



The ITC e-Choupal Rural Health Initiative *Baseline Report*







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**Market-based
Partnerships for Health**



THE ITC E-CHOUPAL

RURAL HEALTH INITIATIVE

BASELINE REPORT

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ACKNOWLEDGEMENTS

The Market-based Partnerships for Health (MBPH) project is funded by the United States Agency for International Development (USAID). As the lead partner on MBPH, Abt Associate's responsibilities range from conceptualization to the implementation of the program, including designing the program models, fostering partnerships, developing research and evaluation framework and executing the program at ground level. Developed in close collaboration with ITC and several other partners, the ITC e-Choupal Rural Health Initiative is MBPH's rural-market focused pilot program. Abt's prime responsibility for this pilot includes designing and implementing the research program for assessing the effect of the intervention on the supply and use of health commodities as well as the financial viability of the model. Data collection for the pilot's qualitative and quantitative baseline studies was completed with assistance from local research firms.

All the information presented in this report comes from the research efforts of the teams at IMRB/SRI and Abt Associates led by Ramakrishnan Ganesan and Vivek Sharma and at Purple Audacity led by Sharmila Das. The Abt research team thanks them for the hard work that went into collecting and analyzing the data. The project is also grateful to all the individuals who participated in the baseline studies. By responding to the quantitative study questionnaires and participating in the in-depth interviews (IDIs) and focus group discussions (FGDs) that were the basis for the qualitative research study, they have provided us valuable information for both improving the design of the pilot and assessing its impact.

The Abt research team thanks USAID|India for its support, especially Sheena Chhabra and Moni Sagar whose inputs and guidance have been invaluable in shaping the design and implementation of the program. The pilot program would not have been possible but for the ideas and enthusiasm of ITC, our key collaborator, as well as our supply-side partners Pfizer, Ranbaxy, Medentech, Royal Hygiene and Vision Spring. We would like to take this opportunity to recognize the contributions of some of the key personnel from the partner firms: Sivakumar, Rajnikant Rai, L Prabhakar, Shailesh Naik and Kavitha David from ITC; Sunil Madhok, Arun Shaju and Anil Bajaj from Pfizer; Brijesh Kapil, Venu Madhav, and Sanjay Rana from Ranbaxy; Michael Gately and Vijay Malik from Medentech; Rakesh Kaul from Royal Hygiene; Maruti Ram from Vision Spring. We also thank Parijat Ghosh and Anshul Goswami, our colleagues from Monitor, a project partner, for providing key inputs into the design of the pilot study, and Mr. Saroj Kumar Mohanta and his team from MART that developed the business and soft skill training component of the program.

Last, but not the least, we would like to thank the entire MBPH project team for their hard work and continuous support, and the large network of e-Choupal staff, village health champions, and project field staff who are jointly implementing the pilot.

ACRONYMS

ANMs	Auxiliary Nurse Midwives
ASHA	Accredited Social Health Activist
BoP	Base of the Pyramid
FMCG	Fast Moving Consumer Goods
FP	Family Planning
IDIs	In-depth Interviews
IUD	Intrauterine device
MBPH	Market-based Partnerships for Health
MRP	Maximum Retail Price
NFHS	National Family Health Survey
OCP	Oral Contraceptive Pills
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
OTC	Over the Counter
UP	Uttar Pradesh
VHC	Village Health Champion
RH	Reproductive Health
FGD	Focus Group Discussion

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EXECUTIVE SUMMARY

As USAID|India's flagship private health sector project, the Market-based Partnerships for Health (MBPH) provides technical assistance to private sector initiatives; focuses on strategic partnerships and helps foster commercial alliances to address a wide range of health issues including reproductive health (RH), maternal and child survival, tuberculosis, water, hygiene, HIV/AIDS. Aimed at delivering health impacts that are commercially viable and scalable, one of the key focus areas of the project is to develop commercial sector interest in the public health issues being addressed by it, in the lower socio-economic sections in urban and rural India.

In line with this philosophy, the MBPH project has partnered with ITC, a leading Indian company (with an annual gross revenue of approximately USD 7 billion), through its e-Choupal network to develop a commercially sustainable rural health model, focused on increasing access to and creating awareness around public health issues like family planning (FP), diarrhea management and menstrual hygiene. Created by ITC over the last decade, the e-Choupal network is a rural procurement and marketing infrastructure which combines internet connectivity with physical infrastructure that provides rural communities greater access to information, goods and markets for their crops. Over the years, the scope of activities under the e-Choupal umbrella has increased substantially and apart from offering procurement services as well as providing information on enhancing farm productivity, the network now supports information dissemination around a diverse range of issues, sale of products and services through ITC-owned exclusive retail network (known as Sagars) at select locations.

This pilot program leverages e-Choupal's inherent procurement and distribution capabilities and has appointed community-based point persons under the e-Choupal umbrella, to deliver a range of health products to 66 villages in the districts of Chandauli and Gonda in Uttar Pradesh (UP). At present, the product basket includes FP products like condoms and oral contraceptive pills (OCPs) and intends to include diarrhea management products like oral rehydration salt (ORS), which for this particular pilot are defined as primary health products. The primary health basket has been layered with a range of secondary health products including OCPs, sanitary napkins, water purification tablets, nutrition supplements, reading glasses and over the counter (OTC) medication to make the entire initiative commercially viable for the carriers of these products. The program has recruited a team of community-based health workers, branded as Village Health Champions (VHCs), who are expected to act as the access points for these products. These products are stocked at the e-Choupal rural hypermarkets, branded as Choupal Sagars, and VHCs visit these outlets to buy the health products at wholesale prices at regular intervals. These products are then sold to the village communities by the VHCs at retail prices, giving VHCs a healthy source of income through retail margins.

This pilot focuses on enhancing the public health outcomes as well as establishing commercial viability of the model. If this rural health pilot proves to be commercially sustainable for ITC, the partner firms as well as the VHCs, then ITC will consider scaling up this model to all those locations which have enhanced hubs with front-end retail outlets called Sagars. The program target is to ensure that VHCs earn a minimum income of Rs. 1,200/- per month from this pilot as well as establish VHCs as credible health workers within their community.

In order to establish an evaluation framework for the program, the program team conducted a baseline

study before the start of the program. Along with it, the team also carried out a small qualitative research study to better understand the constitution of the secondary health products for the pilot initiative.

The qualitative research was used to provide formative inputs for expanding the product basket beyond FP and diarrhea management products to make it more robust. As per the design of the project, baseline and endline surveys will be used to compare the performance of consumers and retailers in the pilot villages of Chandauli and Gonda to that of the villages in the control district, Jagdishpur. The sample sizes for the baseline study were 1520 consumers each for the two intervention districts and one control district. The sample was equally split between men and women. Apart from this, the study also interviewed 185 retailers in Gonda, 145 retailers in Chandauli and 191 retailers in the control district of Jagdishpur. As mentioned earlier, the team also undertook qualitative research as part of the formative research, in the program districts to shed light on knowledge and patterns of use of the secondary health products. The sample size for the qualitative research consisted of 9 focus group discussions (FGD) and 12 in-depth interviews (IDIs) across the two intervention districts.

This report synthesizes the results from the quantitative survey among consumers and retailers in the program and control districts, and the qualitative research among consumers in the two program districts. The key findings that emerge from these studies are as follows:

- The populations in the intervention and control areas were found to be comparable in terms of background characteristics like average income, education levels, primary occupations, age and gender composition.
- Knowledge of FP methods was found to be high; over 95 percent of respondents in both the intervention and control areas were aware of at least one FP method while 60 percent of the respondents were aware of any modern FP method. Use of FP however was significantly lower; 28.5 percent and 21.5 percent in the intervention and control groups respectively reported current use of the products. Both demand and supply side factors contribute to this gap between knowledge and usage. Access to methods is an issue and less than 50 percent of the villages in the intervention districts have at least one shop selling contraceptives as compared to 62.5 percent in the control district. The intention to use any FP method scores were comparable across intervention and control districts (16 percent for the intervention and 14 percent for the control) while the intention to use FP methods in future, among those who had never used a FP method, was 11 percent in the intervention and 8 percent in the control district respectively. The key barriers mentioned by people include issues related to availability, embarrassment in buying products like condoms and some degree of negative attitude towards products like condoms and OCPs.
- Given that the main focus of the program is on OTC methods, and that the delivery agents are rural women with minimal education, it is logical that the FP methods being promoted by the program are condoms and OCPs, which do not require any sales or drug license for being dispensed by the VHCs. The awareness levels of condoms and OCPs were comparable in the intervention and control areas; almost 33 percent of the respondents were spontaneously aware of condoms in the intervention and control areas while 32 percent and 29 percent were aware of OCPs in the intervention and control areas, respectively. The current use of condoms and OCPs

was found to be quite low; 9.34 percent for condoms and 1.8 percent for the OCPs in the intervention districts and 11.9 percent and 3.2 percent for the condoms and OCPs, in the control district respectively. Barriers related to access and hesitation in buying these products from the local shop, were found to be some of the reasons for low usage. The proportion of children who had diarrhea in the 3 months prior to the survey was 19 percent in the intervention area and 13 percent in the control district. Over 80 percent of the mothers in both intervention and control areas reported seeking care for their sick child from health service providers during the most recent incidence of diarrhea. However, use of home-based solutions like sugar and salt/ gruel etc., as well as the use of ORS and increasing the intake of fluids during the diarrhea episodes was found to be low. The ORS use among women whose children had a bout of diarrhea in the last 3 months was 36 percent in the intervention and 43 percent in the control district. The use of home-made fluids was even lower, with 30 percent and 28 percent of respondents reporting use in the intervention and the control districts, respectively. Thus, though the incidence of diarrhea is quite high, the use of home-made remedies as well as ORT is quite low along with little emphasis on increasing the intake of fluids. Keeping this in context, the outreach activities should focus on educating consumers about increasing the use of ORT and ORS.

- The use of secondary health products like sanitary napkins and pregnancy test kits was low among women interviewed in the survey. Only 17 percent of the women in intervention and 15 percent in the control district reported current use of sanitary napkins, while the use of pregnancy test kits was even lower at 7.8 percent in the intervention and 7.25 percent in the control district, respectively. This is primarily due to limited availability of these products in the villages as well as limited financial resources available with the women in these areas.
- Though e-Choupals have been in existence in the intervention villages for over a decade now, the awareness among the community about e-Choupal was in single digit in both intervention and control districts. Yet given the fact that local area retailers do not carry many of the health products in question, respondents welcomed the idea of increasing their availability through the e-Choupal system. Currently, the most popular source for health products are the shops outside the villages, especially in the feeder markets, which are essentially the markets on the roads/ highways connecting to the village.
- The qualitative research undertaken revealed that introducing last mile distribution partners in the form of the women VHCs will stimulate greater use of the health products. Direct contact of the VHCs with consumers, will result in increased use as well as increased awareness levels. The decision to have a direct channel also stemmed from the fact that the awareness of alternate channels like e-Choupal was quite low among women and the VHC channel was ideally suited to address social barriers regarding issues related to FP, menstrual hygiene, which have been traditionally neglected by women and families, through face-to-face interactions. The VHC was expected to maintain client confidentiality since she would have access to substantial personal information about her clients in the village.
- The qualitative research also revealed that apart from FP and diarrhea management products, the villagers also expected the VHCs to stock sanitary napkins, pregnancy test kits, OTC medicines, Glucon D, undergarments and health food drinks. Most of the respondents expressed a desire for these products to be appropriately priced for the rural markets.

Overall, the key expectation from the program was that VHCs should be accessible to everyone in the village and should also be competent in handling sensitive categories. It was quite evident from the qualitative research that the perception of VHCs among the community would be critical to the success of the program.

INTRODUCTION

Targeting the base of the pyramid (BoP) is a business approach that has become a key focus for an increasing number of businesses in recent years. Its proponents believe that it has the potential to generate innovative but profitable business solutions in emerging markets, and do so in ways that can alleviate poverty and positively impact social sectors like health¹. BoP refers to the population in the lowest socio-economic category and the approach involves developing and selling products that cater to this group. In India, the majority of BoP strategies are focused on the country's vast rural market. An estimated 70 percent of the Indian population lives in rural areas. On average, this large rural majority is poorer and less educated than the urban minority and has limited access to goods and services. Over the last decade, businesses in India have recognized the potential of tapping into the rural BoP markets and have made significant investments in reaching out to rural consumers through innovative BoP business models. These rural BoP models have been welcomed by the development community as a way to leverage the profit motive and harness the innovativeness of the private sector to address a range of social challenges faced by developing countries.²

The appeal of the BoP approach for the health sector and related social sectors like water and sanitation is obvious. It is a well-documented fact that poorer people on average have worse health outcomes and more limited access to health care services than their wealthier counterparts³. Several BoP models have been launched to improve health among the under-served in India, especially in rural areas. For example, health care delivery models like the Aravind Eye Care System and Narayana Hrudalaya are implementing sustainable models for delivering advanced medical treatments like cataract and heart surgery at low costs to poorer sections of the population⁴. Tata's low-cost water purification system that is not reliant on electricity is a good example of a commodity in the fast moving consumer goods (FMCG) industry that caters to the needs of BoP consumers⁵.

While there is considerable excitement about BoP approaches, doubts remain about their scalability as well as sustainability. Many of the BoP success stories are concentrated in some select industries like telecommunications, FMCG, and pharmaceuticals, while companies in other areas have struggled to find profitable ways of entering the BoP market⁶. Even some of the more successful BoP models have struggled in terms of long-term financial sustainability. Hence, the search for viable BoP models continues. More experiments with BoP models can generate valuable evidence on how the private sector can be leveraged to address development challenges in sustainable ways.

¹ Prahalad, Bottom of the Pyramid; London and Hart, Reinventing strategies for emerging markets, <http://www.palgrave-journals.com/jibs/journal/v35/n5/abs/8400099a.html>, accessed April 15, 2011; <http://www.majoritymarkets.org/news/achieving-results-priority-latin-america-and-caribbean-bop-agenda>;

² <http://content.undp.org/go/newsroom/2010/september/world-business-and-development-award-fighting-poverty-can-benefit-business.en>

³ Report by the Commission on the Social Determinants of Health, http://www.who.int/social_determinants/thecommission/finalreport/en/index.html.

⁴ <http://www.business-standard.com/india/news/sunil-jain-bypass-forhealth-sector/243365/>;
<http://www.aravind.org/tribute/A%20Man%20Who%20Saved%202.4%20Million%20Eyes.pdf>

⁵ <http://www.deccanherald.com/content/40000/tata-launches-swach-water-filters.html>

⁶ Karamchandani et al. Is the bottom of the pyramid really for you?, Harvard Business Review, <http://hbr.org/2011/03/the-globe-is-the-bottom-of-the-pyramid-really-for-you/ar/1>;
http://www.oikos-international.org/fileadmin/oikos-international/international/Case_competition/oikos_CWC_2nd_2008_Christensen.pdf

Keeping this in context, this report focuses on a promising BoP experiment for improving access to health products in rural India. The ITC e-Choupal Rural Health Initiative is a pilot program that is being implemented by the USAID-funded MBPH project in collaboration with ITC Limited, one of India's largest business conglomerates, and several other project partners. The pilot program builds on ITC's existing e-Choupal system to improve access to and consumption of health products in two districts in UP.

The existing e-Choupal system combines internet connectivity with an advanced rural procurement and distribution infrastructure to give rural communities greater access to information, goods, and markets for their crops. ITC uses the IT systems to connect directly with farmers in rural India to buy agricultural products like wheat and soya bean. Farmers can use internet portals that are installed at each e-Choupal or village hub to verify that the prices offered by ITC are fair, and use it to access other information about prevailing crop prices, market trends, and weather changes that may impact their production. Today, 6,500 e-Choupals cover 40,000 villages and reach out to almost 4 million farmers in ten states⁷ in India. These 6,500 Choupals are managed by approximately 110 second-level hubs, which have warehouse facilities for storing grains. Simultaneously, ITC uses the same procurement logistics chain to also distribute a range of agricultural inputs like fertilizer and seeds as well as FMCG products to retail outlets in rural areas. The company has been building its own rural retail network of rural supermarkets branded as Choupal Sagars that sell a range of products and are strategically integrated with the grain procurement centers to provide quality products to farmers who sell their agri-produce to ITC and the wider village community.

With the growth of the e-Choupal network, ITC has been looking to evolve the system from its focus on agriculture to include other goods and services that are relevant for rural markets like, health and finance. It has been especially keen to leverage the Choupal Sagar infrastructure, which can be easily expanded to supply non-agricultural goods and services, with e-Choupals acting as the demand aggregators for these products and services. In line with this, the MBPH project worked with ITC to design a pilot program that uses the e-Choupal and Choupal Sagar network to increase the supply of health products in rural areas.

The result is the ITC e-Choupal Rural Health Initiative, which is being piloted in 66 villages in Chandauli and Gonda districts of UP through a team of community-based health workers recruited, trained and branded as Village Health Champions (VHCs). This MBPH model uses product partnerships between ITC and manufacturers of health products as well as the ITC's logistics infrastructure to increase the supply of a range of health products in the pilot areas. Guided by market research and USAID|India's health priorities for rural areas, the project selected a primary basket of products (that includes FP and diarrhea management products) and a secondary basket of health consumables such as sanitary pads, water purification tables, nutrition supplements, and reading glasses. The VHCs buy the products from ITC distribution points and sell the products through face-to-face interactions with the community and promote health awareness among their clients. The latter is aimed at improving knowledge about the benefits and proper usage of the health products, which in turn is expected to boost the demand for these commodities.

⁷ The ten states covered by ITC e-Choupal model are Madhya Pradesh, Haryana, Uttarakhand, Karnataka, Andhra Pradesh, Rajasthan, Maharashtra, Kerala, Uttar Pradesh and Tamil Nadu.

In order to test the effect of the model regarding increasing access to and use of these health products as well as its commercial sustainability, the MBPH team is implementing a range of program evaluation and research activities. The evaluation of the program's impact is based on a quasi-experimental study design, whereby performance in the pilot villages will be compared with villages in a control district in UP, Jagdishpur. Given that the pilot is being implemented only in districts with Choupal Sagar, the rationale for choosing Jagdishpur as a control district was that apart from having a Choupal Sagar, it was closest to the intervention districts in terms of health and demographic indicators.

Prior to the initiation of the pilot program, quantitative baseline studies were conducted among consumers and retailers in both the intervention and control districts. End-line surveys implemented at the end of the program period will allow the team to assess relative changes in the two groups. Prior to the start of the pilot, the research team also implemented exploratory research using qualitative methods in the pilot districts. The baseline survey and the exploratory research have yielded information that helped the team, first, fine-tune the design of the pilot program and, second, establish baseline measures for a range of key indicators related to the intervention.

This report synthesizes the findings from the baseline survey and exploratory research implemented in 2010 before the pilot was launched. The objective of the report is to provide a comprehensive picture of the conditions that prevailed in both the intervention and control districts with respect to the supply and consumption of the health products included in the pilot program.

Section 2 of this report provides information about the existing ITC e-Choupal system and the pilot program that MBPH designed in collaboration with ITC and other partners to extend the base model so as to improve access to a range of health commodities. Section 3 provides a brief overview of the research design. Section 4 reviews background characteristics of the study population. Sections 5, 6, and 7 present findings from the qualitative and quantitative baseline studies about the supply and consumption patterns associated with FP, diarrhea management, and secondary health products respectively. Section 8 analyzes knowledge about the standard ITC e-Choupal model and views about the pilot project expressed by focus group participants. Finally, Section 9 summarizes the key findings and its implications for the program.

THE MODEL

The MBPH pilot program, ITC e-Choupal Rural Health Initiative, leverages ITC's highly acclaimed e-Choupal model to improve access to health products in rural areas. The pilot program introduces a range of FP, childhood diarrhea management and OTC health and wellness products into the ITC e-Choupal system by brokering product partnerships between ITC and the manufacturers of the products. It then augments the basic e-Choupal platform with last mile delivery agents in the form of VHCs, who both sell the health products locally and serve as resource persons for health information. The standard ITC e-Choupal structure is described in brief below, followed by a more detailed explanation of the model piloted by MBPH.

THE ITC E-CHOUPAL INITIATIVE

ITC Limited, one of India's leading agricultural processing companies, launched the e-Choupal initiative in June 2000. The initiative is widely recognized for revolutionizing the agricultural sector in India by linking farmers in rural areas to markets beyond their villages through both information technology and an extensive procurement network. ITC e-Choupal has been the focus of numerous case studies and articles⁸. The brief summary of the system that follows draws heavily from these descriptions as well as from information from the company's website⁹.

The ITC e-Choupal initiative was designed to tackle many of the challenges posed by the way the agriculture sector is organized in India. Land holdings are typically small and fragmented, and farmers have poor access to information about the markets for their goods. Agri-businesses interested in purchasing agricultural products have limited direct access to the farmers. Altogether, these factors allow layers of middlemen, who mediate between individual farmers and the purchasers of their yields, to engage in arbitrage.

As a way to remedy this situation, ITC launched the e-Choupal program, which put in place a "hub and spoke" model that provides rural communities greater access to information about market conditions and allows the company to reach rural markets, both to source agricultural produce directly from farmers and sell a range of products to rural consumers. A Choupal in Hindi refers to a place for 'village gathering'. E-Choupal refers to the internet-enabled gathering places set up by ITC at the village level. These e-Choupals are operated by a Sanchalak, a literate farmer selected from the village. He acts as the source for information for the farmers in a cluster of villages served by the e-Choupal and the primary point of contact for the company. The farmers can use the computer to access a variety of information that impact their business including crop prices, weather forecasts, scientific farming practices, farmer peer groups, and soil-testing services.

Each of the village-level e-Choupals are in turn linked to a collection and storage centers, which acts as the hub for several e-Choupals in its catchment area. A typical farmer will take a sample of his crop

⁸ <http://cb.hbsp.harvard.edu/cb/product/604016-PDF-ENG>;
http://siteresources.worldbank.org/INTEMPowerment/Resources/14647_E-choupal-web.pdf;
http://planningcommission.nic.in/reports/sereport/ser/stdy_ict/4_e-choupal%20.pdf;
<http://www.fao.org/irdd/doc/ITC%20e-Choupal.pdf>

⁹ <http://www.itcportal.com/sustainability/lets-put-india-first/echoupal.aspx>

to a local e-Choupal and receive a price quote from the Sanchalak. If the farmer accepts the quote, he can then transport his crops directly to an ITC collection center and receive a payment in return. The collection center is equipped with modern tools and technology for unloading, weighing and storing produce with accuracy and minimal wastage. The company also has the necessary transport to collect stored stocks from the storage facilities. This model has improved the decision-making abilities of farmers significantly by providing them real time information on their farm produce and eliminated the need for wasteful intermediaries.

This supply chain used to procure and transport the products sold by the farmers is simultaneously used by ITC to supply rural markets with agricultural inputs like fertilizers and a range of consumer goods. When MBPH partnered with ITC, the latter was supplying both its own products and third party products to multi-brand retail outlets in rural areas. Each hub operator or Sanyojak would coordinate forward-distribution of goods for sale to local retailers. In some cases, Sanchalaks would operate as local retailers themselves. Additionally, ITC set up rural supermarkets known as Choupal Sagars at 22 percent of the hub-level collection centers that similarly sold products manufactured by ITC and other companies. These marts sell a range of consumer goods, agricultural products, electronic appliances, and equipments and have in place other infrastructure as well, including a food court, training center (at all locations), bank, tractor repair workshop, petrol pump (at some of the locations). In the design blueprint, these hypermarts also had provision for health services like pharmacy, clinic, etc. which are currently not being utilized. Situated adjacent to the grain procurement and storage centers, the Choupal Sagars are strategically placed to cater to farmers who come to the hub to sell their agri-produce.

In early 2011, the company decided to eliminate the distribution of products manufactured by other companies referred to as third party products to independent, multi-brand retailers in local areas. Instead, the company decided to focus on distributing its own range of food and FMCG products to the local outlets through the larger ITC distribution system and not through the Sanyojak. The focus is on selling the third party products at Choupal Sagars, the company-owned supermarkets. This change is a result of its strategic focus on building up the Choupal Sagars to serve as a hypermart for the local communities.

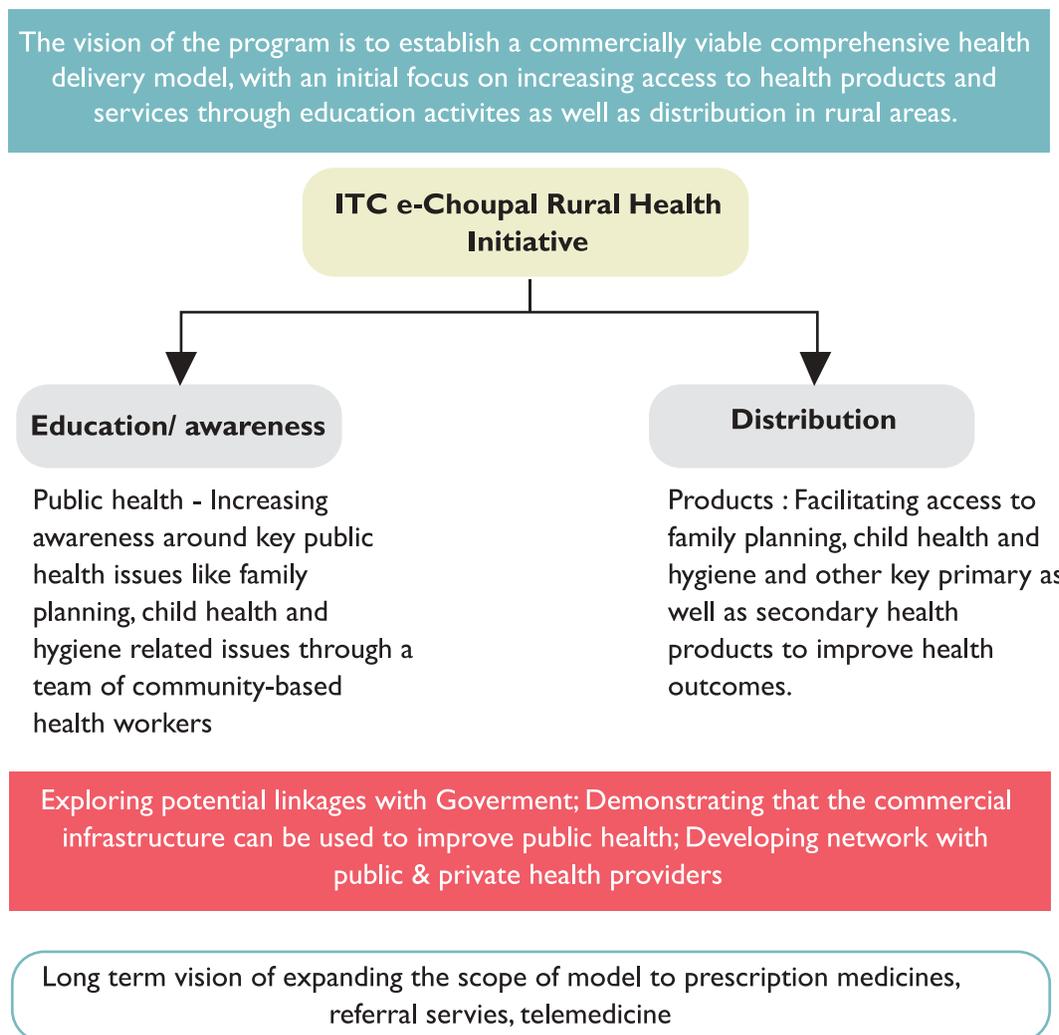
ITC has decided to discontinue its distribution network supplying other companies' products to the rural retailers through Sanyojaks, since most of the partner firms have started setting up their own distribution channels in the rural markets, due the growing importance of these markets. Instead of this, the focus on its own branded retail is expected to increase further in these markets.

ITC plans to develop the Choupal Sagars further as one-stop-shops for a range of other goods and services beyond agricultural goods and FMCGs, including financial products like insurance as well as health products and services. The ITC e-Choupal initiative has allowed ITC to successfully implement direct BoP sourcing for agricultural products and create a BoP market for a range of agricultural inputs and consumer goods. It is now set to expand the system to sell a range of non-agricultural products and services, especially health and financial services, to rural consumers.

The ITC e-Choupal Rural Health pilot program leverages the existing e-Choupal platform to improve both the supply and demand for health commodities. The model intends to increase the use of a range of health products, with a focus on FP and diarrhea management methods, through a two-pronged

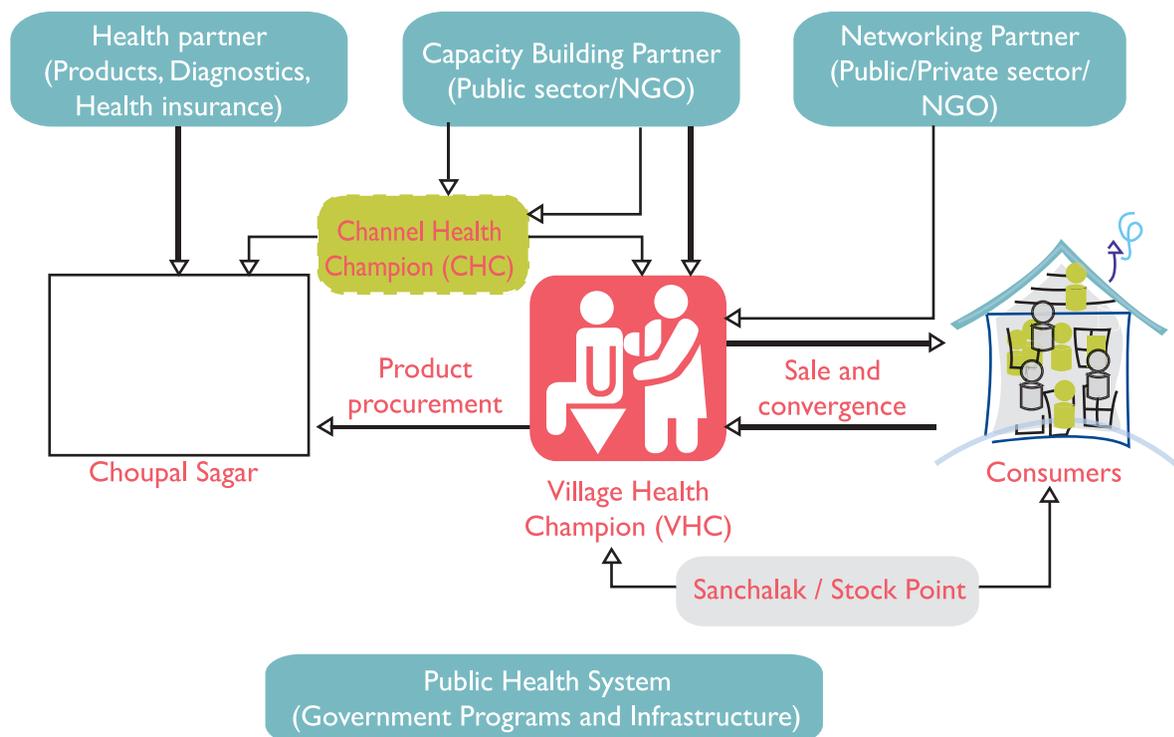
approach: first, by increasing access to these commodities and, second, by stimulating demand for them through dissemination of health information. These two areas of intervention and the overall vision for the project are depicted in Figure 2.1 below. On the distribution side, MBPH has facilitated product partnerships between ITC and manufacturers of health products whereby health products will be distributed down to the village level using the existing e-Choupal platform. The project has also recruited, trained and deployed VHCs who serve as last mile delivery agents for the health commodities and information, procuring the health products from ITC at wholesale prices and selling them directly to consumers at retail prices. On the education side, the project trains the VHCs to implement group activities and one-on-one mentoring to increase health awareness and stimulate demand.

FIGURE 2.1: GOALS OF THE ITC E-CHOUPAL RURAL HEALTH INITIATIVE



The pilot program was officially launched in November 2010 in the Gonda district, with formal operations scaling up in January 2011. The MBPH project aims to prove the impact and viability of the model, pending which ITC is committed to scaling up the model to other e-Choupal locations. Below, we describe the inception of the model, the selection of health products for inclusion in the product basket, the selection and training of VHCs, and the structure of the pilot program on the ground.

FIGURE 2.2: THE ITC E-CHOUPAL RURAL HEALTH INITIATIVE MODEL



INCEPTION OF THE PILOT PROGRAM

In early 2009, the MBPH team formally approached ITC to develop a model to jointly address the public health issues in the rural markets. Multiple assessments in the past have revealed that a range of factors were contributing to poor access to quality health products and services in areas like FP, diarrhea management and reproductive health. The MBPH team along with the Monitor Group worked extensively with the ITC senior management team to arrive at a model to address these constraints. The team undertook formative research, interviewed key stakeholders including consumers, government health workers, and senior managers at ITC and several pharmaceutical companies to arrive at a model that had the potential to mitigate the supply- and demand-side barriers to access to health products and services. ITC signed a formal Memorandum of Understanding (MOU) with the MBPH team in September, 2009 to design and launch the e-Choupal Rural Health Initiative.

PRODUCT SELECTION

Based on the formative research that was conducted as well as information from secondary data sources, FP and childhood diarrhea management were selected as the primary focus areas for the project. The National Family Health Survey (NFHS) conducted in 2005-06 showed that 63 percent of women in UP got married and 29 percent got pregnant by the age of 18 years. Approximately 23 percent of currently married women in the age group of 15-49 years reported that their needs for contraception remained unmet. This documented need for greater access to FP services was the primary reason why FP was a key focus of the program.

In India, diarrheal diseases account for nearly 300,000 deaths per year among children under the age of 5 years. According to NFHS, 2005-06, only 39 percent of the children under 5 years afflicted with diarrhea in the two weeks before the survey received some kind of ORS packet and 20 percent received gruel. Approximately 16 percent received antibiotics, which are not normally recommended for treating childhood diarrhea. More than a quarter did not receive any kind of treatment. Given that childhood diarrhea is both easily manageable and curable, these statistics are alarming and hence the rationale for including diarrhea management products as part of the health basket in the pilot initiative. Furthermore, the program chose to focus on women of reproductive age in recognition of the fact that in spite of them being primary care-givers for the majority of children afflicted with diarrhea, they face challenges in accessing the required health services

In spite of the program's focus on FP and childhood diarrhea management, based on the formative research conducted by the program team, it became evident that a product basket consisting of only FP and diarrhea management products will not prove to be commercially sustainable for the VHCs. This was due to the fact that the demand for FP products are limited to a certain segment and diarrhea management products will only be purchased around the rainy season. This will result in limited income opportunities for the VHCs, thus making the entire model unattractive for her. Therefore, it was decided to expand the product basket to other OTC health and wellness products, thereby allowing the VHCs to reach a critical level of monthly revenues to sustain their selling activities. The program team also reached a broad agreement with USAID and ITC that the product portfolio could be expanded to include other products which will not have any negative health impact, even if its public health benefits are limited in nature. Based on this rationalization, the FP and childhood diarrhea management products were grouped into the primary health basket while the supplementary health products like OTC health and wellness products, which includes items such as feminine hygiene products, eye-glasses and nutrition supplements, were grouped into the secondary health basket.

PRODUCT PARTNERSHIPS

For this pilot, all product partnerships were facilitated by MBPH. This process included identifying potential partners, due diligence to minimize reputational and financial risks for USAID from any of these partnerships. Post this, MBPH facilitated partnerships between ITC and the identified health and pharmaceutical companies in order to introduce the health products manufactured by the latter into the e-Choupal Rural Health pilot program.

The team achieved this by demonstrating to the product partners their potential of expansion within rural markets. As a result of MBPH's efforts, these partners have started to view rural markets in a strategic manner and are accordingly trying to develop their internal approach to address these markets effectively. ITC charges partners an access fee for using the e-Choupal network for distributing their products. The willingness of the partners to pay this fee for accessing the ITC e-Choupal infrastructure for distribution and communication purposes, is a testimony to the value that they attribute to the ITC model. However, some of the partners have been given a partial waiver since the potential revenues from the pilot districts at current levels of demand do not justify the access fee amount. The access fee is essentially used to cover the cost of conducting communication activities at the ground-level as well as for compensating the VHCs for their visits to Choupal Sagars for procurement of health products.

Table 2.1 provides the details of the key partners along with the brands/ products they have introduced in this model. ITC procures these products from the product partners at wholesale prices, transports them to its local distribution points (Choupal Sagars) from where they are purchased by VHCs and other rural retailers at wholesale prices and sold to consumers at their maximum retail price (MRP).

TABLE 2.1: SUMMARY OF PRODUCTS AND PRODUCT PARTNERS

Partner name	Intervention area	Product (Brand)	Maximum Retail Price
Pfizer	Family planning	Oral contraceptive pills (Ovral L and Nordett-21)	Rs. 86 ¹⁰ /-
JK Ansell	Family planning	Condoms (KS Smooth and Sajan)	Tentatively fixed at Rs. 5/- for Sajan and Rs. 10/- for KS Smooth
Medentech	Childhood diarrhea management	Water purification tablets (Aquatabs)	Rs. 1/- per tablet
Royal Hygiene	Feminine hygiene	Sanitary napkins (SheComfort)	Rs. 20/- for a pack of 6
Pfizer	Diarrhea management	ORS (AT FINAL STAGES OF DISCUSSION)	TBD
Vision Spring	Eye care	Reading glasses	Rs. 200/-
Ranbaxy	Wellness/ nutrition	Vitamin-mineral supplement (Revital)	Rs. 80/- for a pack of 10

¹⁰ Though, the MRP of Ovral L is Rs. 86/-, Pfizer is working towards bringing down the effective price for the consumers through trade promotions.

SELECTION OF VILLAGE HEALTH CHAMPIONS

A comprehensive process was put in place by the MBPH team for selection and identification of VHCs. While announcing the requirements in the villages, it was clearly articulated that the program was looking only for women, who were willing to work as community-based health workers and were keen to improve the health outcomes in their respective territories. Potential candidates were identified through the existing network of ITC e-Choupal Sanchalaks, who assisted the program team in providing leads for the potential candidates. The program team asked interested candidates to apply and also collected references from Sanchalaks and village leaders. This was followed by a rigorous interview process, where apart from the potential candidates, their families and specifically the spouses were interviewed. This was done to ensure that the potential VHCs had complete support of their families to start working on this initiative, as this was deemed crucial for their effective performance.

The program selected candidates based on their demographic profile. The following characteristics were considered:

- women who were married and between the age of 28 and 45 years
- whose youngest child was older than 5 years of age
- who were residents of the respective e-Choupal village and
- who had at least middle-school level of education.

The team also assessed the ease with which the women could play the role of VHC by determining whether they had access to public transport, which would allow them to travel to neighboring villages within the coverage area of their e-Choupal, had access to a phone, had the support of their families and were respected in their communities. Finally, the project also assessed the personality traits of each candidate, including their self-confidence, ability to communicate clearly and effectively, and whether they had aspirations to be a self-driven and hardworking entrepreneur. Once selected, the VHCs received intensive training. The training on public health issues was provided by the MBPH team while MART, a rural marketing agency and a program partner on the MBPH project, provided the business skill training to the VHCs. Prior to the start of operation in their respective districts, each VHC had received 15 days of training on key health issues and business skills.

THE E-CHOUPAL RURAL HEALTH INTERVENTION

The ITC e-Choupal model has been designed around the e-Choupal infrastructure and is currently being tested in two districts in UP, Gonda and Chandauli. The program has established a team of 66 VHCs for promoting and selling health products in the Choupal villages. Initially, the intervention model was designed around the distribution capabilities of the e-Choupal procurement network. VHCs were being supplied health products by ITC's procurement agent at the hub-level called Sanyojaks. In line with the changes in the e-Choupal model, the company has changed the way VHCs procure the products due to internal changes within the organization. Specifically, the distribution role has been taken away from the Sanyojaks, who were earlier distributing the products through their vans from the hub to the independent retailers in the villages. Under this new model, VHCs now have to physically visit Choupal Sagar at the hub-level to buy the health products from these marts at wholesale prices. The program ensures that the Choupal Sagar are stocked with the health products selected to be in the primary and secondary product baskets. ITC plans to reimburse the travel cost to the VHCs by clubbing these visits with other regular meetings at Choupal Sagar. The access fee paid by partners

will help compensate the travel costs of VHCs to Choupal Sagar for product procurement, and the MBPH team has already received the consent of the partners for utilizing the access fee for this particular purpose.

VHCs are responsible for promoting and selling the health products in their villages. As mentioned before, the VHCs received intensive training on public health issues as well as business and management skills. In addition to increasing rural communities' access to the intervention products, VHCs are expected to serve as community-based public health workers, create awareness of priority health issues through a communication platform. The VHCs earn margin based income from the sale of the health products in their respective areas. They will soon start getting a nominal amount of money for doing demand generation activities in their areas for creating awareness around the intervention health issues. The money for incentives would come from the access fee which has been charged from the partners firms. The demand generation activities fall into the following three categories:

- Household visits to do one-on-one calls with the prospective customers to create awareness as well as sell products
- Group meetings to create awareness around health issues as well as sell the relevant health products
- Mahila Haats or large community events targeted only at women to create awareness around intervention health issues and do free sampling to induce trials.

The VHCs are expected to hold at least one group meeting per week and the program intends to do at least 200 Mahila Haats¹ per year to create awareness around the health issues as well as generate demand for the intervention products. The program is also working towards assisting VHCs in developing a network with local doctors as well as health workers to help them enhance their credibility in their community.

These VHCs are supervised by the field staff positioned by the program team at the district level. The field staff is managed by the hub-in-charge (HIC) who is an employee of ITC and is responsible for procurement and retail operations at the district level. The HIC reports to the Regional Manager based at ITC's Regional office in UP. While the MBPH team is actively involved in the day to day management of the project, it is working closely with ITC to ensure that ITC staff take ownership of the program and develop systems and capacity to manage it independently in the long run. Ultimately, MBPH's goal is to prove the viability of the model, and once that is established, ITC is committed to scaling up the model to other e-Choupals. The MBPH team is attempting to build a commercially sustainable rural health model that can both be taken to scale and transferred completely to ITC, once proof of concept is established.

¹ Haat means a congregation point in a village and this term is currently used to describe the rural events. Mahila Haat is an event organized under the e-Choupal Rural Health Initiative focused exclusively on rural women.

RESEARCH DESIGN

The principal goal of the pilot program is to increase use of the health products. Hence the program activities are designed to, first, improve the distribution of the products in the intervention areas and, second, promote awareness, knowledge related to health issues as well as the relevant products.

The extent to which these activities will have any impact on consumption patterns is mediated by a host of factors. On the demand side, this includes socio-economic characteristics of the consumers, such as their income, age and gender, as well as their current knowledge and perceptions about the benefits of these commodities, which in turn influence their decision to buy health products, their willingness to pay for health products, and the probability of routine use of the products. Many of the health products being supplied under this intervention are not new to these areas; hence existing brand recognition and preferences are likely to affect responses to the intervention. The level of access that consumers have to these commodities is not simply a function of supply or an economic relationship between price and disposable income; it is also related to social barriers that may prevent potential consumers from purchasing the product. Hence, existing social and cultural norms will be a key determinant of the success of the model. The frequency and depth of exposure to project messages intended to increase use of the health products on the part of the consumers is a key determinant of demand generation for the intervention health products.

On the supply side, consistent availability of the health products through the e-Choupal distribution network and the ability of VHCs to effectively communicate the benefits of the health products and sell them are key factors driving the success of the program. Together, the extent to which the supply of and demand for the products is increased will drive usage levels of the health products and, ultimately, the financial viability of the model. The MBPH team has designed a comprehensive evaluation and research program keeping the above factors in mind.

PROGRAM EVALUATION

The evaluation plan for the pilot program uses a quasi experimental design. The effect of the program will be assessed by comparing the changes in the two intervention districts with a control district, also in UP. The treatment areas consist of a total of 66 villages in the districts of Chandauli and Gonda where the standard ITC e-Choupal program is already operational. The villages in the district of Jagdishpur that have the standard e-Choupal platform but are not a part of the MBPH pilot study, form the control group and none of the intervention health products have been introduced in these villages. Jagdishpur was selected as the control district because it is comparable both in terms of wealth and health indicators to Gonda and Chandauli. To determine the impact of the program, the evaluation will measure the following in both the intervention and control arm:

- a. Changes in knowledge, attitudes, perceptions and use of promoted products among the target audience
- b. Changes in the availability and access of promoted products and brands.

A baseline consumer and retailer survey was conducted to establish the pre-intervention measures of relevant indicators for both intervention and control groups. A similar survey will be conducted at the

end of the pilot period towards the end of 2011, to measure changes over time.

The consumer survey sampled married women between the ages of 18 and 34 years and their husbands. As shown in table 3.1, a total of 1520 respondents were surveyed from each of the three districts using a multi-stage sampling design.

TABLE 3.1: SAMPLE SIZE

Survey	Intervention Area		Control Area
Consumer Survey	Gonda	Chandauli	Jagdishpur
<i>Women</i>	760	760	760
<i>Men</i>	760	760	760
<i>Total</i>	1520	1520	1520
Retailer Survey			
<i>Retailers</i>	185	145	191

In the first stage, 40 villages were selected using systematic random sampling from the list of e-Choupal villages in the district. The second stage included a mapping exercise that was conducted in the selected villages. Each village was divided into hamlets of 30 households each, from which 4 hamlets were randomly selected. A complete listing of the households was conducted within these selected hamlets. The purpose of the listing exercise was to identify households that were eligible to be included in the sampling frame for the survey; specifically households with married men and women between the ages of 18 and 34 years, and children below the age of 5 years. In the third stage, 38 eligible households were selected for interviewing from the sampling frame developed during the listing exercise. The retailer survey was administered at all retail outlets for health products in the villages that were selected in the first stage of the consumer survey. The same survey will be repeated at the end of the project to capture the change over time.

EXPLORATORY RESEARCH

In addition to these baseline surveys, the research team undertook a qualitative study focusing on gauging the perception of the intervention model and understanding current purchase and use patterns related to the proposed secondary health products. FGDs and IDIs were conducted with men and women in the target audience in 3 villages in the 2 intervention districts.

The long-term sustainability of the model depends both on the impact in terms of increased use of the intervention health products, and also on the program partners' opinions of the pilot model in terms of its viability, fit with its objectives, and their interest in continuing with the scale-up of the model. A separate study will assess these factors drawing on information about sales volume, profitability, and ease of implementation in intervention villages from project records and the project management information system.

THE BASELINE REPORT

This report synthesizes key findings from the following studies:

- (1) The baseline survey of consumers and retailers in both arms of the evaluation study, which was designed and implemented with support from Social Research Unit of IMRB, and
- (2) The qualitative study in the intervention districts, which was designed and implemented with support from Purple Audacity.

More information on the data collection methods employed by the two studies, including the sample design of the consumer survey, can be found in annexes A and B respectively.

BACKGROUND CHARACTERISTICS

This section presents background information about consumers and retailers of the health products that are being promoted in the intervention and control regions of the study.

CONSUMER SURVEY

The survey targeted married women between the age of 18 and 34 years and their husbands since this population sub-group is the primary audience for the health products that the pilot program is promoting. The summary statistics for key socio-economic variables for this sub-population, disaggregated by control and intervention areas, are summarized in Table 4.1.

TABLE 4.1: BACKGROUND CHARACTERISTICS OF CONSUMERS

	Treatment	Control
Percent female	50.1	50.2
Age distribution among men		
18-21	2.1	3.6
22-25	24.8	22.7
26-30	42.6	40.6
over 30	30.5	33.1
Age distribution among woman		
18-21	11.3	8.9
22-25	32.8	32.3
26-30	40.1	39.3
over 30	15.7	19.6
Income		
Less than Rs. 1,000	5.0	3.4
Rs. 1,000 to Rs. 2,000	23.1	33.1
Rs. 2,001 to Rs. 3,000	31.7	33.5
Rs. 3,001 to Rs. 5,000	24.6	20.3
Rs. 5,001 to Rs. 10,000	10.9	6.7
Above Rs.10,000	4.2	3.1
No Response	0.5	0.0
Education among men		
Illiterate or no formal education	28.3	29.7
Up to middle school	36.0	43.6
Secondary school	11.8	10.3
Higher secondary school and above	23.8	16.4

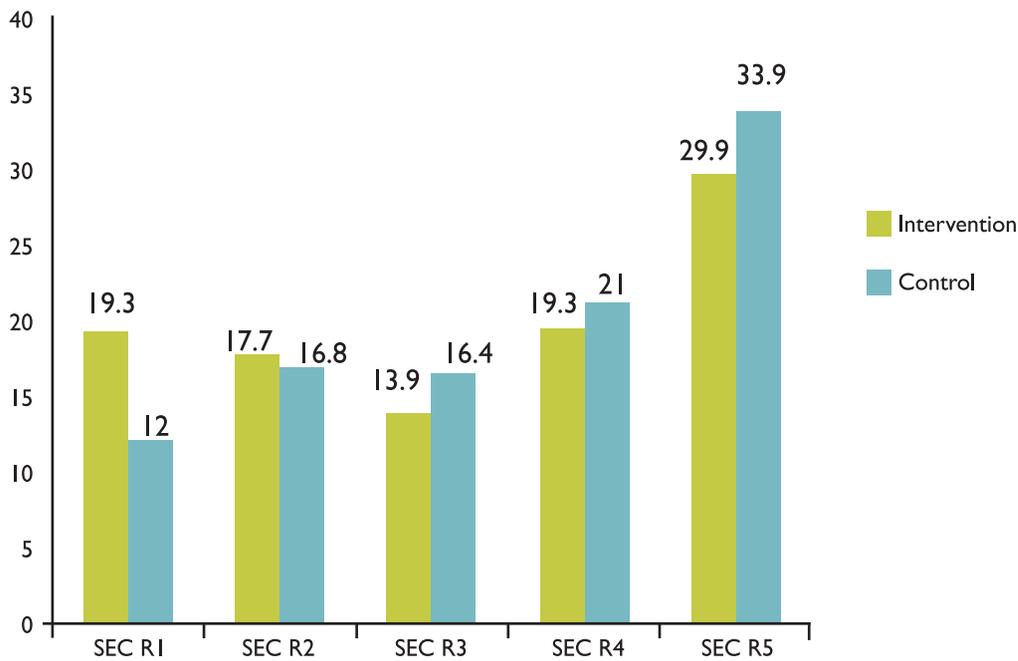
	Treatment	Control
Education among women		
Illiterate or no formal education	59.1	57.0
Upto Middle school	22.0	29.7
Secondary school	7.6	6.0
Higher Secondary and above	11.3	7.4
Occupation among men		
Agricultural sector	43.8	37.1
Unskilled worker/day laborer	29.4	31.1
Small shop owner	7.7	13.0
Manufacturing (skilled and semi skilled)	4.6	3.4
Service sector (private or government)	5.0	4.4
Other	9.5	11.0
Occupation among women		
Housewife	83.0	91.0
Agricultural sector	11.0	5.3
Other	6.0	3.7

In both intervention and control groups, roughly half the respondents were female. The two groups had comparable age profiles among both men and women. Only around 28 percent of men in both the control and intervention districts were illiterate or had no formal education, compared to an illiteracy rate of 57 percent and 59 percent among women in the control and intervention groups, respectively. Most of the women in both arms of the study were housewives and the men were employed in the agricultural sector or as unskilled day labor.

A majority of the households reported total household earnings of less than Rs. 3,000/- per month. Type of house, education and occupation of the chief wage earner were used to classify households into five socioeconomic groups ranging from SEC R1 as the highest and R5¹ as the lowest. Figure 4.1 compares the socio-economic profiles of the control and intervention groups. It shows that the control group had a slightly larger share of households in the bottom three socio-economic groups than the intervention group.

¹² Please refer to ANNEXURE C for an explanation of socio-economic classification in rural areas.

FIGURE 4.1: SOCIO-ECONOMIC PROFILE, INTERVENTION VERSUS CONTROL GROUP

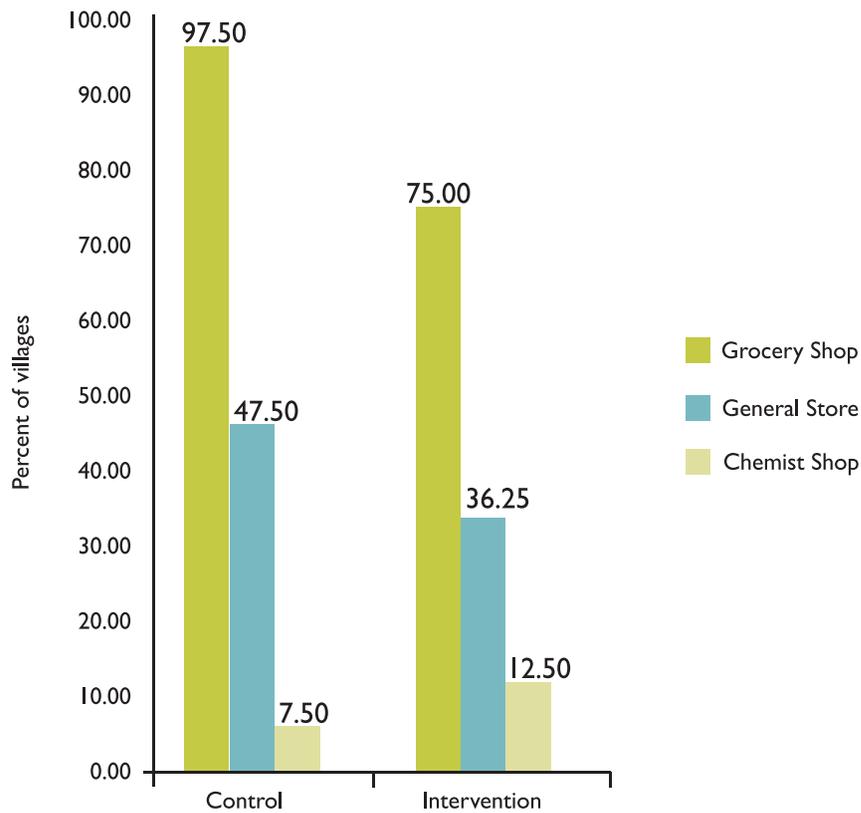


Overall, the intervention and control areas were comparable in terms of the background demographic and socio-economic characteristics of the target consumer population. At the end-line, any differences in profile of the respondents would influence levels of outcomes due to program activities. Therefore, the respondent’s characteristics will be used to “control” for or net out observed differences in profiling variables such as wealth between the two groups in order to ascertain the impact of the pilot program.

RETAILER SURVEY

The purpose of the retailer survey was to gain a better understanding of their stocking and sales patterns with regard to the products to be studied in the ITC baseline study. In each district, 40 villages were selected as primary sampling units for the consumer survey. A complete census of retail outlets was carried out in all these villages. There were primarily three types of retailers: general stores, grocery stores, and chemists. Figure 4.2 shows the percent of villages in the intervention and control area that had each of the three types of retailers. The percent of villages that had a chemist was 12.5 percent and 7.5 percent in the intervention and control areas, respectively.

FIGURE 4.2: ACCESS TO DIFFERENT TYPES OF RETAILERS IN INTERVENTION AND CONTROL VILLAGES



The survey also revealed that all the owners of the shops were men in both the groups; in the intervention area, 13.3 percent of retailers reported that their wives managed the shop in their absence as compared to 9.1 percent in control areas. Hence, the intervention and control areas are comparable in terms of supply-side factors driving access to health products.

FAMILY PLANNING

Improving the supply of FP products and stimulating demand for them are key goals of the ITC e-Choupal Rural Health Initiative. In this section, we synthesize findings regarding the supply and demand for FP products, specifically condoms and OCPs, from the baseline consumer and retailer surveys conducted among the intervention and control groups respectively. The baseline consumer survey measured a range of indicators related to knowledge and use of condoms and OCPs, prevalent attitudes towards these products, brand preferences and barriers to use. The retailer survey documented the supply of condoms and OCPs, as well as perceived demand on the part of the retailers.

AWARENESS ABOUT FP METHODS

For making informed choices about contraception, provision of contraceptive information to the target population is fundamental. In this survey, women and men were asked about their knowledge of nine methods of contraception: OCP, condoms, injectables, IUDs, emergency contraception, male sterilization, female sterilization, and two traditional methods, withdrawal and the rhythm method. Information on knowledge of contraception was collected in two ways. First, respondents were asked to spontaneously mention all the methods of contraception that they had heard of. For methods not mentioned spontaneously, the interviewer described the method and probed further to see if the respondent recognized it. In addition, a provision was made in the questionnaire to record any other methods named spontaneously by the respondents.

TABLE 5.1 COMPARES KEY INDICATORS RELATED TO AWARENESS AND USE OF FP IN THE INTERVENTION AND CONTROL AREAS.

Indicators	Intervention Areas	Control Areas
Percent of respondents who are aware of any FP method	97.4	96.0
Percent of respondents who are aware of modern FP methods (temporary and permanent)	62.2	59.7
Percent of respondents to have ever used any FP method	39.2	30.7
Percent of respondents currently using a temporary FP method	18.8	16.9
Percent of respondents currently using a modern temporary FP method	11.7	15.9
Percent of male respondents currently using condoms	15.6	19.5
Percent of female respondents currently using OCPs	1.9	4.5
Intention of future use among current users	15.7	14.2
Intention of future use among non-users/never used	10.5	7.7
Percent of retailers who stock condoms	23.6	24.6
Percent of retailers who stock OCPs	9.3	5.2

The first indicator in the table shows that respondents in both arms of the study had a high level of awareness of modern FP methods based on the spontaneous responses. Respondents to the survey were asked to spontaneously mention all methods of contraception that they had heard of. Approximately 64.6 percent of respondents in the intervention arm and 60.2 percent of respondents in the control arm were aware of one or more FP methods; the percent who knew about at least one modern method, which includes both temporary methods like OCPs and condoms as well as permanent methods like sterilization, was 62.2 percent and 59.7 percent in the two groups. Figures 5.1 and 5.2 disaggregate these results further by gender. The first two sets of bars from the top compares the percentage of respondents who were aware of any modern versus traditional FP methods. The percent of men who knew any modern FP method in the intervention and control areas was 63.8 and 61.5, respectively; the corresponding percentage for women was 60.5 and 57.9. In comparison, fewer than 10 percent of the respondents were aware of traditional methods in any of the groups.

FIGURE 5.1: SPONTANEOUS AWARENESS ABOUT FP METHODS AMONG MEN

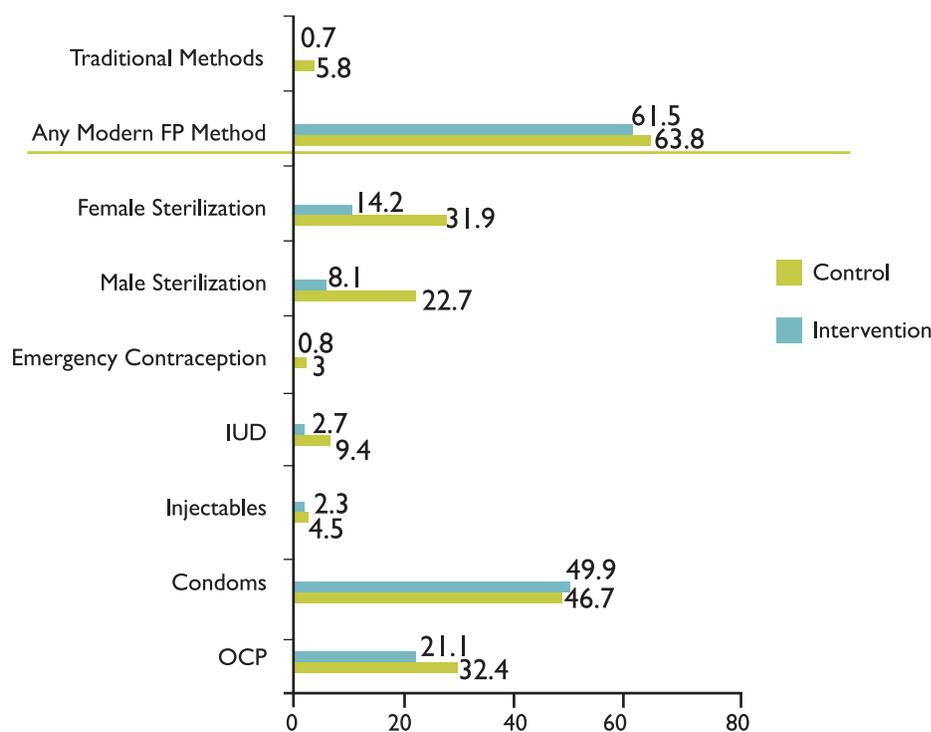
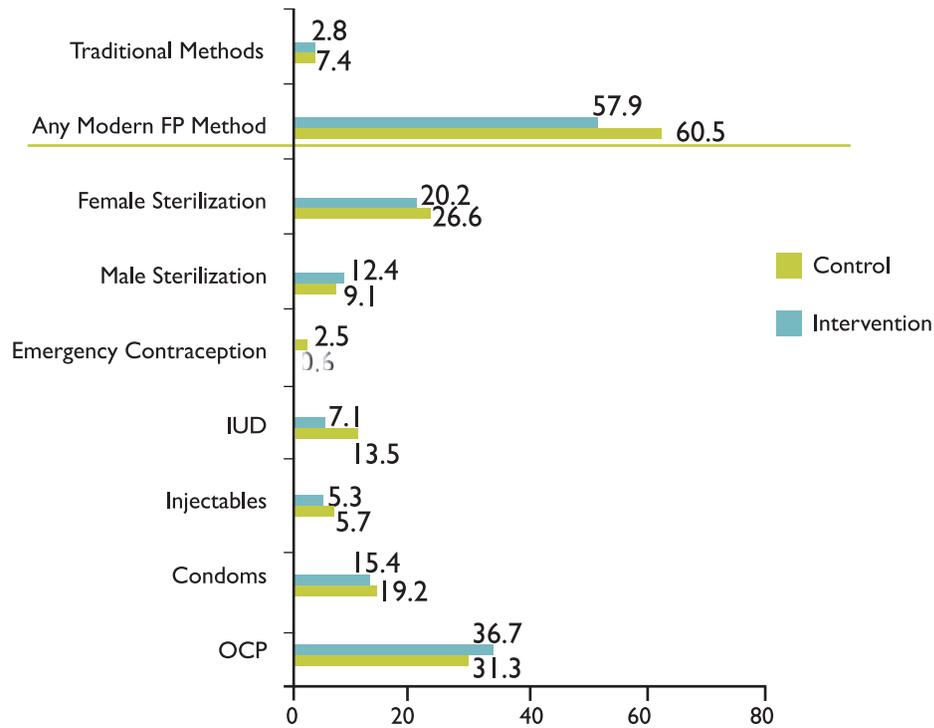


FIGURE 5.2: SPONTANEOUS AWARENESS ABOUT FP METHODS AMONG WOMEN



Below the red line, both the graphs show the percent of respondents who knew specific types of modern FP methods. Approximately 50 percent of the male respondents reported knowing about condoms in the control area, compared to 47 percent of men in the intervention area. The second most frequently cited method by men were OCPs; 32.4 percent and 21.1 percent of men in the intervention and control areas respectively listed it as a common FP method. While sterilization was also relatively well-known, nearly double the percentage of men in the intervention area listed male and female sterilization as common FP methods than in the control area. Among women, OCPs were the most well-known FP method, but fewer than 40 percent of women mentioned it in both groups. Other relatively well known methods were female sterilization and condoms. Fewer than 3 percent of women mentioned emergency contraception in the two groups.

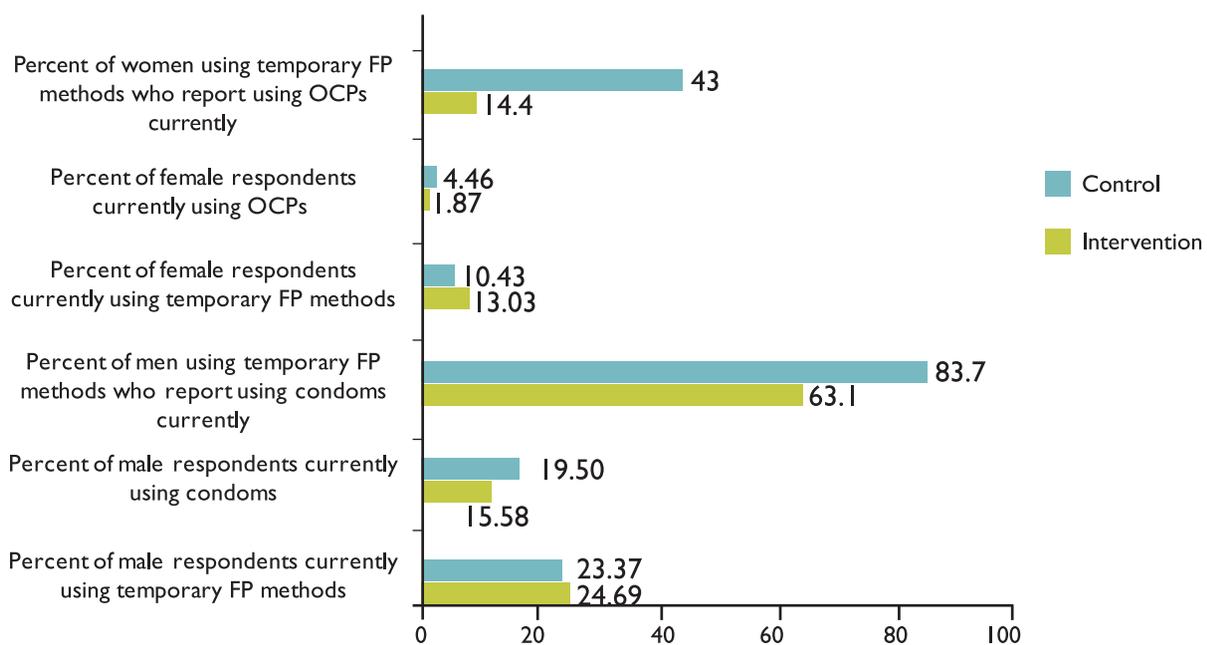
The survey also assessed awareness using a second question that provided greater assistance to the respondents to remember different FP methods. Specifically, the interviewer described FP methods that the respondent had not spontaneously mentioned in order to gauge the respondent’s familiarity with them. Over 90 percent of the respondents were aware of at least one modern method when they were prompted by the interviewer in this way.

In sum, these results suggest that the target populations for this pilot study have a reasonably high level of awareness of modern FP methods in general.

USE OF FP METHODS

The high levels of spontaneous awareness about FP methods, however, were not accompanied by high rates of use. Table 5.1 lists the percent of respondents who report having used any FP method at any point as well as those who are currently using any FP method. This includes all methods, modern and traditional. A relative small fraction of the respondents – 39.2 percent and 31.7 percent in the intervention and control groups, respectively – reported ever having used any FP method. Less than a fifth of the respondents were currently using some form of temporary contraception.

FIGURE 5.3: TYPES OF FP METHODS CURRENTLY BEING USED BY RESPONDENTS



The pilot program focuses on promoting condoms and OCPs. Therefore the survey included questions to assess current patterns of use of condoms among men and OCPs among women. Figure 5.3 shows these results. Among women in the sample, the percentage that reported using a temporary method of FP currently, which includes both modern and traditional methods but excludes sterilization, was 10 percent and 13 percent in the control and intervention areas respectively. Among women using temporary methods, a much higher fraction reported using OCPs in the control area (43 percent) compared to the intervention area (14.4 percent). Similarly, the percent of current OCP users in the whole sample of women was higher in the control area (4.5 percent) compared to the intervention area (2 percent).

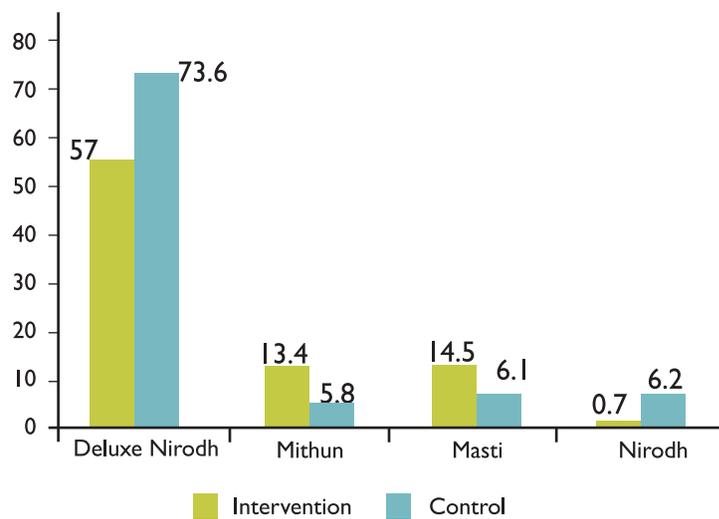
Use of condoms was similarly higher among men in the control area compared to men in the intervention area, but the gap was smaller than amongst women. Approximately a quarter of male respondents in both groups reported using temporary FP methods at the time of the survey. The percent of men currently using condoms were 84 percent and 63 percent in the control and intervention areas, respectively. Current condom users comprised 20 percent and 16 percent of the total sample of men in the control and intervention areas.

Overall, these results underscore the large gap between awareness of FP methods and their use. While over 95 percent of respondents in both areas are aware of FP methods, approximately the same share of respondents have never practiced any FP method in both groups. Less than a fifth of the men in the two groups are currently using condoms; while usage rate of OCPs was even lower.

SOURCES AND BRANDS OF CONDOMS AND OCPs

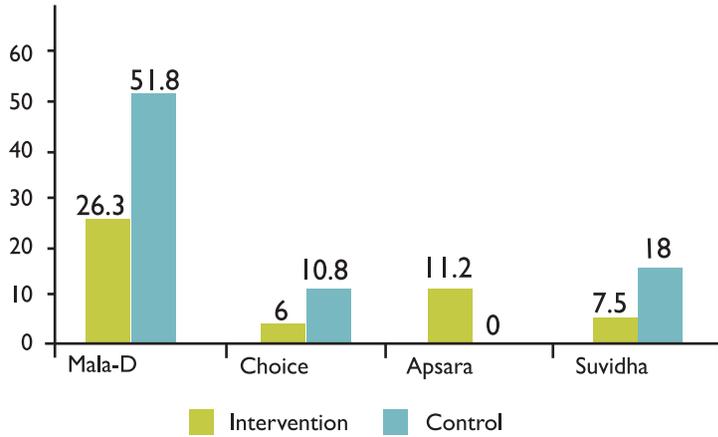
The chemist was the primary source for condoms among men and OCPs among women; 66 percent and 63 percent of men reported buying condoms from chemists in the intervention and control areas respectively while 49 percent and 53 percent of women referenced chemists as their supplier in the intervention and control groups, respectively. It is interesting to note that only 10 percent of the villages in Gonda and 15 percent of villages in Chandauli had chemist shops. Women also reported purchasing OCPs from auxiliary nursing and midwifery workers (ANMs) and Anganwadi workers. In Gonda, 4 percent of women reported procurement of OCPs from ANMs, while in Chandauli, 8.1 percent of women procured products from ANMs as compared to more than 20 percent of women procuring OCPs from ANMs in Jagdishpur. Survey findings point to heavy reliance of rural women on public health / service delivery agents for public health products and clearly point out the importance of community-based agents for increasing access to relevant public health products in rural markets.

FIGURE 5.4: LEADING BRANDS OF CONDOMS AMONG CURRENT MALE USERS



The most common brand of condoms was Deluxe Nirodh (Rs.3/- per pack), while Mala-D (Rs. 3/- per pack) was the most widely used OCP among current users of the two methods. Both the products had much greater market share in the control area than in the intervention area, as shown in Figures 5.4 and 5.5, respectively. Deluxe Nirodh was mentioned by 74 percent of the men in the control area compared to 57 percent in the intervention area. Approximately 52 percent of the women in the control area named Mala-D as a brand that is commonly used, compared to only 26 percent of women in the intervention area.

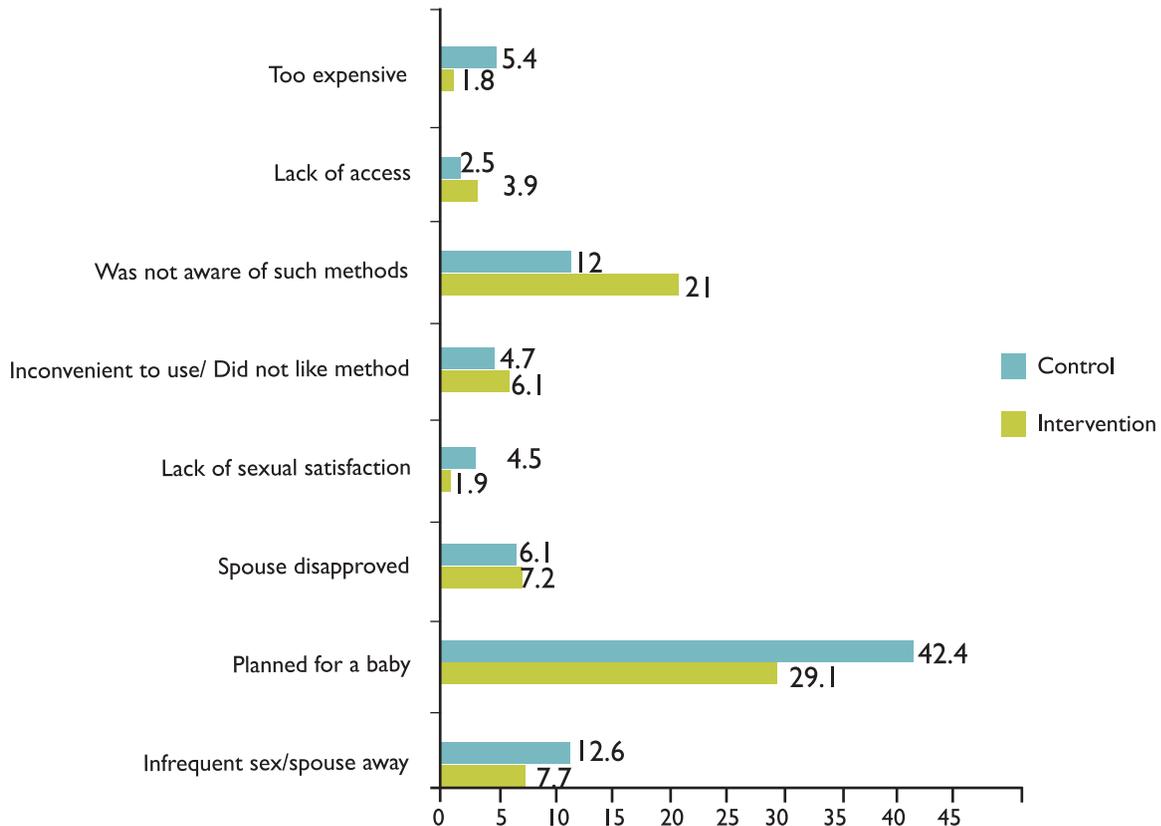
FIGURE 5.5: LEADING BRANDS OF OCP AMONG CURRENT FEMALE USERS



REPORTED BARRIERS TO USE OF FP

The survey included a range of questions that explored the potential causes for the knowledge-usage gap. Respondents who had either never used or were currently not using contraception were asked to explain why. The most commonly cited reasons for not using FP by those in this group are shown in Figure 5.6.

FIGURE 5.6: LEADING REASONS FOR NOT USING CONTRACEPTION



A sizeable portion of the respondents, about 29 percent in the intervention districts and 42 percent in the control district, were attempting to conceive a child. A much higher share of the respondents in the control area were attempting to conceive compared to the intervention area, despite them having similar awareness and usage patterns. Given the age group of the respondents, who were all in the 18 to 34 year range, this was not surprising. However, all the respondents selected for the survey had at least one child below the age of 5 years, and more than 60 percent of the respondents in both the control and intervention areas had children below the age of 2 years. The fact that a large portion of the respondents were attempting to conceive at the time of the survey does raise concerns about adequate birth spacing, indicating the need for programmatic interventions such as behavior change communication (BCC) on healthy motherhood practices.

CONSUMER PERCEPTIONS ABOUT ACCESS TO CONDOMS AND OCPs

The survey included questions to gauge perceptions about access to FP methods among those who reported having used them. Availability of condoms appeared to be a bigger problem in the intervention areas than in the control areas; while 58 percent of male respondents in the intervention area disagreed with the statement that condoms were easily available in their village, the corresponding figure in the control area was 26 percent. Men in the intervention areas expressed greater hesitation to purchase condoms from a local vendor for fear of hurting their own reputation; 41 percent of men in the intervention area expressed this sentiment, compared to only 14 percent of men in the control area. Lack of affordability was a concern for 1.8 percent and 5 percent of the respondents in the control and intervention areas, respectively.

With respect to OCPs, 28 percent and 38 percent of women in the intervention and control areas respectively answered that OCPs were easily available in their villages. The fraction of women who expressed hesitation to purchase OCPs over the counter in the intervention area (46 percent) was double that of those in the control area (20 percent). A minority of the women – between 37-42 percent in both intervention and control districts stated that they could afford to purchase the brands that were available. On several questions that aimed to assess knowledge about the level of protection afforded by OCPs as well as their side effects, nearly half the women opted to neither agree nor disagree with the statement provided in both control and intervention districts. This suggests considerable lack of knowledge about the benefits and proper use of OCPs.

Overall, limited access and social taboos surrounding the purchase and use of condoms and OCPs emerged as key barriers to their use rather than affordability.

SUPPLY-SIDE BARRIERS TO USE

Both the quantitative and qualitative studies also revealed limited consumer access to contraceptives and other public health products primarily due to low stocking at the retail outlets. About 23.6 percent of retailers in intervention areas reported that they stocked condoms, which was comparable to the control area where 24.6 percent of retailers surveyed stocked condoms. Nearly 89 percent and 94 percent of retailers reported never having stocked OCPs in the intervention and control areas, respectively. Chemists were reported to be the primary source for condoms and OCPs by the consumers; however, the number of chemists stocking OCPs and condoms in these areas remains very low.

The findings from the retailer survey reiterate the view expressed by consumers about the limited supply of condoms and OCPs. The pilot program will attempt to fill this gap by improving the supply of both products, while also enhancing greater demand for them through education and outreach activities.

WILLINGNESS TO PAY AND PRICE SENSITIVITY MEASUREMENT

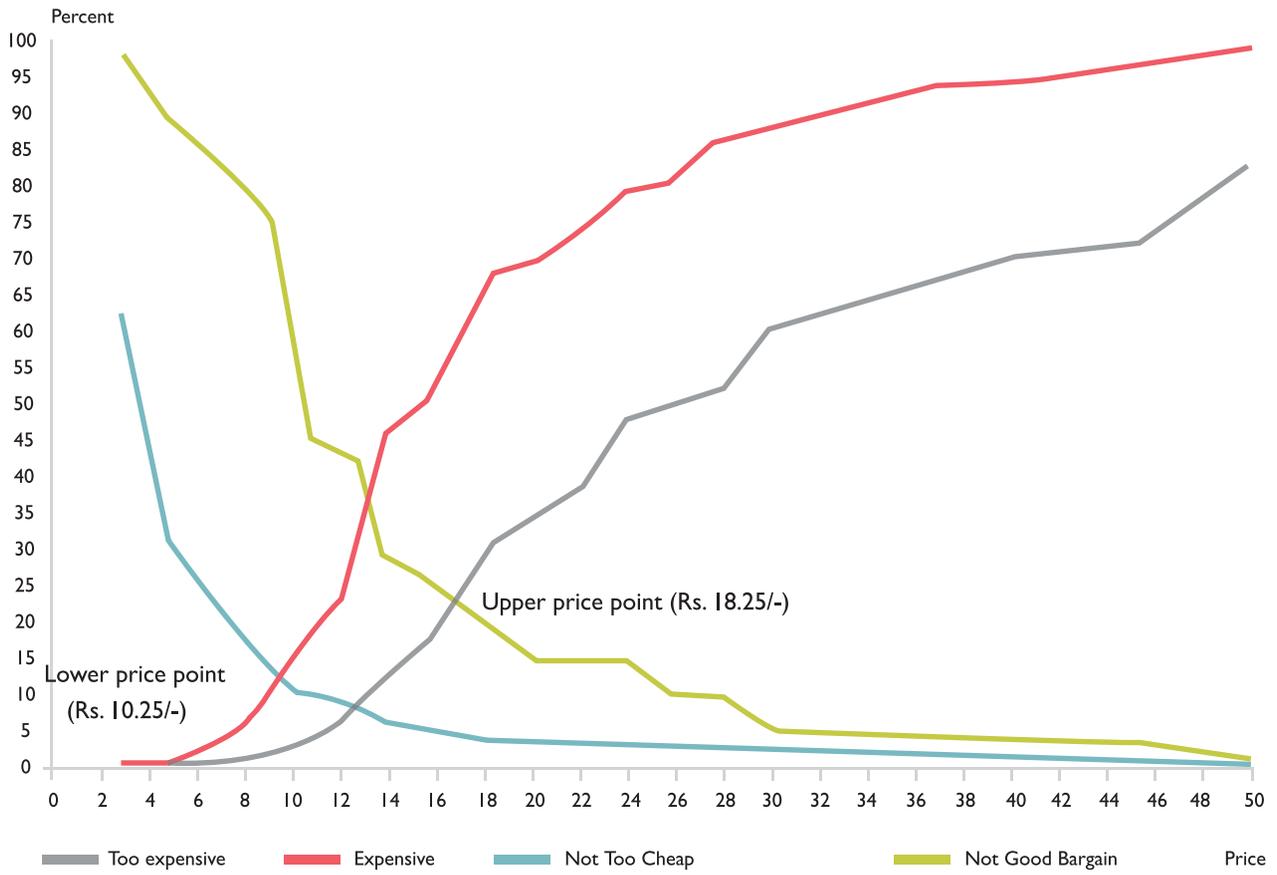
Van Westendorp's price sensitivity meter was used for determining consumer price preferences for OCPs. As per the model, four standard price related questions were asked to the consumers to gauge their preference for various price points for OCPs :

- At what price would they consider the product to be so expensive that they would not consider buying it? (Too expensive)
- At what price would they consider the product to be priced so low that they would feel the quality could not be very good? (Too Cheap)
- At what price would they consider the product starting to get expensive, so that it is not out of the question, but they would have to give some thought to buying it? (Expensive/High Side)
- At what price would they consider the product to be a bargain—a great buy for the money? (Good Bargain)

The responses of these questions were then evaluated as a series of four cumulative distributions, one distribution for each question. The cumulative frequencies were plotted, taking proportion of respondent on the Y axis and price on the X axis. The cumulative frequencies for "too cheap" and "good bargain" were inverted in order to get the intersection points. As is evident from Figure 5.7, the lines in the graph indicate "not too cheap" and "not a good bargain". The intersection of "not too cheap" and "expensive" provides the lower bound of an acceptable price range, as shown in Figure 5.7. Similarly, the intersection of the "too expensive" and "not a good bargain" lines can be viewed as the upper bound of an acceptable price range. Further, the curve formed by the lines "too expensive" and "not a good bargain" provides the buying curve and it maximizes at the upper bound, indicating that the demand maximizes at this price for the particular product. In other words, the proportion of respondent willing to buy maximizes at the upper bound of acceptable price.

Fig 5.7 indicates that the lower bound of an acceptable price was Rs. 10.25. For the upper bound, the lines "too expensive" and "not a good bargain" intersects at Rs. 18.25. This shows that the buying curve maximizes at Rs. 18.25. It indicates that the proportion of respondent willing to buy maximizes at Rs. 18.25, revealing demand optimization at this price.

FIGURE 5.7: PRICE SENSITIVITY CHART FOR OCPS



DIARRHEA MANAGEMENT

Diarrhea is among the top 5 causes of death among infants and children in India. Diarrheal disease accounts for nearly 300,000 deaths per year among children under the age of 5¹³. According to NFHS 2005-06, only 39 percent of children under 5 years with diarrhea in the two weeks before the survey received some kind of ORT. About 26 percent were treated with a solution prepared from ORS packets and 20 percent received gruel. Approximately 16 percent received antibiotics, which are not normally recommended for treating childhood diarrhea. More than one-quarter did not receive any kind of treatment. Given that diarrhea is both manageable and curable, these statistics are alarming. Hence, diarrhea management products were included in the basket of primary products for the MBPH ITC e-Choupal pilot.

This section presents findings from the consumer and retailer baseline surveys pertaining to diarrhea management. In the consumer survey, the diarrhea related questions were administered to the women in the sample, who were all between the ages of 18 and 34 years and had children under the age of 5 years.

DIARRHEA INCIDENCE

The reported incidence of diarrhea was higher in the intervention area than in the control area, as shown in table 6.1. Women respondents were asked about any episodes of diarrhea experienced by their children under the age of 5 in the recent 3 months. Incidence measured in this way was 19 percent and 13 percent in the intervention and control areas, respectively.

TABLE 6.1: KEY INDICATORS FOR DIARRHEA MANAGEMENT

Indicators	Intervention Areas	Control Areas
Number of children below 5 years of age	2545	1388
Incidence of diarrhea in the 3 months prior to the survey (%)	18.9	12.7
Knowledge of ORS among all respondents (based on spontaneous response) (%)	17.9	19.5
Reported use of ORS in the most recent diarrhea case (%)	36.2	43.3

¹³ <http://www.ncbi.nlm.nih.gov/pubmed/21075444>

TREATMENT PRACTICES

Women who reported that one of their children had experienced diarrhea recently were asked about the treatment received by such children. A high percent of the women reported that they took the child to a doctor in both the intervention (79 percent) and the control (81 percent) areas as shown in Figure 6.1. In contrast, a much lower percent of the respondents appear to be adopting diarrhea management practices at home. Less than half the respondents reported having used ORS; the percent of women who gave ORS to the child suffering from diarrhea was 43 percent and 36 percent in the intervention and control areas, respectively. Figure 6.2 shows the most common providers from whom ORS was purchased. A majority of the women in both groups bought ORS from private sector providers. Approximately 38 percent of respondents in the control areas and 41 percent in the intervention area accessed ORS from private doctors and clinics, while private hospitals were responsible for supplying 23 percent and 18 percent of the cases in the control and intervention areas respectively. Only 6 percent of the respondents mentioned accessing government infrastructure for procurement of ORS in the intervention districts as compared to 11 percent in the control district.

FIGURE 6.1: TYPE OF TREATMENT SOUGHT FOR DIARRHEA

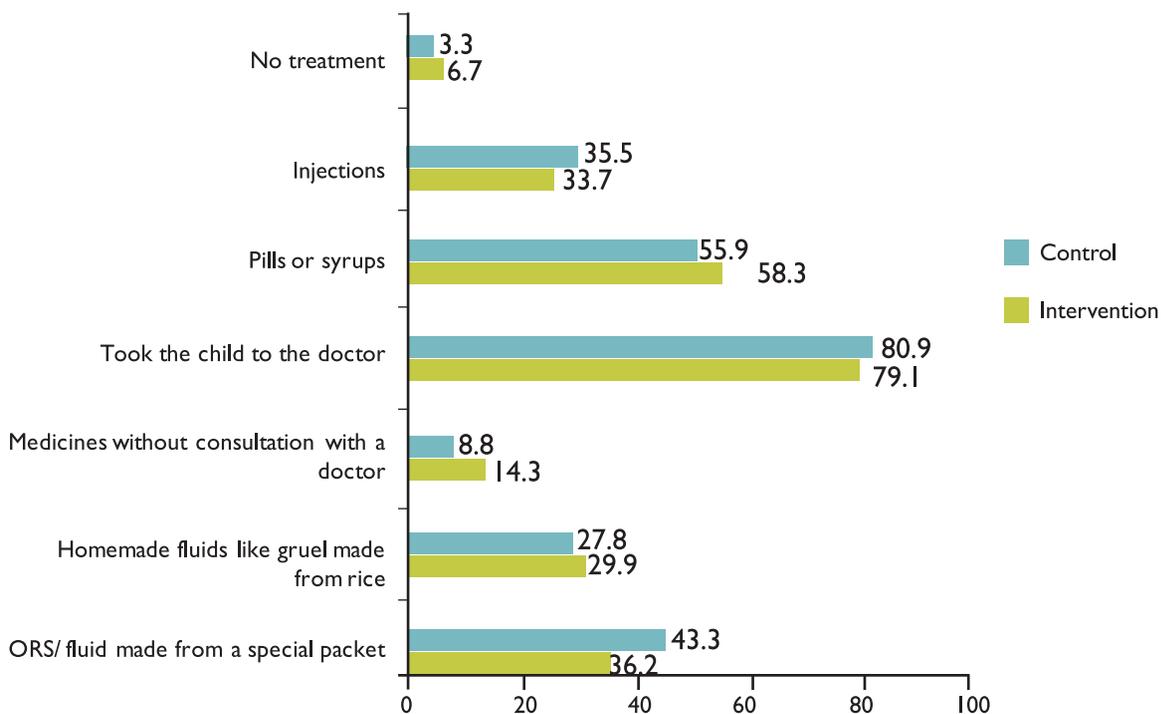
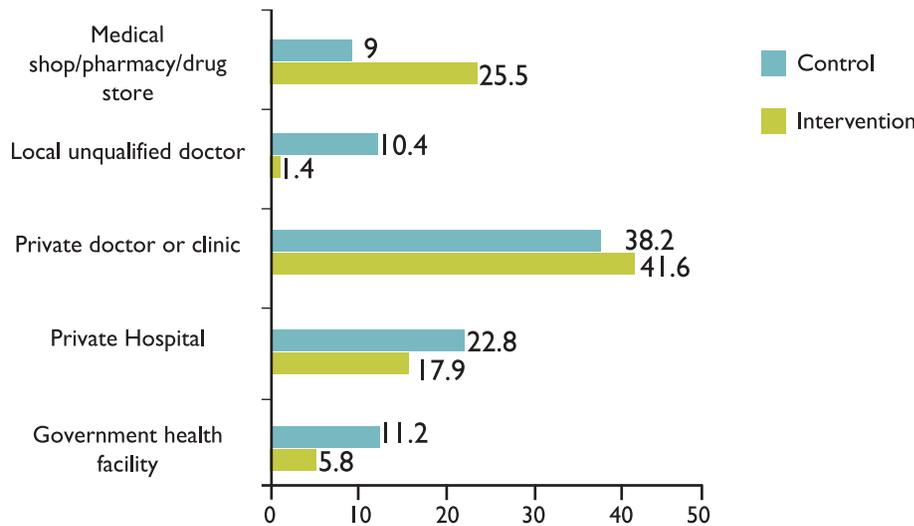


FIGURE 6.2: SUPPLIERS OF ORS



As is evident from figure 6.1, apart from ORS, many respondents reported giving children homemade fluids. However, Figures 6.3 and 6.4 shows that a vast majority of the women reported having either reduced or held constant the amount of food and water that was given to the child suffering from diarrhea. These findings suggest that more information and education is needed to promote diarrhea management practices among mothers in this community, at least on keeping the food and water intake at the same level, if not increasing it.

FIGURE 6.3: REPORTED WATER INTAKE AMONG CHILDREN WITH DIARRHEA

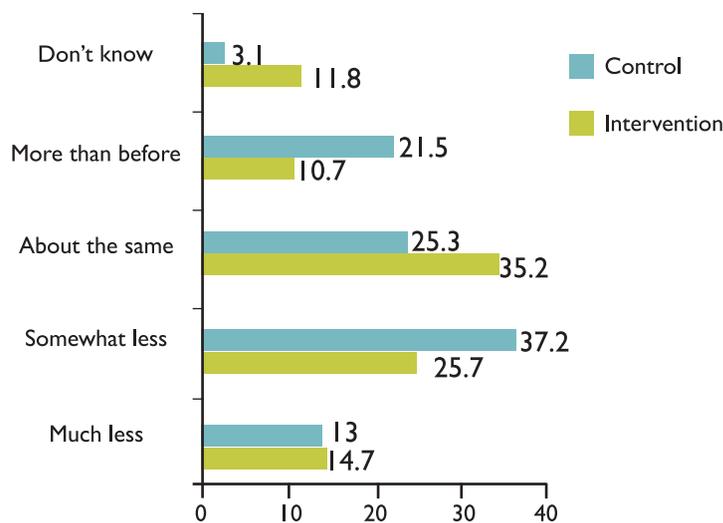
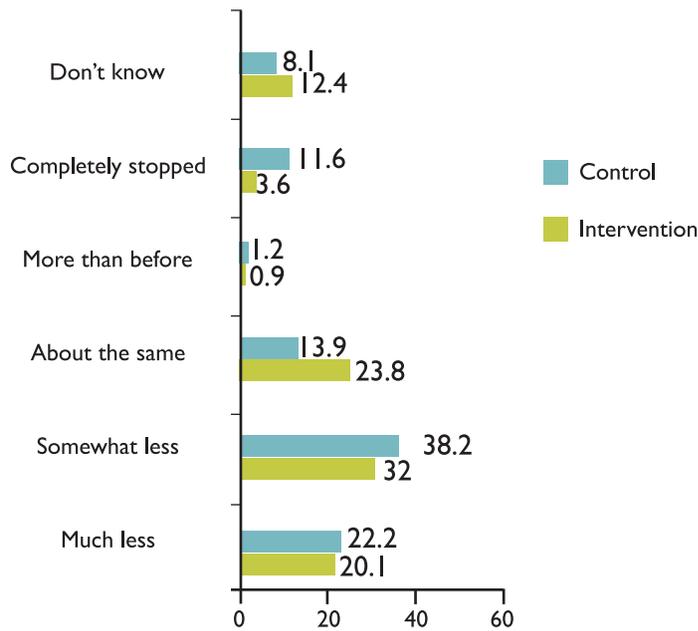


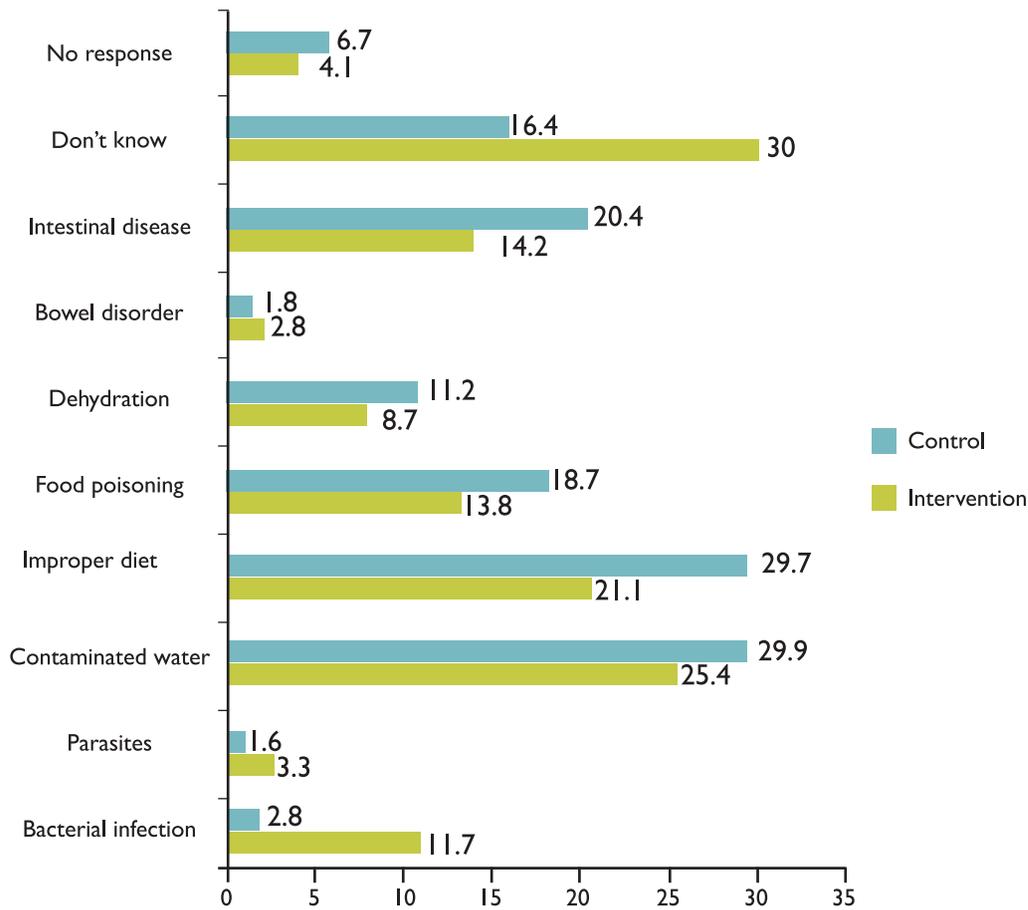
FIGURE 6.4: REPORTED FOOD INTAKE AMONG CHILDREN SUFFERING FROM DIARRHEA



KNOWLEDGE ABOUT DIARRHEA CAUSES, SYMPTOMS, PREVENTION METHODS, AND TREATMENT

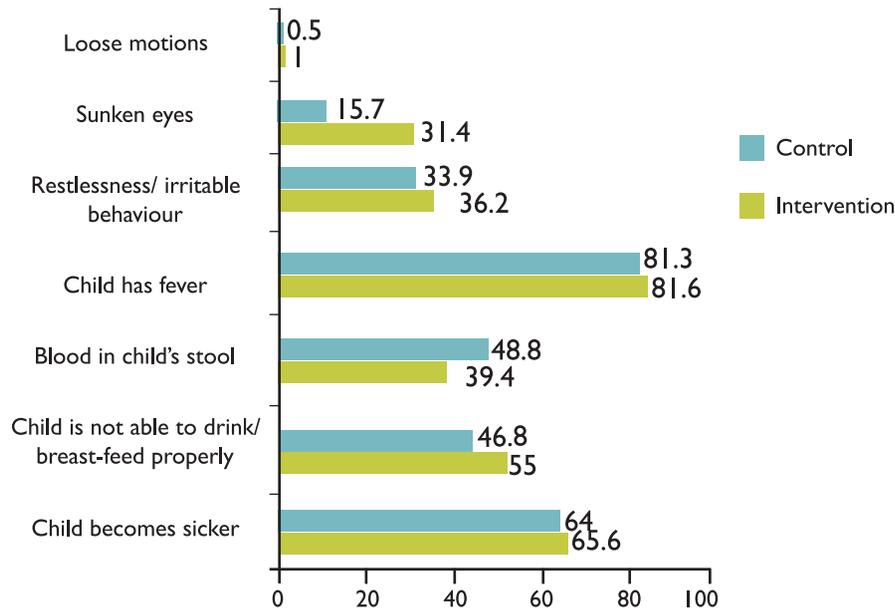
While the questions about treatment given to children with diarrhea was only asked of respondents whose child had experienced a diarrhea episode in the past three months, all women in the sample were asked a range of questions to test their knowledge about diarrhea causes, symptoms, treatment options, and prevention strategies. The objective of asking these questions was to check whether caregivers had adequate knowledge of prevention steps, danger signs of diarrhea and ORT being the first line of treatment.

As far as knowledge of causes of diarrhea was concerned, approximately 30 percent of respondents in the intervention areas and 16 percent in the control area admitted to not knowing about the causes of diarrhea. Figure 6.5 mentions the most frequently cited reasons, which include contaminated water, poor diet, intestinal diseases and food poisoning.

FIGURE 6.5: KNOWLEDGE ABOUT CAUSES OF DIARRHEA

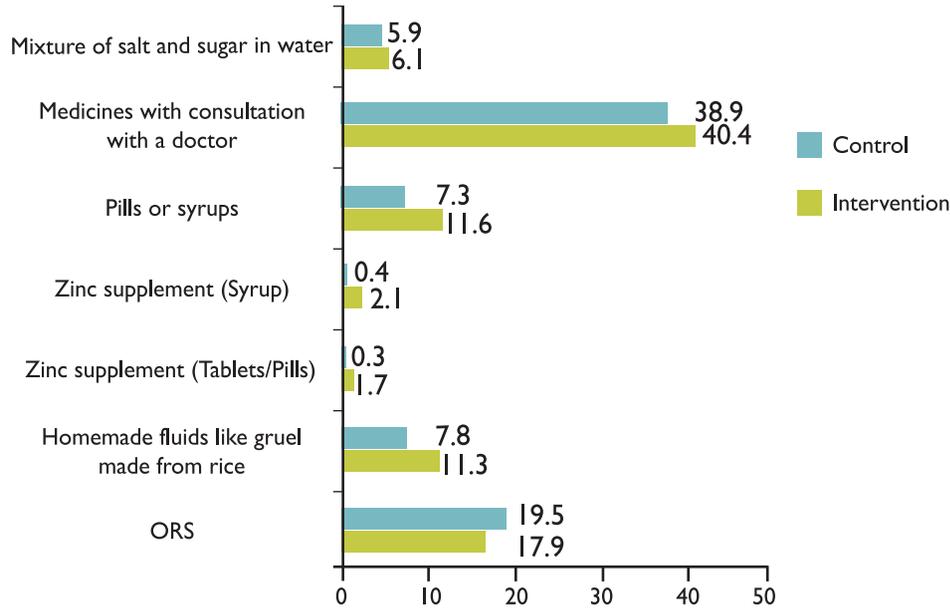
Most women cited fever as the most common symptom for diarrhea, while surprisingly loose motions were cited as a reason by a negligible number of women. Overall, the knowledge of critical symptoms of diarrhea was moderate among caregivers.

FIGURE 6.6: KNOWLEDGE ABOUT SYMPTOMS OF DIARRHEA



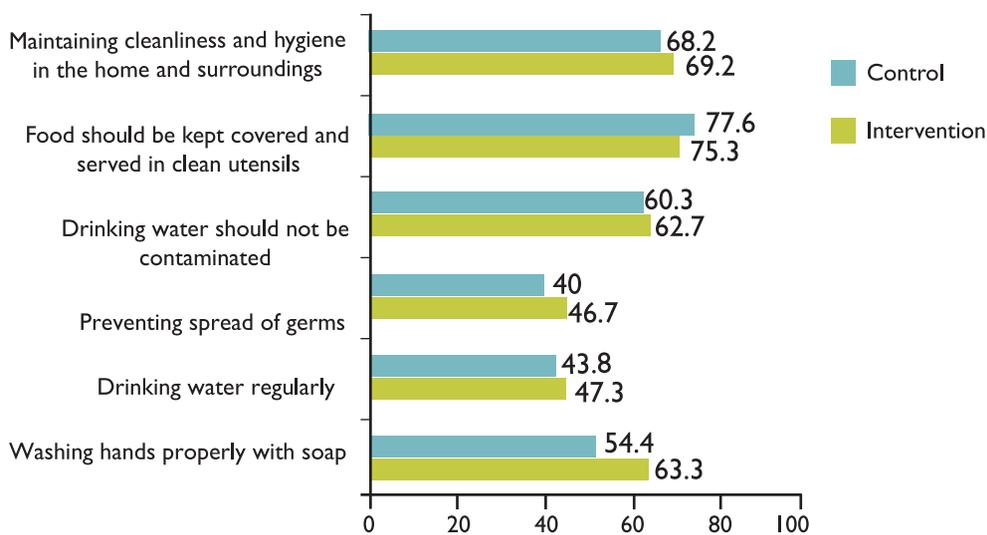
The knowledge that ORT should be used as the first line of treatment for diarrhea was low among all the caregivers, with only 11 percent mentioning use of home-made fluids for treatment of diarrhea and only 6 percent mentioning use of mixture of salt and sugar in water for hydrating the children. Surprisingly, as shown in figure 6.7, seeking medication following a consultation with a doctor was the most often cited treatment response by the caregivers. Fewer than 20 percent mentioned ORS, and less than 2 percent mentioned zinc supplements in both groups. This further corroborates the finding from the responses of the sub-sample of women with children who had diarrhea in the recent past that seeking medical treatment is viewed as the only proper response to diarrhea. As mentioned earlier, awareness about home-based diarrhea management solutions, which can both complement care from a provider as well as be a temporary substitute (if seeking care from a provider is not an immediate option), is low. It also points to the potential over-use of antibiotics to treat childhood diarrhea. It also points out to the need for programmatic intervention to promote ORT as the first line of treatment for children suffering from diarrhea.

FIGURE 6.7: KNOWLEDGE ABOUT TREATMENT OF DIARRHEA



As is evident from Figure 6.8, knowledge levels about diarrhea prevention seemed to be quite high in both the intervention and control groups. Specifically, the mention of healthy behaviors like hand-washing, ensuring safety of drinking water, protecting food from contamination etc., was high in both the intervention and control groups.

FIGURE 6.8: KNOWLEDGE ABOUT WAYS TO PREVENT DIARRHEA



Overall, the findings suggest that fostering greater awareness about prevention steps, danger signs of diarrhea, and especially the use of ORT including ORS for diarrhea management should be the focus of educational outreach services provided by the pilot program through the VHCs.

RETAILER STOCKING PATTERNS

The retailer survey primarily attempted to assess the extent to which the retail outlets in the intervention and control areas stocked ORS. The percentage of retailers who sold ORS was lower in control areas (6.3 percent) as compared to intervention areas (14.1 percent). Low demand was the most commonly cited reason by almost 60 percent of the retailers in the intervention and control areas for not stocking diarrhea management products. This is in line with the reported behavior of consumers, who typically take their child to see doctors. Only a small fraction of the respondents appear to buy diarrhea management products directly from retailers.

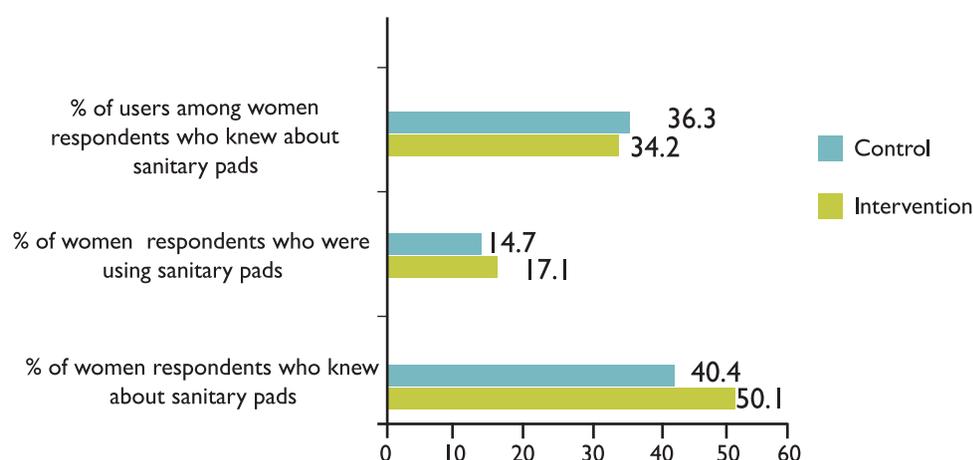
SECONDARY HEALTH COMMODITIES

The primary health basket promoted by the MBPH ITC e-Choupal pilot focuses on FP and diarrhea management. In addition, the pilot is also enabling VHCs to distribute a set of secondary health products, which includes sanitary napkins, pregnancy kits, OTC medicines, a range of wellness products, water purification tables and hand-washing soap. To better understand consumer and retailer behavior vis-à-vis these products, questions pertaining to their sale and consumption were included in the consumer and retailer quantitative baseline. In addition, the qualitative study conducted among focus groups explored demand-side factors influencing the purchase of these secondary health products. In this section, we present findings from these studies.

KNOWLEDGE AND USE OF SANITARY PADS

In the case of sanitary pads, only female respondents were asked about their knowledge and use of the product. It is evident from Figure 7.1 that slightly more than a third of the female respondents in the survey had heard of sanitary pads. Less than half of those who had heard about sanitary pads had used them. Usage rate among all female respondents was 17 percent and 15 percent in the intervention and control groups respectively. The most common brands used included Kotex, Whisper and Stayfree.

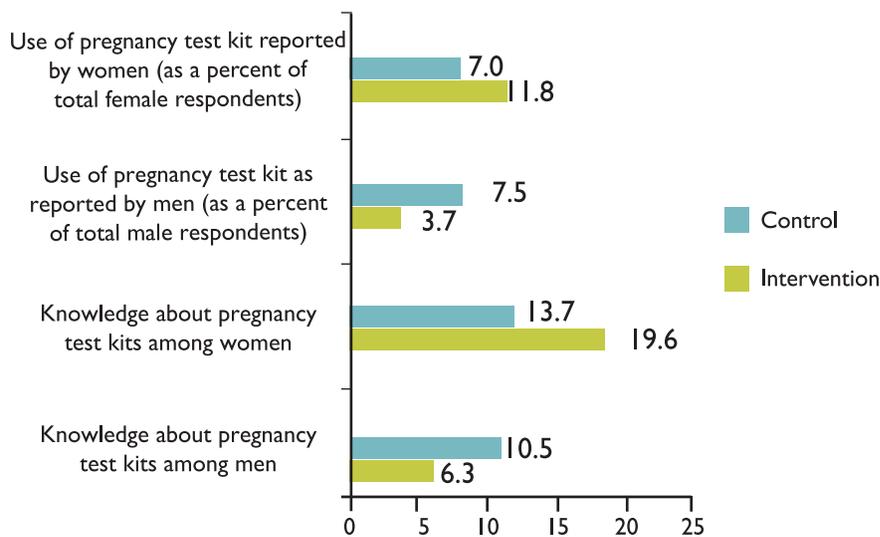
FIGURE 7.1: KNOWLEDGE AND USE OF SANITARY PADS AMONG WOMEN



KNOWLEDGE AND USE OF PREGNANCY TEST KITS

Similar issues emerged in the case of self-administered pregnancy tests. Both men and women were asked about knowledge and use of pregnancy testing kits; the results are shown in figure 18. Among men, 11 percent of respondents in the control group and 6.3 percent in the treatment group knew about pregnancy kits; the comparable figures among women were higher at 14 percent and 20 percent respectively. However, reported use by both men and women was lower, with the two genders providing conflicting information. A higher fraction of men in the control group (7.5 percent) reported use of pregnancy kits by their partner than men in the intervention group (3.7 percent). The pattern was reversed among women, with 12 percent of women in the intervention group reporting use of pregnancy kits compared to 7 percent in the control group. Despite this inconsistency, it was evident that both knowledge and use of pregnancy kits among both intervention and control groups was low.

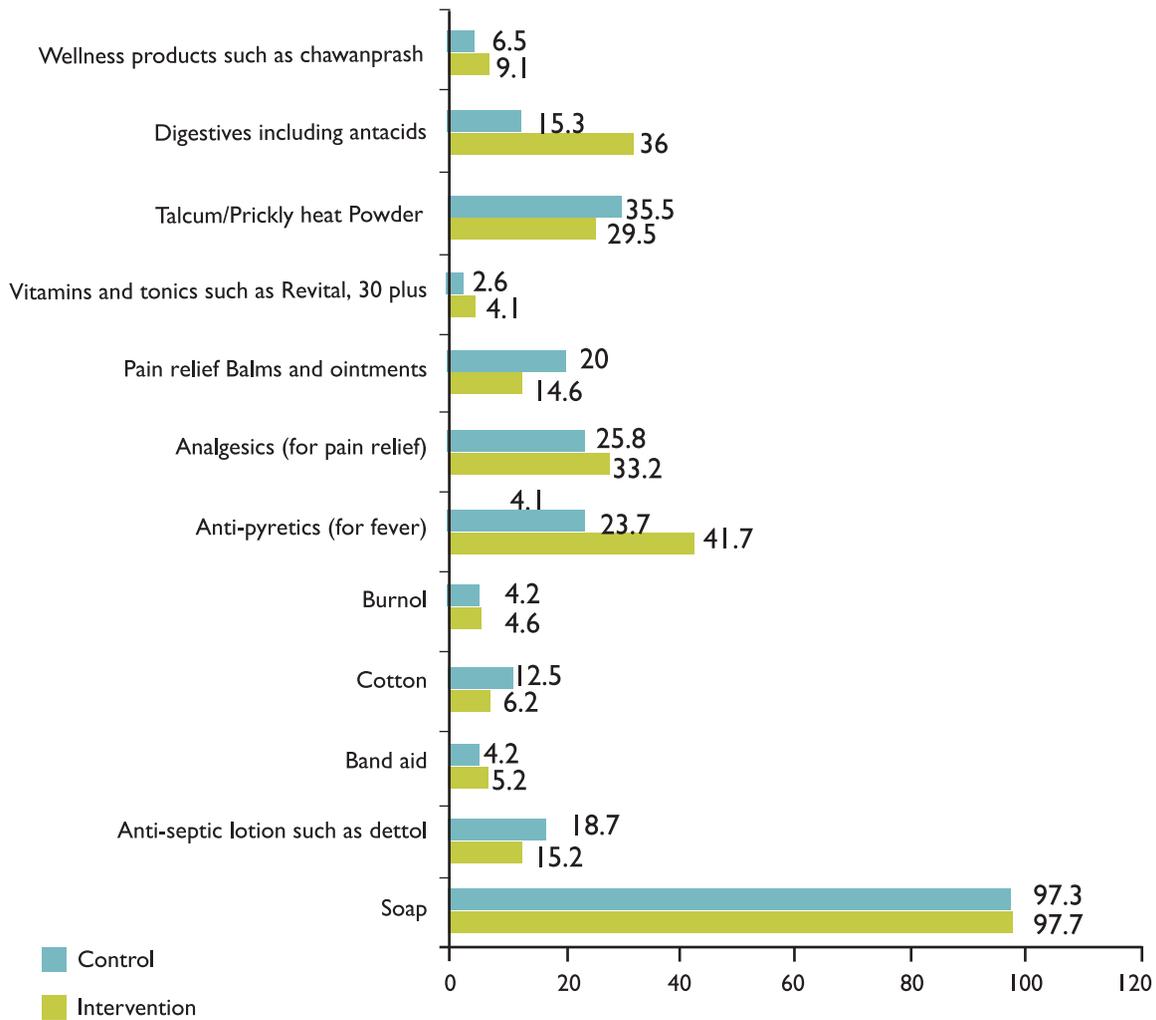
FIGURE 7.2: KNOWLEDGE AND USE OF PREGNANCY TEST KITS AMONG MEN AND WOMEN



WELLNESS PRODUCTS AND OTHER HEALTH CONSUMABLES

Finally, all respondents were asked about their consumption of a range of health consumables. As shown in figure 19, with the exception of hand washing soap, which well over 95 percent of respondents in both intervention and control areas reported using, all other health products were not routinely purchased by consumers in either of the two groups. Anti-pyretics, antacids, analgesics, pain relief balms, and prickly heat powder were purchased by a quarter to a third of the respondents; fewer than 10 percent of the respondents reported purchasing wellness and first aid-products.

FIGURE 7.3: CONSUMPTION OF OTHER SECONDARY HEALTH PRODUCTS AMONG ALL RESPONDENTS



BARRIERS TO ACCESS AND USE

The qualitative study provided additional information regarding patterns of use vis-à-vis the secondary health commodities. In the case of sanitary napkins, the IDIs shed light on some of the most common barriers to the use of feminine hygiene products. Money was the most significant constraint. Even though napkins are known to provide greater comfort than alternatives like *kapda* or cloth as well as cotton, they are not a viable substitute given their price. Women were hesitant to spend scarce rupees on products that were viewed as enhancing their personal comfort rather than being a health need. The second barrier to use was lack of access driven by both demand- and supply-side factors. On the demand side, participants in the study noted that it was quite common for women in their communities to not be allowed to leave their homes and that their husbands are frequently unwilling to purchase such products for them. Women also expressed hesitation to buy these commodities from retailers in their own village fearing the lack of confidentiality. Instead, they preferred to purchase

sanitary napkins from the nearest town so as to maintain their anonymity. On the supply-side, the respondents mentioned that village retailers do not stock napkins.

With respect to OTC health products, the qualitative interviews revealed that knowledge about the OTC medicines was high, especially in Chandauli. The level of brand awareness was also higher in Chandauli than in Gonda. However, the village retailer in both Chandauli and Gonda did not stock medicines except for herbal remedies. Most respondents in Chandauli preferred OTC medicines and considered it quicker, cheaper and more than travelling to visit a doctor. In Gonda, most respondents preferred going to a doctor than resorting to self-medication.

The qualitative study documented that many respondents were aware of the benefits of using the wellness products like vitamin supplements or *Chyawanprash*, a herbal supplement, but they use such products only during period of illness or for short durations of time. Cost is a major barrier to greater consumption of these products, which are viewed as non-essential commodities.

The qualitative study also showed that respondents had no awareness of water purification tablets. All the respondents perceived that water from India Mark II (a type of hand pump) was the purest form of water and thus felt no need for the water purification tablets. Most also said that when a member of their household falls ill, they give them boiled water to drink

THE MBPH ITC E-CHOUPAL MODEL

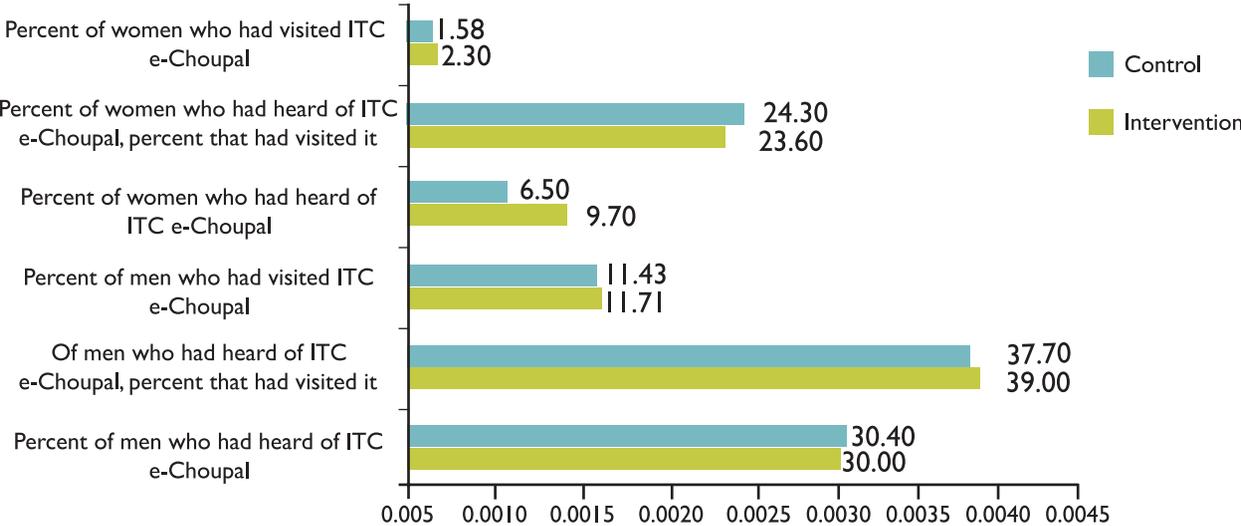
This section synthesizes findings from the quantitative baseline survey about knowledge and use of the standard e-Choupal program in the control and intervention districts. It also analyzes perceptions and opinions expressed by participants in the qualitative study about the MPBH ITC e-Choupal Rural Health Initiative.

AWARENESS AND USE OF ITC E-CHOUPAL NETWORK

As part of the quantitative baseline survey, all respondents were asked if they had heard about the ITC e-Choupal program as well as about their direct experience visiting any of the ITC e-choupal locations. The responses received varied markedly by gender, with many more men expressing familiarity with e-Choupal than women. Given the agricultural focus of the standard e-Choupal model, this result is not surprising. The difference between the intervention and control areas, on the other hand, was minimal as far as e-Choupal awareness was concerned.

As shown in Figure 8.1, approximately 30 percent of male respondents in both areas had heard of the ITC e-Choupal program. Among men who were aware of the program, the percent who had visited it at least once was 38 percent and 39 percent in the control and intervention areas respectively. The percent of total male respondents who had ever interacted with the ITC e-Choupal system was 11 percent and 12 percent in the control and intervention areas respectively.

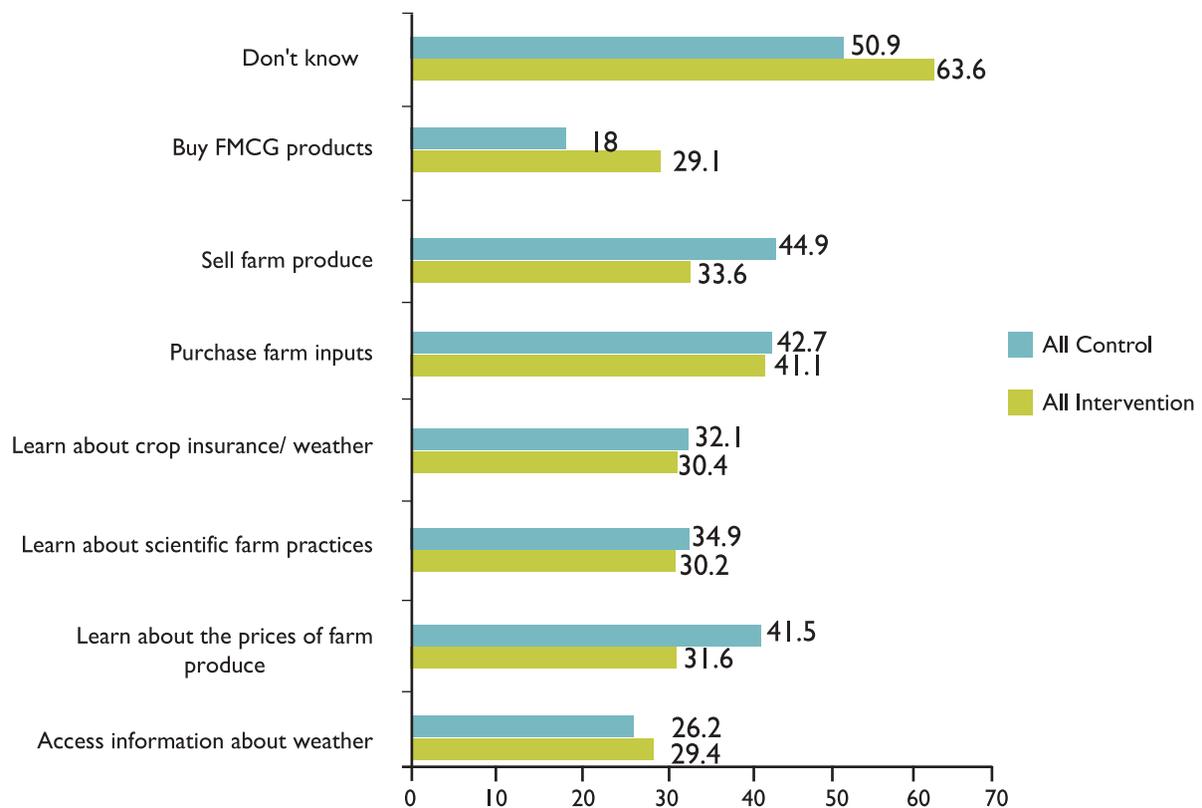
FIGURE 8.1: EXPOSURE TO ITC E-CHOUPAL SYSTEM AMONG WOMEN



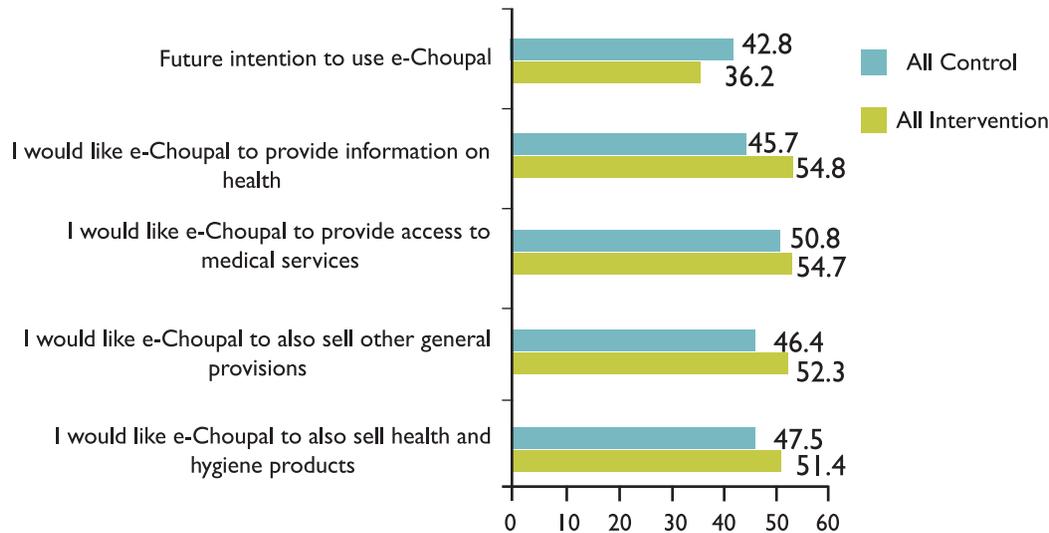
In contrast, the percent of women who had even heard about e-Choupal in the control and intervention areas was 6.5 percent and 9.7 percent respectively. Among those who had heard of it, fewer than a quarter had ever been to one. The percent of total women in the sample who had been to an e-Choupal was below 3 percent in both areas.

The survey next asked respondents whether they were aware of the e-Choupal program and whether they knew about its functions. The results for male respondents are shown in Figure 8.2. Strikingly, 51 percent of men in the control area and 64 percent of men in the intervention area did not know what services, the e-Choupals provided. The remainder identified e-Choupals with the sale of farm produce, the purchase of farm inputs, information about farm prices, weather, and scientific farming practices, and the sale and purchase of FMCG goods. Since awareness of e-Choupals in general was very low among women, their responses to this question is not shown.

FIGURE 8.2: KNOWLEDGE ABOUT E-CHOUPAL SERVICES AMONG MEN



The same respondents, namely those who stated some awareness of e-Choupals, were asked about their future intent to use it. 43 percent of men in the control area and 36 percent of men in the intervention area expressed future intention of using e-Choupals. Finally, the respondents were asked about other goods and services they would want e-Choupals to provide. In the intervention group, the percent of respondents who expressed a preference for health products and services was between 50 percent and 55 percent; in the control group, the percentages ranged between 45 percent and 50 percent. This indicates a high demand for health products and services among those who are aware of the e-Choupal model.

FIGURE 8.3: STATED PREFERENCES ABOUT FUTURE USE OF E-CHOU PAL

REACTIONS TO THE MBPH ITC PILOT

The pilot program will train and deploy VHCs who will both serve as last-mile channel partners, selling health commodities to villagers in the intervention area, and who also act as outreach workers increasing health awareness and promoting the use of health and hygiene products. As part of the qualitative research study, participants in the focus group were asked about their views on the VHCs. Most women in the focus group expressed a strong preference for a female VHC, while males suggested having both a man and a woman in each village. This idea was that both men and women would be more comfortable speaking to people of their own sex. Concerns were expressed about VHCs keeping transactions and information shared with them confidential; this was especially a concern in the case of sensitive products such as pregnancy test kits and contraceptives. A VHC respecting the confidentiality of their clients was seen as being essential for her building trust with the villagers. Some respondents expressed concerns about social dynamics related to caste negatively affecting the way VHCs interact with their clients. In their experience, women community health workers such as, ASHAs, who are typically more educated and likely to seek such economic opportunities, come from higher caste families. In the past, they have been reluctant to help families from lower castes.

CONCLUSION

Leveraging the private sector to increase access to health care services is both a necessity and a smart strategy in India. The necessity derives from the fact that the private sector is currently responsible for delivering 75 percent of health services in India.¹ In spite of the common perception that the government takes care of supplying primary health products like contraceptives and ORS in rural markets, the data presented earlier emphasizes that this is not the case. Therefore national strategies for achieving universal access to health care cannot afford to ignore the large role that the private sector is already playing in the delivery of healthcare in India. The attraction of private sector solutions is also driven by the fact that the private sector is known for being a source for both innovation and efficiency. Key stakeholders in the public health arena are increasingly interested in exploring strategies for harnessing those capabilities to both increase access to care for the underserved and improve the effectiveness with which the care is delivered within the health system. These have taken the form of public-private partnerships, typically between the government and private health providers.

As the development community shifts towards accepting the value that the private sector brings, the private sector has become increasingly more interested in approaches that target consumers in the poorest socio-economic group. In India, this has taken the shape of business strategies for tapping into rural markets. In comparison to their urban counterparts, 72 percent of the Indian population (742 million people), that live in rural areas on average has lower income levels and limited access to goods and services. This segment of the population of India is increasingly viewed as an untapped market by private firms, which have started exploring approaches to build their business among this client-base.

This report synthesizes results from several baseline studies that were done to both guide the design of the model and document existing patterns of knowledge and use, which in the future can be compared with end-line results to determine the effect of the program. From an evaluation perspective, the single-most important finding that emerges from the baseline quantitative study of consumers was the comparison of the intervention villages with the villages in the control district. The background chapter reports measures of socio-economic variables, disaggregated by intervention and control area, and shows that the difference between the two groups is minimal. Subsequent chapters report a range of indicators related to knowledge and use of the health products included for distribution in the product basket for the pilot study. Knowing these baselines measures from the two groups will allow the research team to “net out” these differences at the end-line to isolate the effect of the program.

From a program perspective, the findings from the baseline studies reaffirm the overarching vision of the project playing a catalytic role by bridging several existing gaps that contribute to low use of health products by rural consumers. First, the model addresses the considerable supply gap that prevails in rural India. The quantitative survey of consumers and retailers documents that the supply of health products is inadequate in the targets areas through both public and private routes. With respect to both FP and diarrhea management — the two priority areas for the project — consumers report not having sufficient access to health products. The studies of retailers’ stocking patterns suggest that they

¹⁴ NRHM: http://mohfw.nic.in/NRHM/Documents/Mission_Document.pdf; Accessed April 25, 2011

do not consistently carry these products. These facts confirm that the strategy of using the ITC e-Choupal platform to increase the supply of health products in rural areas has the potential to be highly impactful.

The results also confirm that the project has the potential to bridge a second supply-side gap, namely women's inability to access health products for a range of social reasons. Women living in traditional communities in rural India face social barriers that limit their access to retail outlets for health products. In the case of FP products, concerns about lack of confidentiality compound the existing barriers. The pilot project seeks to bridge this gap by introducing community health workers who can serve as last-mile delivery agents, bringing the health products all the way to the doorstep of the consumers. Findings from the baseline studies suggest that VHCs, who are all women, have the potential to be more readily accessible to women consumers than male shopkeepers, both in terms of actual proximity and social proximity.

The third gap that the pilot program aims to bridge is that of demand. Retailers in rural areas are not stocking health products in part because there is limited demand for them. Therefore ensuring that health products are now easily available for purchase in rural areas is insufficient for ensuring use. Even as the project is working on the supply-side to improve the availability of products at the local level, it is training and deploying health champions who can promote health awareness and promote the use of health products in their respective communities. As part of the program, VHCs are engaging in a range of one-to-one and group education activities to promote knowledge and use of the health products, which in turn is likely to stimulate the demand for these products.

This gets to the final gap that the MBPH model seeks to address in terms of the evidence base for sustainable BoP approaches. The comprehensive research strategy being implemented by the program is not only focused on measuring the effect of the intervention model but also developing the business case for it. By demonstrating an increase in demand and willingness to pay for health products on the part of the consumers, the pilot will hopefully be able to demonstrate long term financial viability and sustainability of this BoP approach.

BASELINE CONSUMER AND RETAILER STUDY

INTRODUCTION

The consumer survey drew equal sized samples from each of the two intervention districts of Gonda and Chandauli and the control district of Jagdishpur in the state of UP. The target audience for the health products also formed the study population for the consumer survey. Amongst them, an emphasis was placed on married women between the ages of 18 and 34, as they are the high risk group when it comes to maternal complications and are also the primary care givers for the children. An equal number of men – the spouses of the women who were selected in the sample — were also interviewed due to the role they are likely to play in FP decisions. They were typically the spouses of the young married women who were selected as respondents for the survey.

In order to understand the supply chain and demand for the primary and the secondary products, a census of all the retailers were conducted within the selected areas. Within the retailers, the wholesalers supplying the retailers within the selected areas were also covered as part of the study.

SAMPLE SIZE CALCULATION FOR THE CONSUMER SURVEY

The sample size in the consumer survey was chosen keeping in mind the need for efficiency of the sample size to measure change while also being statistically significant. It was also important that the control district and the two intervention districts received equal representation in order to avoid any statistical bias. Sample sizes were calculated with an objective to detect a change in difference of 10 percentage points in critical knowledge indicators at 95 percentage confidence 80 percent power and a design effect of 1.5. For calculating sample sizes, the following assumptions have been taken into consideration.

- For FP indicators:
 - 5 percent DID if baseline = 6 percent (assumed level of behavior)
 - 9 percent DID if baseline = 50 percent (assumed level of knowledge/attitude)
- ORS indicators (assuming 75 percent+ respondents have a child under than 5 years):
 - 10 percent DID if baseline = 50 percent (assumed level of knowledge/attitude)

The sample size for the consumer segment was set at 1520 per district. This was further subdivided into 760 married women and an equal number of married men. The number of villages per district which were to form the sample was set at 40 thus allowing for 38 respondents per village in the consumer segment.

In the retailer segment, a census approach was taken. All retailers among the selected village hamlets were covered as part of the study. In Table A.1 the sample size and distribution is presented.

TABLE A.1: SAMPLE SIZE AND DISTRIBUTION

Category	Gonda	Chandauli	Jagdishpur	Total
Women	760	760	760	2280
Men	760	760	760	2280
Retailers	185	145	191	524

SAMPLING METHODOLOGY FOR THE CONSUMER SURVEY

The methodology that was used to draw the sample for the survey comprised of three stages. These three stages were used for both intervention and control areas. In the first stage, 40 villages were selected using systematic random sampling from the list of e-Choupal villages in intervention and control districts. All the villages were arranged by population and given a unique number. The sampling interval was taken as the division of the total number of villages from the number of villages to be selected for the study. A random number was then generated to select the first village and all subsequent villages were selected on addition of the sampling interval. This method was used to draw the sample from both the intervention and the control area.

In the second stage, a mapping exercise for these villages was carried out. Each village was divided into hamlets of 30 households each from which 4 such hamlets were randomly selected and complete listing of the households within these selected hamlets were completed. In this process 120 households were listed from each village. In the third stage, the listing exercise provided the sampling frame for selecting 38 eligible respondents for the survey using the method of systematic random sampling of eligible households. Households with married men and women in the age group of 18-34 years and having children between 0-5 years met the eligibility criteria for the survey. All the households meeting the above two criteria were selected for the study.

DEVELOPMENT OF RESEARCH TOOLS

The instruments for the surveys were designed to capture critical areas of information related to the health products included in the product basket. The draft of the tool was then taken to the field for pilot testing and refined further based on the feedback that was received. They were then translated into Hindi and back translated in English again to verify the impact of translations on the finalised tools.

TRAINING OF INVESTIGATORS

A team of investigators in UP were trained to carry out the fieldwork in the study area. The 3-day training involved sessions on sampling methodology, questionnaire design and survey interview skills. The focus of the training was to introduce the study to the investigators and familiarise them with the methodology and the questionnaire.

FIELDWORK

The fieldwork took place in the months of April and May of 2010 in the study areas. The fieldwork was carried out in the pre-monsoon weather conditions and therefore the data, particularly on the incidence of diarrhoea have some impact of the period of data collection on findings. The initial estimation for duration of fieldwork was extended due to the season of *Katai* or period of harvest in the study area, resulting in extension of the fieldwork phase for the study.

DATA ANALYSIS

All the data from the questionnaires was entered, cleaned and analyzed using various proprietary statistical softwares of the agency as well as SPSS.

QUALITATIVE CONSUMER BASELINE STUDY

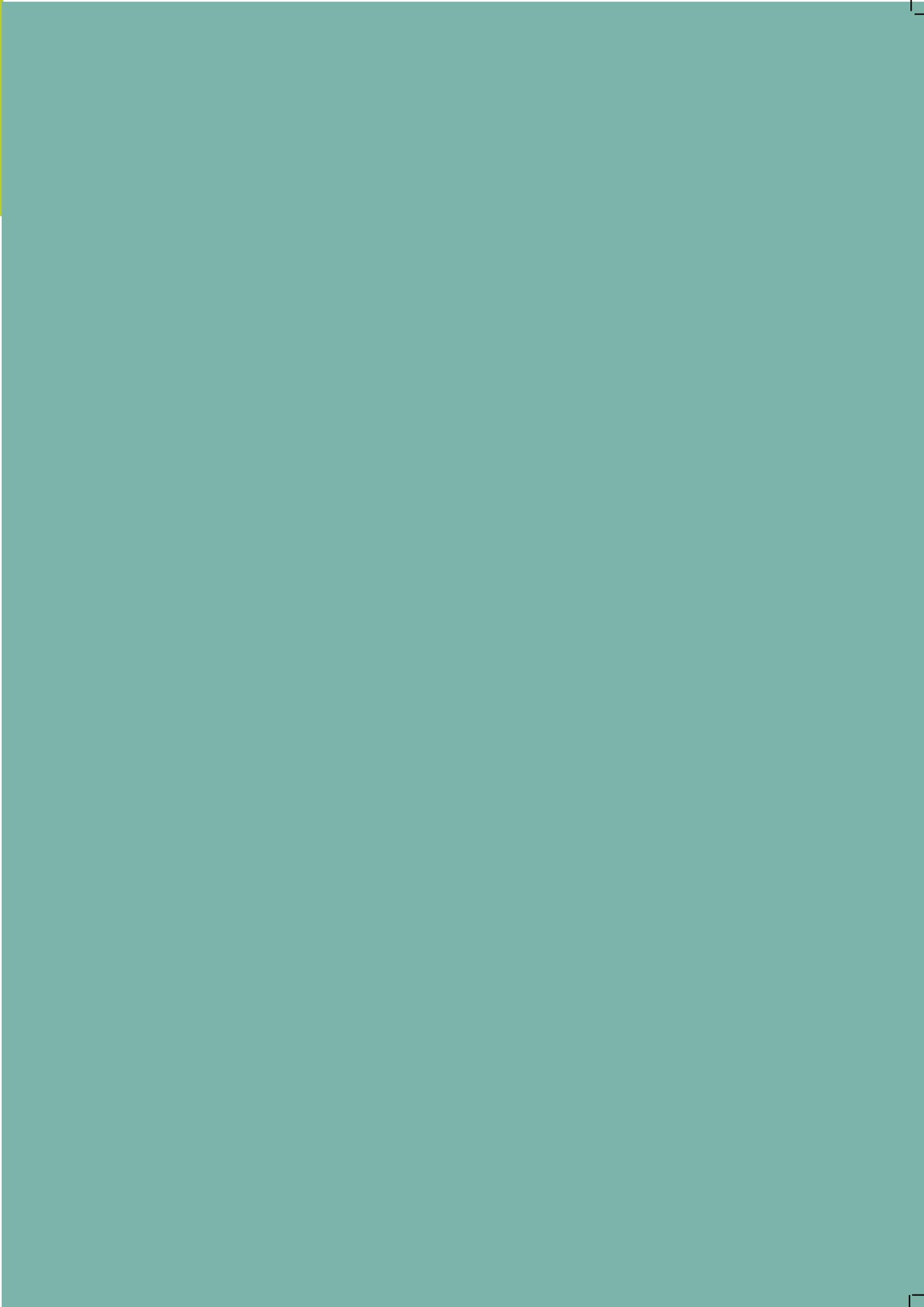
The qualitative study used FGDs and IDIs to understand consumer preferences to a range of secondary health products and the design of the pilot program. The research was conducted in two villages in Gonda, Tulsipur and Bhawinya Pur Updhy, as well as Jhansi in Chandauli district. The primary target groups for the study were men and women of reproductive age from the bottom three socio-economic groups. The IDIs and FGDs used the Magic Box method. There were 6 Magic Boxes, each one containing a category descriptor card with photographs of different products/brands within that. This included sanitary napkins, pregnancy kits, OTC medicines, wellness products, water purification tablets and hand washing soap. Cards were drawn from the box, and an interview guide was used to structure the discussion around the product on the card.

ANNEXURE C:

RURAL SOCIO-ECONOMIC CLASSIFICATION

Rural socio-economic classification is a function of education of the chief wage earner of the household, his occupation and the type of dwelling owned by him, as shown in the table below:

Occupation		Educational Qualification		Type of House		
				PUCCA HOUSE	SEMI PUCCA HOUSE	KUTCHA HOUSE
				1	2	3
Occu.: Level 1 (busi / ind / off / exec / sup / 5+ acre / clerk / self emp / shop own)	1	College /	1	R1	R1	R2
		Graduates / PG /				
		Prof.	2	R1	R2	R3
		SSC / HHC	3	R1	R2	R3
		Literate	4	R2	R3	R4
Semi Literate	5	R2	R3	R4		
Illiterate						
Occu: Level 2 (skilled work / petty trader / 2- 5 acre)	2	College /	1	R1	R2	R3
		Graduates / PG /				
		Prof.	2	R2	R2	R3
		SSC / HHC	3	R2	R3	R4
		Literate	4	R3	R4	R4
Semi Literate	5	R3	R4	R5		
Illiterate						
Occu : Level 3 (unskilled work / artisan / craft / culti-non owner / agri lab / herd / fish / 0-2 acre)	3	College /	1	R2	R3	R4
		Graduates / PG /				
		Prof.	2	R2	R4	R4
		SSC / HHC	3	R3	R4	R5
		Literate	4	R4	R5	R5
Semi Literate	5	R4	R5	R5		
Illiterate						





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