



UGANDA

Partnering with the private sector to meet Uganda's health care needs

PROGRAM OBJECTIVE

The Commercial Market Strategies (CMS) project in Uganda aims to improve reproductive, maternal, and child health.

Program efforts focus on the social marketing of reproductive health products and services; increasing the capability of private-sector providers to deliver affordable, quality services; and encouraging the creation of innovative health financing mechanisms to increase access to health care.

UGANDA AT A GLANCE

Population	24.7 million
Growth rate	2.9 percent
Per-capita income	\$260
Literacy rate (women)	57 percent
Literacy rate (men)	78 percent
Health	
Fertility rate	6.9
CPR*	23 percent
CPR, modern	18 percent
Maternal mortality	1,100/100,000
Infant mortality	88/1,000
HIV prevalence	6.1 percent
Life expectancy (women)	43 years
Life expectancy (men)	42 years

*Contraceptive prevalence rate.

PROGRAM CONTEXT

Uganda's population growth and fertility rates are high. Knowledge of modern contraceptives, however, is also high: Ninety-two percent of married women and 91 percent of married men are aware of oral contraceptives, and over 96 percent of both women and men are aware of at least one contraceptive method. Uganda's contraceptive prevalence rate — 23 percent for all methods and 18 percent for modern methods — is high among African countries.

Uganda has been cited as Sub-Saharan Africa's success story for its efforts to reduce HIV prevalence. Nonetheless, HIV/AIDS continues to be a major health problem, with an estimated infection rate of 6.1 percent.

Overall health indicators in Uganda are poor. Life expectancy is low and child, infant, and maternal mortality rates are high. Malaria kills between 70,000 and 100,000 people each year — most are children under five.

Even with additional revenue from donor funds, the Ugandan government cannot satisfy its population's health needs. But the private sector, including for-profit and non-profit providers, can help. The CMS project works to improve the capacity of private providers to respond to the health needs of Ugandans, as well as to increase access to affordable, quality products and services. To achieve these objectives, CMS uses three strategies: social marketing, including behavior-change communications; support for private providers; and the identification and development of alternative sources of health financing.

SOCIAL MARKETING

CMS's approach — accessibility and distribution. Uganda is the CMS project's largest and most diverse social marketing program. Products and activities fit under three broad categories:

- **Family planning** — *Pilplan* oral contraceptives and *Injectaplan* injectable contraceptives

- **Maternal and child health** — *New Maama* clean delivery kits and *SmartNet* insecticide-treated nets

- **HIV/AIDS prevention** — *Protector* condoms, *Clear Seven* STI-treatment kits, and voluntary counseling and testing services

CMS/Uganda's social marketing efforts are characterized by an emphasis on accessibility and distribution. This approach has paid off: A distribution survey conducted in 2000 revealed that *Protector* condoms were available in 91 percent of pharmacies, 86 percent of drug shops, 76 percent of clinics, and 44 percent of general merchandise shops. The distribution strategy evolved from a traditional urban-based system to a segmented approach based on specific program objectives. For example, in 2000, CMS expanded its geographic penetration and focused its distribution efforts on the northern region of Uganda, where there is high unmet need for family planning as well as malaria-prevention products. In the case of insecticide-treated nets (ITNs), CMS phased out urban distribution of its subsidized brand, *SmartNet*, to allow for the expansion of commercial-sector brands.

In addition to implementing brand-specific campaigns, CMS also develops behavior-change communication (BCC) activities to respond to barriers identified by program monitoring data. For example, CMS funded two radio programs — *Triple S* and *Capital Doctor* — that provided candid information about sexuality, reproductive health, and HIV/AIDS while promoting a range of preventive behaviors, including abstinence, partner reduction, and condom use. In collaboration with the Straight Talk Foundation, a local NGO, CMS contributed to a monthly tabloid, *Straight Talk*, and organized school visits, road shows, and promotions in bars and nightclubs. CMS also reinforced its *SmartNet* and *New Maama* programs with behavior-change communications designed to raise awareness of the dangers of malaria and unsanitary birth practices.

Pilplan and Injectaplan hormonal contraceptives. *Pilplan* pills have been marketed in Uganda since 1993. Sales in 2002 reached 970,000 cycles, and the product was sold in over 2,500 outlets, including pharmacies, clinics, maternity homes, and drug shops. *Injectaplan* was launched in 1996. Sales in 2002 reached 540,000 vials and the product was sold in over 1,500 retail outlets. Distribution for both products is supported by seven distributors and NGO partners, among them the Family Planning Association of Uganda and the Uganda Private Midwives Association. The pill market in Uganda is shared between *Pilplan* and several other brands that are supplied through the public sector. The injectable market is shared between *Injectaplan*, which is accessed through private health facilities, and *Depo-Provera*, which is supplied by the government in public health facilities. According to a 2002 CMS tracking study, *Pilplan* has the largest market share, with 64 percent of pill users, and *Injectaplan* has over one-third of the injectable market, at 37 percent.

To achieve economies of scale, CMS promotes *Pilplan* and *Injectaplan* together — marketing efforts focus on increasing consumer awareness, implementing a BCC campaign, improving product accessibility (particularly in the eastern districts of Tororo and Iganga, where there are high levels of unmet need), and on improving provider knowledge.

A national, branded radio campaign addresses product benefits, use, side effects, myths, and misconceptions. This campaign is complemented by behavior-change efforts that focus on educating couples about the benefits of using modern contraceptive methods. These behavior-change efforts include radio shows, dramatic performances, and point-of-sale materials.

To improve provider knowledge and product accessibility, CMS detailing staff conduct site visits and outreach training, focusing on the Tororo and Iganga districts. CMS also conducts monthly training sessions for midwives, in cooperation with the Uganda Private Midwives Association. To date, over 1,000 providers have been trained on the safe administration of *Injectaplan*, as well as

on the proper management of side effects. In an effort to improve the safety of family planning clients and health workers, CMS revised the *Injectaplan* delivery system, replacing the standard syringe (which can be re-used) with a safer auto-disable syringe.

SmartNet insecticide-treated nets. In December 2000, CMS introduced *SmartNet* in six pilot districts to test market viability and a new wash-resistant formulation, called *PermaNet*. The pilot was successful and, in March 2001, the Ministry of Health approved a rapid national expansion.

CMS quickly launched a brand awareness campaign, and soon began distributing *SmartNet* in over 1,000 outlets throughout the country. Five months later — encouraged by *SmartNet's* success as well as government tax incentives — two private companies began marketing nets in Kampala (and another two companies have since entered the market).

In early 2002, the MOH established an ITN Working Group to develop a national strategy that recognized the private-sector model as the future of ITN supply in Uganda. Free and highly-subsidized distribution (through social marketing programs) was to be limited to remote and at-risk populations. Accordingly, CMS focused on distributing *SmartNet* to low-income groups in Northern Uganda, limited its advertising, and worked to increase malaria risk-awareness with information, education, and communication (IEC) and BCC campaigns. Activities included drama performances at work sites and in rural communities on key market days. The two commercial firms in Kampala continued their aggressive net advertising. The synergy created by these combined promotional efforts increased sales for all three brands.

CMS launched *Unite to Fight Malaria*, an ITN voucher pilot project, in mid-2003. At 27 sites in Mbarara and Mbale, selected public health centers issued special ITN vouchers to pregnant women and caretakers of children under five years. Recipients used the vouchers to purchase — at a significant discount — commercially available insecticide-treated nets. The pilot was designed to test key



Straight Talk, the monthly tabloid for adolescents published by the Straight Talk Foundation, promotes CMS's *Capital Doctor* and *Triple-S* radio shows while reinforcing their positive reproductive health messages.



Don Brady, acting USAID/Uganda mission director, addresses the crowd at CMS's December 2000 *SmartNet* launch in Kampala. *SmartNet* — an insecticide-treated net — can lower childhood mortality by 15 to 35 percent.



SmartNet on display at the launch ceremony.

THE CLEAR SEVEN STI KIT

The name of the *Clear Seven* STI kit tells the user that the infection will clear after seven days of treatment. *Clear Seven* allows urethritis sufferers to seek treatment in outlets such as pharmacies and drugstores that are easily accessible and free of the stigma associated with STD clinics. The kit contains antibiotics, condoms to prevent reinfection, and reference cards to encourage users' partners to seek treatment. As part of a pilot project, CMS placed the product in more than 250 outlets and trained drugstore owners to show customers how to use it. CMS also trained providers in the syndromic management of urethritis.

Research conducted by the Uganda Medical Research Council to assess the pilot found that *Clear Seven* cured 84 percent of users — and that 93 percent complied with the treatment. *Clear Seven* users were also twice as likely to use a condom during treatment (36 percent, versus 18 percent in the control group), with 22 percent using a condom for the first time.



The *Clear Seven* kit treats urethritis in men and has proved to be a great success in improving access to treatment and promoting condom use.

Photo: CMS/Susan Wood



CMS's *My Choice* campaign repositioned *Protector* condoms as a lifestyle product. *Protector* is designed to prevent HIV/AIDS transmission. Campaign messages focus on healthy life choices in general, not only on choices related to sexuality.

mechanisms related to vouchers as well as target group, health center, and sales outlet selection. CMS/Uganda managed the pilot, which included distributing vouchers at the health centers and ITNs to nearby sales outlets. The MOH and its ITN Working Group will use CMS's *Unite to Fight Malaria* monitoring findings to scale up a national voucher scheme, planned for 2004.

Protector condoms. *Protector* was originally introduced in a family planning context under the *Be Wise* campaign. In 2000, CMS launched the *My Choice* campaign and repositioned *Protector* as a lifestyle choice. The campaign targeted sexually active youth, aged 15 to 25, and was designed to prevent HIV/AIDS transmission.

The initial strategy for *Protector* included creating a nationwide distribution system to facilitate accessibility, build brand equity and awareness, and reach out to high-risk groups with messages emphasizing correct and consistent use. CMS established over 6,000 sales outlets and marketed *Protector* with outdoor, point-of-sale, and radio campaigns. This strategy relied on intensive use of branded communications. A CMS survey conducted two years later found that the *Protector* condom campaign had achieved more than just brand recognition: CMS appears to have significantly increased acceptance of condoms overall. Over 90 percent of users of other condom brands had been exposed to a *Protector* communication campaign.

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

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

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

Voluntary counseling and testing (VCT). In 2002, CMS implemented a pilot VCT project in Uganda's Mbarara and Kasese districts. The project linked a generic awareness campaign — targeting young couples and those planning to have children — with referrals to a network of public-sector testing centers. CMS worked closely with the Ugandan Ministry of Health and the AIDS Information Centre. In addition to providing VCT services at its own sites, the AIDS Information Centre provides training, support, and quality assurance to MOH centers.

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

To complement and strengthen its advertising efforts, CMS supported PTCs. Several PTCs formed drama groups, which CMS supported with technical guidance on message delivery, as well as with props and costumes. CMS developed promotional materials to identify PTC members, including T-shirts, caps, and AIDS-awareness ribbons. Other PTC groups were given logistical support, such as transport to and from outreach activities.

CMS also conducted advocacy meetings with community leaders, since community support is an important component of VCT programs.

Initial assessments found that the campaign has had high recall and has helped increase client uptake in pilot VCT centers by over 50 percent.

SOCIAL MARKETING RESULTS

Increased use of modern contraceptives.

CMS/Uganda provided more than 829,000 couple-years of protection between 1998 and 2002. Contraceptive prevalence for modern methods increased from 16.5 percent in 2001 to 18.2 percent in 2002. Use of injectables by married women increased from 6.4 percent in 2001 to 13.1 percent in 2002. Research data indicates that CMS/Uganda also succeeded in growing the overall con-

traceptive market in Uganda. The percentage of women of reproductive age who use CMS contraceptive brands grew from 5 to 9 percent between 2000 and 2002, while the combined market for condoms, pills, and injectables grew from 12 to 19 percent. Injectables were the fastest-growing method in Uganda, with a 16 percent sales increase.

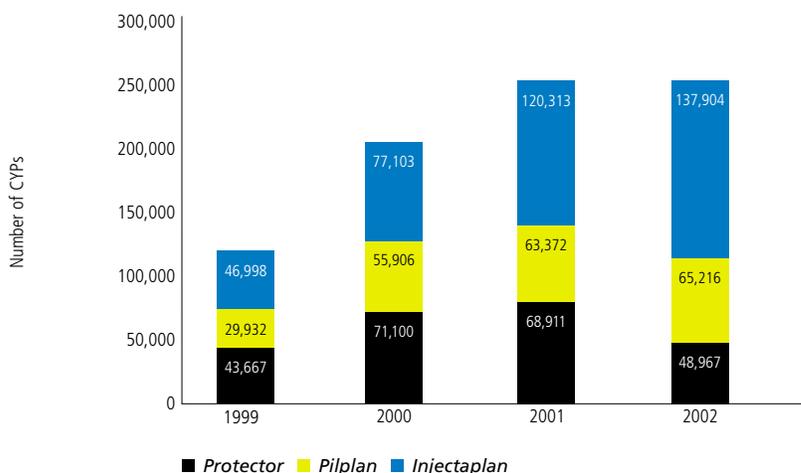
Protector condoms — increased access, thriving market. CMS activities contributed to increased access to condoms and a strong condom market in Uganda. When CMS took over the management of *Protector* in 1998, it focused on expanding product access and increasing the acceptability of condom use. CMS developed a nationwide distribution network of nearly 6,000 outlets, and aired advertising campaigns that earned the brand strong recognition among 98 percent of Ugandans. In addition, CMS/Uganda conducted targeted activities to increase STI awareness and promoted consistent condom use among high-risk groups. Annual *Protector* sales rose to 10 million units in 2001 — and then fell by almost 50 percent in 2002, despite a national increase in condom consumption. The condom market had become extremely competitive — a second social-marketing brand, *Lifeguard*, and a public-sector brand, *Engabu*, provided users with new lower-cost product options.

HIV COUNSELING AND TESTING IN UGANDA

CMS's VCT campaign uses a traditional Ugandan saying — "A stone that can be seen will not strike the hoe" — to remind people that it is easier to protect oneself against a known danger. Personal testimonials, which appear on radio, posters, and billboards, promote VCT testing by illustrating how knowledge of HIV status helps people stay healthy and prevent transmission.

Ignacious and Mary (shown in the poster below) are one of the couples who agreed to tell their story for the CMS campaign. Ignacious, a District Councilor, is HIV-positive; Mary is not: "When I got my results... I knew I had to be strong for the sake of my family. I went home to tell my wife but quite honestly I was so worried about how she would take it. She asked me to give her some time to think about it. She packed her bags and returned to her father's home. I felt hopeless and scared but my heart told me that everything will be all right. Life must go on. My wife returned after one month and agreed to stand with me against this battle... My wife, children and I are all happy and my wife is such an encouraging example to those in our village. I can look after all my children and that encourages me to remain strong. In my work as District Councilor, I sensitize people about AIDS. And I know that if all Ugandans are fully educated about the dangers of AIDS, they will win this war. So you out there who are still scared of knowing your status, testing is important because if you know your HIV status it helps you to plan your future."

Figure 1 ■ *Protector, Pilplan, and Injectaplan* CYPs, 1998 to 2002



A CMS tracking study found that in the first year of the *SmartNet* campaign, ITN use increased from 22 to 35 percent of households in the pilot districts.

In addition, the number of commercial brands sold at retail outlets appeared to increase, which reflected the growing attractiveness of the Ugandan market for private-sector suppliers.

Essential products developed. CMS actively explored opportunities to develop and market essential health products. Under CMS management, the project pilot-tested several new products, including *Clear Seven* and the *New Maama Kit*. *Clear Seven* found a major client in the military, whose members are at high risk of contracting STIs, including HIV. To date, more than 37,000 kits have been sold to the military and CMS promoted *Clear Seven* at bases throughout Uganda. The *New Maama Kit*, introduced in collaboration with CARE, enjoyed wide acceptance among local midwives, although funding limitations restricted the program to four districts in southwestern Uganda.

SmartNet — a successful public-private partnership. CMS was instrumental in stimulating demand for branded commercial nets, thereby building the ITN market in Uganda. When CMS launched *SmartNet* in December 2000, commercially available nets were virtually non-existent — fewer than 40,000 were sold each year. But by 2002, ITN sales increased to over 280,000, and

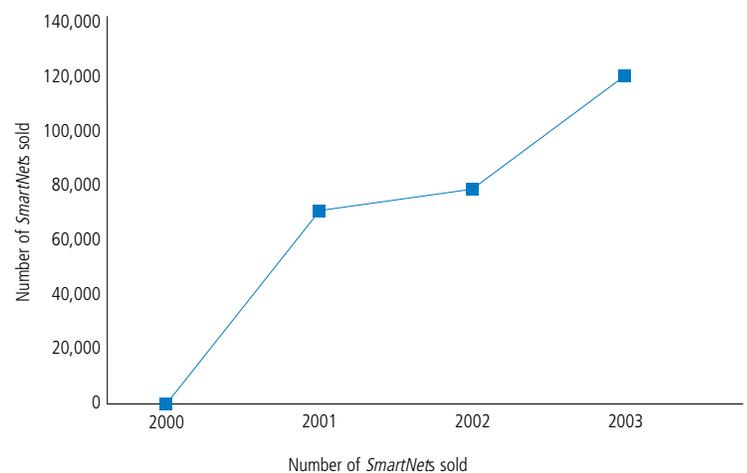
almost 78,000 of these were *SmartNets*. In 2003, total net sales are expected to grow to 450,000, with *SmartNet* accounting for 30 percent of the market. Moreover, while previously there were no firms in the commercial market, there are now four companies selling ITNs: Quality Chemicals, A-Z, Syngenta, and Vestergaard Frandsen. To maximize health impact and ensure that subsidized products do not compete with commercial brands, CMS collaborates with public- and commercial-sector partners to segment the ITN market, with CMS targeting remote and high-risk groups.

Effective advertising campaigns. CMS/ Uganda's advertising campaigns stimulated demand for reproductive health and other essential health products. A CMS tracking study found that in the first year of the *SmartNet* campaign, ITN use increased from 22 to 35 percent of households in the pilot districts. The same survey found that men of reproductive age who recall being exposed to a CMS advertisement for condoms are more likely to use condoms.

SOCIAL MARKETING LESSONS

Some products face significant policy obstacles. Despite efforts to inform the Ministry of Health and agencies such as the National

Figure 2 ■ *SmartNet* sales, December 2000 to September 2003



Drug Authority (NDA) about the unmet need for STI treatment and injectables, these products faced legal restrictions. It took more than three years for the NDA to allow CMS [to extend the sales of STI kits beyond the limited pilot areas, and authorization for nationwide distribution still has not been received. (CMS is currently conducting a study to demonstrate that providers are complying with the treatment guidelines, which ideally will clear the way for national distribution.) The NDA also forbids mass media advertising of *Injectaplan* and *Clear Seven*.

Competition between social marketing programs can lead to productive dialogue. A CMS tracking survey found that three socially marketed condom brands were competing for the same users, instead of recruiting new users. Since 2001, *Protector* and *Lifeguard* (marketed by Marie Stopes) have traded market share, while *Engabu*, a leaked public-sector condom, has increasingly captured private-sector users in commercial outlets. CMS advocated for a stakeholder dialogue, and is now actively engaged in the development of Uganda's first national condom policy and strategy document.

Successful products may require additional support. CMS enjoyed fast-growing demand for hormonal methods, especially injectables, which required adjustments in its marketing approach. While qualified personnel in the public sector typically administer injectables, the situation is different in the private sector, where illegal sales through unregistered and untrained clinics and drug shops are common. In 2002, CMS conducted a distribution survey and found that 36 percent of drug shops surveyed carried *Injectaplan*, even though this product can be sold legally only at pharmacies and clinics. CMS's two-person detailing team was quickly overwhelmed by the growing number of clinics and outlets.

Social marketing programs can stimulate private-sector participation. The *SmartNet* experience is evidence that the introduction of appropriately priced socially marketed products can attract private manufacturers

and distributors who are interested in supplying affordable products. Since the launch of *SmartNet*, four new commercial nets have been introduced in Uganda at affordable prices, an indication that CMS successfully primed the market for commercial ITN distributors. Opportunities for cooperation with commercial manufacturers have been spearheaded by the ITN voucher program and may eventually include the development of bundled products, such as prepackaged ITNs and re-treatment kits.

Population-based research provides essential insights. Population-based research identifies opportunities for social marketing programs to develop a variety of behavior-change activities. For example, CMS's 2002 tracking survey provided important information about reproductive health behaviors in Uganda. It helped identify more precise targets for condom promotion and also highlighted increased adoption of other behaviors, including abstinence and partner reduction, by large portions of Uganda's youth population. As a result, CMS began to develop more comprehensive programs and partnerships with NGOs, and modified its work plan to include a multi-behavioral approach to HIV/AIDS prevention.

SUPPORTING PRIVATE PROVIDERS

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

VOICES FROM THE FIELD

Peer educator in the UPMA's regional representative program

On my first visit to a certain midwife, the floor was covered by papyrus, and her record keeping and storage of drugs were poor. She had no privacy for her patients. However, on my second visit, I found she had plastered, painted the labor suite, cemented the floor and she had created some private space.

I visited another midwife who had no infection control. The labor suite was congested. On the second visit, I found no change but by the time I left her clinic, we had put everything right in the labor suite and the midwife promised to maintain her clinic.

Rose, a 28-year-old Bushenyi District resident

In 1997 I got pregnant with my fifth child. I did not want to have more children. I shared my worries with women in the self-help group I belong to. They told me that the UPMA clinic in our community had solutions for me. I went to the UPMA clinic the next day. A midwife well trained in family planning services educated me about the available methods. I settled for *Injectaplan*, which has helped me. I was also very happy to learn that UPMA clinics offer a variety of services, besides family planning.



Through a revolving loan fund created by the Summa Foundation, midwives from the Uganda Private Midwives Association receive practical business skills training. Training sessions also include instruction on quality of care, with an emphasis on how improving quality can help providers draw more clients.

Photo: CMS/Susan Wood

CMS developed a microloan program through the Summa Foundation (a not-for-profit organization that operates under the CMS project) after an assessment revealed that there was a significant demand for credit to expand and improve private-provider practices, and sufficient capacity to repay the loans.

CMS developed a micro-loan program to help private providers, including midwives, nurses, and doctors, deliver enhanced care. CMS also facilitated training programs in the integrated management of childhood illnesses to improve provider quality, as well as in business skills to develop provider efficiency and viability.

The Uganda Private Midwives Association.

In 2000, CMS began working to strengthen the UPMA, a valuable partner in reaching private midwives and their clients. CMS provides the association with institutional support. For example, CMS funded an executive director to improve financial and organizational accountability, and helped manage the association's funding and budget. CMS also helped the association create a membership database and a directory to enhance member communications.

CMS worked with the UPMA to expand its membership base and provide value-added services to members. As a result, active association membership has grown from fewer than 200 dues-paying members to more than 270. To reinforce the value of UPMA membership, CMS helped the association to restructure its monthly general meetings, which now include a continuing education component with guest speakers. As a result, average attendance increased from 40 to nearly 90 midwives. Similarly, CMS helped the UPMA establish a quarterly newsletter that informs members about association activities and provides health updates to members and other stakeholders. The newsletter generates income through the sale of display advertisements — and provides an excellent outlet for CMS to promote its products.

Since Ugandan laws prohibit the direct advertising or promotion of health care interests, one of the value-added services UPMA membership offers is indirect promotion to help build clinic clientele. CMS helped the UPMA develop and sell clinic signposts. Members use the signposts to

announce their membership in the association, since clients associate UPMA membership with higher-quality services. CMS also developed and distributed more than 40,000 newspaper supplements promoting the UPMA and listing clinics with UPMA members in locations throughout the country.

CMS provided funding and technical support for UPMA's regional representative program, a peer education and support program that uses UPMA members as trained volunteers. The volunteers visit clinics and advise fellow midwives on ways to improve the quality of their services and facilities. More than 50 midwives volunteer in this program and they have visited nearly 300 clinics. CMS developed a database to enable the UPMA to collect, record, and analyze information from regional representative visits so it can assess whether midwives have improved their practices over time and compare performance at the branch level. This information is shared at association meetings to develop a greater understanding among members of opportunities for improvement. CMS also worked with the association to improve its ability to collect utilization statistics to gain better insight into the care provided by UPMA members. This data is helpful in approaching donors and government agencies for support, as well as in other advocacy efforts.

CMS worked closely with the UPMA to improve and broaden its donor base, with the goal of covering a portion of overhead costs through donor funding. The association has received funding from various donors for specific project activities, including funding from the United Nations Population Fund, Family Care International, and the Global Fund for Women. In helping UPMA expand its capacity to generate its own sources of income, CMS supported the association in selling advertising, stationery, commodities, signposts, and other items. These sales activities raised nearly \$9,000 for the association in 2002, more than twice the amount raised in 2000.

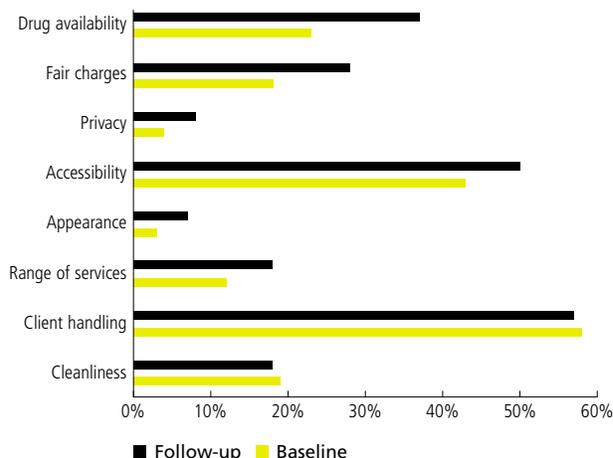
CMS extended favorable pricing of its social marketing products to UPMA members, with a commission going to the UPMA. Similarly, CMS helped negotiate an agreement with a pharmaceutical company to offer preferred pricing to UMPA members. More significantly, CMS helped the UPMA to restructure the under-performing association-owned Kansanga Health Centre. As a result, the clinic is now an income-generating asset for the association, contributing more than \$7,000 in rent annually.

Business skills training. CMS has provided training in basic business skills to nearly 350 private providers (in 10 of the 11 UPMA branches). The training includes business planning and management, record keeping, financial reporting, credit management, and marketing. For example, providers are taught how to maintain outpatient treatment registers and other clinical and financial records. Special attention is paid to strategies for improving quality of care, including client-provider interactions, availability of drugs and supplies, hygiene and sanitation, patient confidentiality, and the affordability and accessibility of services. CMS contracted with the National Smallholders Business Centre to conduct the training. The training is structured to accommodate the needs of

private providers — who cannot leave their clinics for extended periods — by running one day a week for five weeks. Two months after training, CMS conducts follow-up visits to determine whether trainees are applying their new skills and to offer supplemental support. Follow-up visits demonstrate that providers have improved their record-keeping skills and enhanced their ability to promote and expand their services.

Private providers loan fund. CMS developed a microloan program through the Summa Foundation (a not-for-profit organization that operates under the CMS project) after an assessment revealed that there was a significant demand for credit to expand and improve private-provider practices, and sufficient capacity to repay the loans. The loan fund targets small private providers, including midwives, nurses, and doctors. The Summa Foundation approved a loan fund of \$350,000, to be administered by the Uganda Microfinance Union. Potential loan recipients are identified through professional associations such as the UPMA, the Uganda Medical Association, and the Uganda National Association of Nurses and Midwives. Potential recipients are also recruited through direct marketing to private practices, especially those whose providers

Figure 3 ■ Changes in perceived quality of services among clients at intervention clinics



To date, most efforts to improve the treatment of childhood diseases in Uganda have focused on the public sector, yet the private sector is often the first place parents seek care for a sick child.

have participated in the business skills training program. Loans range from roughly \$200 to more than \$7,000; average loan size is \$920. Loans are extended for 6 to 12 months, at a 3.5 percent monthly interest rate. Providers typically use the funds to buy drugs and equipment, and to renovate and expand their clinics. Providers who successfully repay their first loan can take out additional loans for larger amounts. As of April 2003, a total of 880 loans had been made to 454 borrowers. This includes 426 repeat loans, with some providers on their third or fourth loan. The 99 percent repayment rate is excellent by microfinance standards.

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

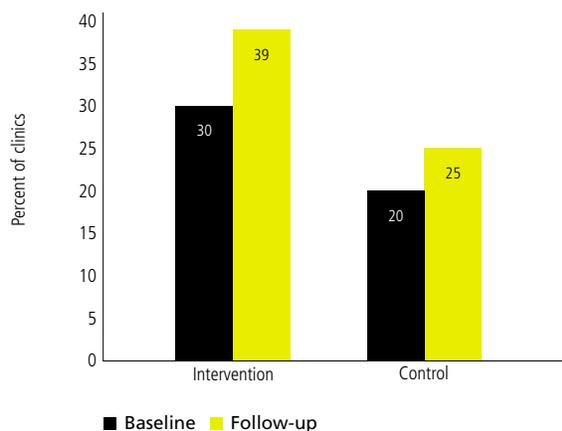
Staying connected — linking private providers. CMS found that many private providers do not collect or exchange information about their operations. In response, CMS positioned itself as an information center, maintaining a private-provider data-

base of business skills training and loan program attendees. CMS has used this database to reach out to these providers through a bi-monthly bulletin, which is mailed to all training participants. Each bulletin profiles a clinic that has gone through either the business skills training or loan program, and that is now implementing a best practice that other clinics can emulate. Topics have included family planning services, community outreach, and immunizations.

Using data collected as part of the loan application and business skills training program, CMS has produced an operating-indicators report that provides clinics with information on financial performance and utilization indicators, including volume of clinic visits, revenues, expenses, and net income. The report enables clinics to compare their performance with other clinics. (The research sponsorship has also provided an avenue to promote CMS products.) This effort has provided the first information on the economics of private clinics in Uganda. The information has proved helpful to policymakers and professional associations in their advocacy efforts.

Integrated management of childhood illnesses. Working closely with other donor-funded projects and the Ministry of Health,

Figure 4 ■ Percent of clients reporting that maternal and child health visits increased at intervention clinics



CMS piloted a new approach to integrated management of childhood illness (IMCI) training for private health providers. To date, most efforts to improve the treatment of childhood diseases in Uganda have focused on the public sector, yet the private sector is often the first place parents seek care for a sick child. CMS contributed to the development of IMCI training guidelines and conducted three training sessions for providers who participated in the business skills training course. The strong foundation CMS established with these providers — as well as their enhanced understanding of record keeping, quality care, and marketing — created a fertile environment for introducing improved clinical practices. A follow-up evaluation of the training sessions, which involved 59 providers, found marked improvement in provider assessment, diagnosis, and treatment capabilities.

PRIVATE-PROVIDER CHALLENGES

Resources devoted to private providers promote sound business practices, enhance access to services, and improve clinical practices. Despite this, not enough resources have been invested in the private, for-profit sector in Uganda. Scaling-up successful interventions will require policy changes at the national and district levels, as well as adequate resources to effectively leverage private-sector capacity to meet national health goals. Toward this end, CMS has had policy discussions with key stakeholders, including the Public-Private Partnership for Health Office within the Ministry of Health. CMS's policy efforts aim to improve the environment in which private health providers function, and to help providers to adapt to evolving priorities and regulatory parameters.

The policy process involves work in three areas: assisting the Ministry of Health to develop a private health provider policy framework and implementation guidelines; working with three medical bureaus in Uganda to explore opportunities to accelerate the reduction of user fees in private, nonprofit facilities; and partnering on a World Bank pilot project to examine how performance-based contracting mechanisms can improve access to health services for

low-income populations. The CMS project is able to contribute to policy change because the project is well-established as a trusted partner of the private sector.

PRIVATE-PROVIDER RESULTS

Dues-paying UPMA membership increased by 35 percent. By adding valuable services, the UPMA was able to dramatically increase dues-paying members. Key services included a newsletter linking individual midwives, a database for comparing practice methods and performance, a member directory, training programs, and income-generating activities.

Service quality improved. Service quality improved among private providers who received Summa Foundation loans and training. To date, providers have used Summa loans to buy drugs and equipment, and to renovate and expand their clinics. Each loan recipient receives five days of business-skills training, including business planning and management, financial record-keeping, and loan management. The training emphasizes that improving quality can help providers draw more clients, with modules on the importance of good client-provider interaction and patient confidentiality. An evaluation of the impact of the Summa loan fund found that clients at intervention clinics were more likely to mention quality-related factors (such as availability of drugs, privacy, and fair charges) as their reason for visiting the clinic than clients at these same clinics in the baseline survey. (See Figure 3.) Increases in perceived quality indicators were significantly higher than control-group changes for the same variables.

The private providers' loan fund expanded maternal and child health services. An evaluation of the microloan program's impact found that there was a significant increase (from 30 percent to 39 percent) in the proportion of clients who received maternal and child health services at loan-recipient intervention clinics. Clients at intervention clinics were 1.6 times more likely to report maternal and child health services as the reason for their visit than at baseline. (See Figure 4.)



Traditional birth attendants wear *New Maama* headscarves at a launch in Kabale, Uganda. These attendants, as well as community reproductive health workers, are trained in the proper use of the *New Maama* clean delivery kit.

Photo: Elizabeth Gardiner

Having private providers at the table with public sector representatives strengthens public-private understanding and respect.

The private providers' loan fund increased borrower savings. Savings are an important safety net for small businesses. Only 33 percent of borrowers reported savings of \$168 or more at the time of the first loan application. But by the time of the second loan application, 58 percent of borrowers reported savings of \$168 or more.

PRIVATE-PROVIDER LESSONS

To improve sustainability, associations must deliver value. Association members need to see value in membership before contributing to and participating in programs that improve overall sustainability. CMS assistance to UPMA improved the value the association provided to its members through a wide range of services. As a result, active membership grew by 35 percent.

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

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

HEALTH FINANCING

CMS implements health financing activities in Uganda in close collaboration with HealthPartners, a Minnesota-based managed care organization, to improve access to affordable, quality health services. Together with HealthPartners' Uganda affiliate, the Uganda Health Cooperative, CMS provides technical assistance and support to assist in the development of community-based prepaid health insurance plans. In addition, CMS supports the Mothers Uplifting Child Health (MUCH) Project at St. Mary's Hospital in northern Uganda.

Community-based health insurance. Despite free services in the public health system, over 60 percent of Ugandans seek care from the private sector. However, paying for private health care can place a serious financial burden on lower-income families, who have no financial safety net in times of crisis. Community health insurance, which works by pooling community resources to help families share the risk of health care costs, can improve access to quality health care by reducing financial barriers and diminishing the economic burden of illness.

The Ugandan Health Cooperative (UHC) and CMS set up pre-paid health care plans to help the rural poor access care. The plans are based on existing community groups such as dairy and tea cooperatives. The individual plans contract with private clinics, mission clinics, and hospitals to provide care to the group. Several groups may contract with the same provider. CMS also works to provide affordable health insurance for school-age children through school-based plans. Excluding the school-based plans, there are currently 46 health plan groups serviced by six providers enrolling more than 5,000 members. The average yearly premium for a family of four is 48,000 Ugandan shillings (about \$29). The plans have similar benefits packages, including inpatient and outpatient care, deliveries, antenatal care, and treatment of infectious diseases and injuries. Providers that have the facilities to do so cover caesarian sections. Chronic diseases and HIV/AIDS are not covered because the cost of care would raise the premiums beyond affordability.

CMS-affiliated plans are centered in Bushenyi in western Uganda and Mukono, a Kampala suburb. In Mukono, the plans cover the clients of a micro-credit scheme, the Foundation for Community Assistance. In Bushenyi, under the *School Health Made Easy* scheme, the Bushenyi Medical Center, a for-profit commercial health care provider, contracts with 12 schools to provide coverage to 9,000 students between the ages of 7 and 19. Enrollees pay a small annual fee that is deducted from their school fees and a small copayment at the point of service. The benefits package for schools includes annual check-ups, mobile clinic visits at the schools, treatment at the Bushenyi Medical Center for most primary health care needs, eye exams, and basic dental care.

The Mother Child Rescue Project, based in Buhweju, a mountainous area of the Bushenyi district with no electricity or telephone service, pools proceeds from the tea harvests of the local tea cooperative to pay for health insurance. A local health clinic has also been established to provide basic care so that local residents do not have to pay costly taxi fares — an expense that deterred many from getting care — to get to the Bushenyi Medical Center, the nearest health care facility. For emergency cases, a radio link has been established between the clinic and a taxi company that can transport patients to the Bushenyi Medical Center. The local clinic has resulted in improved health outcomes for the village.

Malaria prevention. One benefit of capitated, prepaid health insurance plans is that they increase incentives for providers to help maintain the health of the insured population and prevent disease. In Uganda, private providers have traditionally concentrated on curative care, with the government taking primary responsibility for prevention. In addition, members of community health plans typically do not join for preventive services — they want protection from the high costs of care when they fall sick. However, a few of the health plans have recognized the financial benefits of investing in prevention.

It has become increasingly clear to many of the community health schemes in Uganda that malaria is a major source of their costs. The Insurance-Net (*In-Net*) program, which promotes use of CMS's *SmartNet* insecticide-treated mosquito net among members of UHC health plans, is a unique prevention activity integrating social marketing and health financing. CMS developed the *In-Net* program to improve the health of pregnant women and children under five, two groups with high malaria mortality and morbidity. CMS offers nets to the plans at a reduced cost if the plans further subsidize a portion of the cost and sell the nets to their members at a discounted price. Typically, a treated net is sold to a plan at 8,000 shillings and resold to the plan member for between 6,000 and 7,000 shillings. CMS helps the plans sell nets by providing promotional materials; more than 5,500 *SmartNets* have been sold as a result of the program. CMS is conducting a survey to assess the use of nets among health plan members.

Mother Uplifting Child Health project. In the war-torn Gulu district in northern Uganda, CMS and UHC designed the MUCH project to improve maternal health outcomes and increase child survival, as well as to improve the financial sustainability of St. Mary's Hospital in Lacor. The MUCH project has three components: improving accounting and inventory management systems at St. Mary's Hospital, upgrading hospital health information system, and establishing a community-based health insurance plan.

An armed rebellion in the Gulu district has forced an estimated 370,000 people to relocate to displaced-persons camps. The rebellion has disrupted agriculture, the main source of livelihood for the people of Gulu, and as a result many residents depend heavily on relief since only occasional small-scale farming is possible. The Gulu district has the highest poverty level in Uganda: 60 percent of the population survives on less than \$1 a day. Beyond the high malaria morbidity level for mothers and children under five, other leading causes of morbidity



Julius, the CMS/Health Partners Marketing Coordinator in Gulu, talks to members of a rock-breaking co-op who have joined the health plan: They like the plan — the medical care is good, and drugs are available. And some have been able to get surgery they could never afford without insurance.

Photo: CMS/Rich Feeley

include respiratory infections, diarrheal diseases, and malnutrition. The district ranks highest in infant mortality in Uganda, with 172 deaths per 1,000 live births; the maternal mortality rate stands at 700 per 10,000 live births.

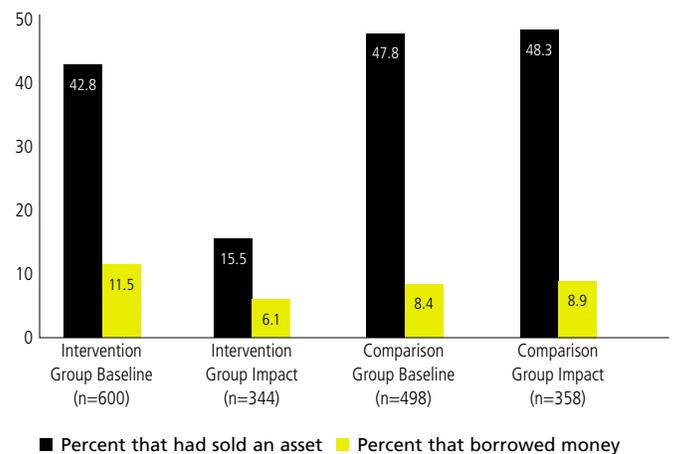
Lacor's St. Mary's Hospital is a large Catholic mission hospital, which employs more than 500 people and provides services for 25,000 inpatient admissions and 150,000 outpatient visits each year. The hospital is a key health care and employment resource as well as an oasis of stability for the impoverished Gulu population. Since only about 15 percent of the hospital's costs are covered by user fees (to keep services accessible, the hospital charges a flat fee for admissions and an additional fee for surgeries) with an additional 25 percent covered by government subsidies, the hospital needs to improve stability — it now relies heavily on donor funds.

While the subsidies and charitable donations have ensured that St. Mary's fees remain low, they nevertheless pose a barrier to care for Gulu's extremely poor residents. A feasi-

bility study conducted among district officials and residents in the St. Mary's Hospital area found support for a prepaid health plan. CMS, through the MUCH project, subcontracted UHC to implement a pilot health insurance program based at the hospital. Since enrolled groups include some of the poorest people in the area (for example, a rock breakers' cooperative and a group of refugee widows), plan members are offered a heavily subsidized benefit package. CMS supplements this with a direct subsidy to women, children, and the elderly to further lower the cost of the premium for these groups. Premiums are further stratified according to ability to pay and the socioeconomic status of each health plan group.

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

Figure 5 ■ Percent of households that sold an asset or that borrowed money to pay for healthcare during an illness in the past month



HEALTH FINANCING RESULTS

Increased access to care for low-income populations. Through its cooperation with HealthPartners/UHC, CMS has increased access to affordable health care for 14,000 low-income Ugandans, of which 9,000 are school children benefiting from health care through school-based programs.

Moreover, after obtaining insurance from Lacor hospital, 33 percent of insureds sought health care for an illness in the previous month, doubling from 15.5 percent in the same group before the insurance plan.

Fewer people forced to sell assets or borrow money. Among members of the Lacor prepaid health plan, there was a decline in the sale of assets and borrowing of money to pay for health care. Respondents who obtained health care in the past month were asked if they had been forced to sell an asset or borrow money to pay for such care. Before the insurance program began in Lacor, 42.8 percent of the patients who later enrolled and 48 percent of the patients in the comparison group were forced to sell an asset to pay for health care. In addition, 11.5 percent in the intervention area and 8 percent in the control group had to borrow money. In the follow-up survey, only 15.5 percent of the insured that obtained care in the previous month reported selling assets, while 48 percent in the uninsured comparison group had done so. Only 6.1 percent had to borrow money to pay for health care versus 8.9 percent in the control group. (See Figure 5.)

HEALTH FINANCING LESSONS

Community-based health plans can improve access to private health services and can have a significant economic effect on member households. As the above results show, the plan has been effective in improving utilization of health services and in reducing the need to sell an asset or borrow to pay for health costs.

Focus on larger groups. Since small community-based health insurance plans are not cost-effective to manage and are difficult to sustain, efforts should focus on enrolling larger groups with attributes that simplify premium collection. In the *School Health Made Easy* scheme in Bushenyi, for example, premiums are collected along with tuition, bringing several hundred people into the plan with each sale. In addition to benefiting the Bushenyi Medical Center by having relatively low-risk enrollees, the prepaid school plans have also led to a profitable market expansion for the medical center.

Community health plans can contribute to disease prevention. The successful *In-Net* experiment by CMS/Uganda (marketing insecticide-treated bed nets through participating community plans) shows the disease-prevention benefits of the plans. When the plans recognized the burden of malaria on the insured population and its effect on plan profitability, they were willing to partially subsidize the cost of the nets.

There is a role for community-based health insurance in an environment of free public health care. Even though the government of Uganda has abolished user fees at public facilities, it does not have the capacity to provide free, quality health care to the entire population. Contrary to expectations, the elimination of user fees did not result in a significant dip in community-based plan enrollment. Plan members have been willing to continue paying premiums and obtaining services at facilities that charge fees, probably because of perceived higher-quality services. The abolition of user fees, however, has probably eased the burden on those who cannot afford community health insurance plan premiums, or who do not belong to an organization that qualifies them for membership.

Through its cooperation with HealthPartners/UHC, CMS has increased access to affordable health care for 14,000 low-income Ugandans, of which 9,000 are school children benefiting from health care through school-based programs.

ADDITIONAL RESOURCES

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Cover photo: CMS/Elizabeth Gardiner.
A drama performance raises awareness about the dangers of unsanitary birth practices and promotes CMS's *New Maama* clean-delivery kit. In addition to brand-specific advertising for its social marketing products, the CMS project develops behavior-change communication activities like this community drama.



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