Best Practices from COVID-19 response efforts targeting marginalised women and communities

ADB CoE Progress Report - 4

Swasti THE HEALTH CATALYST

ADB

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List of Abbreviations

CAC	COVIDActionCollab
CG	Catalyst Group
CoE	Centre of Excellence
HII	High Impact Interventions
IC	Impact Canvas
JSP	Joint Strategic Plan
NCD	Non-communicable diseases
VP	Vulnerable people

1 PREFACE

In a humanitarian crisis, "a combination of factors – climate change, urbanisation and population growth, among others – means that many emergencies are now much larger and more complex than before. This in turn has led to responses becoming larger and more complex. No single agency can meet all needs. The number and diversity of humanitarian actors have also increased, which can make coordination seem an almost impossible task."[1]

The COVID-19 pandemic was a crisis that required large-scale collaboration among government and non-government players. The pandemic left no life untouched, affecting not only health, but through lockdowns and mobility restrictions, also livelihoods, food security, migration, education, etc. Such severe detrimental impact was exacerbated for the poor and socially excluded communities in general, and women in particular. It required larger and complex responses, and governments, the private sector, civil society, donors, stepped up to support these communities tide over the pandemic. A collaborative initiative of the Catalyst Group[2] of organisations in India, the #COVIDActionCollab (CAC)[3] was successful in bringing together and channelling the efforts of these institutions, matching the providers to the needy towards a cohesive response for vulnerable people (VP) at scale and with speed. Over the 2.5 years of its operations, CAC's 359 strong member network and over 2,000 volunteers have been instrumental in reaching over 15 million vulnerable people (VP) with over 23 million service instances. CAC's experience provides a rich learning pool to spotlight lessons for government agencies, implementers and donors on effective intervention and collaboration.

The Genesis of CAC

Swasti[4], given its experience in public health as a 'health catalyst', and its connections to a global roster of epidemiology experts, was tracking the spread of COVID-19 from its first reported cases. In early 2020 it realised that India would also be affected, and the spread was going to be fast, wide and extreme. It also understood that this epidemic was not like any other humanitarian crisis, which, over the last decade or so, the country as a whole, including the government and non-government agencies and communities, had learned to effectively mitigate and respond to. This meant that response agencies would need to be equipped with new learning, and probably some relearning.

[1] Working together in the field for effective humanitarian response Background paper 30th ALNAP Annual Meeting 3 –4 March, Berlin
[2] https://catalysts.global/
[3] https://COVIDactioncollab.org/
[4] www.swastihc.org

Swasti led the health strategy of CAC, embedding it into its overall strategic direction and aligning health priorities. It designed health packages as part of the high impact interventions (HII) of CAC and participated in capacity building as required. Swasti fronted some of the health-related innovative interventions, such as the Precision Health intervention on early warning of the virus spread through sewage treatment. It interfaced with partners, government officials and governing council members as required. Swasti also built a knowledge repository of COVID-19 related information products and collaterals.

Establishing the CoE

Continuing its knowledge and capacity building mandate, Swasti established the Centre of Excellence (CoE) to capture and disseminate learnings on COVID-19 response efforts for vulnerable women. Swasti and ADB have partnered to establish this CoE, a knowledge-management and learning platform for (1) connecting and collaborating with partners; (2) working to bridge the gap between communities and services to combat COVID-19; (3) institutionalising these practices. The focus of CoE is on women due to the multi-layered challenges they face on account of socio-economic factors and inequitable gender norms. The Center generates learnings from COVID-19 response efforts towards vulnerable and marginalised women for improved engagement and outcomes in other humanitarian crises.

This report follows three other reports by the CoE. The first report outlined lessons on building a collaborative, working with the government, partner organisations and the community. In the second report, CoE put together guidelines on an inclusive COVID-19 response for women from marginalised communities. The third report laid out a road map on the training and capacity building efforts required during the management of the crisis to ensure that services were reaching the last mile.

The best practice report

This report builds on the earlier reports, sharing how good practices of inclusive, people-centred strategies, partnership management, innovation and governance contribute to successful collaboration and efficient last mile reach in a humanitarian crisis.

This report curates select best practices related to designing and operating a collaborative and highlights key takeaways including a playbook for other networks, alliances and collaborations to ensure that VPs do not just survive, but thrive in order to respond to humanitarian crises not just limited to pandemics.

The best practices in this document cover some of the most important aspects that make a people-centred collaboration a success, particularly in a pandemic context where speed, scale and inclusion are paramount.

The first practice on building a comprehensive people-centred framework shows how in a pandemic or other humanitarian crisis, the focus must be on avoiding the risk of creating "cookie-cutter" responses based on templates that can fail to address the special needs of VPs and women, because their experiences are not necessarily "average" or "standard". It also risks missing out on the many different facets to ensure that VPs receive bundled, complementary services rather than piecemeal support.

The next two practices draw from two of the important aspects of the framework – partnerships and innovation. It is vital for people-centred intent to be coupled with partnerships- multiple organisations of different profiles (implementers, policy makers, donors, etc.) coming together to mount a synced response. In a pandemic, given the pan India impact, a collaborative does not have the luxury of time to identify partners across domains working with different types of VPs in different geographies. Making partnerships work requires being agile so as to reach out to large numbers of partners across sectors and to contextualise value added services to partners based on the changing ground realities to keep them engaged in the collaborative and able to support their communities.

The third best practice, the "impact canvas", is also an integral element of the framework. Humanitarian crises lead to many intractable problems as well as provide opportunities to find solutions. In a large collaborative context with multi-sectoral partners, problems must be considered through varied perspectives bringing richer and deeper understanding and better solutions. This is what the impact canvas approach allowed us to do.

The final best practice on governance ties these practices together. It was the CAC governance mechanism that contributed to the people-centric framework, constantly bringing attention back to people-centred outcomes. The governing council helped build the partnerships and has contributed significantly to many of CAC's innovative solutions. The form, function and engagement architecture enabled contribution, and ensured transparency and accountability, looping back to constant reviews of strategies, building trust with partners and improving innovations.

Each of these practices is detailed in the following sections of this document, elucidating why it is a best practice, how it was implemented, and the consequent challenges and results.

2 BEST PRACTICES

2.1 Comprehensive inclusive, people-centred framework

Introduction

The vision of CAC was to enable vulnerable communities not just survive through the COVID-19 pandemic, but also to thrive. This meant building individual, community and systemic agency to be able to mitigate or respond to COVID-19 waves, and future humanitarian crises, with greater efficiency and effectiveness. Such agency could be in terms of infrastructure, capacities, resources, and knowledge.

With people at the centre of the response, CAC drove comprehensive and coordinated action, leading to the prevention of new infections and mitigating the impact on those affected. **CAC was a synthesis of expertise in the areas of public health, medicine, engineering, technology, sociology, behavioural engineering, mental health, migration, financing, social protection, livelihoods, humanitarian emergencies, environmental science, geospatial science, architecture and more**. These were individuals, organisations and networks representing the public, private, civil society, academic and other sectors. Pooling expertise and resources while focusing on proven actions and innovations aided in effectively responding to COVID-19, streamlining comprehensive efforts and filling important gaps.

CAC developed an action framework (Figure 1) which, visualised below, shows its approach and strategies.

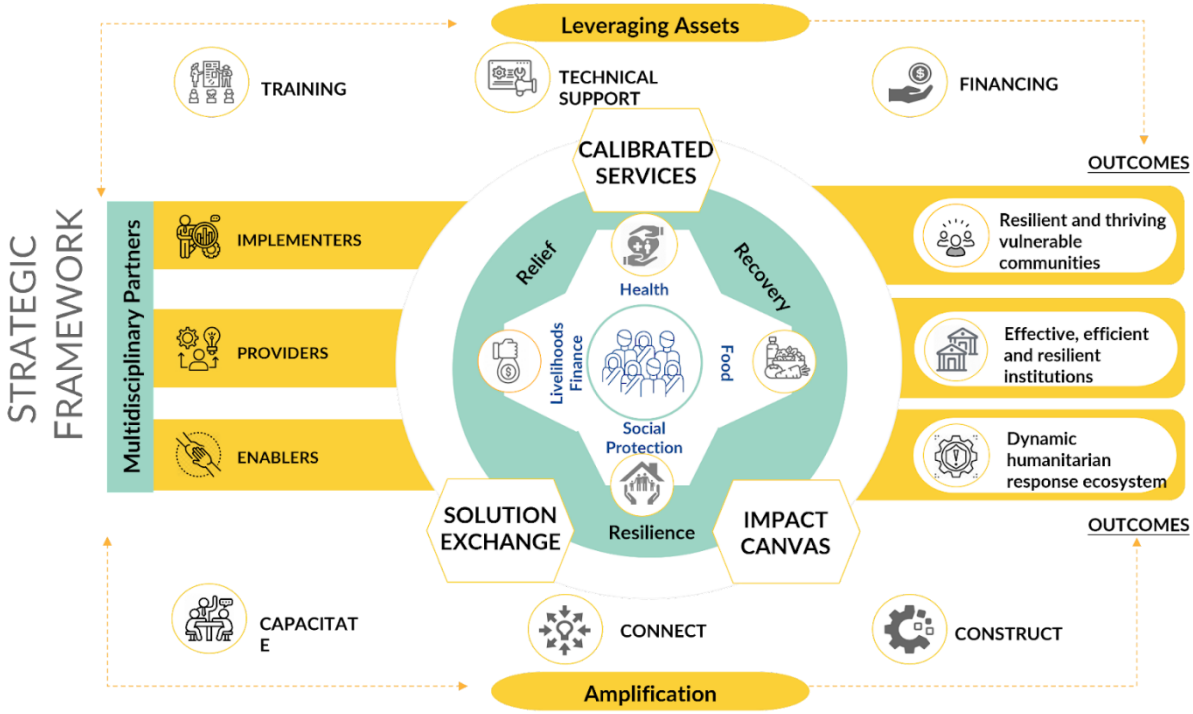

Figure 1: CAC's Strategic Framework

The CAC strategic framework illustrates the collaborative approach with the people at its core. In this strategy, multi-disciplinary partners were capacitated and connected with each other to leverage assets towards effective community interventions by receiving and/or providing training, technical support and financing. Services were calibrated to the needs of the communities, and collaborating partners offered solutions and learnings that improved the effectiveness of each one's interventions. Innovative solutions for more complex and intractable problems were designed, tested and then scaled through the partners. This entire system functions across the phases of relief, recovery and resilience. Together, this collaborative machinery leads to better outcomes at the community, institutional and ecosystem levels to build resilience for the sustained well-being of the vulnerable communities during the COVID-19 pandemic and beyond.

This **comprehensive framework can be considered a best practice because the framework guides all critical decisions such as identification of partners, prioritisation and planning of initiatives, communication and media, and so on, providing a clear pathway to collaborative partners on their engagement with the larger collaborative (CAC) and identifying clear outcomes.** Specifically:

1. Being people-centred and *not COVID-centred*, meant that CAC tailored its activities around people's needs. For instance, elderly people were served in their homes with essential COVID-19 care kits, testing, tele-medicine, home quarantine kits,

etc. rather than a passive approach where an elderly person is required to reach a health centre to avail services or products. One of the initiatives of CAC was VaxNow where CAC supported vaccinations of excluded communities, such as the trans community. The number of trans people being vaccinated was impressive after the first month of roll-out of vaccination. The CAC approach was to create safe spaces for targeted vaccinations. This included the presence of trans health counsellors and doctors, and distribution of food ration kits. This enabled this stigmatised and often excluded group access to life-saving vaccination.

2. In addition, multi-disciplinary partners were capacitated and connected with each other to leverage assets towards effective community interventions by receiving and/or providing training, technical support and financing. Services were calibrated to the needs of the communities, keeping them engaged in the collaborative with the right spirit.

Image 1: CAC partners supporting communities in Salem, Tamil Nādu; (L) Community organisation Salem Thirunangaigal Nala Sangam making 300 food packets for distribution; (R) Oxygen concentrators being deployed at Urban Primary Health Centres and COVID care centres

Implementation

From an inclusive VP perspective, this framework was implemented in the following way:

1. By orienting the framework to existing partners, potential partners and other stakeholders, as appropriate, during the start of the partnerships work stream and before other critical engagements such as planning for service delivery.
2. By ensuring partners covering different VP types from different domains, geographies and service areas were identified and onboarded.
3. Building a platform for comprehensive solutions, often customised to specific VP requirements, including material distribution, COVID-19 awareness building, household and community care, access to social protection, telehealth, livelihoods support, vaccination and non-communicable screening camps, and so on. Partners were able to take on new initiatives, expand their reach or just ensure communities they work with had solutions.
4. Providing investors a menu of options for investments - including channelling investments to a specific community group, cause, partner and/or geography.
5. Representation of expertise in various fields at the various governance and management structures.

Results

Adopting a people-centric approach has enabled CAC to reach VPs across India in large numbers - 15 million people and 23 million services. It has also ensured coverage of 13 different VP groups.

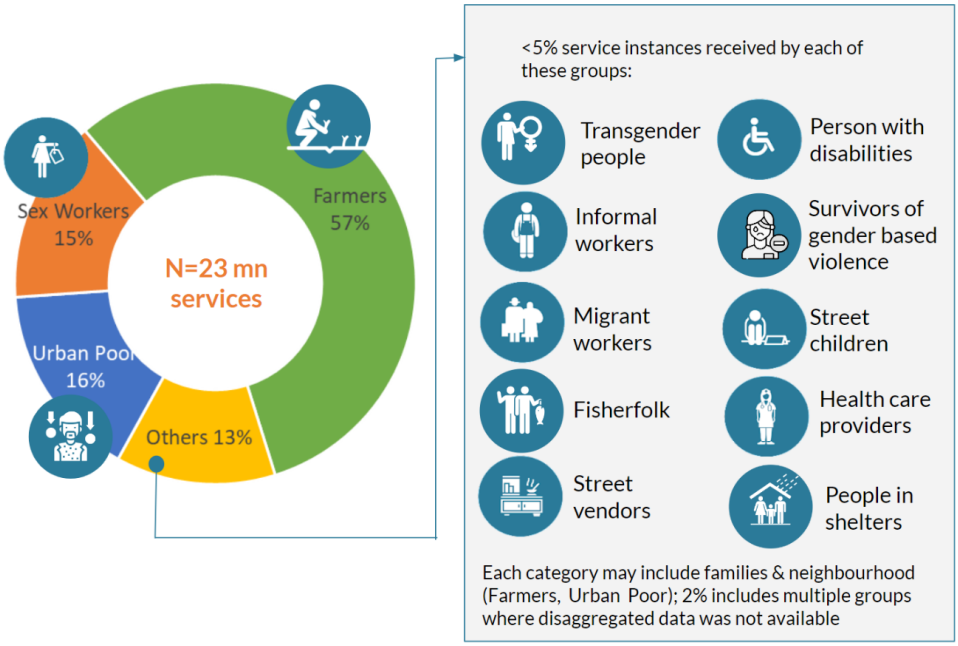

Figure 2: CAC's service contribution to various vulnerable peoples

The sterling results that CAC has achieved is owed primarily to the integrated model of partnerships and enabled scaling as each partner was able to address existing demands or gaps among the communities they served.

The integrated model enabled the government to implement targeted COVID-19 relief interventions for the communities and strengthened collaboration between partners and government agencies to act in synergy and jointly address the challenges induced by COVID-19. The comprehensiveness of the results enabled resilience building and further development work for vulnerable communities even when the threat of COVID-19 ceased to exist and was no longer prioritised.

Challenges

- Although the framework was meant to be comprehensive, the domain of education was not adequately covered as there was more interest in health, livelihood and social protection initiatives during the peak of the waves and relief efforts. In addition, none of the partners working on education were willing to take leadership in this area.
- It took time and effort to persuade those with deep domain expertise to incorporate other domains towards a people-centred response rather than a system's response. For example, some scientists from a health background failed to see the necessity for alternative livelihoods and economic resilience programming, and clinicians had to be convinced to prioritise life skills and mental health programming till they realised its value. Hence, resourcing a comprehensive approach was difficult and was more domain or activity focussed. While the program was comprehensive for the most part, most partners were comfortable with their own themes, domains, geo-locations and specific vulnerable populations.

Key takeaways

A people-centred response must address all immediate needs of communities, which must be matched with system requirements. For instance, vulnerable people lost their livelihoods and prioritised economic sufficiency, whereas the system required people to get tested and/or vaccinated. The priorities of transgendered people included daily survival, general health check-ups and addressing concerns around hormonal effects of the vaccinations. CAC was able to facilitate food rations, alternative livelihood facilities like trans-kitchens, and making available trans-friendly and qualified doctors to address their concerns. When all of these services were available, vaccine uptake among this

population increased to desired levels. Similar concerns emerged for street hawkers, sex workers, slum dwellers facing long lockdowns and breakdown of supply chains that did not incentivise COVID-19 testing or vaccine uptake. By ensuring layered solutions that were relevant, CAC was able to rapidly scale vaccinations within months.

Therefore, defining a people-centred framework enabled the inclusion of VPs and women and maintained the focus of partners and implementing teams on outcomes for people.

2.2 Making partnerships work

Introduction

A collaborative is as successful as the engagement of its partners, which in turn is dependent on the initiative's structure, systems and processes.

CAC's founding group of organisations, the Catalyst Group[5] (CG) was already reaching over seven hundred thousand VPs including women in sex work, transgender people, smallholder farmers and fisherfolk. Even before COVID-19 cases were on the rise in India, the CG organisations recognised the potential negative impact it could have on VPs across the country. They realised that given the intensity and novelty of the pandemic, governments, healthcare providers and civil society would struggle to mount an effective response. Finally, it saw an opportunity to support inclusive and effective outreach well beyond its own traditional geographies and constituents.

CAC built and ran an extensive, pan India collaborative with a multi-sectoral partner base which enabled it to address the adverse impacts of the pandemic on VPs.

Making partnership work is a best practice on account of a few elements that ensured that CAC was able to reach large numbers, and different groups of VPs. It was able to contextualise the diverse and changing on-ground needs at the speed required to effectively respond in a humanitarian crisis.

- Partner mobilisation through multiple strategies ensured the spread of the service offerings across the pandemic waves at scale based on ground needs and targeting the most vulnerable.
- A well-resourced secretariat performing multiple functions of partner engagement, design, execution of value added services, technical support and resource mobilisation was instrumental in ensuring that multiple services were available under one roof, assuring relevance, speed and quality.
- A dynamic partner engagement model that supported partner's results and worked through frequent partner interactions allowed for information flow from the ground about the VP needs and changing scenarios, enabling provisioning of need-based and contextual service.

[5] The Catalyst Group, working in the social sector for the wealth and wellbeing of poor and vulnerable communities includes Catalyst Management Services - a social investment specialist organisation; Swasti, a health catalyst; Vrutti a livelihoods impact partner; GREEN Foundation, working on women's livelihoods and biodiversity conservation; and Fuzhio, making markets work for vulnerable people.

The following section elaborates these partnership operations.

Implementation

Partner mobilisation

A collaborative provides the opportunity for each member of the collaborative to learn, contribute and expand their reach well beyond their usual boundaries, be it in numbers reached, type of VPs reached, or type of services provided. To reach a large number of VPs affected by the pandemic, CAC needed to bring a large number of partners on board.

The partner mobilisations strategy had three phases:

Phase 1: CAC, leveraging the existing social capital of the CG organisations, extended invitations to organisations they had previously worked with or knew, and asked them to join the collaborative. These organisations were further requested to refer the collaborative to other interested organisations. Since the CG had long standing associations or connections with these organisations, and a mutual trust and respect, it was easy to identify the value that they could bring to the collaborative, and to convince organisations to partner.

Phase 2: As known partners were being onboarded, CAC hosted a website for interested organisations (known and new) to register. It used social media to communicate about the collaborative and drive the interest of organisations that did not have a direct or referred connection. The website allowed these new partners to get a brief of CAC and for CAC to easily collate basic details of partners - such as VP numbers and type covered, location of initiatives, domain of operations, contact details etc. A due diligence followed registration of new partners so that the CAC team could identify the value that these partners could give to and derive from the collaborative.

Phase 3: After the first few months of operations, the CAC team realised that COVID-19 would be around for the long haul. Through their experience with existing partners, they knew that their health, social protection and livelihoods service packages were helping the partners provide critical knowledge and support to their communities. They recognised the need to expand the reach of the collaborative - in numbers and types of VP served. At this time, they identified a few organisations and networks with large reach or reach with specific vulnerable groups to encourage them to join the collaborative. This effort-intensive activity required senior management of CAC to engage in cold calling, frequent follow-ups and perspective building on how these organisations could serve their community better through collaboration and the collaborative service offerings.

During the phases, CAC also reached out to the government (at state and local levels) and private sector partners. The government had several programmes including vaccination,

food distribution, COVID care etc. and the private sector had funds, management capacities, technology, communication and more. Both these institutional types had limited reach on the ground and connections with the affected VPs. Civil society partners were able to bridge these gaps.

The outreach to a mix of partners, including resource agencies (for communications, technology etc.), grassroots implementation agencies, health service providers, social enterprises, private sector organisations, networks, associations, academic and research institutes, and donors, enabled CAC to build a range of knowledge and provide services to the last mile.

Image 3: Working with different types of partners – (Top left) Dr. Angela Chaudhuri sharing the CAC HII at the Private Hospitals & Nursing Homes Association (PHANA)investiture ceremony, Nov 2020; (Right) Orientation to the National Hawkers Federation; (Bottom left) Inauguration of the COVID Field Hospital, Govt. of Karnataka

A well-resourced secretariat

Usually, the secretariats of networks and collaboratives play a coordination and monitoring role and are sometimes engaged in quality assurance as well. Technical and resource inputs are often drawn from within the partners or from external experts. The

coordination of these inputs can be time consuming, an element that is in short supply in the midst of a pandemic.

In addition to these roles, the CAC Secretariat was actively involved with partner engagement, design and execution of value added services to partners, technical support in the domains of health, livelihoods and social protection (SP), and resource mobilisation. By doing so, CAC was able to provide expedited and relevant services to partners.

Each team within the secretariat had a clear role, and coordination and communication mechanisms between the team such as meeting frequencies and WhatsApp groups were also defined.

- The partner engagement team identified partner and community needs and what they could offer the collaborative (please see the next section).
- The domain support team assessed needs in health and social protection among others and designed High Impact Packages (HII). This team also led the perspective-building activity with government institutions and other large reach partners on the value of collaboration.
- The value added services team oriented all implementing partners on the HII packages. Those partners who chose to implement the HII were first engaged though the development of a joint support plan (JSP) that determined the specific areas of the HII that were a priority, such as COVID-19 awareness, COVID-19 screening/risk assessment, screening of non-communicable diseases (NCD), home isolation, vaccine readiness and telecare. The JSP also looked at resourcing of the HII - people and funds, and helped partners leverage existing funding sources towards HII implementation or supported them in securing additional funds where possible. The plan included execution timelines and any handholding support required.
- The resource mobilisation team helped mobilise funds in cash or kind that partners received.
- The monitoring and evaluation team maintained data for decision making and undertook an evaluation of the collaborative.
- The governance and management teams worked on coordination of the Governing Council and Investment Committee (please see the governance best practice section) and on finance, HR and communication.

A dynamic partner engagement model

Regular engagement of partners was a prerequisite to reach a large number of VPs. The implementing partners in particular were already reaching out to their communities with services that they could provide in the pandemic context. Partner engagement was

required to understand the gaps in their interventions that the collaborative could bridge. In addition, it was important to understand what partners were willing to offer to the collaborative in terms of knowledge, tools, resources, connections, etc.

CAC designed an operational model where each partner had a dedicated anchor - called a Partner Results Accelerator (PRA) responsible for connecting with the partners at least once a month, if not more often. The PRAs shared CAC's work, understood the partners needs from and contributions to the collaborative. The PRA worked with the value delivery team to connect their partners with solutions wherever relevant.

The PRA also served as "listening posts", updating the CAC service design teams on the emerging priority needs. For instance, during the COVID-19 second wave from around March-July 2021, the CAC Secretariat was able to mobilise a large number of oxygen concentrators, which the PRA was able to channel to priority locations.

Results

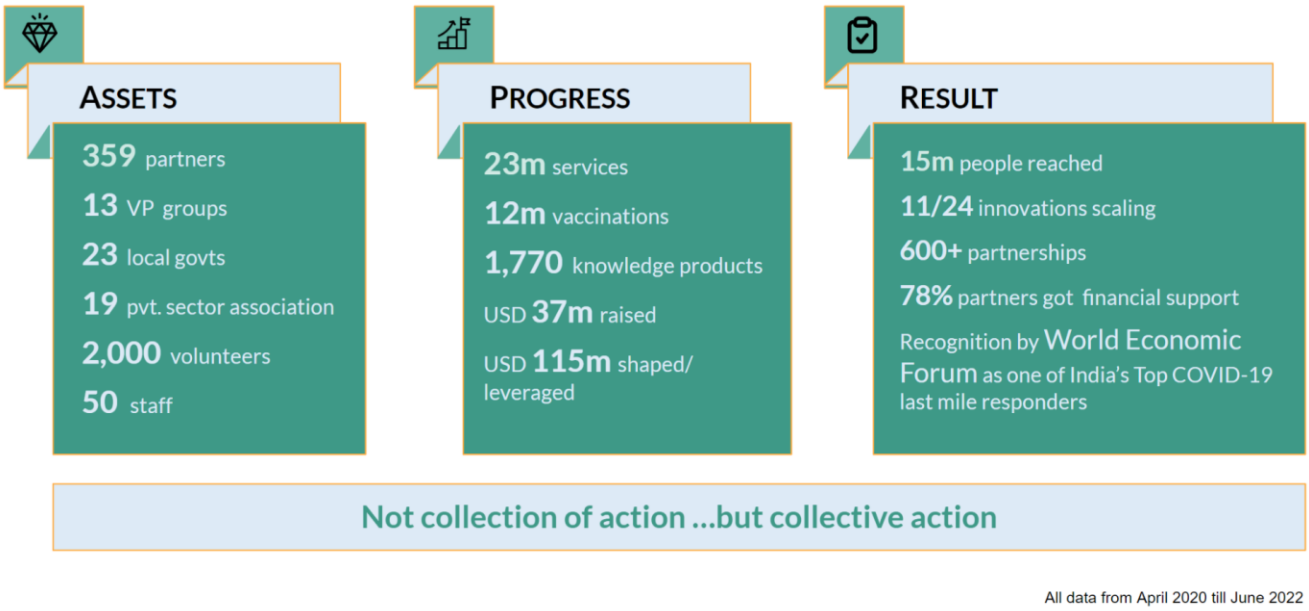

Figure 3: Assets built, progress and results achieved [6]

[6] Monies Raised: Where CAC is clear about purpose and has mobilised resources from donors in cash and in-kind; Shaped: Where CAC has played a key role in conceptualising, calibrating, connecting, facilitating resource mobilisation for specific / priority causes and partners; Leveraged: complementary and supplementary funding channelised through govt and private sector programmes and assets. Includes large part which is social protection monies from govt. which has reached communities

Covid and after: How a collaborative helped sex workers

BENGALURU, DHNS

Thousands of sex workers in Karnataka have received social security benefits and telecare in the two years since the pandemic began, thanks to Covid Action Collab (CAC), a network of 13 NGOs in the state.

The CAC, which says it has 350 organisations across the country, has provided 5.87 lakh social protection and telecare services to sex workers in Karnataka. These include 1.86 lakh teleconsultations for Covid, domestic violence and other stress-related issues and anxiety. Now that the pandemic is over, the collaborative is focusing on the financial recovery and rehabilitation of sex workers.

CAC founder, Shiv Kumar, says the women are trying to get on their feet. They are trying to repay debts and reduce the losses of the previous Covid waves.

Swathi Jyothi, a microfinance institution, is helping them open savings bank and recurring deposit accounts as well as short-term loans. The Catalyst Group, which founded the CAC, was also involved in the founding of Swathi Jyothi, Kumar adds.

Swathi Mahila Sangha (SMS), a community-based organisation that works with 15,000 female sex workers, is one of the 13 NGOs that form the CAC in Karnataka.

Khushi B, programme director at SMS, said many sex workers had received loans of Rs 10,000 and started new businesses such as selling flowers and running petty shops.

KHUSHI B
Programme Director, Swathi Mahila Sangha

"Sex workers are now doing business such as selling flowers and running petty shops. Many have left sex work.

"Many have left sex work," she adds.

During the pandemic, the CAC distributed face masks and grocery kits to the sex workers. According to Khushi, with the third wave of Covid over, it would be helpful if they get monetary assistance for children's education and jobs for family members.

Venkatesh N R, manager of the SMS' Bommanahalli Zone, said the CAC helped the sex workers with the vaccination through a door-to-door campaign. "The CAC provided all the necessary resources like masks, gloves and sanitisers," Venkatesh said. "Though vaccination is free in government hospitals, we have to stand in a queue for it."

Samara, a Dasarahalli non-profit with 30 transgenders as its members, is also part of the CAC. One of its members, Sarla Das, 36, said: "We received both Covid treatment and vaccines. We also got medicine kits."

Bengaluru

TIMES CITY

80k people turn up at Khunti health camp

Union Tribal Affairs Minister Elated Over 'Success'

Govt's withdrawal of Pathalgarhi cases boosts footfall at Birsa college ground

Image 4: Newspaper articles on CAC partner initiatives

Challenges

- The PRA team was 14 people strong with diverse skills and backgrounds. Engaging with partners requires many competencies including good communication, management skills, lots of patience, understanding of the context, agility to respond to new, changed needs and so on. Not all PRAs had these skills in good measure, and where skills were limited, partner engagement was less than optimal. For example, when partners required frequent changes to scheduled meetings and PRAs without patience or good communication could appear aggressive or could just give up on follow-up.
- Though 50% of partners were active, CAC was conscious that half the number of partners was not. Many inactive partners were engaged in their own initiatives and especially during the height of the waves, were not able to give time to the collaborative. Some did not find value in the offerings of CAC. Resource organisation's engagement dropped once lockdowns were eased and they became busy with their daily work. There were also cases where PRA's communication and engagement strategy was wanting.
- Making partners understand the big picture of a collaborative's strengths was an effort-intensive and exhausting process and delayed the response efforts.
- Most of the CAC initiatives were designed by the Secretariat, and there was limited sharing of partner models. This was because the speed of response required in the pandemic context left limited time and resources to channel towards identifying and creating spaces for partner experiences and models.

- Evolving strategies to suit the changing requirements of COVID-19 relief projects built a lot of pressure on teams that were implementing programs.

Key Takeaways

Making partnerships work in a large and diverse collaborative in order to mount an effective response for VPs in a pandemic context **requires a large partner base.** Since time is at a premium, multiple strategies are required to onboard partners. Partners too need to be from different sectors to optimise give and take.

Partnership engagement in the collaborative also **needs very close engagement** since partners are involved in other initiatives beyond CAC, and their attention needs to be constantly channelled to the value offerings of the collaborative. A prerequisite for this is partner anchors who are invested in ensuring that partners are able to draw and give value to the collaborative.

'Value connect' with partners in the pandemic context is also **dependent on speed**, which a well-resourced secretariat having domain and delivery expertise must be able to achieve.

2.3 Impact Canvas model for designing innovation

Introduction

Many COVID-19-related challenges are complex in nature. Significant, timely and long-term changes in this context necessitate systems thinking, innovation, co-creation and an integrated, comprehensive response - which most organisations do not have the expertise, resources, or reach to provide on their own at scale. This indicates the need for multidisciplinary teams and resources from multiple organisations. Even when there is an intention to pool resources, and organisations are working toward the same goals, cooperation is difficult for a variety of reasons. A few of these reasons include viewing other organisations as competitors, a lack of common/safe spaces to collaborate, lack of a trusted or committed facilitator, of new ways of engagement and of win-win formulas - all of which are required for resource-sharing and effective collaboration.

The Impact Canvas (IC) model is unique and considered a best practice for the following reason:

1. It first focuses on the intractable problem at hand.
2. The problem statement, causality and correlations are interrogated deeply.
3. Diverse experts are brought together to this process so that everyone can benefit from diverse expertise and viewpoints.
4. It uses a 'Socratic' method of inquiry which is an iterative form of cooperative , argumentative dialogue between individuals based on asking and answering questions to stimulate critical thinking and to draw out ideas and underlying assumptions.

The model brings together impact-focused partners who can rally around one ultimate outcome (e.g., higher testing, cleaner public spaces) to provide effective, meaningful solutions that mitigate pandemic effects and achieve scale, impact, and sustainability collectively. It is a facilitated alliance of stakeholders who have common interests in an outcome and play complementary roles in driving solutions toward that outcome.

An Impact Canvas increases the likelihood of achieving the desired outcome in two ways: (a) by providing a mechanism for identifying, assembling, sequencing, and activating all relevant stakeholders around an outcome; and (b) by examining the phrasing of the problem at hand and iteratively rephrasing it with all relevant stakeholders until the root problem is identified.

Implementation

An Impact Canvas process will most likely go through eight stages: nomination, conceptualisation, piloting, deployment, pre-scaling, scaling, and hibernation/closure. Each Impact Canvas is collaboratively operationalised with partners while adhering to the ten-step framework.

Each impact canvas has design teams (creating globally informed, locally adaptable solutions), implementation teams (ensuring effective and timely operationalisation), and influence teams (ensuring long-term impact at scale; ensuring working solutions are connected to the right contexts and stakeholders to drive scale). A group of advisors with extensive domain and business knowledge also guides Impact Canvases.

Impact canvases seek to drive sectoral progress toward priority impact areas through well-resourced, comprehensive teams and ideas, as well as critical sectoral engagements: increased community resilience, improved access to quality care, prevention of new infections (in public, work, and private spaces), evidence-based local response (ward, city, district levels), reduced knowledge gaps in COVID response, improved wellness of vulnerable populations (including the elderly, COVID-affected individuals, and others), as well as mitigation of adverse COVID-19 impact (reduced digital divide, increased livelihoods opportunities and so on).

Results

In total, there are 13 Impact Canvases and 24 initiatives. 11 initiatives are active. (Figure 3)

Figure 4: Active impact canvas initiatives

Around 13 initiatives which were incubated are in hibernation for now because of change in context, absence of partners willing to take the lead, internal resource constraints, etc. For instance, an initiative on digital education had no lead; one on community-based testing has lost relevance for COVID-19 testing. Those that continue to be relevant such as the apparel industry revival or elderly care will be scaled at an appropriate time. This approach inspired out-of-the-box thinking with many initiatives being pioneering.

First in India: Sewage in 45 city wards to be tested for virus clusters

BENGALURU, DHNS

Karnataka will start testing sewage water to assess the prevalence of Covid-19 with a surveillance system in Bengaluru where traces of the novel coronavirus will help identify potential clusters and any alarming variants that may spring up due to the mutation.

To begin with, the testing will be done in 45 wards, and the system will eventually cover over 75% of Bengaluru's nine million residents by generating over 90 data points per week, which would signal the emergence or exit of Covid-19 cluster from an area, said Rakesh Singh, Additional Chief Secretary, Urban Development Department. "We are happy to launch this model in Bengaluru, the first in India," he added.

Singh said wastewater testing could be a cost-effective early warning system to assess the increase in Covid-19 cases before the number of official cases goes up. "Early identification of these clusters can help guide the Covid-19 response and give policymakers the information they need to better allocate the limited pandemic resources," he said.

Officials hope the exercise will help avoid city-wide lockdowns by focusing on micro-containment zones, where restrictions are imposed on a small area.

The project has been launched in association with PCMH Restore Health and Wellness, which is part of the CovidActionCollab collective, and supported by United States Agency for International Development (USAID) and the Skoll Foundation.

Experts from the World Health Organisation, the National Institute of Virology and other agencies will be part of the initiative, said Shan Venkat, co-founder of PCMH Restore Health and Wellness.

Tracing the virus

Venkat said samples would be pulled from 45 wards every day for the next year. "We will not only check for the traces of the virus but also do genome sequencing. The early warning system will identify the infected areas and give an indication of major variants of concern, if any," he explained.

When a different variant of the virus is found, experts will collaborate to study it and provide key insights that will help make better policy decisions. "We will have a meeting with the BBMP chief commissioner every month where our findings will be discussed and decisions taken," Venkat said.

The project would involve tracing the origin point as far as possible. For example, if the lab finds the virus or its trace in the main sewage line, the next step will involve pulling samples from all the trunk lines, lines from a particular ward, area or even a road.

Image 5: (Top) Article on precision health in Deccan Herald, May 28, 2021; (Bottom left) Collecting samples for COID surveillance; (bottom right) Spreading awareness on Telehealth

Challenges

- There were team structure modifications and sparse resource capacity to respond to new requests. Collaboration and learning platforms between different impact canvas models did not happen as much as we would have liked it. Academic rigour and grounding across impact canvases need to be improved. Business model building for rapid scale needs to be built.
- Funding strategy: The long span of COVID has resulted in financing for a number of ICs becoming challenging. We need to explore alternatives to time-intensive, case-by-case fundraising and obtain research grants for rigorous evidence generation for our unique models. The Foreign Contribution Regulation Act (FCRA) makes it challenging to make subgrants, especially in a collaborative model.
- Awareness generation for government officials of less common models and promoting utilisation of Impact Canvas insights by local bodies requires more effort.

Key Takeaways

Impact Canvas stands out because:

(i) It increased social and professional capital in order to strengthen capacities and collaboration to achieve larger and seemingly more difficult goals.

(ii) It resulted in national recognition and international collaborations for programs.

(iii) Impact Canvas gives participants courage to do things differently, nudging partners away from competition and towards collaboration to achieve results.

2.4 Governance

Introduction

Given the dynamic nature of the pandemic, the ambition of scale in terms of partners and locations, the multidimensional nature of on-ground needs and interventions, and the large volume of resources raised in cash and kind, a strong steering mechanism was essential for the success of CAC.

The CAC secretariat from the very start instituted a governance mechanism to:

1. Guide the design of the collaborative and its initiative.
2. Connect and influence key stakeholders including the government to be members or to participate in the collaborative's activities.
3. Ensure the integrity of CAC through accountability and transparency mechanisms.
4. Be an ambassador - represent and promote CAC across national and international forums.

Unlike many collaboratives, CAC governance was not member-driven, i.e., the Governance Council (GC) did not have members that were elected by partners but were purposely chosen by the Secretariat. Some GC members were from partner organisations, however, they were not partner representatives and were chosen because they were experts from the sector.

Governance in CAC is a best practice because of the immense symbiotic value the mechanism provided to the GC members and to CAC, proven by the active engagement of most members and their own testimonials. The mechanisms governed large monies. The focus on accountability in this regard was constant and ensured fairness and transparency in CAC's engagement with partners while maintaining the focus on the needs of vulnerable people.

Implementation

Establishing the GC:

A GC for a collaborative can be elected from among its members or be independent of the members. The CAC GC was the latter with membership being by invitation. CAC drew on years of relationships with some of the stalwarts of the social sector and brought them onto the CAC governance platform. Some GC members were from the partner pool but their representation was independent of the partnership engagement. Some members were independent professionals. Their professional associations did not affect any decisions and only their expertise and leadership were considered.

To start with, the CAC secretariat invited 7 known and respected experts from previous engagements. At the end of 2.5 years there were 16, with a total of 22 over the full period. The GC had a diverse member profile that included donors, experts from the social and private sector, former government officials and CAC founders. The profiles covered health, epidemiology, livelihoods, disaster risk reduction, youth, migrant issues, marketing and communications and more.

New members were invited based on gaps identified. For example, as on-ground focus shifted to migrants, we invited an expert working in the space of migrant labour. As the second wave emerged and there was the understanding that more waves were possible, we brought an expert on disaster risk reduction. We also onboarded representatives of three major donors to ensure they had visibility and CAC delivered accountability for the funds that it received. A few members resigned in between when they felt their time commitments did not permit them to add value to the GC of such a collaborative. They did continue however to be available for advice even after stepping down.

Identifying GC roles and responsibilities: The GC was constituted as an advisory and not a decision-making body. This was a conscious approach by the founders of CAC to ensure that decisions that would help VPs in the pandemic could be taken promptly without tedious convening procedures. The GC members were therefore responsible for guiding the CAC strategies and forging connections with key stakeholders and experts in the sector.

Convening the GC: Meetings were one of the main GC engagement mechanisms. The first GC meeting was held on 31 March 2020. During April 2020, meetings were conducted weekly, the cadence was then changed to fortnightly till October 2021, following which the meetings were held monthly.

The GC meeting agenda was varied, and included strategy discussions, implementing insights, monitoring, evaluation and learning updates, listening posts from the field, and sharing by partners and community voices. GC members brought in external perspectives, as well as learned from the rich information-sharing and discussions.

Engaging GC beyond meetings: In addition to meetings, the Secretariat set up an engagement mechanism where a senior secretariat lead was the ‘anchor’ for one or more GC members. Regular calls were planned with GC members on follow-ups from the meetings to share updates, seek feedback and discuss expectations on governance. Such

engagements were particularly important for some members who had expressed difficulties in attending GC meetings but were keen to be involved with CAC.

Establishing the InCom: InCom, or the investment committee, came into being in August 2021 as an independent body that identified partners who would receive some of the open-ended funding being offered by donors. It was important for such funding allocation to be seen as fair and unbiased.

The InCom process was as follows: when a funder expressed interest in funding without earmarking the deployment to a particular organisation, the secretariat's resource mobilisation (RM) team would shortlist potential recipients based on specifications of the funder (such as deploying the funds for vaccination). The partners on the shortlist were also intimated of the potential source and asked to express their interest and capacity. The InCom received these details and made the decision on the final recipients. As such, unlike the GC, the InCom was a decision-making body. Once the funds were deployed, the InCom was no longer involved in implementation and fund utilisation.

Image 6: A CAC GC member on a site visit at a vaccination camp

Results

- 7 GC members at the start, 16 as CAC builds its future. 22 GC members total between 31 March 2020 and 2 August 2022
- 50 GC and 18 InCom meetings over this period. Average rate of 60% participation of members in GC meetings.

- GC members found great value in their tenure because they learned a lot about the pandemic and its evolution, about multiple domains, and had insights into what was happening on the ground, giving them further credibility in their own COVID-19-related engagements.
- GC members contributed to the design of 15 strategies of CAC such as its overall strategic framework, operations strategy, strategy to reach 10 million vulnerable people, strategy to work with the government, VaxNow strategy, evaluation strategy and vision for the future of CAC. At all turns, it highlighted the potential risks of all strategies, which helped the secretariat in risk mitigation planning.
- INR 18 crore of funding allocated to partners by InCom.

Challenges

- Despite the intention of the GC members, they were not able to find time for field visits, which may have further increased the depth of their engagement with CAC.
- Though evangelisation was a GC mandate, there was limited representation of CAC by members in forums they were a part of.
- GC engagements apart from meetings were not standardised. Though a process was designed, follow-through was weak.

Key Takeaways

- Involvement of a GC built on sustained and meaningful relationships is high. During the course of CAC, a few GC members who were onboarded on the basis of perceived value or required institutional representation were less engaged or stayed on for shorter periods.
- In a pandemic situation, getting senior experts in the sector to actively participate in governance can be a challenge. Adding value to them by bringing in new ideas, involving them in the design processes and understanding their expectations helps sustain their interest and instil a sense of pride and fulfilment.
- Not all members are able to attend frequent governance meetings. Creating mechanisms for engagement beyond meetings ensures high involvement of members.
- Expecting members not directly involved in an initiative to be evangelists of the initiative requires greater effort by the secretariat to understand the audiences with whom they engage and to support them through general and customised collaterals and talking points. This is one area that CAC was not able to adequately enable.