**mHealth Working Group Meeting**

**Tuesday, September 27th, 9:30 am – 11:30 am (Eastern US)**

**Held at USAID, Washington DC**

**AGENDA**   
Panel presentation on Mobile Alliance for Maternal Action (MAMA)

1. Sandhya Rao, Senior Advisor for Private Sector Partnerships, USAID Office of Health, Infectious Diseases and Nutrition
2. Cat Meurn, Program Associate, the Maternal and Newborn mHealth Initiative, the mHealth Alliance
3. Pamela Riley, Senior mHealth Advisor of SHOPS Project (Strengthening Health Outcomes through the Private Sector), Abt Associates

Health Unbound (HUB)

1. Soma Ghoshal, HUB Community Manager, the mHealth Alliance

Review of the National mHealth Strategy Workshop in Tanzania

1. Nate Clarke, mHealth Initiative,  Deloitte Consulting

The materials that accompany these notes, as well as those from previous mHealth Working Group meetings, are available on the mHealth Toolkit at: <http://www.k4health.org/toolkits/mhealth/mhealth-working-group-0>.

Slides from the MAMA presentations will be posted at a later date.

**The next monthly meeting of the mHealth Working Group will be hosted the morning of October 20th by Jhpiego at their Washington DC office at 1776 Massachusetts Avenue, NW, Suite 300.** Further details will be announced. If your organization is interested in hosting a future meeting of the mHealth Working Group, or for comments, please contact Kelly Keisling ([Keisling.kelly@gmail.com](mailto:Keisling.kelly@gmail.com)) or Laura Raney ([lraney@fhi.org](mailto:lraney@fhi.org)), co-chairs of the mHealth Working Group.

**Panel presentation on Mobile Alliance for Maternal Action (MAMA)**

**1. MAMA Overview by Sandhya Rao, USAID**

The Mobile Alliance for Maternal Action (MAMA) was launched on May 3, 2011 by USAID, Johnson & Johnson, BabyCenter, the mHealth Alliance, and the UN Foundation. MAMA uses mobile technology to provide health information to expectant and new mothers, promoting healthy behaviors to ensure safe pregnancies and healthy babies. In particular, the project focuses on low-income mothers and household decision-makers with access to mobile phones.

As a major provider of online health information for mothers, BabyCenter is developing generic content that can be localized to individual countries.

MAMA’s approach emphasizes the opportunity for scalability, sustainability, and evaluation. To achieve scale, MAMA plans to develop programs that reach hundreds of thousands of mothers per country. Financial sustainability is sought by developing innovative business models with multiple revenue streams from advertisers and user fees. This is balanced to ensure affordable or free service cost for the end user. MAMA will be independently evaluated to determine whether it is effective and cost-effective at promoting healthy behaviors. The monitoring and evaluation plan will enable cross-country comparisons.

Evaluated results will contribute to the replication of MAMA in target countries. MAMA is in different stages of development in Bangladesh, South Africa, and India. Bangladesh is currently hosting a MAMA pilot through a coalition of partners. In South Africa, a coalition of partners is being developed. India will conduct a landscape analysis in early 2012. These countries have high maternal/infant mortality and morbidity, with prevention of mother to child transmission also prioritized in South Africa. The project accordingly fits with aspects of the US Global Health Initiative and the UN Secretary-General’s Global Strategy on Women’s and Children’s Health. Other criteria for country selection include mobile penetration, interest from public and private partners, a local mobile health ecosystem, and potential for linkages to other services.

Program delivery is complemented by capacity building efforts to provide tools, expertise linkages and knowledge exchange. The Health Unbound (HUB) website makes the mHealth Alliance well positioned for knowledge exchange on mHealth.

**2. MAMA: Global Capacity Building by Cat Meurn, the mHealth Alliance**

The mHealth Alliance mobilizes innovation to deliver quality health at the furthest reaches of wireless networks and mobile devices. Through its Maternal-newborn mHealth Initiative (MMI), it supports enabling environments and provides thought leadership and best practices for mobile technologies to improve access for maternal healthcare.

MAMA will build capacity with partnered organizations by using expertise from MAMA partners. Through its MMI project, the mHealth Alliance’s role in MAMA will be to build global capacity and provide a coordinated exchange of information, best practices and lessons learned from MAMA and other mHealth MNCH programs. It will also develop a collection of tools to build the field beyond the MAMA partners.

These are initial areas of capacity building that the mHealth Alliance is currently defining. The mHealth Alliance is contracting an external consultant to provide a needs assessment of MAMA partners to develop a capacity building strategy. The Alliance will perform a landscape analysis to further define its capacity building effort and to engage with the HUB online community. The mHealth Alliance is also a sponsor of the mHealth Summit, and will use Hub spaces to engage users leading up to the Summit.

**3. MAMA Country Update on Bangladesh by Pam Riley, Abt Associates**

MAMA was launched as part of the US Global Health Initiative and builds upon a history of maternal and child health and family planning programs by USAID and the Government of Bangladesh (GOB). It is in line with the GOB’s Digital Bangladesh Initiative, as well as Millennium Development Goals 4 and 5. These support MAMA’s goal to reach 500,000 women within three years with health information via mobile phone, leading to sustained improvements in health knowledge, behaviors and outcomes.

Coalition Formation and Service Design

In the first phase of development, MAMA assessed the mHealth environment and stakeholder interest. Key accomplishments included coalition formation, content development and approval, regulatory approvals, and outreach training. The service design provides for two stage-based messages per week to be sent during a woman’s pregnancy and the first year of a baby’s life. Enrollment will be facilitated by health outreach partners with extensive networks of community health workers serving women of reproductive age.

Formative researchwith usersapplied ethnographic techniques with women and family members. A needs assessment of 168 participants, 55% below poverty level, found their access to healthcare providers depended on family support. 80% of participants had phone availability, but only 40% had direct access to phones. Trust agents are thus considered critical to access mobile phone information. Testing of message format with 30 users found preference for a drama format, female voice, and non-medical vocabulary. Branding was tested with 114 users, identifying values of information reliability, trusted source, privacy /discretion, and aspirational and pioneering tone. An audience communications audit was also performed to inform media promotion strategy.

Aponjon Pilot

MAMA is currently in its second phase, addressing formative research on user experience, mobile operator agreements, and corporate sponsorships. A six-month pilot of its “Aponjon” service was begun in September of 2011. The pilot conducts formative research on the acceptability of service format and content specific to user needs. This includes coverage, duration of delivery, length of messages, language, message animation, comprehension, style, comprehensiveness, usefulness, completeness, convenience, and ease of use. Users’ dropout rate and ease of opt out will also be tested, as well as the technical reliability of the platform. The pilot will explore the role of family and peer gatekeepers for the engagement strategy. It will also determine the feasibility of using community health workers as key partners in service promotion and registration. To determine the affordability and sustainability of service, there will be an examination of the pricing and subsidy policies, billing modalities, and business model inputs. This will help determine what level of service fee is either a barrier to use or a necessary revenue source for long-term financial sustainability.

Registered pilot participants include 1,000 expectant women and new mothers and 1,000 gatekeepers from 13 districts of various income levels. In response to formative research, messages are spoken by a doctor as trusted source. Message design also uses edutainment to combine health information with drama. To reach illiterate users, messages are delivered through mobile phones by interactive voice response, as explained further below. Evidence-based health content was co-developed with maternal and child health experts in Bangladesh and approved by a Health Advisory Board led by the MOH of Bangladesh.

National Scale Up and Evaluation

The third phase will be a national rollout of the Aponjon service in Bangladesh in 2012. This will include marketing and national promotion, monitoring of key metrics, adaptation of content and format, and corresponding evolution of the MAMA service. The program is planned to be available through all six licensed mobile operators.Impact evaluation will be conducted by an external research institution, the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B).

Partnership Coalition

MAMA has attracted over 25 partners into the country coalition. These partnerships reflect an emphasis on program development that is locally-designed, implemented, owned, co-funded, and championed. Stewardship is provided by the Ministry of Health and Prime Minister’s Access to Information Task Force of Bangladesh. The coalition coordinator is D.Net, a local not-for-profit with over ten years of experience in ICT for development. Its capacity and history has been a crucial factor in MAMA’s progress in Bangladesh. Other key resource and implementing partners include BRAC, Smiling Sun, Save the Children, Multimedia Content & Communications, SSD-Tech , InSTEDD, Beximco and Grameenphone.

Interactive Voice Response (IVR) Platform

Formative research indicates that texting was not appropriate for MAMA’s target populations, the rural and urban poor. Health messages are thus provided in an audio format to ensure equitable access for low literacy populations in Bangladesh. Live call centers are a popular local option in Bangladesh, but automated IVR is less costly and more scalable. IVR also allows more informational and dramatic content in Bangla language than text messages. MAMA’s Aponjon service thus uses a IVR platform to deliver health messages.

Challenges with IVR platforms include usability issues such as ease of navigation and cultural preferences. To ensure Aponjon is widely available, the service will be offered by all six mobile operators in Bangladesh, but each has unique requirements which increase system costs. Mobile Network Operators resist implementation of centralized platform, preferring charging gateways at each network. “Calling party pays” billing poses problems for a “push” messaging model. It may also be difficult for network operators to deliver services at variable charges for free or fee-based use, requiring options such as manual “top ups” to subsidize eligible users.

Technical Challenges

Local mobile operators also require commercial grade IVR solutions, and there is no low-cost IVR platform option with sufficient reliability and capacity for a national scale service. Since this is a global challenge, InSTEDD has been contracted to design a strategy for transitioning from high cost proprietary solutions to more portable, replicable approaches that leverage the expertise of developers form around the world through open source communities. Elements of the strategy will include steps for bridging low cost voice application programming interface (API) layers with the underlying call handling systems. **MAMA is seeking partners to co-fund development of an open source IVR platform that can be replicated globally.**

MAMA Bangladesh Business Model

To address financial sustainability, MAMA will pilot cost-recovery methods and promote private sector engagement. MAMA is piloting message sponsorship and user fees. User fees are consistent with other value added services such as health hotlines. User fees are also necessary for revenue-sharing agreements with mobile operators that offer tremendous capacity for marketing support. To offset subscription costs, subsidies will be are provided for lowest-income subscribers.

MAMA has conducted active outreach to corporate sponsors, with a range of options for support including co-branded, point-of-sale promotions, and in-kind contributions such as media channels. Companies also suggest creative solutions, such as making the service available to employees and suppliers. Sponsor recognition is tied to the value of contributions. While sector exclusivity is highly valued by sponsors, it is difficult in practice due to the diversified business lines of conglomerates. Services can also be combined with complementary programs serving women, such using micro-entrepreneurs as a sales force of a bundled service.

*(For further information on formative research, see the* [*January 2011*](http://www.k4health.org/toolkits/mhealth/january-19-2011) *meeting notes of the mHealth Working Group. For further information on partnerships with ICT organizations, see the* [*December 2010*](http://www.k4health.org/toolkits/mhealth/december-13-2010) *meeting notes.)*

**4. Health Unbound (HUB) – Soma Ghoshal, the mHealth Alliance**

The Health Unbound (HUB) website was re-launched by the mHealth Alliance in mid-August as an interactive network and online knowledge resource center for mHealth. The updated website features new sections and new features. Users can become members and add blog posts. A database of programs, technologies and policies can also be searched by topic or country. This database should help reduce duplication in mHealth. Group and discussion pages are also dedicated to key topics of maternal-newborn mHealth and non-communicable diseases. Both public and private group pages are available for sharing information. Content is monitored by mHealth Alliance staff and organizations can check the accuracy of information about their covered projects. For further information on HUB, see <http://www.healthunbound.org>.

**5. National mHealth Strategy Workshop in Tanzania by Nate Clarke, Deloitte Consulting**

The Tanzanian Ministry of Health and Social Work (MOHSW) and Deloitte Consulting convened a national mHealth strategy workshop in August. The two-day strategy workshop was held with local stakeholders from health providers, funders, mobile network operators, application developers, eHealth, technology and innovation promotion, academia and research. The workshop was based on local stakeholder calls for a national strategy, local stakeholder interviews, MOHSW guidance, and Deloitte’s experience in designing national strategies. The effort was supported with global lessons learned from literature and expert interviews. A participatory process and graphic facilitation were employed to elicit input on stakeholders’ vision, concerns and priorities. Stakeholders voted on key issues in roadmaps for short-term action and a framework for continued development of a national mHealth strategy. The MOHSW will make decisions about integrating the mHealth strategy with eHealth strategy. Deloitte also discussed the option of an open source platform to support interoperability between mHealth programs. A meeting participant mentioned that NetHope is also working on a similar effort. Another participant asked whether the local ministry of health had preferred a prepackaged mHealth strategy. Deloitte responded that the MOHSW had supported a collaborative approach to strategy development.

*(For further information on collaborative approaches at the country and organizational levels, see the* [*July 2011*](http://www.k4health.org/toolkits/mhealth/july-20-2011) *meeting notes of the mHealth Working Group.)*

**About the mHealth Working Group**

The mHealth Working Group is a collaborative forum for sharing knowledge and developing promising practices on mobile technology for health. Founded in 2009 with global health organizations, the Working Group frames mHealth within global health strategies and standards. We promote approaches that are appropriate, evidence-based, interoperable, scalable and sustainable in resource-poor settings. The Working Group holds regular meetings in Washington, DC to discuss promising approaches, challenges and lessons learned. Meetings are hosted by member organizations, recently including USAID, JSI, the World Bank, FHI, PSI, and MSH. Meeting notes are available on the mHealth Toolkit at <http://www.k4health.org/toolkits/mhealth/mhealth-working-group-0>. The mHealth Working Group is facilitated and supported by USAID’s K4Health Project. Over 500 representatives of more than 150 organizations in over 20 countries participate in the mHealth Working Group. You are welcome to receive future announcements by joining the mHealth listserv at <http://my.ibpinitiative.org/mhealth>.

**Participant List September 27th, 2011**

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| --- | --- | --- |
|  | **Name** | **Organization** |
| 1 | Pam Riley | Abt Associates |
| 2 | Egbe Osifo-Dawodu | Anadach Group |
| 3 | Farya Karim | Chemonics |
| 4 | Joel Selanikio | Datadyne |
| 5 | Jon Tigges | Deloitte |
| 6 | Nathaniel Clarke | Deloitte |
| 7 | Olga Robinson | Deloitte |
| 8 | Marc Mitchell | D-Tree |
| 9 | Christopher Lindahl | EngenderHealth |
| 10 | David Wolfe | FHI360 |
| 11 | Trinity Zan | FHI360 |
| 12 | Lawrence Wasserman | Forsight 2000 |
| 13 | Christy Gillmore | GBI |
| 14 | Laurie Moy | GBI |
| 15 | Andrew Wyborn | Greenmash |
| 16 | Bart Stidham | GSMA |
| 17 | Matthew Dettman | ICF Macro |
| 18 | Hilde Eugelink | IICD |
| 19 | James BonTempo | Jhpiego |
| 20 | Larry Lee | JHU |
| 21 | Heidi Good Boncana | JHUCCP |
| 22 | Kirsten Bose | JHUCCP |
| 23 | Angela Nash Mercado | JHUCCP K4Health |
| 24 | Elsie Mwaniki | JHUCCP K4Health |
| 25 | Piers Bocock | JHUCCP K4Health |
| 26 | Sarah Hiller | JSI |
| 27 | Ashley Barash | JSI |
| 28 | Marasi Mwenchwa | JSI |
| 29 | Nathalie Albrow | JSI |
| 30 | Anne Marie DiNardo | Manoff Group |
| 31 | Christina Wakefield | Manoff Group |
| 32 | Cathryn Meurn | mHealth Alliance |
| 33 | Dayle Kern | mHealth Alliance |
| 34 | Kelly Keisling | mHealth Working Group |

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| --- | --- | --- |
|  | **Name** | **Organization** |
| 35 | Michael Gehron | Movirtu |
| 36 | Maria Madrid | MSH |
| 37 | Margaret Hartley | MSH |
| 38 | Haroun Habib | OGAC |
| 39 | Lucia Ruggiero | PAHO |
| 40 | Stacyann Forrester | Panagora Group |
| 41 | Debjeet Sen | PATH |
| 42 | Michael Gehron | Pepfar |
| 43 | Mariah Preston | PSI |
| 44 | Abigail Gacusana | Relief International |
| 45 | Trevor Lewis | Results for Development |
| 46 | Donna Medeiros | RTI |
| 47 | David Blackburn | Sapient |
| 48 | Soma Ghoshal | UN Foundation |
| 49 | Mei Song | University of Pittsburgh |
| 50 | Jennifer Bergeson-Lockwood | USAID |
| 51 | Peggy D'Adamo | USAID |
| 52 | Sandhya Rao | USAID |
| 53 | Lindabeth Doby | USAID |
| 54 | Christy Wahle | USAID |
| 55 | Jonathan Shepard | USAID |
| 56 | Erin Boardman | USAID |
| 57 | Megan Matthews | USAID |
| 58 | Mikell Brough | USAID |
| 59 | Adam Slote | USAID |
| 60 | Sanjay Patel | WebFirst, Inc. |
| 61 | Madeline Taskier | Women Deliver |
| 62 | Paul Robinson | World Concern |
| 63 | Dennis Cherian | World Vision |
| 64 | Jahera Otieno | World Vision |
| 65 | Heather Cole-Lewis | Yale |
| 66 | Courtney Roberts |  |
| 67 | Jerome Axle Brown |  |
| 68 | William C. Philbrick |  |