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Expanding Family Planning Options in India:
Lessons from the Dimpa Program

BRIEF

Summary: Twelve years since its initiation, the Dimpa program has created lasting change in the private health sector and achieved significant improvements in access, quality, demand, and use of depot medroxyprogesterone acetate (DMPA) in Uttar Pradesh. Most notably, the program supported the introduction of DMPA in India's national family planning program. This brief describes approaches, lessons, and results from implementing the Dimpa program. The approaches and lessons have broad relevance to implementers that use a network or social franchising strategy, and to those who aim to promote family planning options.

Keywords: demand generation, DMPA, family planning, India, injectable, mhealth, private provider networks

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Cover photo: Devika Varghese

Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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November 2015

Expanding Family Planning Options in India: Lessons from the Dimpa Program

Devika Varghese

INTRODUCTION

India was one of the first countries to adopt a national family planning program. Initiated in 1951, the program is led by the Ministry of Health and Family Welfare (MOHFW) and today offers six contraceptive methods: condoms, combined oral contraceptive pills, IUDs, male and female sterilization, and emergency contraceptives. Clients can access these methods free of charge from an extensive network of public health facilities. Condoms, combined oral contraceptive pills, and emergency contraceptives are also distributed by frontline health workers in rural communities. Contraceptive products and services are available in the private sector at varying price points in India. Social marketing organizations and pharmaceutical companies promote family planning methods, and a large number of private health care providers offer contraceptive counseling and services to their clients.

As a result, India has made considerable progress in slowing population growth and reducing fertility levels. From 1993 to 2006, the total fertility rate among women ages 15 to 49 decreased from 3.4 to 2.7 (International Institute for Population Sciences and ORC Macro, 2000), and the decadal population growth declined from 24 percent between 1981 and 1991 to 18 percent between 2001 and 2011 (Government of India, Ministry of Home Affairs; 2011). The modern contraceptive prevalence rate increased from 45 percent in 1993 to 56 percent in 2006, and the percent of family planning demand that was satisfied increased from 75 percent in 1999 to 82 percent in 2006 (International Institute for Population Sciences and Macro International, 2007). These improvements helped individuals better meet their reproductive goals and reduce maternal and child mortality.

However, these improvements mask a key issue: According to the National Family Health Survey – 2 (International Institute for Population Sciences and ORC Macro, 2000), while 86 percent of the total demand for limiting methods was met, only 30 percent of the total demand for spacing methods was met in 1999. The underlying reason for the high unmet need for spacing methods was the MOHFW's initial focus on population stabilization, which translated to an emphasis on permanent methods and a limited choice of spacing methods.

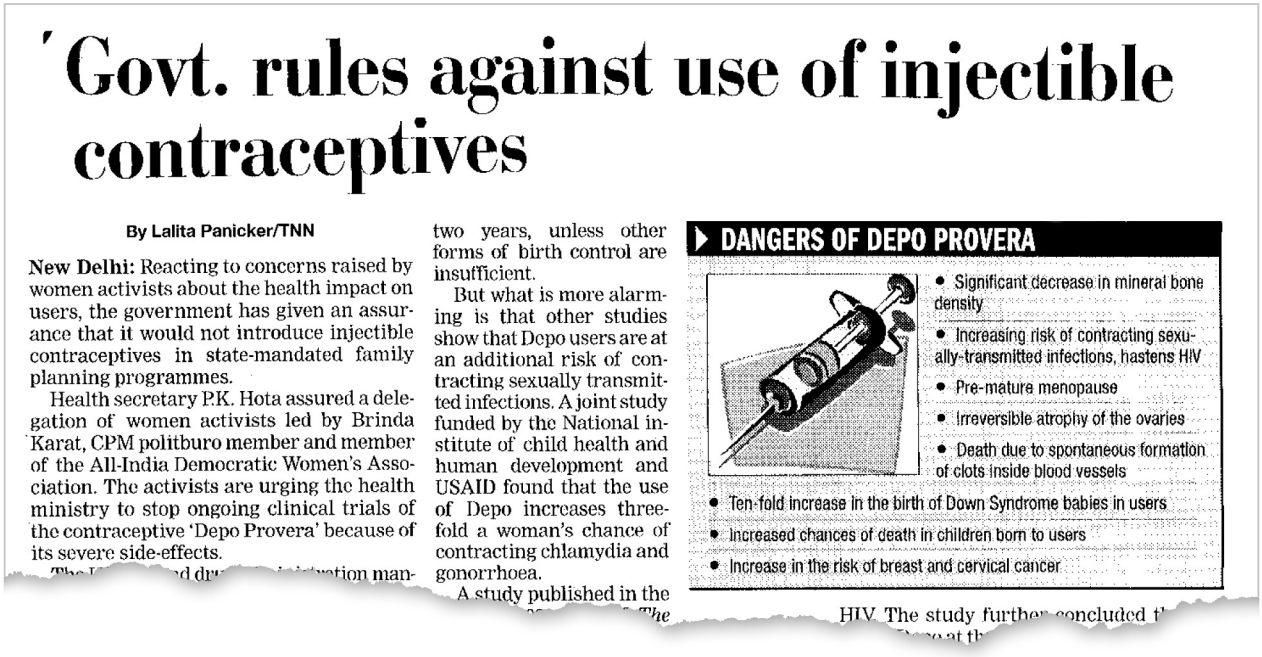
Consequently, many women give birth to their desired number of children early in marriage and at short intervals, and then opt for sterilization.

Studies show that the addition of one method available to at least half the population correlates with an increase of four to eight percentage points in the use of modern methods (Ross and Stover, 2013). The MOHFW considered adding depot medroxyprogesterone acetate (DMPA), a three-month, progestin-only injectable contraceptive, as an option in the national family planning program in 1995. DMPA is a safe and effective contraceptive used by more than 12 million women in more than 106 countries, and is known to be very effective with a low failure rate. The Drug Controller General of India (DCGI) had approved DMPA for marketing through the private sector as a prescription drug in 1993, and the product was available in-country in the private sector.

DMPA is preferred by women who have difficulty remembering to take a method every day or before sexual intercourse, and because it offers privacy to those wishing to conceal contraceptive use. DMPA can be safely used by women who cannot use estrogen-based methods, such as women undergoing antitubercular treatment or who are lactating. In spite of the potential benefits of offering DMPA to couples in India, it has been mired in controversies. Women's groups and health action groups have been vocal in objecting to the introduction of DMPA and cite the following reasons:

- Concerns about adverse health effects, triggered by public hearings in the U.S. and U.K., regarding the safety of DMPA in the 1980s and 1990s and the U.S. Food and Drug Administration's black box warning regarding loss of bone density.
- Inadequacies in the public health system, specifically concerns that women may be administered injectable contraceptives without informed consent, and that the public health system did not have the capacity to provide follow-up care and support.
- Belief that clinical trials and post-marketing surveillance on DMPA were inadequate, incomplete, or biased.

As a result of these controversies, in 1995 the DCGI recommended that DMPA not be offered as a contraceptive option in the national family planning program. Pfizer also curtailed investments in promoting and distributing DMPA due to these controversies. Though DMPA was approved for marketing through the private sector, very few consumers were aware of the method, health care providers had numerous misconceptions and concerns, and the product was only available in a few pharmacies.



'Govt. rules against use of injectible contraceptives

By Lalita Panicker/TNN

New Delhi: Reacting to concerns raised by women activists about the health impact on users, the government has given an assurance that it would not introduce injectible contraceptives in state-mandated family planning programmes.

Health secretary P.K. Hota assured a delegation of women activists led by Brinda Karat, CPM politburo member and member of the All-India Democratic Women's Association. The activists are urging the health ministry to stop ongoing clinical trials of the contraceptive 'Depo Provera' because of its severe side-effects.

The I... d dr... ...ation man-

two years, unless other forms of birth control are insufficient.

But what is more alarming is that other studies show that Depo users are at an additional risk of contracting sexually transmitted infections. A joint study funded by the National institute of child health and human development and USAID found that the use of Depo increases three-fold a woman's chance of contracting chlamydia and gonorrhoea.

A study published in the ...*The*

DANGERS OF DEPO PROVERA

- Significant decrease in mineral bone density
- Increasing risk of contracting sexually-transmitted infections, hastens HIV
- Pre-mature menopause
- Irreversible atrophy of the ovaries
- Death due to spontaneous formation of clots inside blood vessels
- Ten-fold increase in the birth of Down Syndrome babies in users
- Increased chances of death in children born to users
- Increase in the risk of breast and cervical cancer

HIV. The study further concluded t... ...at th...

An 2005 article in the Times of India *listed the dangers of Depo Provera.*

PROGRAM OBJECTIVES AND APPROACH

Against the backdrop of DMPA not being included in the national family planning program—and low availability and service provision by the private sector despite regulatory approvals—the United States Agency for International Development (USAID) initiated the Dimpa program in 2003, which had the following objectives:

- Demonstrate feasibility of safe provision of DMPA through the private sector.
- Expand contraceptive options available to couples, thereby decreasing unmet need for spacing and increasing contraceptive prevalence rates.
- Build evidence on client acceptance and satisfaction with DMPA to support policy advocacy on inclusion of DMPA in the national family planning program.

A formative assessment carried out in 2002 among 1,769 intended beneficiaries (non-sterilized married women ages 15 to 49), 152 qualified private sector health practitioners, and 599 pharmacies in the northern Indian state of Uttar Pradesh highlighted the following:

- *Potential clients*: Though very few women were aware of DMPA, when the method was explained to them, 21 percent reported likelihood of trying DMPA in the next year. Further, the projected method mix based on reported intention to use family planning methods in the future indicated the potential to increase temporary method use by 3 percent.
- *Health care providers*: A large number of qualified health care providers, particularly obstetricians/gynecologists and female general practitioners in the private sector, provided family planning methods other than DMPA. Ob/gyns were most likely to offer DMPA to their clients, in comparison to other health care providers such as pediatricians and general practitioners. However, nearly 50 percent of ob/gyns expressed concerns or had questions on the side effects of DMPA.
- *Product availability and pricing*: Availability of DMPA—even in large towns—was low, and doctors were unsure where it would be available. Further, price was a significant deterrent to health care providers and potential clients.
- *Environment*: Adverse reactions from women's groups and negative media coverage on DMPA were key reasons behind the hesitation of many organizations to endorse, promote, or offer DMPA.

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A clinic in the Dimpa network. Key components of the Dimpa program included product supply; demand generation; continuity of care; policy and media advocacy; and quality assurance, monitoring, and evaluation.

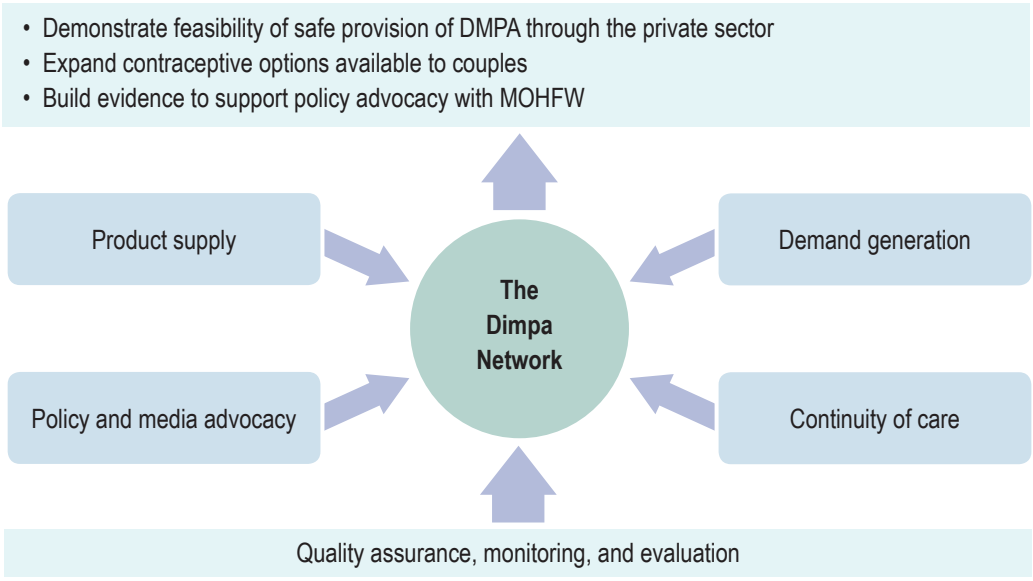
Informed by the findings of the formative assessment, the Dimpa program placed quality of care at its core design by creating a network of private sector clinics called the Dimpa network (Figure 1). The program chose a network approach because the network offered protection to individual practitioners from being singled out by interest groups opposing DMPA. Additionally, the approach allowed for training, support, monitoring, and evaluation needed to alleviate concerns raised by interest groups and to provide the evidence for policy change.

The Dimpa network comprised private sector clinics, each with a practicing ob/gyn or a female general practitioner. Before joining the network, each clinic saw at least five family planning clients per month. The SHOPS project trained all Dimpa clinic doctors in the provision of DMPA and in turn, the doctors agreed to offer the method as a contraceptive option (in addition to other methods that they were currently offering) to eligible clients in accordance with appropriate medical protocols for screening, counseling, product stocking, injection, and follow-up. The typical Dimpa clinic was a small facility with two or three rooms and a waiting area. The primary services were outpatient reproductive and maternal care.

Other key components of the Dimpa program were:

- **Product supply:** Establishing partnerships with DMPA marketers to assure availability of the product in network clinics and nearby pharmacies.
- **Demand generation:** Executing communication campaigns and introducing a telephonic helpline to increase awareness of and demand for DMPA.
- **Continuity of care:** Using client reminder cards and introducing a telephonic follow-up support system for DMPA adopters called the Dimpa Careline, which provided counseling about side effects and reminders about DMPA doses.
- **Policy and media advocacy:** Partnering with provider associations and advocacy groups to build support for DMPA, and sensitizing media to enable balanced reporting.
- **Quality assurance, monitoring, and evaluation:** Collecting service statistics to monitor progress, using clinic checklists and mystery client surveys to assure the quality of service provision at Dimpa network clinics, and implementing cross-sectional surveys among health care providers and potential clients to assess the overall impact of the Dimpa program.

Figure 1. The Dimpa program approach



PROGRAM PHASES, COVERAGE, AND SCALE

The Dimpa program began as a pilot activity in three cities of Uttar Pradesh—Agra, Kanpur, and Varanasi—in 2003, initiated by the USAID-funded Commercial Marketing Strategies project. Beginning in 2004, Abt Associates led the implementation of the Dimpa program for the next 11 years under the Private Sector Partnerships-*One* project (2004–2009), the Market-based Partnerships for Health project (2010–2011) and the Strengthening Health Outcomes through the Private Sector (2012–2015) project. The Dimpa program was scaled in phases, with each phase building upon the momentum and learning from the previous phase, while addressing emergent challenges (Figure 2).

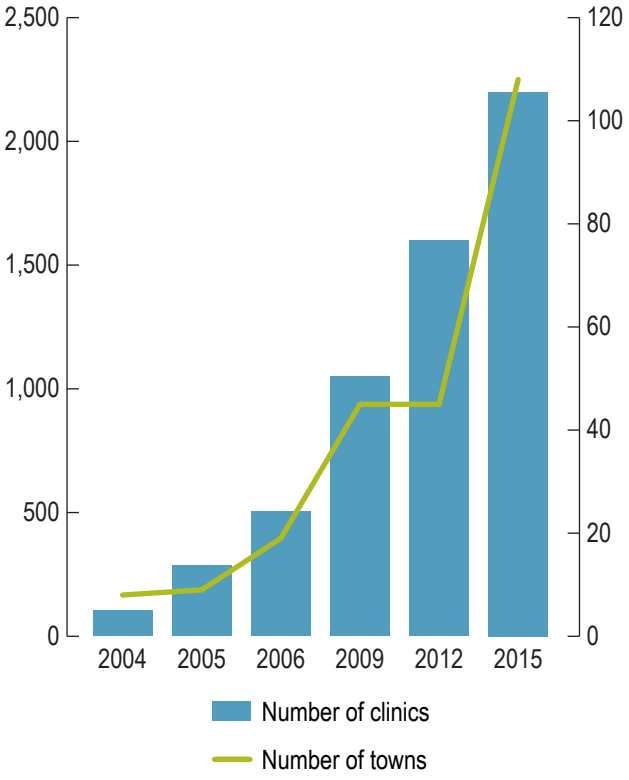
Through support from USAID, the Dimpa program was scaled up to a network of more than 1,600 clinics covering 45 towns in Uttar Pradesh, Uttarakhand, and Jharkhand by 2012. With additional support from the Packard Foundation starting in 2012 and the Bill and Melinda Gates Foundation starting in 2014, the Dimpa program was expanded into Bihar. Today, the Dimpa program covers 108 towns of Uttar Pradesh and Bihar, has more than 2,200 clinics in the network (Figure 3), and serves a population of 28 million people.

This brief describes the approach, innovations, key achievements, and lessons from 12 years of program implementation.

Figure 2. Timeline of the Dimpa program

Phase	Objectives
2003	• Show feasibility of providing DMPA through the private sector with quality care • Forge partnerships with advocacy groups and provider associations
2004–2006	Develop mechanisms for scale-up; sensitize media to mitigate negative reportage
2007–2009	Test demand generation themes and material
2010–2015	• Develop tools to address high discontinuation rates in DMPA use • Advocate for policy change

Figure 3. The number of Dimpa clinics grew over 11 years



Approach

Kara Newhouse

APPROACH

Creating and assuring quality in the Dimpa network

To establish the network, the Dimpa program implementers first identified eligible clinics. The program's field representatives obtained a list of the members of the Federation of Obstetric and Gynecological Societies of India (FOGSI) in a city to identify ob/gyns with private practices. Recognizing that these lists were not updated regularly and did not include clinics staffed with a female general practitioner, field representatives walked through each neighborhood in the city to locate other private sector clinics that could potentially be eligible for inclusion in the Dimpa network. Field representatives used a form to collect information from each of the clinics regarding the number of personnel, their qualifications, the total monthly client volume, and the number of family planning clients served each month.

> Initially, all clinics received support. As the network grew, the team targeted support to certain clinics and deprioritized others.

Implementers invited all eligible providers to a series of training sessions, positioned as "contraceptive updates." The program's medical trainers—qualified medical practitioners with extensive experience in family planning training—conducted interactive training sessions lasting two hours each. The training sessions covered medical protocols for screening, counseling, product stocking, injection, and follow-up for DMPA clients. Instructors discussed evidence of the safety and side effects of DMPA and acceptance and use of DMPA worldwide, as well as the Dimpa program objectives, current status, and future plans. At the end of the sessions, doctors were offered an opportunity to participate in the Dimpa network by signing an enrollment form.

Field representatives and the medical training team provided ongoing support to Dimpa clinics through monthly visits. They provided Dimpa clinics with screening and counseling tools developed within the program, and informational material and reminder cards for clients. Recognizing that clients often pose questions they have to paramedical staff, the Dimpa program trained all paramedical staff at clinics within the Dimpa network. After the initial training, Dimpa network doctors received annual refresher training called an "exchange forum." Designed as peer-learning sessions, doctors discussed challenges in offering DMPA and approaches to overcoming them.

As the Dimpa program became more established, the team focused on scaling up the number of clinics in the network more rapidly, and making the provider training and support activities more efficient.

The program used media advocacy and IPAN (Indian Public Affairs Network), a public relations agency, to increase the training attendance ratio (the number of doctors invited to the number who attended training) and the enrollment success ratio (the ratio of doctors agreeing to be a part of the network to those who attended training). The day before Dimpa program trainings were organized, program representatives held a press briefing explaining the objectives of the Dimpa program and its successes, as well as facts regarding DMPA. IPAN coordinated the meetings and ensured that local reporters attended the press briefings. These briefings and the subsequent press helped generate interest among doctors in being a part of the network and thus facilitated faster scale-up of the network.

As the geographical scope and number of clinics in the Dimpa program grew, program staff realized that it was not feasible for the medical team to provide uniform support to all providers. They also realized that there were variations in abilities of doctors within the network to counsel and offer DMPA to their clients. The Dimpa program developed a provider segmentation approach that delivered targeted support to doctors according to their needs. The program segmented the clinics based on reporting data: the number of family planning clients seen in a month and the number of clients who accepted DMPA. Based on these two factors, network clinics

were categorized into four groups (Figure 4). The characteristics and inputs to these groups are described below.

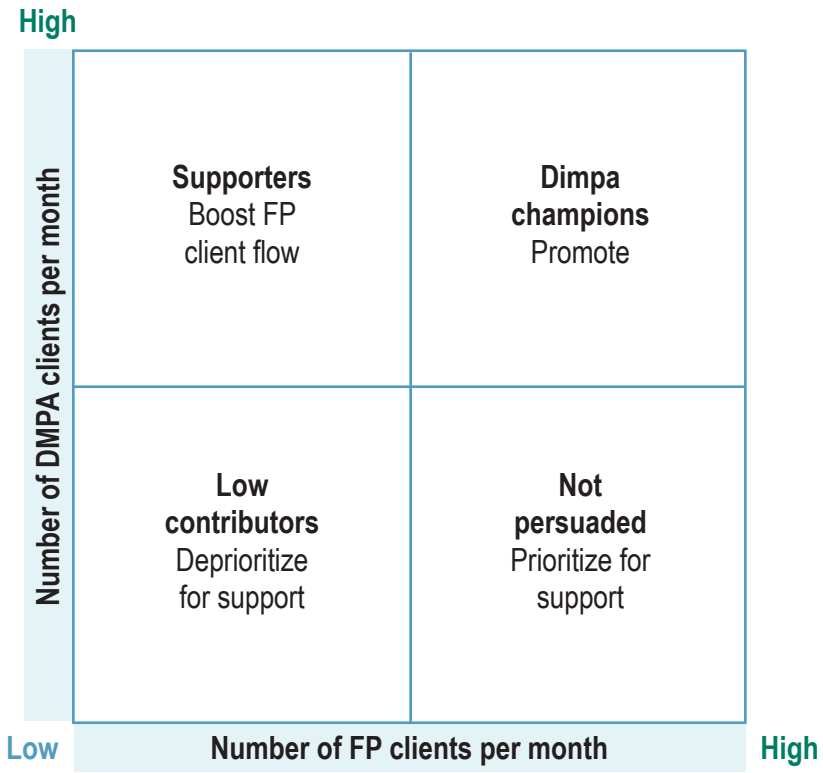
Supporters were providers who had the knowledge and confidence to provide DMPA but did not have a large client flow or appropriate profile of clients. To reach this group, the program created awareness of DMPA in and around their clinics through counseling activities such as community meetings.

Dimpa champions were high-performing doctors who had the clientele and the confidence to provide DMPA. These providers were recognized as role models and their contribution was highlighted during Dimpa network meetings and through newspaper articles. They served as catalysts in increasing confidence of other doctors in providing DMPA and in enrolling new doctors into the network.

Low contributors consisted of providers who did not receive many clients seeking contraception at their clinics. The Dimpa program deprioritized these clinics for follow-up support.

The **not persuaded** group comprised providers who had lower levels of knowledge and confidence in providing DMPA but had a large number of clients seeking contraception at their clinics. These providers were earmarked for intensive support through in-clinic and group training sessions by the program team because they had the potential to contribute substantially to the program.

Figure 4. The Dimpa program delivered targeted support to four groups of providers



Forming partnerships for product supply

When the Dimpa program began, Pfizer (formerly Pharmacia) was the only company marketing DMPA in India. The program faced two challenges: DMPA was not available in most pharmacies and the retail price of Pfizer's DMPA, at 230 rupees ($3.54), was a deterrent to providers and clients. To address the first challenge, the Dimpa program negotiated a partnership with Pfizer in which the company supplied DMPA to network clinics and adjacent pharmacies at the manufacturing cost. In addition, the Dimpa program used evidence from the formative survey conducted in 2002 to persuade Pfizer that the demand for DMPA and Pfizer's revenue from sales of DMPA could be maximized if the price of DMPA were reduced from 230 rupees to 100 ($3.54 to $1.54). As a result of these negotiations, Pfizer provided DKT—a social marketing organization—with DMPA at a discounted price of 100 rupees to supply to pharmacies and clinics serving lower-income populations.

As the Dimpa network grew and the demand for DMPA increased, other marketers introduced their own brands of DMPA in the market at different prices. Consequently, the Dimpa program expanded product partnerships to include all marketers of DMPA. To establish and strengthen sustainable linkages between the Dimpa network and the marketers, the program invited sales representatives of all marketers to introduce their products to the Dimpa network doctors during training sessions organized by the program. Though there are multiple brands of DMPA available today at a price range of 90 to 120 rupees ($1.38 to $1.85), ability to pay continues to be a challenge for increased uptake of the method.

Generating demand for DMPA

The Dimpa program implemented three types of demand generation activities: DMPA-focused mass media campaigns, women's community meetings, and a toll-free hotline for information on family

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Women's community meetings held around clinics, called Mahila Ghoshties, were aimed at helping women choose a contraceptive method and directing them to a provider.

planning and referral to appropriate health care providers.

The mass media campaigns were aimed at increasing couples' awareness and interest in DMPA. Formative research conducted in 2008 revealed that many couples with an unmet need for birth spacing were not using condoms or combined oral contraceptive pills because they found these methods inconvenient or difficult to remember to take regularly. Further, the study showed that such women avoided having sex with their husbands because they feared an unwanted pregnancy. The DMPA mass media campaigns were based on these insights and positioned DMPA as giving three months of freedom from the need to avoid one's husband. The campaigns were implemented through television, radio, newspapers, and billboards. Post-campaign surveys showed that those exposed to the mass media campaigns were associated with higher levels of awareness, knowledge, and use of DMPA (Private Sector Partnerships-*One* Project, 2009).

Women's community meetings held around clinics, called Mahila Ghoshties, were aimed at helping women choose a contraceptive method and then directing them to an appropriate provider. Outreach workers in the Dimpa program organized these meetings and counseled participants on family planning methods, including DMPA. Participants were encouraged to attend subsequent family planning "health camps" at Dimpa network clinics, where doctors offered free family planning counseling and helped women adopt the method of their choice.

An advertisement in Hindi reads, "Why excuses every day? Worried about pregnancy? Now one injection gives you freedom from excuses for three months."

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Doctors offered free family planning counseling and helped women adopt the method of their choice at "health camps" at Dimpa network clinics.

The rapid growth in telephone access brought on by the rise of mobile phones offered an opportunity to communicate directly with target audiences and counsel individuals on family planning methods. To test the feasibility and effectiveness of telephones as a medium for contraceptive counseling and referral to providers, the Dimpa program introduced a toll-free, gender-specific helpline. Trained tele-counselors with experience in family planning counseling answered client queries and, if needed, referred callers to network doctors or pharmacies. In its five years of implementation, the helpline received nearly one million calls seeking contraceptive information. Further, a study conducted by the Dimpa program showed that 12 percent of callers adopted DMPA within two weeks of calling the helpline (United States Agency for International Development, 2012).

Improving DMPA continuation rates

The Dimpa program emphasized continuity of care from the beginning. Early approaches to improve the continuity of care focused on client reminder cards and asking providers to encourage clients to visit them if they had any questions or concerns. Despite these efforts, a review of service statistics suggested that discontinuation among DMPA users remained high.

Formative research conducted by the Dimpa program showed that counseling potential adopters on side effects at the time of administration—while important—is insufficient. When experiencing side effects, women need additional reassurance and guidance. However, such women may not return to their provider to discuss their experience or seek alternatives because of physical and financial access

barriers. To address this challenge—and learning from the acceptance of the telephonic helpline among nonusers of family planning—the program initiated the Dimpa Careline, a telephone-based comprehensive counseling service targeted at DMPA users. The Careline provided DMPA users with information on possible side effects, how to manage them, when to return to a provider, and reminders about subsequent injection dates. The Careline service comprised seven calls to the user spread over a 12-month period, covering four injection cycles. In the first 15 months of implementation, 12,300 voluntary registrants enrolled in the Careline, accounting for 40 percent coverage of the estimated DMPA users in the project area.

Advocating for policy change

The Dimpa program implemented a three-part advocacy strategy: (1) build and leverage the support of FOGSI, (2) partner with family planning advocacy groups, and (3) work with a public relations agency to neutralize the distrust of DMPA.

From the beginning, the program developed a strong partnership with FOGSI to garner the support of its vast network of doctors. With support from the program, FOGSI issued a statement endorsing the safety and benefits of DMPA and later, the tools and approaches used by the Dimpa program.

In coordination with other like-minded organizations such as the Family Planning Association of India, social marketing organizations promoting DMPA, and donor organizations in India, the Dimpa program formed an advocacy coalition—Advocating Reproductive Choices (ARC). The ARC coalition has been at the forefront of policy advocacy efforts to include DMPA in the national family planning program. As a founding member of ARC, the Dimpa program has guided the ARC strategy, providing the coalition with evidence and tools to support advocacy. ARC developed policy briefs supporting the introduction of DMPA in the national family planning program, collated and published evidence of the acceptance and use of DMPA in India, and organized consultations with the MOHFW to advocate for adding DMPA to the national family planning program.

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Trained counselors with the Dimpa Careline provided DMPA users with information on the method and reminders about injection dates.

With the support of a public relations agency, the Dimpa program educated national and regional health reporters about the facts and evidence regarding DMPA to facilitate accurate and balanced reporting on issues involving the method. The program also identified DMPA advocates among these reporters and provided them with the latest achievements of the Dimpa program to generate positive reporting. With support from ARC, the program reached out to reporters when their coverage did not reflect the complete facts or latest evidence and provided them with required information. Through these efforts, there were no major instances of negative reporting in nearly five years.

Quality Assurance, Monitoring, and Evaluation

To assess the quality and effectiveness of the Dimpa program, staff used mystery client surveys; clinic checklists; and knowledge, attitude, and practice surveys of providers and clients.

Mystery client surveys: The program conducted regular mystery client surveys to assess whether network providers were offering DMPA along with other contraceptive options to eligible clients and whether DMPA was being offered with appropriate counseling. In the initial years, mystery client surveys were conducted every three months and all network providers were visited by a mystery client at least once a year. The program gradually reduced the frequency and coverage of mystery client surveys in the last five years of the program since evidence showed that the capacity building and supportive supervision tools were effective in ensuring a high quality of counseling at network clinics.

Clinic checklists: Field representatives of the Dimpa program used clinic checklists to monitor safe injection practices, stock levels, safe storage of DMPA, and adequacy of client counseling and informational material at the network clinics. Representatives conducted clinic audits once a month for all network clinics.

Provider and client knowledge, attitude, and practice surveys: To evaluate program outcomes, use of DMPA by clients, and prescription of DMPA among providers, the Dimpa program conducted four rounds of cross-sectional surveys.

Findings from these quality assurance, monitoring, and evaluation activities are described in the following section.

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An outreach worker provides counseling at a community event.

Results

Water.org

RESULTS

The Dimpa program served as a significant catalyst to both the private and public sectors, and led to changes in policy, market dynamics, and media coverage. The program achieved measurable increases in access, awareness, demand, and use of DMPA in Uttar Pradesh, where the program has been implemented for the last 12 years.

National drug controller approval to include DMPA in the national family planning program: After turning down the MOHFW request for approval to include DMPA in the national family planning program, the DCGI—based on recommendations from the Drug Technical Advisory Board and inputs from an expert group of ob/gyns—approved inclusion of DMPA in the national family planning program in August 2015. The Dimpa program's partnership with advocacy organizations such as ARC and with FOGSI, as well as the evidence and tools developed and disseminated, had a critical role in this significant policy change.

Catalyzing the private sector: As a result of increased demand and use of DMPA in India, additional marketers introduced DMPA in the country. In 2003, just one vendor sold DMPA at a price of 230 rupees ($3.54). Today, there are eight brands of DMPA marketed in India, retailing at prices ranging from 90 to 250 rupees ($1.38 to $3.85). The Dimpa program's market-shaping efforts were instrumental in this development.

Overcoming the negative press surrounding DMPA: The Dimpa program's outreach to health reporters at the local and national levels—equipping them with the facts on DMPA and rebutting myths with evidence—created a body of well-informed media personnel. This has been another critical achievement of the Dimpa program.

Awareness and knowledge of DMPA: The awareness of DMPA among married, non-sterilized women ages 18 to 49 in project areas increased from 44 percent in a survey in 2002 to 76 percent in 2015. Evidence from client surveys showed that women's knowledge of DMPA being effective for three months increased from 3 percent in 2002 to 34 percent in 2015 (Figure 5).

Figure 5. Awareness and knowledge of DMPA increased

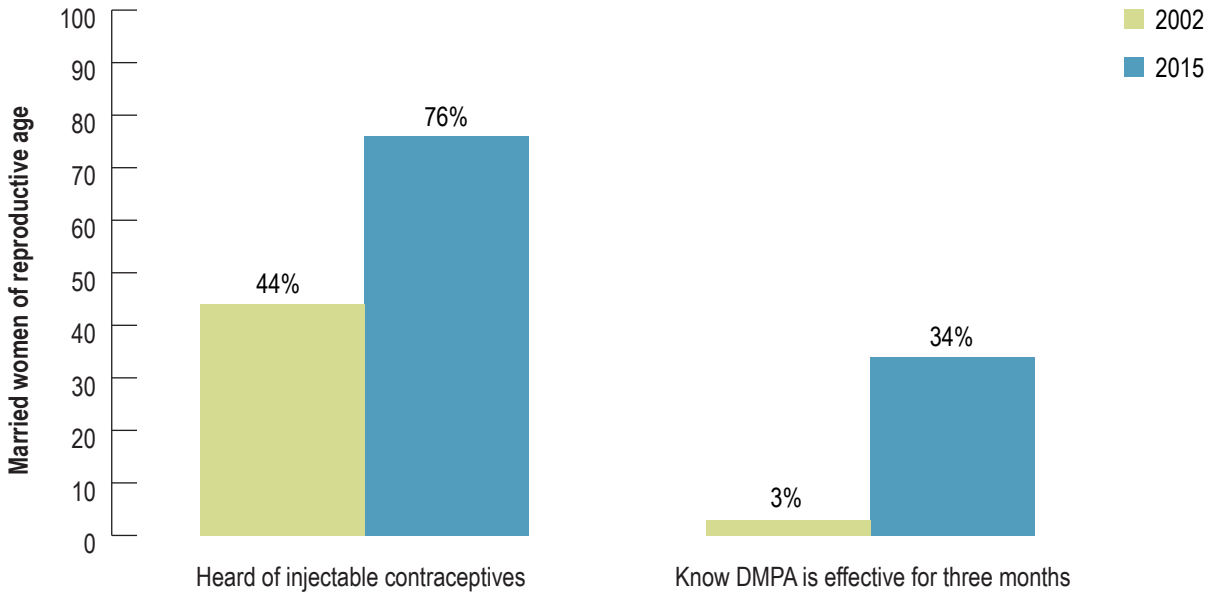
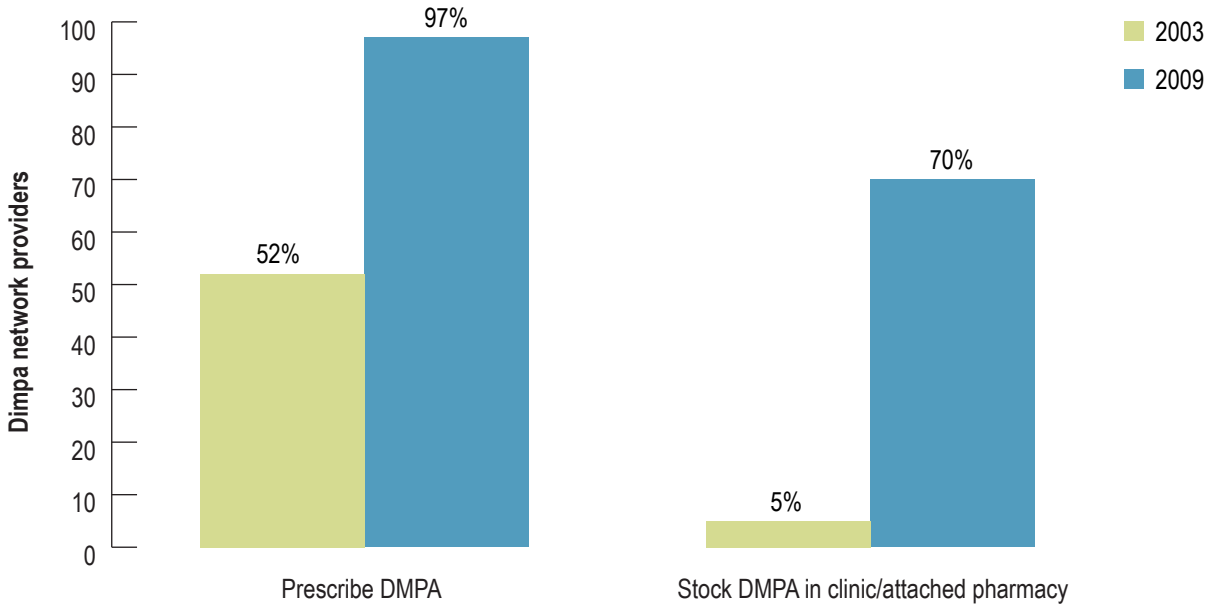


Figure 6. Network providers' attitude and behavior



Access to DMPA: Surveys among Dimpa network providers showed that the proportion of providers reporting that they were prescribing DMPA increased from 52 percent in 2003 to 97 percent in 2009. Similarly, between 2003 and 2009, the percent of network providers stocking DMPA increased from 5 percent to 70 percent (Figure 6).

Quality of counseling: Eighty-five percent of Dimpa network providers offered DMPA and at least one other method to a mystery client who asked for a contraceptive to space births. Further, 87 percent of network providers spontaneously informed the mystery client that one of the side effects of using DMPA was that periods could be affected (Figure 7).

Figure 7. Quality of care at Dimpa clinics in 2015

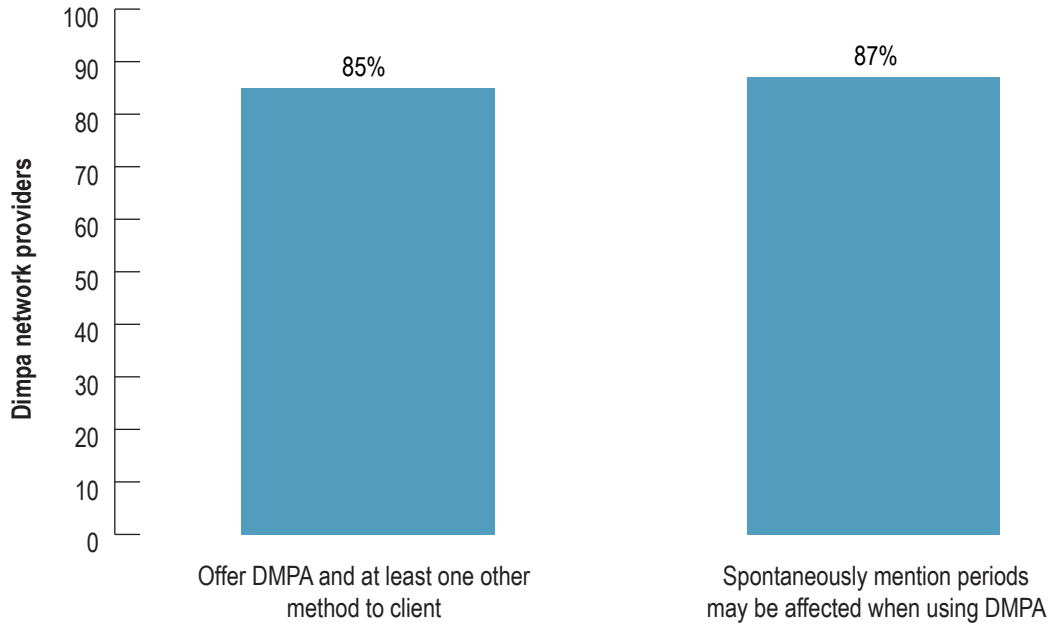
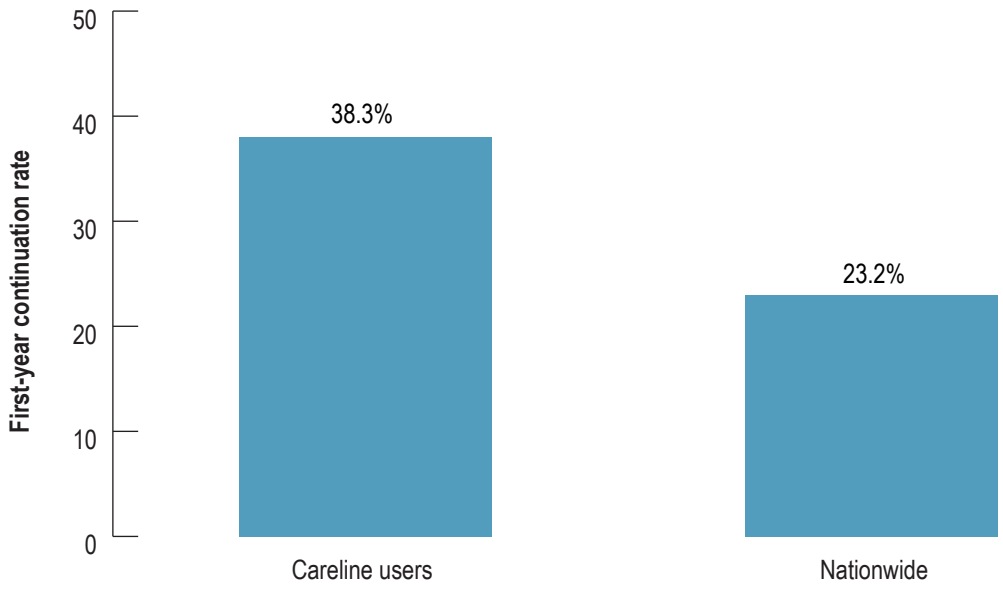


Figure 8. First-year DMPA continuation rate among Careline recipients higher than national continuation rate

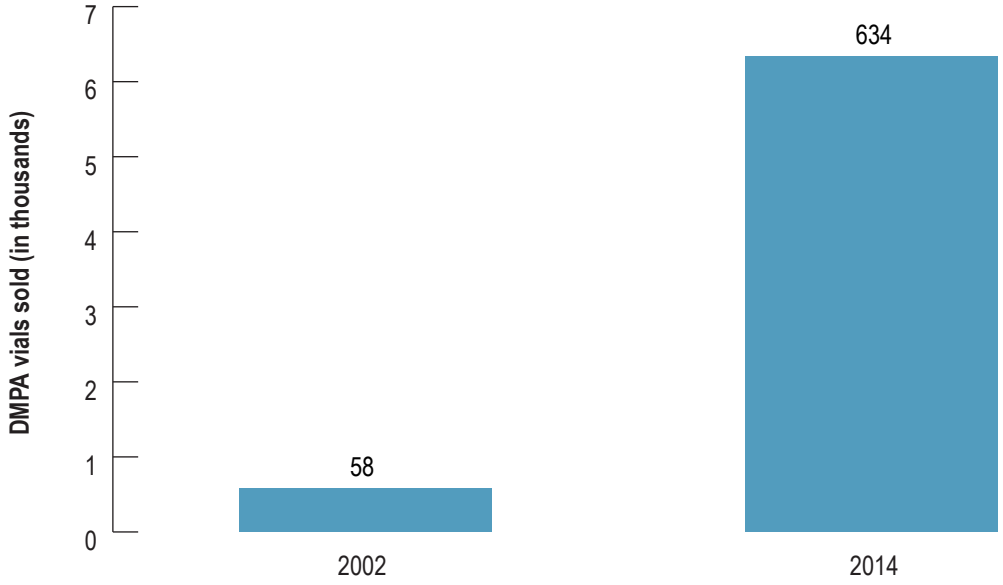


Nationwide source: 2005-2006 National Family Health Survey

First-year continuation rate among DMPA users: Thirty-eight percent of new users of DMPA who used the Dimpa Careline services continued using the method for one year or more, compared to 23 percent of DMPA users in a national survey prior to the introduction of the Dimpa Careline (Figure 8).

Annual sales: The annual sales of DMPA by social marketing organizations increased from 58,000 vials in 2002 to 634,000 vials in 2014 (Figure 9).

Figure 9. Dimpa sales increased



CONCLUSION

The Dimpa program found that even if a family planning method is initially unpopular, or deeply mired in controversy, it can be successfully introduced in a country through the private sector. The program also demonstrated that the private sector, particularly with a clinic network approach, can be a quick route for introducing a new method, while assuring high quality care. The experience suggests that in a controversial environment, focusing first on health care providers can establish a credible platform to build on in succeeding years.

The program demonstrated that bottom-up advocacy—the steady but soft push from confident providers and clients using the method, an informed media, and from marketers and policymakers who see a growing market and growing number of acceptors—can create the impetus for a policy change.

Affordability is a key challenge for any method dependent on private sector service providers. DMPA's inclusion in the national family planning program will provide critical impetus to increase use of DMPA and provide another option to the population.

The Dimpa program highlights a number of lessons to enhance operating efficiencies and effectiveness. These lessons can be applied to programs using network or social franchising strategies or those that aim to introduce a new family planning method:

- **Engaging with opinion leaders and professional associations** of providers to build credibility and support for DMPA is critical to gain acceptance among a wider group of providers and other stakeholders. When introducing a new concept or a method, it may be beneficial to initially target opinion leaders and professional associations to gain acceptance more quickly.
- **A segmented approach to supporting providers** is an essential strategy to manage rapid growth without compromising quality. By segmenting the providers, tailoring inputs, and delineating roles of each provider segment, programs can increase efficiencies in operations and better use the capacities of high-performing groups in the program.
- **Public relations and media advocacy** are essential to increase providers' interest in being part of the network. Programs should recognize that providers are an equally important target audience (as clients) and must develop activities that address providers' needs and aspirations.
- **Telephone-based interventions are effective in increasing adoption of family planning methods** (through family planning hotlines) **and improving continuation rates** (by following up with users). With high mobile telephone use in many countries, telephone-based interventions are likely to be effective solutions in a variety of settings and health areas.

USAID's 12 years of investment in the Dimpa program has ended with the inclusion of DMPA in the national family planning program. Building on this investment, the Gates and Packard foundations are now using the lessons learned and momentum created to continue to scale up the availability of DMPA in the public and private sectors and expand family planning method choice in India.

REFERENCES

Government of India, Ministry of Home Affairs. Office of the Registrar General and Census Commissioner, India. “Census of India 2011.” http://censusindia.gov.in.

International Institute for Population Sciences and Macro International. 2007. *National Family Health Survey (NFHS-3), 2005–06: India: Volume I*. Mumbai, India: IIPS.

International Institute for Population Sciences and ORC Macro. 2000. *The National Family Health Survey (NFHS-2), 1998–99*. Mumbai, India: IIPS.

Private Sector Partnerships-*One* Project. 2009. *The Dimpa Program: Growing the Three Monthly Injectable Category In India*.

Ross J. and J. Stover. 2013. “Use of Modern Contraception Increases When More Methods Become Available: Analysis of Evidence from 1982–2009.” *Global Health: Science and Practice* 1 (2): 203–212.

United States Agency for International Development. 2012. *Market-Based Partnerships in Health (MBPH) Final Evaluation USAID/India Final Report*. Arlington, VA: Social Impact, Inc.

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