TECHNICAL BRIEF

Transforming a Network of Donor-Dependent Clinics into a Financially Sustainable Social Enterprise

Charting pathways for the Surjer Hashi Network in Bangladesh

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Introduction

Under the U.S. Agency for International Development (USAID) Advancing Universal Health Coverage (AUHC) activity, the Surjer Hashi Network (SHN), a private network of health facilities in Bangladesh, aimed to transition from a donor-dependent social franchise to a financially viable private chain of clinics. By the close of the project, cost recovery at the network level increased from 35% in 2019 to 76.6% in 2023, and the 35 top-performing facilities achieved 112% aggregated cost recovery in 2023 . While it continues to work toward its goal of becoming fully financially sustainable, SHN is delivering on its mission to provide high-quality, customer-oriented, and affordable healthcare to all, including the poorest. This paper describes operational, technical, and financial adjustments SHN made to improve financial sustainability (measured by cost recovery) and the drivers of financial sustainability and several paths forward for SHN. The insights shared in this paper reflect the experiences of AUHC and SHN staff, and do not necessarily express the views or endorsement of USAID or Chemonics.

Background

USAID Investments

Twenty five years ago, USAID launched its flagship program to deliver primary healthcare services to Bangladeshi citizens through a network of static health facilities operated by 24 nongovernmental organizations (NGOs). This network was first called Smiling Sun, a social franchise known for delivering affordable maternal and child health (MCH) and family planning (FP) services. At its height in 2014, this network was serving nearly 17% of the Bangladeshi population.

Since that time, Bangladesh's public health system in rural areas has expanded significantly with the introduction of more than 13,000 community clinics offering essential primary healthcare services at the doorsteps of rural households. This reduced the demand for services from Smiling Sun clinics in rural areas. However, in urban areas, a significant gap in public primary care persisted. In 2017, USAID made the strategic choice to maximize urban coverage by supporting the transition of Smiling Sun clinics into a financially sustainable private chain of clinics, the Surjer Hashi Network (SHN), through the AUHC Activity being implemented by Chemonics. SHN's vision is to grow into a fully sustainable social enterprise dedicated to better human lives. Its mission is to deliver high-quality, customer-oriented, and affordable healthcare to all, including the poorest. Achieving this mission is only possible if SHN sustains operations, making financial sustainability a critically important goal for SHN.

Under a social franchising structure, USAID invested extensively in Smiling Sun network NGOs' technical and managerial ability to help them move away from donor dependence without compromising service delivery. Eventually, it became evident that at 35% cost recovery (as of April 2019), the network would remain dependent on donors (i.e., USAID) unless drastic changes were made. While SHN is registered as a non-profit private company in Bangladesh, its goal is to achieve a level of profitability that enables it to sustain, and potentially expand, the network with little or no reliance on grant funding or any type of

external subsidies. The following paragraphs explore the strengths and weaknesses of various private sector model options available to SHN.

Private Sector Network Models

Common approaches to creating a network structure in private sector healthcare delivery include 1) single-owner (centrally managed) 'chains' and 2) multiple-owner business format franchises and social franchises. Each of these models has strengths and limitations in their ability to engage the private sector in contributing to UHC goals by addressing sustainability (ability to operate without a subsidy), scalability (ability to increase the number of clinics in the network), and equity (ability to provide equal access to services, regardless of capacity to pay).

1) Chains: A healthcare chain comprises a network of clinics that are owned and operated by a single entity (e.g., corporation or non-profit organization). A chain structure is often chosen when organizations desire greater direct control over how locations are operated and have access to large amounts of growth capital, since all expansion costs will be incurred by them. This is different from franchising (see below), where franchisees are responsible for financing startup and operations of their locations.

The cost of operating a chain is higher than the cost of operating a franchise, but all the revenue generated through clinics remains in the network. Chains achieve financial sustainability when the total revenue generated by their clinics is sufficient to cover all the network expenses, including individual clinic expenses and headquarters (HQ) expenses. Chains can be scaled to the extent that they are able to raise growth capital to open new clinics and maintain HQ's operational efficiency. Chains may be better positioned to achieve equity goals than social franchise models because they have authority over how clinic revenues are used and can cross-subsidize clinics with lower cost recovery potential (i.e., clinics that are located in lower income communities where clients may not be able to pay the full price for services). This is how a network could maintain a "pro-poor" focus while operating a sustainable enterprise.

2) Social Franchises: The term "social franchising"[4] is used by many members of the global health community to describe a donor/subsidy-based approach to delivering health impact at scale. In this model, non-profit organizations connect, support, and upgrade (e.g., via training and infrastructure improvements) existing healthcare facilities under a branded network. In return, franchisees are asked to commit to delivering quality services to lower-income clients in their communities. The non-profit franchisor typically relies on grant financing, as opposed to franchise royalties, to cover the costs of improving, supporting, and marketing the clinics in the network. Social franchising's key strength lies in its ability to scale the size of the network and, assuming network members deliver better care to an

[4] High Impact Practices in Family Planning (HIPs). Social franchising: Improving quality and expanding contraceptive choice in the private sector. Washington, DC: United States Agency for International Development; 2018 March. Available from: https://www.fphighimpactpractices.org/briefs/social-franchising

expanded clientele, achieve greater impact. However, withouth strong evidence validating these assumptions it is difficult to justify the large investment required to finance this model.

Although social franchise programs strive for equity by including clinics in underserved communities in their networks, their influence over service pricing and target customer base is limited. Oftentimes, private clinic owners' decisions are driven by their own cost recovery needs. While social franchising programs establish quality standards and train providers in delivering care to those standards, their ability to monitor and enforce compliance with such standards is limited by a) costs involved in monitoring large networks; and b) the influence they have over behaviors of fully independent business owners whose success is not strongly tied to the franchise. In her 2018 Lancet article, Zubia Mumtaz notes that while there is some evidence that social franchises "increased client volume and satisfaction in some contexts, it did not necessarily improve quality of care, cost effectiveness, or equity." Therefore, it is difficult to assess the real potential for cost recovery or impact of social franchising.

History of Social Franchises

Population Services International (PSI) pioneered this version of social franchising in Pakistan in 1995 and referred to it as the Green Star Network. The model showed early promise in its ability to build the capacity of healthcare providers to improve quality and influence where and how consumers used the healthcare system. However, as more funding became available for this model, so did the push for rapid and vast scale up of social franchises and social franchising as an approach. By 2015, some 90 donor-funded social franchise programs in 40 low-income countries were being managed by NGOs. This resulted in multiple variations of a model that had yet to be proven and fully understood and a missed opportunity to learn and refine it before adopting it so widely.

"Business Format Franchising" (BFF)[5]**:** This is a market-based approach to scale viable social enterprises that address societal issues such as access to clean water, sanitation, health, education, and housing. It offers individuals the rights to open and operate a profitable and impactful business using the franchisor's brand and system in exchange for fees and royalties. The fees and royalties are used to cover the franchisor's costs of supporting and marketing its network of franchisees. Franchisors typically offer services such as staff training, facilitating access to financing, new product and service development, national brand campaigns, local marketing, and/or guidelines development. BFF has high potential for financial sustainability because the healthcare business being franchised is designed to be profitable enough to cover both its own costs and a share of the network operating costs. Franchisees are willing to contribute to the financial sustainability of the network because of the substantial value they derive from the brand and support they receive. The success of BFFs is tied to the value of the franchisor, namely, the potential for franchise owners to earn a decent livelihood from the business being franchised. BFFs also have high scalability potential because they leverage local human and financial resources needed to expand to new markets efficiently. While BFF franchisors may be primarily concerned with scaling impact, their impact must be limited to serving communities that are willing and able to pay service

[5] International Franchise Association: https://www.franchise.org/faqs/basics/what-is-a-franchise

fees sufficient to cover costs. By designing the business model to operate efficiently, the franchise can serve lower-income communities better than individual private clinics otherwise could. The extent to which BFFs expand equitable access is limited to clinic cost recovery requirements and consumer purchasing power. As with all private healthcare models, BFFs can serve lower-income patients without the means to pay the full cost of services when a third party (e.g., private or public health insurance providers) reimburses the clinics for the cost of care delivered.

From Social Franchise (Smiling Sun) to Healthcare Chain (Surjer Hashi Network)

The decision to transform Smiling Sun from a social franchise to a chain was based on four key factors:

1. A desire for greater standardization and control over a portfolio of services and quality of care being delivered by clinics.
2. A need for greater control over decisions that drive financial sustainability of the clinics and the network as a whole.
3. A need for revenue protection to fuel growth.
4. Access to USAID funding and start-up capital needed to acquire the clinics that were operating under the Smiling Sun brand. Without USAID support through AUHC, the cost of transitioning to a wholly owned chain would be prohibitive.

Additionally, the SHN board felt strongly about maintaining NGO status due to alignment with its mission and additional benefits associated with this designation.

The AUHC project began supporting the Smiling Sun clinics' journey toward sustainability by transitioning 369 of the 399 clinics, each with its own management systems and operating procedures, toward the management of a unique organization. Once SHN was established, the AUHC project supported the development and testing of strategies to improve cost recovery at the clinic level and financial sustainability at the network level. The financial performance of clinics was not tracked until AUHC introduced facility-level profit and loss statements to the network in April 2019, so data related to financial growth is limited to the AUHC project period. By the end of the project, the following results were achieved:

- Doubled cost recovery at the network level from 35% in 2019 to 76.6% in 2023.
- Increased profitability (increased revenue and decreased costs) at facility level with top performing 35 facilities achieving 112% aggregated cost recovery in 2023.
- Demonstrated viability, at the clinic level, of at least two distinct clinic typologies—Basic and Advanced—through which a different list services are provided based on population needs and clinic capacity.

- Secured funding commitment from the government of Bangladesh to provide a two-year runway, or supplemental short-term funding from the government, for SHN (2024-2025), ensuring its financial viability to continue operating at its current capacity and growing toward full financial sustainability.

Improving SHN Operational and Financial Performance

Consolidating Geographic Focus: SHN's emphasis on financial sustainability necessitated a shift from nationwide coverage to maximizing urban coverage. In urban areas, where 40% of the population resides, there is a greater ability to pay for services since wealthier clients can subsidize the cost of services for the poorest. SHN downsized from 369 clinics in 2018 to 134 clinics in 2020, with 84% located in urban areas. Clinics were relocated to high-traffic areas to generate higher client volumes, a key driver of sustainability. Most clinics that were not achieving a minimum of 40% cost recovery were shut down, unless they showed high growth potential or could be relocated to attract more clients. Some lower revenue clinics (15) were retained, though, due to the significant role they play in addressing the needs of vulnerable and hard-to-reach communities.

Strengthening Efficiency of Network Level Oversight Through Digitalization: AUHC financed and managed the establishment of SHN as a local private nonprofit governed by a volunteer board of directors. All assets from the existing network were transferred to the new entity. This included clinic equipment, furnishings, and supplies; a fund for medicines procurement; and the SHN Brand rights. At the network level, AUHC digitized essential business functions that drive efficiency and provide HQ with reliable and actionable data. Examples include centrally managed accounting, EMR (electronic medical record)-based HMIS (health management information system), HRIS (human resources information system), and QIS (quality improvement system) databases for clinical performance tracking. Centralization of drug procurement enabled SHN to leverage the network's purchasing power in supplier contract negotiations and better manage costs and quality of medicines and supplies that its clinics use.

Standardizing Health Facility Offerings: AUHC optimized and standardized operations at the healthcare facility level to reduce costs without compromising quality in several ways. First, AUHC standardized service offerings into three clinic typologies: basic care, basic with normal vaginal deliveries, and advanced care with C-sections. AUHC also standardized 1) clinic design/layout to maximize use of space and reduce rental costs; 2) operating procedures, equipment, and staffing by types of clinics; and 3) minimum pricing (with flexibility built in for the poorest clients). Finally, in-facility pharmacies were relocated outside the clinic to allow clients of other facilities to purchase their medicines at the SHN pharmacies.

Integrating Utilization and Financial Data for Decision Making: Revenues depend on service utilization and service utilization is driven by quality. AUHC improved the effectiveness of SHN quality functions in several ways. By introducing a strong facility-based QI component and a facility-level customer feedback system, SHN could track and compare trends in customer satisfaction and improve decision making. AUHC also introduced systems to track performance and accountability, including a performance dashboard that tracks revenue, expenses, and cost recovery at both the facility and network

levels. The dashboard enables segmenting of facilities by geography and clinic typology so that SHN can make data-driven decisions about marketing and operations that continue to drive sustainability into the future.

Optimizing Staff and Leadership: A highly capable leadership team for SHN was hired to manage the organization as a business, including a CEO who brings a strong private sector background, coupled with experience of building a social enterprise in Bangladesh. Some difficult decisions were made to reduce employee headcount in clinics for an optimum balance of clinical and support staff, resulting in an average of 20% reduction in operating expenses at the clinic level. AUHC also developed pay structures that incentivized achievement of performance goals and introduced non-financial incentives. These took the form of reward/recognition of clinics who performed highly in specific areas such as quality, compliance, operational performance, and business performance.

Figure 1. *'Surjer Hashi' Brand Refresh Initiative. Photo by Chemonics International.*

Improving Marketing to Attract Clients: Under AUHC, SHN expanded service offerings, including specialty services, maternity services, and vision care, to attract additional paying clients to facilities. It also introduced a systematic approach to optimize clinic service hours, to reach a greater number and variety of clients without increasing operational costs. The marketing budget was optimized to focus on outreach activities that increased SHN's brand awareness among the urban middle class. As the SHN brand was repositioned to attract higher-income clients, it was able to offset the costs of serving the poor.

Ensuring Sustainability: Standardized minimum pricing for services was implemented across the network to protect revenue. SHN maintained its pro-poor focus by benchmarking prices at 30-40% below the competition. This helped service prices to better align with costs of service delivery and competition, resulting in increased sales margins from an average of 15% to 21%. A systematic discount strategy, including criteria and tracking, for clients unable to pay the full price of services was also introduced. Finally, as part of updating its business plan, SHN secured a commitment from the government of Bangladesh for financing to cover operational expenses for an additional two years, after which the network will either need to achieve 100% cost recovery or raise additional funds.

Achieving Fiancial Viability: SHN's Path Forward

Moving forward, the SHN faces the challenge of striking a balance between financial sustainability, equity of financial access, affordability to lower-income populations, and scale of the network without the backing and financial support of USAID. Five years of performance data and financial projections indicate that tradeoffs in equity in financial access, which depends on the affordability of services across the population, and scale goals (either geographic or profitability expansion) will be necessary to build a sustainable enterprise. Once the enterprise is self-sustaining, it should be able to establish additional healthcare facilities and expand its customer base to the middle-to-higher income populations. With a two-year commitment of external financing from the government of Bangladesh, SHN has a short runway to realize its sustainability goals. Options for continuing SHN's growth into a viable enterprise are identified and explained below.

Option #1: Growth in scale starting from point of profitability (Healthcare Chain)

Since the SHN Board decided to pursue becoming a healthcare chain and cannot rely on donors subsidizing services or private sector investments, it will have to prioritize short-term financial viability. This option reduces the size of the SHN in order to focus on expanding profitable clinics. Currently, 16 of 134 of the facilities in SHN's network are sufficiently profitable to sustain themselves without external financing (see table below). At the network level, SHN could streamline HQ costs, build a track record of success, use additional insights to inform growth decisions, determine startup costs and break-even time for new clinics, and manage clinics to meet performance objectives. The $214K annual surplus generated could be used to cross-subsidize some of the lower-revenue clinics in the network, self-fund expansion (i.e., opening additional clinics), or secure and service debt financing required to accelerate expansion.

This option is lower risk to SHN as a business but would dramatically reduce its short-term impact (i.e., number of clients served). This option achieves SHN's vision (becoming a fully sustainable social enterprise) at the short-term expense of its mission (deliver high-quality, affordable healthcare to all, including the poorest). However, the resulting viable business could be leveraged to open a wider array of growth financing options to SHN in the future. A smaller but financially sustainable and profitable network is more likely to attract equity investors to support sustainable expansion.

Exhibit 1: Projected annual statement for reduced size (16 clinic) network

Aggregate net profit	$326,000
Basic (7)	$41,000
Basic+ (2)	$28,000
Advanced (7)	$257,000
Average annual expenditure ($7,000/clinic)	$112,000
Annual surplus	$214,000

Option #2: Growth in profitability starting from a point of scale (social franchise)

If SHN wanted to continue operating the 134 clinic network, it would need to secure additional external funding to subsidize clinic and HQ costs until 100% cost recovery is achieved. This approach would continue to serve the poor while demonstrating to potential funders, such as the government of Bangladesh, an increasingly greater value (impact per $) compared with the previous Smiling Sun clinics. However, achieving 100% cost recovery without further changes to the size and nature (e.g., types and locations of clinics) of the network and/or reducing HQ/overhead expenses is not feasible in the two-year timeframe under which the government of Bangladesh has agreed to subsidize SHN.

Complicating the picture is that the three different clinic types have different cost recovery rates and profitability projections (see Exhibit 2 below). Basic+ clinics, with a negative 6% growth rate from 2022-2023, have a business model problem that SHN will have to critically review going forward or these clinics will become an increasingly high burden on the sustainability of the network. Advanced clinics have the greatest revenue potential for the network and play an important role in SHN's cost recovery. At the current rate, advanced clinics will offset the operating loss of the Basic+ clinics starting in 2026 and generate profit in 2029.

While the clinics would have achieved full cost recovery in 2029, the projected surplus revenue generated by clinics will not be sufficient to cover HQ expenses. If the network continues to operate in its current form and HQ expenses remain at their current level, the network-level deficit will continue to rise and remain between US $1.16 million and $1.3 million between 2029 and 2032. Unless SHN can secure grant financing to cover HQ expenses, it will need to make significant adjustments to its model to remain viable.

Exhibit 2: Cost recovery and projected profitability by clinic typology

	Basic	Basic+	Advanced
Current cost recovery rate	60%	–	82%
Annual cost recovery growth rate	7%	-6%	8.3%
Year profitability is reached	2029 (102% CR)	Unknown	2026 (106% CR)

Option #3: Leveraging private investments (Business format franchising)

If SHN does not want to sacrifice either scale or financial sustainability, it could reconsider changing its registration from a ‘nonprofit’ to a ‘for-profit’ organization. This would open the door to a business format franchising approach whereby private investors could open SHN franchises and contribute fees and royalties to cover SHN HQ costs (see case study below). This reconsolidation would reform its business structure to protect investment, diversify risk, and provide funding for operational sustainability and growth. However, this would reduce the financial and decision-making power of SHN, since franchisees would earn a return on investment rather than all proceeds funneling back to HQ. This option focuses on long-term survival and profitability of the network, as well as allowing SHN to maintain its current scale.

Building on the profitable clinics in the network (N=16), the enterprise would be in a position to attract private capital (investment) to sustain and grow its portfolio of profitable clinics. Approximately 30 additional clinics are at the tipping point to become profitable in the next couple of years, at which point they can move over to the for-profit business category. To create a model based on profitable clinics, SHN will have to adopt a different positioning within the community and funding strategy for clinics that are currently not profitable. This option is not exclusive of the other two options presented above and may allow SHN to combine the two options by restructuring its business.

As a first step in that direction, the institutional structure of SHN will need to primarily focus on the profitable clinics. This set of clinics will need tailored branding and marketing strategies specific to their unique market characteristics or risk compromising their growth. The next consideration is SHN's ability to leverage its experience and analyses of the profitable clinics as it opens new clinics and extend its reach. It is important to underscore at this point that clinics were established during past USAID programs without systematic assessment of market and viability. The experience of the profitable clinics in the network will allow SHN to generate insights for future investment decisions. SHN will then be able to strategically borrow or solicit private capital for investing in growth using the evidence generated by profitable clinics.

Unfortunately, SHN's current legal status is prohibitive of private investors' involvement. As a nonprofit, SHN is not allowed to offer returns on investment to prospective private equity. Unjani's franchising model (described below) may provide an alternative solution to SHN's ability to grow while maintaining its not-for-profit status.

Case Study: Unjani Clinic Network

Unjani Clinic Network, a healthcare business format franchise for low-income communities in South Africa, illustrates how BFF can be used to scale a viable healthcare enterprise targeting low-income communities effectively and efficiently. By following a similar pathway, SHN could expand in scale while also reducing its capital raising and management burden. Unjani was founded in 2012 and spent its early years developing, testing, and refining a viable clinic model for low-income communities. Once it had demonstrated a viable clinic model, it began scaling it through business format franchising. By 2016, the network comprised 28 clinics and continued to grow at a steady annual pace. In 2021, Unjani reached the critical mass of 100 clinics required for full cost recovery and the pace of growth accelerated. By 2022 the network grew to 141 clinics serving an average combined total of 78,241 clients per month. Thirteen years after its founding, Unjani comprises 193 locally owned and operated clinics.

Like SHN, Unjani developed a highly efficient clinic operating model and determined the combination of client volumes and pricing needed to achieve both its equity/affordability and sustainability goals. It also determined a realistic time frame for achieving these goals at both the clinic and network level. For example, Unjani learned that a 3-year ramping up period was needed for a new clinic (in Unjani's case a franchisee) to generate the volume of clients paying minimum consultation fee to achieve break-even. During this ramp-up period, access to low cost working capital was provided by a variety of funders. The investment that Unjani made in understanding the key drivers of a clinic's success was utilized to help Unjani clinic owners succeed.

Lessons Learned

Important lessons were learned from the SHN experience that may be relevant to other private health care networks willing to contribute to UHC in different contexts.

- **Adopting a more efficient business model versus a non-profit drove efficiency and improved cost recovery for the Surjer Hashi Network.** Different network structures are appropriate for different circumstances. Decisions about the type of structure/business model should be informed by priorities related to financial sustainability, scale/geographic coverage, equity of access and affordability to the population identified by SHN's social impact mission, and the quality of services–all interconnected factors. The network structures discussed in this paper should be regarded as scaling strategies for healthcare network models with a proven track record of performance. Without a clinic model that has demonstrated its ability to achieve the desired goals, it is unrealistic to expect the network to sustain its financial and technical operations.
- **The transformation of a donor-dependent social franchise model into a financially sustainable private enterprise requires time and a paradigm shift that addresses the tension between cost recovery and a UHC-focused mission.** AUHC's experience with SHN indicates that the private sector's role in expanding universal access to high-quality affordable healthcare can be strengthened through initiatives that reduce clinic and HQ operating expenses, expand the client base through the addition of services, and increase client volumes. SHN's transition from a social franchise to a private chain of clinics has resulted in substantial cost reductions and increased revenue. In five years, AUHC was able to more than double SHN's rate of cost recovery and achieve profitability for 16 clinics and the general growth trend for clinics in the network is positive. However, SHN chooses to take the network into the future, there is an opportunity for continued experimentation and learning that further advances the field's understanding of how to effectively engage the private sector in efforts to strengthen the ability of health systems to achieve UHC. Achieving SHN's mission to deliver quality services to all at scale depends on its financial viability. This requires continuous adaptation of the current model based on analysis of financial and clinical data on supply and demand determinants of services, including price elasticity. These will inform decisions on the adaptation of its structure, processes, and overall business model.
- **Serving the poorest of the poor through the private sector can only be achieved at scale when a third party subsidizes the cost of the services delivered through direct payment to the providers or indirect payment to the network.** It may not be realistic to expect the private sector to serve the lowest-income communities without third-party subsidies. Private sector clinics sustain their businesses through client fees, and unless a third party compensates them for services delivered to clients who cannot pay the full costs for services, they may not be willing or able to expand their client base to lower-income communities. This situation limits clients' choice of providers, who might prefer private clinics over public ones but cannot afford them without a financial protection mechanism (e.g., insurance scheme). Subsidies can be delivered at the clinic level to offset costs that cannot be recovered through client fees. For example, SHN could continue to operate sustainably while serving the poor through a strategic third-party purchase arrangement or at the client level through public insurance programs. This would

ensure providers are sufficiently reimbursed for their services. Without reliable reimbursement schemes, private clinics will be pressured to raise prices to a level that crowds out lower-income clients.

Other Considerations

AUHC also found that drivers of clinic financial performance include financial/business incentives that drive efficiency; locating clinics where there is sufficient demand; offering a mix of products and services that deliver customer value; and offering services at times that are convenient to customers (e.g., opening hours). Additionally, operating a chain of clinics allows for financial cross-subsidization and the ability to serve the poorest of the poor, achieving greater equity among lower-income communities.

Conclusion

With USAID's support, SHN has made impressive progress over the past six years. However, it has some challenging decisions ahead as it works to achieve both its vision (financial independence and sustainability) and mission (providing high-quality, affordable care to all). The work done to date should be viewed as part of a longer iterative process of building a viable business and harnessing the private sector to help achieve UHC.

For additional information about the activities under AUHC see this brief on the maternal and child health quality improvement initiative, this brief on the installation of a quality management system, and the forthcoming AUHC Legacy Report.

CONTACT INFORMATION

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About Chemonics: Founded in 1975, Chemonics is an international development consulting firm. In more than 100 countries around the globe, our network of approximately 6,000 specialists shares a simple belief: that the challenges we face today are best solved through the right partnerships – sharing knowledge, expertise, and experience to deliver results. Where Chemonics works, development works.

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