Advanced Leadership Field Perspectives: Public Health in India

The Advanced Leadership Initiative (ALI) represents a new stage in higher education designed to prepare experienced leaders to take on new challenges in the social sector where they can potentially make an even greater societal impact than they did in their careers. Through the Advanced Leadership Initiative, Harvard seeks to tap into the experience of a socially conscious generation of leaders and help redirect and broaden their skills to fill critical leadership gaps and solve major social issues. During their year at Harvard, Fellows will be able to take advantage of the vast intellectual resources of the University to learn, teach, mentor, consult, reflect, and plan in preparation for their post-Fellowship project. Advanced Leadership involves many disciplines and fields, explores many industries and sectors, and often requires an interdisciplinary lens to solve the complex challenges.

ALI Faculty Co-Chair Professor Howard Koh from the Harvard T.H. Chan School of Public Health along with his fellow public health colleague Professor K. “Vish” Viswanath spearheaded the 2015 ALI Global Conference in Mumbai, India. (See Exhibit 1 for the 2015 ALI Global Conference Agenda and Field Visit Summaries.) ALI Faculty Chair and Director Professor Rosabeth Moss Kanter of Harvard Business School and ALI Faculty Co-Chair Professor Charles Ogletree of Harvard Law School along with Professor David Hunter and Professor Peter Berman of the Harvard T.H. Chan School of Public Health all had an active role during the event. 2015 Advanced Leadership Fellows Jagannatha Kumar, Sutapa Banerjee, and Akhil Gupta provided additional support.

Global Conference Introduction

The event capitalized on India’s sense of dynamism infused by the new Modi administration and explored themes related to health and social change more broadly, as well as the role of business, government, and entrepreneurs. India was particularly compelling because as one leader Padmini Somani, Founder and Director of Salaam Bombay Foundation, said, “If you change the statistics in India, you change them for the world.” India had a unique set of challenges: a massively large and diverse population, widespread poverty, a large informal economy, and growing public health issues that afflicted both developing and developed countries. In response to these challenges, India also had talented and passionate social change leaders that developed and implemented creative solutions. Additionally, the government recently enacted a mandate (“2 percent rule”) that would incentivize certain private companies to invest in the social sector.
Much of the material and discussions from ALI’s Challenges and Opportunities in Advanced Leadership (COAL) course and think tanks resonated in India.

It is one thing to assemble the facts and teachable data, but going through this experience in India brought the lessons to life. – 2011 AL Fellow and 2012 Senior AL Fellow Issa Baluch

In addressing societal problems in the ALI experiences thus far in the year, it has been challenging to understand the size, the numbers, or the scale of the problems in real, tangible human terms. The speakers, and more importantly sights, sounds, and smells of our touring reinforced the enormity of the problems to be addressed (including my own project idea). The conference provided an emotional and visceral understanding to the stupefying problem of getting to scale! – 2015 AL Fellow Ken Kelley

The AL Fellows heard from an array of highly engaged leaders in the public health, business, civic, and philanthropic/nonprofit space. (See Exhibit 2. Leadership Lesson from Ratan Tata.) AL Fellows paid close attention to what they heard and what they did not hear. Some AL Fellows raised concerns about the global conference’s lack of conversation on corruption, inter-religious strife, and the caste system. In addition to the panels and speakers, field visits were integral to the experience. These visits allowed the AL Fellows to have a firsthand account of change efforts. (See Appendix A) Despite India’s challenges, the AL Fellows were inspired by the progress that social innovators were making in India. For every challenge, Indian leaders presented a solution with a track record of success. (See “Innovation” insets embedded through the report.)

India is still a long way from resolving its healthcare problems thanks to the complexity, geographic diversity, the scale of the problem and the multiplicity of issues, all of which clearly points to no one simple solution. Paradoxically however some of the most innovative path-breaking solutions are happening in India by Indians. – 2015 AL Fellow Sutapa Banerjee

Global Conference participants learned a lot and wrestled with difficult questions. How will India overcome the vast public health challenges it faces, particularly given their size, diversity, widespread poverty, large informal economy, and women’s issues? Will the new 2 percent rule lead the way to social change through increased corporate engagement? How will the different sectors work together to address the array of challenges facing India? Is India positioned to re-imagine and re-invent healthcare delivery? Will India be able to create an ecosystem that supports all of its citizens? Will the inspiring social innovators succeed in India? How will experienced leaders who were immersed in the Advanced Leadership program view India?

**Advanced Leadership Lens**

The AL Fellows experienced as much of India as they could, including the 10 year record breaking rain. In addition to the rich conference experience, AL Fellows had meaningful self-organized trips pre- and post- conference to various places: the world’s largest dairy cooperative (AMUL in Vadodara, India), Bhutan, Kashmir, New Delhi, Agra, and Jaipur. (See Exhibit 3 for a photo collage.) The Global Conference fostered stronger relationships amongst the cohort and most importantly, reinforced the ideas, tools, and concepts that were explored in the Advanced Leadership program.

The COAL course provided a few macro-frameworks to analyze, compare, understand, and appreciate the field trip experience in India. For example, the body of work on U.S.
competitiveness earlier in the year became an obvious benchmark for understanding many of the speakers’ comments on industry, government, and society in India. The EBC (Even Bigger Change) Matrix and the Change Masters skill lists provided a tool to analyze several of the speakers (founders of non-profits or companies) addressing unmet medical needs in India. The most important concept from the ALI semester was to find a means to test one’s theory of change (quickly, practically, and well) and yet with the prospect to scale. – 2015 AL Fellow Ken Kelley

While I was aware of the complex nuanced nature of the problem and hence that any of the solutions needed a carefully thought through approach (keeping in mind the nuances sensitivities and sheer scale of the problems), my time at ALI helped revalidate this in more ways than one. – 2015 AL Fellow Sutapa Banerjee

I audited two courses at the Harvard T.H. Chan School of Public Health during the spring. One was titled “Measuring General Population Health” (Joshua Salomon), and the other was the “Politics and Economics of Global Health” (Michael Reich). Both of these courses increased my fluency in the language of global health challenges that were addressed during the conference. The courses dovetailed precisely with the much of the Mumbai inquiries. – 2015 AL Fellow Charles Fleischman

The whole idea of cross-disciplinary work across sectors is so applicable here – every hand on deck is needed to stem the tide of poverty and lack of access. The think tanks have all been terrific ways to take a deep dive – and so they prepared me for a similar experience when it came to India. – 2015 AL Partner Lisa Anderson Kelley

**Background on India**

With over 1.2 billion people, India had the second largest population in the world and was projected to overtake China, currently over 1.3 billion people, as the world’s most populous country by 2028 and continue to grow while China began to decline. Harvard T. H. Chan School of Public Health Professor Peter Berman described India as having the same physical size and population size as four United States combined. India’s population growth was characterized by a 2/3/4/5 phenomenon. The growth rate in India was 2 percent overall; urban was 3 percent; large cities were 4 percent; and urban slums were 5 percent. In short, the urban population was outpacing the rural population and the amount of urban poor was increasing the fastest. (Exhibit 4) Many speakers also noted that India had the world’s largest youth population (ages 10 to 19), accounting for 19.3 percent of their total population. Because of the size of the Indian population, issues of scale became extremely pressing and very clear to the Global Conference participants.

It finally sunk in what huge problems India faces due to the sheer number of people - it’s almost incomprehensible that such a successful country, in many ways, still have half the population living in the streets. All of the innovative efforts that are being tried by the government and NGOs still only affect a small percentage of people at any one time. – 2015 AL Partner Lisa Anderson Kelley

The sheer size of the population and its growth (~70,000 babies born every day) makes any measure to remedy anything look small, however significant. – 2015 AL Fellow Horst Melcher
Diversity

In addition to the large population size, India was a very complex country with a lot of diversity in terms of culture, beliefs, languages, and environments. For instance, there was a language barrier. Hindi is India’s national language, but in many Indian towns people have never heard or spoken Hindi. The state of Maharashtra contains Mumbai, where many languages were spoken, and a town hundred-kilometer from Mumbai that was completely tribal. That tribal belt did not speak Marathi, the local language in Mumbai, or English or Hindi. They spoke their local tribal language. For a government representative this meant a 1.6 million constituency was a mix of languages, rural, urban, and Indian and Western traditions.

Poverty

The AL Fellows saw India’s poverty firsthand in Dharavi, the world’s biggest slum.

India’s extremes are extreme, more extreme than I’ve ever seen before. We went from talking to Ratan Tata to visiting Dharavi. – 2015 AL Fellow Horst Melcher

Walking around Dharavi Locality in the rain was eye opening, instructive, and fantastic; the skies opened up in Dharavi and it poured rain and so many people continued their day in the downpour. The contrast between that and the lovely art in the Piramal Tower could not have been more dramatic. – 2015 AL Fellow Charles Fleischman

30 percent of the population lived on less than $1.25 per day; 70 percent lived on less than $2.00 per day; and about 99 percent or 1.1 billion people lived on less than $5 per day.

Innovation: Creating Employment Opportunities

Tic Tac Factory - Many speakers emphasized the need for job creation as a responsibility of the government and an important part of social change. For instance, the tic-tacs that were on the desks in the classroom were made in India, providing jobs to the local economy. Many Indian leaders felt the government’s duty to the large and young Indian population was to educate them and provide them with opportunities to earn a living.

In Mumbai, 56 percent of residents lived in slums covering a mere 6 percent of land.

Innovation: Addressing the Urban Poor

Population Foundation of India (PFI) - The Executive Director of Population Foundation of India (PFI) Poonam Muttreja described PFI as a national level non-government organization at the forefront of policy advocacy and research on population, health, and development issues in the country. In addition to its efforts repositioning family planning in the rights based and women’s empowerment frameworks, PFI worked on behavior change communication, community action for health, and health of the urban poor. The organization’s Health of the Urban Poor program successfully tested urban health interventions and provided technical assistance to the central, state, and local government institutions in rolling out the Urban Health Mission. The program started in 5 cities and scaled up to 18 cities, 2 mega cities and encompassed a 2.2 million slum population. Muttreja explained the five-pronged strategy that included 1) engaging women’s health group in mapping slums/vulnerability assessment; 2) slum level health and nutrition days; 3) coordinating city and ward interactions to strengthen linkages; 4) mother and child tracking; 5) city health plan.
In India, 620 million people lacked access to sanitation and 125 million people lacked access to safe drinking water. 70 percent of the rural population drank water from an untreated source.

### Innovation: Safe Drinking Water

**Piramal Sarvajal** - One of the Piramal Foundation’s initiatives, Piramal Sarvajal, had a for-profit and non-profit component. It covered 8 states, processed 8 billion liters of water and prevented an epidemic when a natural disaster left drinking water contaminated with dead animals. The entrepreneurs that sold the water made a profit, while the development, distribution, and monitoring of the water purification micro utilities was a non-profit. The non-profit provided high purity standards, the infrastructure, technology, training, and support to the for-profit entrepreneurs.

### Large Informal Economy

India only collected income tax from 2 to 3 percent of the population because the overwhelming majority (over 90 percent) of the workforce was in an informal industry. Gathering contributions from payroll deductions was virtually impossible. Without the ability for the government to collect taxes, they had a limited budget to pay for public projects. Additionally, the government had limited control to regulate the harmful outcomes that resulted from the large informal economy. These unregulated industries included a variety of tobacco distributors as well as private primary health care providers that delivered poor quality, unpredictable services.

### Women’s Rights

The Global Conference had an incredible line-up of powerful, impactful female leaders who believed that social change comes when the woman of the house is empowered. They advocated for more women’s rights and described situations where girls were pulled out of school early to work and/or marry as commonplace. **Vice Chairperson of Piramal Enterprises Swati Piramal** described investing in girls’ education as not just a moral issue, but an issue of public health, national security, and the economy. Piramal explained that females that are educated immunize their children (26 percent for mothers with no schooling and 64 percent for mothers with over 5 years of schooling), have lower rates of HIV/AIDS and maternal and infant mortality, prevent violent extremists, and boost the economy.

### Innovation: Ecosystem for Female Empowerment

**Dasra** - Deval Sanghavi described Dasra’s approach to funding an ecosystem around girls’ empowerment issue. Dasra gathered 1,300 stakeholders and $12 million for a number of initiatives that came from 66 donors, 44 of which were new to the space. Dasra had alliances with foundations, USAID, and many more.

### Public Health

**Harvard T.H. Chan School of Public Health Acting Dean for Academic Affairs and Professor David Hunter** explained how India made gains in life expectancy and child and maternal mortality. For example, India’s life expectancy was 67 years of age, which was on par with the world average. (Exhibit 5) Public health interventions in vaccines, clean water, sanitation, maternity care, and better diets contributed to the gains in life expectancy. (Exhibit 6) Despite progress, inequalities by socioeconomic status, geography, and gender persisted for the most vulnerable populations.
Hunter described India’s “intense health transition” as “unlike anything the world has seen before.” Infectious diseases (diarrhea, HIV, tuberculosis, neonatal infections, and malaria) were still common, while non-communicable chronic diseases (cancer, heart disease, and diabetes) were increasing in volume. This meant that both conditions of risk factors and diseases characteristic of developing and developed countries co-existed. (Exhibit 7)

Maternal and Child Mortality

Maternal mortality, while showing some improvement, was still behind other countries. There was a 36 percent reduction in maternal mortality, but it still fell short of the Millennium Development Goal (MDG) 2015 target to reach a maternal mortality ratio of less than 100 per 100,000. In regards to women’s health, the need for contraception was largely unmet, adolescent pregnancies were common, and access to safe abortions was inadequate. Another important issue facing women was anemia; in 2004 more than 75 percent of all women were anemic.

Each day in India more than one child each minute under the age of 5 died from preventable diseases. Immunization rates were 64 percent, lower than other sub-saharan African countries at the height of the civil war. Infants and young children lacked access to effective treatment for neonatal illness, diarrhea, pneumonia, and malnutrition. This had implications for the child’s educational attainment, adult height, income, and birth weight of subsequent offspring. Under 5 child mortality rates did decrease in recent decades, however inequities between wealth, education, and rural versus urban remained. (Exhibit 8)

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<th>Innovation: Addressing Maternal and Child Mortality</th>
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<td>Society for Nutrition, Education &amp; Health Action (SNEHA) - The non-profit, established in 1999, created a number of urban health intervention models focused on the following areas and succeeded and making a significant impact.</td>
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1) Maternal and Newborn Health: Established referral networks of government hospitals for high risk pregnancies, trained hospital staff to improve maternal and newborn care, and worked directly with women in high-need areas.

**Impact:** assisted 21,000 women with potential complications, conducted home visits and counseling to 4,500 women, trained over 3,000 healthcare providers and 2,900 government outreach workers.

2) Child and Health Nutrition: Focuses on early screening and treatment for the urban poor.

**Impact:** screened 24,000 children in Dharavi, counseled 4,200 pregnant women, reduced wasting by 18% between 2011 and 2014, trained over 500 government health workers and improved food distribution by 40%.

3) Sexual and Reproductive Health: Worked with youth to educate and empower them on sexual & reproductive health, gender equality & vocational skills.

**Impact:** Health and life skills education to over 10,000 youth, and vocational training to over 2,000 youth.

4) Prevention of Violence Against Women and Children: Provided crisis counseling, legal support, follow-up visits, and community outreach.
Impact: Addressed over 4,000 cases of violence, trained 4,500 police officers, trained over 2,100 hospital staff.

Piramal Foundation’s Hot Lunch Program - The program delivered 150,000 hot lunches a day to Mumbai schools. This was accomplished using a very organized system with automation, sterile steel trays, and delivery vans.

Growth in Non-communicable Diseases

India had an increasing population of overweight citizens and the largest number of diabetics with an estimated 80 million by 2030. (Exhibit 9) The burden of cancer was growing in India. (Exhibit 10 and 11) Mental health was becoming an increasing concern with suicides growing 160 percent in 20 years. India had a huge burden of cardiovascular disease, with Indians being three times more vulnerable to heart attacks and the first heart attack occurring 10 years ahead of the west. India had a need for 2 million heart surgeries per year, but only had capacity for 120,000.

Innovation: Building Healthcare Capacity at a Low Cost

Narayana Group of Hospitals - Dr. Devi Shetty, a health care innovator and world renowned heart surgeon and chairman of the Narayana Group of Hospitals, believed that in order to have capacity for the growing heart surgeries needed, a different type of hospital was required. His 30 hospitals across India performed 12 percent of all heart surgeries in India. Shetty recently completed construction on a 300 bed low cost heart hospital with the goal of building it in 6 months for $6 million. In reality it took 8 months and $7 million, which was still a huge accomplishment.

Tobacco

A number of speakers spoke passionately about the challenges and consequences of tobacco in India, a country with the second highest consumption of tobacco products. India had 270 million adult tobacco users, about one-third of all adults. Of these users, 160 million engaged in chew tobacco, 70 million smoked (80 percent bidis/small hand-rolled cigarettes, 20 percent cigarettes), and 40 million both chewed and smoked. (Exhibit 12) In the slums, 5 out of 6 homes had active tobacco use among more than one family member. Tobacco use was responsible for 6 million deaths globally and over a million deaths in India every year. About 900,000 deaths were due to smoking – 300,000 cigarettes, 600,000 bidis – and about 350,000 deaths were due to smokeless tobacco. 40 percent of all cancers were related to tobacco use.

India had a lot of different tobacco products that were manufactured by small local producers and large industrial players. In addition to cigarettes and bidis, there were countless forms of smokeless tobacco that could be chewed (products with leaf tobacco, areca nut, other leaves and substances e.g. twist tobacco, roll tobacco, gutka, mawa, betel quid, etc.); sucked (products with crushed tobacco e.g. khaini, snus, newly marketed products, etc.); applied (tobacco pastes and powders e.g. creamy snuff, moist snuff, gudakhu, mishri, etc.); sipped/gargled (tuibur, others); and inhaled (very fine dry powder - nasal snuff). (Exhibit 13) Healis-Sekhsaria Institute of Public Health Director Prakash Gupta explained that tobacco toothpaste, now labeled as creamy snuff, was previously used in dental offices and many people falsely believed that tobacco was good for their dental health.

Tobacco products were very accessible and often advertised and packaged in enticing colors with Hindu Gods. Tobacco products were very affordable. A pack of bidis cost less than USD 0.25 and a pack of cigarettes cost a little more than USD 1. Cigarettes cost more because as a regulated industry it was possible for the right political will to succeed in increasing taxes. Bidis were not highly taxed
because they were part of a large informal industry that was difficult to regulate. Compounding this large tobacco use challenge was the lack of cessation programs, help lines, or education even for doctors to help patients quit. Laws regarding tobacco control were difficult to enforce. (Exhibit 14)

**Innovation: The Fight against Tobacco**

_**Salaam Bombay Foundation** - Founder and Director of Salaam Bombay Foundation Padmini Somani described the tobacco prevention program that catered to students in grades 7 to 9, ages 12 to 17, as being successful by using sports, theatre, and arts to engage students, in addition to the leadership component that empowered students to be anti-tobacco advocates. (Exhibit 15) The organization started in 2 schools in 2002, and by 2015 was in over 200 schools in Mumbai, and 15,000 schools across Maharashtra with 60,000 teachers, and entering 4 new states. This growth was achieved by working with the government and other non-profits. Despite their positive outcomes, Somani recalled how she had to overcome resistance from many principals that did not want the program in their schools because they believed it would introduce kids to tobacco or was not relevant to girls. Somani was determined and once she got one school to agree, she used that school as the proof of concept to gain entrance into other schools.

_**Voice of Tobacco Victims campaign** - Tata Memorial Hospital’s Dr. Pankaj Chaturvedi spoke very passionately about the Voice of Tobacco Victims campaign that he started with support from Tata Memorial Hospital, Action Council against Tobacco India, Healis, Salaam Bombay Foundation, World Health Organization, American Cancer Society, World Lung Foundation, Campaign for Tobacco Free Kids, Indian Dental Association, and more. Chaturvedi explained that all doctors (more than 300 from all over India) worked pro bono. The goal was to make the victims (nearly 600 cancer patients from across India) the public face of the campaign to encourage tobacco prevention and cessation. (Exhibit 16) Chaturvedi’s persuasive arguments included: 1) people were suffering due to the inaction of policy makers by allowing a product that kills a third of its most loyal patrons and has no benefits and; 2) personal choice to use tobacco only existed at entry and not at the time of cessation. His efforts had results. Chaturvedi reported that while 2010 had a 15 percent growth in smokeless tobacco market annually, since 2011 there has been an 80 percent reduction in smokeless tobacco use. (Exhibit 17) The campaign also created the political will for many states to ban gutka and increase the taxes on cigarettes. They also worked on adding graphic warning labels to tobacco products.

_**Bajaj Electricals** - Bajaj Electricals had approximately 2000 employees. Chairman and Managing Director Shekhar Bajaj of Bajaj Electricals took a conscious step to work towards making the company tobacco free. The offices were tobacco free since 2005. In 2010, Mr. Bajaj started a proactive anti-tobacco campaign with its employees. By 2012, the company became tobacco-free when 153 employees were able to give up tobacco with the help of support groups, public recognition, peer pressure, and direct communications from Bajaj. All new hires, who were tobacco users, were given one month to abstain from tobacco in order to join the company. Surveys were conducted annually and there was a follow up with employees if there was a relapse. Mr. Bajaj also added that he was working on extending his tobacco free policy to his factories and vendors and the company has worked on a few sites in partnership with Salaam Bombay Foundation for implementing the tobacco cessation program. The employees volunteered with the Anti-Tobacco Awareness sessions with the community.

**Health Care Spending**

India spent roughly $60 per person per year on all health care, accounting for about 4 percent of GDP. Of the $60, about $15 was spent by the government (1 to 1.2 percent of GDP), while the remaining $45 was out of pocket expenses by the individual. India had among the highest out of pocket
expenditures in the world and spent significantly below the $4,000 per person per year expended in
developed countries. Health shocks sent 63 million families into poverty each year.

About 10 percent of the Indian population had health insurance. This included all of the government
employees and a small percentage from other sectors. In 2008, Swasthya Bima Yojana also known as
the National Health Insurance Program provided health insurance for informal workers below the
poverty line. The program had 185 million beneficiaries and was expected to grow to over 300 million.
But the coverage was extremely limited.

**Innovation: Accessible Health Insurance**

*Yeshaswini* - Working with the government of Karnataka, Dr. Shetty launched a health insurance
program called Yeshaswini, where 1.7 million farmers pay 11 cents per month. After 10 years, over
710,000 patients had a variety of surgeries in 400 network hospitals, and 85,000 farmers had a heart
operation. By 2015, the premium increased to 22 cents per month and included 4 million farmers. Dr.
Shetty added, "We are trying to convince our government that we have 850 million mobile phone subscribers
who spend about 150 rupees per month just to speak on a mobile phone. If you can collect 20 rupees from each
mobile phone subscriber, we will be able to offer healthcare to 850 million people."

**Social Determinants of Health**

During the Advanced Leadership program, Professor Koh explained that public health was not just
about doctors and hospitals, but was "where people live, labor, learn, play, and pray." Ultimately, non-
medical factors, which include education, income level, housing, stress, environment, social relations,
transportation, food, and behavior, have greater influence over health outcomes. The issues discussed
earlier such as the lack of sanitation, clean drinking water, women’s rights, food security, and poverty
all have a large impact on health outcomes. Any improvement in these social determinants would have
a positive public health impact.

Progress in public health also required an understanding of other existing practices and norms. For
instance, in terms of sanitation, many speakers explained how important cleanliness was in Indian
homes and toilets were generally viewed as unclean. With a limited drainage and water system, many
homes lacked proper sanitation, which created a practice of open defecation outside the home.
Implementing toilets in homes or in public would require both a behavior change and a way to ensure
that they would meet high cleanliness standards.

**Innovation: Sanitation**

*Dasra* - Dasra’s Deval Sanghavi recalled how a sanitation solution in Pune initially had a target to
implement 1,500 toilets in living spaces within three years, with families paying a third of the cost.
However after two years because of a partnership with the government and business, the goal
increased to 40,000 toilets.

**Government in Public Health**

Many speakers agreed that the Indian government historically had a very low focus on public health
relative to other issues and it was never the top priority. Public Health was ultimately the responsibility
of the state government.

The United Nations Millennium Development Goals (MDGs) helped incentivize the Indian
government to focus on maternal and child health (MCH). Chief Executive Officer of the Wish
Foundation Soumitro Ghosh said the government’s vertical focus on MCH was at the expense of primary care, which contributed to its limited impact. Ghosh explained, “It’s like developing skyscrapers when you haven’t really created the ground. So you don’t have the primary health care system functioning, but you have created those verticals, and you’re expecting the MDGs to be met.” For example, the launch of the 2005 National Rural Health Mission included conditional cash transfers to incentivize hospital births. While this increased the number of hospital deliveries, the inadequate infrastructure prevented any large gains. There was a lack of skilled personnel and a lack of surgical tools and resources at hospitals. Board Chair of Sugha Vazhu Health Dr. Nachiket Mor felt that “any gains of healthcare have come more from natural economic growth than anything the health system had done.”

Health Care Delivery and Inequities

Rural and urban health care delivery both had a unique set of challenges. Urban areas had 80 percent of the doctors, 75 percent of pharmacies, and 50 percent of hospitals, despite a lot of government investment in building the rural health infrastructure. It was commonly believed that health indicators were much worse in rural areas than urban areas. But when studies accounted for income difference in urban areas, it was clear the urban poor had worse health indicators than the rural poor. (Exhibit 18)

Rural and urban residents both faced an unpredictable, non-transparent market for health care. Access, affordability, and quality were all major barriers. The primary care clinics were delivered by three main sources: the government, charitable/non-profit organizations, and the private sector. The public facilities were generally inadequate, difficult to reach, of poor quality, and lacked qualified medical professionals. Charitable organization had mixed results. Private clinics did offer more convenience and faster services than the other two alternatives, but the quality of care was questionable. Private practitioners typically had higher costs that exploited patients. Many were unlicensed and untrained and provided incorrect diagnosis and overused drugs, especially steroids.

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<th>Innovation: Healthcare Delivery</th>
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<td><strong>Swasth India</strong> - Co-Founder of Swasth Foundation Sundee Kapila described his organization as an important health care alternative to the government, charitable and private sector primary care facilities that were riddled with challenges. The 16 existing centers covered close to 1.5 million people, with close to 280,000 patients and 70,000 families. Swasth Health Centers were affordable because of ~40% reduction in the cost of delivery of care driven by numerous innovations across the healthcare value chain like (a) Backward integration into drug supply chain and pathology lab (b) Incentive structure of doctors linked to patient satisfaction and not financial outcomes. The Health Centers were also strategically located in highly populated commercial areas with ~100,000 people living within one kilometer radius. This meant that the centers were very small and had to efficiently use as little as 250 square feet. To increase accessibility, their hours of operation were from 8AM to 1:30PM to accommodate fasting samples and 5:30 to 9:30PM for people who did not want to miss work. The final component was high quality, patient-focused care. Centers were equipped with electronic records, diagnostics, dental services, and a 24 hour phone line. Proactive surveys were regularly conducted to determine customer satisfaction. The model was sustainable, scalable and cash flow positive in 12 to 18 months. The centers employed people from the community, comprising of 70 percent women.</td>
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<td><strong>Piramal e-Swasthya</strong> - The AL Fellows’ COAL (Challenges and Opportunities in Advanced Leadership) curriculum included the Harvard Business School case study “Piramal e-Swasthya: Attempting Big Changes for Small Places – in India and Beyond.” Piramal explained that despite all the difficulties and challenges outlined in the case study, they were dedicated to overcoming the barriers and providing health care. Ultimately, Piramal e-Swasthya achieved a lot of success by building trust through free 24</td>
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hour help lines and mobile vans that always showed up on schedule. The vans were equipped with primary health care workers that had access to doctors through telemedicine.

Dr. Devi Shetty and the Narayana Group of Hospitals - Solar-powered low-cost mobile shipping container health clinics (equipped with technology to leverage tele-medicine and easy to replicate) made it feasible to serve vulnerable populations. The goal was to reach 100 patients per day. If they were unable to meet this in a particular region, the clinic would easily move to another region. Shetty also highlighted the potential of using technology for outpatient care. He gave an example of a health care professional (who takes care of her children and works from her home) who advised a diabetic patient’s son through whatsapp, a popular messaging application. The patient’s son was able to share information by taking a picture of his mother’s medicine, medical history, and more. And the health care professional was able to keep a record of everything for their future interactions. (Exhibit 19)

Economic Consequences of Poor Health

In addition to the obvious tragedy of unnecessary lives lost as a result of India’s poor health system, the poor health outcomes had severe consequences for the economy. For the age group 35 to 64, there were potentially 9.2 million productive years lost. This was 570 percent more than the United States in 2000. By 2030, India was predicted to lose about 18 million productive years, which would be 900 percent more than the United States. Dr. K. Srinath Reddy, President of the Public Health Foundation of India, warned, “No country which asks first for accelerated economic growth and positions itself at the potential economic power in the 21st century can afford such a hemorrhaging of human resources in the productive prime of midlife.”

Corporate Social Responsibility

Since 2000, philanthropic donations increased. Between 2010 and 2012, giving doubled from 0.2 percent of GDP to 0.4 percent, despite the economic crisis. From 2010 to 2015, 100 million new givers were added. And in 2010 and 2011, three high net worth individuals sold their businesses and collectively gave over $2 billion to their respective foundations.

Companies Act 2013

After several years of discussion, on September 12, 2013 India adopted the Companies Act 2013 (replacing the Companies Act 1956) that included a corporate social responsibility mandate, known as the “2 percent rule”, which went into effect on April 1, 2014. Companies impacted met the following conditions: (1) net worth of Rs. 5 billion or more (US$83 million); (2) turnover of Rs. 10 billion or more (US$160 million); and (3) net profit of Rs. 50 million or more (US$830,000). These companies were expected to spend at least 2 percent of their average net profits made during the three immediately preceding financial years on CSR activities within India. This meant, about 8,000 companies could bring $2.6 to $3.4 billion into the economy after the law went into effect. (Exhibit 20) Prior to the law, the top 100 companies spent $454 million, and with the law this will need to be increased by 109 percent. (Exhibit 21) Companies will be penalized not for their lack of spending, but for their failure to report their CSR spending or why they failed to spend the required amount.

Corporate Engagement Challenges

Founder and Director of Salaam Bombay Foundation Padmini Somani, outlined a number of funding challenges that non-profits had when engaging corporate partners. First, she described a horizon mismatch, where companies wanted to have a large short-term impact while non-profits
needed sustained multi-year support for a long-term impact. Not having a continuous source of funding made it difficult for nonprofits to deliver a consistent level of service that was needed to gain trust within their communities. Financial investments needed to be strategic otherwise the organization would not survive. Somani explained how money sometimes created distortion, having too large upfront funds could lead to unsustainable expenditures and less efficient operations. Additionally, grants sometimes led to mission drift, where organizations would try and tailor themselves to meet the requirements of a particular grant. And companies also funded the “usual suspects” which left promising new social innovations without the funds needed to develop and prove themselves. Investment in early stages was lacking.

Somani also described the challenges of aligning social impact goals with business goals. “How do I go and convince somebody that working in my slum community is going to really translate into money in their business for them?” The business community wanted measurements and metrics to understand their return on investment (ROI) and most NGOs lacked the capacity to develop this analysis.

Solutions for Social Change in India

India had many characteristics and assets that could contribute to the social innovations that would create an equitable, healthy, and educated society. The opportunity for large scale social change in India was huge. The sheer size of India was a challenge as well as an asset.

For public health, India’s “health exchange rate” could be as low as 3 INR to 1 USD and was very good, especially when compared to the dollar exchange rate of 60 INR to 1 USD; and the purchasing power exchange rate of 15 INR to 1 USD. Mor explained that the health exchange rate may be so low because of India’s natural advantages and the labor intensiveness of healthcare. India had the manpower (average nurse salary in India was US$3,000 versus US$70,000 in the US), the technology (fiber optic/unlimited bandwidth, average computer programmer salary in India was US$5,000 versus US$80,000 in the US), and the medicine (25 percent of generics made in India, i.e., Tylenol was US$.01 cents versus US$.07 cents in the U.S.) to provide comprehensive healthcare despite its low per-capita GDP. Dr. Shetty believed that India would become the first country in the world to dissociate healthcare from affluence. Shetty and others reinforced the importance of leveraging technology as evidenced in many of the social efforts captured in the “Innovation” insets.

Cross Sector Multi-Stakeholder Coalition

The advanced leadership concept of a “cross sector multi-stakeholder coalition” was very applicable to solving the large and complex challenges in India.

“If we want to significantly decrease the number of diseases and deaths related to tobacco we need to have leaders and policy makers collaborate and come together from different sectors including agriculture, finance, law, public health, medicine, education, and NGOs who are doing excellent work in this space. If we can create and implement policies to change the patterns of production, distribution, access and consumption of tobacco products in India we truly can improve the health and well-being of millions of people!” Dr. Rati Godrej, Internal Medicine physician and Public Health Consultant (Rural Health and Tobacco Control)

“The problems of India are so large that nobody, no one foundation, no one company, no one state, no one government can do it alone.” Swati Piramal, Vice Chairperson of Piramal Enterprises

Innovation: Organizations Facilitating Cross-Sector Collaboration
**Wadhwani Initiative for Sustainable Healthcare (WISH) Foundation** - Chief Executive Officer of the WISH Foundation Soumitro Ghosh described his organization as serving a critical role in strengthening primary care. The foundation worked in partnership with the state governments and social entrepreneurs to create important connections. The organization served as a knowledge hub for both parties and had physical and virtual summits to facilitate these needed interactions. In addition to connections, they identified, prepared, and guided promising social innovators on how to work with the government and scale their businesses.

**Dasra** - Partners and Co-Founders of Dasra (meaning enlightened giving), Deval Sanghavi and Neera Nundy explained how their organization supported philanthropists and social entrepreneurs to increase and their impact. As analysts at Morgan Stanley, Sanghavi and Nundy were inspired by the rigorous and disciplined business practices used when researching, identifying, vetting, funding, and supporting management teams. They saw an opportunity to apply an investment banking approach to the social sector. Sanghavi and Nundy started raising funds. They initially raised $10,000 from Morgan Stanley associates and VPs. Then the former chairman of Morgan Stanley Richard Fisher gave them $250,000 to launch their non-profit organization. After two years at Morgan Stanley, Sanghavi left the U.S. to start Dasra in India, while Nundy pursued her MBA at Harvard before joining Dasra full-time. The company focused on four areas: empowering women, governance, sanitation, and capacity building. They researched 200 to 300 organizations working in each space. They identified the theories of change and selected a couple of groups that created significant impact. Dasra helped to strengthen those organizations by providing guidance on their strategic plan, leadership development, management tools, and access to capital.

**Contrarian Capital India Partners** - Somak Ghosh, a 2011 Advanced Leadership Fellow, started Contrarian Capital India Partners, an early stage investment fund. Ghosh explained that his fund focused on people that lived on $1.50 to $4 per day, about half the Indian population. This segment was typically left out of grant-led, CSR-led, philanthropy-led access to basic goods and services, as well as the target market of the large corporations. His goal was to connect a holistic economic system providing affordable healthcare, education, housing, employment/agribusiness opportunities to mainstream capital. After a nearly three year journey, Ghosh raised $3 million and after evaluating over 300 deals has made 3 investments and has a further 3 in the pipeline. His investments (both completed and pipeline) includes low cost sanitary napkins, rural sanitation, rural chain of healthcare clinics, natural and organic products retailing where the produce was sourced directly from rural producers and a low cost feto-maternal monitoring device. See Exhibit 22 for a detailed example of one investment.

**Society for Nutrition, Education & Health Action (SNEHA)** - CEO Vanessa D’Souza highlighted SNEHA’s role in various public-private partnerships. They have partnered with Siemens to provide mobile health services in underserved urban and peri-urban areas. They also facilitated a partnership with ICICI bank (funding partner), Municipal Corp (health care provider/implementing partner), and the University College London (research and data management partner) that provided antenatal clinics in government health posts. SNEHA also partners with the Integrated Child Development Scheme (a World Bank-funded initiative) on prevention & treatment of malnutrition and works with municipal corporation health services that provided immunization to young children. D’Souza explained that convergence was increasingly important to save resources and deliver services to the same population more effectively.
**Ecosystem**

A large part of a “cross sector multi-stakeholder coalition” involved the creation of ecosystems. The ecosystem approach had a long history in India. In 1947, J.R.D. Tata, then chairman of the Tata Group pioneered a business model with an ecosystem approach. The company set up an entire township with housing, hospitals, schools, parks, transportation, and more. The Steel Authority of India adopted a similar model, with one township being ranked the 14th best city in terms of sanitation and cleanliness.

“Solutions have to be at an ecosystem level, not at the individual organization tackling a specific problem level.” Deval Sanghavi, Partner and Co-Founder of Dasra

“A business cannot be rich if society is poor. No way can you start a CSR program without an ecosystem in place. A CSR program, at its best, is always an ecosystem at play, not a company at play, trying to transform life over a period of time. The bank, the educators, the innovation behind the tractor – every single thing must be tied together, and this takes time.” D. Shivakumar, Chief Executive Officer, PepsiCo India Holdings Private Limited

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**Innovation: Corporate Role in Building an Ecosystem**

**PepsiCo** - PepsiCo spent a lot of time working on creating ecosystems. PepsiCo India worked with over 24,000 farmers across eleven states through a 360-degree collaborative model that included, assured buy-back of produce at pre-agreed prices; Supply of high quality planting material and advanced agronomic practices; and soft loans through a tie-up with State Bank of India. This helped PepsiCo ensure the quality of their raw materials. This also helped the farmers to improve their economic well-being, including providing education to their children. PepsiCo adapted global technological expertise to Indian conditions. For example, they worked with Mitsubishi to introduce a small low cost tractor as a collaborative investment opportunity for farmers.

**Nokia** - Shivakumar previously worked at Nokia and described one of their business ventures that benefitted everyone involved. In 2008, Nokia recognized that women were not buying cell phones despite wanting them. Nokia created an ecosystem by getting 1) Airtel to provide a free sim card upfront and make money on recharging fees and 2) SKS microfinance to designate the phone purchase as an income generating activity so women could get a loan. There were 10 million users and everyone, including the women, benefitted, and made a profit.

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**Leveraging Core Competencies**

Globally, the private sector’s role in the social sector evolved over the years. As a faculty moderator explained, there has been a shift to “real change”, meaning using corporate capabilities towards creating impactful social innovations, away from “spare change”, where companies just donated money and seemed more concerned with optics than impact.

The scale of the problems demand that the private corporate sector step in and cater to the ‘bottom of the pyramid’ consumers as a business; obviously with help/support from the government, NGOs, and social entrepreneurs. Just as the private corporate sector was responsible for the telecom revolution in India, the same needs to happen in the sphere of essential services and what is termed ‘public goods’. – 2015 AL Fellow Sutapa Banerjee

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**Innovation: Socially Responsible Products**

PepsiCo - Shivakumar explained that profitable companies of the 21st century will be those that align the needs of their business with the needs of the world around them. With this in mind, PepsiCo looked...
out across the food and beverage landscape around 2005 and charted a new course. The company recognized a simple truth, “There is profit in purpose.” He explained, “Sustainability is not something to support with the profits we make, but rather a path to delivering profitability. Weaving sustainability into the very fabric of our organization is a way to help future-proof our business for the changing world around us. At PepsiCo, we focus on three pillars of sustainability: Human, Environmental and Talent.” On Human Sustainability, PepsiCo worked to improve the nutritional profile of their products and offer a wider selection of nutritious foods and beverages in response to growing consumer demand.

This shift also had very large and tangible positive benefits for the company. These developments for the social sector had huge profit potential when applied and modified to the private sector for commercial gain. Engaging employees in social impact work increasingly created a lot of enthusiasm, increased productivity, and ultimately made the companies more profitable.

**The Role of Government**

Dr. K. Srinath Reddy offered some hope for the future in his keynote address. He said, “The new government did announce even prior to the election as a political platform that they will bring in national health assurance, although it was not clearly defined what they meant. A slew of several programs have been launched.” He continued to explain that despite a lower budgetary allocation, the optimism comes from the fact that the finance commission recommended (and the central government accepted) an increase in the share of state tax revenue that will be allocated to public health programs. These programs were until 2015 centrally funded, but executed by the state.

While governments generally had a poor reputation for efficiency and execution, Board Chair of Sugha Vazhu Health Dr. Nachiket Mor provided examples that demonstrated the Indian government’s ability to manage people and deliver results. Mor referenced the government-run railway systems, one of the best and largest in the world; one of the largest standing and highly effective armies in the world; a large and efficient tax administration; and the largest electronic voting system in the world. Making the point that there was no fundamental reason why it cannot deliver good healthcare even in remote rural settings in India. After all, the successful campaign that eradicated polio was done in partnership with the government.

A number of speakers reiterated the need to use the government as a scaling mechanism for proven social innovations.

“If one has to work in India with sustainable impact at a meaningful scale, you have to partner with the government.” Padmini Somani, Founder and Director of Salaam Bombay Foundation

“In the rural areas, you cannot work without the government. There’s nothing that exists except the government.” Soumitro Ghosh, Chief Executive Officer of the WISH Foundation

“It’s really hard to scale things independent of the government.” Neera Nundy, Partner and Co-Founder of Dasra

“We discovered that we could not reach scale until we worked with the government. We had to show them our innovations. We had to convince them. I’ve done 2,000 schools, but there are 60,000, so how do I reach that?” Swati Piramal, Vice Chairperson of Piramal Enterprises

**Innovation: Technical Assistance for the Government**
Public Health Foundation of India (PHFI) - Dr. K. Srinath Reddy, President of the Public Health Foundation of India, described how the organization formed as a technical support group to bring more public health expertise to policy, program design and evaluation, and capacity building. It grew into four functioning institutes of public health, working with central and state governments. Reddy emphasized their multidisciplinary approach to public health and focused on PHFI’s strength as a platform for learning and practice.

AL Fellows also had ideas on how the government could contribute to social change in India.

The largest opportunities from a macro view may be to have the government simply shift more of its budget to healthcare, the fine tuning of the 2013 Companies Act with a mechanism that steers more and more funds over time to workable winning solutions, perhaps more industry titans (Tata, Ambani, Piramal) will step up to sign the “Giving Pledge” and donate that capital in self-reinforcing solutions that scale, and lastly perhaps Narendra Modi will imitate his peer Barack Obama and create an office of social innovation and civic participation. I still wrestle with the moral question of why it does not do more and am a neophyte at understanding Indian politics, but I left with more of a sense of hope in the new Modi administration (than a fear of civil unrest from economic shortfalls in the years ahead). – 2015 AL Fellow Ken Kelley

I saw people at work and the conversion of challenges to opportunities. And more striking was the involvement of young people. If anything, the government needs to set the scene to encourage more young people to get involved. People revered their government in India so more vocal interaction is needed. I was also enthused to see the engagement of celebrities who are revered in India. All this is a recipe for success for the betterment of Indian citizens and their vulnerable societies. I would, particularly, want to see more focus for young girls & women. There is still a lot of marginalization going on driven by the caste system at play. So more focus and education needs to be asserted to overcome this stigma. – 2011 AL Fellow and 2012 AL Senior Fellow Issa Baluch

Conclusion

Advanced Leadership Fellows immersed themselves in learning about the incredible challenges and promising solutions during the Global Conference. The Global Conference exemplified the spirit of the Advanced Leadership Initiative with attendees using their past experience and recent learnings to think critically with a solution focused orientation about large, complex challenges facing a country and all of its residents. See below for a couple examples:

Every Indian that makes it out of the quagmire of poverty needs to give back - especially the diaspora. During the Salaam Bombay Foundation dinner, I sat with a psychiatrist – who said how few mental health professionals were actually living and working in India – especially compared to the number working just in NYC! The government has an opportunity to incentivize overseas Indians to return home to improve the country at so many levels. – 2015 AL Partner Lisa Anderson Kelley

What is required is rapid development of Indian Advanced Leaders (or something similar) – a growing cadre of folks – like many who came to speak to us who can lead change. Right now there are simply too few of these types (in my opinion) to take on the massive challenges ahead. I also think there is huge opportunity in a delivery mechanism that was hinted at by a few speakers but one that we did not explore as much as we could:
mobile telephony. This is a personable, addressable, and trackable device that has so many innovative uses in the world of health, gender equity, safety, etc. that I would have loved learning more about as a way to help serve the most vulnerable populations. – 2015 AL Fellow Monty Simus
Appendix A  2015 AL Fellow Account of Salaam Bombay Foundation Field Visit

My field trip to the Andheri Tata Compound Municipal School in Mumbai, which integrates the Saalam Bombay Foundation’s anti-tobacco teaching into numerous aspects of the core curriculum, and the home visit that followed were life-changing. I was delighted to get to spend the day with Kirk Vanda of the Harvard T.H. Chan School of Public Health and Issa Baluch (2011 AL Fellow and 2012 AL Senior Fellow). The van ride to the school was cheerful despite the continuously running scenes of abject poverty, destitution and despair that we passed. We chatted about home life in Mumbai with Aditi Parikhhere, our host from Salaam Bombay Foundation, and a young intern. We all shared stories and laughs as if we were chatting after a parent-teacher meeting or at a neighborhood barbecue. The exchange confirmed for me, once again, how much we have in common with those across the world and our common desire to make our children’s world a bit better than that which we experienced when we were young.

Our designated school was in a very high poverty area, in proximity with the everyday life challenges the students must overcome to survive. We went to understand and be inspired by the source of the local children’s strength and hopefulness. We were not disappointed; at least for me personally, answers were found. The school facilities were run down—paint peeling, minimal lighting, and relied on rudimentary furnishings and equipment, but the classrooms and hallways were clean and filled with an air of happiness and curiosity about the day’s visitors.

The children in the school were each neat and clean— their uniforms pressed, their hair combed and perfectly braided. Their smiles welcomed us to each room as they were eager to perform their dance, volunteer to answer a question, or demonstrate a theatrical exercise. We were interviewed by two young girls who write for a school newspaper; their curiosity was topped only by their appreciation of our answers. The teachers and principal were open and forthright about their lack of resources, need for more teachers, and determination to make a difference in each child’s life. They humbled us with their sense of service.

As we left the school, we were each invited to the home of a student, where a mom welcomed and hosted us. We walked through fetid waters shin-deep, back and forth through the narrow alley ways that serve as the slum equivalent of modern subdivision roads. The rains were coming down hard but umbrellas were hardly useful as they had to be held down more often than not to avoid getting hit by the low hanging tin roofs. The little girls doing the day’s laundry in the doorways of their homes often interrupted their chore to give us a wide-brimming smile, likely more curious about my dyed blonde hair than anything else.

When we finally arrived at Shubham’s home, his mom welcomed me with grace and warmth. Their home for which they pay 1300 Rupees per month, was at best 6’ x 10’ and one of the four walls was a tree trunk. One of the remaining walls was covered with pots and pans and eating utensils, another stuffed with bags and suitcases holding their possessions. There was one bench with a cushion where not only the mom sleeps, but under which they place the school uniforms each night to press them. The stench of kerosene, the fuel source of choice, was overwhelming. The electricity when on, was dim and there was no clean water source or plumbing.

Shubham’s mom said through an interpreter that she was honored to have me in her home and offered me a biscuit and water in a tin cup. If she only knew how humbling it was to be in her presence— a mom who not only works multiple domestic jobs to support her family, but a woman who suffers the challenges of an alcoholic husband who had difficulty holding a steady a job. Her son, Shubham, was a 16 year old talented puppeteer and he loved theatre, having performed in several plays. If he continued to work hard in his studies as he progresses forward from 10th grade, his mom would like to see him continue in school. She was not certain that she wants the same for Shubham’s younger sister, as it was nearing the time she should work with her mom and hopefully, marry.

I told Shubham’s mom that she must be terribly proud of her son and daughter and all that they had accomplished thus far. More importantly, I told her, she must have such a sense of accomplishment knowing that she had dedicated her life to raising such fine children and giving them support and confidence to stand on their own. I told her, “moms have a special place in the world” and that “we were blessed.” Indeed, we are...especially those of us who have experienced the warmth and hope of the Indian people, especially, its children.

Source:  2015 AL Fellow Judy Perry Martinez
Exhibit 1  Agenda

Wednesday, June 17, 2015

9:00 AM  Welcome & Introductions

Speakers: Rosabeth Moss Kanter
Ernest L. Arbuckle Professor of Business Administration
Harvard Business School
Chair & Director, Harvard Advanced Leadership Initiative

Dr. Howard K. Koh, MD, MPH
Professor of the Practice of Public Health Leadership
Harvard T.H. Chan School of Public Health
Co-Chair, Harvard Advanced Leadership Initiative

K. Viswanath
Professor of Health Communications
Harvard T.H. Chan School of Public Health

9:30 AM  The Companies Act, 2013 Overview: CSR Requirements & Political Context

Speaker: Deval Sanghavi
Partner & Co-Founder, Dasra

10:15 AM  The Law & Social Change

Speaker: Charles J. Ogletree, Jr.
Jesse Climenko Professor of Law, Harvard Law School
Co-Chair, Advanced Leadership Initiative

11:15 AM  Corporate Engagement in Public Health & CSR

Speaker: Dr. Swati Piramal
Vice Chairperson, Piramal Enterprises Ltd.

1:00 PM  Non-Governmental Organizational Perspectives on CSR

Speaker: Padmini Somani
Founder and Director, Salaam Bombay Foundation

1:45 PM  Politics’ Impact on Social Change and Health

Speaker: Supriya Sule
Member of Parliament (MP), 16th Lok Sabha

2:45 PM  Panel: Corporate Responses to the Companies Act, 2013

Moderator: Rosabeth Moss Kanter
Panelists: Vanitha Narayanan  
Managing Director, IBM India Private, Ltd  
Dr. Swati Piramal  
Vice Chairperson, Piramal Enterprises, Ltd  
D. Shivakumar  
Chief Executive Officer, PepsiCo India Holdings Private Limited

7:00 PM  
Participant, Alumni, & Public Reception hosted by  
Mr. Ajay and Dr. Swati Piramal

Location: Piramal Tower

Speakers:  
Global Health: Opportunities and Threats over the next 20 years  
David Hunter  
Vincent L. Gregory Professor in Cancer Prevention  
Dean for Academic Affairs  
Harvard T.H. Chan School of Public Health

Move: Putting Infrastructure Back in the Lead  
Rosabeth Moss Kanter  

Communicating the End of Health Disparities  
K. Viswanath

Thursday, June 18, 2015

Times vary  
Depart for Mumbai Site Visits, See “Field Visit Summaries” section

1:15 PM  
Missing Links in Universal Health Care

Speaker: Dr. Nachiket Mor  
Board Chair, SughaVazhu Health

2:00 PM  
Entrepreneurial Primary Care Interventions in India

Moderator: Peter Berman  
Professor of the Practice of Global Health Systems and Economics  
Harvard T.H. Chan School of Public Health

Panelists: Dr. Soumitro Ghosh  
Chief Executive Officer, Wish Foundation

Sundeep Kapila  
Co-Founder, Swasth India

Poonam Muttreja  
Executive Director, Population Foundation of India
3:15 PM  Tobacco Control in India

Moderator: Dr. Rati Godrej  
Internal Medicine; and Board Member,  
IKP Centre for Technologies in Public Health

Panelists: Shekhar Bajaj  
Chairman & Managing Director, Bajaj Electricals Limited

Dr. Pankaj Chaturvedi  
Tata Memorial Hospital

Dr. Prakash C. Gupta  
Director, Healis-Sekhsaria Institute of Public Health

6:30 PM  Dinner hosted by Salaam Bombay Foundation and Narotam Sekhsaria Foundation

Location: Palladium Hotel

Welcome: K. Viswanath

Padmini Somani  
Founder and Director, Salaam Bombay Foundation

7:00 PM  Dinner Keynote: Overview of Universal Health Care & Health Reform in India

Speaker: Dr. K. Srinath Reddy  
President, Public Health Foundation of India

Friday, June 19, 2015

Times vary  Depart for Mumbai Site Visits, note: Cancelled due to weather.

1:30 PM  Insights from a Business and Thought Leader

Moderator: K. Viswanath

Speaker: Ratan Tata  
Chairman Emeritus, Tata Sons

2:00 PM  Panel: Initiating Change in India

Moderator: Charles J. Ogletree, Jr.

Panelists: Vanessa D'Souza  
Chief Executive Officer, Society for Nutrition, Education & Health Action

Somak Ghosh
Advanced Leadership Field Perspectives: Public Health in India

Co-Founder, Contrarian Capital India Partners
2011 AL Fellow

Neera Nundy
Partner & Co-Founder, Dasra

3:15 PM Achieving Equity in Health Care in India
Speaker: Dr. Devi Shetty
Chairman, Narayana Health

4:15 PM Closing Remarks

FIELD VISIT SUMMARIES

Dharavi Locality

Dharavi is a locality in Mumbai, India. It houses one of the largest slums in the world. Dharavi slum was founded in 1882 during the British colonial era. It is currently a multi-religious, multi-ethnic, diverse settlement. Dharavi's total population estimates vary between 300,000 to about 1 million. This makes Dharavi the most densely populated place on the planet. Dharavi has an active informal economy in which numerous household enterprises employ many of the slum residents. It exports goods around the world. Leather, textiles and pottery products are among the goods made inside Dharavi by the slum residents. The total annual turnover has been estimated at over US$500 million. Dharavi has suffered through many incidences of epidemics and other disasters. It currently covers an area of 217 hectares (535 acres).

Salaam Bombay Foundation School Visits

Salaam Bombay Foundation works towards children's empowerment, encouraging them to live a healthy, successful & tobacco free life. Over 500,000 Mumbai children get an education at the local municipal or government-aided school. Most of them live in Mumbai’s crowded, infrastructure-challenged slums. 36% are malnourished. Other deterrents to their progress are the absolute poverty, uncertain and fluctuating income of parents, multiple responsibilities, low quality education and the lack of physical space. These circumstances contribute to a highly pressured childhood and negatively impact their ability to contribute to productive human capital building. These conditions also leave them particularly vulnerable and susceptible to substance abuse, in particular tobacco. Every day, more than 5,500 children in India below the age of 10 are estimated to try tobacco for the first time. Over 10 million (10,000,000) Indian children are estimated to be users of tobacco. There is an urgent need to develop an engaging and innovative curriculum supporting the holistic development of the child in order to empower her to take better decisions for her health and education.

Society for Nutrition, Education & Health Action (SNEHA)

A secular, Mumbai-based non-profit organization, SNEHA believes that investing in women's health is essential to building viable urban communities. SNEHA targets four large public health areas - Maternal and Newborn Health, Child Health and Nutrition, Sexual and Reproductive Health and Prevention of Violence against Women and Children. Its approach is two pronged: it recognizes that in order to improve urban health standards, its initiatives must target both care seekers and care providers. It works at the community level to empower women and slum communities to be catalysts
of change in their own right and collaborate with existing public health systems and health care providers to create sustainable improvements in urban health.

**Swasth India**

Swasth Foundation is an NGO working towards improving the health of low-income segments in urban and rural India. Its mission is “To ensure access to affordable and quality health services to 10 million low-income people by 2018” Its mission is driven by the motto “Health for all.” India’s healthcare scenario has seen significant improvements, enhancements and innovations in the past few years along various dimensions – expanding network of private healthcare providers, a competitive pharmaceutical industry and dynamic health insurance products. Swasth Foundation aims to extend these benefits (which, until now, have been accessible and affordable only to the high-income segments) to even the low-income segments.

**Tata Memorial Hospital**

The Tata Memorial Hospital is situated in Parel, Mumbai in India. It is a specialist cancer treatment and research centre, closely associated with the Advanced Centre for Treatment, Research and Education in Cancer (ACTREC). One of the fields of specialization of this hospital is in the treatment of acute lymphoblastic leukemia (A.L.L). The hospital claims to treat and cure 99% of the A.L.L patients. This hospital is also one of the few in India to have a P.E.T. scanner. The Director of this hospital is Dr. Rajendra A Badwe, who took over from director Dr. K.A. Dinshaw.

The Tata Memorial Centre is the national comprehensive cancer center for the prevention, treatment, education and research in Cancer and is recognized as one of the leading cancer centers in this part of the world. This achievement has been possible due to the far-sighted and total support of the Department of Atomic Energy, under Dr. Homi N Sethna responsible for managing this Institution since 1962. The Tata Memorial Hospital was initially commissioned by the Sir Dorabji Tata Trust on 28 February 1941 as a center with enduring value and a mission for concern for the Indian people.

Source: Advanced Leadership Initiative.
Exhibit 2  Leadership Lessons from Ratan Tata

Ratan Tata, Chairman Emeritus of Tata Sons (the holding company of one of the world’s largest conglomerates) answered questions from participants. Tata was incredibly humble and when questioned about how he maintained it, he responded that he was just being himself, a “really shy person.” When explaining his journey to being one of the most successful businessmen in the world, he simply explained, “I worked in an architect’s office and came back to India only because my grandmother was ill and called for me. One thing led to another and I never went back to the U.S. So much of this journey that I embarked on evolved as we went along based on circumstance. If that did not happen, I probably would’ve still been in the U.S. today as we speak.”

Tata shared his invaluable insights on leadership. He emphasized the need to “be with your troops in the field when it gets rough.” Tata illustrated this point when recounting the 2008 terrorist attacks at his Taj Mahal Palace and Hotel that had 450 guests and restaurants at capacity. Two terrorist set fires, tossed grenades, and killed people. The terror lasted three days. Tata explained that there were no manuals or instructions. He joined the inner group, doing everything he could on the ground to support people and stay with them, taking part in the pain and anguish. Tata also recalled the Tata Motors strike saying, “I rolled up my sleeves and got involved and stood side by side with the people that were suffering rather than getting periodic information on what was happening.”

Source:  Casewriters.
Exhibit 3  June 2015 India Photo Collage

Source: Lisa Anderson Kelley and Harvard Advanced Leadership Initiative.
Exhibit 4  India’s Growing Urban Poor

Source:  Poonam Muttreja, Population Foundation of India.

Exhibit 5  India’s Life Expectancy (2000 and 2012)

Exhibit 6  India Population with Improved Water and Sanitation


Exhibit 7  Estimated Cause of Death and DALYs in India, 2005

Exhibit 8  Inequities in Mortality in Children Younger than 5 in India


Exhibit 9  India’s Overweight Population (over 30) by Gender in 2005 and 2015

Exhibit 10  Prevalence of Cancer among Men and Women (2012)


Exhibit 11  Cancer Mortality among Men and Women (2012)

Exhibit 12  Prevalence of Tobacco and Alcohol Use in India (1998-99)

Exhibit 13  Smokeless Tobacco Products in India

Source: Prakash Gupta, Healis-Sekhsaria Institute of Public Health.
**Exhibit 14**  Key Provisions of the Indian Tobacco Control Act, 2003

- Ban on smoking in public places
- Ban on direct and indirect advertisement of cigarettes and other tobacco products in print, electronic and outdoor media (ban on tobacco use in films to be implemented from October, 2005)
- Ban on sales to and by people younger than 18 years of age
- Tobacco products cannot be sold near educational institutions
- Mandatory depiction of statutory health warning (in one or more Indian languages) and pictorial warning, on all tobacco products
- Product regulation: tar and nicotine levels to be declared on tobacco product packages


**Exhibit 15**  Salaam Bombay Foundation Approach: Socio-Ecological Model

Source: Padmini Somani, Salaam Bombay Foundation.
Exhibit 16  Anti-Tobacco Media Campaign

Exhibit 17  Decreasing Trend in Smokeless Tobacco Products (2008 to 2013)

Source:  Pankaj Chaturvedi, Tata Memorial Hospital.
Exhibit 18  Health Statistics Comparing the Urban (Poor and Non Poor) and Rural

<table>
<thead>
<tr>
<th>Plight of the Urban Poor vis-à-vis Urban Non-poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>NFHS-2</td>
</tr>
<tr>
<td>Women age 15-49 with <strong>anaemia</strong></td>
</tr>
<tr>
<td>Children completely <strong>immunized</strong></td>
</tr>
<tr>
<td>Children who are <strong>underweight</strong></td>
</tr>
<tr>
<td>U5MR</td>
</tr>
<tr>
<td><strong>Contraceptive use - modern method</strong></td>
</tr>
</tbody>
</table>

Source: USAID analysis of NFHS data

NFHS-2 was in 1998-99 and NFHS-3 was 2005-06; Reanalysis dis-aggregated urban data from NFHS – 2 and 3

Source: Poonam Muttreja, Population Foundation of India.

Exhibit 19  Photos of Diabetes Management Using Whatsapp

Source: Dr. Devi Shetty, Narayana Health.
**Exhibit 20**  The Companies Act 2013 – CSR Mandate

The Companies Act 2013 Recognizes that Companies Can Help Solve These Challenges

- Net worth > INR 500 crores (USD 85.5 mn)
  - OR
- Turnover > INR 1000 crores (USD 170 mn)
  - OR
- Profit > INR 5 crores (USD 855,000)

2% of pre-tax profits to Corporate Social Responsibility activities in areas such as:
- Hunger and poverty
- Healthcare
- Sanitation
- Education
- Livelihoods
- Gender equity
- Environment

This landmark legislation has the potential to unlock an annual capital influx of USD 2.6 – 3.4 billion from 8000 companies

Source: Deval Sanghavi, Dasra.

**Exhibit 21**  India’s Top 100 Companies CSR Spend

![Pie chart showing percentage of profit spent on CSR](image)

<table>
<thead>
<tr>
<th>Percentage of Profit Spent on CSR</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spend less than 0.5%</td>
<td>15%</td>
</tr>
<tr>
<td>Spend 0.5-1%</td>
<td>22%</td>
</tr>
<tr>
<td>Spend 1-2%</td>
<td>28%</td>
</tr>
<tr>
<td>Spend more than 2%</td>
<td>16%</td>
</tr>
</tbody>
</table>

The top 100 companies cumulatively spent USD 454 mn on CSR. The expected expenditure for the same group should increase by 109% annually.

Source: Deval Sanghavi, Dasra.
### Exhibit 22  Example of Contrarian Capital Investment

**Providing access to low-cost sanitary pads, promoting rural entrepreneurship**

**Entrepreneur background**
- Promoter team has prior corporate as well as social entrepreneurship experience. The company has been incubated by CIIE (IIM Ahmedabad).
- The promoters have successfully developed the product after 4 years of product development trials.

**Transaction positives**
- Innovative product, with robust R&D over the past few years. Patent awaited.
- Superior quality of end product while maintaining competitive pricing of the machine.
- Little competition from other players in the low-cost sanitary pads segment.
- Huge domestic market for affordable menstrual care in India due to lack of options.
- Demand in international markets, specially in African countries.

**Business Model**
- Company is in the business of design and sales of machines that produce high quality, hygienic and biodegradable sanitary pads.
- The company sells these machines to NGOs, and local entrepreneurs, to produce sanitary pads.
- It also provides the machine buyers with raw material required to manufacture the pads and maintenance services for its machines.
- Apart from selling the machines, the company also sells sanitary pads, under its own brand.
- Revenues of INR 0.2 cr till date with a large order book of INR 18 crs.

**Challenges**
- Tie-ups with financial institutions for financing of the machines.
- Capacity building is difficult and creating awareness for end product off-take will require additional capital.

**Potential Exit**
- Strategic sale to a mainstream hygiene product company on account of the market penetrated.
- Secondary sale to future round investors.

<table>
<thead>
<tr>
<th>Investment sought</th>
<th>INR 0.8crs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deal source</td>
<td>Angel Network</td>
</tr>
<tr>
<td>Area of operation</td>
<td>Gujarat and Maharashtra (currently)</td>
</tr>
</tbody>
</table>

Source: Somak Ghosh, Contrarian Capital India Partners.