Overview of the Social Franchise Model for Delivering Counseling Services on Infant and Young Child Feeding

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THE LITTLE SUN
Nutrition today, health tomorrow

Alive & Thrive is an initiative to improve infant and young child feeding practices by increasing rates of exclusive breastfeeding and improving complementary feeding practices. The first two years provide a window of opportunity to prevent child deaths and ensure healthy growth and brain development. Alive & Thrive (A&T) aims to reach more than 16 million children under 2 years old in Bangladesh, Ethiopia, and Viet Nam through various delivery models. Learning will be shared widely to inform policies and programs throughout the world. Alive & Thrive is funded by the Bill & Melinda Gates Foundation and managed by FHI 360. Other members of the A&T consortium include BRAC, GMMB, the International Food Policy Research Institute (IFPRI), Save the Children, the University of California Davis, and World Vision.

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Acronyms

A&T	Alive & Thrive
CBW	Community-based Worker
CF	Complementary Feeding
CHC	Commune Health Center
DHCs	District Health Centers
DMB	District Management Board
DoH	Department of Health
EBF	Exclusive Breastfeeding
IEC	Information, Education and Communication
IPC	Interpersonal Communication
IYCF	Infant and Young Child Feeding
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
MTBT	Mat Troi Be Tho
NIN	National Institute of Nutrition
OAM	Opportunity, Ability and Motivation
PBI	Performance Based Incentives
PMB	Provincial Management Board
RHCs	Reproductive Health Centers
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

Alive & Thrive is an initiative to improve infant and young child feeding practices by increasing rates of exclusive breastfeeding and improving complementary feeding practices. The first 1,000 days, from the start of pregnancy through the child's first two years of life, provide a window of opportunity to prevent death and ensure healthy growth and brain development in young children. Alive & Thrive (A&T) aims to reach more than 16 million children under 2 years old in Bangladesh, Ethiopia, and Viet Nam through various delivery models. Learning will be shared widely to inform policies and programs throughout the world. Alive & Thrive is funded by the Bill & Melinda Gates Foundation and managed by FHI 360. Other members of the A&T consortium include BRAC, GMMB, the International Food Policy Research Institute (IFPRI), Save the Children, the University of California Davis, and World Vision.

PURPOSE OF THE SUMMARY DOCUMENT

This document provides an overview of the A&T *Mat Thoi Be Tho* (MTBT) franchise model, its development and evolutionary path, and lessons emerging from this innovative platform for delivering infant and young child feeding (IYCF) counseling services. The document will be shared with practitioners and donors interested in addressing IYCF practices and nutrition in the critical 1,000 day period.

METHODOLOGY FOR PREPARATION OF THE SUMMARY DOCUMENT

This document has been developed using the following methodology:

- Catalogue and review of existing documentation on the MTBT social franchise and the broader operational environment prepared as part of the A&T project in Viet Nam. Annex 1 contains a full 'tool kit' of catalogued materials.
- Interviews with personnel involved in implementation of the MTBT franchise to glean lessons learned through implementation experience.
- Synthesis of information to present the 'evolutionary course' of the franchise model in Viet Nam. This synthesis is presented in Annex 2.

Background

NUTRITION SITUATION AND IYCF BARRIERS IN VIET NAM

Viet Nam has experienced significant economic growth in the last decade, yet malnutrition persists. Underweight and, in particular, stunting among children under two years old remain high in Viet Nam compared to countries with the same economic status in the region. Although child malnutrition has declined considerably over the last decade, stunting reduction has stagnated since 2005. Nearly one-third (29.3 percent) of children under five are stunted while underweight and wasting are estimated at 17.5 per cent and 7.1 percent respectively.[1] Data collected on IYCF practices as part of the National Institute of Nutrition (NIN) surveillance in 2010 are presented in Table 1.

Table 1: Infant and young child feeding practices in Viet Nam

Breastfeeding (BF)	Complementary Feeding (CF)
• Initiation of breastfeeding within one hour - **61.7%** • No squeezing of colostrum – **69.9%** • Exclusive breastfeeding under six months – **19.6%** • Predominant breastfeeding under 6 months – **30.8%** • Continued breastfeeding at two years – **22%**	• Minimum acceptable diet – **51.7%** • Minimum meal frequency – **85.6%** • Minimum dietary diversity – **71.6%** • Consumption of iron-rich foods – **82.4%**

There remain significant variations in nutritional indicators and IYCF practices between and within provinces and socio-economic groups. Stunting, underweight, and wasting rates are higher among rural, poor populations as well as ethnic minorities. However, rural and ethnic minority women are more likely to initiate breastfeeding (BF) within an hour of birth and exclusively or predominantly breastfeed their infants for the first six months of life than urban women. In contrast, children aged 6-23 months living in urban areas are more likely to achieve minimum dietary diversity than those living in rural areas; the same holds true for children receiving minimum meal frequency and acceptable diets.

RATIONALE FOR INTERVENTION

Although child malnutrition has declined considerably in Viet Nam over the last decade, considerable barriers remain to achieving optimal nutrition, many of which relate to IYCF practices. They have both geographic as well as demographic dimensions. One of the goals of the NIN strategy for the period 2001-2010 was achieving 60 percent exclusive breastfeeding in the first four months by 2010. The IYCF action plan, approved by the government in December 2006, also called for doubling the rate of exclusive breastfeeding for the first six months, from 12.5 percent in 2005 to 25 percent in 2010.

Box 1: Window of Opportunity

The first 24 months of life are not only the "window of vulnerability," where stunting and underweight rates increase sharply, but also the ***"window of opportunity,"*** when nutrition interventions carried out effectively can have the greatest impact in preventing under-nutrition in children.

Bryce *et at:* Maternal and child under nutrition: effective action at national level. *Lancet* 2008, 371 (9611):510-526.

An opportune window for intervention was recognized by A&T, which had started its baseline research in 2009. The project recognizes the last trimester of pregnancy and the first 24 months of life as a window of

[1] National Institute of Nutrition. NIN surveillance report on feeding practices in 63 provinces. Hanoi, Viet Nam: NIN, 2010.

vulnerability but also a window of opportunity (Box 1). With this in mind, Alive & Thrive, in alignment with Government of Viet Nam goals[2], proposed to:

- Double the exclusive breastfeeding rate
- Improve the quality and quantity of complementary foods
- Reduce the rate of stunting by 1.5 – 2 percentage points per year

To achieve these ambitious goals, A&T determined that a multi-pronged model was necessary focusing on IYCF practices recommended by the WHO and endorsed by NIN. These practices are outlined in Table 2.

Table 2: Ideal breastfeeding and complementary feeding practices

Ideal BF practices	Ideal CF practices for children (6-23 months old)
✓ All newborns are breastfed for the first time within the first hour after birth ✓ No newborns are given pre-lacteals before breastfeeding ✓ All newborns are fed colostrum ✓ All infants and young children are breastfed on demand, during the day and night ✓ All infants are exclusively breastfed until 6 months of age (180 days). ✓ All children are breastfed until at least 24 months of age ✓ No children are fed with bottles and pacifiers	✓ All infants are fed semi-solid complementary food beginning at 6 months of age (180 days) ✓ All young children are fed the recommended number of meals daily ✓ All young children meet their recommended daily energy requirements ✓ All young children are fed nutrient- and energy-dense food ✓ All young children are given a variety of food (from four food groups or more) ✓ All young children are given iron-rich food or an iron supplement daily. ✓ All young children are fed meat, fish, and poultry daily ✓ All young children are supported and motivated to eat to satiety during meal times

PROJECT OVERVIEW

The project devised a two-pronged approach to increase adoption of the recommended feeding practices:

- Improve the policy and regulatory environment to support IYCF interventions and practices;
- Create, shape, and support demand for improved IYCF social norms and practices at community and family levels

Key activities in Viet Nam under each intervention arm are outlined in Table 3.

Table 3: A&T intervention arms and key activities

Intervention arm	Key activities
Strengthen policies that protect and promote IYCF	• Support national nutrition policies • Strengthen Decree 21 (marketing of breast milk substitutes) and maternity leave policy • Strengthen province-specific nutrition plans
Create and shape demand for IYCF	• Integrate elements of social franchising in health facilities and provide good quality IYCF counseling services • Create IYCF support groups in remote areas • Promote improved feeding practices through use of mass media and information communication technology • Pilot workplace interventions

The focus of this report is on the social franchising component, the key strategy employed to ***'create and shape demand for IYCF'.***

[2] These are provincial targets set for sites where A&T has operations.

Innovation

FORMATIVE RESEARCH

To inform key decisions about program design, A&T conducted two phases of formative research related to IYCF practices. Phase one research, completed in 2009, looked at barriers to IYCF.[3] The research identified several barriers to ideal breastfeeding practices immediately after birth, exclusively for the first six months, and continuing until 24 months. For example, some Vietnamese mothers believe that they have insufficient milk, both in terms of quantity and quality. Another barrier is mothers' lack of information on how much milk is needed by infants during the first few days and months of life. These barriers affect both initiation of breastfeeding and exclusive breastfeeding. Another barrier identified relates to caesarean sections, which create both a physical barrier due to separation of the mother from the baby after surgery - for as long as 24 hours in some cases - to perceptions that mothers cannot breastfeed while they recover from the procedure. Additionally, the need to return to work is a barrier to exclusive and predominant breastfeeding and may also affect the quality of diets in older children. In general, complementary foods are introduced too early, the consistency of complementary foods is too thin with little or no oil or fat, and food preparation processes may not be appropriate. Selected feedback from participants in the formative research is highlighted in Box 2.

Box 2: Feedback from formative research participants

"I think 'exclusive breastfeeding in the first six months' means it's possible to feed the baby water and use honey to clean thrush". – *mother in Hanoi*

"I had a cesarean section, so I didn't have breast milk right away. – *mother in Hanoi*

"Organ meats contain poison, so we shouldn't feed them to children". – *mother in Vinh Long*

"Mothers should start to breastfeed their babies one or two days after birth, because breastfeeding immediately after birth isn't good. The outside environment is different from the mother's womb. Formula milk should be fed to infants". – *father in Qunag Ngai*

Extracts from Alive & Thrive. *Formative Research on Infant and Young Child Feeding in Viet Nam – Phase One Summary Report.* Hanoi, Viet Nam: Alive & Thrive, August 2012.

[3] Alive & Thrive. *Formative Research on Infant and Young Child Feeding in Viet Nam – Phase One Summary Report.* Hanoi, Viet Nam: Alive & Thrive, August 2012.

TRIALS OF IMPROVED PRACTICES

Phase one formative research informed the selection of improved practices to pilot in phase two.[4] Trials of improved practices, a formative research technique, were undertaken to pre-test practices that A&T Viet Nam planned to promote. The trials, conducted in 2010, were designed to:

- Test the acceptability and feasibility of recommended priority feeding practices
- Identify barriers and facilitating factors to the adoption of recommended practices
- Document changes in behavior that mothers make as a result of the trials
- Obtain information on how to facilitate mothers' adoption of improved feeding practices
- Identify messages that effectively encourage mothers to adopt the recommended practices

There were two rounds of trials. Round one identified sub-optimal feeding practices. During round two, mothers were counseled to try modified practices and recipes, and feedback was gathered on respondent experiences in trying and sustaining new or modified practices. Findings showed that mothers were more likely to initiate breastfeeding within one hour if counseled before delivery. The results also showed that after pregnant women and mothers were counseled on the quality of their breast milk and the child's energy and nutrition demands, they understood the need to exclusively breastfeed to six months, introduce complementary foods at six months, and continue breastfeeding for at least 24 months. Recipes with options for variation were well received and used by mothers. The need for counseling on hygienic meal preparation was also identified through observation of feeding practices. The findings suggested that information needs to be disseminated to mothers through a trusted source and appropriately timed and targeted to build their confidence. Recommendations on the best communication channels varied by location but included a range of sources such as health workers, pre-schools and women's unions, loudspeaker networks, TV, family, friends, and other pregnant women.

SOCIAL FRANCHISING FEASIBILITY

At the same time that phase one formative research on IYCF practices was being conducted, A&T Viet Nam commissioned a social franchising feasibility study. The purpose of this study was to assess whether a social franchising model of IYCF service delivery would be feasible to implement in Viet Nam and if so, how it could be adapted to the Vietnamese context. To determine the feasibility of establishing and sustaining an effective social franchise model of IYCF service delivery, the following questions (Box 3) were considered.

The feasibility study[5] concluded that social franchising was viable in Viet Nam and would have the potential to bring about wide spread improve-ments in IYCF practices. The study further concluded that the franchise model be designed to include both the public and private sectors. In practice, the A&T franchise has focused predominantly on the public sector.

Box 3: Social franchising feasibility study questions

- Is there evidence that the government would support the establishment of a franchise to achieve nutrition objectives?
- Is there an adequate healthcare infrastructure through which IYCF counseling and support services could be delivered to the target audience (public, private, or both)?
- Is there potential to deliver IYCF counseling and support services through the existing infrastructure?
- Is the marketing environment conducive to social franchising?
- In the case of a government model, is there evidence that provincial health authorities would either be willing and able to manage the operations of the franchise or be willing to cooperate with an outside body?
- Is there evidence that franchisees could benefit financially (at the very minimum recover costs and ideally generate additional clinic revenues) by establishing fees for services?
- Is there evidence that the franchisor could recover some or all of its operating costs in the long term?
- Is there an existing sustainable organization that would be a suitable candidate for functioning as the franchise coordinating body (i.e. franchisor) over time?

[4] Alive & Thrive. *Formative Research on Infant and Young Child Feeding in Viet Nam – Phase Two Summary Report: Trials for Improved Practices.* Hanoi, Viet Nam: Alive & Thrive, August 2012.
[5] McBride, J. *Franchise Feasibility Study.* Hanoi, Viet Nam: Alive & Thrive, September, 2009.

Franchising of public sector facilities is a departure from most social franchising arrangements which have traditionally focused on the private sector.[6] Table 4 considers common characteristics of private sector franchising[7] and compares these to features that operate in a similar manner in the public sector.

Table 4: Common characteristics of social franchises

Common characteristics of private sector franchising	Public sector features that operate in a similar manner to private sector franchising
Outlets are operator-owned	Stability in public sites in terms of staffing and infrastructure (low mobility of providers so that once trained they are available in that location) Decentralized healthcare system that exhibits independence at sub national level (e.g., provinces and districts have some control over resources and are empowered to make decisions) Ability of potential franchise sites to self select rather than being 'appointed' to join the franchise Officials who are responsible for facility operations are able and willing to contractually enter franchise agreements
Payments to outlets are based on services provided	There is scope to reward health providers for increased quality and volume of services delivered There is scope to recognize good performance
Services are standardized	Adequate staff are available and can dedicate time for services
Clinical services are offered with or without franchise-branded commodities	Commodity supply chain is functional with infrequent stock outs, or the program can overcome these issues Public sector sites can be branded and promoted

The Vietnamese public health care system exhibits the public sector features outlined in Table 4 (right hand column). The system is functional and capable of reaching a majority of the population, providing an efficient platform for delivering program interventions, achieving impact at scale, and building sustainability. The backbone of the system is the Commune Health Center (CHC), the primary unit of the public health care system in Viet Nam. In rural areas, 94 percent of communes have their own CHC.[8] Figure 1 presents an overview of the political and health care system in Viet Nam and social structures that support it such as the Women's Union which has over 13 million members across the country. This entity provides an effective vehicle for community mobilization.

[6] In the case of the MTBT franchise, only five facilities are private.
[7] Characteristics are based on the definition used by the University of California, San Francisco 2012 Global Health Group which states that a *'social franchise encompasses a network of private health practitioners linked through contracts to provide socially beneficial services under a common brand.'*.
[8] Committee for Population, Planning and Children (Vietnam) and ORC Marco, 2003, Vietnam Demographic and Health Survey 2002.

Figure 1 Vietnamese political and health structure

THE A&T FRANCHISE MODEL

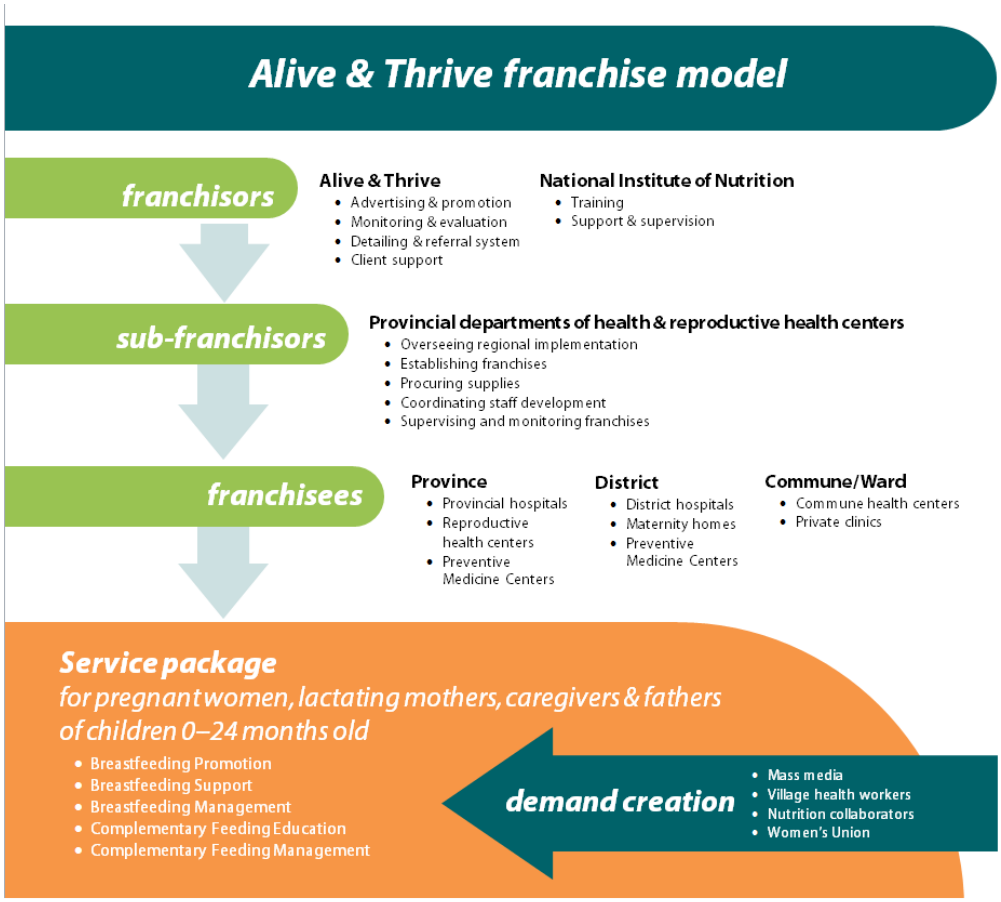
The A&T franchise model is presented in Figure 2. The brand, referred to as *Mat Troi Be Tho* (MTBT)(Little Sun), operates similarly to other franchise models and promotes the counseling space within franchised health facilities as well as the service itself. The MTBT franchise has a three-tiered management structure, presented in Table 5.

Table 5: Management structure

Management Tier	Body	Role
Franchisor (national level)	A&T and NIN	A&T: technical and support teams; NIN: technical oversight
Sub franchisor (provincial and district level)	Provincial Management Boards District Management Boards	District and facility selection; management oversight
Franchisee (facility level)	Franchise Manager	Facility and franchise service oversight

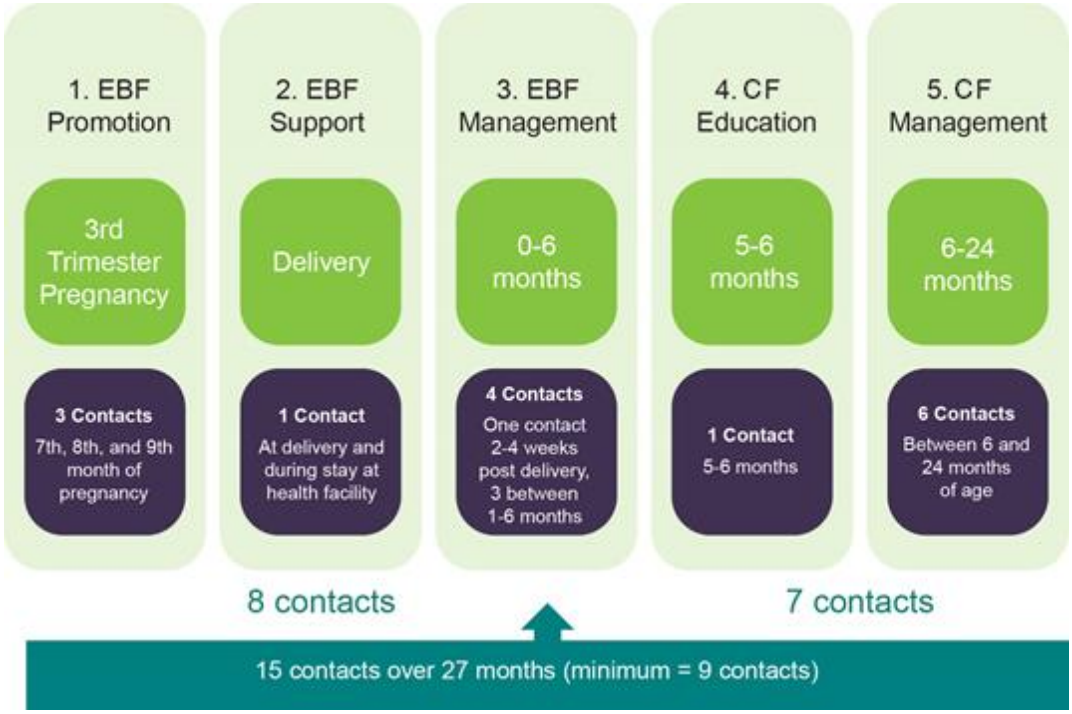
The A&T project in partnership with NIN functions as the national franchisor with overall operational oversight and authority. Franchisor roles and responsibilities are implemented regionally by selected "sub-franchisors", the Provincial and District Management Boards (PMBs and DMBs respectively). These comprise influential health authorities for the provision of guidance, support, monitoring, and supervision for districts and franchise facilities located at provincial level. Franchise services are delivered through a range of facilities operating at different levels of the health care system with the predominant focus at CHC level. The role of A&T has been to provide a standardized framework and ensure capacity to deliver services according to standardized protocols so that the brand promise is realized.

Figure 2 A&T franchise model



Unlike most social franchises which franchise clinical services, the A&T franchise promotes standardized counseling services. IYCF counseling services, designed based on A&T's formative research and through consultation with stakeholders, are divided into five major components (Figure 3).

Figure 3 A&T counseling package



A brief description of each of the five packages is provided below.

Exclusive breastfeeding (EBF) promotion package during third trimester of pregnancy provides timely and appropriate information on EBF for mothers before delivery and in the third trimester of pregnancy so mothers will:

- Know the importance of BF and believe that it is the best choice for their babies
- Know the activities that support BF and want to go to health facilities for further information as well as specific support
- Believe in their ability to exclusively breastfeed and commit to EBF
- Select an appropriate place to deliver where they will receive BF support within the first hour after delivery (including support to give colostrum)

EBF support package supports mothers to initiate BF after delivery at health facilities with the purpose of:

- Helping mothers successfully give colostrum and no pre-lacteal feeds in the first hours after delivery
- Helping mothers carry out and maintain their BF decision
- Encouraging mothers to go to health facilities for EBF management after delivery

EBF management package follows up and supports a mother to maintain EBF in the first six months with the purpose of:

- Supporting mothers in maintaining EBF as long as possible, preferably up to six months
- Making mothers aware of how to prevent common breastfeeding problems and what to do or where to find help when they occur
- Encouraging mothers to go for individual or group counseling

Complementary feeding (CF) education package provides basic information needed for mothers to introduce appropriate complementary foods at 6 months of age – not earlier, not later.

CF management package is carried out between 6-24 months postpartum so mothers will:

- Know age-appropriate CF practices
- Have skills to practice age-appropriate CF
- Know and have the skills to prepare age-appropriate complementary food
- Know appropriate foods, particularly iron-rich foods, to feed babies by age
- Practice good hygiene
- Support and encourage mothers to come for individual or group counseling that offers follow-up and support in CF

With the design of the franchise model and the IYCF counseling package, the program was ready for application. The formative phase of the program elicited a number of learnings. Some of the lessons from the A&T experience are outlined in Box 4.

Box 4. Top tip: Lessons from the formative research

One of the lessons learned was that the scope of the formative research was too broad. This delayed start up. For example, pre-testing took longer than expected. Consultation with stakeholders in the design of materials was also time consuming and caused delays. Months were spent in discussions with NIN on what standards to adopt for finalizing complementary feeding recipes, causing delay in finalization of counseling cards and leaflets.

Because of delays in development of behavior change communication (BCC) materials, which were dependent on the formative research, the full set of materials was not available for the first round of training. Trainers had to be retrained when the materials became available. Development and finalization of monitoring tools also took an exceptionally long time because of the number of stakeholders that were engaged. Consequently, franchises were launched without all of the materials and monitoring tools required to ensure the highest level of service.

A&T 'top tip': develop a task force with representatives of key stakeholders and with the mandate to turn around decisions quickly. Ensure that stakeholders understand the project objectives and agree to and work within the project workplan and timeline.

Application

Development of the franchise model followed an evolutionary path that can be divided into three major stages:

- Planning and preparation
- Start up
- Launch and delivery

Table 6 presents an overview of the three implementation stages and the key activities at each phase. The overall implementation strategy can be described as 'start up at scale'. This emphasis largely came from the donor who encouraged the three countries under the A&T project to plan and deliver at scale so that results, learning, and impact would also be generated at scale.

Table 6 Franchise steps and key interventions

Planning and preparation (2009-2010)	Start up (2011-2012)	Launch and delivery (2012 - ongoing)
Formative research (including trials of improved practices) Franchise feasibility study Consultation with stakeholders and selection of program areas Formal agreements – national, provincial, district Development of selection criteria for franchisees Development and pre-testing of the brand (logo and tag line) and development of branding guidelines Training – development of training modules, training of trainers	4-province franchise model impact evaluation baseline survey (IFPRI) 11-province mass media impact evaluation baseline survey (ISMS) Training – roll out of training for counselors, community-based workers, and managers Site selection Franchisee agreements with each facility Infrastructure development Hiring and orientation of monitoring staff and establishment of monitoring system Development of job aids and client materials Development of an interactive web site	Launch of franchisees Certification of franchisees Refresher training to address quality gaps Development of additional job aids (counseling protocol and cards) Development and roll out of demand generation plan including media promotion Development and roll out of performance-based incentive plan Target setting (quality and quantity) Strengthening of supportive supervision Benchmark franchisee performance and address performance gaps

PLANNING AND PREPARATION

The planning and preparation phase of the project involved extensive stakeholder consultation and approval at national and provincial levels. It also involved development of the franchise brand and preparation of infrastructure for the delivery of franchise services. Activities during the planning and preparation phase are described in detail below.

Stakeholder consultations: Planning and preparation included consultation with all the stakeholders outlined in Figure 1 as well as international partners active in nutrition or social franchising in Viet Nam, such as the WHO, UNICEF, and Marie Stopes International.[9] The planning and preparation phase involved a series of consensus building and planning workshops. During these workshops, consensus was developed around the social franchising model and the service delivery package. Criteria for geographic inclusion were further agreed. Based on this, 11 provinces and four cities were selected to participate in the A&T social franchise.

[9] Marie Stopes International also operates a social franchise in the public sector focused on reproductive health services.

These provinces and cities were selected as they represent seven geographical regions of Viet Nam, have large populations of children under five years of age, and stunting rates of 30 percent or more. They also had previous experience working in partnership with Save the Children and expressed willingness to partner on the A&T franchise model. Provinces and cities were given the latitude to select districts to participate in the franchise.

Government and facility approvals: Broad consensus on the model and implementation focus was followed by approvals documented through formal agreements or memorandums of understanding (MoUs) as well as detailed implementation planning workshops. MoUs were established at national level between A&T and the Ministry of Health (MoH), A&T and NIN, and A&T and the Women's Union. At sub national level, MoUs were signed between A&T and the Departments of Health (DoHs) in the selected provinces and cities. This was followed by approvals issued by the Provincial People's Committees authorizing implementation of project activities. From this point, the process was decentralized to DoHs that signed franchise agreements with districts and districts signing MoUs with individual facilities (once selected). The process of provincial approval was extremely lengthy with a two-year span between the first province issuing its approval and the last one. However, government consultation and approvals resulted in broad ownership of the franchise model as well as detailed plans for its establishment and launch.

Franchise branding: While approvals were being organized and detailed implementation plans worked out at provincial level, A&T Viet Nam set about developing the franchise brand. After testing three options for the franchise logo, tag line, and name, the name 'Mat Troi Be Tho' (MTBT) was selected as was the tag line 'nutrition today, health tomorrow'. Box 5 contains more detailed information on the brand name and image.

The core values reflected by the MTBT brand are:

- Professional
- Trustworthy
- High quality
- Functional
- Welcoming
- Child friendly

Infrastructure upgrades: Once the franchise brand and name were selected, a firm was chosen to design how the franchise facility should be laid out and to develop environmental branding guidelines, so all rooms, irrespective of facility type and location, would have the same look and feel. The MTBT franchise room, the MTBT brand, and the branded environment design are intended to create a positive experience for clients and staff. The franchise counseling room has been designed to be functional and meet clients' needs. It contains four areas (aligned with the four corners of a room) for counseling, waiting, play, and cooking demonstration. The brand is intended to increase utilization by clients, both repeat as well as prospective, increase staff morale and motivation, and inspire others to try the MTBT franchise. Figure 4 is an image of a branded franchise room.

Box 5: Franchise brand

Visual image: The beaming sun symbolizes both a blooming sunflower and a smiling child in good care. The sun represents life while the two leaves stand for nurturing hands. The overall meaning is caring for a healthy, happy child and the future generation.

Clinic name: "Mặt trời bé thơ" is synonymous with the above meaning emphasizing "child" as the prime target of the clinic. The clinic name is short and easy to remember and understand. It is highly indicative of the nature of the project as well as its target.

Tag line: "Nutrition today, health tomorrow". The slogan emphasizes the importance of appropriate nutrition for babies to create a foundation for their future development and for the future of Viet Nam.

Figure 3 Branded franchise room

At the end of the planning and preparation phase, which also coincided with the end of the second year of the project, 16 franchise orientation workshops and 13 detailed implementation planning workshops had been held. MoUs were signed and in place with the MoH, NIN, and 15 DoHs. Additionally, 13 letters of approval had been received from Provincial People's Committees, and sub-grants were in place with half of the provinces for franchise activities. Training manuals and branding guidelines were available. Master trainers had been trained and had started to roll out training in selected provinces.
The project was poised for start up at scale.

START UP AT SCALE

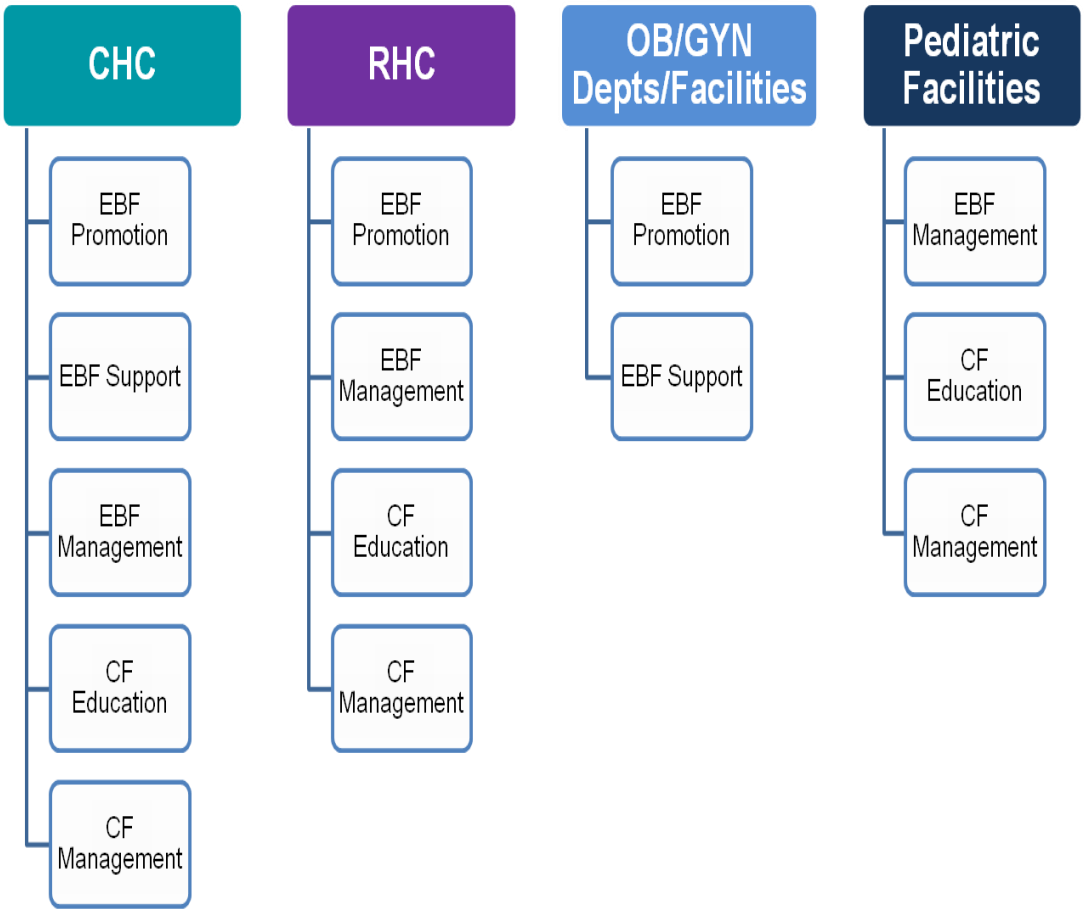
Within the 11 provinces and four cities, A&T set about to franchise 860 facilities by the end of year three of the project. This involved a rolling sequence of setup procedures supported by A&T Hanoi and its three regional offices and implemented in partnership with the PMBs. Site selection was guided by the development of clear selection criteria. Criteria were used by PMBs and DMBs to select facilities for inclusion in the MTBT franchise. Table 7 lists the selection criteria used for this purpose.

Table 7 Franchisee selection criteria

	Necessary criteria	Preferred criteria
Material, facilities, equipment	• Easily accessible, centrally located with good utilization of services • Adequate population catchment size at CHC level of > 200 • Running water and electricity available • Clean environment and well maintained infrastructure • Space available for counseling in privacy • Space available for group counseling and/or nutrition classes • Basic communications (telephone network)	• Basic cooking supplies (saucepan, pan), gas or electric cookers • Area that is or could be used as a children's play area while the mother is receiving services • Computer and internet capabilities (connect to the internet and staff that know how to use the internet) • Basic equipment such as growth chart, scale, and height boards
Human resources	• Adequate qualified staff available to delivery services to allow for at least three staff to be trained as counselors. This should include at least two midwives and one doctor. • Positive attitude of facility staff members, particularly the head of the facility, towards IYCF counseling and related support services • Facility staff functions, responsibilities and management structure are well defined • Infrequent staff turnover • Facilities with experience in managing and reporting on health projects • Network of active community-based workers (enthusiastic, experienced from the village to the commune level)	• Facility has available staff to serve a large number of clients • Facility is located in one of key communes in the National Nutrition Program (this allows for program leverage)

In each province, a range of facilities operates at different levels of the health care system within the franchise network. This is in recognition that IYCF barriers cut across socio-economic groups and settings. Not all facilities can offer all counseling services. For example, only CHCs that do deliveries can provide all five services. A reproductive health center can only provide four services because they do not do deliveries and so cannot provide EBF support. An OB/GYN hospital can only provide two services – EBF promotion and EBF Support – while pediatric facilities or pediatric departments in hospitals can provide three services. Franchisees operate as part of a larger system where clients are referred to other franchisees for services that they do not offer themselves. Figure 4 outlines the services delivered at different facilities.

Figure 4 Service delivery structure



At each facility, one franchise manager was appointed; this individual was usually the head of the facility or department depending on the facility type. At least three health workers were appointed to deliver the counseling service. At all CHC facilities, approximately 15-20 community-based workers (CBWs) were selected to promote the franchise service in the community. CBWs were selected from the pool of Nutrition Collaborators, Village Health Workers, and Women's Union members available in the communes. A profile of CBWs engaged in the MTBT franchise is provided in Box 6.

Human resources at franchisee level were supported by trained individuals in district and provincial management boards. Often these individuals performed dual functions as master trainers and supervisors.

Preparing this human resource base for delivering and managing franchise services involved training on:

- Franchise operations: 1-day training delivered to 1,500 franchise managers
- IYCF services: 5-day training delivered to 3,300 franchise counselors
- IYCF mobilization: 3-day training delivered to 15,112 CBWs

Box 6: Profile of CBWs

CBWs range in age from 18-60; half are female. They have attained either primary or secondary education. CBWs support government family planning services, promote health education, and periodically weigh children. They introduce mothers/caregivers to franchisees and share positive stories on IYCF practices in the villages they support as a result of the franchise services. The CBWs deliver invitation cards to mothers inviting them to attend an individual or group counseling session at a franchise facility on a specific day. They meet monthly with the franchise counselors. As of December 2012, A&T was working with 15,112 CBWs, each of whom had received a three-day training from A&T.

The scale of training outlined above was delivered as part of the start up of the franchises. It was not completed until mid-2012 and involved 724 training courses for almost 20,000 participants. In 2013, a second wave of three-day refresher training was conducted for 1,100 counselors delivered through 39 training courses

to address weaknesses or gaps in franchise service delivery, particularly in relation to demand creation and supportive supervision. Box 7 shows participant feedback to A&T training.

Box 7: Training and capacity building

The feedback on training has been very positive. Participants found the training to be comprehensive and of high quality. The content of the training was very engaging; participants particularly valued the use of interactive learning methods and the variety of materials. Moreover, these interactive learning methods gave trainees a deeper understanding of the key messages on IYCF. Participants liked different teaching methods (presentations, role play, discussion, etc.). They particularly enjoyed the dolls and breast model when learning about breastfeeding. Some staff said the A&T training package was the best they had received so far. Before this training course, they had received some training on nutrition and IYCF from NIN, but the course was usually short, so they did not have much time to digest and practice their new knowledge. Participants also liked the trainee handbooks provided by A&T after the training course, as they can refer to them later when they are working with the franchise.

Extracts from Alive & Thrive. *Report on the Assessment of Master Training and Roll Out Training*. Hanoi, Viet Nam: Alive & Thrive, May, 2011.

Alongside human resource capacity building, preparation of the physical space for delivering counseling services was undertaken. Again, this was a large-scale operation and consumed much of A&T regional team members' time and energy. Job aids and IEC materials were also produced. This included a set of 21 counseling cards, a mother-baby booklet, a series of four posters, and informational leaflets and invitation cards for mothers and other care givers. Job aids went through several rounds of development, pre-testing, review by all stakeholders (since they were co-branded in many cases); this process, and in particular the review, took a lot of time but has resulted in widespread ownership. Monitoring and reporting tools were also developed. The tools also went through a series of drafts and were not available at the time of training. Franchisee managers and counselors were subsequently oriented on these as sites were readied for launch.

LAUNCH AND DELIVERY

Launch: Once the human resources were trained and the franchise counseling room was prepared and branded, the facility was deemed ready for franchise launch. Launches were undertaken in waves and involved an event at the facility usually with entertainment, speeches by health officials, and local media coverage. At the end of the third program year (2011), 492 franchise sites had been launched in the public sector facilities, and pilot activities were being implemented in five private facilities. An additional 290 franchisees were launched in 2012, the fourth year of operations bringing the total to 782 franchise sites. Table 8 presents the current configuration of franchisees by province. This number may change over the remaining period of the project should the need to de-franchise sites be required. The distribution of franchisees by province is presented in Figure 5.

Table 8 Franchise coverage

Level	Number	Franchise sites	Percent coverage
Province	63	15	23%
District	649	64	9%
Commune	11,112	660	6%
Villages	93,971	7,718	8%
No. children under 2	2,755,066	214,874	8%
Total population	85,846,997	5,714,874	7%

Figure 5: Distribution of franchisees by province

Certification: Franchises were launched before they were certified. This decision was taken as the certification process would only have delayed further the delivery of franchise services. Certification involved using a 130 point checklist administered by the sub-franchisor. The checklist addresses five areas – franchise commitment, infrastructure and equipment, human resources, demand creation, reporting and compliance with the breastfeeding substitute law. Completed check-lists were submitted alongside recommendations for certification to the national franchisor (NIN and A&T) which then authorized certification based on the sub-franchisor's recommendations. Once the national franchisor gave the sub-franchisor written approval to certify the facility, the sub-franchisor signed a franchise certificate which was then displayed at the facility to signal standards compliance and high quality IYCF counseling services. This process was completed in March 2013.

Delivery: Franchise launch created interest in the franchise services but not to the extent that had been expected. Service contacts were not high in the initial months of franchise operations. There was also indication that services were not being utilized as expected. Process evaluation data from September 2012 showed that utilization rates were low and coverage was not significantly greater among those franchise facilities that had been in operation for a longer period of time. Additionally, utilization of counseling packages dropped significantly after the EBF promotion package. Utilization of franchise services among mothers with children of six months of age and older was nearly absent.

Top tip: Once franchisees are selected, attention should focus on capacity building of staff – the site manager and staff selected to provide the IYCF counseling services. Adequate demand should be generated so that counselors have enough opportunity to practice their skills and see the benefits for their clients. This can be initiated through a 'soft launch' of the site. At the end of six months, a performance review should be undertaken. In essence this would be a 'mini certification' addressing all aspects of the franchise except for the physical infrastructure. If the mini review is positive, then the site may receive infrastructural upgrades as a form of performance incentive. This can be followed by an official launch of the site through a mini event of other formal activity.

Evolution

Evolutionary challenges of the A&T franchise are presented in this section; they consider three key aspects of the franchise model:

- Provider and client behavior
- Partnership development
- Innovation at scale

These areas, while not exhaustive, direct attention to the organizational and behavioral issues that require critical attention for anyone considering replication of the model.

PROVIDER AND CLIENT BEHAVIOR – OPPORTUNITY, ABILITY, AND MOTIVATION

Once the shift from start up to service delivery was made, teams had to also be reoriented. The regional A&T teams, alongside their respective provincial and district counterparts, had been focused on logistical and capacity building requirements of franchisees for much of the start up phase, a period that lasted almost two years. Once franchises were launched, attention was drawn to quality of service delivery and reporting. It became clear post franchise launch that quality of counseling was variable and depended to a large extent on health worker motivation, personal attributes, and competing priorities. Sub-franchisors and A&T personnel revealed that they had broader concerns with the franchise operations including lack of demand for services, limited productivity of franchisees, and lack of incentives, particularly for CBWs.

A franchise review conducted in May/June 2012 was commissioned to look at the franchise model and identify areas for improvement. This review introduced a simple behavioral framework for analyzing performance barriers. The framework considered the opportunity, ability, and motivation (OAM) of franchise personnel – managers and counselors – to provide the IYCF service package according to its design. OAM requires that franchisee personnel understand what is expected of them, have the requisite knowledge and skills to deliver the service package, and have the motivation and time to do so.

Facilitating opportunity, ability, and motivation of providers is an integral feature of social franchising. In private sector social franchising, providers are motivated through increased profit, visibility through improved reputation and brand recognition, and achievement of public health goals. Public sector franchising has fewer tangible motivators. Health workers in the public sector may not be motivated by increased client flow without the realization of any reward (in whatever form) for their additional effort.

The review concluded that franchisee performance was not aligned with staff and facility performance reviews, reward systems, or promotional opportunities. Similarly, staff did not have the 'opportunity' to deliver services due to low demand for the IYCF services, competing priorities, and heavy workloads (the latter was mainly a feature of higher level facilities). A&T had been preoccupied with the 'ability' part of the 'OAM' equation without giving due attention to other barriers to service delivery. An A&T team member comment at the time encapsulated this pre-occupation: *'If we improve quality, the women will come'*. There were concerns expressed that enthusiasm of being part of the franchise might wane over time if 'OAM' was not addressed. As an outcome of the review, attention expanded beyond quality to consider:

- Target setting so that productivity expectations are clearly communicated and understood
- Demand generation at commune, facility, district, provincial and national levels
- Performance-based incentives to incentivize facilities and individuals delivering IYCF services
- Supportive supervision to address quality as well as productivity

Guidelines and capacity building were re-drawn to consider these elements. This remains a focal area of support for franchise operations in years 5 and 6 of the project.

STAKEHOLDER ENGAGEMENT – FORMING, STORMING, NORMING, PERFORMING

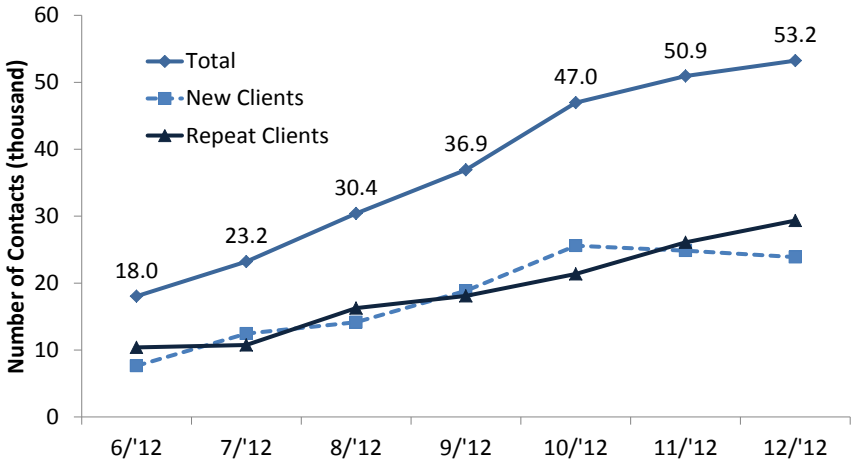
At the partnership "forming stage," selected provinces and cities saw the franchise as an opportunity to improve IYCF and reduce stunting and malnutrition. Management boards were formed at district and provincial levels. These entities have maintained close contact with A&T regional offices; however, the level of engagement differs across the provinces/cities.

Post launch, a "storming phase" was apparent between management boards and A&T, especially in relation to financial incentives, a topic that dominated stakeholder consultations during the period of the franchise review. Despite precedents being set by other programs, notably NIN's work with Nutrition Collaborators and Marie Stopes International's public sector franchise, A&T management remained steadfast and did not pursue a financial incentive scheme that could not be sustained. From a practical standpoint, the scale of operations simply made this unviable. Performance has continued to increase despite the lack of a financial incentive system. Other, more sustainable, incentives have been provided in lieu of financial incentives. These include mechanisms to recognize good performance, the provision of additional equipment, and peer interaction opportunities.

The "norming stage" involved the integration of the franchise model into the provincial plans of some management boards. For example, one province printed the franchise logo onto staff uniforms. Another province bought additional job aids, such as dolls and food demonstration items. Most provinces have adopted the training materials and job aids for non franchise districts and facilities and have trained non franchise staff on the same. Widespread adoption of elements of the A&T franchise model at provincial level may create the impetus for their integration into national strategies, plans, and budgets.

The "performing phase" shows steady improvement in both new and repeat clients as seen from data collected in June 2012 and presented in Figure 6. At that time, most franchises had been launched and were providing regular monthly reports.

Figure 6 Number of counseling contacts (thousand) by month, June 2012



INHERENT CHALLENGES WITH INNOVATION AT SCALE

Some of the 'dynamics' of the social franchising model have been eroded due to the scale and time required to set up the A&T franchise. Franchise start-up involved implementation 'waves' to advance the model in fifteen provinces and cities simultaneously. The initial wave involved agreements with DoH and planning workshops; a second wave involved formative research to develop the service package, brand, and IEC materials; and a third wave included the identification of franchisees, infrastructure setup, and training. More recent waves have focused on the launch of franchisees and support for service uptake through efforts to define targets, increase demand, and improve performance. While there is nothing inherently wrong with this sequence, the amount of time required for each wave, given the scale of operations, has resulted in sequential implementation of what should be interdependent components. This has sometimes meant that supply and demand functions have not been adequately addressed in a mutually-reinforcing manner.

The novelty of the A&T IYCF counseling service, previously unknown by providers or clients alike, has also added to the time required to establish the franchise and gauge its effect. Social franchising typically is applied to socially beneficial services *known* to providers and clients. In the case of A&T, service novelty has been combined with service delivery through a novel public sector franchise model. Both are relatively untested concepts. The original feasibility study had recommended a 'design and development phase' under which *'a limited number of franchisees would be developed over a defined period of time (e.g. six months) to test and refine the franchise systems before expanding nationally.'*[10] This phase was replaced with start-up at scale. The learning sequence did not allow opportunity to pilot (the exception being the trials of improved practices), adapt, and then replicate. Any adaptations – or mid-course corrections – were also made at scale. Delivering innovation at scale may have delayed the launch and delivery phase of the project reducing the timescale available for delivering franchise services.

[10] Alive & Thrive. *Franchise Feasibility Study.* Hanoi, Viet Nam: Alive & Thrive, September, 2009.

Conclusion

Implementation of the A&T franchise model in Viet Nam has not been without its challenges. The primary challenges have centered on the novelty of the franchise innovation, the scale of its delivery, and more process-oriented issues related to stakeholder buy-in and support. Despite inherent challenges, the social franchise model has reinvigorated interest in tackling the 'last nutrition mile' in Vet Nam and has galvanized national and provincial support for addressing intractable stunting rates and focusing on the window of opportunity in the first 1,000 days. As the social franchise is embedded within the Vietnamese health structure and given the level of effort undertaken by A&T to ensure national ownership, there are positive indications that the social franchise model can be sustained after the project ends.

Annex 1: Franchise Tool Kit

Set-Up

Document	Summary
Alive & Thrive. Mat Troi Be Tho Logo, Materials and Merchandise for IYCF Franchises. **Hanoi, Viet Nam: Alive & Thrive, 2010.**	A characteristic of a franchise is an easily identifiable brand. The branding guidelines ensure appropriate use of the logo and tag line in all forms of communications.
Alive & Thrive. Mat Troi Be Tho Room & Spaces: Environmental Branding Guidelines for IYCF Franchises. **Hanoi, Viet Nam: Alive & Thrive, 2011.**	This document provides detailed information on the Mat Troi Be Tho (MTBT) environmental branding guidelines including instructions for setting up the MTBT counseling room in a franchise facility with various options and configurations for a range of facility types.
Alive & Thrive. Mat Troi Be Tho Certification Scorecard for IYCF franchises. **Hanoi, Viet Nam: Alive & Thrive. 2013**	The certification scorecard outlines all of the criteria that must be met in order for a franchise to be certified. Certification signals standards compliance and high quality IYCF counseling services.

Capacity Building

Document	Summary
Alive & Thrive. Mat Troi Be Tho Trainer Manual 1: Management and operation of the IYCF franchise model. **Hanoi, Viet Nam: Alive & Thrive, 2011.**	This training manual is designed for use by provincial trainers to enhance capacity on IYCF franchise management for franchise managers and staff who are working at identified health facilities to provide franchise services. It provides an overview of social franchising and the IYCF franchise model. It then describes the IYCF service packages, BCC and demand generation, operational procedures, monitoring and supportive supervision as well as an overview of Decree 21.
Alive & Thrive. Mat Troi Be Tho Trainer Manual 2: Counseling on IYCF at a health facility. **Hanoi, Viet Nam: Alive & Thrive, 2011.**	Training Manual 2 is used by provincial trainers to prepare health-facility workers on IYCF counseling. This manual offers an overview of IYCF, nutrition and health care for pregnant women and lactating mothers, breastfeeding, complementary feeding, hygiene, and child feeding during illness. The manual's principal purpose is to provide essential counseling and communication skills for trainers at a provincial level so that they, in turn, can provide the updated information and necessary skills to health workers who are responsible for the direct provision of IYCF counseling services at health facilities.
Alive & Thrive. Mat Troi Be Tho Trainer Manual 3: BCC on IYCF at community (franchise model). **Hanoi, Viet Nam: Alive & Thrive, 2011.**	This manual is designed for use by district trainers to enhance the capacity of community-based workers (CBWs) on IYCF within provinces where the IYCF social franchise models will be implemented. Trainers can apply the interactive training methods included in this manual or creatively adjust sections in accordance with trainees' education level, demands, and cultural characteristics. The manual contains an overview of IYCF, the A&T project, and the franchise model; BCC on IYCF in the community; and technical content on IYCF applicable to CBWs.
Alive & Thrive. Mat Troi Be Tho Trainee Handbook 1: Management	This is the accompanying handbook to the Training Manual 1 and is given to training participants. It provides participants with reference materials on social franchising and the IYCF franchise model. It also

***and operation of the IYCF franchise model*.** **Hanoi, Viet Nam: Alive & Thrive, 2011.**	contains information and tools for IYCF service packages, behavior change communication and demand generation, operational procedures, monitoring and supportive supervision as well as an overview of Decree 21
Alive & Thrive. Mat Troi Be Tho Trainee Handbook 2: Counseling on IYCF at a health facility. **Hanoi, Viet Nam: Alive & Thrive.**	This is the accompanying handbook to the Training Manual 2 and is given to training participants. The handbook contains reference materials on IYCF, nutrition and health care for pregnant women and lactating mothers, hygiene, child feeding during illness, and counseling and communication skills.
Alive & Thrive. Mat Troi Be Tho Trainee Handbook 3: BCC on IYCF at community (franchise model). **Hanoi, Viet Nam: Alive & Thrive, 2011.**	This is the accompanying handbook to the Training Manual 3 and is given to training participants. The handbook contains reference materials on IYCF, the A&T project, the franchise model; and behavior change communication on IYCF in the community.

Implementation

Document	Summary
Alive & Thrive. Mat Troi Be Tho Franchise Monitoring and Reporting Manual **Hanoi, Viet Nam: Alive & Thrive, 2013.**	The manual describes the data collected at the franchises and how they are aggregated and reported from individual franchises to district, provincial, and central levels. The manual includes the forms used at each level of the system, instructions for completing each form, and information about how data from each form are compiled into reports and shared from one level to the next.
Alive & Thrive. Mat Troi Be Tho Franchisor Manual: Standards and Procedures for Selecting, Developing, and Managing Franchisees to Improve Infant and Young Child Feeding. **Hanoi, Viet Nam: Alive & Thrive, October 2013.**	The manual includes an overview of the nutrition situation in Viet Nam, gives a detailed description of infant and young child feeding services delivered through the franchise model, outlines selection and development procedures for franchisees, performance management, demand generation and, finally, monitoring and evaluation. The manual is intended for franchise managers at national, provincial, and district levels and can serve as a resource for those considering replication of the model.
Alive & Thrive. Mat Troi Be Tho Franchisee Manual: Standards and Procedures for Managing Franchisee Operations to Improve Infant and Young Child Feeding. **Hanoi, Viet Nam: Alive & Thrive, October 2013.**	The manual is intended for facility managers and counselors that are operating the infant and young child feeding (IIYCF) counseling franchisees. It presents the nutrition situation in Viet Nam and describes the structure of the IYCF franchise and service package, franchisee development procedures, franchisee performance management, franchisee demand generation, and franchisee monitoring and evaluation. The manual complements the more detailed franchisor manual.

Job Aids

Document	Summary
Alive & Thrive. Mat Troi Be Tho Supportive Supervision Protocol and Checklist for IYCF franchises. **Hanoi, Viet Nam: Alive & Thrive, 2013**	The document outlines the objectives of supportive supervision and includes the protocol follow the checklist to be used during supervisory visits to a Mai Troi BeTho the franchise.
Infant and Young Child Feeding counseling cards. **Hanoi, Viet Nam: Alive & Thrive, 2012.**	A set of 21 counseling cards enable health workers to counsel mothers and other caregivers about IYCF. Specific cards are used to facilitate the delivery of messages for each of 15 defined counseling sessions over a 27 month period, from the third trimester of pregnancy through to two years of age.

Annex 2: Timeline