



Reproductive health services: “Business-in-a-Box” as a model social innovation

Abdur Rehman Cheema & Abid Mehmood

To cite this article: Abdur Rehman Cheema & Abid Mehmood (2018): Reproductive health services: “Business-in-a-Box” as a model social innovation, *Development in Practice*, DOI: [10.1080/09614524.2018.1541166](https://doi.org/10.1080/09614524.2018.1541166)

To link to this article: <https://doi.org/10.1080/09614524.2018.1541166>



© 2018 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group



Published online: 07 Nov 2018.



Submit your article to this journal [↗](#)



Article views: 244



View Crossmark data [↗](#)

Reproductive health services: “Business-in-a-Box” as a model social innovation

Abdur Rehman Cheema  and Abid Mehmood 

ABSTRACT

Access to reproductive health services and products in remote and rural communities is a critical area of concern for developing countries. This article considers a pilot intervention in three districts of Pakistan where “Business-in-a-Box” as a model of place-based social innovation is used to improve the socio-economic conditions of women in remote rural settings through socially responsible micro-franchising. It finds that such programmes help build a sense of community, ownership and grassroots capabilities and skills. The article also discusses the impacts of such actions on the individual and community life, and the need to upscale and sustain these initiatives.

ARTICLE HISTORY

Received 11 November 2017
Accepted 13 August 2018

KEYWORDS

Aid – Development policies;
Civil society – NGOs,
Partnership, Participation
Gender and diversity; Social
sector – HIV/AIDS and sexual
health, Health; South Asia

Introduction: the challenge of reproductive health services

Of the eight Millennium Development Goals (MDGs) established with a global focus on reducing extreme poverty at the turn of the century, MDG 5 aimed to reduce maternal mortality ratios by three-quarters between 1999 and 2015 (United Nations 2000). However, South Asian countries in particular struggled with improving reproductive health as the maternal mortality rate only dropped 64%, missing the target (Aasen 2011; United Nations 2015). A World Bank study attributed this to the lack of skilled birth attendants, early marriages, high pregnancy rates, low contraceptive prevalence rate, and inequity in access to maternal health due to gender and income inequality (El-Saharty et al. 2014). As a successor to the MDGs, the Sustainable Development Goals (SDGs) have set wider, less quantified but more ambitious targets and objectives, with a particular focus on policy and governance. SDG 3 calls for ensuring “universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes” by 2030 (United Nations 2015). Accordingly, everyone should have access to a high standard of health services. This goal, however, can only be accomplished through adequate primary healthcare systems that cater to all individuals of reproductive ages irrespective of their marital status or socio-economic background, and have widespread coverage and more attention to communities in remote and rural areas (Scheil-Adlung 2015).

A key challenge for reproductive health services in many developing countries is to reach the underserved populations that reside in rural and remote areas, such as in South Asia where rural inhabitants are 67% of the total population (World Bank 2014). South Asia also has the second highest rate of maternal mortality (MMR), behind sub-Saharan Africa. On average, there are around 190 deaths per 100,000 live births in the region. Afghanistan has the highest MMR in South Asia at 400, followed by India and Nepal at 190, and Pakistan at 170, whereas Sri Lanka and the Maldives have the lowest rates, at 29 and 31 respectively (El-Saharty et al. 2014). Even though the contraceptive prevalence rate has recorded a sharp increase throughout the region in the

CONTACT Abdur Rehman Cheema  arehmancheema@gmail.com

© 2018 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group
This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

recent past, there are still high levels of unfulfilled social, economic and healthcare needs. The contraceptive prevalence rate is highest in Maldives (28.1%), followed by Nepal (27%) and Pakistan (20.1%), and lowest in Sri Lanka (7.3%) (El-Saharty et al. 2014).

The structure and procedures of public health provision in South Asian countries are very weak and often exclude poorer, remote and rural areas (Haider and Mukherjee 2010). The population in these areas mostly have either no or limited access to reproductive health services, leaving an enormous gap between demand and supply. Private sector (formal and informal) reproductive health service providers only partially fill this gap, leaving a huge unmet demand. Even when private health services are made affordable to the poor, the standards and quality of services remain questionable in the light of weak health regulations (McDonald and Ruiters 2012). More challenging is the fact that due to a lack of awareness about the availability of maternal and reproductive health services in remote and rural areas, their utilisation remains negligible. Therefore, many reproductive health interventions face the crucial task of raising awareness about birth spacing, control and other healthy options (Cheema and Malik 2016). Non-governmental reproductive health interventions funded by international and national development agencies have been partly successful in awareness raising, meeting needs and ensuring access to reproductive health services in deprived, remote and rural areas (Huff-Rousselle and Pickering 2001).

However, these NGOs have to confront some significant barriers (Dawn and Kishore 2016). First, there is opposition from local communities where reproductive health remains a cultural taboo, especially in contraceptive methods. Then there are issues of norms, values and practices. Social norms and religious interpretations strongly influence the use of different contraceptive methods. For example, in many rural parts of Pakistan, the prevailing notion is that contraceptives are unacceptable on religious grounds. The women in these areas who do wish to stop childbearing via contraception are unable to access or interact with the product and service providers due to pressures from husbands and family (Ali and Ushijima 2005). Therefore, without increasing the acceptance and changing the attitudes and behaviours of households and communities, reproductive health interventions fail to avail the desired results. This can also be attributed to a general lack of innovation by the NGOs when addressing the problems faced by women in rural communities. Finally, there is a general concern for the maintenance of interventions beyond the project or funding life. In most cases, development interventions and outcomes end with the conclusion of external support. In recent years, some international and local NGOs have begun fostering self-sustaining mechanisms to deliver reproductive health services in areas not accessible to the public health sector (BRAC 2011). Yet, long-term sustainability in terms of funding, continuation, and management of such initiatives remains a major concern (Mehmood 2016).

Looking at these challenges and barriers in relation to gender and income inequality, maternal health and contraceptive provision, and socio-economic hurdles faced by individuals and institutions that strive to provide such services in the remote and rural areas, this study aims to address the following questions: What kind of approach can help with the support and provision of reproductive health services in remote, rural and deprived neighbourhoods and communities? How can such approach be made “socially responsible” on part of the service providers in order to help fulfil the public health needs while promoting individual (women) and collective (family) well-being? What roles can such initiatives play in the lives of the actors and stakeholders concerned?

To answer these questions, we refer to “Business-in-a-Box” (BiB) as a model of social innovation for providing basic reproductive health products and services in remote and rural areas in Pakistan, from two main perspectives. First, the provision of socially responsible micro-franchising to promote micro-entrepreneurship by the NGOs and large organisations; and second, use of community-based initiatives by public bodies and institutions to support grassroots capabilities and skills for longer-term sustainability of health-related initiatives at large. The collaborative and community-based approach has often been used in resource conservation and disaster management (Marshall 2009; Mwakaje et al. 2013). Here, we expand it to the role of social capital and stakeholder engagement in planning and decision-making for providing reproductive health services and promoting

socially responsible entrepreneurship. The article looks at the importance of micro-franchising for improving reproductive health, drawing on examples from South Asia about experiments in micro-entrepreneurship and micro-franchising to address the challenges of gender and income inequality, maternal health and contraceptive provision.

The study was conducted in three rural districts in Pakistan to look at the impact of a pilot programme for improving reproductive health while helping the women volunteers to establish their own micro-businesses. The research results indicate how a combination of socially responsible micro-franchising (such as BiB) along with village health communities as units of community-based structures has been more successful than the many other government-funded public health programmes. This indicates the need to incorporate approaches to social innovation in order to meet social, economic and health needs of the communities whilst promoting gender equality and improving social relations within and between the communities.

Micro-entrepreneurship for improving reproductive health

A microenterprise is often categorised as a business with less than five employees (Maloney 2004). However, the term can be misleading as in many developing economies such businesses are run on a self-employed or part-time individual basis, largely in an informal manner with little resemblance to an organised business enterprise (Hipsher 2010; Naz and Bogenhold 2016). Still, Munoz considers microenterprise as the core of the business evolution since the model is “... built on practical and time-tested approaches. In recent years, microenterprises have survived and even flourished in the toughest economic situations” (Munoz 2010, 1). Street vendors and traders can be considered typical forms of microbusinesses that try to reap maximum benefits from limited resources, competencies and skills, often providing incubators for a new industry in the postmodern world (Cross 2000). They can make use of their social networks and personal traits to market and profitably sell their products and services. High mobility aspects help micro-entrepreneurs to flexibly access their customers and respond to specific needs. There is no surprise then that such businesses tend to thrive in remote, rural and deprived areas and neighbourhoods.

Understandably, micro-entrepreneurs face a variety of challenges in making ends meet and fulfilling their needs as well as those of their customers. Two key challenges are the informality of the sector and access to capital. The unregulated, unprotected and self-employed nature and perception of an informal (micro)business leave it vulnerable to economic fluctuations. Microcredit and microfinance provisions are offered as a panacea to help women establish micro-businesses through the credit spiral. Nevertheless, most microcredit models have been criticised for being unable to contribute to micro-savings or lifting rural women out of the poverty trap as much of the trade credit ends up being spent by families in meeting their own basic needs (Bond 2007).

As an alternative, the business approach to micro-franchising has been successfully implemented in various developing economies (Thieme 2015; Webb and Fairbourne 2016). It addresses these two challenges by applying a systematic process of formal franchising in an informal micro-entrepreneurial setting to help sell low-cost services and products (Evans 2013). As a “development franchising” approach it provides the basic infrastructure (credit lending for inventory, access to formal supply chains, and branding) to promote micro-entrepreneurship through scaling up, building skills, and adding into value chains. It can be termed a form of social innovation (Smith and Seawright 2015) when coupled with a strong social objective to protect people at the bottom end of the economic ladder from the credit spiral and help them with some savings (Mehmood, Jamal, and Sriram 2015). A downside of the franchising model is the attachment with particular brands, suppliers or product providers. We argue that in order to be truly socially innovative franchisees should be empowered to adjust their business value and supply chains in accordance with community needs. In the following, we explore examples of integrating women’s micro-entrepreneurship initiatives with micro-franchising for healthcare provision.

Building Resources Across Community (BRAC) is widely known for initiating the first programme that, besides other initiatives, successfully adopted a self-sustaining approach to the provision of health services in rural neighbourhoods in Bangladesh (BRAC 2011). Female volunteers were trained as community health promoters (CHPs) to sell essential healthcare products and services including reproductive health commodities and contraceptives within their communities. Having community-based volunteers helped reducing local resistance and ensured easier household access. During the project tenure, CHPs were remunerated through a monthly honorarium, a small monthly salary from the project, besides other cash incentives on the sale of medicines. These financial incentives were useful in motivating and retaining the CHPs once they were trained. However, once the project concluded, funding finished and financial incentives withdrawn, there was little motivation left for the CHPs. Realising this, BRAC advocated the business-in-a-box approach through micro-franchising (BRAC 2011). Based on their experience of micro-franchising and value-chain management in agricultural services (Abed et al. 2011) BRAC applied similar principles in providing healthcare through a sustainable business model for the CHPs to help them become self-employed micro-entrepreneurs and earn decent incomes delivering products and services for the benefit of the community. BRAC provided branding, inventory and training to the micro-franchisees, who then supplied products to their clients in selected villages. Branding remained a key element in the process as the products offered to the CHPs were produced by and carried the BRAC brand name. BRAC also collaborated with another NGO, “LivingGoods” in Uganda where female CHPs’ selection was based on their strong social networks and social capital to spread health awareness alongside building their microbusinesses. The CHPs received a health kit containing preventive medications and hygiene and reproductive health products and basic advice for their customers (LivingGoods 2016).

Another example of micro-franchising by large multinational enterprises is “Project Shakti” by Hindustan Unilever Limited. Initiated in 1999, female micro-franchisees, largely selected from poor illiterate and rural backgrounds, were trained in basic accounting and sales skills, health and hygiene to sell health-related products door-to-door (Xavier, Raja, and Nandhini 2007). By 2005, the project had expanded to 50,000 villages in 13 states with about 13,000 women serving nearly 15 million people in rural India, boosting corporate sales by 17% (Shah 2016). While the socio-economic benefits of this micro-franchising model cannot be ignored, it remains an aspect of rural marketing and fulfilment of corporate social responsibility primarily focused on increasing sales rather than maternal or community well-being. In 2010, the micro-franchisee base was extended to the spouses and male siblings of the female micro-entrepreneurs to approach more customers and increase product sales (Hindustan Unilever Limited 2016). However, in the cases of both BRAC and Hindustan Unilever, the approach appears quite top-down with minimal or no efforts to empower the women to play a wider role in community development.

Business-in-a-Box (BiB) as a social innovation

Moulaert, MacCallum, and Hamdouch (2013) relate social innovation for human and community development to three key aspects: satisfaction of basic human needs; improving social relations; and socio-political empowerment. The BiB model follows this definition. According to Pakistan Demographic Health Survey 2012–13, the contraceptive prevalence rate in Pakistan is only 35% (26% modern methods and 9% traditional methods). The current unmet need for family planning is 20%, and is higher in deprived, remote and rural areas. To overcome the deficit in fulfilling maternal and reproductive health provision a pilot project was launched in three rural districts of Punjab. The project was initiated by Rural Support Programmes Network (RSPN) in partnership with Population Services International (PSI) and implemented through the National Rural Support Programme (NRSP) and Punjab Rural Support Programme (PRSP). The first phase of the project took place between April 2013 and 2015, with the second phase between April 2015 and June 2016. The project’s primary aims were to reduce maternal mortality rates (MMR) and infant mortality rates (IMR) by increasing contraceptive prevalence rate and providing maternal health products and services

in the three districts, alongside promoting female micro-entrepreneurship through micro-franchising. This study looked only at the BiB intervention as means of post-project sustainability for socially responsible female micro-entrepreneurship and did not assess impacts on MMR and IMR.

The project introduced more than 600 women to the concept of social microenterprise. Of these, 450 chose to pursue the course and were subsequently trained as community resource persons (CRP) to assess community needs and market potential for health-related products, and sell products through household visits. Each CRP was given a BiB kit: a shoulder bag with products that included daily household usage goods, health and hygiene commodities and short-term contraceptive items. As informal micro-entrepreneurs, CRPs had the choice of including additional items of interest and relevance to their customers.

A micro-franchise supply chain was established to ensure the regular provision of BiB products and help the women establish their microenterprises to meet the needs of the community. Union Councils, as the lowest tier of administration in Pakistan, were involved in the procurement of BiB items based on the CRPs' requirements. These demands were conveyed through Village Health Committees (VHC) established under the pilot project. Fresh supplies were made available at the VHCs for collection and sales by the CRPs. Each CRP was to reach 300 married women of reproductive age in her area through BiB. [Figure 1](#) shows the place-based supply chain, starting from Union Council Health Committees (UCHC) to CRPs.

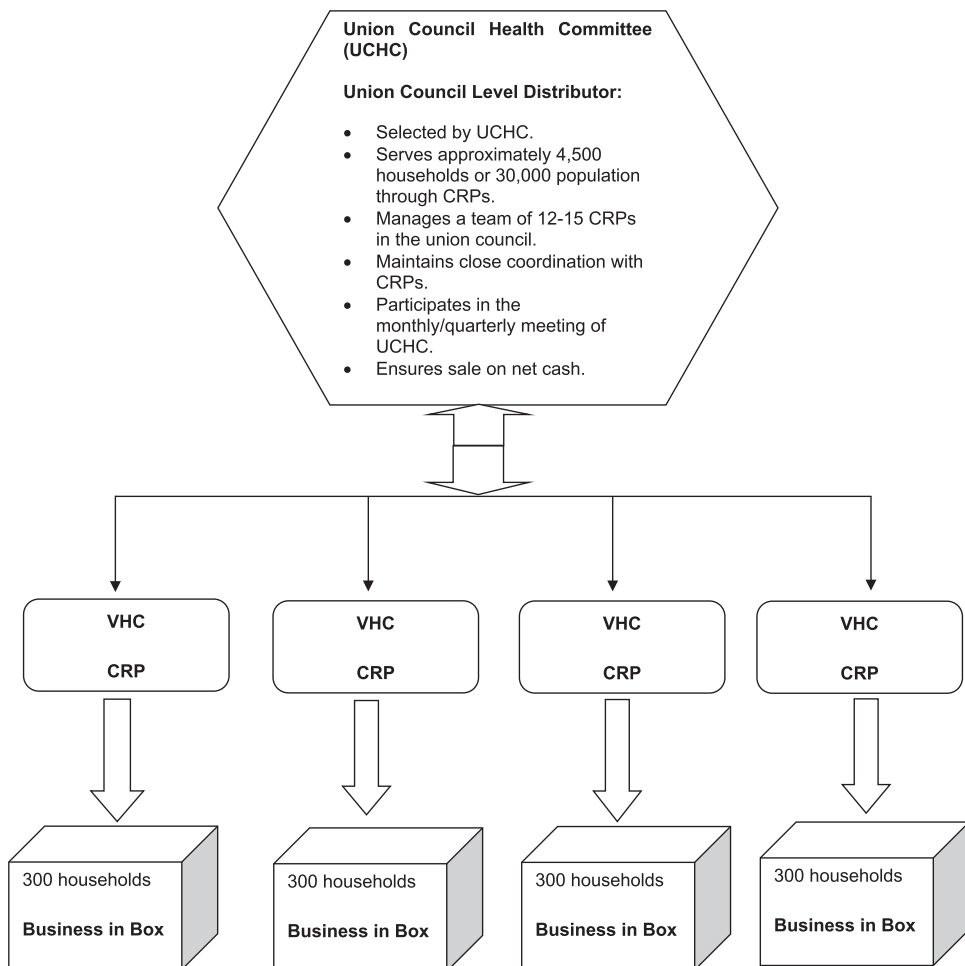


Figure 1. BiB supply chain at union council level.

Research methods and objectives

The study was primarily designed to evaluate the intervention of BiB as a means of short-term family planning methods continuing to be a source of stable income for CRPs even after the pilot project's end. It focused on the post-project sustainability for socially responsible female micro-entrepreneurship, as well as establishing long-term demand-side and supply-side collaborations based on micro-franchise between these entrepreneurs, their communities and relevant institutions. The study was conducted in all three project locations (Bahawalpur, Jhang and Rahim Yar Khan) in Punjab, the most populous province of Pakistan. The process aimed to gather information from the CRPs who were given BiB kits as well as community members from the areas covered by CRPs. A structured questionnaire was used with CRPs, and a different set of open-ended and semi-structured questions developed for focus group discussions with individual BiB beneficiaries and representatives of VHCs as key stakeholders in the areas that benefitted from the pilot programme.

A sample of 45 CRPs were selected as 10% of the cohort, with 15 CRPs from each programme district. Focus group discussions were held in Bahawalpur and Rahim Yar Khan, with each group comprising 10-12 community members. In Jhang, eight interviews were conducted with individual beneficiaries. Moreover, three separate focus group discussions (one in each district) were held with VHCs. The selection process of CRPs for interviews was:

Step 1: List all members of CRP cohort that were given BiB kit, with their monthly profit of the previous month (i.e. December 2015);

Step 2: Divide the CRPs into three categories: top performers, average performers and low performers, on the basis of the profits earned from sales in December 2015;

Step 3: Using systematic sampling, the top five and bottom five names of CRPs were selected on the basis of their performance and profits earned on monthly basis. In addition, five average performing CRPs were selected by using convenience random sampling, due to a high number of CRPs in this category.

Step 4: Steps 1-3 were repeated in each district and an equal number of CRPs selected from each district.

The selected CRPs represented all districts where the project was implemented. [Table 1](#) shows the breakdown by place.

Data were collected by two female members who worked independently as a team in the field, under the supportive supervision of the lead author and other senior staff, through field visits between January and March 2016. Before conducting interviews and focus groups, all participants were briefed about the study, their willingness to participate in the research based on the selection criteria, and right to refuse any question or not to participate. Willing respondents' answers were recorded. All focus group participants were encouraged to speak during the discussion. Respondents' answers were recorded on questionnaires during the interviews, and field diaries were maintained during the focus group discussions. Pseudonyms were used to protect the privacy of participants.

Key findings and analysis

The pilot project followed the model of organising and mobilising local communities into small committees as key actors and stakeholders such as VHCs. The VHCs served as mediators for social acceptability and support of the project and were sufficiently empowered to take collective actions, especially when negotiating with public and private institutions (such as District and Union Councils, NGOs and trade suppliers). The VHCs in each district were formed of ten prominent male and female community members with the required sets of skills, who subsequently nominated CRPs from within the communities. After training, the CRPs were assigned to first register all married women of reproductive ages in their designated geographic coverage areas. Through regular monthly visits, the CRPs conveyed information on birth spacing and contraceptive methods, advised and counselled on the use of government's facilities, and referred potential beneficiaries to the "Lady Health Visitor" camps

Table 1. Sample selection for community resource persons.

Union councils from Bahawalpur district	No of respondents
24 BC	1
Ali Kharrak	4
Jalalabad	4
Jamrani Kohna	3
Mari Shaikh Shajran	3
Union Councils from Jhang District	15
Chak 446	1
Haveli Laal	1
Kot Lakhnana	3
Maluwand	1
SCH	1
Shah Sadiq Nahang	5
Sheikh Chauhar	2
Sultanpur	1
Union Councils from Rahim Yar Khan District	15
B.P.Q	1
Badli Shareef	2
Mau Mubarak	2
Mian wali Sheikhan	2
M. Pur Lama	1
Ranjhay Khan	1
Rasool pur	1
Shahpur	3
Sonak	2
Grand total	45

organised by the programme. During the household visits, CRPs acted as informal and non-traditional service providers to sell short-term contraceptive procedures that they purchased from project-organised suppliers.

The micro-franchising part of the project combined the elements of social responsibility and micro-entrepreneurship, named Business-in-a-Box (BiB). Initially, 600 CRPs were trained to serve a population of 900,000 spread over various villages in the three districts. A monthly honorarium of PKR1000 (about US\$10) was offered as a financial incentive to these women. In order to sustain the initiative beyond the project's life, 450 CRPs (out of total 600) were given BiB kits to kick-start their own microbusinesses.

Each BiB kit initially contained commodities worth PKR3000 (US\$30) as seed cost. The basic inventory included short-term contraceptives (condoms and pills), health and hygiene commodities (folic acid, iodised salt, sanitary napkins, iron, zinc and vitamin A supplements, shampoo, toothpaste, pregnancy strips) and over the counter medicines (such as aspirin, paracetamol, oral rehydration solution). CRPs were trained on social marketing, sales and entrepreneurship, and to identify the demand for these products and other maternal and reproductive health needs of the community so that they could continue their microbusinesses in the longer term. It was anticipated that the profit earned would replace the CRPs' honorarium after the project ended. This approach differs from traditional micro-franchising models in that once the CRP was given a BiB kit, she could use her discretion in buying a new and wider range of products, therefore allowing flexibility in the type of products and services to provide. The only compulsory category of products to be included was short-term contraceptives. However, the anticipation proved too ambitious.

The study showed that 35 (78%) of CRPs were successful in selling all BiB products. These CRPs continued topping up the inventory, adding new items to the initial BiB kit as demanded by these customers to meet their everyday consumption and usage needs. About 15 (33%) of CRPs established their own microbusiness, setting up small shops in their homes which they could operate 24/7, alongside their monthly household visits. One interviewee, Asma (24-year-old CRP from Bahawalpur), said that most of her clients were happy with the visits as they did not need to leave their houses since the items were available from the CRPs who lived nearby. According to her: *"my profit is gradually increasing over the last four months from 200 to 500 rupees per month. I am empowered and I am less*

dependent on others as I have my own business now". This reflects a consensus among CRPs around their increased mobility, higher income, and broadening of everyday choices and decision-making in a patriarchal environment.

Although direct links were set up via the programme between specific vendors and CRPs to facilitate the supply chain, the study also revealed that 31 (68%) CRPs went to the market by themselves (or with a male member of the family) to purchase BiB-related products. They established their own procurement mechanisms with local shopkeepers on mutually beneficial terms and often received wholesale or bulk-buying discounts. This saved them at least 6% on the charges paid to the project-supported intermediaries. *"BiB helped me in making my own way, I can now finance my own education and expenses, I don't need to depend on anyone"* said 23-year-old Sharifa (CRP from Bahawalpur). Similarly, it has also not stopped 25-year-old Sadia from Rahim Yar Khan, who has a physical disability, from introducing contraceptive products to nearly 90 new clients: *"I wanted to be independent but I could not study as I couldn't walk to my school, an hour's walk away. Though I have a foot abnormality, I am standing on my own feet now"*. One key aspect of BiB is accessibility, as people do not have to travel long distances to purchase staple items. As one client described.

it takes us 30 minutes on a motorbike and one hour by rickshaw and costs 100 rupees to buy health and hygiene items from Sadiqabad [the nearest town]. Before Sadia, we had to wait for one of the male members of the family to take us to Sadiqabad. Now it is easier to buy them from Sadia in our neighbourhood. She is also flexible with payments.

In some cases, male family members were initially reluctant to allow their households to be visited or female CRPs to work. However, such resistance was overcome through the involvement of VHCs.

Regarding the BiB's role in the lives of the actors and stakeholders, the study results further revealed that 29 (64%) of the CRPs were either unemployed or financially dependent on male family members before they joined the programme. Those already employed full-time or part-time expanded BiB according to the nature of their work. For example, one beautician started selling beauty products in her kit, earning a higher surplus. Overall, one-fourth of CRPs were earning an average monthly profit of 100-150 rupees, 10 (22%) were earning between 150 and 200, whereas 2 (5%) were earning between PKR3500-4000 average profits each month from BiB. When CRPs were asked whether BiB would ensure their financial stability after the project's completion, 36 (80%) agreed whereas 9 (20%) disagreed. CRPs were asked if they were willing to continue working with BiB after the project, with 38 (84%) responding positively, while 7 (16%) did not show any intention to continue beyond the programme's life. Most CRPs, 38 (84%), expressed their satisfaction with the initiative. The other 16% said that BiB is demanding work with minimal or no profit at all.

Two main factors can be attributed to the lack of income or profit. Those CRPs who were dependent on the honorarium as their sole source of income could not expand their business since they were already cash-starved and failed to reinvest any surplus from sales. At the time of recruitment and training, commitments were sought from CRPs to fully dedicate their time and efforts to the opportunity. However, some lacked the motivation to operate a business, while for others it was due to the shortage of interest or demand for BiB products in their target communities. Based on focus group discussions with community members and village health committees, the lack of demand could be attributed to various reasons such as the income of households in a community and proximity to an urban settlement. Villages closer to small and medium-sized towns and cities were considered tough to work with as the women preferred to do their own shopping rather than purchasing at their doorsteps. Demand for BiB products was much higher in remote villages located farther from small towns.

Analysis of BiB initiative

Business-in-a-Box (BiB) has emerged as an experiment in socially responsible micro-franchising to provide reproductive health products and services to remote village communities. It has also

served as a springboard helping micro-entrepreneurs to take responsibility, progress with their microbusiness, and exploit opportunities beyond the initial confines of the franchise. The CRPs were offered pathways to start-up their efforts with initial support for reproductive health products, and subsequently allowed the flexibility expand their range of products and services in accordance with the needs and necessities of the households and communities they served. This ensured profitability, savings and reinvestment for the majority of CRPs, with higher chances of sustaining their ventures. Despite some shortcomings in the implementation, the initial results of the pilot phases reflect that, though the concept and practice are still in their infancy, there is a potential for scaling up as a model of place-based social innovation (Moulaert and Mehmood 2011), to avail positive behavioural changes along with financial sustainability. BiB's potential impact on the actors and stakeholders remains crucial to the economic participation and opportunity for women in developing countries.

More importantly, the BiB model has added the advantage of VHCs as key actors of community-based institutions and catalysts for community development in rural areas (Isely and Martin 1977). In the programme, VHCs served as institutionalised vehicles advocating on matters of maternal and reproductive health. VHC members were socially embedded in the communities and collaboratively supported the CRPs. CRP performances were discussed in monthly VHC meetings where the franchisees would highlight any issues they were facing in households or neighbourhoods. VHC members would subsequently consider ways to tackle the issues through personal interaction, using their privileged positions in the communities, or by accompanying the CRP to the resistant households. Similarly, male VHC members would directly interact with male family members or spouses of the clients. VHC members also teamed up with prominent local religious figures to clarify any faith-based misconceptions. In this manner, the interventions were able to overcome social, cultural and religious barriers. Despite meaningful efforts to engage VHCs in CRP selection and support, not all VHCs effectively backed up their CRPs. Part of this lack of support was due to the nature of the reproductive health as a social and cultural taboo.

This study discovered that in many of the areas, the VHC turned out to be the first and only pathway for community mobilisation. As their role grew in promoting reproductive health, VHC members became more expressive in their concerns about a variety of other community health matters. The VHC members suitably integrated themselves in the health chain, both horizontally and vertically. The addition of VHC with the teams of CRP created a horizontal linkage in the health chain which increased outreach for governmental resources, as well as making them more efficient and sustainable in the longer term. Vertically, with their position at the grassroots of the supply chain empowered by the programme/NGO support, the VHCs had direct linkages with the formal Union Council Health Committees (UHC). They were subsequently allowed to represent their villages in the UHCs and were able to discuss and make a case for community health needs. In terms of hierarchy, the UHCs are directly connected upwards to the district health departments that function under the provincial health department which corresponds to the federal-level health ministry.

Concluding remarks

BiB is not a substitute for a wider spectrum of public health mechanisms. Such a systemic change would require addressing larger governance issues, especially in the case of reproductive health and for effective reduction in MMR and IMR. The pilot programme only concentrated on short-term contraceptives rather than long-term clinical methods which would require expert training. Micro-entrepreneurship, we argue, as an empowering approach can help rural women leave the poverty trap while providing reproductive health access to households in remote areas. As a model of socially responsible micro-franchising, BiB allows communities to co-produce pathways to satisfy their immediate social, economic and health-related needs. The flexible and adaptive mechanism offers rural women the opportunity to tap into their entrepreneurial potential by engaging with those community members who do not have sufficient means, knowledge or resources, as in

the case of maternal health. The place-based implementation of social innovation facilitates improving social and gender relations at neighbourhood levels by addressing cultural and religious concerns. This leads to capacity building to upscale and sustain these initiatives in the longer term and confront the bigger challenges of epidemics or viral infections. The resurgence of polio is an example where the safety and security of health workers are seen as one of the reasons for their inaccessibility, as well as the reluctance of communities due to misinformation and misunderstanding. The relative success of the pilot BiB model in maternal and reproductive health improvement through community-embedded and locally trusted CRPs demonstrates the potential for using similar methods and instruments to gain people's trust for administering polio vaccinations, especially in rural and remote areas.

BiB, therefore, highlights the significance and wider opportunity for designing and delivering health interventions that may be initiated top-down, but with grassroots support prevail in the longer term. For the CRPs, as non-traditional and informal providers of health services, the model has offered a means to financial independence. The programme encouraged these community-based workers to continue after their external funding and support ended. Once provided with the seed investment, 80% of CRPs believed that they had become financially stable and therefore were willing to continue working with BiB beyond the project life.

Though a successful model within the project life with an affirmative commitment by CRPs, the question remains as to how many of these BiB CRPs will continue to provide contraceptives and associated products and services, and not completely move to more marketable and profitable options. While financially sustainable, a certain level of handholding, social guidance and patronage are deemed necessary for such initiatives to sustain and flourish. As a model of social innovation, BiB leverages a fusion of micro-franchising and community-based co-ownership and support. Its design is scalable, adaptable, and can provide high social impact, including women's economic participation and opportunity for development interventions to improve the livelihoods of the poor in deprived rural and remote locations.

Acknowledgements

Tahira Tarique and Majida Malik's work in data collection and writing the initial report is duly acknowledged. The opinions expressed in this paper are those of the authors only and do not necessarily reflect the views of RSPN or its partners. A draft version of this paper was presented at the 1st International Conference Science, Technology and Innovation Policy and Management, 16–17 November 2016 at Mövenpick Hotel Karachi, Sindh, Pakistan.

Disclosure Statement

No potential conflict of interest was reported by the authors.

Notes on contributors

Abdur Rehman Cheema is a Team Leader Research at the Rural Support Programmes Network, Islamabad, Pakistan. His areas of interest have been the interconnected issues of socio-economic development, including governance, education, agribusiness, environment and climate change, and of regional developments, for example, the China Pakistan Economic Corridor (CPEC).

Abid Mehmood is a Research Fellow in Sustainable Places Research Institute, School of Social Sciences, Cardiff University, UK. His broader research expertise is in social innovation and governance. He has experience of research in climate change, socio-economic development, and social cohesion for local and regional development policy and practice.

ORCID

Abdur Rehman Cheema  <http://orcid.org/0000-0003-0945-1986>

Abid Mehmood  <http://orcid.org/0000-0003-3719-6388>

References

- Aasen, H. S. 2011. "Maternal Mortality and Women's Right to Health." In *Women's Human Rights: CEDAW in International, Regional and National Law*, edited by A. Hellum, and H. S. Aasen, 292–320. Cambridge: Cambridge University Press.
- Abed, F. H., M. Hossain, S. Davis, and R. Dubitsky. 2011. "Using Microfinance Plus Agricultural Services to Improve Rural Livelihoods and Food Security." In *New Pathways Out of Poverty*, edited by S. Daley-Harris, and A. Awimbo, 143–184. Colorado: Kumarian Press.
- Ali, M., and H. Ushijima. 2005. "Perception of Men on Role of Religious Leaders in Reproductive Health Issues in Rural Pakistan." *Journal of Biosocial Science* 37 (1): 115–122.
- Bond, P. 2007. "Microcredit Evangelism, Health, and Social Policy." *International Journal of Health Services* 37 (2): 229–249.
- BRAC. 2011. "Microfinance Pioneer Sir Fazle Hasan Abed, Founder of BRAC, Advances 'Business in a Box' Strategy." Building Resources Across Communities (BRAC). Accessed November 11, 2017. www.brac.net/latest-news/item/489-microfinance-pioneer-sir-fazle-hasan-abed-founder-of-brac-advances-business-in-a-box-strategy.
- Cheema, A. R., and M. Malik. 2016. "Development: Thinking Outside the Box within a Box." *DAWN News*. Accessed November 11, 2017. www.dawn.com/news/1275544.
- Cross, J. 2000. "Street Vendors, and Postmodernity: Conflict and Compromise in the Global Economy." *International Journal of Sociology and Social Policy* 20 (1/2): 29–51.
- Dawn, M., and G. Kishore. 2016. "Real Challenges in the Empowerment and Development of the Women of Bangladesh." *The Journal of Indian Management* 6 (1): 1–8.
- El-Saharty, S., O. Naoko, S. Intissar, and S. Federica. 2014. "South Asia: Maternal and Reproductive Health at a Glance'." Accessed November 11, 2017. www.wds.worldbank.org/external/default/WDSContentServer/WDS/IB/2015/01/08/000470435_20150108095221/Rendered/PDF/935520BRI0Box30pro0Health0Sept02014.pdf.
- Evans, M. 2013. "Small Business Ownership: Start Out Small With A Microfranchise." *Forbes*, Accessed November 11, 2017. www.forbes.com/sites/allbusiness/2013/11/27/small-business-ownership-start-out-small-with-a-microfranchise/#7f8f37b465ed.
- Haider, M., and A. Mukherjee. 2010. "Analysis of Neonatal Health in South Asia." *International Journal of Pharmaceutical and Healthcare Marketing* 4 (1): 40–59.
- Hindustan Unilever Limited. 2016. "Enhancing Livelihoods through Project Shakti." Accessed November 11, 2017. www.hul.co.in/sustainable-living/case-studies/enhancing-livelihoods-through-project-shakti.html.
- Hipsher, S. A. 2010. "Theoretical View on Microenterprise Entrepreneurial Motivators." In *Contemporary Microenterprise: Concepts and Cases*, edited by J. M. S. Munoz, 49–60. Cheltenham: Edward Elgar.
- Huff-Rousselle, M., and H. Pickering. 2001. "Crossing the Public–Private Sector Divide with Reproductive Health in Cambodia: Out-Patient Services in a Local NGO and the National MCH Clinic." *The International Journal of Health Planning and Management* 16 (1): 33–46.
- Iseely, R. B., and J. F. Martin. 1977. "The Village Health Committee. Starting Point for Rural Development." *WHO Chronicle* 31 (8): 307–315.
- LivingGoods. 2016. "LivingGoods-BRAC Joint Venture in Uganda." Building Resources Across Communities (BRAC).
- Maloney, William F. 2004. "Informality Revisited." *World Development* 32 (7): 1159–1178.
- Marshall, G. R. 2009. "Polycentricity, Reciprocity, and Farmer Adoption of Conservation Practices Under Community-Based Governance." *Ecological Economics* 68 (5): 1507–1520.
- McDonald, D. A., and G. Ruiters. 2012. *Alternatives to Privatization: Public Options for Essential Services in the Global South*. New York: Routledge.
- Mehmood, A. 2016. "Institutional Forms of Social Innovation." *International Journal of Innovation and Sustainable Development* 10 (3): 300–311.
- Mehmood, A., A. Jamal, and V. Sriram. 2015. "Ethnic Marketing, Ethnic Entrepreneurship and Social Innovation." In *The Routledge Companion to Ethnic Marketing*, edited by A. Jamal, L. Peñaloza, and M. Laroche, 84–96. Oxford: Routledge.
- Moulaert, F., A. MacCallum, and A. Hamdouch. 2013. *The International Handbook on Social Innovation: Collective Action, Social Learning and Transdisciplinary Research*. Cheltenham: Edward Elgar Publishing.
- Moulaert, F., and A. Mehmood. 2011. *Spaces of Social Innovation*. London: Routledge.
- Munoz, J. M. S. 2010. "Introduction." In *Contemporary Microenterprise: Concepts and Cases*, edited by J. M. S. Munoz, 1–8. Cheltenham: Edward Elgar Publishing.
- Mwakaje, A. G., E. Manyasa, N. Wawire, M. Muchai, D. Ongare, C. Mugoya, C. W. Masiga, and A. Nikundiwe. 2013. "Community Based Conservation, Income Governance and Poverty Alleviation in Tanzania: The Case of Serengeti Ecosystem." *The Journal of Environment & Development* 22 (1): 51–73.
- Naz, F., and D. Bogenhold. 2016. *Micro Entrepreneurship and Female Homework in Developing Countries: On the Limited Capacity of Micro Entrepreneurship as Analytical Term*. Contemporary Entrepreneurship. Basel: Springer International.
- Scheil-Adlung, X., ed. 2015. *Global Evidence on Inequities in Rural Health Protection: New Data on Rural Deficits in Health Coverage for 174 Countries*. Geneva: International Labour Office.
- Shah, R. J. 2016. "An Evaluation of Socio-Economic Development through Partnership of Micro-Finance and Corporate Social Responsibility." Accessed November 11, 2017. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2735439.

- Smith, I. H., and K. W. Seawright. 2015. *Social Innovation Through Development Franchising: Compensating for a Lack of Entrepreneurial Expertise and Connecting to Formal Supply Chains*, edited by E.W. Griffin-EL, V. Bitzer, R. Hamann, and M. Hall. Heidelberg: Springer.
- Thieme. 2015. "Turning Hustlers Into Entrepreneurs, and Social Needs Into Market Demands: Corporate–Community Encounters in Nairobi, Kenya." *Geoforum; Journal of Physical, Human, and Regional Geosciences* 59: 228–239.
- United Nations. 2000. "United Nations Millennium Resolution: Resolution Adopted by the General Assembly." Accessed November 11, 2017. www.un.org/millennium/declaration/ares552e.pdf.
- United Nations. 2015. "Sustainability Development Goals." Accessed November 11, 2017. www.un.org/sustainabledevelopment/health.
- Webb, P., and J. Fairbourne. 2016. *Microfranchising: A Solution to Necessity Entrepreneurship*. Cheltenham: Edward Elgar.
- World Bank. 2014. "Data- Agriculture and Rural Development." Accessed November 11, 2017. <http://data.worldbank.org/topic/agriculture-and-rural-development>.
- Xavier, M. J., J. Raja, and S. U. Nandhini. 2007. "Impact of Entrepreneurship Development Through Corporate Interventions: An Assessment of the Case of HLL's Project Shakti." *Advances in International Management* 20: 135–149.