

# **Market-based Partnerships for Health Annual Progress Report: Year 3**

**PSP India Task Order**

**Market-based Partnerships for Health**

**Contract # GPO-I-00-04-00007-03**

## Contents

Acronyms.....	3
Introduction .....	7
Project Performance Indicators .....	10
Component One.....	12
Saathiya .....	13
ITC e-Choupal Health@BoP.....	22
Shakti Health@BoP Partnership.....	29
Saathi Bachpan Ke.....	33
Advanced Cook Stoves Initiative.....	41
Tuberculosis Control and Care Initiative.....	48
Component Two .....	62
Center of Excellence for MBPH and Health Leadership Council.....	63
Component Three.....	69
Dimpa.....	70
MBPH Operations, Human Resources and Leveraging .....	81
Leveraging (All in USD).....	85

## Acronyms

ACS	Advanced Cook Stoves
ACSM	Advocacy, Communication and Social Mobilisation
AIDS	Acquired Immunodeficiency (or Immune Deficiency) Syndrome
ANM	Auxiliary Nurse Midwife
APAC	AIDS Prevention and Control
ARC	Advocating Reproductive Choices
ASHA	Accredited Social Health Activist
ATL	Above-the-Line (referring to communication)
ATT	Anti-TB treatment
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy
BCC	Behavior Change Communication
BCS	Balanced Counseling Strategy
BHEL	Bharat Heavy Electricals Limited
BOP	Bottom (or Base) of Pyramid
BTL	Below-the-Line (referring to communication)
CB	Capacity Building
CBCI	Catholic Bishops Conference of India
CBO	Community Based Organizations
CBQA	Capacity Building and Quality Assurance
CDP	Community DOT Providers
CHC	Channel Health Champions
CHDM	Complete Home Diarrhea Management
CII	Confederation of Indian Industry
CME	Continuing Medical Education
CMO	Chief Medical Officer
CoE	Centre of Excellence
COPD	Chronic Obstructive Pulmonary Disease
CSR	Corporate Social Responsibility
CTD	Central TB Division
CTU	Contraceptive Technology Update
DDG	Deputy Director General
DEO	Data Entry Operator
DFID	Department for International Development
DLHS	District Level Health Survey
DMPA	Depot Medroxyprogesterone Acetate
DOTS	Directly Observed Treatment, Short course
DTO	District TB Officer
EC	Emergency Contraceptive
EoI	Expression of Interest
EoP	End of Project
EQA	External Quality Assurance
FDC	Fixed Dose Combination
FHI	Family Health International
FMCG	Fast Moving Consumer Goods
FOGSI	Federation of Obstetric and Gynecological Societies of India

FP	Family Planning
GAFTM	Global Fund against AIDS, TB and Malaria
GoI	Government of India
GP	General Practitioners
GSK	GlaxoSmithKline
H@BOP	Health at Bottom of Pyramid
HH	Household
HIP	Hygiene Improvement Project
HIV	Human Immunodeficiency Virus
HLC	Health Leadership Council
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HLL	Hindustan Lifecare Limited (Formerly Hindustan Latex Limited –HLL)
HUL	Hindustan Unilever Limited (Formerly Hindustan Lever Limited – HLL)
HUP	Health of Urban Poor
IAP	Indoor Air Pollution/Indian Academy of Pediatrics
ICT	Information and Communication Technology
IEC	Information, Education, and Communication
IFC	International Finance Corporation
IIHMR	Indian Institute of Health Management Research
IIT	Indian Institute of Technology
ILF&S	Infrastructure Leasing and Financial Services Ltd.
IMA	Indian Medical Association
IMPACT	Indian Medical Professional Associations' Coalition against TB
IMRB	Indian Market Research Bureau
IPC	Inter-personal Communication
IPPIUCD	Immediate Post Partum IUCD
IRB	Institutional Review Board
IRH	Institute for Reproductive Health
ISMH	Indian System of Medicine and Homeopathy
ISMP	Indigenous Systems of Medicine Providers
ISTC	International Standards of TB Care
ITC-ABD	ITC's Agri Business Division
ITM	Identification and Training Manager
IUATLD	The International Union against TB and Lung Diseases
IUCD	Intra Uterine Contraceptive Device
IUD	Intra Uterine Device
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JKAL	J.K. Ansell Limited
KSS	<i>Kamasutra</i> Smooth (manufactured by JK Ansell Ltd.)
LCRA	Lucknow Chemists Retail Association
LoE	Level of Effort
LoP	Life of Project
M & E	Monitoring and Evaluation
MART	Marketing and Research Team
MBBS	Bachelor of Medicine and Bachelor of Surgery
MBPH	Market-based Partnerships for Health
MCH	Maternal and Child Health
MDG	Millennium Development Goals

MDR	Multi-drug Resistant
MFI	Micro-finance Institution
MIS	Management Information System
MNRE	Ministry of New and Renewable Energy
MoHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MTOT	Master Training of Trainers
NGO	Non-government Organization
NIMA	National Integrated Medical Association
NMU	Network Management Unit
NRHM	National Rural Health Mission
Ob/Gyn	Obstetrician/Gynecologist
OCP	Oral Contraceptive Pills
ORS	Oral Rehydration Salts
OTC	Over-the-counter
PACT-CRH	Program for Advancement of Commercial Technology-Child and Reproductive Health
PAL	Practical Approach to Lung Health
PIP	Program Implementation Plan
PMP	Performance Monitoring Plan
POS	Point of Sale
PPM-DOTS	Public-Private Mix – DOTS
PR	Public Relations
PSA	Professional Service Agreement
PSI	Population Services International
PSP-One	Private Sector Partnerships – One
PTK	Pregnancy Test Kit
PWC	PricewaterhouseCoopers
QA	Quality Assurance
RCO	Regional Contracts Office
RFA	Requests for Application
RFP	Request for Proposal
RH	Reproductive Health
RME	Research, Monitoring and Evaluation
RNTCP	Revised National TB Control Program in India
SAFHI	South Asian Foundation for Human Initiatives
SBK	<i>Saathi Bachpan Ke</i>
SCC	Sputum Collection Centre
SE	<i>Shakti</i> Entrepreneur
SEC	Socio-Economic Classification
SHG	Self Help Groups
SJRI	St. John's Research Institute
SME	Small and Medium Enterprises
SMS	Short Messaging Service
SOW	Scope of Work
SRI	Social and Rural Research Institute
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections

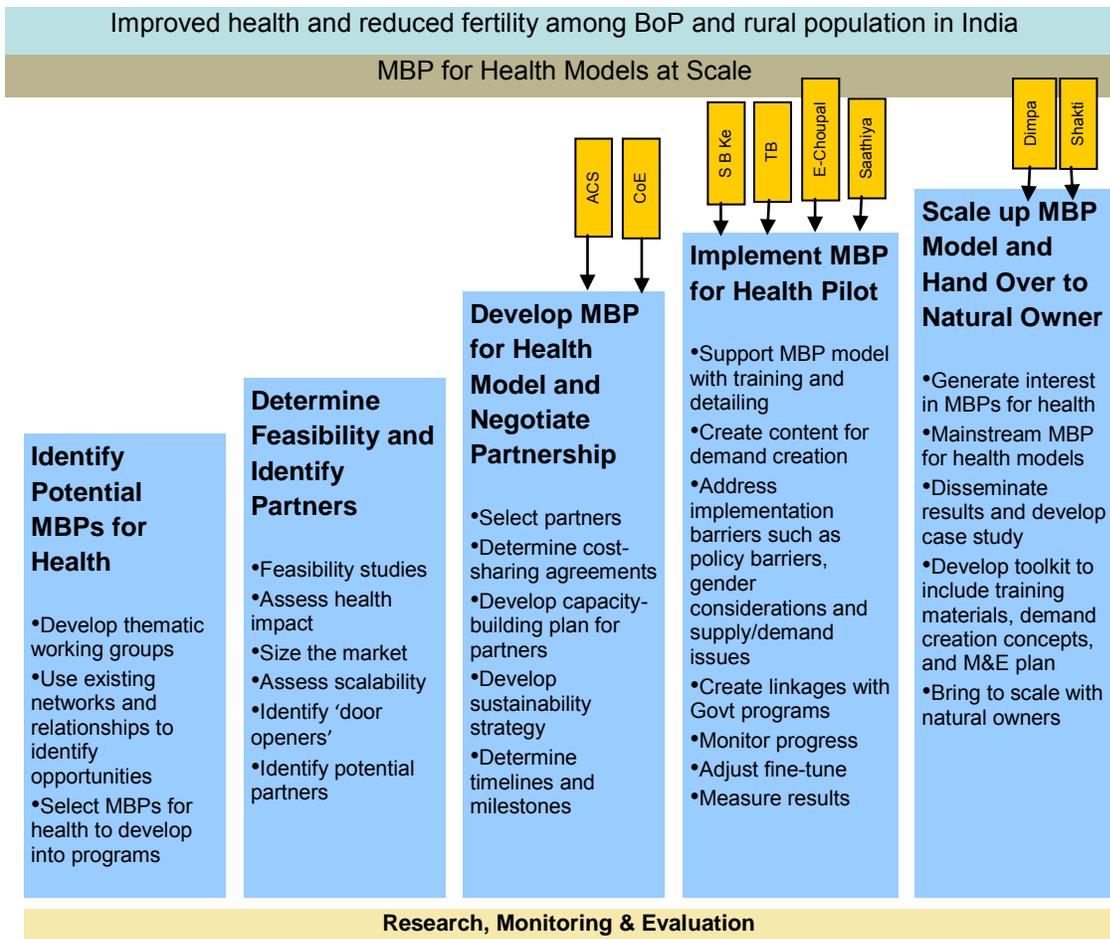
STO	State TB Officer
TB	Tuberculosis
TBD	To Be Decided
TNA	Training Needs Assessment
TOR	Terms of Reference
UHRC	Urban Health Resource Centre
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
VHC	Village Health Champion
WHO	World health Organization
WSP	Water Sanitation Program

## Introduction

The Market-based Partnerships for Health (MBPH) project is USAID India's flagship project to test commercially viable models, engage the private sector, and use private sector strategies, for delivering public health services to Base of the Pyramid populations. The MBPH team currently manages eight different programs that can be cast under the three active components as given below:

<b>Component and Program</b>	<b>Program Description</b>
Component I Saathiya	Strengthen and promote a network of private providers to offer high quality FP services to young married couple in 7 towns of UP
Saathi Bachpan Ke	Establish and lead a commercial alliance to promote home-based diarrhea prevention and management practices and demonstration in 3 cities in UP
TB - PPM	Demonstrate private sector engagement and support in providing TB services in UP and Karnataka
e-Choupal	Partner with ITC and health marketers to establish and test a rural market-based health product and service delivery model in UP
Shakti	Partner with HUL and health marketers to establish and test a rural market-based model for delivery of child health products in UP
Advanced Cook stoves	Pilot models for increased access and demand for advanced cook stoves and advocate for removal of regulatory barriers
Component II Centre of Excellence	Institutionalize capacity to develop and implement MBPs for Health with a local organization sustainably
Component III Dimpa	Expand access to and demand for Injectable contraceptives through the private sector, and advocate for expanded access

Some of these are programs carried on from the earlier PSP-One project and some of these are new. At the end of Year 2 these programs were at various stages on the MBPH program development framework. While some were at early stages of development where pilot programs are being designed and partnerships are in the process of being formalized, others were in an operational phase where implementation was in progress and large procurements to support them were being completed, and some of the more mature programs are starting to test assumptions about viability and commercial sustainability. In Year 3 there has been significant movement and all the programs have entered the implementation phase, and some are at a point of scale up.



### Highlights from Year Three:

**ACS:** Field implementation of the project in two districts in UP and completion of the Carbon Financing Task

**CoE and HLC:** Selection and contracting of Swasti and team mobilisation, initiation of activities to support the MBPH program and two new partnerships with Eureka Forbes and with Wellcome Trust being scoped. The HLC had its first two meetings with significant inputs for the MBPH project

**Saathi Bachpan Ke:** Partnership with Tata Swachh saw significantly higher levels of investment, and scalable models for on-ground activation were established through Pratinidhi. Communication research identified some highly and unique insights that are being used for the development of some very innovative communication messages

**Tuberculosis:** Field training modules were finalized and implementation has started in both UP and Karnataka

**ITC e-Choupal:** Launch and field implementation started in Chandauli, and a active partnership with Pfizer saw the introduction of oral contraceptives in the product basket

**Saathiya:** Roll out and completion of the Balanced Counselling Toolkit training and initiation of training on PPIUCD in partnership with JHPIEGO

**Dimpa:** A number of partnerships have been formalized with PSI, Janani, Packard and Dkt to use modules and components (Training, Helpline, Communication) developed by the Dimpa program

**Shakti:** Average sales of ORS through SEs have doubled and Pharma Synth has started doing direct delivery of products to the HUL rural network in the pilot districts

In Year 3 there was a sharp focus on implementation and testing sustainability of models, and moving away from the earlier stages of activities that was focused on assessments, design, partnerships, procurements and capacity building. This focus on implementation and sustainability aims at delivering two sets of outputs that become crucial to the last year (Year 4) of the project. The first are the project deliverables and health outcomes that are outlined in the Performance Management Plan (PMP). The second set of outputs is the knowledge products that document key learnings that an innovative project like MBPH should produce.

The following sections provide an overview of the progress till date.

## Project Performance Indicators

Development Result	Indicator	Program Element	Target Year 1 (FY 2009)	Achievement Year 1		Total Achievement (Oct 08-Sep09)	Ann. Target Year 2 (Oct09-Sep10)	Achievement Year 2		Total Achievement (Oct09-Sep10)	Ann. Target Year 3 (Oct10-Sep11)	Achievement Year 3		Total Achievement (Oct 10-Sept 11)	Total Achievement (Yr 1 +Yr2+Yr3) October 2008 - September 2011
				Male	Female			Male	Female			Male	Female		
<b>Comp 1:</b> Develop successful partnership models for MBPs for Health	No of USG assisted service delivery points providing FP counseling or services	A053 FP/RH	2,430			3,210	2,060			2,429	2,600			2,592	2,592
	No of people trained in FP/RH with USG funds		2,800	2,614	596	3,210	2,400	2234	330	2,564	1,115			2,103	7,877
	No of people trained in maternal/ new born health through USG supported programs	A052-MCH	200		158	158	100	399	209	608	0			511	1,277
	No. of people trained in Child Health and Nutrition	A052-MCH	0			0	0			0	350			620	620
	No. of feasibility of baseline studies	A052 sub-element A0216 (Wat-San)	1			0	1	1		1	0	1		1	2
	No. of feasibility of baseline studies	A048-TB	0			0	0			0	1	0		1	1
	No. of people trained in DOTS with USG funding	A048-TB									3,200			1,933	1,933
	Percent of estimated no.of new smear-positive pulmonary TB cases that were detected under DOTS (i.e. case detection rate)	A048-TB	0			0	0				0	5%		3.6%	3.6%

Development Result	Indicator	Program Element	Target Year 1 (FY 2009)	Achievement Year 1		Total Achievement (Oct 08-Sep09)	Ann. Target Year 2 (Oct09-Sep10)	Achievement Year 2		Total Achievement (Oct09-Sep10)	Ann. Target Year 3 (Oct10-Sep11)	Achievement Year 3		Total Achievement (Oct 10-Sept 11)	Total Achievement (Yr 1 +Yr2+Yr3) October 2008 - September 2011
				Male	Female			Male	Female			Male	Female		
<b>Comp 2:</b> Develop suitable mechanism for harnessing market-based partnerships and establish effective linkages with USAID, National & State and other programs for scale-up	No. of information gathering or research activities ( FP/CS/Water/TB)	A053 FP/RH	5			14	4			5	4			1	34
		A048-TB	1			1				1		2			
		A052-MCH	2			1				4		3			
		A052 sub-element A0216 (Wat-San)								1		1			
<b>Comp 3:</b> Provision of injectable contraceptives through the private sector	No. of people trained in FP/ RH with USG funds	A053 FP/RH					3,400	3,999	1,819	5,818	810			1,902	7,720
	No. of counseling visits for Family Planning/ Reproductive Health as a result of USG assistance						400,000			317,242	300,000			301,313	618,555
	No. of USG-assisted service delivery points providing FP counseling or services						1,700			1,402	1,500			1,626	1,626

## **Component One**

# **Implement and Institutionalize MBP for Health Models**

## Saathiya

### *A family planning network for young married couples*

#### **Program Vision**

Initiated in 2007, the overall vision of MBPH's Saathiya program is to create a sustainable provider network to improve contraceptive seeking behavior amongst young married couples (ages 15-29) in the lower socio-economic groups across key cities in Uttar Pradesh (UP) and Uttarakhand. The program helps young married couples prevent unintended pregnancies, reduce sexually transmitted infections (STI's), and adopt the practice of birth spacing for new mothers through an established network of health providers.

Positioning the Saathiya brand and the network as a trusted source for advice and access to reproductive health products and services for young married couples is an important element of Saathiya's program strategy. Apart from building recognition and recall of the network, this also allows the network to create consumer demand and leverage investments by commercial companies whose businesses align with this concept.

In year 4 of MBPH, the Saathiya exit strategy focuses on planning for transfer of the commercially viable components of the network to the natural owners for those components identified in year 3. These include elements such as capacity building modules and processes, product distribution and the helpline. By the second quarter of year 4, the program in association with the Centre of Excellence (CoE) will finalize plans to transfer the identified components to their "natural owners" which may be an existing institution (such as National Integrated Medical Association or NIMA which is the provider association for Indigenous Systems of Medicine Practitioners or ISMPs). In this capacity, NIMA could successfully leverage capacity building for FP from FOGSI and demand creation from pharmaceutical companies to drive FP clients to ISMP providers in the Saathiya network by continuing to position them as FP providers.

#### **Background**

Piloted in Lucknow in 2007-09, the Saathiya program leveraged over \$200,000 from nine different pharmaceutical and medical association partners for the initial phase. During this phase, program partners contributed their time along with publicity support materials. Based on the interest and successful engagement of partners, there was an expansion of the network in Lucknow and the program was scaled-up to six additional cities in UP and Uttarakhand in Year 2 of MBPH. By the end of Year 2, (2009-10) a total of 36 different medical associations and pharmaceutical companies were supporting the Saathiya program. Currently the network has more than 3,000 trained providers across Agra, Allahabad, Barabanki, Lucknow and Varanasi in Uttar Pradesh and in the cities of Dehradun and Haridwar in Uttarakhand (this includes 423 Ob/Gyn from the Dimpa network across these seven cities). The Saathiya helpline has received over 400,000 calls since its inception in Oct 2007.

In Year 3 of MBPH, efforts were made to strengthen the capacity of Indigenous Systems of Medicine and Homeopathy or ISMH doctors. 1,065 ISMH doctors were trained in using the Balanced Counseling Strategy (BCS) Toolkit to improve their FP counseling skills. Simultaneously, the pilot to encourage these doctors to stock and sell Over the Counter

(OTC) contraceptive products was designed and rolled out. The program also worked with the Mother and Child Integrated (MCHIP) Project to initiate the training of 230 Saathiya network Ob/Gyn doctors in Post-Partum Intra Uterine Contraceptive Device (PPIUCD) in the seven program cities.

### **Milestones Achieved, Barriers and Challenges in Year Three**

While in Year 2, the focus of Saathiya was on refining program strategy to streamline the program based on results from the Lucknow pilot, the emphasis in Year 3 was on strengthening service delivery by further investments in provider capacity building.

#### ***Provider capacity building:***

The BCS Toolkit was translated by MBPH into Hindi in partnership with the Population Council and Family Health International (FHI) and adapted to suit the Indian cultural context. A three day Training of Trainers (TOT) on counseling with regard to BCS Toolkit was organized by FHI's Program Research for Strengthening Services (PROGRESS) project in Lucknow (March 9 – 11). At this meeting, ten MBPH field trainers and representatives along with seven network Ob/Gyns were trained by two international trainers from Population Council on using the BCS toolkit in counseling FP clients.

During the second phase of the cascade trainings, MBPH trainers (with support from network Ob/Gyn doctors) trained 1,065 ISMH doctors (out of 1,170 ISHM providers in the Saathiya network) across the seven program cities on the BCS. Additionally, a client screening checklist to find out if a client was pregnant along with job aids on use of Condoms, Combined Oral Contraceptives (CoCs) and ECs in Hindi were designed produced and introduced to ISMH doctors of the network.

Since it has been observed that in most instances, the paramedic (instead of the doctor) counsels the FP clients, in the program cities, the program field trainers trained 410 paramedics of family doctor clinics (against the annual target of 200) on FP counseling for clients in 13 training sessions held across the seven program cities.

Additionally, the program identified network chemist outlets where trained sales staff had moved out and hence there was a shortage of trained personnel at the previously trained outlets. Priority was given to training the shop owners of these outlets, followed by the sales staff and 327 retail shop owners/sales staff were covered.

#### ***Strengthening Commercial Viability of network:***

ISMH Stocking Pilot: In 2011, to strengthen the commercial viability of the Saathiya, a pilot was designed encouraging ISMH providers to stock and sell OTC contraceptive products. Based on a rapid assessment conducted by MBPH, to understand the current stocking behavior of family doctors and their intention to stock contraceptive products, a detailed Scope of Work (SOW) was developed for field work and data collection and Aim Research, Lucknow was awarded the sub contract. The field work was completed by Aim Research, Lucknow in the third week of December 2010.

According to the key survey findings, at present only 20.6 per cent family doctors in the network are stocking contraceptives. Of the latter, 94.24 per cent providers have never stocked any contraceptives, compared to only 5.76 percent that had ever stocked. More importantly, 33 per cent of the entire network providers (including both that are stocking and

not stocking) expressed the desire to stock contraceptives in the near future, indicating the positive response of network providers in stocking and dispensing OTC methods such as condoms, Oral Contraceptives (OC) and Emergency Contraceptives (ECs).

Based on these findings, a pilot was designed to motivate ISMH providers to stock contraceptives, link them to stockists of Saathiya's commercial partners for procurement of stocks, communicate availability of contraceptives at ISMH clinics and measure and evaluate the effort. A detailed business plan was developed and shared with JK Ansell Ltd. (JKAL) and DKT India. The program identified five cities (Allahabad, Barabanki, Lucknow, Dehradun and Haridwar) for the stocking pilot wherein providers would be encouraged to stock condoms and Oral Contraceptive Pills. However, due to the low priority given to this by JKAL, the commercial partner for condoms, the activity was delayed. JKAL responded in the first week of September '11 with the product price details of KSS and Sajan along with the details of their stockists in the five Saathiya cities where the stocking pilot is planned to be undertaken. The program plans to initiate ground implementation of the ISMH stocking pilot from October '11 with JKAL (condoms) and DKT (condoms and pills) as the two partners.

PPIUCD Services: With the objective of introducing IUCD services for Saathiya Ob/Gyn specialists, an in-house survey was conducted by MBPH in December 2010 to understand the needs and gaps in the knowledge of these providers. The survey revealed that while providers were not interested in learning about the insertion of IUCDs, they seemed keen to learn about post-partum use of IUCD. In partnership with MCHIP, the program identified 230 providers (based on an assessment checklist developed for this purpose) to be invited for PPIUCD training. The shortlisted providers have delivery facilities at their clinics, are practicing interval IUD insertion and are willing to be trained on IPPIUCD insertion.

On its part, MCHIP identified two master training sites (one each in UP and one in Uttarakhand) and a Master TOT was conducted in Dehradun where six doctors were trained. MCHIP has developed checklists for identifying nodal training sites at five cities where the master trainers will train Saathiya providers. The site assessment of Merrygold hospitals in four cities of UP along with some public/private hospitals is being conducted by MCHIP. PPIUCD counseling and Infection Prevention training for staff of the site in Agra and Varanasi has commenced.

In preparation for the training, MCHIP, in collaboration with MBPH, conducted the PPIUCD service delivery standards adaptation workshop for the private sector in April '11. At this workshop, doctors and experts from both public as well as private sector discussed and finalized the standards for private sector based on those available for the government sector. These standards, adapted without any significant changes will be adhered to by the Saathiya Ob/Gyns in their PPIUCD clinical practice.

MBPH collaborated with MCHIP in finalizing the design of the client card for PPIUCD, mailer for providers, in-clinic thematic poster, client education materials, training certificate for Saathiya providers and a web-based reporting tool for MBPH field teams to collect client data from provider clinics.

The training of Saathiya network Ob/Gyn was initiated in the last week of August in Dehradun and so far a total of five doctors have been trained (up to Sept 3).

MBPH also signed a partnership MoU with DKT India, the marketers of Cu 380A, whereby DKT has already provided free product samples for training and will design mailers that MBPH will use to invite doctors to the trainings. DKT will also provide client education materials and help make Cu 380A available to trained doctors of the network as a subsidized product.

### ***Steering Committee Meetings:***

The Steering Committee meeting is an engagement strategy with program partners at the town level. These meetings have resulted in increasing the partners' familiarity and participation with the program in Lucknow where they have been conducted regularly since the beginning of the program.

MBPH continued the Program Steering Committee meetings in Lucknow and initiated the first Steering Committee meetings in Agra and Barabanki.

### ***Demand generation activities***

Communication campaign: Existing materials for interim campaigns were used in Year 3 for communication activities in the first (Oct-Dec '10) and the third quarter (March-May '11). This included radio spots on private and All India Radio FM radio channels, newspaper advertisements in mass circulated Hindi Magazines.

Simultaneously, the Saathiya field team inserted program leaflets inside and pasted information stickers on the mastheads of different vernacular dailies at the city level. Network providers appreciated the communication campaign and as a result of the campaign, the Saathiya helpline has seen an increase in first time callers and a decline in repeat callers.

An article on Saathiya titled 'Parivar Niyojan mein Saath Nibhata Saathiya' (Saathiya lending a helping hand in Family Planning) was developed and was carried in May '11 by 34 vernacular dailies in the cities of Lucknow, Agra, Allahabad, Dehradun and Varanasi as part of the interim communication plan.

The contracts of MBPH communication agencies – JWT for creative development, Maxus for media planning and placement and Hanmer MSL PR for Public Relations were in place in June 2011 after a round of competitive bidding. All agencies have received a clear SOW and a detailed briefing by the program. Plans are now being finalized with these agencies for developing and implementing a communication campaign by mid-September 2011, to position the neighborhood Saathiya family doctors as an expert who has been especially trained to provide customized FP advice. A detailed PR plan has also been finalized with Hanmer MSL PR and activities such as developing media stories around program initiatives and conducting visits of journalists to outreach programs. The Saathiya website ([www.Saathiyaindia.com](http://www.Saathiyaindia.com)) aimed at communicating with the provider groups and partners was improved in terms of the design. Features and content relating to program research and communication were updated and added.

Outreach by MBPH field teams: In Year 3, as in previous years, the MBPH field teams continued to provide counseling to clients at the network clinics through the Umbrella (Chattri) activity. 772 women in the reproductive age group were counseled by the Saathiya field teams as a part of this activity at provider clinics in 19 sessions held up to August 31.

Outreach activities were conducted by the MBPH field teams by way of counseling potential family planning client's at large public and corporate hospitals and in institutions. Seven such activities (up to August 31) resulted in counseling of 661 women of reproductive age.

In January 2011, the program devised a new outreach activity wherein small community meetings (mahila goshties) for 25-30 women of reproductive age were conducted every week with the help of Aanganwadi workers in low-income areas of the seven program cities. At these meetings, the field team members provided basic FP counseling and women who expressed interest in adopting any non-clinical FP method at the counseling meeting were invited to a health camp, which are conducted at the clinic of an ISMH doctor. Women interested in adopting DMPA or an IUD are directed to the Ob/Gyn network clinic. The following is the data regarding mahila goshties and Health Camps conducted across seven Saathiya cities in Year 3 (up to August 31) and these are in addition to the activities conducted in these cities under the Dimpa program:

Mahila Goshties (MG) Conducted	No- of women who attended MGs	Health Camps (HC) Conducted	No. of women who attended HCs
85	2,957	19	919

This activity is continuing to show good results with providers and partners both wanting to participate.

#### **Saathiya helpline:**

In Year 3, the Saathiya helpline received a total of 76,737 calls (up to September 15) of which 51% were from female callers.

The new Helpline contract was awarded to the Indian Society of Agribusiness Professionals (ISAP) in March 2011. Ten tele-counselors (five each for Saathiya and Dimpa) have been trained to answer client calls on the helpline. Most of the counselors who worked under the previous sub-contractor were retained.

A new software for capturing helpline call data by tele-counselors has been designed and developed by ISAP and has been introduced since June. The software has resulted in improving the efficiency of the tele-counselors.

Although the number of client calls to the helpline has been growing steadily, the project has not been able to measure the extent to which these calls have translated to walk-ins to Saathiya provider outlets or off-take of contraceptives resulting from these referrals. Hence, the program is exploring new strategies to measure Helpline referrals through a telephone-based survey and also to reposition itself to support existing users of FP rather than being the first point of contact for new users.

The Saathiya helpline is currently partnering on a pilot being implemented by the Institute of Reproductive Health (IRH). IRH is piloting CycleTel – a mobile application that supplies the Standard Days Method (SDM) directly through a user's cell phone. The pilot has been designed with about 750 users of CycleTel in Delhi and the NCR. IRH is providing financial support for two Saathiya tele-counselors to answer user queries related to the method. From Jul 1 to Sep 15, 234 users have called on the Saathiya female helpline regarding various queries about the CycleTel method, registration of the application, etc.

All helpline tele-counselors received training support from CB&QA team and on an average, one training session was held every month during the year. Additionally, IRH conducted a two day training session for helpline tele-counselors on Standard Days Method and CycleTel in July 2011.

Program commercial partnerships: While fresh MoUs were signed with Wyeth (a subsidiary company of Pfizer) and DKT India, the existing MoU with JKAL was redrafted and signed to include Sajan Luxury Condom, their recently re-launched low-cost brand in addition to Kama Sutra Smooth which has been a program partner brand since the beginning. The program achieved substantial leverage through the partnership with JKAL in Year 3 as the partner provided client educational materials in the form of leaflets (for KSS and Sajan) and medicine pouches (for Sajan).

The MoU with Wyeth includes participation of Ovral-L, India's largest selling Oral Contraceptive Pill brand in the commercial sector. Collaboration with Wyeth will include working together in provider capacity building, development and provision of client education materials and outreach activation. The partnership with DKT India will focus on Zaroor condom, Choice OCP and two, soon to be launched, brands of Emergency Contraceptives. As discussed earlier, the partnership will also include Cu 380A for PPIUCD. DKT is keen to participate in the ISMH stocking pilot with Zaroor condom and Choice OCP and this activity will be initiated in September 2011. A partnership for developing a new brand of mid-prices Oral Contraceptive Pills was explored with MSD. This is in an early stage of discussion and MBPH will pursue this in Year 4.

Initiate plans for transfer of Saathiya components to natural owners: Sustainability opportunities for Saathiya were discussed in details at the initial HLC meeting held in May 2011. Details regarding this have been provided in the HLC/CoE section of the work plan.

In the area of helpline sustainability, two tele-counselors are now being paid for by IRH, as part of the CycleTel partnership. Additionally, DKT India has agreed to support one of the existing tele-counselor. On its part, ISAP has substantially leveraged support for the helpline set-up in terms of providing space for the facility, etc. ISAP, the helpline subcontractor has been tasked with the identification of corporates who could support the helpline under their strategic Corporate Social Responsibility (CSR) plans.

Advocacy to mainstream ISMH in FP services: The assessment report on understanding current laws and environment to develop a framework for advocating legal rights for ISMHs to practice non-OTC methods has been drafted and will shortly be shared with USAID India. The report presents the current legal rights of ISMH doctors and the views of various key stakeholders on this subject. It also covers viewpoints of central government and state health ministry officials, Central Council of Indian Medicine (CCIM), National Integrated Medical Association (NIMA), Indian Medical Council (IMC) and that of the National Rural Health Mission (NRHM).

The next steps on the advocacy plans are being finalized and will be shared with USAID in October 2011.

### **Research and M&E**

Provider mystery client and consumer endline studies: The RFPs for the studies were released in June '11 and proposals from four agencies were received. The panel formed to review and evaluate the proposals, awarded the studies to Sigma. The field work for the provider study will

commence in September while the consumer endline will begin by mid-October. The study reports are expected to be finalized by March '12.

Helpline tracking study: The helpline tracking exercise was piloted in the first quarter of year 3 to understand the behavior of helpline callers who are referred to any network provider by the tele-counselors. Out of a total of 505 clients contacted in October and November 2010, 23 percent were referred to a Saathiya chemist, 7 percent to a family doctor and 70 percent were referred to a specialist. 146 callers selected from the 505 were called back by the helpline in October-November 2010. However, only 50 callers could be reached (another 50 were unreachable on the number provided by them and numbers of 16 others were unavailable). Further, of the 50 callers who could be reached, 42 did not take any action regarding the referral to the Saathiya doctor, 7 did not visit the referred doctor due to time shortage, 25 provided no reason and finally 2 gave other reasons for not meeting a Saathiya provider. Of the 8 that visited a Saathiya doctor based on the referral provided, 6 expressed satisfaction with their visit while the remaining 2 were dissatisfied.

Given the low success rate in reaching the clients that were referred, the entire methodology was revisited with regard to this activity. New discussion flows and scripts were designed for collecting additional client information and for better tracking of referrals.

As a part of the revised effort, a limited number of those clients who were referred to the chemists will be called back as part of the caller referral tracking. With the new helpline set up in place, post award of the contract to ISAP, the MBPH research team has reinitiated the helpline tracking study. The results of the pilot are now expected by the first quarter of Year 4 following which the activity will be appropriately scaled.

### **Barriers and Challenges:**

***Insufficient communication budgets for city-level impact:*** Investments required for creating awareness and recall of Saathiya were estimated based on the Lucknow pilot. It was estimated that in order to make a city level impact through communication, the program will need a budget of at least Rs. 40 lakh each for five large cities & 15 lakhs for the 2 smaller cities (versus Rs.87 lakh available). Only a part of the budget deficit can be overcome through materials provided by commercial partners and other leveraging activities and this will continue to be a challenge for the program in Year 4.

***Challenges in tracking FP beneficiaries:*** Most providers are too busy or lack motivation to maintain patient records and therefore it becomes difficult for the program to show any real and concrete progress through tracking of referrals and prescriptions. The program will undertake a telephone-based survey to measure the extent of referrals and will test a client card which to be placed at the clinics of Saathiya family doctors to record FP clients visiting these clinics.

***Challenges in identifying new Commercial Partners:*** The year under review also had its share of partnership challenges. This included partnership efforts with HLL LifeCare for CycleBeads, which did not materialize as the company was not forthcoming to test market a commercial version of product. Partnership with MSD (Merck/Organon) for an IUCD could not be finalized. Even though the company was quite keen to sign a MoU, the government approved only Cu 380A for PPIUCD and Organon only had Multiload in its product portfolio.

Similarly, a partnership with M/s Pregna International Limited on IUCDs did not work out as the company was not willing to make any substantial investments in distribution or marketing under the partnership. They were seen to be new to trade marketing (having so far focused entirely on institutional supplies) and are yet to decide on their future business strategy.

The partnership dialogue with emergency contraception manufacturer Bestochem Formulations Pvt. Ltd. could not progress due to a lack of response from their end on a partnership proposal. Information from the market suggests that Bestochem is a very small player in the EC and OCP domain and this may limit their ability to offer any significant partnership support.

### Progress and achievements in Year 3

Activity	O	N	D	J	F	M	A	M	J	J	A	S	% Complete
<b>Strengthen commercial viability of network</b>													
Advocacy for mainstreaming of ISMP doctors	█	█	█	█	█								50%
Approval of ISMP in provisioning of a range of additional FP services						█	█	█					-
Saathiya network ISMP are supported by pharmaceutical partners for provisioning of approved FP products									█	█			50%
Govt./associations agree to support/adopt the model											█	█	-
MBPH PR agency on board	█										█	█	100%
Develop PR and leveraging plans		█	█	█	█								100%
Design and implement 3 city pilot for stocking and dispensing of OTC contraceptives at Family Doctor Clinics			█	█	█	█							60%
Document experience of stocking pilot and plan scale up							█						-
<b>Identify 'natural owners' of program components of Lucknow network and plan for transfer</b>													
Explore interest and capability of NIMA Lucknow for network administration							█	█					100%
Evaluate interest of commercial partners in providing marketing & communication support								█	█				50%
Document experience of Lucknow pilot and plan for other program cities									█	█			20%
Explore CSR interest of commercial entities in supporting helpline operations									█	█			100%
<b>Increase Access to Saathiya Network</b>													
Identify and train 200 Ob/Gyn on provisioning of IPPIUCD (IA: Jhpiego)			█	█	█								30%
Identify and train 200 paramedics of Family Doctors	█	█											100%
Train 500 Family Doctors on BCS toolkit						█	█	█					100%
Develop & introduce FP screening checklists & counseling flipchart to Family Doctors					█	█	█	█					100%

Activity	O	N	D	J	F	M	A	M	J	J	A	S	% Complete
Ongoing refresher trainings for Tele-counselors/ Managers	■		■		■		■		■		■		100%
Pilot Exchange Forum for Family Doctors in Lucknow						■							-
<b>Create Demand for Saathiya Network Products and Services</b>													
Use existing materials for interim campaign (Street Life Advertising)	■	■	■										100%
Integrated MBPH communication and media agency on board		■											100%
Roll out communication campaign across seven program cities						■	■	■		■	■	■	100%
Outreach by MBPH field team and activation agency	■	■	■	■	■	■	■	■	■	■	■	■	100%
Helpline tracking study (internal)	■												50%
Mystery client study	■	■	■										50%
Communication development study		■	■										Dropped
Communication pre-test study													Dropped
Provider endline												■	20%
Consumer endline												■	20%

In Year 4 of MBPH project, the Abt team will develop, finalize and execute plans for program sustainability with the CoE and will document and disseminate program highlights, stories and successes in addressing reproductive health and family planning needs of urban, low-income young married couples. Additionally, the program will continue to invest in maintenance level activities to increase access to the network, create demand for network products and services and strengthen the commercial viability of the network.

The program will focus on the following activities:

- Finalize and implement the sustainability strategy and plan for the ISHM network and helpline
- Documentation of program highlights, stories and successes

Additional maintenance activities will include:

- Create demand for Saathiya network products and services by implementing communication (spots on radio and cable TV, radio program, commercial on cable TV, billboards, in-clinic client education materials) and outreach plans (mahila goshties and health camps)
- Strengthen commercial viability of network by advocating to mainstream ISMH doctors in FP provisioning and encouraging these providers to stock and dispense condoms and oral contraceptive pills

## ITC e-Choupal Health@BoP

### Program Vision and Objectives and Overview

ITC e-Choupal Rural health Initiative is the flagship rural marketing program of the Market-based Partnerships for Health Project (MBPH). The goal of the ITC program is to demonstrate a commercially viable and scalable rural distribution model that leads to increased access to family planning (FP), child health and hygiene related products and services. In addition to this, the program also intends to promote adoption of relevant public health practices in the rural areas.

The pilot program leverages e-Choupal's inherent procurement and distribution capabilities. It has appointed community-based health workers, branded as Village Health Champions (VHC), under the e-Choupal umbrella in the intervention villages. The VHC are responsible for creating awareness around different public health issues, as well as for the supply of health products, to consumers in 66 intervention villages in the districts of Gonda and Chandauli in Uttar Pradesh (UP).

The health issues being addressed by the program are family planning, diarrhea management, menstrual hygiene, water purification and reading glasses. The product basket currently includes primary health products, condoms and oral contraceptive pills (OCP) and a range of secondary health products including sanitary napkins, nutrition supplements, and reading glasses. It is intended to include diarrhea management products like oral rehydration salt (ORS) as a primary health product in the basket. The e-Choupal rural hypermarkets are used as the stocking points for these products. These are visited by VHC from each intervention villages, who procure the products once a month. These products in turn are sold by VHC to consumers in their villages.

On proof of commercial sustainability, the ITC e-Choupal team has agreed to scale-up this model to all locations that have enhanced hubs with front-end retail outlets, or Sagars. The program targets to ensure that VHC earn a minimum income of Rs. 1,200/- per month from this pilot and establish themselves as credible health workers within their communities. The promise for product partners is that they should see the program to be profitable in its scaled-up version.

### Achievements of Year Three

The achievements as per activities planned for Year Three are tabled below:

S. No.	Activity	% Complete	Justification
<b>1</b>	<b>Positioning VHCs as credible health workers in their community</b>		
1a	Training on public health issues	100%	
1b	Product training	100%	
1c	Soft/ business skill training	100%	
1d	New product and ongoing training	100%	As per plan
<b>2</b>	<b>Creating awareness around VHCs and the program</b>		

S. No.	Activity	% Complete	Justification
2a	Introducing VHCs to the community through one on one as well as group meetings	100%	
2b	Implementation of pilot <i>Haat</i> activity	100%	
2c	Implementation of health <i>Haats</i> in the intervention villages	100%	As per plan
2d	Planning and implementation of village community meetings to promote awareness around public health issues	100%	
2e	Liaising with OCP partner to develop appropriate promotional schemes to bring down the effective price of OCPs	100%	
<b>3</b>	<b>Introduction of existing and new product / services in VHC basket</b>		
3a	Placement of seed stock with the VHCs	100%	
3b	Introduction of OCPs	100%	
3c	Introduction of condoms	75%	MoU to be signed
3d	Introduction of OTC health products <sup>1</sup> like Tata <i>Swach</i> , Cookstoves, Milk food drinks, pain relieving balms, digestives etc.	0%	Ongoing discussions for Cookstoves, pain relieving balms
3e	Development of commercial terms for bringing supply-side partners on-board only for doing promotional activities through VHCs	0%	Preliminary discussions initiated with Abbott. Commercials to be finalized
<b>4</b>	<b>Introduction of ORS</b>		
4a	Developing/ Finalizing/ Tracking calendar for development of powder variant of ORS brand for the intervention areas	25%	Pfizer in discussion with their contract manufacturer
4b	Introduction of powder based variant of ORS into the pilot	0%	Awaiting for Pfizer to finalize their vendor for manufacturing powder variant
<b>5</b>	<b>Formation of referral network</b>		
5a	Formation of initial referral network with a local doctor, eye clinic, diagnostic center, local PHC and nearby chemist	Ongoing	Initiated through workshops with local doctors & community health workers
5b	Expansion of referral network to GPs, Gynecologists, diagnostic centers in the city	Ongoing	Pfizer has initiated work on it for OCPs
<b>6</b>	<b>Program monitoring</b>		

<sup>1</sup> This activity is going to be dependent upon receipt of approval from USAID for inclusion of these products into the VHC basket

S. No.	Activity	% Complete	Justification
6a	Ensuring regular forecasting and order placement by VHCs	100%	
6b	Monitoring VHC activities, sales levels achieved, BCC <sup>2</sup> activities done	100%	
6c	Review meetings with partners	100%	
<b>7</b>	<b>VHC retention</b>		
7a	Designing retention schemes for VHCs	100%	
7b	Putting a replacement plan in place	Not required	
<b>8</b>	<b>Research</b>		
8a	VHC baseline study	100%	
8b	Endline consumer / VHC studies : Initiation of contracting process	100%	Consumer endline study fieldwork started
<b>9</b>	<b>Initiate work on development of transition strategy</b>	Ongoing	Discussions initiated with CoE

The current year started with finalization of training content for 66 VHC, who were identified and recruited in Year 3. All the VHC have been comprehensively trained on all program issues by the MBPH capacity building team. VHC have also received extensive training on the products in the basket from product partners. Moreover, all of them have also undergone business skill training conducted by MART. MBPH has carried out refresher training programs for VHC to update them on intervention health issues.

The major highlight of the program during the year was the launch of the initiative in Gonda and Chandauli. Both the launch events were successful and received positive support from the public sector district administration and also from opinion leaders of the Choupal villages. Each launch event was attended by more than 400 people.

The program is operational in both districts after its launch in Chandauli in July, 2011.

MBPH is carrying out ground level promotional activities in the two districts on a continuous basis in the form of Mahila Haats (events centered on women's issues). Targeted specifically at women, these Haats address issues related to family planning, diarrhea management, menstrual hygiene, and water purification. Thus far, 60 Haats have been conducted by the program and they are a popular activity in which women receive free intervention health products for trial.

As part of the operation, VHC are carrying out communication activities and are counseling consumers. They are also supplying health products to their clients in the intervention districts. The sales volumes over the months are shown below:

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<sup>2</sup> BCC : Behaviour change communication

	Dec '10	Jan '11	Feb '11	Mar '11	Apr '11	May '11	Jun '11	Jul '11	Aug <sup>3</sup> '11
Sanitary napkins	41	61	67	115	105	96	250	130	275
Aquatabs tablets	292	104	63	547	1,309	980	835	975	1,817
Revital tablets	200	277	494	990	390	630	1,060	310	860
Reading glasses	--	--	--	27	30	14	15	8	57
Oral Contraceptive Pill	--	--	--	--	--	--	--	--	36

### *Revisions in ITC e-Choupal Model and their Impact*

There was a significant dip in the sales volumes and value in July, 2011 due to irregular supply of stock. This was, in turn, a result of delays in order placement from ITC, primarily due to the modifications in ITC's e-Choupal model. Previously, distribution of health products to VHC was through ITC e-Choupal's procurement agent, *Sanyojak*. This was discontinued and stocking of products was done at *Choupal Sagars*. Instead of getting products at their doorstep, VHC now visit the *Choupal Sagars* to procure products at wholesale/dealer prices. VHC in turn, retail the products at maximum retail price (MRP) within their communities and earn the difference as their income.

Based on information provided by ITC about the changes in the model in early April, the MBPH program team visited each of the partner firms to inform them about the changes in the model as well as to get their buy-in for the modified model. After informing the MBPH team about the proposed changes in the e-Choupal model, the ITC management then undertook an extensive exercise to communicate the changes in the model to e-Choupal staff. The entire transition process took a few months to finalize and the revised model was operationalized at end of July, 2011.

### *Family Planning Products*

A major highlight of the year was finalization of the FP portfolio for the program. A MoU was signed with Pfizer and the company decided to bring down the effective price of its oral contraceptive pill (OCP) from Rs. 80/- per cycle to Rs. 63/- per cycle, through an offer where it gave one pack free with every three strips bought by VHC. Apart from this, Pfizer has done extensive training of VHC on OCP use and also helped develop detailers and other communication material for VHC to enable them to do demand generation activities for the product. Similarly, JK Ansell has agreed to come on-board with its condom brands and the program expects to close the MoU with the company by early October, 2011. The delay in signing the MoU has been due to movement of the model to the consignment model, which requires clearance from the regulatory team in JK Ansell. The alliance is expected to be fully operational in the first quarter of Year 4. The commitment levels shown by the FP partners, is very high. MBPH is not planning to explore additional partnerships in the FP space, so as to ensure success of, as well as due to the exclusive nature of, these partnerships.

<sup>3</sup> The August onwards figures are for Gonda and Chandauli while sales figures before August are only for Gonda, since the program got operationalized in Chandauli from August onwards.

## Barriers and Challenges

A major challenge for the program during the year resulted from changes in the ITC *e-Choupal* model. These modifications led to significant changes within ITC and had a resultant impact on program execution for the period April-July, 2011. MBPH mitigated this challenge by proactively communicating with partners and getting their buy-in for the proposed changes in the model, where instead of direct distribution of products to VHC at their residence, the stock are now kept at *Choupal Sagars* and VHC visit these outlets periodically to procure them. Apart from communicating the changes to partners, MBPH also continued with temporary arrangements of supplying the goods to VHC through the existing distributor of ITC. The changes in the ITC *e-Choupal* model and scope of operations did, however, have an impact on the order placement system, which led to a decline in sales. The new ordering system is functional since August, 2011.

The introduction of GP products into the VHC portfolio has been a major challenge this year. Due to a relatively steep entry fee, discussions with a number of partners did not progress. The two partners who showed some degree of interest were Pfizer and JK Ansell, though the program team had to negotiate a 50% discount in access fee for JK Ansell. The alliance with Pfizer was operationalized in the month of August, 2011 and the program team is in the process of getting the MoU signed with JK Ansell. Pfizer has already introduced OCPs into the pilot while JK Ansell will introduce condoms into the project as soon as the MoU is signed. The family planning alliance took substantial amount of time to get closed. Both ITC and JK Ansell have approved the MoU draft and the MoU would be signed as soon as the amendment related to movement of the model to consignment model is approved.

Efforts to introduce ORS into the pilot have been unsuccessful thus far. The program had explored the possibility of forging a partnership with Pharma Synth for the supply of ORS. However, discussions did not move forward due to the high entry fee for this partnership that Pharma Synth was not willing to pay. The program team also tried to initiate dialogue with various other ORS manufacturers and marketers like Ranbaxy, FDC and Alkem. These discussions also did not progress due to high entry fee as well as lack of fit of rural markets with the overall business strategy of the company. In case of Ranbaxy, the discussions did not progress because ORS as a product is handled by a different division, which operates from Mumbai and their response for this tie-up was quite lukewarm. To overcome, this, MBPH is following a two-pronged strategy: one, continuing the dialogue with Pfizer to explore the possibility of getting an ORS powder variant in place for the pilot and the second, encouraging VHC to procure ORS locally and sell it to their clients, as per requirement.

Another key challenge towards the end of Year 4 concerns manpower issues in Chandauli where the Channel Health Champion (CHC) was injured in a road accident in September, 2011 and will not be available till about the end of November. This is affecting the program. The program team has initiated the process of identifying a temporary replacement for the CHC and has briefed the District Health Coordinator (DHC) to double up as the CHC as required.

In the current year, the sales achieved by VHC have been fluctuating, but largely below what was intended and thought necessary for their sustained engagement. It will be critical, from a program sustainability point of view, to find a solution to the problem of low sales and income.

## Plan for Year Four

The focus for Year 4 is on identifying a suitable sustainability mechanism for the program. Documentation and research will also be priority activities for the year. MBPH intends to work closely with the ITC team in conjunction with CoE to work on additional changes in the model and to develop a business plan which can be used to advocate for scale-up across all *Choupal Sagar* locations.

The specific activities, which would need to be undertaken to achieve the above objectives, are as follows:

Activities	O	N	D	J	F	M	A	M
<b>Demand generation activities - Continuation</b>								
On-ground communication activities								
Special promotional offers to off-load stocks through partners/ MBPH								
<b>Designing communication module through JWT</b>								
Cost negotiation								
Finalization of approach/ plan for activities								
Developing format for village-level activities								
Developing generic communication modules for partners								
Initiation of implementation on-ground activities								
Development of standard operating procedure (SoP) document								
Communication workshop with ITC								
<b>Expansion of basket</b>								
Finalization of calendar with partners like Pfizer to introduce new products								
Introduction of 2 new products in the pilot								
<b>Capacity building</b>								
Public health training - refresher								
OCP training								
Product training on condoms								
How to organize group meetings - Refreshers								
<b>Research, Monitoring and evaluation</b>								
Consumer endline study								
VHC endline study								
<b>Documentation and Knowledge Management</b>								

Start-up package for partners									
Endline report									
<b>Scale-up plans</b>									
Scale-up plans workshop									
Finalization of scale-up plan									
Development of business plan									
Initiation of discussion with social venture funds (if required)									
Handing over of the pilot and initiation of scale-up across locations									
Final handing over of the pilot									
Project closure activities									

## Shakti Health@BoP Partnership

What started as a tentative attempt to explore the possibility of providing a regular supply of life saving ORS in remote villages in India is now a self-sustaining supply and knowledge platform that can evolve into a commercially viable model. This model leverages HUL's Shakti network of rural retailers, the Shakti Entrepreneurs (SE) to introduce Pharma Synth, a small-scale ORS manufacturer to its aggregated platform of retailers to whom the ORS is supplied and sold.

A complete handover to the natural owner – the ORS manufacturer, is expected by the end of the project. HUL, as the aggregator of rural retailers, through its Shakti network, is a key partner in this pilot and a successful scale-up would require participation from both partners.

### Background

The Shakti H@BoP pilot optimizes the strength of the two partners – the aggregator of retailers and the ORS manufacturer to increase access to ORS in rural populations. Startup costs associated with rural market entry by a pharmaceutical manufacturer, such as village identification, retailer selection and identification and developing a relationship with the retailer are reduced due to the partnership with an existing network of retailers. In this pilot, the ORS manufacturer invests in extending/deepening its distribution to the network retailers for a limited period – during months of high diarrheal prevalence. The retailers/villages are selected in such way that they are within a 10 km radius of a tier 3-4 town serviced by Pharma Synth. During this period the SEs are supplied the product through the Pharma Synth sales force. A low-cost demand generation module which targets the top performing 20% SEs has been implemented.

A preliminary assessment based on sales figures and Pharma Synth's involvement in the key function of distribution suggests that the pilot can indeed be transferred to Pharma Synth or a similar pharmaceutical company– a thorough cost-benefit analysis however needs to be carried out to make a more compelling case for this strategy. It must also be added that an aggregator of commercially trained retailers like the Hindustan Unilever (HUL) Shakti network is a crucial element of this pilot, since it allows the ORS manufacturer to significantly reduce the start-up costs required to enter the rural market. The participation of HUL is critical to the scale-up of this model; the pilot will need a support from the Shakti field teams in during the expansion process. Support required from HUL would be intensive during the initiation of the pilot in a new market (SE and village identification, village location, joint visits) but will significantly reduce after entry.

### Achievements of Year Three

The achievements as per activities planned for Year Three are tabled below:

Activities	% Complete	Justification
Implement a Pharma Synth led-commercially sustainable rural distribution model for ORS		
Selection of SE in the pilot districts	100	

<b>Activities</b>	<b>% Complete</b>	<b>Justification</b>
Facilitating Pharma Synth in augmenting existing supply chain in pilot districts	100	
Monitoring sales, stock outs and turnaround time and collecting orders	100	
Implementation of the mobile tracking system	100	
Analysis and documentation of pilot results	50	Sales and supply related results have been collected. However a crucial part of the results analysis is the cost benefit study which will be initiated next year.
Transference of SE training component to Pharma Synth		
M ToT of Pharma Synth field staff	100	
Develop handover tools for Pharma Synth (SE identification, village identification, coordination with HUL, etc)	100	
Training of Pharma Synth staff on the mobile tracking system	100	
Advocate with HUL for greater corporate level involvement in the initiative		
Document case studies of successful SE	0	This will be carried out as part of the cost benefit study.
Meeting/workshop with HUL management to discuss pilot results and next steps	20	Based on feedback from one of the HLC members, MBPH has contacted the HUL CSR division.

### ***Commercially viable distribution model for ORS designed***

The objective was to design a commercially viable distribution model that did not deviate significantly from the existing Pharma Synth operations and would therefore be a cost effective system that would be likely to be carried on by the partner after the end of the pilot. The program team was able to design an innovative distribution model that leveraged existing Pharma Synth sales and supply infrastructure to reach rural markets. This model was designed after extensive consultations with the product partner.

### ***Distribution function completely transferred to Pharma Synth***

Given that the distribution model was designed in consultation with Pharma Synth, there was sufficient buy-in in the company for them completely to take over this function in the pilot districts. This required investment and commitment from Pharma Synth both at the levels of the field and the management, which was obtained because the company saw a potential in the rural market. In order to optimize revenue and enable stricter monitoring of ORS supply to the SE (by Pharma Synth management), it was decided that the Pharma Synth sales representative would be responsible for supplying ORS to the SE. Pharma Synth is able to supply 70% of the SEs within a time span of 15 days, which while not conforming to the PMP indicators of supply within 10 days, is still a reasonably quick turnaround time for a rural supply endeavor.

### **Contribution to overall Pharma Synth ORS sales in the pilot districts in the tune of 20%**

Pharma Synth has given its sales representatives in each of the three districts a sales target of approximately INR 120,000 for ORS sales in the months of April-May-June-July. As highlighted in table below, sales from this pilot accounts for at least 20% of the total ORS sales for this year in the pilot districts. This is a significant contribution that however needs to be weighed against the costs of the pilot. There has been a 50% increase in sales and income for the SE compared to sales in 2008-09. The increase can be attributed to the solving of the supply issue, since demand side intervention has been minimal.

<b>Indicators</b>	<b>April '11</b>	<b>May '11</b>	<b>Jun '11</b>	<b>Jul '11</b>	<b>Average</b>
Total sales (Pharma Synth)	15,558	31,210	25,026	24,813	24,152
Sales/district	5,186	10,403	8,342	8,271	8,051
Sales INR/SE	678	391	463	605	534
Total SEs	23	80	54	41	50

### **Barriers and Challenges**

#### **Single Seasonal Product**

The major limitation of this pilot is that ORS is a seasonal product, which generates sales only for 4-5 months of the year. Thus while the contribution from rural sales is high during these months, there is limited potential during the rest of the year. This may not allow Pharma Synth to build on its relationship with the SE, since there is a long break in interaction. Pharma Synth does not have other OTC products in its basket, and hence there seems to be no solution to this barrier. However, given our pilot results and following a cost benefit analysis of the pilot, this model can be taken to other pharmaceutical companies that have a basket of OTC products and might be willing to invest in distribution.

#### **Plan for Year Four**

The objective of Year 4 is to assess the impact of the pilot, with respect to the sustainability of the distribution model, the revenue impact on the product partner, Pharma Synth and the interest of the Shakti Entrepreneur in continuing with this line of business that positions her as a health marketer in the community. In year four MBPH will partner with the CoE to undertake a cost benefit analysis of the pilot in terms of revenues, costs and impact, from the perspective of the partners, the SE and the sustainability of the model. We will then disseminate the findings of the analysis to other interested groups operating in the rural marketing/ Pharma space. These might include other pharmaceutical manufacturers, rural aggregators such as FMCG companies, MFIs, and think tanks.

The specific activities, which would need to be undertaken to achieve the above objectives, are as follows:

<b>Activity</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>	<b>A</b>	<b>M</b>
Cost Benefit Study								
Engagement with HUL								
Documentation								
Dissemination								

## Saathi Bachpan Ke

### *Friends of Childhood; Program on diarrhea prevention and management*

#### **Program Vision, Objectives**

Saathi Bachpan Ke (SBK or 'Friends of Childhood' in Hindi), aims at improving child health by reducing the incidence of diarrheal diseases in children under five by promoting simple and effective solutions. The program has taken an “Alliance” route and has established diverse partnerships with both public and private sectors and non-government organizations working in the areas of hand washing with soap, purification of drinking water and Oral Rehydration Salts (ORS) therapy. The vision of the program is to improve child health by reduction in diarrheal diseases in children under five through engagement of commercial and non-commercial partners.

The Program objectives are two-fold:

1. Build awareness and practice on handwashing with soap, adoption of water purification methods and use of ORS for diarrhea prevention and management amongst caregivers of children under five
2. Engage commercial partners in outreach and to facilitate inclusion of diarrhea messaging as part of brand communication

#### **Background**

The program has gone through a two-step evolution. The original objective was to design a market-based partnership for promoting hygiene and hand washing by setting up a **Hand Washing Alliance**. When it was clear that commercially competitive players in hand washing were unwilling to join the alliance, MBPH decided to set up a **Health and Hygiene Alliance** with a broader issue focus on comprehensive diarrhea prevention and management, not simply limited to hand washing.

The thought behind this was that it would encourage non-competing product partners to come on board and also have a larger public health impact by addressing the inter-linked prevention and management aspects of diarrhea in children (validated by Lancet and other available WHO, UNICEF studies). As a catalyst, MBPH is bringing together partners, designing the Alliance structure and guidelines and acting as a Secretariat driving Alliance strategy, investment and implementation.

The government was envisioned as a neutral owner of the Alliance. Interaction with the government for MBPH programs is routed through USAID. The linkage with the government has been deferred to the end of the project so that the evidence gained from executing commercial sector partnership and activities on-ground can be presented in a convincing manner.

Commercial sector organizations were initially reluctant to join this Alliance, which may only be active till 2012 (the life of the MBPH project). However, the investment made by MBPH in category promotion through mass media and on-ground activation has been an important driver for finalizing commercial sector partnerships.

## Achievements of Year Three

With this backdrop, the SBK program in Year 3 entered into direct implementation mode, executing activities on-ground and developing mass media campaigns. The focus was on:

1. Developing and implementing category campaigns around which commercial partners will converge. The health issue focus was hand washing with soap, ORT and purification of drinking water. The goals of the program continued to be improving child health by reduction in diarrheal diseases in children under five, through promotion of these simple and effective solutions.
2. Implementing outreach interventions targeted at caregivers of children under five in identified urban slums in 3 cities of UP, i.e. Lucknow, Kanpur and Varanasi.
3. Signing at least one key commercial partner for soap, water purification and ORS for supporting and partnering with SBK for field activities in these cities e.g. by provision of co-branded communication materials, product samples, give-away, etc. These commercial brands would include diarrhea prevention and management messaging to raise consumer awareness as well.
4. Utilizing public relations as a means to create SBK Alliance visibility and issue salience for diarrheal disease.

Program on Diarrhea Prevention and Management	% Completed	Justification
<b>Commercial partnerships</b>		
At least one commercial partner on board in each area of handwashing , water purification and ORS Use	100%	Reckitt Benckiser- Dettol, TATA Chemicals- TATA Swach, Medentech- Aquatabs, Alkem Laboratories - ORS
On-ground execution of partnership commitments as per partnership agreements	100%	
Quarterly meetings and updates with partners	100%	
Finalize partnership plan with key non-commercial partners	100%	<i>Sulabh International</i>
<b>Communications/ Activation/ PR</b>		
Communications, PR and media buying agency contracted	100%	JWT, Maxus, Hanmer MS&L contracted
Finalization of creative strategy	100%	
Pilot-test of creative materials	100%	
Finalization of creative materials	100%	

<b>Program on Diarrhea Prevention and Management</b>	<b>% Completed</b>	<b>Justification</b>
Finalization of activation strategy	100%	
Production of creative and activation materials	100%	
Activation roll-out	100%	
Finalization of mass media plans	100%	
<b>Activation execution by Field/ Outreach team</b>		
Execution of direct contact program and health camps	100%	<i>Pratinidhi Samiti</i> has been contracted for the direct outreach program
<b>Training and Outreach</b>		
Training of ISMH providers	100%	Alkem Doctor network has supported these trainings
<b>Research</b>		
SBK baseline study and qualitative completed	100%	
SBK research shared with partners	100%	
Research insights integrated into creative strategy	100%	
Research Report documented and ready for dissemination	90%	Is currently being printed and will be ready in October for dissemination

### **Key activities and achievements in Year 3**

#### **Research**

SBK's baseline quantitative and qualitative study has been completed and shared with partners. The research insights have been integrated into the communication strategy. The SBK Baseline Research Report is being printed and will be ready for dissemination to partners, non-governmental organizations, donors and other agencies working in the area of public health.

#### **Partnerships**

SBK signed MOU with Medentech for Aquatabs and has integrated Aquatabs into its outreach activities. With existing partners, Dettol, TATA Swach and Alkem Laboratories, SBK has engaged in various on-ground activities with caregivers in intervention settlements and children in schools. Tata "Swachrakshak" performed in various schools in Lucknow to drive home the safe water message. Correct Handwashing with Dettol soaps was demonstrated in both settlements, health camps and school activities. Alkem Laboratories had not been participating in the outreach program but the partnership was revived and their doctor network has been leveraged to provide training to SBK's Indian Systems of Medicine and Homeopathy (ISMH)

providers. SBK has initiated MOU with two new partners: Save The Children- *Bal Raksha Bharat* (a premier international Child Rights organization working in the area of child survival and health and advocacy) and Ion Exchange India (manufacturers of Zero B *Suraksha* water purification solutions). These are under consideration and review. SBK has contracted a grassroots partner, *Pratinidhi Samiti* to implement group meetings with caregivers and organised health camps where all 3 messages on handwashing, water testing and purification and ORS use are communicated. *Pratinidhi* is also providing access to water purification products such as Aquatabs so there is increased use of products in the intervention areas. The various activities with Partners are detailed in the Field interventions mentioned below:

### **Field interventions**

With active participation of partner brands Dettol and TATA *Swach*, SBK implemented several on-ground programs in settlements and schools in intervention areas. These included street theatre, school activation events, and Global Handwashing Day celebrations in October 2010 and reached 150 schools and 34174 children in the primary and middle school in the 3 program cities (Lucknow, Varanasi and Kanpur) directly.

*Saathi Bachpan Ke* organised 709 group meetings with mothers of children in 10 settlements each in Lucknow, Varanasi and Kanpur and 41 slum activities reaching 16,552 Caregivers in all three cities. 50 Women promoters, SBK 'health messengers' from *Pratinidhi Samiti* reached out to caregivers and conducted meetings with mothers of children aged 5 and below. They promoted hand washing with soap, water purification and correct ORS use amongst caregivers. The women promoters were trained by SBK technical team of doctors and experts to communicate with caregivers on diarrhea prevention and management and were equipped with various BCC materials (flipbooks, games, leaflets, handwashing with soap tool) to impart key messages from the SBK campaign.

SBK engaged with Medentech in India for provision of Aquatabs as a low cost solution for water purification and these are being provided through *Pratinidhi Samiti's* women promoters. Water testing kits have been used to demonstrate the quality of water and to establish the need to treat water and purify it before use. 1,349 Aquatabs were sold in the 1<sup>st</sup> month of Behavior Change Communication (BCC) activities.

SBK organised 53 health camps in the intervention settlements. Health camps have been used to increase awareness amongst caregivers (both mothers and fathers and elder siblings of children under 5 years) on diarrhea. The camps have used 'edutainment' to teach important life-saving behaviors – from washing hands with soap and purifying water to rehydrating children suffering with diarrhea. Key messages have been reinforced through puppet shows, interactive games and quizzes. Presentations and demonstrations are provided by physicians and other program supporters including manufacturers of soap, water purifiers and ORS, and by public sector partners.

During the year, SBK trained 89 TATA *Swach* Sales representatives from Delhi NCR, NOIDA, Lucknow, Kanpur, Varanasi, Agra, Gorakhpur and Meerut on diarrhea prevention and management and the role of water quality and safety. All trainings used handouts, role play and quizzes to ensure retention of key messages. The purpose of the training was to build capacity of the TATA *Swach* team to deliver health messages with respect to diarrhea prevention and management and to enable the team to understand and integrate 'Diarrheal diseases and the

toll they take' messages along with water treatment and safety. The Sessions covered the following topics:

1. *Saathi Bachpan Ke*: A program overview and partnership with TATA, Medentech, Dettol and Alkem for Diarrhea Prevention and Management. The session was a brief introduction to the program and was conducted by Kavita Ayyagari, Program Director, SBK Alliance, and Abt Associates.
2. Diarrhea prevention and management: An overview of Diarrhea, its causes, prevention and management methods. The importance of ORS, its correct preparation and dosage and other important information in diarrhea management. The session was conducted by Dr. Shalini Suri, Expert Trainer, and Abt Associates.
3. Water Quality and need for treatment: An overview of water quality, its treatment at the municipal plants, need for treated water (both urban and rural), current availability of drinkable water in the above areas, water quality guidelines by WHO and BIS, types of contamination and various treatments available. The session was conducted by Mr Depinder Kapur, water expert, previously with WaterAid in India.

The average score in the post test following the training was 86%. The feedback received from the participants was positive and they recommended that the same training be conducted for their colleagues from other towns. TATA has been asking the SBK team to train its staff nationally.

ISMH trainings were conducted by the MBPH CBQA team for 370 ISMH providers in all 3 intervention cities. SBK leveraged the resources and time from Alkem Ulticare's Pediatrician Network for refresher trainings. To ensure consistency in treatment practices for diarrhea management in children under 5 years, 7 refresher trainings were conducted for 250 ISMH providers who are linked with SBK. The focus of the training was to ensure correct advice on how to manage diarrhea cases, importance of recommending WHO promoted ORS, the correct dosage as per the child's age and weight and preparation and storage practices. The providers were also informed about the importance of preventive measures like handwashing with soap, water purification and about nutritional advice for children suffering from diarrhea that are to be given to caregivers of children.

SBK organised a 3-day on-air and on-ground activity on the occasion of ORS Day, July 29, 2011, through a partnership with RED FM. There was a 3-day on-air activity that involved the radio channel actively giving messages on the importance of ORS in diarrhea management and hand washing and water purification in diarrhea prevention. Listeners from various walks of life called in at the radio station and took the pledge to save a child's life from Diarrhea. The program had 426 spots of 30 seconds each, with radio jockey (RJ) mentions, interviews with the Program Director and program staff and with doctors associated with SBK. More than 12,780 seconds of free commercial time were leveraged.

On World ORS Day, RED FM also organised a painting competition on "*Dast ke rakshas ki haar, hamari jeet*" (defeating the diarrhea monster is our win) in 18 schools in the 3 program cities with 900 students participating in the multicity event. A mega health camp was organised by the SBK field team on the same day, in all three cities, with several doctors (pediatricians and ISMH providers) participating in them. The events were reported in 58 publications including the Hindustan Times, Hindustan, Times of India, *Dainik Jagran*, *Amar Ujala*, Pioneer and several other local dailies. Hanmer MS&L, SBK's PR agency organised the vast media coverage and this

resulted in high leveraging values for the program. Kanpur's Siticable News carried celebrity ORS campaign messages from Shabana Azmi, Sanjeev Kapoor, Mandira Bedi, Arshad Warsi, Sakshi Tanwar on ORS use as part of the news coverage on ORS Day. BIG FM carried news bytes on facts about diarrhea through the day on July 29.

### **Communication**

SBK's communication agency JWT presented a communication strategy with creatives for ORS, Handwashing and Water purification. Based on the strategy, SBK tested five concepts with caregivers in Lucknow and Varanasi, one for ORS, two each for hand washing and water purification. Research results and recommendations were shared with USAID. On the basis of this, SBK is currently producing the ORS advertisement based on the theme of "*Pyari ma, jo kabhi haar nahin maanti*". The advert is an ode to a mother who never gives up. The communication task was to establish that 'it is important that the mother persists and continues to give frequent doses of ORS to her child suffering from diarrhea, even if child refuses' so that diarrhea doesn't lead to dangerous dehydration.

The handwashing and water film themes were based on the idea that 'germs are not affected by water and survive in water'. Therefore soap is essential for handwashing and water purification tablets and filters are essential for treating water.

On discussion with USAID, it was felt that 'water purification' was best handled on-ground through water testing demonstrations and actual interactions with caregivers, exploring reasons why they don't treat their water and why they should. Direct interventions through health camps, doctor recommendations and BCC activities by the outreach promoters would have better results. Therefore, it was decided that SBK will not be producing the water safety advertisement.

Hanmer MS&L, the PR agency, has been providing support for building SBK visibility and issue salience for diarrhea. The objectives for PR are to build issue salience on diarrhea as a major killer of children in the less-than 5 age group. The special focus of the intervention in UP is to highlight SBK efforts to promote simple and effective measures that can help curb the crisis and to engage stakeholders that can both influence and help change the practices of caregivers of children of the target age group. The overarching messages being communicated through PR is 'despite simple, effective and proven lifesaving solutions being available today, diarrhea remains a leading cause of preventable death, among children under five in India' and that 'the SBK alliance works towards changing this by working in 3 core areas of handwashing with soap, water purification and ORS use through an integrated social-private sector alliance approach'. SBK has achieved more than 72 print and 14 online articles besides coverage on RED and BIG FM and Siticable for ORS Day, leading to a PR leveraging of more than 90 lakhs for the quarter.

### **Barriers and Challenges**

Although partnerships with 3 partners – Dettol, TATA Swach and Alkem were finalized in Year 2, operationalizing these partnerships on-ground took considerable time. Individual partners were interested in specific components, e.g. Dettol in school activation and TATA Swach in health camps in their launch phase. Alkem Laboratories was not participating in any activity and it was a challenge to get them to commit time and resources to the project which they finally did with the refresher ISMH trainings planned with their doctor network.

Also, partners like Dettol and TATA Swach demanded visibility of their logos with SBK Alliance branding. SBK in its branding guidelines had clearly promised that only SBK logo can be used by partners in their material but in all SBK material that carries USAID logo on it, no partner branding would be allowed. This was seen as a barrier by Partner Brands as they would not gain any visibility from the SBK Communication campaign being developed.

The communication contract was delayed, impacting the launch of the campaign.

### Strategic focus and Activities for Year 4

Program on Diarrhea Prevention and Management	O	N	D	J	F	M	A	M
<b>Commercial partnerships</b>								
On-ground execution of partnership commitments	■	■						
Quarterly meetings and updates with partners	■	■	■	■	■	■		
Finalize partnership plan with key non-commercial partners	■							
Implement partnership plan with non-commercial partner	■	■	■	■	■	■		
<b>Communications/ Activation/ PR</b>								
Finalization of creative materials	■	■						
Finalization of activation strategy	■							
Production of creative and activation materials	■	■						
Activation roll-out	■	■						
Finalization of mass media plans	■	■						
Mass media roll out	■	■						
<b>Activation execution by Field team</b>								
Execution of school, urban settlement program and health camps	■	■						
<b>Research, Monitoring and Evaluation</b>								
Endline evaluation plan finalized	■							
Endline Evaluation begins		■	■					
Evaluation results shared and documented				■	■	■		
<b>Documentation</b>								

<b>Program on Diarrhea Prevention and Management</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>	<b>A</b>	<b>M</b>
MBPH Website updated								
Baseline Research Report printed and disseminated								
End of project Report printed and disseminated								
<b>Advocacy</b>								
Position Paper on Zinc inclusion for Diarrhea management								
<b>Program Closure activities</b>								
Transfer of learning from program to COE								
Exploration with MOHFW and NRHM for transfer of communication material and BCC model								

## Advanced Cook Stoves Initiative

### Program Objectives

The aim of the MBPH ACS Initiative is to work in partnership with key stakeholders, including the Government of India, ACS manufacturers, micro-finance institutions, rural distribution networks, scientists and sector experts towards a common vision of increasing adoption of and access to ACS. In India, the ACS initiative was previously led by the public sector, with limited role for private industry. This approach has recently undergone a change, with both the Government and donors acknowledging the potential of the private sector to increase access to ACS among base of pyramid populations. However this market is still relatively nascent, with few manufacturers and marketers being able to avail of the benefits of mass manufacturing and economies of scale. It is envisaged that by the end of the project, the inputs provided by the MBPH ACS initiative will pave the way for an in-depth understanding of consumer behavior with respect to ACS, provide insights into attributes of a workable distribution model, lay out potential consumer financing options and create an enabling regulatory environment for enhanced private sector participation in the ACS industry.

Based on an extensive assessment of the issue and the sector conducted by MBPH in late 2009, the ACS program focuses on the following key objectives:

Pilot a commercially viable ACS program

Develop and test innovative demand generation strategies with a focus on Base of the Pyramid (BOP) consumers

Design and test financially viable strategies to increase affordability and adoption through implementation of a pilot involving ACS marketers, micro-finance institutions (MFIs) and rural distribution networks

Develop a supportive environment for ACS

Support the relevant authorities in the development and acceptance of product design and manufacturing standards

Initiate an advocacy strategy directed towards the national and state government for rationalization of the tax and tariff barriers to increase access for lower income groups to ACS

Create a road map of carbon financing options

It is envisaged that by the end of the project, the inputs provided by the MBPH ACS initiative will pave the way for an in-depth understanding of consumer behavior with respect to ACS, provide insights into attributes of a workable distribution model, lay out potential consumer financing options and create an enabling regulatory environment for enhanced private sector participation in the ACS industry.

## Achievements of Year Three

The achievements as per activities planned for Year Three are tabled below:

Activity	% Complete	Justification
<b>Design and test market introduction strategies with respect to distribution, financing and demand generation and launch pilot</b>		
Decide on margins and/or credit terms between partners	100%	
Identify intervention villages and feeder towns	100%	
Set up supply chain systems for ACS	100%	
Draw up roles and responsibilities of all participants	100%	
Complete launch baseline fieldwork	100%	
Launch pilot	100%	
<b>Develop communication strategy for ACS</b>		
Complete formative research and formulate demand generation strategies	100%	
Identify and formulate demand generation strategies for priority customer segments for ACS	100%	
Develop “sales pitch” for early adopters and other segments	50%	There was an interim sales pitch in use, however after JwT was contracted as the ad agency, we are in the process of revising the pitch and promotional toolkit
Develop key messages and master templates	100%	
Roll out activation and outreach in rural intervention sites	50%	Though the activation has been rolled out basis the interim materials (from Shell), we are working with JWT in revising this and will roll out a more focused activation format in Oct-Nov
Launch activation event in the urban intervention site	100%	
<b>Produce a report on carbon financing options and roadmap for ACS</b>		
Produce a report on carbon financing	90%	A workshop has been organized to share best practices. The workshop report is in the final

options and roadmap for ACS		stages of completion.
<b>Conduct a landscaping of the tax and tariff structure in the ACS industry</b>		
Complete report in trade and tariff regulations for ACS	0%	Hitches in the contracting process, first with IIT D and then with E & Y has delayed the initiation of this activity.
Draft advocacy plan	0%	The advocacy plan is an outcome, and part of the tax and tariff assessment.
<b>Initiate work on preparing a guidebook on ACS standards</b>		
First draft of guidebook produced	0%	There has been a delay in the identification and recruitment of consultants.
<b>Continue engagement with key stakeholders in the industry</b>		
Organize at least work-shop on the issue of commercialization of ACS	100%	
<b>Recruitment of consultants</b>		
Recruitment of BCC, research, advocacy and standards consultant	80%	One of the two consultants for standards has yet to be recruited.

### ***Partnership with a Last-mile Distribution Network***

The need for providing higher channel margins across the supply chain and the limitations of a traditional retailer network in promoting a new category such as ACS, influenced MBPH's decision to partner with a village-level distribution network, Project Dharma. Project Dharma has set up distribution infrastructure in one of the MBPH districts of the ACS program i.e. Sultanpur. In the second district namely Faizabad, the infrastructure is being put in place. The infrastructure includes Village Level Entrepreneurs (VLE) for the village clusters in the pilot and a super VLE, or a Stockist, in each district.

### ***Development of a Zero-Interest Loan Product***

A 'zero-interest' loan product for clients of the micro finance institution (MFI), SONATA has been developed by MBPH for this pilot. This is the first time that such a financial structure has been developed for the ACS category. This structure is designed to commercially benefit the MFI, with the distributor compensating the MFI by paying it a marketing commission over and above the interest on the loan itself. The distributor gets easy access and conversion from a niche segment that, though small, often consists of early adopters who could cause a trickle effect for their product. This is especially crucial for a new, high-engagement and testimonial-driven product like ACS.

SONATA and Project Dharma, in a meeting facilitated by MBPH, have agreed to the interest and commission terms. The processes for approving the loan, transferring payments and

supplying the products have also been agreed to by both parties. A draft agreement has been prepared and this has been cleared by Dharma and has been signed by SONATA.

### ***Market Building***

A two-day format for promoting ACS that includes the identification of model consumers, community meetings and product demonstration has been developed to create awareness of the category, and to identify potential leads. These leads have been shared with Dharma VLEs for final sales closure. The current promotional design is resource intensive. However this intensity is required to reach a critical mass of consumers. A minimalistic promotional module can then be developed based on a study of this group of consumers. A “try before you buy” strategy for potential buyers will be implemented in the pilot, wherein potential consumers can use the product and experience its benefits to speed up the decision making process. The MBPH advertising agency, JWT, has been briefed on the program and its communication objectives – the brief has stressed upon the direct marketing approach of this high engagement product. The agency has shared a timeline according to which a brand communication strategy as well as the creatives should be delivered by the end of August.

### ***Pilot Launch***

The ACS pilot was launched in 25 villages in Faizabad, UP, on April 14, 2011 and in the same number of villages in Sultanpur, UP, on June 24, 2011. The launch involved product training by representatives from Envirofit and an overview on the sales and promotional design. Participants at these launch events included VLE, stockists, MFI representatives and the Dharma district manager. Since the zero-interest financing is available only in Sultanpur, the VLE orientation module included details on the loan product, the process for working with MFI loan officers, etc.

Feedback from the Faizabad intervention is that a loan product can be an essential tool for breaking into the market and creating the initial set of consumers. The lack of such a product has lengthened the duration of conversion and decreased the ‘conversion rate’. The loan for ACS is a tool for addressing the cash flow constraint rather than affordability, at least for the early adopters. It must be noted that this is a zero interest loan for consumers and hence they only pay the MRP for the product. In Sultanpur, where the loan option is available, the first results have been highly positive, with 30 loan forms being filled up within a week of the launch.

### ***ACS Promotion in the Sanjay Gandhi Urban Settlement***

Hope Worldwide, which has been sub-contracted to carry out awareness generation activities for ACS, has organized meetings, product demonstrations and other mother and/or child-oriented events to promote the category. On April 26, 2001, the outgoing US Ambassador to India, Mr. Timothy Roemer, attended one such promotional meeting and product demonstration and interacted with the community. While the response from the community has been positive, most interested women believe that the current retail price of the ACS is not justified. This is a reflection of the value-for-money consideration given to these products.

A key hurdle in this intervention is supplying the product to interested consumers. Hope Worldwide, being a non-profit organization, cannot sell any product, even at cost; Envirofit on the other hand, cannot supply and sell to end users. Alternative avenues, such as identification of potential retailers/stockists are being explored.

### ***Tax and Tariff Study***

IIT Delhi expressed its inability to work with USAID|India or MBPH on the ACS Tax and Tariff study. Since the ACS program has lost time in pursuing the contract with IIT Delhi, and since it will be difficult to achieve the advocacy agenda (workshops/meetings with the Government of India) without them, the SoW was modified to lay greater emphasis on the assessment on the tax and tariff structure for ACS. The time for completion has also been compressed from the earlier duration of 90 days to 60 days. An open competition was held, with an advertisement placed in the Economic Times, Delhi edition, and interests received from seven organizations. Four organizations submitted proposals which were rated by an internal team, based on which Ernst & Young was selected to carry out this study. However the contract could not be carried through due to legal differences between Abt and E&Y, specifically with respect to the clause on jurisdiction. Abt is now in the process on contracting MART, whose proposal which was ranked second in the score sheet.

### ***Carbon Financing Workshop***

As per USAID|India's direction, MBPH organized a dissemination workshop on 10<sup>th</sup> August 2011, to contextualize various carbon finance roadmaps for the Indian ACS milieu. The workshop helped identify key trends, opportunities, challenges related to developing carbon finance for ACS in India, as well as the most effective ways in which USAID and other donors can accelerate its development. This includes strategizing on how to coordinate with the Global Alliance, the Indian National Initiative for Improved Biomass Cook Stoves and other such initiatives.

A total of 64 participants attended the workshop with representatives from USAID|India, Ministry of New and Renewal Energy, Government of India, Global Alliance, Indian Institute of Technology, Delhi, Shell Foundation and Envirofit, amongst others.

### ***Developing Standards for ACS***

The preliminary work on this assignment has begun, with the identification of key experts. Prof. Rajendra Prasad and Dr. Karabi Dutta will be contracted to consult with MBPH. Both Prof. Prasad and Dr. Dutta have worked closely on the Government of India's National Cookstove Initiative. Dr. Dutta has also worked as an ACS standards expert in the Global Alliance. The SoW have been finalized and shared with USAID|India. This assignment will present a critique of existing ACS standards and identify gaps, if any, in these standards. The objective of this study is to propose a set of recommendations to stakeholders and regulators as they develop universal standards for ACS in India. The recommendations will consider the perspectives of all the key elements in the value chain – from the consumer to the manufacturer and the distributor to the regulator.

## ***Expansion to Uttarakhand***

MBPH has received USAID|India's approval to initiate the expansion of the ACS pilot in Uttarakhand. The objective of the Uttarakhand pilot is to show case that an implementing partner can be a one-stop-shop for the promotion and sales of ACS. The implementing partner is envisaged to be a NGO (or a consortium of NGOs), with a spin-off marketing company and a micro finance institution. This is an open bid, and an advertisement with these details was placed on the website 'DevNetIndia.org'. The last date for submission of proposals was June 24, 2011. Four organizations submitted proposals, of which an internal team rated the Appropriate Technology India proposal as the best. The next steps will be to finalize the contract and initiate operations.

## ***Ross School of Business - Multidisciplinary Action Project (MAP) Presentation***

On behalf of MBPH, a team of four students from the Ross School of Business, University of Michigan were engaged in developing a set of implementable marketing tactics/strategies for generating sales and increased usage of ACS among rural BOP populations. This was a component of the Multidisciplinary Action Project (MAP) – a part of their business school curriculum, for which Abt Associates had submitted a proposal which was accepted by the school and the students. The MAP assignment has proposed a strategy for introducing ACS to rural markets in India. This approach includes a marketing, distribution, and training strategy to increase adoption and usage of ACS in UP. The MAP team has developed a market introduction framework called the '5 As of Adoption' in order to better understand how to drive product adoption. The five A's are: attributes, awareness, affordability, availability, and adaptability. This model has been created by adapting common BoP frameworks focused on driving rural product adoption, as well primary and secondary research.

## ***Barriers and Challenges***

Category Expansion: Though MBPH has partnered with Philips and Envirofit for piloting the ACS intervention, discussions with Philips indicate that the company is moving out of the ACS space and has not been an active partner. The very nascent stage of the ACS industry, with only two to three manufacturers operating mass manufactured outfits, has limited the expansion of this pilot to include other models. Selco, a distributor of ACS, has shared that their focus areas at present do not include UP or Uttarakhand. Prakti, another manufacturer, at present cannot make investments in distribution and promotion, and is designed to manufacture products only on an assured delivery basis. First Energy, the manufacturers of the popular, Oorja ACS stated that their stoves will not function in the MBPH pilot areas, since their operations include the use of processed biomass pellets which is difficult to obtain in MBPH's pilot territories. They however, did mention their plans to introduce 'wood fueled stoves' in the market in the next 2-3 months; a potential partnership with First Energy could be explored at that point in time.

Product Supply in the SG Settlement: Awareness generation campaign regarding Indoor Air Pollution (IAP) and ACS is being carried out in the SG Settlement. The next steps for this intervention in terms of product supply needs to be explored and assessed. This is a small

settlement and it does not make commercial sense for the manufacturer to invest in a distribution network specifically for this settlement. Our recommendation to USAID will be to discontinue this activity.

**Market creation:** The market for an ACS, especially in UP is currently almost non-existent. Consumers are not aware of a product option that exists between the high end LPG stove and the traditional open stove. Even if awareness is generated among the target consumers, with regard to ACS, there needs to be research to describe the likely adopter group/s and an assessment as to whether this segment size can be of any interest to ACS manufacturers and channel partners. The qualitative researches conducted by Monitor followed by the quantitative study done by GfK-Mode have answered these questions to a certain extent.

**Private sector reach:** There are a limited number of private ACS manufacturers, all of whom are at different stages of entering into the ACS market. Cooking behavior, product acceptance and demand dynamics in UP is still an unknown to these manufacturers who thus far have been developing the ACS markets in South and West India.

**Financing options:** As identified in our initial landscaping, one of the barriers to use in the case of ACS is the price barrier. While loans by MFIs emerge as a potential means to overcome this issue, convincing MFIs to enter this market can be challenging. Concerns related to the small ticket size of loans and the reluctance of MFIs to finance consumption related loans need to be addressed including the question regarding how MFIs might access seed funding to provide these loans to potential consumers.

**Limited reach of MFIs:** While participation by MFIs by extending their network and easy loan options for the purchase of ACS has helped MBPH enter the market, limited penetration of MFIs is restricting MBPH in un-tapping the full potential of the market.

### Plan for Year Four

In year four, MBPH will focus on will be on continuing to monitor the pilot, expanding the intervention to the remaining 50 villages in Faizabad and Sultanpur districts, developing creatives for category promotion and producing deliverables related to the carbon finance, standards and tax and tariff assignments.

The specific activities, which would need to be undertaken to achieve the above objectives, are as follows:

Activity	O	N	D	J	F	M	A	M
Expand current operations in Sultanpur & Faizabad								
Expand to Uttarakhand								
Develop & Implement Communication Strategy								
Assessment of Taxes & Tariffs								
Develop Standards for ACS								

## Tuberculosis Control and Care Initiative

### Program Vision and Objectives

The vision of private participation in TB control and care, under the USAID-funded Market-based Partnerships for Health (MBPH) project, is that private healthcare providers (pHCP) are empowered and motivated to practice evidence-based TB management that would ensure the best outcomes for their patients and contribute to TB control in India. The objectives of the program are to increase community demand for DOTS, strengthen the private sector for delivery of high quality, standardized TB-control services and improve access through a professional interface mechanism. To help attain this vision and to reach its objectives, MBPH has designed and implemented initiatives that attempt to improve public health indicators for Base of Pyramid populations in the TB-control space, through the gainful engagement of pHCP endorsing national and international standards of TB care.

### Background

Prompt, quality-assured, diagnosis and treatment are the keys to both improving patient treatment outcomes and controlling the TB epidemic. Currently, however, there are delays in patients seeking care, receiving appropriate diagnostic tests, being prescribed suitable therapy and inadequacies in follow-up of patients on treatment. The non-government sector, i.e. the private sector is a critical part of health care delivery in India and hence needs to be tapped if the program is to achieve universal access to TB care.

The private sector in India is a vibrant but varied set of sub-groups that provides services that are preferred by the majority of Indians. The sector offers services that are generally described as being more affordable, accessible, and responsive to the needs of patients. On the other hand, this sector remains largely unregulated and the technical quality of some sections of the sector remains an area of concern. The private sector is often left out of major national health programs, despite its large size, scope and penetration into micro-communities.

While the reality of this sector creates constraints as well as potential for improvements in service delivery of public health programs, its integration into public health systems is the way to enable provision of service elements in a seamless continuum of care, increase coverage of health service dispensation and contribute to decrease in response time.

The objectives of the Stop-TB Strategy, including achieving Universal Access, can realistically be fulfilled in India by engaging the entire spectrum of the dominant private healthcare sector and by systematically scaling it up to provide improved service delivery, diagnostics, social mobilization and demand creation for DOTS.

## Achievements in Year Three

The table below shows the activities planned for year three (2010-11) and the level of accomplishment achieved against each.

S.No.	Activity	% Complete
1	<b>Research</b>	
1a	Completion of baseline studies (FW)	67% <sup>4</sup>
1b	Report on baseline studies	75%
1c	Initiation of process for selection of agencies for endline studies	100%
2	<b>MIS Package Development</b>	
2a	Selection of agency to develop MIS	100%
2b	Agency develops MIS and key personnel from implementing agencies trained	100%
3	<b>CB Package Development</b>	
3a	CB package developed and key personnel from implementing agencies trained	100%
4	<b>Implementation in Karnataka</b>	
4a	HR procurement and training	100%
4b	Mapping of implementation areas	100%
4c	Initiation and continuation of ACSM and CB of pHCP, coordination with RNTCP	100%
5	<b>Implementation in UP</b>	
5a	HR procurement and training	100%
5b	Mapping of implementation areas	100%
5c	Initiation and continuation of ACSM and CB of pHCP, coordination with RNTCP	100%
6	<b>Partner's workshop for PPM-DOTS</b>	0% <sup>5</sup>
<b>Milestones</b>		

## MAJOR PROCUREMENTS

At the beginning of the third year of the MBPH project, processes were underway to engage with sub-contractors for the fulfillment of the TB program's various components. While the sub-contracts with Indian Market Research Bureau (IMRB) for carrying out the baseline studies and with St. John's Research Institute (SJRI) for the development of the Capacity Building package were completed prior to the third year, the two large sub-contracts with Medica Synergie Pvt. Ltd. (MSPL) for operations in Uttar Pradesh (UP) and with Population Services

<sup>4</sup> Two out of three baselines studies ('Consumer' and 'Provider') were completed as scheduled. The baseline study for 'Delay in Diagnosis and Treatment of TB' was delayed as state-level ethical clearance was required before permission could be made available through state RNTCP cells to access information from its TB Registers. Subsequent to getting the requisite ethical clearances for both states, there has been further delay in getting access to RNTCP TB Registers in UP.

<sup>5</sup> The program implementation has not reached a critical point in its cycle to validate a Partners' Workshop where lessons and outcomes can be disseminated

International (PSI) for operations in Karnataka, were signed during the first two quarters of the third year, after receiving approvals from USAID|India. To take to the next level the work done on the TB MIS, Ekgaon was sub-contracted in the first quarter to develop the MIS software, develop the Operations Manual and train the end-users of the MIS. Later in the year, IMRB was also awarded a sub-contract for carrying out the endline studies.

## RESEARCH

Two baseline studies were carried out during the year. These included one on understanding care-seeking behavior of pulmonary TB suspects in urban slums and the other on understanding TB management behavior of private providers. The results of these studies are summarized here:

*Consumer Study Results:* Chest symptomatics (1526 in UP and 1515 in Karnataka) were interviewed by December 2010. Most respondents (75% in UP and 58% in Karnataka) sought treatment from healthcare providers. Among this group, the majority (78% in UP and 99% in Karnataka), visited practitioners of modern medicine (or allopaths). Most are stated to have followed provider advice on diagnosis and treatment. Only 16% of respondents in UP and 48% in Karnataka reported that providers recommended sputum microscopy. In UP, the risk perception of TB and knowledge of how TB is caused are drivers of positive behavior, while in Karnataka, quality of care and knowledge that TB is curable are determinants of positive health seeking behavior.

*Provider Study Results:* Different type of pHCP (1408: 888 in Uttar Pradesh and 520 in Karnataka) were interviewed, including 521 practitioners of modern medicine, 524 practitioners of Indian systems of medicine and homeopathy and 363 less-than-fully qualified providers. Knowledge on the DOTS strategy was poor among all type of providers. While X-rays and blood tests were the main investigations sought by them, less than 50% stated recommendation of sputum microscopy. Around 30% practitioners of modern medicine and 21% of less-than-fully qualified providers referred TB patients for DOTS.

The findings of these studies were presented and discussed with the program implementing teams of UP and Karnataka as there were clear recommendations that could be discerned from the results. They were also presented to USAID. Abstracts were prepared for each of the studies and submitted for oral and poster presentations at the 42nd Union World Conference on Lung Health and both were accepted for poster presentation.

*'Delay in Diagnosis and Treatment of TB' study:* The start of this baseline study was delayed for reasons explained below under 'Barriers and Challenges'. During the year, MBPH received ethical clearances from universities in both implementation states, namely, CSM Medical University, Lucknow for UP and KLE University, Belgaum, for Karnataka. The questionnaire was completed and field tested. The field work is expected to begin in early to mid-September.

## MIS PACKAGE DEVELOPMENT

MIS aligns the project matrix with RNTCP and is the primary monitoring tool for the TB program. The TB MIS software was developed during the year. Preliminary work was carried out towards the end of year two when a Systems Requirement Specification (SRS) document was prepared by a vendor. During year three, Ekgaon, the agency sub-contracted for the purpose developed first a System Design Document (SDD) which details the MIS development process and serves as the blueprint for the software. After the SDD was approved, the agency

developed the software. Third and fourth versions of the software were developed, based on field trials, and the software has been uploaded on the Internet. The Uniform Resource Locator (URL) for this site is <https://www.tbmismbph.org/>.

The forms, records and registers intended to be used to collect data have been finalized and are ready to use. Both higher and field-level data quality managers were trained. A working group, consisting of senior managers from state implementing agencies, Abt and Ekgaon, are in regular contact with each other to ensure an effective software. A user manual has been developed for the use of the software. This is work-in-progress as software features are being improved.

## CAPACITY BUILDING PACKAGE DEVELOPMENT

Capacity building tools and methodologies were developed during the year and are in use. SJRI, the agency that developed the first versions of the tools and documents, was provided technical support by Abt and USAID and also by a varied host of external experts, including private providers, pulmonologists, public health specialists and experts on TB research and RNTCP. All external experts contributed their time and efforts pro bono (valued at approximately \$2,394). With the exception of the Counseling Flip Chart, all the documents listed below were developed and produced during the year:

1. ***Documents for building the capacity of allopath providers***
  - a. PowerPoint presentations for the sensitization of allopaths – this included separate presentations, for UP and Karnataka, on program implementation in the two states and a common technical presentation.
  - b. RNTCP Training Module for Medical Practitioners – this is an RNTCP document developed by Central TB Division, Ministry of health and Family Welfare, Government of India. The document was reprinted by MBPH. It is necessary to use this module as allopaths trained are intended to be certified by RNTCP.
  - c. Workbook for Training of Medical Practitioners – this book is a comprehensive adjunct to RNTCP module and is the mainstay of the training package for allopaths.
  - d. Facilitator’s Manual – a manual that details training processes and helps training facilitators to prepare for the training of allopath providers.
  - e. PowerPoint presentations (six) to be used during the training of allopaths – these include presentations titled ‘Introduction’, ‘Diagnosis of pulmonary TB in adults’, ‘Classification and treatment of TB’, ‘Scientific basis and rationale of DOTS’, ‘Monitoring patients on treatment’ and ‘Records and reports’.
  - f. Quick Reference Guide – an in-clinic referral document for trained allopaths for quick and easy access to important information.
2. ***Documents for building the capacity of non-allopath providers***; includes three PowerPoint presentations
  - a. Suggested agenda for each session.
  - b. Introduction – this briefly describes the program and assistance that would be provided to non-allopath providers by the implementing agencies. It is therefore different for UP and Karnataka.
  - c. RNTCP for healthcare providers – a common technical presentation on RNTCP, DOTS and on how private providers can be involved. This is developed in English, for all non-allopath providers in Karnataka, and in Hindi, for UP.
3. ***Documents common for all pHCP***

- a. A counseling flip chart is being prepared for use by all providers when managing TB suspects, patients and their families. This will be developed in Hindi, Kannada and English and is expected to be ready for use by mid-October.
- b. Pre-sensitization/training and post-sensitization/training tests for all type of providers.
- c. Feedback forms to be used at the end of sensitization/training sessions.
- d. Certificates for distribution to participants.
- e. Quality Assurance form for trainers, monitors and mentors to be used for reporting after conducting or attending, capacity building sessions

MBPH has added value to capacity building of pHCP by introducing tools and methodologies that are informative, instructive, interactive and participatory. The sensitization/training sessions are designed to generate high levels of interest and desire to get involved in RNTCP, or at least to practice evidence-based TB management outside the national program at the very least. Sensitizations (orientation) carried out so far have generated positive responses from participants. Training sessions for allopaths were started in September. MBPH has also planned for continued support and mentoring of pHCP involved in the program through supportive supervision and monitoring visits and structured exchange forums, carried out periodically.

An initial Training of Master Trainers (TOT) on the use of the above listed tools was conducted by SJRI in March. After revisions and finalization of the tools, a second TOT for the training of allopaths was conducted by Abt in September.

## PROGRAM IMPLEMENTATION IN UTTAR PRADESH

After getting USAID |India approval and signing of the sub-contract, MSPL, the agency selected to carry out MBPH-TB program activities in UP started by recruiting the project and district-level personnel. A consultative meeting was organised to initiate the project through orientation of RNTCP officials from the government. This early engagement of public sector officials was viewed positively by incumbent officials, including the State TB Officer (STO) and District TB Officers (DTO) and promised good and full support to the MBPH operations in the selected districts.

Mapping of intervention towns and slums was carried out next. A plan was developed to carry out GIS mapping at a later stage, but this has been shelved due to paucity of resources. In the meantime, activities to build rapport with, and gain effective support from, RNTCP program officials were carried out. Official letters were sent to each DTO by the STO communicating the need to support the MBPH program. Internal capacity building of implementing agency staff was carried out during the same period.

A project implementation plan (PIP) for the TB program in UP was developed by MSPL. The workplan clearly articulated the link between the program objectives, its activities and outcomes. An important component of the PIP was a Gantt chart that spelt out the monthly activities, deliverables and expected MIS indicator numbers. This remains a useful monitoring tool for the program. Early communication and demand creation activities were started in UP. Small and large group/community meetings and meetings with opinion leaders using Information, Education and Communication (IEC) material of RNTCP have generated interest among target communities, public and private healthcare providers and print media. Similarly

sessions to sensitize allopath and non-allopath pHCP are getting varied, but on the whole, a better-than-expected, response. Provider associations, their office bearers, RNTCP officials as well as individual pHCP have participated quite enthusiastically in the capacity building sessions held during the year.

Liaison activities with the government and other partners have remained a major focus in implementation. Continued and consistent networking with RNTCP officials at the district and sub-district levels appears to yield positive results as evidenced by their participation in communication and capacity building activities.

#### Details and Definitions of Activities Conducted in UP

*Small Group Meeting (Communication):* An activity with groups of around 15 to 35 persons, this consists of presentations on TB, its symptoms and discussions based on the disease and its management. A quiz is conducted after the meeting to make it participatory and interesting. The materials used include charts and posters prepared by district teams and IEC material from RNTCP. The key messages communicated during the meeting are:

- a) Persistent cough of more than 2 weeks or more should be taken seriously
- b) Anyone with this symptom should go to the nearest health care provider and get sputum tested at an accredited SCC or DMC
- c) If sputum is positive, then free TB medicines are available at the nearest DOTS center
- d) Call the helpline number of the DOTS *mitra* (friend) if there are any problems

While generally interested in what was offered or said by MBPH, participants had concerns about the government system, stating that people at these places were usually not receptive. They are hoping MBPH can make a change in the government system. They also said that the behavior of government officials needs to be changed and they should behave in a friendly manner.

*Large Group Meetings (Communication):* This is usually a gathering of larger numbers (50 to 100) of people and is mostly held outdoors. It involves making of presentations and speeches about TB and its symptoms, and as with small group meeting usually ends with a quiz. The materials used, messages and responses are similar to those for small group meetings.

*Door-to-Door Visits (Communication):* This involves house visits and talks with individuals or families about TB and its symptoms. Sometimes this involves meeting small groups on shop *verandahs* (porches). The material used so far is from RNTCP as MBPH communication material is yet to be produced. The messages are similar to what is noted above. This method of communication was particularly effective (in terms of positive responses and engagement) in Mathura district.

*Meetings with Opinion Leaders (Communication):* This is usually conducted with small groups of opinion leaders in each slum. The method of sensitization, materials used and messages are similar to those for small group meetings. In most of the locations the opinion leaders are very cooperative and ready to help the team in organizing community meetings and to refer TB suspects.

*Sensitization of LTFQ (Capacity Building):* The target group was sensitized, in groups, to the problem and magnitude of TB, its types and symptoms and about RNTCP. They were informed about how they could be involved through referral of TB suspects and by being DOT providers. MBPH tools developed for non-allopaths (see above), including PowerPoint presentations and pre

and post-tests were used for these sessions. The Project Director (MSPL) conducted the sessions. Public sector RNTCP officials were involved in Gautam Budh Nagar, Mathura and Bulandshahar. In Hathras the government is against involving the LTFQ. This is generally an enthusiastic group which welcomed the project and which is ready to be part of it. Many agreed to refer TB suspects.

*Sensitization of Chemists (Capacity Building):* The sessions and tools were similar to other non-allopath sensitization meetings. Chemists were largely positive, but seemed to be only willing to refer poor patients to DOTS. Many agreed to put RNTCP signage in their pharmacies.

*Sensitization of ISMH Providers (Capacity Building):* These were very similar to that for LTFQ. Some ISMH providers expressed reluctance to promote modern medicine; many felt that the TB program should encourage the use of 'alternative' medicines.

*Sensitization of Allopath Providers (Capacity Building):* The purposes of these group sessions were to tell allopaths about the MBPH project, to motivate them to attend training sessions on RNTCP and to encourage them to refer pTB suspects for sputum microscopy. The sessions were conducted by the Project Director, assisted by RNTCP program officials using the PowerPoint presentation developed by MBPH. Most doctors are not interested in referring patients to government centers as they suspect they will lose their patients. Some are also concerned that patients who are being sent to government sputum collection centers or government DMC don't get proper attention from the health workers there and that this will create problems for their patients.

*Training of Allopath Providers (Capacity Building):* Providers were trained on RNTCP and evidence-based TB management. The RNTCP Module for Medical Practitioners, PowerPoint presentations and other capacity building tools (described above) developed by MBPH were used for training. The sessions were facilitated by the trained program Training Coordinator, supported by program and district staff. DTOs and other RNTCP (public sector) personnel also attend the training. Doctors were largely reluctant to fill the post-test and feedback forms. They also expressed concern about the way patients are treated in government centers. However some have agreed to refer patients and have asked MBPH team to ensure that these patients get proper attention and care.

*Monthly RNTCP Review Meetings Attended by MBPH (Interface):* MBPH teams were part of the district RNTCP monthly review meetings in all 7 implementation districts. The meetings are generally coordinated by the DTO and attended by medical officers and RNTCP program staff such as Senior Treatment Supervisors (STS) and Senior Treatment Laboratory Supervisors (STLS). The MBPH team would share their experience and activities in the field.

*MBPH Events Attended by RNTCP Officials, WHO Consultants and/or Other Govt Officials (Interface):* RNTCP officials are informed about MBPH communication and capacity building activities in their districts and invited to attend and participate in them. Most events have public sector participation.

*Letters of Support Issued by District RNTCP Officials (Interface):* A letter from district RNTCP officials asking pHCP to participate in MBPH capacity building events/sessions was issued in most of districts. These letters conveyed to private providers the desire of the public sector to involve them in the national TB control program.

*Letters of Support Issued by Provider Associations such as IMA, NIMA, etc. (Interface):* In coordination with local branches of provider associations in the area, MBPH was able to issue letters to their members, inviting them to attend the sensitization and training events/sessions.

## PROGRAM IMPLEMENTATION IN KARNATAKA

USAID|India approval and signing of the sub-contract with PSI, the agency selected to carry out MBPH-TB program activities in Karnataka took longer than for MSPL. The on-ground activities in Karnataka, however, moved at a faster pace as PSI, and its sub-awardee, Karnataka Health Promotion Trust (KHPT), had established presence in the state health space and also because a lot of the ground-work with the public sector at the state level were covered prior to the signing of the contract. As with MSPL, recruitment of project and district-level personnel was carried out at an early stage. A consultative meeting was organised to initiate the project through orientation of RNTCP officials from the government. At this meeting, the Karnataka STO emphasized the importance of the MBPH initiative and directed district RNTCP official to work together with the MBPH team in carrying out activities that will benefit the national TB control program in the state. Subsequent engagement with public sector officials has been positive throughout the remaining part of the year.

Other activities carried out in Karnataka were similar to those done in UP. These include mapping of intervention towns and slums, rapport building, or interface activities with the district and sub-district RNTCP, internal capacity building of PSI and KHPT staff and development of a PIP for program implementation in Karnataka, with setting of monthly deliverable and indicator targets. Communication and capacity building activities were also started in Karnataka. In addition to mandated activities, the MBPH team was able to identify, and bring back to therapy, several primary default patients living in the intervention slums. This procured credibility to the MBPH initiative at an early stage on intervention.

### Details and Definitions of Activities (Karnataka)

*Small Group Meeting (Communication):* This activity consists of meetings with mothers at *Anganwadi* centers and with small groups (7 to 10) of volunteers. A flip chart is usually used to sensitize group members about TB. The general message is that sputum microscopy is the best test for the diagnosis of TB and that one should visit a DMC for this if suffering from persistent cough for 2 weeks or more. These meetings tend to generate good participation and sometimes results in referral of defaulters and symptomatic patients.

*Large Group Meetings (Communication):* These were carried out only in 4 out of 12 (actually 13, but one district was split after the start of the project and hence these 2 are clubbed for reporting) districts at the start of the program around World TB Day. The main tools used were a RNTC film called *Kshya Maya* and speeches. The message communicated was the same as for small group meetings and participation was low key.

*Door-to-Door Visits (Communication):* Houses were visited and people – individuals and families – were sensitized using flip charts. The message was the same as mentioned above. However, people were found to be much more receptive and better engaged. Some visits resulted in TB symptomatics being referred for sputum microscopy.

*One-to-One Meetings (Communication):* These are similar to meetings with individuals during house visits, but were held outdoors in the intervention slums. The material used, message and response was similar to visits to houses.

*Meetings with Opinion Leaders (Communication):* Called slum-entry programs, meetings were held at Anganwadi centers with local stakeholders and slum leaders. Discussions were held and no material was used during these sessions. On the whole, nearly all leaders were supportive and agreed to spread TB related messages in the community.

*Sensitization of LTFQ (Capacity Building):* Less-than-fully-qualified (LTFQ) providers were sensitized on TB and encouraged to send TB suspect to DMCs for sputum microscopy. They were also informed that they could become DOT providers. The non-allopath PowerPoint presentation developed by MBPH was used along with group discussions, group work, pre and post-tests. RNTCP treatment kits were shown to the providers. The sessions were conducted by program Network Coordinators and Training Specialists and most sessions were attended by the DTO or a medical officer from the public sector. Most participants were interested to know more on treatment aspects of TB.

*Sensitization of Chemists (Capacity Building):* This was not done in Karnataka during year 3.

*Sensitization of ISMH Providers (Capacity Building):* Very similar to that for LTFQ

*Sensitization of Allopath Providers (Capacity Building):* The purpose of these one-on-one sessions was to tell allopaths about the MBPH project and motivate them to attend training sessions on RNTCP. The sessions were conducted by program Network Coordinators and Training Specialists using the PowerPoint presentation developed by MBPH and discussion.

*Training of Allopath Providers (Capacity Building):* Providers were trained on RNTCP and evidence-based TB management. The RNTCP Module for Medical Practitioners, PowerPoint presentations and other capacity building tools (described above) developed by MBPH were used for training. The sessions were facilitated by trained program Training Specialists, supported by Network Coordinators. DTOs and other RNTCP (public sector) personnel also attended the training.

*Monthly RNTCP Review Meetings Attended by MBPH (Interface):* MBPH teams were part of the district RNTCP monthly review meetings in all 13 implementation districts. The meetings are generally coordinated by the DTO and attended by medical officers and RNTCP program staff such as Senior Treatment Supervisors (STS) and Senior Treatment Laboratory Supervisors (STLS). The MBPH team comprising of a Network Coordinator and the Interpersonal Communications Coordinator makes a presentation on field activities in the district. On the other hand, the DTO provides an update to the MBPH team on upcoming public sector RNTCP programs.

*MBPH Events Attended by RNTCP Officials, WHO Consultants and/or Other Govt Officials (Interface):* RNTCP officials are informed about MBPH communication and capacity building activities in their districts and invited to attend and participate in them. Most events have public sector participation. The DTO, medical officer, STS, STLS and/or the TBHV (TB Health Visitor) visited MBPH field activities, including, World TB Day program meetings, allopath and non-allopath sensitization or training sessions, community mobilizer's training and SHG group meetings. In some districts, slum entry programs were conducted, in which district RNTCP officials have participated.

*Letters of Support Issued by District RNTCP Officials (Interface):* In Chitradurga, the DTO issued a letter to the district government hospital to provide free X-ray facility for sputum negative TB suspects to confirm the TB status. Through MBPH efforts, this facility is made available in the

government hospital. In Shimoga, the DTO issued a letter to the RNTCP staff to attend the launch of the MBPH-TB project.

*Letters of Support Issued by Provider Associations such as IMA, NIMA, etc. (Interface):* IMA, Chitradurga Branch, is supporting MBPH by sending an invitation letter to eligible (based on the list given by MBPH) allopath doctors requesting them to attend the MBPH training. The Additional Drug Controller has issued a letter to MBPH along with giving a soft-copy of the Druggist and Chemist Association members list in Davangere district.

The program results – outputs and outcomes – achieved as a result of implementation in UP and Karnataka (results) are tabulated below:

S No	Indicator	Baseline Value	EoP Target <sup>6</sup>	Year 3 Target	Achieved
<b>Indicators Sourced from MIS</b>					
M01	No. of ISMH pHCP sensitized to PPM-DOTS	0	305	305	<b>511</b>
M02	No. of pharmacists/chemists sensitized to PPM-DOTS	0	641	188	<b>271</b>
M03	No. of LTFQ pHCP sensitized to PPM-DOTS	0	305	305	<b>233</b>
M04	No. of pHCP of modern medicines(MBBS) trained	0	547	547	<b>291</b>
M05	No. of sets of sputum samples tested by DMC (40% of all CS from Intervention slums as per Lab Reg)	0	10,637	3,427	<b>4,312</b>
M06	No. of pts referred to DMC as per records kept by pHCP (all types)	0	3,767	354	<b>412</b>
M07	No of SSP pts. over total no. of sets of sp. samples tested at DMC	0	1,064	342	<b>576</b>
M08	No of NSP TB cases that were detected (CDR)	0	707	227	<b>320</b>
M09	Percentage of non-compliance to ATT by pts. treated by pHCP	0	<10%	<10%	<b>NA</b>
M10	No. of TB pts. administered ATT by CDP and pHCP	0	956	368	<b>12</b>
M11	No. of TB patients who have been successfully treated by pHCP	0	206	0	<b>0</b>
M12	Number of pHCP (all type) who are practicing DOTS	0	932	466	<b>496</b>
M13	No. of private DOT Centers created through signing of MoU with pHCP	0	466	0	<b>4</b>
<b>Additional Non-PMP MIS Indicators</b>					
M14	No. of TB patients of all forms detected and put on treatment	0	1,330	736	<b>695</b>

<sup>6</sup> The LOP MIS-based indicators have been rationalized in the Year-4 workplan, along with the working budgets of sub-contractors, PSI and MSPL

S No	Indicator	Baseline Value	EoP Target <sup>6</sup>		Year 3 Target	Achieved	
M15	No. of TB patients of all forms detected and started on treatment by pHCP	0	731		401	22	
M16	No. of pHCP of modern medicines(MBBS) Sensitized	0	666		666	572	
<b>Indicators Sourced from baseline and Endline Studies</b>							
R01	Time taken between development of TB symptoms and start of TB treatment using a correct regimen under DOTS	NA	Decrease of 25% in EL, from BL, of pHCP + patient delay		To carry out baseline (BL)	BL study not done in Y-3 (see section on Barriers)	
R02	Among those aware of TB, percentage with correct knowledge: <sup>7</sup> <ul style="list-style-type: none"> <li>Of symptoms of pTB</li> <li>On where to go for appropriate medical care, and</li> <li>That TB is curable</li> </ul>	NA	<u>UP</u> 62%	<u>KA</u> 49%	To carry out BL	<u>UP</u> 62%	<u>KA</u> 49%
R03	Percentage reporting correct awareness about RNCP logo <ul style="list-style-type: none"> <li>Percentage of target audience who recall seeing the RNTCP logo</li> <li>Among those who have seen the RNTCP logo, percentage who are aware that the logo stands for DOTS (or TB management)</li> </ul>	NA	<u>UP</u> 44%	<u>KA</u> 30%	To carry out BL	<u>UP</u> 39%	<u>KA</u> 25%
R04	Percentage of pHCP with correct knowledge of DOTS protocols, i.e.: <sup>8</sup> <ul style="list-style-type: none"> <li>All pTB suspects should have sputum microscopy done</li> <li>All TB patients should be treated using appropriate regimens (right drugs, dosages, duration)</li> <li>All TB patients should be followed up to ensure treatment completion</li> </ul>	NA	<u>UP</u> 14%	<u>KA</u> 18%	To carry out BL	<u>UP</u> 4%	<u>KA</u> 8%
<b>Other Indicators</b>							
O01	Amount of resources leveraged	0	\$302,628 (Estimated)		\$196,578	\$349,273	
O02	Number of information gathering or research activities	0	2		2	2	
O03	MBPH website created and has updated information about the TB initiative and its achievements	0	Yes		Yes	Yes	
O04	At least two project briefs disseminated over LoP	0	Yes		Yes	Yes	

<sup>7</sup> The indicator value is the percentage of respondents who have met all 3 knowledge criteria

<sup>8</sup> The indicator value is where all 3 criteria have been met

<b>Results of Communication Activities</b>					
<b>S No</b>	<b>Activity</b>	<b>UP</b>	<b>KA</b>	<b>Total</b>	<b>Remarks</b>
C01	Small group meetings	1,689	58,442	60,131	No. TG reached
C02	Large group meetings	3,018	3,141	6,159	No. TG reached
C03	One-to-one meetings	-	16,771	16,771	No. TG reached
C04	Door-to-door visits	7,624	111,546	119,170	No. TG reached
C05	Opinion leader meetings	282	5,804	6,087	No. TG reached
<b>Results of Public-Private and Community Coordination (Interface) Activities</b>					
I01	No. of monthly district RNTCP review meetings attended by MBPH	24	58	82	MBPH attends public sector activity
I02	No. of MBPH events attended by RNTCP program managers and govt. officials	26	227	253	Public sector officials attend MBPH event
I03	No. of letters of support Issued by district RNTCP officials	20	2	22	
I04	No. of letters of support issued by provider associations (IMA, FPPAI, NIMA, etc.)	18	3	21	
I05	No. of TB suspects referred by MBPH (through ACSM/Community Activity)	975	5,549	6,524	No. of TB suspects
I06	No. of TB patients diagnosed (through referrals)	186	640	826	No. of TB patients

## **Barriers and Challenges**

Most components of the TB program faced some levels of difficulty during the third year of MBPH, largely resulting in implementation delays.

### **RESEARCH ACTIVITIES:**

For the 'Delay in Diagnosis and Treatment of TB' study, MBPH was advised by Dr. L S Chauhan, the incumbent Deputy Director General (DDG), TB, that internal (state-level) ethical clearance would be required before permission could be made available through state RNTCP cells to access information from its TB Registers. As this information was essential to enable the planned study, MBPH approached the Ethical Committees of CSM Medical University, Lucknow (UP), and KLE University, Belgaum (Karnataka), to process the study tools and protocols. This process delayed the start of the study.

### **MIS PACKAGE:**

The software developed by Ekgaon has certain unique aspects, which requires that a comprehensive blueprint for the software be developed. As a result, it took a while to finalize the SDD. Additionally, testing of the first version of the software revealed several corruptions, or 'bugs', that led to temporary delays which needed to be addressed. Initially functional only

on the Internet browser, Mozilla Firefox, version 3.62, the software is now available through all updated versions of Firefox.

#### **CAPACITY BUILDING PACKAGE:**

There was two-month delay in the submission of the final set of capacity building products by SJRI and for the conduction of the initial TOT in March. The products needed further refinement and technical editing before they could be printed. Some of the presentations, such as the sensitization presentations for allopaths in UP and Karnataka had to be redeveloped. Other presentations and documents underwent similar scrutiny and revisions were incorporated for improved salience and clarity.

#### **PROGRAM ROLL-OUT:**

There was significant delay in starting the project in UP. Getting appointments and setting dates for meetings with the state RNTCP officials took more time than envisaged. MSPL being new to UP had to spend time and effort to establish contacts with district and sub-district RNTCP officials, set up offices and recruit staff.

Since the onset of the program and initial meetings with RNTCP program officials in UP, there has been a change in attitude among DTOs and other RNTCP public sector staff. While initial responses were quite positive and support was promised by the public sector, there has been increasing resistance, especially in sharing of information about patients reported to be registered by the national program. DTOs have refused to allow RNTCP TB registers to be accessed by MBPH in 4 districts; one has put this in writing. Despite trying for more than 3 months, MBPH only has access to TB registers in Ghaziabad. This will affect the conduction of the 'Delay in Diagnosis and Treatment' study in UP. DTOs have also (unofficially) shared information.

In Karnataka, the challenges reported are few and patchy. There are some reports of laboratory technicians (of DMC) sending away patients referred by MBPH staff. A few communities in north Karnataka have resisted MBPH workers from carrying out communication activities in their slums due to mislaid suspicions of purpose that have more to do with communal insecurity than any rational thought.

Nearly all the contacted allopaths in UP and Karnataka are unwilling to attend training sessions of more than 3 hours. Many, in fact, want these sessions to be even shorter than that. This challenge is not unique to MBPH as other programs also face the same problem. MBPH training of allopath sessions are planned for a total of about 6 to 7 hours, including time to cover the technical modules and for group work, discussions, questions and answers, introductions, pre and post-tests, feedback and refreshment. Reducing the duration of the training will compromise its quality, value and impact. On the other hand, without serious efforts to compensate providers for their time, this attitude is unlikely to change.

#### **Plan for Year Four**

The focus in the fourth year of the project will be on ensuring that vital components of the TB Control and Care program are identified and carried through to fruition. This will be challenging, given the reduction in funds available for program implementation. The workplan for year four is thus divided into four separate sets of activities, namely:

- a) **Planning and strategizing:** MBPH, including the implementing agencies, will plan to use the rationalized resources available to best show-case the program by the end of the project.
- b) **Maintaining implementation thrust:** Implementing agencies and Abt, India, will carry out activities that will attempt to maintain the impetus reached hitherto so that gains achieved will not be undermined by reductions and withdrawals.
- c) **Program closure, withdrawal and handing over:** Program activities will start to wind down from January, 2012, with field implementation ending by March. The program and implementing agencies will explore additional/alternative sources of financial support to continue this demonstration in these geographical areas.
- d) **Documentation, dissemination and advocacy:** MBPH will document lessons learnt, good practices, program outcomes and other forms or type of knowledge gained. Products developed out of efforts and resources used by the program will be made available for dissemination to the government and other agencies as seen fit by USAID|India.

The timeline for activities in year four is as planned as per the following table:

S No	Activity	O	N	D	J	F	M	A	M
1	<b>Research</b>								
1a	Baseline evaluation report								
1b	'Delay in Diagnosis & Treatment of TB' study – Field Work								
1c	'Delay' study – Analysis & presentation to USAID India								
1d	'Consumer' endline study – FW, analysis & presentation to USAID								
1e	'Provider' endline study – FW, analysis & presentation to USAID								
2	<b>MIS Package Development</b>								
2a	MIS software used, maintained & periodically improved								
2b	TB MIS package delivered to USAID India								
3	<b>CB Package Development</b>								
3a	CB Package completed								
4	<b>Implementation in Uttar Pradesh (UP)</b>								
4a	Revision of implementation plan & realignment of budget for UP								
4b	ACSM activities in intervention slums								
4c	Capacity building activities of identified pHCP								
4d	Interface activities between pHCP and public sector/patients								
5	<b>Implementation in Karnataka (KA)</b>								
5a	Revision of implementation plan & realignment of budget for KA								
5b	ACSM activities in intervention slums								
5c	Capacity building activities of identified pHCP								
5d	Interface activities between pHCP and public sector/patients								

## **Component Two**

**Develop a Suitable Mechanism for Harnessing MBP for Health and Establish Effective Linkages**

## Center of Excellence for MBPH and Health Leadership Council

### Background

One of the key mandates of MBPH is to institutionalize capacity for fostering and maintaining commercial partnerships for public health through the establishment of a Health Leadership Council (HLC) and a Center of Excellence (CoE).

The **HLC** is envisioned to be an advisory body consisting of eight to ten experts from various fields such as public health, micro-finance, rural marketing, venture funds, the government and other donors, who will advise the program team on various strategies for MBPH. The HLC is also expected to provide the initial support and expert inputs to the CoE, along with senior managers of the MBPH project. After MBPH officially ends in 2012, the HLC will continue to act as an advisory group for the CoE and continue to provide technical support to the CoE. The expectation is that from the second HLC meeting, scheduled for September 2011, there will be direct interaction between the CoE and the HLC.

The **CoE** will be an existing organization that offers strategic partnership support, research, analysis and information dissemination support to advocate for greater engagement in market-based health programs. Its main objective will be to institutionalize capacity for designing, implementing and monitoring bottom of the pyramid market-based health programs both within and beyond the life of the MBPH project which ends in 2012.

### Achievements in Year 3

There has been significant progress in involving the HLC members and Swasti, the designated CoE with MBPH programs and activities as detailed below:

- The first HLC meeting was conducted on May 26 & 27, 2011
- Second HLC meeting was conducted on September 08, 2011
- Swasti was designated as the CoE for the MBPH project

### *Meeting with HLC members*

#### First HLC meeting

On receiving the formal approval for the HLC from USAID in October 2011, MBPH reconnected with all selected member, renewed their commitments and updated them about the on-going MBPH tasks and progress.

Given the busy schedules of the HLC members, it was challenging to schedule the initial meeting. With considerable advance planning through a process of open communication with all HLC members, the first HLC meeting was held on May 26 and 27, 2011 in Delhi. Seven HLC members participated in this meeting, including Ms. Kerry Pelzman, Ms. Sheena Chhabra, Mr. Pradeep Kashyap, Mr. Anant Kumar, Mr. Vijaya Sharma, Ms. Sofi Bergkvist and Ms. Mona Kachhwaha. One member Mr. Varun Sahni joined the meeting via teleconference from Sweden. The meeting was very productive and included detailed discussions on all the MBPH programs. HLC members provided their feedback about the different programs. Most of the discussions with the HLC focused on exploring sustainability options for these different programs beyond

the life of MBPH and also the key challenges that each of the programs were facing. Based on these discussions, at the end of the meeting, action items for each program area were drawn up and various HLC members volunteered to 'champion' certain action items and carry them forward. These assignments were based on each member's expertise, area of interest and as well as contacts in that particular arena.

One of the most important discussions of the HLC meeting was with regards to the future of the CoE. A key topic of discussion was whether given the limited time left on the project, the CoE would be able to take the current MBPH projects to scale? There was a wide ranging discussion about how the COE should work, who its clients should be and how it should be positioned in the marketplace. Many of the questions raised were deferred for more in depth analysis during the creation of a strategic plan for the COE. Overall it was decided that the subsequent HLC meetings would largely focus on the future plans for the CoE including its scalability and sustainability beyond MBPH.

### Second HLC meeting

Six members participated in this meeting. The members were recognised for their significant contributions in terms of providing reviews, introduction to the key contacts as below:

- Sofi Bergkvist linked us with the International Partnerships to advance Innovative Health Delivery (IPIHD) work of World Economic Forum (WEF). MBPH found the work of WEF to be similar to its work in India. IPIHD might look India partners and Swasti/CoE will be natural partner to this. She also introduced LGT venture philanthropy fund team to us. We came to know about the investment parameters of the venture philanthropy funds. LGT solicited more details on the MBPH models.
- Anant connected us to Medcall, Mexico i.e. a very successful paid helpline in MCH area. Medcall has been successfully catering to numerous clients through clinical protocol partners, Business Process Outsourcing (BPO) of the call center operation with cutting edge technologies, bulk deal with health product marketer and telecom operators. This learning will help us and Swasti in our helpline sustainability work for Saathiya and Dimpa helpline.
- Pradeep went through the entire advance cookstoves consumer segmentation research done by MBPH. He confirmed our findings for the early adopters and advised on how to target the consumers for early purchase. He also advised that our advertising agency should be in full cognizance of these findings to evolve the right BCC tools.
- Mona validated our work with Sonata on innovative financing options i.e. zero interest loan. She advised that the current EMI working with Sonata is extremely attractive and project Dharma should go all out for provision of cook stoves. Mona also connected us to an entrepreneur working on the syndicated distribution of rural products and services.
- Vijay is currently reviewing our note for Hindustan Unilever reconnection for Shakti program.
- Varun has gone through the CoE strategic plan and specially met the CoE team. He provided valuable feedback to University of Michigan student interns work and the discussion tools.

As discussed in the first HLC meeting this was focused on the functioning of CoE. Both the CoE team and MBPH task team presented the joint module framework for key sustainable tasks

for Saathiya, Shakti and ITC program. Support areas for Advanced Cookstoves program was also discussed extensively. CoE presented a long term action plan for 2012-2017 beyond MBPH and solicited member feedback.

On the draft long term plan presented to the members it was opined that CoE need to focus on core functions and repackage the offering. As the client universe is broad i.e. foundations, donors, commercial sector it needs to have specific offering for the quick win in terms of Strategic advisory and implementation services only to a specific group to start with. USAID team will be taken through the re-thinking process as the current plan was based on the Terms of Reference laid out in the proposal and there might be multiple consultations to arrive out the top-most priorities.

#### Enrollment of Swasti - the designated CoE with MBPH programs and activities

The 'Request for application' process to host and establish the CoE was completed in October 2010. Of the sixty four applications received, only eleven organizations were shortlisted for being selected as the CoE, based on certain selection criteria. Of these, MBPH decided to recommend Swasti, Bangalore to USAID in December 2010. The CoE formally came into existence on May 2011.

Once selected Swasti, the grantee host organization for CoE focused its attention on enhancing its manpower and infrastructure for the CoE. One of the key Portfolio Manager positions have been filled by Swasti, while other portfolio manager and project director position are currently being filled by Swasti's existing pool of talented staff. Given that there is now in place a clear work plan for Swasti, these positions will be recruited.

As far as the infrastructure is concerned, the current Swasti office at Chittaranjan Park has moved to a new premise in the Safdarjung area, of South Delhi. The newly recruited CoE team will be placed with other Swasti project members at this new premise and the infrastructure expenses will be shared across projects.

Swasti has also completed most of the work in shaping their administrative and reporting systems to manage grant operations of MBPH / Abt and ensure tracking of the grant as well as leveraging, if any.

#### Strategizing the CoE long term work plan

A priority of the CoE was to provide support to MBPH programs as well as to strategically help its visibility and credibility to expand its client base for MBPs. SBK, Saathiya, ITC e-Choupal and Shakti were selected for detailed assessment by the CoE so that its capacity to develop MBPs involving family planning products and pharmaceutical companies would be enhanced.

As a result of Abt's corporate tie-up with University of Michigan, an intern from the Ross School of Business has been engaged by MBPH to support Swasti in assessing the client demand for CoE services and identify priority services with an objective of developing a business plan for the CoE. These types of activities and services can then become the focal areas on which Swasti can concentrate in the immediate future.

The findings and report has been finalized and Swasti is acting on some of the recommendations. Few salient points that emerged out of this study are:

- CoE needs to support the business development/incubation of healthcare focused social enterprises and startups to reach investable state
- CoE should bring in significant value in a flexible financing facility to provide seed and working capital to social enterprises and startups prior to being investor ready
- CoE should put in efforts in reducing discovery costs associated with finding partners and brokering relationships
- CoE needs to demonstrate value in the market and with individual clients initially through implementation services prior to engaging in strategic consulting relationships
- CoE needs to add value in engaging with the government to implement regulations and remove barriers or as bulk purchasers, but policy advocacy activities are best undertaken opportunistically

There were many leads generated during this assessment process. Swasti / CoE would continue to follow up with these leads. Swasti team will be continuously guided in this process by MBPH through multiple consultative meetings with USAID.

### Barriers and Challenges

In spite of the fact that the HLC members during the initial meeting have discussed critical project issues and volunteered to champion specific program elements, given that the project is in its last phase of implementation, there is little or no room for engaging them extensively with the program components. A key challenge will be to sustain the interest of the HLC members in these MBPH program components beyond the life of the MBPH project.

Selecting another public health expert before the next HLC meeting and ensuring that he/she is brought up to speed on the happenings thus far will be challenging in this short time frame.

The CoE strategy has been largely thought through the lens of MBPH program asks. As HLC members have put more emphasis on to define focus, clients and sustainability we may have to re-negotiate the scope of CoE with USAID.

### Achievements against timeline in Year 3

Activity	O	N	D	J	F	M	A	M	J	J	A	S	% Complete
<b>Establishment of the Health Leadership Council</b>													
Individual meetings with the proposed HLC members	■												100%
Send formal invitation to HLC members	■	■											100%
Convene HLC meetings				■			■					■	66%
HLC members visit to project interventions as required					■	■					■		
Involvement of HLC members as project champions								■	■	■	■		70%
Participation of HLC members for CoE tasks												■	70%
<b>Establishment of the CoE</b>													
Shortlist the candidate CoE based on the RFP process	■												100%

Activity	O	N	D	J	F	M	A	M	J	J	A	S	% Complete
Signing of the Grant	■	■											100%
CoE institutional set up i.e. infrastructure & manpower			■	■									75%
Sensitization of CoE on MBPH and project visits and Workplan finalization					■								100%
Implementation of CoE work plan						■	■	■	■	■	■	■	75%
Engagement on the MBPH assignment(s)						■			■	■	■		100%
First set of engagement outcomes for MBPH project(s) delivered								■	■	■	■		As per new workplan it will be delivered in Y4
Workshops for Private Sector, Donors and Consultative Meeting with government programs									■	■	■		Deferred to align with End of Project
CoE signs on MBP engagements with clients other than MBPH									■	■	■	■	50%
Reviews of CoE engagement work-plan					■				■		■		100%

## Way Forward

The next quarter marks a crucial phase in the operationalization of the CoE plan. The preparation for sustainability discussions will be anchored with the program key stakeholders of Shakti, Saathiya and ITC program. The first draft of the partnership learning and hybrid alliance models will be evolved. Similarly the first draft of the syndicated rural distribution plan will also be tabled for discussion. There will be quite an action on the policy, advocacy take –off points with the interested stakeholders. Swasti / CoE will also significantly proceed with the Eureka Forbes work. The model database of various health initiatives will be electronically documented.

HLC meeting in December will be largely on the sustainability and scaling up themes and will be drawn heavily on the CoE tasks on the three programs of Saathiya, Shakti and ITC.

Activity	O	N	D	J	F	M
<b>HLC meeting and engagements</b>						
Convene HLC meetings			■			■
Involvement of HLC members as project champions	■	■	■	■	■	■
Participation of HLC members for CoE tasks	■	■	■	■	■	■
<b>COE institution formalization</b>						
Technical assistance to four MBPH programs	■	■	■	■	■	■
Continuation of research, policy and advocacy supports	■		■		■	
Development of new knowledge tools i.e. database, syndicated distribution and hybrid model			■	■	■	■
Engagement outcomes for MBPH project(s) delivered			■	■	■	

<b>Activity</b>	<b>O</b>	<b>N</b>	<b>D</b>	<b>J</b>	<b>F</b>	<b>M</b>
Workshops for Private Sector, Donors and Consultative Meeting with government programs						
CoE signs on MBP engagements with clients other than MBPH						
Reviews of CoE engagement work-plan						

## **Component Three**

# **Provision of Injectable Contraceptives through the Private Sector**

## Dimpa

### *A program to promote demand and use of Depot Medroxyprogesterone Acetate*

#### **Overview and Background**

Initiated in 2003, the Dimpa Injectable program under the USAID funded MBPH project entered the 5th phase in 2009. The goal of the program is to increase the overall use of modern reversible methods of contraception. The program aims to address a critical gap. Till now, only three types of modern, reversible family planning methods have been available to Indian women: oral contraceptives, IUDs, and condoms. This, in spite of the well-established fact that expanding the basket of contraceptive choices increases overall contraceptive prevalence as more couples are likely to find a method appropriate for their reproductive health needs.

While DMPA, the three month injectable contraceptive, has been available in India through the private sector since 1994 (Depo-Provera marketed by Pfizer has been India's first and largest DMPA brand), its use has been negligible (less than 0.01%). This is due to the low awareness levels and incorrect knowledge about the method, both amongst consumers and providers, and low access to the method.

However, in the last few years, the injectable arena has witnessed heightened activity with both social as well as commercially marketed brands of DMPA engaging with both providers and consumers. In this time frame, more brands of DMPA have entered the Indian market and its price has come down to approximately Rs. 50 to 100 (from the earlier price range of Rs. 200 to 300) for the majority of the brands.

#### **Objectives**

The objective for the pilot program was to demonstrate the feasibility of providing DMPA through the private sector with high quality of care.

The specific objectives of the program are:

1. Increase awareness of DMPA as a safe and effective method
2. Increase access to and use of DMPA through the private health sector by training private sector doctors and enrolling them into a Network

The network of clinics (branded as the Dimpa network clinics) uses existing infrastructure of Ob/Gyn providers and their clinics to provide a platform for category promotion and increase access at a set price point.

#### **Program History**

During the initial phases, faced with a hostile operating environment from women's groups who were not convinced about the safety of the product and concerned about ensuring high quality standards required for providing the method, the program adopted a 'network of clinics' model as its entry strategy. This strategy emphasized collective ownership of the program by

providers, training of doctors in the network, monitoring the quality of service provision, and ensuring product access. It initially focused on supply side issues with low-key consumer directed communications. In addition to launching the network, the project also implemented an advocacy campaign to enhance correct knowledge about injectables and neutralize negative media reporting about the product.

During this early phase (between 2003-2006), the Dimpa program successfully demonstrated that DMPA can be provided through trained private providers with high quality standards. In 2008-2009 the program began to focus more on category promotion and demand creation for injectables and launched the No Bahana (No excuses) multimedia category campaign for Injectables.

In May-Jun 2009, USAID-India commissioned an external assessment of the Dimpa program. The assessment report (“Building access and demand for DMPA in Uttar Pradesh, Jharkhand, and Uttarakhand” - June 2009) highlighted several recommendations.

- Evaluate approaches needed to achieve adequate follow-up of DMPA clients
- Consider expanding provider network base by inducting GPs
- Lift visibility of the mass media and IPC campaigns by increasing reach and frequency
- Advocacy initiatives should become more proactive and visible, focusing on building a coalition of supporting providers and satisfied users of injectable contraceptives
- Facilitate the integration of DMPA into the public health system

These recommendations were the key considerations in the development of the work plans for the program in MBPH Year 2 and 3. Efforts in Year 3 were made to consolidate the investments made in Year 2 in these areas as described in the next section.

### **Milestones Achieved, Barriers and Challenge in Year Three**

The key focus areas of the program for year three of MBPH were:

- Improve quality of DMPA service delivery through the private sector by provision of technical support and quality assurance
- Create demand for DMPA through category promotion for injectables
- Plan for program sustainability
- Provide support for advocacy for inclusion of DMPA in the public health system

#### ***Improve quality of DMPA Service Delivery***

Provider Exchange Forum Meetings: As part of continued technical assistance to the network doctors, Exchange Forums were organized periodically. In Year 3 of the project, Exchange Forums were organized in eight cities – Bokaro, Jamshedpur and Ranchi in the state of Jharkhand and Agra, Gorakhpur, Kanpur, Mathura and Lucknow in UP wherein network doctors discussed their experience around DMPA client management, expectation from the program, etc. Led by the CBQA team, this activity was attended by local experts from the network, FOGSI office bearers and faculty from local medical colleges. To make the sessions more diverse and engaging, experts from the field of tax planning and also from a beauty and grooming chain were invited to make presentations.

Exchange forums conducted in eight cities saw a good turnout from network doctors with about 42% of network providers attending the events. Participation of client couples who have been on the method for about 3 to 5 years (along with their provider) worked well and served as a live testimonial to those doctors who seemed a little unsure about the method. Another two events are scheduled till end of Year 3 (Aligarh and Moradabad in Uttar Pradesh) and these will be completed by Sept '11.

Client screening checklist for use by Dimpa doctors developed: The checklist includes criteria to screen clients for DMPA and also covers IUDs, COCs and the pregnancy checklist. The checklists were produced and introduced to doctors in the Dimpa network as a part of the technical guidance by the program.

Technical assistance visits to network doctors and new Mentoring Program: The CBQA team conducted support visit to the network doctors in a few selected project cities. The main aim of these visits was to have one-to-one interactions with providers to address their doubts regarding any contraceptive methods, and provide guidance for client counseling, management of side effects, and the importance of maintaining client records.

To promote adequate mentoring of network doctors, it was decided to select and designate three or more network doctors in each city (initially as a pilot in four cities) as 'Dimpa Champions' to mentor other network providers.

The appointment of 'Dimpa Champions' in six cities in Year 3 (Agra, Kanpur, Ranchi, Jamshedpur, Mathura and Lucknow) was completed during the Exchange Forums and efforts will now be made to support 'Dimpa Champions' in mentoring other network providers in these cities.

Complete training and enrollment of 130 Ob/Gyn doctors/GPs in the Dimpa network: Taking into consideration the recommendations of the Dimpa assessment mentioned above, training of 153 additional Ob/Gyns and GPs was undertaken.

- Trainings were organized in Uttarakhand (Haridwar and Roorkee), UP (Allahabad, Barabanki, Ghaziabad, Noida, Sahibabad and Varanasi) and Jharkhand (Bokaro, Chaibasa, Deoghar, Giridih and Jamshedpur)
- Of the 153 providers trained, 106 were Ob/Gyns and 47 are GPs
- The total number of providers enrolled in the network in Year 3 now stands at 122 (against 153 providers trained), as compared to the annual target of 130

At present, the network comprises of 1,626 providers (1,434 Ob/Gyns and 192 GPs) against the life of project target of 1,500. Providers are being trained and added in the towns of Rishikesh and Roorkee in the state of Uttarakhand in September '11 to meet the annual target.

In Year 3, the focus was on adding network providers in those cities where their numbers were sub-optimal (less than 15 in the town). Emphasis was also given to training and enrolling women GP's, as female clients usually prefer to visit them to seek contraceptive advice and services.

Complete training targets for chemists: As more and more injectable manufacturers/marketers are entering the market, DMPA is increasingly being stocked at chemist outlets. It was therefore important to educate the chemists by:

- Providing an overview of FP methods and characteristics of injectable contraceptives

- Explaining the need for educating clients and the need to refer them to Dimpa helpline/Dimpa clinic
- Improving the linkages between DMPA distributors and retail chemists

Fourteen chemist training sessions were organized in the program cities, in which a total of 545 chemists were trained in Year 3.

Paramedic training: Given the observation that clients often spend considerable amount of time with paramedics in any health care facility and often it is the paramedic rather than the doctor that provides FP counseling to the client, the program developed a training module in Year 2, focusing on increasing the knowledge of paramedics in areas such as:

- Contraceptive methods including DMPA
- Family planning counseling skills
- Client record keeping and follow up

In Year 3, the program reviewed and revised this existing training module for paramedics by adding key points regarding counseling to help clients continue with the method and the helpline support available to clients.

Against the Year 3 annual training target of 200 paramedics from Dimpa network clinics, a total of 890 were trained over 25 training sessions. The annual training figure of 890 paramedics includes those from large hospitals and nursing homes which are not a part of the Dimpa network but requested that their nursing staff be trained by the program.

***Demand creation:***

Mass media support for demand creation: There was limited mass media activity in Year 3, pending the selection and contracting of the communication agencies. When MBPH finalized its agreements with communication agencies – JWT (creative development), Maxus (media planning and placement) and Hanmer PR (Public Relations) and briefed these agencies on the different components of the communication campaign. In the absence of the support of an advertising agency, efforts were made by the program team to provide some basic communication support in the form of radio spots that were placed in key cities which was complemented by the efforts of the field teams inserting Dimpa program leaflets in vernacular women’s magazines. New in-clinic posters and merchandize were developed by the program team, displaying the helpline number to serve as a reminder for both doctors and clients in the clinic environment. The field teams continued to put up client education and POS materials at provider clinics and retail chemist shops to create visibility for the method and for the program.

In July 2011, the program organized health camps at select Dimpa network clinics in the cities of Kanpur and Ranchi for World Population Day and this event (handled by Hanmer PR) received good media coverage.

Outreach by MBPH field team and activation agency: In year 3, as in previous years, the MBPH field teams continued to provide counseling to clients at the network clinics through the Umbrella (Chattri) activity. 48,644 women in the reproductive age group were counseled by the Dimpa field team as a part of this activity at provider clinics in 1,813 sessions up to August 31. Additionally, 140 mass contact events (FP information dissemination at large public/private hospitals or institutions) were organized at large public hospitals across the network cities and a total of 8,549 women were provided information on family planning through these events.

In order to spread the FP message and to build better access of low-income groups to FP methods (including DMPA), the program devised a new outreach activity in January 2011 in the form of mahila goshties (small community meetings of 25-30 women of reproductive age that are convened every week in pre-identified low-income areas of 18 headquarter towns with the help of the Aanganwadi workers) followed by FP health camps at Dimpa provider clinics. At these mahila goshties, MBPH field team members provide basic FP counseling and women are encouraged to ask questions on the subject. Based on the interest expressed by women in adopting any FP method, they are then invited to a FP health camp which is conducted at the clinic of a Dimpa network provider.

The field team conducted 602 mahila goshties (Jan to August 2011) in low socio-economic category localities and provided FP counseling to 23,120 women of reproductive age. Out of these 10,445 women attended the subsequent FP health camps (a total of 213 such health camps were organized) at Dimpa provider clinics where network doctors offered free counseling and consultation on FP. A total of 1,750 women attending the health camps adopted DMPA as a method (Jan to July 2011) and got it injected at the health camps.

Dimpa helpline: In Year 3, the helpline received a total of 34,349 calls (up to September 15) of which a majority of the callers (56%) were females.

In March 2011, the Dimpa helpline contract was awarded to ISAP (Indian Society of Agribusiness Professionals) after a competitive bidding process which saw participation from five bidders. The services of the new helpline set-up re-commenced in Lucknow from May '11. At present, the helpline has ten trained tele-counselors (five each for Dimpa and Saathiya).

To ensure that all calls are answered and no calls are missed, two additional tele-counselors are being added to the Dimpa helpline. Software for collating calls has been developed by ISAP and has been introduced since June.

Acting upon the feedback that women were hesitant to call the helpline since they thought the phone would be answered by a male counselor, another toll-free number was established in January 2011 and communications materials including in-clinic and in-shop posters as well as the new client-clinic cards specified that one number had male counselors and another one female counselors (1800 1800 555 – female counselors and 1800 1800 556 – male counselors).

After a review in the beginning of Year 3, and the recommendations of the external assessment of the Dimpa program (in 2009) about increasing follow up and continuation, the Dimpa helpline was repositioned as a tool for current users of DMPA as against a general helpline for anyone who wants to seek any information about injectable contraceptives or any other FP method. The expectation is that this will help align the number of callers with the bandwidth of the helpline and will cater to the needs of those callers who are in genuine need of information. With this repositioning, the Dimpa helpline numbers will not be advertised in mass media but will be placed inside doctor clinics, on client cards and on DMPA product packs of partner manufacturers.

The helpline tele-counselors received training support from CB&QA team and on an average, one training session was held every month during the year.

Paid helpline pilot: A pilot to evaluate partial helpline sustainability through paid helpline calls was planned and undertaken in the months of August-September, 2010. During this pilot, the program aired radio adverts ('No Bahana' campaign) with the new paid helpline number (1860

1803 672) across UP and Jharkhand. Program inserts were placed in magazine and newspapers in priority towns to advertise the paid number. The toll-free lines were discontinued during the pilot phase and a pre-recorded message informed callers to call the new paid helpline number for information on DMPA.

The paid helpline pilot was inconclusive and the toll-free number was restored as the number of calls to the paid helpline on a daily basis remained in single digits. One reason for the low volume of calls could be due to the lack of publicity of the paid helpline as the 'No Bahana' Television Commercial was not aired during this period as the contracts of the communication agencies were not in place at that time, and the fact that old communication materials that talked about the toll-free helpline were not completely withdrawn, and poor communication to people who called in on the toll-free number about the new paid service.

Client follow up mechanism: The internal study to put in place a client follow-up mechanism and its subsequent scale-up met with numerous challenges. A key challenge was the fact that very few phone numbers of DMPA clients were available from network clinics, since most clients prefer to keep their contact details private. Also in many cases where clients did provide their phone number, it turned out to be wrong, making it impossible to get in touch with them. Furthermore, the frequency of data collection from network clinics was also too long. Based on these challenges, it was decided to first strengthen the MIS and data gathered and then reinstate the study in August 2011.

Helpline User Study: Quality Assurance systems introduced in the helpline in Year 2 were continued in Year 3 as part of the project monitoring systems. The quality assessment checklist developed for evaluating tele-counselors' technical and soft skills such as offering a choice of contraceptive choices, correct technical information, asking probing and relevant questions, use of appropriate words, language and active listening continues to be used by the helpline supervisors. The checklist is being used by the helpline supervisor for monitoring quality of information provided.

A two-tier helpline Quality Assurance (QA) process is followed, in which the first level of checks are done by the helpline manager followed by another done by the CB&QA team. Based on the quality assessment, every month, technical assistance and training plans are designed and executed by the CB&QA team.

Besides conducting regular refresher trainings and practice sessions for all the tele-counselors, they are also being coached individually for improvement of quality.

Data on DMPA clients: It was observed that only 20 to 30% of the network doctors were filling in the DMPA patient case registers. Many doctors and paramedics felt that it was tedious to fill in the case register. Keeping this in mind, a new simplified client-clinic card (with a perforation in between) was developed and tested in three cities (Bareilly, Dehradun and Ranchi). With 95% compliance during the pilot phase, the card was subsequently simplified even further and columns to record the weight and blood pressure were added to the card along with space to record the reason for discontinuation of the injection (based on input from USAID). This new client-clinic card has now been introduced to all 45 program cities through a detailing script and the field teams are following up with network doctors and paramedics to get them to fill the client cards on a regular basis. Regular use of the client-clinic card has also been taken up at

Exchange Form meetings and initial field reports seem encouraging with a compliance rate of about 60 to 70 per cent.

Program Advocacy efforts: The last quarter of Year 2 saw a lot of media activity around the issue of the introduction of injectables in the contraceptive basket in the public sector. After political activist Ms. Brinda Karat's objection to the inclusion of DMPA in the public sector contraceptive basket by the government, Advocating Reproductive Choices group (ARC) called a meeting of its core group at Mumbai on December 8, 2010. MBPH attended this meeting along with other participants from PSI, PSS, Janani, DKT and FPAI. The following were the key features of the ARC meeting:

- Evidence, facts and experiences of providers and clients were collated and shared with the ARC General Body on 14 December 2010 at Delhi
- Spokespersons for DMPA at the national and state level were identified by the ARC for being oriented on media engagement by a PR agency. This effort was going to be led by MBPH.

However, in the year under review, advocacy efforts by ARC did not see much movement, and MBPH was unable to contribute much to these efforts. This was largely due to the decision that MBPH would support the advocacy efforts of ARC and not engage in any direct advocacy on the issue of injectables.

MBPH developed and circulated three issues of the quarterly newsletter 'Dimpa Outlook' amongst network providers, program partners and marketers of DMPA and other key program stakeholders. Some of the focal themes of these newsletters were: Improving adherence and continuity rates for DMPA, Role of client counseling for DMPA, Setting quality assurance systems for DMPA and Global delivery practices of injectable contraceptives.

DMPA Product Quality Testing: The work plan for Year 3 provisioned for the DMPA product quality testing. In recent years there had been a proliferation of DMPA brands in the Indian marketplace with multiple manufacturers/marketers entering the space. DMPA was available across a wide variety of price points in the market in India (between INR 40 to 200) and hence there were questions about uniformity and quality of the available brands.

As the DMPA market is at a nascent stage, and the role of the Dimpa program is to be a category champion, it becomes important to ascertain that the products available in the market are of a high quality. It was planned that the results of this assessment would be limited to assessing the capacity of DMPA manufacturers, and would be used for driving the advocacy objective in terms of making recommendations to the donor (USAID) and Gol about what they can do to collectively and separately to improve the quality of the DMPA product in the Indian market.

MBPH contacted several international drug quality testing experts to work on DMPA product quality testing. The experts were unanimous in their advice that instead of lot testing products available off the shelf; a facility assessment should be carried out as a better indicator of which manufacturers were capable of producing quality DMPA. However, since MBPH has no authority to approve or accredit manufacturers, it may be difficult to obtain their cooperation and it might simply call into question approvals that these manufacturers have already obtained from the government of India. It might also call into question DMPA products that could be

effective and raise doubts in the minds of consumers without providing a means for dispelling those doubts. Facility testing is also a more complex, expensive and time consuming process.

In light of this advice, the MBPH team and USAID-India in January '11 agreed not to move forward with the DMPA product quality testing as laid out in the annual work plan for year 3. Instead the program would focus on getting marketers' certification of product quality (as recognized by the government). This request for certification would be a part of the MoU that the program signs with each one of the manufacturers/ marketers that MBPH works with.

Explore opportunities, facilitate MoU with at least one DMPA marketer/manufacturer: The overall vision of the Dimpa program is to create acceptance of DMPA as a safe and effective contraceptive option through the private sector for couples who want to plan their family. In line with this vision and the Dimpa program strategy, a key focus of the program is to explore potential partnerships that will create demand for DMPA and improve service delivery for this method.

Exploring partnerships is also important given the multiple numbers of manufacturers/marketers and the need for common approaches amongst them (for eg, using tools already created by the Dimpa program rather than rebuilding or reinventing them). Given this objective, in Year 3, Dimpa program signed partnership MoUs with Janani, PSI and DKT India and initiated discussions with URHI/FHI and Sun Pharmaceuticals Private Ltd.

Janani, PSI and DKT have agreed to collaborate with MBPH in four broad areas – 1. Using communication materials developed by Dimpa program 2. Using technical materials developed by the Dimpa program (including training modules for doctors, chemists and paramedics) 3. Sharing helpline resources for calls originating from partner catchment areas and 4. Collaborating on outreach activation

Janani has placed the Dimpa category logo and helpline numbers on the packs of its DMPA brand (Pari) and on the in-pack leaflets and has agreed to provide financial resources to the Dimpa helpline.

The program has shared communication materials (such as TV commercials, radio spots) and client-education materials, provider training materials and job aides and also the new client-clinic card with partners. Janani has aired the Dimpa TV and radio spots in 2010-11. Partners have also shown interest in the client screening checklists and client-clinic cards developed by the program and efforts are being made to get partners to adopt these collaterals as well.

Improve linkages for effective distribution to network clinics and chemists for Contraceptive Injections: The program team was proactive with regard to availability of DMPA and alerted the manufacturer/marketer whenever there were any product availability issues with network providers. Field teams at all locations exchanged lists of network providers with local stockists of DMPA marketers/manufacturers and vice versa to facilitate better linkages.

By and large DMPA is available in all cities across India but the withdrawal of DKT's product in September 2010 led to the lack of availability of DMPA in some program cities. A new manufacturer – Sun Pharmaceutical Industries Ltd. launched its DMPA brand – My One Depot at the end of 2010 and is ramping up its availability in northern India. Similarly PSI is increasing availability of Procostron across Uttarakhand and Jharkhand. In March '11, DKT India launched

its brand of DMPA (Depo-Kare manufactured by Star Labs) and Janani is expanding to cover more markets in the state of UP at this time with its brand 'Pari'.

### Research Studies

Provider Mystery Client and Consumer Endline Studies: The RFP for the mystery client study was released in June 2011 and proposals from four agencies were received. The evaluation panel awarded the study to Sigma and field work for the study will commence in October 2011. The final report is expected in December 2011.

### Barriers and Challenges:

**Dropout rate after the first injection is high:** One of the program's observations has been the challenging fact that many clients do not come back to the clinics for the subsequent injection. This is usually the case in those cities where the network is relatively new and doctors have yet to gain experience in providing counseling for management of side effects. Also, for understandable reasons, many women will not return for successive injections without being reminded and encouraged. Therefore the program is currently piloting a mechanism of reminding clients (those who have voluntarily disclosed their phone number to the doctor and have given their consent to be contacted on their phone) through the DMPA helpline about their next injection.

**Advocacy support:** As mentioned above, there has been minimal advocacy support from MBPH on DMPA. This was based on USAID's decision that the role of MBPH would be limited to supporting other bodies such as ARC), advocating to the Ministry of Health and Family Welfare (MoHFW), or to the government of UP if they moved forward with DMPA trials, but neither of these have happened in year 3. In the absence of a clearly defined role for MBPH, a pro-active and visible advocacy initiative as recommended by the external assessment team in 2009, the task of building access and demand for DMPA in UP, Uttarakhand and Jharkhand and the inclusion of DMPA in the public health basket in India might take longer to be achieved.

**Data collection of DMPA users:** Although somewhat more streamlined than before, the collection of client data continues to pose challenges. It has been seen that providers are not motivated to record client data and most clients prefer privacy resulting in deficit of data to put in place a client reminder mechanism for increasing continuity of use. Given that DMPA provision represents a small part of providers' business, it is also challenging to design incentives to reward better record keeping.

### Progress and achievements in Year 3

Activity	O	N	D	J	F	M	A	M	J	J	A	S	% Complete
<b>Sustain network of trained DMPA providers (Ob/Gyn and GPs)</b>													
Implement exchange forums in ten cities and provide technical support to existing 1400 network members													80%

Activity	O	N	D	J	F	M	A	M	J	J	A	S	% Complete
Explore opportunities, facilitate MoU with at least 1 DMPA marketers/ manufacturer		■	■										100%
Share communication campaign with partners for supporting communication activities				■	■	■	■	■	■	■	■	■	100%
Improve linkages for effective distribution to network clinics and chemists for Contraceptive Injections				■	■	■							100%
<b>Provide support for advocacy for inclusion of DMPA in the public system</b>													
MBPH PR agency on board	■												100%
Develop PR, leveraging and advocacy plans		■	■										100%
Implement PR and advocacy plan				■	■	■	■	■	■	■	■	■	100%
Prepare documentation for supporting USAID/ARC for discussions with Ministry						■	■	■	■				50%
<b>DMPA Product quality testing – Activity dropped in Jan '11 in consultation with USAID</b>													
Identification of Technical Consultant for writing RFP	■												
Finalize and issue RFP for testing		■	■										
Conduct study and finalize report				■	■	■	■						
Use findings for advocacy & dissemination							■	■	■				
<b>Consumer directed communication</b>													
Use existing materials for interim campaign	■	■	■										100%
Integrated MBPH communication and media agency on board	■												100%
Roll out communication campaign with adaptations of existing communication materials				■	■	■	■			■	■	■	100%
Outreach by MBPH field team and activation agency	■	■	■	■	■	■	■	■	■	■	■	■	100%
<b>Continuation of Contraceptive Helpline</b>													
Evaluate results of paid helpline pilot	■												100%
Ongoing refresher trainings for Tele-counselors/ Managers	■		■	■	■	■	■	■	■	■	■	■	100%
Promote and sustain Helpline through PR and BTL promotions			■	■	■	■	■	■	■	■	■	■	100%
<b>Provider and client directed activities to support repeat use of DMPA</b>													
Provide technical assistance on better counseling and side effect management practices to network providers with high volume of clients			■	■			■	■			■	■	100%
Implement training programs for 400 paramedics across project towns						■	■						100%
Scale-up helpline ICT intervention for promoting repeat use				■	■	■	■	■	■	■	■	■	50%
<b>Research Studies</b>													
Paid helpline study (internal)	■												100%
Communication development study		■	■	■									Dropped

Activity	O	N	D	J	F	M	A	M	J	J	A	S	% Complete
Communication pre-test study													Dropped
DMPA Rx audit													Dropped
Provider endline													30%
Consumer endline													30%

**Objectives and strategies for Year 4:**

Going forward in MBPH Year 4, the program will focus on the following objectives:

- Document program highlights, stories and successes
- Plan for program sustainability
- Pilot mechanism to improve client continuation rates and scale-up

Additionally, the program will undertake the following maintenance activities:

- Demand creation for DMPA through category promotion for injectables
- Continuation of technical support and quality assurance for improvement of quality of service delivery

## MBPH Operations, Human Resources and Leveraging

### MBPH Staff Status

Name	Designation
Anand V. Sinha	Chief of Party, Key
Oommen George	Deputy Chief of Party, Key
Ramesh Navaladi	Director of Operations, Key
Shivani Kapoor	Policy and Advocacy Advisor,(Futures Group), Key
Rohini K Sahu	Partnerships Director, Key

### Other Positions

Sanjeev Vyas	Program Director
Dr Jaya Lal Mohan	Director Capacity Building & Quality Assurance
Kavita Ayyagari	Program Director
Mahesh Kalra	Director of Field Operations
Vivek Sharma	Research Director
Gaurav Gopal Verma	Program Director
Arunesh Singh	Program Director
Manisha Mishra**	Communication/Knowledge Management Specialist
Suma Pathy	Program Manager
Ashish Sinha**	Research Manager
Laliteswar Kumar	Manager Field Operations
Vandana Siwal	Assistant Program Manager
Neetika Madan	Finance and Administration Manager
Hari Shankar Singh	Finance and Administration Officer
Manmeet Bhalla	Administrative Assistant

R. Venkataramanan Executive Assistant

Gopal Giri Office Assistant

\*\* Resigned

## Field Positions

Table I: Summary list of Feld Positions are as follows:

Program	Saathiya	Dimpa	Shakti	SBK	ITC	ACS	Shared resources	Total
Regional Manager							4	4
Tr. Manager	1							2
Field Rep's	18	22	1	4	2	2		48
CBQA	2	1						3
<b>Total</b>	<b>21</b>	<b>23</b>	<b>1</b>	<b>4</b>	<b>2</b>	<b>2</b>	<b>4</b>	<b>57</b>

Below are details of field consultants appointed for the various projects.

## SAATHIYA

S No	Name	Designation	Program	Location
1	Bikash Chandra Mishra	Regional Manager	MBPH	Lucknow
2	Shaheen Akhtar	Regional Manager	MBPH	Varanasi
3	Jyoti Thareja	Regional Manager	MBPH	Noida
4	Prabhash Chandra Sinha	Regional Manager	MBPH	Ranchi
5	Kumaril Mishra	Training Manager	Saathiya	Varanasi
6	Deepti Mishra	Field Training Coordinator	Saathiya	Lucknow
7	Deepak Chandra Joshi	Team Leader	Saathiya	Lucknow
8	Ritesh K Nigam	Field Representative	Saathiya	Barabanki
9	Narendra	Field Representative	Saathiya	Lucknow
10	Nisha Shukla	Field Representative	Saathiya	Lucknow
11	Preeti Yadav	Field Representative	Saathiya	Lucknow
12	Mahendra Shukla	Field Representative	Saathiya	Agra
13	Shweta Pandey	Field Representative	Saathiya	Agra
14	Anoop Srivastava	Field Representative	Saathiya	Allahabad
15	Ajay Pal Singh	Field Training Consultant	Saathiya	Allahabad
16	Kalpna Singh	Field Representative	Saathiya	Allahabad
17	Ashish Kumar Pathak	Field Representative	Saathiya	Varanasi

<b>S No</b>	<b>Name</b>	<b>Designation</b>	<b>Program</b>	<b>Location</b>
18	Harsh Kumar Dubey	Field Representative	Saathiya	Varanasi
19	Bhagwati Bisht	Admin. Assistant	Saathiya	Lucknow
20	Sanjeev Dhawan	Team Leader	Saathiya	Dehradun
21	Suresh Mishra	Field Representative	Saathiya	Haridwar
22	Suman Katara	Training coordinator	Saathiya	Agra
23	Hukam singh	S. Field Rep	Saathiya	Agra

### **DIMPA**

<b>S No</b>	<b>Name</b>	<b>Designation</b>	<b>Program</b>	<b>Location</b>
1	Purnima Tiwari	Team Leader	Dimpa	Kanpur
2	Vinay Kumar	Field Representative	Dimpa	Kanpur
3	Pradeep Kimar Sinha	Senior Field Representative	Dimpa	Ranchi
4	Ruby Sinha	Field Rep	Dimpa	Ranchi
5	Kumar Viresh	S. Field Rep	Dimpa	Jamshedpur
6	Vibha Mishra	Field Rep	Dimpa	Jamshedpur
7	Abhay Kumar	Field Rep	Dimpa	Bokaro
8	Neeta Pandey	S. Field Rep	Dimpa	Dhanbad
9	Sanjeev Kumar Thakur	Field Rep	Dimpa	Giridih
10	Aditya	Admin. Assistant	Dimpa	Noida
11	Sadhna Saxena	Training coordinator	Dimpa	Bareilly
12	Jayanti saxena	Field Rep.	Dimpa	Bareilly
13	Tanzeem Ara	Field Rep.	Dimpa	Muradabad
14	Vibha Kesri	Field representative	Dimpa	Gorakhpur
15	Fatima Bano	Field Rep	Dimpa	Aligarh
16	Teena Chandra	Field Rep	Dimpa	Ghaziabad
17	Sonika Agarwal	Field Rep	Dimpa	Meerut
18	Neelam Kagneja	Field Rep	Dimpa	Saharanpur
19	Rajni Bhatia	Field Rep	Dimpa	Dehradun
20	Pragya Srivastava	Field rep	Dimpa	Jhansi
21	Kamleshwari	Field representative	Dimpa	Varanasi
22	Vacant	Field Rep	Dimpa	Dehradun

### **SHAKTI**

<b>S No</b>	<b>Name</b>	<b>Designation</b>	<b>Program</b>	<b>Location</b>
1	Vijay Bahadur Yadav	Shakti Representative	Shakti	Hardoi

### **ITC**

<b>S No</b>	<b>Name</b>	<b>Designation</b>	<b>Program</b>	<b>Location</b>
1	Jeetindra Kumar Srivastava	ITC Representative	ITC	Gonda
2	Akhand Pratap Singh	ITC Representative	ITC	Chandauli

**ACS**

<b>S No</b>	<b>Name</b>	<b>Designation</b>	<b>Program</b>	<b>Location</b>
1	Vishrut Mohan Tiwari	ACS Representative	ACS	Faizabad
2	Anil Kumar Dwivedi	Shakti Representative	ACS	Sultanpur

**SBK**

<b>S No</b>	<b>Name</b>	<b>Designation</b>	<b>Program</b>	<b>Location</b>
1	Varun Kumar Tripathi	SBK Representative	SBK	Kanpur
2	Manoj Srivastava	SBK Representative	SBK	Varanasi
3	Brijesh Kumar	SBK Representative	SBK	Lucknow
4	Vacant	SBK Representative	SBK	Kanpur

**CBQA**

<b>S No</b>	<b>Name</b>	<b>Designation</b>	<b>Program</b>	<b>Location</b>
1	Suzie F Paul	CBQA Consultant	CBQA	Delhi
2	Shalini Suri	CBQA Consultant	CBQA	Lucknow
3	Vacant	CBQA Consultant	CBQA	Lucknow

## Leveraging (All in USD)

Leverage Achieved in Y1, Y2 & Y3

Program	LOP target US \$ *	October 2008- September 2009 (Year 1) US \$	October 2009 - September 2010 (Year 2) US \$	October 2010 - September 2011 (Year 3) US \$	Y1+Y2+Y3 Achievement US\$
<b>Component 1 (MBPH Program)*</b>	5,768,700	385,065	769,409	1,593,182	2,747,656
Advanced Cook Stove		-	5,585	48,239	53,824
Shakti		4,172	3,856	49,297	57,325
ITC		6,355	47,969	330,330	384,654
TB		369	5,593	349,273	355,235
Saathiya		320,352	65,726	537,977	924,055
Saathi Bachpan Ke - Alliance		53,817	640,680	278,066	972,563
<b>Component 2 (CoE and HLC)*</b>			1,251	3,160	46,796
<b>Optional Component 3 (Injectable)</b>	823,900	-	71,332	521,114	592,446
<b>Total (Comp.1+Comp.2+ Comp.3)</b>	<b>6,592,600</b>	386,316	843,901	2,161,092	3,391,309





















