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EXPANDING ACCESS AND DEMAND FOR DMPA IN UTTAR PRADESH, JHARKHAND, AND UTTARAKHAND

June 2009

This publication was produced for review by the United States Agency for International Development. It was prepared by Tennyson (Don) Levy, Dinesh Agarwal, and Peter Miller through the Global Health Technical Assistance Project.

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This document was submitted by The QED Group, LLC, with CAMRIS International and Social & Scientific Systems, Inc., to the United States Agency for International Development under USAID Contract No. GHS-I-00-05-00005-00.

ACKNOWLEDGMENTS

The evaluation team wishes to express its appreciation for the guidance, collaboration, information, and hospitality provided by all with whom we were associated on this task. Without their invaluable support we would not have been able to effectively deliver on this evaluation. We also take this opportunity to specially acknowledge the following:

- The leadership and staff of USAID/Delhi;
- The management and staff of Abt India, especially the field team in Lucknow;
- Representatives of the Indian Ministry of Health and Family Welfare;
- The NGO and private sector partners of the DIMPA project;
- The many private ob/gyns, indigenous medicine providers, and chemists; and
- Those identified in Appendix B.

To all, our sincere thanks, and to the DIMPA team good luck as you continue your good work in expanding choice and access to modern contraceptives.

ACRONYMS

ANM	Auxiliary nurse midwives
ASHA	Accredited Social Health Activists
BCC	Behavior change communication
CMS	Commercial Market Strategies
DMPA	Depo medroxy-progesterone acetate
DTAB	Drug Technical Advisory Board
FOGSI	Federation of Obstetric and Gynecological Societies of India
FP	Family planning
FPAI	Family Planning Association of India
GPs	General practitioners
HLL	Hindustan Latex Ltd.
ICMR	Indian Council of Medical Research
IEC	Information, education, and communication
IMA	Indian Medical Association
IPC	Interpersonal communication
ISMP	Indigenous systems of medicine providers
IUDs	Intrauterine devices
KAP	Knowledge, attitudes, and practices
MBP	Market-based Partnerships for Health
MIS	Management information system
MOHFW	Ministry of Health and Family Welfare
NGO	Nongovernmental organization
NRHM	National Rural Health Mission
Ob/gyn	Obstetrician and gynecologist
OR	Operations research
PFI	Population Foundation of India
PHS	Population & Health Services
PR	Public relations
PSP	Private Sector Partnerships Project
RCH	Reproductive and child health

SDRL	Star Drugs and Research Laboratories Ltd.
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

BACKGROUND

Depo Medroxy-Progesterone Acetate (DMPA) was introduced in India in 1994 after the Drug Controller of India cleared it for marketing through the private sector as a prescription drug to be provided by qualified health practitioners as another option for women seeking family planning (FP). To generate demand for DMPA as a safe and effective contraceptive choice and increase its availability through partnership with commercial and social marketing agencies, the United States Agency for International Development (USAID) launched the DIMPA program to expand the choice of modern contraceptive methods to include the three-month injectable DMPA. The program began in 2003 through the Commercial Market Strategies (CMS) project and continued through the Private Sector Partnerships One (PSP-One) USAID global field support mechanism in Uttar Pradesh (UP), Jharkhand, and Uttarakhand. Currently the program has a fractional franchising arrangement with 1,150 clinics in 45 towns, the objectives being to

- Increase awareness of DMPA as a safe and effective method, and
- Increase use of DMPA among the target population.

Since the current DMPA program will end in September 2009, USAID/India has initiated this evaluation, the outcome of which will inform the USAID/India decision on whether the injectable contraceptive options will be exercised under another Mission task order for the Market-based Partnerships in Health (MBP) program.

The objectives of the evaluation are to:

- **Assess the policy environment for expanding contraceptive choice:** Analyze the current environment especially in terms of provision of injectable contraceptives, especially DMPA.
- **Assess experience with provision of injectable contraceptives:** Meet with other donors, social marketing companies, and the private sector to gain insights into which program approaches are working and which are not.
- **Review the DIMPA program:** Analyze the program strategies, technical approaches, demand creation and advocacy strategies, and management systems adopted by PSP-One to increase awareness and build positive attitudes about DMPA among providers and clients; build demand from users; and provide quality services for provision of DMPA through private providers.
- **Capture lessons learned:** Identify and document the lessons learned in the project.
- **Recommend future directions:** Discuss strategies for strengthening the inclusion of injectables as safe, effective, and convenient options in the basket of modern contraceptive methods. Recommendations, applying to both the public and the private sector, will be based on the current policy environment, lessons from the DIMPA experience, and situational analysis and will include options for promoting injectables within programs already funded by USAID in India.

The evaluation was conducted by a team of three consultants under the USAID/Washington-funded Global Health Technical Assistance Project (GH Tech) mechanism.

The team was provided with copious documentation on the DIMPA program both before evaluation activities commenced and immediately after and had detailed briefings and consultations with USAID/Delhi and Abt Associates. Interviews were conducted with stakeholders (the Ministry of Health and Family Welfare [MOHFW], the Federation of Obstetric and Gynecological Societies of India [FOGSI], etc.); health providers, particularly obstetricians and gynecologists (ob/gyns); private sector partners; and resource organizations, including nongovernmental organizations (NGOs). For a complete

list of persons contacted, see Appendix B. Field visits were made to Agra, Barabanki, Lucknow, Mathura, and Mumbai. In-country the evaluation occurred May 10–23, 2009.

MAJOR FINDINGS

Technical Services

- Depo-Provera is well accepted by ob/gyns and patients. Injectable contraceptives—specifically DMPA—seem to have an important place among temporary FP methods, particularly for postpartum use. While its long-term prevalence in the cafeteria of methods in India has yet to be determined, it will in all probability emerge as an important modern spacing method.

- The DIMPA project strategy of focusing initially on distribution through ob/gyns has worked well. Working city by city and backed by FOGSI and by well-known senior ob/gyns has given the project a stamp of respectability and quality that is needed for any new method. Local practitioners are recruited and trained by senior physicians they respect and trust, which greatly enhances their willingness to participate. This in turn appears to protect the project from both potentially hostile media and local rumor. Other approaches are unlikely to have worked as well.

- Other than rare cases of heavy menstrual bleeding, no physician we interviewed was aware of any serious medical problems reported by DMPA users, either among their own clients or in the community. While it is true that follow-up of clients is limited, it is likely that at least some clients experiencing serious distress would go to an ob/gyn for treatment, whether it is their contraceptives provider or someone else. If there are significant numbers of clients in distress, some word of it would undoubtedly have caught the attention of the DIMPA provider community.

- The anticipated backlash against the use of DMPA did not occur. No provider interviewed reported negative publicity in the local press or among social activist groups. Press conferences are routine when the project is launched in a new city, and while concerns are sometimes raised at the conferences, there have been no hostile accusations. Factors contributing to this welcome result may include a general reduction in the force of this issue among activists nationally; the choice of project states where social activists may be less vocal than in some other areas; and careful introduction through FOGSI and senior ob/gyns. For whatever reason, the project's crisis training has proven to be little needed.

- With the exception of follow-up, quality of care has been adequate to good. Clients are given a full choice of methods, and there is no evidence of failure to elicit informed consent. Intrauterine devices (IUDs), oral contraceptives, and sometimes other methods are usually available at the clinics, and others are available on referral. Clients are counseled, respectfully treated, and given privacy and confidentiality, and the providers have solid technical competence.

- Special efforts are needed to achieve adequate follow-up. For understandable reasons, many clients will not return for successor shots of injectable contraceptives without being reminded and encouraged. Low follow-up implies lack of knowledge of the client experience, the possibility of negative experience being passed around the community, reduced product sales, and reduced project effect.

- The potential of the ob/gyn network for introducing injectables has largely been realized. Most ob/gyns in the project cities are now part of the DIMPA network. Their clientele is primarily drawn from their own practice, and it is unlikely that large numbers of clients who are solely in need of FP services will go to ob/gyns in the future. Hence the majority of women whose deliveries are not attended by private ob/gyns or who need FP at times other than postpartum will not be reached by the network. To expand the use of DMPA within project cities, other providers, such as the general practitioners who must be at least M.B.B.S., must be enlisted.

Product Integration into the Public Sector

- Injectables are already included in the contraceptive choices in the National Reproductive & Child Health (RCH) 2 program. In addition to DMPA, Cyclofem (a one-month injectable) and Net-En (a two-month injectable), while not in general use, are both undergoing Phase IV clinical trials under the auspices of the Indian Council for Medical Research (ICMR). Final results from these trials are expected in two to three years. It may be noted that, while DMPA is not provided by MOHFW, it is available through other government and quasi-government institutions, such as the Ministry of Labor's Employee State Insurance Corporation.

- Thus far there has been little engagement of the DIMPA project with the public sector at either the national or state level. However, at a meeting with the evaluation team, MOHFW representatives informally requested that DMPA data be shared with them to help them prepare the briefing dossier for submission to the Drug Technical Advisory Board (DTAB), and the project may be asked to give a presentation to the MOHFW. The availability of hard data that demonstrates the success of DMPA will support the case for inclusion of the product.

- Public sector delivery of injectable contraceptives will be both competitive with and supportive of the private sector. Clearly, availability through the MOHFW will offer consumers a major alternative to purchasing through the private sector. At the same time, MOHFW adoption will validate private sector use. It will also allow for more widespread and aggressive use of mass media to create demand.

- There is more amenable political climate for introduction of injectable contraceptives in India. There is hope, therefore, that DTAB can be encouraged to make a favorable recommendation on the use of DMPA. If so, it is expected that it will focus primarily on the ability of the MOHFW to provide an appropriate quality of care more than on the intrinsic safety of the product, which is well established. The concerns may have to do with ensuring that the initial prescription is given by a knowledgeable provider, that counseling is available, and that adequate provision can be made for follow-up and the treatment of side effects.

Marketing

- The introduction of injectable contraceptives through the private sector and their absence in the public sector have given the private sector an incentive to take risks and invest—though modestly—in this new market opportunity.

- The absence of government endorsement of product use in the public sector has slowed the pace of growth of the overall market. Not only does the absence of the product from the public health system affect volumes, but as a result some private providers and marketers may have taken a very cautious approach to the method.

- The participation of Star Drugs and Research Laboratories Ltd. (SDRL) and the introduction of Kushi have reset the price bar much lower, putting pressure on current and future competitors to the benefit of the consumer. This is an example of the working of market forces at its best. Significant market momentum will be generated at the bottom of the pyramid among low-income consumers, spearheaded by Kushi and sustained when other low-price brands enter the market.

- Pfizer is interested primarily in the institutional market (public sector purchases) and will not be a major factor in increasing the private market. However, it will be critical to retain the Pfizer brand, Depo-Provera, in the DIMPA program because of the credibility and quality image (foreign-made) it provides for the product category.

- DMPA is the future of the injectable contraceptives market given provider interest; as the flagship product, it will therefore have responsibility for market expansion. The one-month injectable contraceptive, when introduced, will create its own niche based on pricing.

Communication

- The DIMPA Helpline is hugely popular; daily call volume is increasing and it has a good reputation among providers, stakeholders, and retailers. It has provided a vital information link for target clients by extending product information and counseling beyond the provider.
- The program has used other innovative measures to support the providers, like the in-clinic counseling by DIMPA staff and "tea parties," which contribute to the increased familiarity of the product. Providers generally welcome this support, primarily because it reduces their time spent in addressing client concerns.
- The communication program has made a significant break-through in connecting with males. This augurs well in building a constituency of support around the product and its eventual users.
- Couples have been motivated to talk about the product, which enhances the opportunity for trial and sustained use.
- The environment generally, both at the national and state levels, may be becoming more conducive to the promotion and support of injectable contraceptives. In the absence of any objections, especially from "self-interest" sources, providers and stakeholders are growing more confident and comfortable about their involvement with the product. The evolving situation is mostly attributable to the winds of political change and the careful and methodical strategy assumed in implementing the DIMPA program.
- Although there is increasing awareness of DMPA, there is not yet any evidence that awareness is being converted to product trial to any significant extent.

Management

- The MBP program is a very suitable vehicle for continuing the DIMPA program, assuming that additional resources are added to the current MBP infrastructure. Within MBP there is already institutional memory and familiarity with DIMPA, staff are already private-sector oriented, there is increasing synergy between Saathiya[1] and DIMPA, to the benefit of both programs, and MBP will have the opportunity of using lessons learned from DIMPA to inform other market development activities.
- DIMPA will have the opportunity to integrate with other private health initiatives, specifically Merrygold-franchised private hospitals in UP and the Gates Foundation initiative in six cities in UP.

RECOMMENDATIONS

- Over the past five years the DIMPA program has cautiously and methodically put in place a market development strategy to ensure the stability and viable growth of the injectable contraceptives market. The program now needs to achieve a critical mass of users and impact, and the MBP project is the ideal vehicle to manage this new initiative for the product.
- While developing the new strategy for DIMPA within MBP, marketing and communication costs must eventually be assumed by those in the private sector to the extent it serves their needs. In addition, technical services need to be gradually divested to institutions with such interests, like FOGSI, the Indian Medical Association (IMA), medical colleges, and the like.
- The project should be expanded to systematically include general practitioners (GPs). This can be done by working with the IMA, as was done with FOGSI for ob/gyns, as a way to legitimize the

[1] In seven cities in UP, USAID/India's program "Saathiya" for promoting youth-friendly reproductive health services began in March 2009.

activity among nonspecialist doctors. This should be considered partly demand creation, so inclusion of GPs should be attempted even where profitability may be marginal. Initial efforts should be evaluated carefully, in terms not only of sales but of the nature of the clientele and their motivations and experiences. In expanding to new cities, however, initial penetration through ob/gyns should be continued, but GPs should be included early.

- There needs to be more emphasis on follow-up in training, counseling, field visits, record-keeping, etc. The technical support system, including training modules; information, education, and communication (IEC) materials; procedures; etc., for both providers and clients should be carefully reviewed and revised to add emphasis on the need for return visits. Some experimentation is advisable to find the best way to get this message across.
- The integration of DMPA into the public health system can be facilitated by carefully packaging and providing to the MOHFW information that speaks to DMPA's acceptability and safety based on the experiences of the DIMPA project.
- Operations research (OR) can be used to test and develop protocols and modalities to support the anticipated adoption of injectable contraceptives in the national program.
- The program needs to focus on promoting the DIMPA service as a constellation of promises of quality, value, and client-centeredness. In so doing the program would avoid the dangers of creating a brand (product) expectation that could lead to consumer confusion, or worse frustration, when they cannot find the DIMPA brand.
- Support for current brands—Kushi, Depo-Provera, and Depo-Progestin—should continue but with encouragement for the introduction of additional brands to expand choice and stimulate market momentum. To this end the program should seek partnerships with other commercial marketers and distributors and not limit itself to social marketing organizations.
- The geographical coverage of the program should be expanded to other north India states to create economies of scale for the private market. Present partners are especially interested in building markets in Madhya Pradesh, Rajasthan, and Punjab. The program should also further expand the number of towns and providers in Jharkhand.
- Manufacturing and marketing partners need to assume more equity in future investments given the substantial investments USAID has made in policy and marketing to build the injectable contraceptives market. A deliberate effort is required to convince partners to consistently participate in and eventually assume costs for provider training, point-of-sale material, behavior change communications (BCC), interpersonal communications (IPC), market research, and other consumer-driven initiatives.
- The advocacy program should remain vigilant and especially stay prepared for crisis management. Advocacy initiatives should also be more proactive and visible, focusing on building a coalition of supporting providers and satisfied users to add credibility and motivate increased interest in and use of injectable contraceptives.
- The current campaign should be continued to cement in consumers and mine the benefits of extended protection and appropriateness while breastfeeding. There is a need to emphasize that an injection is required every three months to ensure compliance and continuity.
- The visibility of the mass media and IPC campaigns should be lifted by increasing reach and frequency.

I. OBJECTIVES

The specific objectives of the evaluation, as given in the scope of work, are to

- **Assess the policy environment for expanding contraceptive choice:** Analyze the current environment, especially in terms of provision of injectable contraceptives, particularly Depo Medroxy-Progesterone Acetate (DMPA).
- **Assess experience with provision of injectable contraceptives:** Meet with other donors, social marketing companies, and representatives of the private sector to gain insights into what is working and what is not.
- **Review the DIMPA program:** Analyze program strategies, technical approaches, demand creation and advocacy strategies, and the management systems adopted by PSP-One to increase awareness and build positive attitudes about DMPA among both providers and clients; build demand; and provide quality services for provision of DMPA through private providers.
- **Capture lessons learned:** Document the lessons learned in the project.
- **Recommend future directions:** Discuss strategies for including DMPA and other injectable contraceptives as safe, effective, and convenient options in the basket of modern contraceptive methods. The recommendations will be based on the current policy environment, key lessons from DIMPA experience, and situational analysis and will be directed to both the public and the private sectors. The recommendations should also discuss opportunities for promoting injectable contraceptives within programs already funded by USAID in India.

II. BACKGROUND

- USAID/India works with the Government of India to reorient and revitalize the country's family planning (FP) and reproductive health services, targeting the states of Uttar Pradesh (UP), Jharkhand, and Uttarakhand for demonstrating program innovations.

- DMPA was introduced in India in 1994 after the Drug Controller of India cleared it for marketing through the private sector as a drug to be prescribed by qualified health practitioners as an option for women seeking FP. Backed by 40 years of research, DMPA is a safe and effective contraceptive being used by more than 12 million women in over 106 countries. In most developing countries the product is provided free by the government but is also available commercially and through social marketing. However, in India, because of a history of concerns about safety and quality of care, DMPA is not provided by the Ministry of Health and Family Welfare (MOHFW). Over the past 10 years there have been sustained efforts by USAID and others to overcome the cultural, political, and legal barriers to public health system acceptance of injectable contraceptives, especially DMPA. The current change in the environment strongly suggests that these obstacles can soon be overcome.

- To generate demand for DMPA as a safe and effective contraceptive choice and increase its availability through partnership with commercial and social marketing agencies, USAID launched the DIMPA program. The project started in 2003 in three cities through the Commercial Market Strategies (CMS) project and was expanded to 45 cities in UP, Jharkhand, and Uttarakhand through the USAID-funded global PSP-One field support mechanism.

- The program has followed a fractional franchising method wherein the method is added to those already available to private MBBS providers. The network of practitioners making it available is branded as the DIMPA network of clinics, which represent highly qualified practitioners trained and supported by the program to provide DMPA. DIMPA network providers are given the latest updates on DMPA; adhere to strict guidelines for screening and counseling clients, needle disposal, pricing, and stocking of injectable contraceptives; and are willing to be monitored by the DIMPA program.

- Currently the program has a fractional franchising arrangement with 1,150 clinics in 45 towns in the three focus states. Doctors offer the clients a complete range of contraceptives, not just injectables. They do a thorough counseling and medical examination of a woman before providing the three-month contraceptives. The project aims to train providers to adhere to the correct protocol when offering DMPA in line with the World Health Organization (WHO) guidelines for screening for contraindications, informed choice, and correct method usage.

- The three project states are adjacent to one another in northern India. UP is the most populous state in India, with an estimated population of over 190 million; if it were an independent country, it would be the world's fifth largest. It is also one of India's least developed states and its maternal and child health indicators are poor. Uttarakhand was created in 2000 from some prosperous sections of UP in the north. Jharkhand, to the east, is partly tribal, and is also poorly developed. Table 1 gives some basic data:

TABLE 1. COMPARISON OF THE THREE PROJECT STATES				
	Uttar Pradesh	**Uttarakhand**	**Jharkhand**	**India**
Population (millions)	190	8.5	26.9	1,170
% in lowest quintile of wealth index	25.3	6.0	49.6	20.0
Percent females with no schooling	49.6	34.9	53.3	41.5
Percent married women of reproductive age currently using family planning				
Any method	43.6	59.3	35.7	56.3
Any modern method	29.3	55.5	31.1	48.5
Injectable contraceptives	0.1	0.1	0.1	0.1

Sources: National Family Health Survey – 3.

- The DIMPA program is supported by the Federation of Obstetric and Gynecological Societies of India (FOGSI) and three social and commercial marketing agencies—DKT India, Population and Health Services (PHS), and Pfizer. The program is implemented by Abt Associates.
- As the DIMPA program will end in September 2009, USAID/India is undertaking an end-term evaluation that will inform USAID/India's decision on whether injectable contraceptive options will be exercised under another Mission task order for the Market-based Partnerships (MBP) for Health program.
- The evaluation was conducted by a team of three consultants through the Global Health Techical Assistance Project (GH Tech). Dr. Dinesh Agarwal, national program officer, reproductive health, UNFPA, who is based in Delhi, was tasked with assessing the potential for integrating DMPA injectables into FP services in the public sector. Peter Miller was tasked with evaluating technical services (including but not limited to quality, training, providers and client services); and Tennyson (Don) Levy, team leader and private sector specialist, was tasked with evaluating marketing, communication, and management initiatives. The team was provided with copious documentation on the DIMPA program both before evaluation began and immediately after. In addition to the documentary information, the team had detailed briefings and consultations with USAID/Delhi and Abt Associates. Interviews were conducted with stakeholders (from the MOHFW, FOGSI, etc.); various health providers, particularly obstetricians and gynecologists (ob/gyns); private sector partners; and resource organizations including nongovernmental organizations (NGOs) (see Appendix B for a complete list of persons contacted). Field visits were made to Agra, Barabanki, Lucknow, Mathura, and Mumbai. The team operated in India May 10–23, 2009.

III. TECHNICAL SERVICES

The team visited ob/gyn clinics in four cities (Lucknow, Barabanki, Agra and Mathura), was briefed by PSP-One both at the headquarters in New Delhi and at the regional office in Lucknow, and discussed technical issues with several organizations, including the MOHFW, USAID, FOGSI, the Population Foundation of India (PFI), and Parivar Seva Sanstha (PSS) among others (see Appendix B). Its findings are drawn from those discussions, observations during field visits, and project documents.

FINDINGS

Providers

About 90 percent of the providers are ob/gyns, the rest being female general practitioners (GPs). The team visited 11 ob/gyns in the four cities, most of whom operated nursing homes. Of these, 10 were women; some had been in the program since Phase I (2003), the others joining in Phase II (2005–06). Nearly all had been formally trained by DIMPA; those brought in for Phase II had either attended the DIMPA training sessions or (in two cases) been trained separately by DIMPA staff. All were receiving regular supplies; some kept vials of DMPA in their offices; others relied on chemists located either within or near the nursing home. None reported stockouts at any time. All had received information, education, and communication (IEC) materials, which they made readily available. DIMPA boards were prominently displayed; Tiahrt charts[2] were on the walls of all clinics; flipcharts and brochures seemed to be used by both physicians and paramedics,[3] and all used project-supplied case registers and client cards. The project also distributes a newsletter to providers.

These ob/gyns are not primarily motivated by financial interests; neither sales nor consultation is a significant part of their income, which is mostly based on deliveries and other specialized services. For most, FP is an intrinsic part of their work, and injectable contraceptives are an attractive option. For a few, FP is also a passion, and injectables serve a core interest in ensuring reproductive health for Indian women.

While at first training was outsourced to the Family Planning Association of India (FPAI), since 2005 DIMPA has had in-house training capacity, with separate modules for physicians, paramedics, and chemists. To avoid taking providers away from clinics, training sessions are generally held on-site in two-hour sessions in the early afternoons when clinics are closed. While most of the ob/gyns had heard of injectable contraceptives previously, they knew little about them, and the DIMPA training was greatly valued. Trainees are given copies of the FP "green book"[4] and taught to use it. The doctors keep these books in their offices, and while they do not appear to be used often for reference, they are valued as authoritative.

Both DIMPA and the providers report that it has become much easier to convince doctors to join the project and be trained and that providers, who were often doubtful about injectable contraceptives initially, are increasingly comfortable with them. Much of the improvement seems to be due to the support of FOGSI and the personal stature of Dr. Ravi Anand, the DIMPA program manager based in Lucknow. With the visible participation of senior ob/gyns, there is a strong sense of DIMPA as an activity of the central professional society of these physicians. Perhaps partly because it was decided to initiate activities gradually through the ob/gyns, there were no reports of backlash in the press or citizens' groups, and no reports of serious unanticipated health events.

[2] These are informed choice wall charts with details on the basket of methods.

[3] Paramedics: Physician assistants providing basic client services, counseling, and administrative function of the clinic.

[4] Green Book: The Essential of Contraceptive Technology: A Handbook for Clinical Staff. Johns Hopkins Population Information Program.

Clients

There is not much systematic data on the clientele. There has been no follow-up study based on acceptor records. Case register information on client characteristics is limited to age, obstetric history, and future reproductive intentions. From the clinic visits it appears that most of the clients are married, urban (although a significant number come from rural areas), lower-middle to middle class, parity 1-4. Few nulliparous women accept injectable contraceptives. Most of the clinics' clientele consists of established obstetric patients, although a significant number of clients do come in specifically for FP. For obstetric patients, the focus is on postpartum care, notably at the six-week visit for immunizations; particular attention is paid to post-Caesarean-section clients. These women are counseled on the cafeteria of methods; in the clinics we visited, substantial minorities were opting for injectable contraceptives.

All the physicians talked about significant numbers of clients for whom confidentiality is an important factor in their choice of method; in particular, they do not want certain family members—e.g., mothers-in-law or husbands—to know they are using FP. These women usually do not give contact information and in general do not want to be contacted outside the clinic. Most physicians mentioned clients whose husbands are working abroad and whose use of injectable contraceptives is to avoid pregnancy during their occasional return visits. They therefore need only a single injection. While such clients are probably only a small minority of the total, their lack of repeat visits has a different implication than for most clients.

Provider Perceptions

The perceptions of ob/gyns are skewed by the fact that most of the clients whose views about injectable contraceptives they know are those who return for reinjection, that is, satisfied users. Nevertheless, their perceptions are important, and their views are quite consistent:

- Injectables have become more acceptable during the time they have been providing them, from an initially low base. (However, our impression from a brief review of the case registers is that while acceptance increased, it has now tended to plateau at a fairly constant level.)
- Clients were initially afraid of menstrual side effects, but these fears have receded.
- The comfort levels of clients depend on the comfort level of the ob/gyn herself. In the beginning, they were less comfortable; now that they themselves are convinced, their clients are more relaxed.
- Very few side effects are reported other than menstrual ones. We heard of two cases of heavy menstrual bleeding, both successfully treated.
- Some providers feel that amenorrhea is the side effect that bothers women the most; others feel that menstrual irregularity is more troublesome.
- They all report no adverse publicity since they have been providing injectable contraceptives.
- They generally feel that project communication efforts, whether through mass or local media, have had only modest effect on their clientele. They would welcome more media reports directing specific attention to their clinics. They know of the Helpline and think it potentially useful but have not received much feedback in their practice, presumably because it is quite new.

Quality of Care

Using the framework for assessing quality of care developed by Bruce and Jain,[5] the following observations can be made:

Method choice. The essential purpose of the DIMPA project was to expand contraceptive choice by adding injectables to the mix; this has been done. However, it is important to determine whether, in offering that option, the choice of other methods is compromised. It does not appear that this occurs to any substantial extent. Training and IEC materials are geared to ensuring that the full range of methods is offered. Providers and paramedics say they are explaining and offering all methods, and mystery client studies conducted on four occasions[6] confirms this. The project appears to be Tiahrt-compliant.[7]

Information given. The structure for providing information to clients is sound. Providers are trained, and a variety of IEC materials are available, including a flip chart, a brochure, and an all-method wall chart in each clinic. These materials seem to be used. The "umbrella camps"[8] seem to be effective in modeling how to provide information appropriately. However, only in just over half of all cases are side effects discussed with clients; this is a serious omission. Also, as will be discussed below, not enough attention is being paid to informing clients about the reasons for return visits.

Technical competence. Technical competence is a strength of this program. The ob/gyns, with a solid professional background in reproductive medicine, can absorb training on injectable contraceptives more deeply than other providers would. Further, the fact that most clients for injectables are already obstetric patients means the provider will have prior knowledge of their health. Disposal of medical wastes, notably needles and syringes, is sound; all physicians separate the two, usually with a cutter and a separate box for the needles. In all four cities, medical waste is collected daily. Finally, ob/gyns have the training and facilities to deal with whatever complications may arise.

Interpersonal relations. While the team was unable to observe relations between physicians and clients, they seem generally to be appropriate. Clients appear to be treated with respect. They presumably have confidence in the doctor. There is usually a substantial status difference between the ob/gyn and the client, which probably inhibits two-way communication, but the status differential is less with the paramedics, who also talk with clients. In the ob/gyn's office, there is privacy for the interaction. There is less privacy when counseling is conducted by paramedics in the waiting room.

Continuity of care. This is the primary threat to quality of care in this project. In part, this is intrinsic to the method; remembering an event after three months and being able to make separate visits at regular intervals is difficult. Clinical services that focus on clients who come into the clinic rather than those who do not are not generally oriented to managing follow-up. It appears that this is true in this project. The data may understate the actual rates of reinjection, because in some cases clinicians are preparing new data pages for returning clients, in effect treating them as new acceptors. It was not possible to make quantitative estimates of the extent of this practice. Nevertheless, it is likely that continuation rates are in fact quite low, perhaps not more than 25 percent at one year. This is consistent with other findings in India. In general, clients are given a card with the expected date of the return visit on it. The date is also noted in the case register. However, no systematic attempt is generally made to consult the register to see which clients are due on a given day or who has missed appointments, and no active effort is made to

[5] Bruce & Jain framework: "Six elements of quality are: choice of methods, information given to clients, technical competence, interpersonal relations, mechanisms to encourage continuity, and an appropriate constellation of services. The kind of care offered by a program therefore will be determined by the degree of attention providers and managers pay to these elements."

[6] Mystery client research

[7] Tiahrt Compliant: adheres to principles of informed voluntary choice of contraceptive method.

[8] Umbrella camps held on the premises of DIMPA providers by the PSP-One team last 4-5 hours. Waiting clients are counseled on the different FP methods using flip charts and other communication aids.

contact those who do not come in. A notable exception is the FPAI clinic in Lucknow, which does active follow-up. FPAI has an outreach program in peri-urban areas where monthly camps are organized. During these camps an attempt is made to contact current users of FP methods, including DMPA.

One factor contributing to this situation is the relative lack of attention given to this issue in the basic project structure. In training modules, IEC materials, record keeping, management information systems (MIS), etc., very little attention is given to the need to follow up with patients, so clinic staff are not aware of the need to make such efforts. A second problem is the confidentiality issue: Some clients clearly would not welcome being contacted by telephone or a home visit. Clients are not asked at intake whether they would be willing to be reminded of the need for repeat visits, so when a patient has missed a visit, it is not known whether a reminder would be acceptable. The team asked some providers whether they could obtain this information at intake, and they agreed they could. However, it was not clear that they would all be willing to do follow-up. As a result of this combination of problems, the levels and reasons for discontinuation are not known; nor is it clear whether there are substantial numbers of users who are in distress over menstrual or other problems, and hence whether there are substantial numbers of dissatisfied past users. Neither the DIMPA project nor the providers have a useful profile of acceptors.

Array of services. The clinics visited all provided a wide range of reproductive health services and could manage most serious complications. This is especially true of the multiservice nursing homes.

Record Keeping

Record keeping at DIMPA clinics is based on case register books, which are available and used. Data from these are collated monthly by the DIMPA project field representatives, who enter them into the DIMPA database the same day or at latest the following day. Hence real-time data are available from the MIS on the status of project activities. However, in some clinics significant amounts of data are missing. Also, as previously noted, return patients in a significant proportion of clinics are entered as new patients, so the proportion of return visits in those clinics is not known. Since the providers are not DIMPA employees, they cannot be supervised and corrected as regular employees can, and the field representatives may not have the status to influence them. Continuous efforts are made to improve this situation, but there are limits as to what can be expected. One limitation is that the data are used only for DIMPA purposes; the providers do not in general have the practice of using client records for patient care. For example, in addition to the lack of a reminder system, the spaces for recording weight, blood pressure, menstrual complaints, and advice/treatment may not be filled in, and the form is generally not referred to in the course of care.

RESULTS AND LESSONS LEARNED

Injectable contraceptives have significant acceptability among patients of private ob/gyns. It appears that injectables, specifically DMPA, have an important place among temporary FP methods, particularly postpartum. While DMPA's long-term prevalence in the cafeteria of methods in India has yet to be determined, it will in all probability emerge as an important modern spacing method.

The DIMPA strategy of focusing initially on distribution through ob/gyns has worked well. Working city by city through local practitioners, backed by FOGSI and by well-known senior ob/gyns, has given the project a stamp of respectability and quality that any new method needs. Local practitioners are recruited and trained by senior physicians whom they respect and trust, which greatly enhances their willingness to participate. This in turn seems to protect the project from both potentially hostile media response and local rumor. It is unlikely that other approaches would have worked as well.

Clients have reported few serious problems. Other than rare cases of heavy menstrual bleeding, no physician we interviewed was aware of serious medical problems among DMPA users, either their own patients or in the community. While follow-up is limited, it is likely that at least some clients experiencing serious distress would go to an ob/gyns for treatment, either their contraceptive provider or

someone else. If there are significant numbers of clients in distress, some word of this would undoubtedly have caught the attention of the DIMPA network.

The anticipated backlash against the use of DMPA has not occurred. No provider we interviewed reported negative publicity in local press or among social activist groups. The press is aware of the project. Press conferences are routine when the project is launched in a new city, and while concerns are sometimes raised at those conferences, hostile accusations do not result. Factors contributing to this welcome result may include a general reduction in the force of this issue among activists nationally; the choice of project states where social activists may be less vocal than in other areas; and the careful strategy for introducing the project. Whatever the cause, the project's crisis training has proven to be little needed.

Except for follow-up, quality of care has been adequate to good. Clients are given a full choice of methods and there is no evidence of failure to elicit informed consent. Intrauterine devices (IUDs), oral contraceptives, and sometimes other methods are usually available at the clinics and others are available on referral. Clients are counseled, respectfully treated, given privacy and confidentiality, and deal with technically competent providers.

Special efforts are needed to achieve adequate follow-up. For understandable reasons, many clients will not return for repeat injections without reminder and encouragement. Low follow-up carries with it lack of knowledge of the client experience, the possibility of negative experience being passed around the community, reduced product sales, and reduced project effect.

The potential of the ob/gyn network for introducing injectable contraceptives has largely been realized. Most ob/gyns in project cities are now part of the DIMPA network. Their clientele is primarily drawn from their own practice, and it is unlikely that large numbers of clients who are solely in need of FP services will go to ob/gyns in the future. Hence the majority of women who are not delivered by private ob/gyns or who need FP at times other than postpartum will not be reached by this network. To expand the use of DMPA within project cities, other providers must be enlisted.

Behavior change communications (BCC) efforts have had little effect to date. So far the modest sales and demand for DMPA suggest that the limited and cautious use of media has not had much direct effect on demand. The reasons for caution (avoiding backlash, focusing on quality of service, etc.) are understandable, but greater efforts to attract media support will probably be needed to increase knowledge of and demand for injectables.

IMPLICATIONS

Expansion of service providers is a logical next step. There is widespread agreement that more systematic efforts to recruit GPs, including males, are appropriate. Using the Indian Medical Association (IMA) for this purpose, as FOGSI was used for ob/gyns, is promising. If the project expands to new cities, initial penetration through ob/gyns is still advisable, but rapid expansion to GPs should follow. Expansion to other providers, such as indigenous systems of medicine providers (ISMPs), needs more consideration. ISMPs should be used mainly for referral, or if permitted through Government of India certification could at some point be trained to provide injectables.

Demand creation needs more attention. There are legal, political, and practical obstacles to establishing a full-fledged media support campaign, but without it much of the potential demand for injectable contraceptives will remain unrealized. Working solely on the supply side is not sufficient.

Special efforts for continuation will be needed to ensure responsible client care, maintain a positive reputation for injectable contraceptives in the community, and maximize product sales. Such efforts come more naturally to programs with built-in outreach capabilities, such as the ASHA[9] in the MOHFW

[9] Asha: Accredited Social Health Activists.

system, and once DMPA is used in the public sector, linkages with such systems can be attempted. Meanwhile, within the DIMPA project, to improve continuation rates and increase usage efforts are needed that go beyond the usual marketing activities or clinical services.

Fine-tuning the model is necessary through pilot projects and operations research. Questions remain about how to achieve better follow-up and the role of ISMPs and other providers. The project has been quite good at this so far, and these activities should continue. Given the optimism now prevailing on the likelihood of the public sector adopting injectable contraceptives, USAID can look at the next few years as a window of opportunity to investigate how best to incorporate and institutionalize injectables in both public and private sectors.

RECOMMENDATIONS

Expand the project to systematically include GPs. In so doing, use IMA as FOGSI was used for ob/gyns to legitimize the activity among generalist doctors. Because this should be considered partly as a demand creation activity, inclusion of GPs should be attempted even where profitability may be marginal. Initial efforts should be evaluated carefully, in terms of not only sales but also the nature of the clientele and their motivations and experiences. In expanding to new cities, however, initial penetration should still be through ob/gyns, but with early inclusion of GPs.

Give more emphasis to follow-up in training, counseling, field visits, record-keeping, etc. The technical support system, including training modules, IEC materials, procedures, etc., for both providers and clients should be revised to give more emphasis to the need for return visits. Some experimentation is advisable to find the best way to get this message across.

Use follow-up reminders for clients who are willing to be contacted. At intake, inquire systematically whether clients would be willing to be reminded when their next appointment is due. The follow-up might be done by the clinic itself or by the Helpline. If the latter, the field representatives will need to collect data on next visits. If clients when contacted are unwilling to return, their reasons, especially side effects, should be recorded in the case register.

Add major adverse event reports to the MIS. It seems to be feasible for field representatives collecting monthly data to inquire whether there have been any major unanticipated health events (as in Phase IV trials) since the last visit (not including, for example, routine menstrual irregularities, amenorrhea, headache, nausea, etc.). The database forms should list possible events and an "other" category. This will allow the DIMPA project to affirm that it is making responsible efforts to ensure that it is doing no harm, and also provide information that may be useful to the Government of India and other potential providers about the suitability of providing injectable contraceptives.

Improve the use of mystery client studies to improve quality of care. The mystery client studies provide valuable information on how clients are treated that can be better used—for example, to improve client-provider interaction, make better use of IEC materials, ensure privacy, encourage clients to ask question, avoid medical jargon, etc.

Upgrade the newsletter. With help from communication specialists the project newsletter can be made more attractive and readable, support continuing education, and emphasize follow-up.

(Note: Technical recommendations about research are presented in Section VII, Management Information.)

IV. INTEGRATING THE PRODUCT INTO THE PUBLIC SECTOR

FINDINGS

Current Situation

After many years and considerable controversy, DMPA was registered for commercial sale in 1993. However, because of a ruling of the Supreme Court of India in response to public interest litigation, DMPA was not incorporated into the National Family Planning Programme. The Drug Technical Advisory Board (DTAB), which is responsible for advising the Supreme Court on pharmaceuticals in the national program, is of the view that "DMPA should not be allowed for mass use in National Family Planning Program and its use should be restricted to women who would be aware of all implications of use." On this basis, the MOHFW was prohibited from incorporating DMPA into its activities. However, DTAB may revise this interim ruling if it deems appropriate and reapply to the Supreme Court to allow incorporation of DMPA into the national program.

DTAB seems to have been discouraged from pursuing this case largely because of political considerations. Each time there is some movement in the MOHFW for initiating the necessary actions, several women's activist groups vehemently protest, citing safety and quality of services issues with respect to the public sector. Given the nature of the ruling coalition during the past decade there has been considerable reluctance to address this issue. The MOHFW, however, has expressed its willingness to incorporate DMPA into the national program if permitted to do so.

There are some encouraging signs. Injectable contraceptives are already included within the framework of contraceptive choice in the National Reproductive and Child Health (RCH) 2 program. In addition to DMPA, both Cyclofem (a one-month injectable) and Net-En (a two-month injectable), while not in general use, are undergoing Phase IV clinical trials under the auspices of the Indian Council for Medical Research (ICMR). Final results from these trials are expected in two to three years. It may be noted that, while DMPA is not provided by the MOHFW, it is available through other government and quasi-government institutions, such as the Ministry of Labor's Employee State Insurance Corporation. Based on media reports there seems to be little organized opposition by women's groups to these uses. With the passage of time and the increasingly widespread use of DMPA in the private sector, opposition to it seems to have diminished. Availability of additional resources in the decentralized National Rural Health Mission (NRHM) has also strengthened states to focus on quality issues in delivery of health services in general and reproductive and child health services in particular.

Currently there is more amenable political climate for introduction of injectable contraceptives in India. There is hope, therefore, that DTAB can be encouraged to make a favorable recommendation on the use of DMPA. If so, it is expected that action will focus primarily on the ability of the MOHFW to provide appropriate care more than on the safety of the product, which is well established. The concerns may have to do with ensuring that the initial prescription is given by a knowledgeable provider, that counseling is available, and that provision can be made for follow-up and the treatment of side effects.

There are no deadlines for this process; a ruling may happen soon or be delayed indefinitely. However, there is optimism that including DMPA in the national program will be taken up sooner rather than later.

Thus far, the DIMPA project has had little engagement with the public sector at either national or state levels. However, at a meeting with the evaluation team, MOHFW representatives informally requested that DIMPA data be shared with them to help them prepare the briefing dossier for submission to DTAB, and DIMPA may be asked to give a presentation to MOHFW. The availability of hard data demonstrating the success of DMPA will provide evidence for inclusion of the product.

Needs and Opportunities

If the MOHFW approves DMPA for use in the public sector, there are a number of issues relating to how it is made available. Some promising opportunities would include

- *DMPA as a postpartum contraceptive:* Given the recent rapid increase in deliveries in MOHFW facilities and their improved postpartum follow-up capabilities, DMPA would be an appropriate and effective postpartum contraceptive option.
- *Introduction of DMPA in the rural health system:* Given limited private sector penetration in rural areas, introducing injectables into the NRHM network should be cost-effective, thus making them accessible to rural populations.
- *Access to paramedics (e.g., auxiliary nurse midwives [ANMs]) and ASHAs to increase demand and improve follow-up*: While it is unlikely that ANMs will be allowed to give injectable contraceptives immediately, in the long run they might be more appropriate providers than physicians because they are closer to their clients both geographically and as front-line health providers. In addition, with the ANMs and ASHAs there is a more natural avenue for follow-up than is available with the physicians.

LESSONS LEARNED

- Be patient; circumstances change. USAID is to be commended for continuing to support injectable contraceptives through the private sector for many years in difficult circumstances. This strategy is likely to be vindicated over the next few years by both wider use in the private sector and adoption by the public sector.
- Providing careful, responsible service will in due course lead to community and political acceptance.

IMPLICATIONS

- With the anticipated approval of injectable contraceptives for use in the public sector, there will be a need to plan, deliberate, and experiment to determine the most appropriate ways to do so. Partners, including USAID and its cooperating agencies, might contribute to this by sharing experience and testing approaches and protocols through operations research (OR), e.g.: how best to ensure follow-up in the public or the private sector.
- Public sector delivery of injectable contraceptives will be both competitive with and supportive of the private sector. Clearly, availability through the MOHFW will give consumers a major alternative to purchase through the private sector. At the same time, MOHFW adoption will validate the appropriateness of private sector use. In addition, adoption by MOHFW will allow for more widespread and aggressive use of mass media to create demand.

RECOMMENDATIONS

- DIMPA, with USAID support, should carefully package and provide to the MOHFW information that speaks to the acceptability and safety of DMPA through its network. The recommendation given in Section III to initiate adverse-event reporting through the DIMPA MIS may be particularly useful.
- USAID should look for ways to use OR to support the anticipated adoption of injectable contraceptives in the national program.
- DIMPA should avoid efforts to reach rural areas that are not clearly cost-effective, since in the long run the public sector, because of its infrastructure, will have a comparative advantage there.

V. MARKETING

FINDINGS

Key Findings

The program has successfully attracted and retained the active participation of manufacturers and marketers; this has resulted in a secure, stable, and sustainable supply system. Currently two manufacturers (Pfizer and Star Drugs & Research Laboratories [SDRL]), and three marketing organizations (DKT, PHS, and HLL) market and distribute DMPA injectable contraceptives in north India.

The consumer has access to a choice of products at a range of prices. Four brands—Depo-Provera, Depo-Progestin, Petogen, and Kushi—are offered at prices ranging from IR50 to IR175. There is increasing accessibility to these contraceptives through health providers, mainly ob/gyns but also chemists, and the products are consistently available with few stock-outs. There have been significant increases in sales of injectables in north India, especially over the past year, although volume is still modest. Over the life of the project approximately 700,000 vials of DMPA have been sold.

The three marketing organizations are selling injectable contraceptives beyond the DIMPA sites, and there is a justifiable request that the DIMPA program support potential demand in Madhya Pradesh, Andhra Pradesh, Rajasthan, and Punjab states and further expand the number of towns and providers in Jharkhand.

USAID has effectively primed the market for DMPA contraceptives in north India. It has borne the majority of the investment in developing, building, and expanding the injectable contraceptives market through the private sector over the past five years. With the increasing viability of the commercial market, within the next three to five years manufacturers and marketers should assume a larger share of such investments.

There is little evidence that these health providers, and even less that consumers, have much if any interest in other injectable contraceptive products, specifically Net-En and Cyclofem. The decision by USAID and Abt to focus exclusively on marketing DMPA is logical and justified and should continue for the foreseeable future.

Detailed Findings

Manufacturing Partners: In 2004 when the DIMPA program was initiated it negotiated a memorandum of understanding with Pfizer as the sole supplier of Depo-Provera. The agreement provided for a dual marketing approach through social marketing with DKT and through Pfizer's ethical marketing system. For the social marketing approach, which is essentially the DIMPA effort, the major undertaking was to have Pfizer accept the validity of reducing the price of the product from about IR200 to IR90 to successfully build the market. As the program succeeded in reaching private providers and expanded to more towns with modest increases in demand, the price was further reduced to the current IR60. This allows for a price to the consumer inclusive of provider fees of approximately IR100. However, Pfizer continues to market Depo-Provera through high-end doctors outside the DIMPA target group at IR200. Moreover, Pfizer's major interest is getting the product into the public health system and the expectations of institutional sales through the MOHFW. In short, Pfizer has little interest in serving the consumer market because it has no other product line targeting ob/gyns, which makes their ethical sales of Depo-Provera costly and the product expensive. Pfizer has in the past, however, provided very modest support for DIMPA training costs and expressed willingness to do so again.

SDRL joined DIMPA in 2007. SDRL was established in 1995 to manufacture small-volume parenteral drugs exclusively. SDRL addresses both the human and veterinary segments, with more than 120

products for humans, including steroids and hormones, and more than 60 products for animals. It is producing the Kushi brand of DMPA at an amazing wholesale price of IR25. Besides being marketed in north India under an exclusive distribution agreement, Kushi is also currently exported to Nepal (funded by the World Bank), Sri Lanka, Afghanistan, Kenya, and Uganda. SDRL is committed to long-term development of the Indian injectables market.

Marketing Partners: There are three marketing partners:

- DKT distributes two brands, Depo-Provera (Pfizer) and Depo-Progestin (imported). It is a successful social marketing program emphasizing client service and quality of care. DKT details ob/gyns who stock minimal volumes and also supplies the products to chemists. It intends to secure market share by broadening the choices of injectables and is currently seeking other supply sources. It is, however, sustaining Depo-Provera because of the quality image of the Pfizer name, although the intent is to secure more economically priced products to compete with Kushi.
- PHS, another social marketing organization that is exclusive distributor for the Kushi brand, distributes a complete range of contraceptives in Madhya Pradesh and West Bengal as well as the DIMPA states. Focused on selling rather than detailing, it serves primarily chemists and ISMPs.
- Hindustan Latex Limited (HLL), a Government of India enterprise and one of the largest social marketing organizations in India, joined DIMPA in 2007 and introduced in UP a brand of DMPA imported from South Africa, focusing on private ob/gyns. This was essentially a test market for HLL but because of the high price of the product (IR175) to the doctor, HLL is now seeking a supplier of a more economically priced product.

Products and Pricing

Five DMPA products with a broad range of pricing options are being marketed in north India, which is definitely to the benefit of the consumer. Moreover, HLL will be seeking an alternative brand and DKT is seeking additional suppliers.

TABLE 2. PRODUCTS DISTRIBUTED

Marketer	Brands	Price to Provider (Rupees)
PHS	Kushi	50
DKT	Depo-Provera	70
DKT	Depo-Progestin	60
HLL	Petogen	175
Pfizer	Depo-Provera	200

Pfizer is also exploring introduction of a pre-filled DMPA presentation, but that is likely to be positioned at a high end-niche market at prices unaffordable to low-income consumers.

Distribution

DIMPA is operating in 45 major towns in UP, Uttarakhand, and Jharkhand (see Table 3). Its products are distributed to about 1,300 private ob/gyns who are dispensing and to about 100,000 chemists, mostly in UP. Pfizer markets to pharmaceutical wholesalers who in turn supply chemists. On the team's field visit in Lucknow about half the chemists visited were stocking DMPA; the main reason for not stocking it was that there was no demand from either doctors or customers. Providers and retailers alike requested demand generation support, especially through advertising on television. Elsewhere both DKT and PHS reported sales in Madhya Pradesh, Rajasthan, Andhra Pradesh, and Punjab and were optimistic about increased sales in Jharkhand when DIMPA expands the number of towns it covers in that state.

TABLE 3. DISTRIBUTION OF PRIVATE OB/GYNS						
States	Universe	Trained	Network	Trained (%)	Network (%)	Number of Towns
UP	2,262	1,243	998	55	44	35
Uttarakhand	189	93	79	49	42	6
Jharkhand	780	302	192	39	25	4
Total	3,231	1,638	1,269	51	39	45

The universe refers to doctors in the 45 towns. Trained doctors refer to those trained on DIMPA by the program. Network refers to doctors participating in the DIMPA network.

Sales

Sales volume has been modest because of the conservative approach taken to introduce the product through the private sector (Table 4). The outcome here demonstrates that there is an effective mechanism to generate sales once the program gears up to generate demand. That more than 700,000 vials have been sold over the five-year period suggests latent demand. PHS particularly has reported significant sales growth (over 35% more than in the previous year) and DKT has consistently experienced significant annual growth, though this has been somewhat slowed by the competition from Kushi. Data in the table below represents total sales of the companies in the three program states.

TABLE 4. DMPA SALES VOLUME						
YEAR	Pfizer	DKT	PHS	HLL	TOTAL	%
2004	-	16,607	-	-	16,607	2.4
2005	14,163	13,428	-	-	27,591	4.0
2006	119,507	18,369	-	-	137,876	20.2
2007	149,483	29,260	500	-	179,243	26.2
2008	114,320	25,523	19,638	10,000	169,481	24.8
2009	114,777	9,643	28,550	-	152,970	22.4
TOTAL	512,250	112,830	48,688	10,000	683,768	100.0

LESSONS LEARNED

Introduction of injectable contraceptives through the private sector, while they are absent in the public sector, has provided an incentive for the private sector to take risks and invest, however modestly, in this new market opportunity.

The absence of government endorsement of product use in the public sector has slowed the pace of growth of the market. Not only does the absence of the product from the public health system affect volumes sold, but as a result some private providers and marketers may have taken a very cautious approach to supporting the method.

The participation of SDRL and the introduction of Kushi have lowered the price bar, putting pressure on current and future competitors to the benefit of the consumer. This is an example of market forces working at their best. Moreover, significant market momentum will be generated at the bottom of the

pyramid (low-income consumers), spearheaded by Kushi and sustained when other low-price brands enter the market.

Pfizer is interested primarily in the institutional market (public sector purchases); it will not be a major factor in increasing the private market. However, it will be critical to retain the Pfizer brand, Depo-Provera, in the DIMPA program because of the credibility and quality image (foreign-made) it provides for the product category.

Given provider interests, DMPA is the future of the injectable contraceptives market and as the flagship product must take the lead in market expansion. The one-month injectable contraceptive, when introduced, should create its own niche if well-priced.

RECOMMENDATIONS

- Take care not to create a brand (product) expectation that could lead to confusion, or worse frustration, if consumers cannot find the DIMPA brand. The program needs to promote the DIMPA service as a constellation of promises of quality, value, and client-centeredness.
- Continue to support current brands—Kushi, Depo-Provera, and Depo-Progestin—but encourage introduction of additional brands to expand choice and stimulate market momentum. To do so the program should seek partnerships with other commercial marketers and distributors and not limit itself to social marketing organizations.
- Expand the geographical coverage of the program to other north India states to create economies of scale for the private market. Present partners are especially interested in building markets in Madhya Pradesh, Rajasthan, and Punjab. The program should also expand the number of towns and providers in Jharkhand.
- Explore expanding the provider base beyond ob/gyns to GPs, nursing homes, and medical colleges to generate more access points. If ISMPs become legally qualified to provide injectable contraceptives, they will vastly expand marketing opportunities for the product.
- DIMPA and its commercial partners need to become very consumer-focused and craft strategies beyond communication to market the product directly to consumers.
- Given the substantial and continuing investments USAID has made in policy and marketing to develop the injectable contraceptives market, manufacturing and marketing partners need to assume a greater share in future investments. A deliberate effort is required to convince partners to significantly and consistently participate in and eventually assume costs for provider training, point-of-sale materials, BCC and IPC market research, and other consumer-driven initiatives.

VI. COMMUNICATION

FINDINGS

Key Findings

Product awareness is increasing even with the previously necessary abundance of caution; consumers who have had some exposure to the product are aware of its benefits.

The DIMPA Helpline seems to be is hugely popular based on both the increasing daily call volume and its reputation among providers, stakeholders, and retailers. It has provided a vital information link with target clients by extending product information and counseling beyond the provider.

This communication initiative has begun to resonate effectively among husbands, as evidenced by the high volume (approximately 70%) of male calls and by research on the impact of the advertising campaign. This is a significant achievement that offers further opportunity to cement behavior change and support product trial.

The two advertising campaigns presented different spins on the product, with the result that there does not seem to be a coherent image of DMPA. There have been limited IPC initiatives with a muted (not sufficiently obvious) link between the mass media and the IPC messages. The program has used other innovative measures to support the providers like in-clinic counseling by DIMPA staff and "tea parties" which contribute to the increased familiarity of the product. Providers generally welcome this support primarily since it reduces their time spent in addressing client concerns.

The advocacy/public relations (PR) program has effectively preempted or minimized through proactive crisis management any negative concerns about DMPA or injectable contraceptive services.

Detailed Findings

Advocacy: The DIMPA program has created a comprehensive advocacy program that though somewhat defensive is effective. The major objective was damage control and to the extent possible preempting negative responses to the program from any source. Specifically, the advocacy program anticipated the possibility of opposition from government agencies, medical institutions, and especially activist NGOs. There was also the danger of misinformed or uninformed media disseminating incorrect and harmful information.

The strategy was to develop an emergency communication management plan structured around a crisis management committee of technical, development, and communication experts. A crisis management manual was drafted and spokespersons identified and given media training. Fortunately, there has not yet been cause to mobilize the crisis plan, but DIMPA is encouraged to maintain and regularly refresh the system.

Advocacy has also included the standard approach of including articles on the product in national and local press. In future such articles should concentrate on life-experience stories of users and providers with an emphasis on personal benefits derived (or to be derived) from the method. The PR agency has also organized spokesperson interviews and provided press coverage for the launch of the program in new cities.

Demand Creation: Over the life of the project there have been two mass media, though low-key, communication campaigns, both of which were primarily aimed at creating awareness of DMPA. The campaigns were directed at young married women in urban areas and explained the method (coverage for three months) and the primary benefits of extended coverage and suitability for breastfeeding women. A new current campaign has fine-tuned the target audience to be breastfeeding mothers with babies less than six months old, nonusers of any contraceptive method, and lapsed users of oral contraceptives. The new

communication concept also appeals to men by speaking of another benefit to contraception, removing marital stress. The DIMPA Helpline is a major call to action and successfully promotes the service. The campaign is implemented on television, radio, press, and outdoor venues but with deliberately modest reach and frequency. After two rounds of advertising, neither of which generated any of the expected backlash, the project can also claim to have demonstrated that the environment is conducive to demand-creation initiatives.

Helpline. The DIMPA Helpline was established in Lucknow in October 2008 to provide assistance to callers seeking advice on FP issues and particularly information on DMPA. Calls are made through a national 1-800 number that is accessible from any cell phone service provider as well as by land line. The Helpline is staffed by six trained counselors, four of them women, and operates from 9 am to 9 pm Monday through Saturday except on public holidays. Counselors provide the requested information, offer counseling on method use, and refer callers to DIMPA network providers. The Helpline is promoted in the media to motivate callers. The service is a tremendous success, generating volumes averaging about 600 calls a day, the great majority of them from men. Although callers are referred to providers, there is not yet a noticeable increase in visits to clinics. However, providers (including FOGSI) and chemists are very aware of the Helpline and enthused about the value of the service.

The MBP program is also implementing a Helpline for the Saathiya program, and USAID is considering combining the two Helplines. The team recommends that they remain separate for two reasons. They serve two different audiences: Saathiya is geared to young people—engaged couples, the newly married, and young adults. DIMPA is geared to a somewhat more mature audience—couples with children who are at a very different stage of life. Additionally, the DIMPA Helpline provides a unique venue for information and guidance on a new method for providers, potential injectable users, and especially men.

Outreach/IPC. The program has utilized IPC sparingly, directing most of its efforts at providers. Currently the DIMPA field team is providing in-clinic counseling sessions for clients waiting to see ob/gyns, an initiative that gives clients an opportunity to acquire more detailed information than might be available from the doctor. Although this approach is labor-intensive and time-consuming it effectively reaches unique potential consumers in an environment where they are most conducive to hearing a health message. DIMPA also organizes promotional ‘parties’ for young married women where personal FP issues can be discussed in a relaxed, nonthreatening environment, and the product can be appropriately introduced within the context of informed method choice. With the new emphasis on demand creation it is hoped that DIMPA would make IPC a more integral part of the communication strategy and especially find opportunities to engage young married men, who are clearly needing advice and attention.

LESSONS LEARNED

- The communication program has made a significant break-through in connecting with men that augurs well in building a constituency of support for the product and its eventual users.
- Couples have been motivated to talk about the product, which enhances the opportunity for trial and sustained use.
- The environment generally, both at the national and state levels, may be becoming more conducive to the promotion of injectable contraceptives. In the absence of objections, especially from “self-interest” sources, providers and stakeholders have growing confidence and comfort level about their involvement with the product. The evolving situation is attributable to both the winds of political change and the methodical strategy assumed in implementing the DIMPA program so far.
- Although there is increasing awareness of DMPA, there is not yet any evidence that awareness is being converted to product trial to any significant extent.

RECOMMENDATIONS

- The advocacy program should remain vigilant and especially maintain crisis management preparedness. Additionally, advocacy initiatives should become more proactive and visible, focusing on building a coalition of supporting providers and satisfied users to add credibility and motivate increased interest in and usage of injectable contraceptives.
- The current campaign to cement in the consumer's mind the benefits of extended protection and appropriateness for breastfeeding should be continued. However, there is a need to emphasize that an injection is required every three months to ensure compliance and continuity.
- Themes on benefits should be replicated through IPC opportunities that reach married men and couples and utilize local media to support retailers and providers.
- The visibility of the mass media and IPC campaigns can be lifted by increasing reach and frequency.
- The connection with men should be built on to convert them to change agents that facilitate product trial and consistent use.
- The DIMPA and Saathiya Helplines should remain separate to facilitate continued calls from concerned males.
- Helpline calls should be monitored to ensure quality control and message consistency.
- The feasibility of using the Helpline to contact DMPA users for reminders for follow-up and other consumer-focused proactive services should be explored.
- For customer convenience, consideration should be given to instituting Sunday Helpline service.

VII. MANAGEMENT INFORMATION

RESEARCH

Findings

Abt Associates is to be commended on its use of research. It uses a combination of MIS, formal research studies, and informal testing and data collection to guide management intelligently. Its research studies are well-conceived, properly designed, and intelligently presented. Among the key studies have been a series of knowledge, attitude, and practice (KAP) studies, mystery client studies, and pricing effort and focus group studies, primarily for mass media development. Research has focused on providers and on the general population more than on clients. While much is known about providers, service provision, and the target population in general, less is known about who the clients are and what their experiences with injectable contraceptives have been. Such information would be useful in adjusting service provision, designing marketing strategies, and avoiding possible criticism of the project. Research findings have not been widely shared, at least partly because of the project's intentionally low profile. Not all project research is equally newsworthy, but as a body it adds significantly to India's experience with injectable contraceptives.

Implications

- There is a need for more research on clients. Some kind of follow-up study of acceptors using client records is needed, as well as focus group discussions with homogeneous groups of clients that might explore client characteristics, reasons for using injectable contraceptives, sources of information, knowledge about injectables, exposure to media, general experience with the method, history of side effects, and general levels of satisfaction.

- The research already completed provides a useful base for the next phase. If the next phase involves a major geographic expansion, the research effort should be prepared to respond to dealing with larger populations. A plan should be prepared for major research and evaluation studies.

- One objective for the next phase should be to fine-tune the basic model for the private sector. If so, the next phase of project research should be OR to investigate alternative approaches for various components, such as different types of providers, approaches to improving service delivery, comparison of the cost-effectiveness of different approaches to media, etc. Systematic efforts should be made to obtain views from both inside and outside the project about key questions and useful OR studies.

Recommendations

- Continue the current program of KAP studies, mystery client studies, pricing and media research, etc., though perhaps with broader reach and less intensity.

- Conduct a follow-up study of acceptors to determine client characteristics, continuation rates, user experiences, sources and levels of knowledge, etc. The approach to obtaining the sample for this study needs to be chosen carefully. The sample cannot be totally representative, since it will not reach clients unwilling to be followed up or for whom contact information is not available. A few providers will have usable contact information and could obtain permission from clients for follow up. During the team's clinic visits, some ob/gyns expressed a willingness to make preliminary contact with clients to see if follow-up interviews were acceptable. The prospective approach of requesting permission for follow-up contact at intake is ideal but it would take considerable time to build up a body of user experience compared with existing clients. Samples drawn by these or similar procedures are not ideal but are better than no follow-up.

- Conduct OR, or less formal experimentation, on the effectiveness of various approaches to increasing continuation and follow-up.
- Evaluate the effect of the Helpline on DMPA acceptance. Since this presumably cannot be done by calling back the callers, it is probably best done by having willing clinicians systematically ask about sources of information about injectable contraceptives, specifically mentioning the Helpline.
- Conduct a pilot study on using ISMPs for referral for injectable contraceptives, looking at quantity of referrals as well as levels of retained knowledge and, if possible, whether referrals result in use. The purpose would be to test the cost-effectiveness of broader efforts to reach ISMPs.

MIS

Findings

Because of time limitations the team was not able to do a systematic evaluation of DIMPA's MIS, so these comments should be taken as preliminary. The DIMPA project has a comprehensive database covering product procurement, logistics, providers, and sales. For providers, data are collected monthly and are immediately entered into the database. Presumably a comparable system exists for product distribution, but the team did not look at this. Project managers are thus able to get up-to-date information on key project implementation components. Data at the provider level are collected in case registers, in which are entered a small number of basic client characteristics, reproductive intentions, and selected information on each client visit. Information is collected in such a way that, in principle, the number of return visits for each client is readily available. However, the quality of record-keeping varies; some providers leave information blank and in some cases each client visit results in a separate page in the register, so information on return visits is not readily available. (A few participating physicians use separate record systems and later transfer data to DIMPA case registers; in our visits, this was true only for one FPAI clinic.)

While field representatives do what they can to improve data quality, providers are independent actors and cannot be coerced into keeping records accurately. While data at the provider level are used for project management purposes, providers generally do not use them for patient care, which partly accounts for the uneven quality of record-keeping. DIMPA should seek to convince providers of the value of using good client records as a means to enhance client care, comfort, and satisfaction and therefore retain clients.

A separate database is maintained for the DIMPA Helpline that has information on each call, including limited information on the caller (e.g., male or female); nature of the call (e.g., injectable contraceptives, other FP methods, general FP, crank calls); result of call (e.g., referral); length of call; and counselor. The counselor enters the information during the call, so the data are available in real time.

Recommendations

Data need to be user-friendly and accessible to all partners and field staff for evidence-based decision making, quality control, and program management. DIMPA should encourage access to and utility of the data, research, and other program information developed to create a more informed environment. Abt might consider making the Web-based database available directly to providers, with appropriate password protection.

Providers who are not entering return visit data on the same page as original visit data in the case register should be encouraged to do so, if necessary by reminding them about the how to the client list on the first page of the register to locate each client.

Again, the form filled out by the field representative should contain a place for recording serious adverse events. This information can be obtained from provider records with no change necessary to the record-keeping systems of DIMPA or providers.

VIII. MANAGEMENT

FINDINGS

Key Findings

The MBP program is a highly suitable vehicle for continuing the DIMPA program assuming that additional resources are added to the MBP infrastructure. Within MBP there is already institutional memory and familiarity with DIMPA, staff are already private-sector-oriented, there is already synergy between Saathiya and DIMPA, to the benefit of both programs, and MBP will have the opportunity of utilizing the lessons learned from DIMPA to inform other market development activities

DIMPA will have the opportunity to integrate with other private health initiatives, especially the Merrygold franchise of private hospitals in UP and the Gates Foundation initiative in six cities in UP.

In integrating DIMPA into MBP there should be a robust coordination of technical services (especially planning at the national level) with field support, research, and MIS to ensure evidence-based decision making, strategic planning, implementation, and monitoring. Technical guidance at the national level must be influenced by circumstances at the field level, and the implementation process must be monitored and guided by an interactive MIS. With the expansion of the program to more states and cities, such coordination becomes even more important. This needs to be clearly reflected in national and field-level work plans.

MBP/DIMPA and USAID need to determine an exit strategy that defines the parameters and schedule within which it is expected that the market can be considered viable and sustainable. This strategy should be used to inform the evolution of DIMPA for the immediate future.

Detailed Findings

Organizational Structure. The organization and management structure of DIMPA is realistic and flexible enough to allow the program to respond to the dynamics of the market and providers. The field staffing structure needs to be carefully analyzed to determine how best to expand geographical coverage without a major increase in staff. DIMPA should explore models that divest field operations to the marketing organizations with DIMPA staff concentrating on support and quality control. Consideration should also be given to triaging providers. Having identified four groups of providers by level of service and commitment to DMPA and effectively eliminating or replacing the lowest-performing providers, DIMPA should also minimize or transfer attention to the best-performing providers to marketing organizations. Because these high performers are fully vested and committed, there is less need for them to be detailed to the same extent as doctors being attracted and encouraged. By focusing attention on bringing in new providers and transferring converted providers, the field staff can better maximize staff time and productivity.

RECOMMENDATIONS

- Over the past five years the DIMPA program has methodically put together a market development strategy to ensure the stability and viable growth of the injectable contraceptives market. PSP-One is to be commended on its skillful management of that tenuous and sensitive process. The program now needs to grow to achieve a critical mass of users and impact, and the MBP project is the ideal vehicle to manage this new initiative for the product.
- For drafting the new strategy for DIMPA within MBP, the following thoughts are offered for consideration:

  - Marketing and communication costs must eventually be assumed by the private sector to the extent those activities serve their needs. In any case, donor resources for that purpose are not likely to last forever.
  - Technical services need to be gradually divested to interested institutions like FOGSI, IMA, and medical colleges, and possibly linked to continuing medical education.

- USAID and DIMPA could essentially declare victory in building the injectable contraceptives market when the following milestones are reached:
  - There is a secure, commercially viable and competitive supply mechanism.
  - Sales in north India achieve the annual volumes necessary to sustain profitability and commercial interest.
  - A variety of providers are proactively promoting informed contraceptive choices that clearly include injectable contraceptives in the mix.
  - There is a self-sustaining service delivery mechanism (defined in private sector terms) evidencing acceptable levels of quality of care with mechanisms for maintaining quality assurance.

APPENDIX A. SCOPE OF WORK

BACKGROUND

USAID/India works with the Government of India to reorient and revitalize the country's family planning (FP) and reproductive health services, targeting the states of Uttar Pradesh, Jharkhand, and Uttarakhand for demonstrating program innovations.

DMPA was introduced in India in 1994 after the Drug Controller of India cleared it for marketing through the private sector as a prescription drug to be provided by qualified health practitioners as another option for women seeking family planning. Backed by 40 years of research, DMPA is a safe and effective contraceptive being used by over 12 million women in over 106 countries. In most developing countries, the product is provided free by the government, but is also available through social marketing and the commercial sector.

As in other countries where it is popular, this injectable would have been an excellent contraceptive option in India since it is effective for three months, can be used during breastfeeding, and has other benefits such as prevention of cancers of the endometrial and ovaries. However, when the program was launched, DMPA was not well received by consumers. Several factors, such as protests by women's groups, lack of support by the Government of India Family Welfare program, lack of knowledge and awareness among doctors, chemists, and potential users, and concerns about quality of care and provision by doctors contributed to low acceptability of the product. The main health concerns related to menstrual irregularity, amenorrhea, return to fertility, and screening and follow-up of clients on the method. In addition, women's groups questioned the overall safety of the drug and potential problems associated with long-term use.

Hence to generate demand for DMPA as a safe and effective contraceptive choice and increase availability of DMPA through partnership with commercial and social marketing agencies, USAID launched the DIMPA program to expand the choice of modern contraceptive methods to include the three-month injectable DMPA to be provided through private healthcare providers. The project started in 2003 through the Commercial Market Strategies project (CMS) project, and continued through the PSP-One field support mechanism in UP, Jharkhand, and Uttarakhand.

The program has followed a fractional franchising method wherein the method is added to already practicing private providers. This network is branded as the DIMPA network of clinics that represents highly qualified healthcare practitioners who were trained and supported by the program to provide DMPA. DIMPA network providers are given the latest informational updates on DMPA; adhere to strict guidelines for screening and counseling of clients, needle disposal, and pricing and stocking of the injectable; and are willing to be monitored by the DIMPA program.

Currently the program has a fractional franchising arrangement with 1,150 clinics in 45 towns in the three focus states, Uttar Pradesh, Uttarakhand, and Jharkhand. Doctors offer the clients a complete range of contraceptives, not injectables alone. They do a thorough counseling and medical examination of the woman before providing the three-month injectable. The project aims at training providers so that they adhere to correct protocol when offering DMPA in line with the WHO guidelines for screening and application of correct contraceptives.

The campaign is supported by Federation of Obstetricians and Gynecologist Society of India (FOGSI) and three social and commercial marketing agencies, i.e., DKT India, Population Health Services (PHS), and Pfizer. The program is implemented by Abt Associates.

PROJECT OBJECTIVES

The objectives of the project contribute to the overall Strategic Objective of the Mission: "Improve health and reduce fertility in targeted areas of India through increased use of reproductive health and FP services."

The specific objectives of the program are to

- Increase awareness of DMPA as a safe and effective method
- Increase use of DMPA among the target population

The key program strategies are:

- Create a network of private healthcare providers for providing high-quality options for a range of contraceptive methods.
- Generate demand for DMPA as a safe and effective contraceptive choice.
- Increase availability of DMPA through partnership with commercial and social marketing agencies.

Program evolution and key achievements: The program was initiated in 2003 with a pilot in three cities—Agra, Varanasi, and Kanpur in UP. The program was implemented in four different phases. The table below summarizes the evolution of the program over the last six years.

Objectives	Elements	Time Frame	Phase / Scale
Identify marketing partner. Gauge providers' interest and response.	Test methods for selecting & training providers and network membership.	June 03 – Sept 04	**Phase I** 3 towns in UP 105 clinics
Demonstrate scalability & cost efficiencies.	Build local training capacity; set up single point supply.	Oct 05 – April 06	**Phase II** 9 towns in UP 286 clinics
Strengthen network support and management.	Institutionalize training. Target providers and support.	Jan 06 – Sept 06	**Phase III** 19 towns in UP and Uttarakhand 505 clinics
Create demand and increase access to the product.	Partner more DMPA brands. Create demand (network and product).	Oct 06 – Sep 09	**Phase IV** UP, Uttarakhand, and Jharkhand 45 towns 1150 clinics

A media campaign using a combination of radio, selected television channels, print, and outreach events, to promote the method as a safe and convenient choice is currently on in the three project states of Uttar Pradesh, Uttarakhand, and Jharkhand. A helpline number, operational since 2007, has shown a substantial increase in the number of calls.

In February 2009 the program was expanded to include chemists and the AYSUH[10] providers in counseling for DMPA. This is in line with the regulation that does not authorize these categories of practitioners to administer the injection but they can guide the client to a qualified practitioner. In seven cities in UP, USAID/India's program "Saathiya" for promoting youth-friendly reproductive health services began in March 2009.

Key achievements: The program has been able to create a favorable environment for DMPA in the project areas. Following is an overview of key achievements:

- The Federation of Obstetric and Gynecological Society of India (FOGSI) issued a consensus statement approving DMPA as a safe and effective method and encouraging its 18,000 members to promote it within WHO guidelines.
- Pfizer supported the program by providing subsidized product to DKT and investing in provider training.
- Use of contraceptive injections in urban Uttar Pradesh increased from less than 0.01% to 0.4% (Reproductive Health Indicator Survey conducted by ITAP, late 2005).
- More than 1,700 health providers were trained on FP including provision of DMPA; more than 1,150 providers enrolled in the DIMPA Network.
- Industry investment on DIMPA increased. Four marketers distribute DMPA across northern India, including project areas; DMPA is available at different price points: $1 to $3 (only one manufacturer at the start of the project was selling at $4 per vial).
- Growth in off-take of DMPA from DIMPA Clinics.
- Contraceptive helpline operational.
- Mass media promoting DMPA implemented.

PROPOSED SCOPE OF WORK

The current DMPA program will be coming to an end in September 2009. USAID/India plans to undertake an end-term evaluation. The outcome of the evaluation will also inform the USAID/India decision on whether injectable contraceptive options will be exercised under another Mission Task Order (for the Market-based Partnerships [MBP] in Health program).

One of USAID/India's new projects, the MBP for Health project, is aiming to improve the environment for commercial sector engagement in USAID/India's priority health areas by forging partnerships between the private and the public sectors. The MBP for Health project is looking at building on, implementing, institutionalizing, and scaling-up MBP for health models and exploring new commercial opportunities to accelerate public health improvements, especially in base-of-the pyramid (BOP) and rural population groups. Partnerships include those engaged in health plus innovative partnerships that expand distribution (access), information (demand), and/or service delivery through non-health partners. In this project injectable contraceptives programming is built in as an optional component in case the Mission decides to take the program forward.

The evaluation will assess the current policy environment for expanded contraceptive choice, especially injectable contraceptives and the effectiveness of programmatic approaches and strategies; document lessons learned; and make recommendations for future directions.

[10] AYUSH refers to doctors following the Indian system of medicine, nonallopathic streams; includes Ayurveda, Unani, Siddha and Homoeopathy.

The specific objectives of the evaluation are to

- **Assess the policy environment for expanding contraceptive choice:** Analyze the current environment for expanding contraceptive choice especially in the context of provision of injectable contraceptives, especially DMPA.
- **Assess experience with provision of injectable contraceptives:** Meet with other donors, social marketing companies, and the private sector to gain insights into program approaches, what is working and what is not working.
- **Review the DIMPA program:** Review and analyze program strategies; technical approaches; demand creation and advocacy strategies; and the management systems adopted by PSP-One for increasing correct awareness and building positive attitudes about DMPA among providers and among clients; building demand among users; and providing quality services for provision of DMPA through private providers.
- **Capture lessons learned:** Identify and document the lessons learned in the project.
- **Recommend future directions:** Discuss strategies for strengthening the inclusion of injectables, DMPA, and other injectable contraceptives, as safe, effective, and convenient options in the basket of modern contraceptive methods. The future recommendations will be based on current policy environment, key lessons from DIMPA experience, and a situational analysis and will cover recommendations for both the public and the private sectors. The recommendations should also include opportunities for promoting injectables within the existing programs funded by USAID in India.

REVIEW CURRENT PROGRAM

This section will focus on the following**.** Assess the

- Efficacy of the DIMPA network to promote DMPA;
- Quality of technical support provided to the doctors and later to chemists and AYUSH practitioners;
- Appropriateness and effectiveness of the communication strategies and campaigns on creating correct awareness and generating demand;
- Appropriateness of advocacy strategies to build a more positive environment for provision of injectables;
- Extent and impact of private, especially commercial, sector support for the project, including private provider motivations to be engaged in the project;
- Appropriateness and effectiveness of technical strategies for ensuring appropriate counseling, informed choice, and follow-up; and
- Effectiveness of project management systems, including field management planning, monitoring, finance, technical support, etc.

The team will analyze the appropriateness of the strategies and approaches to achieve the objectives of the project. The specific questions that should be addressed include but are not limited to the following:

- Do the strategies of the project seem appropriate to achieve the objectives of the project?
- Was the phased strategy for expanding the injectables project appropriate?

- What are the successful outcomes in terms of the functioning of the network, technical support to service providers including training of their staff, demand generation, and advocacy activities?
- Were the strategies for identifying and enrolling private providers (doctors and chemists) in the DIMPA program appropriate? What has been the engagement of ISMPs in the program in the recent phase? Is that something that should be continued/expanded in the future?
- Have the demand creation and advocacy activities helped to increase product acceptance and market expansion of select products/services in the program? What worked? What did not work? Why? Is there demand for injectables that the public sector is also experiencing?
- How successful has the project been in addressing key quality of care issues? What worked? What did not work?
- How successful has the project model been in increasing uptake of DMPA? What roles has the project played in improving the image of injectables, i.e., destigmatizing it for both consumers and providers and bringing greater acceptance of injectable contraceptives?
- How has establishing the quality circle and other quality assurance mechanisms worked in the program? Are the MIS and quality assurance systems adequate?
- How was product supply been ensured through partner channels? How effective were the supply channels? Did the linkages between partner marketing organizations and providers (doctors and chemists) work effectively?
- How successful has the project been in addressing key policy issues?
- What are some of the strategies adopted for sustaining the network activities? What has worked or not worked?
- Did the project adequately leverage various partners? What has been the experience of the program in leveraging resources from the commercial sector?
- What is the cost-effectiveness of the various program activities?
- How effective is the DMPA network model and management structure for promoting injectables?
- Is project management at the field and in the central level effective and adequate?

Lessons Learned

The team will assess and document the key lessons learned from the implementation of various components of the project and recommend how they can be used to further design and implement a program for promoting injectables.

Questions that should be addressed include:

- What are the strengths of the project and what lessons can be drawn from these activities for future programs? (quality of services, demand generation, network creation, training stakeholders, policy/advocacy, leveraging, sustainability, overall increase in contraceptive use, etc.)
- What were some of the key pitfalls or obstacles encountered in implementing the program and what lessons can be drawn for future programs?

Recommendations for Future Directions

In addition, the team will assess the current market environment for injectables and recommend a future course of action.

Questions that should be addressed include:

- Is the current policy environment conducive to provision of injectable contraceptives through the private sector? What about the policy environment with regard to provision of injectables through the public sector?
- Should the program promote only the injectables or the expanded basket of contraceptives? Should the focus be only on DMPA or also on other types of injectable contraceptives?
- How can future commercial sector assistance enhance its contributions to the Mission's strategic objective?
- What should be the geographic focus?
- How can project activities be integrated with other initiatives of the MBP project to maximize synergies?
- What opportunities are there for expansion of DMPA within the Mission's reproductive health portfolio?
- How can the project help to mainstream injectables into the public sector? What recommendations can be made about how to do this?
- Recommend ways to further leverage resources from manufacturers, media, and other private sector entities.
- Recommend strategies for the sustainability of project activities.

METHODOLOGY PROPOSED

We propose to engage the services of a team of three consultants. The consultants will be specialists in reproductive health and private commercial sector health programs,who have experience in analyzing strategies and conducting evaluations.

In order to examine the above issues, the following methodology is suggested:

1. Team planning meeting: A one-and-a-half-day in-country team planning meeting will be held to share background, experience, and expectations for the assignment; formulate a common understanding of the assignment and how it fits into USAID's broader program and objectives; review the background of the assignment and its current status; identify clients involved in the task; develop a common understanding of their relationships and interests and agree on an approach to working with clients; agree on the objectives and desired outcomes of the assignment; develop a realistic work plan; gain a common understanding of the project's expectations; develop tools for the assessment; determine roles and responsibilities of each team member; discuss team members' working styles; understand GH Tech's role in assignment completion; orient the team to the report guidelines and financial forms; and discuss all relevant administrative procedures.

2. Data collection (document review): The evaluation team will review the various project documents and reports (to be provided in advance of the assignment by the Mission), including research reports, project progress reports, study summaries, and trip reports. The research reports include provider and

consumer baselines and endlines as well as mystery client surveys among providers to assess quality of care issues.

3. Data collection (interviews): The team will also conduct interviews and consultation meetings with stakeholders and key informants, including but not limited to USAID mission staff; Abt Associates team; private sector partners including Pfizer, DKT, and Population Health Services (PHS); other marketing agencies such as Janani and Population Services International (PSI); media and advertising agencies; doctors, ISMPs, clients, and retail pharmacists; and various development partners, such as UNFPA, the Bill and Melinda Gates Foundation (BMGF), and the Packard Foundation; Advocating Reproductive Choices Coalition (ARC); Family Planning Division in the MOHFW, state government officials; and representatives of various professional agencies, such as FOGSI.

4. Data collection (site visits): The team will undertake site visits to observe on-the-ground functioning of the network and demand-generation activities. In addition to the meetings and interviews in New Delhi, field visits to UP, Jharkhand, and Uttarakhand will be conducted. It is estimated that the team leader will need a one-day trip to Mumbai to meet with the commercial sector partners and the advertising firm. In addition, the consultants will need to travel 3-4 days each to urban cities in UP, Jharkhand, and/or Uttarakhand (e.g., Lucknow, Agra, Varanasi, Dehradun, Ranchi).

The team will be briefed by USAID at the beginning of the evaluation assignment to prepare them for the site visits, clarify issues, review the proposed approach, and plan for the work.

TIME FRAME

The assessment will be undertaken beginning on or about May 5th, with in-country work beginning from May 11, 2009; and the draft report will be made available by May 22, 2009. The team leader will be responsible for the overall planning, design, and implementation of the evaluation. It will be the team leader's responsibility to submit a satisfactory report to USAID within the agreed timelines. The team leader is responsible for report writing and organization of the debriefing presentations.

DELIVERABLES

The following deliverables will be required from the evaluation team for the report:

1. A **draft assessment design** developed by the team before field visits are made. The design may be modified after further discussions with USAID.
2. **Draft questionnaires and discussion guides** will be developed and shared across the divisions of USAID, and their inputs incorporated.
3. A **draft report** of the findings and recommendations that is concise, actionable, and solution-oriented will be developed by the team leader, to be submitted prior to the team's departure.
4. A **debriefing presentation** will be made to the USAID staff within four days of completing the field visits or a suitable mid-point review as agreed to in the team planning meeting.
5. **PowerPoint copies** of all presentations/briefings for the Office of Population, Health and Nutrition use.
6. The team leader will be responsible for reviewing USAID and PSP One/Abt Associates comments on the draft report and correcting any factual inaccuracies or omissions while being aware that this is an independent evaluation and that the findings and recommendations may not necessarily be reflective of USAID or PSP One/Abt associates suggested revisions or comments. Upon completion of the revisions, a **final report** will be submitted to GH Tech and USAID. The final format for the evaluation report is as follows:

a) Executive summary (4-5 pages)

b) Introduction

c) Program background

d) Methodology

e) Observations and findings

f) Recommendations for future

g) Annexes (including but not limited to list of persons and organizations met, and any questionnaires or other tools developed)

GH Tech will provide the edited and formatted final document approximately 30 days after USAID provides final approval of the content. GH Tech will provide printed copies and one electronic copy to USAID. As GH Tech makes the results of its evaluations public, the project will put the final report on the Development Experience Clearinghouse Web site and on its project Web site.

Reporting

The team will report to Sheena Chhabra, Division Chief, HSD of Office of Population, Health and Nutrition.

Logistical Support

USAID and PSP One/Abt Associates will organize meetings and provide assistance for making travel and lodging arrangements. The team members would be required to make their own payments.

Proposed Level of Effort

Activity	Total Person-Days
Make preparations and review documents (to be provided by USAID), to occur out of country and prior to beginning the assessment.	Team Leader: 2 RH Expert: 1 RH Expert/UNFPA: 1
Team travels to India.	Team Leader: 2 RH Expert: 2
Team planning meeting.	Team Leader: 1.5 RH Expert: 1.5 RH Expert/UNFPA: 1.5
Conduct key informant interviews and meetings in Delhi.	Team Leader: 2.5 RH Expert: 2.5 RH Expert/UNFPA: 2.5
Site visits, including travel.	Team Leader: 4 RH Expert: 4 RH Expert/UNFPA: 4
Team analysis of findings/consensus on conclusions and recommendations; prepare draft report and presentation; conduct USAID debriefing; and submit draft report.	Team Leader: 4 RH Expert: 4 RH Expert/UNFPA: 4
Team departs.	Team Leader: 2 RH Expert: 2
Report finalization (based on Mission's comments) - to take place out of country.	Team Leader: 3 RH Expert: 1 RH Expert/UNFPA: 1

Activity	Total Person-Days
Total	**Team Leader: 21 days** **RH Expert: 18 days** **RH Expert/UNFPA: 14 days**

*A six-day work week is authorized for the evaluation team while in India.

QUALIFICATIONS OF THE TEAM MEMBERS

We propose a three–member team with the following range of skills:

1. Team leader: marketing and BCC expert
2. Reproductive health expert (including international reproductive policy and programs)
3. Reproductive health expert (national reproductive health policy & programs)

Team Leader

The team leader will be responsible for looking at the big picture of the project, including coordinating and packaging the deliverables in consultation with other member/s of the team. The team leader, in consultation with other team members, will develop tools for the assessment and a design plan and share it with USAID/India and incorporate comments, if any. S/he will be required to ensure quality of work and provide direction. The team leader will develop the outline for the draft report, present the report, and after incorporating the comments submit the final report to USAID/India within the prescribed timeline.

Skills/Experience: The team leader will be a senior person having more than 15 years experience working in the field of reproductive health and in the private sector and considered a leader in this field. S/he should have good understanding of marketing of products and services in the health arena. S/he should have a good understanding of project administration, financing, and management skills, including an understanding of USAID functioning. S/he should have excellent writing and communication skills. S/he should have past experience of leading a team for evaluation/assessment or related assignments. Past experience of assignments related to use of injectables will be preferred. Knowledge of RCH issues in India will be an asset.

Reproductive Health Expert (International Reproductive Health Policy and Programs)

The reproductive health expert will be responsible for reviewing the RH health impact of the project. S/he will be responsible for providing international perspectives for expanding contraceptive choice to the assessment. S/he will assist in developing tools and a design plan for the assessment. S/he would document the lessons learned and provide recommendations for future directions with respect to the public health impact of project activities.

Skills/Experience: The public health expert will be a senior person having at least 10 years of experience working in the field of RCH. S/he should have thorough knowledge of family planning issues in India, both with regard to the policy environment and the provision of services. S/he should also have a good understanding of the RCH program. S/he should also be familiar with the public and private actors in health and have a good grasp of issues related to the private sector. S/he should have excellent writing and communication skills.

Reproductive Health Expert (National Reproductive Health Policy and Programs)

The reproductive health expert will be responsible for reviewing the RH health impact of the project within the context of the Indian health systems. S/he will be responsible for providing national perspectives for expanding contraceptive choice to the assessment. S/he will be responsible for reviewing issues related to informed consent and quality of care. S/he will also be responsible for providing specific

policy recommendations and programmatic options that are feasible given the current barriers. S/he will assist in developing tools and a design plan for the assessment. S/he would document the lessons learned and provide recommendations for future directions with respect to the public health impact of project activities.

Skills/Experience: The public health expert will be a senior person having at least 10 years of experience working in the field of RCH in India. S/he should have through knowledge of family planning issues in India both with regard to the policy environment and the provision of services. S/he should also have a good understanding of the RCH program. S/he should also be familiar with the public and private actors in health and have a good grasp of issues related to the private sector. S/he should have excellent writing and communication skills. S/he should be fluent in both English and Hindi.

LIST OF REFERENCE MATERIALS PROVIDED

Dimpa Strategy Note (Oct 31st), describes progress till phase 3

Dimpa Strategy Note (April 4th), describes phase 4 exclusively

A detailed PowerPoint on DMPA

DMPA briefer

Crisis Manual

DMPA off-take Sep 06 - Dec 2008

Helpline trends

BRIEF DESCRIPTION OF MARKET-BASED PARTNERSHIPS FOR HEALTH

The MBP for Health project is aiming to improve the environment for commercial sector engagement in USAID India's key priority health areas by forging partnerships between the private and the public sectors. The MBP for Health project is looking at building on, implementing, institutionalizing, and scaling-up MBP for health models and exploring new commercial sector opportunities to accelerate public health improvements, especially in base-of-the pyramid (BOP) and rural population groups.

The prime implementing partner for this project is Abt Associates and the consortium includes four partners: Futures Group, Monitor Group, PSI, and Banyan.

The MBP for Health project has two objectives:

1. Build on, implement, institutionalize, and scale up MBP for health models.
2. Explore new commercial sector opportunities to accelerate public health improvements, especially in BOP and rural population groups. Partnerships include those engaged in health plus innovative partnerships that expand distribution (access), information (demand), and/or service delivery through non-health partners.

The MBP for Health project aims to foster MBPs in reproductive health (RH); maternal and child health (MCH), including hygiene promotion, safe water, and hand washing; and TB. Depending on need and additional funding, the program will explore partnerships in other population, health, and nutrition areas. Two options may also be supported, one on injectable contraceptives and the other for HIV or other health areas. At this point the Mission is exploring initiation of the option of including injectable contraceptives in the MBP program.

The MBP for Health program is aimed at successfully leveraging private sector and community-based resources to create sustainable solutions for India's public health challenges. The program aims to nurture

MBP models that can be brought to scale by commercial partners, government programs, and/or civil society groups; and also to institutionalize local capacity to broker MBPs for health in the future by supporting the establishment of a Centre of Excellence.

The project also aims to establish the Health Leadership Council and other expert advisory subgroups. The Council members will be drawn from four broad sectors—health care, industry associations, development sector, and academia. The Health Leadership Council (HLC) is envisaged to be a governing body that provides strategic direction and oversight to the MBPH projects for the duration of the program. Beyond the duration of the program (post-2012), the HLC will evolve into providing more of an advisory board role for the Centre of Excellence (CoE).

Some of the initiatives started under the MBP project are:

1. Saathiya Pilot Project

The objectives of this are to create sustainable social marketing partnerships to improve contraceptive-seeking knowledge and behavior among married couples (ages15–-24) in lower socioeconomic groups in the urban areas of 6 cities across Uttar Pradesh and Uttarakhand. The program helps young people prevent unintended pregnancies, reduce sexually transmitted infections (STI's),and adopt the concept and practice of birth spacing for new mothers through an established network of three kinds of health providers (chemists, ISMPs, and ob/gyns and GPs).

Promotion of the network is through city-level media activities and the helpline is promoted as a first point of contact. Since its launch the Saathiya program has leveraged considerable resources (approximately US$223, 099). Program partners have contributed through their time and also through publicity support materials, and the helpline today receives an average of over 150 calls per day.

2. The Shakti Health@BoP

This is a groundbreaking pilot that uses a BoP approach to introduce health products in rural areas. In view of continued reluctance from HUL to introduction of contraceptive products into the Shakti channel, we opted for a "soft launch" into health, routed through child health products. Accordingly, this pilot project has successfully introduced oral rehydration salts (ORS) into the Shakti network and has established community acceptance of the Shakti entrepreneur's role as a health advisor. We are now looking at increasing this basket to look at other reproductive and child health products. We will also examine and pilot models for integration of product distribution through the HUL or other commercially viable channels to SEs, and develop and transfer health training modules and skills to commercial partners.

3. ITC e-Choupal Network

ITC has brought markets closer to farmers by using appropriate information technology diffusion and an efficient transaction mechanism. E-Choupal is based on a hub-and-spoke model which consists of villages serviced by a local farmer called the Sanchalak. These villages or spokes aggregate demand and supply to the next tier, which is the district/town-centered hub. The e-Choupal villages supply agricultural produce to ITC at the hub level and also service smaller last-mile villages with FMCG products and agricultural information. The next level is the district-centered hub, which is mainly a procurement and storage space. Enhanced hubs, called Sagars, in addition to procurement and storage functions also serve as retail outlets for products and services ranging from soaps and apparel to tractors and insurance.

During preliminary discussions and field visits the e-Choupal team shared their long-term vision of expanding e-Choupal from a market-based agriculture support program to one that also supports health, education, water, and environment-related aspects in rural areas. The MBP team is working with the e-Choupal network to design an innovative pilot project to introduce RCH products and services through the e-Choupal hub-and-spoke rural distribution infrastructure.

4. TB Intervention

There has been limited involvement of private sector health care providers in the screening and treatment of TB in India. Numerous government schemes and subsidies exist to support TB treatment through the private sector, which suggests there is a significant opportunity to develop a model for TB screening and treatment services through the private sector. The MBP for Health project will test a pilot program that utilizes these subsidies and schemes to develop a social marketing or social franchising program for TB. Based on what is learned and the successes of this pilot program, the government would be encouraged to adopt and scale up this model for replication across an appropriate geographical area.

5. Handwashing Alliance

To catalyze commercial sector engagement in handwashing, MBP plans to establish an industry-wide alliance to address handwashing promotion. This would draw together all major soap and hygiene marketers under a neutral umbrella program as well as corporate partners who have a corporate social responsibility alignment with this cause, industry associations, and development partners. The objective of the handwashing alliance would be to ensure standard and consistent messaging about handwashing and health promotional activities inserted into on-going marketing events to promote the desired behavior change. The program would be able to set the importance of insertion of public health message into the commercial sector communication campaigns. It would be able bring in a coherence for small and big soap manufacturers along with the bilateral / government effort on hygiene and sanitation linkage on handwashing.

APPENDIX B. PERSONS CONTACTED

USAID/INDIA

Elizabeth A. Hogan, Deputy Mission Director
Kerry Pelzman, Director, Office of Population, Health & Nutrition
Sheena Chhabra, Division Chief, Health Systems
Monique Mosolf, Division Chief, Reproductive Health
Mamta Kohli, Senior Equity & Gender Advisor & Activity Manager, DIMPA
Moni S. Sagar, BCC & Marketing Advisor & Activity Manager, Market-Based Partnerships
Dr. Loveleen Johri, Senior Reproductive Health Advisor
S. Kaushik, Senior Policy & Research Advisor
Sweta Verma, Reproductive Health Advisor
Vijay Paul Raj, Reproductive Health Advisor

ABT INDIA

Anand Verdhan Sinha, Country Director
Ramakrishnan Ganesan, Director, New Initiatives
Debabrata Satapathy, Program Director, DIMPA
Rohini Kumar Sahu, Program Director
Sanjeev Vyas, Program Director
Dr. Ravi Anand, Director, Capacity Building & Quality Assurance
Mahesh Kalra, Director, Field Operations
Ashish Sinha, Research Manager
Suma Pathy, Program Manager
Vandana Siwal, Assistant Manager, Field Operations
R. V. Ramani, Executive Assistant
Manmeet Bhalla, Executive Assistant
Kavita Ayyagari, BCC Specialist (Consultant)
Sarita Falcao, Knowledge Management Specialist (Consultant)
Meenakshi Dikshit, Training Manager, Saathiya
Bikash Chandra Mishra, State Manager, UP
Dr. Roli Seth, Medical Advisor, DIMPA
Sumitra Pasrecha, Quality Assurance Coordinator

OTHERS

Dr. Kiran Ambwani, Deputy Commissioner (FP), Ministry of Health and Family Welfare
A.R. Nanda, Executive Director, Population Foundation of India
Sudha Tewari, President, Parivar Seva Sanstha
Dr. Alok Banerjee, Technical Advisor, Parivar Seva Sanstha
Dr. Gadde Narayana, Country Director Futures India & IFPS Technical Assistance Project (ITAP)

Mr. Naveen Chadha, KPN Marketing, DIMPA Helpline
T. Usha Kiran, Senior Program Officer, Bill & Melinda Gates Foundation
Prithi S. Kochhar, CEO, NAARI Pharmaceuticals
Dr. Alka Dhal, Training Consultant
Pradeep Sinha, former Marketing Director, Pfizer
Meenakshi Sharma, former team leader, IPAN (Public Relations)
Sashwati Banerjee, former Program Director, DIMPA
Varsha Chawda, Head, Social Marketing, LOWE
Dr. Kalpana Apte, Assistant Secretary General, Family Planning Association of India (FPAI)
Anjan Sen, Director, Pharmaceutical Marketing, Pfizer Ltd.
Sandra Gaas, Executive Director, DKT India
Dr. Sandeep Ghiya, General Manager, Clinical Initiatives, DKT India
Vivek Malhotra, Director, Population Health Services (PHS)

PHYSICIANS MET ON FIELD VISITS

Lucknow

Dr. Chandrawati, President, Obstetrics/Gynecology Society, Lucknow
Dr. Indu Tandon, ob/gyn clinician
Dr. Seema Tandon, ob/gyn, FPA/India
Dr. Rokhsana, ob/gyn, clinician
Dr. Namita Agrawal, ob/gyn, clinician

Barabanki

Dr. Neelam Jain, ob/gyn, clinician
Dr. Kumar Verma, homeopath

Agra

Dr. Hana Sadana, ob/gyn, clinician
Dr. Shashi Gupta, ob/gyn, clinician
Dr. Narendra Malhotra, ob/gyn, clinician; past president of FOGSI/India
Dr. Shanu Agarwal, ob/gyn, clinician

Mathura

Dr. Mukti Makesh, ob/gyn, clinician

APPENDIX C. DOCUMENTS REVIEWED

Expanding Access and Demand for DMPA in UP and Uttaranchal Phase IV of the DIMPA Project: A Concept Note. Oct.31, 2006. PSP-One, Abt India.

Expanding Access and Demand for DMPA in UP, Jharkhand and Uttaranchal. Phase IV of the DIMPA Project. Final Strategy and Activity Progress. April 4, 2008. PSP-One, Abt India.

DIMPA Phase IV Design, Power Point Presentation to USAID. November 2006, PSP-One, Abt Associates.

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DIMPA: Expanding Voluntary Use of DMPA Through Expanding Contraceptive Work Plan October '06 – December '07. ND. PSP-One, Abt India.

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Injectable Primary Sales in Uttar Pradesh and Madhya Pradesh. May 2009. DKT India.

PHS Primary Sales 2007–2009. May 2009. PSP-One, Abt India.

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DIMPA Budget 2004–2009. May 2009. Abt India.

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DIMPA Helpline Monthly Reports, November '08 to April '09. May 2009. DIMPA, Abt India.

USAID/India's DMPA Program: Increasing Contraceptive Choices Through the Private Sector. Dec. 15, 2008. USAID/India.

DIMPA Crisis Manual. October 2008. PSP-One, Abt India.

Profile and Sales in 45 Cities. May 2009. DIMPA, Abt India.

DIMPA Phase IV Media Brief. ND. PSP-One, Abt India.

DIMPA Phase IV Concept Brief. NA. PSP-One, Abt India.

DIMPA Phase IV Communication Strategy, PowerPoint presentation. May 2009. PSP-One, Abt India.

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Media Strategy for DIMPA Activity, Period: Oct'08 - Mar'09. Sept. 2008, Lintas Media Group.

DIMPA—A Communication Perspective. Feb. 2007. Lowe Advertising.

PR Media Analysis. Dec. 2008. IPAN.

DIMPA PR Communication Plan. June 2008. IPAN.

DIMPA Program in India: PR Campaign Proposal. ND. Weber Shandwick.

DIMPA Clinics Spread and Density Analysis. May 2009. PSP-One, Abt India.

Mystery Client Survey (Round 1 and 2), PowerPoint presentation. ND.

Ad-track Survey, PowerPoint presentation, ND.

DIMPA Baseline Survey (Consumer), PowerPoint presentation. 2007.

DIMPA Baseline Survey (Providers, 3 cities), PowerPoint presentation. 2003.

DIMPA Baseline Survey (Providers, 6 cities), PowerPoint presentation. 2005.

DIMPA Midline Survey (Providers, 3 cities), PowerPoint presentation. 2005.

Injectable Contraceptive Chemist KAP and Stocking, PowerPoint presentation. 2003.

DMPA Demand Estimation Study, PowerPoint presentation. 2001.

Injectable Contraceptives and Their Acceptability in UP and UK—An Exploratory Survey Among Potential Consumers. ND.

Injectable Contraceptives and Their Acceptability in UP and UK—An Exploratory Survey Among Potential Doctors and Chemists. ND.

Analysis of Price Change on the Perceptions and Use of DMPA among Clients Using RH Services. March 2008. Population Council and PSS.

Exploring Factors That Affect the Provision of DMPA in the DIMPA Network: UP. June 2008. Family Health International and PSP-One.

Introducing DMPA Injectable Contraceptives to Private Medical Practitioners in Urban Gujarat. ND. Frontiers in RH: Population Council in collaboration with DKT, EngenderHealth, CORT.

For more information, please visit
http://www.ghtechproject.com/resources.aspx

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