Intervention assessment: Leveraging Networks

Urban Reproductive Health Initiative (URHI)

Discussion document
December 2009

Intervention description and typical delivery model

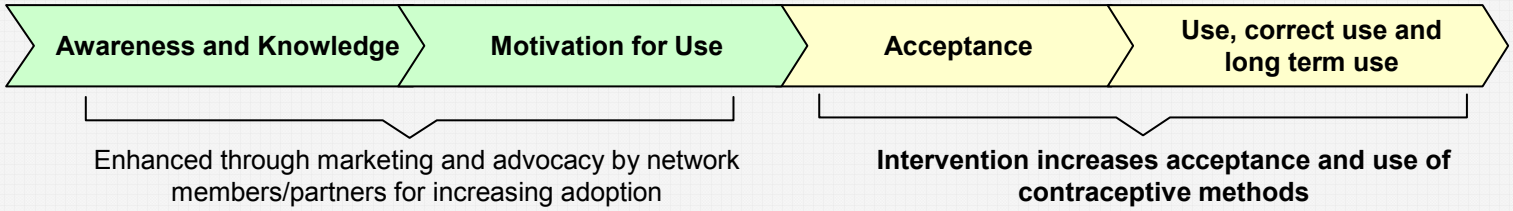
PRELIMINARY

Core activity
Optional activity (not all models)

Description

- Creating a network of health service providers to increase awareness and access to different types of contraceptive products and services
- Network members picked based on the target population and contraceptive method

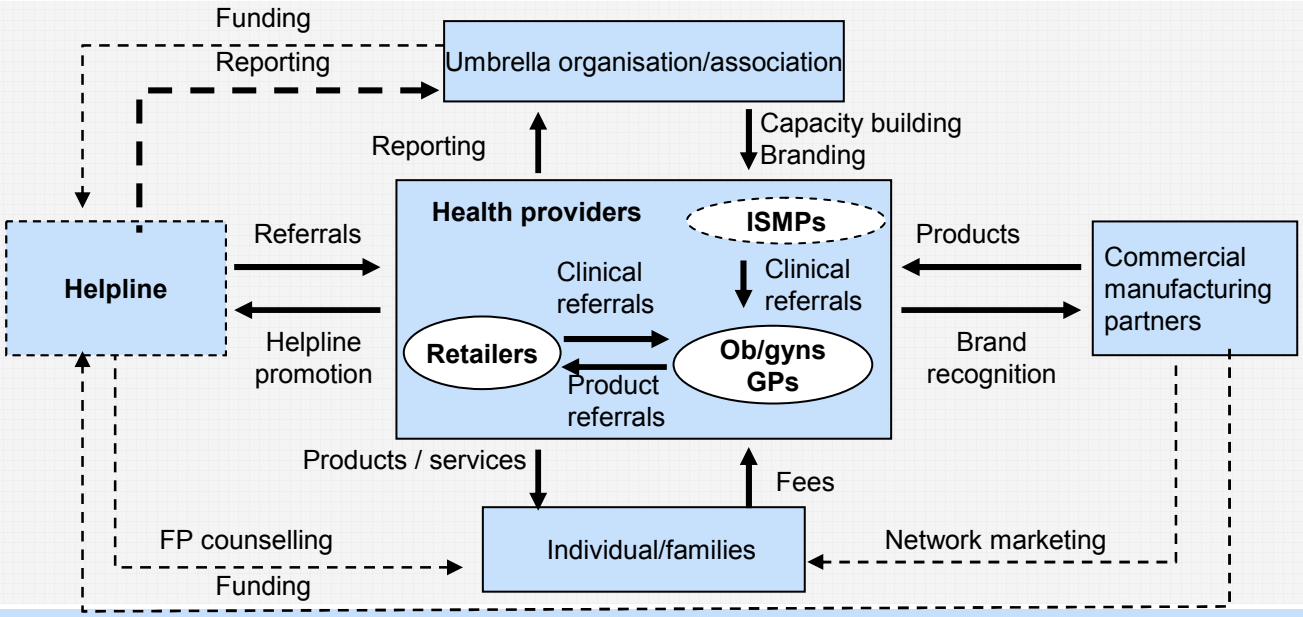
Pathways to affecting contraceptive prevalence



Contraceptive method focus

Female sterilization	Male sterilization	IUDs	Pills	Condoms	Injectables	ECPs
✓	✓	✓	✓	✓	✓	✓

Typical delivery model



SOURCE: Literature search; Interviews; Team analysis

Evidence and relevant examples

PRELIMINARY

Program	Description	Impact	Cost effectiveness	Learnings
1 Dimpa network	▪ Network of Health Service Providers (HSPs) including ob/gyns, GPs, paramedics and chemists to increase access for Injectable contraceptives ▪ Covered FP for urban married women ▪ ~1,250 clinics across 45 cities in 3 states ▪ Program commenced in 2003; is ongoing	▪ Impact on overall increase in CPR unknown ▪ Increase in Injectable contraceptive use from less than 0.01% to 0.4% for target urban UP population over 3 years ▪ Impact on poor populations unknown, program was not aimed at poor populations ▪ Increased awareness –helpline calls increased by 310% in 6 months to ~600 calls/day	▪ No cost information available	▪ Patient follow-up necessary for long-term adoption of injectables ▪ GPs should be included in network to increase access points ▪ Injectable contraception adoption lower than expected because private providers incentives insufficient to cover additional follow-up required ▪ Limited affordability of products for low income households (12 month supply of DMPA costs $24; per capita annual health expenditure in UP ~$22)
2 Saathiya network	▪ Network of HSPs, chemists and helplines to increase awareness and access to reproductive health and FP services for young married couples ▪ Included a health card scheme for discount on products/consultations ▪ 3,200 providers across 7 cities in UP are part of the network ▪ Program commenced in 2007; is ongoing	▪ Impact on CPR not available. However, population aware of Saathiya is more likely to use contraceptives compared to population unaware (60% vs 42%) ▪ Impact on poor unavailable ▪ More than 175,000 calls to the helpline in 2 years; currently averaging ~1000 calls/day; ~70% callers below 25 years of age ▪ Saathiya HSPs scored 22% higher on FP counseling knowledge index compared to non-members	▪ Program cost or effectiveness information not available ▪ Program spent ~$300,000 (in 2 years) on promotion, technical training updates, product samples	▪ Private, confidential and sensitive handling of patients by service providers can increase long term adoption of family planning services ▪ Synergies and cost benefits can be achieved by combining the marketing and supply chain management efforts of HSPs and manufacturing partners
3 Saadhan Network	▪ Network of private ISMPs, pharmacists and other retailers to improve MCH behavior in urban slums of Dehradun and Haridwar. ▪ Also included a community outreach and social marketing component ▪ ~100 trained ISMPs and 3300 outlets selling MCH products were part of the network ▪ Program ran from Jan 2004-May 2005	▪ 3.3 p.p. increase in use of spacing methods among low income parents in target areas (in 16 months) ▪ ~36,000 consultations for MCH related causes in 16 months ▪ 86% of clients were satisfied with the quality of services provided	▪ Program cost or effectiveness not available	▪ Training and monitoring the network service providers can greatly improve the quality of services provided

SOURCE: Literature search; Interviews; Team analysis

Evidence and relevant examples

PRELIMINARY

Program	Description	Impact	Cost effectiveness	Learnings
4 Greenstar Network (Pakistan)	▪ Network of private (franchisee) health service providers to increase awareness and access to FP/MCH services and products for low income families ▪ Also includes a social marketing program ▪ 14,000 active providers (i.e. franchisees) are part of the network ▪ Started in 1995, currently ongoing	▪ Impact on CPR not available. However, 200,000 women annually adopt family planning methods following public education events ▪ The intervention delivered 2.1M CYPs in 2004, delivering more than 25% of all modern methods of contraceptives used in Pakistan ▪ Network reaches 2.5M people through outreach workers every year, 74% of them are poor	▪ Total costs of the program not available ▪ Cost/CYP = $3.66	▪ Product subsidization necessary to ensure affordable product access for low income households ▪ Training of service providers should be ongoing, and not a one-time event, to ensure high service delivery quality ▪ Public education events held by franchisees can be important measures for spreading awareness and increasing adoption

SOURCE: Literature search; Interviews; Team Analysis

Potential impact of intervention

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Type of impact	Magnitude and time to impact
Contraceptive prevalence	▪ **Some evidence on impact on CPR with Saadhan network, but no significant direct impact observed yet with the two networks currently operating in URHI's target cities (i.e., Dimpa and Saathiya)** – 3.3 p.p. increase in use of spacing methods among low income parents in target areas with Saadhan network – Increase in Injectable Contraceptive use from less than 0.01% to 0.4% for target population in urban UP over 3 years with Dimpa network – Population aware of Saathiya is more likely to use contraceptives compared to population unaware (60% vs 42%), but no data on impact on CPR
Type of contraceptive method	▪ **While some networks promote all contraceptive methods, certain networks (e.g., Dimpa) are focused on increasing adoption of particular contraceptive products/services** – Increase in overall family planning adoption (~200K women annually) as part of Greenstar network in Pakistan – Increase in Injectable Contraceptive use from less than 0.01% to 0.4% for target population in urban UP (in 3 years)
Impact on poor	▪ **Limited evidence of networks targeted specifically at low income households and limited evidence of disproportionate impact of networks on poor population** – Greenstar clinics are aimed at providing services to the low income population. Only clinics located near urban slums and/or having at least 50% poor clientele are inducted into the network
Quality	▪ **Some evidence of improvement in quality of services due to accreditation and capacity building of health service providers** – Saathiya network HSPs scored 22% higher on FP counselling knowledge index – 86% of clients were satisfied with the quality of services provided by the Saadhan network
Other	▪ **Improved awareness and knowledge seeking behaviour for FP** – Saathiya helpline received 175,000 calls in 2 years, currently averaging 1,000/day – Dimpa helpline saw 310% increase in information seeking calls in 6 months ▪ **Networks can be tailored to promote one particular method** (e.g. injectables) **or an entire method mix**

SOURCE: Literature search; Interviews; Team Analysis

Cost effectiveness of intervention

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Key drivers of cost

Type of cost	Fixed/ variable
▪ Administrative costs	
– Salaries of staff	Fixed
– Cost of accreditation and audit	Fixed
– Training and capacity building	Variable (# sessions)
▪ Optional activities	
– Operational cost of helpline (e.g., salaries, technology)	Fixed
– Subsidy for customers	Variable (# products consumed)

Cost effectiveness measures

- Cost per person reached
- Cost per new contraceptive user

Evidence on overall cost/cost effectiveness

- **TBD**

SOURCE: Literature review; Interviews; Team analysis

Incentives for stakeholders

PRELIMINARY

Key stakeholders	Typical incentives	Sample incentive models		Implications for URHI
		Dimpa	**Saathiya**	
Ob/gyns, GPs	▪ Higher volume ▪ Accreditation ▪ Training ▪ Subsidised product supply ▪ Promotion material	▪ Accreditation as high quality clinic ▪ Doctor and parametric training ▪ IEC materials	▪ Accreditation ▪ IEC materials ▪ Training	▪ Service providers need to receive appropriate financial incentives to prioritise FP network services and products
ISMPs	▪ Training ▪ Commission per referral	▪ Not included in the network	▪ Incentives provided to this stakeholder are unknown	▪ ISMPs are mainly based in rural areas, hence, are not relevant for URHI
Retailer	▪ Training ▪ Branding ▪ Higher sales volume	▪ Branding	▪ Branding with Saathiya logo ▪ Training ▪ Promotional materials	▪ On the supply side, the benefits of including chemists in the network vis-à-vis social marketing must be considered
Commercial manufacturing partner	▪ Increased access points for products ▪ Increased sales ▪ Brand awareness/ recognition	▪ Increased outlets for DMPA sales	▪ Brand awareness among network doctors ▪ Product reach to a wider audience	▪ Partnership with manufacturing companies can provide access to established supply chains
Beneficiary	▪ Access to quality products/services at discounted prices	▪ Lower prices of DMPA due to competition between different manufacturers	▪ Saathiya health card offering 5% discount on products and 50% discount on consultations	▪ Products/ services need to be discounted sufficiently to make them affordable to low income individuals

SOURCE: Literature search; Interviews; Team analysis

Implications for URHI

PRELIMINARY

- **Overall, based on the evidence and URHI context, we believe that leveraging networks to improve access and adoption of different contraceptive products/services has the potential for making impact but there are significant unanswered questions regarding the model**
  - **The design and feasibility of the model has been tested** and implemented at state-level and national scales. Several networks of healthcare service/product providers for family planning services exist globally (Greenstar, Pakistan) and in India (Dimpa, Saathiya)
  - **While some network schemes have shown some impact on family planning outcome indicators (e.g., Saadhan),** the two networks schemes active in URHC's target cities do not have any studies demonstrating impact on CPR (i.e., Saathiya) or have had a small direct impact on a particular method (i.e., Dimpa)
  - **Limited information exists on the cost-effectiveness of network schemes**
  - Given the context of urban UP, there is a need to improve access to facilities offering quality services. However, with two existing networks in urban UP, the relevance of an additional network is uncertain
- **Long term sustainability of functional networks may be possible with an appropriately designed incentive system and sufficient volume, but has not yet been tested**
- **We believe that the design of the network scheme for URHI will need to be refined with particular emphasis on the following design elements:**
  - Will URHI create new network(s) in addition to Dimpa and Saathiya? If so,
    - How can the network be designed to improve access and affordability for low income households?
    - How can the healthcare service providers be incentivised to prioritize family planning?
    - Which category of healthcare service providers should be included in the network?
    - What are the additional demand-side interventions (e.g., publicity) which need to be conducted to make the network achieve sufficient volume to become self-sustaining ?
  - Will URHI build on network initiatives already existing in UP (Dimpa, Saathiya)? If so,
    - How should URHI link and/or integrate Dimpa and Saathiya with other URHI initiatives?
    - How should URHI's supplement what is already being by Dimpa? By Saathiya?
    - Should URHI's role vary by city?

Sources

PRELIMINARY

- USAID, “The Dimpa Programme - Delivering Injectable Contraceptives at Scale through the Private Sector” (October 2009)
- T. Levy, D. Agarwal, P. Miller, “Expanding access and demand for DMPA in Uttar Pradesh, Jharkhand and Uttarakhand” (June 2009)
- T. Chandani, S. Sulzbach, M. Forzley, “Private Provider Networks: The Role of Viability in Expanding the Supp ly of Reproductive Health and Family Planning Services” (April 2006)
- S. Mehra, S. Malarcher, Futures Group International, “Injectable contraceptives in India – Past, Present & Future” (October 2009)
- J. Barnes, PSP One, USAID” Private Provider Networks: Bringing Order to Chaos” (April 2006)
- DMPA – Programme backgrounder, Abt Associates Inc.
- Dr J P DuConge, Vibha, A. McDonagh, Population services International, “Social Marketing Strategies for Mother & Child Health” (November 2003)
- C. Chan, Vibha, J. Davis, “Social Marketing Strategies for Maternal and Child Health in the States of Uttar Pradesh, Uttaranchal & Jharkhand, India, 2002 – 2005” (May 2005)
- Population Services International profiles, “Giving families more room to breathe” (April 2005)
- USAID, “Addressing Family Planning and Reproductive Health needs of Young Married Couples”
- USAID, “Addressing Reproductive Health & Family Planning Needs of Young Married Couples” (October 2009)

Note: This list does not include site visits and interviews that were also conducted by the project team