The Commercial Market Strategies Project

Final Report 1998–2004

The CMS Project, in partnership with the private and commercial sector, contributes to improved health by increasing the use of quality family planning and other health products and services.

The Commercial Market Strategies Project
Final Report

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COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

COMMERCIAL MARKET STRATEGIES

Commercial Market Strategies (CMS) is the flagship private-sector project of USAID's Office of Population and Reproductive Health. The CMS project, in partnership with the private sector, works to improve health by increasing the use of quality family planning and other health products and services.

EMERGING MARKETS GROUP

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PHOTO CREDITS

Cover text Detail from a *Goli ke Hamjoli* advertisement in Northern India. Between 1999 and 2002, CMS's *Goli ke Hamjoli* (Friends of the Pill) campaign increased the use of low-dose oral contraceptives among young urban women. Sales of all commercially available oral contraceptive brands increased by 42 percent, and surveys revealed positive changes in attitude and knowledge among both providers and consumers.
Page 1 Curt Carnemark/World Bank.
Page 13 © Guy Mansfield/Panos Pictures.
Page 45 © CMS/Frank Feeley. Julius, the CMS/Health Partners Marketing Coordinator in Uganda's Gulu district, talks to members of a rock-breaking co-op who have joined the community health plan.
Page 59 Youth in Jamaica, courtesy of the Pan American Health Organization.
Page 67 © Jeremy Horner/Panos Pictures. People peer out the window of their highland home in Fianarantsoa, Madagascar.
Page 77 CMS/Elizabeth Gardiner. A drama performance raises awareness about the dangers of unsanitary birth practices and promotes CMS's New Maama clean-delivery kit. In addition to brand-specific advertising for its social marketing products, the CMS project develops behavior change communications activities like this community drama.

ABSTRACT

The Commercial Market Strategies (CMS) project was the flagship private-sector project of USAID's Office of Population and Reproductive Health (G/PRH). CMS was designed to increase the use of family planning and other health products and services through the private sector. From 1998 to 2004, CMS worked in 29 countries to develop and implement a wide range of country programs, technical assistance projects, new initiatives, and global research — all with the aim of expanding access of family planning products and services through commercial approaches and private-sector partnerships. The *CMS Final Report* provides a comprehensive examination of the technical strategies, accomplishments, results, and lessons learned from the project's programs and activities. A major finding is that commercial organizations are a key resource for donors and development projects in accomplishing health sector objectives, particularly for family planning and reproductive health care. CMS programs involved partnerships with the private sector in a broad range of countries (including India, Morocco, Jordan, Senegal, Uganda, Ghana, Madagascar, Nepal, Nicaragua, and the Philippines), which resulted in improved access to, and quality of, family planning products and services. Through these programs, CMS provided consumers with valuable information about, and access to, essential health products, such as modern contraceptives, oral rehydration therapies, insecticide-treated malaria nets, treatment kits for sexually transmitted infections, and voluntary testing and counseling services for HIV/AIDS. This report also provides detailed information on the various technical strategies used by CMS, including social marketing, support for provider networks, health financing, sustainability for health care non-governmental organizations, corporate social responsibility, and policy.

KEY WORDS

Commercial Market Strategies, CMS, USAID, population, private sector, commercial sector, family planning, contraceptives, reproductive health, public-private partnerships, social marketing, sustainability, private providers, provider networks, social franchising, corporate social responsibility, policy, health financing.

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CONTENTS

FIGURES

MAPS

ABBREVIATIONS AND ACRONYMS

ADEMAS	Agency for the Development of Social Marketing (Senegal)
ADOPLAFAM	Asociación Dominicana de Planificación Familiar (Dominican Republic)
AIDS	Acquired Immune Deficiency Syndrome
AIDSMark	Acquired Immune Deficiency Syndrome Social Marketing project
ARV	Antiretroviral
BCC	Behavior change communications
BEMFAM	Sociedade Civil Bienestar no Brasil
CA	Cooperating agency
CAPS	Commercial- and Private-Sector Strategies
CELSAM	Centro Latinoamericano Salud y Mujer (Mexico)
CMS	Commercial Market Strategies
CSR	Corporate social responsibility
CYP	Couple year of protection
DHS	Demographic and Health Survey
EC	Emergency contraception
ECOP	Employer's Confederation of the Philippines
EMP	*Empresas Medicas Previsionales* (Nicaragua)
FCFI	Friendly Care Foundation, Inc. (Philippines)
FOGSI	Federation of Obstetricians and Gynecologists of India
FP	Family planning
FPOP	Family Planning Organization of the Philippines
HAART	Highly active antiretroviral therapy
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization
IEC	Information, education, and communication
IFPS	Innovations in Family Planning Services (India)
INSS	Nicaraguan Social Security Institute
IR	Intermediate result
ITN	Insecticide-treated net
IUD	Intrauterine device
JHUCCP	Johns Hopkins University Center for Communications Program
JSI–WFC	John Snow, Inc.–Well Family Clinic
KSM	Key Social Marketing (Pakistan)
LAC	Latin and Central America
MCH	Maternal and child health
MOH	Ministry of Health
MUCH	Mothers Uplifting Children's Health (Uganda)
NFCC	Nepal Fertility Care Center
NFPB	National Family Planning Board (Jamaica)
NGO	Non-governmental organization
OC	Oral contraceptive
ORS	Oral rehydration salts
PACT–CRH	Program for Advancement of Commercial Technology–Child and Reproductive Health (India)
PAI	PharmAccess International (Netherlands)
PBC	Philippine Business Conference
PCCI	Philippine Chamber of Commerce and Industry
PHRPlus	Partnerships for Health Reform Project Plus
PMAC	Population Management Action Center
PMAP	Personnel Management Association of the Philippines
PRH	USAID Office of Population and Reproductive Health
PROFIT	Promoting Financial Investments and Transfers project
PSI	Population Services International
PSSN	Parivar Swasthya Sewa Network (Nepal)
PTC	Post-test club (Uganda)
RH	Reproductive health
RHAC	Reproductive Health Association of Cambodia
RPMCHAP	Responsible Parenthood and Maternal and Child Health Association of the Philippines
SIFPSA	State Innovations in Family Planning Services Agency (India)
SMC	Social Marketing Company (Bangladesh)
SO	Strategic objective
SOMARC	Social Marketing for Change Project
SPARCHS	Strategic Pathways for Reproductive Health Commodity Security
SPHC	San Pablo Hospital Complex (Peru)
STI	Sexually transmitted infection
TA	Technical assistance
TAG	Technical Advisory Group
TIPPS	Technical Information on Population for the Private Sector project
UHC	Ugandan Health Cooperative
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPMA	Uganda Private Midwives Association
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization
WHO–ORS	World Health Organization–oral rehydration salts

1 Introduction

INTRODUCTION

The Commercial Market Strategies (CMS) Project is the United States Agency for International Development's flagship project to increase the use of quality family planning and other health products and services through private-sector partners and commercial strategies.

CMS began operations in October 1998 under a five-year contract (HRN-C-00-98-000-39-00) issued by the United States Agency for International Development (USAID) to the Emerging Markets Group of Deloitte Touche Tohmatsu. With strong private-sector development experience, Deloitte provided overall management for CMS. Additional consortium members included Abt Associates, Inc., which provided expertise in the areas of research, monitoring and evaluation, and health care finance; and Population Services International (PSI), which implemented innovative social marketing programs that encouraged healthy behavior and promoted access to affordable health products. CMS also collaborated with other health sector cooperating agencies (CAs) to implement country programs and technical initiatives, including The Futures Group International, Meridian Group International, Family Health International, Tulane University, and EngenderHealth.

This final project report covers the original contract period through September 2003 and contract extensions through September 2004. Due to the extensive scope of the CMS project, this document does not detail every project activity, but instead focuses on key results and contributions of the CMS project in three main areas: the larger and more significant country programs, technical assistance and core-funded initiatives, and CMS global research and technical studies.

For more details about activities, readers may refer to the CMS technical, research, and other publications contained in a special CD-ROM to be issued in September 2004. (Publications may also be downloaded from the CMS web site, www.cmsproject.com.)

PURPOSE OF THE CMS PROJECT

USAID's Office of Population and Reproductive Health designed the CMS project in 1998, under the Commercial- and Private-Sector Strategies (CAPS) Results Package. CMS was designed to address a projected global surge in demand for family planning and reproductive health services that is expected to exceed available public-sector and donor resources. According to United Nations Population Fund (UNFPA) estimates, the number of people in the developing world who will need family planning goods and services by 2015 will increase dramatically — by an estimated 217 million people. Donors and governments already have difficulty meeting developing countries' reproductive health needs. To meet the anticipated increased need for products and services, additional resources are needed from such sources as private households, employers, and insurers.

USAID has long recognized the private sector's significant potential both to enhance the supply and use of quality family planning and reproductive health (FP/RH) goods and services and to advance population and health goals. USAID began promoting the delivery of family planning services through the private sector in the mid-1980s, supporting both nonprofit and commercial-sector approaches. From 1985 to the present, the numerous USAID projects making voluntary family planning goods and services available through private and commercial channels have included efforts to expand the demand and supply of family planning products through social marketing programs, the creation and promotion of provider networks to expand clinical services, and support for employer-financed and other work-based family planning programs.[1] USAID also provided financing and credits to private providers and hospitals to expand the supply of family planning and maternal and child health (MCH) services.

These efforts underscored the importance of expanding the private sector's role in the provision and financing of FP/RH and other health services worldwide. In many developing countries, the private sector already delivers most basic preventive and curative health services. Traditionally, however, the provision of family planning and other basic health services in developing countries was regarded as the concern of the public sector and the donor community. Although the commercial sector now provides a dominant share of health care services for consumers in developing countries, including those with lower

1 Predecessor private-sector family planning projects to CMS included Social Marketing for Change (SOMARC), Enterprise, Technical Information on Population for the Private-Sector (TIPPS), and Promoting Financial Investments and Transfers (PROFIT).

incomes, only an estimated 33 percent of family planning users outside China and India obtain contraceptives from commercial sources. With the onset of global health care reform, opportunities have emerged for the commercial sector and non-governmental organizations (NGOs) to play a more pivotal role in delivering such services.

Seizing this opportunity, USAID designed CMS to implement programs and strategies that go beyond the traditional social marketing of contraceptives by forging new partnerships with the commercial organizations involved with health care service provision. For example, CMS was to expand the delivery of reproductive health services through private provider networks, explore new health care financing mechanisms to expand access to services, and broaden social marketing strategies by diversifying commercial health products and creating demand. Moreover, CMS was given a mandate to improve the policy environment to enable the private sector to have a more significant role in delivering basic health and family planning services in underserved markets, as well as to new consumers. By increasing the quality and affordability of private reproductive health products and services, CMS was to "shift" clients away from free or subsidized services in the public sector — thereby reducing the financial burden on governments and donors and allowing them to better address the needs of poor and underserved populations.

RESULTS FRAMEWORK

The CMS project had a dual focus:

- to respond to USAID Mission country-specific needs and resources, as well as to support their strategic objectives, and
- to support USAID Office of Population and Reproductive Health (PRH) mandate to provide technical leadership and develop effective, innovative responses to health needs.

To fulfill this dual mandate, CMS developed and implemented

- broad-based country programs, in response to USAID Missions' objectives,
- technical assistance projects, to support USAID Missions and local private-sector organizations active in the field of reproductive health, and
- initiatives and research activities funded by the Office of PRH, to test new approaches and private-sector mechanisms for achieving reproductive health outcomes and to disseminate the findings from these initiatives and research.

The CMS strategic objective (SO) was

> increased use of high-quality family planning and other health products and services through private-sector partners and commercial strategies.

To achieve this SO, the CMS framework outlined three strategies: creating demand for family planning and other health products and services, managing supply, and improving the environment for private-sector participation. CMS was to create partnerships with both commercial (for-profit) and non-profit organizations, which together encompass the "private" sector. Building on the social marketing models implemented under predecessor USAID projects, CMS was to expand the "product" focus of family planning programs to develop private provider networks and employer-based services and to explore health financing alternatives as a way of addressing family planning and reproductive health within the context of broader service delivery.

To achieve its SO, the project pursued three intermediate results (IRs):

> IR 1: *Increasing the demand* for family planning and other health products and services from the private sector,
>
> IR 2: *Increasing the supply* of quality family planning and other health products and services through commercial approaches,
>
> IR 3: *Improving the environment* for the sustainable delivery of family planning and other health products and services through the private sector.

IR 1 sought to increase demand for family planning and other health products and services through sustainable partnerships with the private sector. The project was to develop activities that (1) generated demand, (2) were consistent with the particular country's social

and cultural values, and (3) reflected consumers' ability to purchase or access these products and services. The cornerstone for increasing demand was to apply tested social marketing techniques and to focus on changing consumers' behaviors to consider utilizing health products and services. Additional approaches involved making products and services more affordable and getting users who were able to pay for services to switch from the public to the private sector.

IR 2 addressed issues related to the supply of health products and services. These included (1) improving the quality of products and services delivered through the private sectors; (2) developing new sources of supply (wholesalers, retailers, distributors, and providers) and service methods in order to increase geographic access and expand the variety of products in underserved urban and rural markets; (3) creating third-party payment mechanisms to shift the burden for payment from consumers to insurance or employers; and (4) helping for-profit and non-profit providers improve their ability to sustain their private practices.

IR 3 entailed addressing policy, legal, and regulatory barriers impeding the involvement of the private and commercial sectors in the delivery of health products and services. The thrust of this IR was to create the necessary conditions that would motivate the commercial sector to enter new markets or deliver new products and services without undue restraints or regulation from the government. The ultimate aim was to create the "enabling" environment for private-sector participation and to allow demand and supply mechanisms to work in developing markets. IR3 called upon CMS to address policy, legal, and regulatory barriers affecting demand (e.g., free or subsidized products from the public sector, regulation on brand advertising, and restrictions on dissemination of information) as well as supply (e.g., import regulations and taxes, policies on provider licensing and quality of care, access to credit or foreign exchange, and laws impacting the creation of third-party payment mechanisms for family planning and other health products and services).

TECHNICAL STRATEGIES

To address the key issues and challenges posed by the SO and three IRs , CMS defined an integrated approach that combined a range of technical strategies. These technical strategies were utilized to design country program interventions implemented with funding from USAID Missions. CMS also utilized core funding from USAID/Washington to develop innovative pilot programs and initiatives, all of which were organized around these technical approaches. The technical strategies involved the following major areas of activity: social marketing, working with private providers and networks, strengthening NGOs, developing new sources of health financing, promoting corporate social responsibility, and improving the policy environment. In addition, the CMS project provided loans to commercial providers and health care NGOs through the Summa Foundation, in order to improve quality of services and the financial sustainability of providers. The relationship of these seven strategies, discussed below, to the intermediate results is shown in Figure 1.

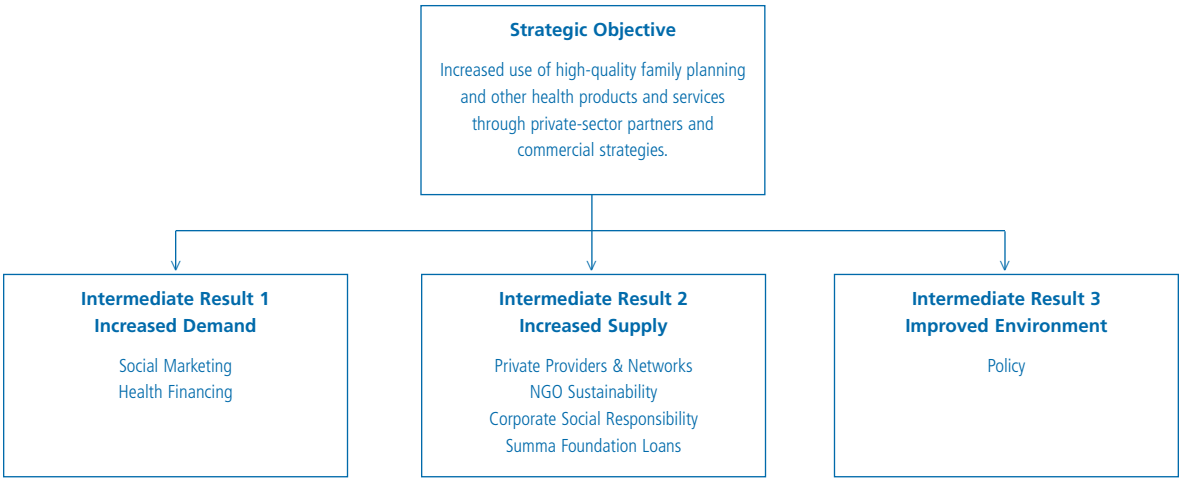
SOCIAL MARKETING

In many CMS country programs, social marketing was the principal means for creating demand and increasing the use of products and services in the private sector, as called for under the SO and IR 1. Social marketing had been validated as a proven technique for promoting the use of modern family planning products in a broad range of developing countries. From its inception, CMS was called upon to take over a large number of existing social marketing programs that had been part of the SOMARC Project, including programs in Uganda, India, Morocco, Jordan, Nepal, Madagascar, Ghana, Jamaica, Turkey, Kazakhstan, and Uzbekistan.

In these countries, CMS continued to implement and support social marketing programs to increase accessibility to a large range of health products and services and to promote the use of contraceptives and other products through behavior change campaigns, in order to achieve health impact in developing countries. CMS programs socially marketed a wide range of contraceptive products, including condoms, oral and injectable contraceptives, intrauterine devices (IUDs), oral rehydration salts, insecticide-treated nets, clean-delivery kits, and kits to treat sexually transmitted infections (STIs).

Because expanding social marketing into FP/RH services was part of its mandate, CMS quickly began to use social marketing to promote not just products, but also

Figure 1. The CMS project results framework



the concept of private provider networks, which offered clinical contraceptive methods, such as IUDs and injectables, and clinics that provided voluntary counseling and testing services for HIV/AIDS. As had the predecessor projects, CMS used a continuum of social marketing models that reflected both the country's economic and social conditions and the realities of the market for family planning. In countries with low disposable incomes, primarily sub-Saharan African countries, CMS adopted the "distribution model," working in partnership with a local NGO, or by direct distribution through a dedicated sales force, to distribute and market products. In middle-income countries, with more vibrant and established private health sectors, CMS partnered with pharmaceutical manufacturers and local distributors and retailers to promote affordable products through established commercial channels, while conducting generic demand-creation activities.

Social marketing programs were the starting point to establish or strengthen networks of private providers, both commercial and non-profit, and to work directly with private providers to improve the quality of their services. The CMS social marketing work also led to CMS's involvement in contraceptive security issues confronting a number of countries.

PRIVATE PROVIDERS AND NETWORKS

In order to increase the supply of quality products and services under IR 2, CMS worked with a wide range of private providers, including physicians, midwives, nurses, and pharmacists. Strengthening their capacity and improving their technical capabilities was seen as essential for increasing the supply of FP/RH services and for increasing the demand among consumers for these services.

Private providers are widely used for a range of child, reproductive, and communicable health problems. A number of studies have suggested that they are more responsive, conveniently located, and sometimes less costly than public providers, and they are used by patients from all socioeconomic groups. Private providers offer opportunities to draw in additional resources for scaling up access to essential health interventions and may allow public-sector resources to be better targeted to priority services and population groups.

However, studies of malaria, STIs, tuberculosis, and reproductive health services have documented a range of problems with private provision of services. The technical quality of care provided varies widely; the distribution of certain types of providers is biased toward urban areas; and private providers are constrained to work within a commercial logic. There is mutual mistrust between the public and private sectors; government relations with the private sector are characterized by a history of strategies of control, rather than partnership and collaboration.

Private providers are a diverse group: They have both for-profit and non-profit motivations; they may be highly trained and specialized professionals or less than fully qualified or unqualified; their

organizations may be simple or complex; what they offer ranges from comprehensive services to simple provision of public health products; and the boundary with the public sector may be blurred due to various forms of dual practice. A clear challenge for expanding the supply of products and services in developing countries is the lack of organized groups of individual providers, many of which operate as small proprietorships with limited resources, poor management, and limited access to information or training to offer quality family planning services.

In addition to providing technical training on family planning counseling and improving providers' ability to dispense contraceptive methods, CMS also sought to increase their ability to attract new clients. CMS helped providers establish group practices and created and strengthened provider networks and franchises, operating under an umbrella brand name and offering a defined package of services at known prices. CMS also provided access to training, business management skills, linkages to reliable sources of contraceptives, and the promotion of services through branding and marketing.

NGO SUSTAINABILITY

The CMS contract put heavy emphasis on strengthening NGOs. As providers of health products and services to underserved and at-risk populations, NGOs provide reproductive health products, services, and information to millions of individuals. They are a key component of civil society, pioneering innovative reproductive health approaches in their communities and launching services where governments are reluctant to do so. Many family planning and reproductive health NGOs face an uphill struggle for survival. Most are heavily dependent on donors; although donor funding levels for population programs have held relatively steady over the past two decades, the number of reproductive health NGOs has grown, leading to intense competition for funds.

CMS's philosophy for providing assistance on NGO sustainability was strongly business oriented: In order to support and maintain quality programs, it was essential to have a healthy financial base, solid governance, and long-term planning processes. CMS defined NGO sustainability as an organization's ability to

- improve its institutional capacity to continue its activities among target populations over an extended period of time,
- minimize financial vulnerability and develop diversified sources of institutional and financial support, and
- maximize impact by providing quality services and products.

CMS helped NGOs gain business and financial management skills essential for long-term financial sustainability. For example, NGOs learned to diversify sources of revenue, develop new product or service lines, restructure pricing, and reduce internal costs. Since organizations often lack the structure and oversight systems to operate as money-making endeavors, CMS also helped managers and directors improve business systems and strengthen institutional stability. Assistance was tailored to the local economic and political environment, organizational priorities, and the specific circumstances of individual NGOs. CMS's technical assistance therefore included individual consultations, workshops and training sessions, and user-friendly planning tools that included strategic plans, business plans, and feasibility studies. CMS's goal was to leave each NGO with a set of business-oriented tools that the organization could use in working toward long-term sustainability.

In providing this support, CMS not only had to confront issues about reconciling the social missions of NGOs with taking a business-like approach for operating their organizations, but also the question of how NGOs could avoid trade-offs between serving lower-income populations while trying to recover more costs in order to survive. Many NGOs also had to face the realities of their marketplace in order to retain clients, who were being drawn to free services from the public sector. Thus CMS was often called upon to resolve critical questions for NGOs faced with curtailed donor funding and little experience in competing in the marketplace to attract and retain clients.

HEALTH FINANCING

Solving payment and financing issues was a critical challenge for increasing both demand for and supply of family planning and other health services and products. Under IR 1, CMS was to identify ways in which

products and services could be made more affordable to consumers through various payment structures and service delivery models being implemented under health care initiatives in many developing countries. Such measures were key for attracting consumers with an ability to pay to the private sector. CMS was also tasked with identifying new third-party payment mechanisms to shift the burden of payment from consumers to other parties, such as employers or insurance models based on U.S. health maintenance organizations (HMOs).

In addition, CMS looked at the specific issues related to payment for family planning, which traditionally has been regarded as a preventive health intervention falling under the auspices of public health systems or subsidized social marketing programs. Thus, it is unusual for family planning to be covered under private insurance plans, and even less so in developing economies, where private insurance plans are fairly new concepts or are only available to those working in the formal sector. An additional factor is that most of the target populations (low- and middle-income) for private-sector interventions still lack access to private insurance plans and the means to pay for coverage.

CMS initially focused on expanding the coverage of FP/RH services through risk-pooling mechanisms – social, private, or community health insurance. CMS identified, developed, or assisted health financing schemes to expand the availability of private-sector services or to reduce the financial burden to consumers. CMS worked with providers, private insurers, community-based plans, and governments to explore ways of adding family planning as a covered benefit, or to improve the utilization of FP/RH services where coverage was available, but not widely utilized. For example, where commercial or community insurance plans were already in operation, CMS analyzed the costs and benefits of adding reproductive health services to the benefit package. CMS also provided technical assistance to establish or expand community health insurance plans and worked with health care practitioners and provider networks to establish new services and pricing for family planning and reproductive health care. CMS also conducted research on the impact of health insurance coverage on family planning usage patterns, to determine how existing plans were influencing consumers' FP practices.

CORPORATE SOCIAL RESPONSIBILITY

All over the world, companies are realizing that business means more than selling products or services. With the advent of the Internet and increased media focus on corporations, consumers have become more informed about companies' social and environmental practices. Companies are recognizing that giving back to their employees, and to the communities in which they operate, is critical to long-term success; they are responding by incorporating outreach activities into their core business agendas. Growing corporate social responsibility (CSR) is causing corporations to look at their relationships with all stakeholders, including customers, employees, communities, owners/investors, governments, suppliers, and competitors.

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CMS pursued CSR opportunities to expand on the established practice of work-based and employer-supported family planning programs implemented by predecessor projects such as Enterprise and TIPPS, among others. Unlike those early models, CSR programs were designed to take advantage of corporate competencies, such as marketing and distribution resources, and to leverage them on behalf of development projects. CMS strategies to involve companies in

CSR included technical assistance to help companies develop CSR policies, MCH programs at the work site, community outreach activities, and cause-related marketing campaigns. CMS also identified ways to involve NGOs in implementing CSR projects with local partners and to help companies establish relations with local governments by addressing public health problems.

CMS designed and implemented CSR activities for corporations and private organizations in a number of countries, with a focus on expanding family planning and reproductive health services. Some of these efforts were initially small in size, such as developing corporate policies for women's health benefits for Brazil's largest association of corporations (Ethos). CMS managed to develop a broader, more cohesive CSR program in Ghana that involved a large number of companies and different models of participation, including technical assistance to several industry associations. In addition, corporate interest in addressing the HIV/AIDS epidemic in many developing countries provided CMS with ample opportunity to create new partnerships with corporations as a way of supporting HIV/AIDS prevention and treatment programs.

POLICY

CMS's policy activities supported IR 3 — improving the environment for the sustainable delivery of family planning and other health products and services through the private sector. Activities to change existing laws, regulations, and policies included reforming laws and regulations, registering new products, and seeking exemptions for categories of products or providers, among others. Activities to make the environment more conducive to the private sector included promoting public-private dialogue and partnerships, clarifying the intent or impact of policies, disseminating information about policies, and promoting dialogue on policy issues.

Unlike other USAID projects, CMS worked in both public and private sectors, rather than just with the public sector. In the public sector, for example, it worked to reduce legal and regulatory barriers and improve governmental regulations for quality of care. In the private sector, CMS worked to involve private companies in population issues and in raising their awareness of their responsibilities to their employees and communities. On some issues — such as facilitating government outsourcing of insurance or health services to the private sector — CMS worked in both the public and the private sector. This approach of working with private and commercial sectors to implement public policy is standard in the developed world, but still rare in the developing world.

CMS worked on broader policy issues than simply reproductive health policy. This was important because very little of what impacts family planning is explicitly called "family planning policy." For example, whether family planning is mandated for inclusion in health insurance programs is a matter of health policy. The issues impacting on this may have to do with policies on prevention or primary health care, rather than policies on family planning or reproductive health. The CMS policy approach targeted many categories of policy that had an impact on family planning.

At CMS, policy activities were rarely stand-alone; they typically accompanied activities in other technical areas, as policy change could be crucial in allowing the technical activity to achieve its expected impact. CMS also linked policy to innovations in financing, supportive social marketing campaigns, and other interventions related to a number of CMS technical areas. For example, product registration was often a necessary prerequisite to social marketing, and training of providers in clinical methods was dependent on the regulatory environment. These types of linkages led to more comprehensive, sustainable programs.

THE SUMMA FOUNDATION

Expanding access to financing for commercial providers and NGOs was an integral, cross-cutting tool of CMS. This was achieved through investments made by the Summa Foundation, an independent non-profit organization that provides loans and technical assistance to expand maternal and child health care and family planning. The Summa Foundation was established under the USAID-funded PROFIT project in 1992 and was designed to facilitate socially responsible investments in the private and commercial health sectors in developing countries, with an emphasis on family planning and reproductive health. The Summa Foundation, which worked jointly with CMS, supported commercial and private providers in a dozen countries to improve the quality of their services and to add MCH and family

planning as part of their services. Summa expanded the supply of affordable family planning and other health products and services available to lower- and middle-income population groups. Summa used both financial and technical assistance to accomplish this goal and leveraged other funds and resources for commercial family planning and health activities.

Summa was a unique financial mechanism because of the variety of financing mechanisms at its disposal: direct loans, equity investments, and revolving loan funds. These various financing mechanisms enabled Summa to reach a broad range of companies, organizations, and individuals working in the private and commercial health sector.

Summa was able to make direct loans to commercial companies, such as private clinics, HMOs, insurance companies, and product distributors. The intent of these investments was to expand and improve existing activities within the lower- and middle-income markets or to encourage a company to enter these markets for the first time. Summa also made direct loans to NGOs involved in product distribution or service provision to help them expand activities and increase their income-generating ability and thus improve sustainability and impact. In addition, Summa designed and financed revolving loan funds that provided small or micro loans to individual health care providers, such as midwives, doctors, and pharmacists. These revolving loan funds were established in partnership with local financial institutions and provider associations, thus giving Summa a mechanism to reach multiple borrowers with smaller loans.

In order to maximize impact and ensure the success of its investments, Summa provided technical assistance along with its financing. Summa's package of technical assistance – which addressed financial and institution management, health service delivery, and family planning – distinguished it from other investment funds.

THE CMS PORTFOLIO OF PROGRAM ACTIVITIES

From October 1998 through September 2004, CMS worked in 29 countries, implementing integrated country programs, technical assistance projects, and core-funded initiatives. CMS also conceived and executed an innovative agenda of global and country-specific research studies, in addition to producing numerous technical papers on issues affecting the private sector's role in family planning and reproductive health (see Map 1).

The CMS program portfolio comprised

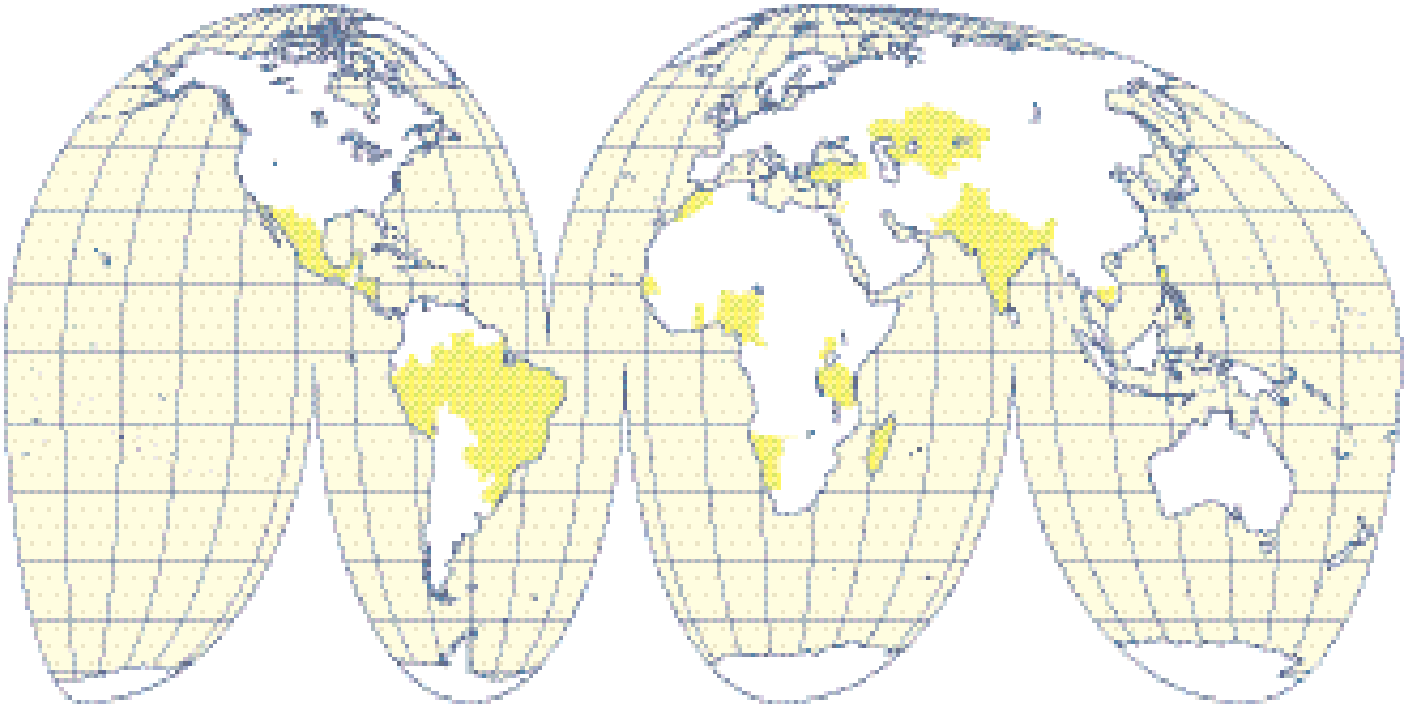
- *Country Programs.* Larger, multi-year programs funded by USAID Missions usually were characterized by the presence of a CMS country office and resident advisors. Many of these programs involved implementation of several technical strategies over the course of the contract.

- *Technical Assistance.* Smaller projects funded by USAID Missions were limited in duration or involved only one or two technical areas. Usually, these projects were implemented through short-term technical assistance and did not involve the presence of permanent CMS field staff. (Map 2 shows activities funded by USAID Missions — country programs and technical assistance.)

- *Core-Funded Initiatives.* As part of its mandate to develop innovative approaches for sustainable health partnerships, CMS implemented core (PRH)-funded new initiatives. These initiatives included conducting country-specific assessments and special studies (e.g., market segmentation) and launching new partnership models that could be scaled up with USAID Mission resources. In addition, CMS received "special initiative" funding to implement activities and research in certain cross-cutting topics, such as contraceptive security and adolescent reproductive health. (Map 3 shows core-funded initiatives.)

Summa Foundation loans were part of many of these activities. Summa worked in tandem with CMS project staff in various countries (see Map 4) to provide financial resources and technical assistance to both commercial and NGO providers. In the pages that follow, Chapter 2 discusses selected country programs in detail; Chapter 3 focuses on technical assistance projects and core-funded initiatives, and Chapter 4 summarizes findings from CMS global and technical research.

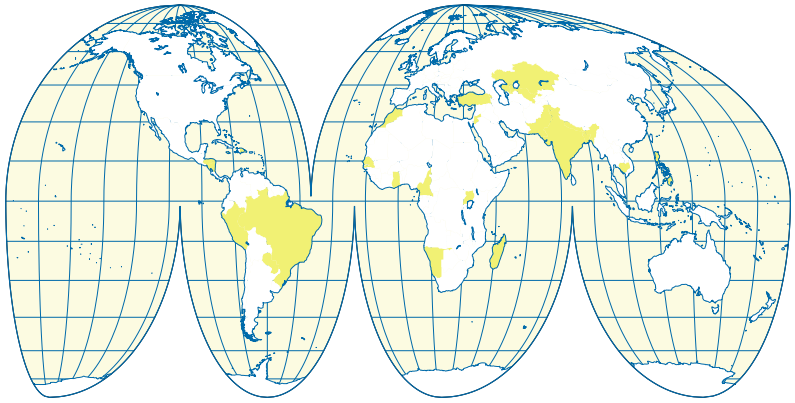
Map 1. Countries where the CMS project worked, 1998 to 2004



Over the course of the project, CMS worked in 29 countries:

Armenia
Bangladesh
Brazil
Cambodia
Cameroon
Dominican Republic
El Salvador
Ghana
Honduras
India
Jamaica
Jordan
Kazakhstan
Madagascar
Mexico
Morocco
Namibia
Nepal
Nicaragua
Nigeria
Pakistan
Paraguay
Peru
Philippines
Senegal
Tanzania
Turkey
Uganda
Uzbekistan

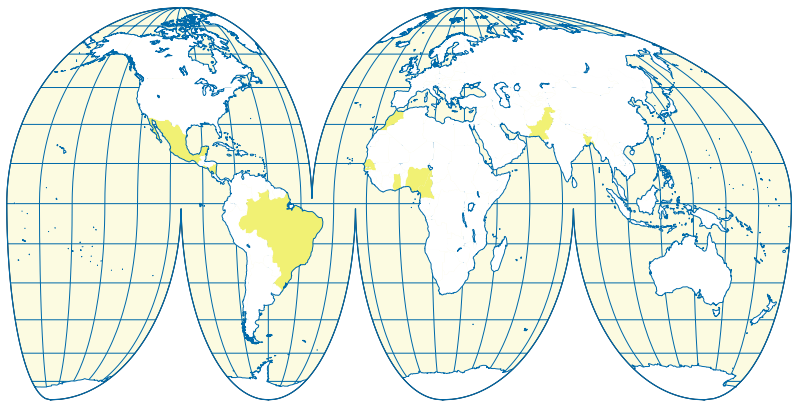
Map 2. Countries with CMS country programs and technical assistance initiatives (funded by USAID Missions)



USAID Missions funded CMS country programs and technical assistance initiatives in 24 countries:

Armenia	Morocco
Bangladesh	Namibia
Brazil	Nepal
Cambodia	Nicaragua
Dominican Republic	Pakistan
Ghana	Paraguay
Honduras	Peru
India	Philippines
Jamaica	Senegal
Jordan	Turkey
Kazakhstan	Uganda
Madagascar	Uzbekistan

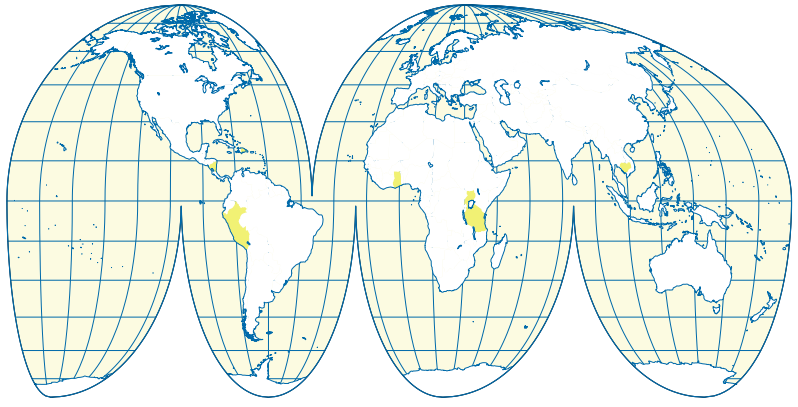
Map 3. Countries with CMS core-funded initiatives



CMS implemented core-funded initiatives in 12 countries:

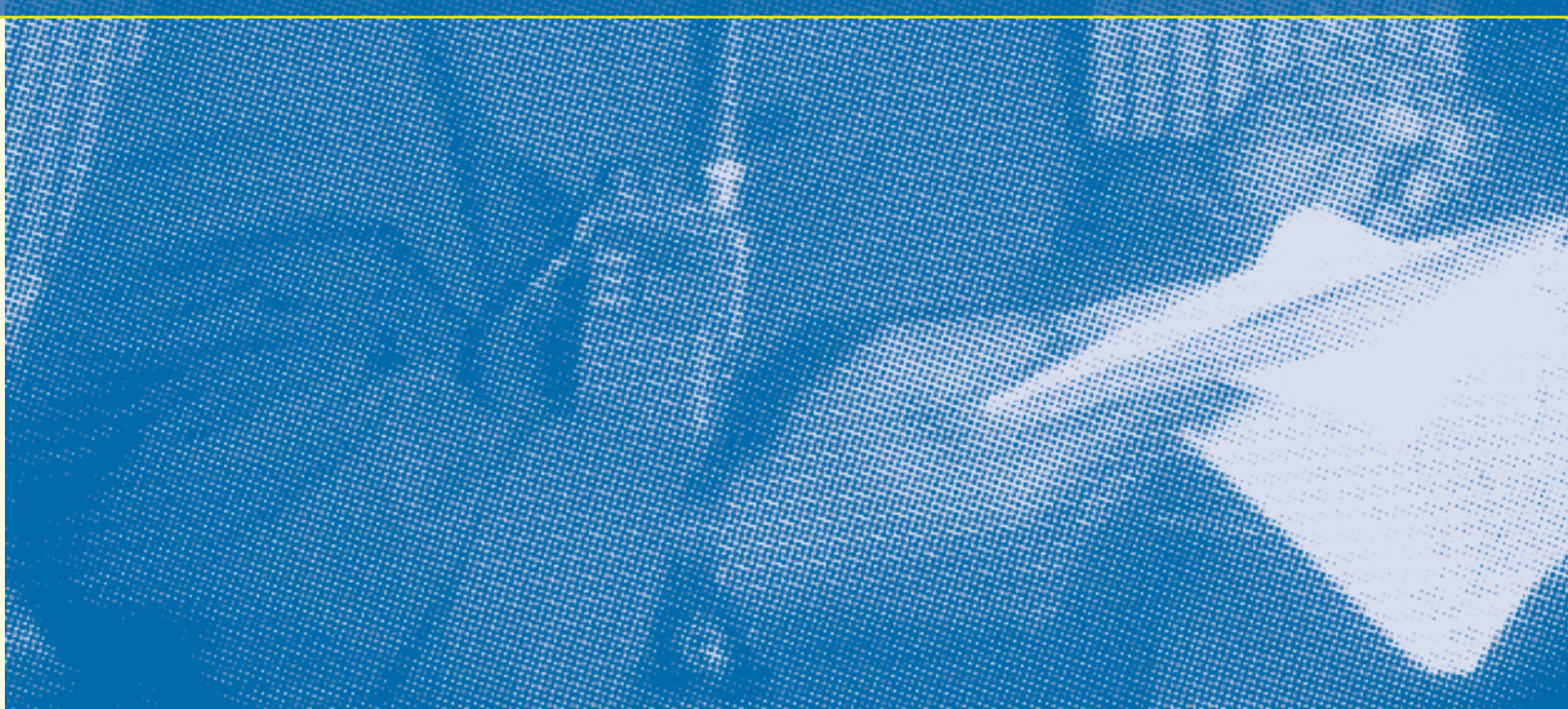
Bangladesh	Mexico
Brazil	Morocco
Cameroon	Nicaragua
El Salvador	Nigeria
Ghana	Pakistan
Jamaica	Senegal

Map 4. Countries with Summa Foundation loans



The Summa Foundation disbursed loans in Cambodia, Dominican Republic, Ghana, Nicaragua, Peru, Tanzania, and Uganda.

2 Country Programs: Achievements and Results



COUNTRY PROGRAMS: ACHIEVEMENTS AND RESULTS

CMS worked in 29 countries over the life of the project, implementing both familiar approaches and newer, integrated programs that combined a number of technical strategies in order to maximize the potential impact and achieve desired health outcomes. This section highlights nine country programs that demonstrated technical breadth and synergies in working with diverse private-sector partners (see Map 5). Although each program responded to the health needs of its country, and must therefore be understood in its particular context, these programs are discussed here because they illustrate how the CMS technical strategies were utilized to address health conditions and challenges under the three IRs.

The programs in Madagascar, Senegal, Morocco, Uganda, and India exemplify various approaches for implementing social marketing programs and achieving results primarily under IR 1 (increasing demand) with respect to distribution models and collaboration with private-sector organizations. These programs dealt with supply-side issues by working with private providers and pharmaceutical firms. The programs in Nepal and Nicaragua focused primarily on IR 2 goals. They emphasized improving and increasing the supply of products and services by implementing provider network models. CMS programs in Uganda, Ghana, and the Philippines featured collaboration with private companies, using the corporate social responsibility model. Health financing activities were prominent in Uganda and Nicaragua, while policy initiatives were undertaken in Morocco, India, the Philippines, and Uganda (focusing on IR 3 goals). Summa Foundation activities were undertaken in Ghana, Uganda, and Nicaragua.

MADAGASCAR: PRIVATE DISTRIBUTION OF CONTRACEPTIVES

Madagascar is one of the least-developed countries in the world. Approximately three-quarters of the population are poor and rural, and almost half are under 15 years old. Access to mass media is low, and only 10 percent of homes have electricity. Women have an average of six children. Access to contraception and other reproductive health services is limited, and people do not have information about family planning options. As a result, there is a tremendous unmet need for family planning (the modern contraceptive prevalence rate was only 7 percent in 1997).

CMS worked in Madagascar from November 1998 until March 2001 to improve reproductive health through private-sector strategies and programs. It worked to decrease HIV/AIDS and other STIs and to increase the use of modern methods of family planning. While the official HIV-infection rate was only about 1 percent in 2000, it is believed to be underreported. Yet it is a potentially explosive problem. Conditions are ripe for the rapid spread of HIV/AIDS: In addition to widespread poverty and an increasingly transient population, the country has some of the world's highest STI rates. The active syphilis rate for the population is close to 40 percent, and some three-quarters of high-risk women have at least one STI.

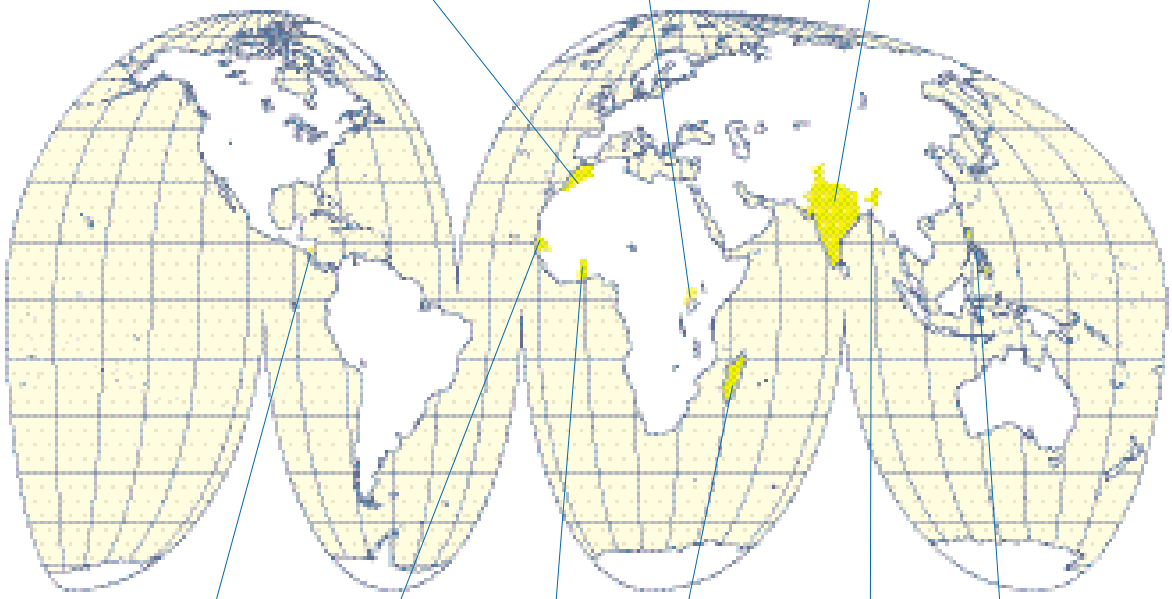
CMS's goal in Madagascar was to increase consistent condom use to prevent STIs and HIV/AIDS and to increase the use of modern family planning methods obtained from the private sector by using a comprehensive approach to address both demand- and supply-side barriers to modern contraceptive use. The project focused on (1) improving product distribution; (2) developing behavior change and information, education, and communication (IEC) campaigns; (3) reaching high-risk youth; (4) increasing community-based sales and education; and (5) strengthening contraceptive supplies.

IMPROVING PRODUCT DISTRIBUTION

CMS revamped and expanded distribution systems for condoms and hormonal contraceptives.

When CMS took over the project in 1998, *Protector* condoms were sold directly to some 8,000 retailers, primarily in the capital of Antananarivo. CMS revamped the system so that retailers could purchase condoms from local wholesalers. This change allowed the project sales team to concentrate on other activities, such as merchandising, opening up new sales points and ensuring better coverage in non-traditional outlets that serve high-risk groups. CMS used mass media advertising to improve awareness of the wholesaler network. The project also installed a new information system to measure sales by province and to assess the effectiveness of the distribution network. As a result of these activities, the project met its goal of increasing the availability of condoms by the end of March

Map 5. Nine CMS countries that demonstrate the project's technical breadth and strategic synergies



Uganda
Social marketing
Health financing
Improved the policy environment
Supported private providers
Summa loans to midwives and three commercial firms

India
Social marketing
Partnerships with pharmaceutical companies
Improved the policy environment

Morocco
Social marketing
Supported private providers
Partnerships with pharmaceutical companies
Improved the policy environment

Senegal
Social marketing
Improved the policy environment

Madagascar
Social marketing
Supported private providers
Improved contraceptive security

Nicaragua
Assisted social marketing NGO
Established and supported private provider networks
Summa loans to four organizations

Ghana
Technical and sustainability assistance to social marketing NGO
Corporate social responsibility
New health financing program for HIV treatment
Summa loan to social marketing NGO

Nepal
Assisted social marketing NGO
Established and supported private provider networks

Philippines
Assisted social marketing NGO
Assisted private providers
Corporate social responsibility
Improved the policy environment
Assessed contraceptive security

2001. The number of *Protector* retailers increased from 8,000 to 21,273, serviced by 639 wholesalers. Between 1998 and 2000, *Protector* sales increased more than 55 percent — from 3.4 million to 5.3 million.

The CMS project also worked to expand the distribution of socially marketed hormonal contraceptives. In 1998, distribution of *Pilplan* oral contraceptives (OCs) and *Confiance* injectables was limited to three cities. CMS took over promotion of the products from the distributor, which continued to oversee distribution with a focus on avoiding stock outages. CMS's promotion strategy targeted providers, such as doctors, midwives, and pharmacists, and worked to improve their ability to offer accurate information on hormonal contraceptives. CMS hired and trained a team of medical detailers to visit providers with information on *Pilplan* and *Confiance*. Point-of-sale materials were developed and given to providers and retailers to increase their motivation to stock the products and to indicate their availability to consumers. By March 2001, more than 1,000 providers had been trained in contraceptive technology and more than 16,000 detailing visits had taken place. More significant, *Pilplan* and *Confiance* were available in almost every pharmacy in the country. Between 1998 and 2000, annual sales of *Pilplan* more than quadrupled from 56,581 to 239,764 cycles. Sales of *Confiance* increased from 10,011 to 78,082 vials.

BEHAVIOR CHANGE/IEC CAMPAIGN

CMS created a comprehensive behavior change campaign (BCC) to address the lack of knowledge about STI/HIV/AIDS. It worked to increase personal risk perception for HIV/AIDS, improve knowledge about the transmission and prevention of STIs and HIV/AIDS, and increase condom use. An IEC campaign was developed to promote hormonal family planning methods. It focused on providing accurate information and dispelling rumors about hormonal contraceptives. Both campaigns promoted healthy sexual choices by stressing abstinence before marriage, monogamy, and condom use – for the prevention of HIV/AIDS *and* unwanted pregnancy.

TARGETING YOUTH

Malagasy youth ages 15 to 24 are at particularly high risk for HIV/AIDS and unwanted pregnancy. CMS designed several program components to target this vulnerable group. Messages were conveyed through mass media and interpersonal communications (peer educators, providers, and mobile video) and emphasized the importance of

- abstinence before marriage,
- being faithful to one partner, and
- the correct and consistent use of condoms.

In addition, CMS repositioned *Protector* condoms to target sexually active youth. CMS conducted focus groups with adolescents to identify barriers to condom use and preferences for a logo and package design.

COMMUNITY-BASED SALES AND EDUCATION

CMS increased the role of community-based sales and educational activities to expand the distribution network for contraceptives, as well as to increase access for underserved populations. CMS recruited a community-based sales coordinator who created education programs for military personnel, commercial sex workers, and employees of various organizations (including company doctors). Peer educators and community-based sales agents conducted educational sessions that reached over 13,200 high-risk people.

CONTRACEPTIVE SECURITY

As in many developing countries, fostering contraceptive security (assuring a reliable, long-term supply of contraceptives) was an important aspect of CMS's activities in Madagascar. As a first step in promoting contraceptive self-reliance, CMS conducted a study examining the feasibility of supplying the 10 largest members of ASSONG, a Malagasy family planning association, with social marketing condoms, pills, and injectables. At the time, ASSONG clinics received free contraceptives from USAID. Following the recommendations of the CMS study, however, USAID stopped providing free products and instead encouraged ASSONG clinics to purchase and distribute CMS's socially marketed products. To support this

change, CMS conducted contraceptive technology training sessions for doctors affiliated with the family planning clinics. As a result, ASSONG clinics moved from being passive recipients of donated products to active buyers — a key step toward developing the capacity for sustainable contraceptive management. For example, ASSONG clinics used their community health worker networks to distribute the socially marketed contraceptives to people in remote areas.

PROGRAM RESULTS

CMS's creative and comprehensive strategy to address both demand- and supply-side barriers to modern method use in Madagascar had an impressive impact. Based on the 1997 *Demographic and Health Survey* (DHS) and the 2000 United Nation's Children Fund (UNICEF) *Multiple Indicator Cluster Survey,* CMS contributed to improvements in the following areas:

INCREASED CONTRACEPTIVE PREVALENCE. The prevalence rate for modern contraceptive methods increased from 7.3 percent in 1997 to 12 percent in 2000.

INCREASED USE OF HORMONAL CONTRACEPTIVES. Use of OCs increased from 2.4 percent in 1997 to 3.3 percent in 2000, while the use of injectables increased from 4.7 percent to 6.7 percent.

MORE COUPLE YEARS OF PROTECTION. While implementing the Madagascar program, CMS provided 160,618 couple years of protection (CYPs). Between 1999 and 2001, sales of *Pilplan* OCs increased 324 percent, sales of the injectable *Confiance* increased 680 percent, and sales of *Protector* condoms increased 55 percent (see Figure 2).

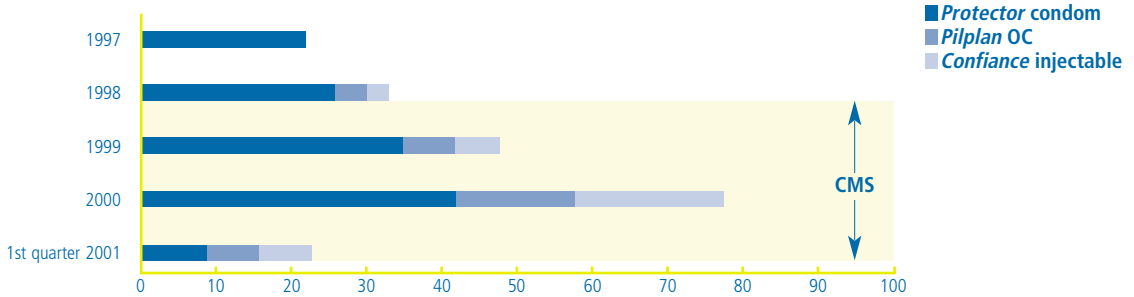
IMPROVED KNOWLEDGE ABOUT STI/HIV/AIDS. Knowledge of STI/HIV/AIDS transmission and prevention improved dramatically. In 1997, 38 percent of women cited fidelity and 27 percent cited consistent condom use as the two main HIV prevention means. In 2000, 42.6 percent of women cited fidelity and 36 percent cited consistent condom use.

SENEGAL: NGO-BASED SOCIAL MARKETING

Senegal has experienced sustained economic growth since emerging from economic difficulties in the 1990s. Despite the encouraging growth rate, more than half of Senegalese families still live in poverty. Senegalese women bear an average of 5.2 children, and the annual population growth rate is 2.6 percent. Although contraceptive awareness is high, use of family planning remains low. In 1997, the contraceptive prevalence rate was 12.9 percent (8.1 percent for modern methods). An estimated 33 percent of couples who do not use contraceptives say they are interested in family planning. Many factors limit the use of modern contraceptives, including frequent stockouts, a shortage of urban providers, lack of information, strict regulations inhibiting promotion of health products, and religious and cultural barriers. The HIV prevalence rate is low in Senegal, due in part to high awareness of this infection and ways to prevent it. Awareness of other STIs, however, is low. Only 5 percent of men and 17 percent of women are aware of gonorrhea, the most common STI.

CMS activities in Senegal included increasing access and expanding contraceptive choice, behavior change, and policy and advocacy.

Figure 2.* Protector, Pilplan, *and* Confiance *CYPs (in thousands)



SOCIAL MARKETING: INCREASING ACCESS AND EXPANDING CHOICE

From 1999 to 2004, CMS implemented its activities in Senegal in partnership with the Agency for the Development of Social Marketing (ADEMAS), a local NGO with 14 years of experience in socially marketing reproductive and other health products. To improve private-sector provision of family planning products and services, CMS provided technical assistance to ADEMAS in the areas of organizational development and financial sustainability. CMS/ADEMAS promoted knowledge and use of condoms, with a focus on *Protec* (ADEMAS's brand). To increase contraceptive choice, it also developed and introduced *Securil,* a low-cost OC.

To improve consumer access, CMS/ADEMAS expanded *Protec's* distribution beyond pharmacies (which are typically closed at night and on weekends) to non-traditional outlets such as nightclubs, gas stations, and grocery stores. CMS/ADEMAS recruited and trained 10 *Protec* sales staff, who visited potential outlets and encouraged them to stock the product. The number of *Protec* outlets grew from 550 pharmacies in 1999 to more than 3,000 outlets (pharmacies and non-traditional outlets) in 2003.

Protec was originally launched as a family planning product, but CMS/ADEMAS positioned it also as an STI- and HIV-prevention product. CMS/ADEMAS launched a public relations campaign targeting wholesalers and retailers and trained more than 1,500 outlet staff on such topics as condom use, STIs and HIV, inventory management, interpersonal communication, and service quality. In addition, CMS/ADEMAS worked with the Union of Pharmacists to update training manuals for pharmacists and counter clerks. Competitions and incentive programs further stimulated interest in the product.

In April 2002, CMS/ADEMAS introduced *Securil.* At the time, only 3.3 percent of Senegalese women used oral contraceptives; and there were no low-cost OCs available through the private sector. The primary objective of the *Securil* program was to reduce Senegal's high maternal mortality rate by providing women with a safe and reliable way to space births.

To ensure that *Securil* would be affordable to the target audience (low- and middle-income women), CMS/ADEMAS set the price based on an ability-to-pay analysis. CMS explored procuring the pills through a partnership with a pharmaceutical manufacturer, but the manufacturer could not reduce its prices sufficiently. CMS/ADEMAS then opted to use the USAID-donated pill *Duofem* as an affordable alternative. Advertising and promotion for *Securil* highlighted the product's proven safety record while addressing public fears surrounding the pill. CMS/ADEMAS developed promotional and educational materials to build consumer confidence in oral contraceptives in general, and in *Securil* in particular. To minimize adverse reactions to the launch of Senegal's first socially marketed oral contraceptive, ADEMAS held public relations events to inform partners and stakeholders about the campaign, including a press conference and a journalists' workshop called "Contraception: A Factor of Well-Being." The *Securil* campaign benefited from the resulting positive press coverage.

Pharmacies in Dakar began stocking *Securil* two months before the official launch in early 2002. By that time, a CMS/ADEMAS team of five medical detailers and a product manager had already visited 90 percent of the city's pharmacies and had begun visiting outlets in semi-urban areas to ensure broad geographic coverage. Over the course of the year, the team conducted 9,811 medical detailing visits, reaching OB/GYNs, general practitioners, midwives, nurses, and pharmacists. Detailers educated medical personnel about *Securil* and distributed materials (posters, pens, mobiles, prescription pads, and brochures) to promote high visibility for the product. The team reported enthusiastic responses from both pharmacists and providers. In addition, CMS/ADEMAS introduced *Securil* to major medical organizations, such as the Association of Gynecologists and Obstetricians and the Association of Midwives.

BEHAVIOR CHANGE COMMUNICATIONS AND EDUCATION CAMPAIGN

To promote awareness of *Protec* condoms, CMS/ADEMAS created a comprehensive behavior change communications and education campaign. The campaign slogan was *"Abstinence, Fidelite, sinon Protec"* ("Abstinence, fidelity, if not *Protec"*). Youssou Ndour, a popular Senegalese singer, supported the campaign with a series of concerts in which he delivered AIDS-prevention messages highlighting the importance of condom use. He also appeared in *Protec* radio and

television ads and emphasized campaign messages in newspaper interviews. In addition, CMS/ADEMAS organized promotional campaigns for special events, such as the International Day against AIDS and the Soccer World Cup.

In August 2001, CMS/ADEMAS partnered with Family Health International, Peace Corps, and the Sengalese Ministry of Health to produce a series of road shows around the theme "AIDS: I care…do you?" The shows, which reached more than 100,000 people nationwide, combined plays, skits, games, songs, and *tassous* (slogans repeated by the audience) to deliver HIV/AIDS-prevention messages. Heavy media coverage, radio shows, and 430 radio spots publicized the road shows and disseminated key messages.

The campaign's closing ceremony featured a 3,000-person march in Dakar. Following the march, local artists such as Youssou Ndour, Omar Péne, and Diarra Gueye addressed the audience and repeated the key messages of the campaign. National media covered the ceremony, and video footage was aired on the evening news. As a result of improved distribution and the behavior change communications and educational campaign, Protec sales increased 66 percent between 1999 and 2003.

POLICY AND ADVOCACY

Senegal's pharmaceutical sector is highly regulated — even changing the color of a product's packaging can invalidate government certification. Also, it is illegal to advertise a specific prescription product. To guide the *Securil* campaign, CMS/ADEMAS conducted an in-depth assessment of the laws and precedents governing the prescribing, delivery, storage, and promotion of hormonal contraceptives. CMS/ADEMAS worked with the Ministry of Health (MOH) to create a technical committee of opinion leaders and public- and private-sector representatives to review the marketing strategy and support *Securil's* launch. The committee carefully vetted all promotional materials and activities, ensuring that they were on target and culturally appropriate.

PROGRAM RESULTS

By focusing on improved product distribution, combined with a targeted brand and generic advertising and behavior change campaign, CMS/ADEMAS

EDUCATING POTENTIAL *SECURIL* USERS

The consumer brochure for *Securil* features an urban, middle-class family. The husband, a secondary target of the marketing campaign, says: "The pill for my family's well-being." The tag line reads: "A simple method for spacing births. For the good health of mother and child." The brochure goes on to dispel common myths and rumors about oral contraceptives.

succeeded in improving condom availability, sales, and use. It also succeeded in improving contraceptive options by introducing an affordable oral contraceptive into the private-sector market. While significant increases in oral contraceptive use will take a long-term focused effort to overcome religious and cultural barriers and misinformation on hormonal contraceptives, the project was able to make an important first step in improving access, use, and choice:

INCREASED CONDOM ACCESS. The *Protec* distribution network expanded from 690 outlets at the end of 1998 to 3,627 outlets at the end of June 2003. According to the nationally representative mid-term survey conducted by CMS/ADEMAS, 70 percent of male users said that they could access a *Protec* outlet within 15 minutes.

LOCAL BRAND SUCCESSFULLY PROMOTED AS CONDOM OF CHOICE. Preliminary data indicate that 72.5 percent of men who usually use condoms use the *Protec* brand. *Protec* condom sales increased by 66 percent from 1998 to 2000 (2,351,410 sold in 1998; 3,909,900 in 2002). Moreover, compared to the 1997 DHS, condom use among men of reproductive age rose from 16.5 percent to 21 percent.

INCREASED CONTRACEPTIVE CHOICE. *Securil* also increased the number of CYPs provided by CMS/ADEMAS. During the first semester of 2003, CMS/ADEMAS contributed 21,250 CYPs, a 23 percent increase over the first semester of 2002. More than 21,700 cycles of *Securil* were sold in 2002, and 22,511 were sold during the first semester of 2003, making *Securil* one of the leading OC brands in the commercial market.

MOROCCO: SOCIAL MARKETING THROUGH COMMERCIAL PARTNERSHIPS

Morocco is a middle-income country with a population of nearly 30 million. The contraceptive prevalence rate rose from 19 percent in 1978 to 60 percent in 2000, with more than 60 percent of users opting for oral contraceptives. Although the public sector is the main provider of family planning products and services, women are increasingly obtaining contraceptives from the private sector. CMS/Morocco's objective was to increase the use of private-sector family planning and child health products and services. CMS worked toward this goal by socially marketing contraceptives and child health products and by providing training and support to private health care providers.

The Moroccan MOH launched the country's first contraceptive social marketing program in 1989. The goal of the program was to use the commercial sector to bring affordable contraceptives to low- and middle-income consumers. The program was established with USAID assistance, first through the SOMARC project and then through CMS. From 1998 to 2003, CMS managed and coordinated the *Al Hilal* family of contraceptive products, as well as *Biosel,* an oral rehydration solution.

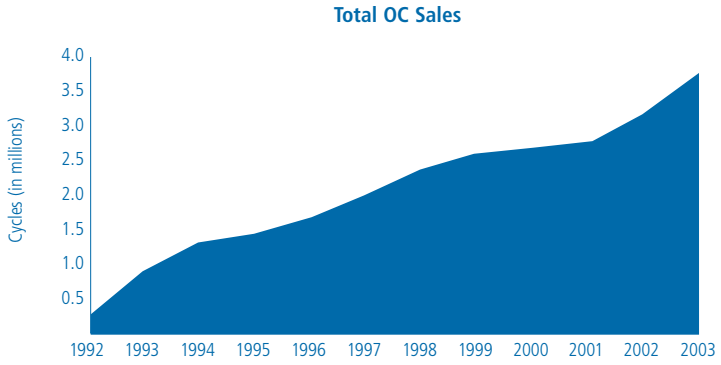
INCREASING THE MARKET FOR ORAL CONTRACEPTIVES

The first socially marketed oral contraceptive was launched in 1992 under the name *Kinat Al Hilal* (Pill of the Moon), an umbrella brand for two moderately priced pills, Wyeth's *Minidril* and Schering's *Microgynon.* Although Moroccan law generally prohibits advertising for branded pharmaceuticals, the Ministry of Health authorized the project to promote *Kinat Al Hilal* directly to consumers and even negotiated discounted commercial airtime with television and radio stations. In exchange for the promotional support, Wyeth and Schering agreed to lower the price of their oral contraceptives by 20 percent.

When CMS took over the project, it negotiated contributions from the two manufacturers in order to fund the production and airing of a new advertising campaign. Launched in April 2002, the campaign targeted women in rural areas, where unmet need is highest. It resulted in a 49 percent increase in sales of *Kinat Al Hilal* between 2001 and 2003 (see Figure 3).

The social marketing of *Kinat Al Hilal* brands made a significant contribution to the development of a commercial market for oral contraceptives. Schering and Wyeth have expressed a commitment to keep social marketing prices low and to sustain advertising investments beyond the life of CMS. However, both companies believe that product sales will likely stagnate if advertising does not continue. Because advertising of contraceptives by private companies is not permitted, CMS helped develop a partnership

Figure 3. Morocco: Sales of* Kinat Al Hilal *oral contraceptives, 1992 to 2003



between the manufacturers and a local family planning association, which supported social marketing activities after the end of the project. However, it is too early to know whether this model of sustainability will succeed without some measure of donor funding and implementation support.

EXPANDING CONTRACEPTIVE CHOICE: INJECTABLES AND IUDS

To expand couples' choice of affordable methods of contraception, the Moroccan social marketing program introduced the *Lawlab Al Hilal* IUD and the *Hoqnat Al Hilal* injectable into the commercial market in 1997. CMS inherited both programs in 1999 and worked to increase the acceptability of these methods. Barriers to long-term contraceptive methods in Morocco included the high cost of IUD insertion at private facilities and strong resistance to injectables among both providers and the public. To address misperceptions among providers, CMS trained general practitioners in IUD insertion and in the management of side effects. Training sessions also included information on general reproductive health issues, the treatment of sexually transmitted diseases, and pregnancy management. CMS also published detailed articles in prominent medical magazines and held panel discussions at health events. To address user concerns, CMS aired radio and television advertisements and organized *mahalla* (community) meetings, which enabled women to discuss family planning methods with physicians. CMS reinforced the marketing of these products by developing agreements with the manufacturer of *Hoqnat Al Hilal* and the local distributor of *Lawlab Al Hilal* that resulted in increased detailing of pharmacists and physicians in target areas.

Despite substantial training and promotional efforts, demand for both IUDs and injectables remained disappointing. Sales of the injectable showed only a marginal increase from 2002 to 2003, and sales of the IUD peaked at 6,000 units in 1999, then dropped again. An assessment of the injectable and IUD social marketing program conducted in 2003 concluded that these products could not be graduated from donor support and would require continued investments in provider training and communication.

CMS/Morocco demonstrated, however, that attitudes can change as a result of communication and training efforts, although efforts may have to be extensive and sustained. For example, an evaluation of CMS provider education sessions found that among those providers who participated in the sessions, only 55 percent expressed reluctance to recommend injectables, compared with 69 percent in the control group.

REDUCING INFANT MORTALITY THROUGH ORAL REHYDRATION

Infant mortality is high in Morocco, and a leading cause of death is dehydration caused by diarrhea. To address this problem, Population Services International (PSI) introduced *Biosel,* a brand of oral rehydration salts (ORS), in 1990. This product was

originally developed with raw material donated by the United Nations Children's fund (UNICEF), in partnership with a local manufacturer, Cooper-Maroc. CMS took over the marketing of *Biosel* in 1998, airing new radio spots and creating a mobile video unit to promote *Biosel* and educate the public about diarrhea prevention and treatment. Between 1990 and 2000, the *Biosel* program helped reduce mortality among children under 5 from 112 per 1,000 to 53 per 1,000. This coincided with an increase in the use of ORS for children with diarrhea from 14 percent in 1992 to 19 percent in 2000. General awareness of ORS increased from 74 percent in 1994 to 87 percent in 2000.

Together with its commercial partner, CMS explored strategies to ensure the financial sustainability of the brand. Large public-sector orders and growing consumer demand allowed for the creation of a return-to-project fund for *Biosel*. In August 2002, CMS and PSI signed a *Biosel* licensing agreement with Cooper-Maroc that transferred full management of the product to the company. The agreement guaranteed a yearly production of at least 360,000 packets, compliance with World Health Organization (WHO) quality standards, and a 2.75 percent yearly cap on price increases. Assistance from CMS helped strengthen local production capacity and re-launch *Diarit,* Cooper-Maroc's own brand of commercial ORS.

PROGRAM RESULTS

The manufacturer's model clearly succeeded in Morocco, though not all products fared equally well. Oral rehydration salts and oral contraceptives had considerable success, benefiting from favorable market conditions, which allowed them to become commercially sustainable. IUDs and injectables, on the other hand, faced cultural and economic barriers and proved to be in need of sustained donor funding. Moreover, because advertising of oral contraceptives is still not permitted by the for-profit sector, the program continues to face the challenge of relying on an intermediary to maintain promotional efforts. Whether this is viable without an external donor such as USAID brokering among the various manufacturers remains to be seen.

MAHALLAS: REACHING WOMEN THROUGH COMMUNITY EDUCATION

In July 2001, CMS utilized the tradition of *mahalla* (community) meetings to help address misconceptions regarding contraceptives — especially IUDs and injectables. At the meetings, women met with providers to discuss issues around family planning. Women were able to ask questions and voice their concerns about the methods and receive straightforward answers.

CMS conducted a total of 74 such sessions in three target regions, bringing family planning information to more than 5,360 women.

UGANDA: INTEGRATED PRIVATE-SECTOR PROGRAM

Uganda's contraceptive prevalence rate — 23 percent for all methods and 18 percent for modern methods — is high among African countries. Uganda has been cited as sub-Saharan Africa's success story for its efforts to reduce HIV prevalence. Nonetheless, HIV/AIDS continues to be a major health problem, with an estimated infection rate of 5.1 percent in 2001. Overall health indicators in Uganda are poor. Life expectancy is low, and child, infant, and maternal mortality rates are high. Malaria kills between 70,000 and 100,000 people each year — the majority children under 5.

Even with added revenue from donor funds, the Ugandan government cannot satisfy its population's health needs without help from the private sector, including for-profit and non-profit providers. CMS worked to improve the capacity of private providers to respond to the health needs of Ugandans, as well as to increase access to affordable, quality products and services. To achieve these objectives, CMS used three strategies: social marketing, including behavior change communications; support for private providers; and identification and development of alternative sources of health financing.

SOCIAL MARKETING PROGRAMS

Uganda is CMS's largest and most diverse social marketing program. CMS began implementation of the Uganda program in late 1998 and continued through September 2003, when it was transitioned to the AIDSMark project. Products and activities fit under three broad categories: family planning, malaria prevention, and HIV/AIDS prevention.

FAMILY PLANNING. CMS family planning activities were focused on expanding distribution of the condom *Protector,* the oral contraceptive *Pilplan,* and the injectable contraceptive *Injectaplan.*

In 2000, CMS launched the *My Choice* campaign, promoting the *Protector* condom to sexually active youth, aged 15 to 25, as a means of preventing HIV/AIDS transmission. This campaign relied on intensive use of branded communications. A CMS

A crowd in Morocco watches a video about diarrhea prevention and oral rehydration therapy on a specially equipped van with a large-screen television.

Moroccan women attend an educational session about hygiene and childhood diarrhea.

survey conducted in 2002 found that the *Protector* condom campaign had achieved more than just brand recognition: CMS appeared to have significantly increased acceptance of condoms overall. More than 90 percent of users of other brands had been exposed to a *Protector* communication campaign.

CMS/Uganda's social marketing efforts emphasized accessibility and distribution — an approach that paid off: A distribution survey conducted in 2000 revealed that *Protector* condoms were available in 91 percent of pharmacies, 86 percent of drug shops, 76 percent of clinics, and 44 percent of general merchandise shops. The distribution strategy evolved from a traditional urban-based system to a segmented approach, based on specific program objectives. CMS promoted *Pilplan* and *Injectaplan* together, with marketing efforts focused on increasing consumer awareness, implementing a BCC campaign, improving product accessibility, and improving provider knowledge.

A national, branded radio campaign addressed product benefits, use, side effects, myths, and misconceptions. This campaign was complemented by behavior change efforts to educate couples about the benefits of using modern contraceptive methods. To improve provider knowledge and product accessibility, CMS detailing staff conducted site visits and outreach training. CMS also conducted monthly training sessions for midwives, in cooperation with the Uganda Private Midwives Association (UPMA). As of September 2003, over 1,000 providers were trained in the safe administration of *Injectaplan,* as well as in the proper management of side effects. In an effort to improve the safety of family planning clients and health workers, CMS revised the *Injectaplan* delivery system, replacing the standard syringe (which can be re-used) with a safer auto-disable syringe.

MALARIA PREVENTION. In December 2000, CMS introduced a program to distribute an insecticide-treated bednet called *SmartNet* in six pilot districts to test market the product's viability, as well as a new wash-resistant formulation called *PermaNet.* The pilot was successful, and in March 2001, the Ministry of Health approved a rapid national expansion.

CMS quickly launched a brand awareness campaign and soon began distributing *SmartNet* in over 1,000 outlets throughout the country. Five months later — encouraged by *SmartNet*'s success, as well as government tax incentives — two private companies began marketing nets in Kampala (another two companies entered the market later). CMS shifted its focus to distributing *SmartNet* to low-income groups in Northern Uganda, limited its advertising, and worked to increase malaria risk awareness with IEC and BCC campaigns. The two commercial firms in Kampala continued their aggressive net advertising. The synergy created by these combined promotional efforts increased sales for all three brands.

STI/HIV/AIDS PREVENTION. In December 1999, CMS launched a four-district pilot test of the *Clear Seven* STI treatment kit, a cost-effective all-in-one treatment for urethritis. *Clear Seven* is a pharmaceutical product whose advertising and distribution is limited by the Ugandan National Drug Authority. CMS's initial strategy used a low-key, interpersonal approach, focusing on provider training and BCC, as well as on provider sales and targeted institutional sales (male-only hostels and university dorms, the military, and police). CMS estimated that in its targeted institutional groups there were more than 130,000 highly mobile men who regularly engaged in casual sex with multiple partners.

To ensure quality, CMS's detailing team trained more than 1,500 health workers in the proper dispensing of *Clear Seven* and the syndromic management of urethritis. For the military and police, CMS developed dramatic performances to promote awareness of STIs and emphasize the importance of early treatment. Activities were also held with university and college students.

Based on *Clear Seven* evaluation data, the Ugandan National Drug Authority approved limited expansion in mid-2003. Going forward, *Clear Seven* will be distributed through clinics and pharmacies in eight Ugandan districts, focusing on outlets located near groups at high risk of STIs, such as army barracks and tertiary educational establishments.

In 2002, CMS implemented a pilot HIV/AIDS voluntary counseling and testing (VCT) project in Uganda's Mbarara and Kasese districts. The project linked a generic awareness campaign — targeting young couples and those planning to have a family — with referrals to a network of public-sector testing centers. CMS worked in close collaboration with the Ugandan MOH and the AIDS Information Centre. In addition to providing VCT services at their own

sites, the AIDS Information Centre provided training, support, and quality assurance to MOH centers.

CMS's initial communications strategy focused on advocacy, increasing awareness about VCT, and promoting post-test clubs (PTCs) — support groups for people who have been tested for HIV (some HIV-positive and others HIV-negative). CMS developed a multi-pronged campaign to disseminate campaign messages. Radio spots featured real-life testimonials and highlighted the positive benefits of VCT. Posters, flyers, and numerous billboards used the same testimonials as the radio spots. Outdoor media also included directional signs and smaller metal signs in suburban areas. To reach remote fishing villages, CMS linked community-based HIV/AIDS education organizations to the VCT sites.

In addition, the project developed and implemented the communication campaign for a government-sponsored VCT pilot program in two districts. Initial assessments found that the campaign had high recall and helped increase client uptake in pilot VCT centers by more than 50 percent.

SUPPORTING PRIVATE PROVIDERS

Uganda has approximately 800 private-provider midwives, roughly one-quarter of whom are active members of the UPMA. On a fee-for-service basis, the country's private midwives provide antenatal and postnatal care, immunizations, and well-baby care; oversee deliveries; and provide family planning services and syndromic management of STIs, as well as HIV counseling and health education. In addition, they provide minor curative services. Midwives are motivated to provide quality services in order to sustain their livelihood and local reputation. (Unlike private doctors, who primarily work in urban areas, midwives are located in urban, peri-urban, and rural areas.)

CMS worked closely with UPMA to improve and broaden its donor base and to expand its capacity to generate its own sources of income. CMS extended favorable pricing of its social marketing products to UPMA members, with a commission going to the UPMA. Similarly, CMS helped negotiate an agreement with a pharmaceutical company to offer preferred pricing to UMPA members. More significant, CMS helped to restructure the under-performing UPMA-owned Kansanga Health Centre.

CMS provided training in basic business skills to nearly 350 private providers (in 10 of the 11 UPMA branches). Special attention was paid to strategies for improving quality of care, including client–provider interactions, availability of drugs and supplies, hygiene and sanitation, patient confidentiality, and the affordability and accessibility of services. Follow-up visits demonstrated that providers improved their record-keeping skills and enhanced their ability to promote and expand their services.

CMS also developed a micro-loan program for private health care providers through the Summa Foundation, after an assessment revealed that there was a significant demand for expanded credit and improved private-provider practices, as well as sufficient capacity to repay the loans. Potential loan recipients were identified through professional associations, such as the UPMA, the Uganda Medical Association, and the Uganda National Association of Nurses and Midwives. They were also recruited through direct marketing to private practices, especially those whose providers participated in the business skills training program. Loans ranged from roughly $200 to more than $7,000; average loan size was $920. Loans were extended for 6 to 12 months, at a 3.5 percent monthly interest rate. Providers typically used the funds to buy drugs and equipment and to renovate and expand their clinics. Providers who successfully repaid their first loan could take out additional loans for larger amounts. As of January 2004, a total of 1,267 loans had been made, of which 733 were to repeat borrowers; some providers were on their third or fourth loan. The 97 percent repayment rate is excellent by micro-finance standards.

With steady growth in the size of the loan portfolio and an increase in the number of participating borrowers, the loan program quickly achieved financial sustainability. CMS provided upfront funding for the effort (for capital requirements and staff support), and within two years, the micro-finance institution was able to meet all of its program operating costs and to generate a profit.

HEALTH FINANCING ACTIVITIES

Despite free services in the public health system, over 60 percent of Ugandans seek care from the private sector. However, paying for private health care can place a serious financial burden on lower-income families, who have no financial safety net in times of crisis. Community health insurance, which works by pooling community resources to help families share the risk of health care costs, can improve access to quality health care by reducing financial barriers and diminishing the economic burden of illness. Working in close collaboration with HealthPartners, a Minnesota-based managed care organization, CMS implemented health financing activities to improve access to affordable, quality health services. The Ugandan Health Cooperative (UHC), an initiative of HealthPartners, together with CMS, set up prepaid health care plans to help the rural poor access care. The plans were based on existing community groups, such as dairy and tea cooperatives. The individual plans contracted with private clinics, Mission clinics, and hospitals to provide care to the group. Several groups could contract with the same provider.

One benefit of capitated, prepaid health insurance plans is that they increase incentives for providers to help maintain the health of the insured population and prevent disease. In Uganda, private providers traditionally have concentrated on curative care, with the government taking primary responsibility for prevention. In addition, members of community health plans do not usually seek preventive services — they want protection from the high costs of care when they fall sick. However, a few health plans have recognized the financial benefits of investing in prevention. Many have recognized that malaria is a major source of their costs. The Insurance-Net *(In-Net)* program, which promoted use of CMS's *SmartNet* insecticide-treated mosquito net among members of UHC health plans, was a unique prevention activity integrating social marketing and health financing. CMS developed the *In-Net* program to improve the health of pregnant women and children under 5, two groups with high malaria mortality and morbidity.

CMS and UHC also collaborated to improve maternal health outcomes and increase child survival in the war-torn Gulu district in northern Uganda and to improve the financial sustainability of St. Mary's Hospital in Lacor. The Mothers Uplifting Children's Health (MUCH) project had three components: an improved accounting and inventory management systems at St. Mary's Hospital, an upgraded hospital health information system, and a community-based health insurance plan. The health insurance plan was based at the hospital and covered some of the poorest people in the area (for example, a rock-breakers' cooperative and a group of refugee widows); plan members were offered a heavily subsidized benefit package. CMS supplemented this with a direct subsidy to women, children, and the elderly to lower the cost of the premium for these vulnerable individuals. Premiums were further stratified according to ability to pay and the socioeconomic status of each health plan group.

CMS also provided the hospital with protection against losses if premiums proved insufficient to cover fees for services used by plan members. In addition to improving health status and easing the burden of health care costs for low-income families, the project helped to cover a percentage of hospital expenditures through patient premiums, increasing the hospital's sustainability.

PROGRAM RESULTS

CMS sought to improve a broad range of health outcomes in Uganda — including HIV/AIDS and malaria prevention, birth spacing, treatment of STIs, maternal and child health services — as well as to improve access to curative care through community health insurance plans. By taking a broad and integrated approach and working through the private sector where most Ugandans seek health care, CMS succeeded in having a significant impact on the health of Ugandans:

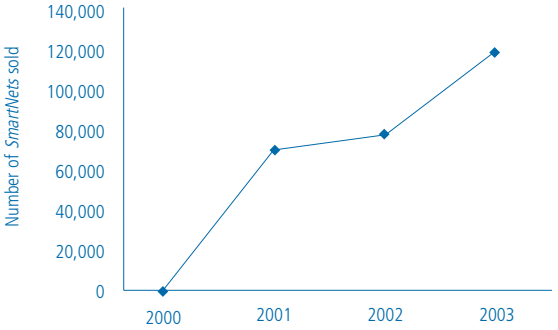
INCREASED USE OF MODERN CONTRACEPTIVES. CMS/Uganda provided more than 829,000 CYPs between 1998 and 2002 — contributing to improvements in contraceptive use and prevalence. Contraceptive prevalence for modern methods increased from 16.5 percent in 2001 to 18.2 percent in 2002, and use of injectables by married women increased from 6.4 percent to 13.1 percent. Research data indicate that CMS/Uganda also succeeded in growing the overall contraceptive market in Uganda. The percentage of women of reproductive age who use CMS contraceptive brands grew from 5 to 9 percent between 2000 and 2002 while the combined market for condoms, pills, and injectables grew from 12 to 19 percent.

CREATION OF SUCCESSFUL PUBLIC-PRIVATE PARTNERSHIP TO PROMOTE MOSQUITO NETS. CMS was instrumental in stimulating demand for branded commercial mosquito nets, thereby building the market for insecticide-treated nets (ITNs) in Uganda. When CMS launched *SmartNet* in December 2000, commercially available nets were virtually non-existent — fewer than 40,000 were sold each year. But by 2002, ITN sales increased to more than 280,000, and almost 78,000 of these were *SmartNets.* In 2003, total net sales grew to 450,000, with *SmartNet* accounting for 30 percent of the market (see Figure 4). Moreover, while previously there were no firms in the commercial market, there were four companies selling ITNs in 2003: Quality Chemicals, A–Z , Syngenta, and Vestergaard Frandsen.

EFFECTIVE ADVERTISING CAMPAIGNS. CMS/Uganda's advertising campaigns stimulated demand for reproductive health and other essential health products. A CMS tracking study found that ITN use increased from 22 to 29 percent of households in the pilot districts in the first year of the *SmartNet* campaign. Similarly, a CMS household survey also showed that women of reproductive age who recall being exposed to CMS advertisements for oral contraceptives or injectables are more likely to use them. The same survey found that men of reproductive age who recall being exposed to a CMS advertisement for condoms are more likely to use condoms (see Figures 5a–c).

INCREASE IN DUES-PAYING UPMA MEMBERSHIP. By adding valuable services, UPMA was able to increase the number of dues-paying members by 35 percent.

Figure 4. Uganda: Sales of* SmartNets, *2000 to 2003



Key services included a newsletter linking individual midwives, a database for comparing practice methods and performance, a member directory, training programs, and income-generating activities.

IMPROVED SERVICE QUALITY. Service quality improved among private providers who received Summa Foundation loans and training. Providers used Summa loans to buy drugs and equipment and to renovate and expand their clinics. Each loan recipient received five days of business-skills training, including business planning and management, financial record keeping, and loan management. The training included modules on the importance of good client–provider interaction and patient confidentiality; it emphasized that improving quality helps to attract more clients. An evaluation of the impact of Summa loans found that clients at intervention clinics were more likely to mention quality-related factors, such as availability of drugs, privacy, fair charges, accessibility, agreeable surroundings, and range of services offered, as their reason for visiting the clinic than clients at these same clinics in the baseline survey or in the control clinics. Loyalty to intervention clinics also increased significantly; clients at intervention clinics were 1.8 times more likely to say that they always visited the same clinic compared to the baseline survey.

EXPANDED MATERNAL AND CHILD HEALTH SERVICES. A rigorous evaluation of the impact of the loan fund on service expansion and quality found that intervention clinics had a significant increase (from 30 to 39 percent) in the proportion of clients who obtained preventive MCH services. Clients at intervention clinics were slightly (1.6 times) more likely to report MCH services as the reason for their visit over baseline, while there was no change in this indicator at control clinics.

INCREASED ACCESS TO CARE FOR LOW-INCOME POPULATIONS. Through its cooperation with HealthPartners/UHC, CMS increased access to affordable health care for 14,000 low-income Ugandans, of whom 9,000 were school children benefiting from health care through school-based programs. Moreover, after obtaining insurance from St. Mary's Hospital in Lacor, 33 percent of insured sought health care for an illness in the previous month, doubling from 15.5 percent in the same group before the insurance plan.

Figure 5a–c. Uganda: Likelihood of using contraception, by whether respondent recalled CMS ad, 2002

Figure 5a. Women of reproductive age who currently use OCs, by exposure to CMS OC ad (percent)

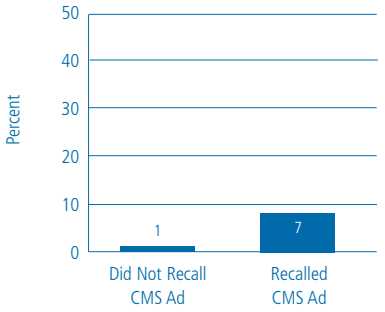


Figure 5b. Women of reproductive age who currently use injectables, by exposure to CMS injectables ad (percent)

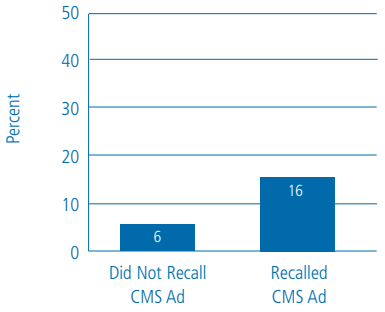
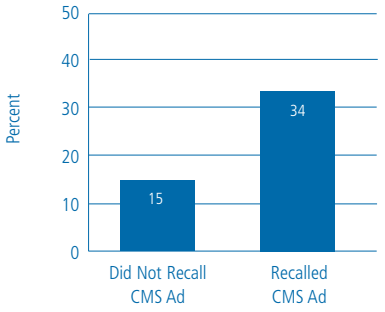


Figure 5c. Men of reproductive age who currently use condoms, by exposure to CMS condom ad (percent)



INCREASED BORROWER SAVINGS. The loan fund contributed to increasing savings — an important safety net for small businesses. Only 33 percent of borrowers reported savings of $168 or more at the time of the first loan application; by the time of the second loan application, that percentage had increased to 58 percent. By January 2004, a total of 1,267 borrowers had received loans — 534 were first-time borrowers; 733 were repeat borrowers. The majority of first-time borrowers used a portion of their loans to purchase drugs (73.9 percent), followed by equipment (34.2 percent), and clinic renovation and expansion (27.4 percent).

FEWER PEOPLE FORCED TO SELL ASSETS OR BORROW MONEY. Before the insurance program began in Lacor, 42.8 percent of the patients who later enrolled and 48 percent of the patients in the comparison group were forced to sell an asset to pay for health care. In addition, 11.5 percent in the intervention area and 8 percent in the control group had to borrow money. In the follow-up survey, only 15.5 percent of the insured who obtained care in the previous month reported selling assets, while 48 percent in the uninsured comparison group had done so. Only 6.1 percent had to borrow money to pay for health care versus 8.9 percent in the control group.

INDIA: INTEGRATED BEHAVIOR CHANGE CAMPAIGN

CMS worked in India from 1998 to 2004 to improve reproductive health and child survival and increase HIV-prevention behaviors. It provided technical and management assistance to the USAID-funded Program for Advancement of Commercial Technology–Child and Reproductive Health (PACT–CRH) for three major efforts: a social marketing campaign to promote commercial low-dose oral contraceptives, a dual-protection condom campaign in cooperation with the private sector, and a campaign to increase use of World Health Organization (WHO)-approved ORS. CMS also provided assistance in private-sector development and social marketing to the State Innovations in Family Planning Services Agency (SIFPSA) and implemented a pilot project to market injectable contraceptives in three cities in Uttar Pradesh.

CONTRACEPTIVE SOCIAL MARKETING

In Uttar Pradesh, a key state in northern India that contains one-sixth of the country's population, the total fertility rate is 4 births per woman. Use of temporary and spacing contraceptive methods — such as OCs, IUDs, and condoms — remains low, at 2 to 3 percent. Injectable use is negligible. To address this, CMS developed three social marketing programs based on close cooperation with the commercial and private sectors, targeting urban and rural areas in northern India. Although awareness of OCs is high in India, use in 1998 was low, at 2.1 percent among married women of reproductive age. Pre-campaign focus groups revealed that two primary barriers limit OC use: (1) fear of short-term side effects such as nausea, weight gain, and dizziness and (2) concerns about long-term side effects such as infertility. Research among doctors and chemists also showed high levels of concern about long-term OC use. Based on these findings, CMS launched a dynamic social marketing campaign in November 1998 designed to increase use of commercially available low-dose OCs. *Goli ke Hamjoli* (Hindi for "Friends of the Pill") targeted urban women, aged 18 to 29, who intend to use family planning. Secondary audiences included doctors, chemists, opinion leaders, civic groups, and the media.

The campaign aimed to promote the entire product category of low-dose pills, rather than focusing on one specific brand, and targeted urban areas of eight states in northern India that are home to almost half of India's population. The pill was positioned as a friend to young women and couples. Advertising and public relations messages reassured potential users that side effects are minimal and temporary, while providing detailed information about safety, correct use, and benefits.

Goli ke Hamjoli used an integrated approach, combining advertising, public relations, and large-scale provider training and detailing, to address barriers to OC use and expand the market. The program was based on partnerships with pharmaceutical manufacturers Wyeth Lederle and Organon, who linked their brands to the campaign by "overbranding" their promotional materials with the *Goli ke Hamjoli* logo. As part of the partnership agreement, these firms intensified the distribution and promotion of their respective brands (OCs are available over the counter in India). The low-dose OC market also included several subsidized social marketing brands, including one promoted by the government of India. Because *Goli ke Hamjoli* promoted the entire category, these lower-priced products benefited from the campaign. Joint promotion of commercial and social marketing products improved the availability of a wide range of affordable OC brands — thus offering something suitable for almost all socioeconomic groups.

Ogilvy & Mather was contracted to develop the advertising, public relations, and other communications components of the campaign. Mass media advertisements addressed fears and raised awareness about the new generation of low-dose pills. Some featured celebrities talking about how side effects are temporary or how the method is reversible, while others discussed benefits, spacing, joint decision making, or what to do if one forgets to take a pill. Advertisements were broadcast over major Indian television channels and augmented with billboards and posters. The mass media campaign was highly successful: In 2002, 80 percent of women in the target audience were able to recall key messages.

To complement the mass media campaign, public relations and training activities reached consumers, opinion leaders, and providers. For example, CMS trained beauticians to work as peer educators, since beauty shops are popular spots for young women to exchange information. Using this same interpersonal approach, the *Hamjoli Batcheet* (Happy User) program linked interested non-users to women who use the pill so that they could discuss experiences and concerns. Briefings for civic groups, such as the Rotary Club, and provider groups, such as the Indian Medical Association, plus training and conferences for physicians helped dispel deeply rooted myths about hormonal contraceptives.

CMS created and managed a medical detailing staff of more than 100 promoters who visited doctors and chemists with information about OCs and educated providers about the advantages and differences between the newer generation of low-dose pills and the older, high-dose formulations. CMS's detailing activities dovetailed with manufacturers' increased marketing efforts, which improved their own brand equity. As of September 2003, CMS had trained 34,012 chemists, 28,360 traditional doctors (who practice non-allopathic forms of medicine), and 6,707 beauticians. Fifty-five thousand providers were revisited on a bi-monthly basis with materials and

detailing messages, and mailers and technical updates were regularly sent to 27,000 doctors. By the end of 2003, the program had detailing teams in 34 cities, and more than 480 physicians were offering free counseling to women interested in OCs.

To complement efforts to address substantial biases against hormonal contraceptives among providers in India, CMS worked with the Federation of Obstetricians and Gynecologists of India (FOGSI) to develop official statements that endorse low-dose oral contraceptives and injectables within the WHO guidelines. As a result, in January 2004, the annual meeting of FOGSI released a consensus statement that low-dose oral contraceptives and the injectable *DPMA* are safe and effective methods of contraception. The statement advised FOGSI members to use these methods within the WHO guidelines. India's example shows that improving the environment goes beyond making a product legal. The attitudinal barriers of providers and clients also shape the decision of whether to offer or accept different methods and thus constrain method choice and a client's ability to use the method best suited to her needs.

PRIVATE-SECTOR APPROACHES

CMS provided technical assistance with private-sector and social marketing initiatives to SIFPSA, the parastatal agency that implements the Innovations in Family Planning Services (IFPS) project, a joint effort of the Indian government and USAID. IFPS works in Uttar Pradesh to implement social marketing programs for pills, condoms, and other maternal and child health products such as ORS, iron folate tablets, and disposable delivery kits. Program activities are implemented by local organizations under performance-based contracts that CMS helped to develop, award, monitor, and evaluate.

In 2000, CMS helped SIFPSA award a contract to Hindustan Latex Limited for the social marketing of condoms and pills throughout Uttar Pradesh. To guide the program, CMS conducted a survey of rural retail outlets and a willingness-to-pay study for condoms and pills among rural consumers. Before the contract was awarded, CMS helped establish contract performance targets and evaluate proposals. This approach, in contrast to relying on internal sales reports, helped focus marketing efforts on priority products, regions, and populations. Based on the impact of the Hindustan Latex rural marketing contract, SIFPSA issued three more contracts. The first was a statewide contract to market the government's social marketing brand of condoms and OCs — both products soon showed sales increases. (In fact, Uttar Pradesh is the only state in India with growing rural condom sales.) The other two contracts were regional and promoted a basket of reproductive health and child health products, including OCs, condoms, ORS, clean-delivery kits, and iron folate tablets.

EXPANDING SOCIAL MARKETING TO ORS

Based on *Goli ke Hamjoli's* success in expanding the oral contraceptive market, CMS was asked to develop a campaign to improve awareness and the correct use of World Health Organization-approved oral rehydration salts (WHO–ORS) in northern India. Diarrhea kills almost 600,000 children under age 5 every year in India. Most of these deaths can be prevented with the correct use of ORS.

CMS designed an integrated communications campaign that addressed the two main barriers to effective ORS use: (1) a lack of awareness, by parents and physicians, that dehydration from diarrhea can be fatal and (2) incorrect use. Launched in April 2002 in partnership with six Indian ORS manufacturers, the campaign combined mass media advertising, public relations and community outreach activities, and provider training and detailing similar to the *Goli ke Hamjoli* campaign. Partner manufacturers used their field teams to promote WHO–ORS to pediatricians, general practitioners, and chemists. In 2003, these teams covered 9,000 providers each, demonstrating correct preparation and distributing generic and branded campaign point-of-sale materials, leaflets, and samples. The manufacturers also produced and distributed generic and brand materials at their own expense. Five out of the six incorporated the campaign logo on their product packs, making it easier for consumers to identify and purchase a WHO-recommended brand.

Media placements and public relations activities coincided with the diarrhea season (April to September). Messages emphasized the importance of administering ORS as soon as diarrhea begins and again after every stool; correct mixing, frequency, and duration of ORS therapy; the need to stock ORS at home; and the value of WHO–ORS versus other

brands and home-made remedies. India's most popular soap opera, *Kyunki Saas Bhi Kabhi Bahu Thi,* integrated WHO–ORS messages into one of its episodes, which was viewed by millions in the target audience. The day after the episode aired, a survey of 291 women revealed that 71 percent correctly recalled the campaign messages.

Other campaign partners included McCann Healthcare, the health care communication division of McCann Erickson, which developed and managed the advertising and public relations components (with technical direction from CMS), and the Indian Academy of Pediatrics, which provided medical guidance, endorsed advertisements, encouraged doctors to prescribe WHO–ORS brands, and participated in outreach activities. CMS convinced the Delhi Transport Corporation, a public company, to advertise on about 2,000 of its buses. By negotiating similar agreements with local businesses throughout northern India, CMS engaged and leveraged the private sector.

At the end of 2003, more than 400 articles repeating intended messages had run in leading Indian newspapers and magazines, and broadcast media had covered events and interviewed key spokespeople. CMS/India field teams delivered campaign messages to over 55,000 providers every two months. The ORS campaign featured a strong community outreach program, including house visits by health promoters to mothers with children under age 3. By the end of 2003, promoters had visited 77,000 households in key cities and handed out over 150,000 samples. Another program, Gift A Life, encouraged traditional doctors to prescribe WHO–ORS brands by providing them with prescription pads.

PROGRAM RESULTS

INCREASED USE OF ORAL CONTRACEPTIVES. *Goli ke Hamjoli* tracking surveys show that use of oral contraceptives increased from 4 to 11 percent of the target audience (young urban women) between 1999 and 2003. Sales of all commercially available brands increased by 42 percent, and 15 percent more chemists stocked OCs. Surveys also showed positive changes in attitude and knowledge among both providers and consumers.

INCREASED CONDOM USE. Between 1999 and 2003, the rural condom market increased by 108 percent — going from 52 million to 110 million condoms sold annually. The number of villages in which condoms were available more than doubled — from 12,000 to 26,000 villages. The percentage of villages in which both condoms and OCs were available increased from 18.5 percent to 48 percent.

INCREASED AWARENESS, USE, SALES, AND AVAILABILITY OF ORS. In the first year of the campaign (2002), mothers reporting use of ORS increased from 26 to 36 percent, and by the end of 2003, half of all mothers surveyed reported using ORS. During the first year of the campaign, sales of WHO brands rose by 45 percent, and the total market increased by 17 percent. After the 2003 campaign, sales of WHO brands increased by another 20 percent, and the total market increased by 9 percent. Share of the WHO–ORS market segment grew to 26 percent at the end of 2003, up from 19 percent before the campaign. Over the same time frame, WHO-recommended brands, only available at 23 percent of pharmacies before the campaign, were found at 62 percent of target-area pharmacies.

PUBLIC RELATIONS EFFORTS EFFECTIVE. More than 420 articles on *Goli ke Hamjoli* and OCs were published in national and northern Indian newspapers and magazines during the course of the 1999–2003 program. *Goli ke Hamjoli* was named the Healthcare Campaign of the Year at the 1999 Asian Public Relations Awards and won India's Abby Award from the Bombay Ad Club for the Best Social Concern Campaign. In September 2004, the campaign was nominated as one of the finalists for the Asian Brand Marketing Effectiveness Awards.

NEPAL: PROVIDER NETWORKS

Nepal is one of the poorest nations in the world, and many of its health and social indicators are among the lowest in South Asia. The majority of the population lives in rural areas without access to basic infrastructure or services. Nepal's infant and maternal mortality rates are among the highest in the world. Its annual population growth rate is 2.1 percent, and women have an average of 4.1 children. The total contraceptive prevalence rate is 39 percent, and the modern contraceptive prevalence rate is 35 percent. Sterilization is the most popular form of contraception, followed by

injectables. The unmet need for family planning in Nepal is estimated at 31 percent: 14 percent for spacing methods and 17 percent for limiting births. There is, therefore, considerable potential for modern temporary methods.

CMS initially took over responsibility for working with the already-established Parivar Swasthya Sewa Network (PSSN) from the SOMARC project. PSSN was a physician network in Kathmandu created to expand and improve the quality of private-sector family planning services. CMS used local advertising agencies to implement an integrated marketing campaign.

After several years of working with PSSN, however, CMS realized that its exclusive reliance on urban-based doctors (who tend to focus on the provision of gynecological services) was limiting the growth of the network as well as its ability to serve lower-income clients. Therefore, CMS proposed developing and testing an alternate model that would build on the PSSN experience, but utilize nurses and paramedics, formally trained clinician groups who serve mostly poor, rural clients.

In May 2001, CMS launched the *Sewa* pilot network in Nepal's Rupandehi district, an area with a lower socioeconomic profile and fewer doctors than Kathmandu. *Sewa* means service in Nepali. The main objective of the pilot was to test whether a nurse and paramedic network could increase the use of family planning and reproductive health services. Intermediate goals included improving service quality at *Sewa* clinics and increasing awareness of *Sewa* at the district level. Rupandehi district has a population of 708,419, a literacy rate of 42 percent, and annual per capita income of $125.

CMS designed the *Sewa* network using a fractional franchise model, where a package of services is added to an existing practice (or business) and offered in accordance with a specific set of guidelines established by the franchiser and outlined in a contract. The franchise network model offered several advantages. First, even though working with individual providers can mean significant variability in the quality of services, the franchise model facilitated ongoing quality monitoring, thus improving and standardizing quality. Second, providing training and promotion for a network, rather than individual providers, offered significant economies of scale. Third, branding the network with a logo created a symbol of high-quality services that in turn attracted new clients to network clinics. Finally, nurses and paramedics were interested in being affiliated with a larger provider community and linked with fellow providers.

KEY PROJECT COMPONENTS

The *Sewa* network included the following key elements:

- *Provider recruitment. Sewa* recruited 64 of the 150 nurses and paramedics with private clinics in the Rupandehi district to join the network. Selection criteria included the presence of a physical facility and a reasonable client volume, level of interest in joining the network, clinic location, existing service mix, and willingness to comply with the clinic monitoring protocols.

- *Membership contract.* The membership contract specifies the roles and responsibilities of the franchiser, Nepal Fertility Care Center (NFCC), and the franchisees, the individual nurse and paramedic providers. The franchiser is responsible for providing training, quality monitoring, and marketing support and for establishing a referral system. In return, the franchisee agrees to pay membership fees, offer family planning and reproductive health services, follow quality protocols, adhere to an agreed upon fee schedule, and maintain service statistics.

- *Training.* Network members received a seven-day, reproductive health training and a two-day session on services marketing. A subset of female nurses and midwives also received 21-day IUD training. The reproductive health training, which included an overview of the service quality protocols outlined in the franchise contract, covered topics such as infection prevention, use of essential supplies, family planning, reproductive health (e.g., antenatal and postnatal care, gynecological problems), and STIs/HIV/AIDS. The services marketing session used role-playing, lectures, and group exercises to emphasize the importance of service quality and *interactive* marketing (the use of interpersonal techniques to build relationships and ensure a positive client–provider interaction) in retaining existing clients and attracting

new clients. The session also outlined the network's external marketing activities (mass media; outreach; and information, education, and communication, or IEC) and encouraged provider participation.

- *Marketing and promotion.* CMS supported network members with a broad range of marketing activities. The *Sewa* name and logo figured prominently on the clinic signboards and white coats given to each provider. Activities aimed at creating awareness for the network services ranged from mass media (radio and print advertisements, billboards, brochures, leaflets) to interpersonal (a door-to-door campaign, clinic open houses, and promotional booths in local farmers' markets). In addition, CMS developed a monthly newsletter that reinforced the value of *Sewa* membership and kept providers informed of network activities.

- *Referrals.* CMS established internal and external referral systems to ensure that the clients had access to an integrated package of services. The internal system allowed network nurses and paramedics to refer a client to a trained female provider for IUD services. For more complicated health problems, the external system provided a link to private physicians and government health facilities.

- *Quality monitoring.* Each month, the franchiser sent a field coordinator to all network clinics to monitor quality of care and ensure that service protocols were followed. The field coordinator checked clinic service statistics, observed service delivery, and administered a detailed checklist to assess technical quality. Checklist categories included infection prevention, availability of essential supplies and equipment, and client–provider interaction. The field coordinator also reinforced services marketing techniques, stressing the importance of good client–provider interaction. To fully assess provider compliance with service protocols, the coordinator also spoke with clients. Upon completing the monitoring visit, the coordinator shared the monitoring results with the service provider and, if necessary, suggested ways to improve weak areas.

The *Sewa* franchise, now managed by Population Services International, was consolidated into a new, expanded network, Sun Quality Health, which operates in rural and peri-urban areas, including the Kathmandu, Bhaktapur, and Lalitpur districts in the Kathmandu Valley. Although the Sun Quality Health network includes doctors, it is a paramedic-focused franchise, drawing heavily on the *Sewa* fractional franchise model. This new network offers a full range of family planning products and services, including long-term and permanent methods, as well as maternal and child health care, STI diagnosis and treatment, and HIV/AIDS prevention.

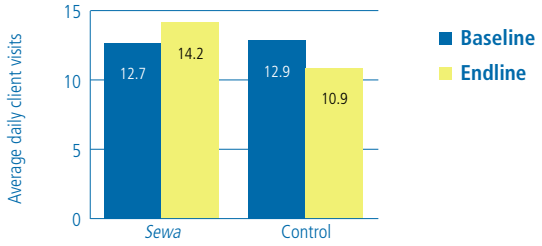
PROGRAM RESULTS

The program was evaluated by using program monitoring data, including evaluation visits by a quality coordinator, mystery client surveys, and clinic service statistics. In addition, an impact evaluation was conducted using a quasi-experimental design. Three instruments used were (1) client exit interviews, (2) provider interviews, and (3) household interviews. The interviews were conducted at two points in time. Baseline surveys were conducted during April and May 2001, and follow-up surveys were conducted during December 2002 and January 2003. Among the findings:

INCREASED REPRODUCTIVE HEALTH SERVICE UTILIZATION AT *SEWA* CLINICS. Service statistics showed an increase in average monthly family planning and reproductive health visits at *Sewa* providers from 28 to 50 clients per month. There was also an increase in total number of clients at *Sewa* clinics (average daily client visits increased from 12.7 to 14.2). An opposite trend was observed in the control group clinics (see Figure 6).

IMPROVED QUALITY AT *SEWA* CLINICS. In addition to the initial training, the franchiser sent a field coordinator to all network clinics each month to monitor quality of care and ensure that service protocols were followed. Upon completing the monitoring visit, the coordinator shared the monitoring results with the service provider and, if necessary, suggested ways to improve weak areas. As a result of this approach, observed technical quality improved on 23 out of 24 indicators. All network clinics improved their average scores for infection prevention, availability of essential supplies, record keeping, and the provision of family planning services. Client satisfaction with *Sewa* clinic services also improved from 58 to 75 percent, while at control group clinics, client satisfaction remained unchanged. Moreover, clients saw *Sewa* providers as "caring" and "reliable," characteristics that CMS

Figure 6. Nepal: Average daily client flow



baseline research had identified as important determinants of provider choice and that had subsequently been incorporated into the training and advertising. The proportion of clients citing "caring provider" as a reason for choosing the clinic increased from 34 to 41 percent at *Sewa* clinics. Similarly, the proportion of clients citing "reliable provider" as a reason for choosing the clinic increased from 35 to 52 percent. An opposite trend was observed in the control group clinics. Similarly, repeat visits were most frequent among satisfied clients and clients reporting caring and reliable providers.

LOW AWARENESS OF *SEWA* BRAND. CMS's marketing efforts did not build sufficient recognition for the *Sewa* brand. Evaluation data show that awareness of the *Sewa* network was very low: 24 percent of respondents at *Sewa* clinics and only 15 percent of married women of reproductive age in the pilot district had ever heard of the franchise. Although baseline research findings were used to develop mass media messages, the limited marketing budget did not allow for extensive formative research or for monitoring the effectiveness of media activities. Radio messages included quality cues (such as friendly, caring providers of reproductive health services), but perhaps fell short of reinforcing the overall *Sewa* brand. Short-term technical assistance to improve the design and implementation of the mass media campaign may have helped, but CMS did not have sufficient funds to send qualified marketing experts. Political unrest and the associated implementation delays may have hampered CMS's efforts: Network promotion (including mass media and outreach) began only two weeks prior to the second-round survey.

NICARAGUA: INTEGRATED CLINIC NETWORK

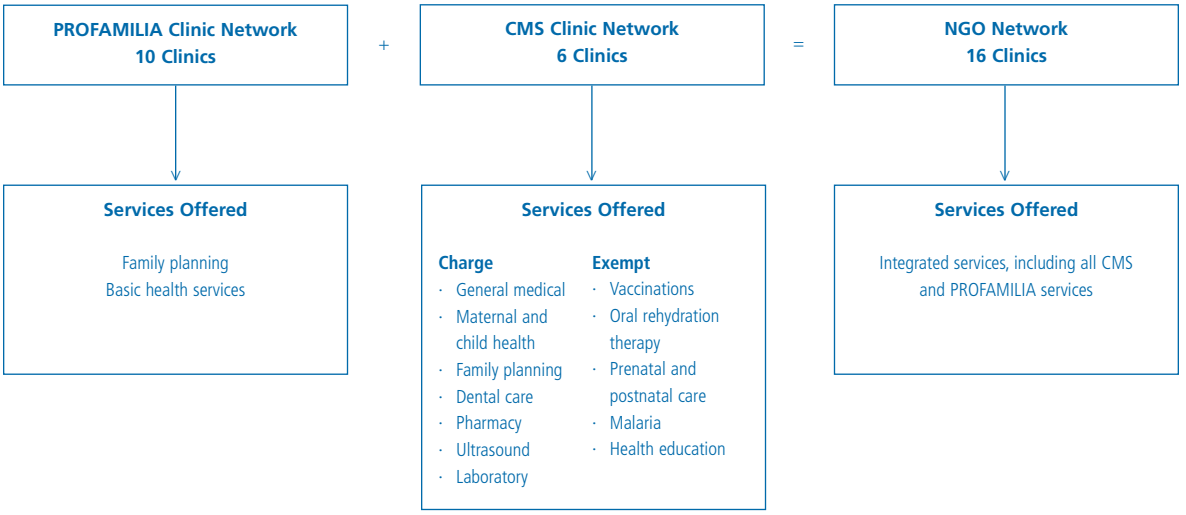
CMS worked in Nicaragua to build the private sector's capacity to offer high-quality and affordable health services. In pursuit of this goal, CMS established a network of clinics in areas affected by Hurricane Mitch, which hit Central America in October 1998, causing massive flooding and mudslides that left 10,000 dead and hundreds of thousands homeless. In Nicaragua alone, the storm caused an estimated $1.5 billion in damage to crops, homes, and infrastructure, including the public health system. CMS proposed a private provider network as a sustainable solution for meeting the health needs of those affected by the hurricane.

One of the goals of the clinic network project was to strengthen private-sector delivery of essential health services. The project replicated a self-sustaining model developed by PROSALUD, a Bolivian NGO with a private clinic network that provides affordable primary care services to a large population while maintaining high levels of sustainability and patient satisfaction. CMS selected Profamilia, a local NGO, as a project partner. As one of the largest non-profit providers in Nicaragua, Profamilia had a reputation for high-quality services.

To the 10 existing Profamilia clinics, CMS added 6 new clinics in areas affected by Hurricane Mitch, in the towns of Tipitapa, Sebaco, Esteli, Jalapa, Somoto, and Rio Blanco. The 6 clinics provided free preventive care, including immunizations, for both adults and children; curative and reproductive health care were provided at locally affordable fees. The clinics in the more-populous municipalities of Tipitapa, Esteli, and Sebaco offered expanded services, including specialized pediatric and OB/GYN care, X-rays, and basic surgical procedures. These expanded clinics acted as referral centers for the basic clinics. Together, the 16 clinics constituted a combined NGO network offering the basic package of health services introduced by CMS in addition to the family planning services historically offered in the Profamilia clinics (see Figure 7).

The development of the private clinic network involved five elements: clinic construction, management, quality of care, marketing, and sustainability.

Figure 7. Nicaragua: Clinic Network Structure



CLINIC CONSTRUCTION

To identify appropriate sites for the six new clinics, CMS assessed 14 geographic areas for competition, consumer demand, and residents' ability to pay for services. Within the selected locations, consumers expressed a need for high-quality, low-cost health care, which they said they were not receiving from the overstrained public sector or the expensive private sector. In addition, people indicated they did not feel that their current health care providers treated them with respect. The overwhelming majority of potential clients said they were looking for "one-stop shopping" in health care.

In the selected sites, the local municipalities agreed to donate the necessary land. However, in certain cases the municipalities failed to follow through, and in others, the plots offered were inappropriate for a clinic; for example, they were in areas lacking electricity or running water. Ultimately, CMS had to buy the land for each of the sites, a process complicated by the fact that some of the titles were encumbered with unanticipated conditions or liens.

MANAGEMENT

A month prior to each clinic's opening, CMS began recruiting and training staff. Candidates were invited to a workshop in which CMS personnel could assess their communication, team building, conflict resolution, and leadership skills. CMS then trained the new managers in general administrative skills, supervision, quality of care, and how to care for HIV/AIDS patients. CMS codified these skills in management manuals and installed an information system that tracks service utilization and costs.

QUALITY OF CARE

High standards and superior quality were of central importance to the clinic network project. CMS's objective was to provide effective and efficient integrated health service based on rigorous norms and procedures. At the inception of the project, CMS developed a manual that highlighted components of quality of care: staff recruitment and selection, training, service delivery, customer service, policies and procedures, and monitoring tools and systems. CMS's operating plans for each of the clinics included quality of care indicators, which were monitored by supervisors who paid the clinics monthly visits, gathered data, and made recommendations as necessary.

CMS trained administrative and medical staff in service delivery, patient care, supervision, human relations, and sales. A "Quality Team" was created in each clinic, and each staff member was made responsible for monitoring a particular aspect of the quality control plan and reporting results on a monthly basis. To assess patient satisfaction, CMS conducted

exit interviews and informal household surveys. In addition, each clinic was outfitted with a suggestion box. Because clinic norms were developed in accordance with Ministry of Health guidelines, by the time CMS ended its involvement, all six of the clinics had been accredited.

MARKETING

CMS helped build awareness of the new clinics through several interlinked marketing strategies, including a media campaign, interpersonal communications, clinic-based marketing, and promotions. CMS positioned the clinics as a one-stop shop for low-cost, quality health care services for the whole family. Associating the Profamilia name and logo with the clinics was a significant element of the marketing strategy.

CMS research indicated that radio campaigns, flyers, loudspeakers, and street announcements were the most effective means of increasing popular awareness of the new clinics. Radio advertisements aired one week prior to each clinic opening. The openings themselves were key promotional activities, designed to be festive events that included national and local health authorities. To promote the events, banners were hung over the towns' main streets, announcements were made from a loudspeaker car, and flyers were distributed door-to-door.

Each clinic had at least one *promotora,* or health promoter, who travels door-to-door to inform the community of clinic locations, hours, and services. The *promotoras* also provided basic preventive health education and ensured that patients comply with treatment regimens.

SUSTAINABILITY

CMS emphasized the clinics' sustainability from the start. Strategies included

- market assessments to set prices and identify needed services,
- business plans with monthly targets for each clinic,
- cost recovery as an integral part of clinic culture,
- use of mass media to raise awareness of the clinics,
- high-quality services to maintain client loyalty,
- health care packages to attract new clients, and
- curative and ancillary services to cross-subsidize preventive services.

CMS set prices at a level that balanced cost recovery and affordability. In order to make Profamilia's services attractive and ensure adequate client flow, the fees were set lower than at other private providers — yet higher than at public facilities — to ensure cost recovery. In addition, physicians were paid on a per-patient basis, rather than at a fixed salary. This innovative, business-oriented payment system helped to cut costs and encourage an entrepreneurial approach. It is a variant of a payment system developed by PROSALUD in which doctors are paid a percentage of each patient's fee. Similarly, CMS developed a service mix that took into account the broad spectrum of health needs. The original Profamilia clinics, because of their focus on reproductive health, primarily served and attracted women. CMS developed services that would also draw men and children to the new clinics, thereby increasing the type and number of clients who would use them.

PROGRAM RESULTS

To monitor and evaluate the new clinic network, CMS used service statistics, financial records, and other data, as well as an impact evaluation. Surveys conducted in mid-2001 (baseline) and spring 2003 (endline) were matched against an equal number of households in four control municipalities. Among the findings:

NEARLY 250,000 PEOPLE IN HURRICANE MITCH-AFFECTED AREAS WERE PROVIDED WITH ACCESS TO HIGH-QUALITY, AFFORDABLE HEALTH CARE. As of early 2003, 25 percent of women in the clinic treatment areas reported that they or a family member had used one of the CMS/Profamilia clinics in the previous 6 months, which is especially noteworthy in light of the fact that the clinics had at that point only been operational for 14 to 24 months. Clients were most likely to report coming to the clinics for curative care (66 percent). They also reported receiving reproductive health services (32 percent) and lab tests (24 percent). Ten percent of clients were men.

HIGH SERVICE UTILIZATION. During the first three months of 2002, the enhanced clinics received about 4,500 client visits, and the basic clinics about 2,500. By 2003, that number had increased by 34 percent for the enhanced clinics (to 6,000) and by 24 percent for the basic clinics (to 4,200).

CMS/PROFAMILIA CLINICS USED BY CLIENTS WHO PREVIOUSLY USED THE PUBLIC SECTOR. CMS surveys showed that 51 percent of network clients had previously received health services from the public sector. Of those clients, 87 percent reported that the quality of services in the Profamilia clinics was superior to that of the public sector.

HIGH SATISFACTION LEVELS. Three-quarters of clients reported that the quality of care they received was good or excellent, and more than 90 percent said they plan to return to a Profamilia clinic in the future. Nearly three-quarters of clients reported that the fees were reasonable or inexpensive. Almost 90 percent said the care they received was well worth the money they spent. Incomes of clients fell between those of other private-sector clients and those of public-sector clients, suggesting that the Profamilia clinics filled a niche between the public and private sectors — one of the goals of the network initiative.

INCREASED SUSTAINABILITY FOR PROFAMILIA. By adding primary health services to their clinics and by improving their marketing and quality of care, reducing the number of staff, and adding a cost-sharing agreement with doctors, the Profamilia clinic network increased its cost recovery rate from 68 percent in 2001 to 84 percent by the end of 2003, indicating an improvement in financial sustainability from the adoption of the CMS model.

GHANA: NGO AND CORPORATE PROGRAMS

In Ghana, CMS worked to improve family health by helping ensure long-term access to reproductive health products and services and developing corporate HIV/AIDS programs. In particular, CMS/Ghana focused on improving the long-term sustainability of GSMF International (previously known as the Ghana Social Marketing Foundation), one of Ghana's largest contraceptive providers, and improving and developing workplace HIV/AIDS awareness and prevention programs and an anti-retroviral (ARV) therapy initiative.

NGO SUSTAINABILITY

GSMF International is Ghana's leading social marketing NGO, providing approximately 43 percent of the country's contraceptives. Founded with help from USAID in 1993, GSMF had 60 employees and a nationwide product-distribution and sales network by 2003. GSMF promotes and distributes 11 socially marketed products, including oral and injectable contraceptives as well as male and female condoms; it targets mainly low- and middle-income populations. Since 1999, GSMF has steadily increased the share of contraceptives it provides in Ghana.

In 2000, CMS began providing technical assistance to GSMF to strengthen its financial sustainability. CMS helped GSMF improve its planning and organizational structures, increase revenues, and diversify sources of funding. With assistance from CMS, GSMF developed a detailed, short-term sustainability plan for the period 2002 to 2004. The plan estimated upcoming costs and potential revenues and set out expectations for reduced dependence on USAID funding. CMS also helped GSMF improve organizational systems — for example, by introducing timesheet use and modifying the cost accounting system.

In May 2000, CMS arranged feasibility studies for five potentially profitable products that GSMF could market through the commercial sector. The studies indicated that GSMF could generate revenue by offering a line of innovative, trendy condoms targeted to upper-income consumers. GSMF proceeded quickly with the condom initiative, moving from the CMS-supported evaluation of the initiative's feasibility study in the spring of 2000 to the launch of a luxury condom brand in the fall of 2001. The *Aganzi* condom line surpassed expectations. In 2002, *Aganzi* sales generated almost $100,000 and represented 13.6 percent of total annual GSMF product sales. In 2003, *Aganzi* not only generated a profit for GSMF, but also cross-subsidized the organization's socially marketed products and increased the overall cost-efficiency of programs.

To help GSMF recover the costs of its socially marketed contraceptives, CMS conducted a study to determine whether people would pay more for these products. The study found that prices could be raised on subsidized family planning products without losing sales. For almost all products, more than 75 percent of clients said they were willing to pay at least 50 percent more than they currently paid. Fewer than 10 percent of current family planning clients said they would stop using contraception if prices were raised too high for them to afford — instead, they would switch methods, switch sources for their method, or use a new brand. Based on the study's findings, GSMF successfully increased the price of its *Champion* condom brand.

HIV/AIDS PREVENTION AND TREATMENT

The HIV infection rate in Ghana is low, estimated at 3 percent at the end of 2001. The Ghanaian government is attempting to contain the epidemic through behavior change communications that target high-risk groups. This approach, however, is limited by a lack of resources and capacity. Recognizing the role that the commercial sector can play in containing and reducing HIV/AIDS, CMS collaborated with private clinics, employers, and NGOs to implement HIV/AIDS prevention and treatment programs through the workplace.

CMS's first HIV/AIDS workplace intervention in Ghana was with Unilever, a major multinational company. Unilever had an HIV/AIDS education program for its employees, but it did not include many recognized best practices. CMS contracted with GSMF to implement an improved workplace program at Unilever. The *Life Check* program, implemented by GSMF with CMS funding, sought to increase knowledge about HIV/AIDS and to reduce transmission among employees and in their communities. GSMF conducted advocacy for the program with Unilever management, held four major sensitization sessions for workers and their communities, trained 94 peer educators, produced and distributed promotional and informational materials, and distributed 8,000 condoms. The program was conducted at Unilever's headquarters in Tema and at two palm plantation sites; it reached 2,100 Unilever employees and approximately 100,000 people in the surrounding communities. The Unilever program showcased an HIV/AIDS awareness and prevention program to the Ghanaian business community and was a catalyst in getting companies interested in responding to HIV/AIDS.

After that initial success, CMS worked with industry associations to cost-effectively scale-up HIV/AIDS workplace programs in high-risk sectors, such as mines, timber, hotels and tourism, manufacturing, and ports and harbors. Anecdotal evidence of the relatively high HIV-prevalence rate among miners and the fact that Ashanti Goldfields Company (the largest mining company in Ghana) already had initiated a well-publicized AIDS awareness program for its employees made the mining sector an obvious candidate for developing CMS's first sector-wide workplace program. A CMS assessment of the Chamber of Mine's membership revealed that although many mining companies had some form of HIV/AIDS prevention program, most fell short of best practices, which should include

- development of an HIV/AIDS workplace policy,
- advocacy and education at all levels in the company,
- peer education,
- condom promotion and distribution,
- voluntary counseling and testing,
- treatment of sexually transmitted infections,
- community outreach, and
- monitoring and evaluation.

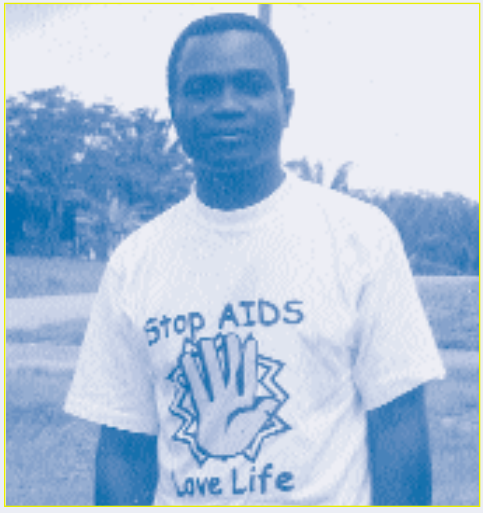
CMS developed HIV/AIDS policy guidelines for the Chamber and assisted member companies in adapting the guidelines for their own purposes. CMS also linked the Chamber of Mines with GSMF International, to help each of the member companies develop and implement a program tailored to its needs and resources. The expectation is that individual mining companies will pay GSMF to implement best practice programs for their employees. The program targeted the Chamber's 18,000 at-risk miners and 200,000 community members.

In addition, CMS undertook efforts to

- *Create commercial-sector demand.* Because HIV/AIDS prevalence rates are low, CMS/Ghana had to convince companies that workplace HIV/AIDS programs are worth undertaking. To demonstrate the potential financial benefit of prevention programs in a tangible manner, CMS developed an advocacy tool — a simple model that estimates the costs versus the benefits of investing in HIV/AIDS prevention and treatment programs. CMS and the firm that developed the model taught local HIV/AIDS organizations how to use it to advocate for workplace HIV/AIDS programs.

- *Build the capacity of private providers to offer HIV/AIDS workplace services.* CMS provided financial support and training in family planning and HIV-related services to C&J Medicare, a commercial health service provider for the 11,000 employees and dependents of 54 Ghanaian and multinational companies. To receive a $200,000 loan from the Summa Foundation for a new hospital with expanded inpatient and outpatient capacity, C&J Medicare was required by Summa to promote family planning and voluntary counseling and testing for HIV and other STIs. The loan was used to open a new hospital with expanded inpatient and outpatient capacity and two consultation rooms dedicated to family planning and VCT. To support C&J Medicare in meeting the loan criteria, CMS trained C&J Medicare staff in family planning and HIV-related services and procedures.

- *Provide HIV/AIDS treatment through the private sector.* In collaboration with PharmAccess International (PAI), a Netherlands-based NGO, CMS developed three private treatment sites that offer VCT, ARV therapy, and treatment of associated infections. The initiative used ARV drugs available in Ghana at a moderate price. Because the clinics already offered a broad range of medical services, individuals seeking treatment there could be identified as AIDS patients. CMS trained staff members to administer VTC, and PAI provided training in ARV treatment. PAI also provided technical assistance to a laboratory (MedLab) in procuring equipment and in the procedures for monitoring viral loads and performing CD4 T-cell counts to support the treatment sites.



Peer education is a key element of best practice HIV/AIDS workplace programs. Emmanuel is the head peer educator at Unilever's Twifo palm plantation.

TARGETING INDUSTRY SECTORS FOR HIV/AIDS PREVENTION: HOTELS AND TOURISM, PORTS AND HARBORS

In collaboration with the Ministry of Tourism and the Ghana AIDS Commission, CMS conducted five workshops in areas with high concentrations of hotels to create awareness about HIV/AIDS and its impact on the hotel and tourism sector, obtain commitments from hotels to implement HIV/AIDS programs, and determine roles and levels of intervention for hotels. More than 300 hotel owners and managers participated in the workshops, and most agreed to explore workplace programs further.

To follow up the successful workshops, CMS conducted a qualitative study to understand the role of hotels in the transmission of HIV/AIDS. CMS organized a national-level meeting to disseminate the results; link hotels with resources for condom procurement, educational materials, and training; and determine the next steps to implementing HIV/AIDS awareness and prevention programs. The program targeted about 200 hotels and should reach 6,000 workers.

GSMF International is implementing an HIV/AIDS workplace program for the ports and harbors sector. CMS assisted the program by identifying high-risk groups in this sector and determining knowledge, attitudes, and practices related to HIV/AIDS. The findings were presented to key stakeholders, such as the Ghana Ports and Harbors Authority, and will guide the design of GSMF's ports and harbors program.

Workers in ports and harbors are at moderate to high risk of HIV/AIDS. GSMF is conducting a program that aims to prevent the spread of the infection.

CMS also helped Ghanaian health insurance firms develop an ARV rider (an optional supplement to their standard benefits package that would cover AIDS treatment). At the end of the CMS project in March 2004, PAI continued supporting existing sites and expanded the program with a two-year grant from the Royal Netherlands Embassy in Ghana.

PROGRAM RESULTS

PROGRESS TOWARD GSMF SUSTAINABILITY. Even with an expanded budget resulting from increased external funding, GSMF's cost-recovery rate increased from 23 to 37 percent between 2000 and 2003. This increase was especially notable because higher levels of donor funding usually depress cost-recovery rates. GSMF's cost-recovery rate of nearly 40 percent at year-end 2003 was much higher than that of comparable programs in Africa, typically between 8 and 10 percent. In addition, the improvements GSMF made in income generation and efficiency did not come at the cost of its social mission. Since 2001, GSMF-supplied CYPs increased by an average of 15 percent annually. GSMF's social marketing activities may also have contributed to increased condom use across Ghana. For example, a reproductive health study conducted by GSMF found that condom use, as reported by men, increased from 9 to 19 percent between 1998 and 2001.

IMPROVED WORKER KNOWLEDGE OF HIV/AIDS. A survey to evaluate the knowledge, attitudes, and behaviors of Unilever employees conducted before and after implementation of the enhanced program revealed an increased proportion of respondents who had accurate knowledge of HIV/AIDS prevention and transmission measures. For instance, 52 percent knew that abstinence could prevent AIDS transmission, compared with 32 percent at baseline. Furthermore, 87 percent knew where to obtain condoms, compared with 80 percent at baseline, and 66 percent knew that condom use could prevent AIDS transmission, compared with 63 percent at baseline. This knowledge will result in reduced HIV-transmission among Unilever employees and in their communities.

INVESTMENT IN HIV/AIDS WORKPLACE PROGRAMS DESPITE LOW HIV PREVALENCE. Despite the challenge of working in a low-HIV-prevalence country, CMS mobilized companies to invest in HIV/AIDS workplace programs. For instance, Unilever contributed about 32

percent of the funding for its workplace program. Using CMS's costing model, C&J convinced two firms to initiate HIV/AIDS workplace programs and its long-term client, Coca-Cola, to enhance its existing program and add a VCT center. After an actuarial study to price the addition of highly active antiretroviral therapy (HAART) to an existing commercial insurance policy, the insurer (covering 10,000 lives) agreed to add the benefit beginning in 2004.

THE PHILIPPINES: CONTRACEPTIVE SECURITY AND PRIVATE-SECTOR STRATEGIES

In 2003, there were 81.6 million people living in the Philippines. At the current annual growth rate of 2.2 percent, the country's population will double in less than 30 years. Already, roughly 40 percent of the population lives at or below the poverty level. Total contraceptive use among married women was 49 percent in 2003—35 percent for modern methods — and has been increasing. The Philippines has a very young population: Women aged 15 to 19 outnumber women aged 45 to 49 by a ratio of more than 2:1. In addition, millions of women who report wanting to space or limit births did not using family planning. The total fertility rate was 3.5, but in the 2000 DHS, desired family size was reported at 2.7. In a national survey, 90 percent of all respondents said that it is important for Filipinos to be able to plan their families by controlling their fertility. As a result, demand for contraception will likely increase in the coming years.

Through its public-sector clinics and hospitals, the government of the Philippines provides family planning to 72 percent of all users in the country. Family planning products and services are offered regardless of clients' income or ability to pay. But many women who use the public sector have the means to pay for private services. Nearly 70 percent of women in the upper-middle quintile obtain their contraceptives from the public sector, as do almost half of all women in the wealthiest quintile. The vast majority of these women indicate that they are willing to pay for family planning services. Segments of the population who live in poverty or reside in rural areas do not have access to family planning other than through public-sector clinics.

For more than 35 years, most public-sector contraceptives provided in the Philippines were donated by USAID. In 2002, USAID announced plans to phase down contraceptive donations and redirect its resources toward more sustainable programs (that is, programs that promote a transition to contraceptive self-reliance). Accordingly, USAID has encouraged the Philippine government to take responsibility for purchasing contraceptives. Despite a budget allocation for contraceptive procurement, however, the national government as of 2003 had not procured contraceptives for its public-sector program. (In fall 2003, the Arroyo government supported a family planning effort that focused on natural methods.) Local governments, which have responsibility for local health care provision, had begun contraceptive procurement in an inconsistent manner.

Failure by the Philippine government to respond to this situation could lead to stock-outs in the public sector. A significant segment of public-sector clients who are too poor or too rural to have access to private providers could be adversely affected, potentially switching to less-effective traditional contraceptive methods or giving up contraception altogether.

To prevent this outcome, USAID is supporting efforts to strengthen private-sector provision of family planning. The underlying strategy is to encourage or require clients with the ability to pay to obtain their contraceptives from the private sector, so that limited government resources can be targeted to clients with the greatest need. Since most family planning users — of all income levels — have sought care from government clinics for the last three decades, private providers' knowledge and attitudes of modern contraceptive methods is sometimes dated.

Early in 2002, CMS began working with physicians, midwives, and pharmacy sales staff to improve their family planning knowledge and counseling skills — critical steps in preparing these providers to play a larger role in meeting the country's reproductive health needs. In addition, CMS facilitated the involvement of the Filipino business community in what the community refers to as the "population management" debate. Along with other social leaders, the commercial sector is concerned that the country's economic growth will be outpaced by population growth, making it difficult to reduce poverty and improve quality of life. Business leaders thus are

considering providing family planning information and services to their employees and encouraging the government to expand its role as well.

Two broad strategies defined CMS's work in the Philippines: (1) training to increase the comfort level and skill of private providers in offering family planning and (2) support for the business sector to expand provision of family planning information and services to employees and to transform its growing population management concerns into an effective public policy voice. Both strategies stemmed from CMS's country assessment, as well as a market segmentation analysis that estimated the potential growth of the private sector if it were to respond to the country's increasing contraceptive demand (coupled with the programmatic interventions required to achieve that potential).

IMPROVING PROVIDERS' KNOWLEDGE OF FAMILY PLANNING

CMS conducted a qualitative study of private providers' knowledge and attitudes toward family planning. Based on its findings, CMS determined that a multifaceted approach involving formal training, targeted communications, and medical detailing would be the best way to improve private providers' contraceptive knowledge and counseling skills (particularly among pharmacy sales staff). CMS established two teams of experienced private-provider specialists — six regionally based field specialists and 40 medical detailers — and launched an evidence-based medicine communications campaign.

In April 2003, CMS, with the help of its field specialists, began developing partnerships with private-provider associations. CMS organized a variety of reproductive health training sessions, including workshops that provide participants with continuing medical education credits and technical sessions attached to association conferences. Between April 2003 and July 2004, an average of 20 training events were held each month — a total of 323 training events with over 14,000 providers in attendance. Private physicians, midwives, and pharmacy sales staff learned about recent findings in contraceptive technology, discussed within the context of evidence-based medicine and best practices.

To help private-sector providers become effective and confident sources of family planning services, CMS supplemented the professional training sessions with medical detailing visits. A team of 31 medical detailers visited providers on a bi-monthly basis, reiterating and reinforcing critical information related to contraceptive counseling and use.

To further reinforce training and detailing efforts, CMS undertook an evidence-based medicine communications campaign. (Evidence-based medicine integrates individual clinical expertise with the best available external clinical evidence from systematic research.) The campaign focused on placing reproductive health articles, technical updates, and medical guides in familiar and respected provider publications, such as professional journals.

PARTNERSHIPS WITH BUSINESS LEADERS AND INSURANCE COMPANIES

Philippine business leaders are concerned that the country's high population growth rate is threatening national economic gains. Over the next few decades, they doubt that economic growth will be high enough to generate sufficient numbers of jobs. And they are increasingly concerned about the government's ability to provide adequate education and health and social services for the rapidly growing population. CMS worked with business leaders and organizations to raise awareness in the business community about the impact of rapid population growth on the business sector. In turn, an increasing number of business leaders spoke out to insist that the government take a more responsive course of action.

By providing technical assistance and organizational support, CMS helped to raise the public policy profile of Filipino business leaders' population concerns. For example, CMS used the electronic network that links geographically dispersed business association members (the Philippines is made up of 7,000 islands) to distribute *BizPop,* CMS's bi-monthly e-newsletter that increases business owners' awareness of population issues. *BizPop* highlighted the unique role that the business sector can play in population management, thereby helping build consensus for taking a public stance on the issue. It also educated businesses on the benefits of offering family planning services directly to employees.

CMS worked with the largest and most influential business associations in the Philippines to promote population awareness and implement population-related activities among the association's members. These associations included the Philippine Chamber of Commerce and Industry (PCCI), the Employer's Confederation of the Philippines (ECOP), the Philippine Exporter's Confederation (PhilExport), the Personnel Management Association of the Philippines (PMAP), and Philippines, Inc. CMS conducted a series of dialogues with these groups in order to share important population management and program information needed to increase advocacy, awareness-raising, and interest-generation efforts among the associations and its members. These dialogues provided a venue for firms that were already providing FP/RH services to share their best practices with the rest of the participants.

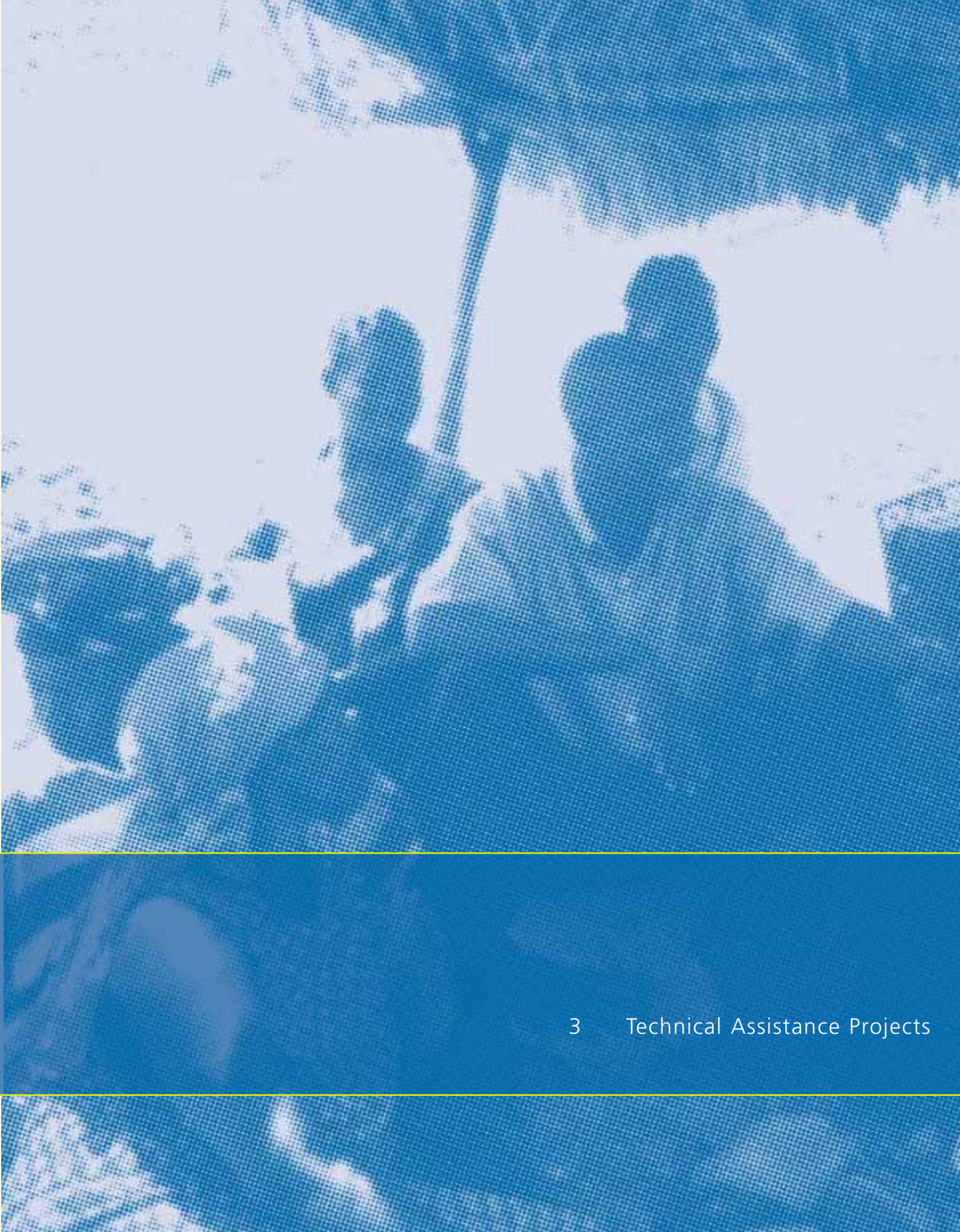
Together with these associations, CMS proposed the formulation of a national business agenda for productivity and global competitiveness, which has as its objective, incorporating FP/RH services provision in the workplace as part of an overall strategy to increase productivity and global competitiveness. CMS linked up with, and tapped the resources of, other existing local FP/RH partners and cooperating agencies, including Responsible Parenthood and Maternal and Child Health Association of the Philippines (RPMCHAP), Friendly Care Foundation, Inc. (FCFI), John Snow, Inc.—Well Family Clinic (JSI—WFC), DKT, and the Family Planning Organization of the Philippines (FPOP).

As of August 2004, a total of 79 workshops and conferences had been held all over the country, with over 12,000 participants in attendance. Advocacy efforts to promote FP in the workplace were received favorably by the business community nationwide and resulted in the following specific accomplishments:

- PCCI's business conferences for each regional area, which were attended by the member chambers of commerce and industry associations for each region (i.e., National Capital Region, North Luzon, South Luzon, Visayas, and Mindanao), resulted in the passage of separate resolutions that urge the government to support private-sector population activities and encourage members to provide FP/RH services to employees. These area conferences culminated in the annual Philippine Business Conference (PBC), where members submit to the President of the Philippines a set of policy recommendations culled from these regional business conferences.
- PCCI reorganized its organizational structures, assigned officers, and identified activities to strengthen population management advocacy campaigns in order to jumpstart and sustain efforts at the local or regional level. Among the changes to its organizational structure is the creation of the PCCI National Population Committee.
- ECOP committed to the formation of the Population Management Action Center (PMAC), which aims to bring FP/RH programs to the firm level.
- PMAP conducted sessions where members shared best practices in the provision of FP/RH services.
- PCCI and Philippines, Inc., formulated and presented a list of 10 priority business issues (including population management) to the president and local candidates during the political parties forum held prior to the May 2004 elections.

PROGRAM RESULTS

The Philippines program has been effective in mobilizing commercial-sector organizations and industry associations to address population issues and in providing up-to-date training and access to information to a large number of private providers about contraceptive technologies. Outcomes from these efforts were not measured in a systematic manner because of the relatively short duration of the program. Nonetheless, they provided USAID in the Philippines with a solid base of evidence that the corporate sector can be a valuable and dependable ally in expanding access to family planning through employer-based activities and provider-targeted initiatives. Both of these components will continue under a USAID-funded project that will follow on the footsteps of CMS, beginning in October 2004.



3 Technical Assistance Projects

TECHNICAL ASSISTANCE PROJECTS

In addition to implementing large-scale, multi-year country programs, CMS also provided USAID Missions and local organizations with focused *technical assistance (TA)* to expand private-sector involvement in family planning and to improve the enabling environment for commercial-sector strategies. The TA provided was fairly broad in nature and included TA for social marketing organizations, TA on NGO sustainability, contraceptive security assessments, market segmentation analyses, and feasibility studies of private-sector HIV/AIDS treatment programs.

These efforts were complemented by *core-funded initiatives* to advance the state of the art in private-sector family planning. The initiatives included diagnostic studies, country assessments, pilot projects, and Summa Foundation loans. They were undertaken as a way to stimulate Mission interest in promising projects and to test the potential for private-sector involvement and desired health outcomes.

Technical assistance activities and core-funded initiatives were generally not undertaken in isolation but in various combinations, depending upon the particular context. Discussed below are selected examples — in selected settings — of these activities. Although more limited in scope and duration than country programs, they provided valuable knowledge and pointed to potential new areas of activity in future USAID programs.

TECHNICAL ASSISTANCE TO NGOS

Between 1998 and 2004, CMS provided sustainability assistance to NGOs in 12 countries and held regional sustainability workshops in Africa, Latin America, and the Arab world. As a leader in private-sector approaches to reproductive health, CMS brought a rigorous, integrated approach to NGO sustainability programs.

In illustrating CMS strategies, results, and lessons learned, this section draws on three examples, in addition to the NGO strengthening activities for Ghana and Nicaragua described in Chapter 2. Discussed here are activities in Dominican Republic, Brazil, and Bangladesh.

DOMINICAN REPUBLIC: TECHNICAL ASSISTANCE TO ADOPLAFAM

The NGO Asociación Dominicana de Planificación Familiar (ADOPLAFAM) was established in 1987 to offer reproductive health products and services to low-income populations. ADOPLAFAM has affiliated clinics and a distribution network of community health workers, which grew from an initial 235 volunteers to over 1,500 in 2003. In 2001, it opened a diagnostic center to provide health services to low-income consumers in an underserved part of Santo Domingo.

CMS began working with ADOPLAFAM to improve its sustainability in 1999, when the NGO's largest donor (USAID/Dominican Republic) began to reduce its funding for population programs. Among other activities, CMS worked with the diagnostic center to increase the number of paying clients; by improving center efficiency, the center was able to increase monthly income from an average of $2,937 in 2001, to $5,085 in 2002, and to $5,710 in 2003.

CMS helped ADOPLAFAM devise an ambitious plan to improve its institutional structure and to strategically diversify its portfolio of services and products. ADOPLAFAM has maintained and protected its social mission, providing for the poorest of the poor via a voucher system, while expanding profitable services that will be used to cross-subsidize other programs. By carefully devising a long-term strategic plan, being responsive to the needs of the surrounding community through the addition of new laboratory services, and adopting good business practices, ADOPLAFAM is now more sustainable and self-sufficient. Between 2000 and 2003, ADOPLAFAM's cost-recovery rate jumped from 26 percent to 52 percent, and the USAID proportion of funding declined by more than half. However, during that time, couple years of protection decreased, as ADOPLAFAM shifted its service delivery focus and USAID population funding decreased. This tendency has been observed in other settings as well (e.g., Cambodia), as NGOs diversify their services from family planning into mother and child health or HIV/AIDS.

	1999	2000	2001	2002	2003
Cost recovery rate	—	26	35	39	52
USAID funding as % of budget	54	24	22	23	20
CYPs generated	—	15,906	31,738	28,510	22,389

BRAZIL: TECHNICAL ASSISTANCE TO BEMFAM

BEMFAM, the Brazilian International Planned Parenthood Federation (IPPF) affiliate, was founded in 1965 as a non-profit NGO with a mission to defend the right of men, women, and teenagers to receive reproductive and sexual health assistance, as well as to uphold their right to informed and free choice on family planning. It provides reproductive health services through a nationwide network of clinics and, over four decades, has become the most significant non-profit family planning organization in Brazil.

BEMFAM works in 16 states and conducts more than 3 million consultations each year, mainly with low-income clients. BEMFAM has contracts with over 1,000 municipalities to support sexual and reproductive health activities. When CMS began working with BEMFAM in 1999, it had an annual operating budget of US$8 million. Of that amount, 63 percent was locally generated revenue and 37 percent came from international donors. With USAID funding scheduled to phase out after 1999, USAID/Brazil asked CMS to help increase BEMFAM's sustainability.

CMS provided targeted assistance to strengthen the NGO's commercial division, which had been created under a previous project to generate revenue. CMS hired an external consultant to conduct an assessment of which areas could become more profitable. Based on the assessment, CMS helped BEMFAM increase the price of its *PROSEX* condoms and to expand marketing and distribution for the brand. During January and February 1999, BEMFAM ran a television advertising campaign for *PROSEX,* created with technical assistance from CMS. The commercial ran 83 times in four targeted regions. In addition to raising awareness, the television campaign increased condom sales in three of the four regions by 91 percent, compared to 44 percent in the country overall. Revenues from *PROSEX* sales increased from $105,000 per month to $140,000 between January and December 1999.

CMS also helped BEMFAM improve the financial profile of its laboratories. Originally, BEMFAM's laboratories served its own clinics and were not intended to generate a profit. CMS's financial assessment determined that by offering their services to other medical providers in the community, the laboratories could become profitable by the end of 1999. With technical guidance from CMS, BEMFAM made several changes to the labs. For example, the sales strategy for the laboratory in Recife was adapted to better suit the characteristics of the local market. While the Recife lab's initial marketing efforts targeted HMOs, the health insurance market was weak in this economically depressed area of Brazil. Therefore, BEMFAM changed the primary target for laboratory services to private doctors. By May 1999, Recife's laboratory had signed agreements with 68 doctors and two mid-sized hospitals to refer patients to BEMFAM's labs. The NGO also explored performing hormonal clinical analysis via a partnership with an independent lab technician and adopting software used by the lab to keep track of commissions for doctors and sales representatives.

By the time CMS completed its work with BEMFAM, the NGO was on track to becoming 90 percent financially self-sufficient. Beyond the improvements facilitated by CMS, progress toward sustainability was also supported by BEMFAM's involvement in new areas (such as HIV/AIDS), which the organization had pursued on its own. BEMFAM's creative and broad-minded approach to increasing revenue through service and product diversification was a significant factor in improving its self-sufficiency. With technical assistance from CMS to help structure its efforts, the NGO demonstrated that building on an established reputation in new ways could yield tangible sustainability results.

BANGLADESH: TECHNICAL ASSISTANCE TO SMC

Bangladesh is one of the most densely populated countries in the world, with an estimated 120 million people. The country has undergone a remarkable demographic transition over the past three decades. The average life expectancy at birth increased from 46 years in 1974 to over 60 years in 2000. Over the

same period, the total fertility rate declined from 6.3 children per woman to 3.3, and total contraceptive prevalence increased from 8 percent to 54 percent. Although Bangladesh has been successful at meeting population goals, new challenges to contraceptive security are emerging. Historically, the country has been dependent on donated commodities to meet its family planning needs. Donations are declining, however, and are expected to fall short of future demand as the population grows and more couples use contraception.

Two players dominate the family planning market in Bangladesh: the public health system and the Social Marketing Company (SMC) — one of the largest social marketing NGOs in the world. The public sector serves 64 percent of modern-method users; SMC provides 71 percent of all condoms and 29 percent of pills. Most of SMC's contraceptive supplies are donated, and the organization traditionally has sold its products for less than cost. As donors are reducing the quantity of contraceptive supplies, SMC must generate new income and improve its long-term sustainability.

To improve SMC's operational efficiency and long-term sustainability, CMS provided technical assistance in several areas, including organizational restructuring, strategic pricing, commercial partnership development, and public relations and advocacy.

ORGANIZATIONAL RESTRUCTURING. CMS's organizational assessment found that SMC could benefit from a more entrepreneurial organizational structure. Specific issues and recommendations included empowering mid-level managers and their staff to handle routine tasks, thereby freeing senior staff to focus on strategic challenges; revising the performance appraisal system, so that individual staff output can be measured against pre-defined goals and indicators and that staff development (training) can be systematic and aligned with tasks and desired results; realigning the staffing structure with existing and anticipated marketing plans; and ensuring that posts are filled by qualified individuals.

CMS's reorganization plan was approved by the SMC board of directors. CMS also helped SMC recruit top managers, revise the SMC administrative manual, and finalize a new compensation package. The immediate outcomes of the restructuring program included a flatter, streamlined organizational structure, supported by revised administrative policies and a company-wide commitment to performance-based staff development.

STRATEGIC PRICING. SMC sells pills and condoms primarily through private-sector outlets and distributes injectable contraceptives through the Blue Star program — a network of more than 2,100 providers, including general practitioners, gynecologists, and indigenous providers. To help, CMS conducted surveys to determine demand and willingness to pay increased prices and helped SMC develop a strategic, long-term approach to product pricing.

COMMERCIAL PARTNERSHIPS. CMS helped SMC negotiate a five-year agreement with the pharmaceutical manufacturer Wyeth for the joint marketing of *Nordette* oral contraceptive pills. CMS assistance was also instrumental in initiating discussions with Ansell India for the marketing of a premium condom brand and with Wyeth for the marketing of the premium pill brand *Loette*.

PUBLIC RELATIONS AND ADVOCACY. Although SMC had been successful in social marketing, it lacked a coherent public relations strategy. To help strengthen SMC's relationships with stakeholders in the public and private sectors, CMS conducted interviews about communications issues with internal and external audiences. CMS found that new generations of government officials did not have a clear understanding of social marketing, SMC's history, or its valuable contribution to national family planning goals. To address this issue, CMS and SMC developed a communication and advocacy strategy, which included

- forming an advocacy team for communication with the government;
- creating a series of presentations, including a video documentary, aimed at improving SMC's image;
- expanding media-relations efforts, using informational media kits, user testimonials, and regular calls to the media;
- conducting reputation surveys among various stakeholders to identify trouble areas; and
- introducing an internal communications plan for better staff engagement.

The new public relations/advocacy strategy was designed to improve SMC's image in the eyes of the government, donors, and other audiences and to create an appreciation for the organization's significant contribution to Bangladesh's family planning program.

NGO SUSTAINABILITY WORKSHOPS

Between 2001 and 2003, CMS sponsored five multiple-day NGO sustainability workshops. These workshops enabled NGOs to learn planning, financial, and business skills from CMS facilitators and to share their experiences with each other. Two of the workshops — one in Africa and one in Latin America — were held in conjunction with Frontiers, a Population Council program. CMS also conducted a workshop for IPPF affiliates in the Arab region and two for affiliates of the African Alliance of the Young Men's Christian Association.

The workshops were rigorous and business focused, with a specific emphasis on planning, marketing, and financial strengthening through income-generating activities. They offered skills and tools for business planning through lectures, group discussion, exercises, case studies, lessons learned and best practice presentations, and breakout sessions. At the end of the conference, participants presented an idea for a new service/product to generate income locally. In some cases, participants were given training material and templates of planning documents on CDs to take back. "South-to-South" sharing of experiences was a constructive, cost-effective way to maximize donor investment in technical assistance. Exposure to other experiences, lessons learned, pitfalls, and success stories benefited NGOs at all stages of development.

CONTRACEPTIVE SECURITY ASSESSMENTS

CMS was a key player in USAID's efforts to address issues of contraceptive security, both in assessing individual country environments and providing recommendations (Bangladesh, Armenia, Dominican Republic, El Salvador, Honduras, and Nicaragua) and in providing technical leadership for defining the private sector's role in contraceptive security matters.

BANGLADESH

In Bangladesh, a market segmentation analysis was conducted to inform the policy dialogue among stakeholders and to help identify the most appropriate target markets for the public, private, and NGO sectors. Market segmentation analysis can highlight duplicated efforts or unproductive competition. Segmentation techniques can be used to meet the family planning needs of an entire population by identifying complementary roles (and target markets) for the public, NGO, and commercial sectors. For example, if upper-income groups can be shifted to the private sector and middle-income groups can be encouraged to use the subsidized (NGO) social marketing programs, then limited public-sector resources can be targeted to meet the needs of the lowest-income groups. CMS worked with the DELIVER Project (which helps developing countries establish effective supply chains for public health and family planning programs) to facilitate a participatory market segmentation approach to family planning policymaking.

CMS and DELIVER produced a market segmentation report that was shared with stakeholders from the public, commercial, and NGO sectors. The analysis found that the Bangladesh market is somewhat segmented, but that there are opportunities for greater efficiency. Overall, the public sector meets between 75 and 90 percent of the contraceptive needs of the poorest quintiles and caters to the bulk of family planning clients in rural areas. NGOs are concentrated in urban areas where they cater mainly to the poor, serving 18 percent in the poorest quintile and 7 percent in the wealthiest. The commercial sector meets the contraceptive needs of more than 49 percent of the richest quintile. Given these findings, a second phase of market segmentation analysis was undertaken to further examine the issues surrounding discontinuation of specific contraceptive methods and opportunities for expanding household financing of contraceptives through government fees or private-sector sales.

A stakeholder conference provided useful feedback that helped tailor the analysis to address various stakeholders' needs and to elaborate on opportunities for each sector. During a second conference, CMS presented tailored analyses to each of the stakeholders, who were then able to identify and discuss appropriate roles for each sector. Participants agreed that

the core objective of improving resource allocation could not be achieved without a coordinated strategy involving the public, commercial, and NGO sectors.

ARMENIA

In Armenia, there is heavy reliance on abortion, and misconceptions about hormonal contraceptives result in low levels of modern contraceptive use. Yet fertility has declined significantly since independence. Low fertility combined with emigration has resulted in a population decline. Despite the potential hardships the nation faces as a result of falling population, at the individual level, Armenians express a strong desire to limit family size.

During the 1990s, a network of family planning cabinets was developed with support from UNFPA and housed in public health clinics and hospitals. Supplies for these cabinets — condoms, oral contraceptives, and IUDs — were provided by UNFPA in 1998. In 2002, these supplies were expected to be exhausted or to expire within 12 to 18 months. Because the government was not likely to step in and procure contraceptives, USAID/Armenia asked CMS to undertake an analysis to examine the following questions:

- What proportion of the population relies on the public sector for provision of family planning methods and, therefore, is at risk for losing access to its method?
- Might social marketing be a cost-effective approach to meeting the needs of family planning users and intenders?
- What is the likely projected demand for modern contraceptive methods in the short term?

The CMS segmentation analysis showed that only 20 percent of ever-married women in Armenia used modern contraception. More women relied on traditional contraceptive methods, while an even higher number used no method at all. Abortions were common, and although the procedure was presumed to be free of charge, women overwhelmingly reported that the cost of abortions was a problem. Although government service providers dominated the market for clinical and long-term methods, condoms were heavily served by the commercial sector. As many as 90 percent of the condoms used by wealthier Armenians were purchased in pharmacies. Even the poor used private-sector sources, although to a lesser extent. A portion of contraceptive users relied on the public sector for their methods, however, and would be vulnerable if donated supplies disappeared.

Based on these findings, CMS recommended that any contraceptive security strategy focus on the needs of the group that relies on public contraceptive sources. Specifically, CMS recommended that IUDs be made available to public-sector clinics for all who sought them and that donated condoms and pills be targeted to clinics that serve the rural and urban poor or women eligible for income assistance. Experience showed that most other Armenians could buy resupply methods in the market. The creation of a social marketing program in Armenia was seen to be cost-prohibitive and to cut into the existing commercial market. In addition, given its pro-natalist tendencies, the Armenian government was not likely to support a visible social marketing campaign. To further strengthen and expand the existing private market, however, CMS recommended that a targeted effort be undertaken to work with existing private-sector distributors to improve patient education.

LATIN AMERICA: A MULTI-COUNTRY STUDY

In 2004, CMS completed a core-funded contraceptive security study of four countries in the Latin American and Caribbean (LAC) region, assessing demand and supply patterns in Dominican Republic, El Salvador, Honduras, and Nicaragua. The study was conducted in response to USAID missions in the LAC region, which are beginning to phase out commodity donations, causing recipient governments and organizations to face the challenge of ensuring continued access to affordable, high-quality contraceptives for those who need them. The study outlined strategies for accessing private-sector suppliers of oral and injectable contraceptives to meet the growing family planning needs of consumers in the region. It examined the ability and willingness of private suppliers to meet the needs of NGOs, governments, and the populations they serve.

The study found that most female users in the four countries studied obtain contraceptives from the public sector or NGOs. Commercial pharmacies represent less than 10 percent of the total volume of

contraceptives distributed in the region and tend to focus on a high-income clientele. Trends showed users' increasing reliance on subsidized products, underscoring the need to identify alternatives sources of supply for governments and NGO programs.

The LAC study identified procurement options for public and social marketing programs, including

- Negotiating for large-volume discounts directly with manufacturers' upper management, rather than a local representative who may not be able or authorized to extend special prices;
- Issuing tenders with local and regional manufacturers of low-cost brands, who may offer a convenient and low-cost alternative for governments;
- Using the services provided by UNFPA's centralized contraceptive procurement office, which offers some of the lowest prices in the world. UNFPA services are accessible to both governments and NGOs together with procurement training, local testing, and inspection; and
- Partnering with IPPF, which is gearing up to be a major provider of low-cost contraceptives in the region to its affiliates, as well as to other NGOs and some governments.

INVOLVING THE PRIVATE SECTOR IN CONTRACEPTIVE SECURITY

As part of its core-funded technical leadership, CMS collaborated with many other USAID projects and partners and contributed to the development of guidelines and best practices.

- CMS was one of the primary authors, with the DELIVER and POLICY projects, of the Strategic Pathways for Reproductive Health Commodity Security (SPARHCS) documentation on conducting contraceptive security assessments, including the framework, approach, and guide to data collection. CMS participation ensured that the private-sector role in contraceptive security was understood and incorporated throughout the materials. In this endeavor, CMS participated in a field test of the diagnostic tool in Nigeria.
- CMS collaborated with the POLICY project, which hosted a workshop in Jordan in June 2002 on "Developing a Common Understanding of Contraceptive Security," where CMS presented its work on the private sector and demand creation.
- For USAID's Contraceptive Security Working Group, CMS was the primary author on two of six lessons on contraceptive security. CMS wrote lessons on defining a role for the private sector through market segmentation and targeting, with input from the POLICY and PHRPlus projects, and on using demand-side interventions of social marketing and communication, with JHUCCP.

SUMMA LOANS TO PRIVATE PROVIDERS

Summa Foundation loans to private providers, both commercial clinics and hospitals, and to health sector NGOs (such as GSMF in Ghana) constituted an important vehicle for expanding the supply of quality health services in the private sector. Summa loans in Peru, Ghana, and Cambodia, summarized here, illustrate the technical approaches and health outcomes that CMS collaboration with Summa achieved.

PERU: SAN PABLO HOSPITAL

In 2001, the Summa Foundation designed an intervention in partnership with the San Pablo Hospital Complex (SPHC), the largest commercial health care provider in Lima, to increase access to care for the underserved. SPHC, which operates five medical facilities and a medical training school in Lima, is an ideal partner for several reasons. First, it was interested in expanding its operations into lower-income areas. Second, the owner recognized the importance of MCH and was willing to work with the Summa Foundation to promote it. Third, SPHC was seeing high rates of STIs and cervical/vaginal disease at its clinics and agreed that there was a demonstrated need for an integrated health program that includes voluntary family planning, STI prevention, and education.

SPHC received a $1 million loan from the Summa Foundation to construct and equip a new MCH clinic in the San Miguel district, a lower-middle-income neighborhood in Lima where health care is dominated by the public sector. SPHC's San Miguel Clinic is

the first large, commercial health care provider in the district. In exchange for the financing for this expansion, SPHC agreed to promote an integrated reproductive health program at all of its facilities.

The loan to SPHC had two primary objectives: (1) to shift middle-lower income users in the San Miguel area from the public sector to the private sector, alleviating some of the demands on the district's public health system, and (2) to improve and expand the commercial delivery of voluntary family planning, reproductive health, and other primary care services in an underserved area of Lima.

The clinic opened in January 2003. During the first three quarters of the year, family planning visits increased across all methods. Family planning and reproductive health visits also increased throughout San Pablo's other facilities, reaching 33,000 through September 2003, an increase of about 30 percent over 2002. The Summa Foundation estimates that the new clinic will benefit directly more than 276,000 residents of San Miguel and neighboring districts, including 49,000 children and 62,000 women of reproductive age. During the term of the loan, SPHC expects to see over 46,000 family planning clients.

GHANA: C&J MEDICARE

In May 2002, the Summa Foundation extended a $200,000 loan to C&J Medicare, a commercial health service provider in Ghana, in order to expand reproductive, pediatric, and other health services. C&J used the loan to complete construction and to equip and refinance a new health facility. The loan enabled C&J to add a surgical theater; increase inpatient and outpatient capacity; improve diagnostic ability; open a stand-alone pharmacy; and promote family planning, voluntary counseling and testing, and maternal and child health.

The new facility opened in January 2003. It offered family planning services, including long-term methods; promoted family planning more widely among clients; promoted and distributed contraceptive products; and dedicated two of its new consultation rooms for family planning and voluntary counseling and testing. C&J clinical staff received VCT training in March 2003 and family planning training in the summer and fall of 2003. Client visits and revenue increased significantly right away; VCT and family planning visits were initially relatively slow, but service statistics in all areas are expected to increase.

CAMBODIA: REPRODUCTIVE HEALTH ASSOCIATION OF CAMBODIA

The Summa Foundation provided a $150,000 loan to the Reproductive Health Association of Cambodia (RHAC) in July 2001 to purchase its main clinic and headquarters in Phnom Penh. The objective of the loan is to increase RHAC's sustainability by no longer having to pay rent on the Phnom Pen property. The loan also allowed the clinic to construct three additional consultation rooms, expanding its capacity by 45 clients per day. Summa also provided technical assistance to RHAC in 2002, promoting sustainability through proper investment of cash reserves.

RHAC is Cambodia's largest private reproductive health provider, offering clinical reproductive health care, health outreach, adolescent and workplace-based programs, and training. RHAC has established itself as a leader in family planning, dual protection, HIV/AIDS counseling, STI prevention, and antenatal and postnatal care. RHAC, known for high-quality care at affordable prices, operates six reproductive health clinics and health outreach programs in five provinces of Cambodia.

Summa is monitoring RHAC to determine whether there is a positive change in revenue during the loan period. As of June 2003, there was a 26 percent increase in revenue compared to the baseline. Clinical care generated the most revenue, followed by pharmacy sales, laboratory fees, and sales of family planning products. By no longer paying rent on the clinic, RHAC had a total cost savings of $21,348 by September 30, 2003. In terms of service delivery, the loan was also contributing to RHAC's mission: compared to the first six months of 2001, the baseline period, there was a 34 percent increase in total client visits for all RHAC clinics and programs. In addition, there was a 24 percent increase in voluntary family planning acceptors and a 16 percent increase in couple years of protection. Nonetheless, RHAC has experienced a 36 percent decrease in family planning clients, as a broader service delivery mix has been introduced, including child survival and HIV/AIDS.

HEALTH FINANCING

Providing access to affordable products and services through health financing mechanisms, including insurance and third-party payments, was an important component of the CMS core-funded technical leadership mandate. CMS addressed this issue through a Technical Advisory Group meeting, which served to frame the key opportunities and constraints for expanding family planning and reproductive health through financing mechanisms. In parallel, CMS provided inputs into the health care financing programs in Uganda and Ghana, and undertook a core-funded initiative in Nicaragua to address key factors impacting utilization of family planning services under an innovative health insurance model involving private providers.

TECHNICAL ADVISORY GROUP

In 2000, CMS convened a one-day Technical Advisory Group (TAG) meeting in Washington, DC, for USAID and the cooperating agency community, for technical experts and corporate representatives in the health insurance field to explore options for utilizing health financing mechanisms to expand family planning service provision in developing countries. The TAG meeting determined the following:

- Geographically, the greatest potential for utilizing health financing lies in Africa and Asia. Although per capita health care spending is low in Africa, the government is usually a weak service provider, and a well-run insurance plan can provide better service at an acceptable cost. In Asia, existing private health care spending, already larger than in Africa, must be structured into health insurance mechanisms. Such mechanisms must move beyond conventional indemnity insurance to use of innovative payment and quality control methods. One strategy would be to move existing insurers "down market" to lower-paid employees in large industrial enterprises, offering group enrollment in a limited benefit policy that includes primary and preventive care. Where social security systems are strong, as in much of Latin America, the market for private health insurance schemes will be limited. In Latin American countries without strong social security systems, there may be some market for "*mutuelle*-type" plans if government services are absent or of poor quality. To prosper, any such plan must be based on a strong pre-existing community group or private provider.

- Support for health insurance mechanisms is, at best, an indirect way of increasing contraceptive prevalence or shifting users from government services. While primary care and reproductive health services can be included in an affordable benefit package, contraceptive usage patterns will not soon change as a result. Improving primary care is a better reason to support health insurance mechanisms. Enlightened managers and most beneficiaries see the advantage of including preventive services. Insurance can lower the barriers to primary care, particularly where competing government services are weak. Support for health insurance mechanisms should be based on achieving broader health system goals, not on a desire to directly impact contraceptive use.

NICARAGUA: PRIVATE PROVIDERS INITIATIVE

In collaboration with the Summa Foundation, CMS undertook a number of initiatives to increase reproductive health care delivery through private-sector providers. These included a public-private partnership to expand the family planning services of two private providers that are under contract to the Nicaraguan Social Security Institute (INSS).

In 2001, CMS and Summa entered into a partnership with the INSS, which contracts out service delivery to private providers under a broad program of decentralization and health care reform. In 1994, the INSS had introduced a new health care financing and service delivery model under which INSS collects contributions from employers and employees and makes monthly per capita payments to public- and private-sector providers for a basic package of health services. The contracted providers, known as *Empresas Medicas Previsionales* (EMPs), include for-profit firms, Ministry of Health facilities, and NGOs. By 2002, the INSS model covered about 13 percent of the population, with 214,000 enrollees and about 466,000 spouses and children.

The INSS package covers a wide range of preventive and curative services, including reproductive health care; maternal and child health care; prenatal care;

family planning counseling; and temporary, long-term, and permanent methods of contraception. The model is ideal for private delivery of reproductive health and family planning services and for shifting users from public-sector to private-sector sources.

To help INSS improve the quality of and capacity for reproductive and maternal health services, CMS and the Summa Foundation also partnered directly with Salud Integral and SuMedico, two of the leading private-sector EMPs working with the INSS. To determine the two EMPs' needs for technical assistance, CMS and Summa surveyed more than 1,000 female clients of reproductive age to measure reproductive health services delivery patterns, utilization, client satisfaction, and unmet demand for services.

The assessment determined that both Salud Integral and SuMedico were delivering low levels of family planning services, even though family planning is in fact part of the INSS benefits package, and beneficiaries are using the EMPs for prenatal, maternity, and postpartum care. Respondents' rates of contraceptive use ran from 55 percent to 62 percent, and more than half said they had been using contraceptives for more than a year. However, about two-thirds of the contraceptive users said they obtained their contraceptives from sources other than their EMP. Of those, half reported paying out-of-pocket at private outlets — usually pharmacies — and half said they received free contraceptives through the public sector. In fact, more than 60 percent said they were not aware that family planning services were included in the INSS package, even though most of the women said they would prefer to use their EMP to receive such services.

The assessment determined that, over the course of a year, 10 to 13 percent of the EMPs' clients of reproductive age were at risk of unintended pregnancy. Since the EMPs are required to provide maternity care, it is cost-effective to promote family planning. However, neither EMP was staffed or set up to systematically promote or deliver family planning services.

Based on the findings of the assessment, CMS developed a detailed technical assistance program to help the EMPs increase the quality and use of family planning services. First, CMS trained the clinical staff of the two EMPs in contraceptive technology and family planning counseling, with an emphasis on promoting informed choice. Second, CMS developed a campaign (including videos, brochures, posters, and murals) to educate EMP clients about the availability and benefits of family planning services. Third, Summa provided financing to the EMPs to expand and upgrade their facilities and reproductive health services. In addition, Salud Integral extended free family planning services to plan members' spouses to maximize the program's potential impact. As a result of the technical assistance and access to financing, both SuMedico and Salud Integral expanded their efforts to promote the benefits of family planning and saw an increase in the use of these services during the first five months of the program (May—September 2003).

To assess the impact of these activities, CMS conducted baseline and endline client exit interviews in clinics of both sets of providers in December 2002 and October 2003, respectively. Among Salud Integral clients who use family planning, the findings show a significant increase (from 27 percent to 48 percent) in the share of clients who obtained their method from Salud Integral and a substantial decrease (from 33 percent to 15 percent) in the share who obtained their method from the public sector. Among SuMedico clients who use family planning, the share of clients who obtained their method from SuMedico remained unchanged at 31 percent, and the share who obtained their method from the public sector declined from 28 percent to 22 percent. This suggests that active promotion coupled with an expansion of family planning benefits to spouses is more effective at increasing service use and shifting family planning users from the public to the private sector than active promotion of family planning benefits alone.

The CMS experience in Nicaragua showed that private providers realize the importance and value of promoting and delivering reproductive health care, particularly in a managed-care model where unintended pregnancy and maternity impact cost recovery and therefore sustainability. Both SuMedico and Salud Integral made capital improvements and enhanced their staffs' knowledge and ability to deliver quality reproductive health care. As a result, USAID and INSS have a strong interest in replicating this technical assistance model to other INSS providers.

CORPORATE PARTNERSHIPS

CMS implemented several corporate partnerships, using core funds, in support of social marketing and provider initiatives.

MEXICO: YOUTH-FRIENDLY PHARMACY INITIATIVE

In Mexico, CMS partnered with Centro Latinoamericano Salud y Mujer (CELSAM), a local NGO established by the Schering Pharmaceutical Company, to create a network of youth friendly pharmacies to improve the supply of reproductive health products and services available through the private sector.

The project involved developing a network of "youth-friendly" pharmacies that provide contraceptives to adolescents in a confidential, respectful environment. It targeted 20,000 youth aged 13 to19 in Guanajuato, Mexico, through two principal strategies: (1) training pharmacists and clerks (to improve the supply and services available to youth and the environment in which they obtain them) and (2) an interpersonal communications campaign (to increase demand for contraceptives in the private sector among sexually active youth).

CMS launched the project in April 2000, with an initial training for pharmacy personnel; a follow-up training was conducted in July 2003. Additional personalized detailing was conducted from September through December 2003, and then a final training session was held in late January 2004. Twenty pharmacies completed the 30 hours of training and demonstrated that they could treat youth with respect, confidentiality, and privacy. CMS awarded these pharmacies a certification that designated them as "youth friendly," and individual clerks received pins depicting the logo so that youth could easily identify trained clerks upon entering the pharmacy.

Promotional activities to attract youth to the pharmacies included

- *Logo for Youth-Friendly Pharmacies.* Local youth were asked to design and develop a logo for the network of pharmacies. The logo was used to identify the Youth-Friendly Pharmacies as client-centered and youth friendly.

- *Hotline.* CELSAM established a 1-800 anonymous phone line available free of charge to youth from private telephones or phone booths on the street. Peer leaders were trained to staff the phone line and respond to questions in a "youth-friendly" manner. The hotline functions 5 days a week and also provides referrals to the Youth-Friendly Pharmacies. The hotline was promoted through on all of the project promotional materials.

- *Referrals to Youth-Friendly Doctors.* The Ministry of Health and the Red Cross established a network of doctors who will serve as referrals for the pharmacy network.

- *School-Based Information.* Promotional materials were made available at 15 schools.

To assess the impact of the network and related activities on the health-seeking behaviors of adolescents, as well as the effect on service provision to youth among participating pharmacists, CMS designed a monitoring and evaluation plan, using mystery client visits. The mystery client study found the following:

To assess the impact of the network and related activities on the health-seeking behaviors of adolescents, as well as the effect on service provision to youth among participating pharmacists, CMS designed a monitoring and evaluation plan, using mystery client visits.

- Whereas 78 percent of the network pharmacies placed contraceptives in plain sight in the pharmacy, only 60 percent of the non-participating pharmacies made contraceptives accessible to youth.

- Overall, the significant differences between the trained pharmacists and the contol pharmacies were in the pharmacy environment, promotional

material available, specific material with information about contraceptive methods and reproductive health, the amount of time the clerk spent with an adolescent, the "friendly" treatment, and how satisfied the adolescents felt about the technical competence of the clerks.

JAMAICA: YOUTH SOCIAL MARKETING PROGRAM

Using an integrated social marketing program in Jamaica, CMS promoted abstinence, consistent and correct condom use, and emergency contraceptive pills as sequential options for sexually active adolescents who are at risk for HIV and unwanted pregnancy. The campaign was implemented in partnership with several private partners, including Gedeon Richter and Medimpex, in collaboration with the Jamaican National Family Planning Board (NFPB).

The campaign addressed a serious health problem among Jamaican youth, who are at high risk for unplanned pregnancy and HIV/AIDS. A high percentage of teenage boys and girls are sexually active — 9 out of 10 adolescents aged 15 to 19 report having sex in the last year, according to CMS research. Despite high rates of sexual activity and unprotected sex, the majority of Jamaican youth said that they did not feel personally at risk of contracting HIV. But in reality, adolescents aged 15 to 19 have one of the highest HIV infection rates in Jamaica, and new HIV infections among adolescents are doubling every year. Rates of teen pregnancy are also very high. Some 40 percent of Jamaican women have been pregnant by the age of 20, and most of these pregnancies are unplanned. In an effort to reduce unplanned teen pregnancies, the Jamaican government reclassified emergency contraceptive pills so they could be dispensed by pharmacists without a doctor's prescription.

The *Learn, Love, and Live* campaign was an integrated mass media and educational campaign designed to promote safer sexual behavior among sexually active youth and raise awareness about emergency contraception (EC). CMS's goal in Jamaica was to increase consistent condom use among sexually active youth while promoting abstinence as the best option for preventing unwanted pregnancy and STIs, including HIV. The project also worked to build awareness and use of EC as a method of last resort for those who have had unprotected sex. The campaign included radio advertising; an EC hotline integrated into the NFPB family planning hotline; information for consumers and pharmacists; and seminars for pharmacists, midwives, police force personnel who deal with rape cases, and rape counselors affiliated with the Jamaican Women's Crisis Centre.

CMS utilized a quarterly adolescent omnibus tracking survey, conducted in January 2002 (baseline) and January 2004 (follow-up,) to monitor the impact of the campaign on abstinence; condom use; and EC awareness, knowledge, acceptance, and use.

- The campaign was heard by approximately a quarter of Jamaican youth. Twenty-seven percent of boys and 31 percent of girls aged 10 to 19 indicated that they had heard the campaign.

- Among 10- to 19-year-olds, abstinence rates remained the same between the baseline (2002) and follow-up (2004) survey periods at 60 percent for boys and 74 percent for girls. However, discussion of abstinence had increased significantly, from 46 percent to 60 percent for boys and from 58 percent to 73 percent for girls.

- With respect to condom use, there was no statistically significant change during the evaluation period. However, consistent condom use increased from 49 percent to 65 percent for boys and from 48 percent to 58 percent for girls.

- Awareness (measured by "ever heard of EC") increased significantly, from 17 percent to 32 percent for boys and from 28 percent to 48 percent for girls. Knowledge about EC also increased, particularly among girls. Girls indicating that they knew EC could be effective up to 72 hours after unprotected sex increased from 8 percent to 23 percent. The percentage of Jamaican girls who would consider taking EC increased from 50 percent of those girls who had ever heard of EC at baseline to 67 percent in the follow-up. However, EC use during the time period did not increase and remained between 1 and 2 percent of adolescent girls.

BRAZIL: MARKETING OF INJECTABLES

CMS worked with the pharmaceutical company Organon to support the marketing of its three-

month injectable contraceptive *Tricilon.* No effort had been made previously to increase consumer awareness of the injectable, and CMS's role was largely to provide support for promotional activities. The SOMARC project had worked with Pharmacia & Upjohn to market the *Depo-Provera* injectable. However, CMS wanted to maintain a price of R$10 per unit to keep the product affordable for lower-income groups, and Pharmacia was uncomfortable with this price. As a result, CMS ended up negotiating with Organon, which was more amenable to maintaining the lower price. Organon also pledged to contribute to the development of educational material for the product to be distributed by BEMFAM.

CMS worked with Organon to launch a television advertising campaign to increase consumer knowledge and awareness of injectable contraceptives. A 30-second generic commercial was developed that premiered in August 2000 and remained on the air for three months. The objective of the campaign was to reach 60 percent of middle- to lower-middle-class Brazilian women aged 25 to 34.

Sales of *Tricilon* doubled in fiscal year 2001, although the share of private-sector sales declined relative to public-sector sales. The brand faces heavy competition from *Depo-Provera,* which has been on the market longer. As a result, BEMFAM developed an agreement with municipalities to sell *Tricilon* to the public sector. As a result of the heavy private-sector competition, however, Organon decided to pull the brand from the market in 2002.

PAKISTAN: PHARMACEUTICAL PARTNERSHIPS FOR KEY SOCIAL MARKETING

In Pakistan, CMS supported Key Social Marketing (KSM), a local family planning program that increases access to high-quality hormonal contraceptive methods. CMS supported KSM from 2002 to 2003, providing interim funding and technical assistance in social marketing during a period of donor reassessment. The program offers low- and middle-income Pakistani couples accurate birth-spacing information and affordable commercially branded hormonal contraceptive products and services. KSM markets two brands of pills, *Nordette-28* and *Famila-28,* as well as *Depo-Provera,* a three-month injectable.

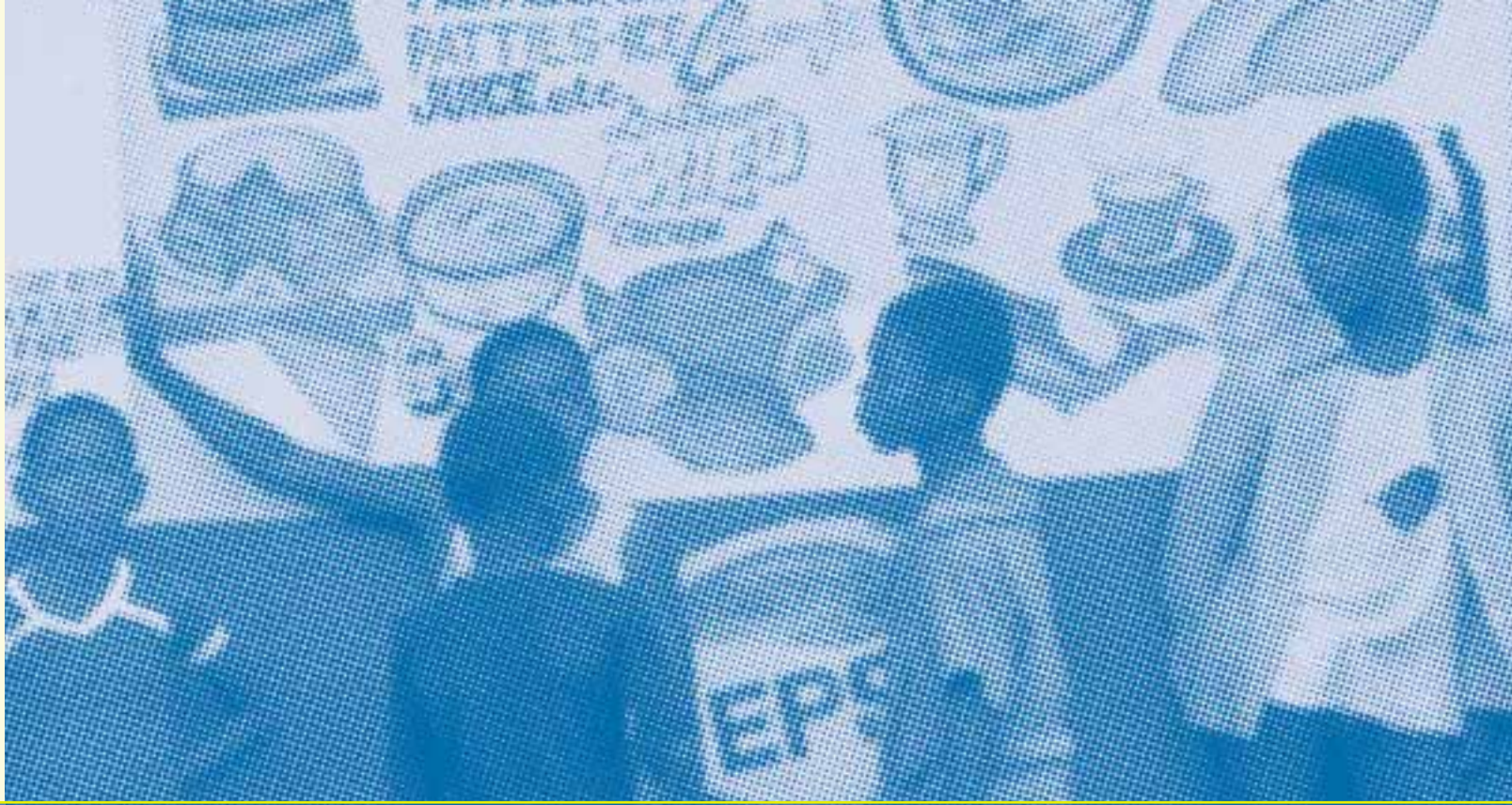
KSM partnered with leading international and local pharmaceutical manufacturers in Pakistan (Pharmacia & Upjohn, Wyeth, and Zafa) to improve the supply of high-quality hormonal contraceptives. The partnerships typically consisted of marketing support by KSM in return for commercial distribution and medical detailing of affordable hormonal methods by the manufacturer.

As part of its partnership with Zafa, a local manufacturer of oral contraceptives, KSM supported promotional activities for *Famila-28.* In return, Zafa invested in a world-class production facility, a national distribution system, and a 52-member detailing team to visit providers with information about hormonal contraceptives. *Famila-28* was positioned as an affordable choice for low-income couples. Within two months of its launch, *Famila-28* was the leading brand on the market.

KSM had a similar arrangement with Pharmacia & Upjohn for its *Depo-Provera.* Under all of these agreements, KSM marketing support was contingent on the manufacturers keeping the prices affordable for the target market. For all of the hormonal products marketed by KSM, the consumer price covers the costs of production and distribution.

The KSM program appears to have contributed to the growth of the private-sector hormonal contraceptive market, although it is difficult to definitively prove attribution. Private-sector sales of injectables increased from less than 60,000 vials in 1994 to more than 380,000 vials in 2001. KSM injectables constituted 42 percent of the private-sector market and contributed over 52 percent of injectable couple years of protection. Sales of private-sector brands of oral contraceptives increased from 1.1 million cycles in 1994 to more than 2.5 million cycles in 2001, with Key pills accounting for about 61 percent of sales.

By partnering with Zafa, a local manufacturer of oral contraceptives, KSM developed the market for an affordable, quality product. *Famila-28,* Zafa's fully priced pill, is of international quality, yet affordable to low-income couples. KSM also demonstrated that a local producer can compete successfully — *Famila 28* became the market leader after only two months. This success built local capacity and enhanced program sustainability.



4 Findings From CMS Global and Technical Research

FINDINGS FROM CMS GLOBAL AND TECHNICAL RESEARCH

In addition to monitoring and evaluation research, CMS conducted global studies and produced a series of Occasional Papers to promote greater understanding of the current and potential role of the private sector in delivering family planning and reproductive health products and services in developing countries. Global studies focused specifically on in-depth explorations of the impact of private-sector technical approaches such as social marketing and third-party payments, and cross-cutting issues such as contraceptive security and the special concerns of adolescents. This chapter highlights key findings from selected studies.

CONTRACEPTIVE SECURITY

With decreased donor and public-sector funding in many developing countries for family planning, coupled with increasing demand for reproductive health care services and products, contraceptive security has become an increasingly important concern in the population community. To address this concern, donors have looked increasingly to the private and commercial sectors to fill the gap between reproductive health needs and what the public sector and donor agencies are able to finance.

CMS completed three important studies that examined the role of the private sector in addressing contraceptive security. *What Influences the Private Provision of Contraceptives?* by Rudolfo Bulatao (2002) identifies and discusses factors that promote or hinder commercial-sector participation. Competition is a key factor, especially when it comes to price differences between publicly and privately provided contraceptives. Other factors that impact the commercial sector's role include market size, an adequate distribution network, the regulatory environment, and the effectiveness of social marketing efforts. Bulatao found that low incomes do not necessarily limit the potential market, since commercial prices are affordable to many, and consumers often choose to spend out-of-pocket for other health care needs.

Broadening the Commercial-Sector Participation in Reproductive Health: The Role of Prices on Markets for Oral Contraceptives, by Karen Foreit (2002), examined the impact of public-sector pricing on commercial oral contraceptive markets. Foreit found that introducing or promoting free oral contraceptives in an established commercial market induces users to abandon the commercial sector without increasing overall use. Conversely, a single policy step of introducing small user fees in free, untargeted government programs might encourage wealthier public-sector clients to switch to commercial outlets — significantly increasing the commercial provision of oral contraceptives and allowing donor and public resources to be used more strategically (such as to meet the needs of poor or hard-to-reach populations).

How Much is Enough? Estimating Requirements for Subsidized Contraceptives. Results from Ten-Country Analysis, by Jeffrey Sine (2002), challenged the widely cited estimate by Ross et al. (1999). Ross estimated that by 2015 there will be a $210 million annual shortfall in donor funding for contraceptives — assuming that the commercial sector's market share remains constant and that public-sector programs continue to use an untargeted distribution approach. Sine presented a new set of estimates based on the assumptions that governments and social marketing programs target their programs to the poor and that the commercial sector will meet the contraceptive needs of clients who are able to pay. He then analyzed ten countries — representing regions where most donated contraceptives are supplied — and found that these assumptions decrease the size of projected donor shortfalls by 43 percent. Sine demonstrated the extent to which a targeted approach could unleash the commercial sector's potential to meet contraceptive needs. His findings illustrate the importance of targeting the distribution of subsidized products and show how this strategic use of limited resources, coupled with an understanding of the potential contribution of the commercial sector, can significantly reduce expected shortages of contraceptives due to limited donor funds. An important area for future research related to contraceptive security will be to monitor the impact of more targeted efforts.

HEALTH FINANCING

To supplement the health financing projects being implemented in African countries and Nicaragua, CMS undertook research to investigate issues surrounding the impact of health insurance coverage on family planning and consumers' utilization patterns.

Though there has been longstanding donor interest in expanding insurance coverage to include reproductive health benefits as a way to increase financial access to these services, there has been little empirical investigation as to whether reproductive health coverage actually leads to increased use in reproductive health service. *The Impact of Health Insurance on the Use of Family Planning and Maternal Health Services,* by Alkenbrack et al. (2004) looked at this issue and found that health insurance coverage may not be an effective vehicle for increasing family planning use. A subsequent CMS evaluation in Nicaragua supports this finding. Although many women were unaware that their insurance covered family planning services, once they were made aware of these benefits, a significant proportion of women took advantage of them.

In the African countries of Ghana, Senegal, and Uganda, CMS provided technical assistance to develop or support community-based health financing schemes. In these insurance-type schemes, households pay modest premiums on a regular basis (quarterly or annually) and in return receive a defined set of health care benefits from a local provider without having to pay normal user fees at the time of service. CMS supported these schemes as part of its effort to find innovative methods of health financing that expand the availability of both primary care and reproductive health services in the private sector. A CMS study, *Commercial Market Strategies in Sub-Saharan Africa: Lessons Learned in Community Health Financing,* by Feeley (2003) found that, while such plans are important for averting financial hardships among poorer households faced with unexpected health problems, reproductive health benefits are difficult to add to community-based health financing schemes. Although the costs of prenatal care and family planning services are fairly predictable, they might be of lower priority compared to the insured's desire for protection against the cost of an unexpected serious illness. In addition, a financially independent health plan (i.e., one not linked to a health care provider) is totally dependent on premium income and must practice fiscal conservatism. Such caution may lead decision makers in the community to reject sound analysis indicating that a modest premium increase will cover a new reproductive health benefit. Fear of eroding the membership base is difficult to overcome, even with a market study documenting high willingness to pay the required additional premium. Other factors inhibiting the addition of reproductive health benefits include the lack of organized political support and male domination of plan decision making.

BEHAVIOR CHANGE COMMUNICATIONS AND SOCIAL MARKETING

CMS relied extensively on behavior change communications, usually conducted as part of social marketing programs, to increase consumers' awareness and knowledge of FP/RH products and services and their availability through private or commercial sector sources.

More mature social marketing programs around the world are experiencing flat or declining sales, causing some social marketers to test more generic behavior change approaches. CMS conducted a study, *Using Behavior Change Communications to Overcome Social Marketing Sales Plateaus: Case Studies of Nigeria and India,* (Meekers et al., 2004), which provided empirical information on this issue and addressed whether behavior change communication activities overcome sales stagnation. In India, the BCC campaign aimed to convert oral contraceptive "intenders" to OC users, as well as to address attitudinal and knowledge barriers to OC use. The survey findings suggested that the campaign was successful in converting intenders to users but, at least initially, did not create new intenders. After a two-year lag, attitudes and knowledge toward use of OCs improved dramatically, suggesting that behavior change can take time and that sales and OC use in India are likely to rebound as improved attitudes and knowledge eventually translate into increased intention to use and actual use.

Another key CMS technical study looked at experience from different models or approaches that donor-funded social marketing programs have utilized to achieve health impact. In *Social Marketing Models for Product-Based Reproductive Health Programs: A Comparative Analysis,* Armand (2003a) examined a variety of social marketing models. These include classic NGO-based social marketing, which is more likely to rely on subsidized products and focus on populations with low purchasing power; the manufacturer's model, based on partnerships with commercial suppliers and the use of commercially sustainable brands; hybrid approaches, such as partnerships between NGOs and manufacturers; and umbrella or BCC campaigns to shift behaviors or grow the overall market for a product.

The study highlighted several key aspects among the different models:

- *The choice of a social marketing approach is subject to both goals and context.* Thus a program designed to increase access to products for low-income people or to increase contraceptive prevalence is likely to look very different from a program that aims to grow commercial market share or to improve an NGO's financial sustainability. Key context-related factors include demand, per capita income (which influences ability to pay), and the presence of commercial suppliers.

- *Different products call for different strategies.* Important factors include whether products require provider involvement, whether the product is already established or is being newly introduced, and whether the product is favorably regarded by providers and potential users.

- *Local NGOs and family planning associations can help sustain programs after a donor phase-out.* Commercial partners, though willing to support social marketing efforts, are not necessarily in a position to implement them, often constrained by either internal capacity or legal barriers. In these situations, local NGOs or family planning associations can support social marketing activities with funding from a manufacturer or distributor, as was the case in both the SOMARC condom program in Turkey and the CMS oral contraceptive program in Morocco.

To better inform efforts to strengthen commercial reproductive health service for youth, CMS conducted a quantitative analysis of the factors that promote and deter commercial-sector condom source choice among adolescents in Jamaica and urban Cameroon.

- *Subsidized, NGO-based social marketing is appropriate for low-demand, low-income countries.* For low-income countries, few opportunities for partnerships exist until market priming activities begin to produce results. In these countries, subsidized programs channeled through social marketing organizations and NGOs may be more likely to produce the health impact expected by donors and ministries of health.

A related technical study, *The Sustainability Challenge: Identifying Appropriate Financing Models for Social Marketing Programs,* by Armand (2003b), addressed the trade-offs that social marketing managers must make in implementing programs in different country contexts and in seeking to achieve some measure of financial or programmatic sustainability. The critical factors most likely to affect the success of these approaches are per capita gross national income (a proxy for ability to pay), donor presence and commercial activity, and the market potential for social marketing products. Armand recommended that social market-

ing programs should be adapted to their local contexts and evolve over time because demand for products and willingness to pay are likely to change, creating opportunities for increased cost recovery and greater program efficiency.

An important area for future research will be to assess the impact of various social marketing models on both method prevalence and sustainability after accounting for socioeconomic context, level of market attractiveness, level of competition, and other such factors.

YOUTH

To better inform efforts to strengthen commercial reproductive health service for youth, CMS conducted a quantitative analysis of the factors that promote and deter commercial-sector condom source choice among adolescents in Jamaica and urban Cameroon. In *Determinants of Commercial-Sector Condom Source Choice Among Adolescents: Jamaica and Urban Cameroon,* Berg and Zellner (2004) used data from recent adolescent household surveys to examine the effects of service access (geographic, psychological, and financial), the demand for service quality, and the demand for condom quality on commercial-sector source choice relative to three alternatives — informal-sector source choice (e.g., friends, partners, or relatives), public-sector source choice, and non-use of any contraceptive method (i.e., no source).

The study found that financial access is an important determinant of commercial-sector use among youth; embarrassment surrounding the purchase of condoms increases the likelihood that girls in both countries rely on informal sources, such as sexual partners, for condoms instead of the commercial sector; a preference for privacy and low prices can reduce the likelihood that boys obtain condoms from the commercial sector; and boys concerned about condom strength and reliability may be more likely to procure condoms from commercial sources than from the informal sector.

The study findings suggest that a key strength of the commercial sector is that youth perceive that it offers relatively high-quality products. A central limitation in both Jamaica and urban Cameroon, however, is that some young people cannot afford commercial-sector condoms and as a result may choose either not to use condoms at all (e.g., Cameroonian girls) or to rely on informal sources, such as friends and relatives for condoms. The findings also suggest that commercial-sector outlets can be even more successful than they already are at attracting young people by improving privacy, making condom purchase less embarrassing, and providing health information.

Given the large role that the informal sector plays in the provision of condoms to adolescent boys and girls, important areas for future research will be to identify (1) the extent to which young people pay for condoms in the informal sector, (2) the price differential between condoms from the informal sector and condoms from the commercial sector, and (3) the extent to which condoms in the informal sector come originally from the public or commercial sectors. Such information can inform program decisions about whether formalizing the informal distribution of condoms through peers would be an effective way to increase access to quality condoms among young people.

CORPORATE SOCIAL RESPONSIBILITY

Corporate social responsibility activities can range from business ethics and corporate philanthropy to integrated programs that are linked to a company's core business. Many CSR programs are run by corporations alone, but there is growing appreciation for the synergies created by CSR partnerships between corporations and the public sector, donors, or NGOs. Although health-related CSR programs are fairly common, reproductive health and family planning is under represented in the global portfolio of CSR programs. CMS conducted research to learn more about how reproductive health and family planning might be included in CRS programs.

CMS conducted in-depth interviews with more than 50 business representatives whose companies are well known for their CSR programs. CMS's research was designed to unearth some of the depth and detail of CSR processes from the perspective of the corporations, seeking to understand why corporations

become involved in CSR, as well as *how* they do it, so that this knowledge could be applied to potential RH initiatives.

Corporate Social Responsibility: Opportunities for Reproductive Health, by Benton et al. (2004) found that corporate culture and values drive CSR initiatives — there are usually both internal and external motivations for the programs. Most companies do not view social and financial responsibilities as mutually exclusive and in fact link CSR to their business strategies. CMS also found that a company's stakeholders are very influential in the formulation and design of its CSR program and that companies are increasingly interested in forming partnerships with the public sector or NGOs, in order to bring technical expertise or other resources to CSR programs.

Many businesses are starting to see the benefits of moving beyond traditional commercial activities to address social or health problems in their own workforce, in their communities, and in the world.

Few of the examined programs addressed reproductive health issues, and opportunity to influence in-place CSR programs is probably limited. As companies expand CSR to address broader issues of infrastructure and systemic problems, the opportunity to include reproductive health projects may present itself. For companies that have an overall global CSR policy, but give field offices discretion about implementation, it may be possible to help the field determine what types of reproductive health programs would make the most sense within the local context.

While many companies are eager to address HIV/AIDS under CSR activities, they appear to find it more difficult to embrace FP/RH as a stand-alone activity. It is unclear what rationale lies behind this reluctance, but possible reasons might include

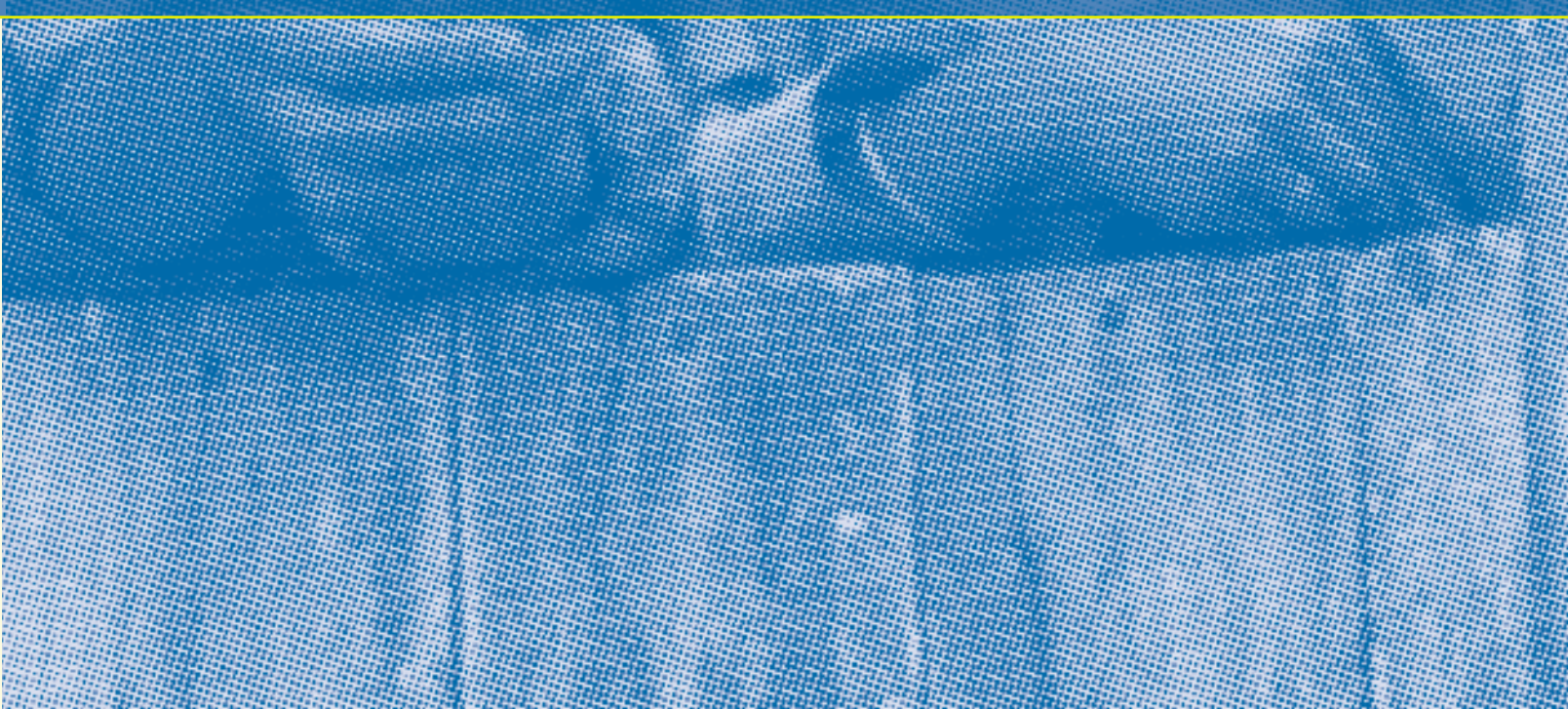
- HIV is seen as impacting entire communities and the workforce, while family planning is seen as less urgent.
- HIV has global appeal as a cause, and global media coverage has de-stigmatized HIV/AIDS prevention programs.
- Family planning is still viewed as a "women's issue," whereas HIV/AIDS affects both men and women, and all classes of employees. Most companies are still headed and staffed by men.
- Companies may be skittish because of historical abuses within employer-sponsored family planning initiatives for female employees, which included forced pregnancy tests, termination due to pregnancy, and even forced use of oral contraceptives.

However, opportunities do exist for donors to encourage companies to include family planning programs. One way to do this is to help companies to rationally and programmatically link and bundle FP/RH to HIV or other initiatives. There is a clear overlap between HIV prevention programs and family planning. Many HIV programs distribute free or

subsidized condoms and include an information and education component. Programs could incorporate messages about condom use for "dual protection" against both pregnancy and HIV/AIDS and STIs. Programs can emphasize that condoms are an effective family planning method for use by couples who wish to delay or space births while protecting themselves against HIV and other sexually transmitted infections. Any health initiative that includes an education component can include information on family planning, maternal and child health, pregnancy testing, and STIs. Unlike other health issues, reproductive health and family planning needs are nearly universal among stakeholders, and donors can emphasize this point when working with companies.

Many businesses are starting to see the benefits of moving beyond traditional commercial activities to address social or health problems in their own workforce, in their communities, and in the world. With a relatively small investment, companies could make a tremendous impact by incorporating reproductive health into their CRS programs.

5 Lessons Learned



LESSONS LEARNED

The body of experience from CMS programs, technical assistance, initiatives, and research has yielded exciting and valuable lessons for private-sector family planning efforts. One of the fundamental lessons has been that effective partnerships can be created with the private sector across diverse program areas. The CMS portfolio of programs has demonstrated that donors and private organizations can collaborate to achieve mutually congruent objectives, in both health and business terms.

Chapter 5 summarizes key lessons from the CMS project, organized under the primary technical strategies pursued under the contract: social marketing, private providers, NGO sustainability, health financing, corporate social responsibility, and policy. These lessons attempt to synthesize key programmatic issues in each area, while providing recommendations for future research in certain technical disciplines.

SOCIAL MARKETING

Social marketing was the cornerstone of many CMS programs, and a wide range of social marketing models were used. These include *classic NGO-based social marketing,* implemented in countries such as Madagascar, Senegal, and Uganda, either through an NGO or by a project-created organization; the *manufacturer's model,* implemented in countries such as India and Morocco in partnerships with pharmaceutical manufacturers; and some *hybrid approaches,* such as the new condom *(Aganzi)* launched in Ghana by the NGO GSMF as a new commercial venture.

Some key lessons from a variety of approaches to social marketing:

- *NGO-based models are harder to sustain without continued donor funding and must be targeted to low-income and hard-to-reach populations.* While the *Aganzi* condom was able to generate "profits" for GSMF, thus enabling it to service its loan to Summa, the programs in Senegal, Madagascar, and Uganda continued to rely on USAID funding after transitioning from CMS. Given the pressing health needs and economic contexts of these countries, however, the choice of this social marketing model should take short-term priority over efforts to achieve program sustainability.

- *The manufacturer's model has greater inherent product sustainability through the use of existing commercial brands, but may be limited in meeting the needs of people outside the mainstream, middle-income population.* The CMS programs in India and Morocco were able to accomplish their objectives through partnerships that reinforced the marketing of commercially sourced products, thereby strengthening markets and expanding the availability of needed products. However, in Senegal this approach did not succeed in introducing commercially marketed oral contraceptives due to limited purchasing power among targeted Senegalese consumers and the constraints of the pharmaceutical partner. This experience reinforced the need to design social marketing activities with full consideration of project goals, cost considerations, market context, and the financial limitations of potential commercial partners.

- *Hybrid approaches that include partial or total cost-recovery and income-generating activities and partnerships between NGOs and manufacturers represent the next generation of social marketing programs.* The CMS experiences in countries such as Brazil (BEMFAM), the Dominican Republic (ADOPLAFAM), and Nicaragua (Profamilia) suggest that NGOs can advance along the "sustainability continuum," and recover a substantial portion of operating or total costs, if they operate in a more business-like manner and expand their services to a broader clientele that can afford to pay for quality services. The trade-off in such situations is that NGOs may de-emphasize their efforts to serve lower-income clients, who traditionally have relied on free or highly subsidized services. Thus donors should consider what objectives they hold paramount in encouraging NGOs to become more sustainable.

- *Social marketing programs can stimulate private-sector participation.* The *SmartNet* experience in Uganda is evidence that the introduction of appropriately priced socially marketed products can attract both private manufacturers and distributors who are interested in supplying affordable products.

- *Pharmaceutical firms can be encouraged to invest in family planning products.* In response to CMS initiatives, commercial manufacturers in India, for example, increased their investment in the oral contraceptive market and expanded their marketing repertoire. Partner firms launched new brands and products (a progestin-only pill, for example), reorganized their detailing teams, paid CMS to conduct training sessions on evidence-based medical detailing, and produced point-of-sale materials for chemist shops and doctors.

- *Sales data are not sufficient for understanding program impact.* The CMS *Goli ke Hamjoli* program in India, launched in 1998, promoted the use of low-dose pills in young urban women and sought to remove barriers to oral contraceptive use. The study results showed that behavior change communications can help define program impact and achieve higher sales. Some results take more time. The minimum intervention period therefore should be three years.

- *Population-based research provides essential insights.* In Uganda and elsewhere, population-based research helped identify more precise targets for condom promotion and highlighted increased adoption of other behaviors, including abstinence and partner reduction. Because of such research, CMS was able to develop more comprehensive programs and partnerships with NGOs and to modify its work plan to include a multi-behavioral approach to HIV/AIDS prevention.

CMS experience shows that involving commercial and for-profit partners at various stages of campaigns is possible in most countries. Commercial networks can be leveraged in all but the least-developed context; commercial brands can be substituted for donated products; donated portfolios can be diversified and segmented with commercial brands; and social marketing brands can be licensed to commercial suppliers after reaching self-sufficiency.

Commercial partnerships are most likely to succeed when a number of key conditions are present:

- the social marketing program is compatible with corporate priorities that include market development and not just profit maximization,
- the method or product is established and in high demand,
- users have access to commercial outlets,
- users can afford commercial brands, and
- free or subsidized products do not "crowd out" commercial brands.

The positive and negative factors that determine commercial involvement are likely to evolve over time — including, in particular, demand and ability and willingness to pay.

The positive and negative factors that determine commercial involvement are likely to evolve over time — including, in particular, demand and ability and willingness to pay. The first sign of such evolution is usually the appearance of commercial suppliers in a market. Over time, commercial brands may even outspend socially marketed brands and thus capture their market share. Such an event should not be seen as a failure but as a sign that the program has successfully primed the market (as has been the case in Turkey and Morocco).

FUTURE RESEARCH DIRECTIONS

An important area for future research is the relative impact that behavior change campaigns, rather than the commonly adopted brand-specific social marketing campaigns, can have on more nascent programs. Another area of useful research is the relative effectiveness of various interpersonal behavior change interventions compared with broader mass media behavior change approaches. Finally, more rigorous research is needed regarding method-specific and context-specific price sensitivity — in particular, research is needed to help social marketing programs balance trade-offs between maximizing access to, and maximizing the sustainability of, social marketing products.

PRIVATE PROVIDERS

CMS worked with private providers, both for-profit and non-profit, to improve the supply of high-quality affordable family planning and other health products and services in the private sector. In the for-profit sector, CMS worked with individual providers (e.g., pharmacists, doctors, midwives) and larger provider groups (e.g., clinics and hospitals).

CMS found that individual providers could be difficult to reach on a large scale without an organizing structure. Therefore, working with provider associations and provider networks was a more effective means of reaching large number of practitioners. Provider networks, in particular, are effective at increasing use by improving quality and access to a standardized package of affordable services. Since most providers identified access to credit as a major constraint, CMS used financing, offered through the Summa Foundation, to help providers achieve scale and improve quality. Integrating family planning services into MCH services attracts more clients and enhances profitability and thus is another means of interesting providers.

By working with a wide variety of providers CMS found that

- *A fractional franchise model can improve service quality at independent, private-provider clinics.* The contractual relationship, which forms the basis of the fractional franchise model, permits the franchiser to regularly monitor the service quality of participating clinics and establishes a framework within which to provide corrective feedback.

- *Improving access to financing is an effective strategy for improving quality of care among individual providers.* Access to small amounts of financial assistance, supported by business training, can help providers improve financial viability and service quality. Borrowers improved on such key measures of service quality as drug availability and privacy and strengthened their financial viability through a higher rate of savings.

- *Detailing is an effective technique for improving reproductive health knowledge on a large scale among private providers.* Training private providers on a large scale has always been a challenge. Detailing, or making frequent short visits directly to the private providers, is a technique used successfully by the pharmaceutical industry to reach a large number of private providers. CMS successfully used detailing in India, Jordan, and Cameroon as a means of improving, on a large scale, the attitudes and knowledge of private providers on a variety or reproductive health products.

- *Offering affordable, high-quality services can succeed in shifting clients who can afford to pay from the public sector to the private sector.* CMS research demonstrated that health care clients who have the ability to pay can be shifted from the public sector to the private sector, thereby decreasing the burden on government. High quality seems to play a major role in both attracting and retaining clients.

- *Private providers are willing to invest resources to promote and deliver quality reproductive health care.* Private providers realize the importance and value of promoting and delivering reproductive health care, particularly in a managed-care model where unintended pregnancy and maternity impact cost recovery and therefore sustainability.

FUTURE RESEARCH DIRECTIONS

Although private provider networks can be effective vehicles for improving quality of care in the private sector and for increasing clinic-specific reproductive health care visits in the short run (less than two years), the impact may not be evident. Given the potential of provider networks to provide quality reproductive health services on a large scale, programs would benefit from research that investigates whether such higher-level outcomes result over a longer time frame.

NGO SUSTAINABILITY

NGOs, which often serve low-income and underserved populations, can be an important source for reproductive health care, including family planning services and products. However, they face several challenges: decreased donor funding, achieving financial sustainability without compromising the organization's social mission, confusion between commercial and public health activities, competition with free or subsidized public-sector products and services, and regulations that hurt or ignore the NGO or private sector.

Although no single definition exists for sustainability, there is consensus on what sustainability includes: a reduction in donor dependency, an increase in financial and managerial self-sufficiency, continued health impact or a sustained social mission, the ability to manage resources cost effectively, flexibility in a changing environment, and a long-term process.

- *For clinic-based NGOs, curative and ancillary services can lead to greater financial sustainability and cross-subsidized preventative services.* For example, in Brazil CMS was able to significantly improve BEMFAM's cost-recovery rate by the addition of laboratory services, which allowed it to expand its traditional services.

- *NGO-based clinics can achieve high levels of financial sustainability in a relatively short time frame, assuming certain conditions are in place.* In Nicaragua, for example, the relevant factors included use of a market assessment to ensure willingness and ability to pay; prices set based on the market; commitment to quality; a service mix that took cost recovery into consideration; cost-sharing agreements with doctors; ongoing monitoring to ensure customer satisfaction; clinic location; and provision of integrated services.

- *Sustainability improvements need to be achieved through a systematic, organization-wide approach.* Most NGO sustainability programs undertaken by CMS required support for three "pillars" of sustainability: institutional strengthening, including improved governance and internal systems; marketing capacity to develop new services and attract clients; and financial capabilities to develop, implement, and track coherent business plans and sustainability objectives. Supporting these three pillars in order to reinforce the organization's evolution to a more business-like processes and operations required a long-term process and commitment by the NGO in order to succeed.

FUTURE RESEARCH DIRECTIONS

The emphasis on achieving financial sustainability improvements was at times at odds with the NGOs' longstanding social missions to help vulnerable populations and those unable to pay for products and services. To help NGOs resolve such trade-offs, more operations research is needed to document whether, and under what circumstances, NGOs can still reach or serve their traditional target populations while pursuing middle-income clients with higher-income-producing strategies.

HEALTH FINANCING

CMS implemented activities in several country programs to reduce financial barriers and thus increase access to family planning and related health services.

In Ghana, Senegal, and Uganda, CMS provided technical assistance to either develop or support community-based health financing schemes. Under these insurance-type schemes, households pay modest premiums on a regular basis (quarterly or annually) and in return receive a defined set of health care benefits from a local provider without having to pay

normal user fees at the time of service. The CMS experience from these efforts showed that

- *Community-based health plans can improve access to private health services and can have a significant economic effect on member households.* For example, the plan in Uganda was effective in improving utilization of health services and in reducing the need to borrow or to sell an asset to pay for health costs.

- *Community health financing plans can contribute to disease prevention.* An example is the successful *In-Net* experiment by CMS/Uganda, which marketed insecticide-treated bed nets through participating community financing schemes. The schemes were willing to partially subsidize the cost of the nets once they recognized the prevalence of malaria in the insured population and its negative effect on plan profitability.

- *Reproductive health benefits are difficult to add to community-based health financing schemes.* Because the costs of prenatal care and family planning services are fairly predictable, they may be of lower priority compared to the insured's desire for protection against the cost of an unexpected serious illness. In addition, a financially independent health plan (that is, one not linked to a health care provider) is totally dependent on premium income and must practice fiscal conservatism. Such caution may lead decision makers to reject sound analysis indicating that a modest increase in premium will cover a new reproductive health benefit. Fear of eroding the membership base is difficult to overcome, even with a market study documenting high willingness to pay the required additional premium. Other factors inhibiting the addition of reproductive health benefits include the lack of organized political support and male domination of plan decision making.

The CMS technical initiative in Nicaragua to increase the utilization of covered family planning services under a "contracting out" model yielded important lessons:

- *Just covering the service is not enough.* Prior to the CMS intervention, a preponderance of female clients did not utilize the covered family planning services, and a large percentage instead used public-sector or other private sources at additional costs, even though they were satisfied with other services offered by their providers. Clients did not know that family planning services were covered, and the providers did not promote the services to minimize their costs in a "capitated" service model.

- *Active promotion of the availability of these services can increase the volume of family planning services obtained through the insurance plan.* With relatively modest resources, providers can attract clients in need of family planning and reproductive health services, particularly if there are evident savings from averting costs from pregnancies or related benefits. One of the participating providers even offered the services to spouses, at no cost, in order to increase the chances of reaping such savings.

- *Donor-funded projects can play an important role in providing state-of-the-art clinical training and family planning counseling skills to private providers to ensure that quality services are being rendered to their clients.* Since many USAID projects already train public-sector providers, there may be opportunities to train private providers to ensure that national protocols and standards are enforced and that private-sector clients are given quality services and information.

FUTURE RESEARCH DIRECTIONS

A promising area of future research involves determining whether more active promotion of family planning benefits in insurance schemes strengthens the impact of insurance coverage on family planning use, particularly whether it increases the private-sector share of contraceptive distribution. In addition, as developing countries reform their health care systems and begin to include family planning and reproductive health as covered benefits in private health insurance plans, it will be useful to examine whether such reforms can help to shift users from public-sector programs.

CORPORATE SOCIAL RESPONSIBILITY

CMS endeavored to create viable partnerships with the corporate sector in a number of country settings, notably India, Morocco, Jordan, Ghana, Uganda, the Philippines, and Brazil. Many of these partnerships were formed in the context of support for social marketing programs. CMS also continued working in the area of employer-based initiatives, to mobilize the private sector to provide employees with access to family planning services in the workplace. This model was especially relevant in African countries in order to promote the importance of HIV/AIDS prevention. In countries such as Ghana, Uganda, Namibia, and the Philippines, CMS fostered partnerships with private companies and industry associations to urge the private sector to play a more visible and "socially responsible" role in the area of reproductive health.

Key lessons from these corporate social responsibility programs are

- *Interest among companies for supporting family planning programs is usually limited, as these are seen as being the responsibility of the public sector or donors.* CMS research in this area confirms that private companies do not see a compelling need to commit their corporate resources for just family planning. In many African countries, where HIV prevalence is rising, however, there is tremendous motivation to support HIV/AIDS prevention or treatment programs. This interest is creating many opportunities for local groups and NGOs to develop or implement HIV/AIDS prevention for corporate clients, thereby creating a source of new revenues for well-qualified organizations, such as GSMF.

- *Working through industry associations is a cost-effective way of scaling-up workplace programs.* HIV/AIDS prevention and awareness initiatives with individual companies are not cost effective, as they do not reach enough high-risk people. While considered a success, the Ghana/Unilever intervention reached only 2,100 employees. Working with Ghanaian industry associations whose member companies employ significant numbers of moderate- to high-risk workers is more cost effective. CMS's work with the Ghana Chamber of Mines reached 18,000 high-risk miners and 200,000 community members.

- *The private sector is interested, and has an important role to play, in providing antiretroviral therapy for treatment of HIV infection.* In assessing sites to support ARV treatment, CMS found interest was high in learning how to provide quality ARV therapy. In Ghana, several companies were already prescribing ARVs, and at least three large multinational employers have made commitments to provide ARV treatment for their employees in the future. With the cost of the drugs falling, more companies will be able to afford ARV therapy, and the importance of building capacity to distribute them will increase.

IMPROVING THE POLICY ENVIRONMENT

A conducive environment is a necessary precondition for the delivery of private-sector products and services, and especially for their sustainability.

CMS was often able to achieve policy changes specifically because they were linked to other CMS interventions, such as social marketing or provider networks. Private-sector partners are invested — financially and programmatically — in the programs and, therefore, are willing to advocate and use their influence to try to change policy regimes. Decision makers in government are usually aware and often supportive of those initiatives and are therefore more receptive to considering policy change. Finally, research conducted to inform programs might also be effectively used to enlighten the debate about specific policy changes.

Key CMS lessons in the policy area include

- *Advocacy of population issues requires identifying influential champions.* This strategy was both effective in removing regulatory barriers such as taxes and duties and in bringing population issues to the fore by influential private-sector champions, such as medical associations and business organizations.

- *Be opportunistic.* Windows of opportunity may arise because of fortuitous timing or because of the interest of an influential policy champion or decision maker. In Jordan, CMS found a supportive ally in the Ministry of Finance and together successfully lobbied the customs office and the sales tax department to have duties and taxes on condoms removed. Eventually, CMS lobbied for removing taxes on all contraceptives.

- *Continually monitoring the environment for potential obstacles or opportunities, and collaborating with influential partners and decision makers, is essential for success in a challenging environment.* This is especially true for conservative countries. For example, in an effort to anticipate and curtail opposition to the launch of a new pill in Senegal, CMS/ADEMAS vetted all key decisions with a technical committee that included representatives from the Ministry of Health, as well as pharmacists, physicians, and midwives. The committee agreed to a branded advertising approach — a first in Senegal — that an earlier CMS/ADEMAS study determined to be legal. Despite these proactive efforts to build support, the project experienced a setback when some members of the technical committee reversed their support for branded advertising. The project was forced to suspend its advertising campaign until the Ministry of Health intervened.

- *Utilize data to support policy change.* Studies and data were highly valuable in successfully arguing for policy change. CMS conducted a legal and regulatory assessment prior to launching the social marketing of an oral contraceptive. The assessment found that despite the widely held perception that media advertising for oral contraceptives is illegal, no such prohibition existed. There was backlash from a group of pharmacists after CMS launched its product, but the Ministry of Health was supportive and used the information from the CMS assessment to explain that the campaign was legal.

- *The process of public–private dialogue is important for building relationships and trust, above and beyond the outcome of the initiative that inspired the dialogue.* In Uganda, for example, CMS participation in a working group on public-private partnerships for health was instrumental in bringing private-sector providers into the dialogue process. CMS was able to secure private-provider participation only because the project had developed an ongoing relationship with providers through the Summa/CMS provider loan fund. Having private providers at the table with public-sector representatives strengthened public-private understanding and respect.

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