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FROM THE AMERICAN PEOPLE



EVALUATION

Market-Based Partnerships In Health (MBPH)

Final Evaluation USAID/India

Final Report

June 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Kevin Kingfield, Anthony Drexler, Anuradha Bhattacharjee, and Beulah Jayakumar under the direction of Social Impact, Inc. with Management Systems International.



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USAID/INDIA

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- The management and staff of Abt and consortium partners
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- The individual clients, consumers, outreach participants who shared their views and opinions with us
- Those identified in Appendix B. List of Contacts

Finally, the international consultants appreciate the international travel, logistics, and professional guidance provided by Social Impact, Inc.

The Consultant Evaluation Team
May 2012

ACRONYMS

ACS	Advanced Cook Stoves
AIDS	Acquired Immunodeficiency (or Immune Deficiency) Syndrome
ARC	Advocating Reproductive Choices
ASHA	Accredited Social Health Activist
ATI	Appropriate Technology India
BCC	Behavior Change Communication
BoP	Bottom (or Base) of Pyramid
CB	Capacity Building
CBQA	Capacity Building and Quality Assurance
CTD	Central Tuberculosis Division
CoE	Center of Excellence
CHC	Channel Health Champions
CoE	Centre of Excellence
CSR	Corporate Social Responsibility
CTU	Contraceptive Technology Update
DCGI	Drug Controller General of India
DLHS	District Level Health Survey
DMC	Designated Microscopy Center
DMPA	Depot Medroxyprogesterone Acetate
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment, Short course
DTO	District TB Officer
EC	Emergency Contraceptive
E/L	Endline
FOGSI	Federation of Obstetric and Gynecological Societies of India
FP	Family Planning
GoI	Government of India
GP	General Practitioners
HIV	Human Immunodeficiency Virus
HLC	Health Leadership Council
HLL	Hindustan Lifecare Limited (Formerly Hindustan Latex Limited –HLL)
HQ	Headquarters
HUL	Hindustan Unilever Limited (Formerly Hindustan Lever Limited – HLL)
IAP	Indoor Air Pollution
IEC	Information, Education, and Communication
IFAD	International Fund for Agricultural Development
IIT	Indian Institute of Technology
IMA	Indian Medical Association
INR	Indian Rupee
IPC	Interpersonal Communication
IPPIUCD	Immediate Post-Partum IUCD
ISHP	Indian Society of Health Professionals
ISMH	Indian System of Medicine and Homeopathy
ISMP	Indigenous Systems of Medicine Providers
ITC-ABD	ITC's Agri Business Division
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device

JWT	J. Walter Thompson Agency
KHPT	Karnataka Health Promotion Trust
LOE	Level of Effort
LoP	Life of Project
M&E	Monitoring and Evaluation
MART	Marketing and Research Team
MBP	Market-based Partnerships
MBPH	Market-based Partnerships for Health
MFI	Micro-finance Institution
MIS	Management Information System
MNRE	Ministry of New and Renewable Energy
MoHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MSD	Merck Sharp & Dohme
NGO	Nongovernmental Organization
NIMA	National Integrated Medical Association
NRHM	National Rural Health Mission
Ob/Gyn	Obstetrician/Gynecologist
OCP	Oral Contraceptive Pills
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OTC	Over-the-counter
PACT-CRH	Program for Advancement of Commercial Technology-Child and Reproductive Health
PHSI	Population Health Services (India)
PIP	Program Implementation Plan
PMP	Performance Monitoring Plan
POS	Point of Sale
PPIUCD	Postpartum Intrauterine Contraceptive Device
PPM	Public-Private Mix
PPM-DOTS	Public-Private Mix – DOTS
PR	Public Relations
PSI	Population Services International
PSP-One	Private Sector Partnerships One project
RCH	Reproductive and Child Health
RNTCP	Revised National Tuberculosis Control Program
SBK	Saathi Bachpan Ke, “friends of childhood”
SE	Shakti Entrepreneur
SEC	Socioeconomic Classification
SHE	Social Health Entrepreneur
SHG	Self-Help Groups
SJRI	St. John’s Research Institute
SMO	Social Marketing Organizations
SOW	Scope of Work
TB	Tuberculosis
TBD	To Be Decided
TV	Television
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund

UP	Uttar Pradesh
UK	Uttarakhand
USAID	United States Agency for International Development
VHC	Village Health Champion
VLE	Village-Level Entrepreneur
WHO	World Health Organization

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EXECUTIVE SUMMARY

SUMMARY OVERVIEW

The Market-based Partnerships for Health (MBPH) project successfully designed, implemented, and evaluated a wide range of private partnerships and initiatives that addressed a number of critical public health issues. In less than four years, and with a modest budget, MPBH made significant progress, building upon previous partnership models and exploring new opportunities to engage commercial private sector partners to test approaches ultimately designed to improve health outcomes for Base-of-Pyramid (BoP) families.

Key MBPH achievements:

1. Developed eight partnership models;
2. Demonstrated some success in execution, cost sharing, and commitment of partners to scale-up (or at least have scale-up potential) in each model;
3. Introduced nine health companies to profitable BoP markets; and
4. Leveraged over six million dollars from partners.

Partners as varied as ITC, Sonata, ISMH doctors, and chemist shop owners joined MBPH to develop concepts and roadmaps to tap new markets and improve access to and use of public health products and services among poorer and hard-to-reach families.

BACKGROUND

Market-based Partnerships for Health (MBPH) is a \$13.5 million USAID/India funded project implemented by Abt Associates between October 1, 2008 and May 11, 2012. MBPH aimed to improve the environment for commercial sector engagement in USAID/India's key priority health areas by forging partnerships between the private and public sectors. MBPH fostered market-based partnerships in reproductive health, maternal health, and child health, including promotion of good hygiene, such as hand washing; safe water; prevention of indoor air pollution (IAP); and the control of tuberculosis. MBPH is operational in Uttar Pradesh, Uttarakhand, Jharkhand and Karnataka.

The project had two primary objectives:

1. Build on, implement, institutionalize, and scale-up MBPH models.
2. Explore new commercial-sector opportunities to accelerate public health improvements, especially in BoP and rural population groups, improving access, demand, and service delivery through health and non-health partners.

The program aimed to create and nurture MBPH models that can be brought to scale by commercial partners, government programs, and/or civil society groups. The program also sought to institutionalize local capacity to broker market-based partnerships for health in the future by supporting the establishment of a Center of Excellence.

The purpose of this final evaluation of MBPH is to:

- Review and analyze the overall program strategies and technical approaches adopted by MBPH for increased involvement of the private—especially commercial—sector in generating awareness and use of select reproductive health, child health, tuberculosis and IAP related products and services.
- Review and assess the effectiveness of the processes adopted for MBPH innovations, including planning, monitoring, finance, and technical support.
- Provide recommendations on future directions, especially introducing new and/or continuing approaches for innovations with the private sector. This would include recommending strategies to extend the reach of USAID/India’s health agenda on innovations and partnerships.

The evaluation team gathered quantitative information from existing data and documents describing aspects of MBPH work. Qualitative information was generated through interviews (in person and by phone) as well as by observation of a variety of project field operations. Field visits sites included Varanasi, Chandauli, Lucknow, Faizabad, Sitapur, Mumbai, Hyderabad, Mysore, Chamaraj Nagar, Bangalore, and Dehradun.

The evaluation team classified the eight models/initiatives of private partnerships that MBPH explored into four major categories: (1) alliances/networks; (2) private, commercial partnerships; (3) public-private mix; (4) health leadership council and Center of Excellence. This classification allowed a more nuanced view and discussion of the principal evaluation questions, namely:

1. To what extent has the project been successful in influencing private sector commitment for potential partnerships for BoP markets for improving health outcomes?
2. Which of the innovations in the different models of the project have contributed to success of these models and have potential for scalability and sustainability in India? What are the “essential ingredients” for private sector engagement in health innovations targeting BoP markets?
3. What type and level of technical assistance has been provided by the implementing mechanism under this project? To what extent is the implementing mechanism efficient and appropriate in addressing the needs and expectations of USAID/India and of the commercial sector?
4. How effective has the Center for Excellence and the Health Leadership Council been under this project? What lessons can be drawn from this model in terms of building local institutional capacity?
5. What lessons/recommendations from the innovations under this project can inform and/or feed into USAID/India’s future strategy and have potential for global scale-up?

THE PARTNERSHIP APPROACH

Private Sector Commitment

The idea that the private sector could play a valuable role in expanding access to, and demand for, priority health products and services among BoP families was widely shared by private partners. That their products and services would also be profitable was a key factor in motivating partner commitment.

Private partner commitment in the form of cost sharing totaled over \$6m.

Innovations and Essential Ingredients

Private partners require time to find common ground and gain confidence.

One partner as owner was important for the ITC, Shakti and advanced cook stove (ACS) models; a natural owner, identified early, would be an essential ingredient for concept scale-up and sustainability. When model ownership was diffuse, a non-commercial owner (government, donor/foundation) would have to assume ownership for scale-up and sustainability (SBK, Saathiya, DIMPA).

MBPH developed strategies to address public policies such as OTC regulations for public health products like zinc; tax and tariff issues that affect pricing of products like advanced cook stoves; and the official position that keeps Depot Medroxyprogesterone Acetate (DMPA) out of the public procurement domain.

Distribution of health products to new hard to reach markets was successfully combined with promotional activities to ensure not only availability but sufficient, ongoing demand.

The innovations MBPH developed and tested included new products, technologies, financing schemes, distribution channels and demand generation activities (Appendix D provides the details and a matrix of MBPH innovations).

MBPH TECHNICAL ASSISTANCE

Each of the models tested by MBPH has demonstrated some success in execution, cost sharing, commitment of partners, and even scale-up or at least maintenance potential.

The evaluation team attributes the MBPH success to three key factors:

- MBPH team brought together expertise (staff, consultants and advisors on Health Leadership Council) in various areas like strategy development, networks and partnership, marketing, capacity building, quality assurance, monitoring, evaluation and advocacy.

- A basic and comprehensive MBPH framework that promoted innovations and partnership building
- Support and advice from USAID/India was critical for this unique effort, which broke new ground with private, commercial sector partners. USAID was elemental in making contacts and consolidating commitments.

HEALTH LEADERSHIP COUNCIL AND CENTER OF EXCELLENCE EFFECTIVENESS

Although the Health Leadership Council (HLC) experienced some delay during project start-up as a result of project and USAID due diligence, it has nonetheless played an effective pro bono advisory role. A future advisory role of HLC with the Center of Excellence (CoE) appears welcomed by both current members and the CoE.

The Center of Excellence has had even less time to establish itself than the HLC, but has begun functioning effectively.

The choice of an Indian firm as the CoE moves USAID toward its objective of institutionalizing local capacity to broker market-based partnerships for health in the future.

LESSONS AND RECOMMENDATIONS FOR THE FUTURE

Saathiya/DIMPA

1. Establish a two-year screening mechanism for DMPA users intending to use indefinitely.
2. Establish procedures to ensure confidentiality of client data gathered during the course of Helpline scale-up.
3. Develop Purush Goshties for men so that they may play a more informed role in the decision for family planning.
4. Involve the Government of India (GoI) in scale-up, if a mechanism can be developed to allow the use of public funds (for example, through its reproductive and child health [RCH] and NRHM programs).
5. Continue to collect client use and satisfaction data for the advocacy campaign to encourage a policy change to allow procurement and distribution of DMPA through the public sector.

Saathi Bachpan Ke (SBK)

1. Transfer the final ownership of SBK (current model) and future SBK types of Alliances where corporate entities are involved and brought together on a single platform to help deliver a public health outcome to the GoI. Public sector programs have the heft to sustain such initiatives financially, take them to scale, integrate them and negotiate with the private sector.

2. Involve the CoE in immediate negotiations with Tata Chemicals Ltd. The NRHM diarrheal disease campaign, now being undertaken with SBK materials, offers an opportunity for the Tata Swatch mass media on Water Filters to be aired in tandem with the NRHM media dissemination. The Tata Group has influence with the GoI and a reputation for multiple corporate social responsibility (CSR) activities, which validates such a strategy.
3. CoE should take on the partnership brokering role of MBPH for SBK for another two years. Child Health is a Millennium Development Goal and a part of the United States Government's Global Health Initiative.¹

Shakti@BoP

1. Pharma Synth ORS should pursue Hindustan Unilever Limited (HUL), formerly Hindustan Lever Limited, or HLL) for permission to carry its ORS the last mile to the SEs through HUL's own distribution system rather than by Pharma Synth field representatives. Such a positive decision would enhance sustainability of the model. This perhaps is the most important avenue to reach replicability and sustainability
2. The net profit margins obtained during the pilot test were very encouraging. However, if resources were available, some of the MBPH inputs would be valuable during the proposed scale-up. For example, a continuing broker role with HUL and some cost sharing of other inputs, such as inventory management, training and promotion inputs for demand generation.
3. With the documented success of this model, a repository of lessons learned with capability to pass it on and adapt for other interested commercial companies is needed. The Center of Excellence would be a candidate for this role.

ITC E-Choupal

1. ITC should expand the program from the current two hubs to a total of 11 as it moves from prototype development to the pilot phase. ITC is aware that while it will need USAID assistance through the pilot phase in 11 hubs, it will need to establish its own ongoing technical assistance mechanism. Projected costs per unit: 300,000 INR for training of Village Health Champions (VHCs) and communication activities and another 300,000 INR for Channel Health Champions (CHC)-related costs. Total: 600,000 INR, or \$12,000 (US) per annum for each activated hub.
2. Follow-on projects should coordinate discussions to bring the private partners together to share experiences and develop common approaches.
3. Referral linkages should be established for potential health complications resulting from product use and a mechanism for ongoing, proactive vetting of content from product partners.
4. The basket of products should be expanded and ITC also should add services.
5. Mohilla Haats should be reduced and replaced with community meetings to increase sales opportunities.
6. The VHCs should be encouraged to use Community Meetings to recruit satisfied customers to further extend the sale of product.

¹ "GHI strategy seeks to achieve significant health improvements and foster sustainable, effective, efficient and country-led programs that deliver essential healthcare... a special focus is on improving the health of children and newborns and delivering clean water...."

ACS

1. Resolve stove cost issue through negotiation with Envirofit, including prospective cost reductions through local manufacturing. If this issue cannot be resolved, additional ACS manufacturers should be considered. Several ACSs have been introduced into the market in the past several years that are culturally appropriate and meet IIT certification requirements. Open competition would improve the prices and choices available.
2. Sonata should expand its partnership with Dharma through sales of cook stoves in a steadily increasing number of Sonata microfinance institution (MFI) branches and provision of installment purchase financing for other products.
3. Future support for other distributor-financier models, such as Applied Technology in Jharkhand, should be considered.
4. Dharma should expand its line of products and village-led entrepreneurs (VLEs) in coordination with Sonata.
5. Efforts should focus on the low-income population in the targeted areas to avoid the tendency to direct more attention towards less poor groups.
6. Marketing efforts need to be more locally oriented and developed based on believable people and locations, including satisfied users and demonstrations.
7. Policy advocacy with the Ministry of New and Renewable Energy (MNRE) and others with regard to carbon credits and MNRE subsidies should be continued and increased to ensure the long term profitability of the project.

Tuberculosis (TB)

The time is right for advocating that the Revised National Tuberculosis Control Program (RNTCP) considers this model for nationwide replication, to extend its services to patients diagnosed and treated in the private sector through a contracting mechanism—a need articulated in RNTCP’s annual report for 2011. There are several initiatives across the country for involving communities and private providers in TB control and care that could join forces for a concerted advocacy effort.

Center of Excellence

Future support can be managed through two mechanisms: CoE and Strengthening Health Options through the Private Sector (SHOPS). With two possible mechanisms the potential for confusion and competition over roles and responsibilities exists, but appears manageable, based on the current experience.

Recommended areas for continued support for market-based partnership through CoE/SHOPS:

1. **New and ongoing private partnerships** that have potential for scale-up and sustainability.
2. **Technical assistance** to add value in areas of training retailers (old and new) and for promotion/outreach and other demand generation efforts.
3. **Advocacy** for issues like public sector for Networks/Alliances and TB scale-up, DMPA procurement, Zinc as an OTC and MNRE price supports/Carbon Credits for ACS.

4. **Institutional memory** or knowledge bank for others to build upon along with dissemination activities

A hybrid approach should be developed for future support. One part of the investment would be grants for new and ongoing private partnerships, knowledge bank management, advocacy, and technical assistance during the early phases of model development. The other part of the investment should be in the form of a capital fund, to be used like a loan, which would be repaid with a defined premium based on success of the venture.

INTRODUCTION

MBPH is a \$13.5 million project funded by USAID/India between October 1, 2008 and May 11, 2012. MBPH aims to improve the environment for commercial sector engagement in USAID India's key priority health areas by forging partnerships between the private and public sectors. MBPH fosters market-based partnerships in reproductive health, maternal and child health (including promotion of good hygiene, such as hand washing, safe water, and prevention of indoor air pollution (IAP)) and the control of tuberculosis. The project is helping to bridge a key gap in the health portfolio of USAID/India, which currently does not fully tap into the private commercial sector, especially the non-health related segment, for expanding access and demand for priority health products and services.

As USAID's history in India illustrates, there is a growing recognition that the private commercial sector can and should make greater contribution to improving public health systems and outcomes. Market-based partnerships leverage the revenue generating mechanisms of the private sector to deliver public health goods, services and information to the poor and those in underserved markets. The rationale for MBPH is to engage the private sector to expand its role in increasing access and demand for health products and services. The project is a formal collaboration between the public and non-public sectors (both commercial and non-profit), to regulate, finance, or implement the delivery of health services, products, equipment, research, communications, or consumer education.

The project is implemented by Abt Associates and a consortium that includes four partners – Futures Group, Monitor Group, Population Services International and Banyan Global. The project is operational in Uttar Pradesh, Uttarakhand and Jharkhand, and for the TB component in Karnataka.

MBPH was built on the lessons learned from the global PSP-One project that aimed to increase sustainable family planning and other health product and service use through the private sector, and one of USAID/India's initiatives, the PACT-CRH (Program for Advancement of Commercial Technologies in the area of Child and Reproductive Health). Both predecessor projects focused on developing successful models for private sector partnerships. MBPH was envisaged to carry forward partnerships forged during the PSP-One and PACT-CRH programs, as well as to expand the relationships established with the private sector. The project has two primary objectives:

1. Build on, implement, institutionalize, and scale-up MBPH models.
2. Explore new commercial sector opportunities to accelerate public health improvements, especially in Base-of-Pyramid (BoP) and rural population groups to improve access, demand and service delivery through health and non-health partners.

The program aims to create and nurture MBPH models that can be brought to scale by commercial partners, government programs and/or civil society groups. The program also aims to institutionalize local capacity to broker MBPs for health in the future by supporting the establishment of a Center of Excellence.

EVALUATION APPROACH AND METHODOLOGY

EVALUATION PURPOSE

The purpose of this final evaluation is to:

- Review and analyze the overall program strategies and technical approaches adopted by MBPH for increased involvement of the private, especially commercial, sector in generating awareness and use of select reproductive health, child health, tuberculosis and IAP related products and services.
- Review and assess the effectiveness of the processes adopted for MBPH innovations including planning, monitoring, finance, and technical support.
- Provide recommendations on future directions, especially introducing new and/or continuing approaches for innovations with the private sector. This would include recommending strategies to extend the reach of USAID/India's health agenda on innovations and partnerships.

EVALUATION TEAM

Two Indian and two international evaluators conducted the evaluation: Dr. Beulah Jayakumar analyzed the public health aspects of the models, especially TB; Anuradha Bhattacharjee analyzed demand generation/behavior change communications; Tony Drexler analyzed the private, commercial sector involvement and the innovations piloted; and Kevin Kingfield, team leader, analyzed the strategic marketing of health products and services.

EVALUATION METHODOLOGY

The assessment team employed both quantitative and qualitative methods. The quantitative information came from existing project data and documents (see Appendix C for a complete list) especially consumer baseline and endline surveys describing aspects of MBPH work. Qualitative information was generated through interviews (in person and by phone) as well as by direct observation of a variety of project field operations. To help ensure that comparable information was collected, the team drafted a structured questionnaire that was followed with all informants. Most of these questions were included in the Pre-Planning/Email Guide; Interview Guide/Questionnaire; and Public Health Questionnaire, all of which are provided in Appendix D. Data Collection Instruments. The team conducted interviews with commercial partners; Health Leadership Council members and other senior advisors to the project; health providers (ob-gyns, general practitioners both MBBS and ISMH) and their associations; non-governmental organizations, including social marketing organizations; and end-user consumers (see Appendix B for a complete list). Field visit sites included Varanasi, Chandauli, Lucknow, Faizabad, Sitapur, Mumbai, Hyderabad, Mysore, Chamaraj Nagar Bangalore, and Dehradun. The team's in-country activities were conducted over the period April 1–May 1, 2012.

The evaluation team classified the eight models/initiatives of private partnerships explored by MBPH into four major categories: (1) Alliances/Networks; (2) Private, Commercial Partnerships; (3) Public-Private Mix;

and (4) Center of Excellence/Health Leadership Council. This classification allowed a more nuanced view and discussion of the principal evaluation questions, namely:

1. To what extent has the project been successful in influencing private sector commitment for potential partnerships for BoP markets for improving health outcomes?
2. Which of the innovations in the different models of the project have contributed to success of these models and have potential for scalability and sustainability in India? What are the “essential ingredients” for private sector engagement in health innovations targeting BoP markets?
3. What type and level of technical assistance has been provided by the implementing mechanism under this project? To what extent is the implementing mechanism efficient and appropriate in addressing the needs and expectations of USAID/India and of the commercial sector?
4. How effective has the Center for Excellence and the Health Leadership Council been under this project? What lessons can be drawn from this model in terms of building local institutional capacity?
5. What lessons/recommendations from the innovations under this project can inform and/or feed into USAID/India’s future strategy and have potential for global scale-up?

Therefore, the sections that follow review each of the eight MBPH models and focuses mainly on the first three questions, along with recommendations for future strategy. The discussion of Health Leadership Council and Center of Excellence also addresses effectiveness (question four) for this model. A summary of MBPH inputs, focusing on evaluation question three regarding the effectiveness and efficiency of the project technical assistance in addressing the needs and expectations of USAID/India and the commercial sector, follows. That section includes observations on five broad issues inherent in the MBPH with implications for the future. Finally, question five is addressed generally throughout the report under each model’s innovations section as well as in the behavior change communication (BCC) section of Market-based Partnerships for Health - Technical Assistance Inputs. Appendix D, MBPH Innovations, summarizes the innovations in terms of USAID’s future strategy along with those that have potential for global scale-up.

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS FOR THE EIGHT MPBH MODELS

INTRODUCTION

This section reviews the eight models designed and tested by MBPH, divided into the four major categories as established by the evaluation team. For each model, an overview is provided, along with the development hypothesis it addresses. Each analysis responds to the evaluation questions regarding the extent to which the project has been successful in influencing private sector commitment for potential partnerships; innovations that contributed to success and that have potential for scalability and sustainability; and the type and level of technical assistance that has been provided.

ALLIANCES/NETWORKS

Saathiya and DIMPA Models

Saathiya Model: Overview

The objectives of the Saathiya model are to create sustainable marketing partnerships to improve contraceptive-seeking knowledge and behavior amongst married couples (ages 15–24) in the lower socioeconomic groups in seven cities across Uttar Pradesh and Uttarakhand. The Saathiya product basket includes condoms, pills, emergency pills, injectables, and Intra-uterine Contraceptive Devices (IUCD). The program has leveraged considerable resources and established a network of over 3,000 pharmacies, family doctors, and specialist obstetrician-gynecologists that works in partnership with various private sector pharmaceutical companies. The focus is to establish a model to make it more relevant to the needs of young married couples from lower socioeconomic groups in urban areas, while strengthening its commercial viability.

Simultaneously, investments have been made in the continuous capacity building of network providers by conducting refresher trainings on provision of reproductive health services to young couples. Promotion of the network, via city level media activities, has been undertaken and a communication campaign has been implemented through local radio stations and regional newspapers. The project has made efforts to ensure that there is greater client utilization of the services being offered by the program. The Balanced Counseling Strategy Toolkit, acclaimed internationally, has been translated and adapted into Hindi and a series of cascade trainings on family planning counseling using this toolkit have been organized for both providers and paramedic staff.

The Saathiya Networks cover seven cities of Uttar Pradesh (UP) and Uttarakhand (UK) while the DIMPA Networks cover 45 cities in UP, UK and Jharkhand. Both Networks build on partnerships with private healthcare providers and their associations—OB/GYN, Federation of Obstetric and Gynecological Societies of India (FOGSI); GPs; IMA/PDA; A/PDA; Indian System of Medicine and Homeopathy (ISMH), National

Integrated Medical Association (NIMA), AMA/HMAI; and Chemists, Local Chemist Associations—and thus, have an overlap which has been used to the programs’ advantage.

DMPA Model: Overview

MBPH also works to increase the overall use of modern, reversible methods of contraception through the expansion of the basket of contraceptive choices to include three-monthly injectable contraceptives. Depot Medroxyprogesterone Acetate (DMPA) is a safe and effective contraceptive used by more than 12 million women in over 106 countries. USAID launched the DMPA program in 2003 under the Private Sector Partnerships-One (PSP-One) project to expand choices of modern contraceptives through private healthcare providers and to increase their availability through partnerships with commercial and social marketing agencies. These efforts continue under the MBPH project. The program continues to focus on capacity building of network providers and demand-generation efforts across 45 towns in UP, Uttarakhand, and Jharkhand, resulting in improved access to counseling for contraceptive use. Mass media channels such as television and radio have been used for demand creation and, simultaneously, outreach activities have been conducted by field teams by way of counseling potential family planning clients at provider clinics and also in large public and corporate hospitals. Local tie-ins with NGOs counsel women in slum communities and women’s self-help groups. The project team continues its technical-assistance visits to network doctors and a new mentoring program has been introduced, under which select doctors have been designated as ‘DMPA Champions’ to mentor other network providers. The program also works to improve linkages with manufacturers for effective distribution to network clinics, and with chemists who provide injectable contraceptives.

Saathiya and DIMPA: Discussion

The development hypothesis behind the support for alliances/networks is that expansion and promotion of access points for quality information and increased choice of products and services increases awareness and willingness to use modern family-planning methods. Increased contraceptive prevalence is associated with lower maternal/child morbidity and mortality rates.

A great deal of overlap exists within the Saathiya and DIMPA Networks. Both models brand and promote specially trained healthcare providers and link them with product manufacturers and social marketing organizations (SMOs) to improve access to family planning knowledge and use for poorer clients. The rationale for the separation into two models lies in DMPA’s unique status. DMPA was cleared by Drug Controller General of India (DCGI) for marketing in the private sector in India in 1994, but not included for procurement or distribution within the public sector. A separate focus on DMPA seemed appropriate to increase awareness and encourage use within the private sector, while minimizing potential backlash from interest groups that originally had opposed the DCGI decision. However, since DMPA activities began under PSP-One in 2003, that concern has diminished. Saathiya now includes DMPA as part of their menu of family planning choices. The evaluation team felt that given the overlap, both models could be discussed as one; however, where specific findings apply to only one model they are identified as such.

Findings cited for the Saathiya/Dimpa model below are based on the review and analysis of multiple sources of information. An in-depth MBPH presentation, supported by data from the project management information system (MIS), provided a useful baseline. The team supplemented this data with field interviews

of providers, provider associations, J. Walter Thompson, United Nations Population Fund (UNFPA), Helpline, SMOs, foundations, and pharmaceutical manufacturers. Finally, field activities such as Mohila Goshties/Health Camps provided a means to interview a variety of end users as well as evaluate the communications used.

Innovations

Among the notable innovations successfully developed and tested during the course of MBPH, several stand out: support of a new consumer choice, Depot Medroxyprogesterone Acetate (DMPA); postpartum, intrauterine contraceptive device training (PPIUCD) for OB/GYNs and their paramedic staff; a helpline with a callback feature that improved DMPA continuation rates; and Mahila Goshties/Health Camps for targeted family planning information/promotion, followed by access to products and services from trained providers.

Saathiya and DIMPA: Findings

The private-sector provider network, supplier, and NGO partnerships were already established under PSP-One. From October 2008 till date, the Saathiya/DIMPA networks have counseled more than 300,000 women on family planning; offered an expanded range of contraceptive choices; received more than 500,000 calls on the helpline; and increased the number of DMPA providers by over 46%, from 1,058 providers (PSP-One) to 1,546 in MBPH.²

Awareness of the Saathiya network has increased, from a baseline of 6.6% to 23.3%, and of DIMPA clinic locations, from a baseline of 9.1% to 19.6%.³ Current use of any family-planning method has increased from a baseline of 45.7% to 63% (among respondents not exposed to communications activities, only 50.4%). Current use of DMPA has increased significantly, from a baseline of 0.2% to 0.7%. Intent to use among target women also increased significantly, from 1.5% at baseline to 2.7% at endline.⁴

Communication interventions were carefully tailored to meet the specific aspirations of the target group. Most private providers involved in Saathiya were interested in promoting family planning but were at different stages of actually meeting the need.

MPBH deserves special credit for bringing DMPA, previously a virtually unused product, to the threshold of sustainable demand. The increased demand has encouraged new manufacturers to enter the market, increasing competition and driving down consumer prices. The project started with only one supplier, Pfizer, offering a relatively expensive product (232 INR). Today, a number of new commercial DMPA brands are on the market, as well as social marketing organization brands (Khushi–60 INR).

One of the intended outcomes not achieved for DMPA was a public policy change, which would have resulted in DMPA procurement by the GoI. The private sector alone, with key USAID support, has been the

² Source: MBPH MIS

³ Source: MBPH Endline Survey to USAID March 9, 2012

⁴ Source: MBPH End of Project Evaluation Report to USAID April 4, 2012

main force bringing the product to near-sustainable levels. The GoI appears closer to such a policy change today as a result of the DIMPA model's success.

During the evaluation team's field visit, DMPA users noted their intended use was for the long term, often to the end of fertility; for many, this meant over five years of continuous use. Current guidelines call for those intending to use DMPA indefinitely to undergo medical screening every two years. No screening mechanism yet exists for MBPH clients.

The project's capacity-building approach combined training events with ongoing support, both through the project and through peers, and served to plug critical gaps in both technical skills (such as PPIUCD insertion and method-specific knowledge) and soft skills (counseling methods).

While family planning (FP) is neither a significant part of their clients' overall needs nor a high-revenue service, providers appear to have made FP counseling and services part of their routine consultation, and are likely to continue the practice.

PPIUCD was introduced late in the project cycle, with the purpose of meeting FP needs of immediate postpartum women (often the group with the highest unmet need), as well as to protect their health. Because of the intervention's short duration, its acceptability—as well as providers' motivation to continue offering the method—remains to be seen.

Saathiya and DIMPA: MBPH Inputs and Technical Assistance

1. MBPH served as the broker and key driver for most of the partnership strategy and activity. Joint planning and participation was encouraged by MBPH, but most activities were directed centrally. Model ownership was diffused without a natural owner who could scale-up activities in a sustainable manner. Project inputs focused both on increasing the number and supply of private providers who offered accurate information and quality products and services, as well as generating demand for those services among low-income couples.
2. Training was valued highly by all providers the team interviewed. Confidence was felt to be the major benefit, especially for ISMH doctors, who had never been exposed to such training before. The ISMH doctors said that after training, they could not only respond to client questions but actually initiate a dialogue about family planning on their own and were motivated to do so.
3. Based on discussions with Johns Hopkins Program for International Education in Gynecology & Obstetrics trainers in Lucknow and Jharkhand, PPIUCD training appears practical for over half of those trained; the remainder does not appear to have enough patients, at this time, to maintain IUD insertion skills. PPIUCD training improves technical skills and expands client choice. The basic training module was extended to paramedics (those who staff OB/GYN network-provider clinics), as they are available, and have the time, to talk about family planning choices to clients and in so doing, create more opportunity for increasing awareness.
4. Promotion (mass media and outreach) was valued by both private providers and product manufacturers. Providers noted increased demand for family planning choices in their clinics, while manufacturers saw higher product sales. It is important to note that mass media for DMPA did not result in any backlash, and the films and radio spots are being used by others, including Janani and

DKT in Bihar. The project's public relations and advocacy generated a positive environment for DMPA through Advocating Reproductive Choices (ARC).

- a. The team saw network branding with signage at all provider clinics and retail outlets visited. Providers noted that visible branding serves to identify sources of FP information to clients and helps open conversations about contraceptive choices. Supporting posters, pamphlets and brochures were visible in the clinics and at community meetings (Mahila Goshties), and provided more visual cues, comprehensible to even the illiterate, that family planning advice was available.
 - b. Based on team evaluation field visits, interpersonal communication (IPC) was used effectively in the Mahila Goshties. These neighborhood meetings of 20–30 women provided an opportunity to hear about family planning methods. Those interested in products and services were referred to Health Camps held at another site, often on another day. The fact that women came to both indicates a strong hunger for accurate information dispensed in a supportive environment, and also for access to the products and services themselves.
5. The helpline is a means of providing accurate, anonymous, reproductive-health information over the phone. Demand for this service is very high, stretching the system's capacity; the helplines are unable to respond to 50–75% of incoming calls.⁵ According to a MBPH survey implemented by the program teams in 2011, about 20% of the calls have led to walk-ins at provider clinics.
 6. One potentially serious issue in managing confidentiality was discussed with regard to the helpline. MBPH is careful to obtain permission from consumers before research and follow-up calls are made: all persons who call the helpline are asked if they agree to share their telephone numbers for FP or helpline information and follow-up, and some Dimpa users provide their telephone numbers for follow-up calls. Consent is registered in the doctor's copy of the Dimpa client card. However, no warnings are given to consumers calling in that the specifics of their call will be put in a database connected to their name. For those calling in with sensitive questions on sexuality, this appears to be a breach of confidentiality.
 7. The project-designed helpline database itself is a component of the innovative "DIMPA Callback Feature" that allows the helpline to actively call DMPA users at critical points after an injection. Initial data suggest that these calls have had a significant impact on reducing DMPA discontinuation rates. From a 60% discontinuation rate after one injection, a call back to users immediately after injections resulted in a significant fall in discontinuation to a very impressive 12%.⁶ Overall, the helpline was mentioned by many private providers as a valued and important promotional input for demand creation.
 8. Product distribution and linkages with SMOs partnered with MBPH extended the reach of the traditional pharmaceutical supply chain. For example, on Chakrata Road in Dehradun, Vaidya V.K.Nayyar (an ISMH provider) was detailed and supplied by Wyeth and J.K.Ansell medical representatives for commercial oral contraceptive pills (OCPs) and condoms, while Dr. Mohammed Shamim Siddiqui (also an ISMH provider), on the same road, was supplied by DKT International with brands of Choice OCPs and Zaroor condoms.

⁵ Source: Financial Sustainability of Family Planning Helplines, p4

⁶ Source: MBPH End of Project Evaluation Report to USAID April 4, 2012

9. Although MBPH has done a credible job in encouraging male involvement in family planning (e.g., the helpline consistently receives a higher number of calls from men rather than women⁷), a component frequently mentioned by the network providers as lacking was Purush Goshties (Meetings for Men), which providers felt could stimulate greater demand for and use of products and services. The success of the Mahila Goshties led to the belief that similar outreach with men would have an added impact. Indeed, this type of intervention was used in Pakistan; subsequent research confirmed that when both husband and wife attended small group discussion sessions, the impact on family planning uptake was greater than when just the wife attended.

Saathiya and DIMPA: Partner Commitment, Scale-up and Sustainability

Private providers and their professional associations (Federation of Obstetric and Gynecological Societies of India [FOGSI], IMA, NIMA and the chemists) expressed commitment to maintaining family planning services and information to clients in the future, based on expectations of increasing demand and achieving a higher profile in the community. They were confident that the skills learned from the MBPH training would be sustained through continued use.

Pharmaceutical producers expressed their intention to ensure sufficient supply and distribution of products to meet demand in MBPH intervention areas. These partners have also invested in message coordination, using and building upon project-developed materials. The producers expect to capture a reasonable share of increased demand from family planning resulting from MBPH activities. Wyeth, for example, noted that their oral contraceptive sales are growing at about 20% annually.

SMOs are committed to continuing and incrementally increasing distribution of products and promotion (detailing) to network and non-network providers. SMOs share the project's commitment to increasing FP access to low-income consumers, while being revenue-driven. In Lucknow, for example, an SMO described their territory as reaching beyond the Saathiya/DIMPA networks into more peri-urban areas. In those areas, they sold DMPA to chemist shops and also detailed to surrounding non-network providers. This detailing resulted in more DMPA prescriptions and more sales to the area chemists.

Saathiya and DIMPA: Conclusions

The Saathiya/DIMPA model of provider/supplier partnership has successfully increased awareness and use of a range of family planning products, including DMPA, in lower-income consumers. The USAID investment has been modest, with private partners offering some product sampling and a regular supply of products.

While private partners were committed to playing defined roles and investing their own resources in common project activities, none was willing or able to play the central MBPH broker role to scale up in a sustainable manner. Pieces of the model may be replicable, however:

⁷ The evaluation team observed that after the male made an initial introduction, he would usually hand the phone over to the wife for the question.

- The helpline is actively building a business plan that will attract future investments. The Center of Excellence has assisted in defining areas for revenue enhancements and cost cutting. The Packard Foundation has shown interest in supporting the helpline in Bihar.
- Some training will be continued by professional organizations like FOGSI, but is not likely to be widespread or frequent. Providers do not value the training enough to pay for it themselves.
- Future promotional efforts are not likely to focus on the Saathiya/DIMPA branded networks. Public sector promotion may fill a part of the void (minus any mention of DMPA) as will other donor/foundation efforts that evolve. For example, Janani (with Gates Foundation resources) is supporting a provider network in Uttar Pradesh and Bihar. The support includes training, a helpline, family planning products, and airing of MBPH Radio and TV spots.

MBPH has not demonstrated that provider networks are a sustainable, commercially viable venture in urban slum areas. Future investments to maintain or expand the model by current partners appear unlikely in the short-term. However, with investments from donors, foundations, and the public sector, and with leveraged support from the commercial, private sector and SMO investments, the basic model can be replicated. This is already happening with Packard and Gates support to SMOs in Bihar.

Saathiya and DIMPA: Recommendations

- Establish a two-year screening mechanism for those who intend to use DMPA indefinitely. Current public health guidelines recommend that those intending to use DMPA indefinitely should undergo medical screening every two years. No screening mechanism yet exists for MBPH clients.
- Establish procedures to ensure confidentiality of client data gathered during the course of helpline scale-up. Callers' personal data (name and questions asked) currently reside in a database, but callers largely are unaware of this.
- Develop Purush Goshties for men so that they may play a more informed role in the decision for family planning.
- Involve the GoI in scale-up, if a mechanism can be developed to allow the use of public funds through programs like RCH and the National Rural Health Mission (NRHM). This is the best option in a scenario where there are vast scale-up needs and none of the current network partners are able or willing to expand network activities, and the traditional funding role has been played by donors and foundations.
- Continue to collect client use and satisfaction data for the advocacy campaign, in order to encourage a policy change that would allow procurement and distribution of DMPA through the public sector.

Saathi Bachpan Ke (SBK) Model

SBK Overview

Saathi Bachpan Ke Alliance (SBK), which means “friends of childhood”, is a national alliance developed by MBPH to improve child health by reducing the incidence of diarrhea. Diarrhea is a major cause of mortality among children under five in India (around 380,000 deaths annually, according to UNICEF in 2009). Most deaths can be prevented with simple and effective home-based solutions which include hand washing with soap, household water treatment, and oral rehydration solution (ORS). The Alliance leverages commercial-sector interest in promoting individual products (soap, water purification tablets and filters, ORS) by providing a platform through NGO outreach to reduce the incidence of diarrhea in children. SBK seeks to bring together corporate and other non-governmental partners to work towards interventions like hand washing with soap, oral rehydration therapy (ORT), and drinking water treatment methods to reduce the incidence of diarrhea in children under five years old.

In the SBK alliance model, various commercial interests came together with NGOs to jointly address the public health issue of home-based diarrhea management. The program has formed partnerships with leading commercial partners like Reckitt Benckiser (Dettol) for hand washing with soap, Tata Chemicals Limited (Tata Swach) for water purification, Alkem Laboratories Limited (Orhydrate) for ORT, and Medentech for water purification. The program has also formed partnerships with non-commercial organizations such as Sulabh International, an international NGO working in sanitation and hygiene, and Save the Children. Through TNS Mode, a research agency, the project carried out a baseline study and exploratory research among caregivers of children under the age of five. Training modules have been developed for indigenous providers and trainings have been completed. MBPH has leveraged the support of all four partners for SBK outreach and training activities. Communication activities included direct contact with caregivers, influencers, and medical service providers as well as engaging commercial sector brands to include diarrhea prevention and management messaging in their brand communication. The project has also hosted outreach events, with on-air and on-ground activation included ORT announcements with diarrhea facts, doctor interviews, school-based awareness activities, health camps, and stories in the media. These activities have resulted in increased visibility for SBK in the intervention areas. The program has also trained ISMP providers, community workers, and partner sales staff on diarrhea prevention and management.

SBK model findings are based on the review and analysis of multiple sources of information. An in-depth MBPH presentation, supported by data from the project MIS, provided the evaluation team’s baseline. The team supplemented this data with field interviews of representatives from Medentech, Tata Chemicals (management and field staff), Reckitt Benckiser management, community outreach NGOs, and school officials. Attendance at community meetings in Lucknow and Varanasi allowed the team to evaluate the effectiveness of communications and field dynamics, including sales at the field level. End users were interviewed at both the field meetings and in their homes.

Saathi Bachpan Ke: Innovations

The key innovation of SBK was the alliance itself. Bringing together the products of three corporate organizations on one public health platform has not been attempted before in the social sector in India. The alliance offers a comprehensive approach to diarrhea prevention and management: hand washing with soap, point-of-use water treatment, and oral-rehydration salts use. This is a classic example of intervention bundling, which has been shown to improve the public health outcome more efficiently than each of the individual interventions alone (e.g., CDC Global Health E-Brief 2007). Other innovations included: (1) leveraging the communication and promotional activities of private companies to include SBK in mass media campaigns and brand messages for increased generation of awareness; and (2) outreach on diarrhea prevention and management by NGOs in urban slum communities, in schools, and in meetings of women's groups.

SBK: Findings

1. Working in conjunction with alliance partners, SBK made sure that distribution of products like Dettol Soap and Aquatabs remained stable in the program areas, while the Tata Swach sales team worked alongside local NGO Pratinidhi in consumer outreach and demonstrations of the water filter in women's group meetings.⁸
2. The training given to the Pratinidhi outreach workers by the SBK team on "the clean water test", and their use of the Flip Book with their target audience to teach correct hand washing and administering of ORS in cases of diarrhea, was effective. Based on Medentech and Tata reports, families who start using water purification tablets as the first stage of making sure of clean water for their families often upgrade to a filter. The evaluation team witnessed orders being booked for 10 Tata Swach Filters on April 12, 2012, at a women's group meeting in the urban slum of Choti Jugauli, Lucknow - an area where 35 Tata Swach filters have already been purchased over February-March 2012. Among users interviewed in that neighborhood, researchers witnessed how families would transition from tablets to filters.
3. Both Reckitt Benckiser (Dettol Soap) and Tata Chemicals (Swach Filters) had highly developed brand communications as well as big budgets for heavy airing on national and regional channels. Under SKB they agreed to coordinate their media campaigns with the timing of the SKB campaigns. This resulted in integrated and high decibel promotion: private sector brand messages on soap, cleanliness and clean water complementing the soap, cleanliness and diarrhea management messages of SBK.
4. Pratinidhi outreach workers said that consumer knowledge of ORS was high and ORS products were readily available in their intervention areas, even in the local grocery shops. ORS was even given to older children and to anyone who worked hard in the sun. This was corroborated when the evaluation team talked to a woman in the urban slum of Choti Jugauli—she knew how to mix and give ORS solution to her two small children and she had purchased a Tata Swach water filter because clean water would ensure that her family remained healthy.

⁸ Note: Medentech operations in India have ceased; all remaining stock has been distributed. Supplies in Lucknow were still available during team's field visit.)

SBK: MBPH Inputs and Technical Assistance

1. The MBPH SBK Alliance is a comprehensive approach to diarrhea prevention and management. Evidence of behavior change after such a short intervention is minimal. The MBPH-SBK Endline Survey shows that knowledge of washing hands with soap increased significantly between Baseline (B/L) and Endline (E/L) Surveys: (a) before eating: 30.6% (B/L) - 50.1% (E/L); (b) before cooking: 35.7% (B/L) - 68.9% (E/L); (c) before feeding child: 34.4% (B/L) - 47.6% (E/L).
2. Based on user interviews target households have begun to see the difference that preventive measures can make; however, there are signs that their expectations related to the effectiveness of interventions are unrealistic. While these interventions are effective, they are not infallible: children could get diarrhea despite the use of these interventions the Alliance promotes.
1. MBPH is leading the advocacy efforts with the Drug Controller General of India for bringing about regulatory relaxation for zinc to ensure wider distribution (with stockists not needing a selling license). The project has drafted and submitted the representation to the Drug Controller General with supporting documents and data evidence through the Center of Excellence–Swasti. Finally MBPH has had regular engagement and co-ordination with stakeholders and champions—engaging with The Clinton Foundation and other players for building momentum for a policy change

SBK: Partner Commitment, Scale-up and Sustainability

1. Private sector partners were willing to commit resources to implementation, with the result that, of all MBPH models, SBK contributed the most to cost-sharing and leveraging. Project data indicate that over \$2.0 million of the total of \$6.1million leveraged by MBPH through March 2012 were attributable to the SBK partners. Saathiya cost leveraging was next highest, at approximately \$1.3million.
2. Private-sector Alliance members had little shared vision. They had little interest in long-term diarrheal disease awareness and prevention. These partners were not owners of the concept and never intended to scale-up or invest in the common platform on their own. From their perspective, SBK was an opportunity for public relations, a sales opportunity, and a window to explore potential new markets at low cost and little risk.
3. Schools liked the MBPH approach and activities, the free samples, and point-of-sale (POS) materials. According to one school principal in an urban slum in Lucknow (Chutki Girls School, Husainabad), the students and their parents were happy with the overall program. She noted the investment of teachers' time and efforts to support messages and felt that some of the interventions could be sustained. For example, the teachers are well oriented to the need for interventions like hand washing and, informally, they were all promoting and reminding children about hand washing before eating *tiffins* regularly, displaying hand washing messages near the wash area and demonstrating the same behavior themselves.
4. The GoI NRHM has taken over the SBK BCC materials (including water quality, hand washing and ORS) and has begun airing SBK Alliance materials on national TV. This started in March 2012 in a national, diarrheal-disease-awareness campaign. This campaign provided an opportunity for alliance members to develop individual product marketing campaigns, coordinated with the national effort as envisaged under this alliance program. What this scale-up lacks, however, is support for the outreach activities that help consolidate awareness and promote access to products.

SBK Model: Conclusions

1. SBK broke new ground in forming an alliance with the commercial sector; more time is needed to show the full potential of how such a partnership can have large-scale impact on changing public behavior towards adopting hygienic practices.
2. Various delays over the program life cycle resulted in loss of time for actual roll-out and activation. However, based on the figures of the SBK Endline Survey, it may be worthwhile to allocate the extra time to see how there can be further impact.
3. The inherent problems of the SBK Alliance were:
 - a. Partner commitments were not clarified and decided at a joint forum with the objective of proving the value of a market-based partnership for diarrhea prevention and management;
 - b. With no natural owner and little commitment to the platform of diarrhea management, private partners were quick to go off on their own. The scale-up subsequently undertaken by NRHM therefore only includes use of MBPH-produced materials, with no coordination with private partners or outreach activities.
4. Under SBK, MBPH began advocacy for zinc to be made into an over-the-counter drug (OTC) and this could, optimistically, soon result in the wider availability of this proven, diarrhea-management nutrient.

SBK Model: Recommendations

1. Transfer the final ownership of SBK (current model) and future SBK-type Alliances—where corporate entities are involved and brought together on a single platform to help deliver a public health outcome—to the GoI, as public sector programs have the heft to sustain such initiatives financially. This transfer to the GoI will likely be limited mostly to the communications component.
2. Involve the CoE in immediate negotiations with Tata Chemicals Ltd. since the NRHM diarrheal disease campaign now using SBK materials offers an opportunity for the Tata Swach mass media on Water Filters, to be aired in tandem with the NRHM media dissemination. The Tata Group has influence with the GoI and a reputation for multiple CSR activities which validates such a strategy.
3. CoE should take on MBPH's partnership-brokering role for SBK for another two years. Child Health is a Millennium Development Goal and a part of the United States government's Global Health Initiative.⁹

⁹ "GHI strategy seeks to achieve significant health improvements and foster sustainable, effective, efficient and country-led programs that deliver essential healthcare... a special focus is on improving the health of children and newborns and delivering clean water...."

PRIVATE COMMERCIAL PARTNERSHIPS

Shakti Model

Overview

The Shakti Model is a pilot that uses a Base-of-Pyramid (BoP) approach to introduce health products in rural areas. This pilot project has successfully introduced oral rehydration salts (ORS) into the Hindustan Unilever’s network of rural entrepreneurs—i.e., the Shakti network—and has established the community acceptance of the Shakti Entrepreneur’s (SE) role as a health advisor. It synthesized core competencies of the commercial partners and developed an innovative, commercially viable distribution system for increasing access to ORS in rural India. A mobile tracking mechanism to track ORS supply in villages has been developed and implemented. The scalability of the model has been proven and the ORS partner is now scaling-up this model to newer districts.

The development hypothesis of the model is based on the fact that dehydration due to diarrhea kills almost 380,000 children under age five in India every year. Most of these deaths can be avoided simply with the correct use of ORS to prevent and manage diarrhea. In rural India, regular access to quality health products, including ORS, is one of the crucial determinants of improved health amongst children. Awareness of ORS is high even in rural areas, but access to the product is low. MBPH interventions were designed to increase ORS availability in rural India.

Shakti model findings are based on a review and analysis of several sources of information. An in-depth MBPH presentation, supported by data from the project management information system (MIS), provided the evaluation team’s baseline. The team supplemented this data with field interviews with the Pharma Synth management, area manager, and medical representative; a stockist (wholesaler) responsible for inventory and order taking from SEs; a SE in her home; and a group of end users.

Shakti Model: Innovations

Innovations included linking of a large-scale, national, commercial-sales network with the producer of a critical child-health product to increase availability of that product at the village level: Pharma Synth medical representatives distributed and sold ORS to HUL’s village level retailers, the “Shakti Entrepreneurs”; demonstrating the commercial profitability of a single seasonal product (ORS) aimed at the rural population; establishing a mobile-phone-based inventory system to account for ORS supplies and to ensure that stocks were delivered to the SEs; and establishing a small medical products producer as the natural owner of a rural-distribution project partnered with a major, national sales and marketing company.

Shakti Model: Findings

MBPH wanted to introduce, in addition to ORS, family-planning products through the Shakti network. It also hoped to use the established distribution system that carries HUL products like soap and shampoo to individual SEs. Initially, senior HUL management was supportive of the initiative, but resistance from middle- and field-level managers resulted in the HUL decision to not associate with family-planning products, nor allow use of its established distribution system for non-HUL products.

This resulted in Pharma Synth using its own medical representatives to carry ORS products to rural SEs. Each medical representative now distributes to about 30 SEs during diarrhea season in addition to their normal, medical-detailing responsibilities. Although HUL had planned to gather SEs for group trainings, this did not continue. Therefore, the medical reps took on the one-on-one SE training. Although this was not as efficient as group training, it did encourage better relationship building with the SE. The reliance on medical representatives to carry this load so far is manageable. The Pharma Synth medical-representative team in Sitapur accepted the new responsibilities and seemed satisfied with the impact on sales.

HUL, with the enthusiastic support of HUL field managers, provided valuable access to micro-level SE retailer information, facilitating identification of high-potential outlets for ORS. This reduced the startup costs for Pharma Synth, the natural owner of this pilot, and offered a low-cost entry to a new market. This was important because retailer relationship building for a product associated with a diarrhea season of only four to five months would otherwise have been a serious barrier to entry. HUL also provided the bulk (over 70%) of the cost sharing provided through this model.

Pharma Synth was interested because about 70% of their sales are generated from peri-urban areas, making the move to more rural areas feasible and a logical next step. Additionally, for a company with over 50 products, a significant share of its revenues (about 12%) is from ORS sales.

The model's natural owner, Pharma Synth was a small company partnering with a major, internationally recognized company. Pharma Synth management clearly was disappointed that the HUL partnership did not result in the inclusion of ORS in the mainstream HUL distribution channel to individual SEs. In this important issue, they felt they had insufficient direct access to their partner, HUL, except through MBPH.

Shakti Model: Key MBPH inputs and Technical Assistance

1. A market assessment by MBPH convinced partners of sufficient sales volume in intervention sites.
2. Management of the Pharma Synth-HUL relationship went through multiple phases starting under PSP-One. Through all the strategy changes MBPH acted as an intermediary for Pharma Synth with HUL. As the model evolved during the design and implementation phases, partners were kept on track to achieve objectives.
3. The use of mobile-phone tracking of SE orders and payments encouraged Pharma Synth to change a long-standing policy prohibiting staff from carrying products. The system eased management fears of product 'dumping' into wholesale markets.

4. Pharma Synth field staff and management were trained on diarrhea prevention, management, and the correct use of ORS. The training design leveraged the Pharma Synth–SE contact during supply of ORS, with one-on-one training of the SE by the medical representative.
5. Development of point-of-sales and promotional materials appeared suitable and effective. One of the key features of this model was the relatively small investment made in demand-generation efforts.

Shakti Model: Partner Commitment Scale-up and Sustainability

The Pharma Synth medical representatives are willing to deliver the ORS to the SEs and to train them on the product features and benefits. The mobile-phone-based inventory and accounting system for ORS has reassured Pharma Synth about the ability of their medical representatives to handle this responsibility properly.

Pharma Synth has realized good results from this marketing effort. Results from the pilot test are positive. Company revenues from sales have grown, from about \$600,000 in 2011 to over \$5.2 million in 2012, largely due to an increase in the number of SEs covered by the program. According to the area sales representative in Sitapur, the level of sales has grown 100% in just that area (30 SEs). Based on his assessment, sales growth will likely continue this year and next at 75% and 50%, respectively, due to unmet demand. Both gross and net operating profits are positive; net profit margin for Pharma Synth in the pilot was measured at 8%.

HUL costs are negligible. By adding a non-competing product to the SE inventory, they may be achieving some additional sales through the positioning of this product with their SEs. SEs also have received some favorable publicity and increased goodwill through this project.

HUL SEs appear satisfied with the program as it has been implemented and also appear motivated by the extra income (5–8%) from sales of ORS. According to project data, SEs' (in the pilot area) average monthly income from the sale of HUL products was 900 INR. Based on a visit to one SE in a village near Sitapur, sales of ORS was brisk (five boxes of 55, per month) during diarrhea season, representing a monthly income of about 270 INR for just one product. Prestige (being seen as not just a retailer but a health provider) may also play a role in the SEs' willingness to participate.

Shakti Model: Conclusions

The Shakti Health@BoP model concept has been tested, successfully, in a pilot involving three districts in Uttar Pradesh. Oral rehydration salts were introduced profitably into the Hindustan Unilever's non-health network of rural entrepreneurs. The Shakti Entrepreneurs' role has been expanded to include health advice and sales of ORS products in rural villages. Village demand for the SEs' advice and ORS has been demonstrated.

Through MBPH, Pharma Synth successfully modified existing sales infrastructure to increase efficiencies and extend distribution to rural areas without negatively affecting its core business in urban and peri-urban areas. Medical representatives have enough flexibility to manage additional duties during diarrhea season and the innovative, mobile-phone, inventory-tracking system encouraged management to permit the medical reps to carry stock.

However, one product is not generating enough revenue for Pharma Synth to invest in major expansion or scale-up. As management notes: “I have an idea that we are not losing money”. This is the only over the counter (OTC) product Pharma Synth has; however they do plan to include water purification tablets and zinc (once it becomes OTC). Therefore, plans for scale up in the short term are modest: currently, Pharma Synth relies on three medical representatives and plans to scale up to nine in the future.

The ability of six new medical representatives to successfully replicate the model in new districts is not clear. Without the concurrent attention and inputs (training, promotion) provided by MBPH during the pilot period, Pharma Synth may not be able match the net margins recorded in the pilot. Thinking about those additional tasks and responsibilities, the area representative in Sitapur suggested that a person be hired to manage the Shakti program expansion in the future, but understood that current revenues would not support such a position.

If one seasonable product can be delivered profitably through the Shakti@BoP model, other companies with a basket of health products (non-HUL competing and non-FP) could also reach rural consumers, perhaps even more profitably.

Shakti Model: Recommendations

1. Pharma Synth ORS should pursue HUL for permission to carry its ORS the last mile to the SEs through HUL’s own distribution system, rather than by Pharma Synth field representatives. Such a positive decision would enhance sustainability of the model. This perhaps is the most important avenue to reach replicability and sustainability.
2. The net profit margins obtained during the pilot test were very encouraging. However, if resources were available, some of the MBPH inputs would be valuable during the proposed scale-up. For example, a continuing-broker role with HUL; perhaps some cost sharing of other inputs such as inventory management; and training and promotion inputs for demand generation. With the documented success of this model, a repository of lessons learned, with the capability to pass it on and adapt it for other interested companies, is needed. The Center of Excellence would be a candidate for this role.

ITC E-Choupal Model

Overview

MBPH partnered with ITC Limited, an Indian public conglomerate company, to introduce RCH products and services through the e-Choupal 'hub and spoke' rural distribution infrastructure. The network has brought markets closer to farmers by using appropriate information technology diffusion and an efficient transaction mechanism. This initiative intended to demonstrate the development of a commercially viable and scalable rural-distribution model that increased access to public health products and services in rural India, as well as to demonstrate the potential of rural BoP markets to commercial sector players. For this, ITC entered into a formal partnership with MBPH for the implementation of the health model. MBPH worked closely with the ITC e-Choupal team to develop partnerships with healthcare-product-manufacturing companies and recruited health workers in the intervention areas. This included the following supply-side partners: Pfizer (oral contraceptive pills), Vision Spring (reading glasses), JK Ansell (condoms), Medentech (Aquatub water purification tablets), Royal Hygiene (sanitary napkins) and Ranbaxy (Revital health supplement). About 66 community health workers called Village Health Champions have been selected and trained on key health issues and the program has been successfully launched in Gonda and Chandauli districts of UP. The VHCs are trained extensively on public health issues like family planning, diarrhea management, menstrual hygiene, water purification, and nutrition. The program conducted communication activities in the intervention districts such as village level events, community meetings, and Mahila Haats (women's market). Targeted at women specifically, these communication activities help raise awareness and generate demand for services, such as family planning and diarrhea management. ITC is fully committed to scaling up the pilot to their entire chaupal network after proof of concept in the pilot phase.

The development hypothesis for the ITC e-Choupal model was to improve health outcomes through increased use of family planning, diarrhea management, water purification, and menstrual hygiene products in conjunction with over the counter medicines and products in rural villages of Uttar Pradesh (UP). The basic premise is that if health and family planning products are available and accessible to village women, and if they are informed about their benefits by village-based sales agents, they will purchase and use them and thus, improve their health status.

ITC established Internet-based information and communication centers (e-Choupals) in rural villages that enabled villagers to obtain agricultural improvement and crop-pricing information and positioned ITC to purchase crops directly from farmers, rather than from rural markets and middlemen. They built on this system to establish rural crop procurement hubs and general stores that provide a range of consumer products and financial services that, through this project, extended the last mile into the rural communities surrounding the e-Choupals to deliver health products directly to rural village women.

ITC e-Choupal model findings are based on the review and analysis of multiple sources of information. An in-depth MBPH presentation, supported by data from the project MIS, provided the evaluation team's baseline. The team supplemented this data with field interviews with ITC and Pfizer management as well as five Village Health Champions in Chandauli. There, field activities were observed including a Mohila Haat and Community Meeting. A group of end users were also interviewed.

ITC E-Choupal Model: Innovations

ITC e-Choupal innovations included: linking of rural, BoP health-products delivery to an effective village agricultural information and products procurement network; creating a new retailer class through the recruitment, training, and support of a cadre of village entrepreneurs, “village health champions” (VHCs), who are supervised from the ITC procurement hubs, inform village women about health and family planning, and sell products, through village-level women’s meetings and door-to-door; and offering a basket of health products package so that product sales could support the rural health workers and also include the availability and sale of FP products.

ITC E-Choupal Model: Findings

Villages surrounding the e-Choupals are rural and undeveloped, with dirt paths and no evidence of stores in the immediate area of the residences. Community meetings were held closer to the e-Choupal and village women came in from their residence to meet with the VHC. The VHCs sold health products at the community meetings and also went out to visit women who attended the meetings and brought products for sale to their homes. The local Mahila Haat (women’s bazaar) was overcrowded, hot, and noisy and may not be a good venue for introducing people and products. On the other hand, community meetings by the VHC were well conducted and informative and the attendees listened and participated. The VHC meetings had the added benefit of offering products for sale—this was not just an information exchange.

VHCs were knowledgeable about the products and happy to be working and earning some money. They were not earning much yet (600–800 INR during the previous month), but had high hopes of earning more; even the little they earned was helpful to them and to their families. They said they had initially been reluctant to go door to door, but now liked the opportunity to interact with other women and to be seen as a useful member of the village. They seemed to have been well trained and well supervised. Accredited Social Health Activists (ASHAs) were initially suspicious of their work and regarded them as competition, but VHCs reached out to them and provided them with leads on possible candidates for permanent FP methods and invited them to participate in some of the training and now there is a good relationship. The highest selling product is sanitary napkins, followed by the vitamin supplement (Revital). The VHCs also sell some OCPs and a few condoms. The women reported that they were willing to pay 63 INR per packet of OCPs and appreciated the VHC delivering OCPs to their house. There was some use of OCPs for dysmenorrhea and menorrhagia.

To date, data on use of family planning products (OCPs, condoms) from project baseline to endline surveys show no statistically significant change attributable to project interventions. In Gonda, current OCP use fell 2.8% to 2.0%; in Chandauli, use declined from 1.2% to 0.6%. For condoms, Gonda current use fell from 4.8% to 3.7% and in Chandauli, current use grew from 1.1% to 2.1%. It is still very early and demand generation efforts could not begin until MoUs were signed with private partners. This only happened in late 2011 for Ansell, the condom supplier.

The OCP provider, Pfizer, said that the work to date in the two initial hubs had provided enough data to establish proof of concept and they were anticipating an expansion of the project to an additional nine hubs. This conclusion may not be inconsistent with project use data because those figures include use from all sources, including the public sector. In any case, Pfizer presented their initial assessment to their board and

received corporate buy-in to the program. Pfizer also is developing an ORS product specifically for this rural, hard-to-reach market. They take a long term view of the project and have a vision of reaching 100,000 villages (there are a little over 300 in the two current hubs).

ITC E-Choupal Model: Issues

The process of negotiation, concept design, formative research, vetting MOUs and startup took time. The participation of five private partners added to the complexity. ITC signed their MOU with the project only at the end of project year one, while Ansell signed theirs in late 2011.

Access fees have been an issue. ITC has been insisting on the fees because they only want serious players who are willing to invest in demand generation. Pharma Synth said that they could not afford the fees that ITC charged for access to the system. However, Pfizer said this was not a problem. ITC noted that access fees for producers depended on the product category and characteristics, that benchmarks are available on the Internet for most products, and that they used a common standard for all products carried in the Sagar. However, in the prototype development phase of the health initiative, they have waived the fee for some products.

ITC made unilateral changes to the model after signing MOUs, changing from a stockist to a consignee model, which required some discussion with the partners, facilitated by MBPH.

Currently, VHCs must travel to the Sagar to pick up product. In the original plan, ITC had assumed the responsibility for delivering products from the Sagar to the village (essentially to the VHC doorstep). The VHCs make trips to the Sagar for other purposes and travel is not a problem at this stage of the program; however, as the program expands, this issue may need to be revisited.

Mohilla Haats have not worked as planned. The Haats are large-scale, village-level events designed to provide information on health issues, introduce the products, and provide the VHCs a platform to establish themselves as credible health workers. However, they are often conducted by the Sanchalak (a man) and other village authorities, do not offer products for sale and may sideline the VHCs, and may not serve a good vehicle for communication. The program has decided to shift its attention to the more productive community meetings conducted by the VHC.

The ITC model does not have a mechanism to proactively vet entry of products (or services) from a public health perspective or VHC counseling quality assurance. One example of this is that OCPs are being given to young, unmarried girls for dysfunctional uterine bleeding, a condition that could be caused by an underlying bleeding disorder or by an infection, such as Chlamydia.

ITC E-Choupal Model: MBPH Inputs and Technical Assistance

1. MBPH provided market studies, identified and developed potential partners, helped organize the partnerships, and provided initial communication and training, which resulted in VHCs who know the products well and are effective in community meetings. MBPH acted as an honest broker between partners.
2. MBPH helped organize joint planning and monitoring and facilitated communication among the partners to resolve issues, such as changes made in the MOUs.
3. ITC said: “We could not have put this together without MBPH. We had been trying for several years to add a rural health model, but Abt enabled us to do it.” MBPH introduced them to all the partners with whom they now work, but following the introduction, ITC performed its own due diligence.

ITC E-Choupal Model: Partner Commitments, Scale-up and Sustainability

1. ITC is willing to own and support the health initiative. It has made a corporate strategic commitment to health as part of its rural-positioning strategy. Their establishment of the e-Choupal as a “village gathering place” to exchange agricultural information (and position ITC to procure produce) is linked to their need to provide a range of community-based services. ITC noted that this broader approach has been part of their corporate strategy for the past 10 years, and that they have made several previous attempts to include health (e-medicine) and education services (vocational training) before being introduced to Abt.
2. Currently, revenues do not match costs for the partners. MBPH five-year cost recovery projections based on the current model (no new products or services) conclude that a positive return is only feasible for the vitamin supplement, Revital, and that only in year three. However, ongoing negotiations among the partners indicate that the expansion to 11 hubs, adjustments in fee structure, and the addition of new products and services should assist the achievement of break-even for all within four years.
3. Partners are willing and able to scale-up to be sustainable. Partners are willing to proceed without a positive return as they feel the project has established Phase I, “Proof of Concept” (what ITC calls “prototype development”), incubation costs and revenues are measurable, and they have a trusted working relationship with ITC. However, it seems that additional products and services will be required to provide sufficient income for a positive return on investment for ITC and the partners.
4. New Products (ORS): Pfizer is developing an inexpensive ORS product for this market. They will require at least 50,000 units per month to justify a new production line and this will be at least partially ensured by ITC expansion to 11 hubs in the pilot phase of the project. Perhaps related to minimal production requirements, Pfizer noted a preference for expanding straight to 68 hubs during a pilot phase. Such a large pilot could also make results more reliable, since partner inputs and efforts would be diffused; the idea being that the intensity of inputs invested in a small effort often cannot be replicated, leading to unexpected difficulties when scaled up.
5. Services: ITC is exploring the possibility of providing health services at the Choupal Sagars. They have space available at the Sagars for a small clinic and are looking for partners who could provide diagnostic and primary health care services.
6. Cost sharing from ITC and partners is on target. To date, over \$835k has been leveraged.

ITC E-Choupal Model: Conclusions

The prototype phase allowed time for partners to build a trusted relationship, confirm costs, and make cost and revenue projections. Although revenues have not met expectations, partners are committed to moving to the next phase. Pfizer has corporate buy-in to the project and has committed to expand OCPs and add ORS.

ITC is committed to scaling up the program, from two hubs currently to 11 in the next phase of work. At present, they have 68 hubs with agricultural procurement, warehousing, and financial services and expect the health project to eventually cover all of these. Their format for developing a project has three phases: prototype; pilot phase; and scale-up. The current project has just finished its prototype phase and will now move into the pilot phase with expansion to 11 hubs in three states. The first two phases are covered by grants, with ITC costs funded internally. After the pilot phase, a business plan will be prepared and presented to the company for expansion to cover 68 hubs. They will require a 30% gross margin for this type of project.

Products with the highest public health effectiveness (such as condoms and OCPs in the present basket) are associated with the lowest revenues, and require the highest level of effort from the VHC to market/sell. The model therefore needs to evolve a mechanism by which profitability of the basket is balanced against the effectiveness of the products it contains.

ITC E-Choupal Model: Recommendations

1. ITC should expand the program from the current two hubs to a total of 11 as it moves from prototype development to the pilot phase. They are aware that, while they will require USAID assistance through the pilot phase in 11 hubs, they will need to establish their own ongoing technical assistance mechanism. Projected costs per unit: 300,000 INR for training of VHCs and communication activities and another 300,000 INR for CHC-related costs. Total: 600,000 INR or US\$12,000 per annum for each activated hub.
2. Follow-on projects should coordinate discussions to bring the private partners together to share experiences and develop common approaches.
3. Referral linkages should be established for potential health complications resulting from product use and a mechanism for ongoing, proactive vetting of content from product partners.
4. The basket of products should be expanded and ITC also should add services.
5. Mohilla Haats should be reduced and replaced with community meetings to increase sales opportunities.
6. The VHCs should be encouraged to use community meetings to recruit satisfied customers to further extend the sale of product.

Advanced Cook Stoves (ACS) Model

ACS Model: Overview

Open fires or *chulhas* without a chimney, used inside poorly ventilated houses, are a major contributor to indoor air pollution (IAP) and related health problems, such as upper respiratory infections. It has been estimated that in India, IAP contributes to 3–5% of the national burden of disease. Considering the impacts of IAP on maternal and child health, in June 2010, the Advanced Cookstoves (ACS) initiative was started in partnership with key stakeholders, including the government of India, Indian Institute of Technology (IIT, Delhi), ACS manufacturers, MFIs and rural distribution networks, working towards a common vision of increasing adoption of and access to ACS among key target groups. The ACS pilot was implemented in two districts of the state of UP and one district of Uttarakhand. The program aimed to develop and demonstrate approaches that contribute to the GOI's Ministry of New and Renewable Energy National Biomass Cook Stove Initiative. The project undertook a landscaping exercise to assess the potential for commercialization of ACS technologies in India, profiling the various manufacturers and marketers engaged in this category. Envirofit and Philips signed partnership MOUs. The project also worked with a distribution partner, Project Dharma, and appointed village-level entrepreneurs (VLEs) and a stockist in each district. Activities for promoting demand for the product and building a market include the identification of model consumers, community meetings, and product demonstrations to create awareness of the product and identify potential buyers.

ACS model findings are based on the review and analysis of multiple sources of information. An in-depth MBPH presentation, supported by data from the project MIS, provided the evaluation team's baseline. The team supplemented this data with field interviews with Envirofit, Dharma, Sonata, Applied Technology India (and their distribution and financier divisions), Indian Institute of Technology, VLEs, and users at a micro-finance group/VLE stove demonstration. Health Leadership Council member Pradeep Kashyap also provided valuable insights for ACS.

ACS Model: Discussion

Advanced Cook Stoves (ACS) is a model for successful rural sales of a consumer-durable product with a positive health impact. MBPH developed this innovative partnership between a product manufacturer, a distributor, and a financier, which was critical to enabling sales of the product.

The development of ACS is based on the premise that exposure to smoke from traditional cook stoves and open fires is the fifth-worst health risk factor in poor countries and leads to nearly two million premature deaths, mostly women and young children, each year (more than twice the mortality from malaria). In India, traditional wood-and coal-burning stoves are a leading cause of death for women and children, killing nearly 500,000 people a year. Cook stoves account for about 3.5 percent of India's national burden of disease and represent about half of its black carbon inventory. Use of Advanced Cook Stoves reduces harmful air pollution exposure by up to 50%.

ACS Model: Innovations

Innovations included matching of a micro-finance institution, which could provide the credit necessary to purchase the product, with a product distributor to improve project reach and product affordability; the establishment of the distributor's representatives as local, village-level entrepreneurs trained and incentivized to sell the product; and the integration of community-level, distributor sales meetings with microfinance group meetings at the village level (an important innovation).

ACS Model: Findings

Dharma/Sonata in Uttar Pradesh: The original model called for two stove manufacturers (Phillips and Envirofit), a financier (Pahel), and Dharma, the distributor (Pahel also had a distributor). However, Phillips' top-loading stoves ran into some consumer resistance and coincidentally, the company decided to shift operations from India. Pahel's operational and structural capabilities were not adequate for the original model; low market capitalization made it difficult to invest in the purchase and stocking products and its small size was deemed too small to benefit from economies of scale. Sonata was then tapped as financier, based on its presence in 24 districts in UP.

This led to the establishment of Dharma as the product distributor and single owner of the project. This enabled a partnership between the distributor and the financier to overcome a price barrier to consumer acceptance of this new technology.

Dharma, a syndicated distributor, brought to the project a basket of products (including solar lamps and sewing machines, in addition to Advanced Cook Stoves), which served to make the partnership more profitable. This also served to increase their commitment to the project and to expand it to cover other products, building on the successful introduction of the cook stoves.

Sonata appreciated the relationship with Dharma and considers MBPH a key factor in making the partnership effective. They regarded the partnership as an opportunity to scale up their work and link loans to the purchase of durable products. This was also the first time Sonata had offered loans at zero interest rate (through the Dharma buy-down). Sonata includes Dharma VLEs at their weekly MFI group meetings, where product information, along with a purchase opportunity, is provided.

Dharma was happy to have access to the Sonata loan facilities, as this enabled them to sell their products in a new, difficult-to-reach, and price-sensitive market. This was the first time they had worked with a micro-finance company and they expected the benefit to spread to a number of products.

Dharma is concerned about increase in price of the Envirofit Tekno-Stove. They are willing to continue with sales of the Envirofit Tekno-Stove at the current price of 1,600 INR but have been informed that the price will now increase to 1,900 INR, which they feel is not acceptable. They would like to look for another ACS manufacturer for this market if this issue cannot be resolved.

Dharma increased VLE incentives to ensure commitment to selling cook stoves in remote areas. Although they consider the added incentives along with their fixed costs for recruitment and training of village level

entrepreneurs, somewhat high, they feel that they are manageable. Dharma, at the time of the report, was seeking new VLEs.

Envirofit India, a subsidiary of Envirofit International, a U.S. nonprofit based in Fort Collins, Colorado, comes from the Colorado State University's (CSU) social entrepreneurship program. The Envirofit Techno-Stove prototype (the stove sold through the ACS project) was designed in India by CSU engineering students and sent to China, where CSU had a plant, to manufacture the stove for the Indian market. Envirofit planned to set up a manufacturing unit in Maharashtra to lower costs and, ultimately, the stove price. They were selling approximately 10,000 stoves per month at the time of this report, and anticipated increasing sales after establishing the manufacturing facility. Most of Envirofit's sales at present are institutional sales to donors and state governments. Private commercial sales are a small part of their business, and they have not paid much attention to this aspect.

Appropriate Technologies India in Uttarakhand: After establishing the Dharma, Sonata, and Envirofit partnership in UP, a new opportunity arose in Uttarakhand with Appropriate Technologies India (ATI). Using the same innovative combination of a distributor, financier, and producer, MBPH approached ATI for talks about marketing the Envirofit Tekno Stove, in May 2011. The idea was attractive to ATI, since the selling points of less fuel and smoke had both biodiversity conservation and health outcomes. ATI was attractive to the project because it was the holding company for both a distributor (Dev Bhumi) and a financier (Ushamath Mahila Mahasangh).

Dev Bhumi buys the stoves directly from Envirofit for cash in advance. As in the case with Dharma, it connects with local micro-finance groups. The geographical area for sales includes 50 villages in two districts. Activation and awareness generation started in September 2011. Based on MBPH records, actual sales started from January 2012 with 316 stoves sold to date. Dharma, since start up, had sold 399.

ATI's appraisal of the Envirofit Tekno Stove indicated that it is priced too high; is too light and thus not suitable for heavy utensils; and not suitable for making *chapatis* (thus the traditional stove is still used). ATI also noted competition from:

- Government stoves on offer for INR 300 to 400.
- Free stoves being distributed under a World Bank-funded "Government of India Watershed Development Program," which has distributed free cook stoves to approximately 50–60 households.
- Other Forest Department and conservation programs, the International Fund for Agricultural Development (IFAD) and NGOs—all working with the objective of reducing pressure on the forests for firewood collection as well as concurrent enterprise development and income generation.
- The availability of the Greenways Stove at 1,250 INR will offer stiff competition

The major costs for ATI include purchase of the stove, transportation, demonstration, marketing and demand-creation activities, and administrative support. Total outlay is about 3,000–4,000 INR per marketing and activation event per area, and does not include the cost of transporting the stoves to those willing to purchase.

The availability of finance through the self-help groups make the women extremely empowered and capable of making decisions like buying a stove for 1,600 INR without referring to the husbands or heads of household. They also have respect and status as earning household members themselves.

ATI feels the need of a go-between such as MBPH for another two to three years more, as maintaining contact with and negotiating with the cook stove manufacturers takes much time and effort. ATI also claims financial support is needed as the cost of selling each cook stove is not covered through the margins available. Based on figures supplied by AT, each stove sold a net profit of 250 INR. This implies that sales of 12–16 stoves would be required at each group meeting to reach break-even.

Other General Expressions of Interest in the ACS Model

- Srei Sahaj approached MBPH to include ACS into its distribution set-up. Srei Sahaj operates and manages 24,000 Common Service Centers (CSC) across six states in India, with each CSC managed by a VLE who caters to a catchment of five to six villages.
- Greenways, an ACS manufacturer, approached MBPH for possible technical assistance in testing and improving on product design and product appeal; accessing capital from social investment firms; and developing business plans to ensure predictable sales and order cycles.
- Cashpore, a microfinance institution operating in Eastern UP, approached MBPH to explore the possibility of providing ACS loans.

ACS Model: MBPH Inputs and Technical Assistance

1. MBPH management of the partnership process was the key to this project. They analyzed the industry and developed the model for the market-based partnership, identified and vetted prospective partners, and then brought prospective partners together to establish the relationships. They carefully followed project progress and financials and acted quickly to identify and resolve issues as they developed.
2. MBPH realized at an early stage that a traditional manufacturer-stockist/wholesaler-retailer market chain would not work in this rural environment. It designed a consumer-financing model that enabled the Sonata MFI clients to purchase the Advanced Cook Stoves through installment payments financed by the product distributor and delivered through a joint sales approach. This entailed financial participation by Dharma in establishing a zero-interest-loan product for the Sonata client, with interest and processing fees borne by Dharma.
3. MBPH monitored and reviewed project financial performance and negotiated a solution with Envirofit to lower Dharma's costs. They recognized after a few months that while Envirofit was profitable, Sonata was breaking even and Dharma was losing money. They then brought the partners together and renegotiated their financial relationship so that Envirofit would absorb primary distribution costs, set up a warehousing facility for the UP market, and budget for marketing and promotional activities in UP; Dharma would provide minimum sales guarantees to Envirofit and ensure VLE and associated infrastructure (recruitment, training, monitoring) across districts. At the same time, Sonata committed to an expansion of the ACS loan product across all 24 districts in UP and to mainstream the product in the Sonata portfolio.

4. The project played a key role in streamlining VLE recruitment and management in Dharma. MBPH shared a profile of an ideal VLE (from Shakti and ITC experiences); assisted in monitoring VLE performance; and developed an optimum compensation structure for VLE.
5. MBPH also developed communication and marketing tools and managed training of the VLEs. The project developed a comprehensive marketing campaign with van publicity, posters and POS materials, marketing activities around cooking and stoves for ACS, along with flipbooks and POS materials for the VLE for use at product demonstrations. Promotional efforts conducted by VLEs during the Sonata group meetings had a positive impact among target consumers. A key indicator, consumer positive disposition to ACS, increased from 38.8% at baseline to 64.4% at endline. Positively disposed consumers are those who consider ACS to be, “Overall, a good cooking device.”
6. MBPH also has played a key role in representation with MNRE on policy issues and mapping a course to use carbon credits. An MBPH-sponsored national conference on carbon credits galvanized the MNRE to set up a Program of Action under the Kyoto Protocol. The project also helped consolidate a set of standards and a stove rating system proposed for ACS in the Indian market; this has helped identify the few indigenous cookstoves by small entrepreneurs that are doing well on standards. These enterprises can be supported in marketing and promotion. Finally, MBPH completed a study on the implication of taxes in the ACS industry.

ACS Model: Partner Commitment, Scale-up and Sustainability

1. Sonata is committed to taking this initiative to all their districts in UP and also exploring the possibility of a pilot in Madhya Pradesh. Dharma is willing to expand its operations across all 24 Sonata districts in UP.
2. The ATI group in Uttarakhand is interested in scaling up operations from 50 villages to all of the 200 villages in its area. Future sustainability is clouded by strong competition from public-sector distribution of subsidized stoves. Also, costs currently exceed revenues and ATI is expecting ongoing support for training and demand generation in the next two to three years.
3. MBPH now calculates that Dharma, Envirofit, and Sonata partners have current positive net revenues. These reach about 150–200 INR on each stove sold for Dharma and Envirofit. Sonata is expected to maintain its current, modest return of less than 100 INR for each stove sold during scale-up.
4. Dharma plans to increase its basket of products marketed through the Sonata partnership to add small items like fortified drink sachets, fortified biscuits, and sanitary napkins.
5. Dharma would like to increase the number of VLEs working with the Sonata MFI teams. Plans also include maintaining sales records on cell phones and establishing Internet kiosks for product display and information dissemination. They note the need for more, and better, demand generation.

ACS Model: Conclusions

1. Dharma, Sonata, and Envirofit have demonstrated proof of concept and profitability. The project has confirmed cost assumptions and a reasonable projection of sales and revenue that enable it to project a substantial (27%) return on investment (ROI) after seven years, with two years of additional donor investment. However, this ROI is dependent on the realization of carbon credits or an MNRE ACS subsidy.
2. The distributor (Dharma) will enhance its profitability with additional products sold through the MFI partnership; current projections already allocate most of the basic infrastructure costs to the one product—cook stoves.
3. The MFI (Sonata) finds value in additional product-based loans to poorer rural clients made through the association with Dharma.
4. Price increases from the manufacturer may require identifying another ACS product (the current ACS is imported and other, local products are available, including Greenways, which is less expensive, culturally appropriate, and IIT certified). However, the Envirofit transition to local manufacturing may reduce production costs and enable the project to renegotiate prices.
5. Other microfinance and self-help groups—including ATI, which includes Ushamath Mahila Mahasangh, self-help groups for women and microfinance, in Uttarakhand—are aware of the Dharma-Sonata project and have indicated interest in developing similar projects.
6. Future availability of carbon credits and/or MNRE subsidies is important for the long-term financial viability of the project. The return on investment for this project is critically affected by the availability of carbon credits or MNRE subsidies to lower costs and improve profitability.

ACS Model: Recommendations

1. Resolve stove-cost issue through negotiation with Envirofit, including prospective cost reductions through local manufacturing. If this issue cannot be resolved, additional ACS manufacturers should be considered. Several ACSs have been introduced into the market in the past several years that are culturally appropriate and meet IIT certification requirements. Open competition would improve the prices and choices available.
2. Sonata should expand its partnership with Dharma through sales of cook stoves in a steadily increasing number of Sonata MFI branches and provision of installment purchase financing for other products.
3. Dharma should expand its line of products and its VLEs in coordination with Sonata.
4. Future support for other distributor-financier models, such as Applied Technology in Jharkhand, should be considered.
5. Care must be taken to focus efforts at the low-income population in the targeted areas. There might be a tendency to direct more attention towards more advantaged groups.
6. Marketing efforts need to be more locally oriented and developed based on believable people and locations, including satisfied users and demonstrations.
7. Policy advocacy with MNRE and others with regard to carbon credits should be continued and increased to ensure the long-term profitability of the project.

PUBLIC PRIVATE PARTNERSHIPS

TB Model

Overview

The TB initiative under MBPH proposed to improve TB health indicators for BoP populations through the gainful engagement of private healthcare providers practicing the directly observed treatment, short-course (DOTS) strategy. The vision was that private healthcare providers are empowered and motivated to practice evidence-based TB management that would ensure the best outcomes for their patients and contribute to TB control in India. This initiative addressed implementation gaps in the RNTCP, assisting the national program in reducing diagnostic and treatment delays and moving toward universal case detection. The project has conducted workshops and meetings for consultation with representatives of various Public-Private Mix/DOTS projects, technical experts, government officials, donors, and other organizations. The program increased community demand for DOTS and strengthened private sector providers through capacity building for delivery of high quality, standardized TB-control services, and improved access through a professional interface mechanism.

Through the research agency, MBPH conducted two baseline studies on understanding care-seeking behavior of pulmonary TB suspects in urban slums and the TB-management behavior of private providers. The TB MIS software was developed to track TB referrals from private providers. TB capacity-building packages were developed in collaboration with St. John's Research Institute for different levels of providers, including both allopathic providers and those in the Integrated System of Medical Practitioners (ISMPs). In UP and Karnataka, the program works closely with the state TB officer and the district TB officers and has (1) completed mapping of intervention towns, slums and healthcare providers; (2) initiated capacity building of allopath and non-allopath providers; and (3) undertaken behavior change communication and demand-creation activities.

TB Model: Discussion

The public-private partnerships model for tuberculosis (TB) control and care seeks to improve TB health indicators for target populations by increasing the involvement of private providers practicing DOTS. The development premise is that if private doctors follow established standards for TB care and patients are encouraged to seek out these providers, outcomes will improve and contribute to TB control.

Tuberculosis kills more people than any other single infectious agent in the world, with about two million lives lost and nine million new TB cases each year. India accounts for one out of every four cases of TB worldwide, with an annual incidence of about two million cases.

TB model findings are based on the review and analysis of multiple sources of information. An in-depth MBPH presentation, supported by data from the project MIS, provided the evaluation team's baseline. The team supplemented this data with field interviews in Karnataka with Population Services International (PSI),

Karnataka Health Promotion Trust (KHPT), private providers, state and district TB officers, TB patients at Prerana meeting, a private laboratory, and St. John's Institute.

TB Model: Innovations

Innovations included an “interface” agency (NGO) to build the capacity of private providers and improve access to these providers for people in urban slums, in support of the national TB control program; an “interface” between persons with symptoms and private providers and between private providers and the local unit of RNTCP, through an NGO that acts as a facilitator/trainer; community-based support for TB patients through “*Prerana*” (a local term for inspiration) meetings; transporting sputum samples from collection points to designated microscopy centers (DMCs); and developing and testing a web-based MIS for TB.

TB Model: Findings

The model aimed to motivate private providers to practice evidence-based management of TB. The premise was that persons with symptoms of TB seek care from multiple providers before being diagnosed and started on treatment; that private providers, who are the first point of contact for a significant proportion of TB patients, do not follow established standards of TB care; and that ensuring the participation of private providers is critical to achieving universal access, a key objective of the RNTCP. The model sought to promote the RNTCP “brand” and worked in close consultation with the state and district TB units. Implementation of the model was delayed, as it took the Central TB Division (CTD) nearly a year to review the model's framework and work plan and clear its implementation. Following this, CTD directed that the project revisit its geographic locations, leading to further delay.

CTD turned down the project's request to direct state TB units to provide access to TB registers at district and sub-district levels. Project teams in both states made efforts in their respective areas to access data in these registers, both for carrying out formative research as well as for implementing planned activities. While the team in Karnataka was successful in gaining access, the UP team faced progressively increasing resistance. Several activities related to demand generation were completed in UP when the project decided to withdraw the intervention from the state. PSI India implemented the model in Karnataka in partnership with KHPT, targeting urban slum populations in 13 districts across the state and reaching a total population of 790,000.

Key messages focused on changing provider behavior to suspect TB in all patients with suggestive symptoms, and subscribing to DOTS therapies. They also targeted consumer behavior for prompt and appropriate care-seeking. While the model was carefully designed and implemented, its effectiveness was offset by issues that are beyond its scope, given its limited duration and geographic scale:

- Allopaths refer to DMCs only those symptomatics whom they assess as poor, while treating non-poor themselves, using a variety of drug combinations and dosages that do not necessarily align with the evidence-based regimens that RNTCP recommends. This often leads to incorrect or incomplete treatment, resulting in issues like multiple drug resistance. They also require a range of costly blood tests and X-rays from poorer patients, prior to referring them to DMCs for sputum testing. Some physicians give a course of antibiotics to TB-symptomatic patients and refer them for sputum testing only if symptoms persist, thereby delaying appropriate care.
- TB symptomatics form less than 1% of provider clients, a negligible income source, so there is little financial incentive for referring symptomatic patients for sputum testing. The apparent disincentive for referring all symptomatic patients to public facilities for appropriate care is the loss of income from additional lab tests and repeat consultations.
- Patients in the intervention areas had “shopped” for treatment from at least four facilities, both public and private, before being referred to a DMC for sputum testing. They also had to do a battery of costly tests at each facility. One patient had suggested in vain to the private provider who attended her to test her for TB. This delay in obtaining appropriate care ranged from a few weeks to several months.

During initial months, the interface agency field staff referred symptomatic persons directly to the DMC and later to the private providers who had been sensitized. This rather circuitous route is likely to be modified by communities as they get along without the project’s input in future.

The sputum pickup and transportation pilot currently underway is a revival of an existing dormant agreement between the state TB unit and a local courier agency that involved sputum collection and transport from the private provider’s facility and returning of results to the provider. The evaluation team found that patients valued time saved by the process, while the providers were happy to have retained their clients and not “lost” them to other providers or to the public system. However, there is the risk of moving patients away from recommended treatment regimens as trips to the DMC get eliminated. Findings from this project and from others in the country show that private providers use their own “tailored” regimes which may or may not be aligned with standard ones. If there is no concomitant improvement in private providers prescribing standard regimens, the improved efficiency that the sputum collection mechanism brings may not lead to better treatment outcomes.

TB Model: MBPH Inputs and Technical Assistance

Interface agencies PSI and KHPT (NGOs) value the research input of MBPH in shaping key messages and training material. KHPT introduced MBPH to St. John’s Research Institute (SJRI), and MBPH actively advised the SJRI expert panel on staying within RNTCP norms during training design. MBPH also closely supported the development of the MIS through numerous iterations and test runs.

MBPH employed a competitive bidding process to select implementing “interface” agencies (NGOs), enabling the evolution and costing of a localized model to aid further replication. The selection process used to identify participating private providers applied standardized criteria to lists of practitioners of Western medicine (“allopaths”), practitioners of Indian Systems of Medicine (ISMPs), retail chemist stores and less-than-fully-qualified providers. Private providers were appreciative of the project’s training input. Allopaths

considered this input as a refresher and ISMPs and less-than-fully-qualified providers valued the attention and recognition they received.

Besides training, a key input was ongoing support through detailing visits that serve as reminders and refreshers. There was a 73% increase in the number of persons with new smear positive TB referred to DMCs from all MBPH target locations in Karnataka between May 2011 and February 2012, compared to the same ten-month period a year earlier. The TB units (TUs),¹⁰ of which the target locations are partially registered, noted a 3% increase in the same number between the same two time periods.

MBPH helped link the *Prerana* meetings with the district TB team, drawing from support group meetings carried out by HIV programs. This partnership was a win-win situation, as the district team looked to improve adherence and retrieve defaulters, and the state's default rate is 8% (against the RNTCP standard of 4% or less). *Prerana* meetings often take place in the DMC premises, with the district TB officer participating. A range of TB-related issues are discussed and ex-patients offer practical advice for those undergoing treatment. Participants are taking over facilitation of these meetings.

TB Model: Partner Commitment, Scale-up and Sustainability

District and state units of RNTCP value the project's input and they consider it to be of high quality, though they would have preferred a longer implementation period and an internal evaluation of the intervention. They appreciate the use of local dialects (rather than the state's official language) in communication activities. They recognize the need for a third party to coordinate and nurture relationships between the program and private providers, because of the two systems' different philosophies and the lack of precedent in working together for TB control. "We learned the true meaning of 'interface' from the MBPH project," says Dr. Sangeeta, a member of the WHO TB technical team in the state. The state TB unit is concerned about unscientific regimens that private providers use for treating TB, and is mulling over the use of existing legislation against this practice. All of these point to a lack of shared vision between private providers and the national program.

The state unit of NRHM recently approved funding of activities for multi-drug resistant TB. This makes the state TB unit hopeful of funding from the NRHM pool for a package of interventions similar to the MBPH model. However, the state and district TB teams find it unlikely that staff of the district TB team will take over aspects of ongoing support to private providers.

In its third phase, RNTCP aimed to achieve universal access to TB care by extending its services, among others, to patients diagnosed and treated in the private sector. RNTCP also sought an extension (up to 2016) and increase in current financing from the World Bank, to focus on several new challenges, including public-private partnerships and contracting out of services, including the necessary accreditation, contract management, and quality control systems; and performance-based financing and incentives systems. This model could well be the way forward to meet these new challenges as identified by RNTCP.

¹⁰ A TU typically consists of five DMCs

TB Model: Conclusions

MBPH developed a robust, integrated model for engaging private providers for TB control and care, *and* for mobilizing communities towards facilitating prompt and appropriate care for symptoms and for adherence to treatment. Its effectiveness in increasing case detection has been demonstrated. The project also developed high quality training and communication materials, while retaining the umbrella brand of RNTCP. An interface agency is integral to the model and is considered by all stakeholders as critical for the continued engagement of private providers. Sputum pick-up and transport saves time and travel for patients, but if there is no concomitant improvement in private providers prescribing standard regimens, the improved efficiency that the sputum collection mechanism brings may not lead to better treatment outcomes. While the MIS is a well-designed software tool, little is known of its effect on the entire model or if it will compromise or enhance its acceptability.

While most of these components are already part of RNTCP's financial (grants-in-aid) schemes, the MBPH model effectively combines them into a single, costed package, delivered through an interface agency at reasonable scale, at state levels or across several contiguous districts. With very little commercial incentive and possible disincentives for private providers to connect with RNTCP, it is essential that an agency continue to engage these providers. This project could be a way to make evidence-based TB management the norm and provide a template for contracting such interface agencies.

TB Model: Recommendations

In its third phase, RNTCP aims to achieve universal access to TB care by extending its services, among others, to patients diagnosed and treated in the private sector. It has sought an extension (up to 2016) and an increase in current financing from the World Bank. This will focus on new challenges, including public-private partnerships and contracting out of services, including accreditation, contract management and quality control systems, and performance-based financing and incentives systems.¹¹ Thus, the time is probably right for advocating that RNTCP consider this model for nationwide replication through a contracting mechanism—this alone could be challenging. There are several initiatives across the country for involving communities and private providers in TB control and care who could join forces for a concerted advocacy effort.

¹¹ TB India 2011: Annual Status Report. Central TB Division, Directorate General of Health Services, MoHFW, Govt of India, p 18. March 2011

Health Leadership Council and Center Of Excellence

Overview

A key mandate of MBPH is to institutionalize capacity for fostering and maintaining commercial partnerships for health through the establishment of a Health Leadership Council (HLC) and Center of Excellence (CoE). The HLC, an advisory body consisting of eight to ten experts from various fields, advises the program team, and later the CoE, on various strategies for MBPH. The CoE will institutionalize capacity for designing, implementing and monitoring BoP market-based health programs both within and beyond the life of the MBPH project.

The HLC/CoE model findings are based on the review and analysis of multiple sources of information. An in-depth MBPH presentation, supported by data from the project MIS, provided the evaluation team's baseline. The team supplemented this data with field interviews with HLC members and CoE staff. Merck management provided insights into CoE interactions on the introduction of a mid-priced oral contraceptive. Anand Sinha (Gates Foundation and ex-MBPH Chief of Party) and Monitor Group provided a valuable historical perspective.

HLC AND CoE: Discussion

Lack of time was a factor limiting the effectiveness of the Health Leadership Council (HLC) and, to a much more significant degree, the effectiveness of the Center of Excellence (COE).

The HLC experienced some delay in getting off the ground, in part due to project and USAID due diligence. Not surprisingly, some HLC members were more active than others, but given the limited time, little could be done to address this issue.

However, to date the HLC has formally met three times; used personal networks/experience to move individual model development forward (e.g., introduction of Sonata to Dharma); and provided timely advice to CoE strategic planning process. The pro bono expertise offered by members was appreciated and valued by MBPH staff, and the experience appeared interesting and stimulating for at least some HLC members.

A future advisory role of HLC with CoE appears welcomed by both current members and the CoE. HLC has already played a supportive role to CoE during the development of the business plan. Some confusion over roles and responsibilities at the CoE Board level has been noted but, optimistically, this issue should be manageable.

CoE has had even less time in which to establish itself and begin functioning effectively. The comprehensive selection process resulted in an award to Swasti in February 2011. The rationale for actual work with MBPH (visiting model partners; field activities) did not start until late June 2011. The original contract expired in April 2012 and future involvement is pending.

The principal objective for CoE is to institutionalize the capacity for market-based partnerships in health beyond the life of the MBPH project. Institutionalizing this capacity in an Indian institution moves

USAID/India far along a desired path to building local institutions for future development work. Specifically, CoE will:

- Build on the projects, lessons learned and activities of the MBPH and other private sector projects;
- Enhance impact by building new partnerships, conducting research, and disseminating best practices; and,
- Evolve into a self-sustaining entity not reliant exclusively on USAID funding.

In a short period of time, CoE has oriented well to MBPH goals, processes and models; developed a business plan with an envisioned break-even time of three to five years; engaged in Zinc advocacy; completed a study with recommendations for the helpline; taken the lead MBPH advisor role with Merck, Sharp & Dohme (MSD) in the development of a new model to introduce a mid-priced oral contraceptive through contracted NGOs with a basket of goods to urban slums. MSD indicated to the evaluation team that their comfort level was very high with CoE, viewing them as equivalent to MBPH.

On the negative side, little interaction/participation is evident on any of the commercial, partnership models being implemented under MBPH that may continue for some time into the future: Shakti@BoP, ACS, TB or ITC. For example, ITC and CoE have had some interaction over the past year, but nothing substantial. CoE was largely left out during the recent ITC partner negotiations and ITC reactions to a future CoE role during the course of this evaluation indicate the relationship must develop further before CoE is or can be effective, even as MBPH ends.

This may not be important for the future success of ongoing commercial health partnerships. An alternative funding mechanism exists for USAID to prolong Abt involvement with these initiatives. A buy-in to the USAID, centrally funded, cooperative agreement, Strengthening Health Outcomes through the Private Sector (SHOPS) project, of which Abt is the prime contractor, offers a way forward.

Proposed CoE areas of focus and expertise seem reasonable to pursue in the post-MBPH period: Knowledge Leader, Network Facilitator & Advocacy; Strategic Consultant; and Enterprise Incubator.

HLC and CoE: Conclusions

The Health Leadership Council has the same valuable role to play with CoE in the future as it had during MBPH. No basic change in its structure or role appears necessary.

The rationale for maintaining CoE is reasonable. The MBPH project time frame was less than four years, yet, according to Monitor Group, a typical incubation period for a market-based partnership to go through idea generation, relationship building, concept testing and scale-up is two to three years at a minimum, and can reach as high as 10 years. Building the capacity of CoE to assume the full MBPH roles as partnership broker, designer, implementer, and manager while MBPH was still operating was an important feature.

Between CoE and SHOPS, a longer transition period would be a favorable to keep current partnerships on track; initiate CoE involvement in ITC, Shakti@BoP, and ACS model development; continue current CoE initiatives, such as the MSD model; and initiate new partnerships. If successful, the end of MBPH would

have minimal impact on the ongoing incubation of market-based initiatives that USAID might continue to support.

With the current project ending, a number of commercial partnership initiatives begun by MBPH have some potential and merit further effort and investment. With the basic parameters of success being potential for scale-up and sustainability, ITC is probably the most worthy of continued attention, followed by ACS, with an honorable mention for Shakti.

For the TB model, the possibility of public sector scale-up using the MBPH approach appears reasonable. Some technical assistance during scale-up may be required.

Advocacy for Public Sector TB scale-up; DMPA procurement; zinc as OTC; and MNRE price supports and Carbon Credits for ACS may need some further support for scale-up.

CoE independently has begun to investigate other possibilities, such as the MSD Model. Although possible that Merck could invest its own resources through the CoE, it is also possible that grants (perhaps in combination with venture capital funds) could be required for technical assistance during the next phase of the process to determine proof of concept.

These various initiatives and ideas need more time for incubation before they can be sustainable, but are worthy of investment in the interim. Access to donor funds during this period will likely be critical for eventual success.

HLC and CoE: Recommendations

Future support can be managed through two mechanisms: CoE and SHOPS. With two possible mechanisms, the possibility of confusion and competition over roles and responsibilities exists, but appears manageable, based on the current experience.

Areas for continued support for market-based partnership through CoE/SHOPS:

1. New and ongoing private partnerships that have potential for scale-up and sustainability
2. Technical assistance to add value in areas of training retailers (old and new) and for promotion/outreach and other demand generation efforts
3. Advocacy for issues like public sector for Networks/Alliances and TB scale-up, DMPA procurement, Zinc as an OTC, and MNRE price supports/carbon credits for ACS
4. Institutional memory or knowledge bank for others to build upon, along with dissemination activities

A hybrid approach should be developed for future support. One portion of the investment would be for new and ongoing private partnerships, knowledge bank management, advocacy, and technical assistance during the early phases of model development. These functions could be provided as a grant or standard project funding.

The other part of the investment should be in the form of a capital fund, to be used like a loan that would be paid back with a defined premium based on success of the venture. The venture capital fund would be valuable as model scale-up begins in earnest, as significant resources will be required. At that point, financial projections and profitability will have been convincing enough for commercial partners to share some of the risk/rewards for moving ahead. Such a fund could be an innovative addition to address risk sharing and create a stable source of future support.

MARKET-BASED PARTNERSHIPS FOR HEALTH

TECHNICAL ASSISTANCE INPUTS

In the earlier section the report focuses on the MBPH technical assistance inputs for individual models. This section deals separately with two specific instances of technical assistance and inputs where MBPH was particularly successful:

1. Achievement of MBPH Project Objective: Explore new commercial sector opportunities to accelerate public health improvements, especially in Base-of-Pyramid (BoP) and rural population groups to improve access, demand and service delivery through health and non-health partners.
2. Answer to the Evaluation Team Question: What type and level of technical assistance has been provided by the implementing mechanism under this project? To what extent is the implementing mechanism efficient and appropriate in addressing the needs and expectations of USAID/India and of the commercial sector?

Improve access, demand and service delivery through health and non-health partners

MBPH worked on the classic push-and-pull method for demand generation, in which it made sure that the models pushed the products and services through the different agencies such as network providers, outreach workers, commercial marketing and distribution channels (Saathiya, DIMPA and SBK), private sector hub and spoke distribution systems (TTC), last-mile retailing and marketing channels (Shakti), new distribution systems and channels (ACS), *inter alia*. Simultaneously, it provided the pull to change behavior in BoP populations and generated demand through communication initiatives, which were either category firsts or innovations in themselves.

Behavior Change Communication (BCC) in MBPH¹²

In MBPH, Behavior Change Communication (BCC) raised awareness, provided information, and as a result, generated demand for the uptake of products and services. Some BCC developed innovative messages and positioning, while others used innovative channels and activities—in each case, customized to the marketing and communication objectives and the profile of the target audiences. In some cases it also created synergies with commercial and private sector involvement /inputs.

¹² This is not an exhaustive list or review of all the BCC done across the different MBPH models and only refers to those campaigns and initiatives where the ideas and/or execution have achieved something new in message creation and execution, and have the potential for high impact if used over an extended period of time. In MBPH, their roll-out came late in the project and no impact studies have been possible till date. But with NRHM taking the SBK materials and Janani/PSI using DIMPA materials in Bihar – there is potential for impact assessment at a later date.

The BCC expenditure was costed as a model-type activity of MBPH and managed centrally, with professional media and PR agency assistance from JWT and Maxus, to develop campaigns, materials, activities, training tools, and advocacy (brief to execution). The support on offer from the private sector partners was for individual company products: (1) POS material, detailers, board games, leaflets (ITC e-Choupal), and (2) brand-communication-led TV commercials for Dettol Soap and Tata Swach water filters (SBK).

Consumer Insights and Message Appropriateness in Saathiya/DIMPA

BCC was integral to improving network provider confidence and reassuring and motivating clients and consumers, which led to increased adoption of family planning methods across oral contraceptives condoms (some IUCD and PPIUCD) and most importantly, DMPA.

The campaigns (films, radio spots), with supporting collaterals for point of sales (POS), outdoor and event visibility, and all pamphlets and literature for Saathiya /DIMPA, were developed with key consumer insights gained from formative research and concept testing on what kind of message would resonate with the target audience.

The exclusive and individual brand identities with logos and taglines that were developed for Saathiya and DIMPA and used across all materials were innovative, effective and aided recall, while increasing footfalls to providers. The key messages suggested an understanding of the target audience at a personal level, while communicating on an intensely private matter: thus, different from run-of-the-mill family planning communication.



(Banner: Message in translation – “Saathiya provides a family planning choice to suit your needs”)



एक इंजेक्शन
तीन महीने,
बहानों से छुड़ी !

अपनी स्त्री-रोग विशेषज्ञ से सलाह लें.
Helpline no. 1800-1800-555



(Hoarding: Message in translation – “Excuses for avoiding sex, because of your fear of pregnancy? One injection, then No Excuses for three months!!”)

Consumer Insights and Message Appropriateness in Saathi Bachpan Ke

BCC in SBK had to combine three messages into one in order to communicate how to prevent and manage diarrhea in children:

- Wash hands with soap to be sure they are really clean
- Use ORS correctly and frequently
- Water which looks clean is not, so take steps to purify it

The First Stage: developing an umbrella brand and logo whose personality was child-friendly and warm, and clearly indicated the three thematic areas of diarrhea prevention and management in the graphics (portrayed as the three ‘Friends of Childhood’—*Saathi Bachpan Ke*). The logo branded all communication materials (information, education, and communication [IEC] posters, banners, flip books, etc.), with guidelines for its use.



(Banner: Message in translation – Let us join hands to prevent diarrhea and ensure healthy lives for thousands of children”)

The Second Stage: developing the BCC message for mass media (ORS and hand washing),¹³ based on research and pre-tests which indicated that caregivers of children and homemakers: (1) did not believe that soap was necessary and washing hands with water was sufficient; (2) knew about ORS but tended to stop giving it to the extent required because a fractious and sick child simply refused it over and over again. From this, two innovative concepts emerged:

1. The Germs (*Kitanu*) hiding in water and having the time of their lives until Soap comes to kill them off. The execution of the “big idea” had high production qualities and made a boring activity like washing hands fun and memorable. The germs themselves were made into comic-book style characters with instant appeal for children and sure to bring a smile to caregivers as well.
2. The Loving Mother untiring in the care she gives her child (*Pyaari Ma Kabhi Haari Na, Ma Kabhi Nahii Thakthey*) and so, she does not give up on ORS until the correct amount is administered to ensure proper management of diarrhea. For an ORS message, appealing to a mother’s maternal instincts, while valuing her as a caregiver, goes straight to the heart and mind.

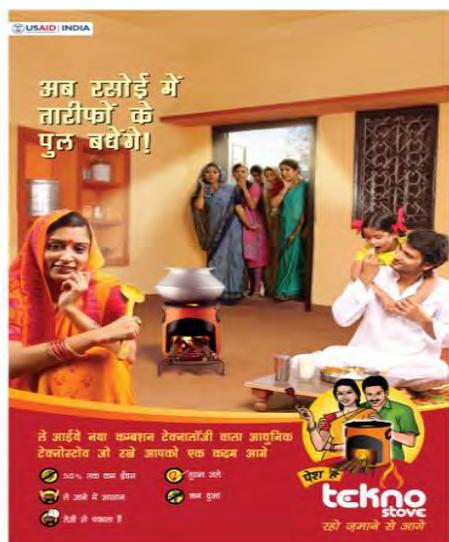
More Consumer Insights and Creating a Buzz with Events – ACS

- How does one convince a consumer to give up the traditional mud stove she and her mother and grandmother before her have used for generations, to a new one which has to be purchased for a fair sum of money? Focus group discussions showed that stoves (any stoves) were a low involvement area—despite awareness of the health hazards of indoor air pollution. Watering eyes and lung problems did not strike any chords during formative research and pre-testing.
- The big idea to emerge was “Aspiration” (the desire to possess something new and different). BCC developed for ACS first branded the product with the name Tekno Stove to cue “Modern and Technically Superior,” then positioned it as a product whose use bestowed status on the family of being “Progressive—a Step Ahead of Others” (*Ek Kadam Aagey*).
- Additionally, the benefits of the Tekno Stove were stated on all promotional materials: less fuel, less smoke, more savings, more time saved, portability. The target audience for the communication included (1) housewives with one or more school-going children responsible for cooking for her family (28 years old and above), and (2) men - the chief family wage earner with income stability (small land owner, small trader, etc.), family size of under 10 members, resident in type R2 and R3 villages.

In the small geographies of UP where the pilot distribution/marketing was launched for the Tekno Stove, mass media was not an option, so an innovative contact program was implemented with on-ground activities. Thus evolved the Activation Event, spread out over five days: announcements; high-visibility promotional materials; audio spots and jingles; direct engagement with clients; and, demonstrations (the latter supported by a flip book). Along with the main event, add-on events were also developed, to keep interest levels high: a tea party for Men (“Chai Party”), where the benefits of the stove were discussed with decision-makers; Tekno

¹³ No Campaign was done for clean water – other than messages in the flipbook for boiling water, using water purification tablets and then using a branded water filter.

Queen contest (*Rasoi ki Rani*), where women were invited to show their skills as cooks and be chosen the Tekno Queen.



(Poster - "Praise for your Cooking")



(Flip Book – "One Step Ahead")

Getting Close and Personal: High-Contact, Interpersonal Communication

The generation of demand for products and services through interpersonal communication (IPC) where, in some cases, even specific "Communicators" were identified, then trained and equipped with supportive materials (mainly Flip Books and POS) was a successful BCC innovation in MBPH and proven to clinch sales, adopt family planning, start using sanitary napkins, etc.

The Communicators used for IPC:

- The Saathiya/DIMPA Network Providers
- The Saathiya DIMPA Outreach Workers
- The SBK Outreach Workers, including the NGO partners
- The Village Health Champion in ITC e-Choupal
- The Village Level Entrepreneur in ACS

Mass media requires big budgets and does not reach all audiences in remote areas. It also results in high levels of waste in areas like urban slums, where commercial advertising and too many TV channels compete for viewer attention. Thus, the idea of person-to-person interaction and communication through IPC has definite advantages: (1) ability to spend more time in educating, motivating and demonstrating; (2) ability to respect privacy when required; and (3) ability to sustain the effort repeatedly, without great expense.

Inherent Sustainability and Campaignability of the BCC used in MBPH

BCC is a long-term engagement and once exposed to different forms of BCC or IPC, target audiences need to see it repeatedly to maintain interest. The kind of BCC used in MBPH has the potential to be taken forward in many creative and innovative ways, building on the momentum already created. Some possible avenues for future BCC:

- Happy DIMPA user endorsements (film, meetings/*goshbies*)
- DIMPA “Happy Couple Love Stories” evolving from “No Excuses” (entertainment-education serials)
- Children’s “Soaps” and entertainment programs (Germ and Soap Warfare, and a young Germ Fighter)
- “Loving Mother Stories” (film, TV serials) – sharing experiences on how to bring up a child
- The progressive cook stove owner’s endorsement – “How Tekno Stove has Changed my Life” (film, meetings, MFI groups)
- VHC and VLE developing peer educators from among current and future product users to reach new consumers, with pyramid marketing plans for commissions and income generation (an Avon Lady kind of concept).

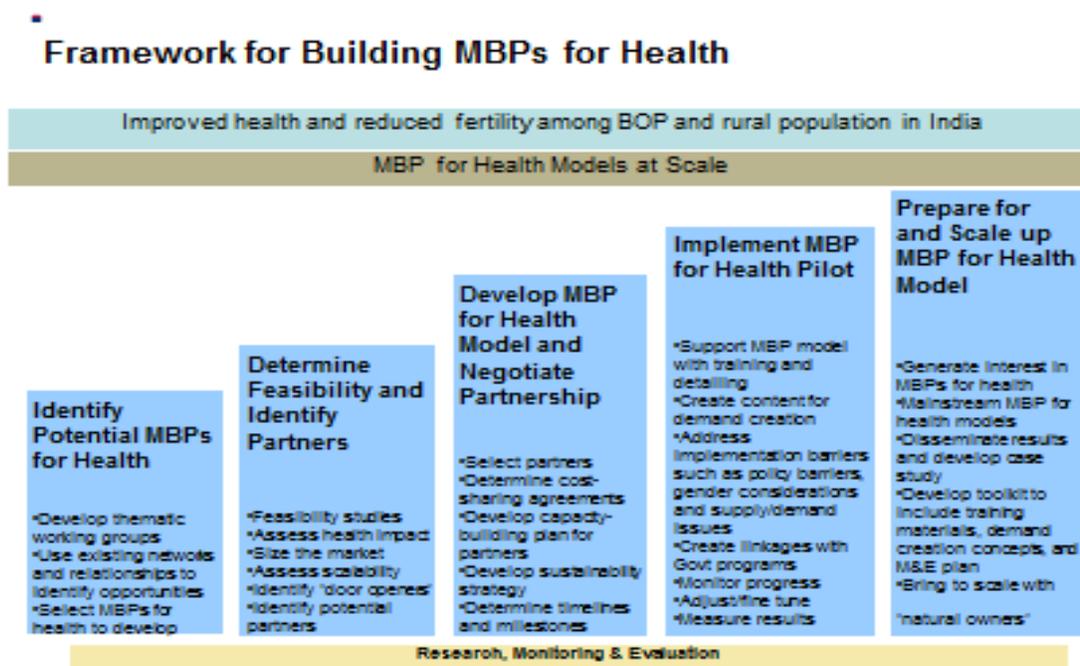
Efficiency and propriety of implementing mechanism in addressing needs and expectations of USAID/India and of the commercial sector

As part of the review of the individual models, the evaluation team addressed private-partner assessments of how the MBPH technical assistance met expectations. In general, partners seemed very satisfied with the appropriateness, level, and timing of assistance provided. This conclusion is based on partner interviews and supported by partner commitments to scale-up models, with continued technical assistance. Illustrating this satisfaction is ITC’s comment: “We could not have put this together without MBPH. We had been trying for several years to add a rural health model, but Abt enabled us to do it.”

MBPH had a relatively modest budget to design, implement, and evaluate a wide range of private partnerships and initiatives in a period of less than four years. The evaluation team attributed MBPH’s success to three key factors.

First, to support such a diverse set of programs, MBPH brought together expertise (staff, consultants, and advisors from the Health Leadership Council) to provide advice on strategy development, networks and partnership, marketing, capacity building, quality assurance, monitoring, evaluation, and advocacy.

Second, the project developed and consistently used a basic framework and process for building market-based partnerships, as illustrated in the chart below:



The evaluation team found that this systematic approach was generally followed, was appropriate, and was valued by private sector partners. In the context of a modest budget, much was accomplished, with many innovations designed and tested, partnerships developed/modified, and ideas incubated. As one HLC member told us: “The distance traversed has been phenomenal.”

Finally, for such a unique effort that broke new ground with private, commercial sector partners, support and advice from USAID/India was critical as these contacts were made and commitments consolidated. MBPH staff, when faced with challenges and problems, was creative in overcoming them. When HUL withdrew support from the Shakti initiative and Pharma Synth was struggling with distribution to SEs, creative solutions were developed that successfully rescued the model. With SBK undergoing two phases of evolution and little time, a final solution was finally reached and an innovative public health platform for diarrhea management developed.

In summary, each of the models tested by MBPH can demonstrate some success in execution, cost sharing, commitment of partners, and even scale-up or maintenance potential. Some broad issues inherent in MBPH with implications for the future are, however, noted:

1. In the context of a commercially viable business, donor funding is a subsidy. In the MBPH models, the issue of viability is not yet fully established. The donor support provided under MBPH has

served well as a catalyst for the incubation of some very innovative and potentially profitable ventures to deliver public health solutions to poorer consumers. It also has provided space for building trusted relationships among partners. The question is one of when, or under what circumstances, should the grant assistance for technical assistance end and thus, when to tap into other types of support (e.g., venture capital funds). Ongoing support could sustain models that are not fully commercially viable. As Louis Boorstin noted: “Subsidies should serve as a complement, not a substitute, for market forces.”¹⁴

2. MBPH had little incentive to cut losses and stop investing resources on any given model or approach; in fact each model was a contract deliverable. If staff were to stop investments on a given model, they would potentially lose their jobs. Essentially, as one observer noted: “It was a low risk, low reward environment.” Access to a venture capital type fund would add another tool to give managers greater flexibility in managing the transition from subsidy to shared risk.
3. MBPH-brokered partnerships focused mostly on smaller prototype developments. The idea was that if successful, the demonstration pilots would be scaled-up by the private sector. This approach was useful for a project with a modest budget. It served the partners well by providing a means for building and consolidating relationships and finding red flags. It might not always be reliable as proof of concept, however. One observer noted, for many companies (especially those conscious of manufacturing capacity), a pilot test of a concept would require activity in seven states, not only seven districts, immediately. As one private partner in the e-Choupal model declared: “straight to 68.” This approach may be useful to justify production volumes for some companies but it is also useful to avoid the fate of many innovative development projects: they work in a small, well controlled environment but once scaled-up cannot seem to succeed.
4. A public health focus can easily get lost in commercial ventures. Although all models successfully addressed public health issues, some of this focus will no doubt be lost in the future. For example, in models with a basket of goods (ACS, ITC) on offer to BoP families, the financial incentive for the end retailer is to focus more on the easy, high profit items in the basket of goods. The family planning products may be viewed as too time consuming (counseling requirements) or not profitable enough to spend so much time promoting. Identifying means of integrating incentives other than profit should be carefully considered.
5. The Base of the Pyramid does not always refer to the most poor. The evaluation team found that some very poor groups were indeed reached during visits to users’ homes. However, based on our observations, the poor category seemed to reach to the B, C or D socioeconomic classes (e.g., Saathiya explicitly included these classes as the target group). This observation does not imply that the project was affected in a negative way. In fact, focusing on those able and willing to purchase the commercial health products on offer is a key feature of MBPH. However, those interested in attaining public health outcomes for poorer target groups may not have found MBPH sufficient.
6. Time was short and resources were limited. The impact on SBK illustrates this point. On a broader level, MBPH was time-bound. The incubation period for model development and testing often involves a much longer timeframe—sometimes as much as 10 years. This implies that some future support will likely be necessary to consolidate progress made to date.

¹⁴ Source: discussion draft for the Workshop on Private Investment for Social Goals, 2004

EVALUATION CONCLUSION

MBPH was a successful project. It designed, implemented and evaluated a wide range of private partnerships and initiatives, which, to a greater or lesser degree, successfully addressed a number of critical public health issues. In less than four years, and with a modest budget, it made significant progress in building upon previous partnership models and exploring new opportunities to engage commercial, private-sector partners in improving health outcomes for BoP families. The Center of Excellence and SHOPS both should play a future role in continuing the work. Finally, a venture capital-type fund could be an innovative addition to address risk sharing and create a more stable source of future support.

APPENDICES

A. REVISED SCOPE OF WORK

B. PERSONS CONTACTED

C. LIST OF DOCUMENTS REVIEWED

D. DATA COLLECTION INSTRUMENTS

E. EVALUATION TIMELINE AND SCHEDULE

F. MBPH INNOVATIONS

APPENDIX A: REVISED SCOPE OF WORK

The Evaluation team met with USAID/India for a Team Planning Meeting at the start of field work in India. During this meeting, several small changes were made to the Evaluation Scope of Work (SOW), and agreed upon between Social Impact and USAID. These modifications are embedded in red in the revised SOW below. All other text within the SOW below remains unchanged from the original SOW provided to Social Impact by USAID/India.

USAID/INDIA
Office of Program Support
DELIVERY ORDER STATEMENT OF WORK
Evaluation of Market-based Partnerships for Health (MBPH)

I. PROGRAM PROJECT INFORMATION

- a. **Program Project Title:** Market-based Partnerships for Health (MBPH)
- b. **Start-End Dates:** October 1, 2008 – May 11, 2012
- c. **Budget:** \$13.5 Million
- d. **Program/Project Description:**

The Market-based Partnerships for Health (MBPH) project aims to improve the environment for commercial sector engagement in USAID India's key priority health areas by forging partnerships between the private and public sectors. The MBPH fosters market based partnerships in reproductive health, maternal health and child health, including promotion of good hygiene, such as hand washing, safe water, prevention of indoor air pollution (IAP) and the control of tuberculosis. The project is helping to bridge a key gap in the health portfolio of USAID/India, which currently does not fully tap into the private commercial sector, especially the non-health related segment, for expanding access and demand for priority health products and services.

The project is implemented by Abt Associates and the consortium that includes four partners – Futures Group, Monitor Group, Population Services International and Banyan Global. The project is currently operational in Uttar Pradesh, Uttarakhand and Jharkhand and for the TB component in Karnataka.

The MBPH project was built on the lessons learned from one of USAID/India's initiatives, the PACT-CRH (Program for Advancement of Commercial Technologies in the area of Child and Reproductive Health), that has been a successful model of private sector partnerships. The MBPH project was envisaged to carry forward partnerships forged during the PACT-CRH program as well as to expand the relationships established with the private sector. The project has two primary objectives:

1. Build on, implement, institutionalize, and scale up MBPH models.
2. Explore new commercial sector opportunities to accelerate public health improvements, especially in Base-of-Pyramid (BoP) and rural population groups to improve access, demand and service delivery through health and non-health partners.

The program aims to create and nurture MBPH models that can be brought to scale by commercial partners, government programs and/or civil society groups. The program also aims to institutionalize local capacity to broker MBPs for health in the future by supporting the establishment of a Center of Excellence.

Some of the key initiatives undertaken and the achievements by the project are:

- **Saathiya pilot project:** The objectives of this pilot project are to create sustainable marketing partnerships to improve contraceptive seeking knowledge and behavior amongst married couples

(ages 15–24) in the lower socioeconomic groups in urban areas of seven cities across Uttar Pradesh and Uttarakhand. The Saathiya product basket includes condoms, pills, emergency pills, injectibles, and Intra-uterine Contraceptive Devices (IUCD). The program has leveraged considerable resources, and established a network of over 3,000 pharmacies, family doctors, and specialist obstetrician-gynecologists that works in partnership with various private sector pharmaceutical companies. The focus is to establish a model to make it more relevant to the needs of young married couples from lower socioeconomic groups in urban areas, while strengthening its commercial viability. Simultaneously, investments have been made on the continuous capacity building of network providers by conducting refresher trainings on provision of reproductive health services to young couples. Promotion of the network via city level media activities has been undertaken and a communication campaign has been implemented through local radio stations and regional newspapers. The project has made efforts to ensure that there is greater client utilization of the services being offered by the program. The Balanced Counseling Strategy Toolkit, acclaimed internationally, has been translated and adapted into Hindi and a series of cascade trainings on family planning counseling using this toolkit have been organized for both the providers as well as the paramedic staff.

- **ITC e-Choupal network:** The MBPH project partners with ITC Limited, an Indian public conglomerate company, to introduce RCH products and services through the e-Choupal ‘hub and spoke’ rural distribution infrastructure. The network has brought markets closer to farmers by using appropriate information technology diffusion and an efficient transaction mechanism. This initiative intends to demonstrate the development of a commercially viable and scalable rural distribution model that increases access to public health products and services in rural India as well as demonstrates the potential of rural BoP markets to commercial sector players. For this ITC has entered into a formal partnership with the project for the implementation of the health model. MBPH works closely with the ITC e-Choupal team to develop partnerships with healthcare product manufacturing companies and recruited health workers in the intervention areas. This includes the following supply-side partners: Pfizer (Oral Contraceptive Pills), Vision Spring (Reading glasses), JK Ansell (condoms), Medentech (Aquatab water purification tablets), Royal Hygiene (Sanitary napkins) and Ranbaxy (Revital health supplement). About 66 community health workers called Village Health Champions have been selected and trained on key health issues and the program has been successfully launched in Gonda and Chandauli districts of UP. The VHCs are trained extensively on public health issues like family planning, diarrhea management, menstrual hygiene, water purification, and nutrition. The program has been conducting communication activities in the intervention districts such as village level events, community meetings and Mahila Haats (women’s market). Targeted at women specifically, these communication activities help raise awareness and generate demand for services such as family planning and diarrhea management. ITC is fully committed to scaling up the pilot to their entire choupal network after proof of concept in the pilot phase.
- **TB intervention:** The TB initiative under MBPH is proposed to improve TB health indicators for BoP populations through the gainful engagement of private healthcare providers practicing the Directly Observed Treatment, Short-course (DOTS) strategy. The vision is that private healthcare providers are empowered and motivated to practice evidence-based TB management that would ensure the best outcomes for their patients and contribute to TB control in India. This initiative addresses implementation gaps in the Revised National TB Control Program (RNTCP), assisting the

national program in reducing diagnostic and treatment delays and moving toward universal case detection. The project has conducted workshops and meetings for consultation with representatives of various Public Private Mix-DOTS projects, technical experts, government officials, donors, and other organizations. The program has increased community demand for DOTS and strengthened private sector providers through capacity building for delivery of high quality, standardized TB-control services, and improved access through a professional interface mechanism. The project through the research agency has conducted two baseline studies on understanding care-seeking behavior of pulmonary TB suspects in urban slums and TB management behavior of private providers. The TB MIS software has been developed to track the TB referrals from private providers. TB capacity building packages were developed in collaboration with St. John's Research Institute for different levels of providers including both allopathic providers and those in the Integrated System of Medical Practitioners (ISMPs). In UP and Karnataka, the program works closely with the State TB Officer and the District TB officers and has 1) completed mapping of intervention towns, slums and healthcare providers; 2) initiated capacity building of allopath and non-allopath providers; and 3) undertaken behavior change communication (BCC) and demand creation activities.

- **Saathi Bachpan Ke** (“Friends of Childhood”) (SBK) The SBK initiative seeks to bring together corporate and other non-governmental partners to work towards interventions like hand washing with soap, oral rehydration therapy (ORT) and drinking water treatment methods, to reduce the incidence of diarrhea in children under 5 years. The program has formed partnerships with leading commercial partners like Reckitt Benckiser (Dettol) for hand washing with soap, Tata Chemicals Limited (Tata Swach) for water purification and Alkem Laboratories Limited (Orhydrate) for ORT, and Medentech for water purification. The program has also formed partnerships with non-commercial partners such as Sulabh International, an International GO working in sanitation and hygiene, and Save the Children. The project through TNS Mode, a research agency, carried out a baseline study among Care Givers of the children under age of five years and an exploratory research on the same group. Training modules have been developed for indigenous providers and trainings have been completed. MBPH has leveraged support of all four partners for the SBK outreach and training activities. Communication activities have been conducted including direct contact with caregivers, influencers and medical service providers on one hand and engaging commercial sector brands on the other, including diarrhea prevention and management messaging in their brand communication. The project has also done outreach events, with on-air and on-ground activation which included ORT day announcements with diarrhea facts, doctor interviews, school based awareness activities, health camps and stories in the media. These activities have resulted in increased visibility for SBK in the intervention areas. The program has also trained ISMP providers, community workers and sales staff of partners on diarrhea prevention and management.
- **Depo medroxy-progesterone acetate (DMPA) program:** The MBPH project also works to increase the overall use of modern reversible methods of contraception through the expansion of the basket of contraceptive choices to include three-monthly injectable contraceptives. DMPA is a safe and effective contraceptive being used by over 12 million women in over 106 countries. USAID launched the DMPA program in 2003 under Private Sector Partnerships-One project to expand choices of modern contraceptives through private healthcare providers and to increase their availability through partnerships with commercial and social marketing agencies. The efforts are now continuing under the MBPH project. The program continues to focus on capacity building of

network providers and demand generation efforts across 45 towns in UP, Uttarakhand and Jharkhand resulting in improved access to counseling for contraceptive use. Mass media channels such as television and radio have been used for demand creation and, simultaneously, outreach activities have been conducted by the field teams by way of counseling potential family planning clients at provider clinics and also in large public and corporate hospitals. Local tie-ups have been done with NGOs to counsel women in slum communities and women self-help groups. The project team continues its technical assistance visits to network doctors and a new mentoring program has been introduced under which select doctors have been designated as 'DMPA Champions' to mentor other network providers. The program also works to improve linkages with manufacturers for effective distribution to network clinics, and with chemists of injectable contraceptives.

- **Cook stoves initiative:** Open fires or chulhas without a chimney, used inside poorly ventilated houses, are a major contributor to IAP and related health problems such as upper respiratory infections. It has been estimated that in India, IAP contributes to 3-5 percent of the national burden of disease. Considering the impacts of IAP on maternal and child health, in June 2010, the Advanced Cookstoves (ACS) initiative was started in partnership with key stakeholders, including the Government of India (GOI), Indian Institute of Technology (IIT, Delhi), ACS manufacturers, micro-finance institutions (MFIs) and rural distribution networks, towards a common vision of increasing adoption of and access to ACS among key target groups. The ACS pilot is being implemented in two districts of the state of UP and one district of Uttarakhand. The program aims to develop and demonstrate approaches that will contribute to the GOI's Ministry of New and Renewable Energy National Biomass Cook Stove Initiative. The project has undertaken a landscaping exercise to assess the potential for commercialization of ACS technologies in India and profiling the various manufacturers and marketers engaged in this category. Envirofit and Philips have signed partnership MOUs. The project also works with a distribution partner Project Dharma, and has appointed Village Level Entrepreneurs and a stockist, in each district. Activities for promoting demand for the product and building a market include the identification of model consumers, community meetings and product demonstrations to create awareness of the product, and to identify potential its buyers.
- **Shakti Health@BoP:** Using a BoP approach to introduce health products in rural areas, this pilot project successfully introduced oral rehydration salts (ORS) into the Hindustan Unilever's network of rural entrepreneurs (Shakti network) and established community acceptance of the Shakti Entrepreneur's role as a health advisor. It synthesized core competencies of the commercial partners and developed an innovative commercially viable distribution system for increasing access to ORS in rural India. A mobile tracking mechanism to track ORS supply in villages was developed and implemented. The scalability of the model was proven and the ORS partner is now scaling-up this model to newer districts.
- **Health Leadership Council (HLC) and a Center of Excellence (CoE):** A key mandate of MBPH project is to institutionalize capacity for fostering and maintaining commercial partnerships for health through the establishment of an HLC and a CoE. The HLC is an advisory body consisting of eight to ten experts from various fields who will advise the program team and later the CoE on various strategies for MBPH. The CoE will institutionalize capacity for designing, implementing and monitoring BoP market-based health programs both within and beyond the life of the MBPH project. Currently, a local organization, Swasti, has been awarded a CoE grant to assess

the client demand for CoE services and identify priority services with an objective of developing a business plan.

I. STATEMENT OF WORK

a. Evaluation Purpose:

The purpose of this end-term evaluation of the project is to:

- Review and analyze the overall program strategies and technical approaches adopted by MBPH *for increased involvement of the private, especially commercial, sector in generating awareness* and use of select reproductive health, child health, tuberculosis and IAP related products and services.
- Review and assess the *effectiveness of the processes adopted for MBPH innovations* including planning, monitoring, finance, and technical support.
- Provide *recommendations on future directions, especially introducing new and/or continuing approaches for innovations* with the private sector. This would include recommending strategies to extend the reach of USAID/India's health agenda on innovations and partnerships.

II. INTENDED USES OR OTHER AUDIENCES FOR THE EVALUATION

The primary **intended users** of this evaluation are the GOI, private sector entities, USAID/Washington and USAID/India. In particular the Health Office, Program Support Office, and Mission management are interested in lessons learned concerning health innovations as the Mission drafts the 2012-2017 Country Development Cooperation Strategy (CDCS). USAID/India will be particularly interested in findings and recommendations concerning how innovations and private sector partnerships can further this strategic plan.

USAID/India will use this evaluation to inform new designs that increasingly focus on innovations in health systems including technology, institutional capacity building, human resources for health, and health-related demonstration models that can be widely replicated and scaled up in India and globally.

The **secondary audience** of the evaluation is local institutions, other donors, and perhaps other USAID missions worldwide.

III. EVALUATION QUESTIONS:

This evaluation will answer the following questions, in priority order:

- a) To what extent has the project been successful in influencing private sector commitment for potential partnerships for BoP markets for improving health outcomes? ~~Delete: What have been the synergies between the private sector and USAID/India health goals?~~
- b) Which of the innovations in the different models of the project have contributed to success of these models and have potential for scalability and sustainability in India? ~~Delete: What components have worked and what did not?~~ What are the “essential ingredients” for private sector engagement in health innovations targeting BoP markets?

- c) What type and level of technical assistance has been provided by the implementing mechanism under this project? To what extent is the implementing mechanism efficient and appropriate in addressing the needs and expectations of USAID/India and of the commercial sector?
- d) How effective has the Center for Excellence and the Health Leadership Council been under this project? What lessons can be drawn from this model in terms of building local institutional capacity?
- e) What lessons/recommendations from the innovations under this project can inform and/or feed into USAID/India's future strategy and have potential for global scale-up?

IV. TECHNICAL REQUIREMENTS FOR EVALUATION:

a. Data collection and Analysis Methods

USAID/India anticipates a 'mixed method' evaluation, including quantitative and qualitative approaches. Data collection methodologies will be discussed with, and approved by, the USAID/India Health Office team prior to the start of the assignment. The evaluators should consider a range of possible methods and approaches for collecting and analyzing the information which is required to assess the evaluation objectives. Data collection methodologies will be discussed with, and approved by the USAID/India team prior to the start of the assignment.

The evaluation will address the key questions stated above, while articulating the framework (or the "essential ingredients") that in combination led to desired outcomes over the life of the project. It is envisioned that this elaborated framework would then be used as a guide to inform future replication strategies. We anticipate that the specific methodology will be discussed at length and refined during the evaluation planning phase and the Team Planning Meeting.

Desk review of documents: USAID/India will provide the team with all relevant country and project specific documents including proposals, evaluation reports, monitoring indicators and other relevant documents for conducting this desk review. The evaluation team is expected to collect and collate relevant international documents, reports, and data, and all team members are expected to review these documents in preparation for the team planning meeting. This desk review will help to organize the materials for the external evaluation team analysis and review of progress to date, and facilitate their utilization during the field work, analysis and report writing stages.

Data sources: Data sources that the team will be expected to utilize, review and analyze include the project design documents, project proposal, annual work plans, M&E data including relevant baseline information on project sub-components, evaluation reports, and other project-related documents and reports. Additional relevant documents related to health programming in India may be utilized as supporting documents, as well as relevant international standards.

b. Composition, Technical Qualifications and Experience Requirements of the Evaluation Team

USAID seeks a four-member evaluation team (two international and two local) comprised of a Team Leader & Marketing Expert, a Communications Expert, an Alliances & Public Private Partnership Expert, and a Senior Public Health Specialist. All team members must have relevant prior experience in India, familiarity with USAID's objectives, approaches, and operations, and prior evaluation/ assessment

experience. Collectively, the team must have experience in evaluating a market-based partnership program. The responsibilities and technical qualifications and required experience of individual team members identified are given below:

Team Leader/Marketing Expert (International)

This Team Leader should have extensive experience in managing RCH, tuberculosis, and private sector health marketing programs. Specifically, s/he should have good knowledge of RCH and TB issues in India and excellent understanding of strategic marketing of products and services in the health arena. The Team Leader will be responsible for coordinating evaluation activities and ensuring the production and completion of a quality report, in conformance with this scope of work. These reports may become a public document for distribution among the program's key stakeholders, including high-level U.S. government policy makers and officials, host country government officials, private sector and NGO leaders, and other audiences. S/he should have proven experience in leading and managing large scale health evaluations specifically in the private health sector. Strong experience in strategic planning, surveillance, operations research, and/or monitoring and evaluation of global and national health programs is required. 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 English language writing, editing and communication skills. In addition to proven ability to provide this leadership role, involving a technically and logistically complex program, he/she should have substantial and demonstrated expertise in evaluation techniques involving projects with technical assistance, training, advocacy, and partnership components. S/he should be familiar with the functioning of large donor funded programs in India. The person must have ability to lead a diverse team of technical and management experts and to interface with various stakeholders ranging from government to non-government organizations, donors and beneficiaries. A minimum of 15 years' experience in design, management and evaluation of RCH/TB and private sector marketing programs is required. The expert should not be directly affiliated with Abt. Associates or its sub-partners. (Level of effort [LOE] up to 34 days)

Alliances & Public Private Partnership Expert (International)

The Alliances & Public Private Partnership expert will be responsible for assessing private commercial sector involvement in the project and assess the innovations piloted by the project. S/he should assess and analyze the processes of identification of opportunity for partnerships, due diligence, negotiating partnerships and signing of MOUs, leveraging, mechanisms to accelerate participation as well as look at sustainability and scalability of partnerships. In addition, s/he should assess private provider networks and provider association involvement in the project including reviewing the process of involvement, mechanisms to accelerate participation as well as constraints faced in greater involvement. S/he should provide lessons learned recommendations for strengthening the project partnerships as well as suggestions for new directions for any future design. This expert should have extensive and proven experience in catalyzing innovation and technologies in the development sector in India, specifically in implementing core business strategies in the private sector. The person should have experience of approaching partnerships from the perspective of business solutions (that is, not only for corporate image, social capital or corporate social responsibility perspectives). Experience of institutional capacity issues related to these types of partnerships will be an asset. Additionally, s/he should have exceptional conceptual, analytical and

reasoning skills as well as ability to analyze disparate information. The Alliances & Public Private Partnership expert should have at least 15 years of experience in commercial private sector, at least some of which has been in the area of health. Experience in working with private enterprise networks--preferably in the area of health,-like social marketing or social franchising--will be an added asset. Experience of working with private provider associations will also be an advantage. S/he should have an understanding of marketing, promotion and consumer research. (LOE up to 30 days)

Communications Specialist (Local)

This Communications Expert will be responsible for assessing the lessons learned from BCC activities, demand generation, marketing and generic promotion activities and will provide recommendations for strengthening these interventions, creating linkages with other activities, as well as suggestions for new directions. The Communications Expert should have at least 10 years' experience working in the areas of marketing and communication. S/he should have a good understanding of generic promotion efforts in the area of health. S/he should have a thorough knowledge of market expansion, brand promotion, advertising and market research. (LOE up to 30 days)

Senior Public Health Specialist (Local)

This Senior Public Health Specialist should have extensive and strong experience in designing, implementing, and evaluating RCH and tuberculosis projects. S/he should be an expert in integrated public health programming. S/he should be familiar with the public and private actors in the health sector and have a good grasp of issues related to the private sector. Additionally, a good understanding of the relevant national programs is desirable. A minimum of 10 years of experience in the design management and evaluation of public health programs including private health sector is required. Excellent writing and communication skills are required. Having excellent understanding of USAID operational, management, and technical approaches including health systems strengthening will be an added advantage. (LOE 30 days)

Other Team Participants: This evaluation may include USAID/India or Washington staff, commercial partners' staff and GOI experts from Ministry of Health (MOH). USAID/ India staff (non-technical staff) may also join the evaluation team during the site visits. Abt Associates may accompany the team on site visits as appropriate, but will not be present during interviews with stakeholders or beneficiaries.

V. EVALUATION MANAGEMENT

- a. **Roles and Responsibilities:** The Health Evaluation Specialist in conjunction with the Evaluation COTR, the MBPH COTR and Activity Managers, other key Health Office team members and the Contracting Officer (CO), will provide overall direction to the assessment team.
 - The Contractor will be responsible for obtaining visas and country clearances for travel for consultants.

- The Contractor will be responsible for coordinating and facilitating assessment-related TPM, field trips, interviews, and meetings in conjunction with USAID and the MBPH Project.
- The Contractor will be responsible for submitting an illustrative budget for all estimated costs incurred in carrying out this review. The proposed cost may include, but not be limited to: (1) international and in-country travel; (2) lodging; (3) M&IE; (4) in-country transportation; and (5) other office supplies and logistical support services (i.e., laptop, communication costs, etc.) as needed.
- The Contractor will be responsible for in-country logistics including transportation, accommodations, communications, office support, etc.

b. Schedule

The duration of the evaluation will be for five weeks, from **March to May 2012**. The evaluation team is expected to provide a schedule (in a tabular form) defining when specific steps in the evaluation process will occur and when deliverables are due.

Team Planning Meeting (TPM): A two-day team planning meeting will be held by the evaluation team at an offsite location before the evaluation begins. This will be facilitated by the evaluation team leader, and will provide the Mission with an opportunity to present the purpose, expectations and agenda of the assignment. The evaluators shall come prepared with a draft set of tools and guidelines and a preliminary itinerary for the proposed evaluations. In addition, the TPM will also:

- Clarify team members' roles and responsibilities
- Establish the timeline, share experiences and firm up the evaluation methodology
- Finalize the methodology guidelines including tools and questionnaires to be used by the team
- Discuss and finalize evaluation questions based on the SOW

Site Visits and Interviews: Conduct a thorough review of the Project through site visits and interviews. Interviewees will include key members from all stakeholder groups, including commercial sector partners, professional associations, health care providers, RNTCP staff, USAID/India and its implementing partners and sub-partners, other donors, communication agencies and beneficiaries. Interview questionnaires will be prepared in advance and finalized during the TPM. Site visits will be planned taking into consideration factors like geographical diversity, representation of various beneficiary groups, and scale of interventions.

The team will evaluate state and district level periodic reports to verify results for the indicators.

c. Reports and Deliverables:

- Draft Work Plan and Pre-Departure Briefings:** The evaluation team will develop a draft work plan prior to arrival in Delhi. The team will meet with USAID/India and other relevant contractor staff for at least three working days prior to departure for the field.

- ii. **Mid-Point Review/Briefing:** The evaluation team will provide a mid-point briefing to the USAID/India team, including evaluation and technical members, to clarify any outstanding queries that may have emerged since the initiation of the evaluation process. If this is not feasible based on scheduled field work, the Team Leader will submit weekly progress reports to the COTR via email by OOB beginning of the next week.
- iii. **Oral Presentation:** The evaluation team will provide an oral briefing on its findings and recommendations to relevant staff in the field, to GOI and state government officials, and to USAID staff at the conclusion of the visits to the various project sites and implementing partners. The evaluation team will be required to debrief the Mission Director and Deputy Mission Director separately on the observations and recommendations. Additionally, the team will also require briefing the Mission CDCS team on its conclusions and recommendations.
- iv. **Reports:** The evaluation will be required to submit the following reports:
 - a) **Draft Report:** The evaluation team will present a draft report of its findings and recommendations to the USAID/India's MBPH COTR and Activity Managers, Health Evaluation Specialist and Evaluation COTR, and other key Health and Program Support Office staff one week after return to the United States.
 - b) **Final Report:** The final report, with executive summary and in electronic form, must be received by the Evaluation COTR, Health Evaluation Specialist and USAID/India MBPH COTR within seven working days after receiving the final comments on the draft evaluation report from USAID/India team. The final report should also be submitted to PPC/CDIE/DI. The final report should include an executive summary of no more than three pages, a main report with conclusions and recommendations not to exceed 20 to 30 pages, a copy of this scope of work, evaluation questionnaires used to collect information on each of the program components, and lists of persons and organizations contacted.

i. Level of Effort:

Team Leader/Marketing Specialist

PHASE	LOE	LOCATION	ACTIVITY
Preparation	3	USA	Desk review of documents and telecon w/ USAID
	2		Travel to D.C.; SI HQ team planning meeting; develop data collection instruments and data analysis plan
TPMS & Field Data Collection	2	Delhi/sites	Travel to Delhi
	1		SI internal planning meeting with full team in Delhi to prepare draft instruments to share w/ USAID TPM @ Maurya ITC
	1		Team planning meeting in Delhi w/ USAID
	16		Data collection Sub team 1 – Delhi, UP, Karnataka, Uttarkhand (inclusive of travel time)
Data Analysis/ Debrief	6	Delhi	Data analysis, draft report writing
	2		Debrief w/ USAID Front office; Presentation to Implementing Partners
	2		Travel back to U.S.
Report Writing	4	USA	Report writing before submission of Draft report
	2		Finalization of report following receipt of USAID comments
TOTAL:	40		

Alliances/PPP Specialist

PHASE	LOE	LOCATION	ACTIVITY
Preparation	3	USA	Desk Review of Documents and telecon w/ USAID
	2		Travel to DC; SI HQ team planning meeting; develop data collection instruments and data analysis plan
TPMS & Field Data Collection	2	Delhi/sites	Travel to Delhi
	1		SI internal planning meeting with full team in Delhi to prepare draft instruments to share w/ USAID TPM @ Maurya ITC
	1		Team Planning Meeting in Delhi w/ USAID
	16		Data Collection Sub team 2– UP, Karnataka, Uttarkhand (inclusive of travel time)
Data Analysis/ Debrief	6	Delhi	Data Analysis, final consultations, draft report writing
	2		Debrief w/ USAID Front office; Presentation to Implementing Partners
	2		Travel back to US
Report Writing	2	USA	Report writing before submission of Draft report
	1		Finalization of report following receipt of USAID comments
TOTAL:	37		

Senior Public Health Specialist and Communications Specialists (locals)

PHASE	LOE	LOCATION	ACTIVITY
Preparation	1	Delhi	Travel from home to Delhi
	2		Desk Review of Documents and telecon w/ USAID
TPMS & Field Data Collection	1	Delhi	SI internal planning meeting with full team in Delhi to prepare draft instruments to share w/ USAID TPM @ Maurya ITC
	2	Tamil Kerala	Team Planning Meeting in Delhi w/ USAID
	16		Data Collection – Delhi, UP, Karnataka, Uttarkhand (inclusive of travel time)
Data Analysis/ Debrief	6	Delhi	Data Analysis, final consultations, draft report writing
	3		Debrief w/ USAID Front office; Presentation to NACO; Presentation to Implementing Partners
	1		Travel home from Delhi
TOTAL	32		

APPENDIX B: PERSONS CONTACTED

USAID

William Hammick	Mission Director
Elizabeth Warfield	Deputy Mission Director
Kerry Pelzman	Director Health Office
Jennifer Graetz	Director, Office of Program Support
Elizabeth Callender	Program Officer
Sheena Chhabra	Team Leader Health Systems Development Health Office
Moni Sagar	BCC & Marketing Advisor Health Office
Charushila Lal	Program Development Specialist Monitoring & Evaluation

ABT Associates *Bethesda Office*

Jeffrey Barnes

Manual Thomas

ABT Associates *MBPH India*

Ramakrishnan Ganesan	Chief of Party
Ramesh Navaladi	Chief Operations Officer
Arunesh Singh	Sr. Program Director
Suma Pathy,	Program Manager
Sanjeev Vyas,	Program Director and Communications Advisor
Rohini Kr. Sahu,	Program Director
Gaurev Gopal Verma	Program Director
Kavita Ayyagari	Program Director
Dr. Jaya Lalmohan	Director Capacity Building & Quality Assurance
Dr. Oommen George	Deputy Chief of Party
Vivek Sharma	Research Director

Market-based Partnerships for Health

Manmeet Bhalla	Administrative Officer
Bikash C. Mishra	Lucknow Representative – Saathiya/SBK/ACS, Shakti
Visruth	Faizabad Representative - ACS
Varun Tripathi	Lucknow Representative – SBK
Jyoti Thareja	Dehra Dun Representative – Saathiya/SBK
Sanjeev Dhavan	Dehra Dun Representative – Saathiya/SBK
Rajni	Outreach Worker – Saathiya/DIMPA
Dr Ravi Anand	Former-Director, Capacity Building and QA
Dr Suzie Francis	CBQA team
Dr Shalini Suri	CBQA team
Mr Shaheen Ahmed	Varanasi Representative, MBPH
Mr Kumaril	Trainer, Saathiya

FUTURES GROUP INDIA

Suneeta Sharma,	Country Director
Shuvi Sharma,	Deputy Country Director
Shivani Kapoor	Director Policy & Advocacy MBPH

MSD PHARMACEUTICALS

Peter Monsy,	Manager Corporate Strategy
Nitin Sharma	Lead New Business Initiatives

MBPH HEALTH LEADERSHIP COUNCIL

Mona Kachhwaha,	Caspian Advisors, Director of Investments
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Pradeep Kashyup, MART

MONITOR GROUP

Parijat Ghosh

GATES FOUNDATION

Anand Sinha, Sr. Program Officer

PACKARD FOUNDATION INDIA

V.S. Chandrashekar, Country Advisor

JANANI

Preeti Anand Deputy Director (Phone Call)

PHSI

Vivek Malholra Managing Director (Phone Call)

UNFPA

Dr. Dinesh Agarwal National Program Officer (Reproductive Health)

PHARMASYNTH FORMULATIONS

A.K. Gupta, Director

Regional Sales Representative Sitapur

Medical Representative Sitapur

SONATA

Anil Kumar Gupta Faizabad Manager

MF Group/Cook Stove Users	Nayaganj, Rudauli, Faizabad District
Loan Representative	Nayaganj, Rudauli, Faizabad District
Two Cook Stove Users	Tehsinpur Village, Suhawal Block. Faizabad District

PROJECT DHARMA

Shashank Shekhar	Lucknow District Manager
Village Level Entrepreneur/s	Faizabad

LUCKNOW

Dr. Md. Faheem Khan	ISM&H Doctor
Dr. Md. Shafeeq	ISM&H Doctor
Dr. Md. Saud Fareedi	ISM&H Doctor
Dr. Manju Agarwal	Lady ISM&H Doctor
Two OCP Users	At Dr Manju Agarwal's Clinic
Dr. Jaya Bhargava	Ob/Gyn Specialist
Three DMPA Users	At Dr. Jaya Bhargava's Clinic
Mr. Sachin Rastogi	Chemist, Shreenath Medicals
Dr. Chandrawati	Past-President, FOGSI, Lucknow
Dr. Rakesh Singh	Past-President, IMA Lucknow
Dr. Ashish Mishra	Vice President - Social Programs, NIMA UP
Mr. Baldev Singh Sachdev	President- Retail Chemist Association, Lucknow
Mr. Devendra Pal Singh	Secretary- Retail Chemist Association, Lucknow
Two DMPA Users	Health Camp at Krishna Medical Center
Mr. Nitin Dwivedi	DKT- Regional Coordinator
Mr. Pradeep Prakash	PHSI –Area Sales Manager
Dr. Dinesh Kumar Singh	Jhpeigo - State Program Manager

Mr. Shoaib Md. Ali	Jhpeigo - Program Assistant
Dr. Anuradha Khairnar	Helpline, ISHP Director
Ms. Suchita Tripathi	Helpline, Operations Manager
Two Outreach Workers	Pratinidhi (SBK) – Choti Jugauli Urban Slum
Women’s Group Meeting	Choti Jugauli Slum (SBK)
Six Housewives/Caregivers	Choti Jugauli Slum (SBK)
Latika Mishra	Principal – Chutki Girls’ School, Husainabad
Mahila Goshti	Nayi Basti Urban Slum
Salma Begum	KOL - Anganwadi Worker, Nayi Basti

WYETH

Gopinath Kulkarni	Manager Market Planning
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TATA CHEMICALS LTD

Amrita Dey	Asst General Manager, Marketing
Tata Swach Sales Team	Lucknow

APPROPRIATE TECHNOLOGY INDIA

Kamal Nayan Badoni,	Executive Director
Harikrishan Bagwani	Project Director
Sailesh Panwar	General Manager
Krishna Dwivedi	Project Manager

CENTER of EXCELLENCE

Shiv Kumar N.	Swasti Health Resource Center
Shruti Veenam	Swasti Health Resource Center

Dr. Angela Chaudhuri Swasti Health Resource Center
Raghunathan N. Vrutti Livelihoods Resource Center

JWT

Saurabh Saxena Executive Business Director & Head Thompson Social
Kalyani Rajan Executive Planning Director & India Strategic Head, Communication for Development
Amit Rangra Associate Vice President & Head of Account Management
Maithili Ganjoo Associate Vice President Strategic Planning Director
Vipul Malviya Client Services Director
Kavita Bisht Account Director
Shreya Mathur Account Manager

RECKITT BENKISER

Sanika Rathod Brand Manager - Dettol Soaps and Antiseptic

MAXUS

Priyambada Choudhary Business Director
Anikit Bhanot Business Executive

DEHRA DUN

Dr. Annu Dhir OB/GYN Specialist (ex-President FOGSI, Dehra Dun)
DMPA Users At Dr. Annu Dhir's Clinic
Dr. Taposhi Patnaik OB/GYN Specialist (ex-President FOGSI, Dehra Dun)
Dr. Nidhi Patnaik daughter-in-law OB/GYN Specialist – Manager of NRHM Urban Health Center (Dr T. Patnaik's)
Anju and Heera Paramedics at Dr. Patnaik's Clinic

Female Patient	At Dr. Patnaik's Clinic
Vaidya V.K. Nayyar	Ayurvedic Practitioner
Dr.Mohammed Siddiqui	Homeopathic Medical Practitioner
Dr. Inderjit Nanda	Homeopathic Medical Practitioner
Dr Arvind Chaudhry	ISM&H, Owner of Ayurmax Clinic
Dr. Rekha Chaudhry	ISM&H, Owner of Ayurmax Clinic (Wife of Rd. Arvind)
Women's Meeting	Mahila Goshti, Chamanpuri Slum
Female Patients	NRHM Urban Health Center, Chamanpuri
Proprietor	New Chemist
Proprietor	Baba Deepsinghji Medical Hall
Proprietor	Ayurmax Chemist
Hari Singh	Area Sales Manager, PHSI
Zain-ul-Abideen	Area Sales Manager, PHSI
Zubair Ahmed Shamsi	Unani Medical Practitioner

VARANASI

Kavita Kumari	ITC Agri Business Division
Tetri Devi	VHC, Dhoos
Vijayalakshmi Pandey	VHC
Annapoorna Devi	VHC
Sushma Devi	VHC
Bela Devi	VHC
Geeta Devi	Client of VHC
Sadhna	Client of VHC
Neera Devi	Client of VHC
Kaushalya	Client of VHC
Urmila	Client of VHC

Manju Devi	Client of VHC
Reena Devi	VHC, Khadera
Farida Khatoon	Caregiver, SBK
Seema & Sadhna	Pratinidhi Volunteers
Shamsun Biwi	Caregiver, SBK
Tahira Biwi	Caregiver, SBK
Khairuddin	Caregiver, SBK
Abdul Kalaam	Shop owner and user, SBK
Dr Tabassum	Saathiya/DIMPA Provider
Nasreen	DMPA user
Husna	DMPA user
Shakeela Bibi	DMPA user
Dr Neha Zama Ansari	Saathiya/DIMPA provider
Mamta	DMPA user
Sunita	DMPA user
Shakila Biwi	DMPA user
Shakila Banu	DMPA user
Dr Usha Gupta	Saathiya/DIMPA Provider
Dr Archana Singh	Saathiya/DIMPA Provider
Poonam	DMPA user
Anjali	DMPA user
Dr Madhulika Sinha	Saathiya/DIMPA Provider
Dr Vikas Pandey	Saathiya Provider ISMP
Dr RK Yadav	Saathiya Provider ISMP
Dr Manoj Sinha	Saathiya Provider ISMP
Ravi Baranwal	Saathiya Provider ISMP

Mr Ashish	TATA Swach Rep
DrAshish Singh	Saathiya Provider ISMP
Dr Smita Tandon	Saathiya/DIMPA Provider

PFIZER

Sunil Madhok	Sr. Director, Business Operations
Arun Shaju	Sr. Manager, Business Planning

ITC AGRI BUSINESS DIVISION

Prabakar	HR Head, ITC Agri Business Division
Kavita Kumari David	Manager, Rural Marketing ITC Agri Business Division

MEDENTECH

Vijay Malik	Former-Country Rep
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PSI

S Shankar Narayanan	Director, TB and NCDs
Shenoy Cherian	PSI team leader
Gururaj	KHPT Ops Manager
Matthew KS	PSI Ops Manager

ENVIROFIT

Harish Anchal	Managing Director
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CHAMARAJNAGAR

Ms Thulasi	TB patient
Mr Sidh Shetty	TB patient
Ms Mahadevi	TB patient

Mr Manjunath	TB patient
Ms Mangalagowri	TB patient
Mrs Mahadevamma	TB patient
Mrs Laxmiamma	TB patient
Ms Leena	TB patient
Mr Philip	PSI Field Rep
Ms Geeta	PSI Field Rep
Mr Bhaskar	PSI Field Rep
Dr Nanjappa	Private Provider
Dr Basava Rajendra	Private Provider
Dr Jaisingh	Private Provider
Dr Chidanand Jadav	Private Provider, ISMP
Mr Najeeb Akthar	Chemist
Dr Prabhuswamy	DTO, DMC Chamarajnar
Mr Mahadeva Swamy	Sr. Treatment Supervisor
Mr Mahadev	Manager, Private lab

BANGALORE

Dr Suryakant	Former State TB Officer
Dr Ramesh VB	State TB Officer
Dr Balaji Naik	WHO TB team
Dr Deepak	WHO TB team
Dr Sangeeta	WHO Sr. Microbiologist

St John's Research Institute, St John's Medical College

Dr John Stephen	Professor, Dept. of Dermatology and Med Education lead
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APPENDIX C. LIST OF DOCUMENTS REVIEWED

Evaluations, Reports and Assessments

- Barnes, Jeffrey. *Designing Public-Private Partnerships in Health*, Bethesda, MD: Abt Associates, July 2011
- Beyna, Larry. "Performance Monitoring & Evaluation: Constructing an Evaluation Report." *TIPS*. 17 (1):1-11. Washington, DC: USAID Center for Development Information and Evaluation, 2010.
- Bhandari, M., K. Brouwer, B. Hartman, K. Schrinisky. *Advanced Cook Stoves in Uttar Pradesh, India: Marketing, Sales, and Distribution Strategy*. Ann Arbor, MI: Michigan Ross School of Business, April 2011.
- Blue, Richard and Molly Hageboeck. *Constructing an Evaluation Report*. Washington, DC: Management Systems International, April 2006.
- Blue, Richard. "Performance Monitoring & Evaluation: Preparing an Evaluation Statement of Work." *TIPS*. 3 (2):1-7. Washington, DC: USAID Center for Development Information and Evaluation, 2010.
- De Muynck, Aime, D. Berger, T. Clary, S. Kumar, Gani. *Evaluation of Tuberculosis Program in India: Path Report*. Arlington, VA: Social Impact, April 2011.
- De Muynck, Aime, D. Berger, T. Clary, S. Kumar, Gani. *Evaluation of Tuberculosis Program in India: WHO Report*. Arlington, VA: Social Impact, April 2011.
- Hope, Ruth, D. Khismatrao, K.B. Pradhan, and B. Spaid. *AVERT End of Project Evaluation*. Arlington, VA: Social Impact. (undated)
- Koh, Harvey, Ashish Ashish Karamchandani, and Robert Katz. *From Blueprint to Scale: The Case for Philanthropy in Impact Investing*. Mumbai: Monitor Group, April 2012.
- Ovral L. Bandra, Mumbai: Wyeth Ltd. (undated)
- United States Agency for International Development (USAID)/India. *Assessment of the Commercial Private Sector for Potential Public-Private Partnerships in Health Report*. Population Services International. (undated)
- USAID. *USAID Evaluation Policy*. Washington, DC: USAID, January 2011.
- USAID/India. *MBP for Health: Advanced Cook Stoves: Offer Development & Communication Prioritization Project Report*. October 2010.
- USAID/India. *Saathi Bachpan Ke Diarrhea - Prevention and Management Baseline Report*. Abt Associates Inc., August 2011.
- USAID/India. *The ITC E-Choupal Rural Health Initiative Baseline Report*. HauzKhas, New Delhi: Abt Associates Inc., July 2011.

USAID/India. *Tuberculosis Control and Care Initiative: A Baseline Survey Report*. Hauz Khas, New Delhi: Abt Associates Inc., February 2012.

USAID/India. *Unlocking Carbon Finance for Advanced Cook Stoves in India: Summary of Proceedings*. Abt Associates India Pvt. Ltd., August 2011.

Progress Reports

USAID/India. *Market-Based Partnerships for Health Contract # GPO-I-00-04-00007-03 Annual Progress Report*. October 2008 - September 2009.

USAID/India. *Market-based Partnerships for Health Annual Progress Report: Year 2 PSP India Task Order Market-based Partnerships for Health Contract # GPO-I-00-04-00007-03*. (undated)

USAID/India. *Market-based Partnerships for Health Annual Progress Report: Year 3 PSP India Task Order Market-based Partnerships for Health Contract # GPO-I-00-04-00007-03*. (undated)

USAID/India. *Market-based Partnerships for Health Year One Workplan PSP India Task Order Market-based Partnerships for Health Contract # GPO-I-00-04-00007-03*. December 2009. (undated)

USAID/India. *Market-based Partnerships for Health Year Two Workplan PSP India Task Order Market-based Partnerships for Health Contract # GPO-I-00-04-00007-03*. December 2009.

USAID/India. *Market-based Partnerships for Health Year Three Workplan PSP India Task Order Market-based Partnerships for Health Contract # GPO-I-00-04-00007-03*. September 2010.

USAID/India. *Market-based Partnerships for Health Year Three Workplan PSP India Task Order Market-based Partnerships for Health Contract # GPO-I-00-04-00007-03*. (undated)

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Leveraging Report*. Abt Associates Inc., October - December 2008.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Leveraging Report*. Abt Associates Inc., January - March 2009.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Leveraging Report*. Abt Associates Inc., April - June 2009.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., October - December 2008.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., January - March 2009.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., April - June 2009.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., July - September 2009.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., October - December 2009.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., January - March 2010.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., July - September 2010.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., October - December 2010.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., January - March 2011.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., April - June 2011.

USAID/India. *Market-based Partnerships for Health # GPO-I-00-04-00007-03: Quarterly Progress Report*. Abt Associates Inc., July - September 2011.

MBPH Project Advertisements

- Revital Booklet
- ORS Flipbook
- She comfort
- KS Smooth
- Sajan Condoms
- She comfort danglers
- Vision Spring

Project Powerpoint Presentations provided to team by USAID and implementing partners:

ACS:

- Market-based Partnerships for Health. Advanced Cook Stove: - *Baseline findings and Way Forward* July 19, 2011
- Market-based Partnerships for Health. Endline Study Findings Advanced Cook Stoves (Uttar Pradesh) 15 February, 2012

DIMPA

- Market-based Partnerships for Health. Endline Survey Among Women Dimpa Program 6 January, 2012
- Market-based Partnerships for Health. Endline Mystery Client Survey Among Network Providers Dimpa Program 25 November, 2011
- A Synthesis of Key Findings from Provider and Consumer Surveys New Delhi, 8 May 2009

ITC Echaupal

- A Baseline Survey in the Abt.-ITC-USAID Project Areas Key Findings Study Conducted for Abt. Associates New Delhi
- Market-based Partnerships for Health. Endline Study Findings ITC e-Choupal Rural Health Model 09 January, 2012

Monitor Landscaping and Design Presentations

- Market-based Partnerships for Health. MBP for Health: Health Leadership Council. April, 2009
- Market-based Partnerships for Health. HLC Profiles
- MBP for Health Centre of Excellence Design. Discussion Document, May 2009

Saathiya

- Market-based Partnerships for Health. Baseline Survey in Expansion Towns November 05, 2009
- Market-based Partnerships for Health. Endline Survey Among Women & Men Saathiya Program 9 March, 2012
- Saathiya Youth Friendly Initiative: Key endline evaluation results. Abt Associates Inc. July 31, 2009
- Market-based Partnerships for Health. Endline Mystery Client Survey Among Network Providers Saathiya Program 25 November, 2011

SBK

- Market-based Partnerships for Health
- Endline Study Findings Saathi Bachpan Ke 9 February, 2012
- Market-based Partnerships for Health
- Saathi Bachpan Ke Baseline Survey Findings & Recommendations for Campaign Strategy May 31, 2011

TB

- Market-based Partnerships for Health. TB Baseline Survey Consumer & Provider 16 Feb 2011
- Market-based Partnerships for Health. TB Endline Survey Provider & Consumer Karnataka 7 March, 2012
- Market-based Partnerships for Health. TB Endline Survey Consumer & Provider Uttar Pradesh 7 March, 2012

APPENDIX D: DATA COLLECTION INSTRUMENTS

The following data collection tools and instruments will be used during the field work for this evaluation:

A. PRE-MEETING PREPARATION TOOL (TELEPHONE/EMAIL QUESTIONS)

For enhancing pre-meeting preparation by implementing partners, collaborators, and others and also telephone/email surveys (as appropriate) the following questionnaire is to be used:

1. What did you want the MBPH Project to accomplish?
2. Were your expectations fulfilled? If not, why?
3. In your experience, what was the largest contribution made by MBPH activities?
4. What was the greatest challenge or constraint faced by the MBPH?
5. If there is to be greater private sector involvement in health services delivery in the future, what will be the most important next steps?
6. How could MBPH better identify and develop partnerships with the private commercial sector?
7. If you were to re-access MBPH Project assistance today, would you do anything differently than you previously did? If so, what and why?
8. Did you find that the MBPH Project provided assistance (e.g. contractual, technical, and financial) in a timely way and appropriate to local conditions?
9. How can MBPH project improve the process of involving the private sector in delivering health services to the BoP sector?
10. Any other comments or recommendations?

B. INTERVIEW GUIDE FOR PRIVATE SECTOR PARTNERS

Assessment of private commercial sector involvement in the project

- What was the processes of identification of this opportunity for partnerships,
- What was the process of due diligence, negotiating the partnership and signing of the MOU for this partner
- What were the leveraging mechanisms to accelerate participation of this partner?
- What is the sustainability and scalability of this partnership?

Assessment of private provider networks and provider association involvement in the project

- What was the process of involvement of this partner
- What mechanisms were used to accelerate the participation of this partner?
- What are the constraints that might be faced in greater involvement?

Conclusions:

- Lessons learned
- Recommendations for strengthening the project partnerships
- Suggestions for new directions for future design.

C. Public Health Questions

(Focused on Saathiya/DiMPA and public-private mix (PPM) TB, and to some extent on Shakti and ITC e-Choupal)

1. What is the extent of change in knowledge and behavior, and what potential exists for more of these?
2. How do the private providers/SEs/VHCs/helpline workers rate the quality of training and ongoing mentoring provided by MBPH? What value did these add?
3. What added value do the private sector providers (Saathiya/DiMPA) and community volunteers (SEs/VHCs) see - perceived and real - in the partnership?
4. What motivation do private sector providers have to continue and grow the partnership? What constraints exist?
5. What is the motivation for private sector companies to continue and grow in the partnership? What synergies exist?
6. For PPM TB:
 - a. RNTCP/WHO: What potential exists in the model to contribute to the national program's goals? What is the value RNTCP sees in the partnership with private providers? What is the perceived value-add of the MIS developed through the project?
 - b. Providers: What value addition did the project's inputs have on their knowledge/skills/service provision/clientele?
 - c. Communities: What is the extent of change in knowledge/care seeking behavior?

APPENDIX E: EVALUATION TIMELINE AND SCHEDULE

MBPH EVALUATION USAID/INDIA CALENDAR						
PERIOD OF PERFORMANCE: MARCH 26 - MAY 30, 2012						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Prep Week-US	US 26	US 27	US 28	US 29	TRAVEL 30	New Delhi 31
Day off	Contract Start Date Home-based drafting instruments and eval work plan	Home-based doc review, drafting instruments	Home-based drafting instruments and eval work plan	Home-based drafting instruments and eval work plan Expats travel to DC (pm)	SI HQ TPM Expats depart USA for New Delhi (pm)	Travel to India, arrive late night
India Week 1 May 1	New Delhi 2	New Delhi 3	New Delhi 4	New Delhi 5	New Delhi 6	New Delhi 7
Day off	Internal SI Team Planning meeting w/ full team to Finalize tools and draft work plan (am) Afternoon: USAID Team Planning Meeting	SI Team Finalize tools and draft work plan Afternoon: USAID Team Planning Meeting – TBD ADDED 2-4 PM USAID	Meetings in Delhi	Meetings in Delhi	Meetings in Delhi	Review & Analysis Day
India Week 2 8	New Delhi 9	New Delhi 10	Uttar Pradesh 11	Uttar Pradesh 12	Uttar Pradesh 13	Uttar Pradesh 14
Day Off	Meetings in Delhi	Meetings in Delhi	Meetings full team	Meetings Full team	Meetings Full team	Meetings Full Team Review and Analysis
India Week3 15	New Delhi 16	Mumbai/Hyderabad 17	Mumbai/Bangalore 18	Uttarakhand/ Karnataka 19	Uttarakhand/ Karnataka 20	Uttarakhand/ Karnataka 21
Day Off Travel to Delhi	Mid-term Debrief TIME SET AT 10-12 Sub-teams split: Travel to Mumbai/Hyderabad (pm)	Sub-team 1: Mumbai Sub-team 2: Hyderabad Sub-team 2 travel to Bangalore (evening)	Sub-team 1: Mumbai Sub team 1 travel to Uttarakhand (pm) MOVED TO THURS AM Sub-team 2: Bangalore	Sub-team 1: Uttarakhand Sub-team 2: Karnataka	Sub-team 1: Uttarakhand Sub-team 2: Karnataka	Sub-team 1: Uttarakhand Sub-team 1 travel to New Delhi (pm) Sub-team 2: Karnataka

MBPH EVALUATION USAID/INDIA CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
India Week 4 22	New Delhi 23	New Delhi 24	New Delhi 25	New Delhi 26	New Delhi 27	New Delhi 28
Sub-team 2 travel to New Delhi Day Off	Full team: Data Analysis/Report Writing	Data Analysis/Report Writing	Data Analysis/Report Writing	Data Analysis/Report Writing	Presentation to Implementing Partners	Data Analysis/Report Writing
India/US Week 5 29	New Delhi 30	New Delhi 1	US 2	US 3	US 4	US 5
Day off	Data Analysis/Report	Oral Debrief for USAID Team Departs India	Travel to US	Report Finalization	Report Finalization	Report Finalization
US 6	US 7	US 8	US 9	US 10	US 11	US 12
Day off	Report Finalization	Report Finalization	SI Quality Assurance/Review	SI Quality Assurance/Review	SI Submit draft report to USAID	
US 13	US 14	US 15	TBD	TBD	TBD	TBD
Day off	USAID Review the draft report	USAID Review the draft report	USAID Review the draft report	USAID Review the draft report	USAID provides SI comments on draft	
TBD	TBD	TBD	TBD			
Day off	Finalize report based on USAID feedback	Finalize report based on USAID feedback	SI internal review/editor	SI internal review/editor	SI Submits Final Report to USAID 7 days after comments received from USAID	

APPENDIX F. MBPH INNOVATIONS

In this section the lessons/recommendations from the MBPH innovations are summarized in terms of USAID/India's future strategy and the potential for global scale-up. The innovations are noted by each of the MBPH models.

The matrix accompanying this appendix illustrates the full range of MBPH innovations introduced across seven models. For inclusion into the matrix the team used the following USAID definition of innovation:

At USAID, we use “innovation” to refer to novel business or organizational models, operational or production processes, or products or services that lead to substantial improvements (not incremental ones) in executing against development challenges. To be meaningful, innovation has to mean more than anything new, interesting, or exciting. That's why we link innovation to producing improvements that are well beyond incremental, in terms of cost, impact, beneficiaries reached, time saved, etc. Innovations can involve everything from novel science and technology programs, like a new disease diagnostic that is far cheaper than previous tests, to novel ways of engaging the private sector to better coordinate development-relevant efforts or obtain far more leverage than the Agency normally gets through partnerships.

SAATHIYA/DIMPA

Among the notable innovations successfully developed and tested during the course of MBPH, were: the support of a new consumer choice, Depot Medroxyprogesterone Acetate (DMPA); postpartum IUCD training (PPIUCD) for OB/GYNs and their paramedic staff; Helpline with a callback feature that improved DMPA continuation rates; and Mahila Goshties/Health Camps for targeted family planning information/promotion followed by access to products and services from trained providers.

In terms of global scale-up the Helpline call-back feature holds a great deal of promise. The potential for this intervention to significantly reduce DMPA discontinuation rates could be a huge contribution to producers, providers and users of the injection worldwide if further research can demonstrate this intervention's value.

SAATHI BACHPAN KE (SBK)

The key innovation of SBK was the Alliance itself. Bringing together the products of three corporate organizations on one public health platform has not been attempted before in the social sector in India. The Alliance is a comprehensive approach to diarrhea prevention and management: hand washing with soap, point-of-use water treatment and oral rehydration salts (ORS) use. This is a classic example of intervention bundling, which has been shown to improve the public health outcome more efficiently than each of the individual interventions alone. Other innovations included: a) leveraging the communication and promotional activities of the private companies with mass media campaigns and brand messages of SBK for added awareness generation; and b) outreach on diarrhea prevention and management by NGOs in urban slum communities, in schools, and in meetings of women's groups.

For global scale-up a single public health platform for multiple products can be replicated. The leveraged mass media campaign combined with outreach activities should be an integral part of those efforts to ensure a greater impact.

SHAKTI@BOP

Innovations included linkage of a large scale national commercial sales network with the producer of a critical child health product to increase availability of that product at the village level: Pharma Synth medical representatives distributed and sold ORS to HUL's village level retailers, the "Shakti Entrepreneurs"; demonstrating the commercial profitability of a single seasonal product (ORS) aimed at the rural population; establishing a mobile-phone based inventory system to account for ORS supplies and to ensure that stocks were delivered to the Shakti Entrepreneurs (SEs); and establishing a small medical products producer as the natural owner of a rural distribution project partnered with a major national sales and marketing company.

For global scale-up the collaboration with an existing large scale commercial sales network can produce excellent results. Distribution systems developed by large companies such as HUL are often beyond a single company's ability to recreate. Pharma Synth's successful collaboration with HUL was a credit to MBPH efforts and could be replicated elsewhere although Pharma Synth with only one seasonal product may be unique.

ITC E-CHOUPAL

ITC e-Choupal innovations include: linking of rural BoP health products delivery to an effective village agricultural information and products procurement network; creating a new retailer class through the recruitment, training and support of a cadre of village entrepreneurs, "village health champions" (VHCs)", who are supervised from the ITC procurement hubs, inform village women about health and family planning, and sell products, through village-level women's meetings and door-to-door; and including a basket of health products package so that product sales could support the rural health workers and also include the availability and sale of FP products.

As in the case of Shakti@BoP the ability of one or a group of companies to connect with an existing distribution system has global implications. As in the case of the e-Choupal model, additional investments in a new retailer class may be required to ensure consistent supply and demand generation.

ADVANCED COOK STOVES (ACS)

Innovations included: matching of a micro-finance institution that could provide the credit necessary to purchase the product with a product distributor to improve reach of the project and affordability of the product: the establishment of the distributor's representatives as local village level entrepreneurs who were trained and incentivized to sell the product; and the integration of distributor community level sales meetings with microfinance group meetings at the village level.

Globally micro-finance institutions are ubiquitous. Successful linking of distributors with these institutions in the ACS model has been met with great interest under MBPH. After the initial success with Dharma and Sonata other combinations of distributors and micro-financers are already operating in India. A key feature of global scale-up will include a means of generating demand at the local level through trained entrepreneurs.

TB

Innovations included: an “interface” agency (NGO) to build the capacity of private providers and improve access to these providers for people in urban slums to support the national TB control program; an “interface” between persons with symptoms and private providers and between private providers and the local unit of RNTCP, through an NGO that acts as a facilitator/trainer; community-based support for TB patients through “*Prerana*” (a local term for *Inspiration*) meetings, transporting sputum samples from collection points to designated microscopy centers (DMCs); and developing and testing a web-based management information system (MIS) for TB.

The interface agency was the key innovation with global implications. The full, costed package of interventions it implemented can be replicated in many public private partnerships. Mobilizing the private sector in such a way should be appealing to many governments.

MBPH Model	Game-changing aspect(s)	Type of Innovation (What is novel):			Results of the Innovation (What were the improvements):			
		Operational Process	Product/Service	Partnership	Health Impact/Outcome	Beneficiaries reached	Time saved	Cost saved
Shakti	Gaining access to a large rural market+critical product+profitability	Demonstrated profitability of a single, seasonal product	A critical child health product	Rode on existing entrepreneur network to deliver product to rural BOP homes	Lives saved from diarrheal dehydration	Young children in rural households with diarrhea	Visits to facility for diarrhea management	Cost of hospital treatment for severe dehydration
	Cellphone-based tracking system to manage stocks of a critical product	Incorporated into existing stock reconciling mechanism			Efficient delivering of supplies to Shakti Entrepreneurs	Potentially - those that could have not accessed ORS during a stock out	Efficiencies for the distributor	
SBK	Bundling of interventions for diarrhea prev & mgt		Multiple products, tied to diarrhea prevention and management	Diverse players brought together by a common public health goal	Reduced incidence of diarrhea; reduced deaths from diarrhea	Caregivers of US children who may not otherwise be reached	Counseling and product at the doorstep	Treatment costs for diarrhea
	Using a transitional product to improve sales	TATA Swach tracks Aquatab users as a potential market			Increased availability of safe water	Households in urban slums		Treatment costs of diarrhea
ACS	Partnership to improve accessibility and affordability			Matching MFI with product distributor	Reduced indoor air pollution and potential reduction in related illness	Rural households, particularly housewives and young children	For providers - time saved (integrated MFI and distributor meetings); For households - trips outside the village to purchase product	
	Working with government on tax/tariffs	Incorporate benefits into the product price				Potentially more beneficiaries owing to reduced price	For households - trips outside the village to purchase product	Reduced price of product
Saathiya	Tying demand generation (Mahila Ghostie) with service delivery (Health Camps)	Using an invite card to link potential users to services			Increase in CPR that would otherwise not have been possible	Several, who may not have otherwise had access to credible information and the service		Services subsidized by project/product partners
	Meeting health/FP needs of a critical group (postpartum women)		Skills building for private providers in PPIUCD (first time in the country)		Protects health of postpartum women	Very insignificant in terms of CPR, but could be significant in terms of protecting these women	Another hospital visit for FP service is avoided	
	Targeting young married couples (high FP need)	Focused key messages and communication to specific audience			Potential delay in birth of first child; CPR increase	Greater reach, owing to use of helpline		Costs of a potential unintended pregnancy saved
DIMPA	Created demand and drove price down for a new efficacious method		A hitherto unused but effective method	with private providers and SMOs	Possible increase in CPR	Several, who may not have otherwise used a modern method		Yes, after prices were brought down following wide use.
	Reduced discontinuation rates with call back function of the Helpline		A new mechanism for providing information and supporting users with side-effects		Reduces discontinuation; effects of a potential abortion arising out of an unintended pregnancy			Costs of a potential unintended pregnancy saved
ITC e-Choupal	Basket of products for BOP homes and improved value for the agri chain		FP and other public health products	Rides on an existing agri procurement and information chain		Products and counseling provided at doorstep	Trips to the market and to health facility	
	Use of a cadre of village entrepreneurs	Tapping into entrepreneurship potential of rural women			Improved health of rural BOP populations	VHEs themselves: recognition; earning rural households - products and counseling at doorstep		
	Health-neutral plus public health products for overall profitability		Improves profitability and advances public health goal		Increased CPR (Need to maintain PH emphasis)	Products and counseling provided at doorstep	Trips to the market; facility	Cost related to trips to market or facility;
Public Private Partnership for TB Control and Care	An integrated package, including contracting mechanism for local player (Interface Agency)	Meets RNTCP gap in contracting mechanism and performance mgt			Potential up take and scale up by RNTCP	Potentially great numbers of symptomatics whose first contact is the PP	Reduced delays in obtaining appropriate care	Reduced costs of "shopping for care and doing frivolous tests
	Patient-led support meetings - to reduce defaults (high in target areas)			Partnership amongst community members with participation from RNTCP	Likely improvements in treatment completion	Likely to reach more of those on treatment than that possible through provider -patient interactions		
	Save cost and time through sputum collection & transport		Specific fee-based transport service		Need to ensure correct treatment regimens as trips to DMC get eliminated		For patients, eliminates need for 2 trips to the DMC	Eliminates costs related to 2 trips to the DMC

APPENDIX G. PUBLIC HEALTH ASPECTS OF INDIVIDUAL MODELS

Each of the MBPH models sought to take evidence-based interventions relevant to the health of women and children to urban and rural BoP populations through the private commercial sector and to assess the feasibility of the intervention itself and its potential for further scale-up. The following sections outline the public health approach and effectiveness of each model.

SAATHI BACHPAN KE

The Alliance is a comprehensive approach to diarrhea prevention and management: hand washing with soap, point-of-use water treatment and ORS use. This is a classic example of intervention bundling, which has been shown to improve the public health outcome more efficiently than each of the individual ones would. The intervention consisted of making the services available to caregivers, along with a well-crafted communication plan. Within a short timeframe, the project generated demand and satisfaction with the products within the target slum populations. Target households have begun to see the difference each intervention can make. However, there are signs that their expectations related to the effectiveness of interventions are unrealistic. While these interventions are effective, they are not infallible: children could get diarrhea despite the use of these interventions the Alliance promotes.

SAATHIYA

This model targeted young married couples, a niche group with high FP need. Communication interventions helped match need with services and products, which were in turn carefully tailored to meet the specific aspirations of the target group. Most private providers involved in Saathiya were interested in promoting FP but were at different stages of actually meeting the need, and there were many missed opportunities. The project's capacity building approach combined training events with ongoing support, both through the project and through peers, and served to plug critical gaps in both technical skills (such as PPIUCD insertion and method-specific knowledge) and soft skills (such as counseling methods). While FP is neither a significant part of their clients' overall needs nor a high-revenue service, providers appear to have made FP counseling and services part of their routine consultation, and are likely to continue the practice.

PPIUCD was introduced late in the project cycle with the purpose of meeting FP needs of immediate postpartum women (often with the highest unmet need) as well as to protect their health. However, its acceptability as well as providers' motivation to continue offering the method remains to be seen.

DIMPA

This model was built on the premise that expanding the range of contraceptive choice results in increased use of contraceptives. Much of the success of the intervention is intrinsic to the method (Depot Injection medroxy progesterone acetate) itself – its low failure rate (3% with typical use), reversibility, ease of administration and manageable side effects. The model, however, combined these factors with focused

communication, capacity building and partnership building to improve the product's acceptability, availability, affordability, accessibility and ultimately, its use as well as helped reduce user error, thus further increasing its efficacy. Once users grew comfortable with the method, they even found the accompanying secondary amenorrhea convenient. The project has also addressed providers' misperceptions about the method, and they are now able to offer the method with skill and confidence. It appears that the project has created a critical mass of providers and users in the 45 towns where it operated, who would continue using and promoting the method. Several users plan to continue with the method indefinitely and they would require screening once in two years for long-term effects of the hormone.

ITC E-CHOUPAL

This model skillfully draws out best practices from a variety of existing community-based interventions, to offer public health products to BoP communities. The current basket of the VHC includes OTC FP products, women's hygiene products as well as those that are health-neutral, but help widen the VHC's profit margins. The project has helped mobilize VHCs which in itself is a public good and constitutes significant social capital in these rural communities.

The model does not yet have a mechanism to proactively vet the entry of products (or services) from a public health perspective. It also does not yet have an ongoing quality assurance of the counseling that VHCs provide. A pertinent example from the current phase is OCPs being given to young unmarried girls for dysfunctional uterine bleeding - a condition that could be caused by an underlying bleeding disorder or infection such as Chlamydia. The other implication of this use is potentially huge, especially if there are a considerable number of unmarried girls on contraceptives. The model could also benefit from linkages to secondary-level healthcare that can be used if and when a product user develops any unintended effect of using a product.

Finally, products with the highest quality of evidence for public health effectiveness (such as condoms and OCPs in the present basket) are associated with the lowest profit margins, and require highest level of effort from the VHC to market/sell. The model therefore needs to evolve a mechanism by which profitability of the basket is balanced against the effectiveness of the products it contains.

PPP FOR TB

The model aims to motivate private providers to practice evidence-based management for TB. The premise is that persons with symptoms of TB seek care from multiple providers before being diagnosed and started on treatment; that private providers, who are the first point of contact for a significant proportion of TB patients, do not follow established standards of TB care and that ensuring the participation of private providers is critical to achieving universal access, a key objective of the Revised National TB Control Program (RNTCP). While RNTCP is fully subscribed to the WHO Stop TB strategy's Global Plan for 2011-'15 and its component of engaging all care providers, the financial (grant-in-aid) schemes that the Program set up for involving private providers have found very few takers and the contribution of the private sector in TB notification and treatment completion in the country has significant scope for improvement.

Key messages focused on changing provider behavior in suspecting TB in all patients with suggestive symptoms, and subscribing to DOTS therapies. They also targeted consumer behavior for prompt and appropriate care seeking.

While the model itself has been carefully designed and implemented, its effectiveness is offset by issues that are beyond its scope, given its limited duration and geographic scale:

- Allopaths refer to DMCs only those symptomatic whom they assessed as being poor, while they would treat the rest themselves, using a variety of drug combinations and dosages and for varying lengths of time, that do not necessarily align with the evidence-based regimens that RNTCP recommends. They also require a range of blood tests and X-rays from their poorer patients, prior to referring them to DMCs for sputum testing. Some of these physicians would give a course of antibiotics for patients with symptoms suggestive of TB, and refer them for sputum testing for TB only if symptoms persist, potentially further delaying appropriate care.
- TB symptomatics form less than 1% of the clientele of these providers and hence are negligible as a source of revenue. Thus there is no financial incentive for referring symptomatic persons for sputum testing. The only apparent disincentive for referring all symptomatic persons to public facilities for appropriate care is the loss of income through potential additional lab tests and repeat consultations.
- Patients in the intervention areas had “shopped” for treatment from at least four facilities, both public and private, before being referred to a DMC for sputum testing. They also had to do a battery of tests at each facility. One of the patients had even suggested in vain to the private provider who attended on her to test her for TB. This translated into delays in obtaining appropriate care that ranged from a few weeks to several months.
- District and state units of RNTCP value the project’s input and they consider it to be of high quality. They perceive the need for a third party to coordinate and nurture relationships between the Program and private providers. However the state and district TB teams find it unlikely that staff of the district TB team will take over aspects of ongoing support to private providers.

The model has evolved a package of interventions for private providers and communities that, if delivered together through an interface agency has shown to improve case detection. It is also likely to improve treatment adherence and completion.

In Its third phase, RNTCP aims to achieve universal access to TB care by extending its services, among others, to patients diagnosed and treated in the private sector. RNTCP has also sought an extension (up to 2016) and increase in current financing from the World Bank, which will focus on several new challenges including public private partnerships and contracting-out of services, including the necessary accreditation, contract management and quality control systems, and performance-based financing and incentives systems. This model could well be the way forward to meet these new challenges that RNTCP has identified.