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Living Goods – Developing a Sustainable Business Model to Provide Healthcare Services in Uganda

*This case was written by **P. Indu,** under the direction of **Vivek Gupta,** IBS Center for Management Research. It was compiled from published sources, and is intended to be used as a basis for class discussion rather than to illustrate either effective or ineffective handling of a management situation.*

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Living Goods – Developing a Sustainable Business Model to Provide Healthcare Services in Uganda

"*A lot of programs give lip service to 'sustainability' - this is the real deal. Living Goods is one of few models with the potential for game-changing scale*."[1]

- Holly Wise, Former Secretariat Director of USAID's Global Development Alliance.

A RESPONSIBILITY PIONEER

In September 2009, *Time* brought out a special section on community service that included a list of '25 Responsibility Pioneers who are changing the world'. US-based Living Goods was placed second in the list. Living Goods, a non-profit organization, was founded by Charles Slaughter (Slaughter) in 2006. Its first venture was in Uganda, where using the direct marketing model pioneered by Avon Products Inc.[2] (Avon), Living Goods provided basic healthcare services to the poor. According to *Time,* "While charity funds and government aid can be short-term and unpredictable, Living Goods' model offers long-term stability. But the organization's economic impact on Uganda goes beyond empowering new entrepreneurs – it makes the country healthier."[3] (Refer Exhibit I for the top ten Responsibility Pioneers – *Time* Magazine).

Living Goods started operating in Uganda in 2007 with a partner, Building Resources Across Communities (BRAC)[4]. BRAC was running several microfinance programs in the country. Living Goods selected a few women who were a part of BRAC's microfinance programs and trained them to function as Community Health Promoters (CHP). CHPs were given a small loan from BRAC, and were trained by Living Goods. Using the loan, they procured essential medicines, mosquito nets, personal hygiene products and other healthcare products. They sold these products in their communities, door-to-door at a marginal profit.

Living Goods focused on few diseases like malaria, diarrheal disease, worms and tuberculosis (TB). These diseases accounted for two-thirds of mortality in Uganda and could be treated at low cost.

The CHPs took the essential medicines to the doorstep of patients in Uganda. These patients would otherwise have to travel long distances to obtain basic medicines - and those they obtained often turned out to be spurious and ineffective. The CHPs also gained by earning a decent income. According to Living Goods, "The model combines the latest and best practices from the worlds of micro enterprise and public health to create a truly sustainable system for defeating diseases of poverty. Living Goods reduces illness and death by significantly improving access to simple,

[1] www.livinggoods.org.

[2] Avon Products Inc. based in the US sold cosmetics, perfumes and few other products in more than 140 countries across the world through independent Avon Representatives, who marketed its products among their acquaintances.

[3] Kate Pickert, "In Uganda, Improving Health (and Wealth) Avon Style," *Time*, September 21, 2009.

[4] Bangladesh-based BRAC is one of the largest development organizations in the world. It has served over five million micro-credit borrowers across the world.

proven health interventions in the many places these are scarce. It also improves livelihoods by providing women a reliable source of income as Living Goods Health Promoters, by keeping wage earners healthy and productive, and by averting costly medical treatments."[5]

BACKGROUND NOTE

Slaughter completed his BA in Public and Private Management from Yale during the mid-1980s, and joined as a program officer for Trickle Up, a microenterprise development program, which had presence in more than ten countries. The challenges he faced at Trickle Up in developing micro enterprises, motivated him to return to Yale to do his masters. He then incorporated TravelSmith Outfitters Inc. (TravelSmith), a direct marketer of travel clothing and gear, in 1991. TravelSmith was the #1 brand in travel wear by the late 1990s. In 2004, TravelSmith was sold to Interactive Corp and in September 2004, Slaughter went on to work with CFW Shops (CFW)[6] as its President and helped to turn it around. After selling TravelSmith, Slaughter worked as an advisor and co-investor in Golden Gate Capital[7] and was involved in the acquisition and turnaround of several apparel companies. These included Spiegel, Newport News, Norm Thompson and Express.

The stint with CFW made Slaughter realize that on an average 25,000 people died around the world every day for want of inexpensive medicines and 10 million children died every year due to diarrhea, malaria and malnutrition. Fifty years of efforts by several international organizations and NGOs, and billions of dollars spent in aid had not improved the health of the poor in developing and under developed countries. People continued to succumb to disease for want of medicine. Slaughter realized that the main reason for this was not lack of appropriate medicines but lack of a sufficient and scalable distribution system that could deliver medicines to the poor.

Slaughter was of the view that to tackle poverty on a global scale, processes and strategies used in running a successful business must be used. He founded Living Goods, based on Avon's direct selling model. Instead of cosmetics (as in Avon's case), he planned to have micro-health entrepreneurs, who would deliver health education and healthcare products, and earn a modest income for their services (Refer Exhibit II for a note on Avon).

Slaughter's vision was to use Living Goods to reinvent the public healthcare delivery system in developing and underdeveloped countries, by delivering high quality healthcare products to the poor at low cost. The concept was based on microfinance, network marketing, and franchising, and was aimed at creating a sustainable system to fight disease and poverty in these countries. Living Goods had a dual purpose as the micro-health entrepreneurs involved in distributing medicines would also earn a regular income.

Living Goods targeted semi-urban and small rural communities, with inadequate access to healthcare products as they were underserved by public and private health distribution systems and areas where the incidence of diseases was very high. In many of the developing and underdeveloped countries, these semi-urban and rural communities constituted at least 30-50% of the population, and in some cases even more. People residing in semi-urban and rural areas often had to travel more than 5-10 kilometers to reach the nearest healthcare centers in the absence of proper transport system. Poor accessibility of the healthcare meant that villagers had to spend the entire day commuting to and from the healthcare center with the patient, incur an average

[5] www.livinggoods.org.

[6] CFW Shops stands for Child and Family Welfare Shops, a project of Health Store Foundation. It is a network of micro pharmacies and clinics, whose mission is to provide access to essential medicines to marginalized populations in the developing world. The CFW outlets target the most common killer diseases including malaria, respiratory infections, and dysentery among others. They also provide health education and prevention services. It was started in Kenya in 2000.

[7] Golden Gate Capital Partners is a private equity firm based in California. The firm had assets over US$ 9 billion under management as of early 2009.

expenditure of US$ 2 on transportation and other costs, and lose a day's wages. This kind of situation was typical of sub-Saharan Africa in particular. Healthcare related problems were further compounded by the presence of counterfeit products, wrong diagnosis, over-prescription, etc. Drug sales were largely unmonitored, encouraging the sale of spurious drugs. Drugs were sold at high prices to patients due to multi-layered wholesaler and retailer distribution systems.

In one instance, Slaughter came across a 13 year girl selling antibiotics in Uganda, without understanding their uses and side effects. In such conditions, though patients managed to obtain the required medicine, it failed to show any positive result. Due to wrong diagnosis, symptoms of malaria were often treated with medicines for fever. Even when there were healthcare centers, patients had to wait in long queues to be diagnosed, and when they were prescribed medicines, they were often out of stock.

THE SOLUTION

Living Goods initially planned to concentrate on diseases that accounted for 2/3rds of mortality and could be treated at a low cost – diseases like malaria, diarrheal diseases, worms and TB. It essentially targeted diseases that could be treated affordably, and which when left untreated, had the potential to claim lives. The main purpose of Living Goods was "to improve the overall health status of the community through health education and information, provision of basic medicines at affordable prices for common and preventable infectious diseases like malaria, typhoid, HIV/AIDS, TB, diarrhea with the ultimate goal of freeing human energy, time and financial savings to be directed into income generating economic activities."[8]

In order to select the country to initiate its program, Living Goods used the World Health Organization's (WHO) health indicators index, and selected the lowest 20 countries. Then Living Goods started ranking these countries, which were all in Africa, based on other indicators like economic conditions, disease burdens, population density, political stability, existing microfinance systems, etc. On this basis, it selected Uganda (Refer Exhibit III for some facts about Uganda).

In Uganda, existing healthcare facilities were beyond reach for most of the country's population. More than half of the population had to travel at least five kilometers to reach the nearest healthcare facility. There were few public healthcare facilities and these too did not have adequate stocks of essential medicines. There were few pharmacy outlets. Pharmacy distribution was dominated by private drug shops, which were highly fragmented, and were unregulated. Untrained healthcare providers, inaccurate diagnosis, counterfeit medicines, expired drugs, inflated prices and middlemen were widespread across the country.

Living Goods targeted its healthcare services at reaching 750,000 people in Uganda by 2012, and at reducing the mortality rate among the 145,000 children in this group by 15-30%. It aimed to provide access to critical health products to more than three million poor people. Living Goods focused on villages which were not served by the existing public and private health facilities and those where there was no access to essential medicines. Access to medicines was measured by proximity, affordability, available stock of medicines, quality of medicines, and a few other parameters. Living Goods targeted low income group people with income in the range of 50 cents to US$ 2 per day in Uganda. Around 30% of the people in Uganda came under this income bracket.

In the first few years of its inception, Living Goods had to depend on donor funding. The annual operating budget of Living Goods was US$ 510,000 in 2007, and this was obtained from The San Francisco Foundation, The Mulago Foundation, The Horace W. Goldsmith Foundation, The Draper Richards Foundation and other donors (Refer Exhibit IV for a list of donors for the program).

[8] BRAC Uganda and BRAC Southern Sudan Annual Report, 2006-07.

MAKING THE MODEL WORK

In order to promote its healthcare activities aimed at poor people, Living Goods intended to partner with local microfinance organizations, NGOs and community organizations, in order to leverage on their existing infrastructure. To pilot its model, Living Goods entered into a joint venture with BRAC in 2007. BRAC had established a presence in Uganda in 2006. The association with BRAC helped Living Goods to scale up quickly by exploiting the existing assets of infrastructure, personnel, and distribution facilities that BRAC had built up. Slaughter was of the view that Living Goods could avoid costs associated with renting office space, hiring people, and creating distribution facilities, through its partnership with BRAC. BRAC implemented its microfinance programs in Uganda through Village Organizations (VO), which consisted of 25-30 women each (Refer Exhibit V for BRAC and its activities).

The CHPs were recruited from the existing members of BRAC's microfinance programs. The members of VOs chose one among them to become a CHP. As all the members of BRAC's programs were pre-screened by BRAC, and were aware of microfinance and its benefits, this gave Living Goods access to motivated personnel.

The women selected as CHPs underwent a three week intensive training by the field agents of Living Goods on topics related to health care, prevention of diseases, diagnosis etc. After the training, CHPs were provided with a uniform consisting of an apron and a T-shirt, backpack, locking chest to store products, health promoter kit consisting of visual flip charts to conduct health forums, cap, an identity card from Living Goods/BRAC, some basic first-aid products and necessary medicines like bandages thermometer, vitamins, paracetamol and oral-rehydration salts. The CHPs also got loan from BRAC to procure their initial stock of medicines and other products. The members of BRAC groups became the natural customer base for Living Goods.

The next step was to make an outreach plan. All the CHPs were required to make a list of their friends, family and acquaintances in a particular area - at schools, local organizations, churches etc. Then the CHP was required to draw a plan to reach all these people to build awareness about staying healthy and things to do to stay healthy like washing hands, sleeping under mosquito nets, basic hygiene, etc. The CHPs collected data from every household before they began their activities in a particular area. The data collected included number of children, their age, water source, sanitation facilities, usage of nets, spending on healthcare, cases of diseases, etc. Living Goods remeasured these periodically to assess the impact of the services of the CHP on the community.

The field agents from Living Goods were stationed at the field offices of BRAC. They arranged community meetings in partnership with schools, churches, local NGOs, village heads, etc, to introduce the CHPs to the community. In order to spread the message about prevention and cure of diseases, Living Goods encouraged CHPs to give health talks at local council meetings, microfinance borrower meetings, local markets, etc. They were also encouraged to meet their customers one-to-one. The CHPs were required to designate some time everyday to meet customers.

Each CHP was made responsible for 150 to 200 households in a particular area and visited them every month. The CHP was required to spend a few hours every day guiding people on different ways to stay healthy. Every month CHPs received refresher training and regular coaching to help them identify and distinguish between health problems CHPs could solve and those that need to be referred to a hospital or health workers. All the CHPs were also required to maintain records of all the contacts with patients and the transactions they made.

As there were no distributors or middlemen and the CHPs procured medicines directly from Living Goods, they were priced much lower as compared to medicines provided by unauthorized agents. The medicines supplied by CHPs were of high quality and were authentic, yet they were priced

lower as they were procured at lowest possible cost by Living Goods. Wherever possible, the company procured medicines at subsidized price by buying them in bulk from pharmaceutical companies and selling them at only a small margin.

Field Agents from Living Goods met CHPs at least once a month to restock supplies, collect payments, educate them on new promotions, and communicate about health education. They also monitored the storage of the products by CHPs and checked if the quality of the products had deteriorated due to improper storage. During the visit, they interacted with the customers to satisfy themselves that the quality of products and services provided was being maintained. Field Agents also collected data pertaining to patient contacts, transactions, etc. This data was then entered into a central database. Living Goods planned to use the data to study the impact its program had on the people.

Apart from the medicines, the CHPs also educated women about family planning, infant care, reducing mortality, etc. They also marketed other products necessary for prevention of diseases like mosquito nets, water treatment equipment, etc. The CHPs offered products procured only from Living Goods and adhered to standard pricing. If the CHPs were found to be violating the rules, they risked losing their livelihood.

Living Goods wanted the CHPs to be running a sustainable business. The company saw it as one way in which they would be able to make enough money to bring them out of the clutches of poverty. But the company realized that just selling medicines might not be enough for CHPs to meet their overheads and achieve economic sustainability and a good income. So apart from medicines, Living Goods provided them with other personal care products like washing soaps, bathing soaps, etc. that could help the CHPs earn higher income and run their business in a sustainable manner. The products provided by Living Goods can be categorized into different categories – prevention, treatment, personal hygiene, and save money-make money products (Refer Exhibit VI for the details of products sold under different categories).

The marginal cost of carrying these extra products was fairly low and by having several products to sell; CHPs could cross subsidize, and charged lower margins on essential products like medicines. According to Slaughter, around 50% of the income was generated from the sales of soaps. He was of the view that subsidized products would act like cost leaders and attract consumers to CHPs.

Both the consumers and CHPs were provided incentives from time to time. Loss leader promotions were carried out on some products, new promotional strategies like school based health screenings, special discounts for old people, buyer discounts, etc were carried out from time to time. The CHPs were also given incentives like phone cards, bicycles and some free products for reaching their targets. In the first year, Living Goods recruited 400 CHPs, and reached 550,000 people through them.

Living Goods was of the view that sustainable distribution platforms could be created for different goods by scaling up the model. The company intended to test market innovative products to help people save on money fuel and other common household inputs. One move in this direction was the sale of fuel efficient stoves in Uganda.

In Uganda, poor families spent between US$ 2.50 and US$ 5 every week on charcoal and wood, which were used as fuel. In mid-2008, Living Goods started distributing high efficiency stove manufactured by Uganda Stoves Manufacturers Limited through its CHPs. The stove, priced at US$ 20, used half the fuel of traditional stove, and generated better heat. Poor families could not afford to buy the stove, so Living Goods, in association with BRAC, provided these stoves on installment, which could be repaid within 16 weeks through the savings on fuel as savings amounted to over US$ 1 a week. The benefit of this saving accrued directly to the household once the installment payments were over.

Another innovative product that Living Goods distributed was solar powered lanterns. Traditionally, people in Uganda used kerosene lanterns, which caused indoor pollution. It was one of the main reasons for widespread respiratory disease in the country. The use of solar powered lanterns reduced environmental pollution, and provided light from a sustainable source.

THE BENEFITS

Living Goods' business model was self funding and provided unemployed women with a living wage. Living Goods planned to bring change in the lives of poor women by giving them ownership of their schemes. If the CHPs earned more, they invested more time in their work, and it benefited others in the community too. When the productivity of CHPs increased, Living Goods also benefited, making the business model sustainable.

Living Goods addressed most of the issues associated with the availability of authentic medicines and preventive measures by providing access to basic medicines right at the doorstep. This helped patients save on transportation expenses and loss of productivity. It also addressed issues like consumption of spurious medicines by providing quality medicines. Analysts were of the view that the burden on public health systems was reduced as many patients were served at their homes. At the same time, Living Goods helped the poor to take preventive steps by educating them about health and hygiene.

By reaching areas with high incidence of disease, Living Goods reduced death and illness rates significantly simply by providing access to basic health interventions. It also addressed the issue of poor quality and counterfeit medicines. The pressure on the overburdened public healthcare system was reduced through the efforts at timely diagnosis and intervention. Through informal education, the people learnt about the causes of certain infectious diseases and this helped them take preventive steps.

According to Living Goods, its business model had all the characteristics of a successful franchise system including agents whose background has been thoroughly checked, well-monitored quality of the products and services, follow up training, uniform branding, promotions, low cost through large scale of operations and penalties for violating the rules.

The benefits derived by the CHPs through their association with Living Goods were also considerable. They were provided with a sustainable income generating model of business that made them financially self-sufficient. Unlike full time work, the CHPs had a flexible schedule, helping them to balance their work, family, and farm related activities.

Initially the CHPs were given a target of US$ 200 a month. According to Slaughter in the first few months, many of the CHPs achieved sales of more than US$ 200. On this a margin was estimated at 25%, and expenses per year amounted to about US$ 100, after which a CHP could earn around US$ 500 a year.

The average rural household in Uganda had 5.5 members. Assuming that a CHP served about 250 households, it amounted to around 1400 people. The required sales per capita to achieve total annual sales of US$ 2400 worked out to be less than US$ 2, equal to around 15 cents a month. According to Slaughter, assuming that the per capita income in Uganda was less than US$ 2 a day, still 15 cents per month was not very high. The wholesale margin for Living Goods stood at 16.5%, and each CHP had to pay Living Goods US$ 2.50 per month as franchisee fees. Thus, each CHP contributed US$ 327[9] to Living Goods in a year.

[9] Living Goods sold products to CHP at US$ 1800 (US$ 2400 minus 24% retailer margin of CHP). On US$ 1800, Living Goods' margin is 16.5% i.e US$ 297 + US$ 30 (2.5*12) = US$ 327.

According to industry analysts, Living Goods' business model delivered public health services at a fraction of cost as compared to the traditional methods. The model was also beneficial to local manufacturers and suppliers as demand for their products increased due to better distribution. As women were empowered thorough entrepreneurship and education, it brought greater social equality in society. The initiatives taken by Living Goods helped in bridging the divide in access to health care services between the poor and the rich in Uganda.

LOOKING AHEAD

The project in Uganda was expected to enable Living Goods to study the effects of the introduction of new system of healthcare distribution on public and primary healthcare delivery. They also needed to know whether it would be successful in curbing private outlets from charging higher prices for medical products. The impact of the program on improvement of health and socio-economic outcomes would also be monitored. For this purpose, Living Goods planned to carry out a survey involving 200 clusters, in each of which 30 households would be surveyed. The survey was scheduled for late 2009. The assistance and help of CHPs was to be taken to carry out the survey.

Living Goods intended to prove that its business model was sustainable in Uganda, and that CHPs could generate enough profit by achieving average sales of US$ 6.60 per day, by the year 2010. Slaughter was of the view that once the sustainability of the model was proved, it would be easy to scale it up.

The company aimed to scale up its network in Uganda to over 20 districts and expand its reach to 650 communities by the year 2011, and to be completely self-funding through the profit margin on its products by the year 2013 (Refer Table I for the goals of the company by 2013).

Analysts believed that Living Goods' business model was sufficiently flexible to be tweaked to suit the requirements of the country and the sector in which it was being used. The model could be as easily adopted by a non-profit social enterprise, by a 'for profit' business or an NGO or even by governments. Living Goods planned to scale up the model rapidly across several countries. According to the studies conducted by Living Goods, a one-time infusion of around US$ 5 million could help organizations or governments develop a sustainable system of healthcare distribution that could potentially reach 20-30% of that country's population.

Table I

Living Goods – Goals 2013

- Improve access to and adoption of affordable health products in underserved communities by deploying 3,000 well-trained, well-stocked mobile Health Promoters serving a total population of three million. Target sustainable income per agent of US$ 200-500 per year.
- Materially reduce mortality and morbidity rates, especially for children under 5 and their mothers - proven through university quality control studies.
- Save poor families money on health care and keep wage earners healthy and productive.
- Become financially self-sufficient on a run rate basis.
- Propagate the replication of the health micro-franchising model by creating an advisory division to help social entrepreneurs replicate the model in other countries.

Source: http://geotourism.changemakers.com.

Living Goods believed that it could replicate its success in Uganda in other places by using the same model at different levels of engagement depending on the circumstances. In the "highly engaged" model, Living Goods planned to own and operate its divisions in other countries. In

businesses where Living Goods wanted only a moderate level of engagement, the company would provide technical consultancy for two to three years, till the new companies/NGOs could operate individually and become financially independent. In the least engaged model, companies could replicate the Living Goods business model as the company was ready to share its modus operandi with others. It was reported that, as of late 2009, half a dozen multinational NGOs had expressed an interest in replicating the Living Goods model.

However, some analysts were of the view that the Living Goods business model could not provide solutions to all the problems related to primary health care systems, and certainly could not substitute for the standard primary health care providers. It could play an important role in providing the drugs and products for prevention of ill health, and help in improving health. Some analysts were of the view that this model could work only in areas with a strong presence of NGOs and self help groups. If the model had to be developed from the grassroots, it would require more time, cost and effort to make the model self-sustainable.

Exhibit I

Time – Responsibility Pioneers

Rank	Company / Individual
1	Recycle Bank
2	Living Goods
3	Huw Kingston
4	Starbucks
5	Cadbury Plc.
6	Sonal Shah
7	Rebecca Hosking
8	Kickstart
9	Daxu
10	PeaceWorks

Source: www.time.com.

Exhibit II

A Note on Avon Products

Avon Products Inc. is the largest direct sales cosmetics company in the world. As of 2008, it operated through more than 5.5 million independent representatives. The company has a presence in 143 countries across the world. For the year ending December 2008, it reported revenues of US$ 10.69 billion and net profit of US$ 875.3 million.

Avon was started in the 1880s, when a book salesman started selling perfume door to door. In order to spread the business, he wanted to develop a network of entrepreneurs who would carry the products from the manufacturer to customers. In 1886, the wife of a senator joined the founder as an agent. She sold products to her acquaintances and also recruited other women as agents to sell the products. This went on to become the business model for the company. Within the first six months, 100 agents were recruited. Then, the business was expanded through catalogues and by adding new products. By 1910, the company had more than 100 products. Several women joined as sales representatives. After the Second World War, many housewives became a part of the network in order to earn some extra income.

In Avon's business model, which is based on networking, representatives take orders from customers, and collate and order stock from the company. The products are then distributed to the representatives, who deliver them to the customers. Catalogues are distributed along with the products, enabling customers to place orders for new products. Every year, Avon produces 18 catalogues and introduces around 1,000 new products. The representatives, also known as Avon ladies, are paid a commission on the products they sell. If a representative recruits a few more representatives, he/she gets commission on the sales generated by them. The representatives can place orders online and check the status of their orders. Though the business was initially limited to women, several men too became Avon representatives after it launched products targeted at men.

Compiled from various sources.

Exhibit III

Living Goods – Key Partners and Supporters

Building Resources Across Communities (BRAC)
Uganda Ministry of Health
Draper Richards Foundation
Freedom from Hunger
The Lemelson Foundation
Poverty Action Lab
Binger Catalog Marketing
Nancy Farese Photography
Rockefeller Foundation
Mulago Foundation
Horace W. Goldsmith Foundation
The David Weekley Family Fund
The Peery Foundation
The Jasmine Charitable Trust
The Causal Fund
The Sister Fund
The Flora Foundation
The Donner Foundation

Source: www.livinggoods.org.

Exhibit IV

About Uganda

The Republic of Uganda is located in East Africa and is a land locked country, surrounded by Kenya, Congo, Sudan, Tanzania and Rwanda. The country was a British colony until independence in 1962. Till the late 1980s, it was in a state of political turmoil. The late 1980s and 1990s ushered a stable government. At the same time, reforms backed by developed countries like the USA helped Uganda to revive rapidly. This led to growth in the economy.

Uganda had a population of (As of 2009, according to IMF estimates, the population of the country was) 32.04 million in 2009. Life expectancy was 52 years for men and 53 years for women. The infant mortality rate (per 1,000 live births) was 80, and under-5 mortality rate (per 1,000 live births) was 137. Uganda is hailed for the way it tackled AIDS epidemic. In the early 1990s, 13.1% of the people in the country were affected by AIDS. The Ugandan government put in a strong effort to fight the spread of AIDS through various means including: the creation of the Uganda AIDS Commission, adopting a multi-sectoral AIDS control approach, adopting Voluntary Counseling and Testing, and several other intervention programs. Infection rates fell dramatically and by 2003, the proportion of HIV +ve people had fallen to 4.1% of the total population.

In 2007, Uganda's GDP stood at US$ 11.916 billion. GDP per capita was US$ 385 in 2007 and was estimated at US$ 454 in 2008. Half of the population lived below the international standard of poverty line (US$ 1.25 a day).

Compiled from various sources.

Exhibit V

About BRAC

BRAC) was incorporated in February 1972 in Bangladesh by Fazle Hasan Abed, as Bangladesh Rural Assistance Committee. At that time, the focus of the organization was on assisting refugees returning to independent Bangladesh from India. Then in 1973, the focus of BRAC was shifted towards longtime poverty reduction and the development of people in Bangladesh through alleviation of poverty and empowerment of women. By the mid-1970s, the name was changed to Bangladesh Rural Advancement Committee marking the change in its focus from rehabilitation to development.

As of 2009, BRAC employed more than 100,000 people and reached more than 110 million people through development interventions in India and Africa. According to BRAC, "Our vision is of just, enlightened, healthy and democratic societies free from hunger, poverty, environmental degradation and all forms of exploitation based on age, sex, religion and ethnicity." BRAC operated through village organizations (VOs), each having around 30-40 members, mostly women. The VOs met every week to provide social support and microfinance services like distributing loans, and collecting repayments and contributions. The VOs also provided training to women and support to use the money they had taken as loan. They also recruited community and healthcare volunteers, agricultural volunteers, to increase the outreach of BRAC's programs. Health volunteers visited the homes of the poor and provided support for healthcare programs. BRAC also ran primary and pre-primary schools, where students were taught by teachers trained by BRAC. BRAC has so far trained some 50,000 teachers worldwide.

BRAC also operated pro-poor social enterprises, and provided value-chain linkages to help the poor run successful businesses. For example, BRAC provided loans for poultry birds and training on poultry farming techniques. It supplied quality poultry feed from feed mills operated by it and encouraged poultry farmers to avail of vaccinations services to protect their poultry.

With the experience it gained in innovating new models to alleviate poverty, BRAC scaled up the model and spread to other countries. The program was first expanded to Afghanistan in 2002. The programs reached 179,000 households and covered 75% of the geographical area. BRAC entered Sri Lanka in 2004, in the aftermath of the devastating tsunami. In 2006, BRAC entered Africa including countries like Tanzania, Uganda, and Southern Sudan. BRAC entered Pakistan and Indonesia in 2007. As the company started expanding internationally, its name was changed to Building Resources Across Communities.

BRAC entered Uganda in 2006 and had opened 35 branches in 22 districts of the country within 18 months. It had 2,000 village groups with 50,000 members, and a default rate of less than 1%. It had emerged as one of the largest NGOs in the country by 2008. It worked in the areas of microfinance, agriculture & livestock, livelihood development, health, youth education, etc. In Uganda, BRAC's microfinance programs reached 33 of the 83 districts in the country and operated through 100 offices. Agriculture & livestock services were provided by 40 branches of BRAC, and by December 2008, around 23,000 farmers were provided with different kinds of assistance, and 800 poultry and livestock assistants were recruited. The Empowerment & Livelihoods program was started in Uganda in 2008, through 10 branches in one rural area and one urban area, to provide young girls with skills training. Under the health program, there were 980 community health promoters and 128 community health assistants as of December 2008. The community health promoters organized more than 3,000 community health forums, and educated participants about malaria, TB, HIV/AIDS prevention, sanitation, maternal health, family planning etc. In the area of youth education, BRAC operated 58 schools, educating 2,000 children. More than 1,000 children were smoothly transitioned into formal education in the state schools after attending BRAC schools.

Compiled from www.brac.net and other sources.

Exhibit VI

Living Goods – Product List

Prevention and Treatment
Insecticide treated bednets,
Clean Water: Water treatment solution/tabs, water filters
Nutrition: Vitamin A, Iron, Zinc, Fortified foods, Iodized Salt
Wound Care: Bandages, topical anti-bacterials
Oral re-hydration salts / zinc
Paracetamol
De-worming tablets (Albendazole)
Antibacterial hand soap
Cough medicine
Antacids
Malaria treatments
Medicines for diarrheal diseases, TB, Cold, and flu
Personal Hygiene
Hand soap & Laundry soap
Skin lotion, cold creams, vaseline, foot cream
Toothpaste
Cosmetics
Shampoo
Diapers
Save Money – Make Money
Solar lanterns and chargers
Efficient cook stoves
Micro irrigation systems
Pedal Irrigation Pumps
High Yield Seeds

Source: www.livinggoods.org.

Suggested Readings and References:

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