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INNOVATIONS IN THE HEALTH SECTOR

Book of Innovations

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FOREWORD

It gives me immense pleasure to share the “Book of Innovations,” a collection of abstracts drawn from USAID projects. Public health has greatly advanced in evidence-based innovations, yet even when such innovations are implemented successfully in one location, they often disseminate slowly – if at all. Diffusion of innovations is a major challenge in all sectors including health. The sharing of innovations in this partners’ meeting represents an important step – disseminating best practices among our partners, Government and other donor agencies.

It is impressive to see such a wide array of innovations from reproductive health, HIV/AIDS, maternal and child health, urban health, nutrition and health systems. This is a testament to our commitment to look for new approaches and innovate. The challenge is to take these innovations to scale at State and national level to have a public health impact. This requires concerted efforts to disseminate the innovations to a wider audience, including policy makers and senior level Government officials. We can only say the job is done when these innovations are translated into national level policies and guidelines and improved programs are implemented.

The innovations identified in this book are very relevant to the present public health context. For example, innovations in public-private partnership are critical in addressing growing needs for expanding health care services. Also, there are a range of innovations in community-led interventions aimed at addressing the critical needs of vulnerable and underserved populations.

It is also important to note that many of these innovations are cross-cutting and could be adapted by various sectors within health. I am confident that the collective wisdom and on-the-ground experience represented in this collection of innovations will go a long way to strengthen the efforts of Government and partners to address the public health challenges of the country.

I would like to sincerely thank the Technical Committee and the Program Committee which labored long hours to review and select the abstracts and prepare this “Book of Innovations.” I would also like to thank our USAID partner agencies for their innovative work.



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Plenary

Session

BINDAAS BOL

Normalizing attitudes and growing the condom market in India

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Background

Condom sales in urban India were declining at the rate of about six per cent per annum from 2001. Formative consumer research revealed barriers to condom use – concerns about reduction in pleasure, embarrassment in purchase and usage, and the perception that condoms are only to be used in high risk situations and not for steady relationships.

Objective

To create a campaign that “normalizes” and creates a positive image of condoms and condom users that involves all stakeholders including manufacturers, retailers, media and the Government.

Approach

Extensive research among consumers, discussions with marketers as well as secondary data review of other condom promotion efforts helped the program to focus on the hitherto unaddressed barrier of “embarrassment”. A television campaign urging men to “just say condoms” was rigorously tested, aired and backed by on-ground activities across retail outlets in partnership with manufacturers. Regular press coverage garnered participation and support.

A tracking study and monthly sales audit reports assessed the impact of the campaign in terms of condoms sales, usage and attitudes.

Major findings

- Total urban condom sales as reported by the Nielsen retail store audit increased by 6.5 per

cent per year (compound annual growth rate) over the three year period in the project states of North India and by 21 per cent in 2006 in the project area as compared to 12 per cent in the rest of India

- Baseline (2004) and endline surveys (2007) showed that reported current use of condom with spouse increased from 38 to 60 per cent
- Consistent use with non-regular partners increased from 75 to 80 per cent
- Those who had been exposed to the campaign reported higher current use and consistent use than those who were not exposed
- The campaign received the UN Grand award by the UN Department of Public Information and the Grand Effie awarded by the Bombay Ad Club for India’s most effective marketing campaign.

Conclusion

- Studying what others are doing in the overall communication environment can help narrow down strategic options and focus the limited resources on unaddressed issues
- Call to action of campaign need not directly address end use (in this case it was “just say it” rather than “just use it”) but overcome initial barriers to achieve increased usage
- Involve the retailer as a change agent rather than merely a medium for message display
- The ‘normalization’ campaign planning should begin with and focus on the market and consumer rather than on the health problems.

EVALUATING EFFECTIVENESS OF TECHNICAL ASSISTANCE FOR BETTER HEALTH IMPACT

FHI experience in India

Organization

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Background

Through the USAID-supported SAMARTH project, FHI was tasked with providing Technical Assistance (TA) to Government and the civil society for mounting effective response on HIV/AIDS issues in India. FHI initially assessed the TA needs of the Government departments and United States Government partners; prioritized the needs to match with SAMARTH expertise; and then selected activities with potential to influence national and state level programming. TA was provided in the areas of program management; HIV prevention, care and treatment technical issues; strategic information and leadership building and communication. The methods used for providing TA included workshops, mentoring support, sharing of lessons learned and best practices, and exposure to demonstration projects supported as learning sites.

Objective

To measure effectiveness of TA to various Government and civil society agencies in mounting an effective response on HIV/AIDS issues in India.

Methods

FHI developed an evaluation framework for measuring effectiveness of TA provided to various agencies in India. The areas for assessment included responsiveness to client's needs, technical expertise, sustainability, management of TA, client satisfaction, and ability to transfer skills. Tools used for measuring effectiveness included questionnaires (client survey, self-assessment by the TA provider and pre- and post-test by the

workshop participants), review by technical peers, and follow-up onsite observation.

Major findings

Based on the client survey assessment, SAMARTH has been recognized by the Government and civil society partners as a critical TA provider in program management, monitoring and evaluation, surveillance and HIV care and treatment including Orphans and Vulnerable Children (OVC). There is increased demand for TA by different agencies and requests for long-term mentoring support. There is an improvement in post-test scores of participants attending workshops on documentation and dissemination, OVC issues, monitoring and evaluation and use of data for programming in areas of both knowledge and skills. Peer review by technical experts has validated the quality of TA provided on OVC issues.

Conclusion and recommendation

More detailed assessment is needed to assess effectiveness of long-term mentoring assistance provided to Government agencies. Lessons learned include: TA needs to be flexible to accommodate changing needs over time; should be well coordinated; should provide platforms to pilot approaches for replication and scale-up; and should follow the principles of equal partnership. The process and principles of TA provided under SAMARTH and the evaluation framework for measuring effectiveness of TA could be adapted for health system strengthening at the national, state and district levels for better health impact.

INSTITUTIONAL MATURITY INDEX AS AN ASSESSMENT TOOL FOR VILLAGE BASED ORGANIZATIONS IN CLICS PROGRAM

Organization

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Background

The Department of Community Medicine of MGIMS has been implementing a 'social franchise model' based on a community-based organization called the Village Coordination Committee (VCC) as part of the CLICS program. So far, 64 VCCs have been developed in the program that covers 67 villages of three Primary Health Center areas in Wardha district.

Objective

To assess the effectiveness of VCC with emphasis on various dimensions of health interventions.

Methodology

The Institutional Maturity Index (IMI) has been developed for the VCC using an index of quantitative and qualitative indicators which include organizational issues, activity related parameters, technical quality, linkages with other functionary, sustainability related parameters, etc. This is being applied as a self assessment tool for assessing the maturity of VCC. Those with high IMI rank are able to develop sustainability plan, identify minimum package of services and resource to sustain child survival interventions. Once VCC achieves a score of 80 out of 100, and reaches a five star status and implements the sustainability plan, it is declared the owner of the program and health related activities at the village level.

Major findings

The IMI has so far proven to be acting as a lever to motivate the VCCs to achieve sufficient maturity to become the owner of the program. The average IMI score of VCCs during the two phases (April-May 2007; November-December 2007) of assessment were 58 and 77 respectively.

IMI Score	April - May 2007	November - December 2007
1-20 (*)	0	0
21-40 (**)	3	0
41-60 (***)	32	3
61-80 (****)	29	35
81-100 (*****)	0	26
Total VCC	64	64

Conclusion

The VCC has synergy with the Village Health, Nutrition and Sanitation Committee (VHNSC) under the National Rural Health Mission. The District Health System of Wardha has already accepted the IMI tool for monitoring the VHNSC under the District Health Action Plan and has been included in the VHNSC training module. The IMI may prove to be an important tool to assess the effectiveness and maturity of community-based organizations at the village level.

SOCIAL FRANCHISING IN HEALTH IN UTTAR PRADESH

Organization

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Background

Social Franchising is a major Public Private Partnership (PPP) model, being supported by SIFPSA and funded by USAID. The project started in August 2007. The Hindustan Latex Family Planning Promotion Trust (HLFPPT) was selected as the Franchiser to cover the State and has set up franchisee hospitals with a brand name “Merrygold” at district level, “Merrysilver” at block level and ‘Merrytarang’ referral network at village level. The Merrygold Health Network has positioned itself to offer low cost but high quality package of Reproductive and Child Health (RCH) and other services to both urban and rural poor.

Objective

To bring about standardization in quality of services, pricing and customer care standards across various franchised hospitals/clinics through appropriate management model.

Approach

The HLFPPT will establish, as a part of “Merrygold Health Network”, 70 fully franchised Merrygold hospitals (Level 1) at district level, 700 partially franchised Merrysilver clinics (Level 2) at block level and 10,500 referral agents as Merrytarang (Level 3) at village level. The ambulance service, on demand, is linked with Merrygold hospitals and Merrysilver clinics.

RCH services at various levels are:

Merrygold: Emergency obstetric care services, all types of deliveries, family planning, ultrasound, diagnostics services, pharmacy, ambulance tie-up, social marketing

of RCH products, Family Planning (FP) counseling, referral services, immunization

Merrysilver: Normal delivery, intrauterine device, social marketing of RCH products, FP counseling, referral services, immunization

Merrytarang: Social marketing of RCH products, FP counseling, referral services, immunization.

Present status

The HLFPPT has established eight Merrygold hospitals, 68 Merrysilver clinics and 967 Merrytarang partners in seven districts.

Conclusion

- The strength of this model is in bringing together a large number of private sector health care providers and build linkages to provide high-quality health services
- A consistent pricing policy needs to be put in place and strictly enforced
- The network member reflects the quality of the brand. Therefore, the inclusion criteria needs to be made stringent
- To overcome issues of long distances for referrals reaching the next tier of clinic or hospital, it is important that the network concentrates and appoints more Level 1 and Level 2 within a district
- Once the Merrygold network is fully operational, the basket of services offered may be expanded to include other need based services
- This platform can be effectively used for Government schemes as private sector has already made investments in infrastructure, trained manpower and above all flexibility of operation.

Concurrent Sessions

ASHA PLUS PROJECT IN UTTARAKHAND

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Background

The National Rural Health Mission (NRHM) has introduced an Accredited Social Health Activist (ASHA) as a village based health volunteer and the first point of contact for the health needs of communities. In most parts of Uttarakhand, the difficult geographical terrain, dispersed populations, poor road connectivity and poor access to transport make access to health care difficult. Though the NRHM has suggested guidelines for ASHAs, the state felt the need to adapt these and develop a model based on local needs. It is in this context that a Public Private Partnership (PPP) initiative was conceptualized for increasing the access to Reproductive and Child Health (RCH) services in difficult terrain through an efficient need based model of ASHAs.

Objective

To conduct an operations research on the functioning of the model developed for ASHA like workers, to be carried out in two select blocks in each of the three upper Himalayan districts, in order to provide the necessary evidence base for its adoption in the hilly region in the state of Uttarakhand.

Approach

The ASHA Plus project is a PPP initiative with roles clearly defined for all the partners. The local NGOs are involved in ASHA Plus workers' recruitment, training and supportive supervision. The ASHA Plus workers have flexible population coverage. The selection of ASHA Plus is done by NGOs, panchayati raj institutions and health functionaries through open community meetings.

Technical assistance from ITAP was provided in developing interactive training materials, conducting training of NGO trainers, developing systems for payments, MIS and logistics, and monitoring and review of the project.

The flow of financial resources to the NGOs is through the Uttarakhand Health and Family Welfare Society. The performance based payments to ASHA are for a wider range of services and are made through the NGOs.

The monitoring of the project is done by the Government health officials and the Project Advisory Group.

As part of the operations research, a baseline survey of health indicators in six intervention blocks and three control blocks was carried out while the process documentation is an on-going activity. An endline evaluation of all the blocks is planned at the end of the project period.

Major activities

- NGOs selected and contracts signed
- 547 ASHA Plus to cover six blocks selected
- Performance based payments system covering a wide range of services finalized
- Interactive training material developed, pretested and finalized
- 547 ASHA Plus workers have undergone three phases of training
- Household survey and ELCO (eligible couple) mapping done by ASHA Plus

- Management information system has been developed and initiated
- Job aids provided to ASHA Plus for interpersonal communication
- Improved mobilization of clients for RCH services
- Documentation of processes is on-going.

Conclusion

- Flexible population coverage in hilly regions improves efficiency
- Quality of training and incremental training is critical in developing the skills of workers
- Payments for wider range of services improves service delivery, better payment package for ASHA Plus and enhanced motivation levels
- Mentoring and supportive supervision by NGOs is key to empowerment of ASHA Plus.

CATALYZING PARTNERSHIPS THROUGH CATEGORY CAMPAIGNS

Examples from ORS and diarrhea management promotion

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Background

The USAID funded Program for Advancement of Commercial Technology – Child and Reproductive Health (PACT-CRH) implemented by ICICI Bank launched the WHO-Oral Rehydrated Salt (ORS) campaign in 2002. The initial focus was on promoting wider adoption of WHO formula ORS. From 2005, it facilitated the shift to the new low osmolarity ORS and from 2006, a broad based diarrhea management program by the name ‘*Saathi Bachpan Ke*’ (Friends for Childhood).

Objectives

While the broader objectives were to increase the use of ORS and improve knowledge and practices about prevention and home management of diarrhea, PSP-One partnership objectives were to support policy advocacy, increase manufacturer’s involvement in ORS promotion and leverage media support to optimize utilization of campaign resources.

Methods

The ORS manufacturers were explained the benefits of partnering with the campaign as well as the size of the potential market. Media and celebrity support was garnered by highlighting the seriousness and dangers of childhood diarrhea and the role of ORS.

For achieving a policy shift to a single low osmolarity formula in the Indian pharmacopoeia, the program facilitated setting up of a task force of experts from the Indian Academy of Pediatrics and the All India Institute of Medical Sciences. ORS manufacturers were also consulted to ensure that they would support the shift to a new formula.

Major findings

Supported by the inputs of the task force in 2004, the Drug Controller of India ordered a single new low osmolarity formula in the Indian pharmacopoeia.

The ORS manufacturers placed campaign logo on their packs, supported material production and provided training and consumer promotions as well as two million of its samples. Media channels provided free airtime and the campaign pioneered in-serial promotion with inserts in Hindi serials as well as *pro bono* support by over 25 celebrities. Additionally, promotional partnerships were struck with Lifebuoy soap, milk cooperatives in Madhya Pradesh and Rajasthan, and the Indian Railways.

The ORS market grew at an annual rate of eight per cent and tracking surveys showed positive changes in knowledge and practices. The campaign managed to leverage almost \$1.5 million in just last three years of the five year program and has been adopted by the National Rural Health Mission ensuring continuation beyond the lifespan of the PACT-CRH program.

Conclusion

Category campaigns are limited to a specific duration, and objectives are usually limited to increasing awareness and use. However, if planned carefully and executed keeping partners well informed and involved, category campaigns can be effective catalysts to build momentum and support for a health issue far beyond its normal boundaries of influence.

CONVERGENCE OF STAKEHOLDERS AT WARD LEVEL FOR IMPROVED HEALTH SERVICE DELIVERY TO THE URBAN POOR

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Background

In Madhya Pradesh, childhood immunization coverage among urban poor is 54 per cent (15 percentage point lower than urban average, National Family Health Survey-III). This indicates poor reach of services to urban poor. In this context, UHRC partnered with Indore Municipal Corporation and District Health Department to pilot an approach of fostering linkages among various stakeholders in a Ward to improve access of health services, through convergence of efforts and complementary resources.

Objective

To institute mechanisms of convergent efforts of Ward level stakeholders and gauge the impact of the approach on health service coverage.

Methods

The initial facilitation process in a Ward included identifying underserved slums, key stakeholders and resources and building consensus. The role of stakeholders for health care delivery was determined and thereafter convergence was facilitated to improve coverage through regular outreach services. A Ward coordination committee (Health Department, Women and Child Development Department, Zonal Officer of Municipal Corporation, Elected Representatives, Social Clubs, Private Schools, Community-based Organizations, NGOs) was constituted. The committee focused on planning health coverage activities for underserved

slums, utilizing local resources in a complementary manner and reviewing the progress. Through joint planning and collective action, immunization and antenatal care camps (seven monthly camps covering 28 underserved slums) were organized. Baseline survey in November 2003 and mid-term survey in June 2005 were conducted by external agencies for evaluation.

Major outcomes

The mid-line survey data indicated that in 28 slums of one ward of Indore (40,000 slum population) immunization, among children 12-23 months had increased from 45.4 to 53.8 per cent. Measles vaccination by 12 months had increased from 67.5 to 74.9 per cent and dropout rate had decreased from 39.5 to 9.5 per cent.

Conclusion

Results demonstrate that convergence of efforts and pooling of local resources can improve the coverage of child health services. Complementing inter-sectoral convergence with demand generation has the potential to further enhance outcomes of this approach. The approach with incorporation of demand generation component has now been replicated in five more Wards in Indore, three Wards in Bhopal, one Ward in Ujjain and two urban health center areas in Agra. Lessons from these replication sites in diverse cities would help incorporate this convergence strategy in the proposed National Urban Health Mission.

DESIGNING A NETWORK OF DIVERSE HEALTH CARE PROVIDERS FOR MEETING REPRODUCTIVE HEALTH NEEDS OF MARRIED YOUTH

Saathiya, the youth friendly initiative program

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Background

A pilot project aptly named *Saathiya* ('trusted partner' in Hindi), was launched in Lucknow, Uttar Pradesh to help young married couples make informed choices about contraception and on delaying or spacing pregnancies. *Saathiya* partnered with a variety of private sector contraceptive manufacturers and offers a "basket" of products comprising condoms, emergency contraceptives, low-dose oral contraceptives and Standard Days Method (CycleBeads).

In an unique program innovation, 150 Indian System of Medicine Practitioner (ISMP) doctors and chemists were selected and trained to augment their skills related to adolescent Reproductive Health (RH) and counseling. The program is complemented by an integrated youth oriented promotional campaign, comprising in-cinema promotions, street theatre, radio advertising, billboards, provider signage, and in-store/in-clinic materials.

Saathiya helpline is a particularly effective element of the communication strategy. The helpline receives about 120 calls everyday and has received over 12,000 calls on RH needs in the first six months of its operation.

Learning objectives

- Discuss minimum market requirements for designing private sector partnerships to meet RH needs of young people

- Describe the designing and integration of a helpline into a youth friendly RH/Family Planning (FP) program
- Outline at least three youth friendly communication channels to promote family planning amongst young married couples.

Method

A formative research was commissioned to:

- Understand knowledge, attitude and practice of youth with respect to FP
- Check their concerns and key influencers
- Gauge reactions of Chemists to the concept of youth friendly pharmacy and that of ISMPs, General Practitioners and Ob/Gyns for inclusion into *Saathiya*, the youth friendly initiative network.

Major findings

Chemists were seen to be more of product specialists and less of FP consultants. They needed transition from being medicine sellers to the ones who can provide basic counseling on contraceptives. ISMPs on the other hand were seen enjoying higher credibility and acceptance amongst youths but needed to strengthen their FP and RH knowledge and consultation skills. Ob/Gyns and GPs were seen more as specialists and for referrals.

Youths interpreted youth friendly services for FP and RH as something that is accessible and offered quick

and convenient information. Privacy, confidentiality and sensitivity were key criteria and the helpline was seen as strengthening this service delivery.

Conclusion

The preliminary data from the helpline confirms *Saathiya's* reach amongst the intended audience and that it has influenced RH choices amongst youths. The program is now being expanded to six additional cities across Uttar Pradesh and Uttarakhand while the number of providers in Lucknow is being doubled.

ENGAGING THE PRIVATE SECTOR AS A PARTNER IN HIV/AIDS CARE, SUPPORT AND TREATMENT IN RESOURCE CONSTRAINT SETTINGS IN TAMIL NADU

Organization

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Challenges to implementation

Nearly 55 per cent of the middle-income (income of \$1000 - \$3000 per year) group people access treatment from the private health care providers. After the emergence of HIV, the People Living with HIV (PLHIV) belonging to the middle-income group were not able to get treatment from private facilities due to high treatment cost (double charges for surgeries and obstetrical procedures).

Objective

To demonstrate a unique private sector model on providing HIV/AIDS care, support and treatment in resource constraint settings in Tamil Nadu.

Intervention or response

The Perundurai Medical College Hospital (PMCH) in Erode district is a subsidiary of the Institute of Road Transport (IRT) in Tamil Nadu with bed strength for 600 patients. PMCH is well known for the institutional care provided to more than 2500 PLHA for more than a decade. The AIDS Prevention and Control (APAC) project collaborated with PMCH to provide training for health care providers in the private sector and clinical care for PLHA. Of the total contract amount, 25 per cent of the clinical cost was borne by the PMCH. The patients were divided into categories and had paid for clinical services. The amount paid by 30

per cent of the patients was utilized for providing free clinical services for the remaining. The continuum of care of the discharged patients was ensured through the NGOs, community-based organizations and private hospitals. Training, capacity building and onsite support on good clinical practice was provided by the PMCH team to these private health care providers. The project conducted rural out reach camps and provided basic clinical care and testing facilities for chronic illness and sexually transmitted infection.

Results and lessons learned

Local NGOs and political leaders actively participated and helped in resource mobilization for conducting camps. These comprehensive medical camps attracted 25 per cent more clients to access clinical services. Increase in the patient caseload (40% at PMCH and 10% at private hospitals) after the camps had increased the revenue for these hospitals and strengthened their collaboration with the APAC-PMCH project. Patients have also informed about a 20 per cent savings by accessing care in their locality.

Key recommendations

Client satisfaction in terms of quality clinical care at affordable rates and at friendly sites had really paved the way for showcasing this as a cost effective model in the private sector. Developing sustainable strategies

for increasing the general client load, income and the capacity of the hospital staff encourages the private sector institution for such partnerships in provision of continuum of care services.

Public private partnership models (involvement of local stakeholders and private hospitals) like these are cost effective and ideal for replication in resource constrained settings.

GENERATING LOCAL OWNERSHIP OF HIV PROGRAMMING THROUGH COMMUNITY MOBILIZATION

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Background

The University of Manitoba is implementing a five-year HIV/AIDS prevention, care, treatment and support program in select districts of rural Karnataka and Andhra Pradesh, called the Samastha project. Prior to the start of the project, HIV programming had never occurred in most of Samastha's intervention villages. Village communities in India are close-knit societies and tend to be wary of outsiders. Villages are often exposed to ad-hoc activities by the commercial sector and NGOs, never to be seen again. A common perception among villagers about these activities is that the community is not involved and there is little personal relevance.

Objective

To gain trust from village communities while mobilizing them to play an active role in the project.

Approach

Samastha recruited local villagers to act as full time outreach workers, known as Link Workers. An activity was designed to create awareness of Link Workers in the communities, while generating local ownership over the project's objectives and activities.

A one-day event, called *Kalajatha*, was developed and teams of theatre artists were trained to perform across intervention villages. Preparations for each *Kalajatha* begin days before the event, with Link Workers meeting local village leaders to solicit their support.

The *Kalajatha* starts in the morning with the team dividing villagers into groups, with a member from the *Kalajatha* team facilitating discussions about the Samastha project, HIV, and other important issues. A kiosk is erected with materials about HIV and services available under the project. In the afternoon, folk dramas are performed delivering information about HIV, Samastha services, and addressing HIV stigma and discrimination. The event closes with village leaders addressing their community and pledging support to the project.

Outcomes

Seven *Kalajatha* troupes performed shows across nearly 900 villages. Involving village communities in activities created ownership over the project's objectives and activities. Endorsement from the village leaders gave Link Workers credibility and created a positive environment to deliver HIV messages.

Recommendations

Programs targeting communities are more effective if ownership of the objectives and activities is shared by community members. Building trust and the perception that programming has the community's interest at heart creates a more enabling environment, and has a multiplier effect on activities otherwise implemented by the organization alone.

HEALTH PROMOTION AND QUALITY ASSURANCE THROUGH PRIVATE SECTOR HEALTH CARE PROVIDER NETWORK

Organization

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Background

The *Dimpa* program and network for promoting use of injectable contraceptives through private health care providers was launched under the USAID-funded Commercial Market Strategies project in 2002.

The project adopted a 'network of clinics' model as its entry strategy. This strategy allowed for collective ownership of the project by providers, training of doctors in the network, monitoring the quality of service provision, ensuring product access and targeted consumer communications.

Learning objectives

The goal of the program is to: create awareness about DMPA as a safe and effective contraceptive option; increase access to and use of DMPA through the private health care providers.

Approach

Various partners have been engaged to accomplish these goals. USAID provides funding and technical assistance through PSP-One, and the Family Welfare Committee of Federation of Obstetric and Gynecological Societies of India (FOGSI) provides a platform to build consensus and support among Ob/Gyn providers for DMPA. Pfizer, DKT and PHS ensure supply of DMPA to all network clinics. IPAN manages public relations and advocacy, and Lowe advertising agency supports mass media activities for the promotion of DMPA.

Major findings

The pilot program was initiated in three cities in Uttar Pradesh and has since expanded to additional 42 cities in Uttar Pradesh, Jharkhand and Uttarakhand.

Since the inception of the network, use of injectables has increased from 0.004 to 0.7 per cent in Uttar Pradesh just as sales have steadily increased with DKT reporting 91 per cent annual growth. The quality DMPA products are now available in a price range of \$ 0.7 – 3.9 per vial, whereas at the start of the project the only product available was at about \$ 5.8 per vial. The program was able to create an advocacy board that includes medical experts, UNFPA and WHO. A consensus statement supporting DMPA was released by FOGSI.

Conclusion

- Network providers have better performance in Mystery Client studies compared to those who are just trained
- Need to segment providers so that inputs can be properly targeted. The two key variables for segmentation are provider's confidence in prescribing and supporting DMPA users, and levels of DMPA users/prescriptions
- Developing and delivering simple overarching communication objectives through sustained media briefings with regional press has yielded strong support and positive or neutral reporting by press
- One of the key reasons that providers join the network is for the promotional and advertising support their clinic receives as part of the network
- Commercial manufacturers and marketers respond quickly to increased support and provision for a new contraceptive method by introducing new brands and reducing prices.

INDIA'S FIRST GROUP HEALTH INSURANCE SCHEME FOR PEOPLE LIVING WITH HIV

A social marketing innovation¹

Organization

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Background

Insurance companies all around the world commonly deny medical coverage for HIV positive individuals because they believe that such insurance policies are not financially viable. Star Health and Allied Insurance Company Limited, a private insurance company developed an insurance product aimed at People Living with HIV (PLHIV) in July 2007. However, the policy had no 'takers' six months after its launch.

With the purpose of engaging the insurance sector in India in the fight against HIV, PSI approached Star Health to better understand the product and to explore what role it could play in support of this initiative. A key decision was made to pilot the policy for the first year in Karnataka in partnership with Karnataka Network for Positive People (KNP+).

Objective

To facilitate the release of group insurance policy for PLHIV in partnership with Star Health and KNP+.

Approach

A systematic marketing mix approach (product, place, price and promotion) was adopted to make the insurance scheme a living reality. In-depth knowledge on the consumer's need for health insurance, willingness to pay for insurance premium, and barriers and motivators

to enroll for the insurance cover was studied. PSI and KNP+ undertook a social mobilization campaign with district level PLHIV networks to generate interest and motivate enrolment.

Major findings

PSI facilitated the India's first ever group health insurance cover for 258 PLHIV in partnership with Star Health and KNP+.

- The Product: On the basis of assessments, PSI assisted Star Health to fine tune the product as follows:
 - ◆ Inclusion of coverage of hospitalization expenses before the AIDS stage
 - ◆ Consideration of the medical status of PLHIV in addition to CD4 count levels as criteria for enrollment
 - ◆ Price: PSI negotiated with the insurance company to bring down the price (by about 40%) to an affordable level and further provided 50 per cent voucher to the initial enrollees from the project
 - ◆ Place and Promotion: The partnership mobilized the enrollment of more than 300 PLHIV from six districts in Karnataka through a social mobilization campaign.

¹This innovation is part of PEPFAR supported project Connect, aimed at catalyzing Public Private Partnerships for mitigating the impact of HIV and TB in India.

Conclusion

This initiative is an excellent example of how social marketing can facilitate an innovative model of public-private partnerships to address HIV/AIDS. This initiative, the first of its kind in India, will not just

pilot what kind of insurance schemes fit the needs of PLHIV, but also strengthen future advocacy efforts with other private and public insurance companies at the national and international levels.

INVOLVEMENT OF RELIGIOUS LEADERS

Making a difference in response to HIV/AIDS

Organization

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Background

Maharashtra is a high prevalence State and has 32 districts in “A” category (> 1% antenatal care prevalence). Involvement of religious leaders with a vision to increase the response to HIV/AIDS is important in reaching general population.

Objective

Religious leaders play a crucial role in influencing the general population, especially youth for behavioral change.

Approach

The targeted interventions of Kripa Foundation in Vasai and Comprehensive Rural and Tribal Development Program (CRTDP) in Nagpur are funded by Avert Society. The focus is on vulnerable population targeting youth, single migrants and sex workers living in the villages and slum areas. Activities include: interpersonal communication and counseling for behavioral change, identification and treatment of Sexually Transmitted Infection (STI), referrals to Integrated Counseling and Testing Centers, community mobilization and advocacy among opinion leaders. The intervention communities were largely Catholics in Vasai and Muslims in Mominpura. In the initial phase it was a challenge to reach these communities with behavioral change messages. Religious leaders were mapped and identified. Sensitization meetings were held especially emphasizing on the impact of HIV/AIDS on the family. An action plan was drawn and the

program started with the involvement of motivated leaders. The program was monitored through the service statistics - Voluntary Counseling and Testing Centers testing and condom programming.

Major findings

In Vasai region, two Catholic Church parishes have started HIV/AIDS sessions in marriage preparation courses. Since December 2007, 100 couples (200 individuals) to be married underwent voluntary counseling and testing. They were provided with pre-test and post-test counseling. Two more parishes have invited the NGO for a similar program. In Nagpur, CRTDP was able to motivate two *imams* (Muslim priest) who give discourses during Friday *Namaaz* (prayer) to inform people about the services available and link people to the NGO. Currently, the NGO has 41 condom outlets and over 30,000 condoms are distributed free. Sites have also been identified for social marketing of condom by Hindustan Latex Family Planning Promotion Trust. About 120 STI cases were identified and treated. Out of 240 peers identified, 180 underwent scientific training.

Conclusion

Involvement of religious leaders helped to scale-up the program, increased community acceptance and uptake of services. Based on these experiences of the two projects, Avert Society will centrally implement the STI/HIV/AIDS prevention program among the faith-based organizations at the State level.

MOVING FROM KNOWLEDGE TO PRACTICE

The evidence review process

Organization

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Background

There is a significant need to take existing Maternal, Newborn and Child Health and Nutrition (MNCHN) knowledge into large scale practice. The Vistaar Project facilitated expert consultations, called “Evidence Reviews,” to help with this effort.

Objectives

The objectives of the evidence review process were:

- Improve access to existing evidence and use of this evidence for decision making
- Increase dialog and consensus about an evidence standard
- Increase consensus about evidence-based programming (“what” needs to be done to improve MNCHN and “how” to do it).

Approach

The Vistaar Project facilitated six Evidence Reviews on Complementary Feeding, Anemia Prevention and Treatment, Delayed Age at Marriage, Community-based Newborn Care, Village Health Committees, and Performance Improvement of Community Health and Nutrition Functionaries. The Project’s approach was:

- Conducting a literature search
- Setting an evidence standard
- Identifying experts to conduct the review
- Facilitating an expert consultation
- Documenting and sharing the expert recommendations.

Major outcomes

Some key lessons learned through this process include:

- Preparing for the evidence review meeting
 - ◆ Conduct evidence reviews on topics of high priority for the adopting agency (the Government in this case)
 - ◆ Involve a wide group of experts
 - ◆ Involve Government (as the adopting agency).
- The evidence review meeting
 - ◆ It is better to include more experts than less in the review meeting
 - ◆ Use participatory approaches to efficiently gather inputs from all experts in a short timeframe, such as: 1) small group work, 2) voting processes to come to consensus; and 3) limiting formal speeches and one-way presentations
 - ◆ It is generally not possible or practical to exclude experts from the expert panel due to potential conflict of interest issues, as most experts will have some association with one or more of the projects being reviewed
 - ◆ It is more successful to focus on the common lessons learned from the selected studies/evaluations – not to try to find a “best model”.
- Applying the results
 - ◆ Share the results with Government policy and program decision makers in person and through short, user friendly documents
 - ◆ Once the Government agrees to adopt a recommended approach, technical assistance is often needed to help support the recommended approaches.

Conclusion and recommendation

We recommend use of the Evidence Review process as an important part of moving from knowledge to practice. The process resulted in the following:

- Improved awareness, access and use of evidence
- Increased agreement about evidence standards
- Improved consensus about evidence-based MNCHN approaches that the Government should and can adopt
- Demonstrated participatory approaches to facilitate consensus building and collaboration
- Better informed technical assistance to Government programs at scale.

SOCIAL FRANCHISE MODEL FOR COMMUNITY OWNERSHIP OF DECENTRALIZED HEALTH CARE

Organization

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Background

The major strategy of the CLICS program has been to build the capacity of community-based organizations to develop, manage and ultimately achieve “ownership” of village-based child survival and health services. The scaling up and inherent sustainability has been achieved by applying the principles of “social franchising” in order to change the health behavior of communities and create a demand for health care.

Objectives

To provide affordable, high quality health care through effective partnerships at the village level and refine and test a Social Franchise (SF) model for the delivery of child survival interventions.

Methodology

The Department of Community Medicine (DCM) of MGIMS, (Franchiser) mobilizes community and enters into contractual agreement with Village Coordinating Committees (VCCs) (Franchisee) to produce package of high quality, affordable child survival and health services (“Social Product”) that address priority health problems. Sixty three VCCs have so far participated in the SF agreement covering 67 villages of Wardha district.

The DCM offers technical support to the VCCs, does quality monitoring of services; while VCC assesses health needs to prepare village health plan, does community-based monitoring, develops a communication plan and

ensures that the social product reaches to at least 60 per cent of the villagers. The social product encompasses revolving village health fund, services by Village Health Worker (VHW), organization of comprehensive maternal, child health day and of campaigns on safe motherhood, child survival, save the girl child and other such events.

Major findings

Apart from services through 20 community health centers and 89 VHW, all campaigns have been celebrated at least once in every village. Every VCC has developed a sustainability plan and cost recovery mechanism to sustain their activities. The mid-term evaluation has shown changes in the health indicators. The program monitoring indicators (early pregnancy registration, coverage of minimum antenatal care package, deliveries conducted by trained personnel, early initiation of breast feeding, early weight of the newborn, immunization coverage and malnutrition) are showing improving trend.

Conclusion

The CLICS program, thematically, has synergy with the National Rural Health Mission (NRHM) since its inception in September 2003. The district health system of Wardha has already accepted various components of the SF model in the District Health Action Plan. The experience gained in this model may have long term repercussion during implementation of NRHM and can guide implementation of NRHM in a better way.

VOUCHER SCHEME FOR EQUITY IN HEALTH

Organization

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Background

Uttar Pradesh has one of the highest Maternal Mortality Rate and Infant Mortality Rate in the country. The utilization of Reproductive and Child Health (RCH) services is poor. The out of pocket expenditure by the clients is high. The private sector has good presence in the urban areas. Voucher scheme is a demand side financing mechanism that helps purchase outputs. Hence, it was introduced as a Public Private Partnership (PPP) model in Agra district to reduce inequities and improve utilization of services.

Objective

To improve accessibility and utilization of antenatal, delivery, postnatal, family planning and reproductive tract infection/sexually transmitted infection management services in Below Poverty Line (BPL) clients from seven select blocks of Agra district.

Approach

The voucher scheme is a PPP model whereby the select RCH services are provided by accredited private practitioners. The District Program Management Unit is the Voucher Management Agency (VMA). The different service vouchers are distributed to the Accredited Social Health Activists (ASHAs) through NGOs who further distribute them to BPL clients as per need. The client can choose to avail services from any of the listed accredited private providers free of cost.

The private providers redeem the vouchers from the VMA. The costs of services were negotiated with the private providers and are lower than current market rates. The vouchers are redeemed by the VMA to the private nursing homes.

The NGOs are involved in distribution of vouchers, demand generation and Information, Education and Communication (IEC) activities to promote the uptake of vouchers.

The Agra Medical College is involved in doing accreditation and medical audit for monitoring the case management.

The Management Information Systems (MIS) were developed. Monitoring and periodic review is done by the Project Advisory Group. Mid-term client satisfaction survey is being done and documentation of the process is on-going.

Major findings

- Preparation of quality standard guidelines for private nursing homes
- Assessment and accreditation of private nursing homes
- Branding of voucher scheme as *SAMBHAV*
- Design and printing of vouchers and IEC materials
- Preparation of monitoring records and reports
- Basic IEC material for clients
- Orientation programs to ASHA, auxiliary nurse midwives and supervisors
- Distribution of vouchers to ASHA
- MIS software package for data entry developed and being used.

Conclusion

- Voucher scheme helps the BPL clients to access quality RCH services
- The high volumes of clients translate into better business proposition for the private providers
- Linking the voucher scheme to *Janani Suraksha Yojana* is still a challenge.

Other
Abstracts

ADDRESSING HIV VIA EXISTING INJECTING DRUG USER PROGRAMMING IN THE NORTHEAST

Organization

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Background

The National Aids Control Organization surveillance data shows an increase in HIV infection in Injecting Drug Users (IDUs) in the Northeast. Among IDUs needle and syringe sharing account for more than 50 per cent of the new infections.

The services and support are inadequate to meet the needs of the People Living with HIV (PLHIV) and to prevent further infection. Discrimination leads to the denial of care to IDUs by both service providers and their families. Within this setting, IDUs resist seeking services even when available or wait until it is too late.

Objective

Since 2004, in Manipur, Nagaland, Mizoram and Assam, Prevention of AIDS in Northeast India (PANI) project of CRS is addressing poor accessibility to Antiretroviral (ARV), quality care and treatment for HIV+ IDUs.

Methods

Complementing the efforts of the Government and other agencies, the model integrates HIV care and treatment services within existing drug rehabilitation or drop in center activities – offering a safe and discrimination free care and support environment for HIV+ IDUs. Linked with the nearest Government Antiretroviral Therapy (ART) center, a typical Center has a full complement of staff – part time ART physicians and nurses, counselors, outreach workers and peer educators. The services provided include health check-ups, patient education, counseling and home visits,

diagnosis and treatment of opportunistic infections and referrals and linkages to hospitals – none of which were provided prior to PANI. The staff facilitates enrolment for ARVs, accompany clients to the hospital for baseline tests/complete registration forms, and facilitate medicine pick up by clients or family members.

Outcomes

PANI has significantly increased the number of clients seeking and receiving ART. To date, PANI has ensured preventive education, treatment, care and support to more than 5,000 IDUs¹ out of a total of 8,000 PLHIV. The project has had an impact on changes in behavior towards IDUs and PLHIVs, including a demonstrated willingness of the community to help and care for them. Key informant feedback from clients as part of a 2007 evaluation indicated improvement in overall health condition, emotional support, increased access to information on treatment and side effects and increased access to opportunistic infection medicines.

Conclusion

This inter-sectoral model, integrating HIV services with IDU rehabilitation and support services, has allowed CRS partners and the Government to serve more clients and offer a more complete package of services.

Model scale up/improvement would include a greater emphasis on creating a supportive environment within clients' homes, a stronger component of promoting viable livelihood opportunities and greater outreach to rural populations.

¹ Total direct and indirect beneficiaries are more than 200,000.

ADDRESSING UNMET NEED OF COUPLES IN JHARKHAND

Expanding family planning options

Organization

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Background

Jharkhand reports a fertility rate of 3.3 (National Family Health Survey-III), an unmet need for spacing at 11 per cent and low modern spacing method use of 7.2 per cent. The Government of Jharkhand is making efforts to strengthen the Family Planning (FP) program in the State by increasing access and availability to contraceptive methods which are effective and community-based. With 61.2 per cent of girls marrying before 18 years there is need to address the delay of first pregnancy for reducing maternal and infant mortality in the State.

Objectives

IRH developed simple, effective, easy to use, scientifically tested fertility awareness based methods as the Standard Days Method (SDM), which can be offered by clinical and community-based providers have no side effects or health risks. These methods appeal to couples who are not using any FP, are newly married or are traditional method users.

Methodology

SDM was integrated into the services provided by the Ministry of Health in two blocks of Ranchi district. All medical officers (40), 94 Auxiliary Nurse Midwives (ANMs) and 44 rural medical practitioners in the intervention area were provided a contraceptive technical update followed by SDM training. One year later, community providers (278) animators and *anganwadi* workers were trained to expand access of SDM in the villages. Data were collected from service statistics, baseline and end line household surveys, and

simulated client visits, while provider knowledge was assessed using knowledge improvement tool.

Major findings

Following the SDM introduction by the Government providers, new SDM users stayed relatively steady over time. However, training community-based providers resulted in a sharp increase in new SDM users – from under 300 to over 1,800 per quarter – and a significant increase in all birth spacing users.

Anganwadi workers had high levels of correct knowledge about the SDM as compared to medical officers and ANMs. The information provided by all the providers during counseling sessions was similar. The clinical providers gave more information on condom use, while *anganwadi* workers on method action mechanisms. Household surveys show that *anganwadis* were the primary source of information about SDM (62% of women and 22% of men). About 88 per cent users of SDM were first time users of FP, thus bringing new people to FP. It reiterates that adding effective and user-friendly contraceptive method into the basket of choice can address the vast unmet need of couples.

Conclusion

Community workers provide SDM services that are of equal or better quality than clinicians. Involvement of community level workers increases knowledge about and use of birth spacing. Based on the encouraging results, the Ministry of Health, Government of Jharkhand is scaling up the SDM in select districts of the State.

AN INNOVATIVE MODEL OF IMPLEMENTING AND EVALUATING A HIV PREVENTION BEHAVIOR CHANGE COMMUNICATION PROJECT AMONG HIGH-RISK ADULT MALES IN 12 PORT CITIES IN INDIA

Organization

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Background

PSI implemented an innovative, integrated and intensive behavior change HIV prevention project (2001-2006), entitled 'Operation Lighthouse (OPL)' in 12 major Indian port cities with funding from USAID. Through interpersonal communications and education and the provision of products and services, OPL worked to decrease the proportion reporting non-spousal sex, increase condom use with non-spousal partner and increase utilization of HIV counseling and testing among truckers and other high risk males. Operating in nine States, the OPL team reached across divides in geography, culture and language to bring a complex set of messages and services to more than 350,000 men each month, reaching members of the target audience an estimated six-nine times annually through targeted Integrated Behavior Change Communication (iBCC) interventions.

Objective

To implement an innovative BCC model at scale and measure impact.

Methods

A unique 'single theme' approach was developed and implemented across all locations. Themes were changed every quarter. Further monthly tracking studies were conducted to gauge reach and recall of interventions and make mid-course corrections. The impact of the interventions was measured by a baseline survey in 2002 and two follow-up surveys in 2004 and 2006.

The surveys utilized a fixed one-level cluster design, with systematic random sampling of individuals within clusters (n=7,424 in 2002; 10,100 in 2004, and 10,013 in 2006).

Outcomes

Condom use with non-spousal partners increased from 57 per cent in 2002 to 75 per cent in 2006 among truckers, and from 45 to 71 per cent among other men. Consistent condom use with commercial partners increased from 51 per cent in 2002 to 60 per cent in 2006 among truckers, and from 48 to 56 per cent among other men; HIV testing increased among both the groups throughout the period (about 1% to 7%)

Both male groups exposed to the program reported significant high condom use than those who were not exposed to program interventions. Exposure to PSI messages was also significantly associated with increased HIV testing.

Conclusion

The OPL communication model demonstrated that focussed message around a single theme and ensuring frequency of exposure is essential for the behavior change. The single theme approach ensured quality of interventions, minimum message fatigue for both the outreach workers and the audiences and provided an excellent opportunity to directly monitor and fine tune inputs on a monthly basis.

COMMUNITY-BASED COMPREHENSIVE CARE PROGRAM FOR CHILDREN LIVING WITH HIV IN BAGALKOT DISTRICT OF KARNATAKA

Organization

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Background

Bagalkot district in has a HIV prevalence of 3.1 per cent among the general adult population with a relatively higher rural prevalence. HIV/AIDS has been reported as the leading cause of death in the people of childbearing age. An Orphan and Vulnerable Child (OVC) is three times more likely to die, even if he or she is HIV negative. OVC face stigmatization, emotional distress, lack of health care and education. There is an urgent need to develop models and community-based programs for OVC.

Objective

To develop and demonstrate a comprehensive and replicable model of care for rural OVC utilizing resources from the community to ensure improved quality of life through providing support in key components including nutrition, education, shelter, protection, health care and psycho-social support.

Methodology

A rapid mapping and situation needs assessment helped estimate the number of OVC. Community workers and volunteers were trained to assess needs and provide care in the six core components of OVC programming. William J. Clinton Foundation provided a grant for Children Living with HIV (CLHIV). Strategies were drawn up to expand coverage of HIV testing and care for OVC. Village health committees were involved in the process;

community leaders and health volunteers took responsibility.

CLHIV were mapped and village clusters of 20–30 were placed under an OVC– supervisor. An abandoned Government premise was renovated with community support to function as a temporary shelter home for double orphans and homeless OVC. The community generated funds to provide nutrition and safe water, school stationery and clothing. The community is being sensitized to prevent sexual abuse and labor exploitation. Efforts are under way to identify families to provide foster care and individuals to provide sponsorship.

Major findings and outcomes

The voluntary counseling and antiretroviral treatment data had 1809 OVC listed in the district. Out of these about 340 children have been identified to be living with HIV and 262 of them have been registered and are continuously monitored. Ninety-seven have received primary direct support and 153 have received supplemental support. Thirty-five OVC are resident in the community temporary shelter home.

Conclusion and programmatic recommendations

Community-based programs for OVC need to be delicately balanced with institutionalized care programs. Most resources to take care of OVC in rural communities can be generated locally.

COMMUNITY-BASED SOCIAL MOBILIZATION AND BEHAVIOR CHANGE MANAGEMENT REDUCES NEONATAL AND MATERNAL MORTALITY IN RURAL UTTAR PRADESH

Organization

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Background

Achieving the Millennium Development Goal 4 and 5 is a global imperative, and India in general and Uttar Pradesh in particular, hold the key to meeting global commitments. Most of the maternal and neonatal deaths occur at home against a backdrop of poverty, unskilled home deliveries and weak health systems. An integrated approach consisting of simultaneous strengthening of community and health system capacity is key to meeting our short-term goals as well as sustaining gains in the long term. This study focuses on building community capacity towards improving neonatal and maternal survival. It was conducted in Shivgarh, a rural administrative block in Uttar Pradesh, with an area of approximately 200 km² and a population of 104,123.

Objectives

The health innovations include participatory approach to intervention development and implementation, contextualization of global evidence to the prevailing socio-cultural-economic context of rural India, intervention delivery to multi-level target groups within communities, behavior change management approach, combination of top-down and ground-up program development, and strategic focus on

hypothermia and application of community skin-to-skin contact.

Methods

A socio-culturally contextualized program of Essential Newborn Care (ENC), including birth preparedness, clean delivery and immediate newborn care, promotion of immediate breastfeeding, clean cord and skin care, thermal care and skin-to-skin care, and care-seeking, was designed based on formative research. A cluster-randomized design was utilized to evaluate the impact of ENC versus usual care (“comparison”).

In intervention clusters, community health workers delivered the intervention package to multiple levels of target groups (community stakeholders, newborn care stakeholders, households) through monthly group meetings and two antenatal and two postnatal household visitations.

Pregnancy outcomes were tracked till 28 days after delivery, and mothers were followed up for 42 days. An end line survey was administered to document household knowledge, attitudes and practices. Neonatal and maternal verbal autopsies were conducted to infer cause of death.

Outcomes

Improvements in antenatal care coverage, birth preparedness, hygienic delivery, thermal care (including skin-to-skin care), umbilical cord care, skin care, breastfeeding, and care-seeking were observed in the intervention arms. Adjusted Neonatal Mortality Rate (NMR) in the ENC arm and ENC plus Thermospot arms was lower than the comparison arm by 51 per cent (rate ratio 0.49 [95% CI 0.38-0.63]) and 47 per cent (rate ratio 0.53 [95% CI 0.38-0.74]), respectively. Cause-specific analysis indicated that a higher proportion of deaths due to sepsis were averted in the intervention arms.

Maternal Mortality Ratio (MMR) was reduced to 495 maternal deaths per 100,000 live births (13 deaths/2627 live births, $p=0.06$, unadjusted, Chi square test) in the intervention arms versus the comparison arm which had a MMR of 1005 (19 deaths/1891 live births). Cause-specific analysis indicated that more deaths due to haemorrhage and puerperal infection were averted in the intervention arms.

Discussion

This rigorously designed and evaluated trial in a very high mortality area of India demonstrated that simple, evidence-based care practices communicated by community-based health workers and carried out by empowered, mobilized and informed families and communities may lead to reduced NMR and MMR.

The socio-culturally contextualized behavior change management approach, simultaneously targeted at multiple levels of stakeholders within the community, stimulated the expeditious adoption of evidence-based care practices, leading to neonatal and maternal mortality reduction, despite scarce resources and a poorly functioning health system.

This approach is scalable and sustainable through rapid building of community capacity, and complements the development of curative care. It has been integrated into the Comprehensive Child Survival program in Uttar Pradesh, which is currently being implemented in 17 districts of the State.

DECENTRALIZING AND MAINSTREAMING HIV/AIDS PROGRAMMING INTO HEALTH SECTOR

Organization

APAC Project^{1,3}, SAATHII², Tamil Nadu; USAID/India⁴

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Challenges to implementation

Over the last decade, the HIV/AIDS epidemic has slowly been moving from the high risk population to the general community. The increase of People Living with HIV/AIDS (PLHAs) in the rural areas has overburdened the district hospitals and has cost patients time, money and loss of daily wages. The challenge was to make clinical services available to PLHAs in every Government establishment in a district.

Objective

To mainstream HIV/AIDS programming into public health sector.

Intervention or response

The AIDS Prevention and Control (APAC) project conceptualized the innovative idea of mainstreaming HIV/AIDS clinical care in the Government health sector during October 2006 to April 2007. SAATHII, an NGO which undertakes large-scale HIV programs was selected as the nodal agency to build the capacity of Government health professionals and mainstream HIV/AIDS care and support services at home, community and institutional levels in the high prevalent district of Salem, Tamil Nadu.

Over 1050 medical fraternity including doctors, nurses, lab technicians, village health nurses in Government sector medical institutions were trained. Onsite support was provided by external consultants to ensure quality medical care for PLHAs. Guidelines were provided on universal precautions and hospital waste management for all the health care providers in the district. The

project had developed a uniform system of reporting HIV cases from the primary level to the tertiary level. The project also envisaged resource mobilization for the Government health care facilities. The entire project was implemented in consultation with the district positive networks and NGOs implementing HIV/AIDS programs.

Results and lessons learned

The coordination meetings in at the village level had ensured involvement of all the village representatives. Medical equipments such as blood pressure apparatus, weighing machines, wheel chairs, needle destroyers, etc., were mobilized from local leaders for the Primary Health Centers. There had been 15 per cent increase in the number of PLHA accessing services from the district and *Taluk* (an administrative division of a district) headquarter's hospitals. Referral of PLHA to access support services from NGOs has increased to 20 per cent. The project has been taken over by the district health authorities to continue these services.

Key recommendations

This project has been a model to showcase mainstreaming HIV/AIDS care in the Government sector. The concept of training followed by onsite support had given confidence to physicians to manage opportunistic infections at the primary health care. This mainstreaming model has been replicated by the State AIDS Control Society in Karur, a high prevalent district of Tamil Nadu.

EMPOWERING LOCAL LANGUAGE COMMUNICATION

A ready reckoner on HIV/AIDS

Organization

Local Voices Project, Internews Network

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Background

Internews's Local Voices project trains mainly Tamil language journalists to produce quality reporting on AIDS to reach the widest possible audience in Tamil Nadu. Though journalists became HIV-informed, they could not use scientifically accurate/sensitive HIV related language in their stories because of the lack of such terms. Journalists also faced difficulties deciphering medical/NGO jargon.

Objective

To increase the quality of HIV reporting by equipping journalists with accurate, non-stigmatizing terminology on HIV/AIDS in Tamil and English.

Methods

A basic HIV glossary/style guide was developed by some journalist trainees and Local Voices project staff. The document served as a discussion starter with more than 50 journalists across Tamil Nadu, who then gave their requirements. The result: reporters and editors designed the shape, size and contents of two ready reckoners- one for field reporters and one for editorial staff.

The editors, chiefs of bureaus and chief reporters of the major English and Tamil newspapers and magazines critiqued and edited the Ready Reckoner. Health professionals, Government officials and NGOs

reviewed it for authenticity and accuracy. The ready reckoner was released by Tamil Nadu's Health Minister on World AIDS Day 2007.

Major findings

The ready reckoner was accepted as a tool that addressed a critical gap in HIV communication.

- The Tamil Nadu State AIDS Control Society decided to adopt the same terms to achieve consistency in HIV related communication between the media and service providers
- The media houses began using the standardized terminology almost immediately. Five hundred copies each (English and Tamil) were absorbed within a month of release. Internews has received requests for the English/local language ready reckoners from other states
- The ready reckoner was used to translate Information, Education and Communication (IEC) materials from Hindi to Tamil in the Red Ribbon Express
- Ten terms in the glossary were incorporated into the latest edition of Cre-A's well-known dictionary of contemporary Tamil
- Sections of the ready reckoner were incorporated into the Indian Institute of Mass Communication's interactive video compact disc "Reporting HIV and AIDS - a Media Resource Tool", brought out by UNESCO for journalists in India.

Policy recommendation

A gold standard of accurate and sensitive terminology in major Indian languages would make a critical difference to IEC quality in the National Aids Control Program - III.

Programmatic recommendation

- Reporters need to be trained in the language they report in for best results
- Ready Reckoner is worth developing in other Indian languages.

ENABLING QUALITY REPRODUCTIVE AND CHILD HEALTH SERVICES IN PUBLIC HEALTH SECTOR IN INDIA

Organization

EngenderHealth, New Delhi

Contact persons

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Background

The Ministry of Health and Family Welfare (MoHFW), Government of India (GoI) is actively pursuing improvement in the quality of Reproductive and Child Health (RCH) services, which is an important strategy element and thrust priorities of National Rural Health Mission (NRHM)/RCH II program. EngenderHealth, Population Council and PATH were approached by MoHFW GoI to develop a methodological framework for assessing and improving the quality of health care services as part of RCH II program strategies. UNFPA contracted out to the three agencies to prepare an integrated Quality Assurance (QA) operation manual. With USAID support under IFPS II Technical Assistance Project through Constella Futures, EngenderHealth

provided technical assistance in the implementation of QA system in 176 public health facilities in Uttar Pradesh and Uttarakhand.

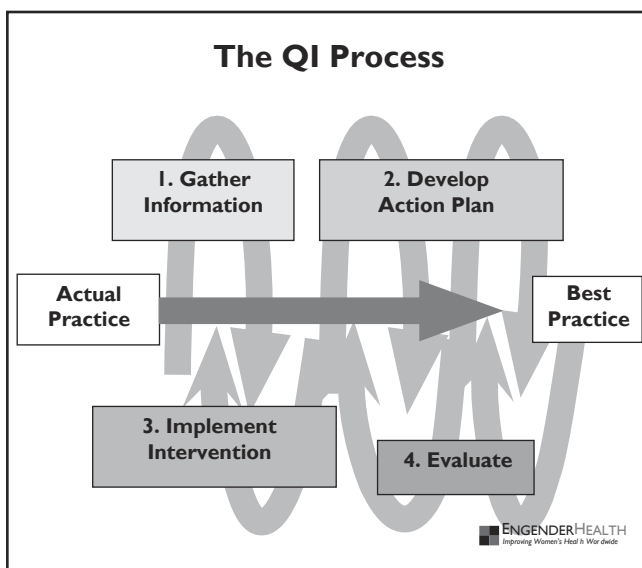
Objectives

The intervention focused on developing simple, field-based, practical methodologies and tools to assess the quality of RCH services being provided within the public health system and to transform supervision practices into standardized and structured QA process, thus ensuring continuous Quality Improvement (QI).

Methodology

The methodology included developing quality assurance manual and indicators for assessing RCH services and incorporated provider/client/community perspectives. Tools were developed for assessing the enabling environment and measuring the inputs, processes, and outputs. Key determinants included technical competence of providers, inter-personal skills, availability of supplies, essential drugs and functional equipment, quality of physical facilities, infrastructure and linkages to other health services.

Orientation of State and district stakeholders and training of QA groups and medical superintendents/medical officer-in-charge was conducted. Using quality improvement tools the sites were assessed bi-annually measuring infrastructure, equipment, supplies, infection



prevention practices, availability of trained provider and other key indicators. QI committees were formed and action plans were developed which were regularly reviewed at the site and district level.

Outcome

The project led to identifying the problems at the site level along with the solutions. The assessment results showed marked improvements in organization of facility, infrastructure, infection prevention practices, equipments/supplies, antenatal care and immunization

services and an increased ownership of the district and site stakeholders.

Conclusion

The QA activities have helped in generating focus on qualitative aspect of RCH services and resulted in better preparedness, organization, upkeep of facilities and better client focused services. The encouraging results have resulted in a decision by MoHFW GoI and State Governments to scale up QA activities to more districts/states.

ENGAGING COMMUNITY AS PEERS

A sustainable peer education model

Organization

Avert Society, Maharashtra

Contact person

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Background

Investing in peer development not only influences behavior of their community members but empowers them to take charge of their lives. The major concern of peer education has been on sustainability issues, financial incentives, low confidence level, appropriate selection of peers, content of training curriculum and lastly the issue of implementing NGOs' concern of sharing their power with the community they serve.

Objective

To building community ownership through sustainable peer education model.

Approach

Avert Society developed a voluntary peer education program in 2003 to prevent HIV among at risk groups/communities and build ownership to the program. In 2005, Avert Society in collaboration with BIRDS (a capacity building institution for peer educators) developed a systematic capacity building model for peer educators and it included hands-on training, mentoring and onsite supervision. The training is carried out in two phases; phase I focuses on programmatic issues while phase II focuses on understanding self, creating confidence, and personal growth. An external evaluation was carried out at the end of two years (2007) of training.

Major findings

Avert-BIRDS has trained 292 master trainers and 1,515 peer educators from the community. The evaluation finding shows that the dropout rate had reduced to less than 10 per cent among master trainers and eight per cent among peer educators in program implementation compared to 20 and 50 per cent prior to the training (2003). Other major finding shows that the overall participation of peer educators in the various behavior change communication activities had increased by 60 per cent, sexually transmitted infection referrals has increased by 60 per cent and follow-up by 40 per cent. Peer led condom outlets had increased by 75 per cent and counseling and testing referral by 40 per cent.

Similarly, the training program had improved the communication skills, knowledge of sexual and reproductive health, decision-making abilities, public speaking capacity, ability to facilitate groups, and their resistance to peer pressure. Training has also equipped them with leadership qualities making them opinion leaders. They have also learned compassion and to be culturally sensitive to people different from them.

Conclusion and recommendation

The cost effective peer-education model by Avert-BIRDS can ensure building of local and regional capacity with long-term sustainability across all types of groups/communities and is a highly replicable model.

ENHANCING SKILLS ON DATA USE LEADS TO IMPROVED DATA QUALITY IN HEALTH PROGRAMS

Organization

Family Health International (FHI), New Delhi

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Background

Implementing agencies collect data and provide reports to satisfy donor's needs without utilizing the data for strengthening health programs. Under the USAID-supported SAMARTH project, FHI provided technical assistance to four NGO demonstration partners in Delhi to develop Data Management System (DMS) which included review and standardization of data collection and collation tools for key HIV prevention, care and treatment monitoring indicators. The key staff members of the NGO partners were trained on the definition of the indicators, use of the tools and data analysis to strengthen existing HIV program. FHI also instituted a system for conducting periodic Data Quality Assessment (DQA) to check for data integrity, validity, reliability and accuracy.

Objectives

DQA was conducted to measure the effectiveness of DMS and identify factors affecting quality of data collected and reported by the four demonstration partners.

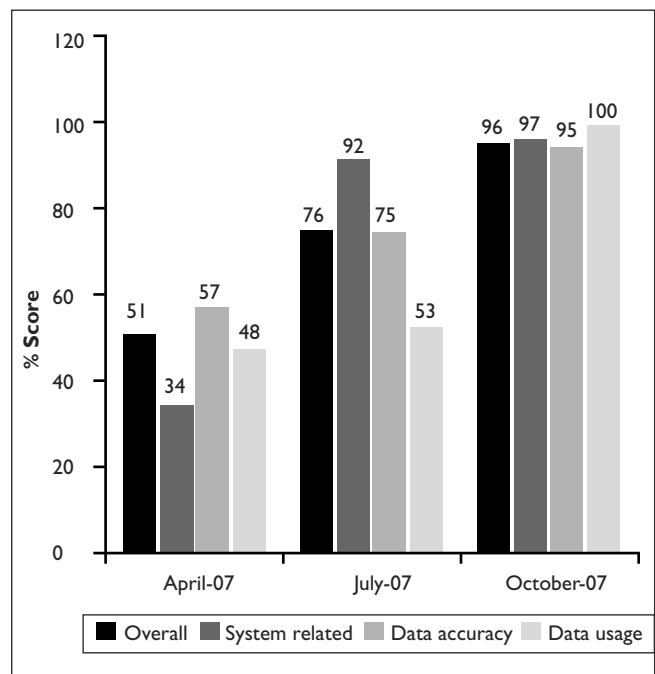
Methods

The SAMARTH staff reviewed the results of the DQA conducted among the four NGO partners in three rounds (April, July and October 2007) using a DQA tool. The tool examined key parameters including system related (monitoring and evaluation management process and system integrity), data accuracy (data validity, data reliability and data integrity), and data usage. The SAMARTH staff also reviewed the feedback on the DQA scores that were shared with the four

NGO partners after each round along with the action plans that were developed by partners for improving the key parameters.

Major findings

Analysis revealed that system related score increased from 34 per cent (April 2007) to 97 per cent in October 2007 as a result of standardization of data collection tools and training. The scores on data usage showed only marginal improvement of 48 per cent in April 2007 to 53 per cent in July 2007. After the provision of training on data analysis and use of data for programs, there was a steep improvement in data usage scores in October 2007 resulting in overall improvement (96%).



Conclusion and recommendation

Building skills of NGO partners in data analysis, interpretation and data use is as critical as developing a robust DMS. Enhancing data utilization improves ownership of data and results in data accuracy. The

DQA tool can be adapted and utilized as a part of regular monitoring system to strengthen Health management information system at the national, state and district levels to ensure data integrity and accuracy for key health indicators.

IMPROVING ACCESSIBILITY OF REPRODUCTIVE AND CHILD HEALTH SERVICES IN REMOTE AREAS OF UTTARAKHAND THROUGH MOBILE HEALTH VANS

Organization

IFPS II Technical Assistance Project (ITAP), Constella Futures, New Delhi

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Background

Certain areas in Nainital district have difficult terrain and poor accessibility to Reproductive and Child Health (RCH) services. Therefore, the State Government bought a mobile van stationing it at community health center in Ramnagar for outreach services. But lack of staff and management systems rendered it non-functional. Hence, the proposal to operationalize the van using a public private partnership (PPP) model was brought forth.

Objective

Increase accessibility of preventive, diagnostic and curative services with emphasis on reproductive health services; using a mobile medical van to supplement the primary health care services in the remote rural areas.

Methods

ITAP conducted a study on existing mobile vans and held a consultative workshop to develop an effective model.

In this PPP initiative, the mobile van purchase and equipping the van was done with the Government funds. A private agency is managing it, and the drugs, essential family planning and vaccination supplies come from the health department.

The mobile van has the personnel and diagnostic facilities to provide RCH services along a predetermined route.

A fixed date approach ensures bi-monthly visits to each of the eight camp sites.

Services are free for below poverty line patients. The user fee paid by above poverty line clients is used for essential requirements for the van. Financial resources reach the agency via the Uttarakhand Health and Family Welfare Society.

The van is linked to public health facilities and a medical college for referral services.

Monitoring and review of activities is done by the Project Advisory group.

Major findings

- A model for mobile van prepared through consultative workshop
- Services include general physician and Obstetric and Gynaecological consultation, immunization, family planning services, reproductive tract infection/sexually transmitted infection management and awareness generation activities
- Diagnostic facilities include simple hematological, biochemistry blood tests, X rays and ultrasound
- Nearly 100 per cent of scheduled camps are being conducted
- Over 30 per cent clients are from below poverty line population
- Two thirds clients are women

- Management of information systems developed and initiated
- Medical officers, Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs) in catchment area oriented to services available in the van
- Government ANMs and ASHAs participate in the camps
- Clients referred from public health facilities to the van due to non-availability of services in the facilities.

Conclusion

- Dedicated staff required for regular and efficient service delivery through the mobile van
- Management of van by external agency improves efficiency
- Mobile van helps reach the unreached and ensures equity of health services
- The van and fixed facilities complement each other's services thereby improving RCH service coverage
- State Government has bought 13 more mobile vans to expand service coverage in all districts.

INSTITUTIONALIZATION OF SYSTEMATIC SCREENING INSTRUMENT WITHIN PUBLIC HEALTH SYSTEM IN THE STATES OF GUJARAT AND UTTARAKHAND

Organization

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Background

The Systematic Screening Instrument (SSI) is a brief checklist used while registering a client at the facility to identify unmet needs of the clients and provide them more services than asked for in the same visit. The approach has been tested in many countries and found effective in increasing use of family planning and reproductive health services. Considering SSI as simple, effective and low cost intervention, Governments of Gujarat and Uttaranchal are introducing it in all maternal and child health clinics in a phased manner.

Objective

To identify an affordable and effective strategy to ensure compliance by provider in using the SSI to identify and serve unmet needs of clients.

Methods

Screening questions for six services – antenatal care, postnatal care, immunization, post-abortion care, family planning and reproductive tract infection/sexually transmitted infection – were included in Auxiliary Nurse Midwives (ANM's) outpatient register. During scale-up in Gujarat, impact of two different levels (high and low level) of system commitment and provision of supervision on provider's compliance was studied. Impact was evaluated through service statistics, exit interviews of clients and mystery client visits.

In Uttarakhand, ANMs' outpatient register and immunization register have been modified by adding screening questions. Training of 50 master trainers and 181 medical officers as trainers has been completed. They are now training 2400 ANMs on SSI.

Findings

In Gujarat service statistics of 69 clinics show that around 73 per cent clients are being screened for assessing their unmet needs. The compliance was around 50 per cent in rural area and above 80 per cent in urban clinics. In both rural and urban areas quality of screening was significantly better in clinics which received closer supervision and higher system commitment. Further, clients were receiving 50 – 90 per cent more services per visit than they asked for. Two main unmet needs identified and served were family planning (49%) and reproductive health (38%). About 70 to 93 per cent of the clients received the additional services on the same visit.

Conclusion

SSI is now considered as well tested tool to identify unmet needs of women which they themselves rarely acknowledge and therefore remain unmet. Use of SSI could significantly increase utilization of clinics and clients could get multiple services in the same visit. Screening improves with better supervision and demonstration of system commitment to screening.

INTRODUCING AND SCALING UP QUALITY ASSURANCE MEASURES IN THE DISTRICT HEALTH MANAGEMENT

Case study of the States of Gujarat, Karnataka and Maharashtra

Organization

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Background

Population Council and UNFPA jointly developed a Quality Assurance (QA) manual and tested it in Gujarat and Maharashtra to demonstrate that QA could be easily integrated at the district level management with significant positive results. QA program was scaled up in all 25 districts of Gujarat with technical assistance from the FRONTIERS program. Now it is being piloted in six States. Population Council with financial assistance from UNFPA is providing technical assistance in Maharashtra and Karnataka.

Objectives

To build capacity of the state and district officials for implementing QA measure, at district level, leading to quality improvement and its institutionalization in the system to ensure its sustainability.

Methods

The method involved formation of District Quality Assurance Group (DQAG) consisting of district health officials, training them in using QA checklists, procedure for conducting QA visits of health facility, analysis of collected data, identifying service gaps and addressing them leading to improved readiness of facility and quality of services.

Major findings

The experiences from all the three States show that QA approach is a good innovation for improving quality. For example four months after the first visit, out of 28 facilities in Ahmadnagar which had scored B grade, 19 moved to A grade. Improvement was observed at all levels – input (infrastructure, human resources), process (the quality of services is provided) and outcome. Key gaps identified and now being addressed at community health centers/primary health centers include: training of providers, purchase of equipments, general cleanliness, infection prevention practices, repair and maintenance of building, updating of records, waste management, among others. Besides using unrestricted fund available at the district and facility level, additional required resources are being generated using District Program Implementation Plan mechanism under the National Rural Health Mission (NRHM).

Conclusion

QA procedure is useful and effective in quality improvement and could be institutionalized in the overall NRHM and reproductive and child health program. However, to involve the State authorities and ensuring proper implementation, it should not be implemented in project mode (in one or two districts) but in program mode (a minimum of 5 - 6 districts) as part of scale up in phased manner.

IMPROVING SUSTAINABLE HEALTH PRODUCT ACCESS IN RURAL COMMUNITIES

Shakti Health@Base of the Pyramid

Organization

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Background

Shakti Health@Base of the Pyramid (H@BoP) is a pioneering exercise built to provide millions of people in rural India with increased access to health products. The PSP-One program seeks to leverage the Shakti network, a Hindustan Unilever Limited (HUL) commercial rural marketing initiative, to improve maternal and child health outcomes in rural India.

Learning objectives

- Understand the opportunities and challenges in reaching rural communities with essential health products through a commercially sustainable base of the pyramid model
- Identify settings where a base of the pyramid approach may be appropriate for increasing sustainable access to health products in rural communities.

Methods

The initiative is being tested as a pilot for a period of nine months with 80 Shakti Entrepreneurs (SE) and their associated villages in Uttar Pradesh. It is envisaged that training the SE on pertinent health issues will position her as a provider of health products and services in addition to her existing role as a provider of HUL brands. The commercial health partner will engage in market building activities and brand/product development at the village level to support the SE in creating awareness and demand for the product/brand. Adequate product supply and proper distribution are other crucial components

for the success of this model which is being ensured by designing a channel built on existing HUL and health partner supply systems. Since this initiative extends the SE's role as a public service provider it is necessary to secure the support and buy-in of the whole community, particularly community influencers and existing village level health care providers. The pilot objectives are to improve health outcomes in the pilot villages, increase the income of the SE and improve standing of the SE in the community. Weekly and monthly sales tracking and activity monitoring will help evaluate the pilot and maintain partner engagement and interest in Shakti H@BoP.

Major findings

- Oral Rehydration Salts (ORS) arm of Shakti H@BoP launched
- Initial sales figures for ORS are positive with all SE being able to sell the product
- Besides top management engagement, significant partner engagement at the field level is crucial to the successful implementation at the ground level
- Profiling a successful SE (awareness about health issues/involvement in their Shakti business/family support) would be key to scale up.

Conclusion

Considering that this investment is backed by HUL's business model, making it fully sustainable, the Shakti H@BoP model offers an innovative approach towards improving health in rural communities.

MAKING USE OF SYSTEM GENERATED DATA FOR IMPROVING ANTENATAL CARE REGISTRATION

Organization

A2Z Micronutrient Project, AED, New Delhi

Contact persons

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Background

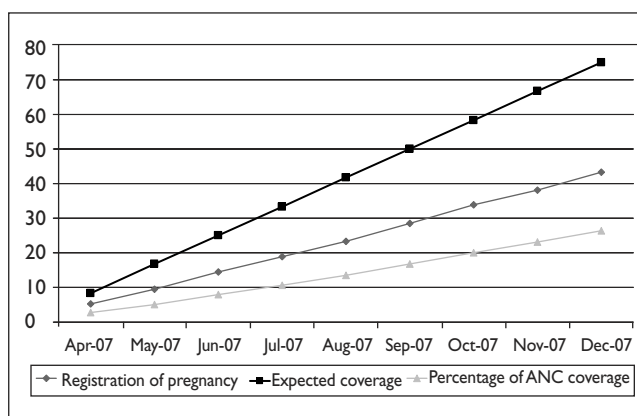
The Government of Jharkhand has initiated maternal anemia control program in seven districts with technical support from A2Z, USAID's micronutrient project. The project aims at capacity building of all the front line providers and senior staff to be able to help identify barriers and effectively manage provision of a comprehensive package for anemia control. Under Reproductive and Child Health (RCH) program, most of the State Governments collect block and district level data in their RCH format recommended from sub-health center right up to the State level.

Objective

To build the capacity of district and State health authorities in using the system generated data more meaningfully and for better planning of services to reach out to the unreached.

Approach

An interactive workshop for three days for Civil Surgeons (CS) and Medical Officer-in-Charge (MOIC) was held. The data collected through the RCH forms were reviewed critically for the contents and its usage. Using the data generated in the system, during the workshop, the population available was used to derive the denominator (innovation) for services and the performance was reviewed against expected denominator to derive actual coverage for antenatal services month wise (innovation). This was then graphically represented.



Major findings

The data from the Forms 6, 7 and 9 gets generated regularly and forwarded to the Government by respective officers- in-charge. However, neither the data receiver nor the data generator was using the data for monitoring or evaluating any activities.

By using the population of the area (part of the system already) and applying birth rate to that data, total number of expected pregnancies in a year was derived. Then the information was tabulated for expected monthly registration of pregnancy and reviewed against actual registration obtained. This was an interesting and eye-opening exercise to health officers. The complete calculation format was shared with them on an excel file and also in a compact disc for future use. The graphic representation of the monthly data has helped them understand how good or weak their performance for Antenatal Care (ANC) registration is and how much needs to improve. Most health officials

were very happy to get this insight and are now using this technical support.

Senior level officer who reviewed the State situation also requested similar assistance for the whole State which A2Z project has been able to infuse in the system now.

Conclusion

The system has large manpower. The data generated are meaningful when used with appropriate tools. In the light of the *Janani Suraksha Yojana*, this tool of system strengthening is used for tracking missed out women for ANC. By using the format derived in the workshop the MOIC and CS are now comfortable in tracking ANC registration performance of their area.

MESSAGE IN YOUR DABBA

An assessment of a partnership model with the ‘Dabbawalas’ to deliver HIV/AIDS messages through a lunch relay system

Organization

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Contact person

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Background

The ‘Dabbawalas’ is a century-old institution that has established a system of multiple relay to deliver lunch boxes everyday to an estimated 200,000 workforce in Mumbai and Thane. Everyday 5,000 ‘Dabbawalas’ pick up lunch boxes from homes and carry them to the workplaces and back. The finely-tuned system earned a Six Sigma rating from Forbes magazine. Given their reach, Johns Hopkins University/Center for Communications Program (JHU/CCP) partnered with the ‘Dabbawala’ association for awareness campaigns on World AIDS Day (WAD) 2005-2007, and to encourage people to seek information on HIV/AIDS including counseling and testing.

Objectives

In 2005 and 2006 the ‘Dabbawalas’ delivered HIV/AIDS information kits to workplaces along with lunch packs on WAD. The assessment found that while this generated some discussion at the workplace the information, however, did not reach those at home. Hence, for 2007 the strategy was changed to enable information to also reach the family members at home.

Methods

On WAD 2007, ‘Dabbawalas’ delivered an information packet containing a *Kaalniray* car calendar with messages on HIV/AIDS transmission, prevention and testing, a pamphlet with basic HIV/AIDS information and a red ribbon along with the empty lunch boxes to homes. Indian movie actor Jackie Shroff launched the program. Various FM Radio channels with a reach of over 10 million people also aired an interactive campaign on HIV/AIDS like live chats, quiz and call in shows.

Major findings

A rapid assessment was conducted to understand reach, recall of messages, liking/dislike and sharing of information among target population i.e. household members who received or gave lunch boxes in the morning and working members who received them at work. Using multistage cluster sampling, 898 respondents were interviewed across greater Mumbai.

Nearly half of them could recall having received information with the lunch packs. Of these 94.7 per cent remembered the calendar, 75.5 per cent remembered the pamphlet while 72.3 per cent the red ribbon. The calendar had the highest recall and largest number of messages remembered. The usefulness of the calendar, handy pocket size and messages given were appreciated. About 29.5 per cent said that others had read the information material. Spouses and partners were the ones most often reading the material, followed by neighbors and friends. About 17.6 per cent said they discussed the content with others.

Programmatic recommendations

Delivering messages to homes was successful in facilitating sharing of information among family members regarding HIV/AIDS. Usability of material, short messages and pictorial presentations aided in increased recall of the messages. More partnerships with civil society organizations could be explored as they are cost efficient, effective and enable sustainability of initiatives.

PARTNERING WITH COMMUNITY-BASED ORGANIZATIONS FOR EFFECTIVE SEX WORKER INTERVENTIONS

Organization

University of Manitoba/Karnataka Health Promotion Trust (KHPT), Bangalore

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Authors

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Background

The University of Manitoba is implementing a five-year HIV/AIDS prevention, care, treatment and support program in select districts of rural Karnataka and Andhra Pradesh, called the Samastha project. An important component of the Samastha project's HIV prevention strategy includes reducing the risk of HIV transmission among Female Sex Workers (FSWs).

In the first year of the Samastha project, KHPT undertook a rapid assessment of HIV risk across rural Karnataka. The results of the assessment were used to prioritize villages for the intervention focus. Villages were selected according to the size of key populations, including FSWs, and the project worked with local partners to design outreach strategies and activities to target FSWs.

Objectives

Reduce HIV transmission among the FSWs and their clients, and improve the health and social outcomes for sex workers living with and affected by HIV in rural Karnataka.

Approach

The Samastha project partnered with Vimukthi, a sex worker Community-Based Organization (CBO) in Bellary district to identify and build the capacity of peer educators for FSW outreach activities. The

project developed outreach strategies based on FSW profiles and client loads, and peer educators were trained to use Samastha program tools, including outreach planning tools, communication materials and management information system forms.

Outcomes

With Vimukthi's support, the Samastha project was able to quickly identify and establish rapport with the FSW community. This enabled immediate results in outreach contacts, treatment for sexually transmitted infections and other health issues, and referrals to Integrated Counseling and Testing Center for HIV testing. Through the Vimukthi partnership, 2,020 FSWs have been contacted across 127 villages. Vimukthi was also able to build rapport with the Government health department and establish referral clinics in health centers to provide services to FSWs.

Recommendations

Working with CBOs enable interventions to reach out to marginalized populations such as FSWs more effectively and efficiently. The intervention can leverage the trust and credibility of select individuals from within the CBO to quickly scale up outreach activities. Collaboration with CBOs should consider all levels within the CBO hierarchy, in order to ensure support and mobilization from within the community.

PUBLIC PRIVATE PARTNERSHIP IN HEALTH CARE

Providing efficiency with equity

Organization

Hindustan Latex Family Planning Promotion Trust (HLFPPT),
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Contact person

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Background

The demographic indicators of Uttar Pradesh reveal that 90 per cent of the State population relies on private health care providers and rate of institutional delivery is merely 22 per cent (National Family Health Survey-3). Merrygold Health Network project was awarded to HLFPPPT as a social franchising initiative through State Innovations in Family Planning Services Project Agency (SIFPSA) in partnership with USAID, Government of India and the State Government of Uttar Pradesh.

Objective

Merrygold Health Network aims at creating access to low cost good quality Maternal and Child Health (MCH) services by networking with private health service providers as franchisees.

Approach

The project has a hub and spoke design with Level 1 franchisees (Merrygold) established at district levels as the hub connected to Level 2 and Level 3. Level 2 comprises of fractional franchisees (Merrysilver) established at subdivision and block level. Level 3 (MerryAYUSH) comprises providers like auxiliary nurse midwives, accredited social health activist and AYUSH and acts as first point of contact with the community as also referral support to Merrysilver and Merrygold hospitals. Emphasis is on affordable pricing, quality assurance, customer servicing and efficient service delivery through standardized operating protocols. Information technology enabled Hospital Management

Information System is also being established. A team of public health and clinical professionals facilitates capacity building and quality assurance. Integrated health insurance policy for coverage of risk during maternity has been introduced, a branded pharmacy and chain of diagnostic facilities is also being strategized.

Major findings

The model, piloted in districts of Kanpur and Agra, has been scaled up to eight districts of Uttar Pradesh and will be expanded to all 70 districts in next two years, reaching out to approximately eight million women. The State Government has accredited Merrygold hospitals for *Janani Suraksha Yojana* and *Sowbhagyavati* scheme to provide free of cost RCH services and emergency obstetric care. The intervention confirms people's willingness to pay and avail of good quality MCH services. Community outreach and strengthened linkages between providers is essential to improve the social franchising model and enable behavior change among the community. Key challenge is skill development of unqualified nursing and technical staff and providing immediate monetary gains to the franchisees.

Conclusion

In States where majority of population relies on private health care providers, public private partnership is an effective strategy in engaging private providers to deliver quality public health services in a cost effective and transparent manner.

RAPID DIFFUSION OF INTRA-UTERINE CONTRACEPTIVE DEVICE TRAINING PROGRAM USING AN ALTERNATIVE TRAINING METHODOLOGY

Organization

Ministry of Health and Family Welfare (MoHFW) and JHPIEGO

Contact persons

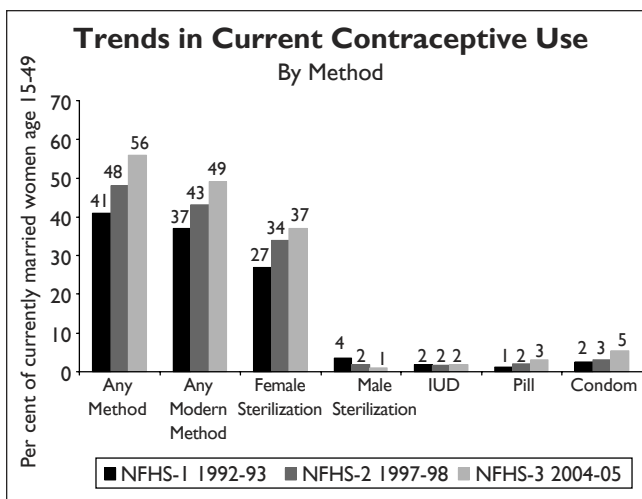
M.S. Jayalakshmi, Deputy Commissioner of Family Planning, MoHFW; Jeffrey Smith, JHPIEGO
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Background

The Copper T Intra-uterine Contraceptive Device (IUCD) was introduced in India in 1993. Yet, nationally, it represents only less than two per cent of the method mix. A renewed attention to Family Planning (FP) and availability of increased resources prompted an effort to reinvigorate access to and use of IUCDs.

Methods

The MoHFW and JHPIEGO developed a six-day clinical and pedagogic course in IUCD service provision using an alternative training methodology – consisting of a structured training approach and use of anatomic pelvic models for developing clinical skills. Participants reviewed recent evidence and scientific literature to dispel myths and misconceptions about IUCDs. All participants were required to demonstrate competency in IUCD clinical services on anatomic models, allowing repeated psychomotor skill practice before working with clients.



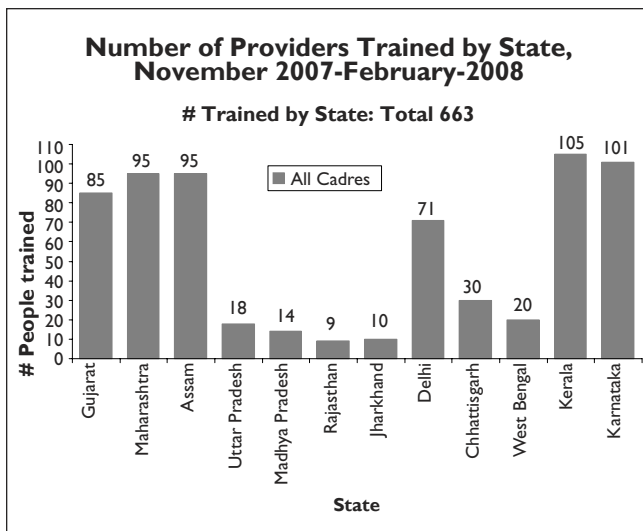
Program objectives

- Develop a competency-based clinical training approach that is rapidly scalable and easily adoptable within government systems
- To support Government of India's (GoI) efforts to substantially increase use of IUCD as a FP method.

The training teams from 12 States developed training skills and were provided anatomic models to replicate the course through a diffusion strategy at the State and district level in their home State. The State training teams prepared district training teams that trained IUCD providers (mainly auxiliary nurse midwives). The MoHFW did a post-training follow up of the training teams for two to four months, monitored the training roll out and supported them to implement the strategy. Follow-up was structured using standardized checklists and clinical and training coaching.

Major findings

- Number of Providers Trained by State, November 2007–February 2008



- Replication of training program achieved in nine of the 12 States within four months and by all States within six months
- Rapid diffusion and institutionalization of training concepts achieved in most States
 - ◆ In Assam, training diffused from State to district to health center level within four months

- ◆ In Gujarat, the approach expanded State-wide. Additional models, trainers and training events were funded. Training rapidly moved into pre-service medical education

- MoHFW engaged other donors – increasing speed and scale
- Immediate, intensive and supportive follow-up by the training coordinator of the MoHFW was key to the successful diffusion
- State training teams presented data at a national meeting which stimulated more rapid action and diffusion, and motivated lagging States.

Conclusion

Well designed and structured training initiatives that are competency-based and skill-focused can be rapidly implemented. Early ownership by GoI and intensive on-site support facilitates institutionalization of the program.

REACHING YOUTH THROUGH INTERACTIVE GAMES FOR HIV/AIDS AWARENESS

An assessment of the youth campaign in Maharashtra

Organization

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Background

Globally young people constitute a third of all new HIV infections and 33 per cent of infections in India are in the 15-29 age group. Hence, it is important to reach young people with prevention messages before they become sexually active. The youth intervention in Maharashtra provided messages on Abstinence, Being Faithful and Condom use (ABC) through a strategic communication campaign.

Objectives

- Increase risk perception on HIV/AIDS
- Increase knowledge about HIV/AIDS and address myths and misconceptions
- Promote responsible conduct, especially safe sexual behavior following the ABC approach.

Methods

The campaign, in urban (slum) and semi-urban settings targeting 15-19 year old single youth, repositioned perceived “old fashioned values” such as delaying sexual initiation, as the new, acceptable norm through mass media (television, radio, bus shelters), mid media (banners, posters, giveaways), and interactive edutainment games. The latter was implemented by partner NGOs with their youth groups in 45 slums/village areas and 15 colleges in seven high prevalence districts.

Findings

The study conducted with 909 unmarried youth (587 males, 322 females) aged 15-19 years, selected by multi-stage stratified random sampling from intervention areas, suggest

that majority of respondents (97.6%) were exposed to at least one mass medium (television, radio, cinema, billboard, bus shelters/panel). Of these, 88 per cent were exposed to television, 55 per cent to radio, and 29 per cent to cinema. About 73 and 74 per cent were exposed to billboards and bus panels/shelters respectively. About 19 per cent were exposed to interactive edutainment materials (including board games and computer games). Two-third of the youth shared messages/information with others and in most cases (70%) it was with their peers. About six per cent shared messages/information with their families and less than one percent shared it with their sexual partner. Over 90 per cent of respondents were aware of the campaign theme - “*Jawan Hoon Nadan Nahin*” (I am young but not naive), mostly through television, mid media and give away materials.

Conclusion and programmatic recommendations

Campaign slogans resonated well with youth as the approach was based on positive, normative influence, was non-judgmental, promoted self-confidence and self-esteem. The campaign grounded in the realities of youth, recognized the challenges that young people face with peer pressure and the difficulty of refusing a sexual advance, especially for women. A media mix is important so that young people from different backgrounds can access information. It is necessary to have more skills-based training of outreach workers to enhance interpersonal communication skills and effectively use campaign materials. Routine monitoring of program activities by NGOs will help make interventions more effective.

SCALING UP HIV CLINICAL MANAGEMENT

An experience with private sector

Organization

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Background

Most of the public health initiatives in the developing countries fail not due to lack of scientific knowledge but due to lack of trained human resources. It has been observed that the trajectory of the HIV epidemic in the state of Tamil Nadu has crept into the general population. People prefer to access treatment from private care providers. But the lack of trained professionals forces the community to throng Government institutions, which increases the workload of hospitals and prevents patients from accessing quality care.

Objective

To train private doctors on diagnosis and management of HIV disease including the rationale use of antiretroviral therapy.

Approach

AIDS Prevention and Control (APAC) project in collaboration with Dr. MGR Medical University designed and sponsored a ten-day residential training program for the physicians. A customized curriculum was developed based on needs assessment. The course provided hands-on training in clinical management of HIV/AIDS. Didactic lectures, discussion of case studies and physical examination of patients were the highlights of the training program. Follow-up was organized to understand the effectiveness of the training program.

Outcomes and challenges

Training has been provided to 203 medical doctors in ten batches. A pre and post-assessment of the trainees revealed that there was a 70 per cent improvement in knowledge on HIV/AIDS clinical management. Change in attitude, increased confidence levels in case management and motivation of the doctors was evident as some of the trainees conducted continuing medical education programs for other health care providers in their respective local areas. The course has been well received and has generated interest among medical practitioners even beyond national boundaries as physicians from Nepal also participated in this training program. Although the number of training opportunities in the area of clinical care for HIV/AIDS continues to increase, meeting the needs of clinicians, especially those located in remote areas of the country remains a challenge.

Key recommendations

The capacity building program for physicians provided holistic insights into current treatment regimens and protocols. The experiential learning has not only instilled confidence in case management but has brought about a positive attitude to treat People Living with HIV/AIDS. Similar trainings can be organized in the country for physicians in the rural areas. Added to the training, a mentor can be assigned to provide hand holding for trainees.

SOCIAL MARKETING WITH NGOs FOR TARGETED INTERVENTION

Organization

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Background

Condom promotion is crucial to address HIV-AIDS epidemic in Maharashtra. USAID contracted HLPPT to launch a generic condom social marketing initiative in this high burden state of India that reports over one fifth of the total HIV cases in the country (Behavior Surveillance Survey: 2006). Studies conducted with High-Risk Groups (HRGs) like Men having Sex with Men, Intravenous Drug Users, Female Sex Workers (FSWs) and People Living with HIV and AIDS indicated that they are hard to reach and maintain anonymity for the fear of being discriminated or humiliated. Local NGOs are very active in targeted intervention programs for community outreach, counseling and referral services.

Objective

Social Marketing with NGOs for targeted intervention was introduced to leverage on strongholds of NGOs in community outreach and of social marketing organizations in brand and product management, distribution and behavior change communication.

Approach

The approach involves mapping NGOs working in targeted interventions and designing a customized social marketing package along with appropriate training for them. NGOs are motivated to become stockiest and distributors in commercial supply chain management and hence get a revenue generating activity. They also benefit from the special promotional schemes that

get transferred to field level workers as performance based honorarium.

Major findings

The staff from 78 NGOs of Maharashtra have been trained and involved in listing outlets for targeted distribution, condom promotion and display. This effort towards a comprehensive targeted intervention has resulted in increased access to quality product for HRGs. The offtake of condoms by NGOs has increased from 23,622 pieces to 270,000 pieces within a period of eleven months (MCSMP, April 2008). NGOs are more accountable towards social marketing of condoms unlike free distribution products. This innovation has capacitated NGOs to take up other such social marketing initiatives and strive towards sustainability. Counselors from NGOs report of more effective counseling with the available product support and client's satisfaction on having a wider choice. Most peer educators working with FSWs are from the same community and take pride in working towards the cause.

Conclusion

Local NGOs are playing a pioneering role in scaling up prevention services among the most vulnerable and high risk groups under National AIDS Control Program- III. However, the need is to strengthen such sustainable partnerships for a comprehensive model of intervention.

SUPPORTIVE SUPERVISION TO IMPROVE QUALITY OF IMMUNIZATION SERVICES

Organization

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Background

Strengthening of routine immunization services in India continues to be perceived through a technocratic lens, with near exclusive focus on "outcomes"- improving coverage. This outcome-focused approach seeks to increase access to immunization services in unreached and under-served populations. Such a focus neglects another key issue- the "process", including quality of services, immunization safety and community participation.

Using a comprehensive approach that combines focus on both outcomes and processes, IMMUNIZATION Basics (IB) uses the supportive supervision strategy to promote continuous improvement in the performance of health workers. Specifically, it aims to monitor the quality of the immunization program, recognize and encourage good performance, help staff identify and solve problems and improve their skills. It also helps local managers to take decisions based on evidence.

Methods

In a supportive supervision initiative in Rewa district in Madhya Pradesh, IB worked closely with the State and district health departments and the general administration to improve coverage (outcomes) by identifying left out and hard to reach areas and reestablishing outreach vaccination. Links were also established between community and service providers in an effort to improve quality, participation and sustainability (processes).

In the first round of the exercise in December 2007, district health officials and supervisors were trained

in key concepts of immunization and supportive supervision. These stakeholders then jointly assessed the various facets of the program, in both health facilities and at outreach services, through the use of simple monitoring tools for performance monitoring, problem solving and corrective actions.

The data was entered in a simple spreadsheet that facilitated easy analysis by generating graphs and charts. The information and recommendations were shared with the facility staff and with health and administrative officials at district and state levels.

In the second round of the activity conducted six months later, in May 2008, the team of trained supervisors assessed the indicators using the same monitoring tools and the process adopted during the first round.

Major findings

Results from the two rounds of supportive supervision indicate significant improvement in process (quality), particularly for micro-planning (availability of maps, estimation of beneficiaries and logistics, supervisory plans), management of cold chain (daily monitoring of temperature and correct storage of vaccines), recording, reporting and immunization waste disposal practices.

Conclusion

The experience of supportive supervision in Rewa and in several districts of Jharkhand and Rajasthan provide evidence that this simple, easy to implement and can be a catalyst in improving both the quality and coverage of the immunization program.

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