Total Market Approach to increase access, choice and quality: Bihar and Orissa

Dr Amit Bhanot
Improved Family Planning and Reproductive Health Services in Bihar and Odisha

Background
Programme Goals and Objectives

- Increase in modern CPR to 42% in Bihar and 48% in Odisha
- Generate around 3 million CYPs in 2 years
- Avert 1657 maternal deaths
- Estimated 780,000 new FP users
- Provide 300,000 RH services
- Establish 280 franchisees
- Set up 18000 social marketing outlets
Implementation Design for Public Private Partnerships

- Prioritize needs
- Determine shared goals
- Engage right partners
- Develop strategic options

Government Leadership and Ownership

- Design and test appropriate models
- Evaluate impact
- Develop costed scale up strategy
- Establish links with policy framework
- Ensure sustainable financing

Source: Futures Group India
Findings from the
Secondary Analysis
Total Fertility Rate in selected Indian States & India, 2010

<table>
<thead>
<tr>
<th>State</th>
<th>Total Fertility Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bihar</td>
<td>3.7</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>3.5</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>3.2</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>3.1</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>3.0</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>2.8</td>
</tr>
<tr>
<td>India</td>
<td>2.5</td>
</tr>
<tr>
<td>Gujarat</td>
<td>2.5</td>
</tr>
<tr>
<td>Assam</td>
<td>2.5</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>2.3</td>
</tr>
<tr>
<td>Haryana</td>
<td>2.3</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>2.0</td>
</tr>
<tr>
<td>Karnataka</td>
<td>2.0</td>
</tr>
<tr>
<td>Delhi</td>
<td>1.9</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>1.9</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>1.8</td>
</tr>
<tr>
<td>W. Bengal</td>
<td>1.8</td>
</tr>
<tr>
<td>Punjab</td>
<td>1.8</td>
</tr>
<tr>
<td>Kerala</td>
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<td>Andhra Pradesh</td>
<td>1.8</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Source: Sample Registration System, Registrar General of India, 2011

TFR = 2.1, replacement level of fertility
Inter linkages – modern CPR, IMR and MMR

Source: IMR (2012) & MMR (2007/09) from
TFR Inequity at District Level in Bihar

- TFR in Bihar is 3.7
- 11 districts have TFR more than 4
- Highest TFR in Sheohar and Lowest in Patna

Source: AHS-2010-11
.....and a similar case in Odisha

Source: AHS-2010-11
Trends in Contraceptive Prevalence Rate

Bihar

Odisha

Source: DLHS 3, 2007-08; AHS, 2010-11
Trends in Contraceptive Prevalence Rate
Modern Methods, Bihar – DLHS–3 and AHS

Sources: AHS, 2010-11 and DLHS, 3 2007-08
Trends in Contraceptive Prevalence Rate
Modern Methods, Odisha – DLHS–3 and AHS

Sources: AHS, 2010-11 and DLHS, 3 2007-08
Current use of Modern Contraception – By Wealth Quintile

**Bihar**

- Lowest: 20.8
- Low: 26.8
- Medium: 34
- High: 42.8
- Highest: 52.4

**Odisha**

- Lowest: 31.9
- Low: 39.8
- Medium: 46.4
- High: 48.5
- Highest: 49.2

*Source: DLHS, 3 2007-08*
Unmet Need for Family Planning – By Quintile

Bihar

<table>
<thead>
<tr>
<th>Quintile</th>
<th>For Spacing</th>
<th>For Limiting</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>13.7</td>
<td>7.8</td>
<td>21.6</td>
</tr>
<tr>
<td>Highest</td>
<td>28.1</td>
<td>13.8</td>
<td>41.9</td>
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</table>

Odisha

<table>
<thead>
<tr>
<th>Quintile</th>
<th>For Spacing</th>
<th>For Limiting</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>9.1</td>
<td>3.9</td>
<td>12.7</td>
</tr>
<tr>
<td>Highest</td>
<td>17.8</td>
<td>16.6</td>
<td>26.9</td>
</tr>
</tbody>
</table>

Source: DLHS, 3 2007-08
Unmet Need for Spacing methods– By Quintile

**Bihar**

<table>
<thead>
<tr>
<th>Quintile</th>
<th>NFHS-3 2005-06</th>
<th>DLHS-3 2007-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>13.7</td>
<td>14.4</td>
</tr>
<tr>
<td>Second</td>
<td>14.4</td>
<td>11.7</td>
</tr>
<tr>
<td>Middle</td>
<td>11.7</td>
<td>9.2</td>
</tr>
<tr>
<td>Fourth</td>
<td>9.2</td>
<td>11.1</td>
</tr>
<tr>
<td>Highest</td>
<td>7.8</td>
<td>11.1</td>
</tr>
</tbody>
</table>

**Odisha**

<table>
<thead>
<tr>
<th>Quintile</th>
<th>NFHS-3 2005-06</th>
<th>DLHS-3 2007-08</th>
</tr>
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<tbody>
<tr>
<td>Lowest</td>
<td>7.5</td>
<td>9.1</td>
</tr>
<tr>
<td>Second</td>
<td>9.1</td>
<td>7.9</td>
</tr>
<tr>
<td>Middle</td>
<td>7.9</td>
<td>8.7</td>
</tr>
<tr>
<td>Fourth</td>
<td>8.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Highest</td>
<td>6.6</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Legend: NFHS-3 2005-06, DLHS-3 2007-08
Unmet Need for Limiting methods – By Quintile

Bihar

- Lowest: 28.1 (NFHS-3 2005-06), 16.3 (DLHS-3 2007-08)
- Second: 22.6 (NFHS-3 2005-06), 12.5 (DLHS-3 2007-08)
- Middle: 19.4 (NFHS-3 2005-06), 11.6 (DLHS-3 2007-08)
- Fourth: 16.9 (NFHS-3 2005-06), 8.4 (DLHS-3 2007-08)
- Highest: 13.8 (NFHS-3 2005-06), 5.4 (DLHS-3 2007-08)

Odisha

- Lowest: 17.8 (NFHS-3 2005-06), 9.7 (DLHS-3 2007-08)
- Second: 14.6 (NFHS-3 2005-06), 7.8 (DLHS-3 2007-08)
- Middle: 14.5 (NFHS-3 2005-06), 8.7 (DLHS-3 2007-08)
- Fourth: 12.8 (NFHS-3 2005-06), 6.4 (DLHS-3 2007-08)
- Highest: 12.7 (NFHS-3 2005-06), 4.4 (DLHS-3 2007-08)
Percent Current use/Intension to use of different FP methods – by age of women

### Bihar

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Sterilisation</th>
<th>IUD</th>
<th>OCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>29</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>25-29</td>
<td>47</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>30-49</td>
<td>48.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

### Odisha

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Sterilisation</th>
<th>IUD</th>
<th>OCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>12.1</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>25-29</td>
<td>17</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>30-49</td>
<td>46.1</td>
<td>0.4</td>
<td>0.4</td>
</tr>
</tbody>
</table>

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**Source:** DLHS, 3 2007-08
Percent Current use/Intension to use of different FP methods – by No. of Sur. Child – Bihar

Source: DLHS, 3 2007-08
Percent Current use/Intension to use of FP methods – by No. of Sur. Child – Odisha

Source: DLHS, 3 2007-08
Current use of Modern Contraception – By Residence

Source: DLHS-3, 2007-08  AHS, 2010-11
Unmet Need for Family Planning – By Residence

**Bihar**

- For Spacing: Rural 22.2, Urban 15.4, Total 40.6
- For Limiting: Rural 18.4, Urban 14.6, Total 30

**Odisha**

- For Spacing: Rural 11.3, Urban 8.2, Total 23.5
- For Limiting: Rural 12.3, Urban 13.4, Total 21.7

*Source: AHS, 2010-11*
Source of Modern Contraception – Spacing Methods

Bihar

- Government
- Private
- Other

Odisha

- Government
- Private
- Other

Source: DLHS, 3 2007-08
Source of Modern Contraception – Limiting Methods

**Bihar**

- Lowest: 66.3
- Low: 63.7
- Medium: 61.1
- High: 55.3
- Highest: 46.3

**Odisha**

- Lowest: 97.3
- Low: 97.2
- Medium: 95.5
- High: 93.8
- Highest: 84.4

*Source: DLHS, 3 2007-08*
Demand Side – Audience Insights

- Female Sterilization most popular as it is relatively widely available
- Large family norms - Sterilization after high parity
- No demand, Negative beliefs, myths and misconceptions for spacing methods - especially for clinical methods for spacing - IUDs, Injectables
- High awareness and utilization of the benefits and reimbursements available for institutional deliveries and sterilization
- In younger age-groups - awareness about spacing methods is lower than older age group
- Low reach of media in villages but high ownership in urban centres
- Use of mobile phones is increasing
Supply Side – Public Sector

- Under resourced public facilities
- Blurred lines between public and private - government doctors with private practice
- Vacancies among frontline health workers and doctors
- Supply disruptions in contraceptive products

Photo: Futures Group
Supply Side – Private Sector

- Rural Medical Practitioners (RMPs) serving the poorest of the poor - 2-3 RMPs in every village

- Availability of qualified providers at the block level in the private sector in Bihar and in few districts in Odisha

- Villagers prefer to access health services from the private sector providers at the bigger block or district level

- Negligible availability of condoms, oral contraceptive pills and emergency contraceptive pills at the village level

- Supply chain does not reach lower than block level

- Retailers not aware of proper use of methods including MTP kits
The Total Market Approach (TMA)
Making Markets Work for the Poor

Health Impact
- Are we changing behavior?
- Are we growing the category for all methods?

Equity
- Do all segments of the population have equal access?
- Are we helping ensure there are options for different income levels and for different age groups?

Subsidy
- Are we managing to reduce the subsidy?
- Do we have a longer-term cost recovery strategy?
- Are we creating a situation that could continue without us?
Project Ujjwal
Programme Goals and Objectives

1: Increased choice of sites providing quality clinical FP/RH services with a focus on clinic-based services in rural and underserved areas

2: Increased access to FP/RH products through social marketing with a focus on rural and underserved areas

3: Build FP/RH capacity of private sector providers, provide training and mentoring support, and facilitate improved implementation of PCPNDT Act

4: Generate demand, overcome barriers to FP uptake, and address gender norms through communications and community outreach
Overarching Principles

• Work within the framework of NRHM as per the government norms and guidelines

• Improve access and utilisation of FP services in urban, rural and remote areas to address gender and equity disparities

• Reach out to young women, girls and men with focus on increasing options for spacing

• Address the cost barriers for accessing services for poor through affordable service delivery models

• Complement existing government programs by leveraging the private sector

• Build sustainable capacities at state level
### Output 1: Increasing Sites Providing Quality FP/ RH Services

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Franchising</strong></td>
<td>• Private facilities networked</td>
</tr>
<tr>
<td></td>
<td>• Tiered network with accreditation and camps</td>
</tr>
<tr>
<td></td>
<td>• Business Management training</td>
</tr>
<tr>
<td><strong>Targeted demand-side financing</strong></td>
<td>• Operationalised for select districts and urban poor</td>
</tr>
<tr>
<td><strong>Mobile Outreach (Contracting-in)</strong></td>
<td>• Integrated FP camps conducted at public facilities through outreach teams</td>
</tr>
<tr>
<td><strong>Outreach for IUDs and Injectables</strong></td>
<td>• Bringing spacing methods and services closer to women</td>
</tr>
<tr>
<td><strong>Helpline</strong></td>
<td>• Integrated helpline to ensure client satisfaction</td>
</tr>
</tbody>
</table>
Social Franchising Network Proposed: Hub and Spoke Model

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>L1 CLINICS (80)</th>
<th>L2 CLINICS (200)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Counselling Available</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Spacing Methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Injectables</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• IUCD (Interval IUCD &amp; PP IUCD)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Permanent Methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Male Sterilization (NSV)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>• Female Sterilization (Minilap)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Female Sterilization (Laparoscopic)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Abortion Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• First Trimester</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Second Trimester</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Post Abortion Family Planning Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Comprehensive Abortion Care</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Output 2: Social Marketing

Overall approach: Expanding overall market for FP products

Basket of Products
Penetration tracking

• Male condoms
• Female condoms
• Oral contraceptive pills
• Emergency Contraceptive Pills
• Medical Termination of Pregnancy
• IUCD
• Safe Day Method
• Injectable Contraceptives
• Pregnancy Test Card
• Sanitary Napkins

• Establish 18,000 new outlets in underserved areas and groups
  • Traditional outlets
  • Non-traditional outlets
  • Linkages with NGOs, SHGs, youth clubs
• Strengthening social marketing skills of ASHAs for community based SM
• Retailer and depot holders strengthened through training on products and FP counselling
# Output 3: Capacity Building and Quality Assurance

## Capacity Building
- Building critical mass of skilled providers
- Needs-based incremental training
- Building capacity for client oriented services
- Partnerships with Professional Bodies and Organisations (FOGSI and IMA)
- Ensure quality of training
- E-learning platforms
- Centre of Excellence

## Quality Assurance
- Develop accreditation standards feasible for private sector
- Forging partnerships for QA implementation in private sector
- Establish institutional mechanism for QA in SF and PPP models
- Capacity building for QA
- Rewards and recognition
Output 4: Generate Demand

360° messaging - inform, persuade and engage

- Correct knowledge, addressing fears and concerns
- Community level role models / positive deviants who have overcome barriers
- Access to correct information, products and services
- Creating an enabling environment, aspirational role models

One Brand – connecting demand and supply
Systems are multi-functional & multi-player

Multi-players
- Government
- Civil Society/NGOs
- Private Sector
- Membership organizations
- Representative bodies
- Informal networks

Private and Public functions and players are part of the system
Other key takeaways

• **Role for both private and public players**
  • Challenge is to define who should perform what in the system

• **Role for subsidies to reach the most vulnerable**
  • Subsidy should not be universal (e.g. preferable to subsidize demand through targeted voucher scheme)
  • Subsidy should help build up commercial channels rather than threaten or disrupt them
  • Transactional subsidies should be provided through government systems (vs donor program)

• **Ramping up the ‘ends’ rapidly risks undermining the ‘means’ of getting there efficiently and sustainably**