ABOUT THE CENTER FOR HEALTH MARKET INNOVATIONS

The Center for Health Market Innovations (CHMI) promotes programs, policies, and practices that make quality healthcare delivered by private organizations affordable and accessible to the world’s poor. Operated through a global network of partners since 2010, CHMI is managed by the Results for Development Institute (R4D) with support from the Bill & Melinda Gates Foundation, the Rockefeller Foundation, and UKaid.

Details about more than 1,200 innovative health enterprises, nonprofits, policies, and public-private partnerships in low- and middle-income countries can be found online at HealthMarketInnovations.org.

R4D also manages the Center for Education Innovations at EducationInnovations.org.

ABOUT THIS REPORT

This report was compiled by the CHMI team at Results for Development: Donika Dimovska, Meredith Kimball, Gina Lagomarsino, Trevor Lewis, Rose Reis, Alex Robinson, Kamal Bazaz Smith, Christina Synowiec, and Arjun Vasan. CHMI’s global partners, listed below, contributed insights on new programs and practices.

RECOMMENDED CITATION


CHMI’S REGIONAL PARTNERS

• ACCESS Health International, India*
• BroadReach Healthcare, South Africa
• Consultation of Investment in Health Promotion, Vietnam
• Freedom from Hunger, Bolivia, Ecuador, Peru
• Institute of Health Policy, Management & Research, Kenya, Rwanda, Tanzania, Uganda*
• Interactive Research and Development, Pakistan*
• Mercy Corps, Indonesia
• Philippine Institute for Development Studies, Philippines*
• Regional AIDS Training Network, East and Southern Africa*
• Swasti Health Resource Centre, India*
• Solna Health, Nigeria*
• The Asia Foundation, Pakistan

*Organizations starred have been active during the 2012-2013 period.

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GLOBAL HEALTH MARKETS IN 2013

The use of market-based approaches is continuing to grow around the world. We recently delved into the data from CHMI’s 1,226 profiled programs to understand emerging practices, identify programs with promising results, and highlight programs scaling up. Browse the panels below to explore some of our latest observations from Highlights: 2013, then turn to the relevant chapters to learn more.

1. One of the fastest growing innovations in the CHMI database is the use of vouchers allowing the poor to access quality health services.

THE USE OF HEALTH VOUCHERS HAS GROWN BY 18%/YEAR SINCE 2000

2. Many low- and middle-income countries are home to diverse and vibrant health markets. India in particular has seen a boom of private healthcare development.

3. Even in fragile states—home to one-third of the world’s poor—promising healthcare solutions are surfacing.

4. Innovators are finding effective solutions to tackle healthcare issues that are top contributors to the developing world’s mortality and morbidity rates.

5. Programs are also using SUPPLY CHAIN INNOVATIONS, such as those depicted below, to ensure that patients have access to life-saving preventive and curative medicines.

6. But the question still remains: WHICH APPROACHES AND PROGRAMS ARE ACTUALLY SHOWING RESULTS?

7. Which programs have the potential to SCALE UP significantly?

One organization in SOUTH AFRICA has used a custom-designed pill bottle to help 90% of patients comply with their TB drug regimen, versus the 22-60% who normally do.

At least 40 programs reported to CHMI in the past year that they had GROWN in terms of the number of clients served, breadth of services offered, or number of facilities within their networks.
The health market is where healthcare transactions are made by consumers and providers of services. These markets are big. In most developing countries, even where public facilities offer care free of charge, the poor rely on private providers operating within the health market for a large portion of their care.

Health markets offer both challenges and opportunities. Patients do not always seek the kind of care that will make them healthier, and providers do not always act in the patients’ best interest. Appropriate care can be expensive, and spending out-of-pocket can push people further into poverty. However, health markets can be a source of creative new approaches with the potential to achieve greater efficiencies, better quality, and increased access to care.

**WHAT ARE HEALTH MARKET INNOVATIONS?**

Health Market Innovations are programs and policies—implemented by governments, non-governmental organizations (NGOs), social enterprises, or private companies—that improve privately delivered healthcare. Health market innovations work in or with the private sector to improve the way practitioners deliver care or the way consumers seek care.

**HOW DOES CHMI IMPROVE HEALTH MARKETS?**

CHMI promotes programs, policies, and practices that improve healthcare delivered by private organizations. Operated through a global network of partners since 2010, CHMI is managed by Results for Development. Our vision is for health systems around the world to better utilize private organizations to deliver quality, affordable, and accessible care, especially for the poorest and most vulnerable.

**WHAT KINDS OF PROGRAMS ARE INCLUDED IN CHMI’S PROGRAMS DATABASE?**

CHMI profiles programs that work in low- and middle-income countries, serve low income communities, and work with private providers—harnessing them to deliver health services, financing care delivered by private providers, or regulating their performance.

All of CHMI’s data on innovative programs are public. Details about innovative health enterprises, nonprofits, policies, and public-private partnerships in low- and middle-income countries can be found online in the free, interactive programs database at HealthMarketInnovations.org.

Through the database, blog posts, in-person events, and research publications, CHMI collects and disseminates information, conducts analysis, and creates connections between people implementing, funding, and studying innovative health programs.

Photo Right: In Orissa, India, Swarna and her baby boy Satyaswara returned home safe from a new neo-natal survival unit, benefiting from a state-wide program funded through a UNICEF and UKaid partnership.
Dear Colleagues,

It’s been another year of exciting developments in health markets around the world, and we are pleased to bring you a third edition of Highlights, with new observations about global health markets.

CHMI was created in 2010 to enable health systems around the world to better utilize private organizations to provide quality, affordable, and accessible healthcare, especially for the poorest and most vulnerable.

Health practitioners, donors, investors, policy makers, and academics rely on CHMI’s digital platform—with its details about more than 1,200 nonprofits, social enterprises, public-private partnerships, and policies—as well as on our analysis of emerging practices in health markets.

Connecting innovators to growth opportunities around the world

Recognizing that there are enormous hurdles to expanding even the most promising healthcare models, CHMI has launched a portfolio of services to connect health programs with mentors, funders, technical experts, and policy makers. In the past year, these efforts have led to new partnerships worth millions of dollars and have helped programs expand the health services they provide to 1.6 million people.

CHMI’s partners—in countries including India, Kenya, Nigeria, Pakistan, and the Philippines—are at the forefront of this work: identifying innovative programs, assessing their growth needs, and making relevant connections to help them scale. We also connect programs with global partners who offer additional growth opportunities. Although this report focuses on CHMI information and analysis, a summary of our partnership building activities starts on page 36.

A new website responding to your interests

With more than 325,000 unique website visitors since our launch, we have gathered feedback about what information, analysis, and connections our community members are looking for. In response, CHMI’s redesigned website includes a number of new features:

• Through our interactive database, CHMI now collects standardized metrics on performance and scale (see page 30).

• New web portals provide custom windows into promising market-based approaches and key themes like maternal health (see page 44).

• A subscriptions feature keeps website members up-to-date on areas of interest—for instance, all new programs launched in Kenya.

New in this report

This report offers highlights of our findings about the most exciting recent developments in health markets.

• Innovators are responding to some of the largest global health threats—tuberculosis, malaria, and maternal mortality—with new approaches to deliver and finance life-saving care for the poorest and most vulnerable. With our colleagues at the University of Toronto, we reviewed hundreds of studies to determine which practices have been proven to work. See page 20 for some of our findings.

• Advances in supply chains can ensure that essential medication and health products are delivered to the most remote communities. See an analysis of these innovations on page 25.

• CHMI has collected 770 indicators of programmatic performance, called Reported Results. Now, in cooperation with the Impact Reporting & Investment Standards of the Global Impact Investing Network, we have launched a catalog of health metrics to identify organizational models with effects on health access, outcomes, and operations/delivery—see page 32.

• More than 40 programs reported to CHMI that they have recently expanded their network of facilities, the breadth of services they offer, or that they are serving significantly more people (see page 35).

As always, we welcome your feedback on Highlights: 2013 and our work to promote programs, policies, and practices improving the quality, affordability, and availability of healthcare for the poor.

Sincerely,

Gina Lagomarsino | glagomarsino@r4d.org
Results for Development Institute, On behalf of the CHMI network
Insights into what innovators are doing to expand health access in 122 countries.

CHMI currently captures data on more than 1,200 health market innovations across 122 countries. Each program uses a unique set of innovative approaches to deliver, finance, or regulate healthcare with an ultimate aim to improve access to quality and affordable healthcare for the poor. This information provides insight into what types of health services programs provide, and how they are providing these services.
CHMI’s data allow for multiple levels of analysis. At the macro level, 377 programs (31% of all profiled programs) report focusing on primary care, and 363 programs (30%) use information and communication technologies as a core approach.

Looking more closely, we see that, of the programs working in primary care, 48 provide care through chains of clinics.

One such program is NationWide Primary Healthcare Services, a rapidly growing chain that serves women and children, aging adults, and patients with chronic diseases in Bangalore and Gurgaon, India (see page 13 to learn more about India’s developing health market).

CHMI’s data also provide information about emerging practices in health programs by health focus and key approach. For instance, when examining the cumulative number of programs across health focus and approach, by program launch year, a few insights become apparent (see graphs starting on page 11).

It is worth noting that apparent growth may be a combination of factors; the numbers may be influenced by donor priorities or explained by biases in how CHMI collects data. Moreover, the CHMI data set is representative of only the healthcare programs that meet our inclusion criteria (see page 4). Therefore, apparent emerging practices in the data may not reflect health markets everywhere.

Since 2000, primary care, HIV/AIDS, MNCH, family planning, and secondary/tertiary care have been the five most common health focuses for programs in CHMI’s database, indicating the importance placed on these health areas.

The number of programs in CHMI’s database that focus on MNCH has grown by 15% per year since 2000, while primary care programs have grown on average by 12%, HIV/AIDS programs by 11%, family planning programs by 10%, and secondary/tertiary care programs by 10%. This growth was driven by new programs launching between 2000 and 2013.
The top six approaches used by programs profiled by CHMI are consumer education, information communication technology, provider training, mobile clinics, micro/community health insurance, and social marketing. The number of information communication technology programs has grown on average by 18% each year, while provider training has grown by 13%, consumer education by 11%, micro/community insurance by 10%, and mobile clinic programs by 10%. The number of programs using health vouchers and monitoring standards has also grown quickly, by 18% and 12% per year respectively since 2000. Advances in mobile technology could help explain the apparently steep increase in technology use. Yet these observations could point to growth in new models improving the quality, affordability, and accessibility of healthcare for the poor. We will look more closely at some of these key approaches and health focuses in forthcoming chapters.

The cumulative number of programs across the top six approaches, by program launch year, is depicted in the graph below.

INDIA’S DYNAMIC HEALTH MARKET

Living in one of the world’s health innovation powerhouses, Indian citizens have seen marked progress as well as pitfalls in the past 20 years as the economy has expanded rapidly. Health indicators are improving: for example, the infant mortality rate was nearly halved between 1993 and 2012. However, India still faces a number of public health challenges that threaten health and financial protection for the poor. Malnutrition afflicts 42% of children under the age of five. In 2011, the country spent 1.2% of its GDP on healthcare, while Ghana and Vietnam, countries of a similar economic status, spent double that on healthcare.1

LARGE AND RAPIDLY GROWING PRIVATE HEALTH MARKETS

India’s health market is growing very quickly. Segments of the market from hospital chains to health technology to diagnostics are expected to expand 9 to 26% within four years.4

Approximately 70% of all health spending in India is private, 86% of which is out-of-pocket—a situation that threatens a growing middle class and often causes financial catastrophe for the poor. The market has also been relatively fragmented and un-monitored, especially in rural areas, where the vast majority of the population still lives, leaving many consumers without guarantees of healthcare quality.

Fortunately, non- and for-profit healthcare organizations are now testing new methods to leverage both public and private resources to meet the health needs of the poor. While India’s government has traditionally prioritized providing needed health services to the poor through public facilities, we have identified growing numbers of public-private partnerships.

1 In 2011, Ghana, India, and Vietnam had similar incomes per capita, but India’s government spent far less of its GDP on healthcare, according to World Development Indicators provided by the World Bank.

4 According to the India Brand Equity Foundation, an initiative of India’s Ministry of Commerce & Industry, per ibef.org.
THE LANDSCAPE OF PRIVATE HEALTH SECTOR ACTIVITY

Innovative Approaches

Health organizations in India are using a variety of business models to improve care. CHMI profiles a total of 250 health market innovations operating in India, with 84 programs organizing providers to better deliver healthcare, and 88 programs mobilizing funds for the poor. In addition, 157 of the 250 programs employ models that focus on enhancing business processes, often to increase quality and efficiency.

Since 2000, several innovative approaches have grown quickly (see graph), including the use of information and communications technology, which is the most common innovative approach applied by programs in CHMI’s database.

CUMULATIVE NUMBER OF CHMI-PROFILED PROGRAMS IN THE SEVEN MOST COMMON INNOVATIVE APPROACHES IN INDIA, BY PROGRAM LAUNCH YEAR

FUNDING SOURCE & HEALTH FOCUS

Approximately 70% of programs in India profiled in the CHMI database are not-for-profits (see graph at right), and most programs rely on some external source of funding for their operations (69%). At least 89 programs are receiving donor support, while 50 are receiving some financing from the government via public-private partnerships. More than a dozen programs have secured debt or equity investments from financiers.

GEOGRAPHIC DISTRIBUTION OF PROGRAMS PROFILED BY CHMI IN INDIA

CHMI-profiled programs focus their operations more in Andhra Pradesh, Maharashtra, Karnataka, and Tamil Nadu than other states (states with fewer than 10 programs on CHMI are not included below). The apparent prevalence of programs in Andhra Pradesh may be partially because ACCESS Health International, one of CHMI’s partners in India, bases its operations in that state.
KEY INNOVATIVE APPROACHES IN INDIA

Information Communication Technology
Just over a third of the programs CHMI profiles in India indicate using technology as a core part of their models. Of the 200 programs targeting India’s rural population, many use technology in interesting new ways, including to facilitate remote diagnosis of rural patients, make health records at peripheral clinics available to central health providers, and allow providers and patients to access health education and awareness information. Saadhan, a PSI-affiliated program, runs a hotline that provides counseling and information services to improve women’s health. Saadhan also tracks clients with software so its counselors can follow-up with repeated callers.

Social Franchising
Health franchises help patients navigate health markets and identify quality-assured care by providing standardized training and branding for each of their providers. The Merrygold Health Network franchises the delivery of maternal and child health services to the poor by private providers in Uttar Pradesh. Branded district-level (Merrygold), block-level (MerrySilver), and community-level (merryHYSHE) providers offer diverse ways for consumers to access care. The network recently expanded from 240 to 441 facilities and launched the new Merrygold Hotline to further increase the program’s reach.

Mobile Clinics
Mobile clinics are one way to provide healthcare to people living beyond the reach of brick-and-mortar health clinics. CHMI profiles 44 programs operating as mobile clinics—and not all on wheels. Since 2005, the not-for-profit Centre for North East Studies and Policy Research, in collaboration with the National Rural Health Mission and the Government of Assam, has been providing basic healthcare services to remote island communities through Boat Clinics equipped with laboratories and pharmacies.

Government Collaborations
Public-Private Partnerships (PPPs) are an important part of the government’s efforts to harness the potential of for- and not-for-profit private players in the health system. CHMI’s database includes 50 such partnerships in India. At least 15 of these programs support health call centers or provide emergency services; other profiles describe government contracts with private organizations to deliver specific services. Several programs use NGOs to increase access to specialized services, from family planning to cancer diagnosis to tuberculosis (TB). The Mahavir Trust Hospital trains private practitioners around Hyderabad to identify and refer TB patients to private clinics for government-provided treatment. PPPs also allow the government to augment the capacity of its directly administered public health system. For example, the state of Orissa contracted with a local NGO, NVSSAADDI, to overhaul a number of previously defunct primary health centers.

Microinsurance Partnerships
State- and national-level government entities are driving many large publicly subsidized health insurance programs that cover hospital care, which can fund private healthcare enterprises while protecting the poor against the financial hardship of health costs. Meanwhile, some private organizations fill gaps in government coverage either by targeting those who are above the poverty line and therefore lack coverage or by offering benefits that complement the government’s coverage. Some microinsurance schemes have even formed formal partnerships with the government.1 One example is Mukhyamantri Jibon Jyoti Bima Achni Insurance, a partnership between the government of Assam and ICICI Lombard Insurance to provide health and personal accident insurance to low-income employees. The premium is shared between the state and individual members. India’s fast-moving health marketplace promises many developments in the coming years with its constantly evolving health information technology, primary care models, and government partnerships. These compelling models are likely to continue to grow within India, and in some cases, inspire adaptations in other countries. In fact, CHMI is working to encourage such replication. See page 36 to learn more about these activities.

Health Innovations in Fragile States

Fragile states or states with unusually weak governance, policies, and institutions are home to one third of the world’s poor and experience an unusually high incidence of disease. Worldwide, these countries account for more than one third of maternal deaths, more than half of the deaths of children under the age of five, and more than one third of the deaths from HIV/AIDS. In many fragile states where the public sector struggles to meet citizens’ basic health needs, the private sector has sometimes worked to fill the gap. CHMI’s database provides insight into unique approaches the private sector employs to deliver care in fragile states.

Of the 75 programs CHMI has identified as operating in a World Bank-designated fragile state most (62) focus their work in one fragile state, while 13 programs operate in two or more fragile states. The three such countries that are home to the greatest number of profiled programs are Haiti (12), Nepal (12), and South Sudan (9). Sixty-seven percent of programs are not-for-profit entities, 11% are public-private partnerships, and 8% are for-profit initiatives. Donors have been the primary funding source for 65% of programs, including most not-for-profit programs.

Many donors prioritize providing basic services and addressing pressing health issues in fragile states.2 CHMI data indicate that 36% of profiled programs focus on HIV/AIDS care, 28% on maternal and child healthcare, 25% on general primary care, and 24% on family planning and reproductive healthcare (see graph on page 18). Only 16% of programs operating in fragile states provide secondary or more specialized services, such as eye care (5%) or chronic diseases (1%).


2 Providing Health Services In Fragile States. USAID and BASICS, 2006. usar.gov
HEALTH FOCUS OF PROGRAMS OPERATING IN FRAGILE STATES

HEALTH FOCUS AREA | NUMBER OF PROGRAMS
---|---
General Primary Care | ✔️
Chronic Diseases | ✔️
Emergency Care | ✔️
Eye Care | ✔️
Family Planning and Reproductive Health | ✔️
General Secondary and Tertiary Care | ✔️
HIV/AIDS | ✔️
Malaria | ✔️
MNCH | ✔️
Nutrition | ✔️
Other/NA | ✔️
TB | ✔️
= 1 PROGRAM

CHMI’S DATABASE REVEALS COMMON PRACTICES IN FRAGILE STATES, INCLUDING:

Training healthcare workers to provide community-based care

• In many fragile states, traveling long distances is impossible due to conflict or lack of infrastructure. Tiyatien Health trains village health workers in Liberia to deliver primary healthcare in communities that were previously thought unreachable.

• The Patan Academy of Health Sciences is a medical school in Kathmandu that provides subsidized medical training to students in exchange for an agreement that graduates will serve in remote areas of Nepal for two to four years after graduation.

Adapting pharmacies and products to use in isolated communities

• Healthy Entrepreneurs’ Pharmacy-In-A-Box is a small pharmacy stocked with 25 essential generic medicines tailored to the specific health needs and infrastructure realities of rural communities. Healthy Entrepreneurs operates in five countries, including the fragile states of Burundi, the Democratic Republic of the Congo, and Haiti.

• In South Sudan, the Maternal, Newborn, and Child Survival Initiative trains frontline health workers to use a specialized kit for midwives that contains basic sterile supplies aiding in delivery in remote communities.

Providing specialized HIV/AIDS education to consumers and providers

• The Omilling HIV/AIDS Project promotes HIV/AIDS awareness and testing in the Omilling countryside of South Sudan, where some communities have high HIV/AIDS rates. The program trains women to educate remote communities about HIV/AIDS and operates support groups for HIV positive women to help them cope with the social stigma attached to HIV/AIDS.

• In East and Central Africa, prostitutes are prevalent at truck stops, and sexual practices have contributed to the spread of HIV/AIDS. SafeTStop provides recreational and resource centers with confidential HIV testing and counseling. SafeTStop operates in eight countries, including Burundi and South Sudan.

Building the capacity of local government institutions and facilitating public-private partnerships

• Some programs from CHMI’s database are working to enhance government health capacity. In Nepal, Nyaya Health constructs healthcare infrastructure, trains local health workers, and provides direct medical services in partnership with local governments in one of Asia’s poorest regions.

• The Afghanistan Health Policy Project strengthens the Ministry of Public Health’s capacity to design, negotiate, and manage hospital public-private partnerships.

Distribution of Programs Operating in World Bank-Identified Fragile States

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<th>NUMBER OF PROGRAMS BY COUNTRY</th>
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<tr>
<td>Afghanistan</td>
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<td>PROGRAM CONCENTRATION</td>
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Photo Left: In the Democratic Republic of the Congo, a Healthy Entrepreneurs pharmacy window.

Of the 37 programs CHMI profiles in Pakistan, 25 focus on primary care, 13 focus on secondary/tertiary care, and nine programs provide primary and secondary care services. Akhuwat Health is one example of a program that provides both primary and secondary care services through its mobile clinic in Punjab.

Also common in Pakistan is the use of online or phone-based health information services to reach providers and consumers with healthcare information. SRHMatters, run by Marie Stopes International Pakistan, is an online counseling service that provides sexual and reproductive health information to Pakistani youth. Healthline, Pakistan provides health information to semi-literate community healthcare workers to enable them to better serve their communities.

The private sector plays an important role in delivering healthcare to the poor in fragile states and can be an important partner in improving health systems. CHMI will increasingly focus on documenting and tracking programs in fragile states to better understand what types of models work in resource-constrained settings.
Some emerging models have evidence of their impact and effectiveness.

Expanding Access to Priority Health Services and Commodities

Many private organizations are experimenting with innovative delivery and financing mechanisms to provide quality services focusing on tuberculosis, malaria, and maternal, newborn, and child health (MNCH) and to deliver medicines for these and other health issues. Some emerging business models have evidence illustrating their impact and effectiveness while others require further research.
INNOVATIONS IN ESSENTIAL HEALTH SERVICES

Private organizations are pioneering new ways to prevent, diagnose, and deliver MNCH, TB, and malaria services. Some programs use innovative business practices like social franchising and high-volume, low-cost service delivery models to target and serve high-priority populations more effectively. Other programs are improving the quality and efficiency of services delivered through existing, and often informal, private providers, who are often the first point of care for poor patients. Innovators are developing mobile-based tools that reinforce treatment adherence and care compliance on the patient side. Others are developing diagnostic tools that are faster, more accurate, mobile, and less expensive than traditional tools.

CHMI partnered with the University of Toronto’s T-HOPE Group to shed light on how organizations are using market-based approaches to provide quality services and which of these are demonstrating promising results. The analysis summarized evidence from the peer-reviewed and gray literature, as well as results reported by programs to CHMI. While the volume of services provided by the private sector is high and the level of experimentation with new approaches is considerable, it is hard to say whether they have actually resulted in improved health outcomes. Below are excerpts from CHMI briefings on MNCH, TB, and malaria.

INNOVATIONS IN TB

CHMI has identified 81 programs working to significantly reduce the burden of TB illness in low- and middle-income countries. Many are experimenting with new methods to increase access to TB care, improve the timeliness and accuracy of diagnosis, and boost adherence to care protocols through the following approaches.

Information technology. Of the innovative approaches used by CHMI’s TB programs, information technology is the most common, with one-third of the programs using it as a core part of their models. A number of programs are using technology to support health workers in care delivery, ranging from mobile diagnostics to programs that ensure treatment adherence. Limited evidence exists concerning the use of ICT in TB, but studies about malaria and MNCH programs indicate that technology may have the potential to improve access and affordability.

Mobile diagnostics. Programs are using mobile diagnostics to speed the diagnosis process and increase accessibility in areas outside of laboratories and health centers. Limited evidence exists concerning whether programs can increase diagnostic accuracy through this approach, with very early findings indicating that accuracy is on par with traditional culture reviews.

Leveraging informal providers. Increasing numbers of programs are now developing ways to treat TB in partnership with informal providers, who are often the first point of contact for patients. These methods can range from programs that train providers to improve their TB management to initiatives incorporating existing informal clinics into national TB control programs. Evidence is limited regarding the use of informal providers to deliver TB care, but some studies indicate it can improve the timeliness of detection and the treatment of TB patients.

Microinsurance. Customized financial services, including microinsurance schemes that cover the basic health needs of women and children, can increase access to MNCH care. Some evidence indicates that microinsurance schemes that include maternal healthcare services increase the use of related services while improving financial protection for the poor. More research could further demonstrate the best ways to target the very poor, who may be unable to afford flat-rate premiums.

Vouchers. MNCH voucher programs in CHMI’s database typically target poor women and often cover services such as deliveries, antenatal and postnatal care, child immunizations, and nutrition services. Programs seem to be more successful if they have strong oversight and management and some relationship with the public sector through funding or stewardship. Some evidence indicates that vouchers increase the utilization of skilled service providers, but the impact of vouchers on maternal mortality is not as well studied.

Sambhav Voucher System is a collaborative program with the Indian government and USAID to increase, through vouchers, access to subsidized reproductive health services for low-income mothers living in three northern states.

INNOVATIONS IN MOTHER, NEWBORN, AND CHILD HEALTH

Social franchising, microinsurance, and vouchers are the most common types of approaches among the 282 programs CHMI has identified as focusing on MNCH.

Evidence indicates they are having some impact, such as increased utilization, improved pro-poor targeting, and reduced out-of-pocket spending.

Franchising. Franchise networks are based on contractual agreements with medical providers in which providers sell services and, in exchange, receive membership benefits, frequently including the right to use the franchise brand and access to training. Evidence indicates that franchises increase service utilization by poor and pregnant women. The model’s effect on quality and client satisfaction is not as well established.

Mahila Swastha Sews is a franchise in Nepal that provides family planning, reproductive health, and MNCH services. In 2010, the program reported that it charged USD$2.81 for an intrauterine contraceptive device, whereas the average cost of this service in Nepal’s private sector was USD$7.

Motech in Ghana sends pregnant women and their families text messages with time-specific updates on the pregnancy in their own language, following up for the first year of life to reinforce child care practices and vaccinations.

D-free International is developing a TB module to help health workers in Tanzania identify TB among HIV-infected clients; the module will suggest diagnostic tests to perform even after clients miss a visit.
Expanding Access to Priority Health Services and Commodities

- **Operation ASHA** establishes TB treatment centers in existing community locales in India, implementing the DOTS program and installing medicine pickup locations in clinics operated by informal providers. The TB-detection rate in areas where the program operates has increased by 95% in four years, and the program reports to have decreased the TB mortality rate in South Delhi from 6% to 2%.

**Electronic medical records.** Several programs are using electronic medical records (EMRs) to strengthen TB surveillance and monitoring. Studies show that this approach increases treatment compliance and facilitates the delivery of medication. Furthermore, programs using EMRs have been shown to lose fewer patients to follow-up.

- **Open Medical Record System in Rwanda** provides free, open-source software to enable data exchange in resource-limited settings.

**INNOVATIONS IN MALARIA**

Seventy-six programs profiled by CHMI are using proven and newer practices to prevent and treat malaria. These approaches include social marketing, rapid diagnostic tests, and mobile phones for supply-chain monitoring to support malaria control efforts. Early evidence indicates that these practices are resulting in cost savings and increased efficiencies, but more research is needed to identify the key factors for success, as well as the effect on malaria outcomes.

**Social marketing.** Social marketing is one way programs generate demand from community members for appropriate treatments. These programs work to change consumer behavior toward consumption of a given good or product through commercial marketing techniques; some programs are also distributing vouchers to ensure that cost is not a barrier to access. Studies show that social marketing and vouchers can, in combination, successfully increase the use of insecticide-treated nets by vulnerable populations, most notably in Tanzania and Ghana.

- **Living Goods,** the network of community health agents, trains representatives to provide basic health counseling about malaria while encouraging clients to call at the first sign of malaria symptoms. The program reports that its prices are 10–30% below market and thus more accessible to people in Ugandan communities.

**Community-administered rapid diagnostics.** Community health workers (CHWs) can help to administer Rapid Diagnostic Tests (RDTs) in hard-to-reach locations.

New approaches are demonstrating that the private sector can contribute to reducing the morbidity and mortality of some of the biggest global killers. The breadth of programs reporting to CHMI on their performance in improving health access, outcomes, and operations is encouraging. More can be done to identify what works (see page 30 for more on CHMI’s new performance metrics) and scale up promising approaches.

Evidence indicates that CHWs are more likely to follow appropriate treatment protocols after receiving test results when compared with other formal and informal providers. However, few studies have explored private providers’ incentives to use RDTs, and research has not indicated whether consumers demand these tests or adhere to the results.

- **Health Care at My Fingertips in Kenya** provides community health workers with RDTs to improve the timeliness and accuracy of diagnosis in rural settings.

**Supply-chain monitoring.** Innovators are also reducing supply-side barriers to malaria care, including by leveraging the private sector’s strong procurement and distribution networks and using mobile phones to track the supply and distribution of malaria health products. Some data specific to CHMI-profiled programs indicate that such tracking can reduce stockout rates for malarial medications and RDTs. More research is needed to explore the affordability of this model and the feasibility of scaling it up.

- **SMS for Life** tracks the supply chain of artemisinin–combination therapies (ACTs) and quinine injectables in Tanzania, using a combination of mobile phones, SMS messages, and electronic mapping technology. At the pilot’s start, 26% of all health facilities had no malaria medicines in stock; by the end of the pilot, only 0.8% of facilities reported stock-outs.

<table>
<thead>
<tr>
<th>SUPPLY CHAINS COMPONENTS</th>
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<tbody>
<tr>
<td>1 Production</td>
</tr>
<tr>
<td>2 Procurement</td>
</tr>
<tr>
<td>3 Distribution</td>
</tr>
<tr>
<td>4 Delivery</td>
</tr>
</tbody>
</table>

Photo Above: Local women with HealthKeepers sell health products in Ghanaian communities.

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8 United Nations Development Group, Indicators for Monitoring the Millennium Development Goals. mdgs.un.org
9 ARV and TB medicine drug supply issues. Hewsten South Africa’s ARV programme. Aidsmap.com
PRODUCTION

One key innovation during the production step is bundling medicines with pharmaceutical or other key products so that consumers are guaranteed to receive everything they need. In 2010, AYZH launched a clean birth kit called JANMA which provides women with all the components recommended by the World Health Organization for safe and hygienic birth. Similarly, CaliaLife in Zambia produces anti-diarrheal kits called “Kit Yamoyo” that contain oral rehydration salts, zinc tablets, soap, and educational materials.

PROCUREMENT

The innovations in procurement captured in the CHMI database consist largely of purchasing tactics that reduce the cost of medicines and health-related products. For example, starting in 2004 in Tanzania, UNICEF and the Global Fund began acting as “buyers of last resort” for bed nets, guaranteeing that they would purchase all long-lasting insecticide-treated bed nets made by A to Z Textile Mills that did not clear normal channels. This arrangement allowed A to Z to sell the nets to consumers for a lower price. In Bangladesh, Kallyani Clinics partners with GRAUS, a local NGO, to purchase drugs from manufacturers at below market rates and provide seed money to clinics to purchase drugs.

DISTRIBUTION

Organizations are using alternative means of transportation to get medicines to remote destinations. As of May 2013, World Health Partners in India was employing 50 locals on motorcycles, called “Last Mile Outriders,” to take drugs to rural clinics. In Peru, APECA uses canoes and boats to distribute cofres medicinales—or medical chests with essential medicines—to communities along the Amazon River.

Another distribution solution that seems to be growing in popularity is using existing supply chains to bring health products to consumers. CalaLife utilizes Coca-Cola’s established supply chains to bring essential medicines to communities. Similarly, ClinicsAll uses commercial supply chains to increase access to medicines across Africa and Asia, as does PSI Angola, PSI Somaliland, and PSI South Sudan.

DELIVERY

Bringing essential health products to consumers’ doorsteps provides crucial access to those who may be unable to travel to pharmacies and other stores selling health products. Healthkeepers in Ghana, Living Goods in Uganda, and Project Shakti in India use a model based on that of Avon, a cosmetic company, by employing local women to sell products to customers in their own communities.

Additionally, several organizations are implementing technology solutions that allow those at the point of delivery to communicate more effectively with the supply chain concerning their stock of medicines and health products. In 2009, Novartis began working with Roll Back Malaria, Vodafone, and IBM to implement mVigil for Life in Tanzania. This initiative uses SMS messages and electronic mapping to track stock of anti-malarial drugs and ensure that necessary replacements are delivered on a weekly basis. Similarly, the UmeedSeey Micro Health Franchise System in Pakistan uses a mobile application that allows community midwives to request health products as necessary from the franchise network.

A final intervention at the point of delivery is the use of chains or franchises of pharmaceutical outlets to help ensure the price, quality, and availability of drugs when they reach the consumer. Botika ng Bayan in the Philippines and Healthy Entrepreneurs in the Caribbean, South Asia, and Africa use a franchise model through which they are able to control the prices, types, and availability of drugs stocked at pharmacies in their networks. Farmacias Similares in Latin America and MedPlus in India use a similar chain model in which the outlets are centrally owned.

CONSUMER-SIDE INNOVATIONS

Even when medicines and products have reached their final consumers, additional interventions can be used to ensure that the supply chain has worked effectively. Spravir, available in Ghana, Nigeria, Kenya, and India, allows users to scratch off a security label on the packaging of medications to reveal a unique code. When this code is tested to Spravir’s system, consumers receive a response indicating whether their medication is legitimate or a possible counterfeit. mPedigree has a similar model.

CREATING A COMPREHENSIVE SOLUTION

Health supply chains are complex systems with the potential for inefficiency throughout the process, possibly resulting in consumers receiving overpriced and low-quality medicines. The innovations above show promise in their abilities to address problems within individual steps. As organizations continue to experiment, they may develop comprehensive solutions to guarantee efficiency, quality, and affordability along each step of the chain, ultimately ensuring consumers have access to the health products they need.

New Research on Informal Providers

In communities with limited numbers of qualified physicians, many programs seek to expand access to quality services using less-trained health workers or even volunteers. Many global policy makers and international agencies have endorsed the use of community health workers to deliver simple preventive and curative care.11

However, while many organizations use community members to deliver basic health services, few explicitly engage the vast number of informal and largely unregulated health workers known as village doctors, drug vendors, and traditional birth attendants, among dozens of other titles.

CHMI commissioned a series of studies in Bangladesh, India, and Nigeria to better identify, describe, and in turn, encourage greater engagement with informal providers, a lesser known but large part of the health system in many countries.

BACKGROUND

Informal providers are a vital source of care for many in low- and middle-income countries. In some regions, they represent a large proportion of available healthcare providers, comprising more than 50% of healthcare workers in India and close to 96% in rural Bangladesh. However, they have little formally recognized training and operate outside the purview of regulatory authority.

Despite these challenges, informal providers may present an opportunity to address several high-priority health system concerns. They routinely fill gaps in formal healthcare provision, with many serving traditionally hard-to-reach populations in rural and remote areas. Thus, with proper interventions, informal providers could potentially be harnessed to expand access to care.

HIGHLIGHTS FROM THE STUDIES’ FINDINGS
Below are brief summaries of findings12 from research commissioned by CHMI and conducted by researchers13 studying diverse groups of informal providers in Bangladesh, India, and Nigeria.

1. Informal providers have strong roots in their communities.

Informal providers studied had well-established practices and were often trusted members of their communities. In India, more than half of the providers studied were born in the same block or district where they practiced. Most had well-established businesses that had been in the same location for 10-15 years.

2. Informal providers often invest in professional health training.

While the duration, format, and content of the training varied widely, most providers did have some form of health training, such as commercially offered courses or public training for community health workers, and had often apprenticed with qualified doctors. In Bangladesh, 91% of providers studied said that they received some form of professional training.

3. Informal providers are integrated with the formal health system.

Informal providers often had ties to other parts of the complex health markets in which they operated, frequently communicating with qualified doctors for medical information and referrals. In Andhra Pradesh, providers surveyed stated they were registered with the PMV Association, which trains, monitors, promotes, and defends members—with legal action, if necessary.

4. Informal providers can be better integrated into health systems with government support.

Some governments are formalizing the practices of informal providers while others remain either ambivalent or hostile. In India, 96% of Private Medical Vendors (PMVs) surveyed stated they were registered with the PMV Association, which trains, monitors, promotes, and defends members—with legal action, if necessary.

5. Informal providers have a mixed record on quality.

The studies found that informal providers had some knowledge about certain care standards but not about all important aspects of care. Further, they often provided unnecessary or wasteful treatment, such as drugs or injections.

We need to know why people still avoid formal healthcare structures even when there is access, and how to better integrate informal providers into the overall system—or to see what formal health systems can learn from informal providers.

— Discussion group contributor Dr. Egbe Osifa-Davodu, Anadach Group

CHMI profiles 52 programs that report an existing engagement with the informal health sector. The examples below represent several promising approaches.

Educating traditional healers about danger signs. In Cambodia, traditional healers called Kruu Boran are often the first point of care. NOMAD RSI established an association to train Kruu Boran to recognize basic diseases and refer patients to qualified health providers where danger signs are evident. The program, which also promotes medicinal plants, is called the Cambodian Medicinal Plants Project.

Involving traditional providers in health awareness campaigns. In Ifugao, the Philippines, traditional birth attendants are included in Ayod Community Health Teams to promote institutional deliveries and raise awareness about malaria, dengue, TB, and other important health issues.

Training birth attendants. Many countries have prioritized increasing the number of birth attendants with life-saving skills and other competencies. Since 2010, Tanzania has formerly accredited midwifery training institutions. Boma la Mama offers a two-year training program in the Arusha region.

Distributing health kits. In Herat Province, Afghanistan, the Afghan Institute of Learning runs a Holistic Health for Mother and Baby program. Women and their traditional birth attendants receive a basic delivery kit at workshops providing detailed health information relating to pregnancy, including normal and complicated delivery, breastfeeding, and high-risk factors. In the project’s pilot, 94.7% of participants gave birth in a clinic or a hospital, compared to the national average of 15%.

Photo Above: An informal provider of dentistry proffers his services in a Dhaka bazaar.

Browse resources on informal providers and explore programs harnessing this large health workforce at HealthMarketInnovations.org/chmi-topics/Informal-Providers

Join the discussion group at informalproviders.org
Tracking Program Performance and Scale

With an aspiration to provide increasingly comprehensive, up-to-date information to our community of program managers, funders, researchers, and policy makers, CHMI has standardized many aspects of data collection. In particular, with an increasing focus on assessing the collective impact of the programs we profile—how they are improving the quality, affordability, and accessibility of healthcare services for the poor—CHMI has focused on standardizing, tracking, and reporting indicators of program performance and scale.
The global health community is increasingly seeking to understand and communicate the results of innovative solutions to improve healthcare options for the poor. Since launching its Reported Results initiative in 2011, CHMI has started to answer the question of “what works,” first by collecting the performance data programs already track and then by moving to standardize how program performance is shared with the global health community.

Reported Results are clear, quantifiable, and time-bound measures of program performance collected across three performance dimensions—Health Access, Health Outcomes, and Operations/Delivery—encompassing several categories (see chart on page 34). CHMI launched the Reported Results initiative as a first step toward identifying innovative solutions that improve the access, quality, and affordability of healthcare for the poor.

Today, more than 240 programs working in 85 countries are reporting more than 770 results, which provide the community with rich, concrete information on the effectiveness of their work.

**DEMONSTRATING PROGRAM IMPACT IN KEY PERFORMANCE AREAS**

Results collected to date indicate that organizations profiled on CHMI are achieving health and financial results important to national and global health policy makers, donors, investors, and others managing health programs. A snapshot of the results reported to CHMI follows.

**Health outputs** are the immediate products or results of an organization’s activities and serve as a foundation for measuring health outcomes and impact. Nearly 100 CHMI programs report health outputs, with 217 output indicators in total.

- Community Health Africa Trust (CHAT) uses mobile facilities to provide family planning, reproductive health, and basic curative services to remote communities in northern Kenya. CHAT reports that between 2009 and 2011, it increased the number of basic curative and reproductive health services provided by 40% and increased the number of patients being counseled and tested for HIV by 30%.

- The Bangladesh Demand Side Financing Pilot Program, launched by the Government of Bangladesh in 2004 to increase the use of quality maternal healthcare services, provides cash subsidies to cover transportation for key health services. An evaluation found that the incidence of stillbirths was 1.37% in participating health facilities, compared to 2.57% in control areas, and that the rate of deliveries by qualified providers was twice as high in participating sub-districts (64%) as in control areas (27%).

**Health outcomes**, which result from an organization’s outputs, are demonstrated by improvements in the health of patients and populations. More than 70 CHMI programs report health outcomes, with 150 results.

- LifeNet International provides primary healthcare to low-income populations in Burundi through church-based clinics and hospitals. The program, which developed a Quality Score Card drawing on standards established by the Burundian Ministry of Health, the USAID-funded Smiling Sun Health Services network, and the IFC, reported that its average quality improvement score more than doubled between March 2012 and December 2013.

**Pro-poor targeting** assesses the proportion of a program’s clients that are poor or disadvantaged. Twenty programs report results in pro-poor targeting, for a total of 34 results.

- BlueStar Pilipinas is a family planning franchise focused on improving access to quality sexual and reproductive health services through existing private providers. In 2011, 46% of the program’s clients belonged to households whose incomes fell below the national poverty line.

**Affordability** is a measure of patients’ ability to pay for a given product or service and helps to explain how well underserved populations can access healthcare. More than 60 programs report on affordability, with 84 results.

- LifeSpring Hospitals Private Ltd. is a chain providing quality healthcare to lower income women and children across Andhra Pradesh, India. Lifespring reported, as of 2010, it priced services between 30% and 50% of prevailing market rates, at USD$440 compared to the standard $200.

**Clinical quality** refers to care that is safe and medically appropriate and is closely linked to health outputs and outcomes. More than 30 programs report results on clinical quality, with 51 results total.

- LifeNet International provides primary healthcare to low-income populations in Burundi through church-based clinics and hospitals. The program, which developed a Quality Score Card drawing on standards established by the Burundian Ministry of Health, the USAID-funded Smiling Sun Health Services network, and the IFC, reported that its average quality improvement score more than doubled between March 2012 and December 2013.

**PROGRAMS FROM CHMI’S DATABASE REPORTING RESULTS IN KEY PERFORMANCE DIMENSIONS**

<table>
<thead>
<tr>
<th>RESULTS CATEGORY</th>
<th>NUMBER OF PROGRAMS REPORTING RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability</td>
<td>57</td>
</tr>
<tr>
<td>Availability</td>
<td>32</td>
</tr>
<tr>
<td>Pro-Poor Targeting</td>
<td>22</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>30</td>
</tr>
<tr>
<td>Efficiency</td>
<td>30</td>
</tr>
<tr>
<td>Financial Sustainability</td>
<td>17</td>
</tr>
<tr>
<td>User Satisfaction</td>
<td>44</td>
</tr>
<tr>
<td>Health Output</td>
<td>83</td>
</tr>
<tr>
<td>Population Coverage</td>
<td>30</td>
</tr>
<tr>
<td>Health Outcome</td>
<td>67</td>
</tr>
</tbody>
</table>
STANDARDIZING PERFORMANCE MEASUREMENT FOR HEALTH ORGANIZATIONS

Building on the Reported Results initiative, CHMI is working with the Impact Reporting and Investment Standards (IRIS) initiative of the Global Impact Investing Network (GIIN) to develop standard definitions for relevant social and financial performance metrics commonly tracked by healthcare organizations serving low-income communities.

An expert working group composed of practitioners, impact investors, donors, and others with health implementation and metrics development experience designed the metrics. They sought to provide a tool for impact investors, funders, and program implementers to identify companies that have the most impact.

Because no single combination of metrics is right for every organization, this set is designed to serve as a catalog that investors and investees can use to select the most appropriate metrics for their work based on their organizational goals. The expert working group reviewed best practices in performance measurement used by health organizations targeting the poor, pulling from such sources as the World Health Organization and the World Bank to identify metrics that map to the key questions below. Practitioners and experts vetted the metrics through open comment periods, soliciting feedback on clarity, usability, and feasibility.

The metrics are focused on three core performance areas that carried over from CHMI’s Reported Results initiative. The metrics an organization selects to report can help to provide a more robust picture of the performance of a health organization.

The metrics will be integrated into CHMI’s Reported Results initiative, which aggregates performance results from hundreds of profiled programs in CHMI’s database. Program managers are encouraged to use metrics applicable to their organizations and integrate them into their performance measurement systems.

Building on this foundation of common metrics, IRIS and CHMI will use the resulting performance data to create benchmarks, identify successful models, and help funding flow to organizations that are effectively delivering quality healthcare services for low-income communities.

For more information on this work, please visit our Reported Results topic page.

Performance Dimensions of Healthcare Metrics

<table>
<thead>
<tr>
<th>1. WHO IS BEING SERVED?</th>
<th>2. WHAT IS BEING DELIVERED?</th>
<th>3. HOW IS IT BEING DELIVERED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro-Poor Targeting</td>
<td>Health Outputs</td>
<td>Clinical Quality</td>
</tr>
<tr>
<td>What is the population</td>
<td>What types of products and</td>
<td>What is the level of quality</td>
</tr>
<tr>
<td>coverage of key</td>
<td>services being delivered?</td>
<td>of services delivered?</td>
</tr>
<tr>
<td>interventions?</td>
<td>Health Outcomes</td>
<td>User Satisfaction</td>
</tr>
<tr>
<td></td>
<td>What are the direct results</td>
<td>Do patients’ experiences</td>
</tr>
<tr>
<td></td>
<td>of products and services</td>
<td>meet expectations?</td>
</tr>
<tr>
<td></td>
<td>delivered?</td>
<td>Financial Sustainability</td>
</tr>
<tr>
<td>Affordability</td>
<td></td>
<td>Are financials sustainable</td>
</tr>
<tr>
<td>Is the product or service affordable?</td>
<td></td>
<td>to maintain operations over the long term?</td>
</tr>
<tr>
<td>Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the scale of the organization’s operations?</td>
<td></td>
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</tbody>
</table>

To track the spread of innovations in health markets worldwide, CHMI profiles include multiple data points to ascertain the size and scope of programs in the database. Indicators of scale captured in CHMI profiles may include the number of facilities a program networks or accredits, the number of clients served, and the breadth of services offered.

At least 40 programs reported growing by one or more of these dimensions in the past year. The following are examples of recent growth.

Crossing Borders: Innovators are adapting models to new countries.

- **APOPO**, which uses trained rats to detect tuberculosis, grew from 17 to 21 centers in Tanzania and launched eight new centers in Mozambique.
- **Living Goods**, whose community health promoters make more than 500,000 visits annually to homes in Uganda selling essential health products, replicated its model in Nairobi.

Expanding Networks: Innovators are increasing their number of facilities in their networks.

- **Red Segura**, a network of clinics providing reproductive health services in Guatemala, expanded from 111 to 347 providers in the past year and increased the number of clients served from 4,580 to 11,612.
- **Ziqitza Healthcare Limited**, an emergency transport service in India, nearly doubled the number of ambulances it operates in the last year from 460 to 860. It manages the government-funded emergency services hotline Dial 108 in three states.

Expanding Benefits: Innovators are incorporating additional health service offerings.

- **Naya Jeewan**, which provides affordable health insurance to low-income families in Pakistan, increased its enrollment from 18,123 to 25,478.
- **HealthKeepers**, which uses a door-to-door sales model, increased the number of clients reached in Ghana from 300,000 to 644,680 in the past year.

Photo Above: APOPO uses trained rats to diagnose TB in Tanzania and Mozambique.
CHMI works to address challenges to growth faced by health innovators.

Helping Promising Health Programs Serve More People

While many health programs are working hard to expand their operations and serve more people, the challenges for a health program to reach a significant scale are numerous. Sourcing, training, and retaining effective personnel; mastering clinical quality standards; accessing funding; and achieving an effective business model are just a few of the many hurdles.
CHMI APPROACHES TO SUPPORTING PROGRAM GROWTH

1. Supporting peer-to-peer learning and partnerships among healthcare practitioners: Connections among program managers can result in the transfer of knowledge, lessons learned, and even operational partnerships. CHMI creates diverse opportunities for practitioner-to-practitioner learning. One way connections happen is through the CHMI website: In the past year, registered members have sent more than 280 messages to program managers, with many connections leading to partnerships (see map on next page).

The Primary Care Learning Collaborative
- Healthcare managers running low-cost clinic chains and franchises in Burundi, India, and Kenya joined a new “collaborative” to provide high quality and affordable primary healthcare. Members are using the collaborative, convened by CHMI, to jointly address the challenges of rapid growth. They are also openly sharing the parts of their business models that are working—offering the best strategies and tactics for reaching the poor, providing high quality care, and creating sustainable businesses. All members pledged to focus on improving key parts of their operations and share their results publicly in one year’s time.

2. Building effective partnerships between healthcare organizations and governments: Private organizations and governments can often jointly benefit through collaboration, from sharing information to partnering via contracts that enable private practitioners to contribute on a significant scale to national health goals. In Kenya and Nigeria, CHMI’s regional partners have created advisory groups with representation from policymakers to ensure that national priorities are reflected in the partners’ approach to scaling up health innovations. In addition, CHMI’s regional partners run “matchmaking” activities connecting innovators to policy makers and encouraging governments to adopt promising privately managed initiatives that can contribute to their larger health agendas.

Innovation Marketplaces
- Several partners are hosting competitions and marketplaces in which innovators will promote their models. CHMI’s partner in the Philippines, the Philippines Institute of Development Studies (PIDS), continues to host events connecting innovators and government representatives to discuss how private-sector innovations could improve healthcare for the poor. These events, held in Manila as well as at the local level, are engaging national and provincial government leaders. At a recent event, Carlos Jericho Petilla, the current Secretary of Energy and former Governor of Leyte in the Philippines, talked passionately about the innovative health schemes that he helped to start in Leyte, including Mother Bes Birthing Clinics, PhilHealth Link, and Hospital Incentive Schemes.

Serving as a pipeline to opportunities: Though a host of competitions and other initiatives have recently been launched to support the growth of innovative health programs, many programs struggle to identify these opportunities. For profiled programs—particularly those reporting on their performance—CHMI boosts global visibility and provides direct access to competitions and mentors (see more about tracking program performance on page 30). CHMI also links programs to funding opportunities by serving as a pipeline for bilateral donors, impact investors, development “Challenge Funds,” and accelerators. CHMI has linked more than 50 programs to fundraising platforms like GlobalGiving; prizes, including the Skoll Awards; and elite networking groups, such as the International Partnership for Innovative Healthcare Delivery.

Photo above: On a visit from Kenya, Vincent Mutugi of Access Afya (left) talks with a clinician at Ross Clinics in Gurgaon, India, about their offerings.

We’ve used the CHMI network to expand our work in a number of ways. CHMI’s regional partner, RATN, introduced us to a local university in Kenya that, in turn, told us about SafeCare, a great quality improvement initiative supported by PharmAccess. CHMI also connected us with LifeNet—a member with us on the primary care collaborative—who tipped us off about a foundation that provided us with a grant at a critical moment.

— Stephanie Koczela, Co-Founder, Penda Health, member of Primary Care Learning Collaborative
Helping Promising Health Programs Serve More People

**CHMI’s Impact Stories Across the Globe**

**CHMI Global Collaborators**
A number of collaborators work alongside CHMI to help health innovators improve on their work and reach more people.

- Abraaj Group
- Acumen
- Ashoka Changemakers
- Business Call to Action
- The Centre for Research on New International Economic Order
- Future Health Systems Consortium
- GlobalGiving
- International Finance Corporation
- Impact Reporting and Investment Standards
- Global Impact Investing Network
- Information Society Innovation Fund
- International Partnership for Innovative Healthcare Delivery
- Micrainsurance Network
- Population Services International
- RFVouthier/ Population Council - Nairobi
- Private Sector Healthcare Initiative, UCSF
- Skill Foundation
- The Tech Awards
- Total Impact Advisors
- USAID/SHOPS Project
- University of Toronto
- World Health Partners

**MAP KEY**
- IRIS Metrics
- Analysis Partner
- Connections Partner

**South Africa: Scaling Up Vision Screening**
After connecting through CHMI, Unjani Primary Health Care Clinics partnered with VisionSpring to offer Unjani’s clients vision screening and affordable reading glasses at Unjani clinics. VisionSpring also used CHMI to partner with Vine Pharmacy in Uganda and ERC Eye Care in India.

**Uganda: Raising Capital**
After connecting with Vine Pharmacy through CHMI, the Abraaj Group made a significant investment through its subsidiary, the Africa Health Fund. The capital will enable the drugstore chain and its wholesale business to expand significantly.

**India: Crossing Borders**
World Health Partners won the 2013 Skoll Foundation award after CHMI nominated the Indian franchising network. The million-dollar prize will help the organization adapt its model to Sub-Saharan Africa.

**Kenya: Fostering Mentorship**
Access Afya, a Nairobi-based chain, developed a mentorship relationship with a fellow innovator in Kenya through CHMI. The chain benefitted from shared insights into the country’s regulatory environment and business practices.

**CHMI’s Regional Partners**
ACCESS Health International, India*
BroadReach Healthcare, South Africa
Consultation of Investment in Health Promotion, Vietnam
Freedom from Hunger, Bolivia, Ecuador, Peru
Institute of Health Policy, Management & Research, Kenya, Rwanda, Tanzania, Uganda*
Interactive Research and Development, Pakistan*
Mercy Corps, Indonesia
Philippine Institute for Development Studies, Philippines*
Regional AIDS Training Network, East and Southern Africa*
Swasti Health Resource Centre, India*
Sulina Health, Nigeria*
The Asia Foundation, Pakistan*

*Organizations starred have been active during the 2012-2013 period.
Register on CHMI to connect with innovators profiled in the database.

How CHMI Can Help with Your Work

1. LEARN ABOUT HEALTH MARKET INNOVATIONS. Search CHMI’s database to find programs and policies that harness private providers and work to improve the quality, affordability, and accessibility of healthcare for the poor.

2. FIND OUT WHAT WORKS. Browse Reported Results—statements of impact in areas such as quality, cost, and sustainability.

3. CONNECT WITH INNOVATORS. Explore the CHMI database to learn about innovative health programs. Then register with CHMI to contact them and create new partnerships.

4. PROFILED ON CHMI? GET THE MOST OUT OF CHMI’S NETWORK. Programs providing regular updates and reporting results become eligible for an expanded set of benefits, including global visibility and connections to potential partners such as funders.

Photo Left: A doctor in a Tanzanian hospital accredited to receive payments through MicroEnsure.
Resources

Over the past year, more than 15 publications have used CHMI’s programs database to review global health markets, analyze new business models, or study promising organizations. Below is a selection of these publications, as well as resources on health market themes from CHMI’s expert partners.

- Franchising. Available at the-icsf.org
- Significant Social Benefit. International Centre for Social Franchising. Available at the-icsf.org

ESSENTIAL RESOURCE: CHMI’S NEW WEBSITE

Updated nearly every day by the CHMI team and community—program managers, academics, and other contributors—the CHMI database remains the most comprehensive resource on private organizations working to improve global health care. Visit HealthMarketInnovations.org to explore further.

- Surf new Topic pages—dynamic web portals with live interactive maps and graphs displaying the latest program data—for key findings on themes, including maternal health, India’s health market, and health metrics.
- Connect directly with managers of profiled programs via CHMI’s simple message function.
- Subscribe to topics of interest, such as for-profit programs or programs in Uganda, to receive email updates when content of interest is added to the site.
- Read the CHMI blog for insights from CHMI’s partners, writing from such countries as Nigeria, Kenya, India, and the Philippines, and browse our Opportunities list, which includes competitions, awards, and event listings.

PHOTO CREDITS

Unless otherwise stated, photos appear in Highlights courtesy of the programs they depict.

Page 5-6: Pippa Ranger/Department for International Development (DFID)
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Page 16 & 19: Trevor Lewis for CHMI
Page 22, 27 & 31: Meredith Kimball for CHMI
Page 29 & 38: Alex Robinson for CHMI
Page 30: Lucy Milmo/DFID
Page 31: Trevor Lewis for CHMI
Page 35: Maarten Neve
Page 40-41: clockwise: Left, courtesy of Unjani, Middle & Bottom, Alex Kamweru for CHMI, Right, Photo of World Health Partners by Meredith Kimball for CHMI
Page 42: David Dorey for MicroEnsure
Page 45

PROGRAMS MENTIONED IN THIS REPORT

Programs providing comprehensive, up-to-date information and reporting results are more likely to be featured in CHMI’s Highlights reports.
INFORMING + CONNECTING
ALL THOSE WHO STRIVE TO IMPROVE THE HEALTH OF THE WORLD’S POOR.

HealthMarketInnovations.org