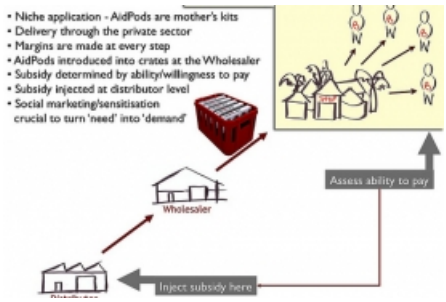
ColaLife: piggybacking simple medicines on Cola supply chains, to save lives in underserved rural areas in Africa

United KingdomZambia

Simon Berry



Organization type:
nonprofit/ngo/citizen sector
Project Stage:
Start-Up
Budget:
$500,000 - $1 million
Website:
http://colalife.org
SHARE

- Corporate social responsibility
- Health care
- Design
- Health education
- Infant health
- Poverty alleviation
- Vulnerable populations

Project Summary

Elevator Pitch

Concise Summary: Help us pitch this solution! Provide an explanation within 3-4 short sentences.

Coca-Cola gets everywhere, yet essential medicines (EMs) are hard to get in rural developing world communities; African public sectors struggle. Diarrhoea kills 1.5 million children/yr: more than AIDS, malaria and measles combined. Over 70% in Africa go without Oral Rehydration Salts (ORS)/zinc. WHO recommend integrated ‘kits’, and ‘market forces’, ‘innovative delivery strategies’ and educational materials, to reach rural communities. Yet transport costs are prohibitive: 40% of prices. Mothers may walk 30 km to a Health Post, to find essential medicines out-of-stock. ColaLife forms partnerships to trial new distribution partnerships and delivery models for EMs, and has designed an 'AidPod' to fit unused space in drinks crates - adaptable/adoptable in a range of countries, for local needs.

About Project

Problem: What problem is this project trying to address?

Coca-Cola gets everywhere, yet essential medicines (EMs) are hard to get in rural developing world communities; African public sectors struggle. Diarrhoea kills 1.5 million children/yr: more than AIDS, malaria and measles combined. Over 70% in Africa go without Oral Rehydration Salts (ORS)/zinc. WHO recommend integrated ‘kits’, and ‘market forces’, ‘innovative delivery strategies’ and educational materials, to reach rural communities. Yet transport costs are prohibitive: 40% of prices. Mothers may walk 30 km to a Health Post, to find essential medicines out-of-stock. ColaLife forms partnerships to trial new distribution partnerships and delivery models for EMs, and has designed an 'AidPod' to fit unused space in drinks crates - adaptable/adoptable in a range of countries, for local needs.

Solution: What is the proposed solution? Please be specific!

Harnessing the secondary Coca-Cola distribution chain for EMs is much discussed, but no fully evaluated trial has given metrics, learning and models for adoption/adaptation/scale-up. (Coca-Cola now advises Gov of Tanzania on logistics; some ad-hoc local co-transport initiatives have been seen). Design of the ‘AidPod’ is unique - 5 large or 10 small AidPods fit in each crate, separating the products physically/ psychologically from beverages. AidPods can be waterproof, trackable and tamper-evident, with potential to explore in future a variety of packaging options including: re-usable; recyclable; bio-degradable; SODIS-enabled (ie PET plastic); returnable; brandable; locally manufactured; cross-subsidised through parallel products sold in wealthier markets (including emerging African middle classes). Using retail/market incentives to improve distribution/access in remote areas to essential medicines is novel: using subsidies to drive demand/improve access. There are parallels/lessons from trials of distributing ant-malarials in Zambia and elsewhere (eg Global Fund), which we draw on. Use of SMS for tracking/authentication, e-vouchers. We draw on NORAD experience in Zambia in the agriculture sector; health product tracking using SMS is new for Zambia. Innovative text-based health messaging may be included. Trialling an ADK for home use by mothers/carers, along guidelines from UNICEF/WHO and including soap/hand-washing: new to Zambia; builds on PSI's work in Cambodia (Orasel: ORS+Zinc only). Evaluation and learning is a key outcome; there is already replication interest.

Impact: How does it Work

Example: Walk us through a specific example(s) of how this solution makes a difference; include its primary activities.

ColaLife brings together unlikely alliances to create 'shared value' and work in new ways - eg in Zambia, the Cola bottler (SABMiller), UNICEF, Min of Health and local NGOs, to trial a new distribution model, slotting ‘AidPods’ in unused space in the drinks crates that micro-retailers carry. This brings simple lifesaving medicines like ORS/zinc closer to rural communities with no additional transport cost, and helps micro-retailers earn a

margin on every AidPod they distribute. AidPods contain EMs and awareness materials, supported by social marketing and retailer para-skilling in simple health advice in areas where drug stores are absent. A first operational trial starting this autumn in Zambia will test the value chain for a locally-determined 'Anti-Diarrhoea Kit' (ADK), will use vouchers to ensure affordability and mobile phones for tracking and authentication. It will establish key metrics and provide learning and models for roll-out, scale up and possible adaptation or transfer to other commodities/supplies and countries. Trial activities will be: • ADKs designed and produced to meet needs at all levels in value chain (est 10,000 units) • Novel leverage of Coca-Cola supply chain to meet demand for ADKs in underserved areas • 30+ Retailers and wholesalers trained in benefits of ADKs, across 2 trial districts • An IEC/Social marketing programme for mothers/carers on benefits of ADKs (reaching an estimated 7,500 mothers/carers and 15,000 children under5, in 30 rural communities across 2 districts).

Sustainability

Marketplace: Who else is addressing the problem outlined here? How does the proposed project differ from these approaches?

In Zambia, rural health posts may serve communities 30 km away, with walking often the only access option, and queuing for ORS, which, although free, may not be in stock. ORS is well known, but zinc is not. Huge distances and distribution bottlenecks at district level stop EMs reaching rural people, and costs of bridging 'the last mile' are prohibitive; so the government is active in pursuing innovative public/private partnerships. Zambia's private health sector is one of the smallest in the world with only 70 registered retail pharmacies (2009) most in major towns; health-seeking behaviour via private sector retailers in rural areas is low. There are 2.3M children under 5 in Zambia; 74,000 die per year (Under-5 mortality rank is in bottom 20); 15% of childhood deaths are diarrhoea-related. Only 56% of Zambian under-5s with diarrhoea received oral rehydration and continuous feeding (World Bank, 2010). Nearly 20% are underweight (UNICEF). Rural mothers/carers ages are 15 to 80 with a median age 37 (eg USAID/SCOPE OVC programme, 2002), 70% are female. Average births is 6/mother and household size typically 6-7. UN estimates 570,000 Zambian children are AIDS orphans, many in extended families. Of $1-2 dollars/day income, 75% may go on food. The latest Demographics and Health Survey (DHS) for Zambia notes that 6 in 10 children with diarrhoea were taken to a health provider (DHS, 2007). Only 60% were treated with an ORS sachet; 10% were given recommended home fluids (RHF) prepared at home; 34% were given increased fluids 16% of children with diarrhoea received no treatment. Handwashing practice is poor in rural areas; UNICEF policy is to improve it. Over 2009/10 we completed 3 fieldtrips and 3 co-design workshops for a first trial of ColaLife localized to Zambian priorities, meeting 50+ professionals (16 NGOs), government and SABMiller and local women/retailers.

About You

Organization:
ColaLife

About You

First Name

Simon

Last Name

Berry

Twitter

http://www.twitter.com/colalife

Facebook Profile

http://www.facebook.com/colalife

About Your Organization

Organization Name

ColaLife

Organization Phone

07932 107109

Organization Address

18a Regent Place, Rugby

Organization Country

, WAR

Country where this project is creating social impact

, XX

How long has your organization been operating?

1-5 years

Is the project that you are entering related to this organization?

Yes

The information you provide here will be used to fill in any parts of your profile that have been left blank, such as interests, organization

information, and website. No contact information will be made public. Please uncheck here if you do not want this to happen..

Innovation

What stage is your project in?

Operating for 1-5 years

Tell us about the community that you engage? eg. economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts.

In Zambia, rural health posts may serve communities 30 km away, with walking often the only access option, and queuing for ORS, which, although free, may not be in stock. ORS is well known, but zinc is not. Huge distances and distribution bottlenecks at district level stop EMs reaching rural people, and costs of bridging 'the last mile' are prohibitive; so the government is active in pursuing innovative public/private partnerships. Zambia's private health sector is one of the smallest in the world with only 70 registered retail pharmacies (2009) most in major towns; health-seeking behaviour via private sector retailers in rural areas is low. There are 2.3M children under 5 in Zambia; 74,000 die per year (Under-5 mortality rank is in bottom 20); 15% of childhood deaths are diarrhoea-related. Only 56% of Zambian under-5s with diarrhoea received oral rehydration and continuous feeding (World Bank, 2010). Nearly 20% are underweight (UNICEF). Rural mothers/carers ages are 15 to 80 with a median age 37 (eg USAID/SCOPE OVC programme, 2002), 70% are female. Average births is 6/mother and household size typically 6-7. UN estimates 570,000 Zambian children are AIDS orphans, many in extended families. Of $1-2 dollars/day income, 75% may go on food. The latest Demographics and Health Survey (DHS) for Zambia notes that 6 in 10 children with diarrhoea were taken to a health provider (DHS, 2007). Only 60% were treated with an ORS sachet; 10% were given recommended home fluids (RHF) prepared at home; 34% were given increased fluids 16% of children with diarrhoea received no treatment. Handwashing practice is poor in rural areas; UNICEF policy is to improve it. Over 2009/10 we completed 3 fieldtrips and 3 co-design workshops for a first trial of ColaLife localized to Zambian priorities, meeting 50+ professionals (16 NGOs), government and SABMiller and local women/retailers.

Share the story of the founder and what inspired the founder to start this project

ColaLife founder/Director Simon Berry, a former British Aid worker, and his wife Jane lived and worked in remote rural Zambia in the late 1980s – when Coca-Cola was commonly available in villages, but ORS not. Then 1 in 5 children under 5 died avoidable deaths (eg from diarrhoea). Today little has changed. The 'co-transport' idea then failed to gain traction, but changes in Social Media (to spread the idea, convene interest and put pressure on corporates) and in CSR and Business Innovation (eg Business Call to Action) and pressure to achieve MDGs have made the idea acceptable now. So in 2008 Simon realised he could employ his stakeholder management, ICT and Social Media skills to resurrect the idea. With Facebook supporters quickly growing into 1000's, and winning support from UK and international media, Simon was able to engage Coca-Cola – which reaches even the most remote developing world communities via small-scale independent entrepreneurs – and persuade them to allow their bottlers to engage in locally determined health projects to carry AidPods, designed by Simon and Jane to fit between bottles within their crates. Simon gave up his job in June 2009 to move the vision forward and Jane has also focussed full-time on the research, legal aspects, business planning and bid-writing needed, both in a voluntary capacity.

Social Impact

Please describe how your project has been successful and how that success is measured

ColaLife's concept builds on 3 years' stakeholder development, research and design, entirely voluntary to date, valued over £250,000. Supported by the UnLtd grant over the last year we have engaged with some 15,000 people online and at events, with a specific focus on motivating UK youth to consider innovative development ideas; grass-roots work includes supporter groups at schools and universities eg 15 students from University College London travelled to Uganda, reaching 750 people, 16 healthposts, 22 schools and 12 shops (04/11) to test reactions to the ColaLife concept. ColaLife has developed via Open Innovation, via Social Media and at international conferences/events including 4TEDx talks. We raised in excess of £6,000 on a long-distance sponsored cycle to fund 3 trips to Zambia, visiting Mpika district Zambia (01/11) (hospital; Mpepo health centre; 15 mothers/carers at a child nutrition workshop; 2 retailers; District Commissioner) as well as convening design workshops in Lusaka. Over 30 world class experts are donating time and expertise pro-bono: eg Prof Dr Prashant Yadav; Rohit Ramchandani, Dr PH Candidate at Johns Hopkins University USA; researchers at UNICEF HQ New York and staff at UNICEF Zambia; members of Business Action for Africa; UN Foundation staff; corporates and team members from the Johnson & Johnson Innovation Centre Belgium and corporates including Coca-Cola, SABMiller and Honda. Over £350,000 is pledged from corporates towards the first trial with 2 other major funders in line to complete the package. We have so far learnt and published on the blog: alignment with relevant government policies/priorities and corporate attitudes; how the secondary Coca-Cola chain operates, and its potential; expert and local advice to focus on over-the-counter simple medicines; past/current academic work on ORS/zinc, and acceptability/awareness in Zambia specifically; developing world health logistics, barriers and opportunities; mobile phone coverage, use and potential; attitudes of micro-businesses and opinions of communities. As a result, a first operational trial has been co-designed to start in late 2011. Costing an estimated USD 1.354m it will focus on delivering Anti-Diarrhoea Kits (ADKs) for mothers and carers of under-fives in under-served rural areas, using a subsidised retail model. The implementation partners in Zambia are the Coca-Cola bottler, SABMiller (Zambian Breweries), UNICEF Zambia, Medical Stores Ltd, and Keepers Zambia Foundation, under guidance from Zambia's Ministry of Health as well as academics, with project management from ColaLife.

How many people have been impacted by your project?

101-1,000

How many people could be impacted by your project in the next three years?

More than 10,000

Winning entries present a strong plan for how they will achieve growth. Identify your six-month milestone for growing your impact

March 2012: Move to Zambia completed with first trial underway and strategic development partnerships for 3 other countries in initiation phase.

Task 1

Sept/Oct '11 - finalise implementation partnership MoUs (underway) and confirm remaining funds required for first trial (underway)

Task 2

Nov/Dec: Begin trial according to plan (already agreed) with M&E commissioned/managed by UNICEF Zambia and first focus group work and test run to rural district underway.

Task 3

Mar 2012 - Follow-up interest developing in Uganda/Tanzania/S Africa to further the strategic Sub-regional development plan.

Identify your 12-month impact milestone

Sept/Oct 2012 - Phase 1 of Zambia trial complete; 30+ micro-retailers recruited/trained. Phase 2 midpoint evaluation (6 months operations in 2 districts, reaching first 3000 mothers/30+ communities)

Task 1

Implement Phase 1 workplan: (women's focus groups; finalise and test ADK design and packing process; test runs to 1 remote district)

Task 2

Implement Phase 2 workplan: Full operational delivery for 12 months; with full M&E and learning framework in place.

Task 3

Receive and analyse mid-point evaluation from UNICEF Zambia, via Steering Group and with Johns Hopkins University.

How will your project evolve over the next three years?

A final evaluation of the first trial will take place in months 18-20; with learning published via academic journals/on blog and other media. An analysis of metrics will help establish the business case for the Zambian partnership and decide the exit/roll out strategy for Zambia via local partners. Analysis of costing/pricing and value for money parameters - eg reducing costs via localisation of manufacture/procurement and economies of scale - we inform future models and help ascertain the need for and source of future subsidy (eg via voucher models and/or corporate sponsorship and/or cross subsidy of commercial products).
We will also analyse/formulate sustainable models to trial with other emerging partnerships, adapted to local needs (likely to be in Uganda/Tanzania/S Africa).

Sustainability

What barriers might hinder the success of your project and how do you plan to overcome them?

Willingness of mothers/carers in target area to pay for the ADK. The trial is designed to establish this. ORS is well known in Zambia and basic literacy is around 70% but access is an issue, rural incomes are low and ZInc use is a new policy. Focus group work will inform the trial pricing and subsidy model and suitable formats of the educational materials/social marketing work. Our research shows mothers may pay in the region of the price of 2-4 eggs; free vouchers will kick-start the social marketing whilst ensuring a market for micro-retailers. Adding soap to the ADK and making it a desirable, attractive, effective product available locally may affect willingness to pay. The trial will indicate parameters and produce options for future products/models.
Willingness to participate among retailers in target area: We assume retailers selling Coca-Cola will have an interest in making additional profit from selling 5 large/10 small ADKs per crate they procure, given that there is no additional transport cost/significant weight increase per crate. Micro-finance may be needed (a learning point), but retailers will likely be willing to pay the wholesale price for ADKs, given an assured market through Social Marketing and vouchers. Focus group work will establish pricing of ADKs all along the value chain and future cost reduction work will seek a sustainable business model suitable for Bottom of Pyramid markets.
Mobile phone coverage/ownership/SMS literacy in target areas: Important for voucher redemption among retailers and for sampling to indicate any tamper issues/authentication. AudienceScape research (2010) indicates this will not be a limiting factor in Zambia. (Only a small number of mothers/carers need to have phones/SMS literacy at this stage for a small sample of responses).
Procurement and legalities: underway with support of Min of Health Zambia; issues largely resolved/avoided.
Robustness of trial design and M&E: underway with support of UNICEF and academic expertise; issues largely resolved/avoided.
Does the secondary Coca-Cola distribution chain give sufficient capacity? The trial is designed to find this out.

Tell us about your partnerships

Selected implementation partners for Zambia are those who contributed and offered their experience, expertise and resource to the co-design and the trial:
Min of Health – oversight, links to District and Provincial Medical Officers, data provision, advice, chair of steering group, options appraisal and approval of exit/roll out strategy
UNICEF Zambia – M&E, technical advice, support for learning analysis, supported by:
Rohit Ramchandani (RR) doctor PH candiate at Johns Hopkins University: Trial design; Public Health Advisor/mentor supported by his tutors/professors
Keepers Zambia Foundation – Community engagement, social marketing, WASH advice; supported by RR and members of the steering group (eg PSI)
Medical Stores Limited (fully owned Zambian gov company) – procurement, packing, distribution to district level (MSL is the major medical distributor, with experience in supporting subsidy-driven private sector distribution trials; willing to support learning)
SAB Miller – liaison with Wholesalers, advice, technical support on Value Chain, retailer training and marketing, support for learning analysis. (The only Coca-Cola bottler in Zambia; interest from their other countries is emerging).
Sub-contractors include:
Mobile Transactions (Zambia) – SMS tracking of ADKs, authentification, tamper protection; health messaging (requisite experience with e-vouchers and SMS, with eg NORAD);
PI Global (packaging design experts who have undertaken early work pro-bono).
Funding support so far comes from SABMiller; Johnson & Johnson Corporate Citizenship Trust/Janssen and Honda's Dream Factory initiative.
Academic support from Prof Prashant Yadav (global expert in health logistics); observation/learning support from various government development agencies is developing (eg NORAD, SIDA, DFID).
In addition there is interest from other potential partnerships in other countries.

Explain your selections

Friends, family, individuals and UnLtd have supported the concept design phase with donations, expertise, time, contacts and accommodation in Zambia. J & J Innovation Centre has given 6 month's business innovation training with transport/accommodation costs and SABMiller has given advice, permissions and funded some international travel. Honda has helped with events/publicity and PR. (Total value in excess of £250,000). For the trial, J&J Corporate Citizenship Trust has pledged $250,00 over 2 years subject to final contract and satisfactory progress; SABMiller Zambia has agreed $50,000 in kind expertise; Coca-Cola has given permission/expertise/insights and is currently considering a support package; Honda may donate a project vehicle. 3 local NGOs in Zambia including UNICEF Zambia have given significant expertise to design the trial. Zambian Min of Health has given expertise insights; international foundations/governments are considering the final funding package. We have been advised by several government development departments and expect financial support from at least one international government funder; negotiations are in hand.

How do you plan to strengthen your project in the next three years?

The objective of the trial is to test and demonstrate the concept rigorously and establish learning and a range of models that are viable for adaptation/ adoption by a range of partners, who are interested in creating shared value. Future adaptations/uptake will be decided/designed by those with the long-term responsibility for public health and/or private sector healthcare development in interested countries. Future corporate partnerships and cross-sector partnerships (public/private partnerships) will be able to take forward other trials and/or roll out/scale up variations of the 'piggy-back' model based on local needs and a win/win business case. ColaLife's role will be to act as the 'trusted intermediary', a role often needed in the innovation space, to bring partnerships together.

Challenges

Which barriers to health and well-being does your innovation address?
Please select up to three in order of relevancy to your project.

PRIMARY

Lack of physical access to care/lack of facilities

SECONDARY

Lack of access to targeted health information and education

TERTIARY

Health behavior change

Please describe how your innovation specifically tackles the barriers listed above.

Remote rural areas in Africa often lack sufficient local provision for simple medicines. In Zambia a health post may serve a 30km radius, with walking the only transport option. Distances, cost and logistics problems mean stock-outs are frequent. Yet commercial fast-moving goods supply chains work well. But in Zambia there are only 70 retail pharmacies and no accredited drug store network (yet). So piggybacking EM distribution to local kiosks using market forces, with para-skilling of retailers and subsidised prices has real potential. Awareness and educational materials will be part of the ADK pack, supported by community-based marketing and events. Eventually, better hand-washing, better point of use water techniques and earlier treatment of diarrhoea will improve child mortality rates.

How are you growing the impact of your organization or initiative?
Please select up to three potential pathways in order of relevancy to you.

PRIMARY

Repurposed your model for other sectors/development needs

SECONDARY

TERTIARY

Grown geographic reach: Multi-country

Please describe which of your growth activities are current or planned for the immediate future.

An agreed trial plan to piggyback on the Coca-Cola distribution chain is in place with in principle agreement of all partners/observers; J&J is actively interested in learning, partnership development and future adaptations. The trial, if effective, will roll out in Zambia. As Coca-Cola has effective distribution chains within most developing countries, and many of its bottlers are interested in enhanced CSR and community impacts, potential for scale-up/roll out is enormous.

Do you collaborate with any of the following: (Check all that apply)

Government, Technology providers, NGOs/Nonprofits, For profit companies, Academia/universities.

If yes, how have these collaborations helped your innovation to succeed?

Pro-bono advisers include academics from MIT/Zaragoza, Johns Hopkins, Univs of Southampton, Dublin, London, the Swiss Water Technology Institute (EAWAG), who have provided advice, guidance, contacts, academic papers/research and rigour to the trial design. We've had free advice from Mobile Transactions Zambia, Nokia and iConnect Zambia and free support from web-hosting services. Co-design and advice in Zambia has included UNICEF Zambia; Keepers Zambia Foundation, TransAid, STEPS OVC and RAPIDS projects (under auspices of World Vision); Churches Health Assoc Zambia; Society for Family Health (part of PSI). We've been interviewed by DFID, USAID, SIDA, NORAD, UN Foundation and UNICEF HQ and spoken at related events, featured in over 600 blog posts, and in several books/publications.