

Primary Health Care At The Base Of The Pyramid: RTT's Unjani Clinic Model

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A B4D Pathfinder Case Study

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1. Executive Summary

The private sector with its skills, knowledge, experience and resources, can play a key role in accelerating progress towards the Millennium Development Goals (MDGs) by improving social infrastructure and employment opportunities that will lift poor households out of the poverty trap. The Southern Africa Trust's *Business for Development (B4D) Pathfinder* focuses on inclusive business, which is defined as the profitable integration of the poor in the value chain of a company. One of the key components of the B4D Pathfinder is the development of knowledge and measurement tools for inclusive business. One of the tools, the B4D Toolkit, will assist businesses to strive towards continuous improvement in developing inclusive business practices, providing guidance on *what* companies can do to progress from one performance level to the next and *how* they can do it.

The following case study was conducted to gain additional knowledge for the further development of the B4D-Toolkit. It articulates business' experiences of steps taken to reach and involve the poor. It also identifies what challenges must be taken into consideration when it comes to looking for new markets and the design and distribution of pro-poor products. Access to health care plays a fundamental role in the economic development and prosperity of a country. Healthier communities are economically more active and productive, and healthy children tend to perform better at school, which in turn increases their chances of earning high incomes later in life. In South Africa, access to health care is, like so many other aspects of life, characterized by significant inequalities: While 17% of the population can afford to pay for private health care (usually of high quality), more than 8 out of 10 South Africans have no health insurance, and rely on an overburdened public sector to meet their health care needs.

While the state has begun the process of implementing ambitious plans to introduce a national health insurance scheme (NHI) for all South Africans, it lacks sufficient resources to provide quality, effective and affordable health care to all. As a result, there is a wide gap between the primary health care and medication needs of millions of poor South Africans and the available services. Market surveys indicate that a significant number of people in poor communities are able and willing to spend modest amounts for easier access to primary health care and medicines. This suggests that inclusive business models that combine commercial models with a strong social impact can help fill the gap that currently exists in access to primary health care and medicines for low-income communities, while at the same time alleviating the financial and logistical burden on overburdened public health care facilities.

A prominent and interesting example of such a non-traditional approach is Unjani Clinic, designed by the RTT Group, one of South Africa's largest logistics firms. RTT Medical, the group's medical subsidiary, reaches 8,000 delivery points every day in the South African market, on behalf of more than 30 local and international pharmaceutical manufacturers. The Unjani model, which is currently in a proof-of-concept phase, aims to meet the need for primary health care at community level, by providing essential medicines and health care education at an easily accessible point of dispensation.

At the same time, it aims to create opportunities for community-based health care workers to develop social franchises and run medical care centres on a commercial basis, as well as, in a later stage, for informal retailers to provide over-the-counter medicines at affordable prices: a type of hub-and-spoke model, with Unjani Clinic at its centre, enabling the community to benefit from its expertise.

RTT is currently testing Unjani Clinic in Etwatwa, a peri-urban township in Gauteng province. For a fee of R 60 (about US \$ 8 at March 2012 exchange rates), patients can receive primary health care and medicines to treat many of the most common health conditions. In addition, Unjani Clinic provides clinical services, such as infant weighing, immunization, HIV and glucose testing, family planning, and basic health education.

Poor local communities benefit from shorter waiting times and a perceived higher quality of primary health care compared to the local public health care facility. Unjani Clinic is also more affordable than other private alternatives, such as doctors or traditional healers, thereby filling a useful gap in the market between available but expensive private health care options, and affordable but often unreliable public health care options.

To achieve the necessary scale that will make a tangible impact, RTT must ensure the model is economically viable, appoint qualified staff who can combine health care with entrepreneurial skills, and build the optimal partnerships needed for the model to function.

If RTT is able to meet these challenges and successfully scale up its model, a future extended network of Unjani Clinic social franchises could potentially reach hundreds of thousands of people in poor communities, especially in isolated rural areas where the availability of any form of primary health care, public or private, is limited. The model could also potentially gain considerably from partnerships with the public sector, as well as with pharmaceutical companies.

2. Access To Primary Health Care And Medicines For Poor South Africans: Can A Market-Based Approach Provide Solutions?

The inequalities that permeate South African society are equally present when it comes to access to health care and primary health care, with significant discrepancies between the tax-funded public health care system and the private health care sector in terms of cost, spend per patient, and quality of care. While a minority of affluent South Africans is able to afford high quality private health care, 83 per cent of the population, a total of 41.7 million people out of South Africa's total population of 50 million, rely on public health care services, which are often understaffed and under-resourced.¹

The gap between the state and the private sector is perhaps most obvious when measured in average spending per patient: At R 8,250 per head (approximately US \$ 1,090), it is 6 times higher in the private sector than in the public sector, where the average annual

Box 1

Health care and Primary Health care

Health care is understood here as “the maintenance and improvement of physical and mental health, especially through the provision of medical services”.

Primary health care, or PHC, refers to “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development (...)”. The main focus in the case study will be on access to primary health care, as an essential component of health care itself.

Source: World Health Organisation (WHO), Declaration of Alma-Ata, 1978.
http://www.who.int/topics/primary_health_care/en/

spend is R 1,372 (approximately US \$ 181).² This level of discrepancy feeds on itself, as the resource gap between public and private health care sectors tends to drive qualified medical staff, especially specialized staff (pharmacists, dentists, optometrists, qualified nurses) away from the public sector.³

Poor South Africans rely mainly on the public health care network because of its relative affordability: Access to the public health care network is nominally free for children under the age of 6 and breastfeeding mothers, and available at very low fees (usually around R 20, the equivalent of US \$

2.60) for outpatients. Since April 2006, primary health care is free for all in South Africa, one of the biggest achievements in public health care since the advent of democracy.⁴ This achievement does not, however, take into account the indirect costs for patients, such as transport to get to a public health facility (especially in remote rural areas), or lost income as a result of many hours and sometimes days waiting in queues.

¹ See, for instance: X, “Health care is Minister’s most critical patient”, *Mail & Guardian*, Johannesburg, 26 August 2011; and COOVADIA, et al, “The health and health system of South Africa: historical roots of current public health challenges”, *The Lancet*, Published online on August 25, 2009.

² NATIONAL PLANNING COMMISSION, *National Development Plan – Vision for 2030*, Pretoria, 2011, p307.

³ *ibid.*

⁴ HARRISON, David, *Department of Health of South Africa, An Overview of Health and Health care in South Africa 1994–2010: Priorities, Progress and Prospects for New Gains*, Discussion Document, Pretoria, December 2009.

One important factor that contributes to the reliance on the public health care network is that with generally low levels of education, many people in low-income communities are reluctant to self-medicate, and seek treatment from already overburdened public health care facilities, at a very high cost to the public health care system.⁵

There remains, therefore, significant demand for primary health care at the base of the economic pyramid in South Africa, most significantly the 41% of the South African population earning or spending less than R 20 or the equivalent of US \$ 3 per day, as well as the “middle of the pyramid”, i.e. those citizens who are on an income of between R 20 and R 140 per day (see Box II).

Against this background, and given the unmet demand for primary health care and medicines, the gap in the market tends to be filled by private alternatives. There is some evidence, for instance, suggesting that illegal health clinics often operate in townships, and that people are prepared to pay for such services despite the obvious risks: One recent report put a standard medical consultation in an illegal health clinic at R 190 (approximately US \$ 25).⁶ The fact that illegal health care services exist at all is a strong indication that people are willing to pay for alternatives to public health facilities if the perceived benefits outstrip the visible and invisible costs. Legal private clinics in the same areas can cost up to R 250.⁷

While it is difficult to estimate the size of this market with any real precision, national household surveys provide useful rough estimates. According to Statistics South Africa (the country’s main national statistical institute), the average annual consumption expenditure of poor Black African households is R 30,509 (approximately US \$ 4,060 per year per household, with an average of 4 people per household).⁸ An estimated 1.5% of that annual expenditure goes to health care, amounting to R 458 per annum per household. Further breaking this figure down, RTT estimates that the annual health spending amounts to around R 153 on pharmaceutical products, and R 229 on clinical services (the rest being spent on other categories of health products and services, including traditional healers).

⁵ RTT Group document, “Unjani Clinic – 18 Month Pilot Overview”. Johannesburg, February 2012.

⁶ MAPUMULO, Zinhle, “Police bust illegal health clinic”, *The New Age*, Johannesburg, 15 August 2011.

⁷ NICOLLE, Trixie-Belle, Project Director, Unjani Clinics, RTT. Interview conducted February 20th, 2012 in Johannesburg.

⁸ Figures compiled from STATISTICS SOUTH AFRICA, *Income and Expenditure Survey 2005/2006*, Statistical Release P0100, Pretoria, March 2008.
<http://www.statssa.gov.za/publications/P0100/P01002005.pdf>

Box II

Defining the “Base of the Pyramid” or BoP

The phrase “bottom of the pyramid”, or “base of the pyramid”, was popularized by CK Prahalad in his seminal work of 2002, *The Fortune at the Bottom of the Pyramid – Eradicating poverty through profits*. The central thesis of this work was that the base of the pyramid represents a significant market opportunity, and that the profit motive driving businesses to benefit from market opportunities often had a more durable impact on improving the lives of people living in poverty than non-commercial approaches. The merits or otherwise of Prahalad’s thesis has triggered much debate in academic, business and civil society circles, but one of the outcomes was a surge of interest in untapped market opportunities in low-income environments.

Considering the challenge of comparing real and relative incomes across the world, there is no standard definition of the BoP. For purposes mostly of convenience and comparability, the phrase generally refers to the global population living on less than US\$ 3,000 per year, measured in local purchasing power. Globally, it is estimated that at least 4 billion people fall into this category, making it the biggest single income group worldwide (Source: *The next 4 billion – Market Size and Business Strategy at the Base of the Pyramid*, jointly authored by the International Finance Corporation and World Resource Institute, Washington DC, 2007).

In South Africa, the BoP threshold is set at 3 US\$ per day (around R 20 at February 2012 exchange rates). According to Eighty20, a South African consultancy based in Cape Town, around 18.2 million people (roughly 41% of the country’s population) fell in this category in 2008 (Source: *The Bottom of the Pyramid in South Africa – 2009* – Eighty20 presentation, Cape Town, 2009). According to the same report, a further 47% of the population is estimated to earn between R 20 and R 140. Very broadly, this second tier forms the emerging “lower middle class”, meaning people who are considered to have some level of economic activity and are gradually moving out of extreme poverty.

Based on approximately 8 million households, it is estimated that the total underserved market at the base of the pyramid represents a monetary value of R 3.2 billion per year (approximately US \$ 430 million at March 2012 exchange rates). This figure is most likely an underestimate: A global study of the BoP market in 2007 estimated that measured in purchasing power parity terms, the overall health care market at the Base of the Pyramid in Africa alone represented US \$ 18 billion at purchasing power parity rates.⁹

The study showcases an example of an innovative business model in the field of access to health care developed by RTT, one of South Africa’s largest logistics firms. The Unjani Clinic model is a market-based approach that seeks to provide low-income communities with access to affordable, quality primary health care and medicines. It is currently in experimental phase and is undergoing proof-of-concept testing in the peri-urban township of Etwatwa in Gauteng province, around 60 kms east of Johannesburg in the Greater Municipality of Ekurhuleni.

⁹ HAMMON, A., et al, “The next four billion – Market size and business strategy at the base of the pyramid”. International Finance Corporation / World Resources Institute, Washington DC, 2007, p34.

The next part of this case study will focus on the design of the inclusive business model, and will seek to answer some basic questions: What is the model's architecture, how is the target market defined, and why did RTT develop this particular approach?

Part III looks at how RTT is implementing its approach in practice: How are partners (including nurses from communities, pharmaceutical companies, local stakeholders and partners) selected, addressed and trained? How does RTT intend to maintain these partnerships? What type of challenges does the company face?

Part IV focuses on the value proposition and the economic and social impact: What is the expected main revenue stream of the model? Who benefits from this model, how, and by how much? What are the future prospects of the model?

Box III

A quick profile of RTT Group

RTT Group is one of South Africa's largest logistics firms. Founded in 1980, its main shareholders include investors from the South African financial services industry, such as Old Mutual and Rand Merchant Bank. It has operations across the African continent, with regional hubs in Kenya and Ghana. The RTT Group has 8 subsidiaries, also referred to as "member companies". Two of these subsidiaries, **RTT Medical** and **RTT ScriptWoRx**, specifically service the health care industry. RTT Group's experience in servicing the health care industry provides the backdrop for the Unjani model.

RTT GROUP STATISTICS:

Employees: 7,000

Turnover: R 2.5 billion

Fleet: 1,400 vehicles

Parcels delivered per day: 70,000

RTT Medical: 8 million units distributed per month

63% of deliveries going to pharmacies, hospitals and dispensing doctors

Source: RTT

3. Social Franchises, Couriers and Spaza Shops: Designing the Unjani Clinic Model

This part of the study will describe the design of the inclusive business model, the defined target market and the particular approach of RTT.

3.1. Description and Architecture¹⁰

The primary unit of Unjani Clinic is made up of three main components: physical infrastructure, human resources, and medical equipment.

The physical infrastructure consists of a storage room, a dispensing room and a consulting room. The unit needs to be air-conditioned (mainly to ensure that medicine is kept at below 25 degrees Celsius and for the general comfort of patients and the staff), have an electricity outlet as well as a toilet, a washbasin (including a water connection), an examination couch, and surgeon chairs.

In many cases, converted shipping containers provide the ideal shell within which to house an Unjani unit: Containers have a number of practical advantages, as they are easily moveable if needed at another location, are cost-effective and can be designed for specific requirements. However, the physical housing of the structure could in future be adapted to fit into a prefabricated building, community centre, school or any other suitable structure.¹¹

With regard to human resources, an Unjani Clinic is staffed by a registered, qualified Primary Health Care nurse in charge of consultations and dispensing, assisted by a colleague in charge of administrative tasks, such as accounting, log keeping and stocking. While the nurse concentrates on attending to patients, her assistant's role includes the management and quality control of the stock, the reconciliation of over-the-counter sales, data management and record keeping. People are also recruited from the community: a full time security guard, a cleaner, and a community marketer.

The unit is stocked with medical equipment that consists of a simplified drug formulary for the most common, treatable conditions, as well as bandages, drips, needles, oxygen, gloves, glucose machines, and stethoscopes.

¹⁰ RTT GROUP, "Clinic-in-a-Box", *First Concept Paper*, 2009.

¹¹ NICOLLE, Trixie-Belle, *Project Director, Unjani Clinics, RTT. Interview conducted February 20th, 2012 in Johannesburg.*

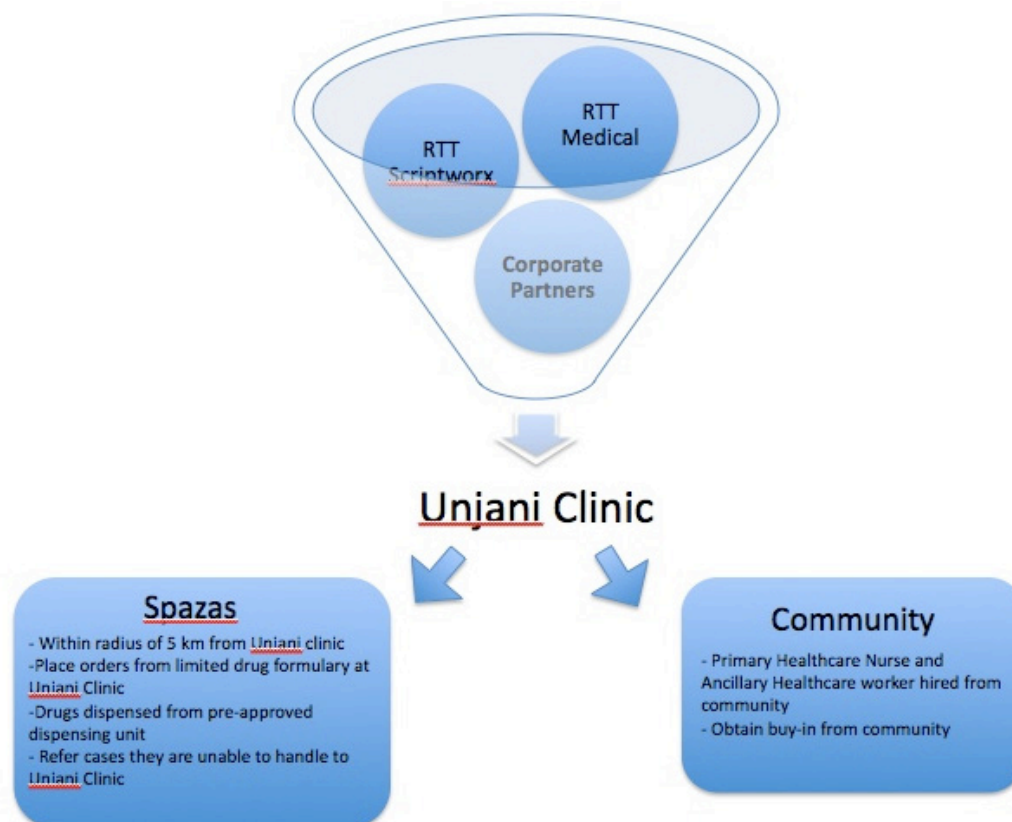


Diagram 1: Simplified Diagram of the Unjani Clinic model (Source: RTT)

When the model has reached full capacity, the Unjani unit will be the nerve centre of a value chain that includes the pharmaceutical companies that are among RTT’s biggest clients, as well as RTT’s own logistical support infrastructure (RTT ScriptWorx, which orders stocks from pharmaceutical companies as a wholesaler, and RTT Solutions, which delivers the stock to the clinic).

3.2. Target Market

The Unjani Clinic is broadly aimed at the under-served market in South Africa: An estimated 35.4 million people in South Africa (over two-thirds of the total population) have inadequate access to primary health care and medicines, either because they are unable to afford it, or because health services and medicines are not physically available.

Table I: Average monthly income per household by LSM segments 1-5, in Rand and US dollar equivalent

LSM 1	LSM 2	LSM 3	LSM 4	LSM 5
R 1,493	R 1,732	R 2,052	R 2,892	R 3,832
US \$ 200	US \$ 230	US \$ 273	US \$ 385	US \$ 510

Based on figures provided by the South African Advertising Research Foundation, January 2011 (Source: RTT)

RTT considers its primary target market to be within poor and very poor communities in peri-urban and, at a later stage, rural areas. Based on their income and living standard measure segments¹² (LSM), the typical Unjani patients and users of over the counter medicine would be in LSM 3-5 segments. Once the model is scaled up, RTT aims to also reach LSM categories 1 and 2.

Based on these LSM stratifications, market research and practical considerations, RTT decided to test the model in Etwatwa, a peri-urban community on the outskirts of Daveyton, about 60 km east of Johannesburg.¹³ With a population of about 60,000 people, Etwatwa is a peri-urban community like many others in South Africa, and one in which the bulk of the population falls within LSM categories 2-5. Unemployment is estimated to be around 60%, and the majority of its population lives in poor households.¹⁴

Public health care is available at the local clinic, known as the Barcelona Clinic, but this facility is unable to cope with the numbers of people it is supposed to serve. Long waiting lines start forming as early as 04h00, with no guarantee that patients will be attended to: “Sometimes you wait all day and they send you home at 16h00, telling you to come back the following morning”, says one patient at the Unjani Clinic.¹⁵ There are also a few private medical practices in the area, but they tend to be beyond the financial reach of most locals, with a typical consultation costing around R 250 for adults and R 180 for children.¹⁶

RTT has chosen Etwatwa to test the Unjani model for two main reasons: The community is representative of the population it intends to reach, and it is sufficiently close to RTT’s headquarters in Boksburg, 50 km away, for the firm to monitor developments, and adapt the experiment to achieve economic viability before expanding further around the country.

3.3. Social Franchises and Spaza Shops

Beyond RTT’s primary objective of improving access to primary health care and over-the-counter medicines, the second pillar of the model is to ensure that the model is economically viable and sustainable, and becomes an empowerment tool for nurses, as well as the owners of informal tuck shops (known around South Africa as ‘spaza’ shops). This is a long-term objective, however, and will involve a number of initial steps as well as seed capital. The pilot currently in progress in Etwatwa will be crucial

¹² LSM or Living Standard Measure is a living standard benchmark developed by the South African Advertising Research Forum (www.saarf.co.za). It aims to provide a more nuanced picture of actual living standards of the population by using income together with 20 other variables, including the presence or absence of specific appliances, hot running water, in-house toilets, type of dwelling, level of access to services, etc.

¹³ VOS, Deon, Project Director, Unjani Clinics (2009-2011). Interview conducted on February 20th, 2012 in Johannesburg.

¹⁴ TATI, Nokwazi, Local Ward Councillor, Etwatwa. Interview conducted on February 20th, 2012.

¹⁵ X, Unjani Clinic patient in Etwatwa. Interview conducted on February 20th, 2012 (Name withheld for confidentiality reasons, record available on request).

¹⁶ On-site research in Etwatwa, February 2012.

in determining whether the clinic can become economically viable, and the levels of outside support that will be required.

RTT is studying two types of scenarios with regard to the ownership structure of the clinic itself, namely an ownership scenario, and a leasing scenario¹⁷:

Ownership Scenario: Under the ownership scenario, the nurse would own a specific share of between 50% and 100% of the clinic after a period of 60 months. In this scenario, the nurse would pay off a loan of about R 100,000 (corresponding to 50% of the initial capital expenditure to set up a clinic) over a 60-month period, at an estimated interest rate of 12% (dependent on the micro-lending institution accessed). The portion of the capital not owned by the nurse would be owned either by RTT on its own, or in conjunction with a number of its clients with a stake in health care, such as pharmaceutical companies and drugs dispensers (Johnson & Johnson, Merck, Glaxo SmithKline), who are among RTT's largest clients.

Leasing scenario: Under a leasing scenario, the nurse would earn either life rights, or rights on a set period. In this scenario, the ownership would remain with RTT and/or its partner firms, but the operational income and profit would go to the nurse and her/his staff.

In either scenario, RTT Group (as the franchisor) would be in charge of branding, quality control, and training. It would also be responsible for supplying and delivering stock of medical equipment and medicines.

The franchisee would be in charge of renting the site, managing the unit's staff, ordering stock and overall management of the clinic's operations (including administration and accounting, for example).

In this model, the nurse becomes not just a health care provider within a low-income community, but also a self-employed entrepreneur and creator of employment opportunities. The clinic's revenue streams include consulting fees and script delivery fees, as well as revenue from over-the-counter sales of medicines, and marketing revenue from advertising, using the space on both sides of the container or building.¹⁸

RTT and its potential partners in this model also have a strong incentive to support the franchise as part of its enterprise development commitments in the framework of South Africa's Broad-Based Black Economic Empowerment (BBBEE) scorecard.

A second key feature of the model, one tier below the social franchise, is to integrate informal retailers (spaza shops) into the model as outlets for basic, over-the-counter medicines for minor ailments. In most low-income communities in South Africa, spaza shops are an essential part of the economic ecosystem and the social fabric. They are often survivalist family businesses run by mothers or grandmothers, selling essentials such as maize meal, cooking oil, candles and soap. RTT's intention is to build on this

¹⁷ NICOLLE, *Trixie-Belle*, *ibid.*

¹⁸ NICOLLE, *Trixie-Belle*, *ibid.*

dense network, in which female small business owners are often breadwinners for their families and are often respected figures in the community. In the words of Iain Barton, RTT Group's Chief Executive Officer, "there are few people in the world who know more about health than mothers – and this is the main reason we want to focus



Taking patient record, Umjani Clinic, Etwatwa (Picture: Trixie-Belle Nicolle, RTT)

on female-owned informal retailers, who really play the role of 'street mothers', not just for their own children and family, but often for their entire neighbourhood".¹⁹

In a hub-and-spoke model, Umjani Clinics would act as central ordering points for a number of spazas in a catchment area of a few

kilometres to provide affordable, over-the-

counter medicines that address some of the most common, self-treatable conditions such as scabies, diarrhoea, worms, pain and fever, sore throats and fungal infections. To ensure cost-effectiveness, spazas would place their orders through the Umjani Clinic and then collect their orders at the clinic. They would also receive basic training in this regard from the Umjani Clinic, as will be explained further below.

The idea is for informal retailers to eventually become the first point of contact for minor health problems, relieving the pressure on clinics and public health facilities which often play this role at the moment at great cost to the public health care system. The retail sale of generic drugs, which can be supplied at very low wholesale prices and facilitated by RTT's partners in the pharmaceutical industry, would also provide much needed additional revenue for informal retailers in low-income areas and boost local economic activity.

3.4. Vision and Motivation

Iain Barton, CEO of RTT Group, explains the origin of the Umjani Clinics vision as part of a personal journey. A medical doctor himself, Barton practiced as a general practitioner for 10 years. In his experience, only a fraction of his patients truly needed the attention of a medical doctor, when many could have been helped by a nurse or even self-medication as a first resort: "From that angle, a medical doctor is a rather expensive resource that is not always used in an optimal way – he or she ends up doing quite a lot of triage, rather than attending to patients in need of medical care provided by a doctor", he says. Barton believes that this problem reaches particularly

¹⁹ BARTON, Iain, Chief Executive Officer, RTT, Interview conducted in Johannesburg on February 20th 2012.

acute levels precisely in areas where doctors and sophisticated health care are in short supply, which is typically the case in low-income communities.

As a result, one way of improving resource use in such areas is what Barton describes as “task shifting” away from doctors, towards nurses, and away from nurses towards self-medication, on the “deal with what you can, refer what you cannot” principle.²⁰

From this perspective, the motivation behind the creation of the Unjani model was the outcome of a deep reflection on how RTT could act on three key levels to improve the primary health care options and access to medicines for people in low-income communities.

Table 2: Steps to improve primary health care and access to medication

Level of action	Defined as	How
Availability of Product	Expanding the range of primary health care options and medicines for people living in low-income communities	By filling the gap between the overstretched public health care network and expensive or non-existent private health care
Affordability of Primary Health care and a basket of medicines	Can patients afford and finance the health services and medicines on offer?	By adjusting pricing policy, expanding use of generic medicines, using loyalty cards, etc.
Access to Knowledge	Awareness of the population on health-related issues (symptoms of common ailments, confidence in the benefits of self-medication and primary health care over “rushing to the public hospital”	By spreading information and education on health care and health issues through key community figures such as Unjani nurses or “street mothers”, i.e. in this instance female spaza shop owners who would sell basic, over-the-counter drugs for minor ailments

Adapted from Haupt & Kraemer (2012)²¹

From a corporate perspective, RTT’s key motivation is the combination of a promising business opportunity and the positive socio-economic impact for people living in low-income communities, says Trixie-Belle Nicolle, Project Director in charge of Unjani

²⁰ BARTON, Ian, *ibid.*

²¹ HAUPT, Solveig, & KRÄMER, Aline, “Bringing Medicines to Low-Income Markets – A guide to creating inclusive business models for pharmaceutical companies”, *Deutsche Gesellschaft für Internationale Zusammenarbeit. Authored by Endeava, Berlin, 2012, pp20-21.*

Clinics at RTT: Through the proposed Unjani model, RTT can help provide access to new distribution points around the country for producers of pharmaceutical products, and



*Dispensing medication, Unjani Clinic
Etswatwa (Picture: Trixie-Belle Nicolle,
RTT)*

give them the opportunity to understand and serve a new market, while at the same time providing better access to primary health care and medicines at the base of the economic pyramid and helping to reinforce local entrepreneurship.²²

RTT's vision within the next 4 years is to build a sustainable network of 500 Unjani Clinics across the country, including in rural and semi-rural areas, where public health care facilities are often far away. The key elements of this vision are to strengthen the health care system through the provision of sustainable and scalable services;

support community development through health education; and create market-based solutions to serve the primary health care needs of the low-income market.

²² NICOLLE, Trixie-Belle, *ibid.*

4. Implementing the Model

This section will expand on how the main partners in the model are selected and trained, how the community at large is engaged in the process, and how RTT envisages maintaining the relationships?

4.1. Selecting the main partners in the model

Qualified Nurses: During the proof-of-concept phase, RTT recruited two nurses through iKhambi Care, a medical service provider of primary health care, occupational care and HIV prevention. From a legal, practical and administrative point of view, it made more sense for RTT to use the services of an experienced medical service provider than to directly employ nurses and ancillary staff in a specialised field that is not part of the company's day-to-day business. Once the proof-of-concept phase is completed, however, RTT may decide to recruit future nurses through RTT Scriptworx, which would act as the in-house clinic management company, providing advice on treatment protocols, stock management, etc., explains Trixie-Belle Nicolle.²³ In the business model envisaged, the nurses will eventually be self-employed, as they will own and manage their clinic themselves, as explained in section 2.3: Social Franchises.

There are two main recruiting criteria for the Unjani nurse:

- She/he must be fully qualified and registered as a nurse, and if possible have a dispensing licence.
- She/he needs to be willing to acquire some business and administrative skills and have the motivation to eventually manage the clinic as a social franchise.

RTT provides on-site, weekly business training and advice to the Unjani nurse (and assistant) in order to prepare them for transition into their future role as social franchisee.

Ancillary health care worker: The second staff member's main task involves patient management, managing stocks of medicines as well as record-keeping of patient data. The ideal profile for this person is to have a background as an ancillary health care worker (which is indeed the case for the current staff member on the Etwatwa site), though the more important criterion is that she (or he) needs to be a member of the local community. In RTT's experience, this is a key factor to help establish trust in the community that the clinic intends to serve.²⁴

The nurse and her ancillary are both provided with in-house basic business skills training provided by RTT, consisting of computer skills, basic accounting and bookkeeping, administration, and stock management. However, RTT is for the present concentrating on increasing patient numbers and productivity so as to ensure the long-term viability of the clinic, meaning that the nurse and the ancillary are mainly left to concentrate on the day-to-day management of the clinic. Considering that productivity

²³ NICOLLE, Trixie-Belle, *ibid.*

²⁴ NICOLLE, Trixie-Belle, *ibid.*

and patient numbers have increased considerably over the last few months at the clinic, the next phase will be to provide the nurse and her ancillary with basic business skills training that includes computer skills, accounting and bookkeeping, marketing and administration training that will be dispensed in-house by RTT. The approach is essentially one of “learning-by-doing”.

Female-owned spaza shops (informal retailers): The task of identifying and recruiting female spaza owners would fall to the local Unjani Clinic, and recruited through interviews. They would receive basic training from the Unjani nurse on the most common non-threatening conditions in the area, as well as guidelines on the use and administration of a package of schedule 0 drugs (over-the-counter medicine that does not require a medical prescription and can be sold through ordinary retail channels in South Africa).

As emphasized by Iain Barton, RTT envisages the spaza shops as “feeder and support mechanisms”, in which spazas are the first line of contact in cases of minor health issues. In this system, the parent or caretaker of a child with a runny nose or with a mild fever can go to the local spaza first, the Unjani clinic as a second resort, and public clinics or hospitals as a third resort.

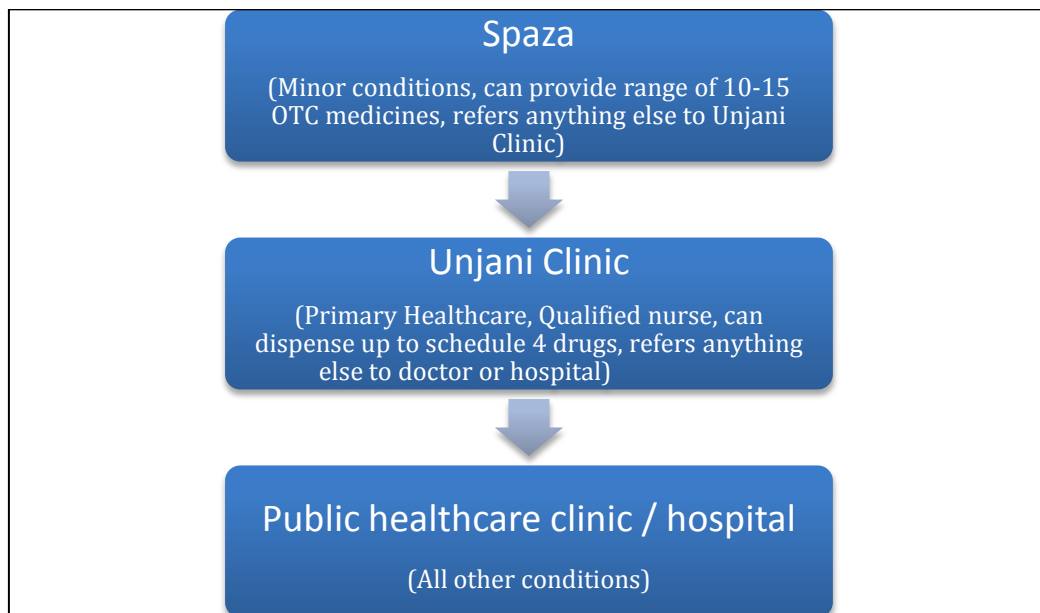


Diagram 2: The “Deal with what you can, refer what you cannot” principle (Source: RTT)

Table3: Overview of training approaches²⁵

Type of training	Group benefiting from training	Main contents of training	Provided By:
Operational Training	Primary Health Care Nurse	IT system, medical operations	RTT
	Ancillary health care worker / Administrative Assistant	Inventory Management, Stock levels	RTT
	Female Spaza Shop owners (“street mothers”)	Basic training, provided by Unjani Clinic nurse, on the uses of a pre-approved list of schedule 0 over-the-counter medicines and the most common non-threatening ailments in the area Inventory and stock management	Unjani Clinic Primary Health Care Nurse
Business Skills	Primary Health Care Nurse	In-house business skills training by RTT: structure of the social franchise model, business management, accounting and bookkeeping, administration.	RTT, possibly outsourced in future to specialised external provider
	Ancillary health care worker / Administrative Assistant	In-house business skills training, data management, administration.	RTT, possibly outsourced in future to specialised external provider

4.2. Getting Buy-In From the Community and the Local Council

Obtaining the necessary buy-in from the local communities it intends to serve is one of the most difficult challenges to overcome. Indeed, RTT faced a number of hurdles in

²⁵ NICOLLE Trixie-Belle, *ibid.*

the process of gaining local community acceptance for its concept, but also had some important breakthroughs which helped it to overcome these difficulties.

According to Trixie-Belle Nicolle, RTT adopted a targeted and determined strategy in order to get the necessary buy-in from the local community in Etwatwa, and intends to replicate the strategy elsewhere. This strategy contains three main elements:

Approaching the local government from the onset (e.g. through the ward councillor)

Getting support from other key players in the local community, notably churches and schools

Building a long-term relationship with these stakeholders to ensure that the buy-in is sustained, and important issues are identified.

The first important step was to obtain the local authority's support for the model, an essential component of success. According to Trixie-Belle Nicolle and Deon Vos, this was done by directly approaching the local ward council in Etwatwa. RTT presented the Unjani concept and asked for the Council's feedback. The local council's initial concern was the fact that the proposed service was fee-based, whereas it is government policy to provide free access to health care and primary health care.

This hurdle was overcome when RTT presented its business plan to local councillors, emphasizing the potential benefits of an Unjani Clinic for the local community, its enterprise development component, and the added value for the local council of additional health infrastructure that could enhance service delivery.²⁶

While simultaneously engaging with the local council to obtain their support, RTT also sought to gain the trust of the community, by sharing information on the project through community focal points, such as churches and schools. The biggest single obstacle was to get introduced to these focal points in the local community: Without contacts and networks, RTT used the services of one of its clients, the South African National Council for Alcohol and Drug Abuse (SANCA), an NGO active in monitoring and preventing alcohol and drug abuse. Through its work, SANCA is in contact with an extensive network of churches, schools and community-based organizations around the country, including in the peri-urban and rural areas that RTT wants to serve through the Unjani model.

With the assistance of SANCA, RTT obtained a level of access to the community that it would not otherwise have had on its own, according to Deon Vos, RTT's former Unjani Project Director and initiator of the Unjani Clinic in Etwatwa.²⁷ Local spiritual leaders and schoolteachers or school principals can be useful in sharing information and sources of support. As is the case for the local council, the key lies in emphasizing the potential benefits of the model in improving access to primary health care, as well as improving awareness of health care and self-medication through educational means.

²⁶ NICOLLE, Trixie-Belle, and VOS Deon, *Interviews, ibid.*

²⁷ VOS, Deon, *Project Director for Unjani Clinics 2009-2011, RTT. Interview on February 20th, in Johannesburg.*

The indirect benefits come from strengthening the local economic fabric by supporting local suppliers (for instance, security services and cleaning services). Informal retailers were also contributing factors in obtaining the support from such figures and institutions.

The project is also promoted through a variety of direct marketing channels, including flyers at taxi ranks and community centres, local radio advertisements, and advertising boards. The Unjani Clinic was officially opened at a public ceremony to which all residents were invited, and where further promotional material such as flyers and T-shirts was distributed.

Trixie-Belle Nicolle and Deon Vos believe that these inclusive marketing approaches had a significant impact in publicising and sustaining the Unjani unit in Etwatwa, and provide important experiences for any future scaling up of the model. RTT has also recruited a community marketer, a local person who spends one day per week on door-to-door visits, not simply handing out pamphlets but actively engaging in further discussions with the community about the Unjani Clinic. Through this channel, RTT is also gaining valuable qualitative information about the community's perceptions of the clinic and the health care needs of the community it intends to serve.

Table 4: Overview of Approaches to Local Stakeholders

Who	How	Outcome	Key Lessons
Local Council (Local Government)	Direct approach to local councillor in charge of health	Local council approves of project, and provides material support such as location and electricity connection	Local council support is crucial in getting authorisations and approval. Emphasis is on added value of Unjani for the community and benefit to local council in terms of service delivery
School	Indirect approach through SANCA (NGO)	School supports Unjani concept with parents and learners, agrees to provide location to Unjani Clinic if needed	As a focal point in the community, a school can be actively involved in promoting a model and help to establish local networks of suppliers
Church	Indirect approach through SANCA (NGO)	Local pastor actively involved in the launch of the clinic; Offered services to do additional marketing and promotion; put RTT in contact with local service suppliers such as security services	As a focal point in the community, a spiritual leader can be actively involved in promoting a model and help to establish local networks of suppliers
Local community	Direct approach through launch event; Continuous marketing effort through radio, flyers and community meetings	Positive image of Unjani; Fee still represents hurdle but feedback from users positively compares Unjani to existing public and private alternatives	Marketing needs to be sustained throughout, with regular events, flyers, and radio adverts and marketing material such as T-shirts

Source: RTT

4.3. Overcoming Challenges to the Inclusive Business Strategy

RTT's immediate challenge is to ensure the success of its proof-of-concept experiment at Etwatwa. This includes addressing productivity issues, which have a direct impact on the financial viability of the model. The next step will be to scale up the model and start building a national network of Unjani Clinics.

Productivity and increasing the number of patients:

In this early 'proof-of-concept' stage, the issue of productivity, as measured by the number of consultations, is important in establishing the chances of sustainability of the overall model, as the income stream is directly dependent on the number of consultations on any given day. At this point RTT believes there is room for further productivity gains, and a number of measures are being taken to reach a target of 23-25 patients per working day.

The clinic's opening times have been adapted to demand, and it now opens on a Saturday morning and closes on a Wednesday afternoon, instead of being open Monday to Friday from 08h00 till 16h30.²⁸ Productivity gains can be made by automating processes that are currently done manually such as patient data management and stock management. Another source of productivity gain could be to link part of the staff's compensation to the number of consultations, although such an approach has some obvious potential drawbacks with regard to quality perceptions and other intangibles such as building relations with the community: Part of the appeal of the Clinic is that the nurse is perceived to be taking the time to consult with patients. In order to increase the number of patients and revenue, RTT has also introduced a loyalty card for patients which provides for a free consultation after 9 visits.

The introduction of the loyalty card significantly pushed up numbers of patients, which grew steadily from April 2011 to reach close to 400 patients a month towards the end of 2011, according to Trixie-Belle Nicolle.²⁹ The steady growth curve in the number of consultations indicates that the clinic is gaining in popularity in the area, and is fast moving towards economic self-sufficiency.

²⁸ NICOLLE, Trixie-Belle, *ibid.*

²⁹ *ibid.*

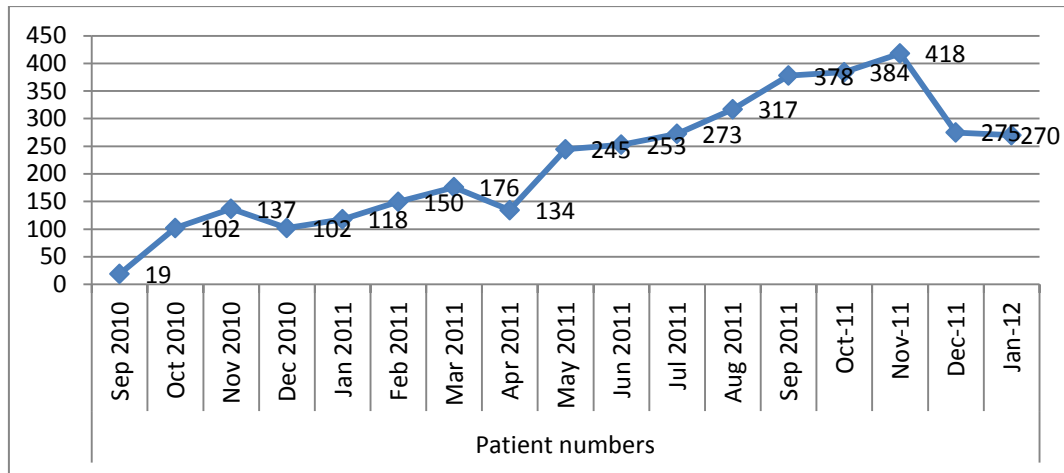


Diagram 3: Number of patient consultations at Unjani Clinic in Etwatwa (Source: RTT)

Ensuring financial viability of the model:

In its current form, the Unjani Clinic is not immediately profitable or financially neutral. Income is generated for the moment mainly from consulting fees, but these do not cover all of the costs that include staff compensation, services, waste collection and stock replenishment. The Etwatwa Clinic currently has a cost base of R 28,000 to R 30,000/month, including personnel costs. The break-even point stands at 460-500 patients per month, which translates into a minimum of 23 consultations per day (on a basis of 20 working days per month). One option under consideration is for the Clinic to extend its opening hours to Saturdays and Sundays as well as during the week, but this means that the Clinic will then need at least one additional nurse, which implies adapting to the current business model to accommodate more than one nurse per clinic.

Revenue can also be generated from additional sources such as over-the-counter (OTC) drug sales, script delivery and management fees, data collection fees (i.e. fees received for sending and feeding data on health treatments and ailments in a particular geographic area in view of promoting cell-phone-based treatment protocol programmes and the mapping of population health profiles in different parts of the country) as well as logistics and marketing fees (i.e. fees collected from partner companies willing to use the advertising space on the container or building).³⁰

The next phase of the funding strategy includes identifying donor funding and requesting enterprise development funding from the RTT client base, including large pharmaceutical firms such as GlaxoSmithKline, Johnson & Johnson, Merck and Carecross. Other potential partners include MTN and Sanlam, who have an interest in the Unjani programme in terms of mobile phone-based treatment protocol programmes, as well as providing basic health insurance.³¹

³⁰ NICOLLE, Trixie-Belle, *ibid.*

³¹ *ibid.*

Scaling Up the Model:

RTT's vision and ambition is to roll out a network of around 500 Unjani Clinics around South Africa. From a logistical and operational point of view, it will take a number of years to reach that target: Over time, RTT intends to roll out Unjani Clinics in the more isolated rural and semi-rural areas, where the need for better access to primary health care is even greater than in peri-urban low-income communities.

Drawing from the learnings of Etwatwa, scaling up the model will require approaching local authorities as well as community focal points as a first priority. The challenges therefore lie in the capacity of RTT to prepare for and implement these consultative processes as well as in the time required to obtain buy-in from the community and the main stakeholders and focal points, as well as the relevant local authorities.

Establishing an Unjani brand and a social franchise network:

Another challenge over the next few years will be to build and establish an Unjani brand, which will be a key element to successfully creating a social franchise network that is recognised around the country. The social franchise concept is the main empowerment element of the model, as each Unjani unit would be registered as a business, with at least 50% black or black female ownership.

Commodifying health care:

A more fundamental, long-term potential challenge for the Unjani Clinic model is arguably how to handle the moral dilemma of commodifying health care. While a consultation fee of R 60 is undoubtedly low, it still represents at least 3 days of income for most people living at the base of the pyramid in South Africa. Proponents of universal free access to health care would argue that unlike other products or services health care should never be "commodified", nor should it be the object of a profit-making venture. This issue may also limit any possible partnerships with the public health care system, which operates on the principle of universal free access.

Universal free access, however, remains to some extent theoretical, since hidden costs are not taken into account: These include transport, which is one of the factors which the Unjani model tries to address, as well as lost revenue caused by long waits as people queuing at a clinic are unable to be at work. The Unjani model thus offers a wider range of options for people living in poverty, and the calculation is that people are often prepared to pay a fee in exchange for shorter waiting periods or shorter distances covered.

5. Revenue Model, Impact and Future Prospects

5.1. Revenue Model

The main revenue stream for the Unjani Clinic consists of consultation fees, charged at R 60 per visit. This price level has remained stable for the past 16 months, and is likely to rise soon to a more realistic R 70 to cover inflation. In addition, Unjani charges R 20 for additional diagnoses (follow-up visits).

A second revenue stream comes from script delivery fees (fees charged for prescription medicine) that nurses are, as provided for in the South African regulations, allowed to issue for a specific set of drugs, and a 25% margin on the sale of OTC medicines.

Based on the assumption of 500 to 550 full patient visits per month, an Unjani Clinic could earn revenue of approximately R 30,000-R 35,000 per month.

The operational costs include site rental, staff wages, services, stock replenishment and waste collection, as well as electricity.

Table 5: Unjani’s Basic Revenue Model over 36 months (in Rands – Lease model)

	Year 1	Year 2	Year 3
SITE RUNNING COSTS			
Professional Nurse Salary	12,000	12,780	13,610
General Assistant Salary	4,000	4,260	4,536
Replenishment Stock	6,390	9,074	12,079
Overheads	4,954	5,276	5,619
Consumables	240	341	453
Clinic Management Fee	5,000	5,325	5,671
Marketing Fee	1,000	1,065	1,134
Staff Incentive	400	639	907
Medical Waste	259	275	293
Office expenses	200	213	226
Repairs	500	533	567
Wages	300	320	340
Site insurance	800	852	907

Professional Indemnity	253	270	287
Lease Payment	2,000	2,130	2,268
Total Running Cost per month	38,296	43,352	48,903
INCOME			
Consultations	24,000	34,080	45,369
Additional Revenue Stream	2,500	5,325	5,671
Total revenue per month	26,500	39,405	51,040
NET (LOSS) / GAIN	(11,796)	(3,947)	2,137

Source: RTT

As indicated by the above projections, an Unjani Clinic will start to cover its costs and generate an operational profit during the third year of operation. This operational revenue model does not, however, take into account the initial capital expenditure of setting up a clinic, which currently amounts to approximately R 200,000, according to RTT.³² This amount covers the site unit itself, medical equipment, furniture, recruitment and training, and the initial inventory.

This capital expenditure is currently funded through RTT Group's Enterprise Development Fund. To cover the cost of expanding the model around the country, RTT is establishing partnerships with the large pharmaceutical companies (Johnson and Johnson, GSK, Merck) as well as software development firms (SAP), and mobile telecommunications company MTN, RTT Solution's biggest client.

5.2. Socio and Economic Impact

Since it commenced operations in October 2010, the Unjani Clinic in Etwatwa has treated approximately 2,550 patients. Average monthly figures have risen considerably from an average of around 150 until the second part of 2011, to reach close to 300 patients a month. This was achieved through increasing productivity, and by gradually automating processes such as data capturing.

As is clear from the revenue model above, at this level the Clinic is able to cover its operational costs, which constitutes a first step towards economic sustainability.

The Clinic has also created two direct employment opportunities as well as some indirect employment (such as cleaning and security services, and deliveries).

In Etwatwa, the Unjani Clinic is succeeding in its biggest single aim, which is to provide access to affordable primary health care and basic medicines to the local low-income communities.

³² NICOLLE, *Trixie-Belle, ibid.*

Indirect beneficiaries include the public health care facility adjacent to Unjani Clinic in Etwatwa, as Unjani's existence helped relieve congestion at the public clinic, enabling it to focus on more serious conditions and better fulfil its own mission.

For the RTT Group, the positive impact so far is mainly measured in terms of its branding presence and employee satisfaction, but perhaps more importantly, in terms of its own engagement towards the empowerment of low-income communities through enterprise development.

The local ward council in Etwatwa has also been closely following the impact of the Clinic in the community and has responded enthusiastically to its perceived benefits: It has, for instance, actively facilitated the Clinic's day-to-day operations by providing it with a venue on council premises, as well as advice to RTT on how best to market the Clinic in the community. The local council also agreed to provide an electricity connection, and is encouraging neighbouring wards to establish their own clinics, according to Nolwazi Tati.³³

5.3. Future Prospects

The Unjani Clinic model is still in its inception phase. Considering the encouraging results of this proof-of-concept phase, RTT is planning to roll out the next phase during the second half of 2012, by opening several more sites including one in Delft, a low-income community 25 kms outside of Cape Town, as well as in Tembisa, a large township north-east of Johannesburg.

RTT is currently exploring multiple avenues to ensure the overall feasibility of the project, and to reach its goal of expanding the Unjani Clinic network to 500 units around the country. It estimates that the total investment needed for this is R 127 million (approximately US \$ 17 million at March 2012 exchange rates).

The company intends to finance a portion of this capital expenditure through its Enterprise Development budget, but the greater part of the required funding must be raised from the corporate partners in the project. Such partners have an incentive to provide an investment that will take the form of equity in individual clinics, and will be recovered in the long run through increased sales of goods and services in the market at the base of the pyramid: Generic drugs for the pharmaceutical companies, and data services for the telecoms and IT firms that are envisaged as ideal partners in the model.

More broadly speaking, a wide range of South African companies could benefit from partnering locally with RTT on the deployment of Unjani Clinics, not least South Africa's huge mining industry, the country's largest single economic sector. Companies like Anglo-American, BHP Billiton, Xstrata, Total Coal and others are under huge pressure to improve their socio-economic impact in the communities in which they operate. The Unjani Clinic model provides an opportunity to improve BB-BEE

³³ TATI, Nolwazi, *ibid.*

scorecards, particularly in the fields of Enterprise Development and Socio-Economic Development.

RTT will also provide a stronger focus in the next phase on transferring business skills to the owners of the future social franchises, as well as providing training to, and establishing partnerships with, informal retailers who will eventually be integrated into the model's value chain. This will be a crucial part of the ultimate success of the model, as the objective of relieving the public health service of unnecessary congestion will be closely linked to people's willingness and ability to identify non-threatening medical conditions and to self-medicate. It will also, if successful, constitute one of the most innovative parts of the model: Low-income communities are not just consumers but benefit in the form of reciprocal partnerships and empowerment through enterprise development.

6. Conclusion

Eighteen months after it was started as a pilot, the Unjani Clinic in Etwatwa has, according to RTT, passed a number of important tests on affordability, access, quality, buy-in from the community and the nurse, as well as a focus on the base of the pyramid.³⁴

1. **Affordability:** At R 60 per consultation and R 20 for a follow-up consultation (including medication), the Unjani Clinic is considerably more affordable than any private alternative;
2. **Access:** The clinic is easy to reach and centrally located in the heart of a community of an estimated 60,000 people;
3. **Quality:** Exit interviews and surveys indicate that quality perceptions and ease of use are the two most important factors for patients when they choose to consult at the Unjani Clinic;
4. **Buy-in from the community, nurse and local authorities:** The clinic has been adopted by the community as well as by the local authority, and its staff seems ready and committed to transition to a full ownership model;
5. **Focus on the base of the pyramid and low-income communities:** The clinic has succeeded in attracting patients on low or very low incomes and aims to reach the very lowest income segments in the future.

The process of setting up its model has also provided an opportunity for RTT to learn a number of key lessons over the past eighteen months, most notably:

- The choice of location is of paramount importance;
- The selection process of the staff is important as they need to combine primary health care expertise with basic business and administrative skills;
- A proper market analysis must be undertaken in order to determine the needs of the local population;
- A targeted marketing campaign must focus on the clinic's primary health care offering.

The next steps to scale up the model will require building long-term corporate partnerships, not only with pharmaceutical companies, but with firms trading or operating in low-income communities. They could, for instance, include mining companies or agribusiness ventures seeking to stimulate economic activity and access to primary health care in the often impoverished rural areas in which they operate. At the other end of the spectrum, the building of a network of informal retailers as "first line" dispensers of basic medicines provide innovative solutions for access to medicines and primary health care, relieving the public health care system and strengthening local enterprise.

In the South African context, characterized by its inequalities and the limited public resources to address the health needs of the poorest, the Unjani Clinic model could help considerably in improving levels of access to primary health care and medicines in low-income communities.

³⁴ NICOLLE, *Trixie-Belle*, *ibid.*