SOCIAL FRANCHISING IN CONTEXT OF MARKETING LONG-TERM AND REVERSIBLE CONTRACEPTIVES (LARCS) IN UGANDA: ANALYSIS OF PACE SOCIAL FRANCHISE MODEL

Simon SENSALIRE (PhD)
Makerere University, School of Statistics and Planning, College of Business and Management Sciences
P.O. Box 7072 Kampala, Uganda
ssensalire@pace.org.ug
Dr. Dorothy Balaba BYANSI (MPH
Program for Accessible health Communication and Education, P.O. Box 27659 Kampala, Uganda
dbalaba@pace.org.ug
Zacch AKINYEMI (MBA)
Program for Accessible health Communication and Education
P.O. Box 27659 Kampala, Uganda
zakinyemi@pace.org.ug

Abstract

Background: *Uganda is TFR is among the world's highest at six children per woman, and contributes to the rising rate of poverty and maternal and infant mortality across the country. A social franchise model was adopted in Uganda to market and scale up contraceptive prevalence through the private sector. In 2008 PACE launched the Women's Health Project, a core component of their reproductive health strategy to increase access to and demand for affordable, quality long-term Family Planning (FP) services, through the setup of a network of private healthcare providers, branded as "ProFam" social franchise health facilities. The program expanded and included services aimed to offer and improve reproductive health services, limiting births through increased use of IUDs and implants as well change negative perceptions to FP. Until 2014, this network consisted of 189 private facilities spread out in 56 districts, following a business model of social franchising.*

Methods: *The multifaceted effect of the social franchise intervention under PACE was then measured through a longitudinal cross sectional survey on perceptions towards Long-Term and Reversible Contraceptives (LARCs) use among the target population through a cross-sectional studies over two periods. The studies covered 53 districts hosting 194 privately owned health facilities branded Profam. Multi-stage cluster sampling approaches was used to draw a representative sample of women of reproductive age group. However, for Kampala (capital city), given its population size, the catchment area was restricted to a parish/Ward.*

Findings: *There is an evident rise in current use of FP methods among WRA. Availability of LARCs particularly IUCDs significantly increased over the two time periods. Use of FP services among WRA is a socially sanctioned behavior/practice. There was reported increase in social support for FP services. There were high levels of correct knowledge about FP services and methods, particularly LARCs and outcome expectations from FP increased*

Conclusion: *There is an opportunity for increasing uptake of LARCs especially IUDS and Implants through the private sector via a social franchising model. Further, positive changes have been registered in the campaign to mutate negative perceptions against LARCs suggesting positive effect of increasing service accessibility within the community of the target group in easily accessible outlets within the network*

Key words: Social franchising model; private sector approach; Long-Term and Reversible Contraceptives; PACE; Women of reproductive age group

JEL Classification: I Health, Education, and Welfare; B History of Economic Thought, Methodology, and Heterodox Approaches

Introduction

Social franchises can be defined as networks of private health providers that use commercial franchising methods to achieve social goals rather than profits (Global health Group). However, there is no standard definition in the literature and social franchise is sometimes mistakenly used as being interchangeable with replication and scale models. In practice, there are several models of replication and social franchising is just one of them. The models of replication vary in intensity of control and can range from being very flexible and loosely controlled, to being more restrictive and tightly controlled. Social franchising sits between these two

extremes, and requires involvement and control from the central organization that licenses the product or service (The Social Enterprise Coalition, 2011).

The private sector plays a major role in providing and increasing access to quality healthcare services to populations in low income countries **(**PSI, 2011**).** It's also the main health provider, offering efficient and responsive services that cover patient needs due to market competition and may overcome government inefficiency and corruption (Berendes et al., 2011).

Although there is no robust evidence that the private sector improves utilization of quality care for the population in need, especially in developing countries, there is some evidence that interventions have worked successfully in poor communities with positive equity impacts (Patouillard et al., 2007). As a relatively flexible model, a social franchise can build upon local expertise by organizing existing private providers into contractually obligated networks. Social franchising may represent an effective approach for the problem of access to quality and affordable health services in poor countries. However, few reviews and evaluations have been conducted to date, and hardly any have demonstrated an impact of social franchises on healthcare interventions, quality or access. This systematic overview of effect of franchising marketing health interventions demonstrate that the evidence to date shows that franchising predominantly has positive effect health seeking behavior and perceptions towards services provided

Description of Social Franchising in Uganda under PACE

PACE (Programme for Accessible health, Communication and Education) is the local affiliate of PSI (Population Services International) in Uganda. Autonomous since 2009, PACE took over PSI local programmes, aligned to the Ministry of Health priority areas: HIV/AIDS, Malaria, child survival, reproductive health and water & sanitation.

In 2008 PACE launched the *Women's Health Project*, a core component of their reproductive health strategy to increase access to and demand for affordable, quality long-term Family Planning services, through the setup of a network of private healthcare providers, branded as "ProFam" social franchise health facilities. The program expanded and included services aimed to offer and improve reproductive health services, limiting births through increased use of IUDs and implants, as well as the prevention of post-partum haemorrhage through the distribution of misoprostol. Until 2014, this network consisted on 189 private facilities spread out in 56 districts, following a business model of fractional franchising. In its original set up, PACE provided family planning training & skills building, access to subsidized products, advertising and community mobilization, and quality supervision and evaluation for each clinic. In return, ProFam clinics provided financial contribution upon entry, committed to service and reporting standards for the concerned services, as well as to a reasonable price structure for Long Term Family Planning services.

PACE uses the segmentation approach to profile target audience for the different health interventions. Population segmentation is in key decisions for social marketing that guides the planning of most health communications. It's key in determining whether to deliver messages to a general audience or whether to segment into target audiences. Audience segmentation is usually based on socio demographic, cultural, and behavioral characteristics that may drive behavior. One important step in realizing segmentation is conducting studies for profiling the target audience. The effect of target segmentation is a tailored communications specific to individualized form of segmentation and generation of highly customized messages on a large scale. Over the past 10 years, PACE has tailored health communications that have been used widely for public health issues to misconceptions on family planning. Such communications have been defined as "any combination of information and behavior change strategies intended to reach one specific person, based on characteristics that are unique to that person, related to the outcome of interest, and derived from an individual assessment.

Methodology

The multifaceted effect of the social franchise intervention under PACE was then measured through a longitudinal cross sectional survey on perceptions towards Long-Term and Reversible Contraceptives (LARCs) use among the target population through a cross-sectional studies over two periods. The studies covered 53 districts hosting 194 privately owned health facilities branded Profam. Multi-stage cluster sampling approaches was used to draw a representative sample of women of reproductive age group. However, for Kampala (capital city), given its population size, the catchment area was restricted to a parish/Ward.

We conducted both univariate and bivariate analysis. Firstly simple frequencies were obtained to check for the distribution of key variables. For any variables of interest that showed significant change over time, a separate

ANOVA analysis was run to examine whether the change is significantly associated with program exposure, with the exposure measurement serving as the group variable and the socio-demographic characteristics serving as covariates. Comparisons of the various behavioral indicators between Round I and Round II were made to identify changes over the two time periods which were statistically significant.

Results

Use of FP services:

There is an evident rise in current use of FP methods among Women of Reproductive Age (WRA), although the change is not statistically significant. Sixty three percent (63.7%) of WRA at follow-up compared to 62.3 percent at baseline were doing something to prevent getting pregnant. A wide range of birth control measures were reported but among them, injectables were the most popular. A comparison over the two time periods shows an increase of no statistical significance among WRA currently using IUCDs (from 1.6% at baseline to 1.9% at follow up).

Table 1: Opportunity and ability indicators

INDICATORS	2012 N=1,460	2013 N=1,604	Sig.
BEHAVIOR/USE	%	%	
-Currently doing something to prevent pregnancy	62.3	63.7	-
-% using a modern family planning method to prevent pregnancy	73.2	62.8	***
- Currently using IUCDs	1.6	1.9	-
OPPORTUNITY	%	%	
Availability			
% who agree IUCDs are available at a facility nearby	42.1	50.4	***
% who agree Profam outlets have any FP method you may want	75.3	80.0	***
% who agree IUCDs are always available at Profam outlets	64.4	74.4	***
Quality of Care			
% who agree Health providers at Profam are friendly	73.5	80.7	***
% who agree Health providers at Profam answer my questions very well	76.2	82.4	***
Social norms			
% who agree In this community many women use IUCDs	17.7	23.6	***
ABILITY			
Social Support			
% who agree My husband/partner' is in favor of me using contraceptives	70.1	76.0	***
% who agree My husband thinks family planning is good	76.3	80.1	***
Knowledge			
% who know IUCDs offer protection for several years	88.4	92.3	***
% who know If you stop using IUCD, you can get pregnant again	94.4	93.4	-

Availability:

Availability of LARCs particularly Intra Uterine Contraceptive Devices (IUCDs) significantly increased over the two time periods. More WRA at follow up compared to baseline agreed with the statement that IUCDs are available at a facility nearby (42.1% during Round I compared to 50.4% during Round II, $p<0.000$). In addition, higher proportions of WRA at follow up (74.4%) acknowledged that IUCDs are always available at Profam outlets compared to 64.4%% at baseline. Similarly, a significant change ($p<0.000$) was also observed with the proportion of WRA who agree that Profam outlets have any FP method you may want.

Quality of Care:

Perceptions about quality of care at Profam outlets improved over time. Although majority of WRA held positive opinions during Round I, there is a noticeably higher proportion of WRA with such positive perceptions at follow up. For instance, the proportion of WRA who shared the view that health providers at Profam are friendly has risen from about 7 in every 10 at baseline to 8 in every 10 WRA at follow up. Further, more changes of statistical significance are observed with regard to WRA who agree that health providers at Profam answer questions very well (p values of 0.000).

Social Norms:

Use of FP services among WRA is a socially sanctioned behavior/practice. Communities are generally in favor of using modern contraceptives. As a measure of social norms, the Round II survey registered a notable change in the perception that *in this community many women use IUCDs* (23.6% at follow up compared to 17.7% at baseline, p<0.000). The proportion of WRA who disagreed with the above statement dropped quite sharply from over 80% at Baseline to nearly 50% at Follow up. In a sense, this social norm is important to WRA who may opt to take a decision to use IUCDs as FP method in future.

Social Support:
Round II results show higher social support for FP services. The perceived level of support from spouses/husbands towards use of contraceptives to avoid pregnancy is significantly higher compared to the time when Round I of the study was conducted. For instance, 76 percent of WRA at follow up compared to 70.1 percent at baseline agreed that their husbands/partners favor use of contraceptives. There is also a rise of statistical significance (p values of 0.000) among WRA who agree that their husband think family planning is good.

Knowledge:
High levels of correct knowledge about FP services and methods, particularly LARCs, were exhibited by WRA. High proportions of WRA, although significantly higher during Round II (92.3% compared to 88.4% during Round I), know for a fact that IUCDs offer protection for several years. They also know that if one stops using IUCDs, the WRA can get pregnant again; over 9 in 10 WRA shared this view both during Round I and Round II.

Table 2: Motivation to practice desired behavior

INDICATORS	2011 N=1,460	2012 N=1,604	Sig.
MOTIVATION			
Attitudes			
% who agree that IUCDs are safe	62.8	66.3	**
% who agree that IUCDs are a good method of family planning	69.4	74.9	***
% who agree that I would recommend an IUCD to a friend	56.5	57.7	**
Beliefs			
% who agree People who use modern contraception might end up having infertility	54.0	50.5	**
% who agree People who use modern contraception might end up having cancer	63.8	59.0	***
% who agree that IUCDs reduce sexual pleasure	66.6	63.0	***
% who agree that Using IUCDs will make me gain weight	64.0	68.0	***
Locus of Control			
% who agree that God decides the number of children I will have	42.4	42.5	***
Response Efficacy			
% who agree that IUCDs are effective in preventing pregnancy	87.0	88.8	***
Outcome expectations			
% who agree that When I use FP, I get the number of children I can feed well	87.9	99.1	-
% who agree that When I use FP, I get the children I can have time to care for while I continue to work	98.4	99.2	***
% who agree that LTMs are convenient to use, so I don't need to go to the clinic several times	88.1	94.4	***
Intention			
% who intend to use injectables (most preferred method) in next 12 months	43.9	51.4	***
% who intend to use IUDs in the next 12 months	9.8	11.9	**
% who intend to use implants in the next 12 months	22.7	30.7	***

Attitudes:
A comparative analysis of data from the two studies shows that attitudes held by WRA about IUCDs are generally positive with some considerable improvement during the program implementation period. For instance, about two thirds of WRA (62.8%at Round I and 66.3% at Round II) recognized that IUCDs are safe. Noticeable differences were also observed with WRA who believed that "*IUCDs are a good method of family planning*" (nearly 74.9% of WRA at follow up, compared to 69.4% at baseline, p<0.000). Further, more than half the WRA in both rounds agreed that they would recommend an IUCD to a friend (see table 2)

Beliefs:

In Table 2, there is considerable reduction in negative perceptions and beliefs about FP services and particularly LARCs. For instance, the proportion of WRA who believed that "*People who use modern contraception might end up having infertility*" dropped from 54 percent at Round 1 to 50.5 percent in Round II. Similarly, notable changes have been registered with WRA who believed that "*People who use modern contraception might end up having health problems like cancer*", it dropped from 63.8 percent in Round I to 59.0 percent in Round II (P<0.000). Reduction in the perception that IUCDs reduce sexual pleasure has also been registered. However, a rise in WRA who agree that using IUCDs will make the WRA gain weight was also registered at follow up.

Locus of Control:
The belief and confidence that a WRA can decide the number of children to give birth to in life has not changed. Fairly high proportions of WRA (4 out of 10 WRA at both baseline and follow up) still believe that God decides the number of children they will have.

Response Efficacy:
With regard to the trust in the efficacy of modern contraceptives, findings show that majority of WRA even during Round I disagreed with statements which portray modern contraceptives as ineffective in preventing pregnancy. On the contrary, over 80 percent agreed that IUCDs are effective in preventing pregnancy (87% at Baseline and 88.8% at follow up, P-value at 0.000).

Outcome Expectations:
Perceived benefits of using some FP methods and particularly LARCs have remained universally high. For instance, over 80 percent agree that "*When I use FP, I get the number of children I can feed well*". Although, no significant change was observed, the proportions remained high. Significant changes were however observed with expectations like "*When I use FP, I get the children I can have time to care for while I continue to work*", "*LARCs are convenient to use since the woman does not need to go the clinic several times*". WRA who agree that LARCs are convenient rose from 88.1 percent at baseline to 94.4 percent at follow up (P-value at 0.000).

Intention to use FP:
Injectables are by far the most preferred method of birth control both at Baseline and Follow up; there was notable increase (p<0.000) in proportion of WRA who prefer injectables (43.9% at baseline and 51.4% at follow up). Preference/intention to use IUCDs registered slight changes (P<0.05) although it remained generally low. Results show that for instance, while about 9.8 percent expressed intention to use an IUCD at Baseline, this proportion rose just slightly to 11.9 percent at Follow up.

Willingness to Pay:
The questions about willingness to pay for IUCDs were reserved only for current users of IUCDs. Overall, use of IUCDs has remained low. Results show that 2.5% and 2.1% of WRA during Round I and Round II respectively reported to have ever used an IUCD. Among the few WRA who ever used an IUCD, willingness to pay is observed on the decline. For instance, whereas at baseline 73.7 percent of WRA who had ever used an IUCD acknowledged that Ug.shs15,000/= was affordable for an IUCD insertion, the proportion dropped to 56.7 percent at follow up. Similarly, the proportion of WRA (among ever used an IUD) willing to pay for IUCD insertion even when price increases to Ug.shs 20,000 reduced (from 36.8% during Round I to 14.3% in Round II).

Effect of exposure to communication
Implementation of the interpersonal communication strategy of the WHP programme is evident. Notable proportions (32.2%) of WRA during Round II recalled being visited by Village Health Workers (VHWs) in the last 6 months and educated about family planning at Profam clinics. Among them, 56.4 percent still had good memory of the discussions held; they recalled the main message of their interaction being focused on safety of IUCDs, their effectiveness and ease to use. Round II also reveals evidence of satisfied users of FP services at Profam facilities reaching out to other WRA in their communities to share with them information regarding FP at Profam.
Slightly over a quarter (28.1%) of WRA acknowledged receiving information from a satisfied user. Exposure was also attained through mass media, particularly radio; 65.6 percent of WRA heard a radio communication about Profam in the last 6 months preceding Round II of the survey. Exposure through the mobile phone was however low, WRA who received phone text and voice messages were a small proportion (2% and 1% respectively). Similarly, physical access/visits by WRA to Profam facilities were generally low; just about a quarter (23.8%) of WRA had visited a Profam clinic in the past 12 months.

Table 3. Exposure

INDICATORS	2011	2012	

	N=1,460	N=1,604	Sig.
Willingness to pay			
% who have ever used an IUCD	2.5	2.1	-
% who think Ug.shs. 15,000 is affordable for an IUCD insertion (among ever used an IUD)	73.7	56.7	-
% willing to pay for IUCD insertion even when price increases to Ug.shs. 20,000	36.8	14.3	-
EXPOSURE			
% visited by a VHT 3 or more times in last 6 months and told about family planning at Profam clinics	-	32.2	
% who recall the following messages from the VHT; IUDs are safe / effective / easy to use	-	56.4	
% who have got messages from someone who got FP services (satisfied user) from Profam in last 12 months	-	28.1	
% who have heard a radio communication about Profam in the last 6 months	-	65.6	
% who have seen a TV communication about Profam in the last 12 months	-	28.9	
% who have seen multiple phone messages about Profam in the last 12 months	-	2.0	
% who have heard multiple phone voice messages about Profam In the last 12 months	-	1.0	
% who have a Profam health facility in their sub county	-	48.1	
% who have visited a Profam health facility in the last 12 month	-	23.8	
% ever been informed by a Profam health provider to use IUDs for family planning in the last 12 months	-	13.3	
% who have ever got family planning services from Profam facility	-	98.0	
% who can finish the phrase 'Profam caring for you'	16.1	18.3	***
% who report that Profam logo means /Availability of FP /Manageable family /Quality FP	92.6	70.5	***

Conclusion

Our study indicates that social franchising may strengthen health behavior and change perceptions. However, gaps in the evidence remain. Additional research should include: further documentation of the effect of social franchising, on health seeking behavior within the context of the general health system Nevertheless, results from the two surveys show a glaring opportunity for programs such as the PACE to make further strides in filling the unmet need for FP in Uganda.

References

1. Berendes, P Heywood, S Oliver, P Garner - PLoS medicine, (2011) *Quality of private and public ambulatory health care in low and middle income countries: systematic review of comparative studies*
2. Edith Patouillard, Catherine A Goodman, Kara G Hanson, and Anne J Mills (20074) *Can working with the private for-profit sector improve utilization of quality health services by the poor?* A systematic review of the literature
3. The Social Franchising Manual - Social Enterprise UK
4. www.socialenterprise.org.uk/.../files/2011/.../social_franchising_manual.
5. globalhealthsciences.ucsf.edu/global-health-group