people, so for the first time they come to the hospital for the money. But if they are not satisfied with the services they are not going to turn up for the second time”

Finally, some specific concerns about a theoretical increase of population related with the incentives (as women are getting money for delivery, they will have more children) were also highlighted

> **Public clinic manager I 6:** “Look it’s only in UP that you get 1400 rupees on every delivery, however in the rest of India, it is only for two child norm.”
>
> **Public clinic manager I 7:** “It will lead to population explosion. I have seen females who were delivering for the 10th-12th time (…)We see that a woman who has been delivering for 10-12 times also gets the money; some criteria should be laid down.”

4.2.1.4. Advantages and disadvantages of both public and franchisee systems

When trying to understand low utilization of services offered by the franchising network, a reason also argued by respondents is about differences among providers. These include quality, prices and affordability of services.

Quality

Public clinic manager I 9: "*the private sector. They are better, the money they ask for, the patient pays, and so, they are provi*
in a very bad condition."

Franchising health manager 8: "*public health facilities in this area are very good and people are getting incentives as well.*"

Costs and affordability

Franchising health manager 4: "*The private sector is better except for the prices, they are a bit expensive when compared to the government facilities, but otherwise the private sector is better in all other facilities. Everything is better, cleanliness is better, doctors are better, nursing is better.*

Public clinic manager I 7: "*Those who can afford go the priva*
want to come here. They d"on't even listen to t

4.2.1.5 Suggested solutions to increase SRH services' utilization

Finally, managers of the franchisee outlets also suggest some strategies to tackle with the identified problems (table 16)

Table 16: Interviewed managers suggested strategies to improve Merrygold service delivery

Identified problem	Suggested solution	Quotes
Unsuccessful marketing strategy	Re-target marketing strategies	**IL3:** "*Marigold, they have to advertise in a better way for all the people so that more and more people come in but if the government will keep on focusing on the poor and the lower middle class only then it might not work.*"
Weak referral system	To improve health	**IL12:** "*we have actually asked them is to please*

	motivators performance	*arrange at least 4-5 local level motivators to interact with us every fortnightly or weekly. So, at least that they know us and then we are able to contac* **IL5:** "*They have to work at the ground level which they are not doing right now*"
Lack of communication between care levels	To increase communication between levels of care	**IL12:** "*Till the trust in the communication is not started, how will you make the wheel push!*"
Competition of other pro-poor schemes	To set-up strict criteria to be benefit of conditional cash assistance	**IL7:** "*The JSY sch very faulty. The payment should be done based on certain categories. We see that a woman who has been delivering for 10-12 times also gets the money; some criteria shoul*
No problem identified	No	**IL9:** "*where the p don't know because I am not getting the patients. The strength of the franchisee is not coming up*"

4.2.2. Access to SRH services.

Franchise network objectives include deliver SRH service to poor population. This is clearly stated by HLFPPT State manager

> *Question: So, you think the services are pro-poor?* ***Implementer Agency manager: Res:*** *Absolutely.*

Main strategies to achieve this goal are the reduced prices and the social marketing strategy

> **Implementer Agency manager::** *"this price of 2000 rupees is the average market price, or maybe this is 25% also. Because prices are unregulated in the private sector, it all depends on your pocket. Largely, it is about 20-30% of the market price"*

> **Franchising health manager** ***12:*** *"The prices are too low"*

However, the current nature of the network (private for-profit outlets based in urban areas) and the highly competitive context (JSY scheme offer cash incentives to women attending public facilities) are noted as handicaps to attract poor-people to the franchising network. Most part of outlets manager' views about the socio-economic status of their patients include both medium and low SES classes.

> **Franchising health manager 3:** *"Our location is such that we usually get the poor or the middle class people (...) Each these BPL"*

> **Franchising health manager** ***3****: "They are basically concentrating on poor people. When I went there, they were very poor people. pay 2000 rupees."*

> **Franchising health manager** ***4:*** *"The lower class comes; middle class also come"*

> **Franchising health manager** ***4:*** *"The basic problem is that they facility. So it's not like that they are going second delivery they come to Marigold, for the second delivery also they will go the CHC only. Money is very big thing for them"*

These perceptions will be triangulated with quantitative data in the discussion chapter.

4.2.3. Response to HIV/AIDS

Semi-structured interviews to health managers of both public and franchise facilities included questions about the response of the facilities to HIV/AIDS. Main sub-themes emerging were the type of services they were providing to tackle with the epidemic, integration of them in national policies and few numbers of cases. Stigma associated with HIV/AIDS emerged as an unexpected issue.

4.2.3.1 HIV/AIDS related services

Franchising network general objectives include the promotion of HIV/AIDS related services. These include counseling, testing and promotion of preventions methods as condoms.

> **Implementer Agency manager::** "*in 5 of our Marigolds we have set up the ICTC centers, Integrated Counseling and Testing Centers given by the NACO. Otherwise, during all the deliveries and the ANCs, we get the HIV status during testing*."

> **Implementer Agency manager::** "*we are promoting condoms also. Basically this network works on social marketing, so they promote condoms, pills, IFAs, sanitary napkins also. So, they basically promote the market based products also and they are into the services*."

However, franchisee providers studied have not these services

> **Franchising health manager 3:** "*We have testing but we don't h There are doctors who take care of that.*"

> **Franchising health manager 8:** "*Testing is not done now, earlier we used to do it, kits were available but no guidelines from the associations were given, whether the patients should be informed or not. No clear cut guidelines were there*"

Other HIV/AIDS related services, as ARV treatment, are also not included in the package of services of the franchisee providers neither the network policies

> **Franchising health manager 3:** "*: We refer them* [patients for the treatment]"

In the other hand, some HIV services that should be delivered in the public facilities, especially testing, don't use to be available due to shortages of staff and materials.

> **Public clinic manager I 13:** "*If there is not any Lab only then how can we do the tests?*"
>
> **Public clinic manager 14:** "*from last 1 and a half year we do Technician, only counselor is there. So, here we are doing only counseling. For the testing, we are sending the samples to the PG*
>
> **Public clinic manager 6:"** *We have counseling centers at the PHC, we have family awareness week once in a year.*

4.2.3.2 Integration of services in national policies

HIV/AIDS services provided by public sector seem to be integrated in national policies and structures

> **MoHFW representant :** "*they are integrated but they are autonomous. Like NACO and SACO. It is the State AIDS Control Society. NACO is the national program which is running and integrating with the health department. They are regulating and monitoring with their own system*."
>
> **Public clinic manager I 6***: ANMs are being provided formats where problems related to STDs are being written and the trea The DOTS patients are mandatory tested for HIV/AIDS*"

4.2.3.3 Few numbers of cases

Both public and private providers agree there are few number of HIV/AIDS cases. Just one recorded explanation was given, highlighting behavior and moral issues as cause of low prevalence of cases

> **Public clinic manager I 6:** *" We don't have red light areas. I*
>
> **Public clinic manager 15:** *" [We have not] reported cases"*
>
> **Public clinic manager 6:** *" I don't think I got any HIV/AIDS haven't conducted any delivery which is HIV/A*

4.2.3.4 HIV-related stigma

Surprisingly, some HIV-related stigma emerged from the interviews. In one case it was the own health manager (franchise provider) stating she doesn't want HIV patients in her clinic. In the other case, it was a perception about partners' testing behaviors.

> **Franchising health manager 5:** " *Frankly speaking I am a privat*
> *want my OT to be unsterilized and my staff to*
>
> **Franchising health manager 4:** "*Their husbands are very reluctant and they wan't them to test f'or HIV/AIDS (...)*

Quantitative data

4.1. Socio-economic characteristics

A total of 124 females were interviewed when living the selected health facilities (*exit-interviews*) between April and May 2010. Seventeen (13.7%) were visiting the clinic first time. One hundred-and-seven (86.3%) already visited the clinic before. Religion of one hundred and thirteen women was Hindi (91.1%) whereas 11 women were Muslims (8.9%). Socio-economic status, casts and main general characteristics of users interviewed are presented in table 17

The median age of all women was of 28.18 years (range: 18 years to 40 years). Median age of women attending franchising facilities was 29.35, whereas for those attending public facilities was 27 (*p value* 0.64, no significant difference). No significant differences in terms of religion are found between users of franchising and public facilities ($p > 0.05$)

Table 17 Characteristics of women attending franchising facilities *vs* attending public facilities

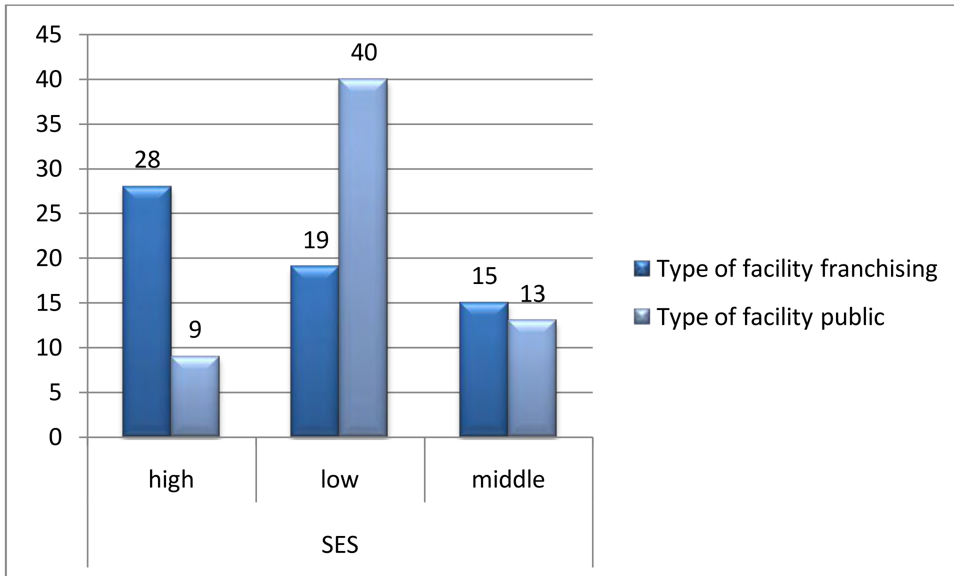
Characteristic	**All** N=124	**Franchising**	**Public facilities**	***p***

Female [n (%)]	124(100)	62 (50)	62(50)	ns
Religion:	124	62	62	ns
Muslim	11 (8.9)	6	5	
Hindi	113 (91.1)	56	57	
Age, yrs [media , SD]	28.18 (7.093)	29.35 (7.245)	27 (6.792)	ns
Level of care	124 (100)	62 (50)	62 (50)	
Primary	68 (54.8)	40	28	
Secondary	56 (45.2)	22	34	
Casts [n (%)]	118	56	62	<0.001
SC	52	16	36	
OBC	22	13	9	
General	30	20	10	
Others	14	7	7	
SES	124	62	62	<0.001
Low	59	19	40	
Medium	28	15	13	
High	37	28	9	

There is an association between type of facility and castes attending the clinics (p<005). Types of cast coded are SC (scheduled castes, representing the lower casts stated in the Indian Constitution), OBC (other backward casts), general casts and others (casts that this research couldn't include in the other codes).

High socio-economic status populations are also more likely to attend franchising facilities than public facilities (p <0.05) whereas populations from low SES are more likely to attend public facilities, as shown in figure 8.

Figure 8. Socio-economic status of women attending franchising facilities *vs* attending public facilities



4.2. Perceived quality

Perceived quality questionnaire was based in Kumari *et al.* (2009) questionnaire, already validated in the same context (Uttar-Pradesh, India). The questionnaire showed good reliability and validity. It includes five dimensions of quality of care: medicine availability, medical information, staff behaviour, doctor behaviour, and hospital infrastructure.

The results show that in each question the answer scores all the range (one to five), although responses were generally skewed towards extreme values (strongly agree and strongly disagree). There were no answers (NA) in all the questions, but in those potential sensitive (availability of medicines, amenities' availability, consultation time) percentage of non-respondents arose almost 30%. Other questions with high number of non-answers, as if the facility has drinking water or the cleanness of the toilets are not responded maybe because of the patients didn't use those services. Table 18 shows percentage of responses for each question

Table 18 Total number of answers and percentage (N;%) in each question (perceived quality)

Scale items	**NA**	**1**	**2**	**3**	**4**	**5**
This hospital has all the medicines needed by you	6 (4.8)	26 (21)	20 (16.1)	30 (24.2)	28 (22.6)	14 (11.3)
You are able to get all the necessary medicines easily	16 (12.9)	24 (19.4)	18 (14.5)	27 (21.8)	24 (19.4)	15 (12.1)
The doctors give you advice about ways to avoid illness and stay healthy	8 (6.4)	9 (7.3)	10 (8.1)	24 (19.4)	46 (37.1)	27 (21.8)
The doctors give you complete information about your illness	11 (8.8)	9 (7.3)	14 (11.3)	25 (20.2)	40 (32.3)	25 (20.2)
The doctors give you complete information about your treatment	4 (3.2)	10 (8.1)	13 (10.5)	27 (21.8)	39 (31.5)	31 (25.0)
Hospital workers talk politely	18 (14.5)	1 (0.8)	1 (0.8)	10 (8.1)	45 (36.3)	49 (39.5)
Hospital workers are helpful to you	18 (14.5)	1 (0.8)	1 (0.8)	11 (8.9)	46 (37.1)	47 (37.9)
You are given enough time to tell the doctor everything	7 (5.6)	3 (2.4)	4 (3.2)	4 (3.2)	51 (41.1)	45 (36.3)
Doctors listen carefully to what you have to say	6 (4.8)	3 (2.4)	3 (2.4)	10 (8.1)	54 (43.5)	48 (38.7)
The doctor checks patients properly	6 (4.8)	3 (2.4)	6 (4.8)	10 (8.1)	50 (40.3)	49 (39.5)
The doctor is always ready to answer your questions	7 (5.6)	4 (3.2)	5 (4.0)	12 (9.7)	50 (40.3)	46 (37.1)
The doctor gave you adequate time	10 (8.0)	3 (2.4)	3 (2.4)	6 (4.8)	52 (41.9)	45 (36.3)
The cleanliness of the hospital is adequate	6 (4.8)	15 (12.1)	2 (1.6)	1 (0.8)	40 (32.3)	50 (40.3)
The condition of the toilets are good	26 (21)	17 (13.7)	4 (3.2)	10 (8.1)	34 (27.4)	33 (26.6)
Drinking water is easily available in the hospital	29 (23.4)	3 (2.4)	3 (2.4)	7 (5.6)	27 (21.8)	55 (44.4)
This hospital has all the requisite amenities	37 (29.9)	11 (8.9)	7 (5.6)	10 (8.1)	25 (20.2)	34 (27.4)

Codes:

NA: Non-answer **1:** Strongly disagree **2:** Disagree **3:** Neutral **4:** Agree **5:** Strongly agree

One aspect representing each dimension of perceived quality was deeply assessed (medicine availability, medical information, staff behaviour, doctor behaviour, and hospital infrastructure).When answering, respondents can opt in each question by five answers (from strongly disagree to strongly agree) or for none responding the questions. Answers were groups as a dichotomous variable: Agree (agree or strongly agree) and don't agree (rest of the answers *plus* non answer). Chi-square was used looking for differences. Results of analysis show a chi-square no significant for the two first dimensions (medicine availability and medical information) and significant for staff behaviour (OR 0.036) ,doctor behaviour (OR 0.006) and facility infrastructure,

where franchising users have slighter higher perception of quality (OR 0.281; 0.134-0.589).

Table 19 Users perceived quality (franchising users *vs* public facilities users)

Type of facility	Agree	Non-agree	p
You are able to get all the necessary medicines easily			
Franchising	24	38	
Public	15	47	
TOTAL	39	85	0.082
The doctors give you complete information about your treatment			
Franchising	37	25	
Public	33	29	
TOTAL	70	54	0.469
Hospital workers talk politely			
Franchising	52	10	
Public	42	20	
TOTAL	94	30	0.036
The doctor gave you adequate time			
Franchising	56	6	
Public	44	18	
TOTAL	100	24	0.006
This hospital has all the requisite amenities			
Franchising	39	23	
Public	20	42	
TOTAL	59	65	0.001

4.3. Users' satisfaction

Three questions were asked to exit-interview respondents about satisfaction:

- Overall how satisfied are you with the services at this hospital?
- How satisfied are you with the services you received at this hospital compared with what you paid?
- Are you completely satisfied with your treatment?

Therefore, three aspects of satisfaction were looked at: overall satisfaction, satisfaction related with payment and satisfaction related with received treatment.

Table 20 Satisfaction status of women attending franchising facilities *vs* attending public facilities

Characteristics	Franchising (N;%)	Public facilities (N;%)	*p value*
Overall quality			< 0.001
• NA	0 (0)	1 (1.6)	
• Strongly agree	14 (22)	14 (22.6)	
• Agree	31 (50)	8 (12.9)	
• Neutral	15 (24)	17 (27)	
• Disagree	2 (3.2)	13 (21)	
• Strongly disagree	0 (0)	9 (14.5)	
ALL	62 (100)	62 (100)	
Satisfaction payment related			<0.001
• NA	1 (1.6)	1 (1.6)	
• Strongly agree	15 (24.2)	14 (22.6)	
• Agree	32 (51.6)	13 (21)	
• Neutral	12 (19.4)	16 (25.8)	
• Disagree	2 (3.2)	9 (14.5)	
• Strongly disagree	0 (0)	9 (14.5)	
ALL	62 (100)	62 (100)	
Satisfaction treatment related			<0.001
• NA	3 (4.8)	2 (3.2)	
• Strongly agree	15 (24.2)	14 (22.6)	
• Agree	32 (51.6)	11 (17.7)	
• Neutral	11 (17.7)	15 (24.2)	
• Disagree	1 (1.6)	10 (16.1)	
• Strongly disagree	0 (0)	10 (16.1)	
ALL	62 (100)	62 (100)	

Answers about satisfaction were grouped as a dichotomous variable: *Non-satisfied* (strongly disagree/disagree) and *other satisfaction status* (NA/ strongly agree/ agree/neutral). Users of public facilities are likely to be not-satisfied than users of franchising facilities ($p<0.001$).

In univariate logistic regression analysis, women attending public facilities are 16.5 times more likely to be overall not–satisfied that those attending franchisee facilities (OR 16.5; 95% CI: 3.675-74.081). For satisfaction related with the money they pay for, women attending public facilities are 12 times more likely to be not satisfied compared to those attending franchising (OR 12.27; 95% CI: 2.7-55.65). For satisfaction related with received treatment, females who attended public facilities are 29 times more likely to be unsatisfied compared to those attending franchisee outlets (OR 29.04; CI 3.75- 224.8).

Other analyzed factors with logistic regression as socio-economic status (OR 2.464; CI 0.536-11.333) , cast (e.g., OR 2.415, CI 0.216 -9.464 for general casts) and religion (OR 0.919, CI 0.185- 4.559) didn't show significant association with overall satisfaction.

Chapter 5 - Discussion

Main results of this research can be grouped in the following six thematic areas: utilization of services, access to services, organizational aspects of the franchising mechanisms, perceived quality, users' satisfaction and response to the HIV/AIDS. Both quantitative and qualitative data are integrated in the discussion.

5.1. Utilization of services

Results emerged from semi-structured interviews show a generalized perception: low utilization of services among potential users (low socio-economic status populations). This finding is not consistent with published researches and reports about franchising networks, which use to show notable improvements in utilization rates (Agha,& Balal, 2002; Lavacke,2003). Wexler (2008) showed higher SRH services efficiency (measured measured in terms of the number of patients) in franchised clinics than those non-franchised after analyzing data of 1,686 health facilities in 3 states of India.However, Koehlmoos *et al.* (2009) highlighted the lack of reliable evidence about how health franchising mechanisms are related with higher utilization rates.

Some reasons were suggested by interviewed health managers to explain low utilization of services. Main of the suggested reasons are *operational* (weak referral system from the community level; weak social marketing strategy) whereas other argued reasons to explain low utilization rates are *strategic* (type of population targeted by the network). A "*contextual*" reason is also argued: poor populations are choosing when health care seeking other providers (Governmental facilities) because of other pro-poor schemes are addressed to them (*JSY* programme, a conditional cash transfer programme). Other factors described in the literature related with utilization of services are perceived quality and users' satisfaction (Montagu, 2002). However, this research argues that this competition between schemes addressed to poor people is the main reason behind low franchising network utilization of services.

<u>Out-of-pocket payments *vs* Conditional cash transfer programmes</u>

The franchising network charges for his services (because of his nature, private for-profit outlets branded into a common name). Prices are lower than private non-franchisee sector, but majority of users are not insured. Therefore, they have to pay out for the services they are receiving (out-of-pocket payments)

These out-of-pocket payments pin out important equity and access issues. Gotsadze *et al.* (2005) showed after a household survey carried out in Georgia that main barrier in health care seeking behaviour among poor populations are out-of-pocket payments. Evidences show that out-of-pocket payments are not an equitable and pro-poor. Out-of-pocket payments at the point of service are considered the most inequitable system of financing health care (Evans, Carrin& Evans, 2005).

Yates (2009) summarizes evidence of out-of-pocket impact at Primary Health Care level in equity, efficiency and effectiveness showing that are not pro-poor addressed. User fees reduce the use of health services, and catastrophic expenditures arise. Therefore, payment system used by the franchise network (out-of-pocket) is not address to poor people, reducing access and utilization and increasing inequities (middle or upper classes will be benefit of reduced prices instead the poorest populations).

In the other hand, conditional cash programmes idea is “to transfer cash to the poor *on condition* that the poor will commit to empower themselves and help bring future generations of poor families out of poverty” (Son, 2008). Even most part of conditional cash programmes have been implemented in Latin America for poverty reduction last decades, they have been also implemented in Asia, like Indonesia conditional cash transfer programme (ILO, 2008).

Devadasan *et al.* (2008) argue demand-side financing initiatives can reduce financial barriers and hence increase institutional delivery and thereby reduce maternal and neonatal deaths

As seen in the results chapter, JSY scheme is widely perceived as “successful”. However, Lim *et al.* (2010) showed after a systematic evaluation of the programme huge differences in the scheme implementation between States and even between Districts. Actually, Uttar Pradesh was one of the states with lower percentage of JSY beneficiary women among all women who have institutional delivery. Reasons to this

mismatching between perceptions and data from quantitative evaluations can be due to

Finally, Paul (2010) recognizes that *JSY* scheme is a great opportunity to reduce MMR and increase service utilization, especially among poor people, even some concerns, as quality of the services, have to be addressed.

In conclusion, this research shows performance of franchising mechanisms in a real setting where different providers compete by the same "market" (poor populations) implementing theorized pro-poor schemes. Results show that a conditional-cash transfer programme is getting better results in terms of utilization than the studied franchising mechanisms. However, other relevant aspects, like cost and efficiency were out of the scope of this research.

5.2. Access to services

Profile of users of the public facilities is different of those attending the franchise network. Scheduled casts and other backward class are more frequent among users of Governmental clinics. Socioeconomic status is also different when comparing users from public and franchisee clinics. High SES populations are also more likely to attend franchising facilities than public facilities ($p < 0.05$). These findings show that the poorest people are not the main beneficiaries of the franchisee network, contradicting most part of the Social franchising literature (McBride& Ahmed, 2001; Montagu et al. , 2009) and other studies including profile of users (Bishai *et al.*, 2008).

These findings can be explained because the "high competitive" environment in India for the poorest. Governmental sector is strongly subsidizing institutional deliveries through a conditioned-cash programme, as seen above. This means *in practice* poor people are going to choose public facilities when care-health-seeking to get the associated benefits (*cash*). Therefore, middle and high socio-economic status populations are the big beneficiaries of the franchising programme.

5.3. Organizational aspects of the franchising network

As seen in the literature review chapter, Montagu framework (Montagu, 2002) suggests three reasons to explain why is useful to private providers to join to a social franchising network and, therefore, *why* franchising is going to be successful: benefits from the publicity of a common brand name, increase of the number of users (so cost can be reduced) and benefits of networking with peers and colleagues of doctors members of the franchise.

Ngo *et al.* (2009) highlight the importance of using “sophisticated social marketing” strategies to achieve franchise network goals. However, as seen in results’ chapter, one of the main reasons because of franchisee services are under-used is a very poor marketing strategy.

Results show almost generalized complains about franchising marketing strategy. It also emerged the generalized view that patients are attending the facilities because they know them previously instead because of the branded publicity. These findings are consistent with other studies in similar settings, that also showed a majority of users of franchisee services are not aware about the clinic they visited is member of a franchising network (Agha & Balal, 2002.)

Trainings were suggested as one the main reasons to join the franchisee network by the private providers. It is supposed also that it is one of the priorities of the network, as stated by the own franchise (Merrygold, 2008): “*Training and capacity building is crucial to Merrygold Health Network* .”However, outlets providers show a quasi-generalized disappointment with trainings. Mismatching between expectations and “obtained benefits” are likely under these views

Finally, it is important to remark that the different existing views about the future of the network among the franchisee outlets (from very pessimist: “*they are going to collapse*” to enthusiastic: “*It* [Merrigold] *is going to grow*”) can influence in the actual evolution of the network. If pessimist views are generalized, franchisee providers can be tented to leave the network in a “snowball” effect.

5.4. Perceived quality

Social franchising theory argues perceived quality is higher among users of franchisee outlets rather than those using public facilities. This is suggested even in Indian context (Yu, Whynes & Sach, 2008). Suggested reasons are franchisees providers are incentivised to get patients (as private providers) plus the quality controls carried out by the franchiser/implementer (Montagu, 2002; England, 2006). However, a study about quality and perceived satisfaction of different types of providers (franchises, Governmental, private non-profit and private for profit) carried out in Pakistan showed also similar levels of satisfaction and quality among providers. (Bishai *et al.*, 2008)

Results of this research show significant differences in three dimensions of perceived quality (staff behaviour; doctor behaviour and physical infrastructure) among users of franchisee outlets *vs* those using public facilities. No significant differences were found in terms of availability of medicines and information provided by the doctor. This is coherent with franchising literature, as seen above. This higher perception of quality will be a factor to take in consideration when analyzing utilization of services. However, as seen above, other factors seem to drive stronger poor populations through public facilities (conditional-cash programmes).

Finally, a possible bias is that some questions have high number of non-respondents, maybe because it is a “sensitive” question or it because of “gratitude” bias. The lack of “criticism” about delivered services when responding standardized questionnaires was also described in Indonesia (Bernhart, 1999), and maybe is also a limitation when interpreting the results.

5.5. Users’ satisfaction

Satisfaction of patients was analyzed with univariante regression analysis. Results showed patients attending public health facilities are 16 times more likely to be overall non-satisfied that those attending franchising facilities. Other aspects of satisfaction, as relation between payment and satisfaction and satisfaction about treatment, also show more probability to be non-satisfied among those attending public facilities. Satisfaction scores were grouped into two categories: non-satisfied *vs* other status (neutral, highly satisfied, satisfied, NA) following Hudak & Wright (2000) framework when suggesting that unsatisfaction can drive patient’s behaviour.

Some points emerge from this data. First, data are congruent with More *et al.* (2009) findings when suggesting that pregnant women prefer private facilities but they have not the capacity to pay. High levels of unsatisfaction can clearly lead to franchised facilities. Second, high unsatisfaction levels are generalized in the three studied aspects (overall, payment, and treatment), suggesting the patients visiting public facilities experienced the visit to the clinic as “bad” or “unsatisfactory”. In-depth-interviews would be adequate to deep understand driven forces to unsatisfaction.

Finally, patients of public facilities also declare to be unsatisfied about quality received related with the payments they do. As theoretically services are free at the point of delivery, and most part of them don’t declare any payment when interviewed, findings are difficult to interpret. One option is that patients have to pay for the prescribed drugs in a private pharmacy, and they consider this payment part of the care that they received. Other option is there are “under-table” payments, so final costs to patients determine their level of unsatisfaction. More research, likely qualitative, it would be necessary to clarify this and former issues. This is also congruent with the approach to users’ satisfaction which argues that qualitative research is more appropriate to measure patients’ satisfaction rather questionnaires. A mixed approach to the topic likely would enhance the capacity of researches to understand patients’ satisfaction.

5.6. HIV/AIDS response

Private-public partnerships can be useful to expand access to HIV interventions and support people living with HIV (UNICEF/ADB, 2010). Franchises specifically can play an important role in ARV treatment delivery, helping to achieve HIV-related goals (England, 2006). However, collected qualitative data shows an underuse of franchising services to address HIV/AIDS related issues, as counselling, testing and treatment. Even analyzed public facilities response is also weak, this is not a reason to don’t utilize potentialities of franchising to increase the range of services addressed to tackle with HIV/AIDS issues.

As seen in results chapter, even general manager of the franchising network states HIV response is aligned with national policies, outlets’ reality shows a weak response to HIV/AIDS. Just a few activities are carried out, there is a lack of trainings and

activities don’t seem to be integrated in national policies. These findings are congruent with results from similar contexts. Sheikh *et al.* (2005) found in a study carried out in India that private provider practices related with HIV use to violate national policy guidelines. Kielmann *et al.* (2005) also showed private providers in India perceive HIV as a “challenging disease” for which they are not enough skilled and trained. This perception, added to HIV stigma (also found in this research), lead to a lack of interest in HIV interventions and, when present, based more in an individualist approach rather than national or standard policies.

Finally, it is mentioned by a public provider reluctance of male partners to get tested. Similar findings are described as well by Joseph *et al.* (2010), who showed males preference to be tested in private clinics instead public facilities. These results point out the need of bigger coordination among public and private providers to address HIV epidemic.

A limitation of the discussion have been that data about HIV/AIDS response came mainly just from semi-structured data. No quantitative data were collected about the theme, so quantitative/qualitative triangulation was not possible.

Chapter 6- Conclusions /recommendations

Most part of franchising networks described in the literature are evaluated as "successful" in increasing access to services for poor people and enhancing services' utilization. This is coherent with the suggested frameworks modelling franchising mechanisms for Sexual and Reproductive Health (Montagu, 2002). However, both emerged qualitative and quantitative data collected from both franchisee outlets and public facilities are not supporting those findings. The studied franchise network is not increasing utilization of services and is not addressed to the poorest people.

Low socio-economic status populations and scheduled and other backward casts are more likely to attend public facilities than franchising facilities. Therefore, poor-populations are not getting theorized benefits of a franchising network (high quality and reduced prices). Indeed, results show higher perceived quality among users of franchising mechanisms than those attending public facilities in terms of inter-personal relation (both with medical and non-medical staff) and infrastructure. Patients attending public facilities are also more likely to be unsatisfied than those attending franchisee outlets.

Therefore, utilization and access to the franchising network remains low among poor populations despite higher perceptions of quality and satisfaction reported by users of the branded facilities. Other factor (presence of other scheme pro-poor addressed, a conditional-cash transfer programme) is leading the care-seeking behaviour of poor populations towards public sector. Therefore this research concludes that external factors to the design and implementation of a franchising network, as competition with other initiatives better pro-poor addressed in terms of affordability and accessibility can determine the success of the franchising mechanism.

Conclusions and attached recommendations are summarized following five of the thematic areas identified in the discussion chapter. Operational and organizational aspects of the franchising network conclusions are mainstreamed in each particular thematic area.

6.1. Utilization of services

This research didn't collect quantitative data about the utilization of services (in terms of increased number of patients among franchisee outlets). However, qualitative data emerged from semi-structured interviews about utilization of services showed a generalized perception: franchisee outlets are not receiving more patients after join the franchise network. Therefore, utilization of services continued low, instead been increased as suggested in the theoretical model. Even more, low utilization of services becomes the major concern looking the sustainability of the model, because to maintain under-market prices depends of the benefits of scale economies, it means, high volume of patients.

Reasons argued by outlets' managers are mainly *operational*: poor coordination between levels of care, especially between the "root level" (health motivators") and the rest; and non optimal marketing strategies. These reasons seem to be reliable, because justify why medium and high SES populations are not attending the networked outlets, even more when perceived quality and satisfaction are higher among users attending franchisee facilities than those attending public clinics.

However main cause explaining los utilization of services among poor-people is the very competitive policies addressed to poor-people. JSY scheme and Merrigold franchising network are basically competing for the same "market": deliveries of poor-women and Sexual and Reproductive Health services. Therefore, main reason will be *external* to the franchising scheme.

It seems very difficult the franchising network (Meryigold) can compete with the conditional cash assistance programmes (JSY) already in place in Uttar Pradesh. Both of them are competing for the same "market" (deliveries of poor women), but JSY programme has important competitive advantages: direct governmental support; national scale; widespread of health facilities; supporting both health motivators and final beneficiaries (poor women) referral system from communities to facilities works. Main disadvantage is the poor image in terms of quality that public sector has among population. In fact, this (the supposed better quality of private sector) is almost the only competitive advantage that franchising network has.

Based in this analysis, it seem reliable assume that main franchising network market *niche* are medium socio-economic classes interested more in quality of services

rather than cash incentives. Even if just mainly medium socio-economic classes are getting benefits of the franchise, It is important to remark that the network is an important step to extend quality SRH services.

Recommendations

Strategy

- Assuming Montagu's framework validity (so the theoretical model supporting the franchising network works in ideal conditions), a deep review of the franchising strategy and goals will be suggested to match the theoretical model to the specific context and needs.
- It is also suggested Government have to develop policies and normative frameworks to regulate public-private partnerships and for monitoring allocation of resources.

Operational

- To strength referral system through better coordination among levels, especially with community health motivators. Out-reach clinics can be useful to disseminate awareness of the network and strength boundaries between health motivators, communities and the franchisee outlets.

- Improvement of social marketing strategies: Some of the changes that can be useful to improve the social marketing strategy are: re-defining targeted population, type of advisements used, media used to deliver the messages and increase the use of local campaigns.

6.2. Access to services

Scheduled casts, other backward casts and people from low socio-economic status attend more to public facilities rather than franchisee outlets in the study area. This

finding is contradictory with most part of Social franchising literature. However, it can be explained because poor people are exposed to two different schemes: a conditional-cash programme and the franchising mechanism. Therefore, we can assume that when competition among schemes those more addressed to the beneficiaries (poor people) are going to have success. No other research studied before franchising networks in this kind of "competitive environments". Therefore, the added value of the network, as quality, don't seem to be an incentive enough strong to motivate poor people to attend the franchising facilities.

Recommendations

Main recommendation for the franchising initiative is to study deeply incentives and "attractors" already in place for poor-people in the area. If are not applicable (e.g., the MoHSW doesn't accept to subsidize institutional deliveries in private clinics), other incentives have to be launched.

6.3. Perceived quality

Results of this research show significant differences in three dimensions of perceived quality (staff behaviour; doctor behaviour and physical infrastructure) among users of franchisee outlets *vs* those using public facilities. No significant differences were found in terms of availability of medicines and information provided by the doctor. Despite this higher quality perception among franchisee users, utilization of services remains low. Therefore perceived quality is not acting as a driven force to attract poor-people to the franchising network.

Recommendations

- Actions to increase perceived quality among public facilities' users have to be launched. Actions should cover mainly inter-relation between patients and medical and non-medical personnel and improvements in infrastructures.
- The franchising network should keep their perceived higher quality standards. More studies will be needed to deep analyze factors driven care-seeking behaviour of poor populations

6.4. Users' satisfaction

Users' satisfaction results showed higher number of unsatisfied patients among those attending public health facilities than those attending franchising facilities. Factors involved in this unsatisfaction levels are not deeply studied.

Recommendations

- More research, including qualitative methodology, is necessary to better understand factors related with patients' satisfaction (and unsatisfaction)

- Public health system has to face patients' high level of unsatisfaction. Although currently public sector has important "competitive" advantages" because of cash-conditioned programmes, if satisfaction problems are not addressed these programmes can fail and women could move to private sector or even could prefer have again domiciliary deliveries.

6.5. HIV/AIDS

Franchising networks can play an important role in the response to HIV/AIDS. However, the potential of the studied branded network to tackle with HIV epidemic is clearly under-used. Although it is supposed that HIV services are included in his "package of services", most past of outlets don't have adequate skilled personnel (e.g., in counselling) neither materials (like tests or ARV treatment) to give an effective response to HIV/AIDS. Even HIV prevalence in the area is low and public facilities also report low number of cases, the franchise network is missing the opportunity to offer quality HIV services to their patients, as counselling or prevention of mother-to-child HIV transmission.

HIV-related stigma also emerged as a critical point to be addressed.

Recommendations

- HIV/AIDS activities could be included in the routine package of services of the franchise network.

- HIV/AIDS activities and services should be aligned and integrated with national HIV/AIDS policies and guidelines.

- More coordination between private and public providers to tackle with HIV/AIDS epidemic is also recommended.

- It is recommended to train health staff in HIV stigma and discrimination issues.

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Appendix 1 Perceived quality and satisfaction questionnaire

Socio-demographic data questionnaire

Serial code:	**Gender: M F**	**Age:**

SOCIO-ECONOMIC STATUS

Source of drinking water	3: own tap	2: shared tap	1: hand pump and well	0: 0ther
Type of house	4: *pucka*	2: semi-*pucka*	0: *Kacha*	
Source of lighting	2: electricity	1: kerosene	0: 0ther	
Fuel for cooking	2: LPG gas/ electricity	1: kersosene	0: 0ther	
Toilet facility	4: own flush toliet	2: own pit toilet	2: shared toilet	0: 0ther

Ownership for items

Item	**Points**
Car	
Tractor	
TV	
Telephone	
Motorcycle	
Fan	
Radio/transistor	
Sewing machine	
Bicycle	
TOTAL	

Total Score :

The Total Score is Graded as f ollows :

Upper	>19
Middle	>9 -19
Lower	< =9

Service you visited:

- ANC
- Vaccination

How much do you expend?

- PNC - FP - paediatric - Other	
How do you pay for the services you received? - Out-of-pocket expenditure - Insurance - Voucher scheme - Other: ______________________	
How long the physician/doctor spent with you? - Less than 5 minutes - 5-10 minutes - 10-15 minutes - More than 15 minutes	
How long do you wait for the doctor? - Less than 10 minutes - 10-30 minutes - 30 minutes -1 hour - More than 1hour	

Perceived quality and general satisfaction questionnaire

Scale items	**1**	**2**	**3**	**4**	**5**
This hospital has all the medicines needed by you					
You are able to get all the necessary medicines easily					
The doctors give you advice about ways to avoid illness and stay healthy					
The doctors give you complete information about your illness					
The doctors give you complete information about your treatment					
Hospital workers talk politely					
Hospital workers are helpful to you					

You are given enough time to tell the doctor everything					
Doctors listen carefully to what you have to say					
The doctor checks patients properly					
The doctor is always ready to answer your questions					
The doctor gave you adequate time					
The cleanliness of the hospital is adequate					
The condition of the toilets are good					
Drinking water is easily available in the hospital					
This hospital has all the requisite amenities					
Satisfaction					
Overall how satisfied are you with the services at this hospital?					
How satisfied are you with the services you received at this hospital compared with what you paid?					
Are you completely satisfied with your treatment?					

Scale: 1- Strongly disagree 2-Disagree 3-Neutral 4- Agree 5- Strongly agree

@

@

Appendix 2 Semi-structured interview to key informants' franchising network related

1-Introduction of the researcher and the aims of the study

2-Introductory questions (type of facility; number of beneficiaries; services provided,...)

3- What do you think are the main reasons because of private providers joined to the franchising network?

3-Which is the socio-economic status of the users of the franchisee facilities?

4- Do you think that your services are pro-poor addressed? Why? (access/ utilization/quality)

5-Which services use more often poor people? (Private/public/franchising)

6- Are the beneficiaries involved in the management of the franchisee facilities ? If yes, how?

7-How are the franchisee facilities addressing HIV issues?

8- what do you think are the advantages and disadvantages of public sector compared with franchising mechanisms? And with the non-franchisee private sector?

9- In general, is the network satisfied with the results of the franchisee providers?

10- What do you think will happen the next 3/5 years with the franchising mechanisms in Uttar Pradesh (extend/reduced/cancelled)?

Any other comments that would like to add

Appendix 3 Semi-structured interview to key informants' public sector

1-Introduction of the researcher and the aims of the study

2-Introductory questions (type of facility; number of beneficiaries; services provided,...)

3- Which is the socio-economic status of the users of the facilities?

4- Do you think that your services are pro-poor addressed? Why? (access/ utilization/quality)

5-Which services use more often poor people? (Private/public/franchising)

6- Are the beneficiaries involved in the management of the public facilities ? If yes, how?

7-How are the public facilities addressing HIV issues?

8-Have you hear about franchising mechanisms? And voucher scheme? Do you have opinion about them?

9- If you are a public provider, what do you think are the advantages and disadvantages of public sector compared with franchising mechanisms? And with private sector?

10- What do you think will happen the next 3/5 years with the franchising mechanisms in Uttar Pradesh (extend/reduced/cancelled)?

Any other comments that would like to add

Appendix 4 FGD-Women UP

Objective:

O.1. to explore women's expectative about health care, and especially about Sexual and Reproductive health care in a District of Uttar Pradesh

O.2. to set up an expected standard of quality about Sexual and Reproductive health care for women in child-bear age

Participants: 5-7 women 18-49 years. No health workers invited.

Place: Comfortable place outside health facilities

Topic guideline:

1-Introduction of the researchers

2- Introduction of the research

3-Confidentiality terms

4- Brief introduction of participants (name and age)

5-Questions

1- What mean for you Reproductive and Sexual health services?
2- Where do you (or your friends/relatives) use to go to get these services?
3- Which SRH services did you use last year (FP/ANC/delivery/ PPC/immunization)?
4- Which things about the SRH services did you like last time you went?
5- Which things about the SRH services did not you like last time you went?
6- What do you expect in terms of:
    - Location of the facility (time , distance)
    - Waiting time
    - Who (doctor, nurse,…) is attending you
    - Time that doctors spend with you

- Personal manner of staff (doctors/nurses/ administration staff)
- Technical skills of health staff (doctors/nurses)
- Availability of drugs/ tests/treatments
- Prices (OPD/in-patients/drugs/tests/treatments)
- Referral system
- Explanations give to you
- Comfort of the facilities
- Others

7- Which is your main reason to choose one health facility for SRH services?

8- Which is your main reason to choose one health facility for any service?

9- Do you know some people that are not using SRH services, even if they need? Why do you think they are not using them?

6-Feed-back to participants

7-Questions from participants

8-Aknowledge to participants

9- Drinks-snacks

Appendix 5 Ethical approval

Pembroke Place,
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Dr Eduardo Celades
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool
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Friday, 26 March 2010

Dear Dr Eduardo Celades

Re: Research Protocol (10.37) Franchising mechanisms in Uttar Pradesh, India: Working for the poor people? Equity and quality aspects

Thank you for your letter dated 24 March 2010 responding to the points raised by the Research Ethics Committee. The protocol now has formal ethical approval from the Chair of LSTM Research Ethics Committee.

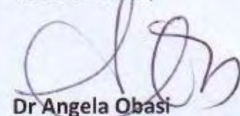
The approval is for a fixed period of three years, renewable annually thereafter. The committee may suspend or withdraw ethical approval at any time if appropriate.

Approval is conditional upon:

- Submission of ethical approval from other ethics committees.
- Notification of all amendments to the protocol for approval before implementation.
- Notification of when the project actually starts.
- Provision of an annual update to the Committee. Failure to do so could result in suspension of the study without further notice.
- Reporting of all severe unexpected Adverse Events to the Committee
- Reporting of new information relevant to patient safety to the Committee
- Provision of Data Monitoring Committee reports (if applicable) to the Committee

Failure to comply with these requirements will result in withdrawal of approval. The Committee would also like to receive copies of the final report once the study is completed.

Yours sincerely



Dr Angela Obasi
Acting Chair, Research Ethics Committee

CC Xiaouyun Liu