



An "economies of worth" perspective of a management innovation adoption process in an organization

Manh-Hung Nguyen

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THÈSE

Pour obtenir le diplôme de doctorat en Sciences de Gestion

Spécialité : Marketing

Préparée au sein de l'Université de Rouen Normandie

An “economies of worth” perspective of a management innovation adoption process in an organization

**Présentée et soutenue par
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« Mon dessin ne représentait pas un chapeau. Il représentait un serpent boa qui digérait un éléphant. J'ai alors dessiné l'intérieur du serpent boa, afin que les grandes personnes puissent comprendre. Elles ont toujours besoin d'explications. »

Le Petit Prince – Antoine de Saint-Exupéry

L'université n'entend donner aucune approbation ni improbation aux opinions émises dans les thèses : celles-ci doivent être considérées comme propres à leurs auteurs.

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---*---*---

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---*---*---

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---*---*---

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All of my efforts over the past five years cannot compare to the sacrifices you made for me.

How lucky I am to have you in my life ...

RÉSUMÉ

Depuis la première révolution industrielle, « l'innovation » a été mentionnée à de nombreuses reprises. Ce terme a souvent été associé à « l'innovation technologique ». Récemment, un nouveau type d'innovation, l'innovation managériale, ainsi que son processus d'adoption sont au cœur de l'attention.

Les chercheurs s'intéressent depuis longtemps à l'innovation, en particulier aux innovations au sein des organisations (l'innovation technologique, l'innovation administrative, l'innovation radicale, etc. mais pas à l'innovation managériale). Dans de nombreuses études sur les innovations organisationnelles, l'innovation technologique reste un sujet dominant et il convient de sortir des limites des études d'innovation technologique. Récemment, des thèmes diversifiés sur les innovations managériales ont été étudiés, montrant l'attrait particulier des innovations managériales pour les chercheurs dans ce domaine.

Dans les organisations, l'innovation managériale n'est pas un "outil statique". Il existe dans les processus en cours de l'organisation. Les chercheurs dans ce domaine ont exploré avec soin les processus de l'innovation managériale, en particulier la génération, la diffusion et l'adoption (avec ou sans adaptation) de l'innovation managériale. Cependant, les études sur l'adoption de l'innovation managériale semblent être négligées.

En outre, l'adaptation mutuelle entre les innovations managériale et les organisations adoptantes doit également être étudiée. De manière plus concrète, il est essentiel d'étudier la tension qui peut apparaître lors de l'introduction d'une innovation

managériale dans une organisation ainsi que de la pression mutuelle entre l'innovation managériale et l'organisation lors du processus d'adoption.

Néanmoins, les études empiriques sur cette question restent encore insuffisantes. Par conséquent, nous nous concentrons sur ***les processus d'adoption d'une innovation managériale et les tensions entre cette innovation managériale et son organisation d'accueil pendant le processus d'adoption.***

Chaque innovation managériale comprend une philosophie de gestion alors que chaque organisation concerne certaines représentations. Par conséquent, les tensions potentielles pendant le processus d'adoption peuvent être considérées comme l'harmonie imparfaite entre la philosophie de l'innovation managériale et les représentations dominantes au sein de l'organisation « hôte ». À partir de cela, trois sous-questions importantes se dégagent : ***(1) comment identifier la philosophie d'innovation managériale et les représentations organisationnelles, (2) comment expliquer leurs accords / désaccords de valeurs pendant le processus d'adoption et (3) comment éviter les désaccords potentiels qui pourraient interrompre ce processus.***

Une innovation managériale peut être « cultivée » dans un environnement assez différent du contexte d'origine (en termes d'aspects culturels, politiques, économiques et sociaux). Cette différence peut conduire à des changements importants, voire à des « chocs » culturels forts, à la fois sur les innovations managériales et sur les organisations d'adoption.

Nous avons porté notre attention sur le Vietnam, un contexte particulièrement adapté aux problématiques de recherche. Le Vietnam est un pays socialiste d'Asie du Sud-

Est où les dirigeants sont encore habitués au style de gestion de la période soviétique. Depuis 1986, le pays a connu des changements positifs : d'une économie planifiée à une économie de marché. Récemment, le Vietnam, dans le but d'ouvrir son économie, a même accepté d'importer des modèles de gestion en provenance de pays développés. L'un de ces modèles est la franchise « business format » (Starbucks, McDonald's, etc.). Pour aller encore plus loin, certaines organisations non gouvernementales ont introduit dans ce pays des modèles de franchise à des fins sociales sous le nom de « franchise sociale ». Jusqu'à présent, la franchise sociale a principalement émergé dans les établissements de santé vietnamiens.

Semblable à la franchise « business format », la franchise sociale a été établie dans certains pays développés (Royaume-Uni, Allemagne, etc.). Elle a aussi été appliquée dans de nombreux pays en voie de développement du monde entier (Inde, Pakistan, Kenya, Éthiopie, etc.). En ce qui concerne le Vietnam, le contexte de ce pays est assez différent des « pays d'origine » du modèle de franchise sociale et la franchise sociale reste un nouveau modèle de gestion pour le Vietnam. En outre, la franchise sociale apparaît principalement dans la santé privée tandis qu'au Vietnam, la franchise sociale est également développée dans le domaine de la santé publique. Tous ces facteurs peuvent être considérés comme des « obstacles » à l'adoption de ce modèle au Vietnam, en prédisant les défis potentiels pendant tout le processus.

Dans notre cas d'étude, nous avons choisi « Sisterhood », un modèle de la franchise sociale gouvernementale dans de nombreux postes de santé communaux du système de santé publique au Vietnam. Ce modèle a été adopté au Vietnam par Marie Stopes International Vietnam.

Plusieurs sources de données qualitatives ont été collectées et nous avons porté une attention particulière à la documentation et aux entretiens semi-structurés. Diverses sources d'information ont également été mobilisées : des informateurs ayant des positions différentes des franchisés et co-franchiseurs de Sisterhood dans le but de comprendre les perceptions des différentes parties prenantes dans toutes les phases du programme.

En ce qui concerne l'analyse des données, pour traiter les problèmes de fiabilité, nous avons appliqué une méthode inspirée de Gioia et ses collègues qui comprenait deux phases principales : l'*analyse de premier ordre* et l'*analyse de deuxième ordre* où nos données ont été analysées et divisées en *concepts de premier ordre* et en *thèmes de second ordre*. Les premiers sont basés sur les mots, les termes ou les expressions des informateurs ; tandis que les seconds sont axés sur les concepts, les thèmes et les dimensions des chercheurs.

Sisterhood a été décrit à travers ses dimensions rhétoriques et technologiques. En ce qui concerne la dimension rhétorique, nos informateurs ont mentionné les objectifs, les activités principales ainsi que les objectifs sociaux de Sisterhood. Ils ont porté une attention particulière à « l'objectif axé sur le client » et aux « objectifs sociaux plutôt qu'aux objectifs commerciaux » de ce programme.

En ce qui concerne la dimension technologique de Sisterhood, tout d'abord, Sisterhood était considéré comme un modèle de franchise sociale dans le secteur de la santé publique au Vietnam. De plus, nos informateurs ont présenté trois éléments principaux de Sisterhood : ses cabinets de consultation « Sisterhood », ses maîtres

formateurs provinciaux (et les activités de formation-supervision-soutien) et ses ambassadeurs de la marque (et les activités de communication).

En raison de ces dimensions, nous avons prédit certaines ruptures liées aux processus d'adoption de Sisterhood dans les postes de santé communaux. En revanche, le modèle comprend également plusieurs personnes qui peuvent devenir les « solutions » à ces tensions (maîtres formateurs provinciaux et ambassadeurs de la marque).

Le processus d'adoption / d'adaptation de Sisterhood a été étudié à travers cinq grandes phases : identification des problèmes organisationnels, sélection du modèle managérial, persuasion du personnel, mise en œuvre du modèle et modèle de gestion en tant que routine et pratique courante.

Lors de l'*identification des problèmes organisationnels*, nos informateurs ont décrit le mauvais état de l'infrastructure et de la qualité des services dans les postes de santé communaux avant la création de Sisterhood. En ce qui concerne la *sélection du modèle managérial*, nous avons compris les processus de sélection du programme Sisterhood, en particulier comment choisir un poste de santé communal pour le programme. Concernant la *persuasion du personnel*, nos informateurs ont décrit les difficultés rencontrées pour faire comprendre aux dirigeants locaux Sisterhood ainsi que les hésitations de plusieurs parties prenantes au début. Les démarches auprès des populations locales et de certains postes de santé communaux ainsi que la présence d'une autre marque de franchise sociale (The Little Sun) ont également été considérées comme des difficultés initiales du processus d'adoption de Sisterhood.

Parmi les cinq phases, la *mise en œuvre du modèle* est au cœur du processus d'adoption / d'adaptation de Sisterhood. Nos informateurs ont confirmé qu'il y avait eu des changements importants dans les activités non-cliniques et cliniques des postes de santé communaux franchisés. Les informateurs ont mis l'accent sur les effets des cabinets de consultation « Sisterhood » sur les postes de santé de la commune. Ces effets sont les suivants : une nouvelle procédure de travail, les améliorations de la consultation, l'autonomisation des clients et le rétablissement de la confiance du public et de la responsabilité du personnel médical. La « concurrence saine » entre postes de santé franchisés et non-franchisés a été confirmée : de nombreux clients de communes non-franchisées se sont rendus chez des franchisés en raison du poste de santé Sisterhood et de son cabinet de consultation.

Dans la dernière phase, *modèle de gestion en tant que routine et pratique courante*, une stratégie de développement à long terme pour Sisterhood a été répétée à plusieurs reprises. Nos informateurs ont également parlé de la situation et du personnel médical des postes de santé communaux franchisés après le départ de Marie Stopes International Vietnam.

Concernant nos questions de recherche, un outil d'analyse est nécessaire pour étudier un processus d'adoption d'une innovation managériale. Il est assez difficile de trouver un tel outil pour analyser la philosophie de gestion dans une innovation managériale et les représentations de son organisation d'accueil. De plus, à notre connaissance, la littérature ne propose aucun outil pour étudier l'harmonie entre eux. Par conséquent, la dissociation entre une innovation managériale et son organisation adoptive en termes de philosophie est encore cachée aux chercheurs dans ce domaine.

Nous proposons de concevoir un tel outil basé sur les « économies de la grandeur » (Boltanski et Thévenot, 2006). Dans cette théorie, différentes situations où les individus devaient justifier leurs actions ont été examinées, y compris les situations de différences culturelles ou idéologiques. Sur la base des « économies de la grandeur », une innovation managériale et une organisation « hôte » peuvent être décrites à travers des mondes. Lorsqu'une innovation managériale est introduite dans une organisation, plusieurs nouveaux accords seront établis. De manière plus concrète, leurs mondes internes peuvent apporter des accords / désaccords. Par conséquent, le processus d'adoption d'une innovation managériale dans une organisation peut impliquer une importance considérable au-delà des limites de la littérature sur l'innovation.

Sur la base des « économies de la grandeur », nous trouvons de nombreux signes de différents mondes au sein de Sisterhood et des postes de santé communaux (avant la création de ce modèle). Par la suite, le processus d'adoption de Sisterhood dans les postes de santé communaux est analysé dans une perspective différente (« économies de la grandeur »). Cela étend non seulement nos connaissances sur le processus d'adoption d'une innovation managériale dans une organisation (au-delà de la littérature sur l'innovation managériale), mais favorise également l'applicabilité de la théorie des « économies de la grandeur ».

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ABBREVIATIONS

AP	The Atlantic Philanthropies
A&T	Alive & Thrive
CHS	commune health station
DHC	district health center
DOH	(provincial) department of health
EU	European Union
IAO	innovation-adopting organization
IGO	innovation-generating organization
MOH	Ministry of Health
MSI	Marie Stopes International
NGO	non-governmental organization
PATH	Program for Appropriate Technology in Health
PI	Plan International
PSI	Population Services International
RHFP	reproductive health and family planning
SC	Save the Children
UNFPA	United Nations Fund for Population Activities

INTRODUCTION

1. From practical to academic requirements

The last few centuries have been a period of inventions and innovations, some of them have significantly changed our lives. We can list some important inventions such as light bulb, airplane, personal computer, vaccines, automobile, telephone, etc. Since the first industrial revolution, “innovation” has been mentioned in numerous occasions. This term has often been associated with "technological innovation". However, innovation is not limited to the technical field. In reality, it can be found in every aspect of life. Besides innovations in technology, there are also innovations in education, agriculture, healthcare, services, social sectors, etc. Technological innovations and other kinds of innovation have some complex entanglements.

In business, technological innovations really get special attention. Recently, when the 4.0 revolution has exploded, technology-related innovations have been paid more attention. Technology companies, whose new products can change the world, are considered to be the leaders in technology innovation (the Big Four tech companies, or “GAFA”, are some famous names). Moreover, in these companies, there are not only technology innovation but also other innovations (for instance, in management practice, process, structure or technique).

People are beginning to pay more attention to a new innovation type, management innovation. Looking at the successes of an organization, we sometimes wonder what is behind these successes? What are the foundations for different innovations to develop within an organization?

A product or service cannot be spontaneously generated, it is the result of a collaboration of numerous people in which management plays a key role. Therefore, understanding and correctly applying management innovations help us change how we are working, in a more effective way.

The problem is that organizations are not always aware of the need to change the way they are operating their establishments. (1) "Why we have to change?" and (2) "How we have to change?" are two common questions. From a manager's point of view, this hesitation is relatively easy to understand because maintaining the old way of doing things can be considered "safer" than adopting a new management approach, especially when it is unlikely to be useful.

Tesla introduces a new electric car or Face ID (a facial recognition system) which has recently been applied to new iPhones by Apple. They are the concretization of technological innovation through specific products. Unlike technological innovation, the "products" of management innovations are often intangible and need time (several years) to measure their efficiency. The Toyota Production System (TPS), the precursor of "lean manufacturing" is a good example. Toyota spent many years of trial and error apprehending and effectively applying this system.

Innovation is presented as new and good. It is also the case of innovations in management. If an effective management innovation is used within an organization only, it will be a big waste. Naturally, it should be diffused and adopted somewhere else. Intangibility, however, appears to be a barrier to understand as well as to adopt management innovations. Therefore, finding a way to describe a management so that it can be applied effectively in various places is an essential requirement. A

management innovation includes not only practices but also theories, through which a managerial idea can be transformed to specific activities of organization or transferred to another organization.

An "object" can be considered to be a management innovation for a certain organization, but it may not be the case for other ones. For example, in Google headquarters, employees can work in a very friendly and open environment where they can be creative and minimize the pressure of work. This can be considered groundbreaking innovations in Google management but if these methods are applied to another organization, in another field or in another country, perhaps they are not a suitable choice. In fact, transforming a management innovation so that it can fit a new environment is quite common. Going back to the example of TPS, when General Motors was interested in the success of Toyota, they transformed TPS to "lean manufacturing" and obviously several elements of this Japanese model were changed to fit this corporation.

However, changes do not only come from management innovations but also from organizations where these innovations are applied. This process flows without interruption and quite complex, sometimes resulting in unintended and unexpected impacts on both of the sides. This is especially true when external/internal environment of organizations is turbulent or has various cultural characteristics. Studying management innovation as well as the process of adopting it is a serious matter that requires not only practical knowledge but also academic research. In other words, a managerial issue should be expressed in both practical and academic languages.

Innovation appears to be a fertile land for researchers. Numerous scholars have contributed to this field for a long time. At first, it is worth to present the definitions of innovation. “An innovation is an idea, practice or object that is perceived as new by an individual or other unit of adoption” (Rogers, 2003, p.12)¹. In this definition, “perceived as new” or the newness of an innovation seems vague. In addition, even when its novelty can be justified, the questions relating to the innovativeness of the idea, practice or object still remain to be studied. Indeed, “the difficulty here is that most of us expect an innovation to be something “good” (Knight, 1967, p.478).

Innovation in the definition of Rogers shares several common points with a change, regardless of its impacts. Knight (1967, p.478) also followed a similar logic because the author defined innovation as follows: “An innovation is the adoption of a change which is new to an organization and to the relevant environment”. In this study, the author interchangeably used “change” and “innovation”. Furthermore, both Rogers and Knight integrated “adoption” into their definitions. However, they only focused on the introduction into practice or the application of innovation and neglected its generation.

In business, innovations within organizations have a special place. They are “considered to be responses to environmental change or means of bringing about change in an organization” (Damanpour & Evan, 1984, p.393). Organizations need to develop innovations which in turn boost their internal changes to be confronted with

¹ Rogers’s influential book “Diffusion of innovations” was first published in 1962. In this thesis, we mobilize its latest edition (the 5th edition) published in 2003.

external uncertainties. That means these authors created a link between innovations and changes in organizations.

Damanpour and his colleagues made a series of research on innovations in organizations² where the authors shared a common definition of this kind of innovation. According to them, in an organization, innovation is an implementation of an idea which is generated internally or borrowed externally. The idea can be a product, device, system, process, policy, program, service, etc. In this definition, the newness of the idea³ is also emphasized: only new to the adopting organization, not the organizational population. This definition is more detailed than the one of Rogers (2003) but cannot escape from the concept of an organizational change (Pettigrew, Woodman, & Cameron, 2001; Van De Ven & Poole, 1995). Furthermore, it mentions where the idea comes from: it can be generated by the organization or other organizations of the population.

An important contribution for this field may be the study of Baregheh, Rowley and Sambrook (2009). Based on 60 definitions of innovation from various disciplines, these authors identified a multidisciplinary definition of innovation within business organizations. Innovation, according to them, is “the multi-stage process whereby organizations transform ideas into new/improved products, service or processes, in order to advance, compete and differentiate themselves successfully in their marketplace” (Baregheh et al., 2009, p.1334).

² For more information, please see Damanpour (1987, 1988, 1991, 1992, 1996), Damanpour and Evan (1984), Damanpour and Gopalakrishnan (1998), Damanpour and Schneider (2006) and Damanpour, Szabat and Evan (1989).

³ In this domain, the novelty of an idea (new to the organization or new to the world) depends on the specific purposes of the study.

In accordance with the specific purposes of each study, innovation in organizations is divided into various categories which are sometimes difficult to distinguish the difference among them. In addition, within each study, scholars often use similar terms for one type of innovation. For instance, strategy innovation (Hamel, 1998a), business model innovation (Hamel, 1998b), organizational innovation (Damanpour & Schneider, 2006, 2009), managerial innovation (Damanpour & Aravind, 2012), management innovation (Birkinshaw, Hamel, & Mol, 2008; Damanpour, 2014; Hamel, 2006; Mamman, 2009; Volberda, Van Den Bosch, & Heij, 2013; Volberda, Van Den Bosch, & Mihalache, 2014), etc. Attempting to build a typology which can satisfy all studies is therefore impossible (Garcia & Calantone, 2002).

Rowley, Baregheh and Sambrook (2011) provided insights into various types of innovation. Furthermore, these authors introduced a diagrammatic overview of innovation typologies over time and an innovation-type mapping tool that facilitated the comprehension of the development (from past to present) as well as the relationships of innovation typologies.

To extend beyond the border of technological innovation studies, Volberda et al. (2013) and Damanpour (2014) introduced non-technological innovation which consisted of administrative, organizational, managerial and management innovation. According to these authors, non-technological innovation is often considered to be management innovation. Therefore, the typology of innovation at organizational level can be viewed as a debate between technological innovation and management innovation.

In several studies, various kinds of innovation were introduced together with the purpose of finding the differences between them. A few common “couples” are administrative-technical innovation, product-process innovation or radical-incremental innovation (Damanpour & Gopalakrishnan, 1999). According to Damanpour and Aravind (2012, p.426), product and process⁴ typology is “the most widely studied innovation typology”. Furthermore, the authors suggested that technical and administrative innovation were also a common typology.

Damanpour and Wischnevsky (2006)⁵ proposed a distinction as follows:

<p>Technical innovation</p> <ul style="list-style-type: none"> - Relating to the technical system and the primary work activity of an organization - Pertaining to a new product/service or new elements of an organization’s production process or service operations 	<p>Administrative innovation</p> <ul style="list-style-type: none"> - Relating to the social system, the relationships among members (or between the environment and members) of an organization - Pertaining to a new management system, organizational structure or administrative process
<p>Product innovation</p> <p>New products or services as a response to the market need, competition, etc.</p>	<p>Process innovation</p> <p>The introduction of new elements to an organization’s production process or service operations</p>
<p>Radical innovation</p> <p>Relating to fundamental changes in organizational activities and very “far” from existing practice</p>	<p>Incremental innovation</p> <p>Resulting in lesser degree of departure (not “far” from existing practice)</p>

Table 1 – The typology of innovation at organizational level

According to this typology, technical innovations closely relate to product and process innovations⁶. However, they can be distinguished from technical innovations because

⁴ Technological innovation consists of product and process innovation (Walker et al., 2015).

⁵ This distinction can be found several times in the articles of Damanpour and his colleagues. For instance, Damanpour (1988, 1991, 1992, 1996); Damanpour and Evan (1984); Damanpour and Gopalakrishnan (1998, 1999); Damanpour et al. (1989) and Gopalakrishnan and Damanpour (1994).

⁶ Damanpour (2010) and Damanpour and Gopalakrishnan (2001) provided more details on product and process innovations.

they are “not merely innovations resulting from the use of technology” (Damanpour & Evan, 1984, p.394). Technical innovations pertain to almost all of the core activities of organizations and they can directly influence the outcomes of organizations.

Regarding administrative innovations, it is quite difficult to evaluate this kind of innovation due to its intangible outcomes and indirect effects. Relationships among members or between the environment and members of an organization, or in a general way, interactions inside a social system, are indeed quite delicate and need a particular set of criteria to measure.

Based on the degree of novelty, we can distinguish radical from incremental innovation (Damanpour & Wischnevsky, 2006). The former relates to significant changes which sometimes affect the whole organization where it serves while the latter is purely an organizational refinement.

Some scholars in this field only paid attention to the novelty of innovations (a quite relative term) and neglected their organizational impacts. According to Rowley, Baregheh and Sambrook (2011), incremental innovation is sometimes material changes of a product only. It can be an updated design, an additional option, etc. In general, incremental innovation can be viewed as an extra “object” which is added to an entity in order to improve or complete it. Only several parts of the entity are improved while its core still remains unchanged. On the contrary, almost all parts of the entity are changed in the case of radical innovation.

In reality, a combination of several innovation types is often introduced. For instance, Nonaka and Peltokorpi (2006) investigated Toyota Prius case in which both technical, product, process and radical innovation appeared together during the development

process of Prius, a hybrid electric automobile. As another example, Twingo project is a typical example (Midler, 2012).

It can be said that scholars have been interested in innovation for a long time, especially innovations within organizations. In numerous studies on organizational innovations, technological innovation is still a dominant subject (Crossan & Apaydin, 2010; Keupp, Palmié, & Gassmann, 2012). Crossan and Apaydin (2010) presented a systematic review of the literature on innovation and argued that: (1) 52% of selected articles pertained to innovation at organizational level and (2) among articles where the type of innovation was clearly defined, studies on technology innovation made up about 20% (the majority).

In addition, among 342 selected articles of a systematic review, the studies relating to product and process innovation (or technological innovation) also dominate the field (Keupp et al., 2012). Indeed, the majority of studies on innovations within organizations focus on technological innovation and there is a need to go outside the limit of technological innovation studies (Birkinshaw et al., 2008; Birkinshaw & Mol, 2006; Mol & Birkinshaw, 2009; Volberda et al., 2013; Walker, Chen, & Aravind, 2015).

2. Management innovations, an emerging field of research

Recently, diversified topics on management innovations have been studied. For a quick view of them, here are some examples. Some scholars studied a set of management innovations (Currie, 1999) while some paid attention to only one management innovation type (Walston, Urden, & Sullivan, 2001). Management innovation is often positioned in a specific management context to be apprehended

easily. For instance, McCabe (2002), Nieves and Segarra-Ciprés (2015) and Walston et al. (2001). The relationship between managers and management innovations that serve their organizations also attracts scholars in this field. Vaccaro, Jansen, Van Den Bosch and Volberda (2012) studied the relationship between leadership style and management innovation. Heyden, Sidhu and Volberda (2015) focused on the impacts of managers' characteristics on management innovation. Antecedents and contextual factors which have impacts on management innovation are also favorite research questions of scholars in this field (Ganter & Hecker, 2014). Other studies on management innovation focused on separate questions such as the evolution of dynamic capabilities (Gebauer, 2011), standardization and consultants (Wright, Sturdy, & Wylie, 2012) or the relationship between competition and a firm's inclination to introduce management innovations (Hecker & Ganter, 2013). Only a few examples above also show the particular attraction of management innovations for scholars in this field.

We have gone through several paragraphs to explore practical as well as academic requirements on management innovations. However, we neglect to really define this concept. Numerous examples, images and definitions of management innovations have been made by scholars in this field to make this abstract concept easier to understand.

Regarding examples of management innovation, Birkinshaw et al. (2008, p.830) provided several ones as follows: modern research lab, divisional (M-)form, Toyota production system, total quality management, discounted cash flow, Spaghetti

organization, cellular manufacturing, NASA new organization, activity-based costing, modern assembly line, balanced scorecard and quality of work life.

As for an image of management innovation, the “3Ps” concentric circles (philosophy, principles and practices) can be considered a general image of this concept (Mamman, 2009). The philosophy of management innovation, which is “a way of thinking or assumptions regarding how to manage an organization or tasks or how to solve organizational problem” (Mamman, 2009, p.36), is situated at the core. Based on this visual aid, the importance of management innovation philosophy is confirmed. Regarding the principles, they are represented by a circle next to the core. They consist of the implementation instructions of management innovation philosophy or in other words, relate to the way management innovation philosophy is applied. At a greater distance from the core, it is “practices” circle or “a set of to-do-list” (Mamman, 2009, p.38) which relates to how a specific mission is conducted from the beginning to the end within management innovation context.

Regarding definitions, each management innovation consists of several management ideas which are defined as “spoken or written discourses that propose and justify a technology to manage different parts of an organization. As discourses they consist of textual elements that can be grouped into two dimensions, rhetorical and technological. The rhetorical dimension consists of the label, a central claim, superiority claims, threats and warrants. The technological dimension consists of principles, practices, techniques and implementation instructions and warnings” (Rauth, 2015, p.6-7).

One of the first and most important “bricks” for building management innovation research field is the study of Birkinshaw et al. (2008). Indeed, numerous succeeding studies have been inspired by this article (Volberda et al., 2014) in which the authors defined management innovation as “the generation and implementation of a management practice, process, structure or technique that is new to the state of the art and is intended to further organizational goals” (Birkinshaw et al., 2008, p.829).

Birkinshaw et al. (2008)’s definition involves three important elements. First, the “generation” and “implementation” mentioned in the definition without any further details can be viewed as two phases within an innovation-generating/adopting organization where innovation is produced and applied in the same organization (Damanpour & Aravind, 2012). The ambiguity is that the “implementation” can be considered a pilot phase and therefore the “generation” and the “implementation” are the two phases inside an innovation-generating organization before they are diffused beyond this organization to organizational population then adopted by other organizations (Damanpour & Aravind, 2012).

Second, the term “new to the state of the art” often pertains to the novelty compared to the world or in a more specific way, the population of organizations. That means the practice, process, structure or technique has never ever been used before. Sometimes scholars in this field focus on more narrow scope, “new to the firm” only (Mol & Birkinshaw, 2009, p.1270). Birkinshaw and Mol (2006, p.81) did not even mentioned this detail clearly and management innovation was defined as “the implementation of new management practices, processes and structures that represent a significant

departure from current norms”. The term “significant departure from current norms” in this definition can be viewed as both “new to the firm” and “new to the state of the art”.

Third, the definition of Birkinshaw et al. (2008) reminded us about the importance of management innovation for organizations. It can significantly contribute to organizational goals which are a “wide” concept but often pertained to financial outcome. However, we believe that management innovation can bring various effects for an organization.

In other studies, scholars introduced different definitions of management innovation.

Table 2 below presents some of them.

Author	Definition of management innovation
Kimberly (1981, p.86)	“... any program, product or technique which represents a significant departure from the state of the art of management at the time it first appears and which affects the nature, location, quality or quantity of information that is available in the decision-making process.”
Hamel (2006, p.3)	“A management innovation can be defined as a marked departure from traditional management principles, processes and practices or a departure from customary organizational forms that significantly alters the way the work of management is performed. Put simply, management innovation changes how managers do what they do.”
Damanpour and Aravind (2012, p.429-431)	“... new approaches in knowledge for performing the work of management and new processes that produce changes in the organization’s strategy, structure, administrative procedures, and systems.” (p.429)

Table 2 – Management innovation definitions

Kimberly (1981) neglected the process, an important element of management innovation. In addition, management innovation in this definition “does not have to be an improvement over the state of the art; that is, it does not have to be more technically efficient than management techniques in use at the time of its introduction, it must only differ significantly from them” (Abrahamson, 1996, p.265). The definitions of Hamel

(2006) and Damanpour and Aravind (2012) also have this issue because the author only considered a management innovation to be “a marked departure” which would “produce changes”. Indeed, the innovativeness of a so-called “management innovation” is still a common issue in this domain.

Although accepting a single definition for management innovations is still a matter of debate, through practical examples and recent studies we have a common vision of management innovations. In addition, scholars affirm the key role of management innovations for organizations (as important as technological innovations), thereby encouraging more research on management innovations in the future.

One of the main goals of innovation at organizational level is improving the performance, competitive advantage, efficiency, effectiveness, etc. of organizations. Technological innovations and its impacts on organizational performance are confirmed through numerous studies (Hervas-Oliver & Sempere-Ripoll, 2015; Walker et al., 2015). Due to its important role, it is easy to understand that technological innovations have been a dominant subject for a long time.

However, management innovations can also improve productivity, competitive advantage, profit, etc. of organizations as efficiently as technological innovation. Over the past 100 years, compared to other kinds of innovation, management innovation seems to be the kind of innovation that matters the most (Hamel, 2006). According to Hamel (2009, p.5), “management innovation has a unique capacity to create long-term advantages.”

Birkinshaw and Mol (2006) introduced a list of management innovation examples in numerous firms that were historical evidence to support the advantages of

management innovation (see table 3 below). In this way, Volberda et al. (2014) reviewed recent studies on management innovation to support the positive effects of management innovation on performance outcome.

Company	Year innovation introduced	Management innovation	Key innovator
Analog Devices United States	1987	Balanced Scorecard for monitoring financial and nonfinancial performance measures	Art Schneiderman
Skandia Sweden	1991–2	Skandia Navigator and measurement of intellectual capital	Leif Edvinsson, Bjorn Wolrathl
Partners for Change United Kingdom	1994–6	Flexible employment/pay model for consulting	Tim Connolly, Mark Smith
Oticon Denmark	1991	“Spaghetti organization” – removal of formal hierarchy and job descriptions	Lars Kolind
Hewlett-Packard United States	1991	Global account management structure for sales organization	Alan Nonnenberg
Wellington Insurance Canada	1988–9	“Wellington Revolution” – radical decentralization of activities	Murray Wallace
Litton Interconnection Products United Kingdom	1991	Business cell structure for manufacturing and selling products	George Black
Shell Holland, United Kingdom	1996	“Gamechanger” – venture capital funding model for new business development	Tim Warren, Leo Roodhart
Sun Microsystems United States	1995	Development of “ecosystem” of software vendors	George Paolini
Motorola United States	1987	“Six Sigma” quality control methodology	Bill Smith, Mikel Harry
GlaxoSmithKline United Kingdom	2000	“Centers of Excellence for Drug Discovery”	Tachi Yamada, Allan Baxter

Table 3 – Examples of management innovations
Source: Birkinshaw and Mol (2006, p.83)

Management innovation effects on organizational performance are not direct and mediated by performance management (Walker, Damanpour, & Devece, 2010). In some studies, management innovation was considered “a lever” which enhanced technological innovation (Camisón & Villar-López, 2014; Hollen, Van Den Bosch, & Volberda, 2013). In addition, according to Walker et al. (2015), the effects of management innovation are similar to that of technological innovation in terms of direction and strength. That means, there is relative balance in terms of performance influences between technological and management innovation.

Indeed, the relationship between technological and management innovation is quite complicated, resulting in inconsistent explanations and conclusions in the field. Therefore, numerous questions relating to this relationship still remained to be studied (Georgantzias & Shapiro, 1993; Hollen et al., 2013). Furthermore, the results of the studies of Damanpour (2014), Damanpour and Aravind (2012) and Damanpour, Walker and Avellaneda (2009) encourage to simultaneously mobilize several innovation types (including technological and management innovation) rather than the introduction of a sole type of innovation with the purpose of attaining an optimal performance of organizations.

3. Research issues

To sum up, it is necessary to go beyond the boundaries of studies on technological innovations and focus on management innovations which, similar to technological innovations, play a key role in organizations. Understanding and applying

management innovations to organizations are both practical and academic requirements. Since being involved in management innovations, we have gradually focused our attention on the process of adopting management innovations. In the next paragraphs, we explain how we have been through to finally approach the research problem.

In organizations, management innovation is not a "static tool"; it exists in the organization's ongoing processes. Scholars in this field explored carefully management innovation processes, in particular the generation, diffusion and adoption process (with or without adaptation) of management innovation (Volberda et al., 2014). However, the studies on management innovation adoption seem to be neglected (Rasmussen & Hall, 2016). Urgent requirements from reality as well as the knowledge deficiency in this field of research encouraged us to focus on the adoption process of management innovations.

Mamman (2009) supported the utility of management innovation modification and argued that there was a dearth of studies in this field. According to this author, during or after adoption process, numerous management innovations can be modified. As an introductory study, the research only focused on the basic elements of management innovation modification such as the reasons why management innovation was modified (rational and non-rational reasons), the structure and the typologies of management innovation modification, the relationships between management innovation attributes and modification, etc.

A considerable contribution in this specific field of research is the study of Ansari, Fiss and Zajac (2010) which marked a significant advance of understanding on

management innovation modification. In this study, the interaction between practice characteristics and those of “host” organization where the practice will be adopted and adapted is a principal issue.

Shared similar views to Mamman (2009), the authors also supported the fact that “management practices often cannot be adopted by user organizations as ‘off-the-shelf’ solutions” (Ansari et al., 2010, p.67). In addition, one of the main reasons to adapt diffusing practices is “the characteristics of the practice do not fit with the adopter organization’s characteristics” (Ansari et al., 2010, p.73). However, the authors only focused on the adaptation of the practice and therefore it is necessary to develop other studies which can discover the mutual adaptation in which both diffusing practice and adopting organization have changes.

The differences in characteristics between management innovations and their “host” organizations (a “gap”) seem to be inevitable. Inspired by Ansari et al. (2010), Ansari, Reinecke, and Spaan (2014) and Mamman (2002, 2009), we suppose that:

- This gap can exist even before the management innovation adoption process occurs. Moreover, according to Ansari et al. (2010, p.73), “the potential for misfit is given across the whole life cycle of the diffusion process”.
- This continuous gap can bring several perturbations or even ruptures for the adoption process when a management innovation is integrated into an organization. In this

case, both of the management innovation and the adopting organization characteristics need to be considered⁷.

As mentioned above, the mutual adaptation between management innovations and adopting organizations need to be studied. In a more concrete way, it is essential to study the tension that can appear when introducing a management innovation into an organization as well as the mutual pressure between them during the adoption process.

Nonetheless, the empirical studies on this issue still remain deficient and that fascinates and urges us to study ***insights into an adoption process of a management innovation***, to explore ***the tensions between this management innovation and its adopting organization during the adoption process***. The process of adopting a management innovation is a common interest of many scholars in this field (Canet, 2012; Dubouloz, 2013). However, this thesis is not merely another empirical study of management innovation adoption process but also a different look at this process.

Every management innovation comprises a management philosophy while every organization pertains to certain representations. Consequently, the potential tensions during the adoption process can be viewed as the imperfect harmony between the management innovation philosophy and the dominant representations within the “host” organization. From that, three important sub-questions emerge: ***(1) how to identify the management innovation philosophy and the organizational***

⁷ Regarding this issue, according to McCabe (2002), the impacts of contextual relations should be mobilized to understand management innovations. Innovation “cannot be understood outside of the social context in which it is embedded” (McCabe, 2002, p.529).

representations, (2) how to explain their agreements/disagreements of values during the adoption process and (3) how to avoid potential disagreements that can interrupt this process. Properly answering these sub-questions can illuminate the process of adopting a management innovation and help to discover the “resistance” that may interrupt this process, even before the process.

The issue becomes more interesting when a management innovation is “cultivated” in an environment that is quite different from the original context (in terms of cultural, political, economic and social aspects). This difference can lead to significant changes, even strong cultural “shocks” on both management innovations and adopting organizations.

We directed our attention to Vietnam, a context particularly well adapted to the research issues. Vietnam is a socialist country in Southeast Asia where managers are still used to the management style of the Soviet period. Since 1986, the country has had positive changes: from a centrally planned to a market economy. Recently, Vietnam, in an effort to open their economy, has even accepted to “import” management models from developed countries. One of these managerial models is business format franchising (through several famous brands such as Starbucks, McDonald’s, KFC, etc.). Going one step further, some non-governmental organizations (NGOs) have brought to this country franchising models for social goals under the name of “social franchising”. Until now, social franchising has primarily emerged in Vietnam's health facilities.

Similar to business format franchising, social franchising has been established in several developed countries (the UK, Germany, etc.). It has also been applied in many

developing countries around the world (India, Pakistan, Kenya, Ethiopia, etc.). Regarding Vietnam, the context of this country is quite different from the “native countries” of social franchising model and it is still a brand-new management model for Vietnam. In addition, social franchising appears mostly in private health while in Vietnam social franchising is also developed in public health. All of these can be considered to be "obstacles" in adopting this model in Vietnam, predicting potential challenges during the whole process.

The ease of access to data as well as the excitement of adopting social franchising in the public health system in Vietnam led to a decision: we decided to look for the illustration of our research issues in this country. In a more concrete way, we were interested in “Sisterhood”, a governmental social franchising model in numerous commune health stations (CHSs) of the public health system in Vietnam. This model was adopted in Vietnam through an NGO, Marie Stopes International Vietnam (MSIVN).

It was the first time a social franchising model (a managerial model of developed countries) had been applied in numerous CHSs of several cities/provinces in Vietnam and there would probably be numerous criticisms during the adoption process. The above reasons (and many other ones which are explained in the methodology part of this thesis) attracted our entire attention and the Sisterhood model was chosen as our case study.

Going back to our research questions where an analysis tool is necessary to study insights into an adoption process of a management innovation, it is quite difficult to find such a tool to analyze the management philosophy inside a management

innovation and the representations of its “host” organization. In addition, to the best of our knowledge, the literature does not propose any tools to study the harmony between them either. Therefore, the (dis)harmony between a management innovation and its adopting organization in terms of philosophy is still kept secret from scholars in this field.

We propose to design such a tool based on “economies of worth” (Boltanski & Thévenot, 2006)⁸. In this study, various situations where individuals had to justify their actions were examined, included the situations of cultural or ideological differences. The authors also presented different “worlds” that consisted of particular registers of justifications. A confrontation of justifications (or systems of specific representations) results in several conflicts.

Based on “economies of worth”, a management innovation and a “host” organization can be described through worlds. When a management innovation is introduced into an organization, several new agreements will be established. In a more concrete way, their internal worlds can bring some agreements/disagreements. Therefore, the process of adopting a management innovation in an organization can imply much significance beyond the border of innovation literature.

A “gap” between a management innovation and a “host” organization, or imperfect harmony between management innovation philosophy and organizational representations can be interpreted as a conflict between worlds that leads to a few minor/major adjustments. If there is finally a compromise between worlds, the management innovation is successfully adopted/adapted in the organization.

⁸ Translated from the original version (Boltanski & Thévenot, 1991).

Therefore, it is necessary to identify worlds so that we can “build agreements, find solutions, solve the inevitable conflicts between ‘worlds’” (Amblard, Bernoux, Herreros, & Livian, 2005, p.83).

Therefore, current research issues can be described in a different way: ***(1) how to identify worlds which represent management innovations and their adopting organizations, (2) explain criticisms/arrangements/compromises among these worlds during the adoption process*** and even ***(3) predict criticisms among worlds before the adoption process to avoid potential ruptures***. Observing the process of adopting a management in an organization based on not only the knowledge of management innovation and its processes but also the "economies of worth" theory lends a fresh perspective to the subject.

4. Thesis structure

This thesis consists of three parts and six chapters (see figure 1 below for a clearer view of the structure).

In *Part 1*, we present the theoretical framework of our thesis. We focus on management innovation processes and social franchising.

-*Chapter 1*: relating to management innovation processes. The center place of this chapter is reserved for the processes of generating, diffusing and adopting a management innovation in an organization.

-*Chapter 2*: after presenting several definitions of social franchising, we pay attention to social franchising in health sector, in particular in developing countries.

Part 2 pertains to the methodology of this thesis. It comprises two chapters.

-*Chapter 3*: in this chapter, we present our qualitative research method and our case study. Both Vietnamese context and the Sisterhood program are carefully introduced.

-*Chapter 4*: this chapter relates to our data collection and analysis methods. Regarding data collection, documentation and interviews are paid attention. As for data analysis, we adopt a method of Gioia et al.

Part 3 is our findings and discussion.

-*Chapter 5, findings*: we discover insights into the Sisterhood program and the process of adopting it in Vietnamese local health facilities.

-*Chapter 6, discussion*: we provide a different look on the adoption process of Sisterhood based on the “economies of worth” theory.

INTRODUCTION

PART 1: THEORETICAL FRAMEWORK

CHAPTER 1: MANAGEMENT INNOVATION PROCESSES

1. The very nature of management innovations
2. Management innovation perspectives
3. Management innovation processes

CHAPTER 2: SOCIAL FRANCHISING

1. Definitions of social franchising
2. Social franchising in health sector

PART 2: METHODOLOGY

CHAPTER 3: RESEARCH METHOD AND CASE STUDY

1. Qualitative research method as an appropriate solution
2. Case study method and the original context of Vietnam

CHAPTER 4: DATA COLLECTION AND ANALYSIS

1. Data collection
2. Data analysis

PART 3: FINDINGS AND DISCUSSION

CHAPTER 5: FINDINGS

1. Sisterhood, a transporter of (potential) ruptures
2. Sisterhood adoption/adaptation process

CHAPTER 6: DISCUSSION

1. Sisterhood adoption – an original process
2. A different look based on “economies of worth”
3. Sisterhood adoption – a theoretical explanation of “economies of worth”

CONCLUSION

Figure 1 – Thesis structure

PART 1: THEORETICAL FRAMEWORK

Aligned with the research issues, part 1 focuses on management innovation and social franchising. This part consists of two chapters. In chapter 1, we spend time studying the very nature as well as the perspectives of management innovations. In addition, we pay special attention to the processes of management innovations. Although our thesis focuses on insights into management innovation adoption process, other processes should be studied because we believe that the knowledge of different management innovation processes can shed light on the adoption process. Therefore, the center of chapter 1 is reserved for three main processes of management innovations: generation, diffusion and adoption processes. Besides the general knowledge of management innovation in Introduction, chapter 1 provides a comprehensive view of the studies in this field, particularly those related to management innovation adoption processes.

In chapter 2, we study social franchising model. While business format franchising has been studied for a long time, social franchising seems to be a new and fascinating field of research and it is worth to spend an important part of this thesis studying this model. We start from the basic steps, defining what social franchising is, then discovering social franchising in health sector. In this subchapter, we pay attention to developing countries where social franchising has recently played an increasingly important role in health sector.

CHAPTER 1: MANAGEMENT INNOVATION PROCESSES

In the introduction of this thesis, we mentioned several examples, images and definitions that can be used to describe a management innovation: “what it is or what it is not” (Adam-Ledunois & Damart, 2017, p.121). In this chapter, we discover the characteristics of a management object which can help it become a management innovation. After understanding the very nature of management innovations, we focus on an overview of the studies pertaining to and the processes of management innovations.

1. The very nature of management innovations

Adam-Ledunois and Damart (2017), with a general purpose was to clarify the very nature of management innovations, provided an analysis method to determine the innovative nature of a management object and mobilized a literature overview in this field to highlight two approaches of management innovations related to their novelty. One is based on relative characteristics of management innovations and pertained to organizational context (contextual approach), the other related to absolute characteristics of management innovations, compared to the state of the art (conceptual approach).

While the conceptual perspective observes management innovations in a generic way, the contextual perspective reserves a central place in organizations for management innovations. These two perspectives focus on the ruptures brought by management objects (presumed innovative). This thesis pays special attention to management innovations within organizational context or in other words, contextual approach.

Regarding contextual approach, a management object (which are presumed to be innovative) can bring ruptures for organizational trajectory (the previous structures, management tools, strategies, philosophy, etc. mobilized by the organization). Conversely, fluctuations in organizations can lead to several modifications of a management object and transform it into a real management innovation. The rupture may be at different levels, at a local level (if a management object used in other organizations then introduced into a new organization for the first time) or at a global level (if a management object has never been implemented elsewhere or only applied within a given population of organizations).

As for conceptual approach, the ruptures brought by management objects are more abstract. Within this approach, the novelty of a management object is compared to the knowledge of practices, methods, concepts, tools, structures, etc. in the academic world. A management object can be totally new to the academic world or it is neglected and has not been “labeled” yet. In other words, the authors were interested in “management innovations as objects produced from management ideas and generic concepts, decontextualized” (Adam-Ledunois & Damart, 2017, p.126) or management innovations as objects already “in use” within the population of organizations but the academic world has not discovered it yet.

2. Management innovation perspectives

Management innovation perspectives provide an overview of the studies in this field. Birkinshaw et al. (2008), for instance, suggested four major perspectives on management innovation in the literature: institutional, fashion, cultural and rational perspective. According to these authors, the *institutional perspective* consists of the

studies pertaining to the institutional conditions of the occurrence and the diffusion of management innovations. In this context, the institutional conditions and major groups of influencers play a significant role in management innovation process. Within the institutional perspective, the role of human agency in shaping the process was not mentioned frequently. Similarly, the role of human agency in driving the process has rarely been discussed within the *fashion perspective*. In this perspective, the emergence of management innovations is influenced by the “fashion setters” (Abrahamson, 1991, 1996) who collect and introduce innovative management ideas to managers in ideas market. Regarding the *cultural perspective*, the key factors which influence the innovation process are the cultural factors inside organization. Relevant studies focus on the relationship between organizational culture and management innovation. Birkinshaw et al. (2008) paid special attention to the *rational perspective* where change agents and human agencies were key factors of the innovation process. In this perspective, the foremost goal of a management innovation is to improve organizational effectiveness.

Studies on management innovation can also be categorized into four main groups: rational, institutional, international business and theory development perspective (Volberda et al., 2014). Similar to Birkinshaw et al. (2008), Volberda et al. (2014) also considered organizational effectiveness to be the main goal of the rational perspective. That means all management innovations which occur inside organizations are derived from rational and careful decisions. Moreover, the studies within the rational perspective focus on the generation stage of management innovation while the institutional perspective studies relate to management innovation diffusion and variation. Furthermore, Volberda et al. (2014) highlighted the important contributions

of neo-institutional and fashion perspective to the institutional perspective. Within the institutional perspective, the importance is not organizational performance or profit any longer because a management innovation can be adopted or imitated without any evidence of efficiency. Only symbolic reasons, reputation, legitimacy, etc. can influence the adoption of management innovation. Management innovation gradually wins recognition and legitimization through extensive adoption. In addition, Volberda et al. (2014) also mentioned the managerial discourses shaped by management consultants, management gurus, etc. as well as the mutual interaction between these external change agents and adopting organizations. The institutional perspective of Volberda et al. (2014) appears to be the combination of the institutional and the fashion perspective of Birkinshaw et al. (2008).

As another categorization, Walker et al. (2015) introduced rational and institutional view (the two most widely used categories in management innovation research, according to them) to explain the relationship between management innovation and firm performance. Similarly, Damanpour (2014) focused on these two perspectives only. These authors tried to explain that under the rational view, management innovations are expected to contribute to organizational outcome and improve organizational efficiency and effectiveness. Moreover, the authors argued that the important factor of institutional explanations⁹ was the behavior of the population surrounding organization. This organizational population can influence the imitation and the adoption of management innovation. In this context, the intention of adopting

⁹ Many explanations of the institutional perspective based on Abrahamson (1991, 1996).

a management innovation is to satisfy social and institutional reasons (unlike technical reasons in the case of the rational perspective).

3. Management innovation processes

This sub-chapter is organized as follows: firstly, we pay attention to various categories of studies on the processes of innovation at organizational level; secondly, the three main processes of management innovations, generation-diffusion-adoption processes, are studied.

3.1. Innovation as a process

Crossan and Apaydin (2010) and Gopalakrishnan and Damanpour (1994) introduced two different categories of studies on innovation at organizational level: one consists of the studies which view innovation as a discrete product/outcome (for instance, Damanpour and Evan, 1984), the other includes the studies in which innovation is considered a process within organization (for exemple, Rogers, 2003). In this thesis, we are interested in innovation as a process and focus on relevant issues.

Among the process theorists, there are two kinds of researchers: ones focus on the diffusion of innovation while the others are interested in the innovation processes within organizations. These organizational innovation process researchers can be divided into two subgroups: generation and adoption process researchers (Gopalakrishnan & Damanpour, 1994; Kimberly, 1981) (see figure 2 below for a visual aid). To summarize, there are two ways to introduce an innovation into an organization: generation or adoption (Damanpour & Gopalakrishnan, 1998).

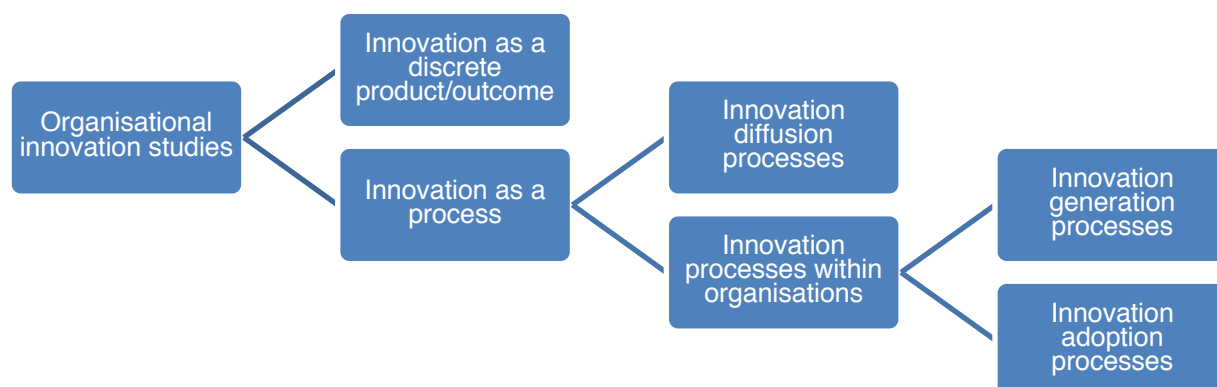


Figure 2 – Studies of innovation at organizational level

Source: Crossan and Apaydin (2010), Gopalakrishnan and Damanpour (1994), Kimberly (1981)

According to Damanpour (1988), the *innovation diffusion process* scholars are attracted by three types of research question: (1) how an innovation diffusion occurs within a social system, (2) the factors which affect diffusion speed and (3) the innovation attributes which influence its adoption rate.

Regarding the *innovation adoption process* scholars, they care about the organizational factors which can be potential levers or obstacles for adoption processes. The studies relating to innovation diffusion processes focus on innovation while the ones pertaining to innovation adoption processes pay attention to organization (Damanpour, 1988; Wolfe, 1994).

As for the *innovation generation process* scholars, they view innovation as a process through which new products, practices, services, etc. are introduced while the innovation adoption process researchers, in turn, view innovation as “a process of

stages” through which an organization adopts and assimilates new products, services, etc. (Gopalakrishnan & Damanpour, 1994, p.97). The generation and the adoption process scholars all argued that a difference between an organizational performance plan and the reality could trigger an innovation process (Gopalakrishnan & Damanpour, 1994).

According to Damanpour (2014), an organization generates an innovation for its specific purposes or for organizational population needs and this innovation generation process results in an outcome (new products, services, programs, technologies, etc.) as a response for market needs. When another organization adopts or imitates this innovation, it initiates another process: the process of adopting an innovation¹⁰. The importance is the innovation occurs in an organization which can considerably differ from the original one. In this context, these two organizations are called innovation-generating organization (IGO, “producer”) and innovation-adopting organization (IAO, “user”) respectively. As mentioned above, the studies on innovations at organizational level view these two processes as innovation processes (see figure 2 above).

The stages of the innovation process within an IGO and an IAO were briefly listed in Damanpour and Gopalakrishnan (1998, 1999). Damanpour and Wischnevsky (2006) made a further step by distinguishing the difference between innovation generation and adoption processes and between an IGO and an IAO. Regarding generation and adoption processes, Damanpour and Wischnevsky (2006) analyzed the studies in the

¹⁰ Damanpour and Aravind (2012) mentioned the situation where both innovation generation and adoption process occur inside an organization. In other words, an innovation can be generated and adopted within an organizational context that is, for the specific purpose of this thesis, not be studied.

field and introduced innovation under generation and adoption perspectives where innovation was considered to be “invention plus exploitation” and “initiation plus implementation”; furthermore, generation and adoption processes were considered “creative processes” and a “problem-solving processes” respectively. The former explore new knowledge while the latter prefer existing one. According to these two authors, selected studies on generation and adoption view “innovation processes” as a general term, including both generation and adoption while these two processes are significantly different. In addition, the factors which pertained to a successful innovation generation or adoption were also paid attention.

Regarding the difference between an IGO and an IAO, several important points are shown in table 4 below.

	IGO	IAO
Outcome	A new product, service or technology	Organizational changes
Strategy	Based on organization’s technological capabilities and existing and new market opportunities	Based on organization’s strategic requirements and existing innovations in the market
Innovation role	Innovation is an “end in itself”	Innovation is a means to attain organizational goals

Table 4 – The difference between an IGO and an IAO
Source: Damanpour and Wischnevsky (2006)

First and foremost, a new product, service or technology is a desired outcome of an IGO while the purpose of an IAO is to achieve organizational changes. Furthermore, as a “producer”, an IGO mobilizes its own resources and focuses on market opportunities while as a “user”, an IAO searches the market for an appropriate innovation. Innovation is one of the most important factors of an IGO while it is only a means to achieve organizational goals in an IAO.

As for the studies in the field of management innovation process, they follow a similar way. These studies primarily focus on one of the three phases of management innovation process¹¹: generation, diffusion and adoption (with or without adaptation) processes (Volberda et al., 2014). Volberda et al. (2014) proposed an overview of the studies on management innovation processes. According to them, the research relating to the processes of generating a management innovation focuses on the reasons why a management practice can be born in an organizational context and these studies pertain to the rational perspective of management innovation. Regarding management innovation diffusion processes, the research on this field studies the diffusion rate of an innovation among adopters (other organizations in the population). Moreover, the inter-organizational level and the institutional perspective were also paid attention. As for the research relating to the process of adopting/adapting a management innovation, based on both of the rational and the institutional perspectives, insights into adopting organizations are discovered.

In the next paragraphs, we discover the studies pertaining to the three processes of management innovations: generation, diffusion and adoption. Among these studies, ones on the process of adopting a management innovation are paid special attention to clarify what this thesis can contribute.

3.2. Management innovation generation processes

In management innovation-generating organizations, the processes before management innovation diffusion to other organizations seem to be quite interesting

¹¹ In this thesis, we do not study the cases of management innovation-generating/adopting organizations where the two processes, generation and adoption, of a management innovation occur in the same organization.

for scholars. Many of them introduced their models for this phase. Rogers (2003), for instance, presented six stages which we could apply for management innovation to understand its evolution before being adopted by other organizations (see figure 3 below). These stages can be described as follows: based on research, innovation (in general) is born as a response for social needs/problems. Afterwards, it is developed and commercialized. At this stage, innovation is expected to meet the needs of potential adopters. The next phase, also the crucial one, relates to the diffusion of innovation. If it is useful for the “population”, it will be adopted by one/several “users”.

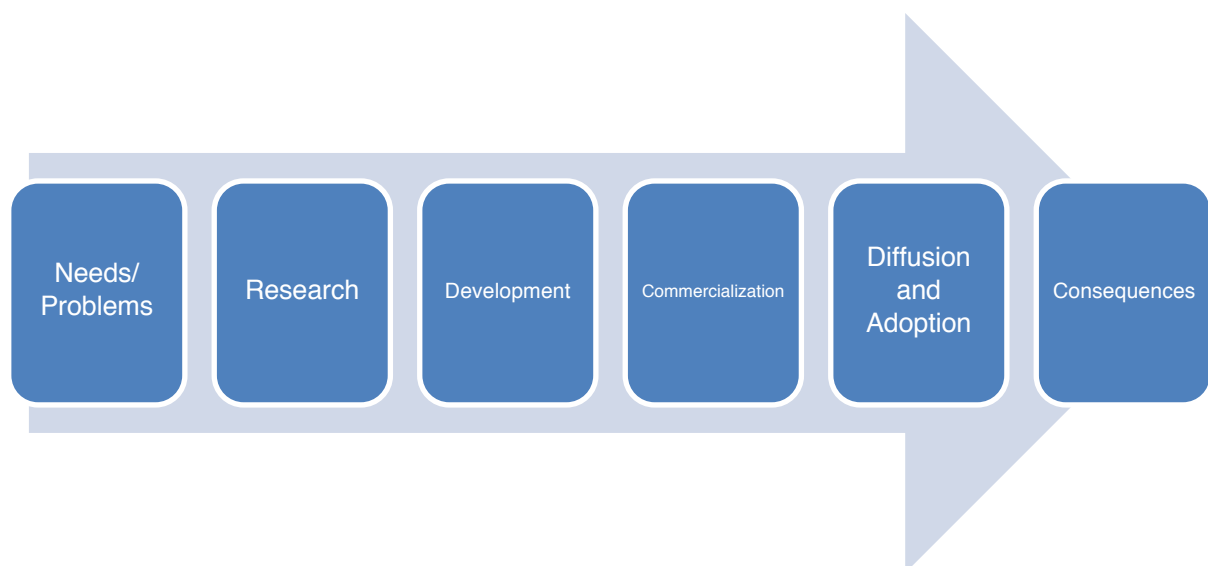


Figure 3 – The innovation-development process
Source: Rogers (2003, p.137)

According to Birkinshaw and Mol (2006), management innovation generation processes can be divided into four main stages: dissatisfaction with the status quo, inspiration from other sources, invention and internal and external validation. In addition, the authors confirmed a significant role of external change agents¹² for management innovations. The generation process of management innovation

¹² Independent consultants, academics and gurus (Birkinshaw et al., 2008).

provided by Birkinshaw et al. (2008) is slightly different from that of Birkinshaw and Mol (2006). It includes: motivation, invention, implementation and theorization and labelling (see figure 4 below). In addition, Birkinshaw et al. (2008) paid attention to both internal¹³ and external change agents.

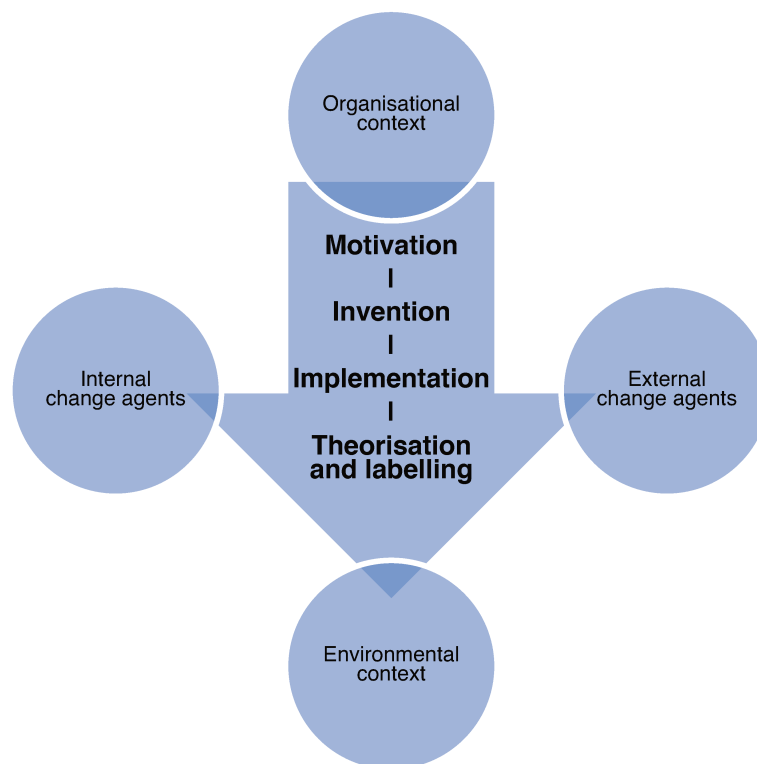


Figure 4 – The management innovation generation process
Source: Birkinshaw et al. (2008, p.832)

In each phase of the process of Birkinshaw et al. (2008), internal and external change agents play important roles. In the *motivation* phase, internal change agents identify potential and novel problems from organizational context that lead to the needs of new management practices. External change agents, in this context, analyze and predict new threats or opportunities from environmental context. In the *invention* phase, both internal and external change agents try to put ideas into practice. This phase is not

¹³ Employees of the innovating firm (Birkinshaw et al., 2008).

merely to choose a practice among hypothetical ones. It consists of numerous activities which aim at finding an appropriate and innovative practice for organizational context. In the *implementation* phase, new practice is implemented inside an organization then it can be ignored or opposed by its employees. External change agents in this phase play an indirect role due to the lack of contextual knowledge of the organization. In *theorization and labelling* phase, internal and external change agents co-establish the legitimacy of the new practice so that it can be accepted widely.

Also studying how management innovations first emerge inside organizations but Mol and Birkinshaw (2014)'s study seems to be an extension of several ideas of Birkinshaw et al. (2008). These authors introduced two further forms of external involvement besides external change agents (external knowledge sourcing and external experience) and discussed in various ways how these external involvements influenced management innovation processes.

External knowledge sourcing is "the observation of related practices in other organizations and contexts that are transferred into the focal organization" while external experience "occurs when an internal change agent brings in relevant novel experience from the outside, either from industry or through some form of training" (Mol & Birkinshaw, 2014, p.1290). External knowledge sourcing has ties with technology innovation and there are three external knowledge sourcing methods: information transfer from informal network, R&D collaboration and technology acquisition (Kang & Kang, 2009). Birkinshaw and Mol (2006), Mol and Birkinshaw (2009, 2014) are not only a presentation of management innovation processes inside

generating organizations but also a significant development among studies in this field in terms of external factors' effects during these processes because many other studies focus on internal factors only.

3.3. Management innovation diffusion processes

Rogers (2003) provided a detailed analysis of innovation diffusion. Diffusion, according to Rogers (2003, p.5), is “the process in which an innovation is communicated through certain channels over time among the members of a social system”. Meaning five main elements in the diffusion of innovations are: innovation, communication, channels, time and social system. Diffusion, also according to Rogers, is both a special kind of communication and social change. It pertains to new ideas and uncertainty (because of the newness of the idea). Moreover, diffusion relates to both planned and unplanned spread of new ideas. Furthermore, diffusion is considered to be one of the six main stages of the innovation-development process in an innovation-generating organization (see figure 3 above). Rogers (2003) argued that in the whole process of innovation-development, the decision-making moment when an innovation started being diffused to the market was quite important and always under pressure. Especially when the innovation aims at resolving the priority cases in the social system.

A large number of studies on the process of diffusing a management innovation are influenced by the study of Abrahamson (1991) in which, unlike most of the studies in the field which primarily focus on innovation diffusion rate (Volberda et al., 2014), the author discovered the reasons of inefficient innovation diffusion and efficient innovation rejection through four perspectives: efficient-choice, forced-selection,

fashion and fad perspectives. The author also introduced the assumptions related to a dominant perspective in the innovation diffusion literature: the efficient-choice perspective.

According to this perspective, organizations make independent and technically efficient choices. In addition, they are quite certain about their objectives as well as the efficiency of these choices in achieving organizational goals. Moreover, Abrahamson (1991) also found the explanations outside the border of efficient-choice perspective which combined performance gaps¹⁴ with the diffusion and the rejection of innovations.

Regarding the forced-selection perspective, according to Abrahamson (1991), external organizations can influence the diffusion of technically inefficient innovations as well as the rejection of technically efficient innovations. Regarding the fashion perspective, Abrahamson (1991) built two counter-assumptions (compared to the efficient-choice perspective): (1) organizations outside a group can influence the choices of organizations inside this group and (2) organizations have unclear goals and they are also uncertain about the efficiency of their choices. The author argued that, because of uncertainty, the imitation among organizations was inevitable and organizational choices were affected by the choices of other organizations.

Abrahamson (1991) paid special attention to the organizations in the fashion-setting network (fashion-setting organizations or fashion setters). These organizations are responsible for selecting a set of fashionable models (potential for imitation). In ideal

¹⁴ Performance gaps are the “discrepancies between an organization’s goals and the goals that this organization can attain” (Abrahamson, 1991, p.592).

cases, fashion setters choose and market efficient models only and they play a positive role for organizations: supporting efficient innovation diffusion and inefficient innovation rejection. However, in some cases, fashion setters only care about the models which can be highly profitable for them and pay less attention to organizational efficiency. For this reason, fashion setters can trigger the diffusion of inefficient innovations and the rejection of efficient ones. Furthermore, the introduction of replacements from fashion setting networks or the tendency of innovation rejection over time may be the reasons for the rejection of efficient innovations.

A common point between the fad and the fashion perspective is the assumption of organizational uncertainty which leads to the diffusion of innovation by imitating the decisions of adopting innovations among organizations. According to the fashion perspective, the organizations in a group imitate other organizations outside this group while the fad perspective focuses on the imitation among organizations within a group.

Management fads and fashions seem to be an attractive field for scholars. Abrahamson (1996), for instance, paid attention to management fashion only. The author developed a management fashion theory based on neo-institutional theory and management culture production. Moreover, the four-fold process of a management technique was also introduced in this study. A management technique is created (creation) and selected by fashion setters (selection) then they process it (processing) to disseminate it to users (dissemination).

In line with Abrahamson (1996), Abrahamson and Fairchild (1999) also focused on management fashion in terms of the factors which influenced this fashion. Numerous studies also discussed the issues of management fads and fashions, such as: lexical

issues (Abrahamson & Eisenman, 2008), the process of management fad creation and replacement in human resource management ideas (Huczynski, 1993), rhetoric in management fashion (Kieser, 1997), management fashion and its various interpretations (“interpretative viability”, “pragmatic ambiguity”) (Benders & van Veen, 2001; Giroux, 2006), etc.

3.4. Management innovation adoption processes

Compared to generation processes, the processes of innovation adoption is less commonly examined (Rasmussen & Hall, 2016). In the next paragraphs, numerous studies on this field are discussed with the purpose of shedding light on the processes of adopting a management innovation. In fact, several studies focused on innovations at organizational level while others directly "attacked" management innovations.

Some scholars in this field are interested in the reasons of innovation adoption. Makkonen, Johnston and Javalgi (2016) introduced a behavioral approach of organizational innovation adoption in which adoption was viewed as a behavioral process, rather than a choice as in other studies. Sturdy (2004) suggested six underlying reasons of management ideas and practices adoption. Also paid attention to the rationales of innovation adoption, Daniel, Myers and Dixon (2012) showed that five of the six rationales of Sturdy (2004) could be identified empirically. These authors help us better understand the causes and the consequences of the adoption of management ideas and practices based on a more complex view, compared to the study of Sturdy (2004). In addition, Daniel, Myers and Dixon (2012) combined rational, emotional and socially conditioned responses.

Also sharing an interest in adoption reasons, however Rogers (2003) discovered this issue in a different way. As mentioned in 3.3. *Management innovation diffusion processes*, the moment when organizations decide to diffuse an innovation to the market is a crucial and often under pressure one. Similarly, when an organization decides to initiate innovation adoption process, it is also a quite important moment. Rogers (2003) investigated the decision process of adopting an innovation which consisted of five stages: knowledge, persuasion, decision, implementation and confirmation (see figure 5 below). This process can be considered a “bridge” linking the diffusion processes of IGOs and the adoption ones of IAOs.

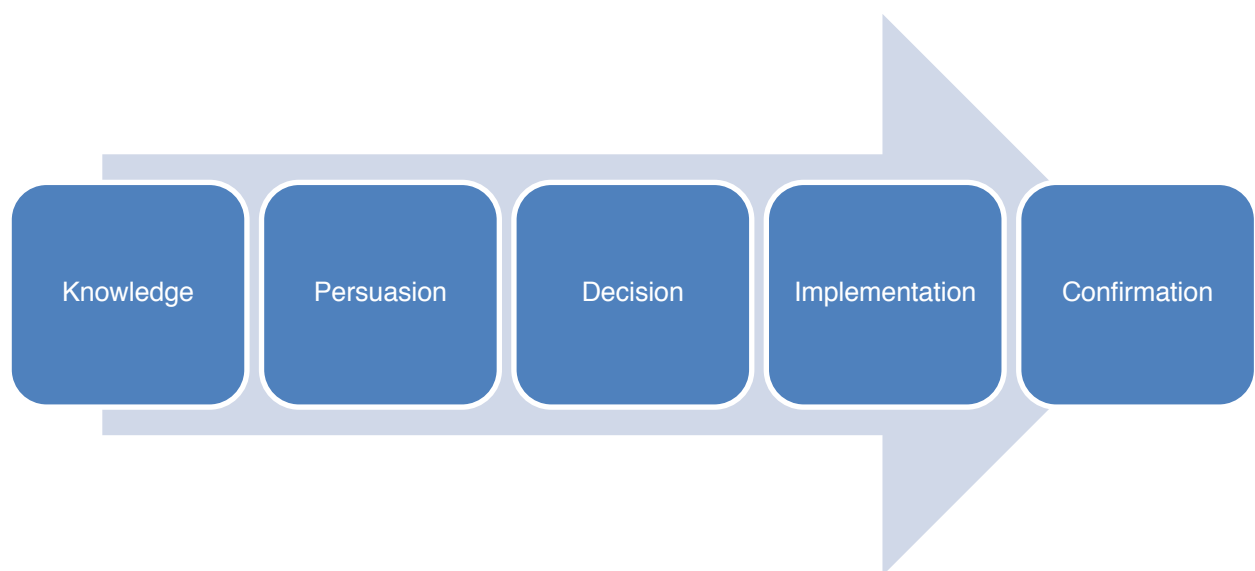


Figure 5 – The innovation decision process
Source: Rogers (2003, p.170)

This process can be used to explain the management innovation decision process inside a management innovation-adopting organization (even the author did not mention it). According to Rogers (2003), after being diffused from a management innovation-generating organization, a management innovation becomes “a product” on the market. It can be distinguished from other management innovations

("knowledge" stage). Based on its characteristics and organizational conditions, managers or other decision-making units have favorable/unfavorable ideas for this innovation ("persuasion" stage) that lead to innovation adoption/rejection respectively ("decision" stage). Afterwards, in case of positive decision, this management innovation is put into use ("implementation" stage). At the final stage, reinforcement is searched for the decisions already made. Organizations can discard the innovations already adopted or adopt the innovations previously rejected ("confirmation" stage).

Also relating to the decision of adoption, another important subject in the study of Rogers (2003) is innovativeness and adopter categories. According to Rogers (2003), different individuals adopt an innovation at different moments, that results in different "adopter categories" which consist of the individuals with the same level of innovativeness¹⁵. There are five adopter categories: innovators, early adopters, early majority, late majority and laggards. Furthermore, "adopter distributions follow a bell-shaped curve over time and approach normality" and this curve describes "the diffusion of a particular new idea among the member units of a specific system" (Rogers, 2003, p.275). At the beginning, the curve gradually rises over time (that corresponds to a few adopters of innovation). Afterwards, the number of adopters increases quite rapidly and that leads to a progressive evolution of the curve, until its maximum point. After this point, among remaining individuals, only some of them adopt the innovation. Therefore, the curve develops fairly slowly.

It will be an incomplete discussion of the studies pertaining to innovation adoption processes if we do not mention Damanpour and his colleagues who made a series of

¹⁵ "... the degree to which an individual (or other unit of adoption) is relatively earlier in adopting new ideas than other members of a system" (Rogers, 2003, p.267).

articles on innovation at organizational level. Among these articles, numerous ones focused on innovation adoption processes and three groups of factors: organisational, individual and environmental factors (see figure 6 below).

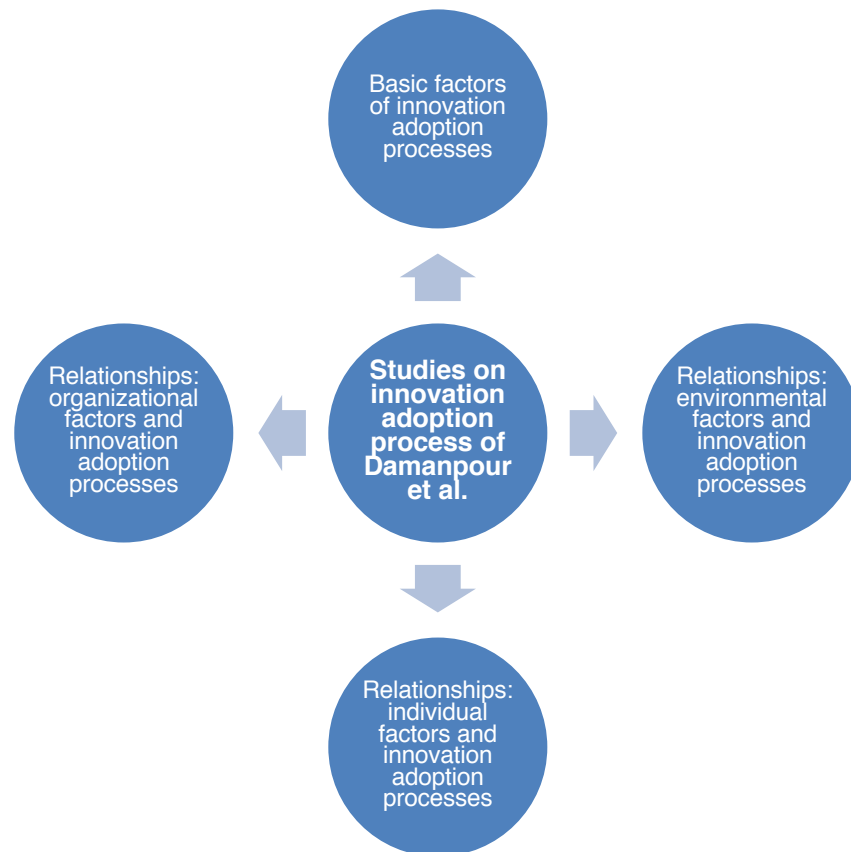


Figure 6 – Studies on innovation adoption process of Damanpour et al.
Source: based on the studies on innovation adoption process of these authors

The initial articles of Damanpour et al. were merely the studies on *basic factors of innovation adoption processes*, for instance the study of Damanpour and Evan (1984). Another example can be the study of Gopalakrishnan and Damanpour (1994) where the authors introduced unitary and multiple sequence patterns in the innovation processes within organizations (including innovation adoption processes) and determined the correspondence between each pattern and these processes.

The relationships between *organizational factors* and innovation adoption processes were also a common research issue of Damanpour et al.'s studies. However, these studies only paid attention to organizational factors and neglected individual and environmental factors (Damanpour, 1987, 1988, 1991, 1992). In the study of Damanpour and Gopalakrishnan (1998), *environment* was finally considered an important factor and these two scholars investigated the relationship between environmental change, organizational structure and management innovation adoption.

According to them, organizational performance is influenced significantly by environment which can “receive” or “reject” products or services from organizations. Therefore, organizations need to change to be suitable for environmental changes. Damanpour and Gopalakrishnan (1998) argued that in this context, innovation adoption could be an appropriate solution because it could make several changes in organizations to facilitate their adaptation to environment. In other words, innovation adoption processes are considered a response of organizations to environmental fluctuations and the authors' interest is how to maintain organizational performance and not the process of adopting an innovation itself.

Damanpour and Gopalakrishnan (1998) also mentioned the rate and the speed of adoption. The former relates to the number of innovations adopted by organization within a period of time while the latter pertains to how fast the innovation adoption is. Rogers (2003) also paid attention to the concept of adoption rate. However, unlike Damanpour and Gopalakrishnan (1998), the rate of adoption is viewed as “the number of individuals who adopt a new idea in a specified period, such as a year” (Rogers,

2003, p.221). The perceived attributes of an innovation and several other variables which could affect innovation adoption rate were described in detail in this study.

Besides environmental and organizational factors, *individual factors* which could have impacts on the processes of adopting innovations were also studied in the studies of Damanpour et al. For instance, Damanpour and Schneider (2006) examined the influences of environmental, organizational and top managers' characteristics on the phases of innovation adoption process in organizations. As another example, Damanpour and Schneider (2009) explored the relationship between organisational innovation characteristics, manager characteristics and innovation adoption in public organisations.

The factors which affect innovation (at organizational level) or management innovation adoption seem to be a common issue in this field of research. Moch and Morse (1977) explored the relationships between organizational attributes and innovation adoption. Daft (1978) examined the role of managers and technical employees in the process which led to innovation adoption. Regarding recent studies, Boyne, Gould-Williams, Law and Walker (2005) focused on the relationship between internal and external constraints and the adoption of innovation in a program of public management reform. In the study of Peeters, Massini and Lewin (2014), the role of absorptive capacity routines, managerial attention and organizational legitimacy in management innovation adoption process was discovered. In addition, Lin, Su and Higgins (2016) explored the influences of dynamic capabilities on management innovation adoption process.

Numerous studies on innovation adoption processes of Damanpour et al. (and even the studies of other authors mentioned from the beginning of this discussion) only discovered the relationships between these processes and internal/external factors of organizations which could impact on them. The processes themselves seemed to be neglected (cf. *3.1. Innovation as a process*). However, many other scholars in this field paid attention to management innovation adoption processes themselves (instead of relevant elements). They tried to establish numerous models which consisted of the steps/phases of innovation adoption processes. In fact, some studies of Damanpour et al. also focused on these models (Damanpour, 1991; Damanpour & Schneider, 2006; Damanpour & Wischnevsky, 2006; Gopalakrishnan & Damanpour, 1994) but they were not the center parts in these studies.

Based on several studies in this field, Dubouloz (2013) proposed three principal phases of innovation adoption processes: (1) initiation and decision, (2) implementation and (3) routinization. In a more concrete way, Rogers (2003) proposed a process of adopting an innovation in an IAO which has been adopted and adapted for several times by numerous scholars in this field. This Rogers' process focused on innovations in organizations and the author introduced several examples related to technological innovations. According to Damanpour and Aravind (2012), the processes of adopting technological innovations and management innovations are similar therefore we believe that Rogers's process can be used for management innovations. Generally, numerous processes which were proposed by Rogers (2003) could be viewed as general processes, "not bound by the type of innovation studied, who the adopters were, or by place or culture" (Rogers, 2003, p.xvi).

The process comprises two main stages, *initiation* and *implementation*, in which there are five sub-stages. *Initiation* consists of *agenda-setting* and *matching* while *implementation* includes *redefining/restructuring*, *clarifying* and *routinizing*. Table 5 below describes in detail these five stages.

Initiation	Necessary information leading to a decision of innovation adoption	<i>Agenda-setting</i>	-Existing organizational problems which need an innovation. -Locating potential innovations which can resolve these problems.
		<i>Matching</i>	An innovation is fit/unfit for organizational needs. That results in a favorable/unfavorable decision of adoption.
Decision			
Implementation	Activities involved in putting the innovation into use	<i>Redefining/restructuring</i>	Changes occur in both of the innovation and the organization so that they can be fit each other.
		<i>Clarifying</i>	Innovation is widely used in the organization and it has so much more meaning to organization members.
		<i>Routinizing</i>	-Innovation becomes a part of organizational activities. -It also loses its identity.

Table 5 – The innovation process in IAOs
Source: Rogers (2003, p.421)

Rogers' process and table 5 above can be explained as follows: an organization has several problems that need an appropriate solution. In this case, the organization has to find an innovation in the market which can potentially be a solution for its problems. Based on the innovation, the needs of the organization as well as many other factors, the organization decides to adopt or reject the innovation. In case of a positive decision, the innovation is implemented inside the organization. However, the innovation does not fit the organization perfectly. Meaning after a period of time, it needs to change to fit the organization again. Similarly, the organization has to alter

itself so that it can also fit the innovation. To fit each other, changes need to occur in both of the sides. Regarding organization members, they get used to the innovation which is widely used in the organization. At this stage, innovation is considered to be a part of the organization and a habit of its members. It also loses its identity and the whole process (maybe) go back to the first steps.

Nonetheless, the innovation processes in innovation-adopting organizations are not as simple as they seemed to be at first glance. To better understand the five stages of Rogers' process, it is necessary to observe them in parallel with other processes of innovation, for instance the innovation decision process (see figure 5 above). Rasmussen and Hall (2016) followed this direction and developed an extended and refined model of management innovation adoption processes that includes decision-making. This is one of a few studies on management innovation adoption processes (almost all of the studies on adoption processes pertain to innovation in general or innovation in organizations).

This consolidated model consists of three phases: *initiation*, *implementation* and *outcomes* (with nine episodes inside these phases). In addition, the decision-making across this process is paid special attention (see figure 7 below).

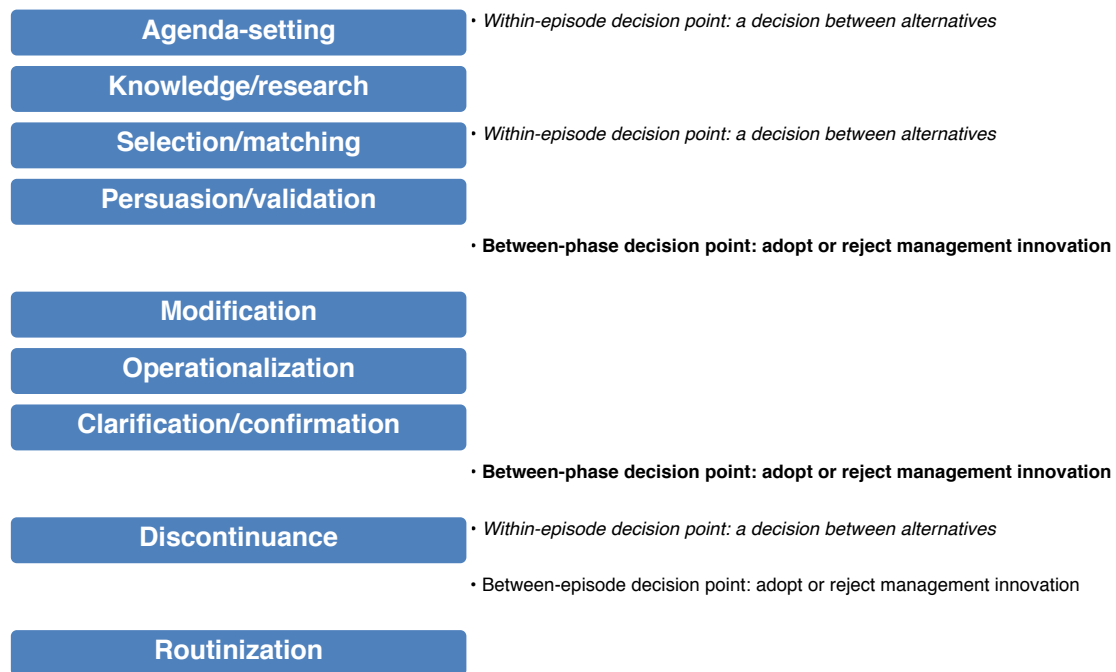


Figure 7 – Management innovation adoption process
Source: Rasmussen and Hall (2016, p.366)

“The phases occur in a linear sequence but may overlap, while the episodes occur in a non-linear sequence; and decision-making occurs within episodes, between phases and between episodes” (Rasmussen & Hall, 2016, p.356). The *initiation* phase includes four episodes: *agenda-setting*, *knowledge/research*, *selection/matching* and *persuasion/validation*; the *implementation* phase comprises three episodes: *modification*, *operationalization* and *clarification/confirmation*; the *outcomes* phase consists of two episodes: *routinization* and *discontinuance*. Among these nine episodes, two of them (*agenda-setting* and *knowledge/research*) are recursive.

In the first episode (*agenda-setting*), an organizational need or problem is defined and the organization initiates a process to find a solution. Among numerous management innovations in the market, the organization carefully looks for an appropriate one (*knowledge/research*). The organization then decides to choose a management innovation which matches the most (*selection/matching*) based on the management

innovation, organizational needs and other factors. In addition, the employees also need to be persuaded to adopt this management innovation (*persuasion/validation*). At this episode, there is a between-phase decision point. If the management innovation is adopted, we move from the initiation to the implementation phase.

In the next episode (*modification*), changes occur from both of the management innovation and the organization to have harmony. In *operationalization* episode, the management innovation is established for the first time (it can be a pilot experiment). After a period of time, the management innovation has so much more meaning to the organization (*clarification/confirmation*). Here, there is another between-phase decision point, the organization continues to adopt or rejects the management innovation. In case the organization continues to apply it, the management innovation can become a routine inside the organization (*routinization*). However, even after this stage, a management innovation can still be ceased (*discontinuance*) because organizational needs change or there are other management innovations on the market.

Rasmussen and Hall (2016) clearly described the main differences between their model and the one of Rogers (2003). Moreover, according to them, failure can be considered to be an outcome while other studies on the field rarely focus on this possibility. In addition, Rasmussen and Hall (2016) suggested that their model could be suitable for not only the organization type mentioned in their study but other types of organization which also adopted management innovations and recommended that future research should assess and test its applicability.

Summary

In this chapter, we understand the innovative nature of a management object. In addition, this chapter also focused on various categorizations of management innovation perspectives.

Management innovation adoption processes are at the heart of our attention. Regarding management innovation generation processes, we introduced several models related to the processes before diffusing a management innovation to other organizations.

As for the processes of management innovation diffusion, we paid special attention to the study of Abrahamson (1991) which influenced numerous studies on the process of diffusing a management innovation. Based on efficient-choice, forced-selection, fashion and fad perspectives, the author discovered the reasons of inefficient innovation diffusion and efficient innovation rejection. Abrahamson focused on fashion-setting organizations (or fashion setters) which were responsible for selecting a set of fashionable models (potential for imitation).

Regarding management innovation adoption processes which directly relate to our research issues, we focused on the management innovation decision process inside a management innovation-adopting organization. We also paid attention to the studies on innovation adoption process of Damanpour et al. which could be divided into four groups: basic factors of innovation adoption processes; the relationships between these processes and organizational, environmental and individual factors.

Other research issues in this field were also introduced and we paid special attention to the model of Rasmussen and Hall (2016) which consisted of nine steps of management innovation adoption processes. The authors suggested that their model could be suitable for various types of organization. Our thesis can test its applicability.

CHAPTER 2: SOCIAL FRANCHISING

As we briefly mentioned in the introduction of this thesis, we paid attention to a social franchise in Vietnam. Franchising has been studied for a long time and can be viewed as an effective model through renowned fast food restaurants or many other business models while the understanding of social franchising is very limited (Alon, 2014; Berelowitz, 2012). Indeed, maybe we once heard about traditional and business-format franchising (Blair & Lafontaine, 2005) but regarding social franchising types, objectives or even definitions, they seem to be given not enough care or attention.

At the beginning, franchising could be considered to be a managerial innovation and this role has recently been provided to social franchising. This model, similar to other models of franchising, tends to further organizational goals, especially social aspects. In addition, it has some innovative characteristics and due to its novelty, it is still unfamiliar to many people. Therefore, the presence of a social franchising model in a context which is quite different from its original context can bring several ruptures of work organization. That leads to some relationships between social franchising and management innovation and we believe that studying this concept can extend our knowledge of management innovation.

The aim of this chapter is to review the literature on social franchising. We first provide some definitions of this new concept. We then discuss social franchising in health sector, with the focus on developing countries.

1. Definitions of social franchising

Social franchising is considered to be “a new chapter in the evolution of franchising” (Alon, 2014, p.3) and a common definition for this concept has not been agreed by the scholars in this field of research yet.

Before introducing some definitions of social franchising, it is necessary to distinguish the differences between social franchising and several similar concepts: social replication, business-format franchising and microfranchising.

1.1. Social franchising and social replication

How to increase the success of local organizations, how social entrepreneurs can effectively spread their social impacts to reach more and more beneficiaries are the common challenges in the social sector.

In this case, scaling up which can expand the scope of local organizations, help them to reach people in a wider geographic area rapidly (Ahlert et al., 2008; André & Pache, 2016; Bloom & Smith, 2010; Dees, Anderson, & Wei-skillern, 2004; Gonsalves, 2001; Jowett & Dyer, 2012) or “refers to identifying opportunities and barriers at broad institutional scales, with the goal of changing the system that created the social problem in the first place” (Westley, Antadze, Riddell, Robinson, & Geobey, 2014, p.4) is considered to be an appropriate solution.

Desa and Koch (2014, p.148) proposed a definition as follows: “scaling social impact is the process of expanding or adapting an organization’s output to better match the magnitude of the social need or problem being tackled”.

Although “replication” term often appears together with “scaling up”, these two concepts are different. Replication is one of the strategies that can be used by an organization to scale up (Ahlert et al., 2008; Bloom & Smith, 2010; Gonsalves, 2001; Jowett & Dyer, 2012). Its objective is “to reproduce a successful program’s results, not to slavishly recreate every one of its features” (Bradach, 2003, p.19). In addition, replication has not been a common practice in the social sector yet because of a dearth of donors who are not willing to support social programs (Ahlert et al., 2008; Letts, Ryan, & Grossman, 1997).

Franchising is considered a form of replication (Bloom & Smith, 2010; Bradach, 2003; Finney, 1993; Jowett & Dyer, 2012) and social franchising can be viewed as a form of replication in the social sector (Ahlert et al., 2008). Nonetheless, there is a clear distinction between “social franchising” and “social replication”.

According to Richardson and Berelowitz (2012) and Berelowitz, Richardson and Towner (2013), when a successful social-driven organization is re-established in a new area, that is called “social replication”; while social franchising is a special form of social replication in which actors such as franchisor and franchisee cooperate under several license agreements.

1.2. Social franchising and business-format franchising

In business-format franchising, franchisees are licensed to use an entire business format of franchisors (the owners of the format) and the franchisees have to pay an amount of money at the beginning of the contract as well as “royalties” depending on their sales revenue (Blair & Lafontaine, 2005).

Social franchising and business-format franchising share numerous common characteristics: there is a franchise agreement (a contract between a franchisor and franchisees) and a franchise operations manual which includes necessary instructions to establish the model; franchisees have a common name; franchisor train, support and supervise franchisees; a set of criteria to achieve and maintain the brand; etc. (du Toit, 2014; Meuter, 2008; Zafeiropoulou & Koufopoulos, 2013).

However, there are various differences between social franchising and business-format franchising. Firstly, the objective of business-format and social franchising is totally different. The former is profit-seeking while the latter aims at achieving social goals. Such differences lead to different target groups: business-format franchises serve customers while social franchises focus on beneficiaries (Ahlert et al., 2008; du Toit, 2014; Meuter, 2008; Volery & Hackl, 2010; Zafeiropoulou & Koufopoulos, 2013). They are also responsible for numerous issues arising from social franchisees selection of social franchisors (Zafeiropoulou & Koufopoulos, 2013).

Secondly, unlike business-format franchising, social franchising models mainly depend on the support of donors (individuals, NGOs, governments, etc.) and that leads to difficulties in finding funding as their financial returns are often low. Banks are therefore reluctant to lend money to social franchisees (Ahlert et al., 2008; Berelowitz et al., 2013; du Toit, 2014; Meuter, 2008).

Furthermore, in business-format franchising models, franchisees have to pay initial fees, royalties or other fees for franchisors while in social franchising models, franchisees cannot occasionally pay fees for their franchisors who, in this case, have

to find financial aid for them such as subsidies or donations (Ahlert et al., 2008; Meuter, 2008; Zafeiropoulou & Koufopoulos, 2013).

1.3. Social franchising and microfranchising

According to some authors, social franchising is similar to microfranchising which aims at achieving both social and financial goals by applying franchising methods (Alon, 2014; Sireau, 2011). Social purpose is a common objective of microfranchising and social franchising. Nonetheless, these two concepts also have different characteristics.

Microfranchising is a useful and simple method to initiate and progress a business model. It principally focuses on the poor (“the bottom of the pyramid”) who cannot afford other forms of franchising (Christensen, Parsons, & Fairbourne, 2010) and help them to establish their own businesses rapidly “through the creation and provision of sound, proven businesses that will in turn increase the earning potential of the microfranchisee” (Fairbourne, 2007, p.2). Some scholars mentioned the term “providing a turnkey business-in-a-box” (Christensen et al., 2010, p.596) which is not the case of social franchising.

Furthermore, microfranchisees are often subsidized by their franchisor (Christensen et al., 2010) while social franchisees often depend on financial supports of donors, NGOs, government, etc. In addition, social franchisors primarily aim at achieving social purposes while microfranchisors are profit-seeking and they also pay attention to how their franchisees learn from the model (Fairbourne, 2007). Therefore, microfranchising is also considered a poverty reduction tool and it is often associated with microcredit

concept (Christensen et al., 2010; Fairbourne, 2007; Kistruck, Webb, Sutter, & Ireland, 2011).

1.4. Social franchising definitions

Social franchising, social replication, business-format franchising and microfranchising have numerous similarities but they are different concepts. Moreover, there is a variety of models established under the “social franchising” title. For this reason, proposing an appropriate definition of social franchising is a difficult task. Table 6 below presents several definitions of social franchising.

Author	Social franchising definition
Berelowitz (2012, p.12)	The simplest form of social franchising is “a social organization that replicates success to scale”
Richardson and Berelowitz (2012, p.21)	“A successful social purpose organization that enables at least one independent franchisee to deliver their proven model under agreement”
Montagu (2002, p.129)	“A franchise system, usually run by a non-governmental organization, which uses the structure of a commercial franchise to achieve social goals”
Montagu (2002, p.123)	“The goal of social franchising programs is to use the commercial relationship of a franchise network to benefit provider members, and then to leverage those benefits into socially beneficial services”
Tracey and Jarvis (2007), cited in Volery and Hackl (2010, p.1)	“An adaptation of commercial franchising in which the developer of a successful social concept (franchisor) enables others (franchisees) to replicate the model using a proven system and a brand name to achieve a social benefit. Social franchising can be defined as a system of contractual relationships, which uses the structure of a commercial franchise to achieve social goals”
Zafeiropoulou and Koufopoulos (2013, p.76)	“An alliance among not-for-profit organizations and social enterprises, where the franchisor is a social enterprise and the franchisees are usually already established not-for-profit organizations”
Zafeiropoulou and Koufopoulos (2013, p.79)	“Social franchising are the channels that allow people who feel that they want to give something back free to the society, through the use on new technologies and social media, where there is collective ownership of what you offer, where people share information/services/products and feel part of this entity”
du Toit (2014, p.13)	“Social franchises pursue social goals through the means of franchising as a model for replication and distribution of the products and services of

	the organization. Social franchises seek sustainability through operating on commercial principles, making enough profit to sustain operations and reinvesting surplus profits into the community they serve”
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Table 6 – Definitions of social franchising¹⁶

Conventional types of franchising aim at making profit while social franchising focuses on social goals (almost all of the definitions in table 6 above mentioned this aspect). However, according to du Toit (2014), commercial principles also need to be paid attention because of the continuity and longevity of social franchises.

In addition, social franchising based on franchising concept in which the relationships of actors (franchisors-franchisees) are under franchise agreements (Montagu, 2002; Richardson & Berelowitz, 2012; Tracey & Jarvis, 2007; Zafeiropoulou & Koufopoulos, 2013). Franchising is an effective means for social franchises to expand their social impacts to beneficiaries (Berelowitz, 2012; du Toit, 2014; Richardson & Berelowitz, 2012; Tracey & Jarvis, 2007).

According to Berelowitz (2012), Richardson and Berelowitz (2012), Tracey and Jarvis (2007) and Zafeiropoulou and Koufopoulos (2013), social franchisor is often a social organization with a proven model. It can also be an NGO (Montagu, 2002).

Differing from other social franchising definitions, Zafeiropoulou and Koufopoulos (2013) paid attention to social franchisees. The authors also proposed a definition of social franchising which referred to a group of volunteers who wanted to “give something back free to the society” (Zafeiropoulou & Koufopoulos, 2013, p.79).

¹⁶ Cf. the study of Crawford-Spencer (2015) in which the author provided another way of collecting and analyzing social franchising definitions.

1.5. Social franchising from a theoretical point of view

Authors in this field often mentioned two theoretical explanations of franchising. The first is the *resource scarcity theory*. According to Oxenfeldt and Kelly (1968), organizations mobilize franchising concept to approach scarce resources. Franchising is considered a tool to overcome several organizational issues such as financial and managerial ones (Combs & Ketchen, 2003; Combs, Michael, & Castrogiovanni, 2004; Tracey & Jarvis, 2007).

The second is the *agency theory* which refers to an arrangement between organization and its outlets (Combs & Ketchen, 2003; Combs et al., 2004; Tracey & Jarvis, 2006). In this theory, there is an agency relationship between two actors, the principal and the agent. The former delegates responsibilities and provides resources to the latter so that the agent can act in the principal's best interest.

There are very few contributions that propose theoretical explanations of social franchising. Tracey and Jarvis (2007), for instance, discussed the relationships of the resource scarcity theory, the agency theory and social franchising through the case of Aspire Group¹⁷. The model collapsed after several years although it had been quite successful at the beginning. Therefore, this case is only a special example and cannot lead to a general theory of social franchising.

On the other hand, Volery and Hackl (2010) focused on the agency theory and the social capital theory to discover not only business-format franchising but also social

¹⁷ Aspire, one of the first social franchising programs in the United Kingdom, established in Bristol in 1999 by Harrod and Richardson. From 1999 to 2001, it included several social franchises in London, Birmingham and other cities in the UK. In 2002, Aspire had to restructure because some franchises had been closed. In 2004, Aspire collapsed (Tracey & Jarvis, 2006, 2007).

franchising. They mainly argued that the concept of “homo economicus” which described humans as rational, self-interested agents was not appropriate for social franchising where collaboration had a dominant role. Alternatively, the authors suggested that social franchising could be grounded in the “homo reciprocans” concept where humans could be viewed as cooperative actors. However, the research is still at its early stage and further developments are needed.

In the case of social franchising, the agency theory can be a useful theoretical framework. However, we believe that it is necessary to find another theoretical and social-economic explanation for the agreements/disagreements in the agency relationship which is out of agency theory border.

2. Social franchising in health sector

Social franchising provides solutions to solve several social issues such as unemployment, poverty, public health access, lack of education, etc. (Berelowitz, 2012; Sireau, 2011; Zafeiropoulou & Koufopoulos, 2013). Furthermore, as we previously mentioned, one of the most important challenges in the social sector is how to scale up the success of social organizations and allow more and more people to benefit from their social impacts. In this case, social franchising is considered to be an effective way to achieve such a goal (Volery & Hackl, 2010).

Several scholars introduced social franchising as a brand-new concept, proposed some definitions of social franchising, explained its advantages and disadvantages, or distinguished social franchising from other traditional forms of franchising. In these

studies, some examples of social franchising were introduced without any analysis (Ahlert et al., 2008; Berelowitz et al., 2013; Meuter, 2008).

Social franchising programs cover various fields and mainly originate in Europe, especially from the UK which takes the lead of social franchising programs in this continent (Richardson & Berelowitz, 2012).

Here are some examples of social franchising: Autonomia (France, helping people with reduced mobility), Aspire (UK, creating jobs for homeless people) (du Toit, 2014; Tracey & Jarvis, 2006, 2007); Wellcome (Germany, supporting new mothers), Reach (worldwide cover, helping poor rural women and their families), Annapurna Conservation Area Project (Nepal, the environment and living conditions), Youth-to-Youth (Ethiopia, Kenya, Tanzania and Uganda; sexual and reproductive health of young people), Time Together (UK, helping refugees), Aflatoun (13 countries, helping children) (Ahlert et al., 2008; Meuter, 2008); Dialogue in the Dark (Germany, raising social awareness), Science-Lab (Germany, education), VisionSpring (USA, producing affordable eyeglasses for developing countries) (Volery & Hackl, 2010). These social franchises were merely introduced as introductory examples. Without a robust methodology, insights into them could not be discovered.

Some studies focused on social franchises in several specific countries. For instance, Richardson and Berelowitz (2012) and Zafeiropoulou and Koufopoulos (2013) presented several social franchises in the UK; Nijmeijer, Huijsman and Fabbriotti (2014a, 2014b) and Nijmeijer, Fabbriotti and Huijsman (2015) paid attention to three clinical social franchises in Netherlands.

However, social franchising principally contributes to the issues of health sector in developing countries. For instance, a list of clinical social franchising programs in numerous countries from different parts in the world can be found in the study of Viswanathan, Behl and Seefeld (2016). Almost all of these programs focus on the health sector of developing countries.

This subchapter is organized as follows. Firstly, we provide an overview of studies relating to social franchising in health sector. Secondly, we pay attention to clinical social franchising in developing countries.

2.1. Overview

Describing social franchising in health sector (clinical social franchising) is not an easy task (Viswanathan et al., 2016). According to Ravindran and Fonn (2011) and Viswanathan et al. (2016), clinical social franchising is considered a network of private sector healthcare providers. However, the important role of franchising concept seems to be neglected. The authors only mentioned some details such as a common brand name, formal agreements or contracts.

On the contrary, Montagu, Sudhinaraset, et al. (2013) emphasized how important it was for the development of clinical social network to apply franchising model. According to these authors, franchising can provide new clinical methods, management skills as well as other business techniques. In addition, they also highlighted the role of clinical social franchisors in supporting their franchisees through training, supervising, providing medicines, etc. The definitions proposed by these scholars complement the knowledge of clinical social franchising. On the one hand,

this model is a clinical model which provides healthcare services; on the other hand, it applies franchising concept.

Lack of firm conclusions based on solid empirical evidence is a common issue in this field of research. In addition, the number of research papers on clinical social franchising with empirical data is still low. Prior studies proposed some reviews on clinical social franchising.

One of the first reviews in this domain is the one of Patouillard, Goodman, Hanson and Mills (2007, p.1) in which the authors discovered “the effectiveness of interventions working with the private for-profit sector to improve utilization of quality health services by the poor”. In this study, franchising was considered to be one of the interventions.

Through six clinical social franchising programs in Pakistan, Ethiopia, India, Nepal and Madagascar, the impacts on access to health services or service quality seemed vague because the evidence was mixed. According to the authors, this review has several limitations, lack of robust studies with firm conclusions in particular.

As another example, Koehlmoos, Gazi, Hossain and Zaman (2009) also examined several social franchising effects. However, “no firm conclusions can be made about the effect of social franchising on access to and quality of health services in low- and middle-income countries” (Koehlmoos et al., 2009, p.7) and it is necessary to develop more high quality studies.

Furthermore, based on twelve studies which pertained to clinical social franchising in Asia and Africa, Koehlmoos, Gazi, Hossain and Rashid (2011) mentioned the

dominance of reproductive health and family planning (RHFP) services in the field and confirmed that social franchising could help private providers to increase client volume. In addition, client's perception was also paid attention in this review. Although the authors tried to make a comparison of these studies, they could not propose any robust conclusions because there was a dearth of qualified studies and the collected results were so mixed that it was quite difficult to analyze.

Beyeler, York De La Cruz and Montagu (2013) assessed the impacts of clinical social franchising in low- and middle-income countries by examining service quality, health impacts (health knowledge development, behavior and service utilization of clients), equity issues, cost-effectiveness (cost of care per client) and market expansion.

Similarly, Nijmeijer, Fabbricotti and Huijsman (2014) proposed a review of franchising in healthcare sector, not only in developing countries but also in developed countries. Although they did not directly mention the term "social franchising", their study pertained to various outcomes of clinical social franchising such as quality, accessibility and utilization of services, client loyalty, client volumes or efficiency (cost of care per client).

In comparison with the previous reviews, these two reviews observed more aspects of clinical social franchising but still faced a lack of eligible studies. Furthermore, the reviews only focused on a few clinical social franchising programs in several countries. Therefore, the authors neither proposed persuasive reasons for their conclusions nor generalized them.

Moreover, the articles of the two reviews were not chosen and grouped in the same way; consequently, different outcomes of social franchising in healthcare sector were

presented. That also implies the heterogeneity of reviews in this field of research. In addition, because of time restriction, these reviews did not include the latest papers in the field where the newness of studies is essential because recently clinical social franchising has developed quite rapidly.

To sum up, the literature on social franchising in health sector is growing and quite often reaches contradictory results. That leads to the necessity of a review at a more advanced level on this new field of research.

2.2. Clinical social franchising in developing countries

The majority of clinical social franchising programs in developing countries aim at serving RHFP services (table 7 below presents some examples of RHFP social franchises in developing countries). In addition, social franchising has recently played an increasingly important role in these services (Montagu, 2002; Stephenson et al., 2004).

Source	Program name
Agha and Balal (2003); Agha, Gage and Balal (2007); Agha, Karim, Balal and Sosler (2007); Agha, Karim, Balal and Sossler (2003)	Sewa
Agha, Fareed and Keating (2011); Bishai, Shah, Walker, Brieger and Peters (2008); Qureshi (2010); Shah, Wang and Bishai (2011); Stephenson et al. (2004)	Green Star
Stephenson et al. (2004)	Green Key, Janani, Ray of Hope
Decker and Montagu (2007)	KMET
Bishai et al. (2013, 2015); Huntington, Mundy, Hom, Li and Aung (2012); O'Connell, Hom, Aung, Theuss and Huntington (2011)	Sun Quality Health
Bishai et al. (2013, 2015)	Sun Primary Health
Azmat et al. (2013)	Suraj

Sieverding, Briegleb and Montagu (2015)	BlueStar, Amua, Tunza
Ngo, Alden, Nguyen and Dinh (2009); Ngo, Alden, Pham and Phan (2010); Ngo, Phan, Pham, Trinh and Truong (2009)	Sisterhood

Table 7 – RHFP social franchises in developing countries

According to Montagu, Ngamkitpaiboon, Duvall and Ratcliffe (2013), social franchises provide RHFP services at their initial steps; afterwards, other health services are added to meet healthcare needs of people as well as to expand the variety of franchisees revenue. Concretely, many studies in the field also addressed other health issues such as tuberculosis (Lönnroth, Aung, Maung, Kluge, & Uplekar, 2007; Montagu, Sudhinaraset, et al., 2013), maternal care services (Kozhimannil, Valera, Adams, & Ross-Degnan, 2009; Tougher et al., 2018), malaria (Berk & Adhvaryu, 2012; Lwin, Sudhinaraset, San, & Aung, 2014; Perrigot, 2018), parasites, respiratory infections, diarrhea, bacterial infections, rapid HIV testing, vaccinations, antenatal care, general health counselling, hygiene products (Berk & Adhvaryu, 2012), diarrhea (Aung et al., 2014), respiratory infections, dysentery, health education, prevention services (Perrigot, 2018), infant and young child feeding (Baker, Sanghvi, Hajeerbhoy, Martin, & Lapping, 2013; Nguyen, Kim, et al., 2014; Nguyen, Menon, et al., 2014; Sanghvi et al., 2013).

Regarding geographical scope, some studies found evidence from numerous countries while others focused on a specific country (table 8 below introduces several examples).

Source	Country
Duvall, Thurston, Weinberger, Nuccio and Fuchs-Montgomery (2014); Montagu, Ngamkitpaiboon, et al. (2013); Prata, Montagu, & Jefferys (2005); Ravindran & Fonn (2011); Schlein,	Evidence from numerous countries

De La Cruz, Gopalakrishnan and Montagu (2013); Thurston, Chakraborty, Hayes, Mackay and Moon (2015)	
Agha and Balal (2003); Agha, Gage and Balal (2007); Agha, Karim, Balal and Sosler (2007); Agha, Karim, Balal and Sossler (2003)	Nepal
Agha et al. (2011); Azmat et al. (2013); Bishai et al. (2008); Hennink and Clements (2005); Qureshi (2010); Shah et al. (2011); Stephenson et al. (2004)	Pakistan
A. Sivakumar and Schoormans (2011); Alur Sivakumar and Schoormans (2011); Stephenson et al. (2004); Tougher et al. (2018)	India
Stephenson et al. (2004)	Ethiopia
Berk and Adhvaryu (2012); Decker and Montagu (2007); Perrigot (2018); Sieverding, Briegleb and Montagu (2015)	Kenya
Aung et al. (2014); Bishai et al. (2013, 2015); Huntington, Mundy, Hom, Li and Aung (2012); Lönnroth et al. (2007); Lwin et al. (2014); Montagu, Sudhinaset, et al. (2013); O'Connell, Hom, Aung, Theuss and Huntington (2011)	Myanmar
Kozhimannil et al. (2009)	Philippines
Sieverding et al. (2015)	Ghana
Baker et al. (2013); Ngo, Alden, et al. (2009); Ngo et al. (2010); Ngo, Phan, et al. (2009); Nguyen, Kim, et al. (2014); Nguyen, Menon, et al. (2014); Sanghvi et al. (2013)	Vietnam

Table 8 – Geographical distribution of some clinical social franchises

Currently, the research issues in this field are limited to several subjects as follows:

- The quality of services in franchised clinics, the perceptions of clients of service quality, client satisfaction, the reasons for choosing franchised clinics, brand name perception;
- Efficiency or cost-effectiveness (cost of care per client), providers' charges;
- The access to health services, the perceptions of clients in access to health services, market expansion;

- Client loyalty (return visits), client volume, the utilization of RHFP services, RHFP purpose-clients percentage, the knowledge of health services;
- The reasons why providers join or remain within a social franchising network;
- Franchisee selection for social franchising success.

According to Ngo, Alden, et al. (2009), Ngo et al. (2010) and Ngo, Phan, et al. (2009), studies pertained to clinical social franchising rarely mentioned public health sector. Bishai et al. (2008) and Shah et al. (2011) examined governmental providers of health services. However, there were only some comparisons between private providers (non-franchised and franchised) and other providers (governmental and NGO providers) in their studies. In the study of du Toit (2014), the author referred to the Gold Star project in Egypt (a well-known example of social franchising in public health sector). Nonetheless, that was just a brief presentation of the program.

Governmental social franchising in Vietnam which has been established since 2005 is a new model of social franchising in which one of the two co-authors are several provincial departments of health and franchisees are a network of selected facilities in Vietnamese public health sector.

Ngo, Alden, et al. (2009), Ngo et al. (2010) and Ngo, Phan, et al. (2009) are some rare studies which examined the elements of the governmental social franchising in Vietnam. Ngo, Alden, et al. (2009) and Ngo, Phan, et al. (2009) qualitatively and quantitatively evaluated the quality of services and the satisfaction of clients of this government social franchising while Ngo et al. (2010) focused on the utilization of health services.

Ngo, Alden, et al. (2009) and Ngo, Phan, et al. (2009) argued that Vietnamese government only paid attention to the subsidization of local health facilities and neglected their quality of services. However, clients did not appreciate the services which were free and had a low quality. They liked affordable prices and high-quality services.

This brand new clinical social franchising model still lacks adequate academic research and many important issues of social franchising in the public health sector in Vietnam need to be addressed.

On the other hand, many studies on clinical social franchising in developing countries mentioned “fractional franchising”¹⁸. In fact, a social franchise can be considered to be an incremental innovation (cf. 1. *From practical to academic requirements*) when it takes this form. But what is fractional franchising? Why a fractional social franchise has the characteristics of an incremental innovation?

Besides stand-alone franchising, fractional franchising is also viewed as a type of franchising in which franchised services are added to franchisee’s existing services (non-franchised ones) in order to generate additional income (Ahlert et al., 2008). The “collaboration” of non-franchised and franchised services in the same place sometimes lead to important (but not complete) changes. Therefore, a fractional social franchise is similar to an incremental innovation. It is necessary to be clear that a stand-alone franchise outlet only sells the products/services of its brand that is not the

¹⁸ For more details, please see Agha and Balal (2003); Agha, Gage, et al. (2007); Agha, Karim, et al. (2007); Agha et al. (2003); Bishai et al. (2013); Bishai et al. (2008); Huntington et al. (2012); Ravindran and Fonn (2011); Schleim et al. (2013); Sieverding et al. (2015); Alur Sivakumar and Schoormans (2011); Stephenson et al. (2004); Thurston et al. (2015).

case of a fractional one (Montagu, 2002). In addition, fractional franchising is rare in commercial retail while it can play an important role in health services (Montagu, 2002).

Indeed, clinical social franchises in developing countries often have this fractional form. Furthermore, these fractional franchises are often established by using existing infrastructure (buildings, rooms, equipment, etc.) or mobilizing health establishments' medical staff (du Toit, 2014; Ngo, Alden, et al., 2009; Ngo, Phan, et al., 2009). Normally, a "package" of medical equipment, services or even trained health workers is added to franchisees (Bishai et al., 2008) and their main operations still work as usual.

du Toit (2014) found some disadvantages of fractional franchising in healthcare sector: regarding non-franchised parts of a health facility, it is almost impossible for franchisor to influence. Therefore, if these parts are ineffective, it can affect the overall reputation of the facility and cause bad effects on the brand. In addition, the basic elements of franchising such as branding guidelines are only applicable to franchised parts that can lead to the situation where "the franchisor does not have direct control over the whole business" (du Toit, 2014, p.22).

Furthermore, according to Agha, Gage and Balal (2007), in a fractional franchise outlet, the ability of clients in distinguishing the difference between franchised and non-franchised services is an important issue that affects clients' perception on franchised ones. However, in health sector, franchised and non-franchised services share the same health establishment, equipment, etc. therefore this task is quite difficult to

clients and they prefer to mention the overall quality of services in a health facility (Montagu, 2002).

Summary

Social franchising tends to further organizational goals (including social aspects) and has some innovative characteristics. Introducing social franchising into a different context (compared to its original context) can lead to several ruptures due to its novelty. It can be said that social franchising and management innovation share common points.

A common definition for this concept has not been found yet. Social franchising is often considered to be social replication, business-format franchising or microfranchising. It can be explained through the agency theory. However, the agreements/disagreements in the agency relationship need another theoretical explanation.

Social franchises play an important role in health sector (in particular in developing countries). Nonetheless, the number of research papers with empirical data and robust conclusions in this field is still low. In developing countries, numerous clinical social franchises aim at serving RHFP services. Currently, the research issues in this field are limited to several subjects only and public health sector is rarely mentioned.

Studies on social franchising in public health sector in Vietnam (governmental social franchising) are quite rare and this brand-new clinical social franchising model as well as numerous issues of social franchising in Vietnam's public health sector still lack adequate academic research.

Finally, yet importantly, many studies on clinical social franchising in developing countries mentioned “fractional franchising” which can be viewed as an incremental innovation.

PART 2: METHODOLOGY

In our research design, each step is established to address the initial research questions. Keeping in mind these questions help us to avoid any deviation; that means using methods, selecting cases, mobilizing data, etc. which are probably not relevant to the research issues.

First, in chapter 3, we present the research method of our thesis: a qualitative one is chosen. Afterwards, we focus on the method of case study and the context of Vietnam. The cultural characteristics as well as the renovation period of this country emphasize its originality. In addition, the Sisterhood program is presented and some main reasons relating to our case selection are also clarified. This chapter provides a general view of Vietnam and our research case, which are still unfamiliar to many scholars, based on that, we explain why Vietnam and Sisterhood can be view as appropriate choices for our research issues.

Second, in chapter 4, data collection and analysis method are paid attention. Our documentation and interviews are carefully presented. Several individual and group semi-structured interviews with a wide range of informants were conducted and that provide a deep understanding of the field. Besides data collection, an important place in this chapter is reserved for our data analysis method. Due to our research issues, collected data and for the purpose of attaining a rigorous data analysis method, we adapt the method of Gioia. We have also consulted numerous articles in the top journals of the field which use/adapt Gioia's method to make it fit for our study.

CHAPTER 3: RESEARCH METHOD AND CASE STUDY

In this chapter we explain why we chose a qualitative research method instead of a quantitative one. Afterwards, among several qualitative methods, case study was selected because it was considered an appropriate solution to address our research issues. An important place in this chapter is dedicated to our empirical context, Vietnam and our case, the Sisterhood program, a governmental social franchising program in the public health sector in Vietnam.

1. Qualitative research method as an appropriate solution

As many other studies in management science, we had to select an appropriate research method for our thesis and we chose a qualitative research method, instead of a quantitative one. The rationale behind our choice is explained as follows.

According to Vanderstoep and Johnston (2009, p.184), the reason to mobilize a qualitative method based on “the basis of the research question, not on the basis of a researcher’s skill or interest in doing a qualitative study”. Our decision to use a qualitative research method also depends on our research questions.

Inspired by Vanderstoep and Johnston (2009, p.165), we aim at exploring processes rather than outcomes and focus on “the meanings of experiences by exploring how people define, describe and metaphorically make sense of these experiences”. In addition, according to Vanderstoep and Johnston (2009, p.165-166), in quantitative research, knowledge is assumed to be “out there” to be discovered while it is not the case in qualitative research. Sharing similar opinion with these authors, we also

believe that knowledge is created by people and we have to find it through their perceptions and interpretations.

Similarly, Gupta and Awasthy (2015, p.16) clarified the significance of qualitative research method through its strength, goal and findings:

- Strength: this method can provide theoretical descriptions of individuals' perception and details about "behaviors, beliefs, opinions, emotions and relationships of individuals".

- Goal: theory development.

- Findings: intangible, for instance, "social norms, socioeconomic status, gender roles, ethnicity and religion, whose role in the research issue may not be readily apparent".

Furthermore, research sample also plays an important role. Qualitative research often uses much smaller samples than quantitative one, normally from 20 to 35 participants (Vanderstoep & Johnston, 2009). Because of time restrictions as well as financial and geographical difficulties, a qualitative research, with around 20-30 participants, is considered an appropriate solution for our research.

We can also find some of the details above in the study of Ritchie, Lewis, Nicholls and Ormston (2014) where the authors provided, after analyzing numerous studies on qualitative research method, methodological stances associated with qualitative research.

Patton (2015, p.22) distinguished the differences between qualitative and quantitative research method by introducing their strengths and weaknesses. According to this

author, because “qualitative and quantitative methods involve differing strengths and weaknesses, they constitute alternative, but not mutually exclusive, strategies for research”. Moreover, Vanderstoep and Johnston (2009) compared the differences between qualitative and quantitative approaches in purpose, focus, method and criteria for truth (see table 9 below). These differences encouraged us to choose a qualitative research method which is more descriptive than predictive and focuses on actors’ perceptions instead of a quantitative one with statistical relationships for our study.

	Qualitative research	Quantitative research
<i>Purpose</i>	<ul style="list-style-type: none"> -more descriptive than predictive -explorer actors’ perceptions -difficult to generalize 	<ul style="list-style-type: none"> -more predictive than descriptive -finding a statistical relationship between independent and dependent variables -can be done with little or no understanding of the process
<i>Focus</i>	<ul style="list-style-type: none"> -describing the meaning of actors’ experiences -sometimes actors’ experiences are not typical 	finding typical characters, average, trends which can be generalized
<i>Method</i>	(Normally) inductive approach	(Normally) deductive approach
<i>Criteria for truth</i>	No statistical analyses	Statistical analyses

Table 9 – The differences between qualitative and quantitative approaches
Source: Vanderstoep and Johnston (2009, p.167-170)

On the other hand, Yin (2011) viewed qualitative research as a method of numerous topics of interest because other research methods had some difficulties to establish research conditions, to obtain a high response rate, etc. In addition, the author also presented the distinctiveness of qualitative research through five features. Among them, we paid special attention to three points: “covering the contextual conditions within which people live; contributing insights into existing or emerging concepts that

may help to explain human social behavior; and striving to use multiple sources of evidence rather than relying on a single source alone” (Yin, 2011, p.7). Compared to our research issues, these points partly explained our research goal and supported our choice in selecting qualitative research method for the thesis.

Finally, yet importantly, several studies on clinical social franchises in developing countries also used qualitative research method (Perrigot, 2018; Sieverding et al., 2015) and that can be view as a good suggestion for this thesis.

2. Case study method and the original context of Vietnam

2.1. Case study method

In this sub-chapter, we explain why case study was chosen among numerous qualitative research methods for our study. In addition, relevant elements of this method are also discussed.

It is necessary to make a clear distinction between tool and method. The former relates to the technique of data collection (interviews, focus groups, etc.) while the latter defines the study focus (Vanderstoep & Johnston, 2009). Creswell (2013) introduced five qualitative approaches¹⁹ (narrative, phenomenological, grounded theory, ethnographic and case study research) while Vanderstoep and Johnston (2009) explored five different ones (ethnography, phenomenology, case study, textual analysis and applied research). As another example, Tracy (2013) presented six key

¹⁹ Creswell (2013) also compared these five approaches.

types of qualitative research: naturalistic inquiry, ethnography, narrative inquiry, autoethnography, impressionist tales and grounded theory.

It can be said that categorization of qualitative research methods depends on personal taste of the scholars and it is difficult to assert that one qualitative research method is more effective than the other. After studying several qualitative research ones, case study research is considered to be a suitable solution for our study. The question of the appropriateness of a qualitative research method, one more time, depends on the research questions (Yin, 2014).

Regarding case study, scholars use this method to discover the characteristics of a bounded system (or multiple bounded ones) and they describe the case by their own interpretation (Creswell, 2013)²⁰. The unit of analysis (or the “case”) can be an organization, a group, an individual, etc. (Yin, 2014).

Case study can be appropriate for “how” and “why” research questions regarding “a contemporary set of events, over which the researcher has little or no control” (Yin, 2014, p.14) or when research questions “require an extensive and ‘in-depth’ description of some social phenomenon” (Yin, 2014, p.4). Yin divided the research process into exploratory, descriptive and explanatory phases and criticized the hierarchical perception which considered case study to be a preliminary research method and only appropriate for the descriptive phase (Yin, 2014). In reality, according to him, case study can be used for both three phases and “every research method can

²⁰ This book also provided a brief history of case study research.

be used for all three purposes – exploratory, descriptive, and explanatory” (Yin, 2014, p.8).

In the next paragraphs, we describe in detail the distinct characteristics of our empirical context and our case; show the compatible points between them and the research issues. That explain why we directed our attention to Vietnam and the case.

2.2. The original context of Vietnam

Through our brief presentation in the introduction, Vietnam has emerged as an active country with “open” policies since 1986 and recently adopted numerous managerial models “made in developed countries”, included social franchising models in the public health sector.

To repeat, our research issues relate to the tensions (or even the ruptures) during the adoption process of a management innovation in an organization. We believe that these tensions become more apparent and promise to bring expected and unexpected impacts if the organizational context of the “host” organization is quite “far” from the original context of the management innovation.

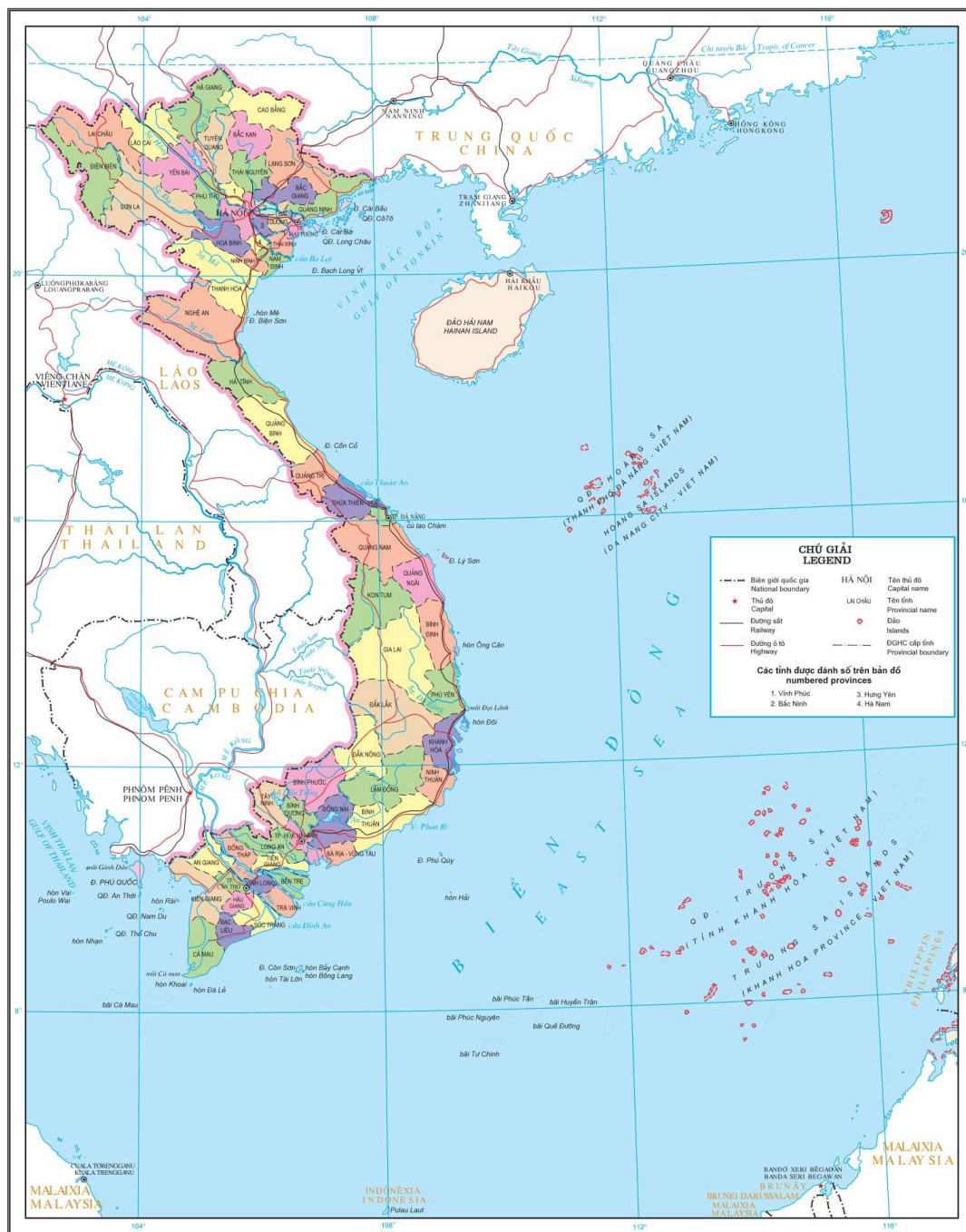
In this case, Vietnam is indeed an interesting choice because, as mentioned in the introduction of the thesis, the differences between Vietnam and the developed countries where social franchising concept was originated are significant. Therefore, the “gap” between the management innovation-generating organizations and adopting organizations are easy to understand. Social franchising, a foreign model, and the ruptures during its adoption process in Vietnamese organizations are relatively certain.

2.2.1. Vietnam at a glance

The Socialist Republic of Viet Nam²¹ is a Southeast Asian country with a total surface area of 331,000 km² and a total population of 92,701,100. The average annual population growth rate of Vietnam is 1.1% (annual urban population growth is 3%) and the population density is 305 people/km². The GDP of Vietnam (current US\$) is 205.28 billion with an annual GDP growth of 6.2%. The percentage of the population living below the national poverty lines is 13.5% and living on less than \$1.9 a day at 2011 international prices is 2.8%. The mortality rate, under-5 (per 1,000 live births) is 22 and the life expectancy at birth is 76 years. There are five centrally-controlled cities (Hanoi, Ho Chi Minh City, Hai Phong, Da Nang and Can Tho) and 58 provinces (see figure 8 below) with 54 different ethnic groups in Vietnam. Administratively, these cities are in the same level with the provinces.

²¹ The data in this paragraph is based on the latest data of World Bank Vietnam.

BẢN ĐỒ HÀNH CHÍNH NƯỚC CỘNG HÒA XÃ HỘI CHỦ NGHĨA VIỆT NAM
ADMINISTRATIVE MAP OF SOCIALIST REPUBLIC OF VIETNAM



BỘ TÀI NGUYÊN VÀ MÔI TRƯỜNG
CỤC ĐO LƯỜNG VÀ BẢN ĐỒ VIỆT NAM

TỈ LỆ SCALE 1 : 9 000 000

Bản đồ này được cung cấp để đăng tải trên Cổng thông tin
điện tử và các trang thông tin điện tử của Cơ quan nhà nước
và các tổ chức, cá nhân.

Figure 8 – Map of Vietnam
Source: Vietnam department of survey, mapping and geographic information
Center of survey and mapping data

Vietnam had to endure 61 years of colonization (1884 – 1945) and four wars: the French war (1945 – 1954), the American war (1955 – 1975), the Cambodian-Vietnamese war (1975 – 1989), and the Sino-Vietnamese war (February – March 1979). Before 1975, Vietnam was divided into two separate countries: North Vietnam (officially the Democratic Republic of Vietnam), under the socialist regime, supported by China and the Soviet Union; and South Vietnam (officially the Republic of Vietnam), under the capitalist regime, supported by the United States and its allies (the situation is similar to North and South Korea).

North Vietnam maintained a centrally planned economy and principally relied on aid from other socialist countries (in particular the Soviet Union and China) while South Vietnam had a market economy. In 1975, Vietnam was unified by the victory of North Vietnam. The government of the North faced great challenges in stabilizing the economy after the war. In 1986, Vietnam implemented “renovation”, a comprehensive reform program that included economic and many other aspects of social life, with the purpose of creating a "socialist-oriented market economy".

Since 1975, Vietnam (along with China, Cuba and Laos) has still maintained a one-party regime and followed communism. The country is under the direction of the Communist Party of Vietnam. Numerous important components of the country such as health, education, industry, commerce, transportation, etc. are still under the strict management of the state. The private sector is still limited despite the fact that the state has many incentive policies.

The foreign policy of Vietnam aims at supporting its economy while ensuring its security issues and making its role more important in the world. In line with its policy

of openness since 1991, Vietnam focuses on international relationships with other countries in the world and participated in several international organizations such as ASEAN (1995), ASEM (1996), APEC (1998) and the WTO (2007)²². In addition, on March 9, 2018, Vietnam and ten other countries signed the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP) which could bring economic benefits for this country.

2.2.2. The originality of Vietnamese culture

Vietnam has cultural characteristics which are quite different from the ones of the developed countries where management innovations were first generated. Internal and external factors of many organizations in Vietnam are significantly influenced by these characteristics and they make these organizations differ from ones in developed countries. State organizations in various fields (including health sector) are typical examples. For this reason, briefly highlighting the originality of Vietnamese culture helps to understand the obstacles during the process of adopting a management innovation, normally from an organization of a developed country, in a Vietnamese organization.

Vietnamese culture can be considered the harmonization of the culture of ethnic groups in this country. It is very diverse, rich and there are many cultural areas with their own characteristics. In addition, in the history of Vietnam, this country was under China's rule for more than 1000 years therefore Vietnamese culture is deeply

²² Source: France Diplomatie.

influenced by Chinese culture. Furthermore, Vietnamese culture is also influenced by French culture due to the prolonged domination.

In Vietnamese culture, families and clans have a particularly important place and the worship of ancestors is considered a sacred responsibility. Multigenerational households are not rare, even in big cities. In addition, in the family as well as in social relationships, the hierarchy is highly respected (expressed through a complex system of pronouns in Vietnamese).

The official language in this country is Vietnamese however each ethnic group in Vietnam has its own language and customs. Numerous ethnic groups live in mountainous areas and they are often called “highland ethnic minority groups”. In Vietnamese, there are many regional differences (North - Central - South), in particular accent and vocabulary.

There are also different customs depending on the region. Vietnam is an agricultural country therefore customs often pertain to agriculture. “Tet” (Vietnamese New Year) is the most important and popular holiday of Vietnamese people. In addition, in Vietnam, there are countless festivals that take place throughout the year for a variety of purposes and many customs associated with daily life.

Cultural differences between regions in Vietnam have existed for a long time and that is one of the characteristics of Vietnamese culture. Due to historical factors and the consequences of various wars (because of different ideologies), the cultural differences between Vietnamese regions become more pronounced and that lead to the differences in many aspects of social life.

2.2.3. Vietnam and its renovation period²³

In 1976, the Fourth Party Congress decided to adopt central planning in the whole country. In this type of economy, private businesses were excluded. Goods were exclusively distributed by the government based on a system of “coupons”. Purchases on the market and exchange in cash were restricted. The government also determined the quantity and the types of goods which can be purchased by each individual. This wrong plan led to a social and economic crisis in Vietnam for ten years.

During this time, although Vietnam was an agricultural country, many Vietnamese people lacked food because the food distribution program was not effective. The amount of food per capita was very low and continually decreased. Industry and commerce stagnated, lack of daily necessities, the living standard was very low for most people. The incomes of many people are even lower than their incomes before the unification of the country.

There were numerous reasons for this situation: at that time, the Vietnam War just ended, many places in this country were heavily damaged and needed time to rebuild; from 1975 to 1994, the U.S. embargo on Vietnam affected every aspect of life in this country; many mistakes in policy and development strategy (for instance, too hasty in applying a centrally planned economy in the South).

In 1986, Vietnam initiated an economic renovation (in Vietnamese “Đổi Mới”²⁴) focused on: (1) price reforms, (2) agriculture sector reforms, (3) economic integration, (4) macroeconomic stabilization, (5) enterprise reforms, (6) decentralization and (7)

²³ Based on World Bank and Ministry of Planning and Investment of Vietnam (2016)

²⁴ This term and this period can be considered to be Vietnamese “perestroika”.

social equity (World Bank & Ministry of Planning and Investment of Vietnam, 2016, p.82). After more than 30 years since “Đổi Mới”, Vietnam has achieved significant results in all aspects: politics, economy, culture and society.

According to World Bank and Ministry of Planning and Investment of Vietnam (2016, p.90), “changes in mindsets over this period were partially reflected in the changing terminology, from questioning the merit of *the bureaucratic, subsidized, command economy* (mid-1980s) to accepting *the multi-actor commodity production economy* (late 1980s), to forming *a market-oriented economy with state management* (1990s), and finally to developing *a socialist-oriented market economy with socialism orientation* (since 2000)”. Regarding the last terminology, it is a market-driven economy under a strict control of the state (or sometimes under the term “the socialist rule-of-law state”).

2.3. The Sisterhood program

Before introducing our case, the Sisterhood program, it is necessary to present the public health system in Vietnam because this one has several characteristics which are not similar to other countries in the world. Afterwards, an important part of this section is dedicated to CHSs in Vietnam, where the Sisterhood social franchising model is established. We also pay attention to NGOs in Vietnam, especially in the health sector because many managerial models (for instance, social franchising ones) were brought into Vietnam by NGOs. Among NGOs in the health sector, MSIVN which brought social franchising model into Vietnam was reserved a center place. Regarding Sisterhood, we introduce the main characteristics of this model as well as explain why this one was chosen as our case.

2.3.1. The public health system in Vietnam

In spite of numerous achievements, in Vietnam there are still limitations in several sectors and the public health sector is no exception. The public health system in Vietnam still has many problems, which can be considered the consequences of wrong management mechanisms after decades.

There are four levels in the public health system of Vietnam: national, provincial, district and communal levels corresponding to different health facilities (see figure 9 below). According to the Ministry of Health, there are 63 provinces, 708 districts and 11,162 communes in Vietnam. At national level, there are the Ministry of Health (MOH) and national hospitals; provincial level corresponds to departments of health (DOHs) and provincial hospitals; at district level, there are district health centers (DHCs); and at communal level, there are CHSs which provide primary healthcare services, including RHFP services, to local people. Because of subsidization from the government, services in CHSs are nearly free of charge while user fees are applied for higher level health facilities.

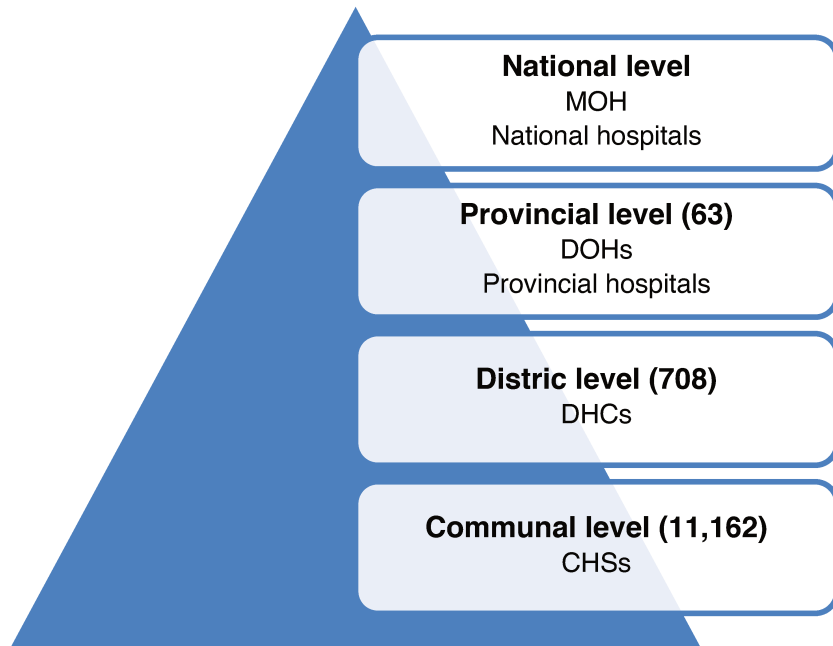


Figure 9 – The health system hierarchy in Vietnam
Source: The Ministry of Health of Vietnam and Hoang (2018)

Before the process of adopting social franchising model in several CHSs in some provinces in Vietnam, based on the studies of Ngo and Hill (2011) and Vu, Tran, Nguyen and Nguyen (2014), we summarize the main elements pertaining to CHSs as follows:

- Local people pay special attention to health services, in particular RHFP services. This is both an opportunity and a challenge that requires CHSs to improve their quality.
- In many areas, women do not have the right to decide on contraceptives (their husbands or mothers decide for them) or under the pressure of having a son.
- The perception of people, in particular people who live in poor areas or from ethnic minority groups is low. They do not voluntarily seek counselling services or essential RHFP services.

-In several remote areas, access to health services in general, RHFP services in particular is very difficult.

-The village health system with numerous village health workers plays an important role in approaching and communicating with local people, in particular people from ethnic minority groups. Therefore, these workers are recruited and trained with consideration of ethnicity to ensure appropriate access to culture and customs. They face many difficulties and the quality of their activities is still limited due to lack of funds, working facilities and communication skills. Furthermore, transportation difficulties (when they have to go to some remote mountain villages) are also important factors. On the other hand, the allowance regime does not really motivate them.

-Numerous CHSs' infrastructure is in bad condition (except the ones renovated by the Atlantic Philanthropies – AP). Lack of working and service delivery rooms is a common issue. Numerous stations are under poor sanitary conditions. The outside of several stations is not well looked after. In addition, the equipment is missing or too old. Lack of basic equipment and materials for RHFP services is also an important problem.

-Human resources of numerous CHSs are insufficient and not well qualified for their jobs. Lack of midwives in some CHSs is an important issue. The health workers in several CHSs are not really satisfied with their remuneration and they still work without confidence. Patients are sometimes transferred to upper level health facilities although the cases are not difficult. The knowledge of several health workers is limited and many of them face difficulties in providing RHFP services to patients. Health workers have difficulties in providing services due to three principal reasons: (1) lack of regular

training courses in skill improvement, (2) lack of necessary equipment relating to service delivery and (3) they have very little opportunity to practice.

-Health workers lack counselling skills and their working style is not really professional. The reasons are simple: fewer and fewer clients choose CHSs' services and therefore health workers do not have the opportunity to improve their experience and skills. In unwanted situations, they are very confused.

-Health workers really want to be regularly trained and improve theory, practices as well as counselling skills.

-Clients often go to upper level health facilities where they provide a comprehensive package of services compared to CHSs.

-The coordination of the Ministry, DOHs, DHCs and CHSs are not effective. Some specialized staff and collaborators (in advertising RHFP services) do not work well therefore clients do not often visit CHSs for RHFP services.

-In addition, there are different difficulties such as: if a CHS is too near a DHC or a provincial hospital, it cannot compete with them because clients will choose to go to upper level health facilities; some women need RHFP services that require modern equipment (CHSs cannot meet this condition); approaching adolescents is not always easy.

In general, at that time, service quality reputation in numerous CHSs reached a low level and for this reason, many patients did not go to CHSs and chose upper level health facilities instead. Firstly, it is a waste of infrastructure, human, equipment, etc. for the inferior level health facilities. Secondly, upper level health facilities have to

suffer from patient overload because patients from many communes all come there for health services. Moreover, patients have more cost because of far distance. Therefore, both patients and service providers have to suffer numerous problems.

In fact, Vietnam had a network of communal cooperatives-funded CHSs which worked quite effectively. However, in “Đổi Mới”, these CHSs started to be supported by the government and from then on, they have been “left to languish” (Hoang, 2018, p.33).

2.3.2. NGOs in Vietnam

a. “Đổi Mới”, an open gate for NGOs

Based on the data on the official website of the Ministry of Foreign Affairs in Vietnam, it is possible to summarize the operation of NGOs in Vietnam through two main stages, before and after “Đổi Mới”:

Before “Đổi Mới”: after 1975, many NGOs stopped their work in the South of Vietnam. Afterwards, they gradually returned to Vietnam. In 1978, there were 70 NGOs in Vietnam with the aid value was about \$ 30 million/year, mainly humanitarian aid to help Vietnam overcome the consequences of the Vietnam War (food, medicine, clothing, etc.).

After “Đổi Mới”: this period “opened the door” for integration, encouraged foreign organizations (included NGOs) to contribute to Vietnam’s development. There were 70-100 NGOs in Vietnam with the total value of aid was about \$ 20-30 million/year (1986-1991). In 1992, there were 183 NGOs in Vietnam; afterwards, NGOs continuously increased in number (210 in 1993, 513 in 2003, 650 in 2006 and 800 in

2010) and aid value (in 1993, \$ 40 million – in 2002, \$ 85 million – in 2004, \$ 140 million – in 2005, \$ 175 million – in 2006, \$ 217 million).

Aid programs of NGOs are implemented throughout the country, in particular in poor and remote areas. These programs focus on sectors which are in line with Vietnam's socio-economic development priorities and orientation. However, the assistance of NGOs is not only in the form of material aid but also the transfer of experience and technology, improvements in people knowledge, healthcare services, universal access to education, etc.

Vietnamese government deeply understands the existing issues of the public health sector in this country, in particular the ones of the basic health units (CHSs). The government has committed itself to improving the situation as well as provided many solutions. Nonetheless, in reality changes are not really clear. Numerous NGOs focus on the health sector in Vietnam (table 10 below introduces several examples).

NGOs	Main activities
The Atlantic Philanthropies Vietnam (AP Vietnam)	Public health, education and many other activities
Marie Stopes International Vietnam (MSIVN)	RHFP services
Alive & Thrive Vietnam (A&T Vietnam)	Maternal, infant and young child nutrition
Population Services International Vietnam (PSI Vietnam)	Safe water and hygiene, undernutrition, hypertension, tuberculosis, HIV/AIDS and viral hepatitis
Program for Appropriate Technology in Health Vietnam (PATH Vietnam)	Emerging and epidemic diseases; vaccines and immunization; reproductive, maternal and child health; digital health solutions

The United Nations Population Fund Vietnam, formerly the United Nations Fund for Population Activities (UNFPA Vietnam)	Gender, population matters, sexual and reproductive health, young people
Plan International Vietnam (PI Vietnam)	Early childhood care, child protection, disaster relief
Save the Children Vietnam (SC Vietnam)	Education, health and nutrition, child protection, child rights governance, child poverty, disaster risk reduction and emergency response

Table 10 – Examples of NGOs in the health sector in Vietnam

Source: The official websites of these NGOs

To make the most of NGOs' aid, the government of Vietnam is continuing to build and improve legal documents to create a favorable legal environment for NGOs in Vietnam.

b. AP Vietnam²⁵

AP was founded in 1982 by a billionaire named Chuck Feeney, who decided to devote his entire fortune to better humanity. "Giving while living" is not only the belief of Feeney but also a driving influence in all activities of AP. This organization completed its grant making at the end of 2016 and plan to close in 2020.

From 1998 to 2013, AP invested \$ 381.6 million in Vietnam. Their projects mainly focused on libraries, universities and public health transformation. Vietnam received 297 grants (almost all of them were for health) from AP. This organization and Vietnamese government built or upgraded 940 CHSs in eight provinces which served nine million people. These provinces are: Da Nang and Khanh Hoa (phase 1); Thai

²⁵ Based on the official website of AP and Hoang (2018).

Nguyen, Thua Thien Hue and Vinh Long (phase 2); Yen Bai, Dak Lak and Ca Mau (phase 3).

The investment in CHSs' renovation brought tremendous changes. According to Hoang (2018), a typical CHS before restoration was a station in a very bad state, the paintwork on the windows and walls was flaking off, the floor was quite dirty, the beds shared a confined space, etc. However, after the renovation, the CHSs had a completely different image: the ugly walls disappeared and instead of them there were clean walls with bright colors, new windows with modern materials, the appearance of modern equipment such as computer and printer, etc.

Simultaneously with the renovation of CHSs, AP financed MSIVN to improve the quality of services in several CHSs in these provinces through an establishment of a social franchising model named "Sisterhood".

c. MSIVN²⁶

Dr. Marie Stopes, a pioneer of family planning and women's rights, established the first family planning clinic of the UK in 1921. In 1976, Dr. Tim Black²⁷ took over this clinic and then improved it significantly, under the name "Marie Stopes International". In 1977, the Dublin Well Woman Centre was set up; afterwards, in 1978, a Marie Stopes center was established in New Delhi (the first overseas branches of MSI). Based on a commercial business model and treated each woman as a client (not a

²⁶ Based on the official website of MSI and MSIVN.

²⁷ In 1970, Dr. Tim Black was also co-founder of PSI.

patient), Dr. Black opened more clinics in the UK within a year and then the model was spread to other countries in the world quite rapidly.

Currently, MSI is an international NGO which focuses on contraception and safe abortion services and appears in 37 countries around the world (see figure 10 below) with 12,000 team members, 4,100 social franchisees and 52,000 outreach locations.

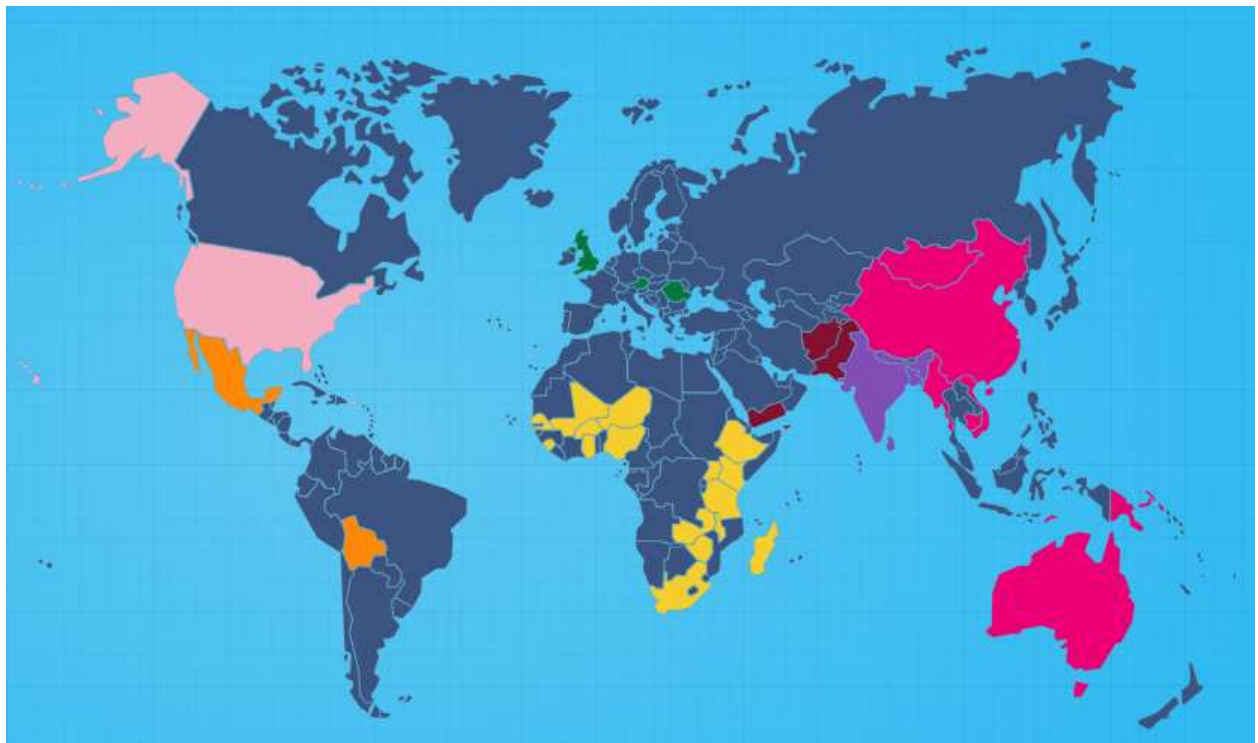


Figure 10 – MSI's geographical distribution
Source: MSI's official website

MSI has a global strategy ("Scaling-Up Excellence") with the purpose of providing services to 214 million women in developing countries who do not have access to contraception. This strategy is based on three pillars: Scale and Impact, Quality and Sustainability. Box 1 below provides more information of these pillars. Regarding the information relating to the governance of MSI, please see box 2 below.

Scale and Impact: the key focus of the next five years will be to double their health impact by delivering contraception and safe abortion delivery at scale. They will:

- Make deliberate choices about where to invest their financial and technical resources, prioritizing countries and client groups, such as 15-19 year olds, that allow them to maximize the global impact of their Partnership.

- Increase access to medical abortion and medical post-abortion care, while also ensuring that women are supported by a continuum of client care, integrated call centers and post-abortion family planning.

- Continue to priorities the needs of their clients, by providing quality counselling and a comprehensive choice of contraception and treating every woman who comes to them with respect.

- Demonstrate that the way that they deliver long-acting and permanent contraception services is the most cost-effective way of increasing the number of women using contraception.

- Use their position as a service provider to “advocate by doing” and working to remove policy and clinical restrictions that limit access to safe abortion and post-abortion care services.

Quality: they will not compromise their absolute commitment to Quality in everything they do. It is the Quality of their services that will drive their ability to achieve Scale and Impact. They will:

- Continue to invest in governance and audit oversight, clinical quality standards and provider training.

- Continue to provide surgical procedures in their own unique way; their procedures have been developed to ensure that clients' discomfort and pain is minimized.

- Invest in their people to nurture their unique MSI culture and grow their capacity by putting their people at the heart of their new strategy.

- Invest in insight so that they are led by the needs voiced by their clients and women and girls with unmet need.

Sustainability: they want to deliver Scale and Impact and maintain their commitment to Quality, not just this year or for the duration of their Scaling-Up Excellence strategy but for generations to come. So, they will:

- Continue to develop sustainable models for all service delivery channels, with every service provided backed by a funding source.

- Evolve a global network of self-sustaining centers, which will set the standard for client care and clinical quality for contraception and safe abortion services across their network and the sector.

- Work with national governments, donors, and others to shape markets and increase access to and funding for contraception and safe abortion services.

- Innovate and test sustainable contraceptive technologies and service delivery models, including safe obstetrics and post-partum family planning (PPFP).

Box 1 – Three pillars of “Scaling-Up Excellence” strategy

Source: MSI’s official website

*Marie Stopes International is a company limited by guarantee, incorporated and registered in England and Wales, and is also registered as a charity.

*In pursuing its mission of “children by choice, not chance” and promoting reproductive health choice across the world, it provides services in 37 countries through its branches and other not for profit companies and organizations which form part of its global Partnership.

*From its international support office in central London, it supports and oversees the impact of its members by setting the strategy, standards and policies for the global partnership. It also provides technical assistance, research and monitoring and promotes and fundraises for the global Partnership. In keeping with its mission, it focuses on creating the conditions that enable the provision of quality services, which are sustainable and reach as many women and men as possible.

*UK division has separate offices and management structure, and provides abortion and other reproductive and sexual health services in the UK through a network of clinics.

*The quality of MSI's services is fundamental to the safety and wellbeing of every single one of their clients. With this in mind they set rigorous standards and have the following systems in place to check and maintain consistently high quality across all their international programs:

- Quality technical assistance (QTA) – internal
- Quality technical assistance (QTA) – external
- Clinical quality accredited spot checks and P2P verifications
- Medical Advisory Team (MAT)
- Clinical quality quarterly reports
- Clinical incident reporting
- Product-related incident reporting
- Risk profiling
- Q-TRAK
- Key clinical governance tools (these tools are expected in all country programs):
 - Incident management system and continuously updated incident database*
 - Clinical competency assessment database*
 - Clinical training database*
 - Continuous supportive supervision – registers as proof of functionality*
 - Quarterly clinical quality reports*
 - Quarterly MAT meetings*
 - Annual internal quality audits (using channel appropriate QTA checklist)*
 - Client record audits monthly at centers and by outreach teams*

Box 2 – MSI's governance
Source: MSI's official website

MSIVN, a branch of MSI, is an NGO which has worked alongside the Vietnamese health system in the RHFP sector for more than 20 years. It is also a pioneer organization which has contributed numerous initiatives to the system. Profoundly understanding the difficulties of the network of CHSs in Vietnam, MSIVN introduced the concept of social franchising as an initiative for the public health sector in Vietnam and convinced several provincial DOHs to collaborate in establishing the Sisterhood governmental social franchising network in a set of CHSs in several cities/provinces in Vietnam.

MSIVN is being operated in 42 provinces²⁸ (35 provinces have active mobile service providers) with 260 members, 520 social franchising establishments in public and private healthcare and 11 clinics. MSIVN works in partnership with public and private health providers through two social franchising networks: “Sisterhood” and “Blue Star” respectively. The Sisterhood program, the illustrated case of this thesis, is introduced in the next paragraphs.

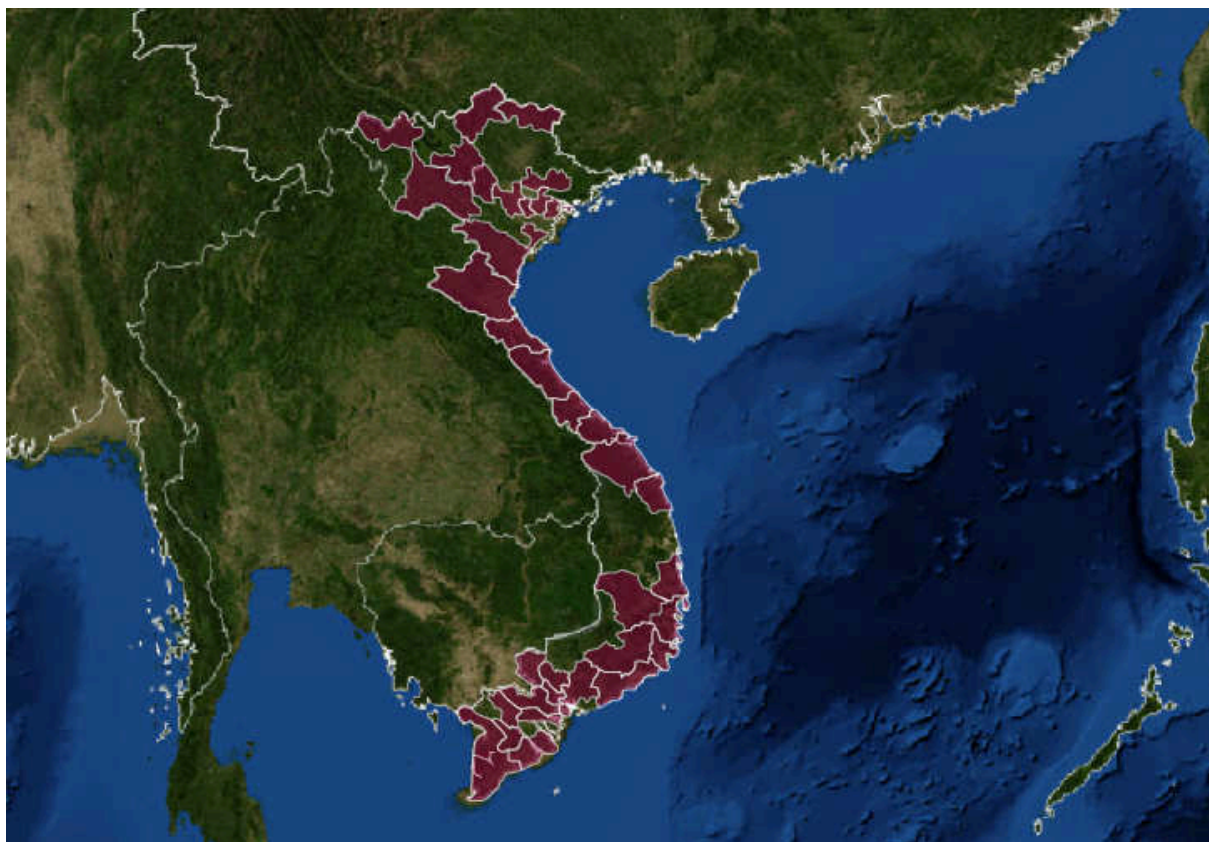


Figure 11 – MSIVN’s geographical distribution
Source: MSINV’s official website

²⁸ See figure 11 above.

2.3.3. Sisterhood as our case

a. The characteristics of Sisterhood

Corresponding to the three phases of AP's renovation, the program consists of (see figure 12 below):

- Phase 1 (2005-2008): in Khanh Hoa and Da Nang;
- Phase 2 (2009-2012): in Thai Nguyen, Thua Thien-Hue and Vinh Long;
- Phase 3 (2013-2016): in Yen Bai, Dak Lak and Ca Mau.

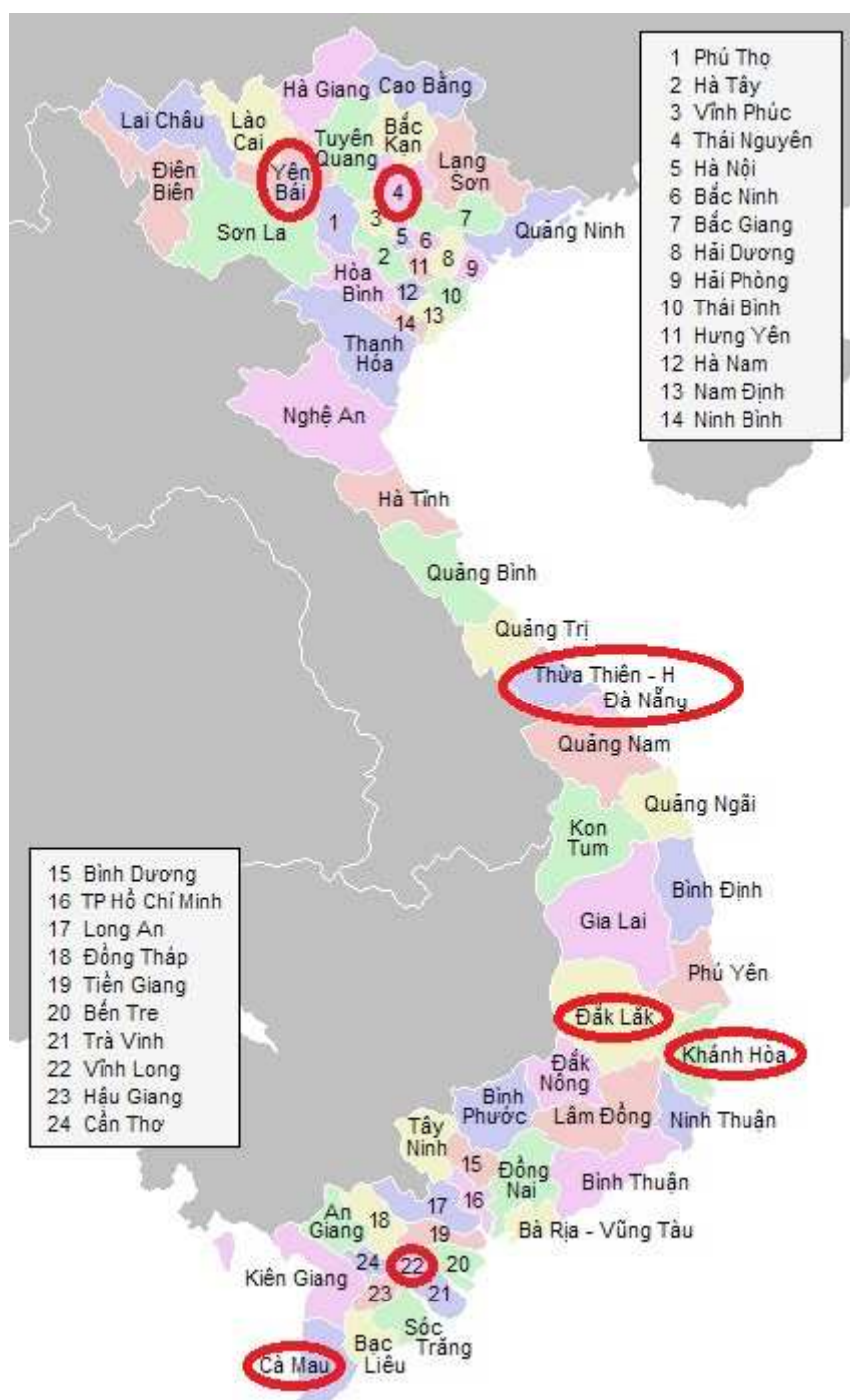


Figure 12 – Eight provinces/cities selected by the Sisterhood program
Source: MSIVN

From the beginning to the end of phase 3 (end of 2016), Sisterhood was financed by AP. The program was also supported by the European Union (EU, for a short period of time). It has been developed and launched by MSIVN and several DOHs in Vietnam.

This program has established, in numerous CHSs of eight cities/provinces in Vietnam, the Sisterhood social franchising model in which one of the most important elements is the system of consulting rooms, also named “Sisterhood”, pertaining to RHFP services.

The room provides several services that have not previously existed in CHSs before such as free counselling services. In addition, it is accompanied by a patient reception in order to orientate patients to suitable services. The layout of the consulting room and both of the clinical and non-clinical activities of franchised CHS must respect the standards of the model. One of the principal objectives of the Sisterhood program is to facilitate access to RHFP services for local people and to improve the quality of services in CHSs. Before the establishment of Sisterhood, many patients had to go to upper level or private health facilities to receive quality services in return for payment (please see *2.3.1. The public health system in Vietnam*). Currently, in their communes there are franchised CHSs which provide high quality services.

The Sisterhood program is one of the first programs which intervene in the network of CHSs. The first and the second phase of the program, when social franchising was introduced to the public health system of Vietnam for the first time, finished with a big success. Regarding the third phase, the program ambition was more challenging than the two previous phases. The sponsor hoped that the program would have more pioneering characteristics and breakthroughs. According to the commitment between the Sisterhood program and the donor, 90 CHSs will be established in three provinces of Vietnam during the third phase of the program.

Sisterhood has the characteristics of a management innovation because of the potential ruptures it can bring to the previous structures, management tools, strategies, philosophy, etc. in selected CHSs. We believe that during the adoption process of Sisterhood in franchised CHSs, these characteristics can be further clarified and based on that insights into this process will be illuminated.

According to Yin (2014, p.50), Sisterhood program can be considered to be an “embedded single case study”, meaning there are several analysis units within a single case study. Indeed, we studied the activities of all managerial levels inside the Sisterhood program. However, we focused on the Sisterhood program as a whole and did not pay too much attention to its subunits²⁹.

Regarding the hierarchy of Sisterhood, this program includes four managerial levels (the right side of figure 13 below), corresponding to the ones of the health system hierarchy in Vietnam (the left side, also cf. figure 9 above): national, provincial, district and communal level.

²⁹ For more information, please see Yin (2014, p.56).

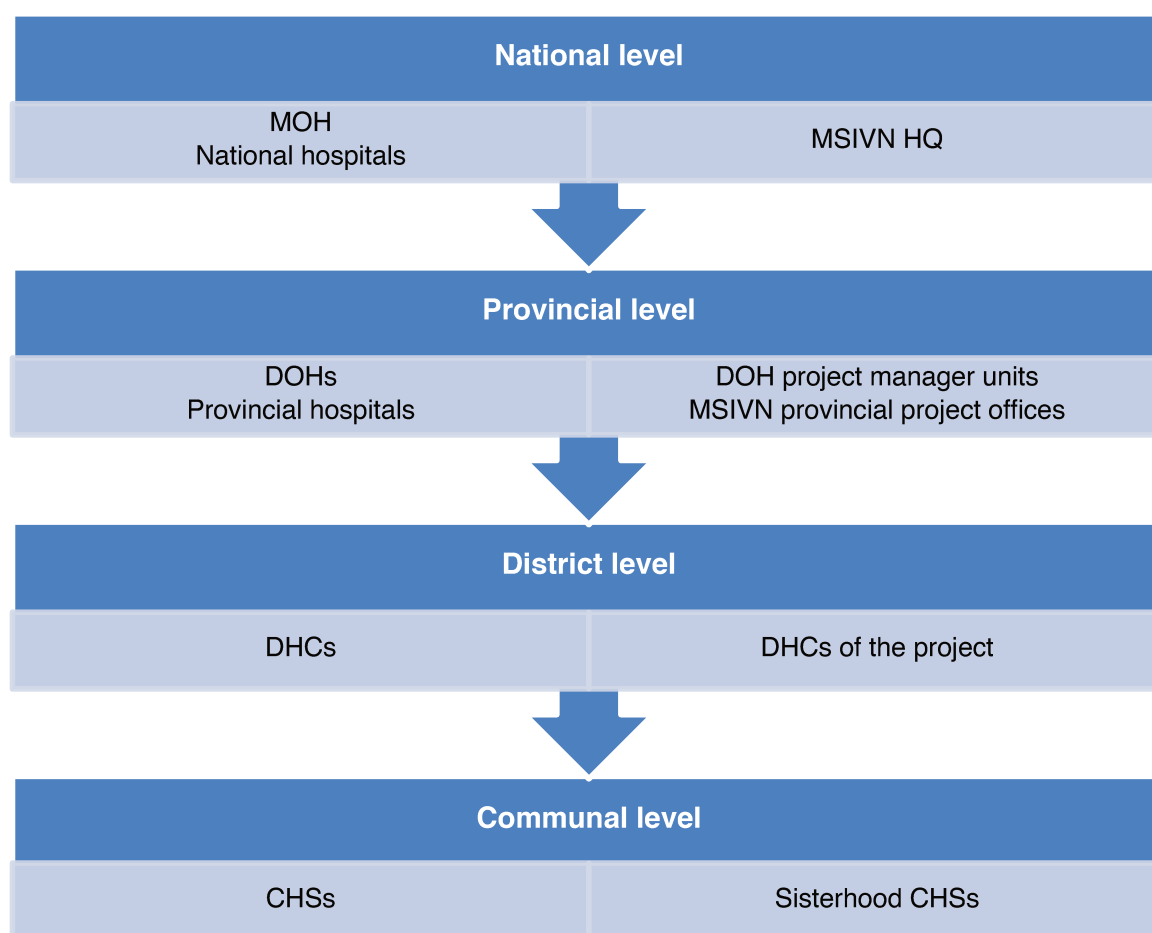


Figure 13 – The hierarchy of Sisterhood
Source: MSIVN

MSIVN headquarters in Hanoi (the capital of Vietnam) is at Sisterhood's national level. It often contacts the MOH and lower levels of Sisterhood, especially provincial levels. In the provinces selected by the program, there are DOH project manager units (their heads are often the (deputy) directors of these DOHs) and a representative system of MSIVN (through provincial project offices). These offices are often situated inside the DOHs and their members are also the members of the DOH (their status: MSIVN's temporary employees). Hiring local officials is one of MSIVN's policies to take advantage of their experience in local health system. The DOH project manager units and the provincial project offices of MSIVN collaborate to organize all activities of the

Sisterhood program in the provinces (under the direction of MSIVN headquarters and the MOH).

Regarding Sisterhood's lower levels, there are DHCs and selected CHSs. The DHCs which play intermediary roles directly manage the CHSs and report their activities to Sisterhood's upper levels. In this context, MSIVN and several DOHs of the program can be considered to be Sisterhood's co-franchisors while the Sisterhood CHSs are franchisees.

b. The reasons why Sisterhood was chosen

The moment when we started to focus on Vietnam, there were four social franchising programs in this country and all of them were in health sector. They were: Blue Star and Sisterhood (of MSIVN), The Little Sun (of A&T Vietnam) and Good Health, Great Life (of PSI Vietnam). However, very little information was available with regard to Good Health, Great Life therefore we decided to only focus on Blue Star, Sisterhood and The Little Sun. Our final decision was Sisterhood.

Our choice was deeply influenced by the suggestions of (Yin, 2014) and one of the main reasons are the access to the data. According to Yin (2014, p.28), "you need sufficient access to the data for your potential case – whether to interview people, review documents or records, or make field observations". Indeed, in the beginning, Sisterhood's representatives were quite enthusiastic about our research and they facilitated our access to the data as well as promised to help us throughout our data collection process.

In addition, Yin (2014, p.28) also suggested that “you should chose the case(s) that will most likely illuminate your research questions”. Undeniably, our research questions played a significant role in selecting Sisterhood as our case. Indeed, based on these questions, we needed a case which consisted of the characteristics of a management innovation and Sisterhood met this condition.

Before our fieldwork, as mentioned in the introduction of this thesis as well as in *a. The characteristics of Sisterhood*, we knew that Sisterhood was the first governmental social franchising model in the public health sector in the world. The fact that a management model is integrated into Vietnamese CHSs for the first time can lead to numerous potential ruptures during the process of adopting it. In addition, in the very first steps of our research, through the information related to Sisterhood from the official websites of MSI, MSIVN, Sisterhood, etc. we were convinced of the innovative characteristics (rhetorical and technological dimensions) of this managerial model.

Besides the access to the data and the illumination for the research questions, the dynamism and enthusiasm of Sisterhood also affected our choice. Since the program was established in Vietnam in 2005, it has tried to scale its social impacts to more and more beneficiaries through establishing franchised CHSs in all over the country. According to an internal report of MSIVN, since the first phase in Khanh Hoa and Da Nang (2005), a total of 346 Sisterhood CHSs have been established in eight provinces/cities of Vietnam (including 98 CHSs established by local health systems). The number of the Sisterhood CHSs in each province/city of the program is presented in table 11 below (two categories: the number of the Sisterhood CHSs established by the model and by local health). Regarding the support of the EU, it funded 40 CHSs in

Thua Thien-Hue and Vinh Long (phase 2) while the majority of franchised CHSs were funded by AP.

Province/City	Phase	CHSs of the program	CHSs of provinces/cities
<i>Khanh Hoa</i>	1	28 (AP-funded)	28
<i>Da Nang</i>		20 (AP-funded)	20
<i>Thai Nguyen</i>	2	25 (AP-funded)	18
<i>Thua Thien-Hue</i>		25 (AP-funded) 20 (EU-funded)	8
<i>Vinh Long</i>		20 (AP-funded) 20 (EU-funded)	24
<i>Yen Bai</i>	3	30 (AP-funded)	To reach full coverage
<i>Dak Lak</i>		30 (AP-funded)	
<i>Ca Mau</i>		30 (AP-funded)	
TOTAL		248	98

Table 11 – The number of the Sisterhood CHSs
Source: MSIVN

Furthermore, the moment when we decided to choose Sisterhood as our case (in 2015), the program had existed in Vietnam for about 10 years. It was a proper moment for our research because at that time, the third phase of the program was being established and it was possible to make comparisons among Sisterhood's three phases.

For these reasons, we believed that Sisterhood could be an appropriate case to shed light on our initial research issues. In the next chapter, we explain how we collected and analyzed the data of the thesis.

Summary

Qualitative research method was considered to be an appropriate solution for our thesis, instead of a quantitative one. Scholars in this field provided several categorizations of qualitative approaches and based on our research issues, we selected case study.

We paid attention to Vietnam where numerous managerial models have been adopted recently (included social franchising). We believe that the “gap” between Vietnam and the countries where social franchising concept originated is important. This gap pertains to numerous factors, in particular ideological and cultural differences (Vietnam is a socialist country with original cultural characteristics). For this reason, we can predict several ruptures during the adoption process of social franchising in Vietnamese organizations.

Our case is the Sisterhood program, a governmental social franchise in the public health sector of Vietnam. We chose Sisterhood due to (1) our research questions, (2) easy access to the data, (3) potential ruptures during the process of adopting this model, (4) its innovative characteristics, (5) its dynamism and enthusiasm and (6) the possibility of making comparisons between the phases of Sisterhood.

CHAPTER 4: DATA COLLECTION AND ANALYSIS

This chapter consists of two sub-chapters, *data collection* and *data analysis* where we present our empirical data, how we collected them as well as how we analyzed them. In *data collection*, we focus on documentation and interviews. Regarding data analysis, we use a method inspired by Gioia, Corley and Hamilton (2012).

1. Data collection

1.1. Data and information sources

The qualitative data we collected before and during our fieldwork consisted of:

- Interviews: recorded and saved as 38 mp3 files. We translated them to English and saved them as pdf files;
- Observations: recorded and saved as seven mp3 files;
- Photographs: we took numerous photographs of Sisterhood CHSs, their consulting rooms (inside and outside) where we visited and our informants. Several photos were provided by some representatives of the program due to our specific purposes. We also downloaded some photos on the official website of MSI, MSIVN and Sisterhood. In addition, at the time of the 10th anniversary of Sisterhood, its manager sent us a photo book of the program;
- Videos: we filmed the main activities of some franchised CHSs when we were there. We also downloaded some on the internet. Furthermore, we received official presentation videos of Sisterhood from its manager;

-The manager of Sisterhood sent us a poster of MSIVN named “Increasing uptake of reproductive health services in the rural Vietnam through an innovative voucher scheme and social franchising”. She presented it in the poster session of the 2nd Global Symposium on Health Systems Research in Beijing (2012);

-We collected several official presentation documents of MSI, MSIVN and the Sisterhood program; one internal report of MSIVN and the Health Strategy and Policy Institute (HSPI) in Vietnam named “Baseline assessment of the project ‘Advancing the government social franchising model of reproductive healthcare services in Vietnam to scale up nationally’” (Vu et al., 2014); two official guidelines (“Sisterhood brand guidelines” and “Sisterhood social franchising model operational guidelines”) and two training guides (“provincial master trainers official training guide” and “service providers official training guide”).

In this thesis, we mobilized two main sources of data: (1) *documentation* and (2) *interviews*. Table 12 below introduces their general information and use in our data analysis.

Source of data	Type of data	Use in the analysis
<i>Documentation</i>	<ul style="list-style-type: none"> -Official presentation documents of Sisterhood (available online) -MSIVN’s internal report -Sisterhood brand guidelines -Sisterhood social franchising model operational guidelines -Provincial master trainers official training guide -Service providers official training guide 	<ul style="list-style-type: none"> -Familiarizing ourselves with the Sisterhood model -Partly understanding the operation and relevant elements of the program -Verifying or corroborating other sources of information -Providing initial inferences

<i>Interviews</i>	<ul style="list-style-type: none"> -18 individual and group semi-structured interviews (direct or by telephone) -informants: almost all stakeholders of the program -around 40min/interview, based on interview guide -December 2015 – January 2016 -Hanoi, Thai Nguyen, Yen Bai and Vinh Long 	<ul style="list-style-type: none"> -Familiarizing ourselves with Sisterhood -Deeply understanding the process of adopting Sisterhood in CHSs
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Table 12 – Data sources and use

We also paid attention to various information sources: informants with different positions from franchisees and co-franchisors of the Sisterhood program.

-Regarding *Sisterhood's co-franchisors*, we visited and worked with the headquarters of MSIVN in Hanoi, the Technical Division Department of the Thai Nguyen DOH (phase 2 of the program), the office of the Deputy Director of the Yen Bai DOH and the representative office of MSIVN in Yen Bai inside this DOH (phase 3 of the program).

-Regarding *Sisterhood's franchisees*, we visited and worked with four franchised CHSs: the Cu Van, Tan Huong (Thai Nguyen province), Van Hoi and Luong Thinh (Yen Bai province) CHSs. The Tan Huong CHS was developed by its local health (after MSIVN left) while the rest were established by the Sisterhood program. It was possible to make comparisons between different types of franchised CHSs and to collect “meaningful cross-site findings and patterns” (Yin 2011, p.126). Table 13 below summarizes the information of our visited places during the fieldwork.

City/Province	District	Commune	Place
<i>Hanoi</i>			MSIVN HQ

<i>Thai Nguyen</i>	Thai Nguyen's center		Technical Division Department Thai Nguyen DOH
	Dai Tu	Cu Van	Cu Van CHS
	Pho Yen	Tan Huong	Tan Huong CHS
<i>Yen Bai</i>	Yen Bai's center		Deputy Director and MSIVN office Yen Bai DOH
	Tran Yen	Van Hoi	Van Hoi CHS
		Luong Thinh	Luong Thinh CHS

Table 13 - Visited places during the fieldwork

1.2. Documentation

As we mentioned (see table 12 above), documentary information mobilized for the thesis took many forms: documents available on the official websites of MSI, MSIVN and Sisterhood; reports, guidelines and training guides of the program.

Our documents were quite useful, we note here several main points:

-Before and during our fieldwork, these documents helped us better understand various aspects of the Sisterhood model such as social franchising concept, the main activities of Sisterhood (communication-training-supervision) or the main tasks of Sisterhood's stakeholders (provincial master trainers, brand ambassadors, service providers, etc.).

-The documents were also quite helpful in verifying numerous details during our fieldwork such as the names of DOHs, DHCs, CHSs, informants, etc. In addition, "documents can provide other specific details to corroborate information from other sources. If the documentary evidence is contradictory rather than corroboratory, you need to pursue the problem by inquiring further into the topic" (Yin, 2014, p.107).

-According to Yin (2014, p.107), “you can make inferences from documents”. Indeed, before our fieldwork, based on numerous documents, we had a general image of Sisterhood and related issues. However, we used them as “clues” (with or without doubt) and a further investigation was conducted during the fieldwork because relying too much on the evidence from documents, a researcher can neglect its role as a phenomena observer. For instance, the official presentation documents of Sisterhood which (often) reflect the perception of co-franchisors only focus on the positive aspects of this model while the perceptions of other Sisterhood’s stakeholders can be quite different. In this situation, only based on documents can lead to incomplete understanding of the phenomena.

-Similar to the situation mentioned by Yin (2014, p.109), we also faced several problems of “the abundance of materials available through Internet searches”. In fact, there were numerous documents (in both Vietnamese and English) related to Sisterhood available online and to collect a proper document, we needed to evaluate its “potential contributions” in illuminating our research issues. Documents which were considered not to be relevant to the process of adopting Sisterhood in CHSs were excluded. In some special cases, we directly received several documents from MSIVN (for instance, the internal reports of MSIVN).

1.3. Interviews

1.3.1. Overview

In total, 18 individual and group semi-structured interviews were conducted in December 2015 and January 2016 in Hanoi, Thai Nguyen, Yen Bai and Vinh Long (see figure 14 below for a visual aid). They lasted an average of 40 minutes and were

based on an interview guide. “Weighting the evidence” (Miles, Huberman, & Saldana, 2014) which suggested to favor several informants over the others was not used and the informants were chosen in terms of their position within the model with the purpose of understanding the perceptions of various stakeholders in all phases of the program³⁰.

³⁰ Yin called that “purposive sampling” (Yin, 2011, p.88) or “purposeful sample”, according to Vanderstoep and Johnston (2009, p.187). Purposive (rather than random) samples were also mentioned in Miles et al. (2014).

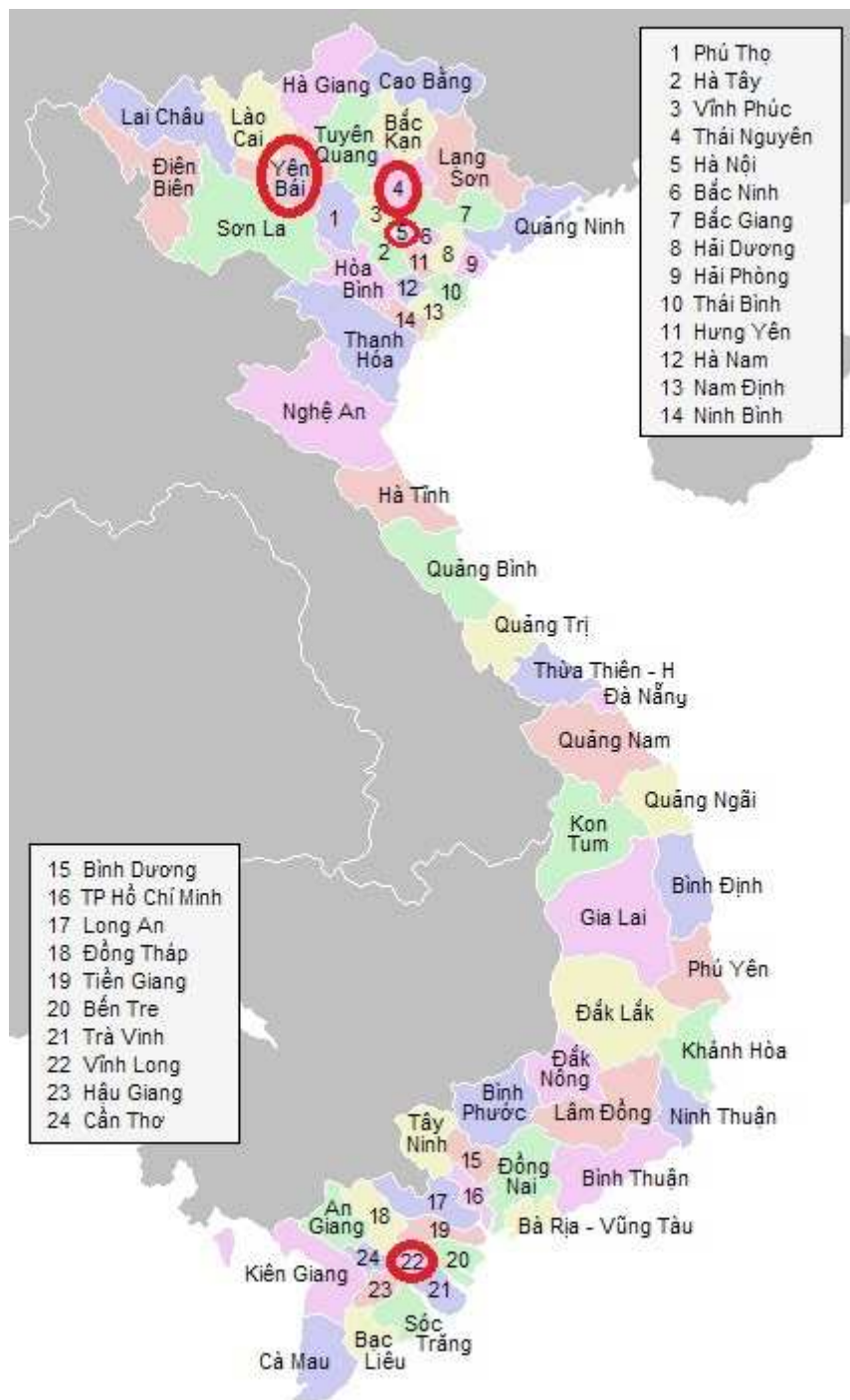


Figure 14 – Four provinces/cities where interviews were conducted
Source: MSIVN

Because of time constraint and geographical difficulties, some interviews in Yen Bai and Vinh Long were conducted by telephone. In addition, besides individual interviews, we conducted some group ones during which we tried to ask each

informant in the group (one after another) similar questions. For this reason, we could collect independent answers for each question. Each group consisted of two informants and as suggested by Yin (2011), we tried to make each person in each group feel like he/she had an equal and not subsidiary role.

Sisterhood was established within the CHSs but all upper level health facilities affected the adoption of this managerial model into these establishments. For this reason, we interviewed the representatives of MSIVN and several DOHs (co-franchisors), the representatives of some DHCs (intermediaries) and franchised CHSs (franchisees). We also interviewed certain provincial master trainers and brand ambassadors, who could be considered to be special franchisors and franchisees of the model.

In addition, our informants were a number of Sisterhood's co-franchisors and franchisees therefore, as suggested in Yin (2011), we could collect the information from contrary points of view and avoid biasing only one perspective. Furthermore, we also avoided only selecting the information sources which supported our preconceptions.

We always received approval from MSIVN, DOHs, DHCs and CHSs to conduct our interviews. Before visited a city/province of the Sisterhood program, we had discussed our interview plan with the governmental social franchise program manager. Afterwards, she contacted necessary representatives to set a visiting plan for us based on informants' availability. The final visiting plans and letters of introduction had often been established a few days before we paid a visit to the sites. The Sisterhood program's manager facilitated our access to the sites however she did not intervene

in our interviews which were not conducted under any artificial conditions. We keep all mp3 files of our interviews and have not shared them to anyone.

Among our interviews, there were two informants whom we interviewed two times because:

-Regarding the first informant, this one held two different positions within the Sisterhood program (interview #9 and #12). In each interview, this informant answered our interview questions from the perspective of different positions.

-As for the second informant, due to the first interview with this person which was interrupted, we had to conduct the second one (interview #16 and #17).

The collection of other relevant materials and the confirmation of collected information after all interviews led to the second interview with the manager of the program (interview #18), where we reached “semantic saturation”³¹ (see table 14 below for more information of the informants).

	Level	Position	Franchisor	Franchisee
#1	National	Governmental social franchise program manager	x	
#18		Governmental social franchise program manager (the same informant as #1)	x	
#7	Provincial	Head of the DOH project manager unit	x	
#2		DOH project coordinator	x	
#8		Project official of MSIVN	x	
		Admin/Accountant of the MSIVN provincial project office	x	

³¹ Or the “redundancy criterion”, when new informants do not bring new information and understanding (Vanderstoep & Johnston, 2009, p.188).

#12		Provincial master trainer of Yen Bai province	x	
#13		Provincial master trainer of Vinh Long province	x	
#3	District	Director of the Dai Tu DHC	Intermediary	
#9		DHC project coordinator (the same informant as #12)	Intermediary	
#4	Communal	Head of the Cu Van CHS		x
		“Sisterhood” room consultant of the Cu Van CHS		x
#5		Head of the Tan Huong CHS		x
#6		“Sisterhood” room consultant of the Tan Huong CHS		x
#10		Head of the Van Hoi CHS		x
		“Sisterhood” room consultant of the Van Hoi CHS		x
#11		Head of the Luong Thinh CHS		x
		“Sisterhood” room consultant of the Luong Thinh CHS		x
#14		Brand ambassador of a commune in Vinh Long province		x
#15		Brand ambassador of a commune in Yen Bai province		x
#16		Brand ambassador of a commune in Yen Bai province		x
#17		Brand ambassador of a commune in Yen Bai province (the same informant as #16)		x
TOTAL			7	11

Table 14 – Informants’ profiles³²

Currently, we continue to maintain contact with Sisterhood’s manager for updated information (by formal and informal ways). For instance, on 8 December 2016, we had a telephone conversation with her (around 20 minutes) where she provided updated information about the program and confirmed some vague pieces of our information.

³² The interviews were numbered chronologically.

1.3.2 Semi-structured interviews

Among various types of interviews, we mobilized semi-structured interviews for our process of collecting data. Generally, semi-structured interviews³³ have the advantages of both informal and structured interviews. In addition, we followed an outline of “open-ended” and “single-issue” questions (Vanderstoep & Johnston, 2009, p.228-230).

Considerably differing from “closed-ended” questions; “open-ended” ones can be considered to be very “open” because informants have many opportunities and time to answer them. Therefore, we can avoid “single-word” answers. In addition, unlike “multiple-issue” questions, “single-issue” ones directly focus on their main ideas (Yin, 2011). Consequently, informants can easily understand these questions and answer them exactly. Furthermore, “open-ended” and “single-issue” questions can give us a chance to ask further questions based on initial answers of informants.

The outline of our interview questions, similar to an “interview protocol” (Yin, 2011, p.139), consisted of several general questions which were divided into “common themes” and “specific themes”. All stakeholders of the Sisterhood program were asked the “common themes” while the “specific themes” were used for the representatives of MSIVN, DOHs, DHCs and for the health workers of franchised CHSs.

As suggested by Yin (2011), we used an outline of questions (in printed version) during our interviews because it could be viewed as a sign of well-prepared and serious questions. Our interview questions can be found in box 3 below.

³³ Or “guided interview”, according to Vanderstoep and Johnston (2009, p.225).

Common themes

1. Would you mind telling me about your work?
2. When did you know about the Sisterhood program?
3. How long have you worked for the Sisterhood program?
4. What are the Sisterhood program's main goals?
5. What are the Sisterhood program's main difficulties?
6. What are the norms of a franchised CHS?
7. What are the main activities of a franchised CHS?
8. *(After MSIVN left, how about these activities?)*³⁴
9. What are the main activities of a "Sisterhood" consulting room?
10. What are the impacts of a "Sisterhood" consulting room on the rest of a franchised CHS?
11. How did MSIVN and DOHs establish franchised CHSs?
12. How did MSIVN and DOHs control franchised CHSs?

Specific themes

1. For the representatives of MSIVN, DOHs and DHCs

- 1.1. What are MSIVN's main activities within the Sisterhood program?
- 1.2. What are your DOH's main activities within the Sisterhood program?
- 1.3. What are your DHC's main activities within the Sisterhood program?

2. For the health workers of franchised CHSs:

- 2.1. What are your main activities in this CHS?
 - a. How do you collaborate with other colleagues in this CHS?
 - b. What are the main differences between your activities in this CHS before and after franchising?
 - c. *(After MSIVN left, how about your activities?)*³⁵
- 2.2. The activities of other non-franchised CHSs?

Box 3 – Interview questions

At the beginning of each interview, we briefly presented to our informants ourselves³⁶ and the purposes, length (estimated time) and type (semi-structured interview with follow-up questions) of the interview. Afterwards, we asked for the permission of our

³⁴ This question was only used for the franchised CHSs of the 1st and the 2nd phase of the program where MSIVN had left. The time when we did our field work, the program was in its 3rd phase (in Yen Bai, Dak Lak and Ca Mau).

³⁵ This question was only used for the health workers in the franchised CHSs of the 1st and the 2nd phase of the program where MSIVN had left.

³⁶ According to Yin (2011), presenting yourself before interviewing someone can be viewed as a professional manner that promises a serious research process, rather than an informal conversation.

informants³⁷ to record the interview (Yin, 2011) and promised to provide our research results to them. This initial interview presentation was followed by questions. Inspired by Vanderstoep and Johnston (2009), we asked our informants three types of questions (cf. box 3 above):

(1) *Demographic and factual questions*: to know about our informants' background. This kind of question helped us start the conversation easily and quickly gave us basic information;

(2) *Description questions*: these questions focused on our informants' experience. According to Vanderstoep and Johnston (2009, p.226), we played the role of "naïve observers" and asked our informants "see, hear, smell, touch and taste" questions (or "sensory questions");

(3) *Comparison-feeling-opinion-value questions*: these questions were delicately used to understand our informants' "meanings, interpretations and associations in regard to the experiences described" (Vanderstoep & Johnston, 2009, p.226). The purpose of these questions was to explore their underlying perspectives. In addition, during this process, we also paid special attention to our verbal and non-verbal feedback to each answer of the informants because, according to Vanderstoep and Johnston (2009), that could encourage them to bring a rich understanding of the context.

In box 3 above, questions 1-3 in the "common themes" are introductory questions that aim at our informants' basic information. In addition, questions 4-9 helped us understand the most important elements of the Sisterhood program. Furthermore,

³⁷ For more information, please see Yin (2014, p.77), "Protecting Human Subjects".

question 10 is an important question pertaining to our informants' perceptions. Through questions 11 and 12, we could understand other activities (supervision) and the initial steps of Sisterhood. Similar logic can be found in the "specific themes".

We did not neglect the closing parts of our interviews. Indeed, after around 40 minutes of each interview trying to gather as much information as possible from the informants, how regrettable it will be if we do not pay attention to the end of our interviews. At that moment, we often asked our informants several questions such as: "Would you like to add anything?" or "Would you like to tell us further information?". These questions gave our informants one more chance to talk about their experiences and ensured that we had almost complete information.

2. Data analysis

In this sub-chapter we present a method to analyze our data. Among numerous data analysis methods, we first explain the reasons why we chose this method then we describe in detail how we used this one.

2.1. The need for a rigorous data analysis method

As suggested by Yin (2014), we clearly distinguished the difference between the unit of data collection and analysis. Regarding the Sisterhood program, our data was collected from several documents and numerous stakeholders of the program while our unit of analysis was the program as a whole.

To familiarize ourselves with the interviews, we listened and read them numerous times, as suggested by Yin (2011). We also tried to systematically organize our data, known as "compiling" (Yin, 2011, p.182), to prepare for a rigorous analysis. According

to Miles et al. (2014), initial elements of a study often show promising signs. However, a researcher cannot condense all information therefore we need to select necessary factors for our study. For this reason, we sought codes³⁸ and patterns then clustered them or generally, subsumed particulars into the general (Miles et al., 2014).

After this preparation phase, we had a list of general themes and sub-themes that helped us understand the important elements of the case, the Sisterhood program. This list was considered to be a *rough draft* of our data analysis. According to several qualitative data analysis books, for instance Miles et al. (2014), we can draw conclusions for our study based on this draft only. However, it can raise doubts about its generation process. How were hundreds of pages of interview transcripts transformed into a few themes and sub-themes?

In quantitative studies, different researchers quantitatively analyze a set of quantitative data based on econometric and statistical tools can lead to similar results. However, we can have different findings from different researchers when they qualitatively analyze³⁹ a qualitative data set (Miles et al., 2014). Is it an advantage of qualitative data analysis methods?

Trustworthiness of conclusions is indeed an important issue in qualitative studies (Gioia et al., 2012; Miles et al., 2014). That also relates to “how much confidence we can place in them [researchers]” (Miles et al., 2014, p.294), and “how do we know you haven’t just made up an interesting interpretation?” Gioia et al. (2012, p.18).

³⁸ There are numerous methods of coding, as suggested by some scholars (Miles et al., 2014; Saldana, 2013; Yin, 2011).

³⁹ Regarding qualitative data, we can qualitatively or quantitatively analyze them.

To deal with these problems of trustworthiness, we mobilized a method significantly inspired by Gioia et al. (2012). The principal elements of this method were used in various studies, not only the studies of Gioia et al.⁴⁰ but also the studies of many other authors. In addition, these studies met rigorous criteria and were published in numerous top journals (for more information, please see table 15 below). All of these reasons encouraged us to use this analysis method for the thesis.

Author(s)	Journal
Studies of Gioia et al.	
Gioia and Chittipeddi (1991)	Strategic Management Journal
Gioia, Thomas, Clark and Chittipeddi (1994)	Organization Science
Gioia and Thomas (1996)	Administrative Science Quarterly
Corley and Gioia (2004)	Administrative Science Quarterly
Corley (2004)	Human Relations
Nag, Corley and Gioia (2007)	Academy of Management Journal
Gioia, Price, Hamilton and Thomas (2010)	Administrative Science Quarterly
Clark, Gioia, Ketchen and Thomas (2010)	Administrative Science Quarterly
Harrison and Corley (2011)	Organization Science
Nag and Gioia (2012)	Academy of Management Journal
Studies of other authors	
Labianca, Gray and Brass (2000)	Organization Science
Thomas, Sussman and Henderson (2001)	Organization Science
Balogun and Johnson (2004)	Academy of Management Journal
Maitlis (2005)	Academy of Management Journal
Pratt, Rockmann and Kaufmann (2006)	Academy of Management Journal
Anand, Gardner and Morris (2007)	Academy of Management Journal

⁴⁰ At least one author is Gioia or Corley or Hamilton.

Maitlis and Lawrence (2007)	Academy of Management Journal
Anand and Jones (2008)	Journal of Management Studies
Maguire and Phillips (2008)	Journal of Management Studies
Dacin, Munir and Tracey (2010)	Academy of Management Journal
Kjærgaard, Morsing and Ravasi (2011)	Journal of Management Studies
Poonamallee (2011)	Journal of Management Inquiry
Ravasi and Phillips (2011)	Strategic Organization
Rerup and Feldman (2011)	Academy of Management Journal
Rindova, Dalpiaz and Ravasi (2011)	Organization Science
Mantere, Schildt and Sillince (2012)	Academy of Management Journal
Stigliani and Ravasi (2012)	Academy of Management Journal

Table 15 – Studies mobilized the principal elements of Gioia et al.’s method
Source: Gioia et al. (2012)

Based on this method, the process of analyzing our data comprised two main phases. In the first phase, named *1st-order analysis*, we analyzed and arranged our data in numerous codes, called *1st-order concepts* (based on informants’ words, terms or phrases). In the second phase, named *2nd-order analysis*, the data was analyzed and divided into several categories, called *2nd-order themes* (focused on researchers’ concepts, themes and dimensions).

Table 16 below provides the general characteristics of data analysis phases proposed by Gioia et al. (2012). During the whole process, the authors paid special attention to both analyzing and presenting data (see *How?* in table 14).

	Why?	How?	Goals?
<i>“1st-order” analysis</i>	Informants are “knowledgeable agents” and their	-Coding interviews (mostly “in vivo” codes) -Organizing them: finding links, seeking	-Establishing a manageable list of representative codes

	perceptions are quite important	similarities and differences among them	based on informants' voices -These codes relate to initial research questions
<i>"2nd-order" analysis</i>	-Researchers are also "knowledgeable agents" who can formulate informants' perceptions into theoretical terms -Avoid "going native"	-Regrouping relevant "1st-order" concepts in "2nd-order" themes -Encouraging nascent concepts	-Providing a list of researchers' theoretical themes which is mainly based on informants' voices -Developing the "2nd-order" themes further into "aggregate dimensions"

Table 16 – General characteristics of data analysis phases
Source: Gioia et al. (2012)

In the next paragraphs, we discuss the advantages of this method and explain in detail how to conduct each phase of analyzing our data.

2.2. The adaption of Gioia et al.'s data analysis method

2.2.1. Advantages

Gioia et al. (2012, p.19) highlighted the disadvantages of "going native". It is a situation where a scholar stays quite close to informants that he/she believes and adopts their views. Similarly, Vanderstoep and Johnston (2009, p.228) emphasized the importance of "boundaries" between researchers and informants. Regarding rigorous qualitative studies, Miles et al. (2014) advised researchers to avoid going native. However, coding methods are principally based on informants' words, terms or phrases (Miles et al., 2014) therefore qualitative data analyses which mobilize these methods can have "going native" issue.

Regarding Gioia et al.'s method, special attention was paid to the importance of both informants and researchers therefore in general the issue of "going native" could be

avoided. The authors considered informants to be “knowledgeable agents” and the duty of researchers was to collect information without imposing prior constructs or theories on that. It is indeed a favorable condition to discover new ideas or concepts. In addition, the role of researchers (also viewed as “knowledgeable agents”) was not neglected. According to Gioia et al. (2012), the researchers should distance themselves from the field and observe its information with “theoretical eyes”.

During data analysis process, numerous authors aimed at condensing their data set to build a visual format where various pieces of information were arranged and presented in a systematic way. Through this “display”, often under the format of a matrix or a network (Miles et al., 2014), conclusions were drawn easily.

Regarding Gioia et al.’s method, it also focused on how to organize and analyze data systematically. According to Gioia et al. (2012), “over the years, we have worked out procedures that not only guide the conduct of the research itself in a way that imposes qualitative rigor, but also encourages the presentation of the research findings in a way that demonstrates the connections among data, the emerging concepts, and the resulting grounded theory” (p.17) and “ we had executed the data gathering and analysis in a systematic way, namely, that we hadn’t just cherry-picked the quotes in the reporting, contrived some clever explanation and slapped a sexy label on it” (p.18).

Indeed, the Gioia data structure which consists of three columns (“1st-order concepts” – “2nd-order themes” – “aggregate dimensions”) is not only a visual aid of data but also a detailed description of the ways by which raw data were analyzed and transformed into final dimensions.

Miles et al. (2014) presented five families of methods of qualitative data analysis through display (or “tools for analysis”): exploring, describing, ordering, explaining and predicting. In fact, we need a combination of these tools to have an appropriate solution for qualitative studies while Gioia method is considered to be an only and robust tool for analyzing qualitative data.

2.2.2. “1st-order” analysis

Our “1st-order” analysis, similar to Gioia et al. (2012), paid special attention to our informants’ voice. During this analysis process, we always tried to maintain our informants’ original words, terms or phrases.

At the beginning, we coded all of our interview transcripts. The majority of the codes were “in vivo” ones⁴¹ and related to our initial research questions. According to Miles et al. (2014, p.72), “... coding is analysis. Some research methodologists believe that coding is merely technical, preparatory work for higher level thinking about the study. But we believe that coding is deep reflection about and, thus, deep analysis and interpretation of the data’s meanings”.

During the process (rather than in its end), we constantly compared the similarities and differences among our codes and “transformed” them into higher level ones⁴². Therefore, the number of codes (which could exceed 200 after a few interviews) was significantly reduced and we finally had a manageable list of codes (20-30 codes) or “1st-order” concepts.

⁴¹ “In vivo” codes are “words or short phrases from the participant’s own language in the data record” (Miles et al., 2014, p.74).

⁴² We did not forget to note down the words, terms or quotations which corresponded to these codes for our later uses.

To prepare for our “2nd-order” analysis, we organized the “1st-order” concepts as follows: although we conducted interviews with an outline of questions, informants’ answers did not strictly follow the order of our questions. For this reason, during the “1st-order” analysis, we had to look for links among our “1st-order” concepts and gather relevant ones in the same place (“cage”).

Our provisional “cages” (where the relevant codes were gathered together) are similar to “deductive codes” that come from “the conceptual framework, list of research questions, hypotheses, problem areas and/or key variables that the researcher brings to the study” (Miles et al., 2014, p.81). These “cages” were a valuable suggestion to establish “2nd-order” themes.

2.2.3. “2nd-order” analysis

To sum up, after the 1st phase of our data analysis (the “1st-order” analysis), we had a list of 20-30 codes (the “1st-order” concepts) under several temporary “cages”.

During our 2nd analysis phase (named “2nd-order” analysis), we assigned “labels” or “phrasal descriptors” to the “1st-order” concepts. These new “cages” can be an identical or a refined version of the provisional ones. We also established several brand-new ones which were similar to “inductive codes”. According to Miles et al. (2014, p.81), “the researcher is open to what the site has to say rather than determined to force-fit the data into preexisting codes”.

The “2nd-order” analysis is an important data analysis phase which distinguishes Gioia et al.’s method from other qualitative data analysis methods. In this phase, although Gioia et al. (2012) preferred to retain informants’ terms, the role of researchers who

could observe and categorize the “1st-order” concepts into more abstract and narrower groups of ideas was highlighted. Gioia et al. (2012) also encouraged emerging concepts that were new to the existing literature. Due to these reasons, the “2nd-order” themes are not similar to “in vivo” codes, an appropriate solution for “beginning qualitative researchers learning how to code data” (Miles et al., 2014, p.74).

In the end of the process, we tried to develop the “2nd-order” themes further into several “aggregate dimensions”. The “1st-order” concepts, the “2nd-order” themes and the “aggregate dimensions” constitute our data structures.

2.2.4. Representative supporting data

Our data analysis method is similar to Gioia et al.’s method but not identical. In a concrete way, we established a table which consisted of representative supporting data for each 2nd-order theme. The supporting data, in this case, are words, terms or quotations corresponding to the “1st-order” concepts.

In fact, this table was not mentioned in Gioia et al.’s analysis method but was mobilized in numerous studies which also used this method (Clark et al., 2010; Dacin et al., 2010; Gioia et al., 2010; Kjærgaard et al., 2011; Labianca et al., 2000; Maitlis & Lawrence, 2007; Mantere et al., 2012; Nag et al., 2007; Nag & Gioia, 2012; Poonamallee, 2011; Pratt et al., 2006; Ravasi & Phillips, 2011; Rerup & Feldman, 2011; Stigliani & Ravasi, 2012).

However, the authors mentioned above only focused on informants’ quotations⁴³ and neglected their words or terms which were scattered everywhere. We believed that

⁴³ Pieces of interviews which consist of at least one or two phrases.

these words or terms could significantly support our 2nd-order themes and therefore added them in our supporting data table.

Finally, yet importantly, according to Miles et al. (2014), “counting” is one of the useful tactics for generating meaning from a data display. Therefore, we counted the appearance of a word or term and its derivative (when we deleted a word or term because of similarities, we also counted it). Obviously, we could not count the appearance of a word or term and its derivative exactly and this job is impossible for a computer software because the similarities/differences among words or terms deeply depend on the context.

Summary

Several sources of qualitative data were collected and we focused on two principal ones: documentation and semi-structured interviews. Various information sources were also mobilized: informants with different positions from Sisterhood's franchisees and co-franchisors with the purpose of understanding the perceptions of various stakeholders in all phases of the program.

Regarding data analysis, to deal with trustworthiness issues, we applied a method inspired by Gioia et al. (2012) which consisted of two main phases: 1st-order analysis and 2nd-order analysis in which our data was analyzed and divided into 1st-order concepts and 2nd-order themes respectively. The 1st-order concepts are based on informants' words, terms or phrases while the 2nd-order themes focus on researchers' concepts, themes and dimensions.

This method focused on both informants and researchers. Therefore, the issue of "going native" could be avoided. In addition, it also paid attention to how data was systematically organized and analyzed.

To "extend" Gioia et al.'s method, we built a table which consisted of representative supporting data for each 2nd-order theme. In addition, we also counted the appearance of a word or term.

PART 3: FINDINGS AND DISCUSSION

Part 3 consists of two chapters, *Findings* and *Discussion*. The former provided detailed information about the Sisterhood model and the process of adopting it in CHSs while the latter suggested a different look at this process. This part is the center of our thesis where we present interesting understanding from the field as well as our own explanations.

Regarding *Findings*, before we went to Vietnam to do our fieldwork, our knowledge of Sisterhood and the process of adopting it in CHSs had principally come from the official documents of the program. Our impression was that Sisterhood could be considered a model with innovative characteristics and it helped further organizational goals. In addition, during the adoption process of this model, there were several difficulties because of the novelty of Sisterhood and many other reasons.

When we analyzed our data, this understanding was clarified. We not only knew about Sisterhood's characteristics and organizational aspects that were improved but also its novelty degree. Compared to other managerial ideas in the academic world, this model is based on a singular concept, governmental social franchising. In addition, Sisterhood brought some ruptures in CHSs and the tensions between this model and CHSs appeared right from the beginning of the adoption process. Moreover, when we studied insights into the adoption process of Sisterhood, further understandings also began to take shape.

As for *Discussion*, we view the adoption process of Sisterhood in Vietnamese CHSs as a process of adopting a management innovation in an organization. Nine phases

of this process, often associated with tensions, are discovered. The heart of our discussion is a different look on this process based on “economies of worth”. We explain the reason why we use this theory. Afterwards, the process of adopting Sisterhood is expressed through the language of “worlds”, “criticisms” and “compromises”. Indeed, numerous signs of different worlds within the Sisterhood program and CHSs (before Sisterhood) appear and based on that, we can understand criticisms and compromises during the adoption process. It can be said that “economies of worth” further our knowledge on management innovation adoption process which is still limited in the scope of innovations in management.

CHAPTER 5: FINDINGS

In this chapter, inspired by Gioia et al.'s method, we describe an informative story. We also focus on “existing concepts that have new twists that produce new insights” (Gioia et al., 2012, p.24). Moreover, this chapter is “suffused with informant quotes – quotes that align with the exemplars shown in the data structure figure. The meta-message to the reader is, ‘This is what the informants told us. We’re not making this stuff up.’” (Gioia et al., 2012, p.23).

Our findings are developed from Sisterhood’s documents as well as the “1st-order” concepts and “2nd-order” themes in two data structures (see figure 15 and figure 16). Furthermore, our supporting data are displayed in table 17 and table 18 and suitable for figure 15 and figure 16 respectively.

1. Sisterhood, a transporter of (potential) ruptures

Based on Sisterhood’s documents as well as the evidence from our interviews, this managerial model can be described through its rhetorical and technological dimensions (Rauth, 2015). These dimensions of Sisterhood are quite new to the knowledge in the academic world and can also bring (potential) ruptures for CHSs (see figure 15 and table 17 below).

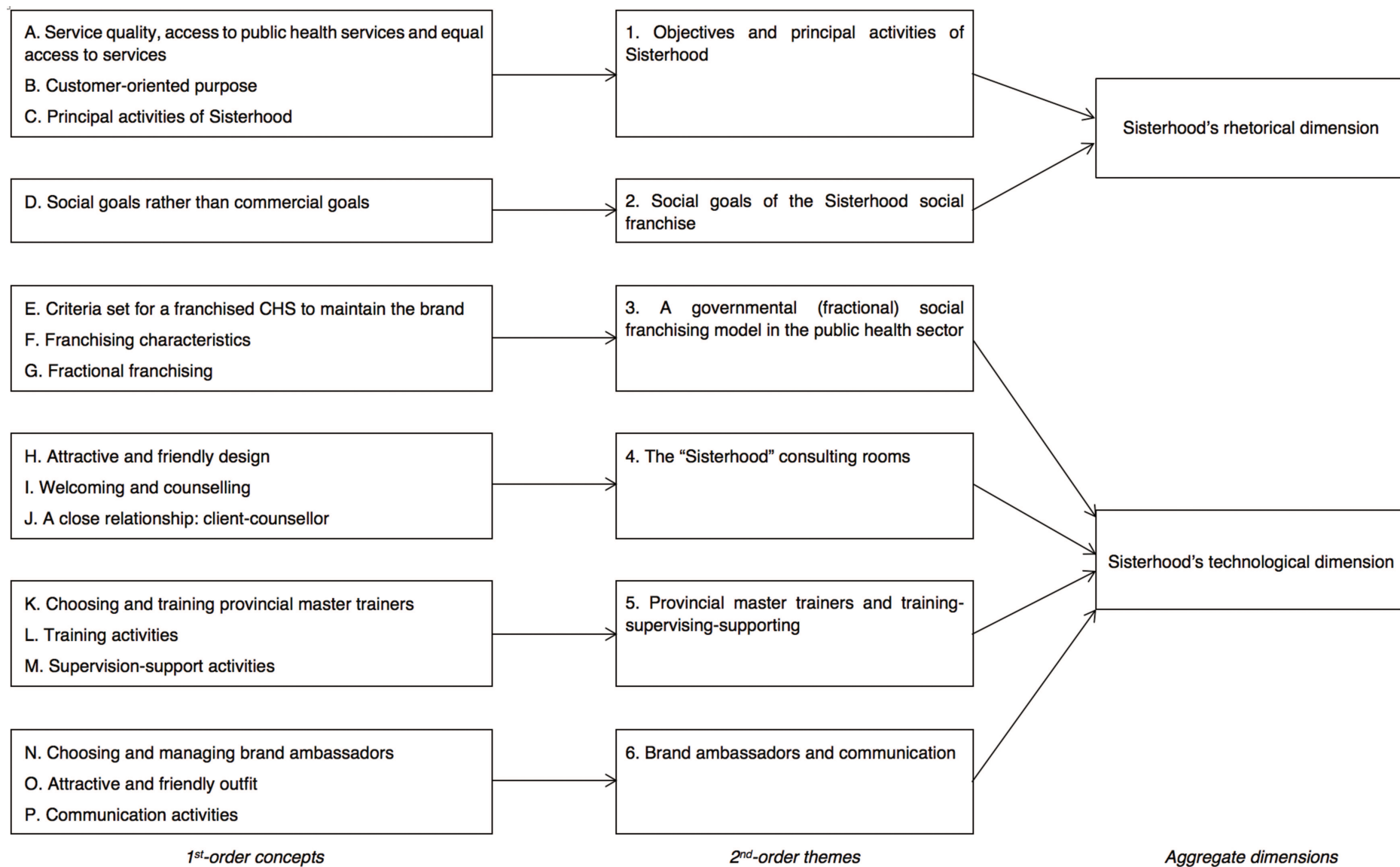


Figure 15 – Data structure 1

1.1. Sisterhood's rhetorical dimension

The rhetorical dimension of Sisterhood pertains to two main questions: “what the Sisterhood program is?” and “why it should be used?” (Rauth, 2015, p.73).

1.1.1. Objectives and principal activities of Sisterhood

According to our collected documents (cf. 2.3.1. *The public health system in Vietnam*) and our informants, before the Sisterhood program, the infrastructure of almost all of CHSs was in bad condition. At that moment, both health workers and patients lacked or had a limited knowledge of service quality. In addition, counselling services did not exist. Sometimes, health workers provided services and counselled patients simultaneously. In this context, the Sisterhood program was considered an appropriate solution to overcome these obstacles.

Sisterhood set two clear objectives: one related to service quality and access, the other pertained to customer-oriented purpose. In addition, our informants also mentioned three principal activities of the program: training, communication (seven occurrences) and supervision (two occurrences).

Regarding service quality and access, one informant asserted the following:

“The objective of the program, first, improving the service quality of the commune health stations, second, increasing the access to public health services of local people. Third, the equal access to services which doesn't depend on religion, wealth or sex.” [#1, Governmental social franchise program manager]

Bui, Vo, Tran, Dang and Dinh (2011, p.5) highlighted that “this model encourages greater reproductive health and family planning service utilization and improves provider knowledge and practices” and it supports for the ideas relating to service access and quality above.

In addition, increasing client volume for CHSs (five occurrences), decreasing client volume for upper level health facilities (three occurrences) and improving the professional skills of medical staff (three occurrences) were paid special attention among other objectives⁴⁴ of Sisterhood by our informants.

Furthermore, all of our informants viewed “patients” as “clients”. Some even used the term “customer-oriented purpose” when they talked about the objectives of the program. One informant we interviewed noted that:

“I also think that the objective of the program ... according to the criteria of the program, is customer-oriented purpose. What I like in this program, compared to other programs, is that they don’t consider patient to be patient but they consider people who come to the station to be clients. The aim of the program is to focus on the satisfaction of people who come for our services.” [#4, Head of the Cu Van CHS]

In addition, a remarkable event which was repeated 26 times in our interviews was the fact that clients understood and could decide to receive (or not) a service. Some informants called it “empowering clients”⁴⁵, a significant change in franchised CHSs

⁴⁴ Other objectives of Sisterhood mentioned by our informants: cost-effectiveness, improving infrastructure, applying new technological advances and increasing income for health workers (see table 17, 1.A2 below).

⁴⁵ This activity can also be classified as one of the technological dimensions of the Sisterhood program.

compared to themselves before and non-franchised CHSs. Furthermore, counselling and a friendly relationship with clients were also repeated several times by our informants (four and two times respectively).

The “promising future” mentioned in Sisterhood’s objectives is indeed quite “far” from CHSs’ real situation before the program (mentioned in our documents). From health facilities without basic knowledge of service quality and customer-oriented services (included counselling), the program aimed at improving them all.

Clients (rather than patients) were considered to be the center and their satisfaction was quite important. As a client, after counselling, he/she could choose a suitable service. Before Sisterhood, clients had been confined to passive roles but when Sisterhood came, the program hoped to change this situation: clients could play a more active part.

Regarding Sisterhood’s three main activities, in fact, as a basic unit of the public health system in Vietnam, there had been also these activities in CHSs before Sisterhood however, the program wanted to improve them or even introduce for the first time several elements.

In general, right from the beginning, Sisterhood planned to introduce market and industrial factors into CHSs. Nonetheless, a “gap” between CHSs’ context and Sisterhood’s plan predicted the occurrence of several ruptures in the near future.

1.1.2. Social goals of the Sisterhood social franchise

To address the question “what is the Sisterhood program?”, we should view it as a social franchise. According to the manager of the Sisterhood program, it is “the first

governmental social franchising model in the public health sector in the world”. Moreover, the title “a public health social franchising program” was repeated nine times in our interviews.

In addition, based on Sisterhood’s official documents and according to our informants, Sisterhood’s first pilot phase (in Khanh Hoa and Da Nang) was the first time when social franchising concept was introduced to the public health sector and Sisterhood was also the first program which intervened in the network of CHSs in Vietnam. One informant said that:

“Regarding the social franchising concept in the public health system of Vietnam, Marie Stopes in Vietnam pioneered to introduce and pilot this concept.” [#18, Government social franchise program manager]

Based on these facts from the field, we believe that Sisterhood model is not only new to the academic world but also to CHSs in Vietnam. Regarding the state of the art, social franchising concept is still in its early steps. Moreover, the majority of studies in this field focused on private health, rather than public health. In addition, we also pay attention to the fact that Sisterhood is the first governmental social franchise in the world (cf. *Chapter 2: Social franchising*). Regarding CHSs, the moment when Sisterhood was introduced to Vietnam, it was new to the whole public health sector.

According to Vu et al. (2014), after two pilot phases, the third phase of the program was established under the title “advancing the governmental social franchising model of sexual/reproductive healthcare services in Vietnam to scale up nationally”. Meaning besides the general objectives, the program aimed at bringing more benefits to many

other people in the country. In this phase, the program hoped that its social impacts could reach not only several communes but also the entire country.

Scaling up to a wider geographical area is one of the advantages of franchising and Sisterhood planned to maximize it. However, this feature, at that moment, was completely unfamiliar to CHSs (and the whole sector in general).

The social goals and benefits of the Sisterhood program were mentioned several times in our interviews. One informant asserted as follows:

“Sisterhood aims at social goals rather than commercial goals ...” [#1, Governmental social franchise program manager]

“‘Benefit’, in this case means ... improving the capacity of medical staff. How to better serve people. And ... having available services for people and creating ... health benefits for the community. I call it ‘benefit’, rather than ‘profit’.” [#1, Governmental social franchise program manager]

As mentioned in 2.2.2. *The originality of Vietnamese culture*, family has a very important role in Vietnam and sometimes that can be viewed as a negative point. As for many Vietnamese people, the narrow thinking within the scope of family benefits is a common phenomenon. Therefore, social goals and helpful or good effects for the community are still strange to many people in Vietnamese society. Consequently, “social goals” and “benefits” introduced by Sisterhood were novel concepts to CHSs and the public health sector in Vietnam.

An interesting proof of Sisterhood's social goals is that this program shared their experience with The Little Sun (of A&T Vietnam), a social franchising program which also intervened in CHSs. One informant we interviewed asserted the following:

"Firstly, Marie Stopes would like to support the community and build the capacity of the provincial healthcare sector. During this process, if the healthcare sector receives a lot of support, it will be a very positive signal. So ... regarding the intervention and the support of The Little Sun, Marie Stopes considers these activities to be good news. First of all, we confirm that it is good news." [#18, Governmental social franchise program manager]

Sisterhood's rhetorical dimension**1. Objectives and principal activities of Sisterhood**

A. Service quality, access to public health services and equal access to services

A1. "The objective of the program, first, improving the service quality of the commune health stations, second, increasing the access to public health services of local people. Third, the equal access to services which doesn't depend on religion, wealth or sex." [#1, Governmental social franchise program manager]

A2. Increasing client volume (5), decreasing client volume for upper level health facilities (3), improving the professional skills of medical staff (3), cost-effectiveness, improving infrastructure, applying new technological advances, increasing income for health workers

B. Customer-oriented purpose

B1. "I also think that the objective of the program ... according to the criteria of the program, is customer-oriented purpose. What I like in this program, compared to other programs, is that they don't consider patient to be patient, but they consider people who come to the station to be clients. The aim of the program is to focus on the satisfaction of people who come for our services." [#4, Head of the Cu Van CHS]

B2. Empowering clients (26), focusing on counselling (4), having a friendly relationship with clients (2)

C. Principal activities of Sisterhood

C1. Training, communication (7), supervision (2)

2. Social goals of the Sisterhood social franchise

D. Social goals rather than commercial goals

D1. A public health social franchising program (9)

D2. "Regarding the social franchising concept in the public health system of Vietnam, Marie Stopes in Vietnam pioneered to introduce and pilot this concept." [#18, Government social franchise program manager]

D3. "Sisterhood aims at social goals rather than commercial goals ..." [#1, Governmental social franchise program manager]

D4. “‘Benefit’, in this case means ... improving the capacity of medical staff. How to better serve people. And ... having available services for people and creating ... health benefits for the community. I call it ‘benefit’, rather than ‘profit’.” [#1, Governmental social franchise program manager]

D5. “Firstly, Marie Stopes would like to support the community and build the capacity of the provincial healthcare sector. During this process, if the healthcare sector receives a lot of support, it will be a very positive signal. So ... regarding the intervention and the support of The Little Sun, Marie Stopes considers these activities to be good news. First of all, we confirm that it is good news.” [#18, Governmental social franchise program manager]

Table 17 – Representative supporting data for each 2nd-order theme of data structure 1

1.2. Sisterhood's technological dimension

Data structure 1 also highlights the important factors relating to Sisterhood's technological dimension. These factors pertain to the elements of Sisterhood, as a governmental (fractional) social franchising model in the public health sector and the "Sisterhood" consulting room. In addition, the information of provincial master trainers, brand ambassadors and their main activities also tells us about the technological dimension of this model.

1.2.1. A governmental (fractional) social franchising model in the public health sector

Similar to other franchising models, Sisterhood also has a set of criteria for franchised CHSs to maintain the brand. If these criteria are not respected, a franchised CHS will lose the brand. These criteria are clearly stated in "Sisterhood brand guidelines" and "Sisterhood social franchising model operational guidelines". They were also repeated several times by our informants.

Among the criteria for maintaining the brand, our informants focused on maintaining client volume (five occurrences) and service quality (five occurrences) of CHSs. In addition, the reputation of the brand and franchised CHSs (three occurrences), equipment (two occurrences) and the sanitary conditions of CHSs (two occurrences) were also paid attention. Furthermore, our informants also viewed the professional skills, the counselling, and the hospitality of franchised CHSs' health workers as important criteria to maintain the brand.

These criteria are suitable to Sisterhood's main objectives and a common characteristic of franchising. In general, a set of criteria for brand maintenance sets a limit for franchisees (CHSs in this case). It also motivates them to keep "working hard" because the standards of franchising are always strict and high. In the case of CHSs, they are a basic unit of Vietnamese public health system and supported by the MOH and the government. CHSs' activities depend on these institutions. Therefore, "losing the brand" and "maintaining the brand" concepts do not exist because CHSs have never ever stopped their activities.

Sisterhood governmental social franchising model, similar to other franchising models, is based on the standardization of franchisees as well as the tools and the processes that structure the franchise. Numerous characteristics of social franchising in this model can be viewed as technological dimension of Sisterhood.

During the interviews, our informants could distinguish between co-franchisors (MSIVN and DOHs) and franchisees (CHSs) of the Sisterhood model. They also recognized Sisterhood's identical standards (four occurrences), one of the principal factors of franchising. The informants understood that the Sisterhood CHSs' health workers had to follow these standards.

In addition, other characteristics of a franchising model were also mentioned in our interviews, such as the brand (eight occurrences), board/logo (five occurrences) and slogan (two occurrences) of Sisterhood. Moreover, a special attention was paid to the "Sisterhood" consulting room (14 occurrences) each time we discussed the elements of Sisterhood (as a social franchising model) with our informants. From a simple work

organization, selected CHSs had to follow Sisterhood's standards. One more time, market and industrial criteria were integrated into CHSs.

Furthermore, our informants also mentioned RHFP services of the Sisterhood CHSs (40 occurrences). Indeed, MSIVN and the Sisterhood CHSs primarily develop these services. Therefore, Sisterhood can be viewed as a fractional franchising model. One informant asserted the following:

"Marie Stopes worked with the departments of health of selected provinces to pilot this model in the commune health stations, in reproductive health and family planning." [#18, Government social franchise program manager]

A different informant mentioned RHFP equipment provided by the program:

"... we provided each commune health station of this program with some instruments and medical equipment (but only for reproductive health and family planning services)." [#1, Governmental social franchise program manager]

"... they are not too expensive equipment because that [providing the equipment] is not the goal of the program." [#1, Governmental social franchise program manager]

We also collected an interesting piece of information pertained to Sisterhood fractional social franchise from this informant:

"... the Sisterhood model is exactly a fractional franchising model. Why? Because ... MSI and departments of health have franchised the Sisterhood model in reproductive health and family planning services only, not all primary

health services in commune health stations. The second reason is ... MSI hasn't financed to build the entire commune health station (in terms of infrastructure, human resources, etc.) Members [of franchised stations] belong to the state and the state, not the program, pays for them." [#1, Governmental social franchise program manager]

The information from our informant not only confirmed but also furthered what we had known before we began to do the fieldwork (cf *b. AP Vietnam*). Regarding infrastructure, numerous CHSs were built or upgraded by AP and DOHs (included Sisterhood CHSs). As for human resources, MSIVN trained the Sisterhood CHSs' health workers but they were still members of the public health system and paid by the state. Indeed, MSIVN tried to collaborate with DOHs: they did not do all the tasks and let the DOHs join them in establishing the Sisterhood model from the beginning. Instead of ruptures, we observe that there was a *common point* between them. That could be seen as a strategy of MSIVN in avoiding potential ruptures during the process of adopting Sisterhood in CHSs.

Similarly, we consider that only CHSs' RHFP services were franchised could also be viewed as a strategy of MSIVN. First, RHFP services are strong points of MSIVN. Second, instead of transforming (through franchising concept) all services in CHSs, MSIVN franchised a package of services. That was indeed a wise choice because the risk of ruptures was far less than franchising all services of CHSs.

Sisterhood's technological dimension

3. A governmental (fractional) social franchising model in the public health sector

E. Criteria set for a franchised CHS to maintain the brand	E1. Maintaining client volume (5), service quality (5), the reputation of the brand/franchised CHSs (3), equipment (2), sanitary conditions (2), professional skills, counselling, hospitality
F. Franchising characteristics	F1. Identical "Sisterhood" consulting rooms (14), brand (8), board/logo (5), identical standards everywhere (4), slogan (2), co-franchisors (MSIVN and DOHs) and franchisees (CHSs)
G. Fractional franchising	<p>G1. "Marie Stopes worked with the departments of health of selected provinces to pilot this model in the commune health stations, in reproductive health and family planning." [#18, Government social franchise program manager]</p> <p>G2. "... we provided each commune health station of this program with some instruments and medical equipment (but only for reproductive health and family planning services)." [#1, Governmental social franchise program manager]</p> <p>G3. "... they are not too expensive equipment because that [the equipment] is not the goal of the program." [#1, Governmental social franchise program manager]</p> <p>G4. "... the Sisterhood model is exactly a fractional franchising model. Why? Because ... MSI and departments of health have franchised the Sisterhood model in reproductive health and family planning services only, not all primary health services in commune health stations. The second reason is ... MSI hasn't financed to build the entire commune health station (in terms of infrastructure, human resources, etc.) Members [of franchised stations] belong to the state and the state, not the program, pays for them." [#1, Governmental social franchise program manager]</p>

Table 17 – Representative supporting data for each 2nd-order theme of data structure 1 (continued)

1.2.2. The “Sisterhood” consulting rooms

An important element of Sisterhood model is a system of consulting rooms (also named “Sisterhood”) established inside franchised CHSs.

Our informants viewed these rooms as a tool to advertise the brand and it attracted their attention (seven occurrences). The visual aids of the room such as documents, paintings, books and models for demonstrations were also mentioned several times (12 times). In addition, the room is entirely painted light blue and simply furnished with bamboo or wooden chairs and tables. Without typical white color and disinfectant smell (as in other health facilities), the general atmosphere of the room is very friendly. According to our informants, this aspect is one of the attractive factors of the room, especially when they first visited it. One informant described the following:

“... [the ‘Sisterhood’ consulting room is] a private room painted blue entirely. Tables and chairs, there are all necessary things in this room.” [#16, Brand ambassador of a commune in Yen Bai province]

Among other rooms of franchised CHSs, the consulting rooms are really eye-catching. This type of design has never appeared in the public health system in Vietnam before. In addition, the room made our informants forget that they were in a CHS due to its pleasant atmosphere. In our opinion, the room is completely different from the rest of its CHS and that can bring several ruptures for the CHS.

Regarding the functions of the “Sisterhood” consulting rooms, all of our informants mentioned “welcoming” and “counselling” (for RHFP clients). Moreover, these services are totally free (seven occurrences).

As for welcome, since the Sisterhood program was established, there has always been a health worker at the reception desk (in the common room) of franchised CHS. Her duty is to welcome and guide clients from the entrance of CHS. If the need of clients relates to RHFP services, they will be guided to the “Sisterhood” consulting room. One informant noted that:

“There will be a person at the reception desk who will guide clients. She will ask for client needs. If they relate to reproductive health, she will guide them to go to the ‘Sisterhood’ room.” [#2, DOH project coordinator]

This room is similar to a coordination room. After counselling, clients choose suitable services and they are guided to a(several) corresponding room(s) in franchised CHS to receive these services. One of our informants described that:

“Now, there is a ‘Sisterhood’ room where we can counsel, and afterwards clients will be sent to other rooms.” [#6, “Sisterhood” room consultant of the Tan Huong CHS]

According to our documents, lack of counselling skills was a common issue of CHSs’ health workers before Sisterhood (cf. 2.3.1. *The public health system in Vietnam*). One informant we interviewed provided more details:

“Before, we had no counselling. Counselling when providing professional activities [laughing].” [#6, “Sisterhood” room consultant of the Tan Huong CHS]

The “Sisterhood” consulting room brought for the first time a package of market-related services into CHSs (welcoming-counselling). Patients were not only considered to be clients but also treated as clients. Numerous informants observed that because of the

room, clients understood and could select services they really wanted or “empowering clients” (26 occurrences).

Empowering clients is an important element of both rhetorical and technological dimensions of the Sisterhood program and it was very good at integrating this concept, originated from marketing, into practices. Among various RHFP services of CHSs, clients can choose a service which, according to her (or him, in some cases), is the most appropriate to her. Counsellors or any other health workers only provide information or advice and not select the service for her.

In general, a “Sisterhood” consulting room is still an element of CHS and it cannot operate independently of the rest of the CHS. Therefore, it is possible to predict that the presence of this room inside a franchised CHS can lead to numerous changes and even ruptures in the CHS’s work organization due to a huge difference between the importance of client, for the room and for the rest of the CHS.

Our informants mentioned a close relationship between client and counsellor. They described that the counsellors of the room treated clients’ health information confidentially for other appointments (the term “consulting records” was repeated six times during our interviews). Moreover, clients can always keep in touch with them for further advice by telephone.

Although some stations are quite small, they manage to have appropriate places for the “Sisterhood” rooms that are often located in discreet and private corners of CHSs. In addition, for client convenience, the rooms are regularly situated close to reproductive health rooms. We consider this uninterrupted chain a concrete proof of

Sisterhood's customer-oriented purpose because the program cares about every single need of its clients.

Inside the room, there is always a consulting table behind a curtain where clients can share their innermost concerns. Moreover, private (12 occurrences), secret (six occurrences) and discreet (five occurrences) were the most common words which were used by our informants to describe the room. Most of our informants perceived that:

"When they [clients] come, they will be counselled and they feel they can share their innermost issues, their hope, etc. all." [#2, DOH project coordinator]

"... they [clients] feel no distance between counsellors and them." [#1, Governmental social franchise program manager]

"Counselling in the way that makes people feel most comfortable when they receive the services in the station." [#2, DOH project coordinator]

In this context, counselling went beyond the limits of a conventional medical service. It became a connection between service providers and their clients. Creating a close relationship with customers is a good preparation for the program to know more about its clients, thereby serving them better.

RHFP services are a very sensitive sector, especially in Asian countries where the role of women has not been respected yet and people are not really open about these topics. MSIVN has been operating in the public health system in Vietnam for a long time and understands these issues. It is probably due to this reason, they encourage health workers to provide counselling services in this way.

We observe that whenever the model had a "disadvantage" factor that could cause criticisms, there was always another factor to "compensate". In this context, the novelty of the “Sisterhood” consulting rooms can cause “chaos” for the usual operation of franchised CHSs, in return, their customer approach makes people lean toward support rather than against its activities.

4. The “Sisterhood” consulting rooms

H. Attractive and friendly design	<p>H1. Visual aids (12), attracting clients (7), advertising the brand, no disinfectant smell of hospitals</p> <p>H2. “... [the ‘Sisterhood’ consulting room is] a private room painted blue entirely. Tables and chairs, there are all necessary things in this room.” [#16, Brand ambassador of a commune in Yen Bai province]</p>
I. Welcoming and counselling	<p>I1. Free (7)</p> <p>I2. “There will be a person at the reception desk who will guide clients. She will ask for client needs. If they relate to reproductive health, she will guide them to go to the ‘Sisterhood’ room.” [#2, DOH project coordinator]</p> <p>I3. “Now, there is a ‘Sisterhood’ room where we can be counselled, and afterwards clients will be sent to other rooms.” [#6, “Sisterhood” room consultant of the Tan Huong CHS]</p> <p>I4. “Before, we had no counselling. Counselling when providing professional activities [laughing].” [#6, “Sisterhood” room consultant of the Tan Huong CHS]</p> <p>I5. Empowering clients (26)</p>
J. Close relationship: client-counsellor	<p>J1. Consulting records (6)</p> <p>J2. Private (12), secret (6), discreet (5), conscientious (4), delicate (3), sympathetic (3), feel secure (3), friendly (2)</p> <p>J3. “When they [clients] come, they will be counselled and they feel they can share their innermost issues, their hope, etc. all.” [#2, DOH project coordinator]</p> <p>J4. “... they [clients] feel no distance between counsellors and them.” [#1, Governmental social franchise program manager]</p> <p>J5. “Counselling in the way that makes people feel most comfortable when they receive the services in the station.” [#2, DOH project coordinator]</p>

Table 17 – Representative supporting data for each 2nd-order theme of data structure 1 (continued)

1.2.3. Provincial master trainers and training-supervising-supporting

According to our informants, MSIVN asked the DOHs of the program to establish groups of 10-15 experts in clinical services, communication, counselling, teaching and management called “provincial master trainers”; and they exclusively trained these trainers (by MSIVN’s experts or invited experts). In reality, old provincial master trainers were sometimes mobilized for some training activities (three occurrences). One informant we interviewed asserted the following:

“The program does not have enough time and resources to train hundreds of officials in a province. That’s why we asked the departments of health to establish a group of 10-15 people called ‘provincial master trainers’ and the program trained these trainers only.

There are criteria for the provincial master trainers: they have expertise in clinical services, communication and management. Then ... they will ... when the program trains them, we will not focus on expert and technical knowledge because they are experts. We will train them in social franchising.” [#1, Governmental social franchise program manager]

According to Marie Stopes International Viet Nam (2012), the training courses for provincial master trainers consist of six major topics: service quality, creating demand for clients, infection prevention, cervical cancer and breast cancer screening, adolescent sexual and reproductive health counselling and the monitoring and evaluation of clinical service quality. These topics, in our opinion, can be divided into two parts, technical and market-related ones.

The groups of provincial master trainers have only been created since the Sisterhood program was established. Therefore, these training topics have not existed before. They are new either to provincial master trainers or to CHSs and can face a lot of “resistance” from the medical staff of franchised CHSs.

We believe that for this reason, besides expertise, the criteria of provincial master trainers’ selection also include experience and age. According to our informants, provincial master trainers are often chosen from experienced people who are working in the health system of the provinces selected by the program. They should be neither too young, because they have to train the health workers of franchised CHSs who have worked there for a long time, nor too old, because MSIVN does not want a situation in which they will soon retire after training courses.

MSIVN did not directly intervene in the process of training franchised CHSs to avoid the risks of small or even big changes in the regular operation of CHSs (and in fact, they could not do that due to a lack of time and resources). In this context, provincial master trainers can be considered intermediaries who “transport” technical and market-related elements of the program to CHSs. Their role is quite important to both Sisterhood and CHSs. Provincial master trainers deeply understand the public health sector of their provinces. Letting them train CHSs, their voices will probably have more influences on health workers and cultural barriers can be overcome easily.

After training courses, the “training need of the province” reports (five occurrences) made by provincial master trainers through the “needs assessment” process (eight occurrences) of franchised CHSs relying on their capacity framework⁴⁶ are sent to

⁴⁶ “Competency-based training”, a term used by the manager of the Sisterhood program.

MSIVN. Based on these reports, MSIVN organized “refresher courses” for all health workers of franchised CHSs. Our informants mentioned these training courses 88 times in our interviews, a significant number that shows the importance of the courses.

Training courses were considered to be homogeneous and equal because “*all [health workers] were trained*” [#4, “*Sisterhood*” room consultant of the Cu Van CHS] and knew how to counsel after these courses. Besides health workers, brand ambassadors were also trained by provincial master trainers. The objectives of the courses are to improve clinical and non-clinical skills for the medical staff of franchised CHSs.

These are very careful steps of the program. Instead of mass training, Sisterhood preferred a pilot and systematic one. The program exactly provided what CHSs were lacking. When supply meets demand, ruptures can be avoided. We believe that MSIVN were well aware of what could happen, included the potential tensions because of the integration into CHSs of new Sisterhood’s elements.

In 2.3.1. *The public health system in Vietnam*, we mentioned the principal reasons related to the difficulties of health workers in CHSs (before Sisterhood) in providing services, included a lack of regular training courses. During our interviews, several informants added more details which related to the question of why the training of provincial master trainers was necessary for CHSs’ health workers. Some of them said that:

“... *because of old habits, we had finished our study many years ago then when we started to work, we forgot many things.*” [#4, “*Sisterhood*” room consultant of the Cu Van CHS]

“As for specialty, in fact they [the health workers of franchised CHSs] are experts but they’ve worked there for a long time, they haven’t participated in refresher courses, they forget or ... they have been trained but when they do directly, they do it in a wrong way. That’s why we have to train and supervise them to see what they learn [from the training courses] and whether they do as what they learn or not.” [#1, Governmental social franchise program manager]

Due to the influence of centrally planned economy period, many government officials are still very passive in their works. In CHSs, a remaining image of that period, health workers share a similar issue. Therefore, refresher courses that aim at improving the knowledge and practices for health workers can lead to their resistance.

Provincial master trainers not only trained franchised CHSs but also supervised their activities. Many informants viewed this activity as supervising and supporting, or rather “building capacity” for the medical staff of CHSs. Some of them affirmed as follows:

“... as for the program of MSI, that is called ‘supervision and support’, or rather support. It’s totally different.” [#7, Head of the DOH project manager unit]

“Its [MSIVN’s] purpose is supervising and supporting. I mean, the purpose is supporting, rather than supervising.” [#8, Admin/Accountant of the MSIVN provincial project office]

“We use the term ‘supervision-support’ because the term ‘monitor-supervision’ is like ... superiors go to check whether health workers do right or wrong. ‘Supervision-support’ also includes this activity and when they do wrong, we support them to do correctly. It ... rather building capacity than supervising and

pointing out to health workers their mistakes.” [#18, Governmental social franchise program manager]

During supervising-supporting activities, provincial master trainers can give points by monitoring tables (six occurrences) and once per month or quarter, they come to CHSs to supervise their activities for one day (three occurrences). Each time we talked about provincial master trainers, all of our informants mentioned the term “taking hand-guiding work” (18 occurrences). That means provincial master trainers guided the medical staff of the Sisterhood CHSs directly and very carefully.

Instead of strict supervision as business-format franchising, the main purpose of Sisterhood’s supervision is to build the capacity for CHSs’ health workers. In addition, to avoid potential ruptures, similar to the “Sisterhood” consulting rooms’ counsellors, provincial master trainers also tried to create a “connection” with the medical staff of CHSs through “taking hand-guiding work” method. Some informants viewed this activity as “human approach” of the program. However, we decide to not re-use this terminology because it is quite complicated and related to many aspects.

5. Provincial master trainers and training-supervising-supporting

K. Choosing and training provincial master trainers

K1. “The program does not have enough time and resources to train hundreds of officials in a province. That’s why we asked the departments of health to establish a group of 10-15 people called ‘provincial master trainers’ and the program trained these trainers only.

There are criteria for the provincial master trainers: they have expertise in clinical services, communication and management. Then ... they will ... when the program trains them, we will not focus on expert and technical knowledge because they are experts. We will train them in social franchising.” [#1, Governmental social franchise program manager]

K2. Sometimes old provincial master trainers were mobilized (3)

L. Training activities

L1. Needs assessment of the CHSs (8), “training need of the province” report (5)

L2. Training courses (88), training health workers (of franchised CHSs) and brand ambassadors (4), improving clinical and non-clinical skills

L3. “It’s homogeneous [the quality of the whole CHS] because all [health workers] were trained.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

L4. “... because of old habits, we had finished our study many years ago then when we started to work, we forgot many things.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

L5. “As for specialty, in fact they [the health workers of franchised CHSs] are experts but they’ve worked there for a long time, they haven’t participated in refresher courses, they forget or ... they have been trained but when they do directly, they do it in a wrong way. That’s why we have to train and supervise them to see what they learn [from the training courses] and whether they do as what they learn or not.” [#1, Governmental social franchise program manager]

M. Supervision-support activities

M1. “... as for the program of MSI, that is called ‘supervision and support’, or rather support. It’s totally different.” [#7, Head of the DOH project manager unit]

M2. “Its [MSIVN’s] purpose is supervising and supporting. I mean, the purpose is supporting, rather than supervising.” [#8, Admin/Accountant of the MSIVN provincial project office]

M3. “We use the term ‘supervision-support’ because the term ‘monitor-supervision’ is like ... superiors go to check whether health workers do right or wrong. ‘Supervision-support’ also includes this activity and when they do wrong, we support them to do correctly. It ... rather building capacity than supervising and pointing out to health workers their mistakes.” [#18, Governmental social franchise program manager]

M4. Taking hand-guiding work (18), monitoring tables (6), monthly/quarterly one-day visits to CHSs (3)

Table 17 – Representative supporting data for each 2nd-order theme of data structure 1 (continued)

1.2.4. Brand ambassadors and communication

At the bottom of the Sisterhood hierarchy and one of the most important factors of the Sisterhood program's communication activities is a network of "brand ambassadors".

From the interviews, we understand that a brand ambassador needs to have several characteristics such as dynamic (four occurrences), enthusiastic (three occurrences), reputable (two occurrences) and knowing about professional expertise (2 occurrences).

Our informants also told us about the criteria of brand ambassadors' selection. One informant described in detail:

"As for choosing ambassadors, we let the communes do this ... as long as it meets the criteria of the program. That person can be a man or a woman, we don't intervene. In fact, a brand ambassador can be a member of the village health group, the women's union, the youth union or the veteran group of the commune. Some people initially thought that only women could do this kind of job but in fact, some man, even old man, could do it very well. By example, in some areas where ... very traditional and feudal, like Hue [in the center of Vietnam], some brand ambassadors are veterans ... Firstly, they are a little bit old. They have children and grandchildren and they are very prestigious in their family. When they talk about something, their children/grandchildren trust them; so do their family and community. Because they are in very traditional and feudal family, like the old days." [#18, Governmental social franchise program manager]

In Vietnamese communes, the village health group's, the women's union's, the youth union's or the veteran group's members are highly respected. In addition, they deeply understand their communes and can approach local people easily, in particular people from ethnic minority groups (cf. 2.3.1 *The public health system in Vietnam*). Therefore, if these members give local people advice, they will trust them.

Similar to provincial master trainers, brand ambassadors can be considered a "bridge" linking Sisterhood and local people. The program trained brand ambassadors then these ambassadors transferred useful information (from training courses) to local people. They play an important role to both Sisterhood and their community.

The counsellor of the "Sisterhood" consulting room directly managed brand ambassadors. In several CHSs, counsellors noted down brand ambassador's name who had introduced client to the room:

"We ... for helping the brand ambassador to do better so we asked clients about his/her information." [#11, Head of the Luong Thinh CHS]

"We asked them [clients] about the brand ambassador who had guided them to the station then we recorded [the information of the brand ambassador]. Based on that, at the end of the month, we would have the data to report." [#11, "Sisterhood" room consultant of the Luong Thinh CHS]

Our informants also mentioned the fact that a small amount had been deducted from the profitable services of CHSs to award brand ambassadors (three occurrences).

Regarding outfit, brand ambassadors often wear a blue bag named "the visual tool kit for family planning measures". It is a handbag when they travel and become an "apron"

when they need to present family planning methods to local people. In each "window" of this "apron", there is a tool such as a condom, the pill, etc. The bag was mentioned seven times in our interviews. Some informants described as follows:

"The first time I came to villages, I wore a bag, I had flyers and products [related to reproductive health]. They [people of the villages] looked at me and they liked immediately. At the beginning, they laughed." [#16, Brand ambassador of a commune in Yen Bai province]

"I wear casual clothes. I have a bag over my breasts and I have reproductive health documents. I have 11 kinds of leaflets. On that bag, there are "boxes" to introduce family planning methods. I will present to them ... for example, this is the pill, condom, etc." [#16, Brand ambassador of a commune in Yen Bai province]

"I ... do not have uniform. I still wear casual clothes. The only difference is there is a handbag. When I introduce my "products", I'll wear it. From my neck down to my feet, there are all necessary products for women of reproductive age." [#17, Brand ambassador of a commune in Yen Bai province]

"That bag, when I wear it on my neck, down to toe. Folding it, it will be as small as a handbag." [#17, Brand ambassador of a commune in Yen Bai province]

As for the case of provincial master trainers mentioned above, potential ruptures can happen inside franchised CHSs while in this case, when the program wants to approach local people, potential tensions can appear outside CHSs. If the program follows traditional marketing methods, we believe that the efficiency will not be high

because, as we mentioned, local people, especially the one who live in poor areas or from ethnic minority groups, do not have a high level of education (cf. 2.3.1. *The public health system in Vietnam*) therefore it is quite difficult for them to understand industry- or market-related terms such as counselling, RHFP services, etc.

In this context, local people can avoid (especially people from ethnic minority groups) meeting brand ambassadors because the services of the program are relatively sensitive. An attractive and friendly outfit can initially attract them and make them curious about brand ambassadors. If brand ambassadors have an opportunity to talk with them, it can be considered an initial success of the model. In addition, the program approached and discussed with people in a visual approach (through the bags) which was very easy to understand. In our opinion, it is an appropriate solution to avoid any “adverse criticism” from the local community.

Regarding the communication activities of brand ambassadors, his/her job is to counsel or advertise to local people about family planning methods, Sisterhood’s RHFP services, the brand and the “Sisterhood” consulting room. Brand ambassadors often approach people of childbearing age (sometimes they can meet them in their houses) then encourage them to go to the Sisterhood CHS of their commune (8 occurrences) instead of going to upper level health facilities. One informant noted that:

“My job is approaching the people of childbearing age, then ... organizing promotional events or advertising in groups. I approach the couples who have given birth to encourage them to use family planning methods, present to them modern contraceptive methods.” [#14, Brand ambassador of a commune in Vinh Long province]

Another informant added some more details:

“At first, I have to advertise the program, the consulting room, etc. Generally, I have to advertise all then I talk about reproductive health and family planning services.” [#14, Brand ambassador of a commune in Vinh Long province]

Furthermore, brand ambassadors often go to communes to organize several communication activities in groups (group talks). According to our informants, sometimes these activities can be combined with local activities. In addition, a counsellor of the CHS in the commune can participate in these activities to supervise and support brand ambassadors. One informant told us that:

“In group talks, they [brand ambassadors] can invite 10-15 women to introduce [the Sisterhood model and the consulting room, family planning methods, etc.]. These talks are organized by themselves. Other group talks have to be combined with several events in the community (...) Therefore, no need to take the effort and resources to invite people to come because they are there anyway. Brand ambassador’s activities are just an addition [to local event] and presented for a little while. During a group talk, a brand ambassador can sometimes invite a midwife from the commune health station [of the commune] to join her. Why? Because talking to people with different levels of education, understanding and socioeconomic conditions, they may have some professional questions which brand ambassadors will not be able to answer. That will require supports from the midwife. Once again the midwife will promote the Sisterhood program but will primarily help answer professional questions.” [#18, Governmental social franchise program manager]

Group talks can be viewed as a solution to approach many local people at the same time and they seemed to be accepted by local governments (combined with some local events). Meaning these activities were supported by both the program and local governments. During group talks, brand ambassadors can face difficult questions from local people therefore the presence of a counsellor from the “Sisterhood” consulting room is necessary.

We observe that the program had a very consistent way of operation. Similar to what we mentioned once (cf. 1.2.2. *The “Sisterhood” consulting rooms*), within the program’s activities, to avoid any adverse criticism which can occur due to one factor, there is always another factor which can “compensate” for this one.

6. Brand ambassadors and communication

N. Choosing and managing brand ambassadors

N1. Dynamic (4), enthusiastic (3), reputable (2), know a little bit about professional expertise (2), self-confident, qualified

N2. “As for choosing ambassadors, we let the communes do this ... as long as it meets the criteria of the program. That person can be a man or a woman, we don’t intervene. In fact, a brand ambassador can be a member of the village health group, the women’s union, the youth union or the veteran group of the commune. Some people initially thought that only women could do this kind of job but in fact, some man, even old man, could do it very well. By example, in some areas where ... very traditional and feudal, like Hue [in the center of Vietnam], some brand ambassadors are veterans ... Firstly, they are a little bit old. They have children and grandchildren and they are very prestigious in their family. When they talk about something, their children/grandchildren trust them; so do their family and community. Because they are in very traditional and feudal family, like the old days.” [#18, Governmental social franchise program manager]

N3. “We ... for helping brand ambassador to do better so we asked clients about his/her information.” [#11, Head of the Luong Thinh CHS]

N4. “We asked them [clients] about the brand ambassador who had guided them to the station then we recorded [the information of the brand ambassador]. Based on that, at the end of the month, we would have the data to report.” [#11, “Sisterhood” room consultant of the Luong Thinh CHS]

N5. A small amount deducted from profitable services to award/encourage them (3)

O. Attractive and friendly outfit

O1. “The first time I came to villages, I wore a bag, I had flyers and products [related to reproductive health]. They [people of the villages] looked at me and they liked immediately. At the beginning, they laughed.” [#16, Brand ambassador of a commune in Yen Bai province]

O2. “I wear casual clothes. I have a bag over my breasts and I have reproductive health documents. I have 11 kinds of leaflets. On that bag, there are “boxes” to introduce family planning methods. I will present to them ... for example, this is the pill, condom, etc.” [#16, Brand ambassador of a commune in Yen Bai province]

O3. “I ... do not have uniform. I still wear casual clothes. The only difference is there is a handbag. When I introduce my “products”, I’ll wear it. From my neck down to my feet, there are all necessary products for women of reproductive age.” [#17, Brand ambassador of a commune in Yen Bai province]

O4. “That bag, when I wear it on my neck, down to toe. Folding it, it will be as small as a handbag.” [#17, Brand ambassador of a commune in Yen Bai province]

P. Communication activities

P1. “My job is approaching the people of childbearing age, then ... organizing promotional events or advertising in groups. I approach the couples who have given birth to encourage them to use family planning methods, present to them modern contraceptive methods.” [#14, Brand ambassador of a commune in Vinh Long province]

P2. Encouraging them to go to the Sisterhood CHSs (8)

P3. “At first, I have to advertise the program, the consulting room, etc. Generally, I have to advertise all then I talk about reproductive health and family planning services.” [#14, Brand ambassador of a commune in Vinh Long province]

P4. “In group talks, they [brand ambassadors] can invite 10-15 women to introduce [the Sisterhood model and the consulting room, family planning methods, etc.]. These talks are organized by themselves. Other group talks have to be combined with several events in the community (...) Therefore, no need to take the effort and resources to invite people to come because they are there anyway. Brand ambassador’s activities are just an addition [to local event] and presented for a little while. During a group talk, a brand ambassador can sometimes invite a midwife from the commune health station [of the commune] to join her. Why? Because talking to people with different levels of education, understanding and socioeconomic conditions, they may have some professional questions which brand ambassadors will not be able to answer. That will require supports from the midwife. Once again the midwife will promote the Sisterhood program but will primarily help answer professional questions.” [#18, Governmental social franchise program manager]

Table 17 – Representative supporting data for each 2nd-order theme of data structure 1 (continued)

Summary

Sisterhood was described through its rhetorical and technological dimensions. Regarding rhetorical dimension, our informants mentioned objectives, principal activities as well as social goals of Sisterhood. They paid special attention to “customer-oriented purpose” and “social goals rather than commercial goals” of this program.

As for Sisterhood’s technological dimension, first of all, Sisterhood was viewed as a governmental (fractional) social franchising model in the public health sector of Vietnam. Furthermore, our informants introduced three principal elements of Sisterhood: its “Sisterhood” consulting rooms, provincial master trainers (and training-supervising-supporting activities) and brand ambassadors (and communication activities).

Due to these dimensions, we predicted several ruptures for the process of adopting Sisterhood in CHSs. In addition, the model also consists of several individuals who can become the “solutions” for these tensions (provincial master trainers and brand ambassadors).

2. Sister adoption/adaptation process

In the first part of the findings, based on data structure 1, numerous innovative characteristics of Sisterhood that aimed at furthering franchised CHSs' goals were introduced. We also understand the novelty of this program, compared to the academic world as well as the organizational context of CHSs.

We observe that this managerial model is not only new to the state of the art but also to CHSs. In terms of work organization, integrating Sisterhood into these health facilities predicts potential ruptures for CHSs (and sometimes several changes for the model) due to the singularity of Sisterhood's elements as well as organizational factors of CHSs. Sisterhood, in this context, has the characteristics of a management innovation.

In fact, based on both our documents and interviews, potential ruptures relate to almost all of rhetorical and technological dimensions of Sisterhood. As for CHSs' organizational factors, sometimes the singularity of Vietnamese culture also has certain "contributions". Nevertheless, our understanding is just at the predicted level.

In this second part of the findings, data structure 2 helps us discover insights into the process of adopting/adapting Sisterhood into selected CHSs. During this process, the tensions between both sides (Sisterhood and CHSs) are clarified and therefore, management innovation characteristics of Sisterhood are clearer. The "aggregate

dimensions” in data structure 2 can be viewed as an adaptation of Rasmussen and Hall (2016)⁴⁷’s management innovation adoption process.

The findings of this sub-chapter are based on Sisterhood’s documents as well as the “1st-order” concepts and “2nd-order” themes in data structure 2 (see figure 16 below). Our supporting data are displayed in table 18.

⁴⁷ Cf. 3.4. *Management innovation adoption processes.*

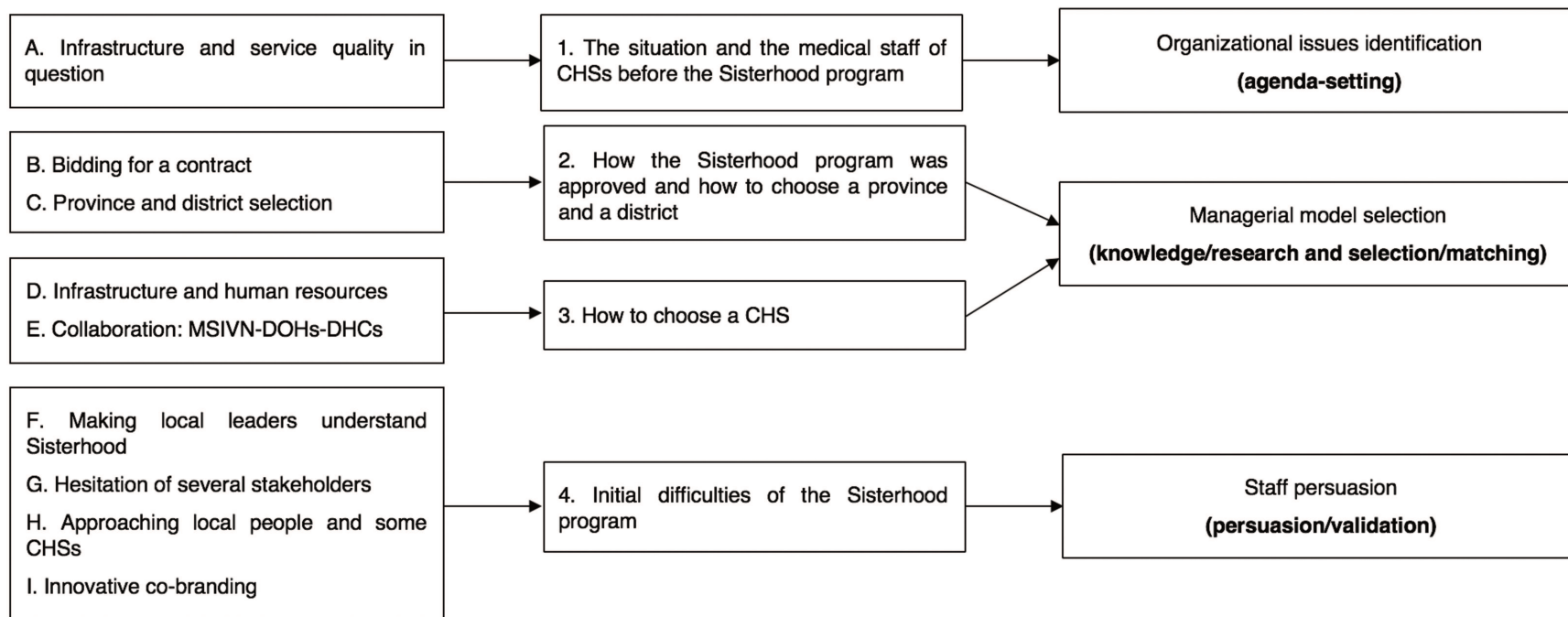


Figure 16 – Data structure 2

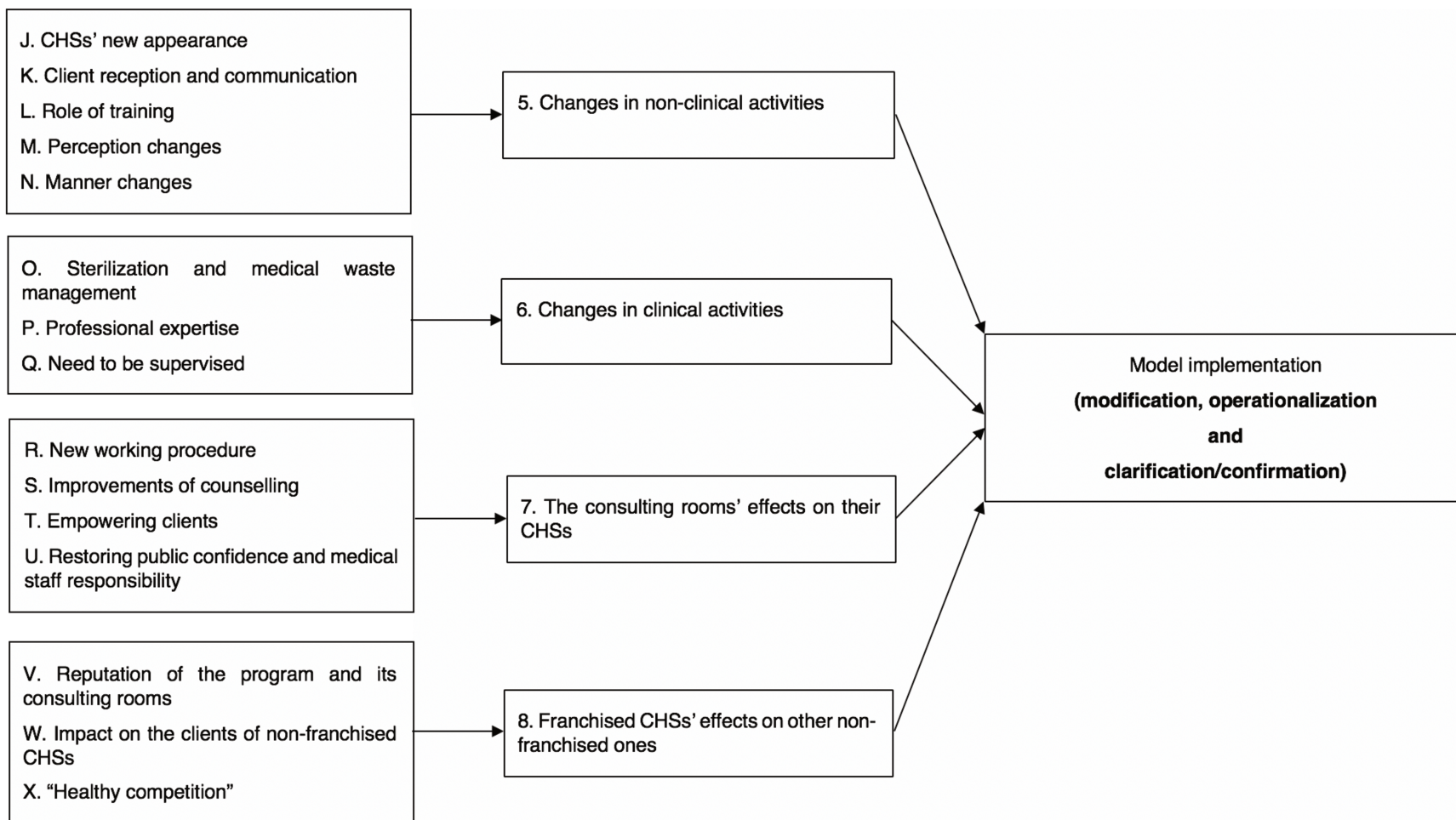


Figure 16 – Data structure 2 (continued)

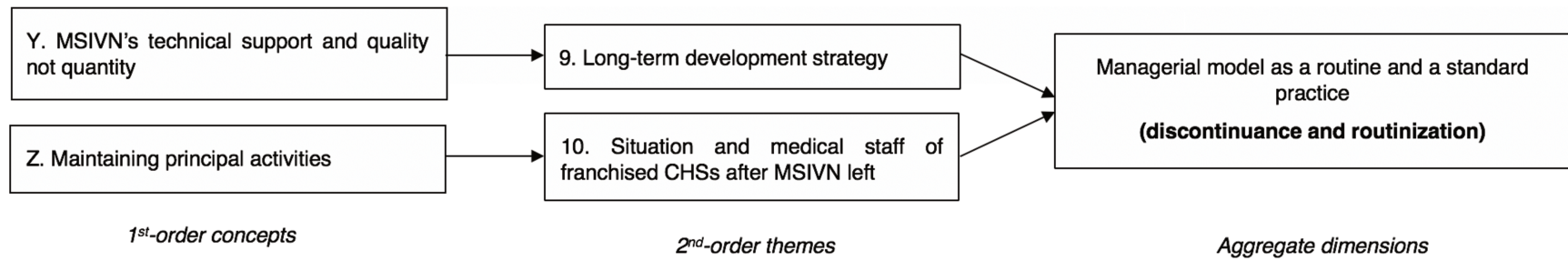


Figure 16 – Data structure 2 (continued)

2.1. Organizational issues identification (agenda-setting)

During the adoption process of Sisterhood in CHSs, this phase helps determine general organizational problems to address of CHSs. It relates to the situation and the medical staff of CHSs before the establishment of Sisterhood. In the next paragraphs, there are several pieces of information that we mentioned in the previous chapters (based on our documents). The field also provided new and interesting details.

2.1.1. The situation and the medical staff of CHSs before the Sisterhood program

According to our documents and informants, CHSs' function is to provide primary healthcare services to local people in the commune. Among CHSs' services, RHFP services play an important role.

Before Sisterhood, the infrastructure of numerous CHSs (especially the ones in the North of Vietnam) was in bad condition. Furthermore, the sterilization in some CHSs was not respected (four occurrences). Lack of equipment and room (two occurrences) was also a problem. One of our informants described this situation as follows:

“Normally, as for some commune health stations in the North [of Vietnam], their infrastructure is very old. The infrastructure of northern mountainous provinces is ... even worse. There are some 40-year-old commune health stations in Yen Bai. Lack of rooms. And climate conditions in the North, in rainy months the infrastructure is devastated. The doors, the paint, mold, that look very ugly. In the South, it's better.” [#1, Governmental social franchise program manager]

Besides infrastructure, service quality was also in question. At that moment, lack of perception of service quality was a general phenomenon. Regarding health workers, they had cold manner (three occurrences), lacked self-confidence (three occurrences) and technical skills (two occurrences). Sometimes, patients could not find them in CHSs (two occurrences). As for clients, they could not make decisions (could not choose appropriate services by themselves) (two occurrences) and did not feel secure when they received CHSs' services (three occurrences). Therefore, they decided to go to upper level health facilities.

The fact that numerous patients bypassed CHSs in their communes (cf. 2.3.1. *The public health system in Vietnam*) was repeated six times in our interviews. This is a significant problem of the public health sector in Vietnam because that can lead to patient overload for upper level providers. One informant we interviewed noted that:

“They [the health workers] have been familiar with shortcuts. The purpose is having final good, without knowing its quality. Neither do local people [the clients], they don’t know about service quality. They only know that there is a place where they can get IUD insertion, and that woman has reputation in IUD insertion, so go to see her.” [#2, DOH project coordinator]

Among numerous issues of service quality, our informants focused on a lack of counselling (11 occurrences) in a private and secret corner of CHSs. In addition, lack of a relationship between health workers and their patients was also observed. Health

workers did not have any feedback on client satisfaction. One informant asserted the following:

“Clients was also asked, cared and ... presented [services] but ... in a working room, not in a private one which could ensure privacy. That’s a difference. Second, after they received the services, we had no feedback about whether the services of the commune health station satisfied clients or not. The actual relationship is different from ... before” [#3, Director of the Dai Tu DHC]

To sum up, before MSIVN established the Sisterhood model, CHSs had had a huge problem of infrastructure and service quality and they really needed a positive change.

Organizational issues identification (agenda-setting)***1. The situation and the medical staff of CHSs before the Sisterhood program*****A. Infrastructure and service quality in question**

A1. “Normally, as for some commune health stations in the North [of Vietnam], their infrastructure is very old. The infrastructure of northern mountainous provinces is ... even worse. There are some 40-year-old commune health stations in Yen Bai. Lack of rooms. And climate conditions in the North, in rainy months the infrastructure is devastated. The doors, the paint, mold, that look very ugly. In the South, it’s better.” [#1, Governmental social franchise program manager]

A2. Lack of sterilization (4), equipment and room (2)

A3. Health workers: cold manner (3), lack of self-confidence (3) and technical skills (2), sometimes not present (2); clients: went to upper level health facilities (6), did not feel secure (3) and could not make decisions (2)

A4. “They [the health workers] have been familiar with shortcuts. The purpose is having final good, without knowing its quality. Neither do local people [the clients], they don’t know about service quality. They only know that there is a place where they can get IUD insertion, and that woman has reputation in IUD insertion, so go to see her.” [#2, DOH project coordinator]

A5. Lack of counselling (11)

A6. “Clients was also asked, cared and ... presented [services] but ... in a working room, not in a private one which could ensure privacy. That’s a difference. Second, after they received the services, we had no feedback about whether the services of the commune health station satisfied clients or not. The actual relationship is different from ... before” [#3, Director of the Dai Tu DHC]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2

2.2. Managerial model selection (knowledge/research and selection/matching)

In this phase, to address organizational issues, an innovative model of management is selected among many other models. The process was conducted as follows: selected the Sisterhood model, several provinces and districts; afterwards, a set of CHSs that met Sisterhood's standards were chosen.

2.2.1. How the Sisterhood program was approved and how to choose a province and a district

At the beginning, AP financially supported several communes so that they could repair or build their CHSs. In addition, they also provided modern equipment for these CHSs. Our informants called that “hardware” support. Furthermore, some organizations (often NGOs) were selected to support CHSs in “software” (focused on medical staff). One informant described that:

“For instance, the 1st phase in Khanh Hoa and Da Nang, they [AP] finished building the whole province [all franchised CHSs in the province]. Every commune health station had two stories, as beautiful as a dream. At that moment, they financed NGOs for ‘software’ intervention. Therefore, it was quite favorable (...) However, in the 2nd phase and even the current 3rd phase, they intervened in ‘hardware’ and selected NGOs for ‘software’ intervention almost simultaneously.” [#18, Governmental social franchise program manager]

In this context, MSIVN persuaded AP to invest in their project: to intervene in the network of CHSs through a governmental social franchising model. AP also provided financial aid for other organizations that had different projects and objectives (cf. *b. AP Vietnam*).

AP organized several events (“bidding for a contract”, term used by our informants) where these organizations could present their projects. One of our informants described this situation as follows:

“Each NGO had to explain their project outline. What was their approach? What was their model? (...) In Vietnam, regarding bidding for a contract, people focus on a single project while [in this context] there are various fields. [#18, Governmental social franchise program manager]

One of the first “obstacles” in adopting Sisterhood in CHSs came from its sponsor. However, between MSIVN and AP, there was not any real discord because they shared a common purpose: improving the public health system in Vietnam. Therefore, the two organizations reached a consensus easily. What MSIVN had to do was simple: persuaded AP that their managerial model could bring the most benefits to the public health system as well as to local people in Vietnam

When MSIVN was selected, they had to find appropriate districts and communes for their program in several pre-selected provinces. One informant noted that:

“When Marie Stopes was chosen, selecting a province for the program was not our decision. It was the provinces where AP had supported in ‘hardware’ before

(...) We [MSIVN] discussed with the departments of health, agreed with them on selecting a district.” [#18, Governmental social franchise program manager]

In this case, the officials of MSIVN and DOHs had to discuss to find a common plan. Their characteristics as well as perspectives on the situation are quite different that can lead to several disagreements. MSIVN, an NGO which aims at integrating a social franchising model into CHSs while DOH is the representative of provincial management level in the public health sector (one of the “receivers”).

According to our informants, MSIVN encouraged direct contact between franchised and non-franchised provinces to facilitate the process of selecting districts or communes for the program. One informant we interviewed asserted the following:

“During the selection process [to choose a district in a province for the program], we introduced to the department of health the social franchising model to make them understand. We also provided the information of activities in other provinces [of the program] for reference. We organized trips to these provinces so that they could directly observe and meet their colleagues in the departments of health, then went to the commune health stations of these provinces to meet and discuss what they wanted to know.” [#18, Governmental social franchise program manager]

Although Vietnam is trying to “open the door” for global integration, several local governments are still cautious in this matter. Integrating a foreign management model into CHSs, to them, implies many risks and challenges. Therefore, to attain an agreement between both sides, MSIVN helped DOHs understand and overcome several “obstacles”

between them (for instance, the novelty of social franchising concept). If DOHs really understand social franchising model, its activities and especially its advantages, they can easily accept it.

To avoid potential competition among health facilities, the program focused on districts which were not near the center:

“In a province, there are always some cities or towns. MSIVN’s plan (we discussed with the province) is that we will not focus on these units (...). There are a nearby provincial hospital and a lot of private health facilities. People there are also wealthier and they have more access to services.” [#18, Governmental social franchise program manager]

“... regarding places near the center, when we went there to counsel, we felt a little shy. Because they ... they have all (...). They have so much knowledge.” [#15, Brand ambassador of a commune in Yen Bai province]

It can be said that, an arrangement or a compromise was in the initial plan of Sisterhood. The purpose of the program is not to compete with other health facilities of the public health system but to focus on people who do not have the access to the best medical services. This also partly reflects the social aspect of social franchising concept (cf. 1.1.2. *Social goals of the Sisterhood social franchise*).

Managerial model selection (knowledge/research and selection/matching)

2. How the Sisterhood program was approved and how to choose a province and a district

B. Bidding for a contract

B1. “For instance, the 1st phase in Khanh Hoa and Da Nang, they [AP] finished building the whole province [all franchised CHSs in the province]. Every commune health station had two stories, as beautiful as a dream. At that moment, they financed NGOs for ‘software’ intervention. Therefore, it was quite favorable (...) However, in the 2nd phase and even the current 3rd phase, they intervened in ‘hardware’ and selected NGOs for ‘software’ intervention almost simultaneously” [#18, Governmental social franchise program manager]

B2. “Each NGO had to explain their project outline. What was their approach? What was their model? (...) In Vietnam, regarding bidding for a contract, people focus on a single project while [in this context] there are various fields. [#18, Governmental social franchise program manager]

C. Province and district selection

C1. “When Marie Stopes was chosen, selecting a province for the program was not our decision. It was the provinces where AP had supported in ‘hardware’ before (...) We [MSIVN] discussed with the departments of health, agreed with them on selecting a district.” [#18, Governmental social franchise program manager]

C2. “During the selection process [to choose a district in a province for the program], we introduced to the department of health the social franchising model to make them understand. We also provided the information of activities in other provinces [of the program] for reference. We organized trips to these provinces so that they could directly observe and meet their colleagues in the departments of health, then went to the commune health stations of these provinces to meet and discuss what they wanted to know.” [#18, Governmental social franchise program manager]

C3. “In a province, there are always some cities or towns. MSIVN’s plan (we discussed with the province) is that we will not focus on these units (...). There are a nearby provincial hospital and a lot of private health facilities. People there

are also wealthier and they have more access to services.” [#18, Governmental social franchise program manager]

C4. “... regarding places near the center, when we went there to counsel, we felt a little shy. Because they ... they have all (...). They have so much knowledge.” [#15, Brand ambassador of a commune in Yen Bai province]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

2.2.2. How to choose a CHS

According to our informants and the collected documents of MSI, MSIVN and the Sisterhood program, a CHS that can participate in the program is often situated in a commune not near the center but clients can come easily. Furthermore, the population of this commune is also an important factor. Moreover, in this CHS, the quality of RHFP services is not good or clients have limited access to these services. It also has difficulties in attracting clients.

Besides initial criteria, our informants mentioned numerous times two principal criteria: infrastructure and human resources. Regarding the infrastructure of CHSs, the right moment needs to be considered. An informant noted that:

“When Sisterhood intervened, maybe the selected station had just been repaired, very beautiful. But some stations (...) they were repairing when we came there (...) How could we select them?” [#18, Governmental social franchise program manager]

“Or some stations, when we visited, they were not too ugly, not too beautiful, not being repaired. However ... they had a repair plan in a few months. So after selection process, if they repair it totally then ... what will we have to do?” [#18, Governmental social franchise program manager]

These quotations show that if the conditions of infrastructure of a CHS are not guaranteed, MSIVN will definitely not develop this model in this CHS. Once the CHS meets these conditions, they can be considered a “potential candidate”.

“However, when they [the stations which had not been selected before because of repairs] completed the repairs ... they were good and beautiful. They also had goodwill and wanted to participate in the program. If department of health replicated the model in this station, it would be ok.” [#18, Governmental social franchise program manager]

Regarding human resources, our informants paid special attention to the heads and the midwives of CHSs.

“... the commune health stations have to care about that [participating in the Sisterhood program]. That means they need to participate in the program. Because we ... we ... have experience that if communes or CHSs’ members don’t need to participate in the model then they will listen to ... the command of their superior without responsibility. So we don’t want to work with that people. First, they have to have need; second, the head of the CHS has to be very enthusiastic because he/she will be an exemplar for others. If he/she is not enthusiastic, others will be like this, and then the investment of the program will be a waste.” [#1, Governmental social franchise program manager]

In MSIVN’s opinion, Sisterhood is an appropriate solution for CHSs. However, CHSs themselves may not share the same opinion. Therefore, only establishing the Sisterhood

model in CHSs which really need to participate in the program is a necessary preparation to avoid potential criticisms during the process.

In addition, due to a simple hierarchy of management (one head and several health workers) and a close relationship among medical workers (similar to a family) in CHSs, the heads of CHSs play a very important role. Their voice is the representative voice of CHSs (like a father in a family). If the heads of CHSs like the model, then so do the others. One informant we interviewed talked about an interesting detail related to the heads of CHSs:

“Not every leader wants a project to intervene in his/her community. Politically they cannot say that they do not want the project. However, in their hearts, not every leader wants it because within a project, they have to work better, study, report and work hard. For them ... how long they work, when they go to station or come back home, they provide services to how many people. They can do what they want. After work, they can work at their surgeries to earn more money, no need to care about the station.” [#18, Governmental social franchise program manager]

This is a common situation in the public health system in Vietnam. Most doctors have their own surgeries to earn extra income after normal working hours. Their permanent job gives them a position in the society (a “title”) while their extra work brings the main income. Therefore, some doctors focus on the second work rather than the first one. Within this thesis, we do not focus on the reasons of this issue. We are interested in whether a station head is willing to welcome the Sisterhood model or not. For this reason, carefully selecting

a CHS with an enthusiastic head can avoid potential ruptures during the process of adopting Sisterhood into this CHS.

Another health worker who is essential for the operation of Sisterhood is a midwife who works as a counsellor in the “Sisterhood” consulting room. Among numerous elements of the Sisterhood program, its network of consulting rooms plays a center role and a station without midwives/counsellors cannot be selected. One informant asserted the followings:

“Regarding personnel, theoretically, there is a midwife or an assistant doctor or an obstetrician in a station. However, in reality, for instance, in a station there are two midwives. One is studying in the city. She will go back to work in three years. The other is on maternity leave. She will go back to work in a half year. Officially, there are two midwives, but in reality, zero, right? Then such stations cannot be selected.” [#18, Governmental social franchise program manager]

Almost all of our informants emphasized the importance of an agreement (11 occurrences) of all stakeholders for all activities of the program. Furthermore, the support and commitment of local government (seven occurrences) are also essential elements because, for instance, if the local government is not interested in developing the public health sector, this lack of interest will be an obstacle in establishing the Sisterhood model.

Our informants also mentioned a “set of criteria” (their term) for the selection of CHSs which consists of various conditions for brand achievement.

“We have a set of criteria which we clearly introduced to departments of health, nothing hidden. The departments also accepted it. They could supplement it or suggest that this criterion might not be appropriate, etc.” [#18, Governmental social franchise program manager]

“When we selected commune health stations to participate in the social franchising program [Sisterhood], Marie Stopes, as a technical supporter for departments of health, developed a set of criteria (...) we and the departments of health were unanimous in this set because we didn’t want to impose anything on anyone. We worked with them and told them that we suggested these criteria based on our experience as well as our technique. And the departments could contribute to them or change them and when we all accepted the set, we would use this set to find in reality suitable commune health stations.” [#1, Government social franchise program manager]

This set of criteria is an innovative object of MSIVN in which each criterion was established by both MSIVN and DOHs. Therefore, it can satisfy the two sides. Due to this set, the process of selecting CHSs received important support from DOHs and therefore could overcome obstacles easily.

In addition, according to our informants, the set of criteria shows two important points of the adoption process of Sisterhood which we have not known before: democratic and culturally appropriate. One informant said that:

"I think ... it is democratic due to the participation of all parties to a common work. Regarding commercial activities, service or brand owner will impose their criteria. As for us ... as a technical support unit, we want everything to fit local situation, even communication materials. In English there is a term, it is "culturally appropriate". We cannot propagandize whatever we want (...) the way we work, it is never overbearing." [#1, Governmental social franchise program manager]

The initial steps of the process of adopting a social franchising model based on the principles of democracy is a big difference from business-format franchising adoption process in which franchisor can impose strict standards on the selection of franchisees. Democracy, in this case, can be viewed as a higher level of agreement among all stakeholders of the program. In addition, the set of criteria can help Sisterhood fit cultural context of CHSs because during the process of establishing this set, DOHs can contribute elements that are suitable for their CHSs and local people.

When MSIVN had a set of criteria, they closely collaborated with DHCs and often let them to make final decisions. One informant observed that:

"We did not need to visit all of 60 stations. First, we worked with the department of health and invited the district health center [of the province where there are these stations] to work with us (i.e. the unit under the department of health and directly manages the communes). In the meeting, because they were local health managers, they could immediately say that with such a set of criteria, among these 60 commune health stations, they were able to find about 10-15 unsuitable

stations, no need to come there.” [#18, Governmental social franchise program manager]

“After visited the stations, we organized a conference in the department of health [of the province where there are these stations]. We invited the district leaders [the districts of these stations]. We introduced all collected information according to this set of criteria of each commune and their points (...) When there were two units with equal score or a difference of one-two points, not significant, we let the local health choose.” [#18, Governmental social franchise program manager]

In this knowledge/research and selection/matching phase, we observed that MSIVN tried to collaborate with two main managerial levels of the public health system in selected provinces: DOHs and DHCs. MSIVN played the role of a technical supporter, a real “counsellor” for local health systems. The decisions that related to the Sisterhood program establishment were discussed and agreed by both MSIVN and local health systems. Therefore, potential ruptures in the next phases can be avoided partly.

3. How to choose a CHS

D. Infrastructure and human resources

D1. “When Sisterhood intervened, maybe the selected station had just been repaired, very beautiful. But some stations (...) they were repairing when we came there (...) How could we select them?” [#18, Governmental social franchise program manager]

D2. “Or some stations, when we visited, they were not too ugly, not too beautiful, not being repaired. However ... they had a repair plan in a few months. So after selection process, if they repair it totally then ... what will we have to do?” [#18, Governmental social franchise program manager]

D3. “However, when they [the stations which had not been selected before because of repairs] completed the repairs ... they were good and beautiful. They also had goodwill and wanted to participate in the program. If department of health replicated the model in this station, it would be ok.” [#18, Governmental social franchise program manager]

D4. “... the commune health stations have to care about that [participating in the Sisterhood program]. That means they need to participate in the program. Because we ... we ... have experience that if the communes or CHSs’ members don’t need to participate in the model then they will listen to ... the command of their superior without responsibility. So we don’t want to work with that people. First, they have to have need; second, the head of the CHS has to be very enthusiastic because he/she will be an exemplar for others. If he/she is not enthusiastic, others will be like this, and then the investment of the program will be a waste.” [#1, Governmental social franchise program manager]

D5. “Not every leader wants a project to intervene in his/her community. Politically they cannot say that they do not want the project. However, in their hearts, not every leader wants it because within a project, they have to work better, study, report and work hard. For them ... how long they work, when they go to station or come back home, they provide services to how many people. They can do what they want. After work, they can work at their surgeries to earn more money, no need to care about the station.” [#18, Governmental social franchise program manager]

D6. “Regarding personnel, theoretically, there is a midwife or an assistant doctor or an obstetrician in a station. However, in reality, for instance, in a station there are two midwives. One is studying in the city. She will go back to work in three years. The other is on maternity leave. She will go back to work in a half year. Officially, there are two midwives, but in reality, zero, right? Then such stations cannot be selected.” [#18, Governmental social franchise program manager]

E. Collaboration: MSIVN-DOHs-DHCs

E1. Agreement (11), support and commitment of local government (7)

E2. “We have a set of criteria which we clearly introduced to departments of health, nothing hidden. The departments also accepted it. They could supplement it or suggest that this criterion might not be appropriate, etc.” [#18, Governmental social franchise program manager]

E3. “When we selected commune health stations to participate in the social franchising program [Sisterhood], Marie Stopes, as a technical supporter for departments of health, developed a set of criteria (...) we and the departments of health were unanimous in this set because we didn’t want to impose anything on anyone. We worked with them and told them that we suggested these criteria based on our experience as well as our technique. And the departments could contribute to them or change them and when we all accepted the set, we would use this set to find in reality suitable commune health stations.” [#1, Government social franchise program manager]

E4. “I think ... it is democratic due to the participation of all parties to a common work. Regarding commercial activities, service or brand owner will impose their criteria. As for us ... as a technical support unit, we want everything to fit local situation, even communication materials. In English there is a term, it is “culturally appropriate”. We cannot propagandize whatever we want (...) the way we work, it is never overbearing.” [#1, Governmental social franchise program manager]

E5. “We did not need to visit all of 60 stations. First, we worked with the department of health and invited the district health center [of the province where there are these stations] to work with us (i.e. the unit under the department of health and directly manages the communes). In the meeting, because they were local health managers, they could immediately say that with such a set of criteria, among these 60 commune health stations, they were able to find about 10-15

unsuitable stations, no need to come there.” [#18, Governmental social franchise program manager]

E6. “After visited the stations, we organized a conference in the department of health [of the province where there are these stations]. We invited the district leaders [the districts of these stations]. We introduced all collected information according to this set of criteria of each commune and their points (...) When there were two units with equal score or a difference of one-two points, not significant, we let the local health choose.” [#18, Governmental social franchise program manager]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

2.3. Staff persuasion (persuasion/validation)

In reality, from the first phase to the present phase, events did not take place sequentially. Sometimes they overlapped each other. This phase relates to the initial difficulties of the Sisterhood program when MSIVN's officials had to persuade DOHs, DHCs and CHSs to accept the model.

2.3.1. Initial difficulties of the Sisterhood program

According to our informants, one of the most significant difficulties of the program came from several local leaders who did not really understand Sisterhood's social objectives. One informant we interviewed noted that:

"They thought that they would have money, assets or something due to the program. They could not see that it was an opportunity to learn, to be trusted by local people, to be promoted, to improve their skills ... The knowledge and the leadership of some local leaders are very limited (...) They are not on the same level. Level and goodwill degree. There are very qualified people but their degree of goodwill is not sure or not as high as the people with lower qualifications." [#18, Governmental social franchise program manager]

Moreover, it was very time consuming to make them understand social franchising concept. One informant provided an example as follows:

"The 1st time we worked with a provincial department of health and introduced social franchising. It was very difficult to make them understand what social

franchising was. Some directors of South-western departments of health (in the provinces of the program), they were very outspoken. When they heard franchising, clients, some “P” of social franchising (place, people, promotion and price), they refused. They said there was no trade here, stop!” [#1, Governmental social franchise program manager]

In our opinion, this is a common obstacle of social-oriented programs. Social purposes still a strange concept for many people. Regarding local leaders in the public health sector in Vietnam, while MSIVN tried to introduce intangible value for local community, they only focused on their own tangible benefits. Their perception was quite simple: if they did something, they would have money. The intangible elements of the Sisterhood program, in this case, seemed not to be important to them. One more time, the narrow thinking within the scope of family benefits (good for me and for my family) appeared (cf. 1.1.2. *Social goals of the Sisterhood social franchise*).

It was quite common to see this issue which appeared in different management levels of local health system. From DOHs to CHSs, MSIVN faced many difficulties in making local leaders (of DOHs, DHCs and CHSs) understand the model. The solution provided by MSIVN was to collaborate with them and let them really participate in establishing the model. One informant noted that:

“When high management levels accepted, we went to lower management levels, especially commune health stations where social franchising model was being set up directly. “Educated” them to understand the model was very difficult. It was very

time consuming. But we worked as a partnership with the health sector of the state. We did not do the work for them. We technically supported them to establish the network step by step. So ... when they directly participated in the program, they did activities, they understood gradually and they liked it.” [#1, Governmental social franchise program manager]

In this case, collaboration among MSIVN and different management levels of local health system helped facilitate the process of adopting Sisterhood in CHSs. In some cases, MSIVN had to accept a temporary plan. As we mentioned, to meet infrastructure criteria of the program was an important question for several stations (three occurrences). To find suitable CHSs for the program, MSIVN and DOHs collaborated to make a set of criteria (see 2.2.2. *How to choose a CHS*) in which infrastructure criteria were important.

In some provinces, to find a CHS which could meet these important criteria of infrastructure was quite difficult because numerous CHSs could not even manage a place for a consulting room inside them (they were too small). Therefore, sometimes the program applied “flexible” criteria. For instance, they accepted that the “Sisterhood” consulting could be a bit small (compared to the criteria of the program) or could be situated outside CHSs.

In this case, several criteria were changed so that more CHSs could meet Sisterhood’s standards and potential ruptures could also be avoided. If they had not changed their criteria, they could not have found any suitable CHSs. That also a difference between

social franchising and business format franchising in which franchisors' standards cannot be changed.

Besides local leaders, MSIVN also faced a lot of resistance from CHSs' health workers who had old habits and working styles and often forgot how to provide services correctly. This issue was repeated 15 times in our interviews. In addition, they were afraid of changing working habits and many of them hesitated to welcome Sisterhood at the beginning. One informant we interviewed observed that:

"... when we participated in the program then (...) we were ... afraid, afraid of changing our habit because at this station, we go to work and leave work as a habit. Now participating in the program, they demand a lot of things, honestly at the beginning ... it was really annoying." [#4, Head of the Cu Van CHS]

"I am a doctor. What I do based on what I learnt at the university. When the program came, I had to change. Then I started to change my habits. That was ... so fearful. I did not feel ... at the beginning, enthusiastic." [#4, Head of the Cu Van CHS]

Such hesitation was also observed in other stakeholders of the program. One informant asserted the following:

"At the beginning, the name of the program sounded strange to me. I thought that the training could be difficult." [#15, Brand ambassador of a commune in Yen Bai province]

Similar to the reasons of local leaders, CHSs' health workers or brand ambassadors were afraid of changes (from Sisterhood). They have been "wrapped up" for a long time in a family-friendly work environment and have received so much support from the government. Therefore, naturally they did not want to change. It was a huge obstacle because the program had to change their mind.

Sometimes resistance came from local people. Our informants described that in numerous communes, approaching local people was difficult. For instance, one informant said that:

"At the beginning, I felt that people avoided me." [#16, Brand ambassador of a commune in Yen Bai province]

In 1.2.4. *Brand ambassadors and communication*, according to our documents as well as our own knowledge, we predicted some potential ruptures among brand ambassadors and local people due to several reasons. The quotation above partly confirmed our supposition. In addition, during the interviews, our informants added some more reasons related to these ruptures as follows.

They said that local people were poor and their perception was limited (three occurrences). For instance, regarding clients who were farmers, sometimes they cancelled to go to CHS because of harvest and the CHS had to remind them. One more reason pertained to the communication with ethnic minorities' people (three occurrences) who (often) could not understand Vietnamese. In addition, some stations, especially in remote areas, were not easy to access (four occurrences).

Our informants also paid attention to The Little Sun of A&T Vietnam, another social franchise in the public health sector in Vietnam. This program aims at improving infant and young child feeding counselling services and primarily works with national, provincial and district levels (only one part of the program focuses on CHSs). The Little Sun does not include professional services, only counselling.

The problem was The Little Sun intervened in some CHSs of Sisterhood or in some provinces, The Little Sun came before Sisterhood. Regarding some DOHs, “co-branding”⁴⁸ (term used by our informants) was unacceptable and they did not accept or tried to avoid this situation. One informant noted that:

“The department of health in Vinh Long replied immediately. They did not accept that there were two brands [‘The Little Sun’ and ‘Sisterhood’] in the same place. That means ... if there is Sisterhood there, The Little Sun has to find another place.” [#18, Governmental social franchise program manager]

One of our informants explained that:

“Firstly ... community, they are used to the ‘Sisterhood’ brand of commune health station. Now if we add another brand, it can lead to misunderstandings or ... confusion for local people. And ... the commune health station only has some functional rooms, not limitless, the station is very narrow. If each brand needs a separate room, it can be a waste. And ... regarding the personnel of the station,

⁴⁸ Two brands, Sisterhood and The Little Sun, in a CHS.

there is only one or two midwives who were trained by the Sisterhood program. They counsel and provide services for clients. If now, there is another brand, The Little Sun, the midwives will also be trained and counsel clients then ... if two group of clients, mother-infant and women-men of reproductive age, simultaneously come to the station, they cannot handle this situation. That's what department of health needs to consider." [#18, Governmental social franchise program manager]

In this context, there were three major obstacles which could partly explain why DOHs opposed "co-branding": the potential confusion of clients, the infrastructure criteria of the program and the potential lack of human resources. Regarding clients, as we mentioned, due to limited awareness, Sisterhood and The Little Sun seemed to be very similar to them. Regarding CHSs, a lack of human resources (for instance, midwives) could lead to several ruptures of work organization in case a health worker had to serve two different types of clients (Sisterhood's and The Little Sun's clients).

One more time, the infrastructure criteria of the program were mentioned. Two places for two consulting rooms, it seems impossible for CHSs. The problem is both Sisterhood and The Little Sun have their own standards for the consulting rooms, including the standards of area. However, almost CHSs are quite small and their standards are simple: we cannot be enlarged (it is all we have).

As we mentioned above, based on a temporary plan with CHSs, Sisterhood could find several CHSs for the program. This case is more complicated, a common plan needed to

be set between three sides: Sisterhood, The Little Sun and CHSs. One informant described this situation as follows:

“I discussed that with departments of health. We are ... not purely commercial units and in this ‘playground’, we are not competitive and take place as in a market. I come first then I will sell first, and if you go here after me then you have to find ... another place. This will not be ... such a game (...) Then ... it will be more effective if the health departments and commune health stations can combine counselling services [of The Little Sun and Sisterhood] in the same room. And ... we need to train midwives very clearly that when they counsel someone, they have to emphasize the brand.” [#18, Governmental social franchise program manager]

Two brands in a CHS and they shared a common consulting room was the solution. In 2.2.2. *How to choose a CHS*, a set of criteria for choosing suitable CHSs for the Sisterhood program was viewed as an innovative object which satisfied both Sisterhood and DOHs. In this case, a common consulting room for two brands could also be viewed as an innovative object. Sisterhood, The Little Sun and CHSs finally found a common plan.

Staff persuasion (persuasion/validation)

4. Initial difficulties of the Sisterhood program

F. Making local leaders understand Sisterhood

F1. "They thought that they would have money, assets or something due to the program. They could not see that it was an opportunity to learn, to be trusted by local people, to be promoted, to improve their skills ... The knowledge and the leadership of some local leaders are very limited (...) They are not on the same level. Level and goodwill degree. There are very qualified people but their degree of goodwill is not sure or not as high as the people with lower qualifications." [#18, Governmental social franchise program manager]

F2. "The 1st time we worked with a provincial department of health and introduced social franchising. It was very difficult to make them understand what social franchising was. Some directors of South-western departments of health (in the provinces of the program), they were very outspoken. When they heard franchising, clients, some "P" of social franchising (place, people, promotion and price), they refused. They said there was no trade here, stop!" [#1, Governmental social franchise program manager]

F3. "When high management levels accepted, we went to lower management levels, especially commune health stations where social franchising model was being set up directly. "Educated" them to understand the model was very difficult. It was very time consuming. But we worked as a partnership with the health sector of the state. We did not do the work for them. We technically supported them to establish the network step by step. So ... when they directly participated in the program, they did activities, they understood gradually and they liked it." [#1, Governmental social franchise program manager]

F4. Infrastructure criteria were difficult to meet (3)

G. Hesitation of several stakeholders

G1. Health workers: old habits/working styles, forgot how to provide services (15)

G2. "... when we participated in the program then (...) we were ... afraid, afraid of changing our habit because at this station, we go to work and leave work as a habit. Now participating in the program, they demand a lot of things, honestly at the beginning ... it was really annoying." [#4, Head of the Cu Van CHS]

G3. "I am a doctor. What I do based on what I learnt at the university. When the program came, I had to change. Then I started to change my habits. That was ... so fearful. I did not feel ... at the beginning, enthusiastic." [#4, Head of the Cu Van CHS]

G4. "At the beginning, the name of the program sounded strange to me. I thought that the training could be difficult." [#15, Brand ambassador of a commune in Yen Bai province]

H. Approaching local people and some CHSs

H1. "At the beginning, I felt that people avoided me." [#16, Brand ambassador of a commune in Yen Bai province]

H2. Poor and limited perception (3), communication with ethnic minority groups (3), access to some CHSs (4)

I. Innovative co-branding

I1. "The department of health in Vinh Long replied immediately. They did not accept that there were two brands ['The Little Sun' and 'Sisterhood'] in the same place. That means ... if there is Sisterhood there, The Little Sun has to find another place." [#18, Governmental social franchise program manager]

I2. "Firstly ... community, they are used to the 'Sisterhood' brand of commune health station. Now if we add another brand, it can lead to misunderstandings or ... confusion for local people. And ... the commune health station only has some functional rooms, not limitless, the station is very narrow. If each brand needs a separate room, it can be a waste. And ... regarding the personnel of the station, there is only one or two midwives who were trained by the Sisterhood program. They counsel and provide services for clients. If now, there is another brand, The Little Sun, the midwives will also be trained and counsel clients then ... if two group of clients, mother-infant and women-men of reproductive age, simultaneously come to the station, they cannot handle this situation. That's what department of health needs to consider." [#18, Governmental social franchise program manager]

I3. "I discussed that with departments of health. We are ... not purely commercial units and in this 'playground', we are not competitive and take place as in a market. I come first then I will sell first, and if you go here after me then you have to find ... another place. This will not be ... such a game (...) Then ... it will be more effective if the health departments and commune health stations can combine counselling services [of The Little Sun and Sisterhood] in the same room. And ...

we need to train midwives very clearly that when they counsel someone, they have to emphasize the brand.” [#18, Governmental social franchise program manager]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

2.4. Model implementation (modification, operationalization and clarification/confirmation)

This is the most important phase of the adoption process of Sisterhood in CHSs. During this phase, numerous changes from both sides appeared. Sometimes these changes became the tensions among the Sisterhood model and these CHSs. The modifications were necessary and once a common point was established, beneficiaries were both the CHSs and their clients.

There were expected influences of Sisterhood on franchised CHSs such as positive changes in clinical and non-clinical activities of medical staff. However, some influences of the consulting rooms on the rest of CHSs and franchised CHSs on other non-franchised ones were completely unexpected.

2.4.1. Changes in non-clinical activities of medical staff

The CHSs where we visited were very beautiful, clean and tidy (even in better condition than the town hall situated beside). In addition, according to our informants, they observed changes in infrastructure and general hygiene inside and outside of franchised CHSs which attracted more clients. One informant asserted the following:

“... the view, the decoration, the general hygiene of station, not only in reproductive area; both of the inside and the outside of the station have been improved. So people ... from the outside, they find that there is no garbage, no medical waste,

no ... dirt then they all want to go inside, don't they? It looks clean, spacious so they want to go inside.” [#1, Government social franchise program manager]

“... from the entrance, tidier, going inside, the precincts of the commune health station are cleaner. There is a botanical garden, a parking for people.” [#1, Government social franchise program manager]

According to some informants, appearance changes also distinguish franchised CHSs from non-franchised ones:

“Franchised commune health stations are different from non-franchised ones. If ... someone who doesn't know about the model comes to a franchised station, she will immediately notice differences.” [#16, Brand ambassador of a commune in Yen Bai province]

CHSs' appearance changes are not the main objectives of the Sisterhood model. According to our informants, this one brought fundamental changes in non-clinical activities of CHSs. Our informants paid special attention to client reception in the Sisterhood CHSs where there is always a health worker at reception desk to welcome clients while in non-franchised stations, sometimes clients do not know what to do, who they can ask, etc.

“A state health station is not similar to a private health facility or a hotel where there is a front desk with people who welcome clients because they don't have permanent members for such activities. But in commune health stations [of

Sisterhood], someone is appointed to welcome women from the entrance.” [#1, Governmental social franchise program manager]

“... as for non-franchised commune health stations, local people come inside and don’t know who they have to find and where this person is. They ask whoever they meet or go everywhere inside the station.” [#1, Government social franchise program manager]

Client reception is a significant difference among Sisterhood’s stations and other stations in the public health system. Some informants asserted the following:

“Now, if I go to a Sisterhood commune health station, I can immediately recognize right from the reception step. I can also recognize a non-Sisterhood station immediately.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

Client reception is a market-related factor which has not existed in the system of Vietnamese CHSs before. The Sisterhood model, after initial difficulties, successfully integrated this factor into franchised CHSs and that was compatible with customer-oriented purpose of the model.

In low- and middle-income countries’ health sector, numerous programs train and send their health workers to rural communes to gain access to their programs. Similarly, based on brand ambassadors, Sisterhood’s communication activities were improved and the program was advertised to all people in the commune. After several training courses, they learnt how to approach and talk with local people. Some informants noted that:

“We were trained. Participated in training courses, I had a lot of new knowledge. The teachers [the provincial master trainers] taught us; then, when we came back to the commune, we knew how to explain to people, to make them understand more clearly and deeply.” [#15, Brand ambassador of a commune in Yen Bai province]

According to our informants, sometimes brand ambassadors were the first members of the Sisterhood program who approached local people. They helped facilitate the access to franchised CHSs. One informant we interviewed observed that:

“Clients, when they met us, they felt comfortable because they had been explained and counselled by brand ambassadors at lower management level. Therefore, when they came here [the Sisterhood station], they weren’t timid like before.” [#11, Head of the Luong Thinh CHS]

We predicted that brand ambassadors could be viewed as a “bridge” linking Sisterhood and local people (cf. 1.2.4. *Brand ambassadors and communication*). Indeed, based on the interviews, our informants confirmed that Sisterhood “integrated” several skills into brand ambassadors then they “transferred” them to clients. Due to brand ambassadors, cultural barriers (for instance, RHFP services were considered to be quite sensitive) between the program and its clients were removed.

Our informants mentioned 15 times work organization changes in CHSs’ activities. In addition, health workers could make accurate reports (five occurrences) for upper-level health facilities. Furthermore, franchised CHSs maintained a continuous and steady

operation while non-franchised ones only increased their activities by campaigns. Client reception, communication as well as these non-clinical changes closely related to Sisterhood's training courses.

MSIVN *"mainly supported in working methods and way of thinking which relate to client approach."* [#2, DOH project coordinator]. For this reason, our informants observed the improvements of service quality, especially working methods. In fact, MSIVN provided some instruments and medical equipment for the Sisterhood CHSs (for RHFP services only) but it is not the goal of the program.

Although the program mainly focused on RHFP services, all members of franchised CHSs were trained. RHFP health workers followed clinical and non-clinical courses while non-RHFP ones learnt non-clinical activities only. This situation was described as follows:

"People who directly provide the services [RHFP ones] will ... learn clinical and non-clinical subjects about social franchising. The rest will be trained but only in social franchising, not in clinical subjects." [#1, Governmental social franchise program manager]

"Those who don't work in reproductive health and family planning sector will still be trained in social franchising, service quality, interpersonal skills and communication. Those who do clinical activities will also be trained like this." [#1, Governmental social franchise program manager]

“First ... they [medical staff] attended training courses to improve their skills and expertise in the field of reproductive health and family planning. Second, soft skills such as how to communicate with people who come to station for services, understanding what social franchising model is. This is a very new concept for health workers in Vietnam.” [18, Governmental social franchise program manager]

MSIVN trained all health workers of CHSs in non-clinical subjects because CHSs' quality depends on each individual and activity. Therefore, only RHFP health workers know about market- and industry-related elements is not enough. One informant we interviewed told us that:

“The whole commune health station will be trained like that because the quality of a commune health station depends not only on its station head but also its medical staff; because all parts have to work with clients. If only doctor knows about it [marketing knowledge] and others don't ... Even person who guides clients to parking place. If he/she doesn't know about it, there will be impact on quality of the whole ... service providing process. We were trained in this method, and I think it's very logical. Like super markets, they care about customers since they park until they leave. It's a new approach in the health sector. I think it's a good method.”
[2, DOH project coordinator]

In a franchised CHS, if only RHFP health workers are transferred industry and market-related elements, there will be a huge difference between other health workers and them.

In this case, several changes in work organization as well as potential ruptures pertaining to the integration of Sisterhood into CHSs are easy to predict. Although MSIVN focuses on RHFP services only, training courses for all (in non-clinical activities) are considered a suitable strategy to avoid potential ruptures during the adoption process of the Sisterhood model.

The changes brought by Sisterhood in terms of the perception of health workers in franchised CHSs were quite important. One of the first changes was to understand service quality. Before, the knowledge about service quality in CHSs was limited and both clients and health workers only knew about professional activities. Non-clinical activities seemed to be neglected. After the training courses of the Sisterhood program, some informants understood how important non-clinical activities were and could (re)define what service quality was. One informant noted that:

“Training in professional knowledge, by example IUD insertion technique, gynecological examination, cervical cancer early screening; and non-professional knowledge, by example what service quality is, what customer needs are? Making them understand what service quality is, not only providing service or completing professional task, it includes all stages. From the moment patients enter station until they leave there, how to care of them. How private, discreet and friendly the environment [of the station] is. They train all.” [#2, DOH project coordinator]

Another informant provided a very detailed description of the quality of services:

“Then they learnt what the quality of services was because in the health system of Vietnam, future doctors are primarily trained in professional knowledge, i.e. which symptom pertains to which disease, how to give prescriptions, how to treat patients, how to make them feel better. That’s very good but another good part is how to make them serve people honestly and respectfully with an affable manner so that people can trust health facilities and come to meet doctor without fear and not only when they have disease but also when they have need. Service quality concept is the combination of professional and soft skills.” [#18, Governmental social franchise program manager]

Besides significant improvements in the knowledge of service quality, perception changes of franchised CHSs’ health workers also consisted of other elements. Similar to what we mentioned in 1.1.1. *Objectives and principal activities of Sisterhood*, our informants viewed patients as clients. Some informants we interviewed asserted the following:

“Perception changes are the most important fact: changes in thought, in client approaches, in working methods. That’s the most valuable fact of the program, I think. The program supports in equipment, small financial aid, report activities (...) that’s not essential. The important thing is, the medical staff of commune health stations, of district health centers, they understand working methods, customer orientation, consider clients to be the center of service-providing activities. That’s effective and sustainable. Supporting in infrastructure, equipment, after a while, it will not exist. I think it’s the best point.” [#2, DOH project coordinator]

A different point of view led to an important change of clients' position in CHSs' activities.

One informant said that:

“... before this program, we had thought that people came here because they needed us. However, when we participated in the program, we thought ... differently, that we needed patients, we needed clients, not conversely.” [#4, Head of the Cu Van CHS]

From “patients need health workers” to “health workers need clients”, the process of adopting Sisterhood successfully brought market-related elements to CHSs. To reach this stage can be viewed as a success of Sisterhood because perception changes are foundations for establishing other changes.

Changes in perception led to changes in manner. Indeed, according to our informants, the Sisterhood CHSs' health workers were more approachable.

“... according to client comments, they feel that we are friendlier than before (between doctors and patients).” [#4, “Sisterhood” room consultant of the Cu Van CHS]

MSIVN trained all members of the Sisterhood CHSs (both reproductive and non-reproductive health workers) in non-clinical activities. Therefore, manner changes could be observed in all health workers of franchised CHSs. Several informants we interviewed asserted the following:

“... there are improvements in communication, in manner towards local people. The whole commune health station, not only reproductive health sector ...” [#1, Governmental social franchise program manager]

“Clients are cared since they start to enter station until they leave station. That means comprehensive care, including physicality and mentality.” [#2, DOH project coordinator]

“We don’t use ‘patients’ but ‘clients’. Since then, the awareness and the manner of health workers have changed completely. They consider that ... these are their clients and they are serving their clients.” [#1, Governmental social franchise program manager]

Furthermore, according to some informants, franchised CHSs successfully established a relationship between their health workers and clients.

“Moreover, there is a relationship. I mean, after receiving services, we will evaluate client needs and their satisfaction through questionnaires or coming to their houses to evaluate. It’s the difference, compared to non-Sisterhood commune health stations.” [#3, Director of the Dai Tu DHC]

In some CHSs, clients even knew the cell phone numbers of health workers that could be viewed as an “uninterrupted” channel between the health workers and their clients.

“... since they joined the Sisterhood program, they have had progress ... they have notice-board in commune health station where there are cell phone numbers of

manager, midwife or personnel on duty so that if people need, they can contact them by mobile phone. Because all health workers live in the commune so in necessary case, they can go to the station.” [#1, Governmental social franchise program manager]

“... their cell phone numbers will be published. These activities ... before in health establishments of the state, did not exist. Sometimes it was impossible to find a health worker. But currently ... these are the changes of manner towards people.”
[#1, Governmental social franchise program manager]

This was a voluntary action of some CHSs, as one informant confirmed:

“... we did not force them, they were voluntary and the program found that this activity was really their passion, enthusiasm in serving local people.” [#1, Governmental social franchise program manager]

We observe that during the process of adopting Sisterhood in CHSs, this model has been adapted several times for CHSs' organizational context. This voluntary action is a good example. Health workers not only did as what they had learnt from MSIVN's training courses but also improved it. Another example relating to manner changes is the fact that in several CHSs, clients can keep their possessions in lockers. Indeed, these CHSs cared about every detail of customer need and focused on client satisfaction therefore they bought the lockers which were not obliged.

Model implementation (modification, operationalization and clarification/confirmation)

5. *Changes in non-clinical activities*

J. CHSs' new appearance

J1. "... the view, the decoration, the general hygiene of station, not only in reproductive area; both of the inside and the outside of the station have been improved. So people ... from the outside, they find that there is no garbage, no medical waste, no ... dirt then they all want to go inside, don't they? It looks clean, spacious so they want to go inside." [#1, Government social franchise program manager]

J2. "... from the entrance, tidier, going inside, the precincts of the commune health station are cleaner. There is a botanical garden, a parking for people." [#1, Government social franchise program manager]

J3. "Franchised commune health stations are different from non-franchised ones. If ... someone who doesn't know about the model comes to a franchised station, she will immediately notice differences." [#16, Brand ambassador of a commune in Yen Bai province]

K. Client reception and communication

K1. "A state health station is not similar to a private health facility or a hotel where there is a front desk with people who welcome clients because they don't have permanent members for such activities. But in commune health stations [of Sisterhood], someone is appointed to welcome women from the entrance." [#1, Governmental social franchise program manager]

K2. "... as for non-franchised commune health stations, local people come inside and don't know who they have to find and where this person is. They ask whoever they meet or go everywhere inside the station." [#1, Government social franchise program manager]

K3. "Now, if I go to a Sisterhood commune health station, I can immediately recognize right from the reception step. I can also recognize a non-Sisterhood station immediately." [#4, "Sisterhood" room consultant of the Cu Van CHS]

K4. "We were trained. Participated in training courses, I had a lot of new knowledge. The teachers [the provincial master trainers] taught us; then, when we came back to the commune, we knew how to explain to people, to make them

understand more clearly and deeply.” [#15, Brand ambassador of a commune in Yen Bai province]

K5. “Clients, when they met us, they felt comfortable because they had been explained and counselled by brand ambassadors at lower management level. Therefore, when they came here [the Sisterhood station], they weren’t timid like before.” [#11, Head of the Luong Thinh CHS]

L. Role of training

L1. Work organization changes (15), accurate reports (5), a continuous and steady operation (2)

L2. “They [MSIVN] mainly supported in working methods and way of thinking which relate to client approach.” [#2, DOH project coordinator].

L3. “People who directly provide the services [RHFP ones] will ... learn clinical and non-clinical subjects about social franchising. The rest will be trained but only in social franchising, not in clinical subjects.” [#1, Governmental social franchise program manager]

L4. “Those who don’t work in reproductive health and family planning sector will still be trained in social franchising, service quality, interpersonal skills and communication. Those who do clinical activities will also be trained like this.” [#1, Governmental social franchise program manager]

L5. “First ... they [medical staff] attended training courses to improve their skills and expertise in the field of reproductive health and family planning. Second, soft skills such as how to communicate with people who come to station for services, understanding what social franchising model is. This is a very new concept for health workers in Vietnam.” [#18, Governmental social franchise program manager]

M. Perception changes

M1. “The whole commune health station will be trained like that because the quality of a commune health station depends not only on its station head but also its medical staff; because all parts have to work with clients. If only doctor knows about it [marketing knowledge] and others don’t ... Even person who guides clients to parking place. If he/she doesn’t know about it, there will be impact on quality of the whole ... service providing process. We were trained in this method, and I think it’s very logical. Like super markets, they care about customers since

they park until they leave. It's a new approach in the health sector. I think it's a good method." [#2, DOH project coordinator]

M2. "Training in professional knowledge, by example IUD insertion technique, gynecological examination, cervical cancer early screening; and non-professional knowledge, by example what service quality is, what customer needs are? Making them understand what service quality is, not only providing service or completing professional task, it includes all stages. From the moment patients enter station until they leave there, how to care of them. How private, discreet and friendly the environment [of the station] is. They train all." [#2, DOH project coordinator]

M3. "Then they learnt what the quality of services was because in the health system of Vietnam, future doctors are primarily trained in professional knowledge, i.e. which symptom pertains to which disease, how to give prescriptions, how to treat patients, how to make them feel better. That's very good but another good part is how to make them serve people honestly and respectfully with an affable manner so that people can trust health facilities and come to meet doctor without fear and not only when they have disease but also when they have need. Service quality concept is the combination of professional and soft skills." [#18, Governmental social franchise program manager]

M4. "Perception changes are the most important fact: changes in thought, in client approaches, in working methods. That's the most valuable fact of the program, I think. The program supports in equipment, small financial aid, report activities (...) that's not essential. The important thing is, the medical staff of commune health stations, of district health centers, they understand working methods, customer orientation, consider clients to be the center of service-providing activities. That's effective and sustainable. Supporting in infrastructure, equipment, after a while, it will not exist. I think it's the best point." [#2, DOH project coordinator]

M5. "... before this program, we had thought that people came here because they needed us. However, when we participated in the program, we thought ... differently, that we needed patients, we needed clients, not conversely." [#4, Head of the Cu Van CHS]

N. Manner changes

N1. "... according to client comments, they feel that we are friendlier than before (between doctors and patients)." [#4, "Sisterhood" room consultant of the Cu Van CHS]

N2. "... there are improvements in communication, in manner towards local people. The whole commune health station, not only reproductive health sector ..." [#1, Governmental social franchise program manager]

N3. "Clients are cared since they start to enter station until they leave station. That means comprehensive care, including physicality and mentality." [#2, DOH project coordinator]

N4. "We don't use 'patients' but 'clients'. Since then, the awareness and the manner of health workers have changed completely. They consider that ... these are their clients and they are serving their clients." [#1, Governmental social franchise program manager]

N5. "Moreover, there is a relationship. I mean, after receiving services, we will evaluate client needs and their satisfaction through questionnaires or coming to their houses to evaluate. It's the difference, compared to non-Sisterhood commune health stations." [#3, Director of the Dai Tu DHC]

N6. "... since they joined the Sisterhood program, they have had progress ... they have notice-board in commune health station where there are cellphone numbers of manager, midwife or personnel on duty so that if people need, they can contact them by mobile phone. Because all health workers live in the commune so in necessary case, they can go to the station." [#1, Governmental social franchise program manager]

N7. "... their cell phone numbers will be published. These activities ... before in health establishments of the state, did not exist. Sometimes it was impossible to find a health worker. But currently ... these are the changes of manner towards people." [#1, Governmental social franchise program manager]

N8. "... we did not force them, they were voluntary and the program found that this activity was really their passion, enthusiasm in serving local people." [#1, Governmental social franchise program manager]

N9. Lockers in some CHSs

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

2.4.2. Changes in clinical activities of medical staff

Since Sisterhood program was established, MSIVN has paid special attention to sterilization and medical waste treatment process in franchised stations. Most of our informants used the word “habit” when they talked about this process. One informant we interviewed asserted the following:

“The difference between a franchised commune health station and a non-franchised one is that it’s very strict with sterilization (when doing clinical activities).” [#6, “Sisterhood” room consultant of the Tan Huong CHS]

Some informants emphasized the fact that because of the program, the CHS could have an incinerator:

“Currently, at the station we have a sterilization habit ... Now, there are separate pockets for the objects which will be buried and burned. Each station of the Sisterhood program built an incinerator ... funded by the program. Previously, no incinerator, all rubbish was buried.” [#5, Head of the Tan Huong CHS]

Regarding franchised CHSs’ medical staff, as we mentioned in 1.2.3. *Provincial master trainers and training-supervising-supporting*, due to old habits or non-updated training, health workers forgot many criteria in providing services. Therefore, MSIVN re-trained them monthly or quarterly through “refresher courses”. In these courses, provincial master trainers provided updated knowledge and repeated what they had learnt before. Because

of these trainers and training courses, health workers felt more confident in professional skills. Some informants confirmed that:

“Although we have worked here for a long time but ... there are updated things, without training, without “taking hand-guiding work” by teachers [provincial master trainers] then for sure, we won’t know about it.” [#6, “Sisterhood” room consultant of the Tan Huong CHS]

“... for sure, it [professional expertise] has been much improved than before, before the program. Because ... currently there is much updated knowledge, new, what we learnt at the university 20 years ago we forget a little bit or that is no longer fit current situation.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

According to our informants, provincial master trainers brought important knowledge to CHSs’ health workers. As we predicted, they can be viewed as a “bridge” linking the program and CHSs. Provincial master trainers had been trained to become an indispensable element of the Sisterhood model. In addition, they also pleased CHSs’ health workers through training courses (they called them “teacher”).

As we mentioned, besides training, one of the main activities of provincial master trainers is to supervise the activities of the Sisterhood CHSs. According to our informants, numerous health workers were afraid of supervision:

“Not only the Sisterhood program, all organizations are the same, frankly, they are afraid of supervision.” [#7, Head of the DOH project manager unit]

“At the beginning, they [health workers of franchised stations] viewed supervision as blaming or finding mistakes so they feared a lot.” [#8, Admin/Accountant of the MSIVN provincial project office]

Health workers felt scared because they always thought that (maybe because of previous programs or activities) supervision meant finding fault. This thought is quite common in public health facilities in Vietnam and that leads to many negative consequences. For instance, health facilities always try to do their best when someone comes to monitor. However, when they leave, everything goes back to old situation.

However, when the health workers of the Sisterhood CHSs understood the activities of provincial master trainers, they considered supervision to be a support and they even liked it, as one informant said:

“We were afraid of supervision at the beginning but when we got used to it, we ... liked it [smiling].” [#4, “Sisterhood” room consultant of the Cu Van CHS]

Some informants said that they needed to be supervised in order to work better:

“At the beginning, we were also afraid of ... tired of ... supervision. I wondered why I had to do like this, like that. Currently, we are used to it. Before ... Ms. Nhu [head of the station] was very good at professional activities but teacher [provincial master trainer] sat right beside her and gave marks. Even that was independent of her job but she still feared. However, after ... we don’t fear anymore. We feel that

... we have a need of being supervised that will show us good and bad points.”

[#4, “Sisterhood” room consultant of the Cu Van CHS]

From something so fearful to an important need, this psychological transformation of CHSs’ health workers has many meanings: as we mentioned, the real objective of supervision was to help medical staff improve their skills, after some time, they understood that this activity was good for them and for CHSs and they accepted (even welcomed) this activity.

Supervision, an important activity of Sisterhood, began with negative feelings of health workers that could easily become ruptures for the adoption process of the model in CHSs. However, this activity ended up being warmly welcomed by medical staff. The model transformed a supervision with strict rules (as other franchises) into a great support for CHSs. This “concession” avoided criticisms from medical staff and therefore facilitated the integration of an industry- and market-related activity (supervision) into CHSs.

In some CHSs, medical staff developed other kinds of supervision: self-supervision and mutual supervision. For this reason, the quality of RHFP services in these stations was quite in sync with other services:

“We set up mutual supervision which we learn from that [the program]. By example, I supervise someone then this one will supervise another one, etc.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

Normally, the quality of RHFP services in the Sisterhood CHSs is higher than other services. Due to self-supervision and mutual supervision in several franchised CHSs, the other services tried to attain similar quality with the RHFP ones and that could lead to several ruptures between them. If these two types of services could resolve their differences and try to get along, the services of these CHSs would be at a higher level of quality.

In the next paragraphs, we introduce more instances of tensions between RHFP and non-RHFP services inside franchised CHSs.

6. Changes in clinical activities

O. Sterilization and medical waste management

O1. "The difference between a franchised commune health station and a non-franchised one is that it's very strict with sterilization (when doing clinical activities)." [#6, "Sisterhood" room consultant of the Tan Huong CHS]

O2. "Currently, at the station we have a sterilization habit ... Now, there are separate pockets for objects which will be buried and burned. Each station of the Sisterhood program has built an incinerator ... funded by the program. Previously, no incinerator, all rubbish was buried." [#5, Head of the Tan Huong CHS]

P. Professional expertise

P1. "Although we have worked here for a long time but ... there are updated things, without training, without "taking hand-guiding work" by teachers [provincial master trainers] then for sure, we won't know about it." [#6, "Sisterhood" room consultant of the Tan Huong CHS]

P2. "... for sure, it [professional expertise] has been much improved than before, before the program. Because ... currently there is much updated knowledge, new, what we learnt at the university 20 years ago we forget a little bit or that is no longer fit current situation." [#4, "Sisterhood" room consultant of the Cu Van CHS]

Q. Need to be supervised

Q1. "Not only the Sisterhood program, all organizations are the same, frankly, they are afraid of supervision." [#7, Head of the DOH project manager unit]

Q2. "At the beginning, they [health workers of franchised stations] viewed supervision as blaming or finding mistakes so they feared a lot." [#8, Admin/Accountant of the MSIVN provincial project office]

Q3. "We were afraid of supervision at the beginning but when we got used to it, we ... liked it [smiling]." [#4, "Sisterhood" room consultant of the Cu Van CHS]

Q4. "At the beginning, we were also afraid of ... tired of ... supervision. I wondered why I had to do like this, like that. Currently, we are used to it. Before ... Ms. Nhu [head of the station] was very good at professional activities but teacher [provincial master trainer] sat right beside her and gave marks. Even that was independent of her job but she still feared. However, after ... we don't fear anymore. We feel

that ... we have a need of being supervised that will show us good and bad points.”
[#4, “Sisterhood” room consultant of the Cu Van CHS]

Q5. “We set up mutual supervision which we learn from that [the program]. By example, I supervise someone then this one will supervise another one, etc.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

2.4.3. The consulting rooms' effects on their CHSs

In 1.2.2. *The “Sisterhood” consulting rooms*, based on the interviews, we described the main characteristics of the consulting room. We also predicted that this room could bring some changes (or even ruptures) for CHSs' work organization. Based on the information obtained from the interviews, this assumption was confirmed. Below we discover the tensions between the “Sisterhood” consulting rooms and the rest of franchised CHSs during the adoption process of Sisterhood in CHSs.

According to some informants, before, there was not counselling service in CHSs. Counselling was done at the same time with professional activities. The program, especially the consulting rooms, brought counselling to franchised stations. Some informants noted that:

“The first goal, the clearest goal [of the program and of the ‘Sisterhood’ consulting rooms], I think, is to make us understand that before doing professional activities, we have to counsel patients well.” [4, “Sisterhood” room consultant of the Cu Van CHS]

When Sisterhood introduced a new element that had never existed before in CHSs, they tried to explain this one to CHSs instead of forcing them to do. This strategy was implemented during the process of adopting Sisterhood in CHSs and that helped avoid unnecessary ruptures. In this case, counselling was a new element in CHSs and Sisterhood made them understand the importance of this service.

All informants observed that “Sisterhood” consulting room had significant impacts on the working procedure of the whole CHS. Because of this room, all activities of franchised CHS had to be done carefully (step by step). For instance, one informant confirmed that:

“Since the ‘Sisterhood’ consulting room was there, my job has had many differences which have brought a lot of advantages for me. By example, from counselling step to doing professional activities step, I find that there are steps which I can’t skip anymore [before, she often skipped some steps], I have to do step by step, and it becomes a habit.” [#6, “Sisterhood” room consultant of the Tan Huong CHS]

It is not the first time our informants mentioned “habit” (cf. 2.4.2. *Changes in clinical activities of medical staff*). During the process of adopting Sisterhood, the program brought several good habits to franchised CHSs’ health workers. Almost all of the health workers easily accepted these habits because they understood that the habits were good for them.

In addition, clients had their own comparisons. They requested other rooms in CHSs to do as well as the “Sisterhood” consulting room. Therefore, the manner of non-RHFP health workers was obliged to change. Some informants we interviewed asserted as follows:

“Yes, significant impact [of the ‘Sisterhood’ consulting room]. Because ... it [the station] has to follow a procedure, services need to be done through steps. Other parts [of the commune health station] which have not been franchised yet must

follow this standard procedure. And clients, they also have their comparisons and higher requirements because they are counselled.” [#3, Director of the Dai Tu DHC]

“They [clients] wonder why in other rooms they are not cared like in the room [the ‘Sisterhood’ consulting room].” [#7, Head of the DOH project manager unit]

“People of the community also wonder why in the same station there are two types of manner [of health workers from the ‘Sisterhood’ consulting room and other rooms] then health workers are obliged to ‘merge’, to meet the requirements of patients in other fields [non-RHFP ones]” [#7, Head of the DOH project manager unit]

To attain the same level of quality of as the “Sisterhood” consulting rooms, non-RHFP health workers in other rooms had to change. This change or more precisely, an improvement, helped avoid ruptures between the franchised room and other non-franchised ones. The improvement also depended on the dominant role of clients who could be viewed as “referees” in this context.

In some stations, the “Sisterhood” consulting room was also used for non-RHFP consultancy. One informant we interviewed asserted the following:

“Since the consulting room was established, they [several franchised stations] have gathered other fields [non-RHFP ones] in this room. That was voluntarily

done by some commune health stations. We didn't force them to do that.” [#9, DHC project coordinator]

This is a very interesting example of non-RHFP fields' improvements in franchised CHSs: they added counselling which had not existed before to their services. However, because of the limited area of the CHSs, they had to take advantage of the "Sisterhood" consulting rooms.

Sisterhood, according to our informants, understood what its clients really needed. Therefore, counselling and other services were gathered together to attract more clients, as one informant described:

“Unlike big cities where you have to pay for counselling and it's very important but people in rural areas don't need to be counselled. Inviting them to come for counselling, maybe they won't come; but come for antenatal checkup, for gynecological examination, they will come and counselling is a supplement (before receiving services). That's better.” [#2, DOH project coordinator]

In this context, the Sisterhood model really understood Vietnamese cultural characteristics, especially in rural areas. Therefore, the program had very suitable solutions to attract local customers.

Know how to organize tasks in a sequential way was just one of the effects of the rooms on their CHSs. In fact, manner of non-RHFP health workers also changed (three occurrences). In addition, an important activity of the “Sisterhood” consulting room was

counselling and it also brought several changes in other rooms. In a more concrete way, the consultancy influenced a wider area, outside the room. It “spread” to other rooms and activities of CHS and the health workers of not only the “Sisterhood” room but also non-RHFP rooms could counsel clients. One informant observed that:

“Clients can be counselled on their health; before, mainly on their health, reproductive health; currently, besides reproductive health, other services also provide counselling service.” [#3, Director of the Dai Tu DHC]

Compared to health workers before Sisterhood’s establishment who had not been good at counselling (cf. 2.3.1. *The public health system in Vietnam*), all health workers of franchised CHSs could counsel. Therefore, they felt more confident. Some informants told us that:

“I feel more confident. Before, if someone demanded counselling from us, for sure we wouldn’t do well. Now not only me but the whole commune health station, everybody can counsel.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

“Regarding changes, I feel more confident ... I ... I have helped people in remote and rural areas access [the services] and be more knowledgeable. I feel very happy and excited (...) Now, I know them, I can go to their homes. Once I came to a family, they felt very excited and I was happy too.” [#15, Brand ambassador of a commune in Yen Bai province]

Before, due to low level, health workers had always been anxious each time they had counselled customers and it had been one of the difficulties of Sisterhood at its first steps (cf. 2.3.1 *Initial difficulties of the Sisterhood program*). The program helped improve counselling skill of medical staff and made them love their job.

At a higher level, not only other rooms and services but also other programs (in non-reproductive sectors) of the Sisterhood station “imported” (from the “Sisterhood” room) counselling into their activities. One informant we interviewed described that:

“Of course, counselling [of the room] also spread to all other programs. For instance, we also provided counselling for vaccination program. Or doing all other activities, we also have consultancy.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

Besides positive changes in working procedure and counselling, our informants observed that because of the “Sisterhood” consulting rooms, clients had more “power” (cf. 1.2.2. *The “Sisterhood” consulting rooms*). Due to counselling, they could understand deeply the advantages/disadvantages of RHFP services. The clients were provided enough information to choose by themselves services that were suitable for them. The term “empowering clients” was mentioned:

“We will introduce to them each method, its advantages and side effects; so that they can choose the one which fits them then health workers will provide it. Health workers also give them professional instructions on which methods they can receive based on their health ... their own choice.” [#2, DOH project coordinator]

“... in franchised reproductive health and family planning sector, people have access to services and they are entitled to make decisions relating to services they choose. In English, there is a term called ‘empowering clients’.” [#1, Governmental social franchise program manager]

In Vietnam, patients who come to a medical facility often feel scared of doctors or health workers because of many reasons such as: they are worried about their health, do not have much information on medical services, do not know what are waiting for them and what they have to do, etc. In particular, in rural areas where local people have low educational level, sometimes a doctor can be considered a father/mother with great credibility.

Normally, the duty of doctors or health workers is to clearly explain the information relating to patients’ health and answer their questions so that patients can feel secure. Nevertheless, in reality, if a patient has some questions, doctors do not respond enthusiastically. This situation is very common in the public health sector in Vietnam and has been widely criticized in the media. Patients often do what the doctors tell them to do without understanding. Sometimes, patients choose a service due to a friend or an acquaintance’s advice.

According to our informants, the Sisterhood program and its consulting rooms helped clients understand CHSs’ RHFP services and gave them the freedom to choose suitable services. This situation was exactly the opposite of what had happened in CHSs before. One informant confirmed that:

“It is totally different from the old days, when people who came to state health facilities were called patient. And at that moment, their position ... they totally depended on doctors. The doctors said you had to get an IUD or contraceptive injection and then you had to do it. They did not understand the disadvantages of IUD insertion, how long birth control pills took effect, whether they were safe or not and ... how their side effects were. They didn’t have information. And... they also... couldn’t make decisions. They heard that their neighbors got IUD insertion or they were encouraged to get IUD insertion then they got IUD insertion. You see, they weren’t empowered.” [#1, Governmental social franchise program manager]

Due to counselling, customers’ position changed. One informant asserted as follows:

“Now, in reproductive health and family planning sector, they are completely counselled, they have access to adequate information and they themselves can choose services that are suitable for them. And they ... after that, they can have access to the services.” [#1, Governmental social franchise program manager]

It was believed that the “Sisterhood” consulting room had positive impact on other rooms/services of its CHS. One informant we interviewed confirmed that:

“I think ... for sure there are positive effects [of the consulting room] on other activities. Ummm ... as I said, the working methods [of the room] had impact on all other parts [of franchised station] in terms of working style, consultancy method, client approach method and especially ... service quality there [in the franchised

room] ... had impact on all other units or other sectors of commune health station.”

[#2, DOH project coordinator]

In this case, not only counselling but also other market-related elements of the “Sisterhood” consulting rooms spread to different parts of franchised stations. In addition, most informants observed that working methods they learnt from the “Sisterhood” consulting room were utilized to serve not only reproductive health clients but also other fields’ clients and beneficiaries were these clients. One informant asserted the following:

“Reproductive health and family planning services are mainly for women from 15 to 49 years old or man of reproductive age. But ... when they already have working method [of the consulting room] in terms of approaching clients, counselling before-during-after providing services and ... all activities relating to clients then for other client groups, they also ... use the same methods, not only this group of clients.” [#2, DOH project coordinator]

Once again, this is a voluntary activity of franchised CHSs (the program did not force them to do). The presence of the “Sisterhood” consulting rooms brought benefits to the medical staff of other rooms and non-RHFP activities inside CHSs, to other programs of franchised CHSs and to other non-RHFP clients.

Some informants observed that clients felt secure and trusted the Sisterhood CHSs’ service quality. Therefore, public confidence was restored. One informant, for instance, said:

“Before, they [clients] didn’t trust the commune health station [of their commune] then they could go to other health facilities at higher levels even the station could provide services they needed. But now, they trust the program, with hospitable reception and qualified services, and they come to the station, no need to go to higher levels.” [#8, Project official of MSIVN]

“Now, all of these processes are done ... very correctly. From ... infection control stage to ... service providing stage, to the end of the service, clients leave and they all feel comfortable, and they feel secure about services.” [#2, DOH project coordinator]

The consulting rooms (and the program in general) changed the reputation of CHSs (as a whole). It was clear that when non-RHFP rooms and activities were significantly improved, they could share a common point with the “Sisterhood” rooms: a high quality of services. That avoided all ruptures inside franchised CHSs and pleased clients.

Obviously, these changes were due to the consulting rooms and the Sisterhood program. In addition, the fact that health workers themselves tried to deserve the brand by changing their habits also led to these changes. One informant told us that:

“Giving them the brand makes them ... understand that they have to try their best to ... deserve the slogan, the logo. And they have to maintain the brand to make differences from other stations.” [#18, Governmental social franchise program manager]

We have mentioned for several times in this thesis this issue (cf. 2.3.1. *Initial difficulties of the Sisterhood program*). Being familiar with an unprofessional and passive working style and often neglecting necessary responsibility seem to be a common point of medical staff in CHSs. The presence of the program and in particular the “Sisterhood” consulting rooms lent a fresh perspective to medical staff: they took their responsibilities as franchised CHSs’ health workers very seriously.

During the process of adopting Sisterhood in CHSs, in this phase, the consulting rooms positively modified the CHSs. Work organization changes in the CHSs were significant (1) a new step by step working procedure, (2) all health workers could counsel with confidence and (3) clients were empowered. The tensions between the “Sisterhood” consulting rooms and other rooms of CHSs were rapidly resolved by improving the quality of these non-RHFP rooms and the presence of clients (a common goal of these rooms was to satisfy their clients). In addition, public confidence and the responsibility of medical staff were restored.

7. The consulting rooms' effects on their CHSs

R. New working procedure

R1. "The first goal, the clearest goal [of the program and of the 'Sisterhood' consulting rooms], I think, is to make us understand that before doing professional activities, we have to counsel patients well." [#4, "Sisterhood" room consultant of the Cu Van CHS]

R2. "Since the 'Sisterhood' consulting room was there, my job has had many differences which have brought a lot of advantages for me. By example, from counselling step to doing professional activities step, I find that there are steps which I can't skip anymore [before, she often skipped some steps], I have to do step by step, and it becomes a habit." [#6, "Sisterhood" room consultant of the Tan Huong CHS]

R3. "Yes, significant impact [of the 'Sisterhood' consulting room]. Because ... it [the station] has to follow a procedure, services need to be done through steps. Other parts [of the commune health station] which have not been franchised yet must follow this standard procedure. And clients, they also have their comparisons and higher requirements because they are counselled." [#3, Director of the Dai Tu DHC]

R4. "They [clients] wonder why in other rooms they are not cared like in the room [the 'Sisterhood' consulting room]." [#7, Head of the DOH project manager unit]

R5. "People of the community also wonder why in the same station there are two types of manner [of health workers from the 'Sisterhood' consulting room and other rooms] then health workers are obliged to 'merge', to meet the requirements of patients in other fields [non-RHFP ones]" [#7, Head of the DOH project manager unit]

R6. "Since the consulting room was established, they [several franchised stations] have gathered other fields [non-RHFP ones] in this room. That was voluntarily done by some commune health stations. We didn't force them to do that." [#9, DHC project coordinator]

R7. "Unlike big cities where you have to pay for counselling and it's very important but people in rural areas don't need to be counselled. Inviting them to come for counselling, maybe they won't come; but come for antenatal checkup, for

gynecological examination, they will come and counselling is a supplement (before receiving services). That's better." [#2, DOH project coordinator]

S. Improvements of counselling

S1. Manner changes of non-RHFP health workers (3)

S2. "Clients can be counselled on their health; before, mainly on their health, reproductive health; currently, besides reproductive health, other services also provide counselling service." [#3, Director of the Dai Tu DHC]

S3. "I feel more confident. Before, if someone demanded counselling from us, for sure we wouldn't do well. Now not only me but the whole commune health station, everybody can counsel." [#4, "Sisterhood" room consultant of the Cu Van CHS]

S4. "Regarding changes, I feel more confident ... I ... I has helped people in remote and rural areas access [the services] and be more knowledgeable. I feel very happy and excited (...) Now, I know them, I can go to their homes. Once I came to a family, they felt very excited and I was happy too." [#15, Brand ambassador of a commune in Yen Bai province]

S5. "Of course, counselling [of the room] also spread to all other programs. For instance, we also provided counselling for vaccination program. Or doing all other activities, we also have consultancy." [#4, "Sisterhood" room consultant of the Cu Van CHS]

T. Empowering clients

T1. "We will introduce to them each method, its advantages and side effects; so that they can choose the one which fits them then health workers will provide it. Health workers also give them professional instructions on which methods they can receive based on their health ... their own choice." [#2, DOH project coordinator]

T2. "... in franchised reproductive health and family planning sector, people have access to services and they are entitled to make decisions relating to services they choose. In English, there is a term called 'empowering clients'." [#1, Governmental social franchise program manager]

T3. "It is totally different from the old days, when people who came to state health facilities were called patient. And at that moment, their position ... they totally depended on doctors. The doctors said you had to get an IUD or contraceptive

injection and then you had to do it. They did not understand the disadvantages of IUD insertion, how long birth control pills took effect, whether they were safe or not and ... how their side effects were. They didn't have information. And... they also... couldn't make decisions. They heard that their neighbors got IUD insertion or they were encouraged to get IUD insertion then they got IUD insertion. You see, they weren't empowered." [#1, Governmental social franchise program manager]

T4. "Now, in reproductive health and family planning sector, they are completely counselled, they have access to adequate information and they themselves can choose services that are suitable for them. And they ... after that, they can have access to the services." [#1, Governmental social franchise program manager]

U. Restoring public confidence and medical staff responsibility

U1. "I think ... for sure there are positive effects [of the consulting room] on other activities. Ummm ... as I said, the working methods [of the room] had impact on all other parts [of franchised station] in terms of working style, consultancy method, client approach method and especially ... service quality there [in the franchised room] ... had impact on all other units or other sectors of commune health station." [#2, DOH project coordinator]

U2. "Reproductive health and family planning services are mainly for women from 15 to 49 years old or man of reproductive age. But ... when they already have working method [of the consulting room] in terms of approaching clients, counselling before-during-after providing services and ... all activities relating to clients then for other client groups, they also ... use the same methods, not only this group of clients." [#2, DOH project coordinator]

U3. "Before, they [clients] didn't trust the commune health station [of their commune] then they could go to other health facilities at higher levels even the station could provide services they needed. But now, they trust the program, with hospitable reception and qualified services, and they come to the station, no need to go to higher levels." [#8, Project official of MSIVN]

U4. "Now, all of these processes are done ... very correctly. From ... infection control stage to ... service providing stage, to the end of the service, clients leave and they all feel comfortable, and they feel secure about services." [#2, DOH project coordinator]

U5. "Giving them the brand makes them ... understand that they have to try their best to ... deserve the slogan, the logo. And they have to maintain the brand to make differences from other stations." [#18, Governmental social franchise program manager]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

2.4.4. Franchised CHSs' effects on other non-franchised ones

The positive effects of the Sisterhood model were not limited to the "Sisterhood" consulting rooms and various positive changes within franchised CHSs but also expanded to non-franchised CHSs nearby, beyond the scope of franchised CHSs.

Our informants mentioned the reputation of the program as well as its consulting rooms, various influences on the clients of non-franchised CHSs and a kind of competition among franchised and non-franchised CHSs.

Regarding the Sisterhood program and the consulting rooms' reputation, one of the reasons why health workers tried their best to deserve the brand (cf. 2.4.3. *The consulting rooms' effects on their CHSs*) was that they perceived having the brand to be an honor. One informant confirmed that:

"As for stations which have this brand, it's very honored ... because not all communes can get the brand." [#16, Brand ambassador of a commune in Yen Bai province]

After a slight hesitation at the beginning (cf. 2.3.1. *Initial difficulties of the Sisterhood program*) and several tensions inside franchised CHSs, the program successfully convinced them. They viewed it as a special recognition.

Moreover, since the program was established, the reputation of the program, the franchised CHSs and the consulting rooms has increased. Some of our informants observed that:

“Asking people about the Sisterhood model, especially women from 15 to 49 years old, then ... I can confidently confirm that they all know about it (...) I think it’s a good point and people trust the quality of the commune health station [in their commune].” [#2, DOH project coordinator]

One informant reinforced as follows:

“Now they all know about the ‘Sisterhood’ consulting room. They come to the station [of the commune] and choose [without passing through the common room] to directly go to the ‘Sisterhood’ room for counselling.” [#5, Head of the Tan Huong CHS]

One informant provided another interesting example pertained to the reputation of the “Sisterhood” consulting room: in some CHSs, local people did not want the counsellor of the room to be transferred to upper-level health facilities within the public health system. These two examples showed the reputation of the room. They also added more details on a close relationship between counsellors and their clients (cf. 1.2.2. *The “Sisterhood” consulting room*).

Some clients who could go to higher-level health facilities, they went back to the Sisterhood CHSs because of the reputation of the stations and especially the consulting rooms. One informant we interviewed observed the following:

“Honestly, not because I’m working here, there were some patients who came to higher level hospitals then they came back here and said that only here they were

counselled. At the higher levels, doctors never talked to them.” [#4, Head of the Cu Van CHS]

Sometimes, the Sisterhood stations had some clients who were overseas Vietnamese:

“... they [overseas Vietnamese] said that the cost of IUD insertion in Canada was 500 CAD. When they came here [the franchised CHS], they found out that the station was very beautiful and clean and ... had a brand name. The price was ... so cheap and ... satisfied. Instead of paying 500 CAD for the hospital [in Canada], they gave it to the station for communication activities for women. There were many overseas Vietnamese who went back to Vietnam for IUD insertion [laughing].” [#1, Governmental social franchise program manager]

Indeed, the program accomplished a very hard task. They changed the public's perception that CHSs were low-quality health facilities. The reputation led to an increase in client volume in the Sisterhood CHSs and that was mentioned 27 times in our interviews. Some stations even had “loyal clients” (term used by some informants).

In reality, an unexpected impact of franchised CHSs was that clients from both their commune and other (non-franchised) communes were attracted by their quality. Due to communication activities and especially “word-of-mouth” marketing (eight occurrences), numerous people in other (non-franchised) communes knew about the program and came for the services of the Sisterhood station. Our informants described this situation as follows:

“I didn’t induce clients from non-franchised communes to go to this franchised commune. They talked to each other then came here because of the reputation of the brand and the station.” [#11, “Sisterhood” room consultant of the Luong Thinh CHS]

“... there were people in surrounding communes where there were also commune health stations but not the Sisterhood ones. The program wasn’t replicated to these communes yet. They came to the Sisterhood commune health station for services. The station serves not only people of its commune but other communes.” [#1, Governmental social franchise program manager]

Compared to the other phases of the process of adopting Sisterhood in CHSs, in this phase, we gained the most unexpected understanding. The fact that clients from non-franchised communes came to franchised commune for the reputed services of Sisterhood surprised us. MSIVN understands local people very well. However, in this case, perhaps they had neither predicted the “power” of Sisterhood’s reputation nor expected that word-of-mouth marketing was quite effective.

In this context, some non-franchised stations wondered with envy (six occurrences) why they were not franchised. That led to “healthy competition” (term used by numerous informants). Some informants explained this situation as follows:

“The Sisterhood brand is competition, but it is ‘healthy’ competition, among commune health stations [franchised-non-franchised stations] and private clinics [among franchised stations and private clinics].” [#5, Head of the Tan Huong CHS]

“I think it is healthy competition. Regarding non-Sisterhood commune health stations, if they still want to have clients, they have to do better.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

Franchised stations had industry- and market-related elements while non-franchised ones had family-related elements. Non-franchised stations also had typical characteristics of a health facility in the public health system of Vietnam. Between franchised and non-franchised stations, there was a “gap” in terms of service quality and that led to the “competition” our informants mentioned.

Similar to the case of the “Sisterhood” consulting rooms and the rest of franchised CHSs (cf. 2.4.3. *The consulting rooms’ effects on their CHSs*), due to the dominant presence of clients, non-franchised stations had to do better so that they could have a common point with franchised ones and both of them needed to satisfy the clients.

To reach the same level of quality with the Sisterhood stations, non-franchised stations had many solutions. Some informants mentioned the fact that several non-franchised stations wanted to be trained as franchised ones. In this case, local health used local resources to help them meet the standards of the Sisterhood stations. One informant noted that:

“... some commune health stations which couldn’t have the franchised model, they also asked for training in reproductive health for its medical staff ... They strived a lot and they asked for training without the privileges of official trainees.” [#13, Provincial master trainer of Vinh Long province]

A similar situation could be observed in the self-expansion phase of the program. Some non-franchised stations wanted to participate in the model voluntarily. One informant described that:

“At the 2nd phase [self-expansion phase], there were some communes, they found out that the program was good, they asked to participate in the model voluntarily although there would be less equipment, less training [than before, when MSIVN had still been there]. They still wanted to ... participate in, to increase the client volume and the reputation of the station.” [#5, Head of the Tan Huong CHS]

At the beginning, the model encountered numerous “obstacles” and many people thought that when they joined this model, they would have “something” (cf. 2.3.1. *Initial difficulties of the Sisterhood program*). However, in this phase, CHSs asked for training or participating in the model voluntarily. They did not care about their interests. Indeed, there was a significant change in perception of non-franchised CHSs.

Sometimes, franchised CHSs had influences on non-franchised ones in a very interesting way. Some informants viewed it as the difficulties of the establishment of the Sisterhood model but we considered its original impact of the model. One informant described that:

“When the network was established and started to work well, there was another difficulty: health worker transfer within the state health system. That meant there were some commune health stations which were working very well. Station head, he/she understood what franchising was. He/she changed the way his/her team

worked. When everything was working well, this head was transferred to another unit.” [#1, Governmental social franchise program manager]

“There was a “gap” between old and new staff. He/she him/herself felt sad. But gradually he/she had to apply what he/she had learnt from the model to the new place.” [#1, Governmental social franchise program manager]

In this case, “the new place” (a non-franchise station) had a new head and he/she played two roles, a provincial master trainer and a brand ambassador. Numerous positive elements of the Sisterhood model were applied to this station.

To sum up, in this phase, there were major changes in work organization within franchised CHSs as well as in the perceptions of the medical staff of these CHSs. That resulted in an increased number of clients and the reputation of the program was enhanced. Both RHFP and non-RHFP clients were beneficiaries in this context.

Non-franchise stations also tried to change the way they organized their work to improve their service quality. At the same time, their perception of the model has also been improved. Therefore, clients from both franchised and non-franchised communes were beneficiaries.

During the process of adopting the Sisterhood model in CHSs, clients played a very important role (as “referees”). In general, all tensions among franchised and non-franchised units needed to be resolved and finally clients were satisfied.

8. Franchised CHSS' effects on other non-franchised ones

V. Reputation of the program and its consulting rooms

V1. "As for stations which have this brand, it's very honored ... because not all communes can get the brand." [#16, Brand ambassador of a commune in Yen Bai province]

V2. "Asking people about the Sisterhood model, especially women from 15 to 49 years old, then ... I can confidently confirm that they all know about it (...) I think it's a good point and people trust the quality of the commune health station [in their commune]." [#2, DOH project coordinator]

V3. "Now they all know about the 'Sisterhood' consulting room. They come to the station [of the commune] and choose [without passing through the common room] to directly go to the 'Sisterhood' room for counselling." [#5, Head of the Tan Huong CHS]

V4. Counsellor of the room were transferred to higher levels

V5. "Honestly, not because I'm working here, there were some patients who came to higher level hospitals then they came back here and said that only here they were counselled. At the higher levels, doctors never talked to them." [#4, Head of the Cu Van CHS]

V6. "... they [overseas Vietnamese] said that the cost of IUD insertion in Canada was 500 CAD. When they came here [the franchised CHS], they found out that the station was very beautiful and clean and ... had a brand name. The price was ... so cheap and ... satisfied. Instead of paying 500 CAD for the hospital [in Canada], they gave it to the station for communication activities for women. There were many overseas Vietnamese who went back to Vietnam for IUD insertion [laughing]." [#1, Governmental social franchise program manager]

V7. An increase in client volume (27), loyal clients

W. Impact on the clients of non-franchised CHSS

W1. Word-of-mouth (8)

W2. "I didn't induce clients from non-franchised communes to go to this franchised commune. They talked to each other then came here because of the reputation of

the brand and the station.” [#11, “Sisterhood” room consultant of the Luong Think CHS]

W3. “... there were people in surrounding communes where there were also commune health stations but not the Sisterhood ones. The program wasn’t replicated to these communes yet. They came to the Sisterhood commune health station for services. The station serves not only people of its commune but other communes.” [#1, Governmental social franchise program manager]

X. “Healthy competition”

X1. Non-franchised CHSs wondered with envy (6)

X2. “The Sisterhood brand is competition, but it is ‘healthy’ competition, among commune health stations [franchised-non-franchised stations] and private clinics [among franchised stations and private clinics].” [#5, Head of the Tan Huong CHS]

X3. “I think it is healthy competition. Regarding non-Sisterhood commune health stations, if they still want to have clients, they have to do better.” [#4, “Sisterhood” room consultant of the Cu Van CHS]

X4. “... some commune health stations which couldn’t have the franchised model, they also asked for training in reproductive health for its medical staff ... They strived a lot and they asked for training without the privileges of official trainees.” [#13, Provincial master trainer of Vinh Long province]

X5. “At the 2nd phase [self-expansion phase], there were some communes, they found out that the program was good, they asked to participate in the model voluntarily although there would be less equipment, less training [than before, when MSIVN had still been there]. They still wanted to ... participate in, to increase the client volume and the reputation of the station.” [#5, Head of the Tan Huong CHS]

X6. “When the network was established and started to work well, there was another difficulty: health worker transfer within the state health system. That meant there were some commune health stations which were working very well. Station head, he/she understood what franchising was. He/she changed the way his/her team worked. When everything was working well, this head was transferred to another unit.” [#1, Governmental social franchise program manager]

X7. “There was a “gap” between old and new staff. He/she him/herself felt sad. But gradually he/she had to apply what he/she had learnt from the model to the new place.” [#1, Governmental social franchise program manager]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

2.5. Managerial model as a routine and a standard practice (discontinuance and routinization)

In these phases, the positive aspects of the model were confirmed. The stakeholders of Sisterhood decided to maintain the model for a long time. When MSIVN left, that was a crucial stage of this phase because the model was organized by local health systems and maintained by medical staff without any support of MSIVN.

2.5.1. Long-term development strategy

All of our informants described that Sisterhood was given a warm welcome from both local government, clients and medical staff of CHSs in acknowledgement of its contribution to the public health sector. Some informants asserted the following:

“Khanh Hoa and Da Nang are [two provinces from] the 1st phase. After the success of the program, assessed after three years in these two provinces, they found out that the program was very effective. It was welcomed by the local people and acknowledged by the local government and especially by the medical staff [of the commune].” [#2, DOH project coordinator]

However, a new problem arose, the program would end and MSIVN would leave. In Vietnam, this is a common situation of not only the Sisterhood program but also many other programs or projects in various fields. Firstly, the programs of NGOs have limited capital and cannot work for a long time. Secondly, to create equal development, after helping one area, they need to focus on other areas. Thirdly, Vietnam is gradually

becoming a middle-income country, therefore the programs like Sisterhood prefer to help low-income countries.

In this context, the program faced a common problem of many previous programs: continued to maintain the model or “went back to zero”. One informant we interviewed said that:

“If the program makes good progress, when it finishes then ... it will be a waste of effort. There are many projects in Vietnam, during the project, it’s very good, but when the project finishes, there isn’t any support, commitment, resource of local government. Then ... everything goes back to the beginning. In Vietnam, we view this situation as a duckweed pond. When you throw a stone into the pond, duckweed will be separated so you can see water and that will make differences. But after that the duckweed will gather together like before.” [#1, Governmental social franchise program manager]

This metaphorical image exactly described the situation of numerous NGOs’ programs in Vietnam. There is always a big “hole” between the beginning and the end of each program. According to our informants, the program needed a sustainable strategy. After MSIVN left, maintained and expanded (sometimes our informants used the term “replicated”) Sisterhood based on local resources were viewed as an appropriate solution. Several informants said that:

“... based on the success of the program then ... the department of health [of the province] continues to request (...) the Sisterhood commune health stations to maintain their activities.” [#2, DOH project coordinator]

“I have followed the programs/projects for years. Therefore, I wished that, because of the effort of many people, we could build an exit or sustainable strategy. And departments of health all accepted that they would maintain it. They all agreed to keep, maintain the model and would use the financial resources of the state to replicate the model in other communes.” [#1, Governmental social franchise program manager]

In this case, there was an agreement of MSIVN and local health systems. They all wanted to maintain the model because of its positive effects and the effort of many people. One more time, we observed that there was a significant change in the perception of people who had opposed the presence of the model before.

In fact, right from the initial steps of the model, MSIVN prepared a strategy for long-term development of Sisterhood. MSIVN played a role of a technical supporter and they established the model with the representatives of local health system (cf. 2.3.1. *Initial difficulties of the Sisterhood program*). The fact that the local health directly participated in the establishment of Sisterhood made them understand the advantages of the model and they can do the job without MSIVN's support. One informant we interviewed asserted the following:

“As an outsider, Marie Stopes does not want and never wants to go to a commune and do the job for the local health [of this commune]. Marie Stopes considers local health sector to be its partner. Partner means to coordinate with each other in every activity. Discussing, agreeing, having respect and equality between two parties and work together. Marie Stopes never does the job for them [local health] because we only stay here for a certain period (...) and when we leave, they must be able to operate what we supported them.” [#18, Governmental social franchise program manager]

Local health systems and MSIVN’s common goal was to expand the model by local resources and its quality rather than quantity that mattered the most. One informant asserted the following:

“... there were some stations suggested but we did not establish the model there because ... easy to establish but difficult to maintain. We cannot massively establish the model then lose the brand.” [#3, Director of the Dai Tu DHC]

In this phase, the stakeholders of Sisterhood could either understand what service quality was or put this concept into practice. Due to the understanding of service quality, they understood that what made Sisterhood’s reputation was its quality. Therefore, the expansion of Sisterhood needed to be accompanied by a high quality of services.

To sum up, there was a need for further development of the Sisterhood model and due to a careful preparation at the beginning of MSIVN, local health systems could expand the model by themselves, even when MSIVN left. In addition, instead of quantity (the

number of new franchised CHSs), the quality of the Sisterhood model was highly respected during the expanded phase. All of that constituted a long-term development strategy for the model.

Managerial model as a routine and a standard practice (discontinuance and routinization)

9. Long-term development strategy

Y. MSIVN's technical support and quality not quantity

Y1. "Khanh Hoa and Da Nang are [two provinces from] the 1st phase. After the success of the program, assessed after three years in these two provinces, they found out that the program was very effective. It was welcomed by the local people and acknowledged by the local government and especially by the medical staff [of the commune]." [#2, DOH project coordinator]

Y2. "If the program makes good progress, when it finishes then ... it will be a waste of effort. There are many projects in Vietnam, during the project, it's very good, but when the project finishes, there isn't any support, commitment, resource of local government. Then ... everything goes back to the beginning. In Vietnam, we view this situation as a duckweed pond. When you throw a stone into the pond, duckweed will be separated so you can see water and that will make differences. But after that the duckweed will gather together like before." [#1, Governmental social franchise program manager]

Y3. "... based on the success of the program then ... the department of health [of the province] continues to request (...) the Sisterhood commune health stations to maintain their activities." [#2, DOH project coordinator]

Y4. "I have followed the programs/projects for years. Therefore, I wished that, because of the effort of many people, we could build an exit or sustainable strategy. And departments of health all accepted that they would maintain it. They all agreed to keep, maintain the model and would use the financial resources of the state to replicate the model in other communes." [#1, Governmental social franchise program manager]

Y5. "As an outsider, Marie Stopes does not want and never wants to go to a commune and do the job for the local health [of this commune]. Marie Stopes considers local health sector to be its partner. Partner means to coordinate with each other in every activity. Discussing, agreeing, having respect and equality between two parties and work together. Marie Stopes never does the job for them [local health] because we only stay here for a certain period (...) and when we

leave, they must be able to operate what we supported them.” [#18, Governmental social franchise program manager]

Y6. “... there were some stations suggested but we did not establish the model there because ... easy to establish but difficult to maintain. We cannot massively establish the model then lose the brand.” [#3, Director of the Dai Tu DHC]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

2.5.2. Situation and medical staff of franchised CHSs after MSIVN left

The stage when MSIVN left was important because during this stage, the viability of the Sisterhood model was challenged. Without the presence of MSIVN, a co-franchisor of the model, how did franchised CHSs and their medical staff work?

According to our informants, the brand, the consulting room and many other elements of the Sisterhood model were still maintained after MSIVN left. One informant we interviewed confirmed that:

“Although the program left but the Sisterhood brand still exists and the medical staff still maintain their working style as before.” [#3, Director of the Dai Tu DHC]

We paid special attention to the fact that the activities of brand ambassadors and provincial master trainers were still maintained. Regarding brand ambassadors, our informants mentioned their activities after MSIVN left 13 times. Before Sisterhood, almost all of them were village health workers. The model came, improved their skills and they had to do more tasks (of both village health workers and brand ambassadors). When MSIVN left, the differences were minor to them. However, their ability changed, and they could surely do better. Brand ambassadors were important to both Sisterhood and local people. They could help expanded CHSs avoid criticisms from local people.

Regarding provincial master trainers, during the process of adopting Sisterhood in CHSs, they were very active members of the program. When MSIVN left, these trainers were mobilized to train expanded CHSs. One informant asserted the following:

“... when the program ends and if provincial departments of health want to replicate the model by themselves then these provincial master trainers who are also health officials of these departments will still be there. Based on the knowledge and the expertise from the training courses of the program, they will train other communes of the province [expanded CHSs] (...) Therefore the province always has a ‘core force’.” [#18, Governmental social franchise program manager]

The one-time training and repeated use of provincial master trainers helped expand the “heritage” of the Sisterhood model even when MSIVN left. In addition, provincial master trainers were important to both Sisterhood and CHSs therefore their presence could avoid criticisms from CHSs during expanded phase.

In addition, MSIVN still kept in touch with their local partners. Some informants asserted the following:

“We have still supported the provinces [of the program] technically since the program ended. If they need consultancy when they maintain and replicate the model ... they still contact, and contact me directly. Then we still ... tell them how to do.” [#1, Governmental social franchise program manager]

From the initial phases of the process of adopting Sisterhood in CHSs until these phases, MSIVN always played the role of a technical supporter. At the beginning, MSIVN’s support was to ensure the autonomy of local health system after MSIVN left while at these phases, they helped local health do better based on their experience.

10. Situation and medical staff of franchised CHSs after MSIVN left

Z. Maintaining principal activities

Z1. “Although the program left but the Sisterhood brand still exists and the medical staff still maintain their working style as before.” [#3, Director of the Dai Tu DHC]

Z2. Brand ambassadors’ activities (13)

Z3. “... when the program ends and if provincial departments of health want to replicate the model by themselves then these provincial master trainers who are also health officials of these departments will still be there. Based on the knowledge and the expertise from the training courses of the program, they will train other communes of the province [expanded CHSs] (...) Therefore the province always has a ‘core force’.” [#18, Governmental social franchise program manager]

Z4. “We have still supported the provinces [of the program] technically since the program ended. If they need consultancy when they maintain and replicate the model ... they still contact, and contact me directly. Then we still ... tell them how to do.” [#1, Governmental social franchise program manager]

Table 18 – Representative supporting data for each 2nd-order theme of data structure 2 (continued)

Summary

The process of adopting/adapting Sisterhood was studied through five big phases: organizational issues identification, managerial model selection, staff persuasion, model implementation and managerial model as a routine and a standard practice.

In this subchapter, several predicted tensions were approved. In “organizational issues identification”, our informants described the bad condition of infrastructure and service quality in CHSs before Sisterhood establishment. Regarding “managerial model selection”, we understood the selection processes of the Sisterhood program, in particular how to choose a CHS for the program. As for “staff persuasion”, our informants described the difficulties of making local leaders understand Sisterhood as well as the hesitation of several stakeholders at the beginning. Approaching local people and some CHSs as well as the presence of another social franchising brand (The Little Sun) were also viewed as initial difficulties of Sisterhood adoption process.

The heart of the process is “model implementation”. Our informants confirmed that there were significant changes in both non-clinical and clinical activities of franchised CHSs. The informants paid attention to the “Sisterhood” consulting rooms’ effects on their CHSs. These effects were: a new working procedure, counselling improvements, empowering clients and restoring public confidence and medical staff responsibility. “Healthy competition” between franchised and non-franchised stations were confirmed: numerous clients from non-franchised communes went to franchised ones because of the Sisterhood CHS and its consulting room.

In the last phase, “managerial model as a routine and a standard practice”, a long-term development strategy for Sisterhood was repeated several times. Our informants also talked about the situation and medical staff of franchised CHSs after MSIVN left.

CHAPTER 6: DISCUSSION

The findings told us a very interesting story, sometimes with unexpected understanding, of the adoption process of Sisterhood in CHSs. As we predicted, the innovative characteristics of the Sisterhood model improved numerous aspects of CHSs. They were also the cause of several tensions during the adoption process of this model in CHSs. Therefore, it can be said that Sisterhood has the characteristics of a management innovation and its adoption process is the process of adopting a management innovation in CHSs.

In the first subchapter, we analyze the main elements of Sisterhood adoption which make it become an original process. Afterwards, nine phases of this process are analyzed, but not in a descriptive way. We focus on numerous tensions during these phases.

The second subchapter proposes a different look on the process of adopting Sisterhood based on the “economies of worth” theory. Several main elements of this theory are introduced (worlds, criticisms and compromises). We also explain why this theory is mobilized for the thesis.

The third subchapter is the center of this chapter and this thesis. Based on “economies of worth”, we find numerous signs of different worlds within CHSs before Sisterhood and the Sisterhood program. Afterwards, the process of adopting Sisterhood in CHSs is analyzed in a different perspective (“economies of worth”). That not only extends our knowledge on the process of adopting a management innovation in an organization

(beyond the scope of management innovation literature) but also furthers the applicability of the “economies of worth” theory.

Finally, yet importantly, we provide some extended thought at the end of this chapter. Based on that several ideas are verified.

1. Sisterhood adoption – an original process

The process of adopting Sisterhood in CHSs can be viewed as an original process due to three elements: (1) the innovation-generating organization (IGO), (2) the innovation-adopting organization (IAO) and (3) the management innovation.

As mentioned in *3.1. Innovation as a process*, a new product, service or technology is an IGO’s desired outcome. Therefore, MSIVN cannot be viewed as an ordinary IGO because it did not generate any innovations. In reality, MSIVN has used an existing concept (social franchising) and applied it in many low- and middle-income countries.

As for the IAO, in this case, it is a network of medical facilities, not a single organization. Regarding the management innovation, unlike other ones, this one (Sisterhood) aimed at social goals rather than commercial goals.

Furthermore, the IAO did not find the Sisterhood model on the market or from IGOs, conversely, it was found by the IGO (in collaboration with DOHs and DHCs). Furthermore, the management innovation did not appear in a purchase where it was sold by one organization and another one bought it. It was a support of the IGO to the IAO.

Indeed, compared to the characteristics of an IGO and an IAO introduced by Damanpour and Wischnevsky (2006), MSIVN and Vietnamese CHSs have original characteristics. Moreover, the Sisterhood model's social goals are also paid special attention. Therefore, we view the process of adopting Sisterhood in selected Vietnamese CHSs as an original process.

This process consisted of nine phases in which there were always tensions between both sides. These phases can be viewed as an adaptation of Rasmussen and Hall (2016)'s management innovation adoption process.

Agenda-setting:

Before the establishment of the Sisterhood program, CHSs had numerous issues, in particular the problems pertained to their quality of services. That led to many criticisms from clients. CHSs' services did not satisfy them therefore they went to upper-level health facilities. MSIVN deeply understood these problems due to a long period of time they worked in RHFP sector in Vietnam.

At that moment, there were not any solutions of the government while MSIVN had already applied social franchising model in many low- and middle-income countries successfully. However, the innovative characteristics of Sisterhood predicted potential ruptures for work organization inside CHSs when they adopted this model.

Knowledge/research and selection/matching:

AP chose Sisterhood and its governmental social franchising project. They also fixed a list of provinces. Between AP and MSIVN, real discord did not exist. Based on AP's financial aid, MSIVN and local representatives selected districts and communes (CHSs) in the pre-selected provinces for the program.

Sisterhood overcame several cultural obstacles and prejudices about a management model with foreign elements. In addition, a set of criteria was established for suitable CHSs selection. This set, established by both MSIVN and local health, facilitated the process of adopting Sisterhood in CHSs.

Persuasion/validation:

MSIVN had to explain the model to different management levels of local health systems and persuade them to establish the model. From a family- and collectivity-related perspective, some leaders of local health system could not understand Sisterhood's industry- and market-related elements. Therefore, their initial criticisms, as mentioned in *2.3.1. Initial difficulties of the Sisterhood program*, were quite strong. The collaboration between MSIVN and these local leaders was finally established, and the program was built in suitable CHSs.

In this phase, the program sometimes changed itself to avoid potential ruptures. The criticisms also came from CHSs' health workers with similar reasons. We also observed local people's resistance.

The presence of The Little Sun, another social franchise in the public health sector in Vietnam, led to some common consulting rooms inside CHSs for both Sisterhood and The Little Sun (co-branding). These rooms could be viewed as innovative objects that pleased all sides.

Modification, operationalization and clarification/confirmation:

During these phases, there were numerous changes from both sides:

-Sisterhood's expected influences: changes in non-clinical and clinical activities of medical staff. All health workers were trained in non-clinical activities to avoid potential tensions inside CHSs (due to quality gap of medical staff). Changes in terms of health workers' perception were quite important and that led to their manner changes. The model was adapted several times to fit CHSs' organizational and cultural context. In addition, many positive elements of Sisterhood became a habit in CHSs.

Provincial master trainers and brand ambassadors could be viewed as “bridges” linking Sisterhood-CHSs and Sisterhood-clients respectively. Therefore, several barriers (especially cultural ones) were removed.

Among three main activities of Sisterhood (communication, training and supervision), supervision seemed to be opposed the most. However, this activity ended up avoiding criticisms from medical staff and being their need. Therefore, the adoption process of Sisterhood was facilitated.

-Sisterhood's unpredicted influences: inside franchised CHSs, the consulting rooms had a good influence on other rooms and activities of the CHSs. Even non-RHFP programs were impacted. The tensions among franchised and non-franchised rooms/activities in these CHSs rapidly became an improvement in quality of non-franchised ones. Therefore, the quality of the whole CHSs increased and that led to a high reputation for them. Similar situation appeared among franchised CHSs and other non-franchised ones, which tried to attain the same level of quality with the Sisterhood stations ("healthy competition").

During this process, clients played a very important role. Non-franchised parts (inside and outside CHSs) improved themselves to meet the standards of franchised ones and finally all of them, franchised and non-franchised parts, had a common purpose: satisfied their clients. Therefore, beneficiaries after numerous tensions were clients.

-Perception changes of clients and medical staff: during these phases, we observed significant changes in the perception of franchised and non-franchised CHSs' medical staff as well as clients from franchised and non-franchised communes.

Regarding franchised CHSs' medical staff, franchised health workers gradually understood the importance of working procedure, counselling, empowering clients and became exemplars for non-franchised ones. These non-franchised health workers also changed their perception and tried to work as well as the franchised ones. Regarding medical staff in non-franchised stations, because of the reputation of the Sisterhood stations, they finally changed their perception of service quality.

As for clients in franchised communes, they trusted the quality of the Sisterhood stations (restoring public confidence). They also perceived their important position and requested a high quality of services in both RHFP and non-RHFP sectors in franchised CHSs. As for clients in non-franchised communes, they noticed the novelty of franchised CHSs and all came there. This situation can only prove the “power” of communication activities and especially “word-of-mouth” marketing. However, over time, we believe that the perception of customers in non-franchised communes will also change.

Discontinuance and routinization

The moment when MSIVN had to leave, local health decided to maintain and expand the model by local resources. MSIVN strengthened the autonomy of local health during the process of adopting Sisterhood. Therefore, they could expand the model without the presence of MSIVN. In addition, due to the knowledge of service quality, they paid special attention to the quality of expanded CHSs.

In addition, the activities of brand ambassadors and provincial master trainers were maintained and that helped avoid any potential criticisms during expanded phase (from local people and CHSs respectively).

2. A different look based on “economies of worth”

During the process of adopting Sisterhood in CHSs, the tensions between both sides could be viewed as the confrontation of justifications between individuals. To resolve

these issues, each individual had to justify their actions. We believe that this adoption process can relate to the knowledge outside management innovation studies.

As we briefly proposed in the introduction of this thesis, the “economies of worth” theory (Boltanski & Thévenot, 2006) could discover insights into a management innovation adoption process, in a different way. Indeed, by being described through “worlds” (a concept of the theory), management innovation, its adopting organization as well as the adoption process of this innovation can be analyzed in a deeper way, beyond the border of innovation literature.

On the other hand, in *1.5. Social franchising from a theoretical point of view*, we suggested that it was necessary to find a theory to explain the agreements/disagreements in the agency relationship which is out of the border of the agency theory. In this situation, “economies of worth” can be an appropriate solution.

2.1. Why “economies of worth”?

“Economies of worth” is based on French (or Western) thought. However, we believe that this theory can be mobilized in the context of Vietnam. In fact, the characteristics of Vietnamese context had several influences on our choice.

Historically, after the fall of the Berlin Wall, West Germany transformed the centrally planned economy of East Germany into a market economy and the political institutions of East Germany were also changed. Regarding to China, it has maintained for a long

time “one country, two systems”, where mainland China uses the socialism with Chinese characteristics system while Macau and Hong Kong are under the capitalist regime.

Vietnam follows its own path: after the unification in 1975, the government of North Vietnam transformed the market economy in South Vietnam into a centrally planned economy. Afterwards, in 1986 the whole country was transformed, one more time, to a market economy (“Đổi Mới”, please see 2.2.3. *Vietnam and its renovation period*). There were early predictions of the “failure” of central planning. However, due to ideological differences, the impatience in following the path of communism, the adoption of the economic models from other socialist countries in a mechanical way, these predictions were neglected.

Indeed, there were significant changes of both capitalism and ideology in Vietnam and it was necessary to have a tool to analyze these changes. Once we deeply understand the context of Vietnam, to shed light on the process of adopting a management innovation into this context can be easier.

That is also the purpose of Boltanski and Chiapello (2007). The authors studied the relations between capitalism and its criticisms and based on that, they explored ideological changes over recent decades. They call “the ideology that justifies engagement in capitalism ‘spirit of capitalism’” (Boltanski & Chiapello, 2007, p.8).

Boltanski and Chiapello (2007, p.10) focused on “capitalism’s need to furnish individual reasons” as well as “justifications” which consisted of individual and general justifications.

According to them, the question of justifications help clarify how developing and former socialist countries are converted to capitalism.

Vietnam's development model can be considered "successful" in terms of changing economic model without changing political system. However, many components of Vietnam's old economic model still exist today, in all fields and the public health is no exception. It is still early to say that Vietnam is being transformed into capitalism. However, we believe that studying capitalism and ideological changes in Vietnam is quite necessary for this thesis because since 1986, many market and industrial components have been introduced into Vietnam. In this context, NGOs played an important role. They presented numerous occidental management models to this country (MSIVN and Sisterhood, for instance).

According to Boltanski and Thévenot (2006) and Nachi (2015), in different social situations such as controversies, disputes, criticisms, denunciations, etc. the actors try to justify their point of view through argumentation and they hope that this register of justifications can be accepted by others. Capitalism is no exception to this rule and according to Boltanski and Chiapello (2007, p.22), the spirit of capitalism needs to focus on "a kind of very general convention directed towards a common good, and claiming universal validity".

The registers of justifications are multiple. From classical works of political philosophy, Boltanski and Thévenot (2006) defined six of them. At metaphysical level, these registers take the form of generalities called *polities*, which can be applied to all types of social

situations. The model of polities is also “a kind of very general convention” mentioned above.

However, we cannot understand how to reach an agreement and how the attribution of states of worth to each individual manifests because the political philosophy and the polity model, which are still at the level of principles, do not focus on these questions. In addition, according to Boltanski and Thévenot (2006), it is necessary to study both of the conditions under which the principles of justice are established and the ones under which they are applied.

In this case, Boltanski and Thévenot (2006) proposed concentrating on actual practice and particular circumstances. Logically, the polity model should be expanded and focus on beings and objects in a specific reality. Furthermore, the authors ruled out the elements which could induce an informal or private arrangement where the principles of justice, according to them, would not be mobilized and we would not really find an acceptable solution to the problem, the quarrel would not be resolved.

At physical level, polities are materialized within the framework of *worlds*. In a simple way, polities pertain to the logic of justifications based on the conception of a common good while worlds relate to a pragmatic “application” of polities. In addition, polities are ideas, statements, discourses, etc. to which Boltanski and Thévenot added objects (materialization) and beings to constitute worlds. It is possible to say that worlds which correspond to concrete situations “materialize” the justifications of polities. According to Nachi (2015, p.128), “without worlds, polities would be superfluous abstractions”.

For these reasons, “economies of worth” can be viewed as an appropriate analysis tool to explore the relations between capitalism and its criticisms as well as ideological changes in the public health sector in Vietnam when a foreign management model with industry- and marketing-related elements is adopted into this context.

In a concrete way, if we only use the adoption process of Rasmussen and Hall (2016), what we can finally understand from the process of adopting Sisterhood is only the answers of the question “what did they do?”. Other questions such as “how and why did they do that?” (in “decision-making” moments in particular) cannot be discovered.

In addition, if there are several issues that arise during the process of adopting Sisterhood, we can only explain them through misfits between management innovation and organizational context or imperfect harmony between management innovation philosophy and organizational philosophy. The contribution of our study, in this case, seems to be “expected results”.

Based on “economies of worth”, we can have deeper understanding of this adoption process through insights into the IGO, the IAO and the management innovation itself. Furthermore, the “economies of worth” theory is not merely a tool for better understanding the process, but also for predicting the future steps in this process. Indeed, thanks to Boltanski and Thévenot and their “economies of worth”, we can anticipate potential conflicts that we can try to avoid or fix. Even when there are unforeseen conflicts (which can happen in reality), we can still control the situation based on our knowledge of worlds, criticisms and compromises.

We now introduce a new point of view, based on “economies of worth”, on the adoption process of Sisterhood in CHSs.

2.2. The “economies of worth” theory

2.2.1. Common worlds

In a framework where people expressed their agreement and sometimes disagreement (without violence), Boltanski and Thévenot (2006) wished to introduce a single set of theoretical instruments and methods with the purpose of shedding light on these situations. Therefore, besides the utility of exploring capitalism and ideological changes, “economies of worth” also pertains to the question of agreements and coordination between people, and the resolution (without violence) for disagreements.

Indeed, “economies of worth” focuses on people’s ability in adjusting to different social situations: “... in a differentiated society, each person regularly has to confront situations stemming from distinct worlds, has to recognize such situations and prove capable of adjusting to them” (Boltanski & Thévenot, 2006, p.216). In addition, the modes through which the agreements between actors can be produced and their actions are coordinated are also highlighted: equivalence, qualification, adjustment and justification modes (Nachi, 2015, p.20-21).

In “economies of worth”, there are six worlds; each corresponds to a particular register of justifications (Boltanski & Thévenot, 2006). In addition, in these worlds which are

considered to be “pure” and ideal forms, we can find a system of relations and situations (Amblard et al., 2005).

The inspired world: it is a world of artistic relationships with a special place for inspiration, passion, love and creation. In the inspired world, uniqueness and originality are appreciated: “the worthy are at once unique and universal” (Boltanski & Thévenot, 2006, p.160). Furthermore, in this world of numerous uncontrolled and mysterious aspects, changes of state are a habit of beings and we need to sacrifice forms of stabilization. Boltanski and Thévenot (2006, p.161) mentioned terms such as “break out of habits and routine”, “accept risks”, “reject habits, norms, sacrosanct principles”, “get rid of one’s old self” or “the unforeseen accidents of creation”. The inspired world is also a world where we can develop our imagination, escape from reality and follow an inner adventure or a voyage of the mind.

The domestic world: in this world, we can find principal elements of personal, familial, friendly or traditional relationships. The higher common principles in the domestic world are generation, tradition and hierarchy. In addition, regarding objects, contributing to determine the position of a person in a hierarchy and facilitating his/her identification (for instance, titles, clothing, etc.) are their most important function. Furthermore, how objects support and maintain hierarchical relationships is also quite essential. For this reason, in the domestic world we can see the exchange of flowers, gifts, candy, books, letters of thanks, greetings, wishes, recommendations, etc. According to Boltanski and Thévenot (2006), habits induce natural act of worthy and if habits can be incorporated in beings early, they will become natural behavior. However, a lack of inhibition should be avoided

(for instance, impolite, blunders, loudmouth, indiscreet, etc.) in order to not become “the most deficient beings” (Boltanski & Thévenot, 2006, p.176).

The world of fame: the higher common principle in this world is opinion of others or in general, the public. However, in this world, memory is a “problem” because one can be forgotten easily and there is a lack of other qualities or profession of beings in establishing equivalences. In the world of fame, distinguishing themselves, being visible, famous and recognized are important characters of worthy beings. Boltanski and Thévenot (2006) mentioned “self-love” and a common desire to be recognized or for respect of beings. In addition, an interesting example of “self-love” within an organization was mobilized: a group of people who work for an organization desire to explain their roles in the organization and to be respected. The organizational reputation and the reputation of beings are undetachable in this case. In the world of fame, being known can be made by having a name (for beings) or a brand name (for products) and communication can be viewed as an effective tool to diffuse fame to a large number of people (for instance, a campaign of some companies with the purpose of planting their image). However, one must reveal all secrets to be known (reaching the state of worthiness) and there are not any forms of “esotericism” in this world (Boltanski & Thévenot, 2006, p.181). The authors also confirmed that in the world of fame, people always make comparisons and the authors mentioned manipulation of ambiance, climate and atmosphere.

The civic world: in the civic world, there are not any places for particular or selfish interests because of pre-eminence of collective interests. All actors need to subordinate their own will to general will. They obtain worth by “sacrificing particular and immediate interests”

(Boltanski & Thévenot, 2006, p.190). Furthermore, in this world, we talk about a “collective action” rather than an “individual action”, a “public space” rather than a “private space” and people are encouraged to work for union, unification, common objectives, etc. (Boltanski & Thévenot, 2006, p.186). In addition, posters, informative signboards, newsletters, brochures, slogans, objectives, etc. or several official forms such as orders, decrees, rulings, etc. are mentioned in the civic world. Moreover, in the context of a state, we can find a typical form of the civic world.

The market world: in the market world, there are traditional elements of market, such as clients, competitors, buyers, sellers, businessmen, etc. Higher common principles in this world are rivalry and competitors and desires motivate individuals to possess the same objects. In addition, price is considered an evaluation of market worth and the authors mentioned worthy objects (saleable goods with strong position) and worthy people (rich ones with high life). Furthermore, object possession implies a hierarchical relation of people and when at least two individuals negotiate to purchase or sale an object (a good or a service) they are doing business. The form of evidence in the market world is money and “the profit, the benefit, the payback, the result of the transaction is thus expressed in cash, a commission, a fee, or an honorarium” (Boltanski & Thévenot, 2006, p.202).

The industrial world: in this world, technological objects and scientific methods possess important places. Regarding beings, efficiency, performance, productivity are necessary factors. Beings that are functional, operational or professional are worthy beings. Conversely, if beings are unproductive, inactive, unemployed, handicapped or inefficient, they are in a state of unworthiness. In the industrial world, there is a hierarchy of states

of worth marked by competencies and responsibilities and based on a scale of professional qualification of people (management, leaders, decision makers, supervisors, etc.). The objects in this world are “instruments, means, mobilized for an action that is presented as a task of production” (Boltanski & Thévenot, 2006, p.206) and progress is the “investment formula” (Boltanski & Thévenot, 2006, p.208). It is indeed imperative to avoid obsolescence in the industrial world therefore the authors proposed to focus on new development that needs time, money and efforts. When an “industrial arrangement” is implanted, it may possibly induce adaptations and redefinitions in the environment (Boltanski & Thévenot, 2006, p.209). In addition, organization of a system or a structure reflects industrial order harmony. In the industrial world, evaluation process is indispensable to organizational performance: to know whether everything works well.

Indeed, Boltanski and Thévenot (2006) described numerous principles, subjects, objects, etc. Several objects that help quickly identify a world can be summarized as follows:

The inspired world: mind, body, dream, unconscious, drug.

The domestic world: good manners, proper behavior, rank, title, dwelling, introduction, signature, announcements, gifts, flowers.

The world of fame: brand, message, sender, receiver, campaign, public relations, press, interview, bulletin, medium, brochure, mailing, badge, audiovisual, atmosphere, setting.

The civic world: rights, legislation, decree, order, measure, courts, formality, procedure, transcript, infringement, capacity (electoral), code, criterion, district, slate (of candidates),

program, policy, statement, poster, brochure, ballot, tract, slogan, seat, headquarters, local office, acronym, card.

The market world: luxury (item).

The industrial world: tool, resource, method, task, space, environment, axis, direction, dimension, criterion, definition, list, graph, chart, calendar, plan, goal, quantity, variable, series, average, probability, standard, factor, cause.

2.2.2. Criticisms and compromises

a. Criticisms

Worlds presented above correspond to ideal situations. In reality, complicated social situations can bring criticisms and therefore potential disagreements between worlds (Rémy & Cléret, 2014).

According to Amblard et al. (2005), there are three situations: (1) worlds with internal disagreements (the *contention*), (2) worlds without real discord and (3) worlds with conflicts among them (the *clash*).

Regarding the conflicts among worlds, we summarize principal elements in table 17 below. In this table, its lines and columns represent worlds. The intersection between a line and a column is the criticisms brought by the representative world of this line to the one of this column. Obviously, the intersection between a line and a column of the same world does not consist of any information.

	Inspired world	Domestic world	World of fame	Civic world	Market world	Industrial world
Inspired world		Stability, hierarchies, verbal precautions are criticized	Self-love, respect and external signs of success need to be eliminated	The most institutionalized forms, heavily instrumented and can be considered inhuman state, are paid attention	-The importance of money is refused -Creativity is not a commercial product	Industrial routines and a hierarchy of authority or competence are criticized
Domestic world	A lack of self-control or composure is targeted		Difference shown in public or attracting attention is not encouraged	Anonymity and collective are refused	-Money must be subordinated to merit -Not everything can be bought -Alienable goods are criticized	-Standardized products are considered low quality ones -The lack of professionalism of workers with diplomas -Ill-adapted formalism
World of fame	-Incompatible with an intimate conviction -Inspiration is criticized	-The opacity of personal relations -Domestic secrecy is refused -Any information via the hierarchy is suspicious			The risks of compromise to which publicity exposes the formation of opinion (public relations and marketing are different)	The esotericism of technicians or experts is criticized
Civic world	-Inspiration is viewed as impulsivity and as individualism	-Paternalism, authoritarianism, knowing one another in election	Public opinion in the world of fame has different meanings		The selfishness of owners and individualism are refused	Technocracy and the risks of bureaucratization are criticized

	-Ferment is criticized (considered a barrier to the unity of collective people)	proceedings are rejected -Denunciations of scandals is criticized -Local ties are suspected	compared to one in the civic world			
Market world	Emotional distance and self-control are necessary to access to the market	-Personal relationships and local attachments are not encouraged -Prejudices are defied	-The damaging effects of speculation should be avoided -Appearances and celebrity are criticized	-Collective actions are criticized -The intervention of justice is refused		-The rigidity of tools and methods are an obstacle -The technocrat is criticized
Industrial world	The wastefulness of improvisation is unacceptable	-What is old or traditional is rejected -The inefficiency of particularisms and the incompetence of an unworthy leader are denounced		The inefficiency of administrative procedures and the costs of a labor policy are criticized	-The conspicuous consumption of useless luxury products and unjustified prices are abandoned -Market fluctuations are criticized	

Table 19 – The critical matrix

Source: the author, based on the theoretical framework proposed by Boltanski and Thévenot (2006)

b. Compromises

When there is a disagreement of worlds, it can be resolved by setting a clarification in one world or a local arrangement/a compromise between worlds (Amblard et al., 2005). Regarding a clarification in one world, actors from different worlds have a disagreement because of opposing opinions or principles and if they still maintain their “standards”, the conflict will not be resolved. In this case, according to Amblard et al. (2005), actors from one world change their principles to adapt themselves to the situation.

We propose an example which can shed light on this situation: in a family where a father and a mother do not share the same view on how to teach their child. The father wants to teach his child in a traditional way and have a certain influence on the development of this child while the mother hopes that her child can live in a free environment where he can express his own opinion. In this case, the father applies the domestic world principles while the method of the mother is based on the civic world ones.

Over time, this conflict will grow quite rapidly if no one changes his/her view. However, observing the development of his child, the father realizes that allowing him to freely develop and express his thoughts in a democratic manner, of course within certain limits, is an effective way. The father gradually changes the way he teaches his child: the domestic world changes to fit the situation. The contradiction in teaching the child based on the principles of two different worlds disappears.

We can also set a plan for how things will happen (an *arrangement*) or reducing/changing actors' demands so that all of them can find a common good (a *compromise*). An arrangement is a situation where each actor stays in his/her world and locally reaches an agreement on a transaction (that can be considered a bargain of actors) (Amblard et al., 2005). According to Amblard et al. (2005), an arrangement is temporary and impossible to generalize while a compromise (a common good) is quite sustainable.

For instance, the representatives of both trade union and employers agree on some additional working hours to complete their project schedule can be viewed as an arrangement between the civic and the industrial world. While standard working hours which are regulated in labor law are considered to be a compromise between these two worlds.

According to Boltanski and Thévenot (2006, p.277), "in a compromise, people agree to come to terms, that is, to suspend a clash – a dispute involving more than one world – without settling it through recourse to a test in just one of the worlds". A compromise should be "worked out" (Boltanski & Thévenot, 2006, p.279) by some "packages" which are built by several objects from different worlds. These objects are endowed with characteristics that help overcome the original opposition, as mentioned in Boltanski and Thévenot (2006, p.278): "one way of solidifying a compromise is to place objects composed of elements stemming from different worlds at the service of the common good and endow them with their own identity". Or, they can be innovative objects combining worlds in conflict (Amblard et al., 2005). In addition, a compromise made by beings or

qualities from more than one world (“ambiguous”) can also be worked out easily (Boltanski & Thévenot, 2006).

Sometimes, the dominant presence of a third world affects the compromise of two existing worlds. In this situation, the compromise pleases not only the worlds in conflict but also the “referee” world (Amblard et al., 2005). For instance, in the field of ceramic production, traditional-manual production (the domestic world) and mass production through modern machinery (the industrial world) can reach a compromise through the presence of a third world, the market world. Two existing worlds have to accept common criteria which satisfy the market so that final products can be sold.

In another case, a compromise can be established by several actors who have special characteristics. They are important in both two existing worlds and can build a “bridge” between them (Amblard et al., 2005). For instance, numerous musicians, actors, footballers, etc. who are quite famous in their field (the world of fame) are also businessmen (the market world).

3. Sisterhood adoption – a theoretical explanation of “economies of worth”

3.1. The signs of different worlds

Based on the knowledge about “economies of worth” and worlds, we can describe the management innovation (the Sisterhood model) and the “host” organization (CHSs)

through the language of worlds. In fact, due to several official documents and our findings, numerous signs of different worlds appeared.

3.1.1. The signs of different worlds within CHSs before Sisterhood

Many official documents and our findings helped us understand the general situation of CHSs before Sisterhood. In the next paragraphs, we only focus on the elements pertaining to worlds (see table 20 below).

The domestic world:

Regarding infrastructure, before Sisterhood, almost all of CHSs (except AP's CHSs) were quite old, small and in bad conditions. Some CHSs had existed for over 40 years. In some CHSs, lack of necessary tools and health equipment was quite common.

As for the relationships among health workers, CHSs had a very simply hierarchy with a head (often a doctor) and some health workers. The head was also the most educated and skilled health worker of CHSs. He/she directly did the most important activities of CHSs. Therefore, he/she was highly respected and was the representative of CHSs. Instead of specialization and professional relationships, there were friendly and familial relationships among medical staff. In addition, health workers often lived near CHSs and in the same commune. Therefore, their relationships were quite close. It could be said that a CHS was quite similar to a family where CHS' head played the role of a father/mother.

Regarding work organization, CHSs applied traditional management approaches and provided technically backward methods in clinical activities. Moreover, CHSs' health workers had old habits and working styles. These characteristics related to the *domestic world*.

The civic world:

The network of CHSs is a basic unit of the public health system in Vietnam. Therefore, CHSs must follow the criteria and the rules of the MOH of Vietnam, a socialist country. In this case, the collective interest is one of their priorities.

Moreover, the main function of CHSs is to provide primary healthcare services to local people and they are almost free. Our informants considered the services of CHSs to be "public services". We propose that they are signs of the *civic world*.

	Inspired world	Domestic world	World of fame	Civic world	Market world	Industrial world
Public health: collective interest				x		
Primary health services for local people: almost free				x		
Old, small and in bad conditions		x				
Simple hierarchy, head as a father/mother, close relationships among health workers		x				
Traditional management approaches		x				
Technically backward methods in clinical activities		x				

Old habits and working styles of medical staff		x				
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Table 20 – The signs of different worlds within CHSs before Sisterhood

Source: the author, based on the theoretical framework proposed by Boltanski and Thévenot (2006)

3.1.2. The signs of different worlds within the Sisterhood program

Based on Sisterhood’s documents, data structure 1 (see figure 15) and its supporting data (see table 17), we observed that Sisterhood had the signs of all worlds (except the inspired world) (see table 21 below).

The market world:

Sisterhood has 11 signs of the market world. The program cared about the access to services (A) and had customer-oriented purpose (B). Furthermore, one of the three principal activities of Sisterhood, communication, is also a sign of the market world (C). In addition, Sisterhood’s social goals (rather than commercial goals) “expand” the market world concept of “economies of worth” (D).

A set of criteria for a franchised CHS to maintain the brand included several market factors, such as the fact that a station had to maintain its client volume, counselling activities, etc. (E). Franchising as well as fractional franchising characteristics of Sisterhood are also the signs of the market world (F and G).

Regarding the “Sisterhood” consulting rooms, they attracted clients (H) and consisted of two important functions: welcoming and counselling (I). All of these elements come from the market world. As for brand ambassadors, their outfits attracted clients (O) and these

ambassadors significantly improved communication activities (P). They are also market world signs.

The industrial world:

Service quality was the most important objective of Sisterhood (A). In addition, two of the three principal activities of this model were training and supervision (C). All of them are industrial signs.

In a set of criteria for a franchised CHS to maintain the brand (E), there are numerous industrial signs, such as maintaining service quality, equipment, sanitary conditions, professional skills, etc. As for franchising and fractional franchising characteristics (F and G), we observed that several characteristics came from the industrial world. For instance, identical “Sisterhood” consulting rooms, identical standards everywhere, etc.

Regarding provincial master trainers (K, L, M), they had many industrial signs. Training-supervising-supporting activities are an example. In choosing and managing brand ambassadors (N), we also found several industrial elements such as: collecting the information of brand ambassadors for reports.

The world of fame:

Sisterhood has seven signs of the world of fame. Its communication activities (C) helped improve the reputation of the program and the “Sisterhood” consulting rooms. In addition, among criteria for maintaining the brand (E), our informants also confirmed that

franchised CHSs needed to maintain Sisterhood's reputation. These elements originated in the world of fame.

As for franchising (F and G), an important factor of the Sisterhood model was its brand. In addition, attractive design of the "Sisterhood" consulting room (H) can be considered a sign of the world of fame. Similarly, attractive outfit of brand ambassadors (O) is also a sign of this world. Brand ambassadors' communication activities (P) improved the reputation of Sisterhood. Therefore, we also considered them to be a sign of the world of fame.

The domestic world:

We presupposed that Sisterhood would only have the signs of the market world, the industrial world and the world of fame. Interestingly, this model also has five signs of the domestic world.

As for the "Sisterhood" consulting rooms, all of our informants were impressed by the friendly design of the rooms (H). In addition, their atmosphere was quite familial due to a warm welcome and counselling (I). Moreover, the counsellors of the rooms established a close relationship with their clients (J).

Provincial master trainers came to franchised CHSs to support and teach their health workers rather than to supervise them (M). In addition, brand ambassadors with friendly outfit (O) often met people of childbearing age at their houses to advertise the model (P). These elements are the signs of the domestic world.

The civic world: board, logo and slogan of the Sisterhood social franchise (F and G) are objects of the civic world.

	Inspired world	Domestic world	World of fame	Civic world	Market world	Industrial world
Sisterhood's rhetorical dimension						
1. Objectives and principal activities of Sisterhood						
A. Service quality, access to public health services and equal access to services					x	x
B. Customer-oriented purpose					x	
C. Principal activities of Sisterhood			x		x	x
2. Social goals of the Sisterhood social franchise						
D. Social goals rather than commercial goals					x	
Sisterhood's technological dimension						
3. A governmental (fractional) social franchising model in the public health sector						
E. Criteria set for a franchised CHS to maintain the brand			x		x	x
F. Franchising characteristics			x	x	x	x
G. Fractional franchising			x	x	x	x
4. The "Sisterhood" consulting rooms						
H. Attractive and friendly design		x	x		x	
I. Welcoming and counselling					x	
J. A close relationship: client-counsellor		x				
5. Provincial master trainers and training-supervising-supporting						
K. Choosing and training provincial master trainers						x

L. Training activities						x
M. Supervision-support activities		x				x
6. Brand ambassadors and communication						
N. Choosing and managing brand ambassadors						x
O. Attractive and friendly outfit		x	x		x	
P. Communication activities		x	x		x	
TOTAL		5	7	2	11	9
	Inspired world	Domestic world	World of fame	Civic world	Market world	Industrial world

Table 21 – The signs of different worlds within the Sisterhood program

Source: the author, based on the theoretical framework proposed by Boltanski and Thévenot (2006)

3.2. Criticisms and compromises during the process of adopting Sisterhood in CHSs

It is possible to say that the whole adoption process of Sisterhood in CHSs is a chain of criticisms-compromises. Meaning criticisms and compromises did not appear in some phases but throughout the process. Therefore, we propose to observe this series of criticisms-compromises along with the adoption process. At each phase of the adoption process, there were criticisms between worlds, inside a world or there were worlds without criticisms between them.

Agenda-setting:

Before Sisterhood, although there were two worlds inside CHSs (the domestic and civic worlds), our informants did not mention any discord between them. That meant a family-

related management system with close relationships could “live together” with a collectivity-related system.

Another hypothesis could be a situation where one world dominated the other world. This situation was possible because Vietnamese government seemed to “neglect” CHSs therefore their service quality was quite low for a long time. For this reason, civic factors became “weaker” than domestic ones. The activities of CHSs were increasingly unprofessional because of an ineffective management mechanism based on close relationships.

CHSs’ service quality was in question. Therefore, instead of going to these CHSs, clients went to upper-level health facilities. Clients had the elements of the market world while CHSs represented the domestic and civic worlds.

Between the market and domestic worlds and from the perspective of the market world, personal relationships and local attachments are not encouraged. Indeed, clients did not like CHSs’ familial management system, without any welcome nor any private corner for counselling.

Between the market and civic worlds, collective actions were criticized (from the market world’s perspective). In fact, collective activities and irresponsibility are “synonyms” in many CHSs of Vietnamese public health system. Health workers did not care about the quality of services and provided services without responsibility.

In addition, sometimes the civic world (of CHSs) also criticized the market world (of clients): the selfishness of owners and individualism were refused. That partly explained the role and position of clients before Sisterhood. They were not important to CHSs.

These disagreements were not resolved because at that moment, Vietnamese government did not provide any solutions. In this context, MSIVN introduced the Sisterhood model. However, its innovative characteristics predicted several criticisms from CHSs.

Knowledge/research and selection/matching:

In these phases, many NGOs had to bid for a contract in several events organized by AP. They came from various fields and focused on different beneficiaries. Regarding MSIVN, they had to persuade AP to invest in “software” of CHSs through its social franchising model (Sisterhood). In fact, both AP and MSIVN are NGOs that share a common goal: improving Vietnamese public health system. They came from the same world. Consequently, an agreement was attained quite rapidly. MSIVN convinced AP of Sisterhood’s benefits for CHSs and local people.

Districts and communes were selected in pre-selected provinces and MSIVN and DOHs had to discuss to find a common plan. Obviously, MSIVN and DOHs represented different worlds. The worlds of MSIVN and DOH were similar to the ones of the Sisterhood model and CHSs respectively. To avoid any criticisms between MSIVN and DOHs, MSIVN organized trips to franchised provinces so that DOHs’ representatives could meet colleagues who had established the model successfully.

They were trained by the program and were also colleagues of these DOHs' representatives. MSIVN encouraged this kind of appointments and based on "economies of worth", it could be said that the compromises between MSIVN and DOHs were "worked out" by mobilizing several actors who were important to both MSIVN and DOHs.

Regarding the selection of CHSs, to alleviate potential criticisms during the process of adopting Sisterhood in CHSs, the model was only established in CHSs which needed to participate in the program. In addition, compromises were "worked out" by selecting CHSs with enthusiastic heads who were willing to welcome the model. In this case, the heads understood the objectives and the main activities of the model and were highly respected in CHSs. Therefore, they were potential compromises between Sisterhood and selected CHSs when the process of adopting this model really operated.

To facilitate the selection of CHSs, a set of criteria was built by both MSIVN and DOHs. As we mentioned, this set could be viewed as an innovative object that combined worlds in conflict. Generally, this set was a compromise of the two sides: MSIVN and DOHs.

In these knowledge/research and selection/matching phases, we observed that MSIVN closely collaborated with DOHs and DHCs. Final decisions were often made by local health that could be seen as a simple arrangement between MSIVN and them.

Persuasion/validation:

At the beginning, MSIVN and the Sisterhood model faced several obstacles from local leaders. It was very time-consuming to "educate" them to understand Sisterhood's

objectives and activities as well as social franchising concept. These issues can be explained as follows:

The system of CHSs, a basic unit of the public health sector in Vietnam (a socialist country), is supported by Vietnamese government and their services are almost free. The appearance of a foreign management model (Sisterhood) with the dominance of industry- and market-related factors (the industrial and market worlds) for the 1st time in this system can "break" the inherent operational structure of CHSs which essentially based on collectivity- and family-related factors (the civic and domestic worlds). In other words, there were some risks of transformation into clash during the meeting of the worlds of Sisterhood and CHSs. Perhaps for this reason, some local leaders expressed disapproval of Sisterhood's activities at the beginning.

In addition, the perspectives of local leaders limited them in accepting the Sisterhood model. Theirs perspectives were based on the domestic and civic worlds while MSIVN hoped to introduce the elements from various worlds of the Sisterhood model in CHSs, in particular the industrial and market worlds. The perspectives of MSIVN and local leaders were based on different worlds and there were criticisms among them that explained the initial opposition.

To sum up, in this phase, there was a disagreement between MSIVN and local leaders and potential controversies between Sisterhood and CHSs. Regarding the former, it was resolved by setting a clarification in the worlds of local leaders. MSIVN played the role of technical supporter and local leaders (and many other officials of provinces) directly

participated in the activities of the program. They finally understood the benefits of Sisterhood for the public health system as well as local people. Therefore, local leaders changed their minds and welcomed the model.

In this phase, the informants mentioned several difficulties in meeting infrastructure standards of CHSs. Based on the knowledge of “economies of worth”, we can view this situation as follows: MSIVN and DOHs had a compromise, a set of criteria, in selecting CHSs. This set facilitated the process of selecting suitable CHSs and avoided potential ruptures. However, in some provinces, many CHSs could not meet all criteria in this set and therefore, some criteria were changed (especially infrastructure criteria). In this case, to avoid disagreements, the worlds of the Sisterhood model and CHSs set a local arrangement.

Besides local leaders, at the beginning, the resistance of CHSs’ medical staff was also quite important. Due to old habits and working styles, they were afraid of changes from Sisterhood. Based on the language of worlds, this situation can be considered a disagreement between the domestic world (medical staff) and the industrial world (Sisterhood) in which what is old or traditional is rejected.

Resistance also came from local people who represented the domestic world. Because of a disagreement between this world and the market world (Sisterhood), the program had several difficulties in approaching them. Indeed, due to some cultural barriers, local people did not want to approach the program (Sisterhood pertained to RHFP services, a

sensitive subject in many Asian countries). In spite of many communication activities, local people sometimes avoided the program.

In this phase, these disagreements were not resolved completely because the program was still in its early steps. However, compromises were established when the program developed at a higher level.

A special attention was paid to The Little Sun of A&T Vietnam and the fact that two brands (The Little Sun and Sisterhood) in the same CHS (co-branding) was vigorously opposed by DOHs at the beginning of the phase.

In fact, A&T Vietnam and The Little Sun were ideologically similar to MSIVN and Sisterhood respectively. Both of them represented the same worlds (principally the industrial and market worlds) while DOHs and CHSs represented the domestic and civic worlds.

Regarding Sisterhood-The Little Sun co-branding, the potential confusion of clients, the infrastructure criteria of the program and the potential lack of human resources led to the opposition of DOHs. Based on “economies of worth”, this situation can be explained as follows. There was probably a disagreement among A&T Vietnam, MSIVN and DOHs. In addition, several ruptures in work organization of CHSs could appear due to the meeting of the worlds of The Little Sun, Sisterhood and CHSs. In this context, an innovative object was introduced: a common consulting room of both Sisterhood and The Little Sun. This consulting room was a compromise of all worlds

Modification, operationalization and clarification/confirmation:

In the previous phase, persuasion/validation, we predicted potential controversies between Sisterhood and CHSs. We also mentioned several disagreements which were not resolved completely. The resistance of CHSs' medical staff when the program came was considered to be a disagreement between the domestic world of CHSs and the industrial world of Sisterhood. In addition, the resistance of local people or in other words, the difficulties of Sisterhood in approaching them was viewed as a disagreement between the domestic world and the market world.

In these phases, some actors who were important in both two existing worlds were mobilized. Provincial master trainers were important to both Sisterhood and CHSs while brand ambassadors were important to both the model and local people. Therefore, based on "economies of worth", provincial master trainers were a compromise between the domestic and industrial worlds while brand ambassadors were a compromise between the domestic and market worlds. Due to these "bridges", CHSs' medical staff and local people accepted the model. The disagreements from the previous phase were resolved.

Both provincial master trainers and brand ambassadors were trained by Sisterhood. Naturally, they were important factors of the model. How could they become important to CHSs' medical staff and local people?

In reality, they approached CHSs and local people in a very "domestic way". Regarding provincial master trainers, they trained and supervised CHSs carefully and friendly ("taking hand guiding work"). Medical staff were afraid of training and supervision then

really liked these activities. As for brand ambassadors, they often came to clients' houses to talk with them about the program and its main activities. Furthermore, they also organized group talks in local communities.

Because of these activities, three main activities of Sisterhood (communication-training-supervision) were easily accepted and both provincial master trainers and brand ambassadors were highly respected.

As for the potential controversies between Sisterhood and CHSs which were predicted in the previous phase (persuasion/validation), in these phases, they came from the presence of the "Sisterhood" consulting rooms in CHSs. These rooms which included the main industrial and market elements of the model brought some significant changes to work organization of CHSs. The industrial and market worlds (represented by the consulting rooms) were integrated into CHSs where there had already been the domestic and civic worlds (represented by non-RHFP rooms, activities and health workers).

However, the disagreements between these worlds were not clearly mentioned. Our informants mainly focused on numerous positive elements of the consulting rooms, that led to positive changes in the rest of franchised CHSs. Based on the language of worlds, there were probably some disagreements between the worlds of the rooms and the rest of CHSs. Afterwards, these disagreements were rapidly resolved by setting a clarification in the worlds of non-RHFP rooms, activities and medical staff: they tried to attain the same quality level as the consulting rooms.

During these phases, we observed that there was a dominant presence of a third world: the market world (represented by clients) which also affected the compromise of the existing worlds. Indeed, due to clients' requests, non-RHFP elements had to change so that the quality gap between RHFP and non-RHFP elements could decrease.

When there were agreements inside franchised CHSs, these stations "imported" the elements of the Sisterhood model and represented the industrial and market worlds, rather than the domestic and civic worlds. However, non-franchised CHSs nearby still represented the civic and domestic worlds. Therefore, there were probably some disagreements between them. This situation was similar to the one mentioned above and there was a clarification in the worlds of non-franchised stations. Indeed, they tried to increase their service quality that was called "healthy competition". The role of clients (the market world, a dominant world in this context) was significantly important because they could decide to go to franchised stations and non-franchised ones had to change themselves.

Our informants mentioned "healthy competition". However, the concept of competition in the market world pertains to a price while the services of CHSs in Vietnam are almost free. Maybe the "healthy competition" concept in this context can expand the market word of "economies of worth".

Discontinuance and routinization:

In these phases, the advantages of the model were confirmed. The industrial and market worlds played a dominant role inside franchised CHSs (compared to the domestic and civic worlds of the CHSs).

Normally, the presence of MSIVN “strengthened” the industrial and market worlds of the Sisterhood model. Therefore, the dominant role of these worlds was maintained. When MSIVN left, this situation risked being undone. The domestic and civic worlds inside franchised CHSs could go back to their position.

Luckily, another actor replaced MSIVN to strengthen the industrial and market worlds of CHSs: local health systems. In addition, two important “bridges”, brand ambassadors and provincial master trainers, were still maintained. Therefore, the compromises between Sisterhood-local people and Sisterhood-CHSs’ medical staff were preserved.

The whole process of adopting Sisterhood in CHSs through the eyes of Boltanski and Thévenot is summarized in table 22 below.

Phase(s)	Situation	World(s) vs. World(s)	Agreement	Disagreement			Remarks
				Clarification	Arrangement	Compromise	
Agenda-setting	The existence of two worlds inside CHSs before Sisterhood	Civic world vs. Domestic world	x				Without real discord
	Clients did not trust the quality of CHSs	Market world vs. Domestic world					Disagreements were not resolved
		Market world vs. Civic world					
	Clients were not important to CHSs	Civic world vs. Market world					
Knowledge/ research and selection/ matching	MSIVN had to persuade AP	Industrial-market worlds vs. Industrial-market worlds	x				MSIVN and AP came from the same worlds. Therefore, an agreement was rapidly established
	To avoid potential criticisms, MSIVN organized trips to franchised provinces for DOHs' representatives	Industrial-market worlds vs.				x	Compromises: the stakeholders of Sisterhood in franchised provinces

		Civic-domestic worlds					
	MSIVN selected CHSs with enthusiastic heads	Industrial-market worlds vs. Civic-domestic worlds				x	Potential compromises: these station heads
	MSIVN and DOHs collaborated to build a set of criteria	Industrial-market worlds vs. Civic-domestic worlds				x	Compromises: this set of criteria (an innovative object)
	MSIVN often lets DOHs and DHCs make final decisions	Industrial-market worlds vs. Civic-domestic worlds			x		
Persuasion/ validation	MSIVN faced a lot of opposition from the local leaders of local health systems	Industrial-market worlds vs. Civic-domestic worlds		x			Local leaders understood then changed their minds
	Potential controversies between Sisterhood and CHSs	Industrial-market worlds vs. Civic-domestic worlds					Stopped at the level of prediction

	Some CHSs could not meet all criteria of Sisterhood	Industrial-market worlds vs. Civic-domestic worlds			x		Several criteria were changed
	The resistance of medical staff	Industrial world vs. Domestic world					These disagreements were not resolved completely
	The resistance of local people	Market world vs. Domestic world					
	A&T Vietnam, MSIVN, co-branding idea and DOHs' opposition	Industrial-market worlds vs. Civic-domestic worlds				x	There was probably a disagreement among A&T Vietnam, MSIVN and DOHs Compromises: common consulting rooms
	Two brands inside franchised CHSs	Industrial-market worlds vs. Civic-domestic worlds				x	Several ruptures could appear inside CHSs Compromises: common consulting rooms
Modification, operationalization and	The resistance of medical staff	Industrial world vs. Domestic world				x	Compromises: provincial master trainers (important to both sides)

clarification/ confirmation	The resistance of local people	Market world vs. Domestic world				x	Compromises: brand ambassadors (important to both sides)
	The “Sisterhood” consulting room affected the rest of franchised CHSs	Industrial-market worlds vs. Civic-domestic worlds		x			There was probably a disagreement between these worlds. The rest of franchised CHSs changed to meet new standards Dominant presence of a third world: the market world (clients)
	Franchised CHSs affected other non-franchised ones nearby	Industrial-market worlds vs. Civic-domestic worlds		x			There was probably a disagreement between these worlds. Non-franchised stations had to change (“healthy competition”) Dominant presence of a third word: the market world (clients)
Discontinuance and Routinization	MSIVN left that led to a (potential) dominant role of the domestic and civic worlds inside franchised CHSs	Industrial-market worlds vs. Civic-domestic worlds				x	Local health systems replaced MSIVN Compromises maintained: provincial master trainers and brand ambassadors

Table 22 – The process of adopting Sisterhood in CHSs based on “economies of worth”
Source: the author, based on the theoretical framework proposed by Boltanski and Thévenot (2006)

4. Extended though

The Sisterhood program and franchised CHSs were built by individuals. Therefore, all changes from both sides needed to rely on them. During the process of adopting Sisterhood in CHSs, MSIVN established a reasonable strategy: changing the perception of individuals that leads to the changes in their manner and other activities. Two human factors which facilitated this process were provincial master trainers and brand ambassadors: they made medical staff and clients understand Sisterhood's activities and changed their perception.

In fact, right from Sisterhood's initial steps, MSIVN sought to avoid potential criticisms by adding some elements of the domestic world to the Sisterhood room. Consequently, MSIVN introduced a new domestic world ("Sisterhood" consulting rooms) into franchised CHSs with the purpose of replacing the existing ones. This is significantly different from bringing a world completely different from the current worlds of franchised CHSs into these CHSs because it can cause a sudden and usually unpleasant experience from all parts of the CHSs. This result was based on a deep understanding of CHSs' system and the experience gained from the pilot phases of the model.

In 2.1. *Clinical social franchising in developing countries*, some authors mentioned fractional franchising and warned that franchisor could not influence non-franchised parts of a health facility (du Toit, 2014). However, our findings proved the opposite: the consulting rooms had a strong influence on the rest (non-franchised) of CHSs.

Furthermore, according to Montagu (2002), distinguishing the difference between franchised and non-franchised services is really difficult to clients. However, based on three main activities (communication, training, supervision), not only clients but all stakeholders of the program could distinguish the difference between Sisterhood's services and non-Sisterhood's ones. For instance, some clients decided to go directly to the consulting room for receiving its franchised services.

Regarding the context of Vietnam, it can be said that this country "succeeded" in changing its economic model and still retaining its political institutions. However, what have happened recently show a more complicated situation. Many NGOs, including MSIVN, have brought numerous management models originated in developed countries into Vietnam. There are many models similar to Sisterhood. They faced some cultural and political barriers at their first steps but they changed the perception of their receivers over time. Therefore, Vietnam is being transformed from within.

CONCLUSION

Due to practical and academic requirements, this thesis focused on management innovation, an emerging field of research. It not only studied the process of adopting a management innovation in an organization but also provided a different look at this process.

We were interested in the Sisterhood model, a governmental social franchising model in the public health system in Vietnam. It was established in numerous CHSs in Vietnam through the collaboration of MSIVN (an NGO which mainly focused on RHFP services) and several provincial DOHs. Regarding Vietnam, this context was original and consisted of some unique cultural elements.

Among our qualitative data, we principally mobilized two main sources: documentation and interviews. In addition, various information sources were paid attention. The data were analyzed through an analysis method inspired by Gioia et al. (2012).

Based on Sisterhood's rhetorical and technological dimensions, we predicted some ruptures in work organization of CHSs due to the novelty of this model. Indeed, our findings confirmed that Sisterhood could be viewed as a transporter of ruptures and its adoption process could be considered a process of adopting a management innovation.

At the beginning, several organizational issues of CHSs were identified. Afterwards, the Sisterhood model was selected among various innovative models of management. All stakeholders of Sisterhood had been persuaded before the model was established. When

the model operated, some modifications appeared from both sides, the model and franchised CHSs. After some years, Sisterhood was viewed as a “habit” and it continued to work in expanded phase.

Based on our data analysis method, the process of adopting Sisterhood in CHSs could be modelled into the management innovation adoption process of nine phases proposed in the study of Rasmussen and Hall (2016).

Right from the beginning of the process, Sisterhood had to face numerous challenges from DOHs, DHCs and CHSs. Despite these difficulties, the model was implemented and that led to expected and unexpected influences on franchised CHSs. Regarding expected influences, the model brought significant changes in both clinical and non-clinical activities of franchised CHSs. As for unanticipated ones, the “Sisterhood” consulting rooms had good influences on the rest of CHSs. In addition, franchised CHSs also positively affected other non-franchised stations nearby. Due to these impacts, the model was replicated in more CHSs, after MSIVN left (expanded phase).

The literature on management innovation and social franchising limited us in describing and explaining the adoption process of Sisterhood. An analysis tool was needed to further our knowledge of the tensions which appeared during the whole process as well as how to resolve them. In this case, the “economies of worth” theory was mobilized and considered an appropriate solution. Based on a theoretical language of worlds, we explained the process of adopting Sisterhood in CHSs through criticisms,

disagreements/agreements, compromises, etc. and that provided a new look at the process of adopting a management innovation in an organization.

1. Contributions of the thesis

1.1. Theoretical contributions

This thesis contributed to a relatively unexplored field of research, management innovation. Insights into the adoption process of Sisterhood could be considered an empirical answer of the call for further research of Rasmussen and Hall (2016). In particular, expected and unexpected understanding of this process furthered our knowledge of management innovation adoption process.

Although social franchising was just an aspect of our research, it was also clarified during the process of adopting Sisterhood. Based on this process, the social aspects of this concept were clearly explained and that shed light on social franchising definitions. To the best of our knowledge, this study is one of the first studies mentioned governmental social franchising in the public health sector. In addition, the characteristics of fractional social franchising in this thesis have rarely been studied before.

By mobilizing a sociological theory for a study in management science, this thesis provided interesting perspectives on the process of adopting a management innovation in CHSs. Instead of explaining the tensions between Sisterhood and CHSs through quality “gaps”, “economies of worth” described this situation through disagreements

between worlds. In addition, this theory also provided numerous solutions to resolve these issues.

However, the “economies of worth” theory in our thesis is not just a “translate” tool for the process of adopting Sisterhood in CHSs: from the language of management innovation to the language of worlds. It really extends our knowledge.

“Economies of worth” was exclusively built for French context (or in general, developed countries). However, the context of Vietnam in this thesis is totally different from the original context of the theory. Therefore, the fact that this theory was mobilized to explain agreements/disagreements in the context of Vietnam could add more details related to developing countries with special cultural elements to “economies of worth” (a potential opening on “culturalist” mobilization of “economies of worth”).

1.2. Managerial implications

Policy makers:

Social franchising in private health is no longer a foreign model in many developing countries. There is much evidence regarding the effectiveness of this model. However, social franchising in public health remains a brand-new model for numerous countries, including Vietnam.

It is understandable to hesitate to adopt this model at an early stage. However, in the case of Sisterhood, this model is not just a typical social franchising model but also has the characteristics of a management innovation. Based on this thesis, policy makers can

find general evidence on the effectiveness of Sisterhood. Thereby, they will have more reasons to support and replicate the model in other cities/provinces of Vietnam.

In fact, Vietnamese policy makers have recognized the advantages of Sisterhood from the very beginning of this model. Several factors of the model have also been incorporated into some policies as an exemplar of management model and service quality. However, more evidence is still needed to support policy makers' decisions.

MSI's and MSIVN's managers:

Regarding MSI's managers, the process of adopting Sisterhood in Vietnamese CHSs can be a valuable lesson for them because MSI has numerous clinical social franchises in developing countries. In addition, Vietnam is in transition phase (from a low to middle income country). Therefore, the process of adopting Sisterhood can also help MSI's managers establish clinical social franchises in similarly developing countries.

As for MSIVN's managers: eight selected cities/provinces of the Sisterhood program are located in all three areas of Vietnam (the north, the south and the center). Each area has its own cultural characteristics that can significantly influence work organization in many sectors, including public health. The experience of collaborating with DOHs, DHCs as well as CHSs in these areas (how to avoid or face criticisms, how to attain arrangements or compromises with officials in these establishments) can help MSIVN's managers expand the model to other provinces/cities without concerns about regional cultural differences.

Furthermore, one day MSIVN can apply social franchising model to non-RHFP services or in a different type of health facilities (not only CHSs). In this case, based on the “lessons” from the establishment of Sisterhood, MSIVN’s managers can avoid any criticisms during the new process.

In reality, MSIVN is running the “BlueStar” private social franchise (more than 300 clinics in all over Vietnam) and “Marie Stopes Vietnam” clinic network (11 clinics in all over Vietnam). Sisterhood aims at serving RHFP services in public health sector while BlueStar focuses on private health sector and Marie Stopes Vietnam are specialized clinics. MSIVN’s managers can learn from the process of adopting Sisterhood in Vietnam’s public health sector to develop the two other networks.

Other social franchises’ managers (especially in health sector): the process of integrating Sisterhood into CHSs can provide other social franchises with invaluable experience. Moreover, Vietnamese context pertains to some typical and atypical factors. Therefore, other social franchises which are planning to install a new model in Vietnam should view this study as a useful help.

2. Researcher position and self-criticism process

Being Vietnamese gave me pre-constructed ideas about Vietnamese health system (the coldness of medical staff manner, the cleanliness of the CHSs, etc.). However, when I did my fieldwork, there were many new ideas (sometimes surprising ones) and I had to not only verify my existing ideas but also compare with new ideas and “add” appropriate ones.

I always had to ask myself where my ideas came from, because of my posture as a researcher or as a Vietnamese? Answering this question depended totally on what I found from the field and in my case, the two postures were used. Indeed, being both a Vietnamese and a researcher allowed me to better understand the cultural adaptation that my informants were not always aware of and to "translate" them during my knowledge production. In addition, the question of "which posture we wish to be?" is as important as what the informants think about us. It is a "reciprocal equation".

The perceptions of informants were sometimes different from mine and it was merely due to the differences of posture (we did not share common posture). During my fieldwork, I did not try to impose my own perceptions on the informants or refuted people who thought differently to me but encouraged them to express what they perceived so that the opinions would be diversified and I could collect crossing views. The more I "collected" informants' perceptions, the more I understood the field and that helped me approach the answers for my research questions. On the other hand, introduced what I saw from my photos, videos or my observations into interview questions was also a wise way to "initiate" the sympathy from informants and that could make them express more.

Questions which relate to researcher posture and emerging ideas which refute our existing ideas are principal issues following every researcher, but there were also several typical and event unique points relating to my fieldwork nevertheless. Being Vietnamese gave me an easy access to the field however at the beginning the informants thought that I had a managerial position within the program because of my appearance and my

research devices (camera, mobile phone, etc.). This particular posture had impact on the informants' answers: timidity, positive results, neutral opinions, quite short answers, etc.

However, a slightly change made a big difference: I explained clearly and sincerely my objective which was purely for research purpose and acted as an “apprentice” who was eager for learning from them; shortly afterwards, their whole manner changed. Furthermore, personal pronouns in Vietnamese are a quite complicated structure which depends on several factors such as age, sex, social position, family hierarchy, etc. Using delicately Vietnamese personal pronouns in daily conversations is a challenge for even Vietnamese people. However, we took advantage of this hierarchical structure to set up advantageous situations for our interviews in which the informants feel free to express themselves.

3. Future research

Naturally, when management innovations are designed, people (and even scholars) often think about efficiency improvements which are normally translated into profit. Nevertheless, in some social-cultural contexts, management innovations can also bring social impacts or “breakthroughs” (which can be viewed as social innovations).

We suggest a study which aims to gain for the first time insights into the “benefit and not for profit” aspect of management innovations, a compromise between management innovations and social impacts, a “hidden charm” which seems to be neglected in research and needs more attention from scholars in the field. As for the advancement of knowledge, this research will provide a different point of view beyond conventional one

on management innovations and suggest an innovative approach to grow and scale social impacts.

Two potential research issues arise: (1) How can a management innovation bring social perspectives into an organization? and (2) How can social impacts be diffused and varied during management innovation processes?

If we view Sisterhood as a social franchise only, we can focus on the relationship between social franchising and social innovation. Further research is needed to prove that Sisterhood has several characteristics of a social innovation. In addition, an analysis model can be built to “recognize” a social innovation. Based on this model, we can confirm whether a business model has the characteristics of a social innovation or not.

Regarding “economies of worth”, in the study of Boltanski and Chiapello (2007), the authors suggested the 7th world for this theory. We believe that based on empirical evidence of Vietnam, a socialist country with special cultural context, a new world can be developed.

REFERENCES

- Abrahamson, E. (1991). Managerial fads and fashions: the diffusion and rejection of innovations. *Academy of Management Review*, 16(3), 586–612.
- Abrahamson, E. (1996). Management fashion. *Academy of Management Review*, 21(1), 254–285.
- Abrahamson, E., & Eisenman, M. (2008). Employee-management techniques: transient fads or trending fashions? *Administrative Science Quarterly*, 53, 719–744.
- Abrahamson, E., & Fairchild, G. (1999). Management fashion: lifecycles, triggers, and collective learning processes. *Administrative Science Quarterly*, 44(4), 708–740.
- Adam-Ledunois, S., & Damart, S. (2017). Innovations managériales, attrapons-les toutes ! Design d'une méthodologie d'analyse critique des objets de management. *Revue Française de Gestion*, 264, 117–142.
- Agha, S., & Balal, A. (2003). *Monitoring the performance of a reproductive health franchise in Nepal*. Washington, DC: USAID/Commercial Market Strategies Project.
- Agha, S., Fareed, A., & Keating, J. (2011). Clinical training alone is not sufficient for reducing barriers to IUD provision among private providers in Pakistan. *Reproductive Health*, 8(40), 1–10.
- Agha, S., Gage, A., & Balal, A. (2007). Changes in perceptions of quality of, and access

- to, services among clients of a fractional franchise network in Nepal. *Journal of Biosocial Science*, 39(3), 341–354.
- Agha, S., Karim, A. M., Balal, A., & Sosler, S. (2007). The impact of a reproductive health franchise on client satisfaction in rural Nepal. *Health Policy and Planning*, 22(5), 320–328.
- Agha, S., Karim, A. M., Balal, A., & Sossler, S. (2003). *A quasi-experimental study to assess the performance of a reproductive health franchise in Nepal*. Washington, DC: USAID/Commercial Market Strategies Project.
- Ahlert, D., Ahlert, M., Dinh, H. V. D., Fleisch, H., Heubler, T., Kilee, L., & Meuter, J. (2008). *Social franchising: a way of systematic replication to increase social impact*.
- Alon, I. (2014). Introduction. In I. Alon (Ed.), *Social franchising* (pp. 1–7). Basingstoke (UK): Palgrave Macmillan.
- Amblard, H., Bernoux, P., Herreros, G., & Livian, Y.-F. (2005). Conventions et accords. In *Les nouvelles approches sociologiques des organisations*. Paris: SEUIL.
- Anand, N., Gardner, H. K., & Morris, T. (2007). Knowledge-based innovation: emergence and embedding of new practice areas in management consulting firms. *Academy of Management Journal*, 50(2), 406–428.
- Anand, N., & Jones, B. C. (2008). Tournament rituals, category dynamics and field configuration: the case of the booker prize. *Journal of Management Studies*, 45(6), 1036–1060.

- André, K., & Pache, A. C. (2016). From caring entrepreneur to caring enterprise: addressing the ethical challenges of scaling up social enterprises. *Journal of Business Ethics*, 133(4), 659–675.
- Ansari, S., Fiss, P., & Zajac, E. (2010). Made to fit: how practices vary as they diffuse. *Academy of Management Review*, 35(1), 67–92.
- Ansari, S., Reinecke, J., & Spaan, A. (2014). How are practices made to vary? Managing practice adaptation in a multinational corporation. *Organization Studies*, 35(9), 1313–1341.
- Aung, T., Montagu, D., Khin, H. S. S., Win, Z., San, A. K., & McFarland, W. (2014). Impact of a social franchising program on uptake of oral rehydration solution plus zinc for childhood diarrhoea in myanmar: a community-level randomised controlled trial. *Journal of Tropical Pediatrics*, 60(3), 189–197.
- Azmat, S. K., Shaikh, B. T., Hameed, W., Mustafa, G., Hussain, W., Asghar, J., ... Bilgrami, M. (2013). Impact of social franchising on contraceptive use when complemented by vouchers: a quasi-experimental study in rural Pakistan. *PLoS ONE*, 8(9), 1–8.
- Baker, J., Sanghvi, T., Hajeerhoy, N., Martin, L., & Lapping, K. (2013). Using an evidence-based approach to design large-scale programs to improve infant and young child feeding. *Food and Nutrition Bulletin*, 34(3), 146–155.
- Balogun, J., & Johnson, G. (2004). Organisational restructuring and middle manager

- sensemaking. *Academy of Management Journal*, 47(4), 523–549.
- Baregheh, A., Rowley, J., & Sambrook, S. (2009). Towards a multidisciplinary definition of innovation. *Management Decision*, 47(8), 1323–1339.
- Benders, J., & van Veen, K. (2001). What's in a fashion? Interpretative viability and management fashions. *Organization*, 8(1), 33–53.
- Berelowitz, D. (2012). *Social franchising: innovation and the power of old ideas*.
- Berelowitz, D., Richardson, M., & Towner, M. (2013). *Realising the potential of social replication (research for The Big Lottery Fund)*.
- Berk, J., & Adhvaryu, A. (2012). The impact of a novel franchise clinic network on access to medicines and vaccinations in Kenya: a cross-sectional study. *BMJ Open*, 2(4), 1–8.
- Beyeler, N., York De La Cruz, A., & Montagu, D. (2013). The impact of clinical social franchising on health services in low- and middle-income countries: a systematic review. *PloS One*, 8(4), 1–9.
- Birkinshaw, J., Hamel, G., & Mol, M. J. (2008). Management innovation. *Academy of Management Review*, 33(4), 825–845.
- Birkinshaw, J., & Mol, M. (2006). How management innovation happens. *MIT Sloan Management Review*, 47(4), 81–88.
- Bishai, D., LeFevre, A., Theuss, M., Boxshall, M., Hetherington, J. D., Zaw, M., &

- Montagu, D. (2013). The cost of service quality improvements: tracking the flow of funds in social franchise networks in Myanmar. *Cost Effectiveness and Resource Allocation*, 11(14), 1–7.
- Bishai, D. M., Shah, N. M., Walker, D. G., Brieger, W. R., & Peters, D. H. (2008). Social franchising to improve quality and access in private health care in developing countries. *Havard Health Policy Review*, 9(1), 184–197.
- Bishai, D., Sachathep, K., LeFevre, A., Thant, H. N. N., Zaw, M., Aung, T., ... SocialFranchisingResearchTeam. (2015). Cost-effectiveness of using a social franchise network to increase uptake of oral rehydration salts and zinc for childhood diarrhea in rural Myanmar. *Effectiveness and Resource Allocation*, 13(3), 1–10.
- Blair, R. D., & Lafontaine, F. (2005). *The economics of franchising*. New York: Cambridge University Press.
- Bloom, P. N., & Smith, B. R. (2010). Identifying the drivers of social entrepreneurial impact: theoretical development and an exploratory empirical test of SCALERS. *Journal of Social Entrepreneurship*, 1(1), 126–145.
- Boltanski, L., & Chiapello, È. (2007). *The new spirit of capitalism - translated by Gregory Elliott*. New York: Verso.
- Boltanski, L., & Thévenot, L. (1991). *De la justification: Les Économies de la Grandeur*. Paris: Gallimard.
- Boltanski, L., & Thévenot, L. (2006). *On justification: economies of worth (Princeton*

studies in cultural sociology series) - translated by Catherine Porter. Princeton (New Jersey): Princeton University Press.

Boyne, G. A., Gould-Williams, J. S., Law, J., & Walker, R. M. (2005). Explaining the adoption of innovation: an empirical analysis of public management reform. *Environment and Planning C: Government and Policy*, 23, 419–435.

Bradach, J. (2003). Going to scale: the challenge of replicating social programs. *Stanford Social Innovation Review*, 19–25.

Bui, M. T., Vo, T. V., Tran, M. H., Dang, L. T. H., & Dinh, N. T. (2011). *Sisterhood (CHMI case study series)*. Ha Noi: CHMI and CIHP.

Camisón, C., & Villar-López, A. (2014). Organizational innovation as an enabler of technological innovation capabilities and firm performance. *Journal of Business Research*, 67, 2891–2902.

Canet, E. (2012). *L'innovation managériale de l'invention à la diffusion. Analyse du processus d'établissement d'une innovation managériale à partir du cas de la méthode 5 steps*. Paris Dauphine University (Paris IX).

Christensen, L. J., Parsons, H., & Fairbourne, J. (2010). Building entrepreneurship in subsistence markets: microfranchising as an employment incubator. *Journal of Business Research*, 63(6), 595–601.

Clark, S. M., Gioia, D. A., Ketchen, D. J., & Thomas, J. B. (2010). Transitional identity as a facilitator of organisational identity change during a merger. *Administrative Science*

Quarterly, 55(3), 397–438.

Combs, J. G., & Ketchen, D. J. (2003). Why do firms use franchising as an entrepreneurial strategy? A meta-analysis. *Journal of Management*, 29(3), 443–465.

Combs, J. G., Michael, S. C., & Castrogiovanni, G. J. (2004). Franchising: a review and avenues to greater theoretical diversity. *Journal of Management*, 30(6), 907–931.

Corley, K. G. (2004). *Defined by our strategy or our culture? Hierarchical differences in perceptions of organisational identity and change*. *Human Relations* (Vol. 57).

Corley, K. G., & Gioia, D. a. (2004). Identity ambiguity and change in the wake of a corporate spin-off. *Administrative Science Quarterly*, 49(2), 173–208.

Crawford-Spencer, E. (2015). Deriving meaning for social franchising from commercial franchising and social enterprise. *Journal of Marketing Channels*, 22(3), 163–174.

Creswell, J. W. (2013). *Qualitative inquiry & research design: choosing among five approaches (3e)*. Thousand Oaks (CA): SAGE Publications, Inc.

Crossan, M. M., & Apaydin, M. (2010). A multi-dimensional framework of organizational innovation: a systematic review of the literature. *Journal of Management Studies*, 47(6), 1154–1191.

Currie, W. L. (1999). Revisiting management innovation and change programmes: strategic vision or tunnel vision? *Omega*, 27, 647–660.

Dacin, M. T., Munir, K., & Tracey, P. (2010). Formal dining at Cambridge colleges: linking

- ritual performance and institutional maintenance. *Academy of Management Journal*, 53(6), 1393–1418.
- Daft, R. L. (1978). A dual-core model of organizational innovation. *Academy of Management Journal*, 21(2), 193–210.
- Damanpour, F. (1987). The adoption of technological, administrative, and ancillary innovations: impact of organizational factors. *Journal of Management*, 13(4), 675–688.
- Damanpour, F. (1988). Innovation type, radicalness, and the adoption process. *Communication Research*, 15(5), 545–567.
- Damanpour, F. (1991). Organizational innovation: a meta-analysis of effects of determinants and moderators. *Academy of Management Journal*, 34(3), 555–590.
- Damanpour, F. (1992). Organizational size and innovation. *Organization Studies*, 13(3), 375–402.
- Damanpour, F. (1996). Organizational complexity and innovation: developing and testing multiple contingency models. *Management Science*, 42(5), 693–716.
- Damanpour, F. (2010). An integration of research findings of effects of firm size and market competition on product and process innovations. *British Journal of Management*, 21, 996–1010.
- Damanpour, F. (2014). Footnotes to research on management innovation. *Organization*

Studies, 35(9), 1265–1285.

Damanpour, F., & Aravind, D. (2012). Managerial innovation: conceptions, processes, and antecedents. *Management and Organization Review*, 8(2), 423–454.

Damanpour, F., & Evan, W. M. (1984). Organizational innovation and performance: the problem of “organizational lag.” *Administrative Science Quarterly*, 29, 392–409.

Damanpour, F., & Gopalakrishnan, S. (1998). Theories of organizational structure and innovation adoption: the role of environmental change. *Journal of Engineering and Technology Management*, 15, 1–24.

Damanpour, F., & Gopalakrishnan, S. (1999). Organizational adaptation and innovation: the dynamics of adopting innovation types. In K. Brockhof, A. K. Chakrabarti, & J. Hauschildt (Eds.), *The dynamics of innovation: strategic and managerial implications* (p. 349). Verlag Berlin Heidelberg New York: Springer.

Damanpour, F., & Gopalakrishnan, S. (2001). The dynamics of the adoption of product and process innovation in organisations. *Journal of Management Studies*, 38(1), 45–65.

Damanpour, F., & Schneider, M. (2006). Phases of the adoption of innovation in organizations: effects of environment, organization and top managers. *British Journal of Management*, 17, 215–236.

Damanpour, F., & Schneider, M. (2009). Characteristics of innovation and innovation adoption in public organizations: assessing the role of managers. *Journal of Public*

Administration Research and Theory, 19(3), 495–522.

Damanpour, F., Szabat, K. A., & Evan, W. M. (1989). The relationship between types of innovation and organizational performance. *Journal of Management Studies*, 26(6), 587–601.

Damanpour, F., Walker, R. M., & Avellaneda, C. N. (2009). Combinative effects of innovation types and organizational performance: a longitudinal study of service organizations. *Journal of Management Studies*, 46(4), 650–675.

Damanpour, F., & Wischnevsky, J. D. (2006). Research on innovation in organizations: distinguishing innovation-generating from innovation-adopting organizations. *Journal of Engineering and Technology Management*, 23, 269–291.

Daniel, E., Myers, A., & Dixon, K. (2012). Adoption rationales of new management practices. *Journal of Business Research*, 65, 371–380.

Decker, M., & Montagu, D. (2007). Reaching youth through franchise clinics: assessment of Kenyan private sector involvement in youth services. *The Journal of Adolescent Health*, 40(3), 280–282.

Dees, J. G., Anderson, B. B., & Wei-skillern, J. (2004). Scaling social impact: strategies for spreading social innovations. *Stanford Social Innovation Review*, 1(4), 24–32.

Desa, G., & Koch, J. L. (2014). Scaling social impact: building sustainable social ventures at the base-of-the-pyramid. *Journal of Social Entrepreneurship*, 5(2), 146–174.

- du Toit, A. (2014). Social franchising as organisational format – an overview. In I. Alon (Ed.), *Social franchising* (pp. 8–32). Basingstoke (UK): Palgrave Macmillan.
- Dubouloz, S. (2013). *L'innovation organisationnelle : antécédents et complémentarité : une approche intégrative appliquée au Lean Management*. Grenoble University.
- Duvall, S., Thurston, S., Weinberger, M., Nuccio, O., & Fuchs-Montgomery, N. (2014). Scaling up delivery of contraceptive implants in sub-Saharan Africa: operational experiences of Marie Stopes International. *Global Health: Science and Practice*, 2(1), 72–92.
- Fairbourne, J. S. (2007). Why Microfranchising is needed now: introduction and book overview. In J. S. Fairbourne, S. W. Gibson, & W. G. Dyer (Eds.), *Microfranchising - creating wealth at the bottom of the pyramid* (pp. 1–11). Cheltenham (UK), Northampton (MA): Edward Elgar Publishing Limited.
- Finney, G. S. (1993). *Building from strength: replication as a strategy for expanding social programs that work*. Philadelphia, PA: Replication and Program Services, Inc.
- Ganter, A., & Hecker, A. (2014). Configurational paths to organizational innovation: qualitative comparative analyses of antecedents and contingencies. *Journal of Business Research*, 67, 1285–1292.
- Garcia, R., & Calantone, R. (2002). A critical look at technological innovation typology and innovativeness terminology: a literature review. *The Journal of Product Innovation Management*, 19, 110–132.

- Gebauer, H. (2011). Exploring the contribution of management innovation to the evolution of dynamic capabilities. *Industrial Marketing Management*, 40, 1238–1250.
- Georgantzas, N. C., & Shapiro, H. J. (1993). Viable theoretical forms of synchronous production innovation. *Journal of Operations Management*, 11, 161–183.
- Gioia, D. A., & Chittipeddi, K. (1991). Sensemaking and sensegiving in strategic change initiation. *Strategic Management Journal*, 12(6), 433–448.
- Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2012). Seeking qualitative rigor in inductive research: notes on the Gioia methodology. *Organizational Research Methods*, 16(1), 15–31.
- Gioia, D. A., Price, K. N., Hamilton, A. L., & Thomas, J. B. (2010). Forging an identity: an insider-outsider study of processes involved in the formation of organisational identity. *Administrative Science Quarterly*, 55(1), 1–46.
- Gioia, D. A., & Thomas, J. B. (1996). Identity, image and issue interpretation: sensemaking during strategic change in academia. *Administrative Science Quarterly*, 41(3), 370–403.
- Gioia, D. A., Thomas, J. B., Clark, S. M., & Chittipeddi, K. (1994). symbolism and strategic change in academia: the dynamics of sensemaking and influence. *Organisation Science*, 5(3), 363–383.
- Giroux, H. (2006). “It was such a handy term”: management fashions and pragmatic ambiguity. *Journal of Management Studies*, 43(6), 1227–1260.

Gonsalves, J. F. (2001). Going to scale: what we have garnered from recent workshops. *Leisa Magazine*, 6–10.

Gopalakrishnan, S., & Damanpour, F. (1994). Patterns of generation and adoption of innovation in organizations: contingency models of innovation attributes. *Journal of Engineering and Technology Management*, 11, 95–116.

Gupta, R. K., & Awasthy, R. (2015). *Qualitative research in management - methods and experiences*. New Delhi: SAGE Publications India Pvt Ltd.

Hamel, G. (1998a). Strategy innovation and the quest for value. *Sloan Management Review*, 7–14.

Hamel, G. (1998b). The challenge today: changing the rules of the game. *Business Strategy Review*, 9(2), 19–26.

Hamel, G. (2006). The why, what, and how of management innovation. *Harvard Business Review*.

Hamel, G. (2009). Management innovation. *Leadership Excellence*, 26(5).

Harrison, S. H., & Corley, K. G. (2011). Clean climbing, carabiners and cultural cultivation: developing an open-systems perspective of culture. *Organisation Science*, 22(2), 391–412.

Hecker, A., & Ganter, A. (2013). The influence of product market competition on technological and management innovation: firm-level evidence from a large-scale

- survey. *European Management Review*, 10, 17–33.
- Hennink, M., & Clements, S. (2005). The impact of franchised family planning clinics in poor urban areas of Pakistan. *Studies in Family Planning*, 36(1), 33–44.
- Hervas-Oliver, J.-L., & Sempere-Ripoll, F. (2015). Disentangling the influence of technological process and product innovations. *Journal of Business Research*, 68, 109–118.
- Heyden, M. L. M., Sidhu, J. S., & Volberda, H. W. (2015). The conjoint influence of top and middle management characteristics on management innovation. *Journal of Management*, 1–25.
- Hoang, L. (2018). *The Atlantic Philanthropies Vietnam*. New York.
- Hollen, R. M. A., Van Den Bosch, F. A. J., & Volberda, H. W. (2013). The role of management innovation in enabling technological process innovation: an inter-organizational perspective. *European Management Review*, 10, 35–50.
- Huczynski, A. A. (1993). Explaining the succession of management fads. *The International Journal of Human Resource Management*, 4(2), 443–464.
- Huntington, D., Mundy, G., Hom, N., Li, Q., & Aung, T. (2012). Physicians in private practice: reasons for being a social franchise member. *Health Research Policy and Systems*, 10(25), 1–8.
- Jowett, A., & Dyer, C. (2012). Scaling-up successfully: pathways to replication for

- educational NGOs. *International Journal of Educational Development*, 32(6), 733–742.
- Kang, K. H., & Kang, J. (2009). How do firms source external knowledge for innovation? Analysing effects of different knowledge sourcing methods. *International Journal of Innovation Management*, 13(1), 1–17.
- Keupp, M. M., Palmié, M., & Gassmann, O. (2012). The strategic management of innovation: a systematic review and paths for future research. *International Journal of Management Reviews*, 14, 367–390.
- Kieser, A. (1997). Rhetoric and myth in management fashion. *Organization*, 4(1), 49–74.
- Kimberly, J. R. (1981). Managerial innovation. In P. C. Nystrom & W. H. Starbuck (Eds.), *Handbook of organizational design (vol.1) - Adapting organizations to their environments* (pp. 84–104). New York: Oxford University Press.
- Kistruck, G. M., Webb, J. W., Sutter, C. J., & Ireland, R. D. (2011). Microfranchising in base-of-the-pyramid markets: institutional challenges and adaptations to the franchise model. *Entrepreneurship: Theory and Practice*, 35(3), 503–531.
- Kjærgaard, A., Morsing, M., & Ravasi, D. (2011). Mediating identity: a study of media influence on organisational identity construction in a celebrity firm. *Journal of Management Studies*, 48(3), 514–543.
- Knight, K. E. (1967). A descriptive model of the intra-firm innovation process. *The Journal of Business*, 40(4), 478–496.

- Koehlmoos, T. P., Gazi, R., Hossain, S. S., & Rashid, M. (2011). *Social franchising evaluations: a scoping review*. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
- Koehlmoos, T. P., Gazi, R., Hossain, S. S., & Zaman, K. (2009). The effect of social franchising on access to and quality of health services in low- and middle-income countries (review). *The Cochrane Library*, (2), 1–18.
- Kozhimannil, K. B., Valera, M. R., Adams, A. S., & Ross-Degnan, D. (2009). The population-level impacts of a national health insurance program and franchise midwife clinics on achievement of prenatal and delivery care standards in the Philippines. *Health Policy*, 92(1), 55–64.
- Labianca, G., Gray, B., & Brass, D. J. (2000). A grounded model of organisational schema change during empowerment. *Organisation Science*, 11(2), 235–257.
- Letts, C. W., Ryan, W., & Grossman, A. (1997). Virtuous capital: what foundations can learn from venture capitalists. *Harvard Business Review*.
- Lin, H.-F., Su, J.-Q., & Higgins, A. (2016). How dynamic capabilities affect adoption of management innovations. *Journal of Business Research*, 69, 862–876.
- Lönnroth, K., Aung, T., Maung, W., Kluge, H., & Uplekar, M. (2007). Social franchising of TB care through private GPs in Myanmar: an assessment of treatment results, access, equity and financial protection. *Health Policy and Planning*, 22(3), 156–166.
- Lwin, M. M., Sudhinaraset, M., San, A. K., & Aung, T. (2014). Improving malaria

- knowledge and practices in rural Myanmar through a village health worker intervention: a cross-sectional study. *Malaria Journal*, 13(5), 1–5.
- Maguire, S., & Phillips, N. (2008). “Citibankers” at Citigroup: a study of the loss of institutional trust after a merger. *Journal of Management Studies*, 45(2), 372–401.
- Maitlis, S. (2005). The social processes of organisational sensemaking. *Academy of Management Journal*, 48(1), 21–49.
- Maitlis, S., & Lawrence, T. B. (2007). Triggers and enabler of sensegiving in organisations. *Academic of Management Journal*, 50(1), 57–84.
- Makkonen, H., Johnston, W. J., & Javalgi, R. G. (2016). A behavioral approach to organizational innovation adoption. *Journal of Business Research*, 69, 2480–2489.
- Mamman, A. (2002). The adoption and modification of management ideas in organizations: towards an analytical framework. *Strategic Change*, 11, 379–389.
- Mamman, A. (2009). From management innovation to management practice. *The International Journal of Organizational Innovation*, 2(2), 22–60.
- Mantere, S., Schildt, H. A., & Sillince, J. A. A. (2012). Reversal of strategic change. *Academy of Management Journal*, 55(1), 172–196.
- Marie Stopes International Viet Nam. (2012). *The official training guide for the provincial master trainers of the Sisterhood social franchising programme*. Ha Noi: MSIVN.
- McCabe, D. (2002). “Waiting for dead men’s shoes”: Towards a cultural understanding of

- management innovation. *Human Relations*, 55(5), 505–536.
- Meuter, J. (2008). Social franchising. *Berlin Institut*, 1–9.
- Midler, C. (2012). *L'Auto qui n'existait pas : management des projets et transformation de l'entreprise*. Paris: Dunod.
- Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: a methods sourcebook (3e)*. Thousand Oaks (CA): SAGE Publications, Inc.
- Moch, M. K., & Morse, E. V. (1977). Size, centralization and organizational adoption of innovations. *American Sociological Review*, 42, 716–725.
- Mol, M. J., & Birkinshaw, J. (2009). The sources of management innovation: when firms introduce new management practices. *Journal of Business Research*, 62, 1269–1280.
- Mol, M. J., & Birkinshaw, J. (2014). The role of external involvement in the creation of management innovations. *Organization Studies*, 35(9), 1287–1312.
- Montagu, D. (2002). Franchising of health services in low-income countries. *Health Policy and Planning*, 17(2), 121–130.
- Montagu, D., Ngamkitpaiboon, L., Duvall, S., & Ratcliffe, A. (2013). Applying the disability-adjusted life year to track health impact of social franchise programs in low- and middle-income countries. *BMC Public Health*, 13(2), 1–12.
- Montagu, D., Sudhinaraset, M., Lwin, T., Onozaki, I., Win, Z., & Aung, T. (2013). Equity

and the Sun Quality Health private provider social franchise: comparative analysis of patient survey data and a nationally representative TB prevalence survey. *International Journal for Equity in Health*, 12(5), 1–7.

Nachi, M. (2015). *Introduction à la sociologie pragmatique*. Armand Colin.

Nag, R., Corley, K. G., & Gioia, D. A. (2007). The intersection of organisational identity, knowledge and practice: attempting strategic change via knowledge grafting. *Academy of Management Journal*, 50(4), 821–847.

Nag, R., & Gioia, D. A. (2012). From common to uncommon knowledge: foundations of firm-specific use of knowledge as a resource. *Academy of Management Journal*, 55(2), 421–457.

Ngo, A. D., Alden, D. L., Nguyen, H., & Dinh, N. (2009). Developing and launching the government social franchise model of reproductive health care service delivery in Vietnam. *Social Marketing Quarterly*, 15(1), 71–89.

Ngo, A. D., Alden, D. L., Pham, V., & Phan, H. (2010). The impact of social franchising on the use of reproductive health and family planning services at public commune health stations in Vietnam. *BMC Health Services Research*, 10(54), 1–8.

Ngo, A. D., & Hill, P. S. (2011). Quality of reproductive health services at commune health stations in Viet Nam: implications for national reproductive health care strategy. *Reproductive Health Matters*, 19(37), 52–61.

Ngo, A. D., Phan, H., Pham, V., Trinh, T., & Truong, K. (2009). *Impacts of a government*

social franchise model on perceptions of service quality and client satisfaction at commune health stations in Vietnam (Global Development Network working paper series No. 21). Hanoi (Vietnam).

Nguyen, P. H., Kim, S. S., Keithly, S. C., Hajeerhoy, N., Tran, L. M., Ruel, M. T., ... Menon, P. (2014). Incorporating elements of social franchising in government health services improves the quality of infant and young child feeding counselling services at commune health centres in Vietnam. *Health Policy and Planning*, 29, 1008–1020.

Nguyen, P. H., Menon, P., Keithly, S. C., Kim, S. S., Hajeerhoy, N., Tran, L. M., ... Rawat, R. (2014). Program impact pathway analysis of a social franchise model shows potential to improve infant and young child feeding practices in Vietnam. *The Journal of Nutrition*, 144(10), 1627–1636.

Nieves, J., & Segarra-Ciprés, M. (2015). Management innovation in the hotel industry. *Tourism Management*, 46, 51–58.

Nijmeijer, K. J., Fabbricotti, I. N., & Huijsman, R. (2014a). Exploring the role of ownership structures in the results of professional health care franchises from a multi-actor perspective. *Journal of Marketing Channels*, 21(3), 159–179.

Nijmeijer, K. J., Fabbricotti, I. N., & Huijsman, R. (2014b). Is franchising in health care valuable? A systematic review. *Health Policy and Planning*, 29(2), 164–176.

Nijmeijer, K. J., Fabbricotti, I. N., & Huijsman, R. (2015). Creating advantages with franchising in healthcare: an explorative mixed methods study on the role of the

- relationship between the franchisor and units. *PLoS ONE*, 10(2), 1–21.
- Nijmeijer, K. J., Huijsman, R., & Fabbriotti, I. N. (2014). Creating advantages through franchising in healthcare: a qualitative, multiple embedded case study on the role of the business format. *BMC Health Services Research*, 14(485), 1–15.
- Nonaka, I., & Peltokorpi, V. (2006). Knowledge-based view of radical innovation: Toyota Prius case. In J. Hage & M. Meeus (Eds.), *Innovation, science, and institutional change: a research handbook* (pp. 88–104). Oxford: Oxford University Press.
- O’Connell, K., Hom, M., Aung, T., Theuss, M., & Huntington, D. (2011). Using and joining a franchised private sector provider network in Myanmar. *PloS One*, 6(12), 1–6.
- Oxenfeldt, M. R., & Kelly, A. O. (1968). Will successful franchise systems ultimately become wholly-owned chains? *Journal of Retailing*, 44(4), 69–83.
- Patouillard, E., Goodman, C. a, Hanson, K. G., & Mills, A. J. (2007). Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature. *International Journal for Equity in Health*, 6(17), 1–11.
- Patton, M. Q. (2015). *Qualitative research & evaluation methods: integrating theory and practice (4th edition)*. Thousand Oaks (CA): SAGE Publications, Inc.
- Peeters, C., Massini, S., & Lewin, A. Y. (2014). Sources of variation in the efficiency of adopting management innovation: the role of absorptive capacity routines, managerial attention and organizational legitimacy. *Organization Studies*, 35(9),

1343–1371.

- Perrigot, R. (2018). Franchising in the healthcare sector: the case of child and family wellness clinics in Kenya. *Journal of Retailing and Consumer Services*, 41, 227–238.
- Pettigrew, A. M., Woodman, R. W., & Cameron, K. S. (2001). Studying organizational change and development: challenges for future research. *Academy of Management Journal*, 44(4), 697–713.
- Poonamallee, L. (2011). Transforming realities-making the improbable possible: reclamation of sacredness as a source of generative capacities. *Journal of Management Inquiry*, 20(3), 242–262.
- Prata, N., Montagu, D., & Jefferys, E. (2005). Private sector, human resources and health franchising in Africa. *Bulletin of the World Health Organisation*, 83(4), 274–279.
- Pratt, M. G., Rockmann, K. W., & Kaufmann, J. B. (2006). Constructing professional identity: the role of work and identity learning cycles in the customisation of identity among medical residents. *Academy of Management Journal*, 49(2), 235–262.
- Qureshi, A. M. (2010). Case Study: does training of private networks of family planning clinicians in urban Pakistan affect service utilization? *BMC International Health and Human Rights*, 10(26), 1–12.
- Rasmussen, L., & Hall, H. (2016). The adoption process in management innovation: a knowledge management case study. *Journal of Information Science*, 42(3), 356–368.

Rauth, I. (2015). *Understanding management ideas: The development of interpretability*.
Chalmers University of Technology.

Ravasi, D., & Phillips, N. (2011). Strategies of alignment: organisational identity management and strategic change at Bang & Olufsen. *Strategic Organisation*, 9(2), 103–135.

Ravindran, T. S., & Fonn, S. (2011). Are social franchises contributing to universal access to reproductive health services in low-income countries? *Reproductive Health Matters*, 19(38), 85–101.

Rémy, É., & Cléret, B. (2014). De l'habillage au déshabillage socio-culturel de la FNAC. In I. Collin-Lachaud (Ed.), *Repenser le commerce: vers une perspective socio-culturelle de la distribution* (pp. 51–74). Cormelles-le-Royal: EMS.

Rerup, C., & Feldman, M. S. (2011). Routine as a source of change in organisational schemata: the role of trial-and-error learning. *Academy of Management Journal*, 54(3), 577–610.

Richardson, M., & Berelowitz, D. (2012). *Investing in social franchising (research for Big Society Capital)*.

Rindova, V., Dalpiaz, E., & Ravasi, D. (2011). A cultural quest: a study of organisational use of new cultural resources in strategy formation. *Organisation Science*, 22(2), 413–431.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2014). *Qualitative research practice*

- *a guide for social science students & researchers (2nd edition)*. London (UK): SAGE Publications Ltd.

Rogers, E. M. (2003). *Diffusion of innovations (5th ed)*. New York: Free Press.

Rowley, J., Baregheh, A., & Sambrook, S. (2011). Towards an innovation-type mapping tool. *Management Decision*, 49(1), 73–86.

Saldana, J. (2013). *The coding manual for qualitative researchers (2e)*. Sage Publication. London (UK): SAGE Publications Ltd.

Sanghvi, T., Martin, L., Hajeerhoy, N., Abrha, T. H., Abebe, Y., Haque, R., ... Roy, S. (2013). Strengthening systems to support mothers in infant and young child feeding at scale. *Food and Nutrition Bulletin*, 34(3), 156–168.

Schlein, K., De La Cruz, A. Y., Gopalakrishnan, T., & Montagu, D. (2013). Private sector delivery of health services in developing countries: a mixed-methods study on quality assurance in social franchises. *BMC Health Services Research*, 13(4), 1–12.

Shah, N. M., Wang, W., & Bishai, D. M. (2011). Comparing private sector family planning services to government and NGO services in Ethiopia and Pakistan: how do social franchises compare across quality, equity and cost? *Health Policy and Planning*, 26, i63–i71.

Sieverding, M., Briegleb, C., & Montagu, D. (2015). User experiences with clinical social franchising: qualitative insights from providers and clients in Ghana and Kenya. *BMC Health Services Research*, 15(49), 1–11.

- Sireau, N. (Ed.). (2011). *Microfranchising: how social entrepreneurs are building a new road to development*. Sheffield (UK): Greenleaf Publishing Limited.
- Sivakumar, A., & Schoormans, J. P. (2011). Sustainable rural healthcare and social franchisee selection - an India study. *Journal of Medical Marketing*, 11(3), 230–236.
- Sivakumar, A., & Schoormans, J. P. L. (2011). Franchisee selection for social franchising success. *Journal of Nonprofit & Public Sector Marketing*, 23, 213–225.
- Stephenson, R., Tsui, A. O., Sulzbach, S., Bardsley, P., Bekele, G., Giday, T., ... Feyesitan, B. (2004). Franchising reproductive health services. *Health Services Research*, 39(6), 2053–2080.
- Stigliani, I., & Ravasi, D. (2012). Organising thoughts and connecting brains: material practices and the transition from individual to group-level prospective sensemaking. *Academy of Management Journal*, 55(5), 1232–1259.
- Sturdy, A. (2004). The adoption of management ideas and practices: theoretical perspectives and possibilities. *Management Learning*, 35(2), 155–179.
- Thomas, J. B., Sussman, S. W., & Henderson, J. C. (2001). Understanding “strategic learning”: linking organisational learning, knowledge management and sensemaking. *Organisation Science*, 12(3), 331–345.
- Thurston, S., Chakraborty, N. M., Hayes, B., Mackay, A., & Moon, P. (2015). Establishing and scaling-up clinical social franchise networks: lessons learned from Marie Stopes International and Population Services International. *Global Health: Science and*

Practice, 3(2), 180–194.

- Tougher, S., Dutt, V., Pereira, S., Haldar, K., Shukla, V., Singh, K., ... Powell-Jackson, T. (2018). Effect of a multifaceted social franchising model on quality and coverage of maternal, newborn, and reproductive health-care services in Uttar Pradesh, India: a quasi-experimental study. *Lancet Global Health*, 6, e211–e221.
- Tracey, P., & Jarvis, O. (2006). An enterprising failure: why a promising social franchise collapsed (case study). *Stanford Social Innovation Review*, 66–70.
- Tracey, P., & Jarvis, O. (2007). Toward a theory of social venture franchising. *Entrepreneurship Theory and Practice*, 31(5), 667–685.
- Tracy, S. J. (2013). *Qualitative research methods: collecting evidence, crafting analysis, communicating impact*. Hoboken (NJ): Wiley-Blackwell.
- Vaccaro, I. G., Jansen, J. J. P., Van Den Bosch, F. A. J., & Volberda, H. W. (2012). Management innovation and leadership: the moderating role of organizational size. *Journal of Management Studies*, 49(1), 28–51.
- Van De Ven, A. H., & Poole, M. S. (1995). Explaining development and change in organizations. *Academy of Management Review*, 20(3), 510–540.
- Vanderstoep, S. W., & Johnston, D. D. (2009). *Research methods for everyday life: blending qualitative and quantitative approaches*. San Francisco: Jossey-Bass.
- Viswanathan, R., Behl, R., & Seefeld, C. A. (2016). *Clinical social franchising*

compendium: an annual survey of programs (findings from 2015). San Francisco: The Global Health Group, Global Health Sciences, University of California, San Francisco.

Volberda, H. W., Van Den Bosch, F. A. J., & Heij, C. V. (2013). Management innovation: management as fertile ground for innovation. *European Management Review*, 10, 1–15.

Volberda, H. W., Van Den Bosch, F. A. J., & Mihalache, O. R. (2014). Advancing management innovation: synthesizing processes, levels of analysis, and change agents. *Organization Studies*, 35(9), 1245–1264.

Volery, T., & Hackl, V. (2010). The promise of social franchising as a model to achieve social goals. In A. Fayolle & H. Matlay (Eds.), *Handbook of Research on Social Entrepreneurship* (pp. 157–181). Cheltenham, UK: Edward Elgar.

Vu, H. V., Tran, T. D., Nguyen, C. M., & Nguyen, T. T. T. (2014). *Baseline assessment of the project “Advancing the government social franchising model of reproductive healthcare services in Vietnam to scale up nationally.”* Ha Noi: Marie Stopes International Viet Nam and Health Strategy and Policy Institute.

Walker, R. M., Chen, J., & Aravind, D. (2015). Management innovation and firm performance: an integration of research findings. *European Management Journal*, 33, 407–422.

Walker, R. M., Damanpour, F., & Devece, C. A. (2010). Management innovation and

- organizational performance: the mediating effect of performance management. *Journal of Public Administration Research and Theory*, 21, 367–386.
- Walston, S. L., Urden, L. D., & Sullivan, P. (2001). Hospital reengineering: an evolving management innovation: history, current status and future direction. *Journal of Health and Human Services Administration*, 23(4), 388–415.
- Westley, F., Antadze, N., Riddell, D. J., Robinson, K., & Geobey, S. (2014). Five configurations for scaling up social innovation: case examples of nonprofit organizations from Canada. *Journal of Applied Behavioral Science*, 50(3), 234–260.
- Wolfe, R. A. (1994). Organizational innovation: review, critique and suggested research directions. *Journal of Management Studies*, 31(3), 405–431.
- World Bank, & Ministry of Planning and Investment of Vietnam. (2016). *Vietnam 2035: toward prosperity, creativity, equity, and democracy*. Washington (DC): World Bank.
- Wright, C., Sturdy, A., & Wylie, N. (2012). Management innovation through standardization: consultants as standardizers of organizational practice. *Research Policy*, 41, 652–662.
- Yin, R. K. (2011). *Qualitative research from start to finish*. New York: The Guilford Press.
- Yin, R. K. (2014). *Case study research: design and methods (5e)*. Thousand Oaks (CA): SAGE Publications, Inc.
- Zafeiropoulou, F. A., & Koufopoulos, D. N. (2013). The influence of relational

embeddedness on the formation and performance of social franchising. *Journal of Marketing Channels*, 20(1–2), 73–98.

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