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Commercial Approaches to Reproductive Health

Innovations, Results and Lessons Learned

COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

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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.

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ABSTRACT
The Commercial Market Strategies (CMS) project is the first USAID contract to be implemented under the Commercial and Private Sector Strategies (CAPS) Results Package, a 10-year package that seeks to increase use of family planning and other health products and services through private-sector partnerships and commercial strategies. The CMS contract began in October 1998 and ended in September 2004. An end-of-project conference was held on December 9, 2003, to present and summarize the lessons and experiences of the CMS project. The conference, entitled "*Commercial Approaches to Reproductive Health: Innovations, Results, and Lessons Learned*," included a series of presentations and panel discussions on a number of technical areas, strategies, and programs implemented by CMS. This report summarizes the proceedings from the CMS end-of-project conference.

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Introduction

The Commercial Market Strategies (CMS) project is a contract of the United States Agency for International Development's (USAID's) Bureau for Global Health, Office of Population and Reproductive Health. CMS is the first contract to be implemented under the Commercial and Private Sector Strategies (CAPS) Results Package, a 10-year package that seeks to increase use of family planning and other health products and services through private-sector partnerships and commercial strategies. The CMS contract began in October 1998 and is scheduled to end in March 2004.

An end-of-project conference was held on December 9, 2003, to present and summarize the lessons and experiences of the CMS project. The conference agenda is attached as Appendix A. The conference, entitled "*Commercial Approaches to Reproductive Health: Innovations, Results, and Lessons Learned*," included a series of presentations and panel discussions on a number of technical areas, strategies, and programs implemented by CMS. This report summarizes the proceedings from the CMS end-of-project conference. For those looking for a more detailed description of the CMS project and its results, CMS will be producing a final report, available in the summer of 2004. In addition, the CMS web site — www.cmsproject.com — provides detailed descriptions of CMS programs as well as access to all the major CMS research studies, including many discussed in this report.

Opening Plenary

Introductory Remarks

Robert Bonardi, Project Director, CMS

Introduction and Objectives

Project Director Robert Bonardi opened the conference by welcoming the audience. He noted that the purpose of the conference is to look at the strategies used and results achieved by the Commercial Market Strategies (CMS) project in working with the private sector to expand delivery of family planning services in developing countries. He identified the objectives of the conference as:

- Taking stock of the principal strategies used to collaborate with the private sector, see what has worked and how these strategies have evolved over time.
- Looking at programs from the perspective of private-sector partners, such as pharmaceutical companies, private providers, and employers, and determining what attracts the private sector so that these programs can be replicated in different countries.
- Look at the implementation challenges and successes experienced by CMS, and to share lessons learned from its programs.

Mr. Bonardi then went over the agenda for the day and introduced the next speaker, Ms. Margaret Neuse, Director of USAID's Office of Population.

Margaret Neuse, Director, Office of Population and Reproductive Health, USAID

Why Commercial-Sector Strategies?

Ms. Neuse provided background information on the rationale for working with the commercial sector. She stressed that along with current rates of population growth, public-sector resources for reproductive health are declining, resulting in a resource gap where many clients will go without services unless affordable, accessible, and high-quality private sector health services are made available. USAID has worked for the last 20 years to improve the affordability, accessibility and quality of private sector reproductive health and family planning services by supporting a number of global and bilateral programs that promote the private sector's role in delivering reproductive health care in developing countries. These programs include:

- Social marketing programs to promote and introduce new methods and expand availability of existing methods
- Collaborative efforts with private providers to form franchised networks that provide family planning services
- Efforts that improve the ability of NGOs to offer affordable quality services
- Work-based programs with local employers to promote family planning

The Commercial Market Strategies project has carried forward USAID's efforts to strengthen the private sector in RH/FP service delivery worldwide, implementing programs in 20 countries. An important part of the mandate of such centrally funded programs is CMS's technical leadership, which has allowed USAID to learn valuable lessons about working with and through the private sector to achieve public health goals. These lessons include:

- The commercial sector and NGOs are important partners in expanding access to RH/FP products and services in developing countries. Over the longer term, the commercial sector can be key in sustaining services and ensuring that scarce government resources are used to subsidize only those in greatest need of assistance.

- Reproductive health and family planning products and services are best delivered through the private sector by being integrated with other services. On their own, family planning products and services are not profitable or sufficiently attractive to enough clients.

- While there is great potential for a variety of types and levels of public–private partnership to advance USAID's goals in global health generally and in reproductive health specifically, mechanisms are needed to bring partners together, test promising models, and scale up proven strategies.

Ms. Neuse also stressed that many challenges remain, including those that relate to the use of the private sector to achieve public health goals:

- How can public-sector subsidies be targeted effectively so that consumers who can afford to pay are motivated to seek services in the private sector?

- How can the quality of services delivered through private-sector providers be assured, particularly when a focus on quality may conflict with the sector's focus on profit making?

Other challenges more specific to family planning and reproductive health include:

- How to interest the private sector in offering reproductive health and family planning services when, like other preventive services, family planning (FP) has a low profit margin and does not generates large client volume.

- How to finance family planning service delivery through the private sector. Are clients able and willing to pay, or can other payment mechanisms be created, such as employer-based approaches or third-party insurance to facilitate access to private sector services?

In designing CMS, Ms Neuse noted that USAID chose a broad approach to working with the private sector, using a variety of strategies. She closed by saying that the audience looked forward to hearing how these strategies were implemented by CMS over the past five and a half years, and what results have been achieved, and lessons learned. She reiterated that private sector programming remains an important priority at USAID, and that the day's discussions on CMS experiences can help inform ongoing and future program implementation in this area.

CMS: Strategies and Accomplishments

Robert Bonardi, Project Director, CMS

Overview of CMS Project

Project Director Robert Bonardi provided an overview of the CMS project. The USAID-funded CMS project is managed by Deloitte Touche Tohmatsu (prime contractor), Abt Associates, and Population Services International. The project is funded by USAID's Service Delivery Improvement Division of the Office of Population and Reproductive Health. The project's budget ceiling over a five-year period has been $88 million, and during its project life CMS has worked in 27 countries. CMS also managed the Summa Foundation, a nonprofit organization providing loans and technical assistance to providers and non-governmental organizations (NGOs) to expand reproductive health products and services.

CMS' strategic objective is to increase use of high-quality family planning and other health products and services through private-sector partners and commercial strategies. To achieve this objective, CMS works to: (1) increase the demand for high-quality family planning and other health products and services from the private sector; (2) increase the supply of affordable family planning and other health products and services through commercial approaches; and (3) improve the environment for the sustained delivery of those products and services through the private sector. "Private sector" refers to commercial or for-profit organizations, as well as nonprofit organizations such as NGOs, private voluntary groups, and professional associations.

Working effectively with the private sector requires an understanding of that sector's motivations. The commercial sector is motivated by profits, which it earns by responding to the needs of consumers or by building and expanding markets for goods and services. The corporate world is also interested in serving its workers and improving the communities where they work. These motivations provide opportunities to create partnerships to reach the public health goals that USAID and other donors want to achieve.

CMS utilizes seven technical approaches to achieve its objectives:

- *Social Marketing*, which uses commercial techniques for marketing health products or services to achieve improved health outcomes. Strategies used include market segmentation; promotion, advertising and distribution; and behavior change communications.

- *Strengthening Private Providers,* including such strategies as establishing provider networks and franchises to improve access to a range of high-quality, affordable services. Other strategies include establishing group practices to help increase efficiency, implementing large-scale training programs to improve quality of care, and providing financing and business skills training to expand provider capacity and sustainability.

- *NGO Sustainability,* which includes enhancing the sustainability of health care NGOs through training and assistance in business planning, marketing, finance, cost control, and governance.

- *Corporate Social Responsibility,* which leverages corporate resources for health initiatives. Strategies include workplace programs for family planning and HIV/AIDS prevention and treatment, and establishing and expanding corporate health policies.

- *Health Financing*, including improving access to health services and products through alternative payment mechanisms. Strategies used include community based insurance plans that pool resources to offset financial risk; the integration of family planning and reproductive health into existing health insurance plans; use of third party payment mechanisms, such as vouchers; and working with social insurance programs that contract with private providers or NGOs to deliver reproductive health and family planning services.

- *Summa Foundation*, a non-profit entity that provides financing and technical assistance to stimulate and expand the role of the private sector in the delivery of affordable health services and products. Strategies employed by Summa include both loans and technical assistance to private providers, NGOs, commercial clinics, and hospitals.

- *Policy Reform*, targeted at improving the environment for private-sector delivery of health products and services. Strategies used include removing regulatory barriers to private-sector expansion, improving the climate for the private-sector provision of reproductive health services, and promoting dialogue between the public and the private sector.

In addition to these technical areas, two additional key components of the CMS project have been research, monitoring, and evaluation efforts; and dissemination of findings and lessons learned from programs, technical activities, and research.

Ruth Berg, Research Director, CMS

CMS Research and Evaluation: An Overview

Dr. Berg discussed the monitoring and evaluation objectives of CMS research, highlighted key findings from CMS technical studies, and outlined key program questions addressed by CMS evaluation studies.

The two main objectives of CMS research and monitoring and evaluation efforts are to: (1) grow the knowledge base through technical studies on the strengths and limitations of commercial strategies to improve reproductive health, and to (2) inform and evaluate CMS programs, done primarily through country-specific research.

CMS has performed 10 technical studies to date. These include:

1. *What Influences the Private Provision of Contraceptives?*

2. *Broadening Commercial Sector Participation in Reproductive Health: The Role of Public Sector Prices on markets for Oral Contraceptives*

3. *How Much is Enough? Estimating Requirements for Subsidized Contraceptives*

4. *The Influence of Maternal and Child Health Service Utilization and Access to Private Sector Family Planning Services on Subsequent Contraceptive Use*

5. *Patterns and Determinants of Commercial Sector Use among Adolescent Condom Users in Jamaica and Urban Cameroon*

6. *The Impact of Health Insurance on the Use of Family Planning and Maternal Health Services*

7. *The Impact of Development Loans on the Delivery and Sustainability of Reproductive Health Services in Developing Countries*

8. *Behavior Change Communications in Social Marketing Programs with Stagnating Sales: Case Studies of Nigeria and India*

9. *The Importance of Socio-Economic Context for Social Marketing Models*

10. *Social Franchising as a Strategy to Expand Access to Reproductive Health Services: A Case Study of the Green Star Service Delivery Network in Pakistan*

Dr. Berg presented key findings from six of these studies:

- *What Influences the Private-Sector Provision of Contraceptives?* by Randy Bulatao. The author examines the private-sector share of the contraceptive market. His analysis includes five case studies as well as a cross-national regression analysis of 62 developing countries. The case study finding that stands out is that competition from the public sector, especially with respect to contraceptive pricing, reduces private-sector share. The cross-national regression results show that private-sector share increases as market size increases. Private-sector share also increases as country program effort scores for method access and marketing increase, and as the duration of social marketing programs increases. Conversely, private-sector share decreases as competition from the public sector increases.

- *Broadening Commercial Sector Participation in Reproductive Health*, by Karen Foreit. This study focuses on competition from the public sector, with a focus on the oral contraceptive market in particular. Research questions addressed by the study include examining the impact of public-sector pricing on commercial markets. The analysis found that as public-sector oral contraceptive (OC) prices rise, the use of commercial-sector outlets and commercial share both increase. In addition, the active promotion of free products can reduce commercial sector share without increasing use.

- *How Much is Enough? Estimating Requirements for Subsidized Contraceptives,* by Jeff Sine. The author asks: What would be the savings in commodity costs to donors and governments if contraceptive subsidies were better targeted to the poor? The study provides an alternative view to the estimates developed by John Ross regarding the need for donated contraceptives. Among the findings: a potential savings of $34 million dollars in 2015 alone in the 10 countries studied.

- *Determinants of Commercial-Sector Use among Adolescent Condom Users in Jamaica and Cameroon,* by Ruth Berg and Sara Zellner. This study seeks to understand what attracts youth to the commercial sector for their condom needs and what serves as a barrier to the sector. The findings indicate the need to continue focusing on improved privacy and confidentiality. The findings also show that the demand for convenience had no effect on condom source choice. Lastly, the analysis shows that lack of financial access is a barrier to greater commercial use in both Jamaica, a fully commercial condom market, and urban Cameroon, a heavily subsidized market.

- *Impact of Health Insurance on Use of Family Planning and Maternal Health Services*, by Sarah Alkenbrack, Leanne Dougherty, and Bill Winfrey. Although there has been longstanding donor interest in expanding insurance coverage to include reproductive health (RH) benefits as a way to increase financial access to these services, there has been little

empirical investigation of whether RH coverage actually leads to increases in service use. The study suggests that health insurance coverage is not always an effective vehicle for increasing family planning use. To help explain this finding, a subsequent CMS evaluation in Nicaragua found that many women were unaware that their insurance covered family planning services. Once made aware of these benefits, however, a significant proportion of women took advantage of them.

- *Behavior Change Communications in Social Marketing Programs with Stagnating Sales: Case Studies of Nigeria and India,* by Dominique Meekers and Ronan Van Rossem. 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. This study aims to provide additional empirical information on this issue and asks, "Can behavior change approaches overcome sales stagnation?" In India, the behavior change communications (BCC) campaign aimed to convert oral contraceptive intenders to oral contraceptive users, and addressed attitudinal and knowledge barriers to be overcome in creating new oral contraceptive intenders and users. Survey findings suggest that the campaign was successful in converting intenders to users, but, at least initially, not in creating new intenders. Some negative attitudes related to oral contraceptives took as long as two years to improve suggesting that behavior change can take time and that sales and oral contraceptive use in India are likely to rebound as improved attitudes and knowledge eventually translate into increased intention to use and use. (See Dominique Meekers' presentation for more details.)

Additional key program questions that CMS evaluation addressed include:

- *In addition to training, how can we improve reproductive health service quality in the private sector?* One CMS study of Summa loans identified improved access to credit for small-scale providers as one approach. (See Meaghan Smith's presentation on Uganda for more details.) CMS research also found that franchise networks that require members to meet standards for services provided can be effective in improving quality. (See Asma Balal's presentation on Nepal for more details.)

- *What are effective strategies for shifting public-sector users to the private sector?* A CMS study in Nicaragua found that one way is to expand the availability of high-quality services in the private sector (See Pilar Sebastian's presentation for more details). Another finding is that actively raising women's awareness when their health insurance covers private-sector family planning services was effective at shifting women to private-sector resources. (See Robert Bonardi's presentation for more details.)

- *What are the effective mechanisms for improving financial access to health services?* One effective mechanism identified is community-based health insurance. (See Joy Batusa's presentation on Uganda for more details.)

Morning Concurrent Sessions

Sustainability Strategies for Reproductive Health NGOs

Moderator: Carlos Carrazana, Director, Summa Foundation

Mr. Carrazana opened the session by providing background information on NGOs that work in the area of reproductive health care and family planning, as well as definitions of, and strategies for attaining, sustainability.

In most countries, NGOs serve as the primary source for reproductive health care, including family planning services and products. These NGOs often serve low-income and underserved groups. They face several challenges, however. These include 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 sustaining a social mission, the ability to manage resources cost effectively, flexibility in a changing environment, and a long-term process.

Most strategies used to attain sustainability involve market assessments, efforts to balance an organization's social mission with achieving financial sustainability, utilization of the low cost–high volume service delivery model, pricing, costing, willingness-to-pay studies, and institutional capacity building. Other strategies include health care reform, program expansion by integrating new services, use of innovative partnerships, and improving the use of fixed resources. These strategies and models were further discussed in the following panel presentations.

Kelly Wolfe, Regional Manager, LAC, CMS

An Integrated Approach to Achieving Financial Sustainability: The PROFAMILIA Clinic Network, Nicaragua

Ms. Wolfe described the sustainability strategy used by the CMS network of clinics in Nicaragua. In 1998, Hurricane Mitch devastated much of the health care infrastructure in Nicaragua. In response, USAID provided CMS with $5.5 million to replicate the proven PROSALUD NGO service-delivery model in Bolivia. CMS was able to effectively replicate the model by constructing, equipping, and recruiting and training staff for six clinics in less than two years.

The goal of the CMS project was to create a sustainable model of service delivery through integrated strategies. The strategies included:

- Making sustainability part of the clinic culture
- Creating a service mix that integrated curative and ancillary services to cross-subsidize family planning services
- Marketing services through external and internal approaches to attract new clients

- Maintaining high-quality, affordable services to retain loyal clients
- Increasing revenues through increased client volume
- Reducing costs by reducing the number of staff positions and implementing an innovative cost-sharing agreement with doctors

An added benefit of the CMS clinic network was that the network was handed over to a local NGO, PROFAMILIA, for ongoing management. PROFAMILIA adopted some aspects of the CMS model to increase the sustainability of its own clinics. This combined network of 16 clinics now has an integrated service delivery model that provides a basic package of curative and preventive services, along with the traditional family planning services offered by PROFAMILIA. The combined network has achieved a 77.4 percent sustainability level.

Alvaro Monroy, Senior Technical Advisor, NGO Sustainability, CMS

Improving Self-Sufficiency: CMS Case Studies from Ghana and the Dominican Republic

Mr. Monroy presented two NGO case studies: the Ghana Social Marketing Foundation (GSMF) and ADOPLAFAM in the Dominican Republic. CMS provided technical assistance to both.

ADOPLAFAM could be characterized as an NGO that was highly dependent on USAID funding, with low cost recovery (19 percent) and weak or nonexistent internal controls. CMS provided technical assistance in three areas: institutional strengthening, service and product diversification, and financial management. The result was an increase in sustainability from the 19 percent baseline in 1999 to 52 percent in 2003. Keys to success included:

- Adoption of new tools (business plans and feasibility studies)
- In-country monitoring, reviewing, and updating
- Service diversification
- Permanent relationship with the community
- NGO mission not sacrificed
- Commitment to quality of care

GSMF was also highly dependent on USAID funding. While CMS provided technical assistance to GSMF on various areas, Mr. Monroy focused in particular on product diversification as a strategy to increase financial sustainability.

GSMF is the most important NGO working on social marketing in Ghana. It was the first African NGO to use its own money to launch a commercially viable condom product. CMS provided technical assistance to GSMF that included:

- Designing a sustainability framework
- Conducting feasibility studies

- Improving product selection
- Identifying funding through a Summa loan
- Forging relationships with manufacturers

The results included:

- The successful launch of a new condom in October 2001. (In two years, the new product generated sales of 450,000 units and net income of over $40,000 after loan repayments.)
- An increase in GSMF's sustainability rate from 32 percent in 2000 to 37 percent in 2003

Keys to GSMF's success include:

- Entrepreneurial motivation
- Willingness to take risks
- Culture of sustainability
- Appropriate incentive structure

Beth Fischer, Private Sector Advisor, CMS/Uganda

Enhancing Sustainability of Associations: The Uganda Private Midwives Association

The final segment of this panel considered a different type of NGO — professional membership associations —– and presented lessons learned from CMS's work with the Uganda Private Midwives Association (UPMA). Associations have unique needs and offer unique opportunities for improving reproductive health outcomes. For example, associations are made up of members with shared values and experiences. Associations often depend heavily on voluntary participation and have limited financial capacity. Governance changes frequently with the election of new leaders.

The logic behind supporting membership associations rests on their linkages to large numbers of providers, which facilitates rapid implementation of interventions over a broad geographic area. Member ownership and management of interventions is also facilitated by working through associations. These organizations offer direct access to and communication with the provider community, and represent a valuable feedback loop and source of data. Associations can also be effective in leveraging peer pressure and peer support to encourage quality of care. They can also be an effective advocacy channel for reaching policymakers.

CMS's interventions with UPMA focused on increasing value added for members and strengthening institutional capacity. Specific strategies included improving member communications, enhancing visibility, providing continuing education, promoting a loan program, and increasing advocacy and quality of care capabilities of members and the association. Institutional strengthening included funding an executive director position, providing budgeting and accounting support, and supporting database development. As a result of CMS interventions, UPMA has become a stronger organization, with an increased number of active members, an expanded revenue base, and enhanced community visibility.

Effective Strategies for Increasing Quality of Care in the Private Sector

Moderator: Dr. William Jansen, Director, IntraHealth International

Dr. Jansen opened with some observations on quality of care in the private sector. He noted that the presentations in this session probe important issues for the delivery of reproductive health services through private-sector channels. The CMS project in particular has contributed to a better understanding of how quality in the commercial sector can be improved, and the techniques that are effective in bringing about positive change in quality of care.

The presentations highlighted positive private-sector quality-of-care outcomes from CMS project interventions. Approaches have included franchising private-sector providers and facilities, networking practitioners, and offering creative financing mechanisms linked to quality care. Asma Balal's presentation on Nepal, Pilar Sebastian's presentation on Nicaragua, and Meaghan Smith's assessment of the Uganda experience all illustrate quality improvement in the private sector. These CMS project findings are consistent with other recent reports (see Stephenson et al.) that also indicate the power of franchising to enhance private-sector quality and utilization.

The presentations also illustrated important lessons learned over the life of the CMS project, including:

- Private-sector practitioners are interested in quality and are responsive to quality interventions (for example, franchising, networking, and creative financing schemes)

- Changes in quality and their impact can be measured using evidence-based methodologies that go beyond sales statistics

- The definition of quality of care should include at least two elements: a clinical or technical dimension, and a client-focused or consumer-defined dimension

The definition of quality of care is an especially important issue, and the work of the CMS project to enhance both technically-based and client-defined quality is valuable. The technical definition of quality can include infection control, correct clinical protocols, and adequate facilities and equipment. Client-defined quality factors include respectful treatment, the observation of privacy, acceptable waiting times, adequate provision of information, and perceptions of provider reliability.

Dr. Jansen closed his remarks by raising issues and questions for the future. He noted that even with the contributions the CMS project made to our understanding of how to improve quality in the private sector, more work is needed. First, a standard definition of quality of care for reproductive health services in the private sector remains to be defined — no commonly accepted international standard yet exists for an operational definition of quality of care in the private sector. Without such a definition, common measurement techniques are difficult to achieve, and cross-country comparisons of private-sector quality of care are virtually impossible.

Dr. Jansen proposed that future efforts to work with the private sector in service delivery should develop common operational definitions of quality of care, and propose minimal measurement indicators that will track quality changes over time. He suggested that perhaps a minimal set of quality indicators could be developed, which would be expected to be present in any country-level program effort with the private sector. Such a minimal set of common quality indicators would facilitate cross-country comparison. Additional indicators relevant for a given could, of

course, also be utilized. If client-defined factors are an important part of the quality-of-care equation in the private sector, Dr. Jansen suggested that we need new ways and methods for measuring client perspectives — methods that are quick, simple, standardized would enhance the ability of service providers or service-delivery managers to apply them in their practices. Dr. Jansen suggested that such indicators are likely to include both qualitative and quantitative measurements.

Increasingly, the private sector will be an important part of health care delivery in the developing world, he noted. Future efforts to collaborate with the private sector should therefore make quality of care a central focus. The CMS project has built a solid foundation from which to pursue a better understanding of how to improve quality of care in private sector service delivery channels.

Asma Balal, Senior Program Manager, ANE, CMS

Franchising Private Providers to Improve Quality: Sewa Network in Nepal

The main objective of the intervention was to establish a pilot nurse and paramedic franchise network in Nepal's Rupandehi district to increase use of private-sector family planning and reproductive health services. While there is a shortage of physicians outside the Khatmandu valley in the country, there are a large number of trained paramedics and nurses. Many of the paramedics have private drug shops where they provide limited health services, often including treatment for minor illnesses and injury, and some reproductive health services, including family planning. CMS preliminary research showed, however, that there was significant room for improving the quality of the reproductive health services offered at paramedic clinics.

Several factors contributed to the decision to implement a franchise network — an arrangement where an additional set of services, provided according to franchiser guidelines, is added to an existing health practice. This contractual arrangement allows the franchiser to monitor the quality of services provided. In addition, there are significant economies of scale in promoting and conducting training for a network compared to doing so for individual providers. CMS baseline research also showed that a franchise network met providers' stated desire to be affiliated with a larger provider community.

A local reproductive health NGO, the Nepal Fertility Care Center (NFCC), served as the network franchiser. A franchise contract between NFCC and individual providers (the franchisees) described roles and responsibilities of both parties. NFCC was responsible for providing training, quality monitoring, marketing support, and establishing a referral system for the network. In return, each franchisee agreed to pay a membership fee, provide family planning and selected reproductive health services, follow the quality protocols, and maintain service statistics at the clinic.

All providers received a seven-day training that included infection prevention, use of essential supplies, family planning, and selected reproductive health services. A subset of female providers (nurses and midwives) received a 21-day training that included IUD insertion and a broader package of reproductive health services.

A separate two-day module focused on service marketing training. The main objective here was to emphasize the importance of provider–client interaction and its impact on client satisfaction and loyalty. CMS research showed that such provider attributes as "caring," "reliable," and "empathetic" are important contributors to perceived quality and to provider choice. These

positive aspects of provider–client interaction were highlighted in the training through role-playing exercises.

NFCC monitored quality on a monthly basis through visits by a quality coordinator, who observed service provision, obtained feedback from clients, and, where necessary, suggested corrective action.

CMS implemented a comprehensive monitoring and evaluation system for the network. Program monitoring was primarily done through quality monitoring visits, a mystery client survey, and review of service statistics. A quasi- experimental design with a comparison group was used for impact evaluation. Baseline and follow-up surveys were conducted with clients, providers, and married women of reproductive age. A comparison group was drawn from the adjacent Nawalparsi district, which has a comparable socio-economic and demographic profile as the intervention Rupandehi district.

Quality monitoring data shows that technical quality improved over the first nine months of the intervention on almost all of the indicators — infection prevention, use of essential supplies, and provision of family planning. In terms of perceived quality, client satisfaction with services at the Sewa network clinics increased from 58 percent at baseline to 75 percent at endline. Over the same time period, client satisfaction remained virtually unchanged at comparison group clinics. Moreover, the percentage of clients reporting "caring" and "reliable provider" as reasons for their provider choice also increased significantly from baseline to follow-up at Sewa clinics. Further analysis showed that highly satisfied clients were more likely to make a repeat visit compared to those clients who did not report high satisfaction with the services.

Service utilization at Sewa clinics improved for both reproductive health (RH) and family planning (FP) services, as well as for overall services. Service statistics show that average monthly client visits for RH and FP increased from 28 clients to 50 clients over the first eight months of the intervention. Data from the client exit interviews suggest that average daily client flow at the clinics for all types of services increased by two clients, whereas comparison group clinics saw a decline of two clients.

Based on the monitoring and evaluation results, we can draw a number of conclusions:

- Improvements in quality lead to higher client satisfaction
- Positive client–provider interaction is integral to client satisfaction and retention
- Satisfied clients are more likely to make repeat visits
- A franchise network can be effective in improving quality, leading to increased use of services at independent private-provider clinics

Pilar Sebastian, Technical Advisor, Population Services International

Improving Quality of Care Through Private-Provider Networks: CMS/PROFAMILIA in Nicaragua

In 1998, Hurricane Mitch devastated much of the health care infrastructure in Nicaragua. In response, USAID funded CMS to create a network of six private clinics to provide basic health serves to affected communities.

The network offered a basic package of preventive, curative, and ancillary care, including general medicine and maternal and child health services (growth monitoring, vaccinations, family planning, pre- and post-natal care services, and deliveries). Preventive services were provided free of charge. In addition, three of the six clinics offered expanded services, such as basic surgical procedures.

Quality of care was central to the clinic network project in Nicaragua. The objective was to provide health services based on scientifically and technically rigorous norms to help ensure safe, effective, and efficient care, with a focus on perceived quality by clients.

The network's medical and administrative staff was selected through a rigorous process in which not only technical expertise was assessed, but also leadership qualities and communication, team-building, and conflict resolution skills. Staff received training in service delivery, patient care, supervision, sales, and human relations.

CMS management developed operating plans for each clinic, including quality-of-care indicators. Clinic norms were developed according to Ministry of Health guidelines, and the Ministry had accredited all of the CMS clinics by the end of the project. Monitoring and supervision consisted of documenting progress against each of the indicators, along recommendations for improving inefficient systems and procedures. Supervisors visited the clinics on a monthly basis and captured the data using four different instruments.

In each of the clinics, Quality Teams were created, with quality becoming part of clinic culture. Each staff member was responsible for monitoring an aspect of the quality control plan and reporting results on a monthly basis. Client satisfaction was assessed through a suggestion box, client exit interviews, and informal household surveys. Evaluation of quality of care was based on both internal and external indicators.

Based on the impact evaluation of the project in Nicaragua, the following conclusions can be drawn about the network's quality of care:

- External marketing was key to increasing awareness about the clinics.
- Clients overwhelmingly rated the CMS services as good or excellent in quality and better than previous care they had received, with nearly all clients reporting that they would return to the clinic for future health care needs.
- Providing high-quality health services was important not only in attracting clients but also in retaining them. Perceived quality was particularly linked to good medical attention and highly trained staff.
- Offering affordable, high-quality services succeeded in shifting clients who can afford to pay from the public sector to the private sector.

Meaghan Smith, Investment Manager, Summa

Taking a Business Approach to Improving Quality of Care: Evidence from the Uganda Private-Provider Loan Fund

Under the CMS project, Summa has used a business approach in working with the private health sector. Private health providers are commercial enterprises that face many of the same

constraints and opportunities as other types of commercial firms. Using a business approach provides a new set of analytical tools and strategies for working with the private health sector. This approach can complement traditional public health programming to achieve measurable impact.

Summa designed an intervention to provide small loans and technical assistance in business skills to small-scale private providers in Uganda, including midwives, nurses, doctors, clinical officers, and drug shop owners. Providers received technical assistance in basic business skills, with a focus on customer service — including the importance of privacy, accessibility, customer satisfaction, cleanliness and hygiene, and affordability of services. A total of 560 providers have received financing, and many borrowers have taken subsequent loans. (The average first loan was $652.) The majority of borrowers were midwives located in peri-urban areas. Loans were used primarily to purchase drugs, followed by equipment purchases and clinic renovation and expansion.

The program was designed under the following hypothesis: credit and business training would increase perceptions of quality by clinic clients, leading to increased client loyalty and new clients — which in turn would increase providers' interest in service provision, leading to increased investment in their practices. To test this hypothesis, CMS and Summa conducted a quasi-experimental study of 15 private midwife clinics in the intervention and seven private midwife clinics in the comparison group. Pre- and post-test client interview surveys were conducted. The survey revealed that client perceptions of quality improved at intervention clinics. In addition, client loyalty increased at intervention clinics but decreased at comparison clinics. While the percentage of clients who reported maternal and child health visits also increased at intervention clinics, the increase was not statistically significant, given the study's short 13-month timeframe.

The study found that increasing access to financing and training for small-scale providers can improve perceived quality. There is a large demand for credit by small-scale providers. This type of program provides donors with a mechanism to reach a large number of providers who would otherwise be too small or inaccessibly located to participate in such a project.

Social Marketing: Delivering Health Impact Through Context-Specific Approaches

Moderator: Francoise Armand, Senior Technical Advisor, Social Marketing, CMS

Ms. Armand provided an overview of social marketing approaches. The three panelists then provided highlights of CMS social marketing programs in India, Uganda, and Morocco.

All CMS social marketing programs share the same mission: to achieve health impact, primarily through the use of behavior change strategies that lead to increased use of health products. In most instances, social marketing programs also increase access to affordable products and services.

A key aspect of social marketing programs is the extent to which they appropriately target those with unmet need, who are at risk, or who are unable to access product and services. Social marketing programs must also pay attention to sustainability — to programmatic sustainability, which allows a program to deliver significant long-term health impact, and to financial sustainability, which means limiting reliance on continued donor funding.

Increasing the role of the private sector in providing reproductive health services is one avenue for improving financial sustainability. Thus several CMS programs have developed or maintained partnerships with commercial suppliers, including manufacturers, distributors, and private health providers. Among the specific objectives of these programs has been increasing the use of commercial brands, expanding access to products and services, and enhancing the quality of products and services through training and detailing. Several CMS programs have had the specific goal of increasing the private-sector share of contraceptive supply.

The CMS social marketing programs have, of course, been implemented in different contexts, which have allowed the project to experiment with different approaches for maximum health impact. Among the programs directly managed by CMS, five were located in sub-Saharan Africa, one in North Africa, two in Asia, one in the Middle East, one in Eastern Europe, and two in the Latin American region. In addition, CMS has provided technical assistance to existing social marketing organizations in Ghana, Bangladesh, and Nepal.

Because CMS social marketing programs have been located in vastly different contexts, they have had different objectives as well. Some had a strong HIV/AIDS component; others were primarily designed to increase the range and quality of family planning methods. Still others have focused on reaching self-sufficiency in the face of a phase-out of donor funding. The project has therefore provided a wealth of opportunities to use the full range of social marketing capabilities and models.

The CMS social marketing programs have been built on existing 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 behavior change campaigns (BCC) to shift behaviors or grow the overall market for a product.

Lessons learned from this variety of approaches have included:

- *The choice of a social marketing approach is subject to both goals and context (to demand, gross national income/capita, and commercial presence).* Thus a program designed to increase access to products for low-income people or 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 here 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 (FPAs) 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.

- *Subsidized, NGO-based social marketing is appropriate for low-demand, low-income countries*. For low-income countries (basically with a GNI/per capita of less than $800), few opportunities for partnerships exist until market priming activities begin to produce results. In these countries, subsidized programs channeled through social marketing organizations (SMOs) and NGOs may be more likely to produce the health impact expected by donors and the country's Ministry of Health (MOH).

CMS learned important lessons in working with commercial partners. These findings are based on experiences in Morocco, Jordan, Cameroon, Brazil, and India, as well as post-SOMARC market assessments conducted by CMS in Turkey and the Philippines.

CMS found that commercial partnerships are most likely to succeed when:

- *The social marketing program is compatible with corporate priorities*, which include market development and not just profit maximization.

- *Method or product is established and in high demand.* There seems to be a certain critical mass needed for commercial partnerships to succeed. The most successful programs have been built on a contraceptive market that was dynamic. The less established and accepted a method is, particularly in the provider community, the more difficult it is to grow a commercial market for these methods.

- *Users have access to commercial outlets.* Access to commercial outlets requires a well-developed infrastructure, which is likely to be found in most urban areas but not in rural areas.

- *Users can afford commercial brands.* A commercial partnership will succeed if a country has enough users willing and able to pay commercial prices. Suppliers will not agree to lower their prices over the long term. Alternatively, however, a low-price brand that does not generate profits for a manufacturer may serve as a hook for other higher-priced products. Such a transfer is likely responsible for making the Morocco oral contraceptive program commercially sustainable for its partners.

- *Free or subsidized products can "crowd out" commercial brands*. The provision of free or subsidized products or services that are not properly targeted continues to be an obstacle to commercial market growth. Unfortunately, countries with higher per capita income tend to have generous public-sector services that often benefit the middle and upper class more than the poor.

CMS experience in such countries as Uganda, Senegal, Ghana, and Madagascar 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.

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).

Karen Bulsara, Social Marketing Director, CMS/Uganda

Using Different Social Marketing Approaches for FP, HIV/AIDS and Malaria: CMS/Uganda

Uganda has a population of over 24 million, 85 percent of which is rural. With an average per capita income of just $200 per annum, it is one of the poorest countries in Africa. The social marketing project in Uganda has been funded by USAID since 1991. Historically, there was a concentration on the donor-funded distribution model until the latter CMS years, when the project experienced rapid growth and became more complex. As the budget grew, CMS diversified into new health arenas, moving from family planning to include HIV, malaria, and maternal and child health (MCH). Product mix grew from three to eight offerings, and sales increased steadily.

Although Uganda is very much a developing market, parts of the country are still untouched by this development. Thus there is a large disparity between places where commercial infrastructure is somewhat present, at least in major district headquarters, and those areas that commercial distributors do not currently reach. These pressures required CMS to carefully consider the marketing requirements and approaches to be used for each product launched.

CMS/Uganda has two family planning products: *Pilplan* oral contraceptives and *Injectaplan* (Depo Provera), and is the primary supplier outside of the public sector. For these products, the NGO distribution model seems to be working, mainly because there is no private-sector interest. In a poor country such as Uganda, few have the ability to pay commercial prices for these products.

With respect to condoms, there are two active social marketing programs. CMS sells the *Protector* brand, and Marie Stopes International markets *Lifeguard*. Both brands have been competing for market share. The Ministry of Health (MOH) imported 80 million condoms in 2003, with no funding or distribution mechanisms in place. A majority of these condoms ended up in the private market.

A national tracking survey shed some light on the more comprehensive way forward for condom social marketing. (See Francis Okello's presentation for more details.) The situation in Uganda called for a market segmentation approach to distribution, focusing on people without previous access and on high-risk groups. It also required addressing non-product-related behaviors through BCC.

CMS added or expanded other HIV interventions, including STI treatment kits and voluntary counseling and testing. And, through its partner Population Services International (PSI), *Neviripine* was added to prevent mother-to-child transmission.

CMS Uganda also socially marketed the *SmartNet* brand of insecticide-treated bed net. When CMS entered the market, there were few alternative nets available and they were costly. When CMS introduced SmartNet, however, this situation changed rapidly; several private-sector brands entered at affordable prices. CMS therefore refocused its efforts on filling the gap with a subsidized product in rural areas. CMS has also experimented with targeted subsidy approaches — for example, with vouchers that enable targeted consumers to buy commercial brands at a discounted price in urban centers.

In addition, CMS launched PPT (a WHO-approved pre-packaged malaria therapy). Before doing so, CMS conducted research that showed a vibrant existing market with local capacity to produce. The research also found that consumers were relatively empowered and knew what to ask for in treating malaria (from drug shops mainly), and could be educated to ask for specific regimens through extensive BCC.

Hompak is the brand name (owned by the MOH) for the unit-dosed, pre-packaged treatment kit. For this product, the manufacturer's model was the best way to proceed. Currently, the private-sector manufacturer is on hold as the Ugandan MOH wants to try free distribution for at least a year before allowing the private sector to use the brand name. (This is a good example of needing different social marketing models for different products, even in the same country.)

CMS has undergone change in the sales and distribution functions, with an eye on efficiency — moving to private distributors where possible, rather than its own distribution team. CMS nevertheless has a good distribution network when compared to local distributor networks, although there is room to push further into peri-urban and rural markets. In both the ITN and condom field, CMS has been asked to assist the MOH in distribution. To truly serve the public interest in Uganda, this option has to be considered; evolving along with changing market conditions is key.

CMS/Uganda has moved from a sales emphasis to a health impact emphasis. This means that there still has been considerable investment in creating effective distribution systems for each product. All of this work has been increasing better-supported products by targeted BCC. To do this job well, there is therefore a need to respond to market changes, which forces social marketing approaches to adapt to serve the ultimate need — that of the target audience.

CMS/Uganda has grown a strong platform for social marketing in Uganda. For example, there are economies of scale in operating across three different health areas. Uganda is the focus for so much donor funding that health dynamics are changing quickly: Global Fund and Presidential Initiative funding has fast-tracked changes in direction for national policies in AIDS and malaria. This in turn requires implementing agencies to adapt to changes quickly. The economy is also growing, attracting some limited private investment. Taken together, these constant changes require a level of flexibility not commonly found in social marketing programs.

Dr. Rita Leavell, Country Representative, CMS/India

Expanding the Market with Commercial Firms: 7 Essential Steps

The Indian Market Scenario. In May 2000, India passed the one billion mark in population. Although there is some concern about continued growth in the population and the burden of poverty, in economic terms there is also much optimism regarding the future. At the end of 2003, India was predicted to reach an annual growth rate of 8 percent, and to continue on this course to become one of the major global economic giants over the next 15 to 20 years. Although the poverty line is 25 percent, or 250 million officially poor in the country, there are also more millionaires than in the United States. The Indian middle class has grown to about 270 million, and both multinationals and national firms are vying for attention in the consumer market. Generic and branded pharmaceuticals, vaccines, condoms — all can be produced for relatively low cost in India to meet this mass market, and for export overseas.

The private health sector, long the major source of health care, is no exception to this growth. Over 75 percent of the population gets its health care from the private sector, and nearly 80 per

cent of health expenditure is out-of-pocket. In addition to 600,000 registered allopathic doctors, there are also an estimated 1.1 million traditional medicine doctors who either practice other systems of medicine recognized in India or simply hang out a shingle and practice without a license. In terms of pharmacists (known in India as chemists), the urban and semi-rural market is well served with over 279,000 pharmacists. Often a chemist (who does not have medical training) is consulted for medicines, rather than a doctor.

Commercial Market Strategies Activities in India. The CMS project provides technical assistance to two major USAID-funded activities in India. Under the Program for Advancement of Commercial Technology – Child and Reproductive Health (PACT – CRH), CMS provides advice and project management for two major campaigns. These are the Goli ke Hamjoli, or Friends of the Pill, campaign to expand use of low-dose oral contraceptive pills, and the WHO-ORS campaign to promote the use of World Health Organization-recommended Oral Rehydration Salts available in the commercial market in North India. In both cases, while many high-quality brands are available at a range of affordable prices, use has suffered due to low demand, and markets have been stagnant.

The program manager for PACT is ICICI Bank of India, which contracts the relevant ad agencies for generic, non-brand-specific communications campaigns. CMS provides technical assistance, coordination with participating pharmaceutical manufacturers, training and detailing of doctors and chemists, market research for communication development and monitoring, and advocacy for policy change. CMS is the primary link for engaging the 10 commercial pharmaceutical firms, three social marketing organizations, and four medical professional associations in promoting use of these products. Through the partner firms or its own field force of 110 promoters, CMS reaches 15,000 allopathic doctors, over 28,000 traditional doctors, and at least 28,000 chemist shops.

CMS also works with the Innovations in Family Planning Services Project in the state of Uttar Pradesh to advise on rural marketing activities for family planning and other health products. Through these efforts, social marketing groups have been contracted to expand the use of oral contraceptives (OCs) and condoms through the private sector to small villages of India's largest state. CMS has also launched a pilot project to promote the use of DMPA injectables through the private medical community in three cities of Uttar Pradesh. The results will enable the Government of India to consider whether to include injectables in an expanded basket of choice of contraceptive methods.

Through the above projects, CMS is active in eight key states of Hindi-speaking North India – in addition to Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Uttaranchal, Jharkand, Chattisgarrh, and Delhi — the states with the highest maternal and infant mortality rates and highest fertility rates. In these areas, CMS activities are reaching out to over 229 million people.

Results include:

- In less than five years of the Goli ke Hamjoli campaign, OC use is up from 4 percent to 11 percent in the target group of urban women 18 to 29 years old. Total OC urban North India sales are up 43 percent.

- In two years of the WHO ORS campaign, use among urban mothers of children less than 3 years old has risen to 50 percent, up from 26 percent. Sales of all ORS are up 28 percent, to 24 million liter packets.

- In rural Uttar Pradesh, with its 36,000 villages, condom sales are up 120 percent and availability of oral contraceptives in a shop in a village has risen from 18 percent to 48 percent.

With this record of successes, CMS has been asked to develop a marketing campaign to promote dual use of condoms: for prevention of pregnancy and prevention of HIV.

Lessons Learned — the 7 Essential Steps. With the above background of positive results, it is time to look at key lessons learned. Given our necessarily short presentation time, these can be boiled down to seven steps that are required for market expansion — at least, as experienced in India.

1. Think Big — Expand the Whole Market. The oral contraceptive market serves as a good model for why thinking holistically in trying to expand a market and use of a product is the right approach, as opposed to focusing on increasing the share of a specific brand. In 1997, a number of both fully-priced commercial low dose OCs and government-subsidized social marketing brands were available in India. Prices ranged from $0.05 to $1.50 per cycle and OCs were available at most chemists over the counter —that is, without prescription. Yet, after 30 years on the market and 10 years of promotion by the government, use was only 2.1 percent nationally.

Market research showed that providers and consumers were frightened of the OC. Most doctors had trained in an anti-hormone era and did not prescribe OCs. Consumers had many myths and misconceptions about devastating side effects and possible infertility. Therefore, the key was to "retrain" the doctors and to create demand among potential consumers through a campaign dispelling myths and showing happy, healthy users.

An integrated, generic communications campaign was developed to promote the use of the newer low-dose OCs with fewer side effects. It included advertising through mass media, especially television, and placement of multiple articles on the safety and benefits of OCs. Journalists were invited to workshops and encouraged to publish correct information. In the later stages, an outreach campaign was developed for the interpersonal persuasion of potential consumers by actual users.

In addition to the above, CMS ensured that a positive, supportive environment was in place for potential consumers, and that both commercial and social marketing brands were promoted in the market. Commercial pharmaceutical firms were made partners in the campaign and began to use the logo on their promotional materials. As partners, these firms gradually realized the value of the OC business. They began to invest more in the market, and in training and detailing to doctors and chemists. Higher-dose OCs were dropped from the market. The Federation of Obstetricians and Gynecologists played a role in educating their members and issuing a consensus statement on low-dose OC safety. Both commercial and social marketing brands saw an increase in sales under the campaign.

By focusing on the factors that affect the overall use of OCs, rather than on promoting particular brands, CMS was able to expand the total market, which benefited all parties — and led to a more sustainable market and growth overall.

2. Work with Partners' Strengths. The basis of the PACT project is working with commercial firms. Most pharmaceutical firms, however, are not used to working with generation of consumer demand. For them, the consumer is the doctor, not the patient. Therefore CMS focused its efforts on reaching the target consumers for OC use, while the partner pharmaceutical firms were

encouraged to focus on their particular strengths — detailing and product improvement. Under this approach, OC product inserts were made more reader-friendly, and consumer brochures were left at doctors' clinics. Both OC firms and ORS firms gave freely of product samples for CMS to use in detailing, training, and sampling programs. Observing these positive results, the firms have become more proactive in reaching out to consumers.

3. Identify the Gaps. One of the key strengths of CMS India has been to identify potential gaps in marketing approaches. For example, it became clear with both the OC and ORS markets that providers knew little about the products. In the case of OCs, there was clearly a negative bias. For ORS, there was little understanding of the role of the product. Through analysis of prescriptions, traditional doctors or ISMP's — Indigenous Systems of Medical Practitioners — were identified as the major source of prescriptions for children under two with diarrhea. ORS was almost never prescribed. CMS therefore reached out with its field force to over 34,000 chemists and 28,000 traditional doctors to deliver a detailing program. Providers were shown the life-saving potential of ORS, and encouraged to prescribe WHO-ORS for every bout of diarrhea. This effort, along with a "mystery client " contest among chemists, led to major increases in stocking and prescribing WHO-ORS.

4. Involve Stakeholders at All Levels. CMS/India has learned the hard way that all levels of management must be informed of project goals. Only after two years was it clear that one partner OC firm had field staff who thought that CMS was promoting their brand and they had no need to do it! Therefore, the effort is now made to meet with partner firm staff at headquarters and in the field to ensure that a single approach is understood and desired by all. The use of a logo to identify partners has helped to ensure a sense of loyalty to the project. Pride in being involved in a social cause that also generates profits is a by-product.

CMS also meets frequently with individual partner firms to review objectives and suggest potential strategies for brand and category promotion. Sales results from the ORG retail audit purchased by CMS are shown to each partner so they can compare their progress with their competitors. (Of course, individual sales firm's strategies and internal sales results are held in strict confidence.)

5. Think Win-Win. In India, commercial full-priced brands and government-subsidized social marketing brands of OCs and condoms compete in the same markets, especially in urban areas. The price differences are enormous, and the commercial brands cannot possibly meet the lower price levels. However, as described at the beginning of this presentation, India is a large market. There are consumers of all socio-economic levels, even in rural areas. Therefore there should be buyers for all prices, as long as the brand images and marketing strategies are directed to the right targets.

CMS/India, as a party interested in the growth of the total market and not just an individual brand, has looked at possibilities for better-targeting of brands and prices to consumers. The generic campaign Goli ke Hamjoli campaign provided an umbrella for all brands and addressed the issues affecting non-use. Nevertheless, in many cases the subsidized brands increased in volume over commercial brands.

One effort that resulted from strategic targeting for social marketing brands is work in rural Uttar Pradesh. As mentioned earlier, the IFPS project was encouraged to focus on rural marketing of OCs and condoms. A social marketing firm was contracted on a statewide basis and paid for its performance in reaching out to small villages. Over a three-year period, this resulted in a major expansion of villages with access to OCs and condoms in shops. Condom sales also increased by over 120 percent, to a volume of 115 million pieces on an annual basis. The subsidized product

of the social marketing firm was clearly the best brand for rural areas; commercial brands would be unlikely to make this kind of effort in the foreseeable future.

6. Be the Category Advocate. CMS/India has been seen as a neutral partner, with the best interests of the total market in mind. Therefore, whenever policy change has been required, all other parties have turned to CMS, expecting action. For example, now that WHO-ORS has become more popular, there is much anticipation of a change to the new WHO-recommended formulation of a lower osmolarity. Once UNICEF and WHO had made their announcement worldwide, India was expected to follow suit with a change in its pharmaceutical formulary. However, nothing happens unless someone is there to follow through — and this is where a category advocate is required.

While Ministry of Health and Family Welfare managers have made their recommendations on the issue to the Drug Controller, they could not force a change. The ORS manufacturers are willing to change their product as soon as the new formulation is legal. However, they clearly felt that individual manufacturers would be suspect in promoting a change, and therefore expected CMS to assist in the effort. This has been done by enrolling the support of the Indian Academy of Pediatrics and conducting a special workshop to update the recommended management of childhood diarrhea, including a change in formulation. CMS/India continues to follow up with each party. The new formulation is expected shortly.

7. Both Value and Volume Are Important for Market Growth. In a complicated market where both commercial full-priced brands and subsidized social marketing brands compete for the consumer's attention, it is important to remember that both are needed. One provides the numbers for the present, while the other represents the future sustainable market. In 1998, while the social marketing brands represented only 30 percent of the value of the OC market, they made up more than 65 percent of its volume. If CMS had concentrated only on growing commercial brands, the total market would not have grown much in volume terms. As all brands increased, so did the total market volume and value.

However, it is the *value* of the market that is important to commercial firms, and determines where they make their decisions to invest further for the future. In the case of OCs in India, the commercial firms have grown in volume by 61 percent. In value, however, this represents growth of 192 percent. This has encouraged one firm to discontinue its high-dose brand, and all firms to introduce new low-dose brands. Investment in training of staff and new detailing methods to doctors have been put to use for OCs, not just for previously more profitable antibiotics. One firm even paid for training by CMS in Evidence-Based Medicine Detailing in order to increase doctors' faith in hormonal contraceptives. Two firms have upgraded their manufacturing facilities and all see contraceptives now as a growth market.

Conclusion. Expansion of markets with commercial firms requires a comprehensive holistic approach. The 7 Essential Steps outlined above are an attempt to make as simple as possible what is a rather complex business.

Dr. Pinar Senlet, Consultant

Post-Exit Strategies for Contraceptive Social Marketing: CMS/Morocco

Contraceptive social marketing efforts in Morocco have been supported first by the Futures Group (1989 to 1998) and then by the CMS project (1999 to 2003). The manufacturer's model approach was used to introduce four contraceptive partnerships with commercial distributors and manufacturers.

A condom was marketed in partnership with the firm Promopharm from 1989 to1996. Sales increased initially, then declined due to competition from new brands with competitive prices. More recently, the private condom market has grown and diversified. Condoms are sold on the counter at pharmacies.

An oral contraceptive was marketed in partnership with Wyeth and Schering from 1992 to 1997. Sales increased 16-fold between 1992 and 2002. Prices have not increased, and are affordable to low-income populations. The total private oral contraceptive market continues to grow and diversify. Schering and Wyeth are committed to continuing the partnerships.

The IUD and injectables were marketed in partnership with Reacting and Pharmacia from 1997 to 2003. Strong consumer biases persist against IUDs. Although demand and sales did not increase, the product is nevertheless likely to remain on the market — the distributor plans to continue product distribution and to maintain low prices. As for injectables, strong biases against the product persist among providers. Demand and sales have not increased. It is not certain whether the manufacturer will maintain the product on the market.

The following conclusions can be derived from these outcomes:

The success of social marketing of contraceptives differs by product category

- Condom and oral contraceptive programs led to market growth and financial sustainability
- Injectable and IUD markets did not grow sufficiently to offer sustainable exit strategies

As an exit strategy for condoms, commercial demand for condoms and sales will likely continue to increase, even if the social marketing brand sales further decline. For OCs, ownership of the brand needs to be transferred to a non-commercial entity when the CMS project ends. AMPF, a local NGO, is preparing to take on its ownership.

Lessons Learned:

- Potential for sustainability is high with the manufacturer's model since it uses existing private-sector infrastructure
- There should be a certain level of market demand before considering a manufacturer's model
- Sustainability of a product is closely linked to the objectives and the commitment of the commercial partner companies
- It is difficult to sustain newly introduced provider-dependent methods
- Simultaneous introduction of IUDs and injectables may not have been a good strategy in the Moroccan context.
- Exit strategies and sustainability prospects for methods should be developed well in advance
- Involvement and support from local players are important, e.g. NGOs, government policies

Lunch Speakers

Grace Migallos, Country Representative, CMS/Philippines

The Philippines: Background and CMS Program

Grace Migallos, CMS Country Representative for the Philippines began the lunch program by providing an overview of that country's population situation and the project's program activities. The Philippines is frequently compared to other countries in its region that were in similar demographic and developmental circumstances 20 years ago. While a number of these neighboring countries have made significant strides in slowing their population growth rates and improving their economies, the Philippines has lagged behind. As a result, an estimated 40 percent of the Philippines' 80 million people now live below the poverty level.

USAID asked CMS to help expand the private sector's role in providing family planning services and products in the Philippines. In a strategic departure from its past approaches, USAID is phasing down its provision of contraceptive commodities (which have constituted virtually all the commodities distributed through the government's public health system) and redirecting these funds to other more strategic program efforts. USAID expects the government to take responsibility for procuring contraceptive commodities low-income people will need, while also redirecting more affluent users who can afford to pay for their contraceptives, to private providers. CMS' role is to help prepare the private sector for this shift.

CMS' program has two main activities. The largest is a multifaceted effort to increase the private sector's provision of contraceptives. This includes conducting training and BCC activities with private physicians, midwives, and pharmacy sales staff, to improve their knowledge and counseling abilities with contraceptives, and supporting efforts to institutionalize this training for longer term impact. It also includes building relations with contraceptive manufacturers and suppliers, to facilitate their quicker entry/expansion into the market place especially with sustainable lower-cost contraceptives.

CMS' second significant activity involves working with leaders from the business sector, to increase their knowledge of the current population situation, and support their efforts to expand the business sector's provision and support for family planning. These efforts include exploring a variety of means for expanding coverage of contraception through expanded insurance coverage, direct provision, or link ups with lower cost private sources and providers. It also includes helping business leaders better understand this issue and its relevance to the business sector, and disseminate this understanding through their membership. In addition, a number of research activities are also underway to inform these and other project efforts.

Donald Dee, President, Employers Confederation of the Philippines

Mobilizing the Business Sector to Support Family Planning

The guest speaker at lunch was Mr. Donald Dee, a leading representative of the Philippine business community. In part through collaboration with CMS, he has become a strong proponent of engaging the business sector in support of family planning. Mr. Dee explained how the current

economic environment makes it imperative that the commercial sector speak out on the country's population management policies.

He noted that the increasing globalization of the world's economies has forced many countries to adopt open market policies, dismantle trade barriers, and tie trade to social policies. For example, market forces are pushing businesses to be more socially compliant, including treating their workers as partners rather than as simply the means to create services or products. Many companies in the Philippines have been unable to cope with these changes, however, and have shut down, bringing serious economic and social problems to the country in the process.

The Philippines' high population growth virtually wipes out the effects of economic growth. For example, the number of new jobs has not been enough to absorb new entrants to the job market, resulting in chronic unemployment and underemployment. Since the government has not implemented a population reduction program, Mr. Dee and other concerned business leaders see no way out of stagnating, or even declining, communities.

For example, the poverty incidence in the Philippines has been growing; by the year 2000, just over a third of the population (26.4 million Filipinos) lived below the poverty line, which is defined as income below US$285 a month for a family of five. Thus the greatest problem facing the Philippines today is poverty, which leaves a blight on everything it touches: the environment, peace and order, economic and political stability, and parents' efforts to adequately nourish their children.

The business sector, led by the Employers Confederation of the Philippines (ECOP) and the Philippine Chamber of Commerce and Industry (PCCI) has been voicing its concern over the country's high rate of population growth, and is urging the government to take steps to mitigate what the sector sees as an economic time bomb that threatens to undermine economic development efforts. The sector sees itself taking up the slack left by the absence of a coherent government program. In particular, ECOP has:

- Passed a resolution among its members urging them to participate in a private-sector-led national awareness campaign on responsible parenthood and family planning.

- Worked closely with the Philippine Department of Labor and Employment to enforce existing regulations that require large employers to provide family planning services to their employees.

- Established a Committee on Healthy Workplace to help strengthen the capacity of enterprises to promote and implement occupational safety and environmental health laws as well as international conventions for a more productive workplace. The committee also addresses issues related to substance abuse, HIV/AIDS, and healthy lifestyle and family welfare, which includes population management and reproductive health.

- Established close working relationships with other business organizations (including the Philippine Chamber of Commerce) and non-governmental organizations from health, labor, and religious areas.

- Has worked closely with CMS to increase the business sector's awareness of the challenges and opportunities related to effective population management initiatives, and to mobilize these business associations for advocacy and action on service delivery.

- Conducted a forum on "Institutionalizing a Population Management Program in the Workplace" in Manila. The forum provided information on the Department of Labor and Employment's Family Welfare Program, corporate best practices in the provision of family planning/reproductive health (FP/RH) services, health insurance coverage for FP/RH needs of employees, and outsourcing options for firms that cannot afford to set up their own FP/RH facilities.

- Worked with CMS to establish a Population Management Action Center, with the goal of establishing a technical assistance process for member firms that decide to implement FP/RH programs.

Mr. Dee ended his presentation by reiterating that ECOP stands prepared to do its part in workforce education on family planning methods, and in providing access to products and services. He stated that the objective is to empower the people to make intelligent choices and to help manage population growth through responsible parenthood and reproductive health care. He stated the hope that the time will come when the Filipino people will be given the necessary basic services to support dignified lives.

Afternoon Concurrent Sessions

Moving Beyond Sales: Evaluation of Social Marketing Programs

Moderator: Dr. Jim Shelton, Senior Medical Advisor, Office of Population & Reproductive Health, USAID

Mr. Shelton introduced the speakers and moderated the afternoon's panel presentations:

Ruth Berg, Research Director, CMS

Toward a More Strategic Evaluation of Social Marketing Programs

Dr. Berg's presentation proposed a more strategic approach to the way both cooperating agencies and donors monitor social marketing programs.

Most social marketing programs strive for similar outcomes, although they may place emphasis on different aspects. In general, the goal of social marketing programs is to improve health, especially among needy populations, by expanding access to health products and services, changing behaviors, and increasing health product and service use. These goals need to be achieved without undermining the commercial sector.

Product sales remain one of the most common indicators that both cooperating agencies and donors use to judge the success of their social marketing program, mainly because it is easy to measure on a regular basis. Social marketing programs also collect data to measure access (e.g. data on distribution coverage and penetration) and behavior change (e.g., indicators of self efficacy, perceived risk or contracting HIV/AIDS, intention to use family planning, etc.). However, these data are much more expensive to collect and require greater technical expertise to collect correctly, and therefore are not available on a regular basis for most social marketing programs. Data on effective targeting and efficient market segmentation are rarely, if ever, assessed or collected since relevant data are not readily available and it is expensive for cooperating agencies to collect the data themselves.

As a result, there remains an over-reliance on sales data as the key indicator of social marketing program success. Yet, an increase in sales does not necessarily mean there has been a health impact. This measure also fails to capture brand-switching by consumers (i.e. from one social marketing brand to another or from the commercial sector to a SM brand).

Project sales data also does not tell whether or not the SM project is reaching the intended target, which for most SM programs are the CD socio economic classes. Sales data also do not reveal whether the market is efficiently segmented across the commercial social marketing and public sector, and also fail to reveal important shifts in market share. Data and slides were presented to show that an over-reliance on sales data does not allow adequate assessment of how SM programs are performing against the goals set for these programs.

More strategic assessments of social marketing performance often require the use of population-based surveys. An increasing number of programs are conducting population surveys that allow a more comprehensive look at the market and social marketing's place in it. A collaborative effort

to fund, design, and evaluate social marketing programs using a common assessment tool has the potential to lead to stronger SM programs and to better performance measurement.

Francis Okello, Research Manager, Anglophone Africa, CMS

Looking Beyond Sales: How Well are Social Marketing Programs in Uganda Reaching At-Risk Groups?

The presentation used an example of HIV/AIDS prevention activities in Uganda through social marketing of condoms to show the insufficiency of relying on sales figures alone to evaluate a social marketing project. Findings from a CMS periodic population based tracking survey were used to assess the extent to which social marketing projects had accessed condoms to various population segments at risk of HIV infection. The tracking survey was designed to monitor trends in sexual behaviors, use and attitudes towards social marketing products and the impact of CMS promotions and advertising on use of its products.

The presentation showed that the two social marketing programs and public sector condoms had reached a similar profile of users, probably as a result of similarities in marketing strategies. The presentation also showed that that the profile of the population reached by social marketing condoms was different from the population whose present sexual behavior puts them at risk of HIV infection (having multiple sex partners without use of any protection), most likely due to inequitable promotion of condom use among the different population segments by the social marketing projects. A majority of the social marketing condom users were younger, most of whom were aged 20-24, while a majority of the population with risky behavior were older, mostly aged 30 or above.

In addition to the differences in profiles of social marketing condom users and the at-risk population, the results also showed that despite heavy reliance on condom promotion among social marketing projects, evidence shows people are using a range of behaviors to avoid HIV/AIDS: 65 percent of the 15-19 age group rely on abstinence (delayed sexual debut or reversed behavior from sexually active to abstinence); 51 percent of the population over 30 years rely on faithfulness to one partner; and over 70 percent of the 20-29 age group either using condoms or faithfulness. Results are based on HIV/AIDS prevention behavior in the past year.

Based on the findings of this study, it was concluded that social marketing programs could achieve even better results by promoting a range of preventive behaviors, analyzing their impact on various population segments and developing more targeted and complementary interventions.

Dominique Meekers, Tulane University

Using Intermediate Behavior Change Indicators in India and Nigeria

The classic sales pattern for many social marketing programs involves a rapid increase in social marketing sales. Increasingly, however, more mature social marketing programs are experiencing stagnating or even declining sales. In response, some programs are turning to behavior change strategies (in contrast to more commonly practiced supply driven strategies) to try to overcome stagnating sales. This presentation examines the effect of behavior change communication strategies on sales, and ultimately contraceptive use, in Nigeria and India. The presentation highlights the importance of using behavior change indictors (including contraceptive prevalence) to better understand sales trends and to better inform social marketing program implementation.

Nigeria. The Society for Family Health (SFH) has socially marketed its Gold Star condom brand in Nigeria since 1992. By 1995, however, Gold Star sales had reached a plateau, and in 1996 and 1997, sales declined. In response, SFH shifted its emphasis from product distribution and branded communications to BCC.

Key campaign messages and objectives ranged from promoting condom negotiation skills and de-stigmatizing condom use to reminders that a healthy-looking person can be HIV positive and that consistent condom use outside of a stable marital union is important. Primary delivery vehicles included a radio program on HIV prevention, and print, radio, and television ads featuring Nigeria's national soccer star. SFH tracked results through eight waves of omnibus survey data, with a sample size of over 5,000 per wave.

Campaign results show positive movement in a number of measures. There was a substantial increase in respondents who identified themselves as having a high personal risk of HIV and who are aware that condoms protect against HIV. There was a substantial drop (although somewhat delayed) in the mean number of partners in the past two months, and an increase in condom use with non-marital partners. Overall, the approach appears successful in overcoming condom sales and in increasing condom use among both men and women with non-marital partners.

India. Among the lessons learned from the CMS Goli ke Hamjoli (Friends of the Pill) program are that sales data are not sufficient for understanding program impact. Goli ke Hamjoli was launched in 1998 in the urban areas of eight North India states that had low and stagnant oral contraceptive (OC) use.

Goli ke Hamjoli has promoted the use of low-dose pills in general among young urban women, rather than any single brand. Key campaign objectives have included removing barriers to OC use in a country where sterilization has been the predominant contraceptive method and where opinions about OC use were primarily formed during the earlier high-dose oral contraceptive era. Thus, the program explains that oral contraceptive side effects are minor and temporary and works to correct the myth that oral contraceptive use can cause infertility. CMS used four waves of tracking surveys, with a sample size of over 2,000 per wave, to measure results.

A largely consistent pattern of results emerged between campaign launch in December of 1998 and April 2002. That is, substantial positive movement was seen in a number of indicators of attitudes toward oral contraceptives, but improvements were evident only after a significant time lag — nearly two years. This was the case, for example, in respondents' belief that oral contraceptive side effects are temporary and do not cause weight gain or infertility, and that oral contraceptives are effective for family planning. Interestingly, the improvement in attitudes toward oral contraceptives occurred after, rather than before, an increase in oral contraceptive sales and oral contraceptive prevalence in the target population. This suggests that the initial rise in oral contraceptive use was driven largely by a conversion of oral contraceptive intenders to users. Attitudes towards oral contraceptives may have improved subsequently as users had positive experiences with low-dose oral contraceptives. Given the significant and recent improvement in attitudes towards oral contraceptives, we expect that sales and use will increase further in the future.

The implication for future programs is that while BCC can help define program impact and achieve higher sales, the minimum intervention period should be at least three years, in order to provide enough time for results to emerge.

Working with the Commercial Sector in the Delivery of Reproductive Health Services

Moderator: Kara Hanson, Lecturer in Health Economics, London School of Hygiene and Tropical Medicine

Private providers are widely used to address for a range of child, reproductive, and communicable health problems in developing countries. A number of studies have suggested that they are more responsive, convenient 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. There are large variations in the technical quality of care provided; the distribution of certain types of providers is biased towards urban areas; and private providers are constrained to work within a commercial logic. There is mutual distrust between the public and private sectors, with government relations with the private sector 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 organizational structures may be simple or complex; the services they provide range from sophisticated to simple public health products; and the boundary with the public sector may be blurred due to various forms of dual practice. Interventions must therefore be tailored to these different provider and service characteristics.

Interventions for working with private providers can be classified into three main groups: supporting consumers, working with providers, and policy- or system-level restructuring:

- *Supporting consumers:* Consumers often lack knowledge about prevention efforts and effective treatments, which limits their ability to ask for effective interventions. Instead, they depend on providers for this information, which makes them vulnerable to providers who may act in their own self-interest. All consumers have difficulty assessing technical aspects of quality, and those with less education or who use the more informal parts of the private sector are more likely to receive poor-quality services. Vouchers are one mechanism for supporting consumers that has attracted increasing attention in the international public health community. For example, they have been used to provide health services to sex workers in Nicaragua and to bring insecticide-treated nets to Tanzania. Vouchers combine a demand-side subsidy, which can be targeted to specific groups. They also have the potential to support the commercial distribution network and to provide technical support to designated providers. Other means of supporting consumers include providing direct information about providers, prices, and quality; creating franchised networks and improving accreditation; launching social marketing programs; enacting consumer protection legislation; and working through civil society groups. With the exception of social marketing, there has been relatively little experience of implementing and evaluating the impact of these mechanisms.

- *Working with providers:* A number of interesting provider interventions will be presented during this session. In order to be successful, interventions need to recognize the multiple influences on provider behavior. These include the professional, policy, economic, and regulatory context; provider knowledge and resources; and the influence of patients and communities. Successful interventions will therefore use a multifaceted approach to altering provider behavior. Most provider-side interventions have worked on a very small scale, with intensive monitoring of quality by the project. Since this level of monitoring is outside the capability of most governments, quality monitoring poses a challenge to sustainable up-scaling of activity.

- *Policy level interventions:* Many countries have undergone or are undergoing health sector reforms that restructure the role of the Ministry of Health, reducing its responsibility for direct service provision and focusing more on a "stewardship" function — that is, providing an appropriate environment for service provision by a mix of public and private providers. This approach has increased attention to regulatory issues of regulation and to developing capacity for purchasing care and contracting with providers, as well as developing such new approaches to assessing and addressing quality as provider accreditation. Government's responsibility in such a policy context also includes ensuring an appropriate policy environment with adequate protection of property rights and regulation, and drawing attention to areas where subsidized supply (by government or donor projects) can be better targeted to avoid crowding out the private sector. There is a capacity paradox, however. In many countries the rationale for working with private providers is that the public sector is weak; but ensuring adequate performance from private providers requires a strong public sector, with new skills in information processing, regulation, payment mechanisms, and specification and monitoring of contracts. Existing evidence suggests that the contracting process is weak in resource-poor environments that have a low level of monitoring capacity. Perhaps because of issues of opportunism, government initiatives to date remain focused on working with public and NGO providers; for-profit providers' roles remain largely outside the public-sector policy framework.

Different strategies for provider interventions are thus needed for different contexts and for different services. Along with careful adaptation of models, new monitoring and evaluation tools need to be developed. Plus, there may be a trade-off between equity and feasibility: for example, those providers who are most important in serving the poor may be the most difficult to reach with policy interventions. Finally, interventions need to be redesigned for the degree of scaling up that is required to make inroads in achieving the United Nations' Millennium Development Goals.

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Carlos Carrazana, Director, Summa Foundation

Expanding RH Services through the Commercial Sector: Lessons from Nicaragua and Peru

The commercial sector has great potential as a sustainable source of family planning (FP) and reproductive health (RH) services. It is important, however, to recognize that commercial motives are different from those of the non-profit sector. Thus, strategies to scale up FP/RH service must be designed around provider motivations. These motivations can include both the profit motive as well as a non-profit motive, such as social responsibility. In providing assistance to the commercial sector to expand the provision of RH services, factors to consider include whether or not the environment supports such growth (with both financial and non-financial incentives); the need for technical support (such as business skills or clinical training); and access to financing.

In Nicaragua, CMS and Summa are partnering with two leading commercial providers, or EMPs (Empresas Medicas Previsionales): Salud Integral and SuMedico. An external baseline assessment of the EMPs found average contraceptive use at 55 to 60 percent, with the EMPs delivering low levels of family planning services. Roughly 30 to 40 percent of respondents were not aware that family planning was included in the Social Security system or INSS (Instituto Nacional de Seguridad Social) package of services. A needs assessment found limited staff training and counseling; a lack of systems to provide FP; a culture of under-supplying preventive health services; and a client turnover rate that served as a disincentive for the EMP to promote family planning.

Summa provided both technical assistance as well as loans to finance upgrades and expansion of provider facilities. CMS provided technical assistance in capacity building, IEC, and organizational support. The goal of this support was increasing voluntary use of family planning.

The results showed that utilization patterns did increase for family planning services: more women of reproductive age (WRA) were seeking FP, with 8 percent of the women seeking FP services in the last three months. Higher numbers of WRA were accepting FP methods after being referred. One EMP was able to shift users from public sector/pharmacies to the EMP: now 47 percent of WRA who are using FP use the EMP, compared to only 28 percent at baseline.

In Peru, Summa assisted the San Pablo Hospital Complex, the largest commercial health provider network in the country. A household survey found that over 60 percent of WRA are in classes C, D, and E. While the private sector delivers low levels of FP services (less than 4 percent, including NGOs), there is a high level of satisfaction with the FP/RH services being provided. The challenges identified were: access to financing; a strong public-sector program; and addressing community needs.

Summa financing was used for the construction and equipment of a maternal and child health clinic in a low-middle income area. The clinic would serve as a community health center, providing primary care (at cost) and FP/RH services (free and at cost). The objective of the project was to improve and expand the delivery of MCH services, while shifting clients with the ability to pay from the public sector to the private sector.

The main conclusion from these case studies is that the commercial sector must have the capacity to delivery RH services. In addition, it should be noted that:

- Commercial providers seek a positive economic return

- Incentives must be clear to providers to promote FP/RH

- There is limited profitability of RH services in a fee-for-service system; there is larger economic impact in a capitated model.

Meaghan Smith, Investment Manager, Summa Foundation

Integration of Reproductive Health Services Through the Commercial Sector: Uganda Bushenyi Medical Centre and Clinica Sanangel, Nicaragua

Traditionally, public health programming has been vertical. Increasingly, however, donors and governments are interested in integrated health care delivery. There are a number of compelling reasons to consider service integration. Integration can reduce the time-related cost of health care, which is a critical factor for lower-income groups. For example, at a one-stop shop, a mother is more likely to address her own health care needs and those of her children. Integration is increasingly considered a strategy for promoting family planning services. A recent research study has shown that contraceptive use is positively associated with the intensity of maternal and child health (MCH) use (Hotchkiss et al., 2002). Integration is therefore a strategy to increase MCH care, including family planning services.

In addition, integration has been identified as an effective strategy for promoting private-sector delivery of reproductive health services, because it appeals to the profit motive of private providers. While family planning alone may not be very profitable, it is a critical part of a more profitable maternal and child health (MCH) care package: If private providers are interested in adding or expanding MCH services, they need to integrate family planning services. And service integration can be tied into a private provider's strategy to diversify in order to increase revenue. By adding and integrating services, a private provider can attract new clients, retain old clients, and increase revenue per patient visit.

The Commercial Market Strategies project used a three-step approach to help private-sector providers integrate reproductive health services into their practices:

- Examine provider motivations (profit-making; payment mechanisms)

- Identify constraints (both general and specific to reproductive health)

- Design comprehensive interventions that account for provider motivation, general constraints and constraints to reproductive health service delivery

Ms. Smith demonstrated how this approach was applied to two commercial providers in Nicaragua and Uganda.

Nicaragua Case Study: The Clinica Materno Infantil Sanangel

The Clinical Materno Infantil Sanangel, a small pediatric clinic based in Managua, Nicaragua, was struggling financially and approached the Summa Foundation for help. After conducting an operational assessment, Summa identified several constraints. Sanangel offered a limited range of services with only one revenue stream — pediatric services. And, as a new service provider, client volume was low and revenue was minimal. In addition, Sanangel had invested most of its financial resources in the start-up of the facility and therefore had high fixed costs that were not being covered by revenue. As a result, Sanangel had a cashflow crisis.

Based on the assessment, Summa recommended that Sanangel add maternal health services to its offerings. Doing so would help diversify the clinic's range of services; utilize fixed capacity; bring in a new revenue stream; and tap a new market — that is, women who were bringing their children in for pediatric visits. In essence, Summa used a for-profit strategy to diversify services by integrating maternal health care into the mix — which also promoted family planning outcomes. (In order to integrate maternal health care at the clinic, Summa discussed with staff the importance of making family planning services available as part of a complete package of maternal and child health services.)

Summa also designed a loan intervention that financed expanding the clinic and increasing its capacity. In addition, Summa provided technical assistance in how to integrate maternal health and family planning services. As a result, Clinica Sanangel hired four gynecologists; opened a women's health consultation room; and added family planning and general OB-GYN services. After two years, OB-GYN visits accounted for 15 percent of total visits, and family planning visits made up 8 percent. Furthermore, by integrating services, Sanangel increased the number of its clients and raised revenue. The clinic is now operating at a profit.

Uganda Case Study: Bushenyi Medical Centre

Bushenyi Medical Centre (BMC) is a commercial provider that operates three clinics in the southwest portion of Uganda. Although BMC was initially established as a fee-for-service provider, it had recently added several prepaid health plans to its mix. Taken together, the plans covered more than 10,000 people. The Summa Foundation conducted an assessment of the medical center's operations and found that the prepaid plans had created several negative, if unintended, consequences.

For example, the prepaid plans significantly increased client visits. By adding new members but keeping the amount of physical space and level of services the same, the three BMC facilities were often overwhelmed. This was especially the case during the rainy season, when malaria was at its height. Clients began complaining about the overcrowding and the limited range of services, and raising significant quality concerns.

BMC realized that it needed to respond to these concerns in order to retain current clients and attract new groups to its pre-paid plans. When the center turned to Summa for help, Summa recommended that in order to meet the needs of the covered population, that BMC increase capacity, improve quality, and integrate additional services, including reproductive health services. Summa provided financing to the center to allow it to implement these recommendations. BMC agreed to train its providers in long-term family planning services as part of an integrated package of care. BMC also used the Summa loan to purchase laboratory equipment for improved testing of sexually transmitted infections (STIs). During the first year of the loan, the center had a 27 percent increase in STI lab tests. After BMC also introduced *Norplant*, tubal ligations, and IUDs, there was a 67 percent increase in family planning clients over the same one-year time period. BMC subsequently added voluntary HIV-AIDS counseling and testing services, along with prevention of mother-to-child transmission services.

Conclusions

More effective service integration is a workable strategy for promoting reproductive health services among private-sector providers. Successful interventions increase provider motivation and reduce both general and more specific constraints to the delivery of reproductive health services. The sustainable integration of reproductive health services in the private sector does,

however, take long-term planning and the patience to watch services grow over time. Finally, it is important to consider scale in selecting partners.

Dr. Joyce Djabatey, Director, C&J Medicare

From the Provider's Perspective: Integrating and Promoting Family Planning and VCT Services in a Commercial Practice in Ghana

Dr. Joyce Djabatey, director of C&J Medicare, a commercial health care provider in Ghana, provided a brief overview of that country and then discussed the opportunities and challenges faced by the private sector in integrating reproductive health services into a service mix. More specifically, she discussed her experience in integrating family planning and voluntary counseling and testing (VCT) services with the assistance of the Summa Foundation and Commercial Market Strategies project.

Ghana Background. Ghana is a West African country with a population of approximately 18.5 million. The total fertility rate is 4.6 children per woman and contraceptive prevalence is 13 percent for modern methods. HIV prevalence is 3.6 percent. While this level is considered relatively low in the Sub-Saharan context, there is concern due to the presence of high-risk groups and cross-border movements. Preventing HIV prevalence from crossing the 5 percent threshold is the goal.

In terms of the health sector in Ghana, it is estimated that there are a total of 1,569 health institutions, of which 37 percent are private, for-profit entities and 8 percent, not-for-profit. In the capital, Accra, the private sector dominates. It is estimated that 85 percent of all health facilities in Accra are commercial practices.

C&J Medicare Background. Dr. Djabatey founded C&J Medicare in July 1993 as a one-stop health care center. Until January of 2003, C&J operated in a small, rented clinic in Accra. During this first decade of operations, the center developed a niche in contracting with companies to provide health care to company employees. C&J now has 61 contracts with companies that cover over 13,000 employees and dependents; four of these contracts include management of company clinics. C&J estimates that 70 percent of its clientele are lower income.

Challenges. Like many other private providers, C&J Medicare has faced a number of challenges. One of the biggest was obtaining financing for expansion — without adequate financing, C&J struggled to offer the one-stop services its founder had envisioned. Other challenges included difficulty in accessing training; learning new technologies; and the costs associated with high staff turnover. Despite these challenges, Dr. Djabatey believed that there were opportunities within the private health sector and continued to seek ways to make additional investments in her practice.

Motivations for Integrating Reproductive Health. Reproductive health was one of the areas that Dr. Djabatey identified for additional investment. There were a number of factors motivating her to do so. First, RH services were needed to carry out C&J's vision of a one-stop shop. Dr. Djabatey was also motivated by a sense of social responsibility. As a doctor, she understands the negative consequences of HIV/AIDS and high population growth, and feels committed to doing something about it. And as a woman, she says she also feels committed to addressing these issues. In addition, in Ghana itself there is a growing public interest and government commitment to addressing HIV/AIDS and the unmet need for family planning services. Dr. Djabatey felt that it was important for her to respond to this public interest. The government has

recently enacted legislation that encourages companies to take responsibility for the health of their workforce. The new law is encouraging companies to fund preventive health and HIV/AIDS workplace programs. Financial support from companies has allowed Dr. Djabatey to expand into these areas.

The Intervention. To carry out her plan to provide reproductive health services, Dr. Djabatey determined that she needed additional funding and technical training. Accordingly, Summa designed an intervention to help C&J Medicare fully integrate family planning, VCT, and workplace programs into its practice — the Summa financing allowed C&J to expand its capacity. The CMS project provided technical assistance in VCT, family planning service delivery, advocacy, and best practices for HIV/AIDS workplace programs.

Outcomes. In January 2003, C&J opened a 20-bed hospital, dedicating two consultation rooms to family planning and VCT services. In addition, C&J conducted advocacy with five companies to encourage them to implement workplace HIV/AIDS programs. To date, four of the five, with a total of 3,200 employees, have agreed to establish workplace programs. In addition, C&J began offering VCT in-house services, and has seen a steady increase in the number of its VCT clients. In addition, with training of C&J staff in family planning service delivery and family planning, those clients are also increasing.

Payment Mechanisms for Reproductive Health

Moderator: Rich Feeley, Senior Technical Advisor, Health Financing, CMS

Conventionally, the link between health financing and family planning is thought to be health insurance. Thus, much effort has been focused on including family planning products and services in insurance packages. Although there have been some notable successes in employer-supported family planning programs (for example, stemming from the USAID-supported TIPPS/Enterprise projects in the Philippines and Zimbabwe), the evidence base for emphasizing insurance coverage as a way to increase family planning services is weak. Even in relatively well-insured societies such as the United States, there is little published research showing a strong causal link between inclusion of family planning in an insurance benefit package and increased contraceptive use.

Nevertheless, it seems that including family planning services in insurance benefits should encourage usage in two ways — by lowering the cost at the point of service, and by increasing the revenue of providers of family planning services, thus extending access or improving quality.

Global research by CMS tested the link between insurance and contraceptive usage by analyzing data from *Demographic and Health Surveys* in three countries (Colombia, Dominican Republic, and Turkey) where a portion of the population is covered by health insurance. While the descriptive statistical analysis does show the expected higher usage of modern methods among the insured sectors of the population, regressions, which remove the effect of education and other socio-demographic factors, tell a different story. Particularly for supply-based methods, the link between health insurance and contraceptive usage largely disappears. Only in Turkey, the country in this group with the lowest modern contraceptive prevalence, does the regression show evidence that insurance coverage leads to higher use of modern family planning.

By comparison, the effects of insurance on the use of pre-natal services and hospital facilities for delivery are much stronger. For these maternal health services, the improved access which

follows from lower out-of-pocket costs does seem to lead to greater service utilization. For family planning, however — particularly in Colombia and the Dominican Republic where contraceptive usage is already high — insurance does *not* seem to increase utilization, nor greatly change the locus of family planning service delivery.

In most of the developing world, health insurance is available only to those who work in the formal sector of the economy or to the wealthy. These are also the individuals who have the highest level of education and the greatest ability to purchase contraceptives using household resources. Thus, simply putting family planning services in the insurance package is likely to have little effect on service utilization.

The data analyzed also show relatively little shift in the locus for the delivery of family planning services that results from insurance coverage. This is the second reason most often given for including family planning services in the insurance benefit: to shift relatively well-to-do citizens with health insurance out of government or donor-supported family planning clinics so that the available resources can be concentrated on reaching the poor. But again, just covering the service is not enough. What does seem to work, as one of the other presentations shows (Robert Bonardi's presentation on Nicaragua) is that a concerted campaign to improve the *quality* of privately provided family planning services within an insurance program, and to actively *promote* the availability of these services, can increase the volume of family planning services obtained through the insurance plan.

In addition, there are other ways in which creative financing can increase the availability and impact of primary care services. The presentations on Uganda (see Batusa, Health Partners, and Peter Cowley, CMS), discuss experiences with community health financing plans. Despite a number of obstacles, these plans give evidence of three very positive impacts of innovative risk-pooling schemes. CMS and Health Partners went to sponsors of the health plans' financial benefits and persuaded them to promote an important preventive service: insecticide-treated bednet benefits. CMS and Health Partners have also experimented with selective subsidies to enroll the very poorest in a health insurance plan. Furthermore, evidence shows that such community insurance plans do provide a barrier against the typical downward spiral of disease and poverty, when households are forced to "sell the cow" (that is, dispose of household assets) in order to pay for medical care.

Given the most common methods of transmission, it is fair to characterize HIV/AIDS as a reproductive health problem. The third presentation is from Tobias Rinke de Wit of PharmAccess International (PAI), an organization working on the front lines to get antiretroviral treatment to patients in resource-poor settings. His report suggests that, for an important segment of the population in developing countries, private-sector clinics and employer financing can be mobilized to provide AIDS treatment.

Rebecca Joy Batusa, Director, Health Partners /Uganda

Dr. Peter Cowley, Country Representative, CMS/Uganda

Community-Based Insurance: Lessons from the CMS/Health Partners Collaboration

This project aims to maintain a healthy community through a partnership arrangement. The Ugandan health care system is typically characterized by poor health outcomes compared to per capita spending on health. While household expenditures on health are less than government

expenditures, out-of-pocket expenditure nevertheless make up a substantial proportion of health care financing in Uganda. User fees were abolished in March 2001 and there is no social security-based health insurance.

Since 1997, HealthPartners has been subcontracted through Land O'Lakes to improve the health of Ugandan dairy cooperative members. Thus, CMS and HealthPartners co-manage the Uganda Health Cooperative (UHC) group of health plans — as a local NGO, UHC helps ensure sustainability. (And, since 2000, HealthPartners has been subcontracted by CMS/Uganda to create a health insurance option in war-torn northern Uganda.)

CMS and HealthPartners support the effort by providing premium calculation, writing contracts, installation of computerized patient utilization systems in three rural sites, management of UHC clients, and marketing and recruitment of group members.

Schools make up the largest percentage of plan membership. The two largest service providers are a Protestant-run group of hospitals (UPMB) and its Catholic counterpart (UCMB); most groups prefer to contract with these facilities due to perceived quality of care. Premiums are 12,000 Ugandan shillings, or $6 per quarter for a family of four. This premium typically represents 6 percent of a families' annual income. The benefit package includes in- and out-patient care and drug coverage, but does not cover chronic diseases. The number of plans and the breadth of their coverage have grown over the years. At the end of 2003, over 6,000 members were enrolled in more than 50 plans. The difference between the total premium and the client's premium cost is being met by CMS.

The lessons learned from this program include:

- It is expensive to market to smaller groups, especially if the group cannot act as a "unified payer," because of difficulties with premium collection, ID cards, and the 60-percent-of-the-group-must-join rule.

- Poorer groups are usually small and not well organized, and use more services.

- Family planning is not a big selling point for insurance and is not included under some UCMB-based plans.

- There is high demand for delivery care.

- AIDS treatment is not covered, but is scheduled to be covered in the future.

While UHC has 5,000 members, it has negotiated on behalf of another 12,000 members. Health insurance efforts in Uganda serve as an experience base for social health insurance. Knowledge of health insurance increased, as over 20 percent of districts now have community-based schemes (UHC or otherwise). Many possibilities lie ahead for expanding this program in the future.

Robert Bonardi, Project Director, CMS

Increasing Family Planning Utilization Through Contracting-Out: INSS/Nicaragua

The presentation is about a CMS pilot initiative to increase family planning (FP) services through contract arrangements with commercial providers that deliver health services under Nicaragua's social insurance program.

Nicaragua is a poor country, with more than half of its 5.3 million population living below the poverty line. There are high rates of both infant and maternal mortality. The country has been undergoing decentralization and health-sector reform. The MOH is the primary health provider, serving over 70 percent of the population. The country spends 12.5 percent of GDP on health care (while high on a percentage basis, still low on a per capita basis). Two-thirds of private health care purchases are for essential drugs.

In 1993, the country's Social Insurance System (INSS) initiated a new health care model for Social Security beneficiaries — that is, those people employed in the formal sector and in the government. The INSS did not have its own health care facilities (they were taken away during the Sandinista regime), so the INSS decided to contract out health care service delivery.

The INSS contracts with both private- and public-sector health care providers (the latter called EMPs). The providers deliver a basic package of preventive and curative services for a capitated fee (one flat charge per insured person). The package includes FP and maternity care for insured, and deliveries for a spouse. In addition, EMPs pay for the insureds' maternity leave for three months.

CMS and Summa wanted to expand commercial-sector delivery of FP services under this model. Together they provided financing in the form of loans through Summa and technical assistance through CMS to two of the largest EMPs (Salud Integral and SuMedico). A baseline assessment revealed that the EMPs were not delivering FP to clients, even though 55 percent of women of reproductive age (WRA) were using contraceptives. Thus, more than two-thirds of women of reproductive age (WRA) were going elsewhere for their family planning services, primarily to either the public sector or to pharmacies. Between and 30 and 40 percent did not know of their family planning benefits.

CMS provided training in FP counseling to the providers' medical staff; implemented a six-month information–education–communication (IEC) campaign to promote the services; and instituted a family planning referral system to identify women of reproductive age who might want or need FP. CMS conducted a cost–benefit analysis to show the EMPs that if they implemented a FP program, they could save between $43,000 and $67,000 each year by averting unplanned pregnancies.

The IEC program reached 5,000 patients through family planning discussion sessions. About 2,000 women of reproductive age were referred to FP clinics for counseling — and of these, more than 1,500 accepted FP methods. An EMP that decided to give spouses free FP services made good on its promise to 300 of them.

After five months, end-line results revealed that utilization patterns had increased for FP services (8 percent more WRA sought FP in the last three months). In addition, higher numbers of women were accepting FP methods after being referred. Also, one EMP was able to shift users from public sector/pharmacies to the EMP. Now 47 percent of WRA who are using FP use the EMP, compared to only 28 percent at baseline.

The pilot initiative showed that commercial providers would deliver FP services if incentive mechanisms are in place. Under the INSS's capitated model, providers have financial risks if women become pregnant, stemming from the costs of pre- and post- natal care and of maternity leave. A well-managed FP promotion program can, however, reduce financial exposure and enhance the perceived quality of services delivered. In addition, one EMP was able to shift

clients who were going to the public sector or other sources for FP services to the EMP, thereby achieving better resource allocation.

In collaboration with USAID and the INSS, the pilot program may be expanded to reach other providers, or to include other RH services, such as cervical cancer or STIs.

Dr. Tobias Rinke de Wit,Operations Director, PharmAccess International

Private Provision and Financing of ARVs: CMS and PAI, Ghana

PharmAccess International (PAI) is a Dutch NGO chartered to improve the availability of AIDS treatment in resource-poor settings. To accomplish its goal, PAI has focused on the private sector — both employers (as a sponsor of medical benefits) and private clinics (as a source of services).

PAI's most important initial client was Heineken, a socially responsible multinational brewer that made the commitment to offer antiretroviral (ARV) treatment to employees and their dependents in its breweries throughout the world. PAI was commissioned to set up these treatment programs, and began by training staff and creating the necessary laboratory capacity within company-run clinics at breweries in Rwanda, Burundi, the Congo, and Nigeria.

In Ghana, PAI realized that the small number of employees and relatively low HIV prevalence rate would make creation of in-plant treatment capacity prohibitively expensive on a per-case basis. Instead, it would be better to upgrade existing private-sector clinics to provide ARV treatment under contract to Heineken's — and also be able to offer these services to the clinic's traditional clientele as well as to other employers.

The CMS project was already working with Ghanaian industries on HIV-prevention programs. PAI teamed with CMS to develop PAI-affiliated treatment centers (ATC's) in Ghana. The first three ATC's, all based at respected clinics in Accra, are now up and operating. PAI has provided medical protocols and training, as well as advice on laboratory tests ands drug selection, and will continue to offer technical assistance, including a telephone-based medical hotline for problem cases. CMS developed the affiliation agreements with the clinics and is assisting in marketing the ARVC service to Ghanaian employers. CMS also commissioned an actuarial study which has led to the addition of full HIV benefits as a rider, available at modest additional cost, on existing commercial health insurance policies.

In the longer run, the ATC model provides a means for employers to increasingly provide AIDS care to their employees at existing private clinics (which now treat other diseases for those in the formal sector and the middle class). Training and quality monitoring by PAI should maintain the standards of care in these clinics. It is hoped that ATC's can even be used to further expand the availability of antiretroviral treatment by partially subsidizing the care of additional patients in these clinics, using funds from international donors.

Plenary

CMS: Lessons Learned and Thoughts for the Future

Susan Mitchell, Director of Country Programs, CMS

Lessons Learned in Private-Sector Reproductive Health Programming

CMS utilized six technical approaches: (1) social marketing, (2) strengthening the provision of products and services through private providers, (3) NGO sustainability, (4) corporate social responsibility, (5) health financing, and (6) improving the environment for the private-sector provision of RH products and services. This presentation summarizes the key lessons learned from CMS programs, organized around the first five approaches.

Social marketing was the cornerstone for many CMS programs. A wide range of social marketing models was used, depending on the type of product, the expected health outcome, the sustainability objective, the country's level of economic development, and the availability of appropriate partners. The various models accommodated a number of different ways to engage the commercial sector. In addition, the level and type of commercial-sector involvement could change over time. CMS found that increased levels of commercial-sector involvement resulted in increased levels of financial sustainability, particularly for product supply. While program managers tracked sales and market share data, it was also important to monitor other information, including behavior change, market segments, and health impact.

CMS worked with two types of private providers: individual providers (for example, doctors and midwives) and larger provider groups (including clinics and hospitals). CMS found that individual providers can be difficult to reach on a large scale without an organizing structure — working with provider associations and provider networks was more effective. In particular, provider networks proved effective at increasing use by enhancing quality and increasing access to a standardized package of affordable services. Detailing — that is, making frequent educational visits directly to the provider — is another effective means. Since most providers identified access to credit as a major constraint, CMS also used financing to support providers in achieving scale and improving quality. To motivate providers to add and promote family planning services, CMS supported integrating them into maternal and child health services, as a way to enhance profitability.

In working with RH NGOs, CMS reconfirmed that cross-subsidy activities are most successful when they are related to the core competencies of the NGO. Service delivery NGOs can improve financial sustainability by diversifying into profitable ancillary services such as laboratories and pharmacies, but such additions must be based on sound business capabilities, including the ability to analyze markets and manage costs and finances. Some NGOs are not able to improve their financial sustainability, however, and must therefore cultivate donor diversification to minimize their financial vulnerability.

CMS research among multinational companies revealed that most firms possess a sense of obligation to give back to society and have a set of core values to guide their corporate social responsibility programs. Nevertheless, finding companies or industries interested in supporting family planning programs was more challenging than expected.

A community-based health scheme is one in which a community group agrees to pre-pay a premium for a set of pre-determined health services, the goal of which is to reduce the financial burden of illness on individuals and families in the community. CMS found that community-based health plans can improve access to private health services and can have significant economic impact on member households — that is, fewer households had to sell an asset or impoverish themselves to pay for health expenses. But routine services such as prenatal care or family planning were considered more predictable and of lower priority to the community, and were therefore harder to add to such health plans. As for larger health insurance plans, if the right incentives are in place, providers can be convinced to include or promote family planning benefits, provided they realize cost savings.

Susan Scribner, Senior Technical Advisor, Policy, CMS

Improving the Environment for the Private Sector in Reproductive Health: Lessons Learned from CMS

The third intermediate result of the CMS project is improving the environment for the sustainable delivery of family planning and other products and services through the private sector. A conducive environment is a necessary precondition for the delivery of private-sector family planning products and services, and especially if they are to achieve sustainability.

For CMS's work, the environment can be divided into the policy regime itself and the surrounding political and cultural environment. Regimes and environments face different challenges and require different approaches — and have resulted in different lessons from CMS's work.

Policy regime is perhaps more typically thought of as the actual policies themselves, the "on the books" regulations, budget line items, registration and licensing procedures, and government health programs. While CMS and other similar projects have a wealth of experience and knowledge about how to encourage and foster changes to policy regimes, much work still remains to be done in this area.

On the other hand, the policy environment is the reality of the cultural and political atmosphere in which the policy regime is carried out. It includes the level of receptivity or hostility to private-sector family planning providers. This reality is often quite different from the printed policies on the books: if hostile, it can lead to legislation that is not implemented; policy statements not backed up by programs, or undermined by other kinds of decisions; and budget allocations not spent, or spent on other priorities. CMS has been especially interested in this reality as perceived by private-sector service providers, including pharmaceutical companies. Private-sector perceptions affect the sector's decisions on whether to offer services or invest in new products. The policy environment is more complex because it is more amorphous; it subsumes policy regimes, and to address it requires innovative, country-specific customized approaches.

CMS was often able to achieve policy changes because they were linked to other interventions, such as a social marketing campaign or a provider network. Private-sector partners are invested — financially and programmatically — in such programs and are therefore willing to advocate and use their influence to try to change policy regimes to accommodate them. Decision makers in government are usually aware and often supportive these initiatives as well, so they are also receptive to considering policy change.

Finally, research conducted to inform programs may also be used effectively to enlighten the debate about specific policy changes. Citing studies and data in arguing for policy change was repeatedly used successfully in CMS's work to change policy regimes. For example, this was the case in CMS's work in Senegal on advertising oral contraceptives; in our work in Ghana on using willingness to pay studies to increase contraceptive prices; and also in India on ORS.

In policy work, it also pays to be opportunistic. Windows of opportunity may arise because of fortuitous timing, or because you have gained the ear of an influential policy champion or decision maker. This happened in CMS's work in Jordan, for example.

The first lesson for changing policy regimes is to recognize when it is the policy *environment* — not the regime — that is the challenge. An example is CMS's work in India on increasing acceptance of the injectable contraceptive.

The next lesson is to be strategic in how and when to use public-private dialogue. On one hand, if the private sector is not approached and handled carefully, its firms may be discouraged from further participation. When managed well, public-private dialogue can be both productive but extremely time-consuming. The focus must therefore be on making such dialogue productive. Some situations that merit the use of public-private dialogue include:

- When the situation is potentially controversial. This was the case, for example, in CMS's work in Ghana, as we worked with the pharmaceutical company HR Pharma to launch a dedicated emergency contraceptive pill.

- When there is the need to form strong and sustainable partnerships. This was the situation in Mexico, where we worked to bring stakeholders together to secure community support for CMS youth programs. And it was the case when CMS was involved in the SPARHCS initiative to analyze contraceptive security challenges.

The last lesson relates to the interaction between the environment and the market for family planning and reproductive health products and services. Typically, the environment and the market are thought of as being fairly distinct. CMS experiences have come to show, however, that the connection between environment and market goes deeper and is much more fundamental; that everything that happens in the environment affects the market. Policy can play an important role in defining a niche in the market for the private sector. (See, for example, CMS's market segmentation study in the Philippines). It is also important to recognize the impact of donor policies and donations on the market for privately provided products and services (See, for example, CMS's contraceptive security study in LAC region).

In conclusion, private-sector partners can be encouraged to advocate for an improved policy context. It is important to keep in mind, however, that private-sector partners operate differently than government or NGO counterparts. Successful private-sector relationships are built on an understanding of what motivates them, and their ways of doing business — and then framing issues to complement their agenda.

Susan Wright, USAID Cognizant Technical Officer, CMS

Concluding Remarks

Ms. Wright reiterated USAID's commitment to working with the private sector as a full partner in tackling many of the most pressing public health priorities in reproductive health, family

planning, and HIV/AIDS. Such joint efforts to catalyze private-sector participation in priority health care are necessary in order to increase access to quality health products and services for clients worldwide.

USAID has seen the value of building partnerships with the private sector through projects like CMS. Private-sector collaboration is an essential ingredient of a sustainable approach to delivering health products and services. And if literally billions of people are to truly benefit from development, the need for accessible and effective products and services has never been greater.

The Global Health Bureau is tasked with providing technical leadership and advancing the state of the art in private-public partnerships to support the health objectives of the Agency. Many of the interventions and initiatives presented today are the type of innovative approaches that are needed in order to:

- Promote healthy behaviors
- Increase the sustainability of NGO service providers
- Expand the availability of goods and services through private and commercial strategies

USAID missions continue to ask for support and technical assistance from the Global Health Bureau for their private- and commercial-sector strategies in family planning and reproductive health. CMS has been an important resource, providing USAID missions with the technical support they need and developing innovative approaches to working with private-sector organizations in their countries. The fact that 25 countries requested CMS assistance testifies to the growing awareness among USAID missions and host-country governments of the importance of private-sector approaches.

Although CMS will be ending in March, USAID will continue to work with the private and commercial sectors through a new mechanism, the Private Sector Program IQC that will be awarded early next year.

Ms. Wright ended her remarks by thanking the CMS team for their work and their efforts, and thanking the audience for coming.

Robert Bonardi, Project Director, CMS

Concluding Remarks

Mr. Bonardi closed the conference with a few remarks, noting that much has been accomplished at CMS in partnering with the commercial sector. CMS's work has added to the existing body of knowledge about successful strategies, including social marketing, working with providers to improve quality, and strengthening NGO sustainability.

CMS pioneered important new approaches to partnering with the commercial sector, including working through corporate social responsibility programs and creating community-based health financing mechanisms that expand financial access to products and services. CMS's work has also illustrated the importance of the policy environment for facilitating the continued involvement of the commercial sector in the delivery of reproductive health services. Much more

can and should be done, however, to tap the potential and leverage the resources of the commercial sector. As examples, Mr. Bonardi raised the following questions:

- How can we help build markets for commercial products, as donated products are phased out — and as consumers are shifted away from free or subsidized products, particularly for long-term methods?

- How can we reduce competition from the public sector in the provision of goods and services to those who can afford to pay?

- How can we convince private providers to integrate FP/RH in a broader offering of services — services that are affordable and of high quality? Will it require more training, or setting up networks?

- How can we work to open up sources of capital in developing countries to help providers expand their practices?

- How do we find ways of working with providers to help them see the commercial advantages of adding FP benefits to health insurance coverage?

- How do we identify business leaders willing to become more involved in the population and health issues that face their countries, and work collaboratively with them to do so?

- How do we help the public sector realize that the commercial sector brings skills, resources and capabilities that need to be harnessed and put to work, so that the public sector can better address the needs of the poorest?

Mr. Bonardi ended his remarks by reiterating that much work still lies ahead in working more effectively with the private sector. He thanked all of the participants and all those who worked to put the conference together.

Appendix A. Conference Agenda

Commercial Approaches to Reproductive Health: Innovations, Results, and Lessons Learned

December 9, 2003, National Press Club, 529 14th Street, NW, Washington, DC

8.00 am	Registration
9.00 – 10.30 am **BALLROOM**	**OPENING PLENARY** **Introductory Remarks** Robert Bonardi, Project Director, CMS *Introduction and Objectives* Margaret Neuse, Director, Office of Population and RH, USAID *Why Commercial-Sector Strategies?* **CMS: Strategies and Accomplishments** Robert Bonardi, Project Director, CMS *Overview of CMS Project* Ruth Berg, Research Director, CMS *CMS Research and Evaluation: An Overview*
10.30 – 10.45 am	Break
10.45 am – 12.15 pm **LISAGOR ROOM**	**MORNING CONCURRENT SESSIONS** **1. Sustainability Strategies for Reproductive Health NGOs** **Moderator:** Carlos Carrazana, Director, Summa Foundation Kelly Wolfe, Regional Manager, LAC, CMS *An Integrated Approach to Achieving Financial Sustainability: The PROFAMILIA Nicaragua Clinic Network* Alvaro Monroy, Senior Technical Advisor, NGO Sustainability, CMS *Improving Self-Sufficiency: CMS Case Studies from Ghana and the Dominican Republic* Beth Fischer, Private Sector Advisor, CMS/Uganda *Enhancing Sustainability of Associations: The Uganda Private Midwives Association*

10.45 am – 12.15 pm
FIRST AMENDMENT LOUNGE

2. Effective Strategies for Increasing Quality of Care in the Private Sector

Moderator: Dr. William Jansen, Director, IntraHealth International

Asma Balal, Senior Program Manager, ANE, CMS
Franchising Private Providers to Achieve Quality Improvement: Nepal

Pilar Sebastian, Technical Advisor, Population Services International
Improving Quality of Care Through Private Provider Networks: CMS/PROFAMILIA Nicaragua

Meaghan Smith, Investment Manager, Summa Foundation
Taking a Business Approach to Improve Quality of Care: Evidence from the Uganda Private-Provider Loan Fund

10.45 am – 12.15 pm
HOLEMAN LOUNGE

3. Social Marketing: Delivering Health Impact Through Context-Specific Approaches

Moderator: Françoise Armand, Senior Technical Advisor, Social Marketing, CMS

Karen Bulsara, Social Marketing Director, CMS/Uganda
Using Different Social Marketing Approaches for FP, HIV/AIDS & Malaria: CMS/Uganda

Dr. Rita Leavell, Country Representative, CMS/India
Expanding the Market with Commercial Firms: CMS/India

Dr. Pinar Senlet, Consultant
Post-Exit Strategies for Contraceptive Social Marketing: CMS/Morocco

12.30 – 2.00 pm
BALLROOM

LUNCH

Lunch Speakers

Grace Migallos, Country Representative, CMS/Philippines
The Philippines: Background and CMS Program

Donald Dee, President, Employers Confederation of the Philippines
Mobilizing the Business Sector to Support Family Planning

2.00 – 3.30 pm
HOLEMAN LOUNGE

AFTERNOON CONCURRENT SESSIONS

1. Moving Beyond Sales: Evaluation of Social Marketing Programs

Moderator: Dr. Jim Shelton, Senior Medical Advisor, Office of Population & RH, USAID

Ruth Berg, Research Director, CMS
Toward a More Strategic Evaluation of Social Marketing Programs

Francis Okello, Research Manager, Anglophone Africa, CMS
Looking Beyond Sales: How Well are Social Marketing Programs in Uganda Reaching At-Risk Groups?

Dominique Meekers, Tulane University
Using Intermediate Behavior Change Indicators in India and Nigeria

2.00 – 3.30 pm
FIRST AMENDMENT LOUNGE

2. Working with the Commercial Sector in the Delivery of Reproductive Health Services

Moderator: Kara Hanson, Lecturer in Health Economics, London School of Hygiene and Tropical Medicine

Carlos Carrazana, Director, Summa Foundation
Expanding RH Services Through the Commercial Sector: Lessons from Nicaragua and Peru

Meaghan Smith, Investment Manager, Summa Foundation
Integration of RH Services Through the Commercial Sector: Uganda Bushenyi Medical Centre and Clinica Sanangel, Nicaragua

Dr. Joyce Djabatey, Director, C&J Medicare
From the Provider's Perspective: Integrating and Promoting Family Planning and VCT Services in a Commercial Practice in Ghana

2.00 – 3.30 pm
LISAGOR ROOM

3. Payment Mechanisms for Reproductive Health

Moderator: Rich Feeley, Senior Technical Advisor, Health Financing, CMS

Rebecca Joy Batusa, Director, Health Partners/Uganda
Dr. Peter Cowley, Country Representative, CMS/Uganda
Community-Based Insurance: Lessons from the CMS/Health Partners Collaboration

Robert Bonardi, Project Director, CMS
Increasing Family Planning Utilization Through Contracting-out: INSS/Nicaragua

Dr. Tobias Rinke de Wit, Operations Director, PharmAccess International
Private Provision and Financing of ARVs: CMS and PAI, Ghana

3.30 – 3:45 pm

Break

3.45 – 5.00 pm
BALLROOM

PLENARY

CMS: Lessons Learned and Thoughts for the Future

Susan Mitchell, Director of Country Programs, CMS
Lessons Learned in Private-Sector Reproductive Health Programming

Susan Scribner, Senior Technical Advisor, Policy, CMS
Improving the Environment for the Private Sector in RH: Lessons Learned from CMS

Robert Bonardi, Director, CMS
Susan Wright, USAID Cognizant Technical Officer, CMS
Concluding Remarks