Market-Based Partnerships for Health

Contract # GPO-I-00-04-00007-03

Annual Progress Report:
October 2008 - September 2009

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MBPH Operations, Mobilization and Work plan

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MBPH Staff Status

Name	Designation
Anand V. Sinha	Chief of Party *
TBD (shortlisted)	Deputy Chief of Party *
Amalendu Pal	Director of Operations *
Ms Shivani Kapoor	Policy and Advocacy Advisor *
Rohini K Sahu	Partnerships Director *

Other Positions

Sanjeev Vyas	Program Director
Dr Ravi Anand	Director Capacity Building & Quality Assurance
Mahesh Kalra	Director of Field Operations
TBD	Research Director
Gaurav Gopal Verma	Program Director- Rural Markets (ITC e-Choupal)
Suma Pathy	Program Manager - Shakti
TBD	Medical Specialist
Hari Shankar Singh	Finance & Administration Manager
Sarita Falcao	Communication/ Knowledge Management - Consultant
Manmeet Bhalla	Administrative Assistant
R. Venkataramanan	Executive Assistant
Gopal Giri	Office Assistant

Staff position clarifications

Deputy Chief of Party

DCoP, who remains a key position, will have responsibilities for team coordination, general management, strategic oversight of programs, providing technical assistance on Tuberculosis, and coordination with government and private partners.

A suitable candidate has been identified for the position of Deputy CoP. It is expected that the Deputy CoP will assume responsibilities by first week of October 2009.

Director, Capacity Building and Quality Assurance

Dr. Ravi Anand has ben promoted to the position of Director, Capacity Building and Quality Assurance. Till September 2009, her role was shared with PSP-One since the relevant programs (Dimpa, Saathiya, Shakti and ITC e-Choupal) were under PSP-One, or in transition from PSP-One to MBPH. From October 2009 the position will be dedicated to the MBPH program.

Research Director

The search for a Research Director is in progress. The candidate is expected to be identified by November 2009.

Short-Term Technical Assistance

The table below indicates the number of field positions

Table 1: List of Shared Field Positions for Shakti, Saathiya

Program	Saathiya	Shakti	Saathiya/Shakti shared resources	Total
Regional Manager	-		4	4
Tr. Manager	2	-	-	2
Field Rep's	23	3	-	26
Total	25	3	-	32

Below are details of field consultants appointed for the Saathiya and Shakti projects.

Table 2: List of Field Personnel Program: Saathiya

	Names	Designation	Program	Location
1	Bikash Chandra Mishra	Regional Manager	MBPH	Lucknow
2	Shaheen Akhtar	Regional Manager	MBPH	Varanasi
3	Jyoti Thareja	Regional Manager	MBPH	Noida
4	Prabhash Chandra Sinha	Regional Manager	MBPH	Ranchi
5	Meenakshi Dikshit	Training Manager	Saathiya	Lucknow
6	Kumaril Mishra	Training	Saathiya	Varanasi

	Names	Designation	Program	Location
		Manager		
7	Deepti Mishra	Field Training Coordinator	Saathiya	Lucknow
8	Deepak Chandra Joshi	Team Leader	Saathiya	Lucknow
9	Ritesh K Nigam	Field Representative	Saathiya	Barabanki
10	Anuj Kumar	Field Representative	Saathiya	Lucknow
11	Rahul Tiwari	Field Representative	Saathiya	Lucknow
12	Varun K. Tripathi	Field Training Coordinator	Saathiya	Agra
13	Mahendra Shukla	Field Representative	Saathiya	Agra
14	Pragati Chaturvedi	Field Representative	Saathiya	Agra
15	Vacant/ Needed	Field Trg. Coordinator	Saathiya	Dehradun
16	Anoop Srivastava	Field Representative	Saathiya	Allahabad
17	Abhishek Pathak	Field Training Consultant	Saathiya	Allahabad
18	Vijay Bahadur Yadav	Field Representative	Saathiya	Allahabad
19	Ashish Kumar Pathak	Field Representative	Saathiya	Varanasi
20	Harsh Kumar Dubey	Field Representative	Saathiya	Varanasi
21	Manoj Kumar Srivastava	Field Representative	Saathiya	Varanasi
22	Sanjeev Dhawan	Team Leader	Saathiya	Dehradun
23	Suresh Mishra	Field Representative	Saathiya	Dehradun

Table 3: List of Field Personnel for Shakti

	Names	Designation	Place
1	Jeetindra Kumar Srivastava	Shakti Representative	Sitapur
2	Anil Kumar Dwivedi	Shakti Representative	Sultanpur
3	Manoj Pandey	Shakti Representative	Fatehpur

Site office staff plan for MBPH year 2 program

Besides the existing staff positions (18), there is a need for the following new positions:

Position (Staff)	TBD (Status)
Manager-IT	To be hired in November 2009
Manager-BCC	To be hired in October 2009
Manager-Knowledge Management	To be hired in October 2009

Short term technical assistance (STTA)	TBD
Consultant-ICT	October 2009 - March 2009

The requirements of these positions have arisen based on work plan for year 2 activity and incorporation of new component i.e. injectable contraceptives.

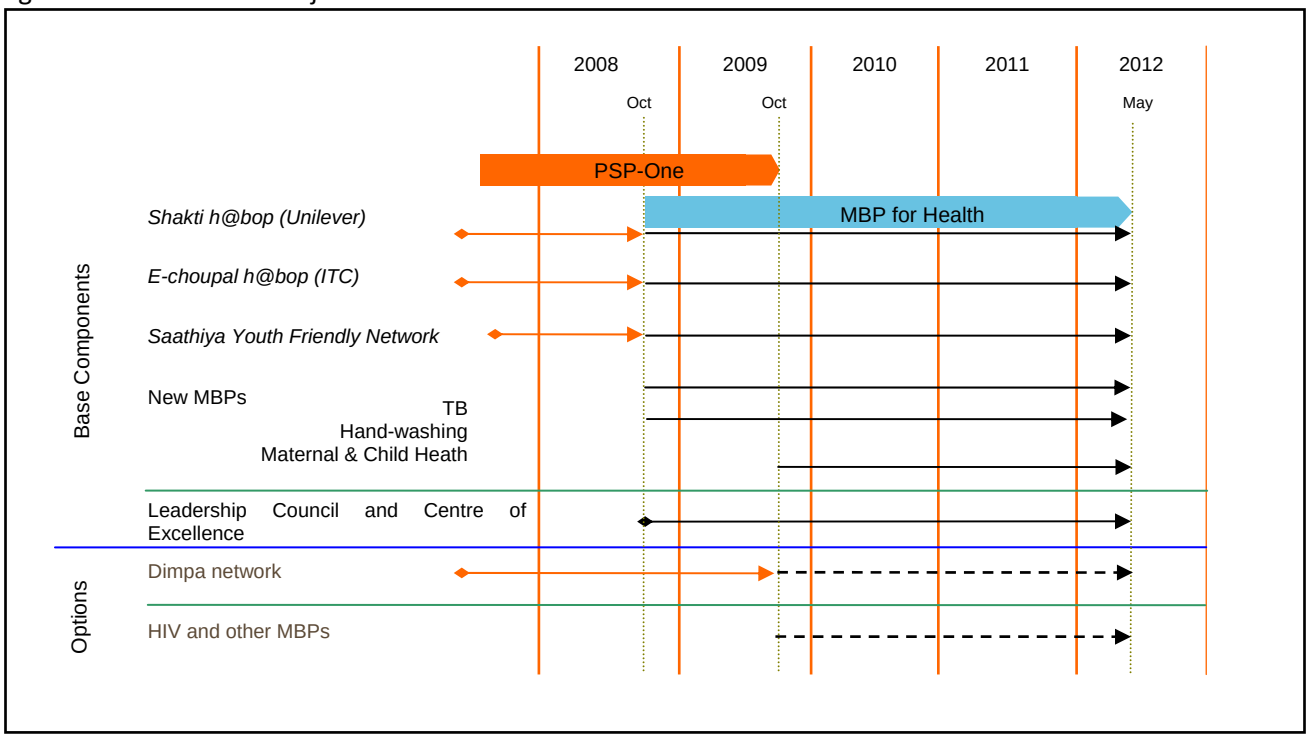
Site office field consultant plan for MBPH year 2 program

Field Consultant Positions	Funding/Existing Consultants Year 1	Funding/Proposed Consultants Year 2
Regional Manager for all field programs	MBPH-Comp (1)-4	MBPH-Comp (1)-4
Training Manager-Saathiya	MBPH-Comp (1)-2	MBPH-Comp (1)-2
Field Consultant-Saathiya	MBPH-Comp (1)17	MBPH-Comp (1)-17
TBD- Training Officer-Medical	Nil	MBPH-Comp (1)-1
Field Consultant-Shakti	MBPH-Comp (1)-3	MBPH-Comp (1)-3
TBD- Field Consultant-TB	Nil	MBPH-Comp (1)-2
TBD- Field Consultant-ITC	Nil	MBPH-Comp (1)-2
Dimpa/ Injectables		
Field Consultants - Dimpa	PSP-One 29	MBPH-Comp(3)-29
Medical Consultant (Training)	PSP-One 1	MBPH-Comp(3)-2
Total		**MBPH-Comp(1&3)-62**

Accomplishment - Analysis Report

The figure below provides a high level timeline of the PSP-One and MBPH activities over the life of the project. Progress on each of these activities is discussed in detail in the following section.

Figure 1: MBPH Life of Project Activities



Saathiya Youth-friendly Network

The goal of the Saathiya program is to meet the reproductive health needs of young, low income married couples by reducing barriers related to embarrassment and privacy, increasing providers' knowledge of contraceptives and their counseling skills, promoting youth-friendly retail outlets, medical providers and products, and expanding the sale of commercially marketed contraceptive products.

In 2008, PSP-*One*/India received additional funding to scale up the Saathiya program to a larger catchment area in Lucknow and six additional cities in two states. Accordingly, the last year saw the successful expansion and completion of the Saathiya program pilot in Lucknow and also to six new cities of Uttar Pradesh and Uttrakhand.

It was an eventful year for the program with the launch of many new private sector partnerships and activities. These were directed at making quality family planning (FP) and reproductive heath products and services reach young married couples in the program geographies. The Lucknow pilot offered an opportunity to test the program model and see how effective its different components are, in overcoming the barriers faced by young married couples in obtaining these services. Several important lessons were learnt from the Lucknow pilot in terms of the program model, partnerships, provider and product approaches, communication, promotions and scaling up and some of these are explained towards the end of this section.

Some of the important activities and milestones of the program through last year are as below:

Table 4**: Saathiya Program Activities Outlined and Accomplished**

Saathiya Workplan	O	N	D	J	F	M	A	M	J	J	A	S	% Accomplished
Scale up Saathiya Network													
Contract Communications Agency													100%
Recruitment of Regional Trainers & Field Teams													100%
Screening & selection of providers													100%
MoUs with local Medical Associations													100%
Provider Trainings													100%
Conduct consumer & provider baseline studies													70%
Program Launch in new cities													100%
Scale-up of Helpline Facility													100%
Development of Communication for Phase II													100%
Roll out of Communication for Phase II & III													100%
Assess Commercial and Health Value of Network Elements													
Study on Regulatory Issues regarding ISMPs													100%
Expand Product Portfolio													
Review sales data and identify potential new products													100%
Identify and negotiate terms with manufacturers / marketers of the health products													50%
Prepare field training and demand creation modules and roll out													100%
Explore extending Saathiya to other Youth Health Services													

Develop appropriate training packages for Saathiya network providers and roll out*													

** To be taken up later*

Activities Undertaken/ Initiated/ Delivered:

Program expansion: An encouraging response from providers and program partners led USAID to call for an expansion of the Saathiya program in four cities of Uttar Pradesh (Agra, Allahabad, Barabanki and Varanasi) and two in Uttarakhand (Dehradun and Haridwar). These cities are the most populous and are also priority cities for program's commercial partners. At the same time the Lucknow provider network was scaled up by doubling the number of providers.

The selection of providers and trainings began in the last quarter of '08 and the program was formally launched in the first and second quarters of '09.

S. No.	City	Program launch
1.	Dehradun	26 March '09
2.	Agra	4th June '09
3.	Barabanki	12th June '09
4.	Allahabad	18th June '09
5.	Varanasi	25th June '09
6.	Haridwar	2nd July '09

Partnerships with city-level Medical Associations: On the public-private partnership component, 28 new MOU's were signed with medical associations such as NIMA, IMA and FOGSI to cooperate in building the Saathiya network.

Provider associations representing the interests for Chemists, ISM&H doctors, GP's and Ob/Gyn's were identified in each of the six expansion cities and a partnership dialogue was initiated. The program successfully entered into a partnership with 28 medical associations across the six expansion cities, taking the total number of medical association partners to 33 (including five associations in Lucknow). These associations helped in the selection and training of providers and in some cases also offered representatives as peer trainers.

The table below shows the status of the MoUs with medical associations in Lucknow and in the six expansion cities.

Table 6: Status of MoUs with City level Medical Provider Associations

Saathiya MoU Status – Provider Medical Associations			
City		**Medical Association**	**Status**
1	**Agra**	Homeopathic Medical Association of India	Signed
		Agra Obst & Gynecological Societies of India (AOGSI)	Signed
		Agra Pharma Association	Signed
		IMA Agra	Signed

Saathiya MoU Status – Provider Medical Associations			
City		Medical Association	Status
2	**Allahabad**	NIMA Agra	Signed
		Prayag Chemist & Druggist Association (PCDA)	Signed
		IMA Allahabad	Signed
		NIMA Allahabad	Signed
		AYUSH Medical Association Allahabad	Signed
		FOGSI Allahabad	Signed
3	**Barabanki**	Private Doctors Association	Signed
		Barabanki Chemists Group	Signed
		IMA Barabanki	Signed
4	**Dehradun**	NIMA Dehradun	Signed
		IMA Dehradun	Signed
		Chemist Association Dehradun	Signed
		FOGSI Dehradun	Signed
		UHMA Dehradun	Signed
5	**Haridwar**	Medical Practioners Association	Signed
		Hardiwar Chemist Association	Signed
		FOGSI Haridwar	Signed
6	**Lucknow**	IMA Lucknow	Signed
		Lucknow Chemist's Retail Association	Signed
		NIMA Lucknow	Signed
		Lucknow Obstetrics & Gynaecological Society	Signed
		Research Society of Homeopathy	Signed
7	**Varanasi**	NIMA Varanasi	Signed
		IMA Varanasi	Signed
		VOGSI (FOGSI of Varanasi)	Signed
		Chemist Association Varanasi	Signed
		BHMA Varanasi	Signed
		AYUSH Medical Association Varanasi	Signed
		HMAI Varanasi	Signed

Meetings/ Trainings/ Workshops held

For the training and Saathiya provider network components, a selection check list was developed to identify health service and product providers who qualified to be part of the Saathiya network.

Additional trainers were hired to conduct family planning counseling and contraceptive update workshops. A Training of Trainers (ToT) was held for them in mid-October '08 and the first workshops were rolled out to train the new chemists and doctors in the next six months.

Communication pieces were developed to explain the Saathiya concept and how network providers could benefit by being a part of this effort. The Saathiya network comprises of a total of 3,200 trained chemists, family doctors and Ob/Gyns as shown below:

S. No.	City	Chemists	ISMP's	GP's	Ob/Gyn's	Total Base
1.	Lucknow – Exp	303	317	50	169	839
2.	Barabanki- New	40	40	30	40	150
3.	Agra - New	204	208	51	108	571
4.	Allahabad- New	212	228	--	63	503
5.	Varanasi- New	302	311	3	60	676
6.	Dehradun- New	151	151	2	42	346
7.	Haridwar- New	51	52	Nil	10	113

Integration of Saathiya and Dimpa Programs

The Saathiya and DiMPA program Ob/Gyns aspire to offer a range of Family Planning methods, and the two programs cover a similar provider base of Ob/Gyns. Therefore, it was felt that the DiMPA program can be merged with Saathiya for better alignment of resources and to attain economies of scale. The Saathiya program is currently exploring partnership opportunities with commercial sector product marketers of Depo Provera to include it in its product basket.

Accordingly, DiMPA clinic providers now form the initial base of Ob/Gyns in Lucknow and in the six expansion cities. The DiMPA field team covers DiMPA clinics and explains about all FP methods in the Saathiya basket. The Saathiya field team continues to cover chemists and traditional doctors.

All DiMPA Ob/Gyns have been oriented on Saathiya through group orientation meetings across seven cities. They have signed the Saathiya Quality Circle agreement, a requirement to be a part of the Saathiya network.

A two-day integration orientation meeting of Saathiya and DiMPA team field was held at Dehradun on 28th and 29th April '09. A training session for Dimpa and Saathiya helpline counselors was held in early May '09 and many follow up sessions have since been conducted.

The training curriculum for Saathiya chemists includes DMPA as a method and trains them for imparting basic information about the method to clients. Keeping in mind that ISMP's are not allowed to offer clinical services for DMPA, the method has been kept out of their training curriculum purposely so that they are discouraged.

With this, DMPA has been integrated into Saathiya in Lucknow and scale-up cities, including the helpline, training component, manufacturing partnership and promotional efforts. Under Saathiya, DiMPA is treated as a product partner, and under DiMPA, Saathiya is considered an access point. Preliminary meetings have been held with Pfizer to get them on board as the commercial partner for Depo Provera.

Support from commercial manufacturing/marketing partners

Manufacturing partners (JK Ansell, Win-Medicare and GlaxoSmithKline Pharmaceuticals) provided campaign support in the form of product samples, leaflets, medicine pouches and posters, and participated in provider training/orientation meetings in Lucknow/expansion cities. Partner representatives attended steering committee meetings and participated in various ground-level and communication campaign activities.

New Partnerships initiated

An MoU was signed with Contech Devices Ltd., manufacturers of IUD's. However, this partnership was not much of a success, as the company could not provision any budgetary allocation for program activities.

Schering-Plough (IUDs and PTKs), Wyeth (low cost OCs), HLL Lifecare (CycleBeads) and Pfizer (DMPA) were identified as potential partners for widening the Saathiya product basket. Activity plans have been developed and presented to these companies, and at present discussions and negotiations for partnering are at various stages of progress.

Discussions with the management of Schering-Plough for a partnership on IUCD's and Pregnancy Test Cards are at an advanced stage. A draft MoU has been shared and a meeting with their regulatory/compliance department is being scheduled to finalize the terms. Wyeth Ltd. has indicated that they would like to postpone the partnership dialogue till the first quarter of 2010, as they currently do not have funds for a partnership with their brand of OC's. Progress with HLL Lifecare for a partnership on CycleBeads has been slow as Mr. Suresh Kumar, Marketing Director, has been traveling. An activity plan was shared with the team and a meeting is being scheduled to take it further.

There has been no response from Pfizer on the inclusion of DMPA, as they are awaiting the merger with Wyeth. Efforts were made to get in touch with the Marketing Director of Bliss GVA (manufacturers of 'Today' vaginal passeries), but the party showed little interest in this partnership.

Consumer endline for Lucknow Pilot

The end-line in the intervention city of Lucknow and in Kanpur Nagar (control) was completed and the detailed report was shared with USAID in the last quarter of this year.

Achievements in Quarter IV:

- Provider Capacity Building: The CB&QA team conducted a detailed Training Needs Assessment with Saathiya chemist and ISMP providers in Lucknow, Agra and Varanasi. It was seen that chemists needed to strengthen their knowledge on OC's and EC's while they had very little knowledge of IUCD's. Chemists also expressed a desire to learn about the female condom and natural methods. Accordingly, the CB&QA team has put together a refresher training module which is of three hours duration. A TOT was held in Lucknow on 22nd and 23rd September for the Saathiya field training team. The chemist refresher trainings are scheduled for Oct/Nov '09 across all seven program cities.
- The CB&QA team is working on the curriculum for refresher training of Family doctors (ISM&H docs and GP's) and this will be ready by end October. The trainings will be scheduled for Nov/December '09.

- New interim campaign: The existing communication campaign was adapted based on insights from the communication development research. The campaign comprised of newspaper ads, a sponsored radio program and outdoor and was aimed at building awareness and recall for Saathiya as a family planning service for young married couples. The campaign was scheduled from 16th Sept to 15th October and has resulted in more than doubling of calls (an increase of 144%) to the Saathiya helpline. There has also been a healthy growth in calls from expansion cities post release of the new communication campaign with a majority of callers citing the radio program and newspaper ads (besides word of mouth) as their source of information.
- Production of new POS Materials: The program invested in development of high visibility and long-term POS items such as Provider Glow Light Box Signs (Lucknow only), Sunboard signs (expansion cities), Tinplate signs (for Ob/Gyn clinics), danglers, framed training certificates and in-clinic signs. Samples developed were shared with providers and were well received by them.
- Media Coverage: As a follow up to the excellent program launch coverage, follow up activity in the form of interviews with key officials of FOGSI (program medical association partner) in all cities was organized. FOGSI Presidents/officials were briefed to highlight the need for a family planning program for young couples and how Saathiya was fulfilling this need by offering quality services through a trained network of providers. The total advertising value of this coverage was equivalent to Rs. 1,655,355 ($ 34,486.56).
- Development of Balanced Counseling Toolkit: The adaptation and translation of the User's Guide, Trainer's Guide, Method Brochures and Method Cards were completed by the Saathiya team in collaboration with FHI and Pop Council. The toolkit will be produced by November and a TOT will be scheduled to train our internal master trainers on the same before rolling out to family doctors.
- Procurement of Helpline services: A new RFP for expansion and automation of the Saathiya and Dimpa helplines was prepared and released. It is proposed to increase the number of telecounselors and work on developing an IVRS as an estimated 30 to 40% of calls were getting dropped as per estimate of the helpline management.
- Consumer Baseline study: The field work for the consumer baseline for expansion cities was completed in the month of August/Sept and the research report will be presented by Sigma Research & Consulting Pvt. Ltd. by the end of October.
- Provider Baseline study: The study for expansion cities has been awarded to GFK Mode and the contracting was completed in September. The research instruments will be finalized in October and the field work will be completed in the same month.
- Advocacy plan for mainstreaming ISMP doctors: The Regulatory barriers assessment study conducted by Sorento Healthcare Communications indicated that ISMP doctors can not prescribe Rx products and can not perform surgical procedures. However, those ISMP doctors who have studied IUCD implantation as a part of their medical college curriculum or have completed formal training on IUCD implantation and are registered with the state medical council are eligible to practice IUCD implantation. Accordingly, the program is working with the Futures team in putting together an advocacy plan to mainstream ISMP's for IUCD implantation. Currently, the program is doing an in house research to understand the existing knowledge and practices of ISMP doctors in the network with regard to IUCD's.
- Consumer & provider baselines in expansion cities: Consumer and provider baselines were conducted in the last quarter. The consumer baseline has been completed and the research instruments for the provider study are being finalized.

Travels/Field Visits

Some of the important visits over the last year were:

1. Ms. Kerry Pelzman, Director of the office of PHN, USAID/India visited the project at Lucknow on 5th November '08.
2. The US Charge d' Affaires A Peter Burleigh visited the Saathiya helpline at Lucknow on 4th of May '09. He was accompanied by Ms. Kerry Pelzman and Moni Sinha Sagar from the mission.
3. Ms. Kerry Pelzman, Ms. Monique Mosolf attended the Saathiya Dehradun launch conference at Dehradun on 26th March '09
4. Ms. Sheena Chhabra, USAID/India attended the Saathiya launch conference at Agra on 4th June '09
5. Ms. Shweta Verma, USAID/India representative for Uttarakhand attended the Saathiya launch conference at Haridwar on 12th June '09

Lucknow Pilot - Key lessons learnt

1. Expectations of communication campaign performance need to be consistent with market-specific media performance and invested resources. This is particularly true when it comes to generating awareness of a new brand (product/service/network) as awareness is typically driven by high reach, high frequency media. If this is not part of the media strategy – which in the case of Saathiya it could not be due to budget limitations and concern for using a broad medium like TV that might reach into the control city, Kanpur – than expectations about awareness targets should reflect this.

2. To understand the relevance and impact of youth-targeted messages, it is important to monitor the behavior changes of the actual users benefiting from the program. While the overall number of respondents in the endline study who were aware of Saathiya was somewhat lower than desired, the perception among those who had ever-heard of Saathiya was predominantly that it was a family planning network (83%). Other attributes that a small number of respondents identified with Saathiya reflected the youth-focus of the initiative including: doctors for young people, discounted contraceptives for youth, and discounted counseling for youth.

   The helpline data shows that the profile of callers closely matched the intended audience in terms of age: callers under age 20 increased slightly over time, from less than 10% in October/November 2007 to just over 20% in April 2009. The largest proportion of calls was from 20-25 year olds at approximately 42% with call volumes from this group remaining relatively constant over time. It will however be important to monitor actual changes, if any in the behavior of our audience after their interaction with the program.

3. The cultural context should be considered when selecting the provider base to serve youth on sensitive issues as FP and RH: Saathiya design started with idea of replicating the CMS-Celsam experience and PATH's RxGen project of reaching young people through pharmacies. Formative research indicated though that working with chemists only will not allow the program to reach its objectives. Findings showed that chemists were perceived as

traders/shopkeepers and not medical experts. The busy and impersonal chemist shop environment posed limitations for women seeking FP advice. As the result, provider base for the Saathiya Initiative's network was expanded to ISM&H providers, general practitioners, and Ob/Gyns that served as a referral point for complicated cases and detailed counseling.

Indigenous doctors and chemists received training through a program designed to advance theirknowledge on contraceptive methods, educate them on peculiarities of adolescent RH, and counseling and customer relation skills required in serving young married people. A mystery shopper study conducted five months after the training found that older doctors tended to be more patronizing and judgmental towards young clients asking for advice. Young female clients would not feel comfortable inquiring about FP information from a male provider. Some providers were passive and did not personally support the Saathiya network vision. The study indicated that characteristics such as gender, age, and willingness to serve a social goal should be factored in the Saathiya network provider selection process.

4. Building referral systems is time-consuming. Finding "mutual" values for all involved is the key to increase participation. If one is planning to have referrals as part of the network, consider the pre-existing referral systems that the selected providers might already have, and make sure this component is synergized with other parts of the program.

5. It is difficult to track referrals made by providers or to monitor if clients actually go to providers once they are referred to by the helpline. Attempts to put in place a tracking mechanism did not work as providers are not in a habit to put down the data.

6. The helpline has proven to be a vital tool to enable access to a network of providers and to provide basic information on contraceptives to current and intending users.

7. Engaging multiple types of providers could be more effective than collaborating with one or few provider types as it covers more points of missed opportunities and it is possible to synergize program activities across provider sets.

Comments on Lucknow Pilot Program: The overall model proved to be effective in increasing FP amongst those who were exposed to the messaging. One of the main goals was to increase demand for and use of contraceptive methods leading to improved birth spacing and better quality of life. From the end-line analysis, as well as with data from the helpline, it appears that the Saathiya program has progressed on this front.

Despite the relatively short intervention period of 16 months before the end-line evaluation, the reported use of modern FP methods was higher amongst married youth in Lucknow who were exposed to Saathiya, as compared to the control city. Respondents who had heard of Saathiya in Lucknow were twice as likely to be current users of modern FP as their counterparts who were not familiar with Saathiya. Even after controlling for other determinants of modern FP use, including gender, age, education, religion and the number of living children, exposed youth in Lucknow were 71% more likely to practice modern FP than their unexposed counterparts at the end-line.

With further refinements of the model and a shift in budgeting to support a broader media approach the model could be optimized to reach awareness goals and continue to increase FP among young married couples.

Based on the lessons learnt from the Lucknow Pilot, the Saathiya program is being strategically reviewed and the model will be refined accordingly.

Barriers

- Communicating FP to lower SEC groups: Communication development research amongst lower income groups shows low expressed need for family planning. Moreover, these groups do not have a habit of going to a doctor for family planning needs as they do not consider it to be an illness. These groups need to be communicated the generic benefits of family planning and a strategy has to be developed to get them to interact with a family doctor for their FP needs.

- Helpline capacity: We need to continue to explore new technology based solutions to improve the efficiency of helpline telecounselors and also to lessen the burden on them of the ever increasing number of calls.

Availability of partner products: The field teams need to continually work with the local teams of commercial partners to increase availability of partner products at Saathiya counters. Wherever possible, the program needs to explore the possibility of getting partners to get ISM&H doctors to stock and retail their products (condoms, CycleBeads).

Shakti Health @Base of Pyramid

Background

The Shakti H@BoP pilot was launched in three Shakti districts in Eastern/Central Uttar Pradesh in May-June '08, with ORS as the first health product introduced in the Shakti basket. During discussions on the roll out, it was agreed that for this pilot to be a success, two critical questions need to be answered:

- Can the Shakti Entrepreneur (SE) sell health products and will there be community acceptance of the SE in the role of a health advisor, and
- Can a sustainable distribution system be designed to support health products in the Shakti network.

The pilot aimed at increasing the income of SEs from the sale of health product/s. The targeted increase was INR 150 per SE/month from the sale of condoms, OC and ORS. Even with ORS as the only product in the SE basket, the profit per SE/month has shown a substantial increase. In 2009, sales peaked in July, with the profit per SE/month at INR 76. This is an impressive 216% increase from the previous year's peak profit.

While this is credible, end-line results show no significant increase in either the awareness or use of ORS compared to the base-line. This situation calls for an in-depth analysis of the sale within the community to gauge impact. The increased sales could be ascribed to:

i. The substitution effect (brand switches)
ii. The promotion of ORS as an overall "well being" product and not restricting its use only during diarrhea
iii. Sales of ORS by the SE *outside* the village – many SEs have more than one shop, one of which is located at the outskirts of the village, often near a town.

Additionally, ORS can only add a minimal amount to the SE's income. In order for the health basket to make a significant contribution, other public health products such as condoms and OCs need to be included in the SE's basket. And though the inclusion of family planning has always been discussed with HUL management, HUL is reluctant, for historic and other reasons, to introduce family planning into the Shakti program. This has severely limited the impact that this partnership could make, both economically (for the SE) and from a public health perspective – for the rural consumer.

Nonetheless, the pilot has clarified that the SE is capable of selling health products. The other critical question of developing a sustainable rural distribution channel by leveraging HUL distribution networks is an issue that remains unresolved. The MBPH team proposed models and designs that leveraged the HUL distribution system to various extents. However, it is our understanding that Shakti is now undergoing a process of consolidation and integration with the core HUL distribution network and therefore the management is not keen to experiment. In this context, UP is a particularly unstable area and the formerly independent Shakti 'division' is now under the Rural Sales Channel.

Barriers

The stalemate on including family planning products and sustainable distribution means that the Shakti H@BoP pilot/partnership has limited scope. As strategic decisions on next steps of the program are considered, it would be useful to discuss the challenges and opportunities of the last 14 months of working in partnership with HUL Shakti.

Project Shakti is touted to be an innovative rural distribution channel led and managed by female entrepreneurs. However, it has been observed that this channel does not substantially differ from a more traditional rural retail channel. This is because:

- A significant percentage of SEs have not been recruited from Self-Help-Groups (SHGs), as was the original design, but are women whose family has an existing retail enterprise. Shakti is more a family business (involving male members of the family) than a woman-centric initiative.
- The sales technique used by the SEs is not the originally envisaged door-to-door selling. 70-80 percent of the SEs own a shop or wholesale to other retailers within and outside of their villages. This approach limits the scope of the SE to influence behavior change and transmit information on health issues.
- The SE does not exclusively stock only HUL products. The fact that the HUL supply is regular is an incentive to stock them, but the shopkeepers often also stock other products. On an average, 50-60 percent of the SE's stock comes from HUL's portfolio- the percentage share increases with the increase in distance from the nearest town.

As a result, the interaction within this network is male-to-male. Rural women (especially our target audience - women with children under five years) are unlikely to venture outside to purchase personal care or other products. However, it must be noted that HUL does attempt to increase participation among women, and in cases where the SE is convinced of a benefit (financial or social), and where she has family support, there is higher involvement of women in the business as compared to traditional retailing.

The SE network receives greater logistic (order, supply, collection) field support than conventional retail channels. Field support for market activation is limited and it appears that the outlets are seen more as points of access than the originally envisaged one stop solution for demand generation and access. The reason for HUL's reluctance to leverage this network for demand creation needs to be explored[1] – is it that an expansion of the rural market does not provide sufficient returns so as to defray costs incurred?

Last mile supply is still an issue, education and awareness generation through this network is limited and HUL is not keen on introducing contraceptives into the Shakti basket. In light of these realities, MBPH has decided to end this partnership within the current context.

On the other hand, a network like Shakti could offer health marketers with an identified and commercially trained list of over 40,000 retailers which for any company to identify from scratch would be cost intensive, and may not even be effective in a rural context. Additionally, as mentioned earlier, though this network resembles a traditional retail channel in many ways, there is a relatively greater involvement of women here, which could be leveraged in some way.

[1] There was a brief mention in a recent Economic Time's article about HUL's intent to utilize Shakti for market activation

Moving on

The sustainability of the MBPH initiative is dependent on brand support from HUL brands, and to this extent, the association with HUL brands such as Lifebuoy or Pureit is crucial for HUL ownership of these health categories. We thus see a greater fit with the Health and Hygiene Alliance (HHA). This network needs to be driven by HUL brands and Lifebuoy and Pureit. As a part of the alliance, they could push innovative hygiene marketing in rural areas. We intend to take our lessons learnt from the Shakti H@BoP pilot to these brands and carry out promotional activities within the HHA.

The pilot in its current shape will be closed unless there are indications from HUL that there is a possibility of introducing family planning products and that distribution pilots can be explored.

ITC e-Choupal Health@BoP

Introduction

The objective of the e-Choupal Health@BoP is to develop a Rural Health Delivery Model under the USAID Market-based Partnerships for Health (MBPH) project. Providing rural health services is a natural extension of the e-Choupal network due to its deep reach into the hinterlands of the country and its long term vision of improving the quality of life in rural India. The pilot program will be implemented in UP and is intended to provide e-Choupal with a framework for scaling up the health initiative across larger areas as well as to position e-Choupal as an entity that can partner with the government in their various health initiatives.

The ultimate objective of the programme is to establish a rural health model focused on improving the quality of life and livelihood opportunities for the rural population, which can be scaled up across the e-Choupal network. The model will be considered successful if it can increase access to public health products or services in rural India, via a commercially sustainable supply chain, and create livelihood opportunities.

The activities in the first year of the program have focused on developing an effective delivery model in the ITC e-Choupal framework. The activities ranged from conducting formative research among consumers and industry experts to doing iterations for the final delivery model with e-Choupal.

The year concluded on a positive note with the ITC Agri-Business Division (ABD) team formally agreeing to come on board for this initiative with the signing of the MoU between ITC and Abt Associates.

The following table outlines various activities[2] which were planned at the beginning of the year and what proportion has been finally achieved:

E-Choupal H@BoP Work plan	O	N	D	J	F	M	A	M	J	J	A	S	%Accomplished
Develop Choupal Sagar Health Services Pilot Package*													
Sign LOI with ITC for capacity building of VHC's in Yavatmal													Nil
Develop content for capacity building catalogue for VHC's training (FP, Diarrhoea)													Nil
Finalise product and services portfolio for VHC's and expand the training modules													Nil
Help in detailing of the public health schemes fitment													Nil
Develop Hub centric Model Pilot for Uttar Pradesh ***													
Sign MoU with ITC for clarity of roles and responsibilities for Uttar Pradesh Pilot													90%
Identify Sanchalak Choupal points													Nil
Identify networks and chains of health care providers to service rural clients													Nil

[2] *The list of activities has also undergone a number of iterations and the proposed list of activities for the second year is given towards the end of this document.*

E-Choupal H@BoP Work plan	O	N	D	J	F	M	A	M	J	J	A	S	%Accomplished
Develop logistics chains for products and services													Nil
Link appropriate product partners to the Choupal hubs													Nil
Train hub health workers on product portfolio, linkages and quality assurance													Nil
Train village health workers to support demand creation for these services													Nil
Announce availability of services at village level and aggregation of demand													Nil
Fine tune the supply chain for distribution of health products													25%
Linkages between E-Choupal Village Level Health Worker and Govt. Program**													
Health experts review of potential linkages between e-Choupal and Govt. health programs													Nil
Design training modules and guidelines for village level health worker													Nil
Research and Monitoring ***													
Scanning the Health environment													50%
Household baseline assessment													Nil
Monitoring sales, referrals and income levels													Nil
Mid line assessment													Nil

** Yavatmal intervention was dropped ** Govt. program linkage on hold *** Model final design with ITC –ABD team cleared in September 2009*

Activities Undertaken/ Initiated/ Delivered

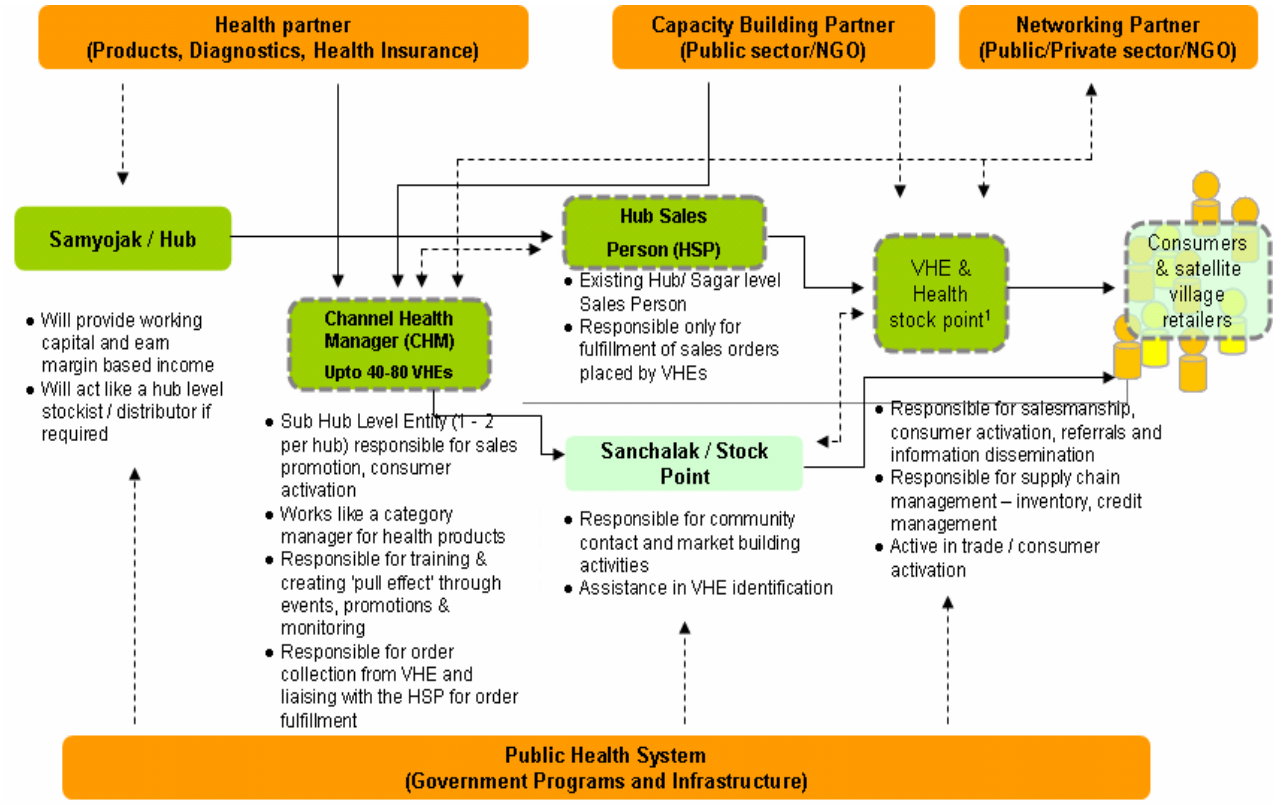
Contact with ITC was made in the first quarter of the year for forming an alliance for the proposed MBPH programme. The e-Choupal management showed a high degree of interest in this initiative and shared an initial list of relevant hubs and Sagars in UP and Uttrakhand.

The scope of work for Monitor Group was defined and the formative research for defining the delivery model took place in the identified hubs. The formative work was done jointly by Abt and the Monitor Group to arrive at an effective delivery model in the e-Choupal framework.

During the course of the year, we shared the proposed distribution model with the ITC team and had a number of iterations with the ITC senior management team to fine-tune the model before agreeing in principle on the delivery model. The proposed model includes the four key products that have been agreed upon between USAID and ITC.

Based on the above discussions, we have now signed the MoU with ITC and are now in a position to execute the model. The MBPH team has developed a document which outlines the programme and roles of various ITC entities in it. This has been shared with the management at ITC and they have circulated it internally to the respective team members.

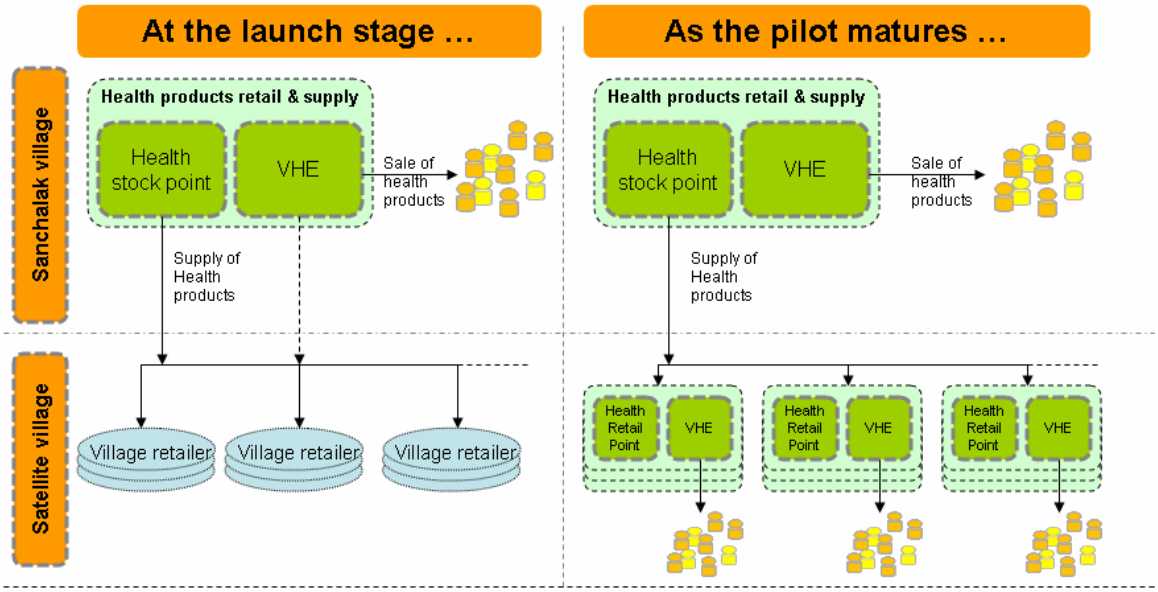
Proposed Business Model



Note 1 : Retail stock point business would be handled by the VHE's family

The proposed health intervention model will require establishing a team of Village Health Champions (VHCs) in rural areas under the e-Choupal umbrella. The VHCs will distribute health products in their respective villages. Abt intends to develop a separate brand for these VHCs under this programme, to promote them and other health products and services. The brand will be part of the overall e-Choupal branding framework. The proposed model is outlined below:

Table 5: Evolution of the Business Model



- During the early stages of the pilot stage, the Sanchalak village VHE will do door-to-door sale of health products only in her village and her family would act as the supply point of Health products for the retailers in the satellite villages.
- As the pilot matures, we envisage that the satellite village retailers would start adopting the role currently being played by the VHE & her family in the Sanchalak village. The VHE in the Sanchalak village would grow to possibly become a super-partner in the chain

As is evident from the above diagrams, the VHCs will be managed by a Channel Health Manager (CHM) based out of a Choupal Sagar, who will work like a Category / Trade Marketing / Training & Business Manager at the Sagar level for the VHCs. The CHM will report to the Hub in-charge functionally and administratively. The recruitment of the VHCs will be done in consultation with Sanchalaks, who will also help us in identifying suitable candidates from their village. The supply-chain, including order fulfillment, will be managed by the Samyojaks and their respective teams.

The pilot will be carried out in only two hubs initially. This is to test the various components of the proposed health intervention model before scaling it up. This will mean:

- Recruitment and training of CHMs & VHCs
- Detailed briefing of the Area Sales Manager, Hub-in-charge, Samyojak and Sanchalak
- Rolling out the programme as a separate sub-brand in the Choupal framework
- Organization of regular village health meetings where VHCs will explain the benefits of various health practices and offer relevant solutions to the rural population
- Supplying relevant health products to the VHCs through the Samyojak van on regular intervals
- Tracking the performance of VHCs and providing her with regular support as and when required

The pilot will also try to establish a relationship between the profile of the VHC and their respective performance. This is going to be a test variable and the profiles which will be tested for this initiative will be the health worker and the entrepreneurial profiles.

Meetings/ Trainings/ Workshops Held

During the course of the year, a number of meetings were held with the ITC team to discuss and present the outcome of the formative work done by Monitor and Abt. The meetings were regularly attended by the senior management team from ITC, demonstrating the commitment from their side.

The ITC team was typically represented by their CEO, SVP-Operations and other senior managers.

Travel/ Field Visits

Some of the relevant visits made last year, were:

- Exploratory visits by Abt senior staff in the first quarter to assess the hub and spoke operations and also understand the administrative and supply chain functions
- Joint visits by Monitor and Abt teams to conduct consumer and supply chain investigations for the qualitative research in Bangarmau, Jagdishpur, Varanasi and Allahabad
- Field visit by the Programme Team to understand the e-Choupal model in greater detail
- Field visit by the Programme Team to understand the Choupal below the line village aggregation activities.

Activities completed in fourth quarter

- Finalization of the delivery model post feedback from the ITC e-Choupal management team
- Signing of MoU with the ITC-ABD for the pilot initiative in two districts of UP
- Developed a comprehensive document, outlining the scope of the project and execution mechanics for various e-Choupal entities that will be involved in this project
- Initiation of dialogue with the prospective product partners.

Barriers

The MBPH team faced a number of barriers during the design stage of the project. The entire concept was quite new to all the stake-holders. It has been a learning process for all the participants since the time the concept of RCH, MCH and the FP portfolio was presented to the e-Choupal management team.

By the second quarter, we found that though the model was accepted by the ITC-ABD, their management wanted all the details to be spelt out. The roles of the CAM and VHC were clearly defined along with basic financials for the pilot.

The ITC management appeared to be quite reluctant to invest in the pilot. They did not want to undertake the risk of supplying the goods on credit to the VHC and didn't want to stretch the Sanchalak in the supply chain. ITC expects product partners to extend some degree of credit to the VHCs and also contribute to market building initiatives. We are trying to address these issues while implementing the pilot programme.

In the fourth quarter, we presented an improved version of the distribution model to the ITC management team and finally sold the concept to them. ITC is in the process of signing the MoU.

Objectives for Next Year

The objective for the year two of the programme is to roll-out the programme at the ground-level in collaboration with the ITC e-Choupal team.

The specific activities, which would need to be undertaken, are as follows:

- Briefing the ITC team which will be involved in the ground-level execution of the programme
- Recruitment of two Channel Health Managers and two District Managers
- Forming alliances with supply-side partners
- Initiating brand development process for the programme with the e-Choupal ad agency
- Initiating and completing baseline and formative research studies
- Developing training content for the VHCs
- Recruitment and training of VHCs
- Developing communication material and calendar of outreach activities
- Capacity building of VHCs and initiation of sales activities at the ground-level

- Market-activation initiatives

MBPH for Tuberculosis Control and Care

Background

The Revised National Tuberculosis Control Program (RNTCP) is one of the successful health programs in India. This program by Government of India has delivered significant results to control the infectious disease, in line with the principles of International Standards on Tuberculosis Care (ISTC) and the 'WHO-Stop TB strategy'. Any efforts in TB treatment and care will therefore have RNTCP as the single owner of a program.

USAID is an important supporter of the TB control program in India. It has provided several constructive ideas and recommendations through the Joint Monitoring Mission, to include private sector providers in the program. Through the MBPH mechanism, effective public-private collaboration can be demonstrated over and above the learning's of the Public-Private mix.

Program Vision

The program seeks to facilitate an enabling environment for the participation of the private sector in TB control and care. It also seeks to demonstrate role/s that the commercial sector, private healthcare providers, workforce and other partners could play in supporting the RNTCP.

Program Design

Consultative Study
The Futures Group was commissioned to review the existing TB treatment environment and various Public Private Mix (PPM) efforts in the past. Through the study, we contacted several implementing organizations as well as State Tuberculosis Departments to learn about the experiences of PPM-DOTs.

The study also directed towards the geographical selection process through availability of private sector and RNTCP indicators such as Case Detection Rate (CDR) and Cure Rate (CR) and suggested Bihar, Madhya Pradesh and Karnataka as possible options

Interactions with the Stakeholders and implementers in TB Care
The program design team contacted many implementing agencies, other donors, technical groups and also a few commercial players, to understand the implementation of the TB program. The organizations contacted were WHO, IUATLD, REACH, Operation Asha, PATH, IFC, World Economic Forum (India Business Alliance), Philips, Novartis-Arogya Parivar, Gates Foundation etc.

Arriving at the intervention design

Our preliminary assessment suggests that creation of a completely commercial, sustainable TB service network may not be viable. There are however a number of government schemes and subsidies that can be used to develop a model to engage private providers in TB screening and

treatment. Therefore, we envision the government as the natural owner of the TB pilot program and central to scaling up the activity. The TB-MBPH program will work with RNTCP for better implementation of comprehensive TB care through PPM DOTs.

The strategy will be to work around innovative design and implementation of ACSM, training to all providers, create an integrated private providers network (PPs, ISMPs, Chemists and other less than qualified health practitioners), work out accreditation for the participant clinics, diagnostic centers, look at sputum transportation, incentives for case referral as well as DOTs providers and PPM –MIS.

We will explore an interface organization to implement the pilot program in a short listed state to work for higher penetration of existing provisions of RNTCP as well as experiment with introducing available PPP instruments to private providers to address key issues of access and quality of TB care. The umbrella mechanism will also address demand generation and branding issues.

Table 6: Work Plan Activities in Year One

TB Pilot Workplan	O	N	D	J	F	M	A	M	J	J	A	S	% Achieved
Identify location, partners and build knowledge													
Review existing knowledge base of RNTCP guideline and past experiences													100%
Field visits to potential networks and MBP-TB partners													100%
Conduct analysis to identify geographical region for pilot program													100%
Develop SOW and identify members of thematic working group													50%
Develop pilot project design													
Conduct feasibility assessment, market estimation													75%
Assess potential health impact and scalability													85%
Implement formative research to test concept among providers													Nil **
Determine program policy issues and advocacy strategy													50%
Convene meeting of thematic working groups and/or MBPH Leadership Council to define objectives and pilot design													75%
Implement pilot project													
Negotiate partnerships terms, cost sharing, roles, and responsibilities													50%
Develop pilot implementation plans, monitoring plan, work plan, and timelines													50%
Initiate program launch in pilot areas													Nil **
Introduction and Scaling of Diagnostics Technologies*													
Identify appropriate diagnostic technologies and manufacturers and marketers													25%
Collaborate to develop product marketing strategies													Nil
Introduce diagnostic technologies in the pilot program and support linkages with other TB programs													Nil

* Diagnostic Technology is kept out of MBPH scope
** Program is yet to be launched

Activities Undertaken/ Initiated/ Delivered

The umbrella scope of the interventions through an interface mechanism was agreed with USAID project team. The intermediary organization will be selected though a bidding process and subcontracted to implement the interventions.

Meetings/ Trainings/ Workshops held

Individual meetings were done with World Economic Forum, International Finance Corporation on workplace related interventions. Technical consultative meetings were carried out with World Health Organizations, International Union against Tuberculosis and Lung Diseases and World Vision – ACSM project team. Brief on various ongoing CME programs were done with Dr. Asokan from IMA. Tele-cons were held with Novartis and Philips.

Travel/ Field Visits

Through the Futures Group consultant, the Central Tuberculosis department facilitated the interactions with state tuberculosis department of Bihar, Karnataka and Gujarat. The program design team visited the field implementation of REACH, Chennai as well as Operation ASHA, Delhi

Achievements in fourth quarter

The initial thought about the interface mechanism addressing the gamut of issues from awareness, screening to treatment were laid out to the various groups / teams of IUATLD in 6th & 20thAugust , WHO on 24th August and World Vision on 8th September.

The role of Abt being the contracting agency for third party implementation has also been discussed. Upon agreement in principle with the RNTCP / Central Tuberculosis Division (CTD) and in principle clearance in the states proposed by us as Bihar, Madhya Pradesh and Karnataka we will formulate an expression of interest and solicit proposals from implementing agencies for TB care. Invited members from RNTCP/CTD and other specialized institutions will lead the evaluation of the proposals for the final award of the contract.

The expert teams welcomed suggestion on incentivization (including possibility of 'Voucher' for additional role of private providers in PPM-DOTS through well thought and detailed plan. They were keen to know the sputum transportation as well as collection center thoughts and partnering with diagnostic chains.

Apart from working directly with the national program we also discussed path breaking innovation triggered by pure private sector players in TB care through insurance. As per our discussion with Maharashtra and Gujarat state TB team they are open for innovations. We evinced our desire to

experiment various new market activations and suggest appropriate necessary advocacy only through proof-of concept.

Largely there was no disagreement with the expert groups on the ideas presented but we were asked to detail it as much possible. We were also asked to simplify the various roles responsibilities of Abt Associates, MBPH, Implementing Agency and the relations thereof with each other and USAID.

We have purchased Anti TB Therapy (ATT) sales data from ORG-MIS and analyzing the private drug market.

Barriers

We will propose the entire approach to the Central Tuberculosis Division who spearheads the RNTCP through DDG-TB. The proposed design is subject to necessary acceptance by the program as well as go-ahead in the select geographies.

Objectives for Next Year

To move forward it is critical to have the buy-in of the national TB program, agree on the areas/states for implementation, arrive at critical issues and gaps through formative research, and feed the same into RfP formulation. We would like to invite proposals and put the EoI in place by next quarter so that we award the contract and launch the program by March 2010. We will have a fully functional program from April 2010 through September 2010.

Health and Hand Washing Alliance

The MBPH project had envisioned establishing a 'Handwashing Alliance' for Hygiene Promotion. However, the analysis based on industry interactions and secondary research informed that it will be more efficient and effective to address a broader set of health issues around the theme of child health and hygiene, both from the perspective of improving the long-term public health outcomes and wider public private participation.

MBPH shared the analysis and revised plan with USAID and after receiving the go-ahead proceeded with the design of a broad-based Child Health and Hygiene Alliance (HHA) with child health and hygiene product marketers and other private and public sector stakeholders.

The vision of this Alliance is to engage with and leverage commercial sector partners who have business interest in improving child health and hygiene and thereby help secure a safer and happier childhood through simple and effective solutions, with the ultimate objective to prevent and manage diarrhea in children under five in India. In India, the commercial sector which manufactures and markets health and hygiene products, such as soap, ORS, Zinc, water purification systems, etc. have a key role to play in improving child health and hygiene. .The Alliance will work with these commercial marketers to stress more on the category use and health behavior aspects instead of solely focusing their efforts on brand promotion. The long term goal of the Alliance will be to improve child health through prevention and improvement of home based diarrhea management practices for children under five. Until 2012, MBPH will play the role of a catalyst and Secretariat, after which, the Alliance will be managed by its natural owner or the anchor partner of the Alliance.

In alignment with Year -1 Workplan for Handwashing, the following table captures the progress of the MBPH HHA activity from October 2008 to September 2009.

Table: MBPH for Handwashing Program Activities Outlined and Accomplished

Handwashing Pilot Work Plan	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	% Accom-plished
Develop Model for Hand-washing Alliance													
Review Indian and global experiences in creating such alliances													85%
Gather and analyze soap market data													65%
Understand consumer habits and barriers													40%
Identify potential alliance partners													90%
Review findings with key stakeholders and approvals													25%
Establish Hand-washing Alliance													
Prepare proposals and MoUs for prospective partners													50%
Negotiate partnerships terms, cost sharing, roles, etc.													25%
Convene first Alliance meeting to define strategies& policies													Nil*

Handwashing Pilot Work Plan	O	N	D	J	F	M	A	M	J	J	A	S	% Accom-plished
Develop Alliance Activity Plan													
Hold meetings with partners to understand plans and strategies													25%
Develop activity and monitoring plans for year one and timelines													Nil*
Announce establishment of Alliance & launch 1st set of activities													Nil*

** Alliance yet to be launched*

Activities Undertaken/ Initiated/ Delivered

MBPH team completed the secondary review on the soap industry and the global and Indian Alliances on similar themes to feed into the Alliance design and approach. A background note on the cause and the Alliance approach was prepared. Also discussion guides were drafted as tools for gathering information and response from potential partners e.g. soap industry, public health organizations and Government.

To begin with, interactions were initiated with the soap industry major, Hindustan Unilever Limited (HUL) to understand the strategic alignment and response. HUL was positive but clarified limitations in partnering with the key rival brand on handwashing i.e. Dettol.

To ensure that the Alliance offers a comprehensive and broader platform for wider participation and commitment from commercial and Government sector, a renewed design for Health and Hygiene Alliance was drafted. The design covered the vision, objective, potential member list and their roles, task force and advisory group constitution and roles, issue focus, indicative deliverables and timeline.

Understanding the partner strategic focus and area of work in country, specific pitch presentations were prepared for different partners for buy-in including product manufacturers, NGOs, media and public health organizations.

Activities completed in fourth quarter

- Interactions with potential partners: MBPH team prepared pitch presentations and organized meetings with UNICEF; WSP/ World Bank (representing public heath organizations); Sulabh social service organization and Sesame Workshop (representing civil society); Lifebuoy soap (HUL) and FDC, Novartis- pharmaceutical companies manufacturing ORS and Zinc (representing commercial sector). Meetings with Ministry of Health, Government of India will be initiated by USAID.
- Co-ordinate HIP's TA: USAID funded Hygiene Improvement Project (HIP) was designated to provide technical assistance to facilitate linkages with stakeholders, provide capacity building for MBP team and stakeholders, review the global alliances and PPPs and to provide inputs on research and communication. Given the broader focus of the Alliance, HIP's scope of work was

sharpened to utilize their expertise in handwashing. Internal capacity building workshop was organized by MBPH with HIP experts as facilitators.

- Formalizing Alliance membership process: Basis discussions with key potential partners and USAID, it was decided that the membership will be a two step process. First, the members would sign on a 'Statement of Intent' document agreeing to work towards the cause of diarrhea prevention and management. This will indicate the partner commitment towards the Alliance vision and objective. Subsequently, in the initial meetings of the Alliance members, the guidelines and protocols would be developed in consultation with members. The documents drafted in consultation would be those on decision making, roles on implementation or as advisory, resource allocations, activity plans, thematic groups, etc. 'Statement of Intent' document was drafted and shared with potential members.
- Alliance launch plan: The Alliance is proposed to be launched in January 2010 with 7-8 representative members from different profiles having signed the 'Statement of Intent' document or by issuing letter of support. To organize the launch event and create a media visibility of the Alliance and its cause, it was decided to contract a specialized communications and PR agency. The RFP for this purpose was developed and circulated. Proposals received were reviewed and negotiations with the selected agency have been completed. The Contract with the Agency is being processed.

Meetings/Trainings/Workshops held

- Participated and presented the Alliance approach in the USAID-HUL meeting on 'Handwashing for newborn care' on 28 July in Delhi. Key participants included USAID, GoI, Lifebuoy Social Mission Team and MCHIP team.
- Meeting with Unilever Global Brand Manager, Anuj Rustagi for Lifebuoy in Mumbai on 26th August to discuss collaboration on Alliance. HUL positively supported the Alliance.
- Participated in a coalition meet organized by HUL and IPAN with key development partners and public health organizations to discuss possible collaborations on August 11 in Delhi.
- Presentation to USAID team in Delhi on August 17 to review and finalize Alliance scope, thematic focus, potential partners and member roles
- On invitation from Unilever, participated in the Lifebuoy Child Health Symposium organized in Delhi on September 4 to assess collaboration opportunity with HUL
- Made a presentation on the Alliance framework and plan to WSP program team of World Bank on September 4
- Organized a two day workshop on September 9 and 10 with HIP-USAID and MBPH team as participants to assimilate global learning and craft the vision and partner roles
- Meetings held with WSP, Sulabh Social Service organizations and contact established with UNICEF and Sesame Workshop.

Travel/ Field Activities

- Field team organized on ground activities on Global Hand Washing Day, 15th October. The activity included painting competitions, slogan writing and debates across 40 schools in 18 towns of Uttar Pradesh, Uttarakhand and Jharkhand. Nearly 6,500 children participated in the painting competitions and approximately 8,000 children were detailed on messages of hand washing by the field team. These children along with their teachers, principal and at a few places, doctors washed their hands with soap. The theme for the painting competition was "Clean Hands Save Life".

- To reinforce the messages on this day, the field team was also able to leverage the time of some local key opinion leaders like the Mayor, MLA, educationists and social leaders. Activity has received letters of appreciation from most of the schools.
- A total of 45 press clippings appeared in the leading newspapers like Amar Ujala, Dainik Jagran, Hindustan, Hindustan times etc. Press clippings showed children washing hands with soap, the importance of hand washing, figures on diseases that could be prevented by a simple act of hand washing.

Barriers

- As the Alliance is a platform for establishing partnerships with multiple and diverse partner groups, ensuring strategic alignment and interests is a challenge. HUL's limitation on partnership with any / all soap brands required a fresh approach. UNICEF and Government, on the other hand, voicing the need for a multi-brand Alliance, led to rethinking and design of the Alliance scope and structure.
- Contribution from HIP on its Technical Assistance in terms of paving the way of initiating the research and Alliance establishment was delayed. Subsequently, there was a revision in HIP's scope of work.
- Procedures and formalities for signing of the Agreements with partners especially UNICEF need clarification and customized solutions to accelerate membership commitments.
- Lack of clarity within organizations on the divisions or departments who need to take a lead on partnerships and alliances. Legal and administrative approvals required within organizations, inter-departmental consensus, etc. require time.

Objectives for Next Year

- Key members representing diverse industry profiles to sign on the 'Letter of Intent' document indicating commitment to the cause
- Launching the Alliance by unveiling the brand and organizing activation events with children and caregivers in Delhi, Uttar Pradesh, Jharkhand and Uttaranchal
- Organize quarterly meeting of the partners
- Discuss with partners and develop guidelines and protocols
- Signing of detailed MoUs with partners stating technical and financial commitment
- Map partner competencies and interests both thematically and geographically
- Develop activity plan for Year-1 for communications, research and pilot interventions with deliverables, timelines and resources
- Initiate implementation of activities

Health Leadership Council and Center of Excellence

Background

The Health Leadership Council (HLC) is an important component of the USAID funded Market-based Partnerships for Health (MBPH) project. MBPH includes, facilitating the establishment of an advisory council comprising of distinguished professionals and thinkers from cross-cutting areas to guide and advise the MBPH team and its partners in realizing the program objectives. The advisory council, which will be known as the *Health Leadership Council* (HLC), is envisaged to be a governing body that provides strategic direction to the various MBPH projects. The HLC will play the role of a think tank by parenting, nurturing and identifying MBP innovations and providing linkages and creating opportunities to support existing and new MBPH initiatives.

Closely tied in with the formation of the HLC, is the creation of local institutional capacity to maintain and build market based partnerships for health. MBPH is mandated with setting up this Centre of Excellence (CoE) that would ensure sustainability and enhancement of MBPH program once USAID's support ends in 2012.

	O	N	D	J	F	M	A	M	J	J	A	S	Accomplished
Health Leadership Council (HLC)													
Develop and review ToRs for the Leadership Council and Sub-committees													100%
Identify individuals and organization as possible members													90%
Invite members and constitute the Leadership Council and sub-committee/s*													Nil
Convene meeting of expert sub-committee													Nil
Center of Excellence (CoE)													
Prepare CoE TOR and Vision document for review by Leadership Council*													100%
Develop list of potential CoE organizations and fact-finding meetings													50%
Convene Leadership Council to decide on selection of CoE													Nil
Announce CoE													Nil
Start development of institutional and business plan and working modalities													Nil

* Awaiting for USAID RLA approval

** The ToR and Vision statement for CoE has been developed but not been shared with HLC because it is still not formalized

Activities completed in fourth quarter

HLC:

- Meetings and final selection of five HLC members
- HLC process and due diligence documents shared with USAID
- Scanning for sixth member of the HLC

CoE:

- Terms of reference for the CoE outlined

Program Vision

The HLC will provide strategic direction and guidance to the MBPH projects for the duration of the program. Beyond the duration of the program (post-2012) it is envisaged that the HLC will evolve into an advisory role for the CoE. The HLC will provide services to the MBPH program team initially and the CoE subsequently, in nurturing and identifying Market Based Partnership (MBP) innovations, providing linkages and creating opportunities to support existing and new MBPH initiatives. The CoE is expected to perform both institutional functions (such as those performed by an academic think-tank) as well as professional services (advisory and project management role) which will help it to attain sustainability and help develop MBPH. HLC over the project period matures as an advisory board for the proposed Center of Excellence.

HLC Structure and Process Mapping

The HLC structure will comprise of several sub-committees who will be responsible for supporting a group of projects (e.g., rural health, distribution) or cross-cutting initiatives with a common theme (e.g., advocacy). The sub-committee in turn will have Champions for specific projects. The HLC is envisaged to be a 10-12 member team with representatives who bring expertise from diverse and relevant fields. In addition to the 6 HLC members, USAID India will have at least two representatives to the HLC. The USAID Mission Director will chair the HLC meetings and the USAID PHN Director will be the second USAID representative. The Mission Director of National Rural Health Mission (NRHM) will invited chair at the HLC. The HLC will also have representation from the CoE organization, as and when it is formed.

Process of Selection

The process of selecting HLC members and convening the group was broken into three broad phases. Regular meetings with USAID have been held to update them on progress and to seek approvals at key decision points.

The first phase included defining the Terms of Reference for the HLC and its members, profiling potential HLC members and defining the process of screening and selection. In order to ensure this diversity in representation, 61 leading personalities across various categories including academia, the development sector, government, healthcare organizations, industry organizations, private sector entities, and civil-society advocates were landscaped. Each entity was assessed along a set of six key dimensions, including prior experience in rural markets, public health and PPP, resulting in an overall assessment. Based on the overall assessment; the universe of entities was categorized into ***High, Medium, and Low*** impact levels across the various categories

Phase two focused on engaging with shortlisted candidates to gauge their interest and fit with the MBPH project and the HLC, conduct due diligence to identify any conflict of interest. Based on inputs from phase two, the third phase of the process will focused on reaching an agreement on the final list of HLC members. We have finalized the following Members: Rama Bijapurkar, Varun Sahni, Lester Coutinho, Pradeep Kashyap and Mona Kachhwaha. A sixth member, from the public health domain needs to be identified.

The requisite documents, including a draft letter of invitation from USAID to HLC members, have

been forwarded to USAID and we are awaiting their response. The next step would be to convene the first meeting of the HLC.

Process Roadmap for CoE

The following process will be followed in setting up the CoE:

Identifying Organizations for CoE through General Expression of Interest
EoI document detailing the goal, objectives and terms of reference for the partner organization to offer their preliminary intent will be finalized. The EoI will have necessary and qualifying criteria's as well as additional preferable criteria's for consideration. The submission of the proof of financial and organizational capability will also been clearly outlined. Upon approval of EoI text by USAID as well as the advert (Sample advert enclosed) a notification will be placed in newspaper seeking mail request from intending organizations. The entire set of EoI documents will be sent electronically to the e-mail requests thus received. Upon the two weeks deadline time for the submission of intent all the details will be screened through the short listed criteria to arrive at top ten best case fit. The short list will be a check list of Yes / No in the qualifying eligibility as well as preferred criteria, which includes experience with USAID, BoP, public health and rural markets. Submission requirement of necessary financial and organization details will also be included in the same.

Soliciting detail business plan through specific Request for Proposal (RfP)
The ten short listed ones from the above will be issued an RfP which will detail on the proposal we solicit for CoE as well as the detailed business plan and financial commitments required. A response time of three weeks will be given to the shortlisted bidders.

Selection of the Agency through the Evaluation Committee
The technical and financial proposal will be screened through a CoE selection committee comprising of USAID members, members from the Health Leadership Council and Key persons from MBPH program. The top three shortlists will be discussed in detail for any clarifications. The short listed topmost bidder will be invited for a presentation on the proposal to the committee and defend the plan and address any further queries. Additional field / office visits of the short listed CoE organizations, meeting their board members etc. will also form part of the selection process.

Contracting
Upon finally negotiating the business plan with the top short listed CoE organization the entire process will be sent to USAID for final approval. Subsequent to the clearance of the proposal the contract will be awarded to the CoE organization with clear deliverables, disbursement schedules and M&E provisions.

Progress in fourth quarter

Mr. Pradeep Kashyap was briefed on HLC in August and Ms. Mona Kachhwaha on September and both of them agreed to be members. Other members Mr. Varun Sahni, Lester Coutinho and Ms. Rama Bijapurkar were contacted in June 2009 and agreed to become members. The entire process of HLC member selection was briefed to USAID / PHN director and it was agreed to move to RLA

for necessary clearance before the issuance of invitation for being the HLC members and ToR. All the necessary documents was placed with RLA for the HLC.

The entire context and basics of CoE organisation selection process was discussed with USAID / PHN director and it was agreed to move through a sub-contract process for the appropriate due diligence. The expression of Interest will be put in national newspaper and short listed ones will be invited to submit proposal through RfP. The final CoE organisation will be proposed to RLA for clearance for the award of the contract.

Barriers

Establishing the CoE organisation is a new process for this contract mechanism. HLC and CoE is linked to each other in the matter of governance. There is likely a thorough due diligence requirement from RLA and USAID mission on the same. The matter of conflict of interest of the existing work / business of proposed CoE organisation , alignment of the governing body of the CoE organisation and the HLC advisory body are some of the factors the MBPH is going to face and resolve.

HLC members are quite renowned people from their respective fields and have multiple engagements and representations at various committees, boards and forums. There might be some issues of various MBPH project partners and them as well.

Objectives for Next Year

- Convene first meeting of the HLC members
- Form various sub-committees and designate champions in the HLC
- Discuss with partners and develop guidelines and protocols
- Post advert for CoE in the media
- Shortlist and select organizations for CoE