



AROGYA PARIVAR

BA 445 Section 002

Presented By Group 3



NOVARTIS



AROGYA PARIVAR

AGENDA

- 1 Company Overview
- 2 Local Context
- 3 Framework Takeaways
- 4 Recommendations
- 5 Questions

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AROGYA PARIVAR

"Healthy Family"



WHERE

Rural India

- Focus on rural families earning \$2-\$5 per day with \$2 max spend on health treatments



WHY

Improving healthcare and health education opportunities



WHAT

Social business model for a larger pharmaceutical company

BUSINESS MODEL

KEY



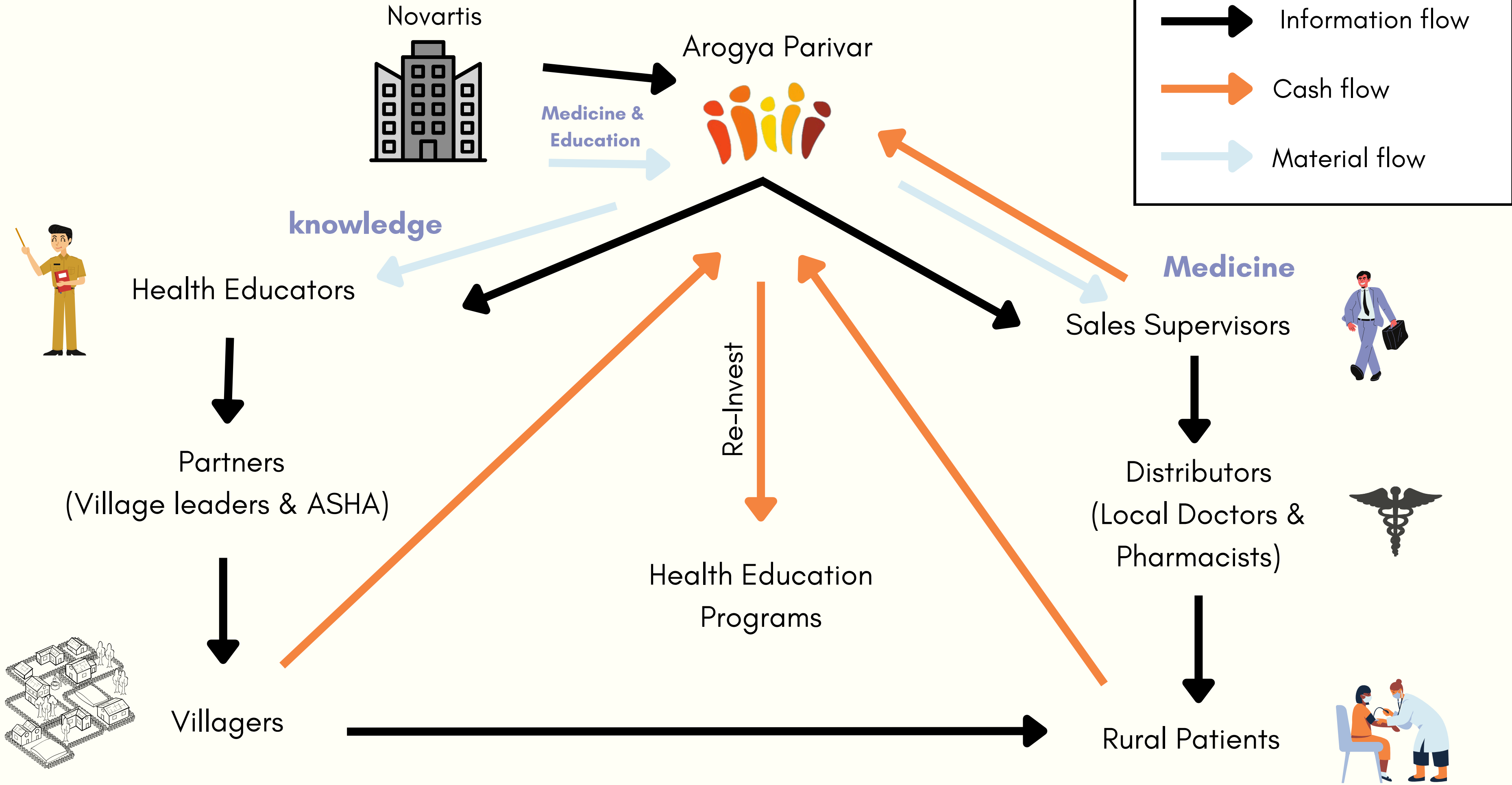
Information flow



Cash flow



Material flow



CURRENT IMPACT

22,000

villages in 15 states



44,000

doctors covered to serve the nation



50M+

rural Indians impacted



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LOCAL CONTEXT- RURAL INDIA



80% of patients paid for medicines and treatments **out-of-pocket** (2013)

69% of India's population lives in **smaller cities/towns**

65% of Indians **lacked access** to essential medicines

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KEY TAKEAWAYS

(BMI FRAMEWORK)

Strengths

- They solved the business problem (profitable distribution to rural markets)
- Good patient capital since they had a willingness to wait 31 months for breakeven which shows their risk tolerance
- Adaptive learning- they quickly pivoted when FMCG agency didn't work; switched to pharmaceutical CSO

Weakness

- Never fully validated they solved the social problem (poverty alleviation through health improvement).
- Referral card return rate less than 10% couldn't reliably track doctor visits or prescriptions filled



Takeaways

- Organizational instability is the single biggest threat to scaling Arogya globally. You cannot build a sustainable business when you're constantly fighting for your right to exist.
- Resource constraints with limited capital for rural distributors (needed several thousands dollars monthly sales to be viable)
- Packaging reconfigurations too costly for limited demand

KEY TAKEAWAYS

ACCESSING BUSINESS MODELS

The Right Balance of Bricolage and De Novo

- Effectively combined Novartis' existing pharma infrastructure (distributors, pharmacies, marketing expertise) with new rural-specific solutions (small medicine packs, health educators, and community partnerships)

Structures and Incentives that Synchronize Scaling of Sub-components

- Arogya's impact mission clashed with Novartis' sales-driven incentives
- Different divisions had mismatched structures and reporting systems
- Early coordination problems and misreporting slowed expansion

Understanding the Need for Demand Creation vs. Demand Fulfillment

- Incomplete follow-through from learning → actual medication use

Net Positive Returns For All Stakeholders

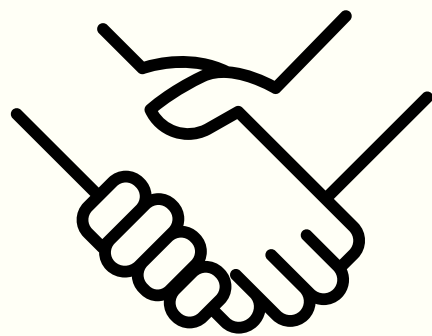
- Improved access to medicine and health knowledge for villagers
- Increased business for local doctors and pharmacies
- Employment and skill development for health educators
- Better public health outcomes for NGOs/government

Addressing the Balance between Business and Social Goals

- Profit-oriented divisions and impact-oriented teams often clashed
- Who is going to be the customer?
- Difficulty obtaining reliable metrics made long-term sustainability harder

Enabling Learning and Continual Improvement

- Adding audits and tracking tools
- Validating data with multiple sources
- Adjusting field structure after finding inefficiencies
- Shifting to more effective educational formats



KEY TAKEAWAYS

(CIE FRAMEWORK)

Strengths

- Involved as much of the communities they can serve through community trust and knowledge transfer – job creation, health camps, health awareness campaigns
- Microfinancing to enable local doctors and pharamists to purchase needed health products

Weakness

- Community trust can be broken if Arogya Parivar is not transparent in any part of its operations
- Current microfinancing streams might not be available in the future to continue enabling local doctors and pharmacists



Takeaways

- Strong partnerships with village leaders, health educators, and NGOs to understand barriers to healthcare access and run frequent health camps
- Microfinancing for local doctors and pharmacists to purchase medication that treats local problems



KEY TAKEAWAYS

(IMPACT ASSESSMENT FRAMEWORK)

Strengths

- This system strengthens economic well-being by preventing people from spending money on unnecessary treatments.
- Having sales supervisors helps ensure that medicines reach the intended people rather than being delivered elsewhere.

Weakness

- Local doctors and pharmacists cannot always volunteer or spend time to visit rural areas.
- Health educators primarily engage with village leaders or ashas, so they may have limited direct interaction with the broader community members.
- It is challenging for people to receive treatment when the price of medicine rises due to inflation.



Takeaways

- Effective that they've hired health educators and sales supervisors to ensure medicines are used properly and kept affordable.
- There is still a need for more long-term medical officials in the villages.
- Need programs that connect villagers directly with supervisors (not only through local ASHAs)

KEY TAKEAWAYS

(PARTNERSHIP ECOSYSTEM FRAMEWORK)

Strengths

- Health education workshops
- Partnership with village leaders, female community health proponents, and Asha (Accredited Social Health Activist)
- Last mile distribution through doctors and pharmacies

Weakness

- Limited involvement with NGOs
- Only collaboration with government through Ashas
- No microfinancing option for consumers
- Limited data collection conducted of common illnesses and needs of villages supported
- Dependence on pro-bono work from physicians to produce sales of Novartis pharmaceuticals



Takeaways

- Effective partnerships and transparency in the villages and with stakeholders
- Understand the next steps to widen outreach - could be produced through partnerships with NGOs with similar goals
- Introduce microfinancing loan to open healthcare access to BoP population making less than \$2/day

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RECOMMENDATION #1

Scholarship Program For Local Students

WHAT

Create a **scholarship program** for local students to become **licensed nurses or pharmacists**, with a required 3 year service commitment in their village after graduation.

WHY

- Local doctors and pharmacists cannot always volunteer to visit rural areas and provide treatment.
- About **38%** of people living in rural India are **illiterate**, making it difficult for rural villagers to access quality education.

HOW

- Select **2+ secondary school students** per village with interest in healthcare.
- Provide **Novartis funded scholarships** for medical-related higher education:



Nursing: 3–4 years
Pharmacy: 2–4 years

- After licensing, students **return to serve as village medical officers** for at least 3 years.
- Allow students to rotate across nearby rural villages to expand access to care.

RECOMMENDATION #1

Cost Benefit Analysis & Risk Assessment & Mitigation Strategy

Cost Benefit Analysis

Cost Analysis Estimate for 4year Nursing Scholarship

Per student	Admission	Semester	Year 1	Year 2	Year 3	Year 4
College Fee	\$240	\$1070	\$2140	\$2180	\$2220	\$2260
Dorm			\$650	\$670	\$690	\$710
Food			\$360	\$390	\$410	\$430
Living			\$300	\$320	\$340	\$360

- Considering inflation, the maximum tuition per student is estimated at \$9,040. (actual costs are going to be significantly lower since this estimate is based on top private nursing institutions.)
- Students choosing 2 or 3 year programs can help reduce scholarship costs.

Risks:

- College tuition and admission fees are expected to rise each year due to inflation.
- Some may take longer to graduate, and it is unclear how many young people in rural areas will desire to apply for medical programs.

Mitigants:

- The cost analysis is based on private university tuition. So actual costs are unlikely to exceed this amount.
- Partner with government and public institutions to reduce costs.
- Fund students from basic to higher education to ensure enough applicants for medical programs.

RECOMMENDATION #2

Monthly Health Seminars

WHAT

Health educators should host monthly seminars to **train villagers on proper medicine use**. These sessions should be **recorded and uploaded** so villagers can revisit the information.

WHY

- There needs to be **stronger communication** and direct interaction between the villagers and the supervisors.
- To fully build **community trust** in the enterprise and **sustain education** on receiving proper treatment.

HOW

- Health educators/sales supervisors visit rural villages **once a month** to host seminars.
- Before ending each seminar, **villagers vote** on which illnesses they want guidance on for the next session to **encourage participation and community involvement**.
- Low rural literacy rates can be mitigated with seminar recordings on platforms like YouTube.
- This allows villagers to revisit the information easily, share it with other villagers, and **avoid repeated explanations**.

RECOMMENDATION #2

Risks:

- Challenges in accessing resources after each monthly health seminar
- Attendance rates can vary in the community if less people are aware of the seminars or don't see its usefulness
- Recording seminars require reliable film and streaming equipment

Mitigants:

- Make seminar recordings accessible in an organized playlist with closed captions on YouTube
- Pair voting with WoM and village announcements to boost turnout
- Provide simple, low-cost recording set-ups and clear upload procedures

Cost Benefit Analysis & Risk Assessment & Mitigation Strategy

Cost Benefit Analysis

- Camera



OBSBOT Tiny 2 Lite 4K Webcam for PC, AI Tracking PTZ Streaming Camera with 1/2" Sensor, Gesture Control, 60 FPS, HDR, Microphones, Web Camera for Desktop Computer, Laptop, Meeting, Video Calls, etc.

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1 sustainability feature

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- YouTube (Free)

RECOMMENDATION #3

Discreet Health Meetings

WHAT

Small, **private health education sessions** are held either early in the morning or late at night, when women and girls can gather discreetly without being observed by the broader community. **Voluntary and flexible meeting times** chosen by the women themselves to ensure the sessions fit around home responsibilities and minimize unwanted attention.

WHY

- **Increases attendance and engagement among women** who avoid daytime public meetings because of gender norms, household surveillance, or intimidation by mixed-gender crowds
- Builds personal relationships overall increasing trust
- **Reduces stigma, shame, and fear of judgment**, especially for conditions like UTIs, reproductive infections, or menstrual issues, problems where girls avoided doctors due to fear of being accused of pregnancy.

HOW

- **Partner with recognized female leaders and women's NGOs** to find times where women feel most comfortable attending
- Assign a female health educator to present the storytelling module that has specific information regarding **women's health**
- Create a **discreet reminder method** to ensure women are aware of meetings happening and have access to schedule follow-ups with doctors

RECOMMENDATION #3

Risks:

- Women's attendance may be discouraged by internalized cultural norms
- Difficulty in maintaining discreet communication channels
- Limited number of female health educators
- Safety and mobility concerns

Mitigants:

- Use respected women's NGOs and local female leaders to legitimize the meetings
- Quiet, relationship-based invitations instead of public announcements. Hold meetings in unsuspecting locations like store storage
- Create a rotating schedule for the current female health educators
- Convince the village chiefs to support the meetings so they can convince men not to suspect
- Pay store owners a small fee to maintain confidentiality

Cost Benefit Analysis & Risk Assessment & Mitigation Strategy

Cost-Benefit Analysis

Cost of health educators = 1.9 Lakh (\$2,000)/year

Confidentiality fee = 886 rupees for store owner



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QUESTIONS

APPENDIX



BMI FRAMEWORK

Resources

- Initially hired a rural marketing agency with FMCG, experience, which they struggled with health information
- switched to a contract service organization (CSO) with pharmaceutical experience
- worked with 54000 local doctors, ,pharmacists, distributors
- initial funding arranged by Batra through the informal steering committee
- started as cost allocation between OTC and Sandoz divisions (proportional to sell) which ended up in a 6-8 month pilots before scale up decisions

Metrics

- tracked both commercial (sales) and social (education, health camps) metrics
- 31-month breakeven was acceptable; didn't force premature profitability
- Sales credited to both Arogya and divisional P&Ls reduced internal resistance
- continued funding despite only 1 of 12 cells being profitable initially allowed model refinement

Problem-Solving

- Understanding the root issues
- Health Education Meetings to teach hygiene and disease prevention
- Adjusting their product to be more accessible to the people
- Breaking the barrier of mistrust with health camps with trusted local professionals

Structure

- the structure allowed replication to Kenya, Vietnam,
- Using their '3 A'S' framework: Affordability, Access, and Awareness
- Cell-based model for education
- Two complementary functions; Social arm and commercial arm
- Hub-and-spoke structure for further reach

ASSESSING BUSINESS MODELS FRAMEWORK

the right balance of bricolage
and de novo

structures and incentives that
synchronize scaling of sub-
components

understanding the need for
demand creation vs. demand
fulfillment

net positive returns for all
stakeholders

addressing the balance
between business and social
goals

enabling learning and
continual improvement

COCREATE-INNOVATE-EMBED FRAMEWORK

Co-Create

- + Partner with village leaders, health educators and NGOS to understand barriers to healthcare access and run frequent health camps
- +/- Deep community trust is critical for informal markets (localizing events)
- + Job creation and built skills and capacity among hundreds of business partners, suppliers and customers

Innovate

- + Health awareness campaigns through local storytelling and visual aids
- + Smaller, lower cost drug packages suited to rural income patterns
- + Developed 11 new products to treat local problems

Embed

- +/- Has republished the same “healthy family” and “shared value” model in different countries
- +/- Microfinancing to enable local doctors/pharmacists to purchase product

IMPACT ASSESSMENT FRAMEWORK

Distributor

Seller

Influencer

Buyer

Community

Economic Well-Being

+ Provide the correct treatment, which is usually carried out with a service oriented mindset.

+Know how many medicines are needed for the distribution.
+ Check whether the medicines are being distributed at the proper price.

+Prevent people from spending extra money on the wrong treatment.

+ Can purchase good quality medicines at low price
For some very low income individuals, this might still be expensive.

+ More economically active workers can remain healthy
-can't receive treatment when the price of medicine increases

Capability Well-Being

+Provide proper treatment based on their medical knowledge
-Low number of Doctors who can visit village

+Track the process to minimize the loss of medicines that spread to the wrong area.
+Practice communication and sales skills

+ Generate awareness of diseases
+Increase recognition of proper treatment.

+ Understand the timing and the proper ways of receiving treatment.

+Can become aware of how to maintain good health.
+they can respond to their own health conditions.

Relationship Well-Being

+Have the highest trust since they are the real trained expert
-Can only visit a few times since they have their own patients.

+Bridge to establish a solid distribution network for medicines.
+Active connections with doctors and pharmacists.

+Build trust with village leaders and local Asha
-Might lack the direct connection with every community members

+Allows for strong connection between doctor and patient, establishing relationships for future medical visits

+ Creates a more positive community atmosphere due to a lower death rate
-Should prevent the monopoly of medicine by the village leaders.

PARTNERSHIP ECOSYSTEM FRAMEWORK

	Enterprise Development	Market Creation
Action Enabling	Market Intelligence • Study of fast moving consumer goods (FMCG) • Not fully comparable to medicine Market Access • Sales supervisors build relationships with locals Value creation (Assess poverty impacts) • Focus on specific community in BoP who make \$2-5 per day, can spend \$2 on medicine at a time	Demand creation • Health education meetings • Examples like UTI encourage women to be safe and educate men about complexities of women's health Supply Enhancement • Organize pro-bono clinics with local doctors • Doctors benefit as business can expand from new patients
Capacity Building	Financial Capital • Profitable venture • Business sustains itself Human Capital • Trained Health Educators and Sales Supervisors Knowledge Capital • Referral cards and easy to understand medical info for illiterate consumers • Limited data collection Social Capital • Social business for Novartis, publicity and exposure of commitment to common good	Value Chain Infrastructure • Accessible last mile distribution Legal Infrastructure • Medicine sales through pharmacies • Minimal government support Institutional Infrastructure • No involvement with NGOs/ organizations with same mission

RECOMMENDATION #4

Digital Health Program

WHAT

Build a digital ecosystem that **connects** health educators, doctors, patients, pharmacists, and distributors **through mobile technology**, from a field-force-driven model to a digitally-enabled healthcare network.

WHY

- Solves the Measurement Crisis: The current 10% referral card return rate makes impact assessment nearly impossible. Digital tracking provides comprehensive, real-time data on patient journeys from education → consultation → treatment → compliance
- Addresses Operational Inefficiencies: Sales supervisors spending 12 of 22 days collecting paper records represents a massive inefficiency. Digitization could free 50%+ of SS time for actual sales and relationship-building activities
- Enables Precision at Scale: The case shows Arogya reached 70M

HOW

- GPS-enabled check-in/check-out for village visits (addresses fraud issues discovered in 2011)
- Digital presentation materials with multimedia content (videos, animations for illiterate audiences)
- Real-time capture of attendance data (replacing manual referral cards)
- Automated scheduling and route optimization
- Digital prescription system linked to Arogya product catalogue
- Continuing medical education modules on rural health issues
- Health camp scheduling and patient pre-registration system