Innovative business practices at the bottom of the pyramid in South Africa

A study of SAHealth Clinic

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Abstract

In an era characterised by tough financial constraints and increased pressure to fulfil social imperatives, bottom of the pyramid (BoP) strategies have been viewed as a possible panacea to attaining the dual goals of generating a profit for companies, as well as contributing to the socio-economic development of the marginalised poor, who live on $2-$5 a day, according to Prahalad (2010). However, literature indicates that there are few examples of successful BoP initiatives. This study set out to investigate Pharma Logistix's innovative business strategy at the bottom of the pyramid in South Africa, called SAHealth Clinic, which aims to increase good-quality, affordable primary healthcare in low-income areas, while promoting entrepreneurship.

A case study approach was used to explain the business model and its impact at four sites in Gauteng from the perspectives of the company, the community which benefits and the nurses who run the clinics as entrepreneurs. The research revealed that the nurses and the community benefitted immensely from the SAHealth Clinic concept; however, the company did not aim to make a profit from this initiative. It gained value through its brand image and reputation, as well as achieving a perfect scorecard in terms of enterprise development and corporate social responsibility. The initiative is relatively sustainable at present, and has the potential to effect major positive change in healthcare provision in time; however, numerous challenges exist.

The business model subverts some of the BoP theoretical norms and blurs the line between BoP, corporate social responsibility and social franchising to achieve its goals.

Declaration

I, Nazli Jugbaran, declare that this research report is my own work except as indicated in the references and acknowledgements. It is submitted in partial fulfilment of the requirements for the degree of Master of Business Administration in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in this or any other university.

It should be noted that the name of the company and the project has been changed for confidentiality purposes.

Nazli Jugbaran

Signed at ……

On the …….. day of …… 2014

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CHAPTER 1: INTRODUCTION

1.1 Context of the study

Porter and Kramer (2011) state that society has transitioned into an era where corporates are under severe pressure to change the way they currently operate. Socio-economic concerns have resulted in external pressures being placed on corporates to broaden their role in society and to contribute towards societal issues through the creation of shared value. In addition, due to the failure of classical capitalism, corporates are finding it difficult to remain financially lucrative and competitive within the present economic climate (Hart, 2009; Zingales, 2009; Barton, 2011).

It has become necessary for corporates to conceptualise alternative business models to maintain a competitive advantage, through innovations in existing markets or by exploring innovative ways of operating in new markets (Nidumolu, Prahalad & Rangaswami, 2009; Porter & Kramer, 2011). Hart and London (2004) and Chipp, Corder and Kapelianis (2012) state that companies are moving away from looking solely at developed markets with high disposable incomes, due to the escalating levels of saturation and competition. In the search for growth and prosperity, some companies are venturing into the very low-income market. This market segment, known as the 'bottom of the pyramid' (BoP), refers to the world's poorest four to five billion people who live on $2 or less every day and is in the most dire need of socio-economic upliftment (Prahalad, 2004, 2010).

a) Poverty and unemployment

Chandy and Gertz (2011) posit that global poverty has decreased over the last six years within developing countries, such as India and China, and that the total number of poor people has fallen from over 1.3 billion in 2005 to under 900 million in 2010. However, they estimate that there will be approximately 600 million people globally earning less than $1.25 a day in 2015. Furthermore, the disparity between the rich and the poor is increasing and poverty remains a formidable challenge globally.

Im *et al* (2012), confirm that South Africa has one of the highest Gini coefficients in the world. In 2008, its income Gini was calculated at around 0.70, and in 2009, its consumption Gini was 0.63, making South Africa one of the most unequal countries in the world. Poverty in South Africa is exacerbated by the high unemployment rate. Heideman (2011) indicated that from 2001 to 2007, South Africa had 12.4 million employed and 4.3 million unemployed people. In 2010, approximately 56 per cent of prime-aged men and 40 per cent of prime-

aged women were engaged in employment (Magruder, 2011). Bernstein (2013) states that in 2012, South Africa's working age population (16 to 65) consisted of 33 million people, of whom only 18 million (56 per cent) were employed or proactively looking for employment. At present, approximately 41 per cent of adults are employed or self-employed, which is lower than the international norm. Youth employment in South Africa is also below international standards, with only one out of eight youth being employed, compared to two out of five in other emerging economies.

b) Healthcare concerns

Many developing countries face major primary healthcare challenges in terms of accessibility and affordability, as a result of the socio-economic problems facing these countries (Peters *et al*, 2008).

Coovadia, Jewkes, Barron, Sanders and McIntyre (2009), state that in SA, less than 15% of the population have medical scheme benefits, which enable access to private healthcare. The majority of the South African population – approximately 67% of the population depends on the public health system, which is plagued by a number of issues such as poor infrastructure and resource capabilities, inefficient management, and an overall skills shortage of healthcare professionals. This problem is confounded by the expensive transport costs, time taken off work and lengthy queues to access adequate healthcare at public health facilities nationwide.

c) The role of business in society

According to London (2008), most funding agencies' initiatives and aid programmes that assist in poverty alleviation have been unsustainable. Furthermore, the quality of life of the poor has not shown a drastic long-term improvement, through their dependence on aid and other interventions implemented by non-governmental organisations (NGOs) and financially constrained governments, thus warranting an alternative approach to achieving development (Sprague, 2008).

This has led to the debate about the role of corporates in society (Banerjee, 2008). There has been a growing emphasis on good corporate citizenship, such as corporate governance and corporate social responsibility (CSR) (Banerjee, 2008; King, 2009). Corporates are realising that their strategic imperatives need to adapt to the changing global environment, in order to remain competitive and to enhance the sustainability of their business practices (Hart & London, 2004; Porter & Kramer, 2011; Boulouta & Pitelis, 2013). This is only

achievable through taking the triple bottom line into consideration when formulating their business strategies (King, 2009; Mark-Herbert, Rotter & Pakseresht, 2010).

According to Jenkins (2005), one way that corporates have tried to serve society is through CSR. However, Banerjee (2008) notes that CSR does not aim to directly generate profits for the company, therefore, there is a perception that many companies do not fully engage with the process; they merely choose initiatives that enable them to fulfil the minimum requirements in the form of a tickbox exercise. These initiatives are not sustainable and offer little value to the recipients, except to enable the company to report on it. This 'greenwashing' approach is superficial as many companies view CSR as being an unnecessary expense rather than an integral component of their corporate strategy (Hamann, Woolman, & Sprague, 2010). Some academics argue that CSR has failed to achieve its social welfare goals (Banerjee, 2008; Visser, 2010; Ismail & Kleyn, 2012).

Is there another approach that can achieve the dual goals of development and profit, while taking into consideration the challenging economic climate? Innovative business strategies implemented at the BoP present an opportunity to create a win-win situation by addressing poverty alleviation through offering solutions that are also financially viable (Prahalad 2010; Porter & Kramer, 2011; Ismail & Kleyn, 2012). They have the potential to increase the lower income market's earnings, through job creation, partnerships and networking, fostering entrepreneurialism, improving infrastructure and access to basic services, and increasing production capabilities, which will invariably improve this market segment's quality of life and South Africa's overall socio-economic status (Seelos & Mair, 2007; Ahlstrom, 2010). When well-conceptualised, these strategies have the propensity to fulfil society's expectations of how a corporate is meant to operate within communities, as well as enable the company to explore alternate sources of revenue that will contribute towards the sustainability of the business (Ahlstrom, 2010).

1.2 Problem statement

1.2.1 *Main problem*

Businesses are struggling to remain financially viable in a competitive market under the current economic climate and their sustainability is threatened (Hart, 2009; Zingales, 2009; Barton, 2011). However, there is also increased pressure for businesses to address societal challenges and contribute in a meaningful way to society (Porter & Kramer, 2011). It is proposed that innovative business strategies at the BoP have the potential to address both

these issues by contributing towards sustainable socio-economic development, while attaining financial goals (Prahalad 2010; Ismail & Kleyn, 2012). Although this approach appears to be an apt solution, successful conceptualisation and implementation has proved to be difficult, and the ultimate aim of creating shared value in terms of profit for the company and socio-economic development in the community in which it operates has not always been achievable (Arora & Romijn, 2009; Karnani, 2009, Simanis & Milstein, 2012).

1.3 Purpose of the study

The study fills a gap in that limited research has been conducted in the South African context to investigate innovations at the bottom of the pyramid that create shared value. With the exception of the financial industry, BoP initiatives implemented in the South African context have only recently been given attention; therefore, there is limited academic literature available. In their recent book *New Markets, New Mindsets*, Ismail and Kleyn (2012) document a number of BoP undertakings by South African corporates, such as Massmart, Clover-Danone and South African Breweries (SAB). However, most of the case studies focus on the companies' perspectives of the BoP venture, and the community perspective is largely omitted. This body of research seeks to include multiple perspectives in order to gain a holistic view of the BoP venture.

Furthermore, critics of BoP theory such as Karnani (2006, 2007, 2009), Jaiswal (2007) and Chatterjee (2009) state that most of the BoP initiatives described took place in India and that many of these cases do not actually adhere to the principles set out in the BoP proposition. They further argue that both the dual goals of profit generation and poverty alleviation or economic development have seldom resulted from BoP undertakings.

This study aims to examine an innovative business strategy at the bottom of the pyramid in South Africa (Pharma Logistix's SAHealth Clinic), and ascertains the extent to which this BoP initiative is able to fulfil the company's financial objectives, while benefiting the communities in which it operates. It also seeks to ascertain if it achieves its objectives according to the BoP proposition.

1.4 Significance of the study

This body of research will be relevant to any corporate employee at managerial or executive level interested in remaining competitive by entering inclusive markets. It will appeal to corporate strategists; BoP consultants; academics; students; practitioners and researchers

interested in business, innovation, public health or development; and to stakeholders in the healthcare industry.

1.5 Delimitations of the study

- This study focuses on one company's BoP initiative in the healthcare sector that is unique and has not been duplicated within South Africa to date.
- The scope of the analysis of the BoP strategy is restricted to financial and developmental goals as set out by the research questions.
- The research involves respondents who are directly involved in the initiative.

1.6 Assumptions

- The BoP business model is an excellent example of a successful and sustainable innovative business strategy in the low-income market.
- The business model adheres to the principles of contemporary BoP theory.
- The community benefits resulting from this model outweigh the company's financial gain.
- It is possible to get pluralistic views from various stakeholders involved in this BoP model.
- All respondents were honest.

1.7 Definition of terms

Bottom of the pyramid: This refers to the world's four billion poorest people, who earn around $2 per day (Prahalad, 2010).

BoP 1.0: This refers to all BoP theory up to the year 2005 (Arora & Romijn, 2009).

BoP 2.0: To address the shortcomings of BoP 1.0, BoP 2.0 is based on opening up, building the eco-system and enterprise creation with co-creation at the centre. This replaces 'the fortune *at* the BoP' with 'the fortune *with* or *for* the BoP' (Hart & Simanis, 2008).

Corporate social responsibility: There is no consensus on a CSR definition. CSR can be defined as the voluntary integration of socio-economic and environmental concerns in enterprises' daily business operations and in the interaction with their stakeholders. It is an

approach that ideally should be integrated into the company's value system (Banerjee, 2008; Hamann *et al*, 2010).

Corporate social investment: Refers to social development activities that are generally donor-related and are not intended to generate an income (Hamann *et al*, 2010).

Entrepreneur: An individual who runs a small business, instead of working for an employer, thus assuming the risks and benefits (Carland, Carland & Hoy, 2002).

Enterprise development: Developing micro- or small enterprises that are 50% black-owned or black female-owned, by providing 3% of the company's profit as funding and support. It generates 15 points on the BEE scorecard (Department of Trade and Industry, 2012).

Shared value creation: Business practices which lead to mutual benefits for business (competitive advantage and profits) as well as society in general (sustainability and socio-economic development) (Porter & Kramer, 2011).

Social franchise: This business model uses commercial franchising principles for a social purpose, such as forming a network of healthcare providers, while it endeavours to make a profit (Beyeler, De La Cruz & Montagu, 2013).

Socio-economic development: This refers to social development or corporate social responsibility programmes that aim to uplift communities. It requires the company to spend 1% of its net operating profit after tax, and gains the company five points on the scorecard (Department of Trade and Industry, 2012).

1.8 Outline of research report

Chapter 1 contextualises the research and explains its purpose and contribution to the literature in the BoP field.

Chapter 2 consists of a literature review which provides a critical analysis of BoP theory and practice since it was popularised by Prahalad in 2002. It documents how the theory has evolved and changed over time, bringing with it new challenges and possibilities for innovative business strategies, and concludes with the research questions to be investigated.

Chapter 3 describes the research methodology process that will be undertaken to enhance the validity and reliability of the data. This chapter also explains the case study site, the

qualitative process that encompasses suitable sampling and data collection methods, as well as the rigorous data analysis process that culminates in triangulation.

Chapter 4 presents the findings of the research in relation to the research questions.

Chapter 5 comprises the analytical discussion of the findings. It triangulates the data between the community, nurses, corporate interviews and corporate documentation, as well as contrasts the data to the BoP proposition as described in the literature review.

Chapter 6 summarises the research report, by highlighting the salient points and conclusions that emanate from the findings and analysis. It further discusses the limitations of the research and the implications of the findings. The report concludes with recommendations and suggestions for future research.

CHAPTER 2: LITERATURE REVIEW

This chapter provides an overview and a critical analysis of the key concepts and practices that underpin the conceptualisation and implementation of innovative business strategies at the bottom of the pyramid (BoP), as the field has evolved over the years. It begins with the motivation for BoP strategies and then describes initial BoP theory, its practice and contentions, followed by a discussion about contemporary BoP theory. The chapter concludes the literature review with the research questions to be investigated.

2.1. The compelling argument for business strategies at the BoP

It is widely accepted that the poor pay more than the wealthier sectors of the population to participate in the market place and to access essential services (Kunrether, 1973; Folse, 2002; Sprague, 2008; Kaplan, 2009; Mendoza, 2011). This 'poverty penalty' manifests in various ways, such as inferior quality, higher price, non-access (caused by exclusion due to exorbitant price) and non-usage (where the person prefers not to participate in the activity and exits the market due to the price or quality) (Mendoza, 2011). It is also evident in the catastrophic spending burden (where a necessary expense such as a dire need for healthcare forces the individual to make detrimental choices such as enter into severe debt, lose employment, or drop out of school) (Mendoza, 2011).

Prahalad and Hammond (2002) have illustrated the poverty penalty concept by contrasting the costs of products and services in the rich Warden Road area and Daravi the poor area, which are located in Mumbai, India. They found that the poor pay a poverty penalty of between 20 per cent and 5300 per cent for the same products and services bought by the rich.

In parallel to the issues around poverty, Prahalad and Hammond (2002) state that it has become increasingly more difficult for companies to achieve sustainable growth. By engaging with the BoP, companies are able to access alternative revenue sources, as these markets are underdeveloped with huge growth potential. The company also stands to benefit from lower cost structures and saving efficiencies, while exploring their innovative potential to serve the needs of the poor. These strategies require a different type of business model when compared to traditional business, and should be based on high volume, low margin per unit, capital efficiency with regard to fixed and working capital and intelligent investment in technology and distribution resources. This has the propensity to lead to a high return on investment (Prahalad & Hammond, 2002).

These arguments provide a compelling justification for proactively serving the BoP (Prahalad & Hammond, 2002). Prahalad's game-changing theory about how businesses can profitably help alleviate poverty through tapping into the BoP officially surfaced in 2002 (Prahalad & Hart, 2002). It built a business case and simultaneously addressed moral societal issues (Rivera-Santos & Rufin, 2010). The concept has gained momentum, having acquired many proponents and dissidents since its inception (Kolk, Rivera-Santos & Rufín, 2012).

Landrum (2007) and Lenz and Pinhanez (2012) state that corporates have found it easy to identify with the BoP proposition, due to its financial imperative and business-friendly approach. Immediate financial benefits are not as evident in other approaches that attempt to coerce companies to align with the triple bottom line and social responsibility principles beyond financial gain.

2.2. Defining the BoP and its financial viability

Prahalad coined the term 'bottom of the pyramid' in 2002, which refers to the world's poorest socio-economic group consisting of four to five billion people, who live on less than $1500 a year (Prahalad & Hart, 2002). The BoP is also known as the 'base of the pyramid', which is deemed more politically correct (Landrum 2007; Hart 2010; Arora & Romijn 2009).

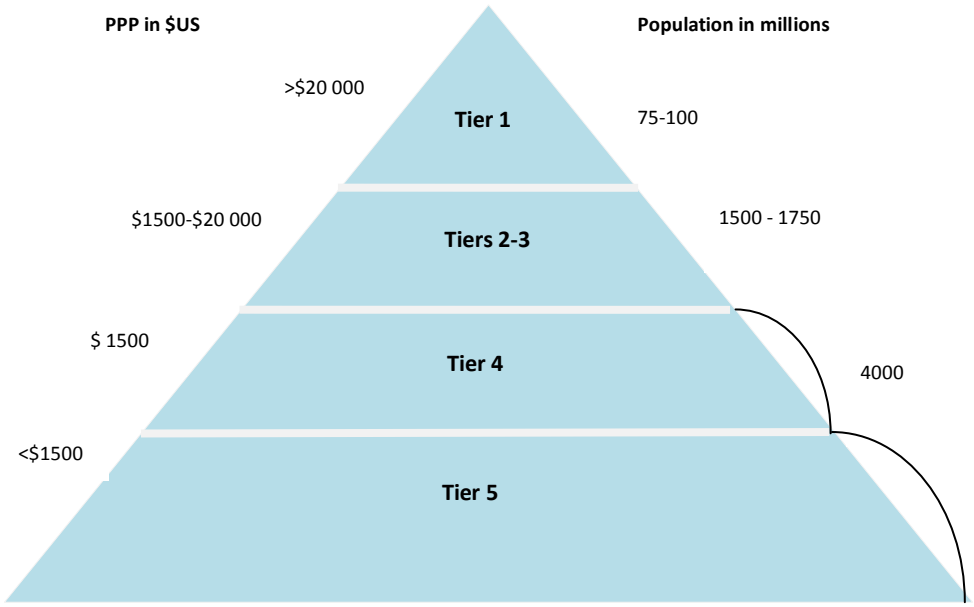

Figure 1: The world economic pyramid

Source: Prahalad (2004, 2010)

This report uses both terms interchangeably, when referring to the BoP, which constitutes Tiers 4 and 5 of the world's economic pyramid in terms of the purchasing power parity (PPP) in US dollars (USD) in relation to the population in millions, as depicted in *Figure 1* (Prahalad 2004, 2010).

The sheer number of people in this category translates into the premise that the BoP is a multi-trillion dollar market (Prahalad & Hart, 2002). Crabtree (2007) and Karnani (2007) challenge the notion of there being a fortune at the bottom of the pyramid. They question the size of the BoP, the reliability of these data, as well as the economic viability of this market.

Relying on the World Bank's statistics from 2002, Karnani (2007) estimates the BoP's purchasing power parity (PPP) to be $1.2 trillion, as opposed to Prahalad and Hart's estimation of $13 trillion. Another key factor is that once profits are redeemed in foreign exchange (and not PPP), the BoP market is only worth $300 billion, which is hardly as appealing as initially envisioned.

Furthermore, Karnani (2007) argues that the BoP is in fact a heterogeneous market, with varying needs, and is generally geographically dispersed. This infers that companies should target a segmented market within the BoP, which further reduces the financial potential for companies. This is compounded by the fact that discretionary spending is limited after accounting for food, transport and healthcare costs. Jaiswal (2007) concurs that the 1.1 billion people earning less than $1 per day, as cited by the World Bank in 2001, are poverty stricken and unable to meet basic needs yet alone be viewed as a profitable market. However, Prahalad and Hammond (2002) opine that the poor are brand conscious and aspirational and sometimes purchase luxury items.

The definition of what constitutes the poor is evidently a contentious issue, as poverty manifests and is experienced differently according to geographic location, sociological and cultural factors, historical legacy and the economic and political contexts (Chatterjee, 2009). In addition, the BoP definition is inconsistent as the minimum financial requirement for what characterises the BoP has been changed over time, from $1500 or less annually (Prahalad & Hart 2002) to $2000 annually (Prahalad & Hammond 2002), or $2 per day (Prahalad 2004). Karnani (2006) asserts that these are very different market segments with different purchasing patterns. To obviate these concerns, the BoP may be used as a generic term to describe people of a low socio-economic status who live in informal settlements (London, Anupindi & Sheth, 2010).

Jaiswal (2007) is adamant that Prahalad and Hart (2002) approach the BoP too simplistically. Most of the BoP is found in developing countries and the least developed countries (LDCs), which have many institutional voids, infrastructural problems, corruption, abject poverty and inadequate regulation. This impedes the business motivation for entering these markets. Furthermore, Landrum (2007) and Jaiswal (2007) share the sentiment that the most successful BoP initiatives cited have been implemented in emerging countries such as India, which does not necessarily mean that similar strategies will be successful when extrapolated to other developing countries or LDCs.

In South Africa, the BoP presents differently. Chipp *et al* (2012) refer to the BoP as the Foundation category, where individuals earn R43.73 per day, as illustrated in *Figure 2*. Due to the current exchange rate, this is aligned to the cut-offs of $5.00 - $5.50 per day that describes the BoP, as reported by Prahalad and Hammond (2002) and Rangan (2005). This daily income is attributed to social welfare grants as well as government intervention, which impact at household level. The average household income of R68.99 per day in the Foundation category becomes significant for companies embarking on BoP initiatives.

Chipp *et al* (2012) state that in comparison to people at the higher levels of the economic pyramid, the BoP most likely consists of black South Africans who live a more traditional lifestyle in communities consisting of fewer than 4000 people. Collectivism is evident at the BoP level, in terms of communitarianism.

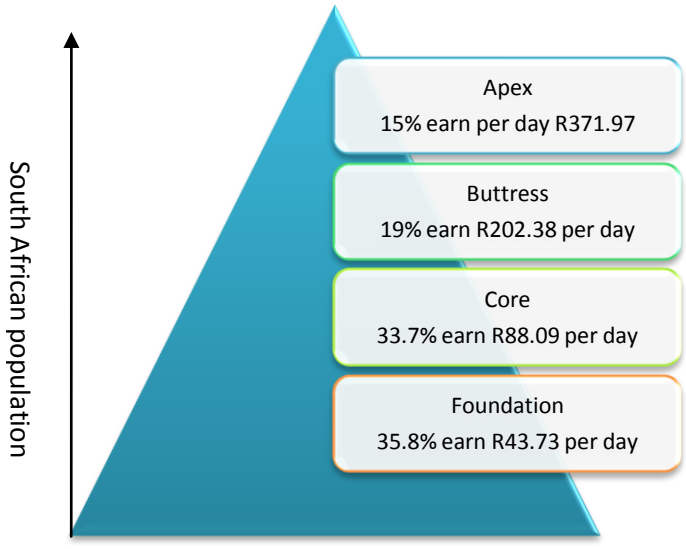

Figure 2: The South African economic pyramid

Source: Chipp et al (2012)

Prahalad and Hammond (2002) and Chipp *et al* (2012) argue that although personal income is an important indicator of BoP classification, household income and sometimes collective

community spending is a more accurate indicator, which further increases the variance at the BoP, thus confounding the BoP classification. The implication, however, is that companies should look at this dimension when entering the BoP, as opposed to focusing on individual spend, because decision making in terms of purchasing patterns is not necessarily restricted to individuals.

2.3. Initial conceptualisation of BoP strategies

Rangan (2007) and London (2008) state that most BoP ventures are characterised by selling goods or services to the poor, or by sourcing goods from the poor in order to increase their quality of life, while being income generating to the corporate. This contextualises the BoP as consumers or producers.

2.3.1. The BoP as consumers

Prahalad and Hart (2002) propose that the poor should not be viewed as victims but as a lucrative consumer market that is value conscious. Prahalad and Hart (2002), Prahalad (2004, 2010) and Ismail and Kleyn (2012) agree that the BoP is an ignored and under-served market by the private sector, both globally and locally. Therefore, multi-national corporations (MNCs) have the opportunity to serve these very specific unmet needs and wants profitably as a social imperative. Prahalad (2004, 2010) and Anderson and Billou (2007) encourage consumption at the BoP level and state that products and services should be accessible (in terms of an excellent distribution network), affordable (without compromising quality), acceptable (good quality and adapted to the unique needs of the sector), and available (for immediate purchasing decisions). In addition, creating awareness of the product or service is pertinent to adoption.

Consumerism may be facilitated through disruptive innovation or frugal engineering which involves developing and designing high-quality products or services, repackaging products and selling them at a suitable price, and offering purchase schemes (Prahalad, 2004; Christensen, 2006). Prahalad and Hammond (2002), Hart and Christensen (2002) and Seelos and Mair (2007) concur that disruptive innovation is a crucial aspect when moving from existing markets into the BoP, which assists business to grow and to maintain a competitive advantage, while deterring new market entrants. However, the resources and capabilities that businesses possess would not be necessarily relevant to the BoP, thus it would take time to build capacity.

Prahalad (2004, 2010) suggests 12 principles of innovation when creating products and services for the BoP (Refer to *Figure 3*).

The 12 principles of innovation

1. Price performance
2. Hybrid solutions
3. Must be scalable
4. Conserve resources
5. Product development and functionality
6. Process innovation and logistics
7. Design of products and deskilling
8. Education
9. Products must work in hostile environment
10. Research
11. Innovation must reach the consumer – distribution
12. Evolution in BoP product development

Figure 3: The 12 principles of innovation

Source: Adapted from Prahalad (2004, 2010)

The following 12 principles listed in *Figure 3* as proposed by Prahalad (2004, 2010) are summarised below.

1. **Price performance** does not merely refer to cheaper prices; it also relates to the performance and value of the product or service that the consumer receives at the cheaper price. The BoP requires a different price-performance relationship to the conventions used in developed countries. It should aim for a 30-100 times increase in price performance, if the project is scalable in order to achieve volume of sales to offset the potential risks involved.
2. In the past, diluted forms of traditional technologies used in developed economies were transferred unsuccessfully to the BoP. **Hybrid innovation** refers to the combination of advanced technologies with existing or advancing infrastructure that is required to better serve the BoP.
3. **Scale of operations** is a pertinent aspect when looking at the commercial business case for engaging in BoP ventures. Because of the low margin per unit, a high volume of sales is necessary for financial viability. Networking with local NGOs can be beneficial in transferring knowledge and skills to help scale these BoP initiatives globally.

4. The BoP comprises over five billion people; therefore, any solutions that are conceived in the production and consumption process should follow the goals of **sustainable development** and be eco-friendly. Serving the needs of the BoP will propel the urgency of seeking innovative ways of conserving and recycling resources, such as minimal use of water for washing clothes and bathing, alternative fuels, and waste disposal of packaging.
5. Identifying the **functionality** of products and services in terms of the BoP is important as this may differ from its use in developed economies. It is necessary to tailor the design to the localised context in which the product of service will be used, by considering local insights into the how the product or service integrates into the lives of the BoP. It may be challenging to develop a product with greater functionality at a reduced cost.
6. Reconceptualising **process innovation** in terms of the manner in which the product or service is delivered within the local infrastructure is vital to increasing affordability for the BoP. This involves the standardisation of processes to deliver consistently high-quality outputs.
7. **Deskilling of work** is imperative due to the skills shortage in the BoP sector. In Peru, healthcare workers in outlying areas did not have to be highly trained in order to diagnose certain diseases. As part of the deskilling process in diagnostic and surveillance programmes, they were given cards with photographs of different stages of disease to enable them to ascertain the severity of the disease and report it telephonically to the health authorities. This did not require advanced medical or communication technology and it occurred in real time, while encompassing expert knowledge represented in the diagnostic cards.
8. **Customer education** forms an integral component of introducing and integrating a product or service into a BoP market, as the recipients need to understand the benefits and how to use of the offering. The communication platform for this education has to be appropriate to the infrastructural context.
9. The **design** of the product or service must be suited to the hostile infrastructure that is generally inherent to the BoP environment. For example, appliances or information technology should be built to accommodate power surges or the voltage fluctuations should be addressed innovatively to allow a constant and even supply of electricity.
10. **Research** should be conducted to understand the BoP's assimilation of products and services. Interfaces should be designed in a simple and user friendly manner to ensure quick learning and easy adoption and assimilation of the product or service, for example using a fingerprint scan to use an automated teller machine (ATM) instead of having to remember a nine-digit code.

11. **The distribution network** is a critical aspect in providing the BoP sector access to the product or service. Infiltrating the BoP's remote areas often requires direct selling through a sales force recruited from the BoP or through non-traditional networks with local groups.
12. BoP ventures force corporates to move away from the conventional ways of doing business that serve the developing markets. They require **innovation that challenges existing paradigms** and biases in product and service delivery and seeks new ways of creating shared value. Some of these innovative ideas can even be transferred into developed markets. It should be noted that the BoP is evolving rapidly.

Landrum (2007) agrees with Prahalad (2004, 2010) that not all BoP projects need to encompass the 12 principles of innovation in order to be successful.

Various authors have documented successful BoP initiatives globally. Anderson and Billou (2007) cite an innovative BoP initiative in China, where a home appliance manufacturer, Haier, decided to adapt its washing machines to cater for the poor who maximised the use of their washing machines by also using it to wash vegetables. This clogged up the machine and rendered it invalid for the warranty. Haier modified its washing machines to cater for vegetable washing, included a feature to convert milk to cheese and provided instructions on how to use the machine safely. This gave the company a distinct competitive advantage and increased its market share and profits.

In India, many poor people are paid daily and can only buy what they need for that day (Prahalad, 2004). Anderson and Makides (2007) describe how Procter & Gamble and Unilever were innovative in providing single-serve portions of shampoo, soap and food to India's poor, which increased affordability and accessibility to a larger range of products.

Ismail and Kleyn (2012) document a BoP business initiative in South Africa, where Danone produced fortified yoghurt with a longer shelf life called Danimal. This product was distributed through micro-distributors and local spaza shops (small informal shops in a township or informal settlement). It aimed to address nutritional inadequacies in these communities and the product was initially sold for R1. The project entailed product innovation, raising awareness in communities, and business training for the micro-entrepreneurs.

Another South African example cited by Ismail and Kleyn (2012) is Massmart, which decided to enter the lower income markets by buying stores at taxi ranks and through acquiring

Cambridge Foods in KwaZulu-Natal. This allowed them to provide products such as dry groceries, vegetables and meat to the low-income groups, by catering to this market's very specific needs and by increasing accessibility, affordability and appropriateness of products. The sheer size of Massmart allows for economies of scale, which benefits this price sensitive market. Massmart also buys into small retailers, and provides financial backing and support.

Beyeler, De La Cruz and Montagu (2013) describe social franchising, an innovative concept that has been in practice for over eight decades, which has become increasingly popular in the last few years. It focuses on providing basic needs, such as access to healthcare in low-income sectors of the population, primarily in Africa and Asia. Social franchising shares certain characteristics with the traditional commercial franchise concept, such as being a private provider network and having contracts that stipulate certain protocols and standard operating practices (SOPs) when selling the standardised products or services under the same brand name. The franchisor is typically an NGO; however, in recent times, this has extended to for-profit social franchises.

Important elements to social franchising include having a franchisor with a successful pilot, which is then replicated and scaled up under the same brand name by franchisees, who offer quality service to the poor in exchange for social results and impact information (Meuter, 2011). The franchisees are provided with training, support and high-quality commodities. According to Volery and Hackl (2009), in a stereotypical franchise model, the franchisees pay a franchise fee that may be fixed or percentage of the profit each month. In social franchising, the social benefit in uplifting the poor may be given more prominence than the profiteering goal. However, research has been limited in showcasing the positive health impact of social franchises, and they have showed limited impact in increasing access to low-income individuals (Beyeler *et al*, 2013).

2.3.2. The BoP as producers

Karnani (2006) postulates that in order to enable sustainable poverty alleviation initiatives, the poor need to be integrated into the market economy as producers. Companies have a role to play in employment creation by forming partnerships to facilitate this process through education and skills development and through providing entrepreneurial and networking opportunities.

Grameen Bank in Bangladesh has been used as an exemplar of a BoP initiative that has enabled poor women, who were marginalised by large financial institutions, to access micro-finance in order to pursue their entrepreneurial activities, which has allowed them to increase

their income over time (Jain, 1996). By offering substantially lower interest rates than other opportunistic micro-lenders, 98% of the women were able to pay back their loans and Grameen Bank maintained a sustainable business model (Schreiner, 2003).

Prahalad (2004) describes how Amul, a dairy co-operative in India collects milk from 12 million farmers from 100 000 villages daily and sells it to middle and upper class customers, while bypassing exploitative middlemen. Farmers have been empowered in procurement, marketing, processing and customer retailing skills.

Multiple studies state how Hindustan Lever engaged in the Shakti project in India, which greatly benefitted the Shakti Ammas, who distributed and sold products in hard-to-access areas of the BoP (Hart & London, 2005; Klein, 2008). The partnership between the company and the Shakti Ammas enabled access to micro-credit, which empowered the women to buy company products and sell them in the villages. The project involved 50 000 villages with 15 million people being serviced by 13 000 Shakti Ammas. Prahalad and Hammond (2002) and Prahalad (2004) emphasise the importance of women at the BoP playing an active role in the market to promote social transformation and economic development.

In South Africa, Pascaral (2008) reports how SAB is working with the Department of Trade and Industry to assist the illegal alcohol retailers and shebeens (bars that are generally part of the informal economy in South Africa) with licensing to bring them into the formal business sector. The licensed tavern owners, who were subsequently trained by SAB, have reported an approximate increase of 31% in sales and around 41% in savings. SAB profits by supplying these taverns with alcohol. Coetzer (2009) describes how SAB incorporated the BoP into its supply chain through its smallholder support programme in South Africa, Zambia, Uganda, Tanzania and India. In 2009, SAB paid around 16800 farmers generally higher than market-related rates, to produce crop such as barley or sorghum. Both the farmers and the company have mutually benefitted from an economic point of view.

2.4. The dark side of the BoP

2.4.1. Too consumer driven

It is evident that a company operating at the BoP does not necessarily espouse the aim of poverty alleviation (Crabtree, 2007). In order to capitalise on the BoP as an untapped market, companies have reduced prices, repackaged and redesigned products, engaged superficially with NGOs and increased distribution in the BoP, with the primary motive of

profit as opposed to welfare. This can be construed as corporate imperialism, as companies exploit the BoP by merely "selling to the poor", without addressing poverty alleviation (Karnani, 2006; Chatterjee, 2009). Although Prahalad (2004, 2010) cites many examples of successful business initiatives at the BoP, BoP theory has been criticised for being too consumer driven (Jenkins, 2005; Karnani 2006, 2007; Crabtree 2007; Jaiswal, 2007; Chatterjee, 2009; Majumder 2012).

In addition, Prahalad and Hart (2002) and Prahalad (2004, 2010) do not adequately explain how poverty can be eradicated by the BoP spending the little they earn on consumerism (Walsh, Kress and Beyerchen, 2005; Jenkins, 2005; Karnani, 2006; Rost & Ydren, 2006; Crabtree, 2007). However, research shows that when consumers integrate into the formal economy, they are able to benefit from price reductions, a greater product variety and improved quality of services such as education and healthcare (Gordon, Dakshinamoorthi & Wang, 2006). Communities also reap the economic benefits and this may be accompanied by increased revenue and income through these market activities (Gordon *et al*, 2006).

2.4.2. Who decides what to sell to the poor

Karnani (2006, 2007, 2009), Jaiswal (2007) and Chatterjee (2009) share the view that there should be discernment as to the type of products and services being marketed to the BoP sector, which should aim to enhance overall wellbeing. Jaiswal (2007) argues that corporates should guard against undesirable inclusion (where their products and services do not improve wellbeing) or undesirable exclusion (which entails the lack of provision of products and services that improve overall community wellbeing). The BoP requires basic needs to be fulfilled before trapping this sector into consumerism. Prahalad (2004, 2010) does not differentiate between the provision of basic services (such as water, sanitation and healthcare) and consumer products (such as televisions and cell phones), and does not consider that the quality of life at the BoP will not be improved by material goods if basic needs are not addressed first (Chatterjee, 2009).

Jaiswal (2007) is adamant that some companies market products that have negative impacts on health, socio-economic status, or the environment. In 2003, Coca-Cola's operations in Kerala, India, produced toxic waste products that led to environmental degradation and the depletion and contamination of drinking water in the area. Another such company is SAB that proactively markets and sells alcohol to the destitute in informal settlements in South Africa, while enhancing the entrepreneurial and distribution capabilities of shebeen owners as their contribution to the BoP, even though alcohol has been associated with increased

accidents, illness, absenteeism from work, violence and crime (Schneider *et al*, 2007; Tsoeu, 2009; Karnani, 2009; Ismail & Kleyn, 2012).

Karnani (2006) vociferously slanders the proposition that single-serve products are cost-effective, as only decreasing the price per unit would impact on overall price. Overall, the cost of single-serve packaging is greater, and the consumer is tricked into thinking that the smaller portions are more affordable. Karnani (2009) also reports on the dangerous ideological issues associated with the marketing of Unilever's Fair & Lovely skin lightening cream in 38 countries. In India, advertising campaigns played on women's aesthetic insecurities and blatantly created the impression that lighter skin complexions are more attractive than darker complexions and allow women to be more successful in life in terms of their careers and relationships. These advertisements have been perceived as racist and sexist, yet Unilever still portrays itself as being a responsible corporate citizen.

Prahalad (2004, 2010) refutes that others have the right to dictate what constitutes the greater good for the BoP, viewing this as arrogant and disempowering to the BoP. The BoP has the right to choose their means of attaining utility. However, Karnani (2006, 2009) states that the poor are vulnerable as they are generally uneducated, with limited access to information; therefore, it is a fallacy that they are well informed and rational in their purchasing decisions. The poor often make choices that do not serve their own interests. The poor spend a higher proportion of their wages on cigarettes and alcohol than higher income earners. Banerjee and Duflo (2007) found that the poor in India actually cut back on nutrition (55% of adults surveyed in the community were anaemic and 65% were underweight). This was attributed to the increasing availability of material goods. They also state that the poor are brand conscious and status conscious in keeping up with the neighbours, therefore, they have little self-restraint on their spending. Karnani (2009) confirms that many people at the BoP are unbanked; consequently, they spend whatever money they have on impulse buys, which augments the argument that material goods may cause temporary utility in the short-term, but may have negative economic repercussions in the long term. He further contends that inadequate consumer protection at the BoP can lead to exploitation; therefore, the government has a potential role to play in this area.

2.4.3. Producers and entrepreneurs

Seelos and Mair (2007) state that entrepreneurship has the potential to make a substantial difference in the context of poverty. Entrepreneurs are resilient and acquire resources and capabilities despite structural hurdles, economic and political institutional voids and a lack of

infrastructure (Seelos & Mair, 2007; Sprague, 2008). Very few BoP initiatives integrate the BoP as producers, which weaken the BoP proposition from a conceptual and empirical point of view (Karnani, 2006). Most entrepreneurs in the BoP become entrepreneurs as a result of the BoP initiative, but in the capacity of product distribution, with a few examples of production and supply (Anderson & Billou, 2007; Kolk *et al*, 2012). These entrepreneurs generally work for below market-related salaries, such as the Shakti Ammas. Furthermore, the Shakti project shows how only one woman from a village of 2000 benefits financially from the initiative.

Karnani (2009) controversially asserts that not everyone is able to be an entrepreneur in terms of possessing the skills set and character attributes such as the vision and creativity that enables one to innovate and follow it through into practice. Even in developed countries, 90% of people are employees and not self-employed. This is reiterated by Arora and Romjin (2009) who state that new BoP discourse romanticises the poor and uncritically assumes that it is populated with entrepreneurs who are eager to collaborate with companies and organisations. Research also shows that the poor find it difficult to fully commit to a profit-generating project from a psychological point of view, despite previously benefitting personally from these initiatives (Banerjee & Duflo, 2007).

Furthermore, Karnani (2009) argues that micro-finance is seen to be the panacea to enabling entrepreneurship and hence alleviating poverty; however, it has the propensity to entrench desperate people further into debt and poverty. Micro-finance loan sharks still exploit the poor by charging exorbitantly high interest rates. The poor in Daravi, Mumbai, pay 600 to 1000 per cent more interest when obtaining credit, which is counterproductive to their entrepreneurial attempts (Sprague, 2008). Instead, there is a need to increase education levels and the income level of the poor by paying fair wages and creating employment, as opposed to increasing consumption and fixating on micro-credit (Karnani, 2007; Jaiswal, 2007).

2.4.4. Do most BoP initiatives conform to the BoP proposition?

There is increasing evidence that few BoP initiatives may be construed as win-win situations for the company and the community in accordance with the BoP proposition, as there are trade-offs between profit and socio-economic development (Karnani, 2006; Arora & Romijn, 2009). In India, Coca Cola and Amul had to eventually increase the price and decrease the portion size of their products, in order to make a profit, which made these products less affordable to people earning less than $2 a day (Karnani, 2006). In India, Hindustan Lever's

iodised salt had a very low penetration of seven to 10 per cent when compared to local brand penetration of 70 to 80 per cent. It also had a 250 per cent price premium, which was not easily acceptable to the price-sensitive poor. Although the iodised salt was manufactured using innovative technology, it was unable to offer a high-quality product at a cheaper price, which characterises the BoP proposition.

Ismail and Kleyn (2012) confirm that in South Africa, the Danimal yoghurt had different performance criteria when compared to the other products at Danone, and was not really seen as a profit-generating initiative. It managed to break even, but was also evaluated according to social indicators, such as how many entrepreneurs were trained. The business model was not sustainable and the project terminated when the project champion left the company.

Jenkins (2005), Karnani (2006), Crabtree (2007) and Arora and Romijn (2009), further assert that a number of the BoP cases or success stories in Prahalad's pioneer book, *Fortune at the bottom of the pyramid: eradicating poverty though profits*, fall short of at least one BoP criteria. For example, the Aravind Eye Care System and Jaipur Foot are self-financing non-business entities that are classified as trusts or NGOs. In addition, the role of partnerships as enablers of successful corporate BoP initiatives has been grossly under-emphasised or ignored (Karnani 2007, Jaiswal, 2007). Partnerships and networks between corporate, government, NGOs, community-based organisation (CBOs), funding organisations, civil society and community leaders are integral to socio-economic development and contribute to the success of BoP strategies (Brugmann & Prahalad, 2007; Arora & Romijn, 2009; Rivera-Santos & Rufin, 2010; London & Anupindi, 2012).

Other important BoP propositions such as the poverty penalty, increasing acceptance of technological advancements and purchasing trends to improve self-esteem cannot be generalised to all global BoP markets, as was revealed in two BoP case studies conducted in Mexico and Indonesia (Rost & Ydren, 2006). In addition, Jenkins (2005) and Karnani (2006, 2007) concur that Prahalad has the tendency to sometimes include people with higher incomes in his examples, such as the case with Casas Bahias in Brazil, which sold its home appliances to low-income earners by offering payment plans and charging interest. However, these consumers earned approximately $800 per month, which far exceeds the average income of $2 per day as initially proposed by Prahalad and Hart (2002).

2.4.5. Are BoP needs really being addressed?

Chatterjee (2009) suggests that the BoP literature decontextualises and desensitises poverty. More emphasis is placed on innovative products and services, as opposed to focusing on understanding how the people at the BoP experience life. It also creates the impression that the BoP should be content with not having their basic needs met, and that products should be created to compensate for the resource scarcity, such as the lack of water, sanitation and other basic needs. Hammond and Prahalad (2004) cite the example of an innovative shampoo that does not require hot water. Karnani (2006) and Chatterjee (2009) state that this perspective does not alleviate poverty in any way and may be construed as being opportunistic and exploitative. Furthermore, it has the potential to obviate or absolve the government's responsibility in addressing these issues. As opposed to appeasing the poor with material goods, corporates should be aiming to correct the disparities and give the poor a voice to oppose the lack of governmental service delivery.

2.4.6. What about small and medium enterprises?

Karnani, (2009), postulates that the BoP proposition focuses on the role of MNCs, and ignores the contribution of small and medium-sized businesses towards employment creation and community upliftment. The fact that small and medium enterprises are more resilient and able to integrate into communities more easily than bureaucratic MNCs, allows them to build strong relationships and provide much needed products and services. Chatterjee (2009) further proposes that there is mistrust of large MNCs globally due to past colonialism, which culminated in resource extraction that primarily benefitted the MNC and its home country.

Crabtree (2007) dismisses Prahalad's thesis as being vague with little supporting evidence and doubts its revolutionary capacity for poverty alleviation. This sentiment is reiterated by Landrum (2007), who expresses that other poverty alleviation strategies, which have been successful globally, should not be ignored. It is also important for corporates not to confuse profit-driven strategies at the base of the pyramid with being socially responsible and sustainable. Furthermore, BoP initiatives should be viewed as complementary to alternative poverty alleviation strategies and not as substitutes (London 2007).

Insights into BoP failures are important to learn and improve on the theory (Jaiswal, 2007; Landrum, 2007). Hellig (2009) confesses that researchers seem have a better idea about what not to do, as opposed to understanding the real success factors. It is clear that BoP

initiatives will vary across company, industry, community and context; therefore, they will have to be tailored and modified accordingly.

However, despite the many criticisms, Landrum (2007) lauds Prahalad (2004) for raising awareness of the BoP and highlighting global poverty, as well as for encouraging corporates to increase their innovative thinking in order to improve the quality of life at the BoP.

2.5. Next generation BoP interventions

Based on first-generation BoP principles, Simanis *et al* (2005) founded the *Base of the Pyramid (BoP) Protocol* between 2003 and 2005, which was an incubation programme that assisted companies to enter the BoP market. Landrum (2007) comments that although it also focused on the BoP as consumers, it was an improved approach to the original BoP proposition as proposed by Prahalad and Hart (2002). It advocated deep listening and mutual dialogue with communities in order to ascertain the needs of the BoP, as opposed to determining it for them without consultation.

However, Hart and Simanis (2008) admit that in attempting to serve this market and drive sales, corporates still remained oblivious to the perspectives of the BoP, and did not fully integrate into the communities; they entered the market while remaining at the periphery. Sprague (2008) and Arora and Romijn (2009) assert that BoP 1.0, which refers to BoP theory up to 2005, was still a top-down approach.

2.5.1. Enter BOP 2.0

In order to ameliorate the shortcomings and criticisms of early BoP theory (BoP 1.0), Hart and Simanis (2008) conceptualised BoP 2.0, which is more adept at addressing the complexities associated with formulating and implementing BoP strategies. It promotes the idea that the dictum of 'the fortune *at* the BoP' should be replaced with 'the fortune *with* or *for* the BoP', which better describes inclusive capitalism (Jaiswal, 2007; London, 2010). *Figure 4* compares the essential differences between BoP 1.0 and BoP 2.0.

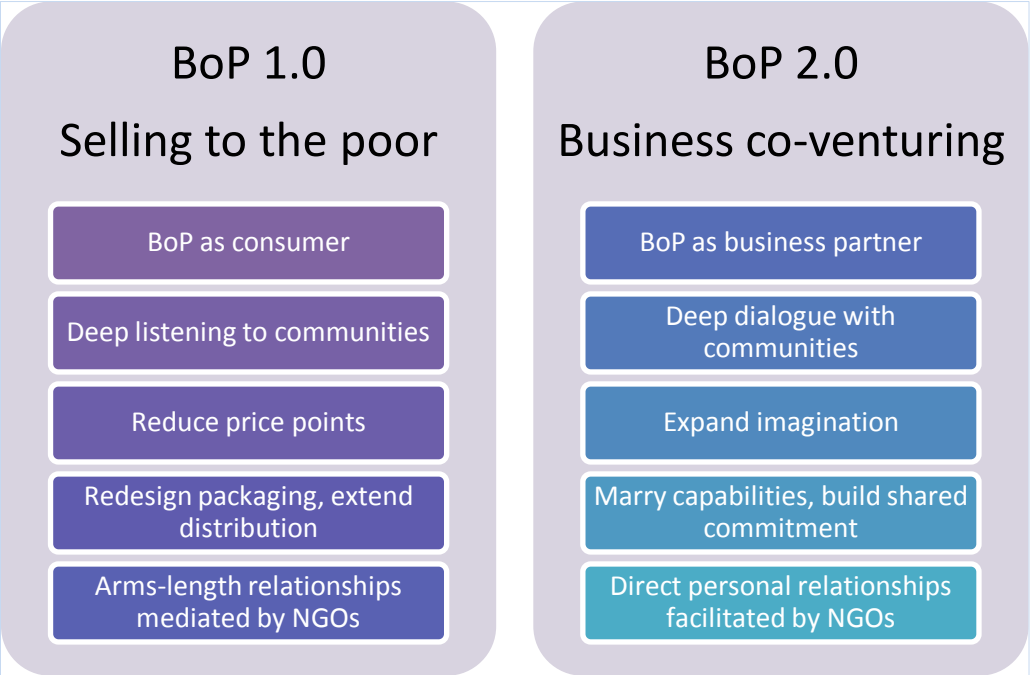

Figure 4: Comparison of BoP 1.0 and BoP 2.0

Source: Simanis & Hart (2008)

According to Hart and Simanis (2008), BoP 2.0 is based on three phases (with co-creation at the centre) (Refer to *Figure 5*):

Phase one - Opening up: This comprises building deep dialogue, project team development and collective entrepreneurship development, which culminates in the co-creation of a business concept.

Phase two - Building the ecosystem: This consists of project team development, building shared commitment and new capability development, leading to business prototype co-creation.

Phase three - Enterprise creation: This phase includes new capability development, building the market base and collective entrepreneurship, resulting in business enterprise co-creation.

Appendix 1 provides an in-depth summary of BoP 2.0.

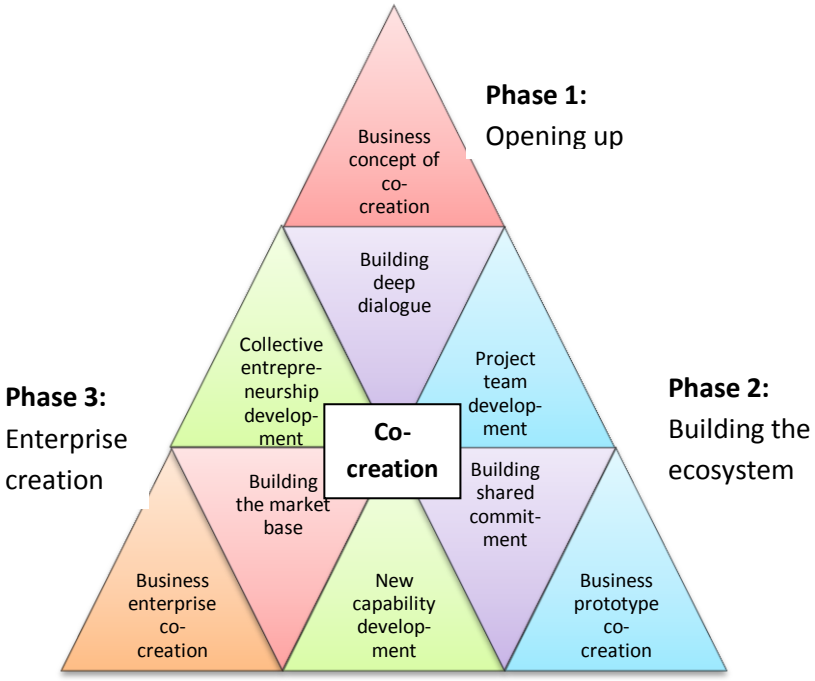

Figure 5: BoP 2.0

Source: Hart and Simanis (2008)

Based on building strong relationships between the corporate and the BoP, BoP 2.0 emphasises the role of *collaboration*, *co-creation* and *networking* in order to become embedded within the community and work together to innovate solutions that will address the community's needs, while being profitable (Hart & Simanis, 2008). This process allows corporates and the BoP to integrate their resources and capabilities, while being imaginative in creating greater sustainable value for both the community and the business, than would have been possible as a one-sided initiative (Hart & Simanis, 2008). London (2008), Hellig (2009) and Lenz and Pinhanez (2012) concur that co-creation is a preferable methodology that does not encompass the migration of strategies and technologies from the top of the pyramid into the BoP; it enables the co-discovery of opportunities between diverse stakeholders, including local ownership.

London (2008) proposes that being socially embedded is a new capability that corporates have to adopt in order to build networks within the BoP, while embracing a bottom-up approach to development. Prahalad and Hammond, (2002), and Hart and Simanis, (2008), state that being embedded in the community is facilitated by partnerships and networks within the community. These networks include NGOs, governmental agencies and CBOs (Arora & Romijn, 2009). Traditional relationships and bonds within the community replace formal institutions and are thus of paramount importance (Arnould & Mohr, 2005).

Hart and Simanis (2008) state that BoP 2.0 draws on various learnings from multi-disciplinary fields to inform the co-venturing process within a corporate entrepreneur framework. Business ideas are co-generated and then implemented through action learning. Co-creation and joint ventures foster mutual commitment and respect and is not centred on 'selling to the poor'. Co-creation also requires the company to interact with the BoP as an equal business partner, without having to make major trade-offs. The concept of shared value creation is pivotal to BoP 2.0. Simanis and Hart (2008) reveal that critics state that MNCs cannot really embed themselves into the community and local economy and that only locally based initiatives can be appropriate. Furthermore, Chatterjee (2009) questions how the poor may be viewed as equal partners within a resource-constrained environment characterised by socio-economic marginalisation, socio-spatial isolation and lack of access to basic needs.

2.5.2. Does BoP 2.0 address all issues?

Arora and Romijn (2009) argue that BoP 2.0 is difficult to operationalise. Building relationships with NGOs and CBOs and creating the goodwill that is required for productive outcomes in the community are challenging. It is also not easy to find a business concept that creates shared value and a win-win proposition, especially when factors such as nationality, race, culture, language, education levels and differing value systems may impact on decision making and negotiation. In addition, Arora and Romijn (2009) contend that BoP 2.0 also underestimates the complexity of grassroots engagements and it assumes that grassroots participation will definitely occur, and that it will occur equitably. However, participation is dependent on the inherent and often inequitable power dynamics that exist within the community, which may have behavioural and attitudinal implications that could adversely affect the business model. While relationship building, community immersion and the entire co-creation process is time-consuming, corporates are under insurmountable pressure to generate profit within a stipulated time. Therefore, patient capital is important in this context, where stakeholders should be patient while investing time and energy into the business, and should accept modest financial return over time, which improves as up scaling, occurs (Hellig 2009). However, this is difficult when a foreseeable return on investment is necessary to elicit buy-in from shareholders and executives (Arora & Romijn, 2009).

Scalability is of paramount importance in generating economies of scale and cost efficiencies, which increase profit (Hart & Simanis, 2008; Prahalad, 2010). Arora and Romijn (2009) express surprise at the little attention given to scalability for profit generation in the

literature. Even Hart and Simanis (2008) admit that a comprehensive scaling methodology still needs to be developed to allow initiatives to be transferred, replicated and embedded into many BoP communities globally. It takes three to five years for a BoP initiative to become fully sustainable, after which the scalability and business expansion becomes a reality. However, it is still debatable whether BoP initiatives can be transferred to other contexts, due to heterogeneity, which would adversely affect scalability (Arora & Romijn, 2009).

London (2011) has modified BoP 2.0 into a model that characterises BoP venture development, by changing the emphases. It focuses on three interrelated aspects: **design** (creation of market opportunities and the crafting of solutions with the BoP), **pilot** (orchestrating effective experiments and managing failures) and **scale** (generating co-mingled competitive advantage), with the enhancement of mutual value as a common theme.

However, Hellig (2009) suggests that simply applying BoP principles as proposed by BoP proponents is not sufficient in ensuring business success. Organisational readiness is a necessary component of this process. Olsen and Boxenbaum (2009) show that internal organisational factors in a company may serve as barriers throughout the planning and implementation of BoP strategies, due to conflicting mindsets within the organisation. Management and executives need to change their mindsets and preconceived ideas about the BoP (Prahalad & Hammond, 2002). Resources, capabilities and skills for BoP strategies may not be available, and corporates may feel uneasy about the lack of familiarity with the business practices required (Olsen & Boxenbaum, 2009).

Seelos and Mair (2007) emphasise the importance of organisational structure. It is advocated that companies should create a separate BoP business development division that is dedicated to research and development and separate from traditionally operating business departments (Prahalad & Hammond, 2002; Hart & Simanis, 2008).

Although Hart and Simanis (2008) conceptualised BoP 2.0, Simanis has changed his view (Simanis & Milstein, 2012). Simanis and Milstein (2012) now argue that contemporary BoP principles have evolved in a manner, which alienates and deters corporates. They cite the following reasons why:

1. The BoP theory no longer includes the language of business. BoP theory focuses more on societal benefits, poverty alleviation, inclusive capitalism and being embedded in the community. Initially, the premise was that companies selling to the

BoP would profit from the process, and that poverty alleviation was a consequence of this exchange. After being critiqued for focusing on consumption, BoP theory shifted to prioritise socio-economic development and poverty alleviation, thus losing the business case for profit.

2. Middle management is generally tasked with BoP initiatives that are not aligned to the rest of the company. These initiatives are viewed as stand-alone, poignant projects that do not have a substantiated business case.
3. It is proposed that community immersion and co-creating the business concept to achieve mutual value ensures success. However, there have been examples, such as the ChotuKool fridge in India that failed dismally, due to fundamental economic and business principles. Furthermore, all three pilot projects discussed in the BoP Protocol have failed. The main reasons attributed for their failure are the lack of performance measures linked to business objectives, the lack of business acumen of the community representatives, a disregard for timelines which were often extended due to the co-creation process, as well as the costly and time-consuming process of awareness raising. When business forecasting was eventually carried out to justify one of the projects, it was discovered that the project would make a loss for the next five years.
4. The BoP initiatives are no longer viewed by the company as being a lucrative business model that taps into a new market and provides a competitive advantage; it is seen as social responsibility.

2.6. The way forward

Controversially, Simanis and Milstein (2012) call for BoP theory to revert back to basics, where the business objectives should take precedence over poverty alleviation and socio-economic development. Terminology needs to change; the BoP segment should be referred to as developing or emerging markets, which denote a socio-economic segment that businesses can relate to. As with other mainstream corporate initiatives, performance criteria and targets are necessary to justify the business case. This should exclude ‘impact assessments’, which are more suited to development agencies and NGOs and fall out of the scope of corporates.

Although poverty alleviation is a valiant cause, the reality facing businesses should be acknowledged, and although they have the propensity to improve the quality of life of the BoP, it is not in the same capacity as government, development agencies and NGOs (Simanis & Milstein, 2012). In South Africa, Ismail and Kleyn, (2012), concur that BoP

initiatives should be viewed as business models with a financial imperative, and not as social responsibility.

2.7. Conclusion

BoP theory has evolved and changed over the last eleven years (Prahalad & Hart, 2002; Prahalad, 2004, 2010; Simanis & Hart, 2008; Simanis & Milstein, 2012). Despite many success stories (Prahalad 2004, 2010; Ismail & Kleyn, 2012), there seems to be many critiques, challenges and deviations from the BoP proposition (Karnani, 2006, 2007, 2009; Jaiwal, 2007; Landrum 2007, Chatterjee, 2009; Simanis & Milstein, 2012). Success factors are not well understood (Hellig, 2009) and performance measures for business objectives have been subordinated to social impact measures (Simanis & Milstein, 2012). Ultimately, it seems that trade-offs between profit and socio-economic development are inherent in the way BoP strategies are currently being practised (Simanis & Milstein, 2012).

2.8. Research questions

Considering the literature review above, this study seeks to understand the BoP initiative, SAHealth Clinic, in relation to following research questions:

2.8.1 To what extent does the community benefit from SAHealth Clinic?

2.8.2 To what degree does SAHealth Clinic fulfil the company's business objectives, in terms of profit generation?

2.8.3 To what extent does SAHealth Clinic fulfil the BoP proposition according to theoretical principles?

The researcher has the following propositions:

1. The community benefits greatly from SAHealth Clinic, in terms of excellent service provision, increased access to high-quality healthcare and noticeable cost savings.
2. The company that runs the initiative generates a profit from this endeavour, in terms of financial and reputational benefits.
3. SAHealth Clinic can be categorised as a BoP initiative, according to theoretical BoP principles.

CHAPTER 3: RESEARCH METHODOLOGY

This chapter discusses the methodology used in the study. It consists of the research strategy, research design, population sample, research procedure and methods. This will be followed by a description on how the data will be analysed. The chapter concludes with the limitations, validity and reliability of the study.

3.1. Research strategy

This study used a qualitative research approach. Saunders, Lewis and Thornhill (2009) broadly define qualitative research as a data collection technique or data analysis procedure that focuses on non-numerical data. Qualitative research allows for an in-depth understanding of issues and phenomena, is explorative in nature and seeks to relate data to theory (Eisenhardt, 1989; Greener, 2008). Greenhalgh and Taylor (1997) state that it enables the researcher to understand the underlying rationale and contextual elements that surround the concepts investigated, and it is best used when answering the what, why and how types of questions. This type of research is useful in interpreting the complexities of a given situation in its natural setting and is able to provide more meaning to quantitative research methods (Cutcliffe & McKenna, 1999).

However, Cutcliffe and McKenna (1999) state that common criticisms of qualitative research include having a small sample, which is not ideally representative of the entire population. This decreases the generalisability and the rigour of the study findings. The qualitative approach is also subjective and may be inherent with the researcher's bias (Altheide & Johnson, 1994).

Due to the complexity of strategies and contextual factors when conceptualising and implementing business initiatives at the BoP, qualitative research has been the predominant research method used in the BoP field to gain a holistic understanding of individualised BoP initiatives, as conducted by Prahalad (2004, 2010), Anderson and Billou (2007), Seshagiri, Aman and Joshi (2007), Kurian, Ray and Toyama (2008) and London, Anupindi and Sheth (2010). For the reasons stated earlier, qualitative research is suitable for this research endeavour, which evaluates an innovative business strategy at the base of the pyramid in South Africa.

3.2. Research design

A case study approach was used, based on the suggestions of well-known case study research methodologist, Yin (2009). Yin (2009, p18) defines a case study as "an empirical inquiry that investigates a contemporary phenomenon in-depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident". This means that the contextual elements are important in gaining an in-depth understanding of the phenomenon. Yin (2009) elaborates that the case study inquiry focuses on more variables than data points and uses various data sources in order to triangulate the information. The data collection and analysis process are also guided by the researcher having developed the theoretical propositions.

Anderson (1998) views case studies as a means of explaining how and why things happen. Case studies are able to compare the reality of the situation with what was intended or planned. Noor (2008) explains that case studies focus on a limited number of issues, without dealing with every aspect of the unit of analysis. Case studies are valuable when the aim is to understand a particular situation in great depth, and when an information-rich case can be identified.

There are advantages to using a case study approach in this research endeavour; it will enhance the ability to understand the causal links and complexity of the BoP business strategy in terms of its conceptualisation, implementation and impact from a holistic point of view (Noor, 2008; Yin, 2009).

Case study methodology has been used by Kapoor and Goyal (2013) to analyse social business ventures that provide healthcare to the poor in India. London *et al* (2010) have also used this method to understand the constraints of BoP producers and the types of strategies that ventures use to overcome these hurdles.

This dissertation used an explanatory, single-unit case study approach, as proposed by Yin (2009), which is appropriate due to the uniqueness of the initiative. BoP strategies are never identical due to the variation in geographical, socio-cultural, economic and anthropological contexts, as well as the fact that the BoP is a heterogeneous market segment (Karnani, 2007; Chatterjee, 2009).

The chosen case site offered the opportunity to investigate how the company conducts its BoP strategy in order to ascertain if it creates sustainable shared value for the company and the community. This initiative is unique to the context of South Africa. This strategy was also evaluated against theoretical BoP principles, to ascertain if there were deviations from theory

that were better suited to fulfilling the company's strategic objectives of shared value creation. It also provided in-depth insights into the impact of the BoP initiative from the perspectives of the company and the communities involved. The researcher gained a multi-dimensional understanding of the BoP initiative within a single context (Tellis, 1997).

Noor (2008) states that case studies are criticised for their lack of generalisability, rigour and reliability. However, the findings of multiple case studies may confer generalisations and have some form of replicability in terms of process. Flyvbjerg (2006) earlier suggested that case studies can be generalised using the falsification argument, as a case study is able to identify 'black swans'. Bryman and Bell (2007) caution that because the researcher becomes inextricably involved in the process, there is a danger of bias and subjectivity, however Flyvbjerg (2006) and Yin (2009) discount this, as biases can creep into other design methods, for example, when formulating quantitative questionnaires. Yin (2009) proposes that case study approaches are generalisable to theoretical propositions but not to populations, therefore it expands or generalises theories. Saunders *et al* (2009) propose that case studies, when well executed, are valuable in challenging existing theory, and may result in new research questions going forward.

Case studies have also erroneously been viewed as being necessarily ethnographic or participant-observation based, but it is possible to produce an excellent quality case study from desktop research and telephonic interviews if the topic is amenable to this option (Yin, 2009).

This case study was primarily based on qualitative research. The information that arose out of the case study was triangulated through a comparison between the perspectives of multiple stakeholders, as well as by introducing secondary data, such as consultants' reports and corporate documents (Yin, 2009).

3.3. Population and sample

3.3.1. Target population/Case site

The case study is based on logistic company Pharma Logistix's BoP initiative, called SAHealth Clinic. Pharma Logistix was bought by a holding company at the beginning of 2013. The description below of the selected case profile has been summarised from a fact sheet written by Fullerton and Coetzer (2010) from Reciprocity and the Base of the Pyramid Southern Africa Learning Lab.

SAHealth Clinic is an innovative business model that serves to increase access to primary healthcare in peri-urban informal settlements in South Africa. These container *clinics-in-boxes* are aimed at the under-served marginalised communities in South Africa, which comprise an estimated 35.4 million people.

The clinic is also a platform for entrepreneurship, which empowers black women. The nurses who run the clinics have the option to buy the clinic, or a portion thereof, as a franchise after a period of 60 months. This allows the nurse to familiarise herself with the management of the operation, while being a salaried employee, until she self-actualises as a business owner, should she choose to. In this way, the nurse provides a valuable service to the community, while being self-employed, and she has the potential to create employment opportunities. The franchisor, Pharma Logistix, is responsible for training and support in terms of increasing business acumen, marketing, quality assurance, and for supply chain management with regard to inventory. It is important to note at this point that the company and the nurses refer to the initiative as a franchise model, even though it deviates from the standard concept of a franchise, in that the nurses do not pay Pharma Logistix royalties each month.

The SAHealth Clinic was piloted at one site in Johannesburg and currently operates in seven sites – five of which are situated in Gauteng, one clinic is located in Cape Town and one is in Mpumalanga. Pharma Logistix aims to rollout 400-500 clinics nationwide within the next four years. The model aims to be sustainable and economically viable to create shared value for the communities in which it operates, as well as for the company.

3.3.2. Sampling method and resulting sample

A purposive sample of twelve qualitative interviews was used to explore the case from a multiple stakeholder perspective (Refer to *Table 1*). Bryman (2012) and Saunders *et al* (2009) describe a purposive sample as a non-probability, non-randomised sample based on the researcher's own judgement and discernment. Seshagiri *et al* (2007) have used purposive sampling when interviewing the BoP sector in a South Indian village about their rural communication environment and communication preferences.

In this study, four individual interviews were conducted with company representatives – the MD, who conceptualised the SAHealth concept; the former CSI manager who headed up the project, but left the company in September 2013; the human resources manager (HR manager) and financial manager (FM) who stepped in after the CSI manager left. From the community perspective, the case study focused on Gauteng for convenience; therefore, the

researcher conducted interviews with nurses and focus groups at four sites in this province. This provided multi-dimensional insights into the operational and strategic elements of the BoP initiative, its sustainability, as well as its impact on the community, the nurses and the company.

Pharma Logistix respondents were transparent and open to their titles being used in the research report; therefore, the researcher has included the information in *Table 1*.

Table 1: Profile of respondents interviewed

Description of respondent type	Number to be sampled
Managing director of Pharma Logistix	1
Former CSI manager - Head of SAHealth Clinics	1
Financial manager	1
HR manager	1
Nurse that runs SAHealth Clinic	4
Community focus groups	4

3.4. Research instrument

The research instrument consisted of three in-depth, semi-structured open-ended interview guides that were targeted at the various stakeholder groups – corporate representatives, nurses and community (Refer to *Appendix 2* for the interview guides).

Saunders *et al* (2009), state that in-depth, semi-structured and open-ended interviews are well suited to explanatory studies, which explore relationships between variables. Semi-structured interviews are based on predetermined themes and related questions, while allowing for flexibility (Bryman & Bell, 2007). It allows the researcher to guide the flow and content of the interview process (Creswell, 2003). The order of questions may change according to the flow of the interview across the various respondents, and some questions may be omitted, while others may be added to further probe and explore certain angles (Saunders *et al*, 2009). Bryman (2012) asserts that the semi-structured questions should always tie back to the research aims and research questions. It is also important to avoid leading questions that may bias the research.

The in-depth semi-structured interview approach has been successfully used by Kistruck, Webb and Ireland (2011) during their qualitative study investigating institutional challenges in micro-franchising at the BoP in Kenya.

3.5. Procedure for data collection

Face-to-face interviews were conducted with all the participants, as this was more personalised and allowed participant observation to take place concurrently (Aronson, 1994; Yin, 2009). All interviews were audio recorded with permission. Note taking supplemented this process. The researcher set up 60-minute interviews with the Pharma Logistix representatives through telephonic and email correspondence, and they took place at Pharma Logistix offices. Pharma Logistix notified the nurses that they would be contacted by the researcher. The interviews with the nurses were arranged telephonically and they were conducted in English at the various SAHealth Clinic sites.

The researcher emailed an explanation of the study, as well as the interview guide, to the corporate representatives and the nurses, so that they could prepare for their respective interviews.

In order to address the language barrier at community level, the researcher enlisted the assistance of a community facilitator from Orange Farm, with whom a prior relationship exists. The facilitator was adept at holding focus groups and assisted with the recruitment process. He spent a day at each site recruiting 6-8 respondents for each focus group, according to specified demographics. In order to be eligible to participate in the study, the respondents were expected to have visited SAHealth Clinic at least twice and they were representative of age and gender. In terms of income, they had a household income between R600 and R3500 per month. A total of 27 focus group respondents was recruited in total. The researcher and facilitator coordinated the interview with the nurse and the focus group so that they could take place on the same day at each site. Each focus group was held at a participant's homes at each site.

The researcher briefed the facilitator on the aim of the research and on the questions to be discussed in the focus group. He co-facilitated the focus groups with the researcher by conducting it in the vernacular and translating the researcher's questions and the respondents' answers throughout the session so that the researcher could understand the content and lead the process with relevant questions and probing. This method instilled trust within the group and the respondents spoke freely. It also increased the richness and authenticity of information and allowed the participants to feel more comfortable, as stated by Welch and Piekkari (2006).

The researcher paid the facilitator and focus group members a stipend for their time and participation, as shown in *Table 2.* The pricing structure was recommended by a

Johannesburg-based NGO, called the Centre for AIDS Development, Research and Evaluation (CADRE).

Table 2: Research costs in data collection process

Activity	Cost
Recruitment at four sites (airtime, transport, food, time, follow-ups)	R2000
Recruitment fee for 27 participants	R810
Co-facilitation of 4 focus groups with translation	R1600
Respondents' time x 27	R2700
Venue x 4	R800
Refreshments x 4	R240
Total costs	**R8150**

Multiple sources of information were consulted to increase the rigour of the research (Noor, 2008; Yin, 2009). The researcher spent time at Pharma Logistix and at the SAHealth sites for further observation of the SAHealth project. Annual reports, consultants' reports, other documents in the public domain and financial statements were used to corroborate the information gleaned from the interviews (Yin, 2009).

3.6. Data analysis and interpretation

Once the interviews took place, the researcher transcribed the individual and focus group interviews. The information contained in the transcripts was then coded thematically, in relation to the research questions, as part of a themed content analysis approach (Attride-Stirling, 2001; Bryman, 2012; Saunders *et al*, 2009).

Braun and Clarke (2006) state that thematic content analysis is used to identify, analyse and report recurring patterns or themes within research data. However, they concede that there is no consensus on how thematic analysis is defined or implemented. Aronson, (1994), states that the themes and sub-themes are generally evident from patterns, experiences or attitudes that arise in the transcripts or they can be easily deduced from the information that arises. It also facilitates the interpretation of different components of the research topic (Boyatzis, 1998).

Bryman (2012) and Saunders *et al* (2009) suggest using computer-aided qualitative data analysis software, for the coding process; however, the researcher manually coded and documented the findings into predetermined themes by reading through each transcript in detail, while identifying relationships between the various codes. This was in alignment to Yin (2009), who warns that it is imperative to have an analytical strategy in place, before engaging in the coding process. This process synthesised the information, so that it could be

analysed. The analysis was based on discussing the similarities and inconsistencies between the various respondents interviewed, as well as on the theoretical presuppositions that informed the research questions. From this perspective, the data were used to thematically analyse whether SAHealth generates profit for the company and how it uplifts the communities in which it operates. It also aimed to ascertain whether the SAHealth model adheres to or deviates from contemporary BoP theory.

It should be noted that for confidentiality reasons, the various sites are referred to as Site 1, 2, 3, 4 and 5, and the nurses and focus group respondents are labelled accordingly in Chapters 4 and 5.

3.7. Limitations of the study

The primary limitation is that this case study, in its individual capacity, is not generalisable. However, Flybjerg (2006) and Yin (2009) question how any single experiment can be used to generalise findings. Because a non-probability purposive sampling technique is used, this case cannot be transferred to other contexts. Purposive sampling relies on the researcher's ability to choose the best-suited respondents who are be able to provide insights into the research questions. A possible limitation was that some information may have been lost in translation during the focus groups due to the fast pace of the conversations. Time constraints and geographic location limited the research to the Gauteng area; therefore, all seven clinics were not surveyed. This case study also relied on the fact that all respondents would be honest and forthcoming with information. This was corroborated through the triangulation of the data.

3.8. Validity and reliability

Research generally uses four criteria to assess rigour – construct validity, external validity, internal validity, and reliability (Yin, 2009). Both validity and reliability measure the degree of error inherent in our research (Leedy & Ormrod, 2001).

3.8.1. Construct validity

This refers to the ability of an instrument to measure what it intends to measure, in terms of having the correct operational measures in place (Leedy & Ormrod, 2001; Bryman, 2012; Yin, 2009).

3.8.2. External validity

External validity defines the boundaries according to the generalisability of the findings of a single case study (Yin, 2009). As stated previously, because BoP initiatives are not identical due to varying contextual factors, the generalisability rationale that is applicable to quantitative sampling does not hold true for case studies (Tellis, 1997). This case study did not aim to be statistically generalisable; it centred around analytical generalisations, (Yin, 2009).

3.8.3. Internal validity

This case study was of an explanatory nature. Yin, (2009), states that internal validity is especially important when conducting explanatory case studies, as the emphasis is on understanding causal relationships. It is disastrous to assume causal relationships without considering all potential causative factors. Furthermore, inferences need to be taken into account.

3.8.4. Reliability

Reliability refers to the extent of transparency, consistency and repeatability of the results should the research be conducted by another researcher using the same research procedure (Leedy & Ormrod, 2001; Bryman 2012; Gibbert, Ruigrok & Wicki, 2008). As this is a case study, the results may not be repeatable, due to the fact that a different purposive sample may be used when identifying participants representing the company and the communities. However, credibility can still be obtained by following case study protocols (Yin, 2009).

The researcher used the following tactics in *Table 3* to increase the validity and reliability of the case study.

Table 3: Tactics to ensure validity and reliability in case study research

Type of tests	Tactics to maximise validity and reliability	When to implement tactic
Construct validity	*The researcher:* • Used multiple sources of information, such as documentation, various interviews and focus groups, direct observations, participant observations and physical artefacts, to develop converging lines of inquiry, triangulation and corroboration. • Established a chain of evidence. This enables a reader to reconstruct the researcher's path from the initial research questions stage through to the research conclusions or vice versa. This led to data source triangulation.	Data collection Data collection
Internal validity	*The researcher:* • Engaged in pattern matching, which compared an empirically based pattern with a predicted pattern or those found in other studies. • Built explanations to analyse the case in an iterative manner. • Addressed rival explanations.	Data analysis
External validity	*The researcher:* • Employed the use of theory in this single-case study to infer analytical generalisations of the results – theoretical triangulation (generalised empirical observations to theory).	Research design
Reliability	*The researcher:* • Adhered to case study protocol. • Created a case study database of information by logically organising and documenting all the research evidence collected, so that the raw data may be accessed for independent inspection.	Data collection

Source: Adapted from Tellis (1997), Morse et al (2008), Gibbert et al (2008) and Yin (2009)

CHAPTER 4: RESULTS

This chapter documents the results that emanated from the interviews and secondary research. It begins with the community perspective of the role of SAHealth Clinic in the community, followed by the nurses' opinion of how SAHealth has impacted on their lives, as well as on the community. The corporate perspective is then noted. This section ends with secondary data that has been extracted from corporate documents, that are extremely pertinent to the case study.

It is important to explain the manner in which the findings are written - where certain comments are attributed to various sites, these are acknowledged; however, statements without an attribution indicate that all the respondents or nurses were in agreement with the general sentiments.

4.1. The community perspective

4.1.1. Healthcare offerings before the establishment of SAHealth

Table 4: Government healthcare facilities visited by respondents at various sites

Site	Institutions
Site 1	Local government clinic, Steve Biko Hospital
Site 2	Barcelona Clinic, Far East Hospital, Charlotte Maxeke Hospital, Daveyton Clinic
Site 3	Baragwanath Hospital
Site 4	Facilities in Brampark and Boksburg

a) Government clinics and hospitals

All respondents unanimously criticised the government clinics in their area, which are listed in *Table 4*. The most frequently cited issue was the long queues that had to be endured. Many respondents complained that they had to arrive at the clinic around 4am or 5am in the hope that they would be at the front of the queue. Often, after waiting in the queue for the entire day, they would be turned away without being helped at 4pm when the clinic closed. Some people stayed overnight to ensure being at the start of the queue the next morning and to save on transport money. The Site 2 respondents reported that in a few instances, some ill patients collapsed, while others have died while waiting in the queue due to the lack of medical attention.

When patients were eventually attended to, the quality of service was perceived to be sub-standard. Two respondents from Site 2 recounted negative experiences at government hospitals, where they were misdiagnosed and received incorrect treatment, which resulted in complications. Another common perception among all respondents was that people went to government hospitals where they either deteriorated or died. Some Site 2 respondents chose to visit government clinics out of their zone (in Daveyton and Kempton Park) to avoid their local government clinic.

The Site 4 respondents preferred the government hospitals to the government clinics; however, they admitted that they were more likely to receive treatment for emergency or critical care situations. They were sometimes turned away from the hospital if the beds were full. The hospital staff was inconsiderate of the time of discharge, and sometimes discharged patients at night when public transport had ceased. These patients would then have to sleep in the waiting room chairs in discomfort and pain, while waiting for the first taxi back home. One respondent mentioned that the hospital had turned away a pregnant woman in labour, stating that it was not her time, and she subsequently she gave birth on her way home.

In general, the respondents agreed that government clinics were acceptable in two instances - if the patients had a chronic condition such as diabetes or HIV as they would receive free chronic medication, or if patients already knew their diagnosis and the medication required in order to relay it to the nurse.

All respondents lambasted the manner in which the nurses treated them at public establishments. The nurses spent approximately five minutes with each patient, did not perform a basic medical examination or take a proper patient history. Instead they expected the patient to self-diagnose and tell them what was wrong, so that they could dispense medication. Another complaint was that the nurses often gave incorrect medication, for example, patients received pain medication for a tummy bug. Many respondents stated that the nurses dispensed Panado irrespective of what the patients presented with, just to appease them, and not to cure them. The nurses also frequently ran out of medication and the patients either returned home without any medication or they received a script for a pharmacy which incurred additional expenses.

Babies were also treated with the same apathy. Nurses asked the mothers to diagnose the babies' condition instead of performing an examination, before dispensing medication.

Female respondents stated that if a child was not eating and had a rash, the nurses automatically attributed it to disposal nappies and advised accordingly. After seeking a

second opinion from a private establishment, it was discovered that the baby's ailment was not associated with Pampers and the condition had in fact deteriorated, as the nurse had not given the relevant ointment to the mother.

The respondents at all the sites concurred that the nurses often treated them with disrespect and shouted at them. The impression was that the nurses vented their frustrations on the patients and that they were working for the money and not for the cause. Another pertinent issue that arose is that of confidentiality. At the government clinics, nurses violated confidentiality by making public announcements in the waiting rooms to separate and categorise patients, for example, they would shout out for all patients with diabetes to stand in one queue or ask all HIV-positive patients to step to the side. This was quite humiliating for patients who had not openly disclosed their HIV status to others. A few respondents from Site 2 also chastised the nurses from their local government for revealing confidential information about certain individuals' medical problems and personal issues to the community if they were in a bad mood or if there was any discord with the patient. The Site 4 respondents mentioned that nurses disclosed one's HIV status to one's spouse even if the individual was not ready to have that conversation. The Site 3 respondents viewed the nurses as being too lazy as they had many long tea breaks and ran errands such as shopping at the local malls during working hours, despite the long queues of patients. The Site 4 respondents shared a similar experience where the nurses just drank tea and saw fewer patients than they potentially could have helped. The respondents also complained about the rough manner that the nurses administered injections, where they hurt or bruised the patients. None of the respondents felt that they could trust or open up to the nurses.

b) Private doctors

Most respondents from all sites stated that they preferred to visit a private doctor instead of a government clinic, as they still saved on costs in the long term. The Site 1 respondents stated that the private doctors were very good. They listened to the patients and the patients felt at ease to ask them questions. Although, the price was the deterring factor, respondents reported that many people preferred to pay the premium price and visited a private doctor instead of resorting to the government clinic. However, at Site 2, respondents asserted that some private doctors took the same approach as the government nurses – they skipped the physical examination, asked the patient what was wrong instead and dispensed five pills in a packet. Some doctors did not ask as many questions as the SAHealth nurse, because they were always in a hurry. Some respondents claimed that after paying R300, they did not necessarily recover and had to return to the doctor and pay again.

4.1.2. General sentiments about SAHealth Clinic and its quality of services

All respondents from all four sites expressed their happiness and satisfaction with SAHealth Clinic. There was consensus that SAHealth was much better than the local government clinics in their respective areas, with respect to the quality of healthcare provided. Due to the lack of queues, patients were attended to quickly and efficiently. Respondents were confident that they would always be healed or cured if they were treated at SAHealth, due to their positive past experiences. The Site 3 respondents went as far as to say that SAHealth was the best clinic they had ever visited. Respondents felt that they were receiving special treatment.

The Site 1 respondents equated the quality of health and the services offered to be on par with the Steve Biko Hospital in Pretoria, which they held in high esteem. Respondents mentioned that they received treatment on a range of conditions such as bladder problems, flu, post-natal concerns, and general feelings of malaise, headache, hypertension, eye infections, menstrual problems, family planning, counselling and paediatrics. At Site 1, respondents were appreciative that HIV-positive people had reliable and easy access to antiretrovirals (ARVs). The Site 3 respondents commented that the SAHealth Clinic was very neat, clean and hygienic, while the government clinics were described as being filthy with a specific horrid smell, which made one feel sick upon entering. The Site 4 respondents were grateful as they claimed that the clinic was the only one in the area.

The treatment offered by the nurses was viewed as excellent and comparable to the expertise of a private doctor. Respondents commended the SAHealth nurses for taking a proper patient history and documenting it, as well as doing a thorough medical examination and checking vital signs, such as weight and blood pressure (BP). Only once an informed diagnosis was made, did the nurse dispense the appropriate medication. The examination was so thorough that co-existing conditions were picked up despite the patient being unaware of its presence. One respondent mentioned that she had uncontrolled hypertension while she frequented the government clinics, however, when she visited SAHealth, not only did her blood pressure normalise, but the nurse also discovered her ulcers, which were subsequently treated. Female respondents stated that the SAHealth nurses also examined their children well before diagnosing and treating the concern.

If the medical condition was beyond the nurse's scope of work, she referred the patient to the nearest hospital and provided sufficient information in her referral note to warrant a successful handover, an accurate diagnosis and appropriate treatment. Respondents

compared this to the government nurses who merely instructed the patients to go to the hospital without supporting documentation.

The SAHealth nurses were described as being extremely warm, kind and caring, as well as experienced and professional. A respondent from Site 3 stated that the nurse was a ‘darling’ and her smile started the healing process before treatment was received. Some respondents thought that the nurse was a doctor because of the treatment received. The respondents felt that the nurses’ passion for helping people was quite evident. They were contrasted to the government nurses and praised for being non-judgemental and spending time with each patient (20 to 30 minutes). SAHealth nurses were viewed as trustworthy and compassionate, which enabled patients to open up and confide in them about issues that they were too embarrassed or ashamed to share with others. The nurses listened to the patients’ problems, asked the right questions to elicit the right responses and offered constructive advice. The nurses embodied the spirit of Ubuntu. The respondents were happy that the nurses explained the necessary information to them and advised them how to use the medication and how to live a healthy lifestyle in terms of diet and exercise.

During an emergency, the nurses assisted by putting up a drip or calling an ambulance to transport the patient to the nearest hospital. The Site 4 respondents felt they were guaranteed to get better by visiting SAHealth, and if their condition did not improve within two days, they had a free follow-up visit. The Site 4 respondents were further thankful that the nurse made house calls when people were extremely sick. A number of respondents commented that SAHealth offered better treatment because the SAHealth nurses gave them four packs of pills in contrast to the private doctor who gave them only one or two packs. At Site 2, the medication was perceived as being special, curing adults and children from their ailments within a few days. There was a belief that the medication was from private hospitals and was of a superior quality, as well as being the right treatment option.

All respondents stated that their positive experience with SAHealth Clinic resulted in their entire family and their friends opting to use SAHealth’s services. Respondents with children and grandchildren chose SAHealth as their preferred healthcare provider. Even many patients who lived near the government clinic preferred to frequent SAHealth.

4.1.3. Affordability of SAHealth's services vs. alternatives

a) Respondents' personal preference

There was a general consensus across all focus groups that life comes first, therefore, the respondents were amenable to paying the SAHealth's consultation fee. All respondents were adamant that SAHealth's service offerings saved them time and money. The respondents who participated in the research did not incur transport costs in the form of taxi fare, as SAHealth was conveniently located and they did not miss a day's work, and hence wages, to stand in queues at government facilities. Prior to SAHealth, respondents from Site 2 stated that they preferred to utilise the services of a private doctor instead of the government clinics, but at a high cost.

Table 5 reflects the costs of healthcare according to the respondents' personal experiences and perceptions.

Table 5: Costs of seeking healthcare at government facilities, private doctors and SAHealth Clinic

Site	Government clinic/hospital costs	Private doctor's cost	SAHealth consultation
Site 1	• R18 transport return to local government clinic • Loss of a day's wages while standing in queues from 7am-4pm • Food for the day	R270-R300 + transport	R130
Site 2	• R48 transport return plus R40 for consultation at Charlotte Maxeke • R20-75 consultation at Far East Hospital • Loss of a day's wages while standing in queues from 7am-4pm • Food for the day	R250-R300 + R28 transport	R130
Site 3	• R60 return for transport to Chris Hani Baragwanath • R70 for consultation and R120 for paediatric overnight stay • Food for the day	R250 upwards + transport	R150
Site 4	• R24 return plus pharmacy prescription for Brampark • R30 return and R120 for consultation at hospital in Boksburg	R200-R250 plus transport to Germiston or Johannesburg	R130

Respondents stated that they had referred family members to SAHealth, as the family saved money overall. The reasons cited were that SAHealth included medication in the consultation fee, SAHealth guaranteed they would get better and follow-ups were seldom required. Repeat visits to government clinics and sometimes private doctors, which included pharmacy scripts, incurred expenses which exceeded SAHealth's fees, especially when taking into consideration the resulting emotional distress and prolonged illness. Respondents agreed that they did not mind paying SAHealth's consultation fee as they received the help they needed, and they received an impeccable standard of service.

One retired soldier from Site 3 noted that he was meant to access healthcare at a base hospital in Pretoria but the transport alone cost R280 return. He was happy to pay SAHealth as he received the same quality of treatment that he would receive in Pretoria. SAHealth also serviced many pensioners who received a monthly allowance and preferred the convenience and ease of accessing good quality treatment. One such respondent stated that she was paid R1200 a month for pension, and she saved R200 each month so that her family members could visit SAHealth when necessary. Some respondents stated that they borrowed money from their spouses, parents, neighbours or friends if they were really sick and did not have any money.

Respondents also viewed the clinic as being affordable even though it is a private entity. The Site 3 respondents felt that they could not really afford the private healthcare, but they made the sacrifice as they did not want to go to the government clinics. SAHealth was thus the perfect option as it was affordable and offered quality healthcare. Only one respondent from Site 3 suggested that SAHealth should reduce the rate for those who were unemployed or not receiving grants or any form of income.

b) Respondents' view of affordability in the community

Due to the high rates of unemployment at Site 1, many people still frequented the government clinics, as they would not lose a day's wages standing in queues. The sentiment was that those who were able to afford to visit private doctors or clinics that are further away would be able to afford SAHealth. Respondents felt that SAHealth's consultation fee was reasonable and affordable.

The Site 3 respondents felt that the community definitely could afford SAHealth's fees as many people worked and were already accessing private healthcare that was far more costly. They felt the fact that a mall was being built in the area proved that people had

money to spend. The mall would also increase employment through the construction, retail and service industry, which would provide people with more income.

Respondents at all sites speculated that at least one person worked in every household, which meant that that person could assist in paying the SAHealth fees, or multiple members of the household received grants. If money was really an issue, then people self-medicated, however, this was not common. Few patients spent their money on clothes or airtime instead of on healthcare.

4.1.4. Suitability of SAHealth's location

In general, respondents felt that location was not an issue as SAHealth's excellent service ensured that people who knew about the calibre of the service would travel to the clinic. *Table 6* captures the respondents' recommendations of how SAHealth's location could be improved.

Table 6: Suitability of location of SAHealth Clinic and recommendations

Site	Suitability of location	Recommendations
Site 1	Convenient	• Needs signage on the roads to direct people.
Site 2	Convenient	• Increase visibility of clinic within the enclosed space so that passers-by on the street can see it. • Make signage more visible, especially on the road • Perhaps make it more central - next to the taxi rank or government clinic, sports ground or the site where the community meetings are held. • Due to shared space with the district councillor, SAHealth should have its own entrance, so that it can be accessed during strikes against the local councillor.
Site 3	Convenient	• It is not central and Site 3 is very large, therefore more clinics are required to service the 14 extensions. • Relocate to near the railway station.
Site 4	Convenient	• Improve signage.

4.1.5. Accessing other services

When asked if there were instances where respondents needed to go to another clinic or doctor instead of SAHealth, many respondents stated that SAHealth's presence meant that they no longer needed to visit another government clinic or private doctor. Only in situations

where SAHealth was closed after hours or where specialist services were required did respondents have to seek help elsewhere at a higher cost, or be referred to the nearest government hospital. Respondents felt that SAHealth almost always addressed their needs and very seldom did they have to be referred to the nearest hospital.

4.1.6. Suggestions on how to improve SAHealth

a) Structural elements

The respondents from all sites motivated that SAHealth should be extended to accommodate more people, as this would attract more patients. People in the community saw the small clinic with few people waiting outside and were sceptical about the quality of service offered. The absence of a waiting area was a deterrent, especially in adverse weather conditions such as rain and heat. The SAHealth Clinic at Site 2 does not even have chairs outside for people who wait. An additional room for monitoring patients or counselling patients was also suggested. The Site 2 respondents stated that they were willing to pay an extra R10-R20 for a larger facility as they felt that the benefit to their health outweighed the cost.

b) Number of clinics

Respondents from Site 3 felt that the number of clinics should be increased – at least one clinic for every two extensions. This would also enable people who travel from other extensions to save on travelling costs. Respondents from Site 4 advocated for more clinics to be built in neighbouring areas.

c) Working hours

It was requested that SAHealth should be open 24-hours to address emergencies, as it is a long distance to the nearest hospital. Respondents from all sites also felt that SAHealth should be open on Saturdays, which would also accommodate those who are employed. The Site 2 respondents intimated that it was good that the clinics closed at 5pm on weekdays due to safety issues – the nurses could be robbed of money, mobile telephones, equipment and medication.

The Site 3 respondents stated that SAHealth was the only clinic that opened every second Saturday and by appointment after hours. They suggested it stay open until 6pm on weekdays. Respondents from Site 4 agreed that the clinic should be open from 7am until

6pm.The respondents were adamant that the community could play a role in protecting the nurses and the clinic by reporting crimes to the police and through vigilantism.

d) Additional services

Respondents felt that services for pregnant women could be extended to include ultrasound scans and childbirth. Respondents with children also requested vaccination services. HIV treatment and counselling services, as well as x-rays, were mentioned as essential additions. A few respondents enquired about ambulance services or emergency services. It was thought that the hiring of a male nurse may encourage more men to seek SAHealth's services. There was a request for specialist services, such as an ophthalmologist, optometrist or dentist, to be brought in once a month, and all the respondents from Sites 1, 2 and 4 were willing to pay between R180 and R250 for the consultation, while the Site 3 respondents were willing to pay up to R300. A mobile service was also welcome so that treatment could be accessed on the spot in an emergency, such as a car accident. The respondents also requested that the nurses should raise awareness about health issues, such as nutrition, mental health, HIV and sexually transmitted infections in the community.

4.1.7. Awareness raising of SAHealth

Respondents who lived in the area where SAHealth was established stated that one day SAHealth just materialised without prior communication. Some respondents who lived nearby saw it being constructed, but did not know what it was. Other respondents went to enquire about employment opportunities. Respondents from Sites 1 and 3 stated that no launch, awareness raising or communication about SAHealth occurred in these areas. However, Site 4 had a community meeting as their launch and the nurse was seen driving around in a car promoting the clinic with a loudspeaker and handing out pamphlets in the community. The Site 2 respondents remembered a small launch where the councillor notified the local community that SAHealth was a clinic that provided a valuable service; however, only people living nearby the site attended.

Most respondents were referred to the clinic through friends and family who had previous experience with the clinic. Word-of-mouth was the most common way information about SAHealth was disseminated - patients who received excellent treatment at SAHealth spread the word within the community.

Respondents emphasised many local community members, people who lived in shacks and people from surrounding extensions were unaware of SAHealth, and still frequented the private doctors.

Respondents confirmed that there was a need for signage in the community to direct people to the clinic. Some people arrived from other areas on referral and often got lost. None of the respondents had heard about SAHealth Clinics in other nearby areas, nor did they identify the company that was behind the SAHealth concept, except for one respondent from Site 4, who noticed Pharma Logistix on the sign.

4.1.8. Community demographics

Respondents were asked to express their opinion of the socio-economic demographics in their areas.

The respondents from Site 1 speculated that unemployment in their area was at 95%. At Site 2, respondents stated that about 60% of the community was unemployed. Some people had *ad hoc* jobs such as gardening or washing clothes, and others had permanent jobs that enabled them to extend their houses. Most youth were unemployed and were viewed as lucky if one family member worked. It was observed that the young girls often asked their boyfriends to help out financially or they moved in with their partners. Others lived off grants, such as children's grant or an HIV grant. Food parcels from the social workers were not consistent. Most people had access to water and electricity and they lived in houses that were part of the government's reconstruction and development programme (RDP). The respondents claimed that they spent money on food and their health, as their lives were more important than clothes and material things.

At Site 3, respondents first speculated that 70% of people were unemployed and then settled on 50%. People were thought to be employed full-time as truck drivers, taxi drivers, bus drivers and teachers in Vereeneging, Meyerton, Vanderbijlpark, Johannesburg and Lenasia. There were many train commuters to work. Many community members were self-employed (baked and sold cakes, owned a taxi, extended their houses and rented out rooms, or rented out shacks). Some people had *ad hoc* jobs, while others received government grants or nothing at all. Most houses were RDP houses and people had access to water and electricity.

At Site 4, it was estimated that 60%-70% of people were unemployed. Some people were hawkers in the streets, while others lived off grants or had *ad hoc* jobs. Most people had

RDP houses; the remainder were on the waiting list. Some people had fancier houses with home loans and everybody appeared to have access to water and electricity.

4.2. Nurses' perspective

4.2.1. Understanding of the SAHealth *model*

a) Purpose of SAHealth

All the nurses agreed that SAHealth Clinic was established to assist people who needed access to affordable healthcare services. It was suitable for those who wanted to access good quality healthcare without having to wait in queues the entire day. It served to close the gaps left by the public healthcare system. The Site 3 nurse stated that SAHealth aimed to help community members who could not afford private healthcare and who were not interested in going to the local government clinics.

b) Target market

Two nurses stated that the target market was the middle class and the remaining two nurses felt that it was for the very poor. The Site 3 nurse was specific in mentioning that the patients targeted were in the R2000-R6000 income group per month.

c) Nurse selection

The Site 4 nurse commented that the entrepreneur had to be a registered nurse with ample experience in primary health and appropriate qualifications, as well as a dispensing licence and a history of community work. According to the Site 1 nurse, information about SAHealth spread by word-of-mouth and there was an application process. After attending franchise presentations, the nurses filled in application forms and waited for approval.

d) Financial component

The nurse bought the franchise by paying a once-off fee of R10 500, and then paid off R180 000 over five years. Pharma Logistix did not ask for royalties. The nurse then had to choose the location of the clinic that is accessible to the community, speak to the ward councillor to gain permission for the use of the land, and either received the land for free, or had to rent or buy it. Thereafter, the nurse hired an administrative assistant and a security guard. The SAHealth model was built around the basic principle that the more patients treated, the sooner the debt could be paid off. Pharma Logistix set the target number of patients per month and suggested a basic price for the consultation fee. The nurse used trial

and error to see what was feasible in her particular area, and the consultation price ranged from R130 to R150 across areas.

The nurse also took home a monthly salary after paying expenses, including staff wages. *Table 7* exhibits the income and expenses as understood by the nurses, after intense prompting during the interview.

Table 7: Nurses' understanding of their income and expenses

Site	Date clinic opened	Expenses	Income
Site 1	April 2013	• Once-off franchise fee of R10 500 • Monthly instalment for franchise to pay R180 000 over five years • Monthly land rental • Monthly stock of medication • Locum nurse's salary – R400 daily • Administrator's salary – R2000-2500 • Security guard • Franchisee's salary	• Patients' consultation fees. • Cash payment gap of R12 000 for one year
Site 2	September 2012	• Once-off franchise fee of R10 500 • Monthly instalment for franchise to pay balance of R180 000 over five years, since it was taken over from another nurse • Monthly stock of medication • Administrator's salary – R2000-2500 • Security guard • Franchisee's salary	• Patients' consultation fees. • Cash payment gap of R12 000 for one year
Site 3	April 2013	• Once-off franchise fee of R10 500 • Monthly instalment for franchise to pay R180 000 over five years • Monthly stock of medication – R10 000 • Administrator's salary – R2500 • Security guard • Franchisee's salary • Waste management – R600 • Marketing - R1000	• Patients' consultation fees. • Cash payment gap of R12 000 for one year
Site 4	October 2012	• Once-off franchise fee of R10 500 • Monthly instalment for franchise of R1900 for five years • Monthly stock of medication – R8000 • Administrator's salary – R2500 • Security guard • Franchisee's salary • Waste management – R400 plus according to weight • Marketing - R1000 • Electricity	• Patients' consultation fees. • Cash payment gap of R4000 for year 2

The nurse and the admin assistant managed the inventory. The Site 2 nurse mentioned a stock card that the admin assistant filled in every afternoon. In general, the nurses explained that one or two stock orders took place every month depending on the business of the clinic. It was important to keep track of the fast-moving medication.

The locum nurse at Site 1 was learning how to run the clinic so that she could eventually open her own SAHealth Clinic.

4.2.2. Benefit to nurses

a) Psychological and emotional benefits

The most common benefit cited by all the nurses was that SAHealth enabled the nurse to work for herself independently as an entrepreneur, and it allowed her to manage her own time. Working for a public or private institution meant that they were employees answerable to authority. SAHealth enabled personal growth, while allowing the nurse to have a positive impact on the community.

Two nurses were grateful for the timing of the opportunity. The Site 1 nurse had resigned from her corporate job when this entrepreneurship opportunity arose. The Site 2 nurse was retired and involved in screening programmes at corporate wellness events through Discovery Health. Due to her age, she would not have been hired in the public or private sector.

The Site 2 nurse mentioned that she had dreamt of being a business woman when she was younger, but never had the opportunity; so SAHealth has enabled her to realise her dream. Similarly, the Site 3 nurse always dreamed of owning her own business, and was confident that SAHealth was the right choice for her as she could combine her nursing expertise with business. She also wanted to break the perception that business only entailed clothing or normal retail, and wanted to change the face of nursing to prove that people could run a healthcare business and be an entrepreneur as a nurse, as she felt this would help others have a vision. She added that SAHealth has enabled her to express her vision and to provide the best healthcare to patients. Other work environments do not allow for proactive ideas and have limitations that inhibit quality healthcare and community-level interventions. For example, if there is a need to implement a de-worming programme at the local crèches, it can be executed quickly and efficiently.

This opportunity made the Site 1 nurse reflect that she grew up in the informal settlement and had moved to an urban area, but was afraid to return, however this experience facilitated her to return to her roots and she now had the ability to touch the lives of many patients. The Site 2 nurse also confirmed that she loved working in the community, and the Site 3 nurse felt it was wonderful to give back and say thank you to her community.

The Site 4 nurse explained that when she worked in a public hospital, it was difficult to provide services that increased patient satisfaction because of a lack of resources, such as basic medication shortages, broken equipment that was not fixed or replaced for years, and low inventory stocks of essential products. Although she learned to adapt to the circumstances, she stated that it made her forget her responsibility to the patients. She felt that in the private sector, there were still many rules and unnecessary red tape that prevented one from adapting to the needs of patients and providing optimal care. However, by owning her own facility, she could do what she loved – be an asset to her patients and have good working conditions, as she would not have to go through bureaucratic red tape to get anything done in addressing the immediate needs of the patients. She provided the example of how easy it was for her to implement her programmes in the community, such as treating skin conditions at crèche or addressing the community about health concerns that plague them such as child accidents. This would be very difficult to accomplish through the hierarchical systems in public and private health spheres.

b) Financial benefit

Table 8: Nurses' understanding of monthly targets and their estimated number of patient visits

Site	Monthly target	Average estimate from September to November 2013
Site 1	400	150
Site 2	400	150-200
Site 3	500	300
Site 4	670	350-400

The Site 1 nurse was not sure what nurses were earning in the public and private sectors, however, she felt that the public sector salaries were better than private due to the occupational specific dispensation. This nurse asserted that her involvement with SAHealth was not based on financial gain, but on fulfilment as she had another business that sustained her financially. She was unable to always make the full monthly payments to Pharma Logistix.

The Site 2 nurse speculated that the public nurses earned R14 000 and above, while private nurses earned R17 000 and above. She stated that after calculating the returns with Pharma Logistix's CSI manager based on seeing 320 patients per month at a consultation fee of R100, they concluded that the nurse could take home approximately R15 000 after paying all the expenses, depending on the cost of the medication dispensed. The nurse at Site 2 was able to pay back the monthly instalment and expenses to Pharma Logistix without any outstanding debt. She was confident that she would be able to sustain a profit without the cash payment gap of R12 000.

According to the Site 3 nurse, she earned approximately R15 000 after tax while working in the public sector. At SAHealth, there was initially no profit generation and the cash gap helped to keep the business afloat. Toward the end of 2013, her clinic started to make a profit. The nurse estimated that on average the monthly expenses worked out to around R15 000 and the income including the cash gap was around R32 000, which implied a R14 000-16 000 income monthly at present. *Table 8* depicts the estimated number of patients the nurses treat versus their target. The Site 3 nurse felt the financial model would be sustainable if the patient numbers continued to increase. However, due to the backlog of payments from the initial months, she felt it was challenging to make up the payments at present.

At Site 4, the nurse had to increase her consultation fee from R100 to R130 as she was struggling to meet her expenses. She saw many patients who regularly required more medication that resulted in losses. After phasing out some of these patients, she was able to work towards striking a balance between the script values of the existing patients, where she was able to make an income and still offer optimal healthcare. She stated that she did not have an alternative source of income and was relying on her daughter to help pay for the franchise. In general she was able to cover her monthly expenses, except for the month of November 2013, as she had encountered banking issues that resulted in a shortfall of R10 000.

4.2.3. Benefits to the community

a) Services

All the nurses offered primary healthcare services. They mentioned the following specific services that they tailored to their community, as listed in *Table 9.*

The Site 2 nurse mentioned that obesity was a problem and that patients came in specifically

to be weighed. She charged them R20 and explained the concept of body mass index (BMI), the complications associated with obesity and the role of diet and exercise in maintaining an optimal health.

Table 9: Some additional services provided by the nurses at each site

Site	Services with additional costs	General consultation fees	Affordable to community
Site 1	• Family planning • Glucose test • HIV testing and counselling • Wound care • Eye tests • BP and cholesterol screening • Immunisations	R130	Yes
Site 2	• HIV testing and counselling; not treatment • Family planning, with contraceptive injection only • Monitoring vital signs • BMI calculation and advice • Glucose test • Cholesterol tests • Wound care • Eye test • Vitamin B injection • Breast examination • Wellness package	R130	Yes
Site 3	• HIV testing and counselling • Pregnancy tests • Eye test • Blood pressure test • Wound care	R150	Yes
Site 4	• Family planning: injection, contraceptive pill • HIV testing and counselling • Supplementation - Vitamin B injection, folic acid • Wound care • Pap smears • Breast examination • Checked vital signs	R100, increased to R130	Yes

The Site 4 nurse stated that one of the local government clinics supplied her with contraceptive pills and the contraceptive injection, with the expectation that she would supply statistics to them in return. The aim was to increase the reach of these family planning services by making them accessible. She also weighed the patients, checked their blood

pressure, and offered Pap smear screening, limited anti- and post-natal services, wound care and stabilisation of chronic illnesses. Coming from an HIV background, she expressed her passion for increasing HIV diagnosis.

With regard to the pricing of the medication, the nurses stated that it was predetermined according to the single exit price (SEP), as stipulated by government. However, the prices of non-medical products such as e-pap, Grandpa, Med-Lemon, Rehydrate and Zambuck were sold to patients a little below market price.

b) High quality of accessible care

The Site 1 nurse was confident that SAHealth offered quality care and quality medication to the community as evidenced by patients' repeat visits either alone or with other family members, and by their referrals.

The nurses offered care according to standard treatment guidelines that were provided by Pharma Logistix. They also referred patients to the nearest public hospital if they were unable to assist.

According to the Site 3 nurse, some patients liked the fact that they could attend a private clinic as it was a status symbol. She noted that in government clinics, HIV confidentiality was often compromised. Patients informed the Site 3 nurse that they were thankful that she respected them and that they were able to confide in her. Patients also complained about their treatment at the government clinics, such as the way the nurses spoke to them and the shortage of medication. She quoted a patient who had come to her after attending a government clinic, where he was ill and the nurses had ignored his acute illness and only gave him medication for his chronic illness. She performed the necessary examination and found that the patient was quite ill, and treated him accordingly. Some patients told her they were tired of waiting in the government clinic's queues and preferred to receive instant help at SAHealth. Some patients preferred SAHealth for family planning and post-natal care. She also asked the patients to fill out an evaluation form. The feedback was that the patients viewed the service as excellent. Patients were so happy that they referred their entire family and friends from other provinces. The Site 3 nurse also donated arthritis ointment to a local old age home in December, as it formed part of her community service. It also allowed the old age home to receive their medication on time. SAHealth also sometimes ordered medication for them so that it came on time. Reading glasses were also sold much cheaper (R50-100) than at the shops.

The nurses felt that SAHealth assisted in relieving the healthcare burden on the government

facilities, hospitals and other clinics. Even some of the government clinics referred patients to SAHealth if the queues were long. Queues at the government facility meant that the patient lost a day's wages as he or she spent the entire day waiting in the queues. There were also costs incurred with transport. The nurses explained that SAHealth was the logical alternative to long queues, poor service, rude nurses, and the lack of medication, or dispensing of the incorrect medication at the public health clinics.

The Site 4 nurse stated that the nearest government clinic was quite a distance away and patients were at risk when travelling to and from the clinic. Local youth robbed the patients of ARVs for Nyaope (ARVs that are crushed and mixed with marijuana and smoked), or stole their money and opportunistically raped people. She felt that she offered some salvation to the community as they did not have to travel far to access low-cost but high-quality healthcare. She also viewed her wellness services as offering the community holistic health in terms of a healthy body and mind within a nurturing environment, which she felt was imperative in propelling development and growth. She advocated that the community should take responsibility for their health and emphasised the importance of healthy lifestyle choices such as healthy eating, drinking sufficient water and exercising daily. She educated people about the harmful effects of sugary drinks and processed and fried food on their body.

c) Local employment

The clinics offered some local employment in terms of the locum sister, admin assistant, gardener, plumber, cleaner, handyman and security guard. The nurse from Site 1 hired a locum nurse from the community. The Site 2 nurse only hired a locum nurse on an *ad hoc* basis when she was unable to be in the clinic. She also hired a lady to do *ad hoc* admin and marketing activities. The Site 4 nurse had a few negative experiences with hiring locals and felt that the community was generally lazy.

d) Affordability in community

Initially, the nurses were sceptical about whether the community would pay to access SAHealth's services. However, it soon became clear that the patients were willing to pay the fees as opposed to dealing with the government clinics. *Table 9* indicates that all nurses felt that their communities could afford their services.

According to the Site 1 nurse, many people in her area did not have a regular income, and some received government grants or pension. However, she stated that they were not poor, but just previously disadvantaged. She disputed the findings of the community surveys, which stated that some households had no income. She felt that many people in this area

had a better quality of life than her suburban life, as they were not paying for their RDP houses, water or electricity; they only paid for food and clothes, and they were able to extend their homes and rent them out. In her opinion, the SAHealth consultation fee was completely affordable in this community, stating that no one in the community was poor.

The Site 2 nurse stated that the income level in her region was quite low and that many people lived off grants. She speculated that the unemployment rates were high due to the fact that many people were rioting on the streets during working hours when the strikes took place at the councillor's office. However, in terms of housing, both shacks and RDP houses were present. She contemplated dropping the price to R100 but that would not make financial sense. The Site 2 nurse mentioned that some patients could not afford to go to private practitioners, which cost around R270 for the consultation and R350 with medication. She felt that patients received excellent care at SAHealth and for R130-R150 they received an antibiotic worth R60 if required, a 'service of love' and an investment of time.

The Site 3 nurse confirmed that her community was comfortable paying R150 as the private doctors charged R250. No research had been conducted to understand the income brackets in the community. The nurse stated that most houses in the community were RDP houses and that people had extra money to spend on services. There were also graduates with jobs who still lived with their parents because it was cheaper; therefore, they had money for healthcare. She speculated that there were more employed people than there were unemployed people, and that most of the 1200 patients she had seen to date were employed. The nurse intended to increase the consultation fee to match the standard of service she was offering as patients had stated that they were willing to pay for the best service. She did add that the few people who could not afford the service could be angry and resort to robbing the facility.

At Site 4, the nurse stated that there were people who bought houses with home loans, while others owned RDP houses or shacks that were in the process of being converted to RDP houses. People worked in steel and carpeting industries and the younger people worked at the supermarkets. In most instances, the men were employed, while the women stayed at home. There were many grandmothers taking care of their grandchildren as their mothers had either died or were products of teenage pregnancies. She speculated that employment was high due to the number of people loitering around the clinic. Although the community did not have lots of money, they preferred to spend whatever little they had on SAHealth's services, as opposed to travelling to a government facility. She confirmed that those who had less money attended the government clinic; however, they eventually visited SAHealth because they did not always receive the help they needed, as the government clinic was not

well-resourced and could not provide adequate diagnosis or treatment. She felt guilty because she thought that these patients had to pay for SAHealth's services at the expense of other essentials such as food.

e) Giving back to the community

With regard to relationship building in the community, the Site 1 nurse stated that she participated in an engagement facilitated by Pharma Logistix, which entailed distributing food and clothes to less advantaged people in the community. She intended to do another charitable event in September 2014. She was also approached by a woman running her own NGO, who organised food parcels. The Site 3 nurse formed relationships with the local crèches, as well as an NGO called Meals on Wheels, which provided food parcels to the community and to some patients. She also stated that she was establishing trust in the community by attending community functions when invited, and by being a reliable service provider to the patients, i.e. ensuring that the patients' medication was always available when promised. The Site 4 nurse formed relationships with the local schools, churches and crèches. She taught the teachers at crèche basic paediatric care that any layperson should know, such as how to stabilise a child with a raging fever before seeking help. She stated that she intended to compile branded first aid kits and sell them at a discounted rate to the crèches.

4.2.4. Challenges

The primary challenge mentioned by all nurses was to increase the patient numbers and grow the business. The nurses were concerned about the cash gap that would decrease from R12 000 to R4 000 per month in the second year. They felt it was difficult to balance quality care with their expenses and income and still be able to take home a salary, especially during months with low patient numbers. The Site 2 nurse added that it was difficult to turn away patients who needed healthcare but claimed to have no money. The nurses agreed that some municipalities and patients expected free services.

Another common challenge was that medication was not cheap; therefore, the nurses had to be cautious to ensure that the patient was receiving optimal treatment without always exceeding the script value of R35. They felt that there were times where a patient was seriously ill and required medicines that severely diminished the profits. The Site 4 nurse stated that she had a high number of patients with chronic illnesses, such as hypertension and diabetes. Most of these patients were pensioners and were being charged R80 for a consultation. She eventually explained to them that she was unable to afford treating them

and they asked her to charge a fair price as they did not want to travel far; however, her conscience affected her. Eventually she managed to decrease the number of these patients utilising her services.

Business acumen was also an issue. The nurses admitted that Pharma Logistix had not involved them in much business training; however, it was in the pipeline. The Site 1 nurse said she was contemplating the merit of studying an MBA to assist in her entrepreneurship. The Site 2 nurse stated that she was trying to learn business skills despite not having a business degree.

Some SAHealth Clinics did not offer family planning services in terms of injectable or oral contraception, as the government clinic administered them free of charge and SAHealth would have to charge approximately R55. The same principle applied to vaccinations.

All the nurses mentioned that the clinic did not have a proper waiting room, therefore, some patients left before they were helped during adverse weather conditions, such as extreme heat or rain.

Safety issues were a concern with three of the nurses. The Site 3 nurse revealed that her clinic was robbed twice, and the computer was stolen both times.

Another issue was power outages, which was disastrous for medication that had to be refrigerated.

Two nurses mentioned that the clinic did not look like a private clinic because of its physical structure, and that people thought that the container meant it was a temporary structure; therefore, people did not respect it as much.

The Site 3 nurse mentioned she experienced a high turnover of admin assistants, as they left to study or found better paying jobs. This meant that new people had to be trained each time.

The Site 1 nurse mentioned that they were still waiting to receive their job descriptions.

4.2.5. Awareness raising

The nurse at Site 1 mentioned that low patient numbers were due to limited marketing endeavours, except for promotion at schools. The reason given was that the clinic was still new and in the process of establishing itself. She felt that the marketing had to be conducted in surrounding areas as there was awareness in SAHealth's vicinity. She also intended to do

free screenings and have monthly talks by experts on various health topics to raise awareness in the community.

The Site 2 nurse employed a local resident to hand out pamphlets, T-shirts and bags with SAHealth branding. She intended to improve the pamphlets and hand out SAHealth pens to her patients. The nurse also mentioned the dire need for signage on the roads to direct people to the clinic. The nurse carried her SAHealth bag when she commuted and people asked her about the clinic, which helped raise awareness. The Site 2 nurse was considering closing on Wednesdays as it was quiet, with the aim of using this day to market. She would then open on Saturdays to make up the lost time. She also expressed her interest in running two clinics concurrently with more staff as a way of growing SAHealth, and suggested Daveyton as being a suitable option.

The Site 3 nurse stated that her target of 500 patients was achievable. However, she stopped marketing as she felt that she did not have sufficient resources to accommodate this number of patients, as she would need another nurse and an additional consultation room. She stated that word-of-mouth assisted in her constant stream of patients. Her deworming campaign at the crèches also marketed her services to the parents of the children, where entire families used her services. She was in the process of planning a campaign to sell reading glasses to pensioners. In the past, she distributed T-shirts to patients.

The nurse at Site 4 recognised loyal customers by offering loyalty cards where the patient received his or her tenth visit free as well as a pen, bag or T-shirt. Pharma Logistix contributed R10 000 to the clinic's launch, which was digitally recorded by professionals. It consisted of food, drinks, singing and dancing. The nurse handed out donated items that she had collected. The nurse, community leader and the former CSI manager delivered speeches to the community and pamphlets were handed out advertising SAHealth's services. The Site 4 nurse handed out pamphlets on occasion at the taxi ranks, spaza shops, library, church and schools. The nurse used Thursday mornings to network and gave talks in the community, at church and school on health-related issues and life skills development. She also provided information on health issues to help students with their assignments. She stated that her future marketing activities would include the wealthier community members who have houses bought through home loans, as they have complained about being marginalised.

4.2.6. How to improve SAHealth Clinic

All the nurses requested that SAHealth be extended, as the clinics could not currently accommodate very large patient numbers. They expressed the need for a second examination room or an observation room, a waiting room for patients, and a small kitchenette. One nurse stated that she would prefer to have a building instead of the container structure, and she suggested approaching Cash Builders for support. The nurse's long-term plan was to have a mini hospital so that patients did not have to go to the government hospitals for minor procedures, such as sterilisations, deliveries, post-natal care, tonsillectomies, or facilities to set up drips.

The nurses put together a training matrix, which identified courses they had to complete to ensure that they were up-to-date with their clinical knowledge and offered quality care to their patients, for example managing HIV-positive patients from diagnosis to treatment. The nurses also requested business training.

The Site 2 nurse stated that her clinic needed to be relocated due to the previous strikes against the municipality, which led to vandalism of her clinic. She also suggested that a second container be set up with a few computers and Internet access, and be named SAHealth Communications. She felt that this would increase SAHealth's awareness and popularity as children could learn computer literacy, while being charged R10 per hour. People who were unable to afford Internet access could check their emails, and have health screenings done at the same time.

For safety reasons, the Site 3 nurse was in discussions with Pick n' Pay about turning her business into a cashless business, where patients could pay the supermarket and bring the slip to the clinic. She thought that security had to be tightened and an alarm installed. She wanted a formal letter from Pharma Logistix explaining SAHealth's services, so that she could network with the local government clinics. She also felt that offering services such as ultrasound scans, and pre-employment examinations, such as ear tests would help the business.

The request from the Site 4 nurse was that Pharma Logistix should arrange a floating ultrasound machine that she could borrow a few times a month to service her pregnant patients. She also felt that Pharma Logistix should help them identify other investors who are interested in developing small businesses in SA, as well as train them in proposal writing, to help them expand.

4.2.7. Perceptions of Pharma Logistix

a) The role of Pharma Logistix

According to the nurses, Pharma Logistix was the franchisor and ensured the wellbeing of the clinic, from a management, operational and administrative point of view. This included keeping track of the monthly record keeping process, the statistics, the attendance register and the financials.

Besides the clinical training, the Site 1 nurse stated that she received training on financial management, which was adequate for her needs. The Site 4 nurse received basic training on financial management, stock control, client services and marketing, which has increased her confidence. The Site 2 nurse did not receive any training, but Pharma Logistix promised to do so in the near future.

The nurses described how Pharma Logistix visited them on a monthly basis to ensure that everything was running smoothly. The Site 2 nurse, who was new, said that Pharma Logistix was helpful and sent people once a week to oversee the daily operations. They ensured that the inventory management was being conducted properly. Pharma Logistix also obliged the nurses' requests in providing resources for the administrative function, such as stationery, as well as marketing material. According to the Site 3 nurse, Pharma Logistix held franchise meetings, where they provided updates on important and relevant SOPs, such as upholding the brand and maintaining the high quality of care through adherence to the treatment guidelines.

b) General perceptions of Pharma Logistix

All the nurses agreed that Pharma Logistix was achieving its objective of positively impacting on society by helping these communities, alleviating the burden on the government clinics, as well as through increasing female entrepreneurship.

The Site 3 nurse stated that she trusted the company and felt like she was Pharma Logistix's partner because the company was always there for the nurses when they needed them. They listened to the nurses opinions and respected them. The nurse stated that both parties contributed mutually. She appreciated their commitment of providing the cash gap and the fact that they delivered stock when the nurses were unable to make the full monthly payments, which assisted their business to continue operating.

The Site 4 nurse stated that she was grateful to Pharma Logistix, as they were involved in a noble cause. She was appreciative of the fact that Pharma Logistix had enabled her to be an

entrepreneur and own her own business in her ‘golden years’ and she promised that she would make herself and the company proud.

However, the Site 1 nurse felt that Pharma Logistix was critical and never commended them. She added that when Pharma Logistix suggested changes and when these were implemented, Pharma Logistix did not document them and no feedback was given, which decreased motivation. She felt that their hard work was not acknowledged, but only scrutinised. As a first-time entrepreneur, she felt that she was still learning and needed more support. She then admitted that she was handed a letter stating that she was not being compliant and was in breach of her contract as her records were not up to date. The locum nurse had also made the mistake of giving out a sick note when it was not warranted. The Site 1 nurse felt that the relationship between her and Pharma Logistix was not an equal partnership at this stage.

The Site 2 nurse, however, stated that she felt like she was a partner to Pharma Logistix and felt incredibly supported. She added that at some point, Pharma Logistix had to let go and allow her to run her business independently as a business woman.

In general, the nurses stated that they trusted Pharma Logistix and understood that they were busy and had a very small team, which made it difficult to deliver what they promised. They knew that Pharma Logistix had good intentions for the communities and with regard to empowering the nurses. The nurses wondered how Pharma Logistix made a profit from SAHealth, though.

4.3. The Pharma Logistix perspective

4.3.1. Motivation underpinning the SAHealth concept

The MD of Pharma Logistix conceptualised the idea based on his personal experiences while practising as a general practitioner at his private practice in Somerset West in the Cape. Fifteen years ago, mothers paid him R150 for a roundworm diagnosis and a Vermox prescription worth R3.50. He realised that many mothers were incurring costs for inappropriate health-seeking behaviour. Later, while working in a state hospital, he observed that some patients wasted a day in hospital, waiting for an intervention that did not require a doctor, but could be provided by a well-trained nursing practitioner.

The MD was also aware of the overburdened public healthcare system and the shortage of medical doctors. He identified a gap to be filled between public and private healthcare

access as there was a willingness from people to pay for better quality healthcare, yet the private healthcare options were too expensive for the majority of the South African population. Due to the socio-economic context in South Africa, the MD's personal fundamental belief was the concept of task shifting, so that nurses could be empowered to service communities from a primary healthcare perspective, without the unrealistic hope that the number of doctors would increase and alleviate the healthcare problems in SA. He reflected on the critical question about how nursing practitioners could be empowered to build a service model that addressed these issues, and this led to the conceptualisation of SAHealth.

Furthermore, the MD felt that the health demographic of the country could be improved by educating and empowering women, which this initiative aims to do through providing the nurses with an entrepreneurial opportunity.

4.3.2. SAHealth's objectives

The MD and the former CSI manager who headed up SAHealth stated their objectives as follows:

a) To create a network of franchise clinics that provides quality and affordable healthcare in low-income areas. The ultimate goal is to rollout 2000 clinics, which services 500 patients each per month. This has the potential to remove a million patients per month from the public healthcare system, which will enable it to cope.

b) To ensure affordable access to healthcare, according to quality standards.

c) To empower the nurses to be entrepreneurial business owners who are financially independent.

4.3.3. The SAHealth model

a) Funding

The MD and CSI manager stated that the current investment to date in setting up seven clinics was estimated at R7.5million. SAHealth is solely funded internally through Pharma Logistix's holding company's enterprise development (ED), socio-economic development (SED) and corporate social investment (CSI) funds. The holding company has committed to investing R60 million over the next three years. The funding was secured in this way to

increases the quantum of funding available to be channelled into the project. This has been matched by a grant from the Jobs Fund for another R60 million. The MD explained that R30 million enabled the rollout of 50 clinics, including the back office costs, which meant that Pharma Logistix had funding to set up 200 clinics over the next three years. The operation would only be able to pay for its own back end services at 200 franchises, until which time Pharma Logistix would have to fund the costs.

b) The process

After funding was secured, a suitable nurse was identified. Newspaper advertisements proved successful in the recruitment of nurses. The nurses were interviewed by Pharma Logistix and selected based on their qualifications, healthcare experience, passion and willingness to embrace entrepreneurship. The nurse signed the franchise agreement and contract. Thereafter, the nurse chose the location of the clinic. The MD stated this had been a haphazard approach to date and that a German donor agency had recently provided a grant to optimise the research methodology on site selection criteria.

The container clinic was then set up, fully-stocked at a cost of R300 000. The initial plan was that the nurse could buy the facilities; however, the downside was that the company became a credit institution. In order to maximise profit, a franchise ownership model seemed more appropriate where Pharma Logistix owned the site and infrastructure, and the nurse owned the franchise. This ensured quality control and an excellent standard of service delivery. As a franchisee, the nurse paid a once-off franchise fee of R10 500 and then repaid R150 000 over a five-year period as monthly instalments; however, Pharma Logistix did not receive monthly royalties. The container was stocked with medication for the first month, thereafter; the nurse had to purchase her own stock. Pharma Logistix provided a cash gap of R12 000 per month for the first year to help cover expenses while the nurse built her business and increased her patient numbers.

The SAHealth model was based on the expectation that the nurse saw 500-550 patients on a monthly basis. The CSI manager explained that this meant that the nurse could spend 15-20 minutes per patient if she worked five days a week, and up to half an hour per patient if she worked on Saturdays too. Pharma Logistix felt this was reasonable as Site 2 achieved this for three consecutive months during the pilot.

The nurse could hire an administration assistant who served the role as receptionist, while taking care of the admin and inventory control, as well as the cleanliness and hygiene of the container.

c) Cost reduction

The nurse purchased the medication from a wholesaler, that was part of Pharma Logistix's centralised procurement process, which was meant to drive down the cost. Formulary management and treatment guidelines further decreased and standardised the costs, which were vital to the sustainability of the business model. The biggest cost driver are the drugs; therefore, most of the medication are generics. The model is also dependent on minimising the cost per patient treated, by adhering to an average of R35 per patient script. The MD asserted that it was important to understand the outliers and the risks associated with them, because if a patient developed a chronic condition such as diabetes, with a script value of R90, this had serious implications on the model.

d) Revenue generation

The business model is based on the following revenue streams:

1. A stand-alone fees for service model, and

2. The cash gap of R12 000 for the first year.

e) SAHealth model's anticipated profit

According to the CSI manager, the financial model is based on seeing 500 patients every month, which would allow a take home salary for the nurses are as follows: in year 1, nurses can expect R12 000 because of the cash gap support, year 2 should yield approximately R15 000, year 3 should give rise to R18 000 to R25 000, year 4 to R30 000 and year 5 up to R50 000.

The MD stated that in the private sector, a nursing sister could earn up to R20 000 a month. This model would allow the SAHealth nurse to own her own business, earn substantially more than in the private and public sector and be in control of her own destiny.

f) Performance measures

The nurses have a franchise or funding agreement that are of a contractual nature. It stipulates certain protocols that should be adhered to, such as being open for a minimum of 40 hours a week, not charging more than R150 for a consultation, paying the monthly rent and not defaulting on payments.

4.3.4. Financial management

When the CSI manager left, the financial manager (FM) and the human resources (HR) manager stepped in to keep the operations running, while a replacement was being found. Due to limited documentation and insufficient communication between staff members, these employees attempted to make sense of the project as they were not included in any discussions related to the rollout of the seven clinics. In the process, a few discrepancies were found. The FM explained that the container set-up was initially costed at R300 000 but now it appeared that it cost R200 000, which impacted on the amount the nurses had to pay. Going forward the new nurses would pay R100 000 over five years. Pharma Logistix also charged the nurses R1000 as a marketing cost each month but the FM was not convinced that this figure was accurate as the marketing initiatives were not transparent, or did not take place often and it was difficult to ascertain the accurate cost of these initiatives when they did take place.

Another issue was that the nurses did not always pay the monthly instalments, which consisted of the franchise payment as well as stock used in the previous month. The perception was that the nurses had previously been allowed to pay according to their discretion; therefore, they were opportunistic in seeing what they could get away with. It was more a matter of education rather than not making enough money each month. The cash gap was meant to help cover some costs, such as pay for the admin assistant; however, one clinic received a further R5000 for this purpose and is still receiving the cash gap despite it being established for more than a year. The nurses were meant to pay the operating costs, however, the FM had never seen the books, and was unable to comment. She speculated that they would have to pay land and container rental, water and electricity, waste management and disposal, security and inventory. The financial director has instructed that all debt be settled by March 2014 and that full instalments be paid every month for stock purchased. The FM felt that it was unfair to enforce this rule suddenly, as the nurses were not previously held accountable and needed to be given more time. It was also discovered that the nurses were unaware that they had to pay income tax, therefore, Pharma Logistix was in the process of registering them and would absorb the penalties. The FM questioned how much the nurse should be obliged to pay in relation to her income, if the expenses were high. The FM had never seen the income statement and presumed that former CSI manager had this information.

All the Pharma Logistix employees interviewed felt that the current clinics were self-sustaining and the former CSI manager stated that they were breaking even.

4.3.5. How does Pharma Logistix benefit?

The MD asserted that SAHealth was a great endeavour from a societal perspective. He claimed it was the smartest CSI and ED points-generating black economic scorecard strategy South Africa had ever seen. Pharma Logistix achieved 100% of its employment equity (EE), ED and SED points due to this initiative. The return on brand image and reputation was also important as clients would know that Pharma Logistix created a health access model that could change the profile of the healthcare system in South Africa by contributing to cost effective high -health interventions in low-income communities.

The former CSI manager stated that the franchise contracts stipulated that the nurses had to buy products from Pharma Logistix's wholesalers, therefore, it was important to ascertain how much money could be made if all the clinics formed part of the holding company's distribution and wholesale network including the purchase of drugs. The MD confirmed that in reality, when calculating the finances at 400 clinics, the amount was very small relative to Pharma Logistix's turnover. He stated that from a mathematical perspective, it was clear that Pharma Logistix did not benefit financially. He added that as a healthcare logistics business, Pharma Logistix did not stand to make a sizeable profit because the model was built on a R35 per patient script per interaction in terms of pharmaceutical costs. If each clinic succeeded in seeing 500 patients a month, the result would be R17 500 per month of drug purchases. Even 2000 clinics would result in R35 000 000 worth of pharmaceutical sales a month, which translated to about four hours of sales or 2.5% of overall monthly sales in this business.

However, the former CSI manager was adamant that this small potential for profit should not be undermined as it still held value. She reiterated that from a strategic point of view, the holding company needed to make the SAHealth offering more inclusive and to think about how to better leverage clients' products and create more market space at the BoP, which would better benefit the company from a financial point of view.

4.3.6. BoP vs. CSR

According to the MD, the goal is sustainability in terms of the BoP model. However, every time Pharma Logistix tried to partner with a franchise medical organisation, they wanted to make huge profits at the franchisor level, which is counterintuitive as the franchisee should be maximising the profit.

The MD then stated that this was not actually a CSI project, but a profit-generating business as the nurses would make a profit, however, Pharma Logistix was leveraging the need of the donor in terms of its CSI, SED and ED funds, which aligned with the balanced scorecard as the means for creating the capital input to deploy the clinics. The CSI manager stated that it was a means of getting internal support before looking externally for funding. She was convinced that the project embodied the values of ED, and not CSI, in the BoP context. She felt that the holding company misunderstood the meaning of ED. The CSI manager explained the main difference in terminology was that SED was five points on the BEE scorecard and entailed 1% of the company's net profit after tax. ED provided 15 points on the scorecard and entailed 3% of the net profit after tax. She stated that CSI in general did not achieve any business imperative or sustainability; it was a straight donor-driven contribution to society and fell under SED. ED encompassed building up small black suppliers and integrating them into the wider supply chain, as well as for growing small black-owned businesses in a sustainable manner. This approach was very much aligned to SAHealth's objectives and outcomes.

The MD confirmed that this was a BoP project and then retracted his words, referring to it as 'off-the bottom of the pyramid', because it aimed to fill the gap between the public health sector and the current private sector offering. He thought that the latter was unaffordable to the emerging middle class; however, this class had the awareness and the desire to purchase good quality healthcare. SAHealth was the business model created to fill this gap. He elaborated that it was not aimed at the indigent $2 per day population; it targeted the $5000 a year population - the emerging middle class. Paying R150 for a consultation with medication included was a bargain for people earning more than R3000 a month, according to the MD. He added that this model was not for people on welfare grants. However, he still asserted that it fulfilled all the criteria of the BoP – the market, the addressees, the back end model, the skills requirement in order to achieve the profit, except that the originator does not make a profit, but the established entity does.

Pharma Logistix staff stated that they were in the process of registering SAHealth as a Section 21 organisation.

4.3.7. Challenges

The MD emphasised that he was under no illusion that BoP models were easy to implement. Although the BoP presented with many opportunities, he admitted it was a difficult process, which took three times as long to build the business.

The former CSI manager stated that her biggest challenge was getting the franchise off the ground and getting buy-in from the relevant stakeholders. The SAHealth franchise was built from scratch, including the writing of the standard operating procedures, designing the franchise agreements, designing the layout of the clinics, determining the contents and facilities needed at the clinics, procurement issues, recruitment, job descriptions, skills training, monitoring and evaluation and supply chain management.

Other challenges included the following:

a) Training of the nurses

The MD admitted that he was unaware of the extent and magnitude of training that was required for the nurses until he spent time with them at the end of 2013. It was clear to him that training had not been the focus to date. His perception of how Pharma Logistix was training the nurses and where they were at, were not aligned, as a naivety was present when it came to business acumen and being financially astute. The basics of understanding productivity, in relation to output and financial output, as well as fundamental principles of successful general practice such as being available, adequate and affable were lacking. He cited an example of how patients who arrived five minutes after closing time were turned away, and the clinics were closed on Saturdays even though this was the busiest day in most doctors' private practices. Financial management training also needed to be intensified.

The CSI manager believed huge strides had been made in terms of the nurses' empowerment, such as communications, the ability to work with partners, engagement with government and financial management and reporting, but not necessarily financial viability.

The administration assistants were also in need of training. They had insufficient product knowledge and found it difficult to memorise the price list.

b) Cost reduction

There was room for improvement in cost reduction. Both the MD and the former CSI manager commented that the nurses needed to take cognisance of the R35 average script value in terms of balancing the costs of the various medications on a regular basis. The SAHealth model was based on tight financial control; therefore, profits were reduced when the script value was exceeded. Pharma Logistix felt that at present, the seven nurses would rather lose money than compromise quality. In addition, the HR manager stated that Pharma

Logistix was investigating alternative options for outsourcing its distribution and warehousing of the medication to the clinics.

c) Low patient numbers

The CSI manager stated that the clinics did not make their patient numbers on a regular basis. Some nurses felt that this was because they were in the wrong location, even though they did not market themselves adequately.

The nurses told Pharma Logistix that selling over-the-counter (OTC) medication would increase their patient numbers and profits; however, the nurses needed to understand that they would only be able to incorporate additional services once they were sustainable on a 'fees to service' model.

d) The Pharma Logistix team

The FM and HR manager stated that when the CSI manager left in September last year, they tried to understand the project. They had not been previously included in the process, as the CSI manager and MD managed SAHealth in its entirety. The HR manager and FM identified many gaps and inconsistencies that need to be solved before the new clinics are rolled out; however, there is a lack of capacity and a lack of communication within the Pharma Logistix team. The HR manager added that they needed to have a team in place to strategise and prepare for the rollout of the new clinics, while still maintaining the support to the existing seven clinics.

4.3.8. Lessons learned

The CSI manager admitted that her biggest lesson was learning that it takes time to grow small businesses. There is a significant amount of 'hand holding' throughout the process, and there has to be ongoing mentoring, coaching, revising, updating and motivating along the journey. It is a fine balancing act between allowing the nurses to run their own business and running it for them.

The MD stated that the location of the clinic was vital for accessibility and that research was required to improve the criteria for site selection. It was also pertinent to choose the franchisee appropriately and the role of marketing should not be underestimated.

4.3.9. The way forward

The most important aim going forward was national scalability to increase patient numbers at each site and to increase the number of clinics. The MD stated that by mid-2014, 10 new clinics would be rolled out. The intention was to identify five sites in one community and one site in five communities, and to see whether the former option creates a self-acceleration through awareness.

He described the following possibilities for SAHealth:

The SAHealth franchise model is in the process of transitioning into a system where the nurse will pay rental each month and if they do not comply with quality and standards and harm the brand, Pharma Logistix would be in a position to take it away. This would give Pharma Logistix a much greater lever of censure against the standards that are applied at a franchisee level.

The MD reiterated that it was important to refine the service offering from the back office. A partnership with Right to Care is underway and once SAHealth receives the endorsement from the public health services, SAHealth would have the service offering and the multiple revenue streams to rollout and deploy more clinics and provide better training. State support for vaccination programmes and donor funds for support of donor-funded programmes, for example, specific health education programmes, would also be beneficial to SAHealth.

Once the clinics are commercially viable on their basic primary service, Pharma Logistix will ascertain how to incorporate secondary income streams into the model, as the second-generation strategy. Spaza shop integration falls into this category. Every clinic sister should establish a relationship with 30 spaza shop owners and educate them on common ailments that every layperson should know, such as managing fever in children, worms, scabies, lice, coughs and colds and basic joint pain and headache. The clinics could also serve as a delivery point for the products sold at the spaza shops.

Another element of the strategy is to expand into insured healthcare provision and approach the medical schemes asking for designated service providers for this network for low-cost insurance products, and running a centralised claims administration structure once 30 clinics have been established.

The clinics could be aligned to the government's National Health Insurance (NHI) plan or become NHI-accredited sites, where the patient would receive treatment subsidised by

government. The clinics could also be a chronic script pick up point and the nurses could receive a cut of the value of the script.

Additional specialised services, such as a mobile gynaecology clinic or mobile dental clinic, may follow.

The CSI manager added that SAHealth should not just be viewed as a healthcare channel in the medium term because the holding company has other businesses, such as car rental and spare parts and financial services and insurance, that have not entered the BoP market as yet; therefore, SAHealth can be leveraged as a market entry point.

4.4. Secondary data

The following tables and figures have been extracted from company documents, reports and financial statements provided by Pharma Logistix.

4.4.1. The SAHealth business model

Table 10: SAHealth's business model

Rands Per Month					
Costs	Year 1	Year 2	Year 3	Year 4	Year 5
Overheads	4 803	5 116	5 448	5 802	6 179
Stock	5 659	11 458	15 605	18 432	21 559
Other salaries	7 570	8 062	8 586	9 144	9 739
Nurse salary	12 000	17 000	19 000	22 000	25 000
Franchise fees	3 500	3 727	3 970	4 228	4 503
Total	**33 532**	**45 363**	**52 609**	**59 606**	**66 980**

Rands Per Month					
Revenue	Year 1	Year 2	Year 3	Year 4	Year 5
Consultation	**21 600**	**45 500**	**63 000**	**75 000**	**88 000**

Profit /month	**- 12 000**	**0**	**10 400**	**15 400**	**21 000**

UNJANI CLINIC

- In year 1 cash gap support of up to R12k/month
- In year 2 cash gap support of up to R4k/month

IMPERIAL HEALTH SCIENCES

	Year 1	Year 2	Year 3	Year 4	Year 5
Patients/month	180	350	450	500	500
Consultation cost	R120	R130	R140	R145	R155

Source: Pharma Logistix *(2012)*

Table 10 depicts the anticipated expenses, income and patient visits per month for the first five years. According to *Table 10*, a nurse's salary is R12 000 in year one. It increases incrementally to R25 000 in year five. Expenses are also estimated at R33 532 in year one and increase to R66 980 by year five. The target number of patients per month is 180 in year one, R130 in year two, and finally reaching the target of 500 by year five. There is an expected loss of R12 000 in the first year, breaking even in the second year. Profit of R10 400 is seen in the third year and this increases to R15 400 and R21 000 in years four and five respectively.

4.4.2. The services rendered by SAHealth Clinic

Table 11: Services offered by SAHealth

Services	
• Consultation adult • Consultation children • Pensioners • Family Planning • Afterhours service • Glucose Test • Pregnancy Test • Cholesterol Test • VCT Test • Couple VCT Test • Removing stiches • Wound Care & Dressings • Follow-up Wound Care • Vision Screening • BP Test • Follow-up (medication) • Follow-up (without) • Referral • Vitamin B Injection • Pap Smear • Wellness package (Glucose, BP, Cholesterol, Height & Weight, BMI) • CD4 count • Breast examination • ARVs • ALT (Liver function test) • Creatinine (Kidney test)	• Blood group • Rheumatoid factor • Uric acid • BHCG (pregnancy) • HIV Elisa • Syphilis (include in ANC) • STI 7 days • STI 14 days **Chronic consultation** • IV Line (Hyperglycaemia) • IV Line (Hypoglycaemia) • IV Line (Rehydration) • Pre-initiation assessment **Laboratory services** • HB test (lab) • Blood group • Rheumatoid factor • Uric acid • BHCG (pregnancy) • CD4 count • HIV Elisa • Pap smear • ALT

• Antenatal clinic: 1st visit - included VCT prick test • ANC: follow-up • ANC: 1st visit no blood • HB test (lab)	• Creatinine • ANC (blood group + RH, syphilis) • RPR (Syphilis) • Sputum TB Micro

Source: Pharma Logistix *(2012)*

Table 11 lists the full service offerings that could be offered by SAHealth Clinic, depending on the nurses' preferences for their respective areas.

4.4.3. Recorded number of patient visits

Table 12 reveals the number of patient visits per month from September 2012, until November 2013 for SAHealth Clinics at Sites 1 to 4. It includes the number of months each clinic has been operational during this period, as well as the monthly average number of patient visits per clinic surveyed.

On average, Site 1 had 140 monthly patient visits from April to November. Site 2 had 231 patient visits on average from September 2012 to November 2013. Site 3 had 193 patient visits on average in a 10-month period and Site 4 saw an average of 283 patients from October 2012 until November 2013.

Table 12: Number of patient visits per month

Clinic Name	Months open	12-Sep	12-Oct	12-Nov	12-Dec	13-Jan	13-Feb	13-Mar	13-Apr	13-May	13-Jun	13-Jul	13-Aug	13-Sep	13-Oct	13-Nov	Monthly average
Site 1	8								25	90	124	164	214	173	182	149	140
Site 2	15	238	294	289	173	189	231	169	190	290	299	381	215	165	203	132	231
Site 3	10						26	82	91	98	165	186	327	382	315	257	193
Site 4	14	-	94	296	264	296	329	303	284	408	344	308	355	250	249	185	283

Source: Pharma Logistix *(2013)*

4.4.4. Financial status of the four clinics surveyed

Table 13 documents the income reported by the nurses, the actual income calculated by Pharma Logistix, as well as the expenses calculated by Pharma Logistix, on a monthly basis

over the period January to August 2013. On average, the reported income from Site 1 was R13 368, its actual income was R12 832 and its expenses were R41 232 (on a monthly basis). Site 2's average reported income was R28 339, its actual income was R15 523 and its expenses were R21 359. Site 3's reported income was R21 534, its actual income was R15 523 and its expenses were R34 849 on average each month. Site 4's reported income was captured as R30 033, its actual income was R32 477 and its expenses were documented as R30 214.

Table 13: Adapted from Pharma Logistix's financial summary from January to August 2013

Month	Site 1 (Rands)	Site 2 (Rands)	Site 3 (Rands)	Site 4 (Rands)
Jan				
Reported income		19918		22790
Actual income		7375		27700
Actual expenses		17496		27852
Profit/Loss		-10121	0	-152
Feb				
Reported income		19834	1520	24469
Actual income		8810	2570	40800
Actual expenses		12970	9320	22864
Profit/Loss		-4160	-6750	17936
March				
Reported income		15925	10870	25167
Actual income		5200	8990	20200
Actual expenses		12073	30515	27811
Profit/Loss		-6873	-21525	-7611
April				
Reported income	4 950	23999	8229	26335
Actual income	1205	24900	13100	35500
Actual expenses	62171	16334	20294	23843
Profit/Loss	-60966	8566	-7194	11657
May				
Reported income	11080	22630	15353	23280
Actual income	7215	13475	14150	26500
Actual expenses	25886	18164	49556	35423
Profit/Loss	-18671	-4689	-35406	-8923
June				
Reported income	11080	30077	21792	30456
Actual income	9995	29400	21780	35700
Actual expenses	29557	27078	31977	30380

Profit/Loss	-19562	2322	-10197	5320
July				
Reported income	14680	33203	22065	35870
Actual income	20280	33605	21150	26865
Actual expenses	49219	23879	42332	34113
Profit/Loss	-28939	9726	-21182	-7248
August				
Reported income	25050	31787	40230	34223
Actual income	25465	24195	7435	37820
Actual expenses	39329	21342	30087	27313
Profit/Loss	-13864	2853	-22652	10507
Average per month				
Reported income	13368	28339	21534	30033
Actual income	12832	25115	15523	32477
Actual expenses	41232	21359	34849	30214
Profit/loss	**-28400**	**3756**	**-19326**	**2263**

Source: Pharma Logistix *(2013)*

CHAPTER 5: DISCUSSION

5.1. Research question 1: To what extent does SAHealth benefit the community?

5.1.1. With respect to the patient community

a) The over-burdened public healthcare system – addressing unmet needs

The MD of Pharma Logistix took cognisance of the fact that the government healthcare system was over-burdened, under-resourced and poorly implemented, especially in low socio-economic areas in South Africa. Combined with his personal experiences as a medical doctor, and his willingness to make a sustainable contribution to this area, he conceptualised the SAHealth Clinic model, as a means of addressing these issues to help alleviate the burden on the public healthcare system, by increasing access to affordable, high-quality healthcare in marginalised areas. Both the community respondents and the nurses interviewed have corroborated the basic need for the improvement of healthcare services in the communities surveyed.

Prior to the establishment of SAHealth Clinic in these areas, the respondents relied on public healthcare facilities. There was consensus from respondents across all sites that they received suboptimal treatment at the government clinics and hospitals. They openly criticised the public healthcare system by citing numerous complaints, ranging from a lack of resources and shortage of medication to poor service delivery, inadequate medical treatment, lack of a proper examination and diagnosis, unprofessional treatment by nurses and horrendous queues, which did not always guarantee service. Many patients shared anecdotes relating to their negative and sometimes aberrant experiences with the public healthcare system. The nurses who ran the SAHealth Clinics expressed similar sentiments, having either worked at government facilities themselves, or being privy to the patients' experiences. Patients were willing to pay exorbitant fees to visit private doctors in order to avoid the public healthcare system.

These issues highlight the importance and validity of Pharma Logistix's stance in formulating the SAHealth Clinic concept as a means of addressing unmet patient needs in these communities.

b) Accessing good quality healthcare in the community

It is evident from all the respondents' input that SAHealth is a welcome addition to their respective communities, as it serves the important function of increasing access to high-quality healthcare. Every respondent was highly appreciative that SAHealth serviced his or her area, and SAHealth was almost revered in contrast to the government clinics. SAHealth's location was deemed satisfactory; however, increasing its visibility and the signage throughout the area was seen to be a necessary improvement. The healthcare offered by SAHealth was viewed as impeccable due to the following factors - the nurses' patient-centred approach, their caring, sympathetic nature and their passion; and the accurate diagnosis and appropriate treatment, which were all based on the standard treatment guidelines and protocols. The quality of care was equated with being on par with that of private healthcare facilities, and the fact that the respondents referred their friends and family to SAHealth was testament to the excellent service provision. The researcher can confirm the passion and altruism that the SAHealth nurses possess based on their interviews. The nurses clearly exhibited sincerity in wanting to provide high-quality healthcare to this marginalised group of patients and they felt that they wanted to 'give back' to these communities. Pharma Logistix also confirmed that the nurses were chosen according to their passion, their experience and their qualifications to ensure excellent provision of healthcare. Most respondents blatantly stated that they would never frequent a government clinic or private doctor ever again; however, it should be noted that SAHealth does not offer the wide variety of services as hospitals and clinics; it focuses on primary healthcare, therefore, SAHealth refers patients when necessary. SAHealth was also viewed as a place that offered a cure, as opposed to a government clinic that did not often cure patients.

With regard to the actual services offered by each clinic, the respondents found it difficult to articulate the types of services they accessed and spoke anecdotally. They were not able to list all the services they could possibly access, but trusted that they would receive the care they needed as the issues arose. The nurses explained that they offered primary care services and some clinics offered additional services according to the needs of the communities, and based on their own insights and initiative. Pharma Logistix allowed the nurses to tailor their service offering as this meant increasing the quality of care available to the respective communities. The nurses failed to describe many of their services to the researcher that are documented by Pharma Logistix as SAHealth's service offerings, as listed in *Table 11*. Not all these services are listed on the board stuck on the wall at SAHealth Clinic; therefore, patients may not request them, unless advised by the nurse.

c) Affordability in the community

Affordability of healthcare was a key component of the SAHealth model, as envisioned by Pharma Logistix. This was a fine balancing act between maintaining affordability to the community, while still being profitable. The nurses were able to set their own consultation price according to their insights into the community in which they operated, under the advisement of Pharma Logistix. Most respondents had resorted to paying high consultation fees at a private doctor, which cost approximately R250 excluding transport, and even visiting the government clinics incurred costs to transport, food, a missed day of wages, and repeat visits or trip to private doctor as they did not get better. For these reasons, patients were more than happy to pay SAHealth's stipulated consultation fee. SAHealth was cheaper overall, as it included the cost of the consultation and the medication and it did not incur additional costs such as transport and food.

The nurses were also convinced that the communities in which they operated were able to afford their services. There was a variation in what the nurses perceived as being the target group, with two nurses stating that it was the middle class, while the remaining two felt that it was for the very poor sector of the population. This shows that it is important to ensure that the nurses are aligned with Pharma Logistix on their business strategy. One nurse was adamant that her community was far from poor, as they received grants and RDP houses, which indicates that people have different perceptions as to what constitutes being poor. It is fortunate that Pharma Logistix will be commissioning demographic research into the various low-income areas in South Africa in order to tailor the business strategy and service offerings accordingly. In this body of research, the respondents' demographic information from all areas surveyed revealed that their monthly household income was between R600 and R3500. It is noteworthy that even the respondents toward the lower income range still preferred to pay for SAHealth's services, proving that the clinic does indeed service the low-income groups. Pharma Logistix's MD views healthcare as a grudge purchase; however, the respondents interviewed were quite clear that they prioritised their wellbeing over material purchases.

d) Contentions

Both the respondents and the nurses requested expensive additional radiological and gynaecological services or improvements and extensions to SAHealth's structure, not fully realising that these had cost implications to the SAHealth model which would invariably result in higher operational costs. Admittedly, it is obvious that a better constructed waiting room is required for patients. When the cost element was pointed out to the respondents,

they were amenable to paying a higher consultation fee for these additions, as well as for specialist services, as long as it was still cheaper than their visits to private doctors. The Site 4 nurse was concerned that her patients would not be able to afford increased fees as they would further compromise on other basic necessities such as food. The Site 4 respondents; however, did indicate their willingness to pay more. This is an appropriate example, which highlights the fact that the nurses need to gain more in-depth insights into the socio-economic conditions and mindsets of the community members, which will assist them to run their business more efficiently.

A pertinent issue that surfaced, which is a concern, is that although the community assessed good-quality healthcare based on a number of criteria, one of them was erroneously linked to the amount of medication dispensed – the patients believed that the more medication they received , the better their treatment. The nurses seem to largely fulfil this expectation, which is counterintuitive to making a profit as it increases the script value, in situations where it may not be indicated.

Many respondents had the expectation that SAHealth should offer employment, and the nurses have tried their best to accommodate this by employing local community members to perform *ad hoc* tasks; however, it should be noted that this is not a primary objective of the business model.

There were numerous perspectives about the nurses' working hours. The communities requested longer hours during the week, as well as Saturdays, with some respondents requesting the clinic be open seven days a week. This is not practical in terms of capacity, unless more locum nurses are hired to assist. This will increase the operational costs, which may not justify the working hours. The nurses also feared for their safety and chose not to stay open at night, which is understandable. However, some nurses were too strict with their opening hours and turned away patients who sought treatment at closing time, which does not make good business sense, nor is it ethical to turn away a patient seeking healthcare for such a reason. From a business perspective, it also makes sense for the nurses to work at least a half day on Saturdays as this is one of the busiest days for most doctors, as confirmed by Pharma Logistix's MD.

5.1.2. With respect to the nurses

a) Fostering entrepreneurship and personal fulfilment

One of Pharma Logistix's key objectives was to facilitate and foster nurses to become entrepreneurial black female business owners. This objective was met as all the nurses interviewed were in deep gratitude for this opportunity as they felt that Pharma Logistix had enabled them to realise their entrepreneurial dreams to become independent and to facilitate personal growth. All the nurses were either retired or had some level of frustration working for someone else.

The SAHealth model subverted the norm, as it was not often that nurses were given an opportunity to be relatively autonomous to make decisions that improved the way they practised healthcare delivery. The opportunity also appealed to their sense of altruism in enabling them to achieve patient satisfaction in areas that were generally marginalised in terms of adequate healthcare access. They now had the resources and capabilities to address these patient needs, while giving back to the communities from which they came.

b) Financial aspects

The SAHealth model was built on the premise that it had to be financially viable, in the sense that it should cover all operational expenses as well as ensure an income for the nurse who runs the clinic as an entrepreneur.

Income potential

The MD's expectation was that the nurses should earn substantially more than they would in the public or private healthcare sectors, which were estimated at R15 000 and R20 000 respectively per month. According to the former CSI manager's calculations, nurses would be able to take home R12 000 each month in year one, increasing to approximately R50 000 in year five, based on 500 monthly patient visits. These figures are used in SAHealth's recruitment presentation, which explains the SAHealth business model and it appears as though the CSI manager has combined the nurses' income with the profit to come up with these figures, as shown in *Table 10*. In reality, the nurses do take home R12 000 per month as expected according to the model in year one, and it is covered by Pharma Logistix's cash gap of R12 000. However, the average expenses for Sites 1 and 3 exceeded their turnover by more than R12 000 per month, as depicted in *Table 13*, which is concerning as the model is based on a consultation fee of R120 and all the clinics are charging R130, except for Site 3 which charges R150, and thus, should be more profitable. It is optimistic to note that Sites

2 and 4 made a small profit on average each month between January and August last year (See *Table 13*), however, it should be acknowledged that they have been in operation for longer. This is more progressive than what the model anticipated, which is encouraging. All the nurses admitted they earned higher salaries in their previous employment, and three nurses confirmed that they were in this role because of the altruism and not because of the money. They were short-sighted and did not give much thought to their prospective income being substantially higher than their current situation. It is important to note that all the nurses, with the exception of one, were married and were fortunate to have a double source of income, as this ameliorated the current financial pressure.

Meeting expenses vs. profitability

With regard to the profitability of the clinics, the nurses had various opinions. In general, all the nurses claimed that they were able to pay back the monthly instalments to Pharma Logistix. Some nurses were able to do this without relying on the cash gap. However, one nurse commented that business was difficult initially, which led to a backlog of payments, and this eroded the current revenue, making it difficult to sustain the payments. The research revealed mixed messages emanating from the Pharma Logistix team - the CSI manager claimed that the clinics were breaking even in terms of income and expenditure, the MD was adamant that the clinics were sustainably financially viable, while the FM and HR practitioner were concerned that the nurses opted to take home salaries, as opposed to regularly paying the full monthly instalment amount. The FM and HR practitioner were trying to consolidate the financial statements to ascertain the real financial status of each clinic at the time of the interviews. The secondary data eventually depicted that the nurses generally overstated their turnover, and the expenses often exceeded their income, as represented in *Table 13.* However, it was also clear that the FM and HR manager did not adequately understand the business model as the nurses were entitled to take home the R12 000 as accommodated for by the business model (See *Table 10*).

It should be acknowledged that start-up businesses are seldom profitable in year 1, as the initial set-up costs and operational costs are high. Therefore, it is admirable that Sites 2 and 4 appear to be sustainable and financially viable, according to *Table 13*.

It seems that some Pharma Logistix staff felt that the nurses did not acknowledge all the expenses that were inherent to the business. *Table 7* lists the expenses that the nurses mentioned after probing, which was not a complete list, according to Pharma Logistix. These staff members intimated that it was not solely the nurses' fault as the gravity of the situation in not making full payments was not adequately explained to them. They were allowed to

default on their payments according to their discretion and were not held accountable for it in the past by the CSI manager, who was incredibly busy with ensuring that the operational aspects of the business model were running smoothly. For example, if the nurse was unable to pay for the previous month's stock, Pharma Logistix still replenished them with new stock to continue running the business. The rationale behind this is understandable from an operational point of view, although financial staff may not agree, but it is important to set up the business efficiently and secure patient numbers to optimise the turnover, before deeming a project financially unviable because of outstanding payments. The lack of accountability was also exacerbated by the fact that the nurses lacked clear job descriptions, and although their contracts laid out the important ground rules, the financial management and financial performance aspect were absent.

On a practical level, the primary reason that turnover was low was due to low patient numbers. As stated earlier, the financial viability of the model is based on the prerequisite that 500 patient visits are secured by each clinic every month. This seems to be the number that Pharma Logistix advocated to the nurses even though they are in year one and two of the business strategy, which contradicts the model laid out in *Table 10*. Despite this inconsistency, Site 4 came closest to this target; however, *Table 12* indicates that all sites had a shortfall of patient visits over the period September 2012 until November 2013. It is clear that the nurses overestimate the number of patients they see and report on as evident in *Table 8*. It is significant to note that all clinics achieve the average patient number of 180 according to the business model in *Table 10*, except for Site 1, and this may be explained by the lack of marketing. Site 3 should be more aligned to the business model's financial expectation as it charges higher consultation fees; however, they had higher expenses, which may be attributed to the fact that it was robbed twice already. The Site 1 clinic's average loss per month may be partially explained by the high cost of security measures and plumbing that was required during its set up. Another possible reason that explains the high expenses overall is that perhaps Pharma Logistix underestimated the overall costs that would be required to set up and run the clinics.

The nurses used issues around location of the clinics to explain the low patient numbers. Except in the case of Site 2, which was involuntarily involved in political strikes, the other clinics do not have a sound reason to blame low patient numbers on location. Two nurses wanted Pharma Logistix to consider relocating them; however, it is clear that if a particular service is exceptional, people will seek out this service, no matter where it is located in the vicinity.

The more logical reason that underpins low patient numbers is inadequate marketing in most instances. Some nurses blatantly confessed that no marketing has been implemented, which is surprising seeing that awareness raising is the obvious way of attracting more patients to the clinic. However, other nurses have been quite innovative when engaging with the community by tailoring their healthcare services to the needs of the community. One nurse admitted that she stopped marketing as she did not want to attract more patients due to her capacity level. Ironically, she was seeing fewer patients than her target, which meant that she was spending too much time with each patient, which is acceptable if there are no other patients waiting to be served. It should be reiterated that the target of 500 patients was calculated in the context of spending 15-20 minutes with a patient. This nurse also felt that she would need an additional consulting room and another locum nurse to accommodate more patients, which would drive up the costs. This begs the question: is it feasible to see 500 patients on a regular monthly basis? According to the CSI manager, this target was practically achieved for three consecutive months by the pilot clinic, therefore, it was a reasonable target. This shows misalignment between the perceptions of the nurses and Pharma Logistix, with regard to what constitutes a viable business.

Another reason for the lower turnover is the script value of each patient. The SAHealth model is based on a script value of R35 per patient, and this is often exceeded by the nurses. As mentioned earlier, this is a difficult issue to tackle because many patients expect more medication as an indication that good medicine is being practised. Alternatively, some patients require more medication, more expensive medication or chronic medication, which increase the script value. Pharma Logistix has briefed the nurses to be more aware of this aspect and to have the conviction to send patients away empty handed if they do not really require medication, in order to balance out the script value between patients seen in a day. One nurse was quite proud of her successful attempt of reducing the number of her chronic patients by referring them elsewhere.

The nurses also pay a marketing fee of R1000 per month to Pharma Logistix for marketing activities. Some nurses mentioned that they received marketing materials, such as pamphlets, however if certain nurses admit that they do not undertake marketing activities, then this payment is unnecessary. Alternatively, this monthly amount could accumulate to finance a larger-scale event. One clinic mentioned that Pharma Logistix sponsored an additional R10 000 to help her host a marketing event. This implies that all clinics do not receive the same support, unless the nurse makes a special request, which relies on the nurses' personal initiative.

The FM at Pharma Logistix did not understand why one of the clinics was still receiving a cash gap of R12 000 even though it was in year two. However, the reason is because a new nurse had taken over the franchise, after the initial nurse was asked to leave. This confirms the lack of communication within Pharma Logistix.

The other issue is the discrepancy in ascertaining the costs of setting up the container. The initial cost was stated as R360 000, and the nurses bought the container for the value of R180 000 over five years. The FM reassessed the cost of the container at the end of 2013 and established it as R200 000, which is significantly less than the initial amount cited. This has huge implications on the monthly instalment each nurse has to pay, and it does not seem fair that the pioneer nurses pay more for the same infrastructure, compared to the newer nurses who will come on board.

d) Skills development and increasing business acumen

In order for SAHealth Clinic to be successful, nurses are expected to display astute business acumen. In terms of idea generation, the nurses were quite innovative in their thinking, from exploring a cashless business, to diversifying services, procuring different sources of funding and expanding their operations. However, from a technical and implementable perspective, business skills fall out of the nurses' repertoire and the formalised training they received, as their focus was on clinical medicine and its practical application.

There are varying opinions on the level or nature of training the nurses have received. Some nurses viewed their training as being negligible or merely focusing on the basics, therefore, they were exploring the viability of studying business courses in the hope that it would increase their acumen. The other nurses appeared to be satisfied with the amount and type of training received. The CSI manager felt significant progress had been made in non-financial aspects of business, but not necessarily with regard to financial viability. When the FM and HR manager took over the project, they were startled at the nurses' dubious financial management skills, such as basic accounting. Although they did embark on an informal training initiative with the nurses, the MD was also taken aback by the realisation that training had been severely neglected and that intensive training would be required to up-skill them to become more competent business women, even from practical and reasonable points of view. Suitable training methodologies were yet to be identified.

On a positive note, the nurses were adept at identifying gaps in their knowledge and requesting the relevant training, which would increase their clinical expertise and better serve their patients.

5.2. Research question 2: To what degree does SAHealth Clinic fulfil the company's business objectives, in terms of profit generation?

5.2.1. Profitability for Pharma Logistix

The simple answer is that currently, Pharma Logistix does not benefit financially from the SAHealth Clinic initiative. There are numerous factors which explain this situation.

The most overt observation is that the objectives of the initiative omit any reference to Pharma Logistix profiting from the endeavour. Instead, they focus on addressing societal needs – increasing access to high-quality affordable healthcare in low-income areas and black female entrepreneurship. Therefore, on the surface it appears that Pharma Logistix lacks a profit-making imperative. This is further entrenched by Pharma Logistix's interpretation of the social franchise model. The SAHealth model has undergone an iterative process of change as new challenges and learnings have come to the fore. At first, the nurse was able to buy the business as a franchise for half the set-up cost. Now, Pharma Logistix has modified the model to ensure that it maintains ownership of the infrastructure, by allowing the nurse to rent the space for her business. Pharma Logistix does not pocket the revenue from both these options; instead it is returned to the pool of money that is used to fund the initiative. Furthermore, it should be reiterated that no royalties are paid to Pharma Logistix, in contrast to the normal principles of a conventional franchise business model.

Instead of making a profit, Pharma Logistix seems to have incurred unexpected expenses. The research indicates that part of the learning curve entailed that Pharma Logistix had to absorb costs such as the nurses' tax requirements that were not factored into the model. They also funded *ad hoc* marketing initiatives upon request and conceded to extending the cash payment gap according to their discretion. The reason was to offer support and contribute toward making the model sustainable. Investing in start-ups is logical; however, more strategic thought and skills development are necessary to ensure that oversights do not occur, and that the money is spent constructively.

The CSI manager was the only Pharma Logistix staff member who felt that the SAHealth model could be profitable to Pharma Logistix and should be leveraged by the holding company's other divisions to better serve the company in its entirety from a financial perspective. She had many innovative ideas on how to achieve this; however, she left the company before they were considered. It is interesting that the MD did not view these

options as being valid. One such example is the profit that could be made from the logistics component of the business. Even though a 'negligible' profit would emanate from rolling out 400 clinics, according to the MD, this still amounted to some form of income none the less. It is surprising that the MD dismissed the R35 million turnover that could result from supplying the utopian dream of 2000 clinics.

5.2.2. The CSI perception

When Pharma Logistix belonged to a previous conglomerate, SAHealth was viewed as a BoP initiative; however, now that it has been acquired by a new holding company, it is viewed as CSI. To date, Pharma Logistix has spent R7.5 million to rollout seven clinics. Pharma Logistix has now created a trust to manage the R60 million it has received from the holding company's CSI and ED fund. This is a large amount of money to invest without expecting a financial return on investment. This has implications on how SAHealth is viewed. Although Pharma Logistix's MD and the former CSI manager explicitly stated that this was just a means to an end in terms of securing the necessary finances to fund 400 clinics, when terminology such as CSI is brandished around, it changes the meaning of how a business model is perceived, as CSI is seen to be non-profit generating. The mere fact that the head of the project was given the title of CSI manager by the new holding company is significant as it sets a precedent as to how the initiative is perceived by the company.

There is clear confusion among the Pharma Logistix staff as to how to construe the SAHealth initiative. The MD contradicted himself a few times during the interview, by referring to this initiative as the best CSR initiative this country has seen. Later he stated that this is not a CSR project and that it is a BoP initiative. He then proceeded to call it an 'off the bottom of the pyramid' initiative, as he acknowledged that the business model deviated from the conventional BoP strategy in terms of the target market. The FM and HR manager both referred to SAHealth as CSR, and reiterated the message that SAHealth was not benefitting Pharma Logistix financially in any way, and that this was aligned to the company's overarching strategy. Ironically, the former CSI manager, who was the most immersed in the initiative, vehemently challenged the notion that this was a CSI strategy. Interestingly, she felt that sustainable profit generation inferred that the initiative was not CSI, as she interpreted the concept as being purely donor related. This contradicts theory, where the ideal is for CSI projects to be self-sustainable.

Referring to this initiative as CSI is dangerous as it undermines all the business principles that are being put in place. It questions the financial viability of the model and other

principles, such as scalability, replication and the general business spirit of the initiative. The nurses are not receiving handouts; they are struggling as health entrepreneurs.

5.2.3. Profitability of business model

Although the MD affirmed that the motivation behind SAHealth was not for Pharma Logistix to gain financially, he did emphasise that it was imperative for the business model to be profit generating, which in his mind translated to the initiative being more aligned to BoP than to CSI. The SAHealth model is still gaining momentum to become consistently financially viable at all clinics. The business acumen and skills of the nurses, which have been discussed earlier, partially explain why the model is not fully financially viable as yet; however, it seems on track according to the business model's five-year plan.

Challenges faced by the back office also contribute to this situation. There is a clear misalignment between Pharma Logistix staff in terms of how the model is perceived and understood. There was also a lack of communication between staff members, for example the HR manager and FM found it difficult to figure out and understand the project and they had many misconceptions due to the fact that the MD and the CSI manager were the only two people at Pharma Logistix who knew all the details of the SAHealth initiative, and other employees were not briefed or updated. This was extremely problematic when the CSI manager left the company and the remaining employees had to try to piece together all the information. In the process, they discovered elements that had slipped through the cracks. The main reason for this is that the team was under resourced. The previous CSI manager was almost single-handedly responsible for all elements of the rollout of the seven clinics, which was a mammoth task. In order for all aspects of the model to be adequately addressed, more capacity and resources are required.

5.2.4. Alternative value creation

Return on investment may be viewed from a non-financial perspective or in terms of an indirect financial benefit. Pharma Logistix is confident that the SAHealth Clinic concept will increase the company's brand equity, reputation and brand image. The holding company's funding ensures that other companies do not have to come on board as co-funders to assist in materialising the main objective of scaling up the initiative to increase reach, as initially envisioned. This means that the holding company can be the sole brand custodian of SAHealth. Furthermore, SAHealth is the means for the holding company to achieve perfect points on the scorecard for EE, ED and CSI. This has the potential to increase their

competitiveness in securing tenders, gaining more trade clients who prefer to do business with suppliers with a social conscience and create a favourable perception in the public eye, which could also indirectly influence sales, due to the holding company's wide portfolio of products in the public domain.

5.3. Research question 3: To what extent does SAHealth fulfil the BoP proposition according to theoretical principles?

5.3.1. Social imperative

The SAHealth concept is a fitting example of Rivera-Santos & Rufin's (2012) sentiment that businesses can be innovative in addressing societal challenges, while still aiming to be profitable. Access to healthcare is a basic human right, and SAHealth is able address this issue in the low-income sectors of the population. SAHealth also appeases Chatterjee (2009), who states that basic needs should be fulfilled at the BoP before corporates drive consumerism of products and services at the BoP level.

5.3.2. Patient demographic

BoP literature discusses the complexity and inconsistencies in defining the BoP market. The BoP in SA has been described as having a higher income than $2 per day as prescribed by Prahalad (2004, 2010), due to social welfare grants and government interventions (Chipp *et al*, 2012). On an individual level, the respondents interviewed revealed their monthly income as being between R600 and R3500 per month, across the four sites, and it was mentioned that many received grants. It is important to note that most of the respondents were unemployed, with a few participants being pensioners or involved in *ad hoc* part time jobs. It is significant to note that with the present exchange rate, this ranges from 2$ per day to $11. Pharma Logistix's MD stated that this model was not targeting the $2 per day group and that it was targeting the middle class who earn approximately $5 000 annually. This is not in accordance with BoP theory, although some examples with significantly higher incomes have been cited as BoP initiatives (Prahalad, 2004, 2010); however, this body of research inadvertently shows that patients who earn the bare minimum are willing to pay for the quality and accessibility of SAHealth's services; therefore, it does provide a service for the poor and underserved population. Either way, London *et al* (2010) state that the discrepancies and inconsistencies in describing the BoP can be addressed by referring to

this sector as the low socio-economic sector that live in informal settlements. From this standpoint, SAHealth clearly addresses the BoP.

It was also apparent that the insights of Prahalad and Hammond (2002) and Chipp *et al* (2013), that household income and collective community spending play an important role in the BoP's affordability of products and services, is valid. Many respondents admitted that they were able to afford SAHealth's services because of their household income, or because they were able to borrow money from other community members.

5.3.3. Benefits to company in terms of profit

The BoP literature indicates that an essential component of a BoP strategy is that the company should profit from the initiative. Pharma Logistix disputes this, by stating that the model is profit generating; however, the entrepreneur should be the recipient of the profit and not the company. In this instance, the fortune at the bottom of the pyramid would then be source of income for the nurses; however, from a practical point of view, the income may be far from a fortune, as the costs of providing healthcare are considerable. From a company perspective, the BoP theory does not delve into companies which derive value solely from their altruism and brand image, as opposed to direct financial returns.

5.3.4. Benefits to community

a) SAHealth and BoP consumption

The SAHealth model aptly relates to Prahalad's notion that the BoP consists of lucrative consumers, whose needs have been unmet or ignored. The patients were eager consumers of SAHealth's high-quality services as they were tired of receiving inadequate healthcare at the government facilities. According to Prahalad (2004, 2010) and Anderson and Billou (2007), the services should be accessible, affordable, acceptable and available. SAHealth fulfils all these criteria; however, accessibility and availability can be improved, in terms of extending working hours, changing the location of the clinics, increasing marketing activities or increasing the number of clinics. They also highlighted the need for raising awareness to enhance adoption of the service, and this area is overtly lacking at many of the SAHealth Clinics.

Although the literature on social franchising seems to indicate limited impact of these initiatives on increasing access to affordable health in low-income areas, SAHealth proves otherwise. SAHealth also improves overall community wellbeing and provides basic

services; therefore, Pharma Logistix is not guilty of undesirable inclusion and exclusion and remains on the moral high ground, as described by Jaiswal (2007).

The 12 principles of innovation

Table 14: Applicability of Prahalad's 12 principles of innovation

12 Principles of Innovation	Applicability to SAHealth model
1. Price performance	Yes
2. Hybrid solutions – new technologies should blend with existing technology	No
3. Must be scalable	Yes
4. Conserve resources	Yes
5. Product development must focus on functionality	Yes
6. Process innovation and logistics	No
7. Design of products must suit skills level, infrastructure, access in remote areas	Yes
8. Education	Yes
9. Products must work in hostile environment	Yes
10. Research	Yes
11. Innovation must reach the consumer – distribution	Yes
12. Evolution in BoP product development, where new features can be added onto platforms	Yes

Source: Adapted from Prahalad (2004, 2010)

It is clear that the **price** charged for SAHealth's services is accepted by the community members who seek healthcare access. This has been confirmed by both the respondents from the community, as well as the nurses. Frugal engineering as mentioned by Christensen (2006) has contributed to the relatively cheap pricing structure, due to the container infrastructure. Pharma Logistix has also capped the consultation fee at R150 to ensure that patients are able to afford the service. The respondents did express that they would be amenable to paying a higher fee should additional services be granted, or to enhance the current infrastructure. In terms of **performance**, SAHealth Clinic offers a high-quality service at a cheaper price, which fulfils the price performance criterium.

With regard to **hybrid solutions**, in terms of new technologies blending with existing technology, this concept is largely absent in the SAHealth model. The infrastructure is based on existing technology, such as the container set-up and the mainstream medical equipment that are required for patient care. The only possible new technology that could be integrated

into the practice is to be innovative in turning this into a cashless business to safeguard the nurses against theft.

Prahalad (2010) emphasises the importance of **scalability** in the success of BoP projects, as it assists in cutting costs from an economies of scale perspective, while increasing the reach and impact of the initiative. The primary objective of SAHealth is to build a network of clinics that provides affordable, quality healthcare in low-income areas. This objective has not been fully achieved as yet, as it has not been scaled nationally; only seven clinics have been established. However, now that the holding company and the Job Fund have provided funding over the next three years, finances are available to roll out 400 clinics. It is a concern; however, that the up scaling will occur before the existing problems are ironed out, which could potentially harm the brand by not operating at maximum efficiency.

Resource conservation is another important element of innovation in BoP markets (Prahalad, 2010). SAHealth is a container clinic, which uses the minimalist approach to cut costs and save on resources. It also has an adequate waste management process in place.

SAHealth certainly fulfils the criterium of **product development, which focuses on functionality** (Prahalad, 2010). The streamlined set-up at SAHealth has been built based on a low-cost model to serve the poorer sector of the population. It has the bare minimum to enable high-quality, affordable primary healthcare.

In terms of **process innovation**, there is no uniqueness in the way that SAHealth operates. It employs the use of basic operational practices, with regard to patient records, patient flow, payments, inventory control and inventory logistics. It can be argued that certain elements, such as logistics, should be improved once SAHealth is scaled up to increase efficiencies and to monopolise on economies of scale.

Prahalad (2010) also states that the **design of the products** must suit skills level and infrastructure, and facilitate access in remote areas. SAHealth's design does enable access to healthcare services in informal settlements, and it does compensate for the inadequate infrastructure in terms of healthcare delivery in this areas. The design of the business model, however, necessitates a level of business acumen that the nurses are still in the process of acquiring, and far more training and development are required to achieve the level of entrepreneurial competence. However, their clinical healthcare expertise and skills are more than adequate. In terms of suitability of the design for patients, this seems adequate for the basic primary healthcare option; however, the respondents have asked for additional services to be included into this business model.

Education is a component of the SAHealth model from two perspectives. Firstly, the nurses are educated and trained on business acumen as well as clinical information that would help them to better serve their patients. Secondly, the communities should be educated on the services offered by SAHealth through marketing and awareness-raising initiatives. The latter should be improved to increase the uptake of the services provided.

One of the principles of innovation is that the **product must work in hostile environment** (Prahalad, 2010). This holds true for SAHealth. It is built for its environment and it is durable against the weather. The only issue is that it is not necessarily always safe from crime. The physical structure needs to have better security.

Research is integral to the SAHealth model from multiple perspectives. Research is pivotal to perfecting the SAHealth model. Insights into the community are important to ascertain their needs in order to tailor the services, in providing the correct 'interface' that the patients want, as well as to gauge how much they are willing to pay for the services. Furthermore, addressing patient needs are improved by having a non-biased attitude toward the patient, without assumptions based on one's own preconceptions; therefore, it is pivotal to understand the context and socio-economic factors and behaviours that impact on healthcare. The SAHealth team should do more research into the communities in which they operate.

Another principle is that the **innovation must reach the consumer**, in terms of distribution. SAHealth does reach patients who live close to the clinic; however, patient numbers are still low. This can be drastically improved through aggressive marketing, improved signage in the area, and through establishing more clinics in an area.

SAHealth is also conducive to **evolution in BoP product development**, as new features can be added onto the existing platform on a physical level, as well as in relation to the business model. For example, more containers could be added as consultation rooms or as an OTC dispensing unit.

b) SAHealth and BoP production

BoP initiatives have been critiqued for not enabling the BoP to be producers and to integrate into the market economy (Karnani, 2006). The same can be said of SAHealth. Although the nurses are entrepreneurs, and hence producers of the services offered, they can hardly be construed as belonging to the BoP sector, due to their profession and income, according to Prahalad (2004). However, Pharma Logistix's MD argues otherwise. Despite that issue, the nurses' up-skilling and enterprise development is certainly admirable and serves a social

imperative. It aligns with the ideologies of Prahalad and Hammond (2002) and Prahalad (2004) who highlight the importance of the role of women in promoting social transformation and economic development.

It is worth mentioning that entrepreneurship is often deemed as the means of escaping poverty (Seelos & Mair, 2007). Karnani (2009) astutely observed that these entrepreneurs often work at below market-related salaries and he also critiqued the idea that everyone has the aptitude and skill to be a successful entrepreneur. Simanis and Milstein (2012) also warn that the reason BoP projects fail is because of the absence of performance measures according to the business objectives, as well as business acumen. All these principles are depicted by the nurses, who are in fact earning less than their peers in the public and private sectors, their entrepreneurial acumen needs to be improved, and they are not held accountable to well-thought out performance measures. However, Pharma Logistix intends to improve this situation over time.

Poverty alleviation as an aim for the nurses is not applicable; however, it could be argued that the provision of adequate healthcare to the BoP enhances the communities' wellbeing and increases their productivity and ability to gain employment, which will positively affect their income levels and decrease poverty.

Karnani (2006) points out that corporates should participate in employment creation through their BoP ventures. SAHealth offers employment to the locals, as admin assistants, and other part-time jobs as a gardener or security guard. However, these jobs will not propel the individuals out of the BoP.

5.3.5. Profitability for Pharma Logistix

Pharma Logistix's view of SAHealth seems aligned with Simanis and Milstein's (2012) critique that BoP theory focuses more on societal benefits and socio-economic development, than on making profits, as the company views it largely as social responsibility and the company does not profit from it. The SAHealth model follows the principles of social franchising as laid out by Volery and Hackl (2009), Meuter (2011) and Beyeler *et al* (2013). It is clear that some Pharma Logistix staff view the social upliftment of the poor as the main priority, instead of extracting profits from the initiative. However, SAHealth is still aligned with Simanis and Milstein (2012) and Ismail and Kleyn (2012) who state that BoP initiatives should be profit-generating business models, where the business objectives are prioritised over socio-economic development, as the nurse (the entrepreneur) works on this premise

and intends to make a profit, therefore SAHealth endeavours to do both from this perspective.

5.3.6. Sustainability

Sustainability is a key component of a successful BoP strategy. Pharma Logistix is confident that the project is sustainable. This is corroborated by the secondary data, which shows that half the clinics surveyed are financially self-sustaining at present (in year two of operations), and they are ahead of the projections of the business model forecasts. Sustainability of the business model as a profit-generating endeavour is important for its success as a BoP initiative. Hart and Simanis (2008) admit that it takes up to five years for a BoP initiative to become sustainable, as it takes time to scale up a project and transfer, replicate and embed into different BoP communities. This shows that SAHealth has considerable potential to make huge inroads by year five.

5.3.7. BoP 2.0

SAHealth seems to have elements of BoP 1.0 and 2.0 as the BoP is a consumer, price reduction is emphasised, and the relationship with the community is direct and not mediated by an NGO, although corroboration is sometimes sought (Hart & Simanis, 2009). Deep dialogue with communities has not really taken place. The business concept was formulated by Pharma Logistix and it was a top-down approach when recruiting the nurses. There was little co-creation initially. Gradually, this is changing as Pharma Logistix and the nurses engage more to share ideas on how to improve the model. Some nurses are also increasing their interaction with their respective communities to ascertain the communities' needs, so there is co-creation taking place on some level. As part of enterprise development, there is development of new capabilities, where the nurses have to undergo training and business skills development. Networking occurs where the nurses form *ad hoc* relationships with local NGOs, schools, churches, crèches and the municipal ward councillors to grow their business, as well as to tailor solutions to their needs. These elements, as well as engaging in public healthcare-related talks, also help to increase social embeddedness. One crucial component is that the nurses originate from the community they serve, which helps to instil trust within the community. However, more effort can be utilised to enhance this to grow their businesses and reach their target patient numbers. Pharma Logistix is unknown in the community and The MD admits that more co-creation and social embeddedness are required.

Arora and Romijin (2009) speak about the difficulty in aligning objectives to create a win-win situation due to various demographic differences between the company and the grassroots component, as well as a lack of skills and business acumen that can impede the success of the business model. In this instance, the nurses are more aligned to healthcare principles as opposed to business principles, which are sometimes in discord, as the nurses would rather lose money in order to provide optimal healthcare.

SAHealth exemplifies the concept of patient capital as stated by Hellig (2009). It will take time for the business to become financially viable as patient numbers gradually increase. The profit will improve as the volume of patients increases and as the operations are scaled up, which should reduce some expenses.

With regard to London's (2011) notion of piloting the project, SAHealth was piloted. The other clinics soon followed and may also be viewed as a pilot seeing that they have yielded key learnings on which the subsequent clinics that are rolled out will benefit from.

Organisational readiness was definitely an issue in terms of conflicting mindsets within the organisation with regard to how SAHealth is viewed and treated. It is also evident that the company was not adequately equipped with enough resources in terms of human capital to deal with all the aspects of the project. Seelos and Mair (2008) and Prahalad and Hammond (2002) advise companies to separate their BoP initiative from other departments in the company and this is exactly what Pharma Logistix is doing by making SAHealth a Section 21 company, which will provide services without the company's intention of making any profit. They rely on funding and are classified as 'not for gain'. However, this has other implications on it being viewed as a not for profit organisation.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

The SAHealth Clinic concept is a dynamic, innovative business strategy that has the potential to positively impact the state of healthcare in South Africa, by serving the marginalised, low socio-economic groups, while fostering entrepreneurship. This study set out to ascertain whether SAHealth fulfilled the BoP proposition in terms of benefitting the communities it served, benefitting the nurses selected as entrepreneurs, as well as profiting the company which conceptualised venture. It also sought to compare the business model to BoP theory.

It is unequivocally evident that SAHealth benefits the community, in terms of providing accessible, affordable high-quality healthcare. SAHealth's impeccable services were held in high esteem compared to government facilities. In addition, SAHealth's services were deemed to be on par, but cheaper than, conventional private healthcare.

All the nurses interviewed concur that they have benefitted substantially from an entrepreneurial point of view, even though the financial benefits are not as yet evident. The psychological benefits seem to outweigh the financial element at present. However, the fact that two of the clinics surveyed are somewhat financially viable in their second year of operations is exceptional, as they are ahead of the business model's projected forecast. This corroborates with one of Pharma Logistix's goals, which is to increase black female empowerment by fostering entrepreneurship and enterprise development.

It is evident that Pharma Logistix intentionally chooses not to reap financial profits from the SAHealth model. It has embraced the social franchise concept and is satisfied with the altruistic elements of the business model, as well as the brand value, reputational benefits, and the perfect points earned in terms of ED, EE and CSI on the scorecard. SAHealth deviates from BoP theory in that the company does not make a financial profit, however, Pharma Logistix's MD validates this as a BoP venture because the business model generates a profit for the entrepreneur.

The manner in which SAHealth was conceived and is perceived by Pharma Logistix in general deviates from the conventional manner in which BoP projects are viewed from a theoretical perspective. On the surface, it appears as though SAHealth is a well thought out CSR initiative that will soon be completely self-sustaining, which would make it an exemplar of the perfect CSR strategy. This is supported by the fact that the former head of the project

was labelled as the CSI manager, and the Pharma Logistix staff was not aligned in the terminology used to describe the project, which ranged from CSR and CSI to BoP and off the BoP. The lines seem to have blurred between the various labels.

Although SAHealth conforms to many BoP principles, it subverts BoP theory, as it reveals how BoP, CSR and social franchising theory can overlap, depending on how profit and shared value are perceived. SAHealth is thus a hybrid model that consists of all of these elements in its conceptualisation, implementation and impact on the communities and the nurses. Another component of CSR is that the company views its return on investment based on the reputational gain and brand image associated with the initiative, which is exactly how Pharma Logistix views SAHealth. The nurses also seem to view this as an altruistic service to the community, instead of as a profit-generating business.

It is clear that it is important to follow the basic tenets of business, in terms of principles and success factors, that would apply to any business whether it is BoP or not, even though the BoP literature makes a differentiation.

In BoP literature, the term BoP refers to the very poor. This business venture serves a range of lower income patients, which adheres to the BoP proposition. However, by being perceived as ‘off the BoP’, the nurses are almost given a licence by Pharma Logistix to be part of the BoP initiative as well, even though they are middle class, which does not fit into the stereotypical category of BoP.

In general, SAHealth does face a few challenges such as management’s failure to provide adequate support or training, the inability of the BoP entrepreneurs to cover costs and manage their finances. However, at present, Pharma Logistix has succeeded in creating a partially sustainable distribution network for its healthcare services, which is in the process of becoming consistently financially viable and scalable.

SAHealth has the ability to bridge the gap between the private and public healthcare systems and it has the potential to decrease the burden on the public healthcare system. Its benefits will be accelerated and its impact will be far more evident once SAHealth is up scaled nationally and increases its reach.

6.2. Recommendations

The following recommendations are suggested to improve SAHealth's business model:

6.2.1. To benefit the community

- It is imperative to address the waiting room issue by modifying the outside area with some form of shelter and seating arrangements so that patients can be comfortable during adverse weather conditions.
- As suggested by the nurses, Pharma Logistix should partner with government to offer more comprehensive family planning and vaccination services.
- Specialist services should be offered on a monthly basis by altruistic doctors who are willing to charge reduced rates.
- Ante-natal services should be extended to include mobile ultrasound scans, as pregnancy rates are high in these areas.

6.2.2. To empower nurses

- Although Pharma Logistix has funding secured for three years, this money will be used to roll out the basic infrastructure required to offer primary healthcare. Pharma Logistix could have a front end model that allows any drug company or any other client to contribute financially in order to receive ED and CSI points on the scorecard. This will enable the nurses to include additional services and perks to enhance and grow their business, such as an extra container, or a better established waiting room, or improved antenatal services.
- Training has to be intensified, in terms of business skills transfer and financial management. The nurses should be empowered on how to be financially astute and cut costs, while performing excellent quality healthcare. New nurses who come on board should serve as locum nurses at the existing clinics for two to three months to gain insights and experience into the workings of the business model. This will give them a better foundation for when they assume their entrepreneurial role.
- The nurses need to be taught basic marketing principles and the rationale for executing a marketing strategy in order to grow their business and increase patient numbers. Embedding themselves in the community through networking and relationship building will be invaluable to their business. Pamphlets should be handed out at community members' residences, churches, taxi ranks, schools, spaza shops and the local shopping

centres. The pamphlets should be tailored to the local languages spoken in the area. The nurses can increase their visibility and credibility by giving talks on community radio stations in the vernacular languages. The clinics also need to have a proper launch event to raise awareness. The patients can also serve as walking advertisements, therefore, providing patients with branded bags or T-shirts will be extremely effective when combined with word-of-mouth.

- More ongoing engagement with the nurses is advocated so that Pharma Logistix and the nurses can discuss and solve issues as they arise. The nurses should be briefed on what is expected of them and they should have performance measures in place.

6.2.3. To benefit Pharma Logistix

- The holding company should aim to make a profit in the long term. They have the potential to leverage SAHealth to enter the BoP market, as all five divisions stand to benefit and profit from this network. The profit generated from this entire network will be significant, especially once the clinics are up scaled nationally and economies of scale are achieved. Initially, the primary aim would be to enter into the space and establish the network, and the profit will then follow, as clients would then be able to utilise this network to enter the BoP, and Pharma Logistix will further benefit financially from this.
- With regard to Pharma Logistix staff, it is vital for communication to improve within the team, so that all members are knowledgeable about the initiative and are aligned in terms of the goals to be achieved. A major gap in the existing operations is that documentation is lacking. This is important as it would have assisted new staff members to get up to speed when the CSI manager left the company. Documentation, especially the financials, is important in tracking progress. There is also a dire need to increase staff capacity. To date, the volume of work involved in setting up seven clinics was excessive for just a few staff members to operationalise. The magnitude of work involved in SAHealth's expanding network would require increased skills and capabilities. Furthermore, it is imperative to address existing hurdles before scaling up.
- The SAHealth Clinic network is supplied by one of Pharma Logistix's wholesalers. It is important for Pharma Logistix to re-negotiate the logistic fees in order to contribute towards the cost-cutting objective. This will become easier as economies of scale are reached.
- SAHealth needs a champion who is passionate about the cause to drive the process, now that that the CSI manager has left. The champion would have to understand the socio-economic, social and political environment, the regulatory elements, and be able to

lobby, cajole and create an enabling environment. Besides project management skills, the person will have to be knowledgeable on social franchising, formularies and guidelines, as well as be comfortable with being in a leadership role when it came to operations and strategy.

6.3. Future research

More research is required in exploring the role of BoP strategies in providing products and services that enhance people's quality of life, while generating a profit for the originator company. In general, most research on BoP initiatives are approached from the corporate's perspective; therefore, more research incorporating the community's perspective is needed. Seeing that BoP projects and the communities they serve are unique to an extent, most BoP research emanates as case studies. In South Africa, we require more local examples of BoP initiatives. Globally, however, there is a paucity of quantitative BoP research, and this should be investigated further. Another interesting aspect to investigate is the evolving nature of BoP theory and the changing perception of BoP initiatives as new challenges are identified in different contexts and new learnings arise, which modify the conventional way of viewing the BoP proposition, as this body of research has revealed.

4. REFERENCES

Ahlstrom, D. (2010). Innovation and growth: How business contributes to society. *The Academy of Management Perspectives*, 24(3), 11-24.

Altheide, D. L., & Johnson, J. M. (1994). Criteria for assessing interpretive validity in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 485-499). Thousand Oaks, CA: Sage.

Anderson, G. (1993). *Fundamentals of Educational Research*. London: Falmer Press.

Anderson, J., & Billou, N. (2007). Serving the world's poor: Innovation at the base of the economic pyramid. *Journal of Business Strategy*, 28(2), 14-21.

Anderson, J. and Markides, C. (2007) Strategic innovation at the base of the pyramid, *MIT Sloan Management Review*, 49(1), 83-88.

Arnould, E. J., & Mohr, J. J. (2005). Dynamic transformations for base-of-the-pyramid market clusters. *Journal of the Academy of Marketing Science*, 33(3), 254-274.

Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report*, 2(1), 1-3.

Arora, S., & Romijn, H. (2009). Innovation for the base of the pyramid: Critical perspectives from development studies on heterogeneity and participation. UNU-MERIT Working Paper 2009-036. Maastricht: United Nations University – Maastricht Economic and Social Research and Training Centre on Innovation and Technology.

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research*, 1(3), 385-405.

Banerjee, S. B. (2008). Corporate social responsibility: The good, the bad and the ugly. *Critical Sociology*, 34(1), 51-79.

Barton, D. (2011). Capitalism for the long term. *Harvard Business Review*, 89(3), 84-91.

Bernstein, A. (2011). A fresh look at unemployment: A conversation among experts. Centre for Development Enterprise (pp. 1-36). Johannesburg: Acumen Publishing Solutions.

Beyeler, N., De La Cruz, A. Y., & 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), e60669.

Boulouta, I., & Pitelis, C. N. (2013). Who needs CSR? The impact of corporate social responsibility on national competitiveness. *Journal of Business Ethics*, 119(3), 1-16.

Boyatzis, R. E. (1998). *Transforming qualitative information: thematic analysis and code development.* Thousand Oaks, CA: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Brugmann, J., & Prahalad, C. K. (2007). Cocreating business's new social compact. *Harvard Business Review*, 85(2), 80-90.

Bryman, A., & Bell, E. (2007). *Business Research Methods* (Fourth ed.). New York:Oxford University Press.

Bryman, A. (2012). *Social Research Methods*. New York: Oxford University Press.

Carland, H., Carland, J. W., & Hoy, F. (2002). Who is an entrepreneur? Is a question worth asking. *Entrepreneurship: Critical Perspectives on Business and Management*, 2, 178.

Chandy, L., & Gertz, G. (2011). Poverty in numbers: The changing state of global poverty from 2005 to 2015. Policy Brief, no. 2011-01. Washington, DC: The Brookings Institution.

Chatterjee, S. (2009). Selling to the poor: reflections, critique, and dialogue. *Occasional Paper*, Department of Economics, Xavier University: Ohio, 1-12.

Chipp, K., Corder, C., & Kapelianis, D. (2012). Where practice meets theory: Defining and reviewing the bottom of the pyramid for South African marketers. *Management Dynamics: Journal of the Southern African Institute for Management Scientists*, 21(1), 18-29.

Chipp, K., Corder, C., & Kapelianis, D. (2013). The role of collectivism in defining the South African bottom of the pyramid. *Management Dynamics : Journal of the Southern African Institute for Management Scientists*, 22(1), 2-13.

Christensen, C. M. (2006). The ongoing process of building a theory of disruption. *Journal of Product Innovation Management*, 23(1), 39-55.

Coetzer, P. (2009). *SAB Miller – Integrating smallholder farmers into the supply chain of an MNC*. Reciprocity and BoP Learning Lab, Accessed 30 August 2013, from *http://reciprocity.co.za/download-the-latest-reciprocity-fact-sheets-here.html*

Coetzer, P., & Pascaral, N. (2012). Primary healthcare at the base of the pyramid: RTT's SAHealth Clinic model. Reciprocity and BoP Learning Lab, Accessed 1 August 2013, from *http://reciprocity.co.za/download-the-latest-reciprocity-fact-sheets-here.html*

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, 374(9692), 817-834.

Creswell, J. W. (2003). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (Second ed.). Thousand Oaks: Sage Publications.

Department Trade and Industry: Republic of South Africa. (2012). Amended broad-based black economic empowerment codes of good practice. (pp. 1-41). Accessed on 4 March 2013, from *https://www.thedti.gov.za/economic_empowerment/docs/bee_launch.pdf*

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, 12(2), 219-245.

Folse, K. A. (2002). The poor pay more. *Teaching Sociology*, 30(3), 342-347.

Fullerton, K., & Coetzer, P. (2010). *RTT Group's "*SAHealth Clinic-*in-a-box" - promoting access to affordable healthcare in rural area*s. Reciprocity and BoP Learning Lab, accessed 30 August 2013, from *http://reciprocity.co.za/download-the-latest-reciprocity-fact-sheets-here.html*

Greenhalgh, T., & Taylor, R. (1997). Papers that go beyond numbers (qualitative research). *British Medical Journal*, 315(7110), 740.

Gibbert, M., Ruigrok, W., & Wicki, B. (2008). What passes as a rigorous case study?. *Strategic Management Journal*, 29(13), 1465-1474.

Heideman, L. (2011). Municipal local economic development and the multiplier effect: piloting a community enterprise identification method in South Africa and Namibia. *Commonwealth Journal of Local Governance*, 8-9, 84-111.

Pharma Logistix. (2012). SAHealth Clinic franchise presentation. (pp. 6-7). Johannesburg.

Pharma Logistix. (2012). Services offered by SAHealth Clinics. (pp. 1). Johannesburg.

Pharma Logistix. (2013). Number of patient visits per month. (pp. 1). Johannesburg.

Pharma Logistix. (2013). Financial summary of SAHealth Clinics 2013. (pp. 1-4). Johannesburg.

Im, F., Mahajan, S., Dennis, A., Tiwari, S., Suarez, A., Mitra, S., Ngwenya, P., & Narayan, A. (2012). South Africa: Economic update - focus on inequality of opportunity. World Bank Report.July 2012 (3). Accessed 2 September 2013, from *http://documents.worldbank.org/curated/en/2012/01/16561374/south-africa-economic-update-focus-inequality-opportunity*

King, M. (2009). King Report on corporate governance for South Africa (III). Institute of Directors (IoD) of Southern Africa, Johannesburg.

Hamann, R., Woolman, S., & Sprague, C. (2010). *The Business of Sustainable Development in Africa: Human Rights, Partnerships, and Alternative Business Models*. Pretoria: UNISA Press.

Hammond, A. L., & Prahalad, C. K. (2004). Selling to the poor. *Foreign Policy*, (142), 30-37.

Hart, S. L (2010). *Capitalism at the crossroads: Next generation business strategies for a post-crisis world.* Upper Saddle River, New Jersey: Wharton School Publishing.

Hart, S. L., & Christensen, C. M. (2002). The great leap. *Sloan Management Review*, 44(1), 51-56.

Hart, S. L., & London, T. (2005). Developing native capability. *Stanford Social Innovation*, 3(2), 28-33.

Hart, S. & Simanis, E. (2008). The base of the pyramid protocol: Toward next generation BoP strategy (version 2.0). New York: Cornell University, Johnson School of Management.

Helling, T. H. T. (2009, 3 December). Barriers at the bottom of the pyramid? Accessed 22 August 2013, from *http://urbancan.com/wp-content/uploads/2010/07/Barriers-at-the-Bottom-of-the-Pyramid.pdf*

Jain, P. S. (1996). Managing credit for the rural poor: Lessons from the Grameen Bank. *World Development*, 24(1), 79-89.

Jaiswal, A. K. (2007). Fortune at the bottom of the pyramid: an alternate perspective. Ahmedabad: Indian Institute of Management.

Jenkins, R. (2005). Globalization, corporate social responsibility and poverty. *International Affairs,* 81(3), 525-540.

Kaplan, G. A. (2009). The poor pay more: poverty's high cost to health. Princeton, New Jersey: Robert Wood Johnson Foundation.

Karnani, A. (2006). Fortune at the bottom of the pyramid: A mirage, how the private sector can help alleviate poverty. Ann Arbor: University of Michigan.

Karnani, A. (2009). The bottom of the pyramid strategy for reducing poverty: A failed promise. *Journal of Economics and Social Affairs*, 80(2), 1-14.

Karnani, A. (2009). Romanticizing the poor. *Stanford Social Innovation Review*, 7(1), 38-43.

Kistruck, G. M., Webb, J. W., Sutter, C. J., & Ireland, R. D. (2011). Micro-franchising in base-of-the-pyramid markets: institutional challenges and adaptations to the franchise model. *Entrepreneurship Theory and Practice*, 35(3), 503-531.

Klein, M. H. (2008). *Poverty Alleviation through Sustainable Strategic Business Models: Essays on Poverty Alleviation as a Business Strategy*. Rotterdam: Erasmus University.

Kolk, A., Rivera-Santos, M., & Rufín, C. (2012). Reviewing a decade of research on the 'base/bottom of the pyramid' (BOP) Concept. *Business & Society*, Forthcoming, doi, 100007650312474928.

Kunreuther, H. (1973). Why the poor may pay more for food: theoretical and empirical evidence. *The Journal of Business*, 46(3), 368-383.

Landrum, N. E. (2007). Advancing the "base of the pyramid" debate. *Strategic Management Review*, 1(1), 1-12.

Leedy, P. D., & Ormrod, J. E. (2001). *Practical Research: Planning and Design.* New Jersey: Practice-Hall.

Lenz, A. K., & Pinhanez, M. (2012, 19-20 March). *A business strategy contribution to poverty alleviation and sustainable development: The base-of-the-pyramid theory's validity and inadequacies.* Paper presented at ème Congrès Transformare, ISC Paris School of Management, Paris.

London, T. (2008, August). *The base-of-the-pyramid perspective: a new approach to poverty alleviation*. Accessed 9 August 2013, from *http://www.myduquesne.duq.edu/s/831/images/editor_documents/Social%20Thought/A%20Base%20of%20the%20Pyramid%20Perspective%20(3).pdf.*

London, T., & Anupindi, R. (2012). Using the base-of-the-pyramid perspective to catalyze interdependence-based collaborations. *Proceedings of the National Academy of Sciences*, 109(31), 12338-12343.

London, T., Anupindi, R., & Sheth, S. (2010). Creating mutual value: lessons learned from ventures serving base of the pyramid producers. *Journal of Business Research*, 63(6), 582-594.

London, T., & Hart, S. L. (2010). *Next Generation Business Strategies for the Base of the Pyramid: New Approaches for Building Mutual Value*. Upper Saddle River, New Jersey: FT Press.

Magruder, J. R. (2011). High unemployment yet few small firms: the role of centralized bargaining in South Africa. Working Paper. Berkeley, CA: University of California.

Mark-Herbert, C., Rotter, J. & Pakersht, A. (2010). *A triple bottom line to ensure corporate responsibility. I*n: Berg, P. (Ed.) Timeless Cityland - An interdisciplinary approach to building the sustainable human habitat. Uppsala: Sveriges lantbruksuniversitet – Stad och land.

Mendoza, R. U. (2011). Why do the poor pay more? Exploring the poverty penalty concept. *Journal of International Development*, 23(1), 1-28.

Meuter, J. (2011). *Social franchising*. Das Online-Handbuch Demographie. Berlin.Germany: Berlin Institut; Accessed on 20 February 2014, from *www.berlin-institu.org*.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2008). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 13-22.

Nidumolu, R., Prahalad, C. K., & Rangaswami, M. R. (2009). Why sustainability is now the key driver of innovation. *Harvard Business Review*, 87(9), 56-64.

Noor, K. B. (2008). Case study: A strategic research methodology. *American Journal of Applied Sciences*, 5(11), 1602.

Olsen, M., & Boxenbaum, E. (2009). Bottom-of-the-pyramid: organizational barriers to implementation. *California Management Review*, 51(4), 100-125.

Pascaral, N. (2008). *From informal to formal, how to uplift your sales network: An SABMiller South Africa initiative*. Reciprocity and BoP Learning Lab, accessed 30 August 2013, from *http://reciprocity.co.za/download-the-latest-reciprocity-fact-sheets-here.html*

Peters, D. H., Garg, A., Bloom, G., Walker, D. G., Brieger, W. R., & Hafizur Rahman, M. (2008). Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences*, 1136(1), 161-171.

Porter, M. E., & Kramer, M. R. (2011). The big idea: creating shared value. *Harvard Business Review*, 89(1), 2.

Prahalad, C., & Hart, S. (2002). The Fortune at the Bottom of the Pyramid. *Strategy+ Business*, (26), 54-67.

Prahalad, C. K., & Hammond, A. (2002). Serving the world's poor, profitably*. Harvard Business Revie*w, 80(9), 48-59.

Pralahad, C. K. (2004). *The Fortune at the Bottom of the Pyramid: Eradicating Poverty through Profits*. New Delhi, India: Pearson Education.

Prahalad, C. K. (2010). *The Fortune at the Bottom of the Pyramid, Revised and Updated 5th Anniversary Edition: Eradicating Poverty Through Profits*. Upper Saddle River, New Jersey: Prentice Hall.

Rivera-Santos, M., & Rufín, C. (2010). Global village vs. small town: understanding networks at the Base of the Pyramid. *International Business Review*, 19(2), 126-139.

Rost, C., & Ydrén, E. (2006). *Profit for the poor: sustainable market development in BOP-markets*. Doctoral dissertation, Mid Sweden University. Jönköping.

Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research Methods for Business Students* (4th ed.). UK:Pearson Education Limited.

Schneider, M., Norman, R., Parry, C., Bradshaw, D., Pluddemann, A., & Collaboration, S. A. C. R. A. (2007). Estimating the burden of disease attributable to alcohol use in South Africa in 2000. *South African Medical Journal*, 97(8), 664-672.

Schreiner, M. (2003). A cost-effectiveness analysis of the Grameen Bank of Bangladesh. *Development Policy Review*, 21(3), 357-382.

Seshagiri, S., Aman, S., & Joshi, D. (2007, 8-12 May). *Connecting the bottom of the pyramid: An exploratory case study of India's rural communication environment*. Paper presented at the 16th International Conference on the World Wide Web, Banff, Alberta, Canada.

Seelos, C., & Mair, J. (2007). Profitable business models and market creation in the context of deep poverty: a strategic view. *The Academy of Management Perspectives*, 21(4), 49-63.

Simanis, E., Hart, S., Enk, G., Duke, D., Gordon, M., and Lippert, A. (2005). *Strategic initiatives at the base of the pyramid: A protocol for mutual value creation.* Base of the Pyramid Protocol 1st Edition. Accessed on 20 August 2013 from *http://www.bop-protocol.org/docs/index.html*

Simanis, E., & Hart, S. (2009). Innovation from the inside out. *MIT Sloan Management Review*, 50(4), 77–86.

Simanis, E., & Milstein, M. (2012). Back to business fundamentals: making "bottom of the pyramid" relevant to core business. Field Actions Science Reports. *The Journal of Field Actions*, (Special Issue 4), 8.

Sprague, C. (2008). Alternative approaches to reaching the bottom of the pyramid. In R Hamann, S. Woolman, & C. Sprague (Eds.), *The Business of Sustainable Development in Africa: Human Rights, Partnerships, and Alternative Business Models*. (pp 83-96). Pretoria: Unisa Press.

Tellis, W. (1997). Application of a case study methodology. *The Qualitative Report*, 3(3), 1-17.

Tsoeu, M. (2009). *A value chain analysis of the formal and the informal economy: a case study of South African Breweries and shebeens in Soweto*. Doctoral dissertation, University of Witwatersrand, Johannesburg.

Visser, W. (2010). The age of responsibility: CSR 2.0 and the new DNA of business. *Journal of Business Systems, Governance and Ethics*, 5(3), 7.

Volery, T., & Hackl, V. (2010). The promise of social franchising as a model to achieve social goals. In Fayolle, A., & Matley, H. (Eds.), *Handbook of Research on Social Entrepreneurship* (pp. 157-181). Cheltenham, UK: Edward Elgar.

Welch, C., & Piekkari, R. (2006). Crossing language boundaries: qualitative interviewing in international business. *Management International Review*, 46(4), 417-437.

Yin, R. K. (2009). *Case Study Research: Design and Methods* (Vol. 5). Thousand Oaks:Sage.

Zingales, L. (2009). Capitalism after the crisis. *National Affairs*, 1, 22-35.

APPENDIX 1

Summary of BoP 2.0

Phase 1 - Opening up

This phase is based on fostering partnerships and building strong relationships based on trust between the corporate and the community, leading to immersion within the community. The relationship built with the community is based on equality, transparency and joint ownership. Building deep dialogue requires the corporate to spend time getting to know and understand the community without any preconceived commercial agendas. The corporate has meetings within the community to explain its presence. A few company representatives live in the community for at least a week in order to build rapport and trust. Thereafter, the company representatives should live near the community to continue with the relationship building process.

Project team development then takes place, where community representatives are recruited by the corporate to co-create business ideas that create shared value. Communities are often sceptical as they may feel let down by government and other aid workers. The advantages and potential of the partnership should be explained, and expectations should be managed. The merits of the community's strengths, experiential knowledge and entrepreneurial capabilities should be highlighted. Community members are carefully chosen through social networks within the community.

Collective entrepreneurship development then ensues with the aim of creating a shared business language and a working relationship as business partners, while taking entrepreneurship into consideration. Joint resources and capabilities are explored in addressing the needs of the community. The interactions are always based on the creation of mutual value.

This phase culminates in the co-creation of a business concept. It involves an iterative process of brainstorming, analytical reflection and evaluation until the final business concept and unique value proposition are rigorously identified. The aim is to harness the resources and capabilities of the community and corporate to generate and implement a business concept better than is achievable alone. Through a learning process, the business evolves and improves.

Phase 2 – Building the ecosystem

In this phase, the organisational foundation is built and the business concept is put into operation as a pilot or prototype through the process of action learning. This phase also reduces the mediation role of the community based organisations and the community representatives and corporate begin to work more closely, having gained trust.

In terms of project team development, the community members formalise who will be part of the diverse project team. They then transition into full-time business roles with the intention that they will eventually manage and be responsible for the new business venture. More community members may be recruited to compensate for skills gaps. All project members will be orientated and receive in-depth understanding of the business concept and process. Expectation will be managed in terms of the hard work required to implement the business concept without the guarantee of success. The corporate representatives should include experienced people in entrepreneurship as well as new business development and community facilitation.

Building shared commitment is vital to ensuring a successful business as this helps deal with

challenges that arise. Strategic alignment in terms of the business concept is important across the project team in order to strive towards creating a sustainable competitive advantage. The relationship between the team members deepens as a common organisational identity forms and the importance of interdependent roles becomes clear.

In terms of new capability development, the project team's knowledge is aligned in order to enable consistency when communicating with the community. The team has to understand the business proposition and principles as well as be proactive in developing the product or service. Where gaps in knowledge and capabilities exist, these have to be found within the corporate, the CBOs and the community itself. The action learning is important in this phase as it enables people's skills and potential to be identified, which helps assignment to business roles.

The aim of this phase is business prototype co-creation. The piloting process occurs as small field experiments within the community network. The wider community feedback informs the development and evolution of the business proposition, while generating demand.

Phase 3 – Enterprise creation

This final phase aims to expand the business prototype, increase the customer base and ensure the sustainability and growth potential of the business model. Flexibility within the organisation and the business model is an initial necessity. By this stage, mutual trust and reliability has been created between the corporate and community members on the project team and they are able to handle conflict and differences effectively. The project team becomes self-sufficient, relying less on external networks and partnerships.

New capability development in relation to all aspects of business, from organisational development to management, operations, financial management and client liaison are emphasised. Knowledge and capabilities are continuously assessed and addressed. Through action learning, practical experience through learning on the job, and working together within the project team (both corporate and community representatives), all business aspects and management decisions are jointly made. Business practices that ensure sustainability are just as important as looking at profit. Documenting the process is also advantageous and provides key learnings. Business practices and organisational factors that can facilitate scalability and replication, such as systemic and structural elements and human capital, are prioritised. Ensuring a supply of skills and knowledge is dependent on having a pipeline of future project managers, which is accomplished through immersion and by training new people in the current business.

At corporate level, patient capital and performance measurement is required. It is imperative that this business model has its own dedicated R&D unit and is not incorporated into departments which operate traditionally, as this will eventually be integrated back into the traditional model of doing business, which is synonymous with BoP 1.0 or targeting the higher income earners.

Building the market base does not revolve around awareness raising or persuading the community that they need a product or service. By involving the community in the business process from the beginning of the process, they are able to give constructive feedback which improves the business model and the offerings, as well as instil more trust in the community. They also feel a sense of co-creation and this creates demand in itself. The business is also more accepted as bonds were formed from the first phase with home stays through to the last phase where they actively participate in aspects of the business process. A community advisory board who is able to access influential community members and increase access points is valuable. Local supply chain logistics is utilised, with local sourcing and distribution network, which also contributes to uplifting the community.

Collective entrepreneurship is achieved by utilising the project team's full set of skills to make the business model work. This includes coming up with creative joint solutions to challenges and looking at innovative ways of developing new products and services while being environmentally and socially responsible. Disruptive technologies can be explored and incubated. A relationship is built between the project team and the corporate R&D and technology departments to enhance the product offering while remaining authentic to the realities of the community.

Business enterprise co-creation is entrenched as the business expands in scope and becomes more complex. Expansion occurs as a phased approach and every step is tested in the community. Key learnings are used to improve the business model. Performance management and evaluation are important in ascertaining progress and attaining targets.

Adapted from Hart & Simanis (2008)

APPENDIX 2

Interview guides

A. Questions for corporate

Business aspect

1. What was the motivation behind entering the BoP sector?
2. How did the company choose what service or products to provide?
3. What were the underlying strategy and objectives?
4. Did you have any presuppositions about the BoP?
5. Tell me about the process - what was involved in the conceptualisation and rollout of the initiative – what were the various steps involved?
6. What were the main challenges and how did you overcome them
7. What are the main lessons learnt
8. Does Pharma Logistix benefit financially from this initiative? Please elaborate on your financial model and objectives.
9. Are there performance measures in place in relation to the business objectives?
10. Tell me about the role of networking and partnerships in this
11. Do you source funding? Please elaborate
12. Where do you see SAHealth in the future, from a business perspective?
13. Do you view SAHealth more as a social responsibility endeavour than a business model?

Social aspect

1. What role does SAHealth have in community development?
2. Have you evaluated the impact on the community in terms of intended and unintended effects; have they really saved money; has this really increased access to healthcare, or is there exclusion.
3. Is the company trusted in the community?
4. Tell me about support, training and capacity building
5. Did you infiltrate and embed into the community? Was it easy? Any issues?
6. Have you engaged in co-creation?
7. How much do nurses charge? How do they decide on the figure? How do you price the products you supply?
8. Do patients still go to other clinics or public hospitals? Why?
9. How much did they spend at other clinics or hospitals before SAHealth? (Probe: Transport costs, time from work)
10. What is the quality of healthcare offered?

B. Questions for nurses

Entrepreneurship

1. Tell me about SAHealth and the services offered
2. How did you get involved with SAHealth?
3. Why did you choose to work at SAHealth instead of public hospitals or private hospitals?
4. Did you buy this as a franchise? Tell me more
5. How have you benefitted (financially and otherwise)
6. How many patients do you see a month?

7. What are your main challenges
8. How can these be solved?
9. What improvements can be made
10. Are you involved in any partnerships?
11. What are your plans going forward?

Perceptions of company

1. How is Pharma Logistix involved? How do they help?
2. Tell me about support, training and capacity building
3. What do you think of the company and what is it trying to achieve?
4. Do your trust the company?
5. Do you feel like a partner? (probe: co-creation and collaboration)
6. Do you think the company really wants to help the community, or do they just want to make money?

Community benefits

1. How does the community benefit from SAHealth?
2. Are you able to provide local employment opportunities?
3. Are there any negative effects in the community?
4. How did you build relationships and trust in the community? Was it easy? Any issues?
5. How much do you charge patients? How did you come to this figure? How do you price products?
6. Do patients still go to other clinics or public hospitals? Why?
7. How much do they spend to go to other clinics or hospitals? (Probe: Transport costs, time from work)
8. What is the quality of healthcare offered?

C. Questions for community focus groups

1. How do you feel about SAHealth? Elaborate.
2. Has SAHealth helped you? How?
3. Has SAHealth helped your community? How?
4. How do you afford to pay for an SAHealth visit?
5. Do you save money now that SAHealth is here? Does your family save money? How much do you save in a month or year?
6. Do you still go to other clinics or public hospitals? Why?
7. How much did you spend on other clinics or hospitals before SAHealth? (Probe: Transport costs, time from work)
8. What type of services does SAHealth offer you?
9. What is the quality of healthcare offered?
10. Do you trust the nurse on duty?
11. Do you have any problems with SAHealth?
12. How can SAHealth be improved?
13. Do you know which company set up SAHealth? What do you think of the company?
14. Tell me about the community – employment rate, access to water, electricity, healthcare, aspirational purchases.

APPENDIX 3

Example of transcript – Focus group at Site 4

Questions were asked by the researcher and translated into the vernacular by the co-facilitator. He then translated the focus group responses into English.

How do you feel about SAHealth Clinic?

I really like it because it is nearby so I don't need to use transport to get there. When I suffer from flu, I just come here and I soon feel better.

I think it's good because it is the cheapest clinic. If you got to the private doctors, you pay a lot of money. At SAHealth, the treatment is affordable. Especially for us as we are unemployed.

It is good especially when it comes to an emergency. While you waiting for the ambulance, you can go to the clinic and get checked in the interim.

SAHealth is good because the people who work there are fast and caring toward the patients.

It's good because when you are sick, they give you the correct medicine for your illness.

It is really good, because if a person is really sick, the nurses will go to the person's house to see them and give them medicine. So it is wonderful that they help people in this way.

I like it a lot. I wish SAHealth can be developed more because this area is very big and it is the only clinic in this area. You have to pay to go to Bram park when you are sick. It's about 20km away. It's the closest government clinic.

Sometimes, the government clinic gives you a prescription to go to the chemist and you pay for the meds and you pay R24 return for transport. But not SAHealth, there you get all the medicines you need.

Can you tell me about your experiences at the government clinic?

They are not open with the patients (not patient-centred), they don't give you the right medicines. If you are sick, they just give you panado.

They don't care for the patients most of the time. Even if a person is extremely sick, they just go around and drink tea, and then in their own time, they may see a few patients.

You don't get help fast at a government clinic, but at SAHealth you do.

The only thing that is good at government clinic is that you get ARVs for free.

Although you go there for those treatments, and you're feeling sick, you only get help in the last few minutes.

There is no confidentiality in government clinics. If I am sick with something, the nurses break the confidentiality. Eg. If I am not ready to tell my wife that I am HIV positive, but they will ask my wife to come in to tell her.

At the government clinics, they don't keep secrets. They expose you in front of all the other people who are waiting for help regarding what you are suffering from. Sometimes they also insult you about your sickness.

I don't care about government clinics. My wish is that SAHealth can be extended because there are too many people seeking healthcare here and they need to be helped.

How long do you stand in queues at the government clinics?

The queues are long. Sometimes you are turned away before they help you. You wait in queues for a very long time. You have to get to the gate at 5am if you want to be helped, and there is already a queue there. They open around 8 or 9 and they close at 5. And lots of people go home without treatment.

How do the nurses treat you at the government clinic?

They are not good. Sometimes a sister can be the only nurse to treat you and shouts at you as she checks you.

Yes they help, but they don't treat me right because when I am sick, she does things that aren't part of her work.

Sometimes you are scared to go to government clinics because they break people's confidentiality.

Sometimes I am afraid to get an injection at the government clinic because they don't inject people properly; they inject them like animals; they hurt you.

If you keep on going to a government clinic they end up not taking care of you. People end up getting sick at home because they don't have money to go to the private doctors.

Government clinics are not good at all. When I was sick, I was meant to get an injection, but they didn't give me one. Eventually I went to SAHealth and got one…I got good treatment and got better.

They don't check people properly. They ask you what you are suffering from, then they give you medicines that will boost your immune system (vitamins). They are not caring. And they don't do check-ups; no physical examination.

The nurses rush to finish the queue so they don't examine anyone.

They spend very little time with each patient. The nurse tells you she is in a hurry; tell me what you are suffering from; here's the tablets. She spends 5 mins.

Then she says sorry im going for lunch and she takes an hour.

Do you always get your meds at the government clinics?

We generally get tablets, but it is not necessarily for the ailments that we have. They just give you a packet of tablets, usually panado.

At the government clinic, there is only one type of tablet for when a person is sick – panado or pink block. It doesn't matter what you are really suffering from.

Do they refer you to the hospital?

Yes they do a referral letter and you go to the hospital in Boksburg. It's about 30-40kms. It costs about R30 return. And you pay R120 for a consultation. You pay the ambulance R35.

How is the quality of service at that hospital?

The hospital is better than the government clinic. Sometimes they delay treatment. They tell you there is no doctor and you have to wait long for a doctor. But if you are serious and need ICU, then they see you in the emergency room.

Sometimes they turn you away from the hospital if the beds are full.

Sometimes they don't check when they discharge you. They may discharge you at night, where there is no transport back home and you have to sleep in the chairs in the waiting areas in pain. You wait until you get a taxi to go home in the morning.

Sometimes we have problems especially when we are pregnant. You feel the labour pains. They will turn you away and say it is not your time. Then you end up giving birth on the way home or at home.

Although they are not bad in certain respects, when it comes to turning you away, at least they give you some tablets. These tablets are better than the government clinic.

So how does SAHealth compare to the hospital and the government clinic?

SAHealth is even better than the hospital.

SAHealth is the best. But I am crying for SAHealth to expand so that everyone who is sitting outside waiting for their turn doesn't have to sit out there when it rains or if it is cold.

SAHealth is the best. If you go there, you are guaranteed to get better, cos if you don't improve within 2 days, they tell you to come back.

They are not stingy with tablets. They give you tablets depending on what you're there for.

It is great because they give you specific medication for your illness/ailment.

As we are saying, SAHealth is the only clinic here and it is good, so it would be great if it was also open at night to deal with emergencies. I'm begging you.

As our brothers have said, SAHealth is the best. SAHealth is doing the same quality of health as the private doctors. So I really like SAHealth.

SAHealth gives you a really good welcome. From the gate you feel a good welcome. And then they are very welcoming and caring and give you a seat when you arrive…a warm reception.

I wish SAHealth would have scanners and x-ray equipment and more resources.

Does the SAHealth nurse do a proper examination?

Yes. It's too good.

They give you good advice even when they give you medication, they explain everything like how to use the medication, how to live healthily, what to eat, exercise.

Is there confidentiality?

Yes the nurses are very confidential. Even if you are scared to go to the clinic, but at SAHealth, you are so open because our secrets are kept safe.

They offer good counselling.

Do you feel comfortable speaking to the nurse; do you trust her?

Yes, at SAHealth they are confidential, they don't shout at you. They are very warm and caring so you feel like you can open up to them.

Because they care. The treatment they give us works.

Before they give you tablets, they examine you properly so they know what to give you. They ask you lots of questions as well…even if its not for the reasons you are there, so they may find out other problems too.

Tell me more about how the SAHealth nurse treats you.

There is nothing bad to say at all. They treat us so well.

Do you prefer to go to SAHealth and pay, as compared to the free government clinic, or the government hospital?

SAHealth most definitely. We rather pay here for the good service.

We still have to pay for transport to go to the hospital and we may not get helped and we would have wasted money. At SAHealth, we know we are going to get helped and we will get better.

Are there lots of private doctors here?

No. Only SAHealth.

Can you afford to pay the fees at SAHealth?

We can afford to pay SAHealth. When you pay SAHealth, you are guaranteed to get treatment. Even if you don't improve, you can go back and they don't charge you. So we can afford to pay R130 at SAHealth.

*everyone feels that R130 is ok.

If I don't have money, it is easy to borrow as their services are good.

If you aren't working, can you still afford this rate?

I prefer to pay to go to SAHealth even if I don't have the money; I will get it by doing a piece job.

Yes it is better to pay R130 at SAHealth than to pay over R200 at a private doctor, plus there's transport.

So do you save money by going to SAHealth?

Yes.

Would you go to a private doctor, government clinic or hospital now SAHealth is here?

No way. There is no reason to go.

What types of services does SAHealth offer?

The services are great. They have everything when it comes to medication, so it's not necessary to go anywhere else.

I'm also ok with the SAHealth's services.

I receive lots of medicine from SAHealth so those are the services that SAHealth helps me with so I don't have to go back and I don't become terminal too.

Even when you are very sick, they put you on a drip, call an ambulance and refer you to a hospital. This is a good service they offer.

They check your eyes if you have a problem there.

Family planning and contraception.

Do you take your children there?

Yes. They treat them the same as us….very good.

Do old people go there?

Yes

And your family and friends?

Yes, people come from afar to go to SAHealth. Friends, family. Even those who live near the government clinic come here...they prefer good service.

Do you have any issues with SAHealth?

No complaints at all, except that it must be extended.

It will be a big problem if SAHealth is removed because it is the only clinic in the area.

How can we improve SAHealth?

Extend it. Employ people to help to avoid queues like in the government clinic. Then the people who go to the government clinics will run away from there and come to SAHealth if it is bigger.

We are currently getting excellent service at SAHealth. But as time goes on, they must think about how to improve things.

I support the statements from the others – they must expand and then they can also create more employment, professionally and even sweeping at the gates or outside.

At the moment I am satisfied with their services. I don't they need to add anything else on for now.

At the moment, I am happy with everything, but we don't know what they are hiding or what is happening behind the scenes.

The only improvement I think SAHealth can make is to have special transport for emergency cases, like if my mother is sick, then we can call an emergency number and we can be helped quickly.

X-rays and scans.

If you are pregnant, SAHealth takes good care of you. You sit down, they talk to you and they examine you, but the only thing that is missing is the scan.

Do you think you need specialist doctors who come once a month to service the community?

Yes we need doctors, but I think the sisters can handle it.

But it would be good to have a specialist come once a month, but so far the sisters have been good, and we haven't needed a specialist yet.

It will be great if that happens as long as people are informed that the doctor will be around on a certain day.

Specialist doctors charge more than a normal doctor. So how much will you be willing to pay a specialist doctor? In private, they charge anything from R600 to R1800 for eg.

If the clinic can subsidise is halfway, that will be great.

If they can add R50, or R100.

But know that this is not linked to the clinic. If the doctor comes they have to pay him separately.

We can afford R200 or R300 seeing that this doctor is a specialist. (everyone concurs)

How did you find out about SAHealth?

There was a community meeting where we found out.

What has the nurses done to market SAHealth?

I think we have helped a lot through word-of-mouth because the nurses treat you so good.

The nurses drive around in a car and talk with a loudspeaker about the clinic.

The nurse hands out pamphlets in the community.

How can the nurses get more people to come to the clinic?

If they can go to Holomisa and tell them about SAHealth because they don't have a clinic either. It's 15kms away.

We like nice things so as it is Dec, SAHealth should have a festive get together/party with food and drinks to promote themselves and build relationships.

Why do you think people still go to the government clinics instead of here?

Most of the people who frequent the government clinic have diabetes or HIV (chronic illnesses).

If you know what meds to take, then its ok to go to the government clinic…if u know what's wrong with you and you take the usual daily medicine. But if you have something else that's wrong, and you don't know, then go to SAHealth.

I will be happy if SAHealth containers can be put in other places, such as Vosloorus, Holomisa, Takane, Loliwe.

Will it be cheaper for them to go to SAHealth instead of public facility?

I think so. Because there are people in these areas who can't even take a taxi to the government clinic.

Do you think all the people in your community know about SAHealth?

Yes, they like it.

Is this location fine?

Its fine.

Everyone's speaking about expanding, which will cost more money. The fees would have to go up slightly. So will they be able to pay more for this?

We will be able to afford a R20 increase, which makes it R150.

What do you think should be the working hours?

They should open from 7am to 6pm because they can't work at night.

Why can't they work at night?

No research has been done to see if they will get patients then. Because it hasn't been done before, if they open til late maybe no one will go.

SAHealth should open at 7am because when the open, people are already waiting at the gate.

The nurses should hire security because the young boys here are rude. They can accost them.

We as a community can play a role in protecting them, but security is still needed.

If I see crime taking place, I will call the police, so we can assist them. If we notice any danger, we will call the police.

If we see people doing something bad to SAHealth or the nurses, we will beat them and burn them.

I think SAHealth is open on every second Saturday. Should it be open every Saturday?

Yes for sure. We suffer if we get sick on the weekends and they are closed.

Even people who work or who have piece jobs can't go there during working hours, so they can go on Saturdays as they are free.

I agree. It should be open on Saturdays.

Let's speak about the community in general. Can they afford to go to SAHealth?

Yes. People can afford to go there, especially because there have been no complaints about SAHealth. And if there is an emergency and someone gets really sick, it is nearby.

What is the employment rate? How many people are not working?

6 to 7 out of 10

Do they get grants? How do they make money?

Some people are hawkers in the streets, selling apples, etc; others get grants.

They do piece jobs sometimes.

Do most people here have RDP houses?

Yes, most have. The others are waiting for their's to be built soon.

And some people have home loans up there. They come to SAHealth too.

Do most people have water and electricity?

Yes. Everyone has it.

How do people spend their money here? On clothes, cell phones, airtime, or would they save money for SAHealth?

I choose my life first so if I am sick, I rather pay SAHealth instead of buying those things.

You should take care of your life first before you go to buy expensive things.

It will be silly to buy clothes if you are sick, cos I could die wearing those clothes.

Has SAHealth made a good difference to the community?

Yes it has. Because it helps us. It increases the quality of our lives. It keeps us alive.

Even when we are sick, we know that SAHealth will make us better.

Before SAHealth, did you all go to the government clinic?

We used to go to government people, but we didn't get quality help, so then we would have to spend more money and go to a private doctor in Germiston or Jhb.

I would rather wait to get money and go to a private doctor than to go to the government clinic.

I agree with everyone. I don't want to go to a clinic where u don't get help, so you rather save money until you are able to go to a private doctor.

If I didn't have money and I couldn't borrow some, then I did go to the government clinic if I was very sick.

What is the best thing you can say about SAHealth?

It's the best treatment. The care they give us is excellent. They cure us.

The only thing I can say is that they must expand it. And the sisters must be comfortable to be able to work in it, and to work at night.

Does anybody know the company that started it?

No.

It's called Pharma Logistix.

Yes I saw the sign, it says SAHealth Pharma Logistix. (one person)

Is there anything else anyone would like to say?

It would be great if Pharma Logistix could afford to give us transport for emergency cases if we are very sick.