INFORMING + CONNECTING
ALL THOSE WHO STRIVE TO IMPROVE THE HEALTH OF THE WORLD’S POOR.

HIGHLIGHTS
FINDINGS FROM 2014

HealthMarketInnovations.org
ABOUT THE CENTER FOR HEALTH MARKET INNOVATIONS

The Center for Health Market Innovations (CHMI) promotes programs, policies, and practices that make quality healthcare 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 1,400 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 (CEI). CEI promotes programs, policies, and practices that encourage access to quality education in low- and middle-income countries. Details about more than 600 innovative education programs can be found online at EducationInnovations.org.

ABOUT THIS REPORT

This report was compiled by the CHMI team at Results for Development: Jeff Arias, Morgan Benson, Cynthia Charchi, Donika Dimovska, Lane Goodman, Gina Lagomarsino, Trevor Lewis, Rachel Neill, Rose Reis, Komal Bazaz Smith, and Christina Synowiec. CHMI’s regional innovation partners, listed below, contributed insights on new programs and practices.

RECOMMENDED CITATION


CHMI’S REGIONAL INNOVATION PARTNERS

• ACCESS Health International: India*
• Bertha Centre for Social Innovation & Entrepreneurship: South Africa*
• 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 & Development: Pakistan*
• Mercy Corps: Indonesia
• Philippine Institute for Development Studies: Philippines*
• Africa Capacity Alliance: Kenya*
• Swasti Health Resource Centre: India*
• Salina Health: Nigeria*
• The Asia Foundation: Pakistan*

*Active during 2014.

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DEAR COLLEAGUES

In this issue of Highlights, we are excited to share insight gathered from hundreds of global health innovations. But first, we will share an update on our own metrics. Four years after launching the Center for Health Market Innovations, our website is the world’s go-to resource on health innovations in low- and middle-income countries, and we are providing our community of innovators with beneficial opportunities to gain practical knowledge and scale-up. As of 2014:

• We have identified more than 1,400 programs in over 130 countries.
• Over 500,000 users have visited HealthMarketInnovations.org.
• CHMI has worked through a network of partners in more than 15 countries.
• CHMI-profiled programs report close to 1,200 performance results, highlighting a commitment to transparency and accountability to share promising practices.
• Over 50 publications have used CHMI as a resource, showing considerable interest in health market innovations among researchers.
• Just over the past year, we have linked over 75 programs to global fundraising platforms, prizes, and networking groups.
• People in over 50 countries have initiated over 800 conversations with innovators through CHMI’s website.

BETTER WEB EXPERIENCE

To continually improve your user experience, we’ve added several new features, including a new “Topics” section pre-filtering information on health and business themes like primary care and franchising. Interactive data visualizations help users understand the innovation landscape at a glance. See more information on this and other web features on page 47.

NEW IN THIS REPORT

In Highlights, we examine our database of programs to understand new developments and evolutions in the universe of health innovation. This year, we’re also sharing a preview of cutting-edge research findings on priority topics for the global health community. Read further to understand key health market issues, such as:

• What types of programs have CHMI’s regional innovation partners identified in rapidly changing health markets around the world? Starting on page 10, we explore how new solutions are expanding health access in the Philippines, Nigeria, and Pakistan.
• Which programs are effectively targeting the poor, increasing quality, boosting population coverage, and delivering other key outputs? With CHMI-profiled programs reporting 400 new results since last year, we can better understand which approaches deliver impact. Browse examples on page 28.
• What are the critical factors enabling primary care organizations to scale-up rapidly? Researchers reviewed 465 primary care programs, then interviewed leaders of 37 programs in 22 countries. Preview their results on page 33.

Our first four years consisted of identifying solutions that improve access to essential services in low-income communities, studying their potential for impact and scale, and promoting the broad diffusion of those solutions that have the potential to improve the lives of the poor. We are now also helping innovators adopt the “active ingredients” of programs with impact (see page 40). CHMI is also launching CHMI PLUS, a new system to increase visibility for programs with completed, up-to-date profiles and monitoring and evaluation systems in place (see page 47).

As always, we welcome your feedback on Highlights: 2014 and our work to promote programs, policies, and practices improving the quality, affordability, and availability of healthcare for the poor.

Donika Dimovska | ddimovska@r4d.org
Results for Development Institute, On behalf of the CHMI network

CHMI-profiled programs report 1,200 performance results, highlighting effective organizations and promising practices.

Photo Left: Varshna, right, teaches the importance of breastfeeding to women in a nutrition rehabilitation clinic in Madhya Pradesh, India.
IN MANY LOW- AND MIDDLE-INCOME COUNTRIES, THE POOR RELY ON THE PRIVATE MARKET FOR MUCH OF THEIR HEALTHCARE—EVEN WHERE PUBLIC FACILITIES OFFER CARE FREE OF CHARGE.

Large and rapidly changing 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 patients’ best interests. 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.

Photo Above: Informal health providers in a Dhaka, Bangladesh bazaar.
Inside Health Markets

The Center for Health Market Innovations’ database of profiled programs captures information about emerging practices in health markets across 131 countries. This includes more than 1,400 programs innovating in service delivery, financing, policy and regulation, technology, processes, and products. Below, we highlight several insights from our database.

Photo Left: ZanaAfrica uses a distribution model that allows women living in informal settlements in Kenya to access sanitary pads from women in their community.

CHMI profiles programs innovating in service delivery, financing, policy and regulation, technology, processes, and products.
In 2014, 55 programs were added to the CHMI database, with many focusing on expanding access to high-priority health services. CHMI added significant numbers of new profiles for programs focusing on priority health areas: maternal, newborn, and child health (MNCH); primary care; non-communicable diseases (NCDs); and family planning and reproductive health. In the space below, we describe several such programs newly profiled.

Maternal, newborn, and child health
PSI’s Familia Social Franchising Network of Tanzania is one of 13 MNCH programs in the CHMI database profiled this year. The Familia franchise incorporates 260 facilities across 16 regions that provide family planning, newborn care, and other services.

Primary care
CHMI profiled 11 new primary care programs in 2014, including SughaVazvhu. SughaVazvhu operates a chain of Rural Micro Health Centers in Tamil Nadu, India, which provide a broad range of health services. The network’s seven centers have served over 40,000 people since 2009.

Non-communicable diseases
This year CHMI added 11 new profiles for programs focusing on NCDs, bringing the total number of such programs in the database to 64. The Linear Accelerator Centre for Radiation Oncology Treatment is a public-private partnership with the Indian state of Rajasthan. Twenty percent of this program’s cancer patients receive free treatment, including those living on less than US$2 per day.

Information and communication technology
CHMI has identified 403 programs working in information and communication technology. MedAfrica, one of 19 technology programs profiled in the past year, has designed a mobile phone application that allows consumers to access medical information and locate reputable doctors and hospitals. The award-winning application has an average of 1,000 downloads per day and is used in Kenya and Uganda.

Maternal, newborn, and reproductive health
CHMI profiled 17 new family planning and reproductive health-focused programs this year. ZanaAfrica, in Kenya, produces affordable sanitary pads from local agricultural resources. The program aims to reduce reproductive tract infections associated with reusable pads, and reduce missed school days for girls who cannot afford sanitary pads.

Mobile Clinics
CHMI has profiled 177 mobile clinics, 11 of which were added this year. To control tuberculosis (TB) in Peruvian prisons, Aicamibals constructs low-cost and portable TB laboratories (called Portalabs) out of shipping containers. Portalabs are designed to be moved around the country, undertaking sequential month-long campaigns of TB testing in all major prisons, and avoiding the expense of building and staffing permanent labs. Aicamibals has now expanded into Somalia, a country with a significant TB burden that has lacked TB culture labs.

PROGRAMS SCALING UP

In 2014, 85 CHMI profiled programs reported to CHMI that they had scaled up, offering clients a wider range of services, adding facilities within their countries, replicating in a new country, or increasing the number of people served.

Offering a wider range of services
• Davao City Central 911 Emergency Response Center began upgrading its systems in 2014. The service, which is the first emergency response service using Geographic Information Systems (GIS) technology in the Philippines, now includes better monitoring of weather patterns, water movements, and land tracking—critical services for effective disaster preparedness and response to flooding.

Replicating in a new country
• eHealth Africa’s Android-based mobile phone application decreased reporting time for new Ebola cases in Nigeria by 75%. Bloomberg News reported that its applications—which are used in Nigeria and Cameroon and focus on a spectrum of health issues from maternal health to polio—will soon be employed by health workers to counteract the spread of Ebola in Liberia, Sierra Leone, and Guinea.

Adding more facilities in the same country
• Jacaranda Health opened its second Nairobi, Kenya-based maternity facility this September with a new operating theater to perform cesarean sections and emergency obstetric care.

Significantly increasing the number of people served
• MicroEnsure, which provides insurance policies for more than 10 million clients in low- and middle-income countries, saw an 88% increase in the number of clients it serves within five months of 2014. In Ghana, MicroEnsure doubled the number of clients served to reach more than half a million people in one month through a partnership with the mobile network provider Airtel Ghana.

TECHNOLOGY, FRANCHISING AND MOBILE CLINICS

In the past year, CHMI has identified significant numbers of new programs organizing the delivery of care through social franchises, applying information communication technologies, and expanding access through mobile clinics.

Social franchising
Social franchises organize providers into networks that operate under the same brand. Of the more than 100 franchise programs in CHMI’s database, 19 were added in the past year, including Tandas de la Salud, a microfranchise health store network delivering high-quality medicines and health products in rural Guatemala.

How are programs innovating to improve health markets?
CHMI identifies and tracks innovative approaches to improving health markets in five categories:

1. Organizing the delivery of healthcare services or the linking of private providers
2. Financing care for the poor
3. Setting standards and enforcing quality of care among private health providers
4. Encouraging consumers to seek better care or health workers to provide better care
5. Applying operational processes or technologies to improve quality, access, efficiency, or cost

Number of programs that reported scaling up in 2014

<table>
<thead>
<tr>
<th>Dimension of Scale</th>
<th>Number of Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly increasing number of people served</td>
<td>50</td>
</tr>
<tr>
<td>Offering a wider range of services</td>
<td>43</td>
</tr>
<tr>
<td>Adding more facilities in the same country</td>
<td>36</td>
</tr>
<tr>
<td>Replicating the program in a new country</td>
<td>19</td>
</tr>
</tbody>
</table>
Health Market Innovations in the Philippines

With large regulatory and investment capabilities, governments can nurture a suitable business environment for the private sector to contribute to national health priorities. In the Philippines, the government takes an active role in stimulating and scaling up innovation. Many of the 79 programs CHMI profiles in the Philippines receive government funding, are implemented in partnership with the state, or collaborate in other ways with government entities. Programs focus on tackling significant Philippine health challenges.1

FUNDING SOURCES FOR PROGRAMS IN THE PHILIPPINES

- 54% Funding from government (36 programs)
- 46% Other sources of funding (43 programs)

HEALTH INNOVATIONS IN THE PHILIPPINES ADDRESS:

- High birth rate and resulting need for maternal and child health services. The Philippines has a high fertility rate relative to its region,1 and a high unmet need for maternal and child health services, especially among lower-income households.
- Provider shortages. Government health provider coverage has not kept pace with population growth. There were 3.38 providers per 10,000 people in 2000 and only 2.95 providers in 2008.
- Out of pocket spending. Despite the growth of PhilHealth, the government’s health insurance program, out-of-pocket spending accounts for 52.7% of total health expenditures.
- Growing burden of non-communicable diseases. These illnesses are complex and expensive, and treatment must span many years.

Below are examples of ways in which the government is addressing these health system challenges through its support for health market innovations.

PROVIDER SHORTAGES AND INSUFFICIENT CAPACITY FOR MATERNAL AND CHILD HEALTHCARE

With the government health provider ratio on the decline, programs are harnessing private providers to deliver quality maternity services paid for by the government.

Out-of-pocket spending.

Of the 21 government-supported programs that finance care for the poor, 12 are insurance programs, with many launched under the PhilHealth umbrella. Some programs expand insurance coverage. Kasapi (now known as iGroup) covers self-employed workers like taxi drivers. Remittance-by-Air facilitates payment of premiums via mobile phones. The Revolving Drug Insurance Fund implemented in partnership with GIZ allows low-income PhilHealth members to purchase medication from private pharmacies for a minimal copayment.

OUT-OF-POCKET SPENDING

Of the 36 government-funded programs CHMI profiles, seven focus on maternal and child health or family planning. PhilHealth increased its maternity coverage package in 2009 and now covers pre- and post-natal services, as well as room and board, medicines, diagnostics, and professional fees.

With PhilHealth revenue assured, a public-private partnership started in Leyte Province has helped convert 60 formerly abandoned government health posts in 11 provinces into accredited birthing centers. KaKaK Foundation repairs, renovates, and equips these health posts to create Mother Bles Birthing Clinics. Private midwives receive financial payments for each birth attended at these facilities, providing an incentive for them to convince women in the community to deliver in clinics.

GOVERNMENT-FUNDED FRANCHISE NETWORKS

Well-Family Midwife Clinics offers franchise midwives a range of financial, business, training, and quality assurance services. Of 132 outlets in 21 provinces, 95% of franchisees were accredited with PhilHealth in 2012.3

Midwives franchised with BlueStar Pilipinas can claim US$120 in reimbursement for each delivery of a PhilHealth-enrolled woman in about half of the network’s 282 nationally dispersed clinics.

1 World Bank Indicators
2 This chapter draws on research by the Philippine Institute of Development Studies (PIDS), CHMI’s partner in the country.
3 Social Franchising for Health February 2014 newsletter. From the Private Sector Healthcare Initiative, Global Health Group, University of California, San Francisco.
**NON-COMMUNICABLE DISEASES**

Chronic kidney disease afflicts 1 in 10 Filipinos. To raise resources to address long-term care for this and other chronic diseases, the government is tapping private resources and introducing incentives not present in publicly owned and managed programs.

Government-owned hospitals like the National Kidney Transplant Institute, Southern Philippines Medical Center and La Union Medical Center work with private partners to expand services without compromising their equity goal.

The National Kidney Transplant Institute is one of the earliest and largest public-private partnerships of its kind in the region. Fresnius Medical Care Phil provides equipment, such as costly new machines. Hemodialysis treatment at the facility costs US$75, compared to other privately owned or government hospitals where treatment can cost more than US$350. Earnings were US$6.2 million in 2012, sufficient to sustain the costs of dialysis treatment and improve the facility.

**ACCELERATING SUPPORT FOR INNOVATION**

State entities must navigate risks when supporting market-driven innovation. For example, when a government body implements a scheme and a private entity provides technical support, schemes are vulnerable to political transience and higher direct costs.

In years to come, government entities could play a greater role in scaling up innovative health programs. To aid in this process, the Philippine Institute of Development Studies (PIDS), CHMI’s partner in the country, has shared information about health market innovations through forums like the Galing Likha-Kalusugan Awards. PIDS recommended creating policies covering processes such as consignments and public-private partnerships. Such policies could officially acknowledge these schemes and create a regulatory environment for implementation and adoption of innovations. To learn more visit HealthMarketInnovations.org/Philippines.

**HEALTHCARE INNOVATIONS IN NIGERIA**

Nigeria is now the largest economy in Africa, and the 26th largest in the world.

Despite economic success, poverty levels have remained stubbornly high. 70% of Nigerians still live below the poverty line, and the country ranks 152nd out of the 187 countries on the UN’s Human Development Index. Extending healthcare to Nigeria’s large and diverse population is an enormous challenge, with persistent instability, weak infrastructure, and low government capacity preventing health services from reaching society’s most vulnerable.

**PRIVATE HEALTH MARKET ACTIVITY**

According to 2012 estimates by the World Health Organization, approximately 70% of Nigeria’s healthcare expenditures originate from the private sector. CHMI profiles 49 programs in Nigeria that are using innovative, market-based approaches to address a wide swath of healthcare concerns. Of these models, 26 rely on donor support, and 14 are funded through revenue, primarily out-of-pocket payments. Other methods of financing include government partnerships, investor capital or self-funded innovations. Most programs are geared towards low-income populations, with 35% targeting the poorest quintile of Nigeria’s population. Programs are located throughout the country, with almost all programs reaching both urban and rural populations.

Photo Above: At the communication center for PhilHealth Link, personnel manage claims for PhilHealth benefits.

Photo Top: eHealth Africa staff travel to remote villages with tablets to collect the GPS coordinate and the village name to ensure that every village appears on the vaccination microplan.

Photo Right: A local health worker visits homes to distribute vaccines during Nigeria’s Immunization Plus Day campaign.

At Calbayog District Hospital, the rate of patients paying for services through PhilHealth increased from less than 1% in 2010, prior to the program’s launch, to 60% in 2011.
INFORMATION AND COMMUNICATION TECHNOLOGY

Nearly 50% of the programs CHMI profiles in Nigeria rely on technology to deliver quality and affordable care. Common ways of utilizing technology include improving health providers’ ability to diagnose and treat patients, improving communications between providers and patients outside traditional doctors’ visits, and improving overall data collection and analysis.

• Learning About Living uses technology to inform and engage with young people about reproductive health and HIV/AIDS. Users submit health questions via text messages to an online platform or by calling a telephone hotline, and questions are answered by trained health counselors.

• Cyber-Sight is an innovative telemedicine program that connects ophthalmologists in developing countries to medical experts that can help them with diagnosis and treatment. The Cyber-Sight web platform provides e-consultations, resources for physicians, and classes to improve skills.

• eHealth Africa’s electronic health solutions can be rapidly deployed to manage patient information, streamline clinical procedures, and provide data and analysis on health program outcomes. eHealth’s technology is designed specifically for hot, humid, and dusty environments with little to no electricity access. Interfaces are designed to be user friendly for healthcare workers with limited technical knowledge. An evaluation showed midwives in northern Nigeria were able to report 100% of vital events with the technology within a week of their occurrence.

DELIVERING PRIMARY CARE FOR HARD-TO-REACH POPULATIONS

Primary care is a major focus of CHMI-profiled programs operating in Nigeria, and many programs are finding new ways to reach rural clients, either through virtual means or by meeting patients in their communities. The River Boat Clinic is a public-private partnership that reaches rural patients living in five communities along the tributaries of the Escravos and Benin Rivers. However, not all hard-to-reach populations live in remote areas. Lagos, a densely populated city of 12 million residents, presents healthcare delivery challenges of its own. R-Jolad Hospital is a social enterprise in Lagos that provides primary care to 200-250 patients a day. Sometimes charging as little as US$1 for a visit, the hospital is providing quality primary care that is affordable for millions of low-income Lagos residents—many of whom are recent internal migrants living in slums—while ensuring financial sustainability through revenue from higher-income patients using a tiered pricing system.

NEW PRODUCTS AND TECHNOLOGIES

Nine programs in Nigeria report that they recently expanded into a new country, and many offer life-saving products and technologies. LifeWrap, an anti-shock garment that helps treat postpartum hemorrhages, was pioneered in a Pakistani hospital. Nigeria was LifeWrap’s second country of operation, and it is now used in ten countries worldwide.

Three replicated innovations in the database were piloted in Nigeria and later expanded into other developing markets. Solar Suitcase, a portable lighting and power unit designed to help increase patients’ access to timely and safe obstetric care in rural clinics with unreliable electricity, was piloted in Nigeria in June 2009, is now used in 25 countries with plans to launch in Sierra Leone, Uganda, and Malawi. Similarly, Sproxil, which allows consumers to use mobile phones to verify the authenticity of drugs, was piloted in Nigeria in 2010; it has since expanded to Ghana, Kenya, and India.

The innovations and trends profiled here represent only a fraction of Nigeria’s dynamic health market (see HealthMarketInnovations.org/Nigeria to browse all programs). As Nigeria’s economy and population continues to grow, entrepreneurs will continue to innovate new solutions to evolving health challenges. CHMI is encouraging new innovation, replication, and scale-up through its Nigeria partner, Solina Health. See page 41 to learn more about Solina Health’s leadership in creating a permanent platform for public-private cooperation in health.
HEALTHCARE INNOVATIONS IN PAKISTAN

Few places embody “the last mile” for health services as much as rural Pakistan, especially the Himalayan region. Challenged by physical and financial obstacles, some programs in Pakistan are using information and communication technology to provide health services in remote regions. Of the 42 programs profiled in Pakistan, 38 provide care to rural communities, where 63% of Pakistan’s population lives.

IMPROVING PHYSICAL ACCESS TO CARE IN PAKISTAN

Making virtual connections

In order to overcome physical barriers to improvements in health, 12 programs profiled by CHMI are virtually connecting health providers and patients. Sehat First is delivering basic care and pharmaceutical services across rural Pakistan by establishing franchised tele-health centers. Franchises consist of a clinic, pharmacy, and tele-center where videophones link local staff to qualified physicians, particularly female doctors, who, for cultural reasons, have not fully engaged in the workforce. This approach has improved access to specialists, including gynecologists and pediatricians.

Bringing care to remote communities

Seven CHMI-profiled programs in Pakistan report using mobile clinics to serve rural populations. Sehat Sahulat Clinic Basic+ retrofitted a truck into a Mobile Health Clinic to enhance accessibility and coverage of primary care services in hard-to-reach areas of Pakistan. The truck includes a doctor’s examination room, pharmacy, and laboratory. This program is one of 23 offering primary care services, and one of nine offering MNCH services in the CHMI database.

Reducing the burden on health workers

Pakistan ranks fifth amongst high-burden tuberculosis (TB) countries, and accounts for 61% of the TB burden in the WHO Eastern Mediterranean Region. Rural healthcare workers waste valuable time traveling between patients to monitor daily therapy. X Out TB created a strategy for reducing time lost by health workers due to transit. Participating patients urinate daily on test strips that detect whether they have taken their medication. For a patient following his or her drug regimen, the urine analysis strip detects traces of the medication and reveals a code the patient can SMS to the designated health worker. Positive compliance is rewarded with monetary credit to the patient can SMS to the designated health worker. Positive compliance is rewarded with monetary credit to the patient can SMS to the designated health worker.

Cross subsidization to cover the most in need

Al-Shifa Trust operates a chain of eye hospitals in Pakistan which utilizes cross subsidization, in which wealthier patients pay full price, covering the cost of treatment for those unable to pay. The program cuts costs by conducting community outreach initiatives which identify patients with eye diseases at early stages. The program also trains and educates doctors, paramedics, and nurses through the Pakistan Institute of Ophthalmology in order to increase the health workforce qualified in eye care. To date, the hospitals have performed over 500,000 operations, with 70% of patients treated free of cost based on financial need.

IMPROVING FINANCIAL ACCESS TO HEALTHCARE IN PAKISTAN

Because many households in Pakistan risk spending catastrophically on health, several programs are streamlining systems to finance care for the poor and reduce this risk.

Cash transfers to reduce the risk of catastrophic spending

Heartfile Health Equity Financing uses information technology to protect the poor from catastrophic expenditures on healthcare. Local healthcare workers seeking urgent support for individuals running the risk of catastrophic spending on health can submit requests through the Heartfile website for funding from a social protection fund. Heartfile processes the requests from healthcare workers, ascertains patient eligibility, verifies requests and authorizes cash transfers to underwrite the cost of the treatment. This automated system has been designed to eliminate duplication and abuse, improve transparency, and provide better visibility to donors.

Cross subsidization to cover the most in need

CHMI IN PAKISTAN

CHMI’s regional partner in Pakistan is Interactive Research & Development (IRD). Working with CHMI, IRD surfaces promising solutions and creates peer-learning opportunities between programs. For example, IRD hosted a four-day workshop with representatives from TB centers in Pakistan, Bangladesh, and Indonesia, fostering a discussion on “disruptive” technologies and the social business models that can both raise revenue and generate wider acceptance of these new technologies. To learn more about the latest news from Pakistan and browse all programs, visit HealthMarketInnovations.org/Pakistan.
Emerging Practices in Health Markets

Three high-potential avenues to rapidly expand health access or improve quality.

CHMI’s programs database can elucidate common approaches as well as promising examples of innovation. This chapter looks at three high-potential avenues to rapidly expand health access or improve quality: information technology used to provide maternal, newborn, and child health (MNCH); growing pharmacy chains; and licensing and accreditation models. Programs working in MNCH often use technology to improve access and quality. Pharmacy chain programs that use innovative organization and delivery methods are often able to scale up rapidly. Programs that rely on a licensing and accreditation scheme are paving the way to quality control for private and informal providers. All such newer models require an objective look at performance results to determine feasibility for scaling up.
Emerging Practices in Health Markets

TECHNOLOGY USE IN MATERNAL, NEWBORN, AND CHILD HEALTH

With the horizon of the Millennium Development Goals fast approaching, international aid organizations have renewed excitement for the progress in maternal, newborn, and child healthcare (MNCH) in developing countries, which have seen a 45% reduction in maternal mortality since 1990. But with nearly 300,000 deaths from complications due to pregnancy and childbirth worldwide in 2013, hope for improvements through innovations such as information and communication technology remains high. There are over 250 programs in the CHMI database working to accelerate improvements in maternal health. Sixty-four of these programs use information communication technology (ICT) to combat maternal and child mortality, increase service availability, and reduce healthcare costs for the poor.

CHMI’s database reveals common practices in ICT use for MNCH, including:

MOBILE APPLICATIONS FOR DATA COLLECTION AND PATIENT COMMUNICATION

ChildCount+ is used for data collection and sharing information in the Millennium Villages Project in ten countries across East and West Africa. This mHealth platform relies on SMS data entry and a centralized database to monitor maternal and child health. By providing important health information via SMS to mothers and health workers, ChildCount+ has helped Millennium Villages reduce maternal mortality by 22%.

Micro Health Franchise System UmeedSey in Pakistan uses technology to lower maternal health costs by empowering midwives and improving the services they provide. UmeedSey’s mobile application allows midwives to access patient information, connect to emergency services, and share data with specialists. The application also forms the basis for clinical decision support and evaluations of community midwives.

HOTLINES AND VOICE RESPONSE TECHNOLOGY

Mobile platforms allow community health workers to enhance care provided to remote populations, but most of these programs only cover specific regions. Eight programs in the CHMI database use widely accessible hotlines for MNCH care. In Sierra Leone, the Fistula Hotline connects women to experts to discuss concerns related to fistula, an all-too-common side effect of prolonged labor in developing countries. Nurses on the hotline determine whether women are eligible for fistula treatment, and then connect them with more resources.

MOTHER, NEWBORN, AND CHILD HEALTH TECHNOLOGY-ENABLED PROGRAMS BY TECHNOLOGY PURPOSE

- Improve data collection, organization, or analysis: 30
- Improve communications between health providers and patients: 29
- Improve a health provider’s ability to diagnose and treat patients: 22
- Virtually connect health provider and patients: 18
- Make financial transactions more efficient: 5
- Prevent fraud and abuse: 3
- Improve health education: 2
- Extend geographic care: 1

Baby Monitor in Kenya links pregnant women with health clinics through interactive voice response technology. As many phone applications that use SMS require patient literacy, illiterate populations are often left out. Baby Monitor is a low-cost screening service that pre-records clinical decision trees in local languages. Mothers who call the hotline are referred to local or regional health centers for further diagnosis or emergency care.

ORGANIZING DELIVERY

MNCH programs that rely on technology do so not only to enhance individual interactions between patients and doctors, but also to enable access to wider networks of services. Out of the 64 MNCH programs using technology, 14 programs combine it with innovative delivery service models such as franchises and health service chains. Mobile phone-equipped community agents employed by Djantoli provide children and mothers in Mali and Burkina Faso with health insurance and preventive education services. These agents are linked to doctors who provide remote monitoring and disease detection. Through home visits, mobile monitoring, and health education talks, Djantoli has treated and prevented diseases among 3,500 children since 2010.

Mat Trai Be Tho promotes exclusive breastfeeding to combat malnutrition in Vietnam. The social franchise promotes its educational campaigns through social media and a mobile service. The Mat Trai Be Tho website also hosts videos and educational resources, manages an active forum for new mothers, enables live chatting with experts, and offers training courses for health workers. With over 700 facilities throughout the country, this franchise has used technology to expand its services and increase access to health education among lower-income Vietnamese women.

Photo Left: A health worker in Mali records the weight of a child enrolled in Djantoli, a program that integrates tele-health outreach between clinics, health workers, and communities.

Photo Top: In Mayanga, Rwanda, community health workers Arkimani Mahoro and Ntamururano Jean Bosco talk with mother Akimana Francine and child Herves.
Emerging Practices in Health Markets

PHARMACY CHAINS AND FRANCHISES

Private pharmacies, drug stores, and drug sellers are often the first point of contact for patients accessing healthcare in low- and middle-income countries. Many increase accessibility and lower costs for consumers when compared with larger healthcare institutions such as hospitals.

Of the 20 programs CHMI profiles that focus on pharmacy services, 12 are pharmacy chains working to improve access to reliable quality medicines for the poor. Despite the diversity of communities in which these programs work, these innovators aim to fulfill the same basic need—accessible and quality healthcare for their communities.

About 15.5% of CHMI-profiled programs are for-profit entities. Among pharmacy chains, this percentage jumps to 75%, indicative of this commercially viable retail model. These for-profit chains, however, target the poor in their design, imbuing their profit mission with a social one.

FRANCHISE MODELS

Pharmaceutical franchises are a commercial retail model, organizing private providers who own their own pharmacy kiosk or store into a network that delivers medicines and health products under a common brand, with a promise of quality assurance.

Many pharmacy chains founded in low- and middle-income countries have scaled to new countries. After establishing a franchise network of Child and Family Wellness Shops (CFW) in Kenya, The HealthStore Foundation signed a unique public-private partnership with the Ministry of Health of Rwanda to replicate their model and establish Health Posts within Rwanda’s public health system.

Mi Farmacita Nacional is a for-profit franchise network in Mexico that offers generic and patented medication at competitive costs thanks to a partnership with a well-established distribution company and generics manufacturer. A digital inventory system allows the company to track inventory, adjust prices, and track sales for all franchises. In-house doctor consultations are priced at about US$32.

In the Philippines, Health Plus Outlets extend pharmacy services to rural areas like the coastal Antique province. Local organizations like an Association of Senior Citizens in San Jose pay US$1,200 to operate these outposts with a nutritionist or health worker, and stock limited products.

NEW RESEARCH SUGGESTS SOME PHARMACY CHAINS IMPROVE DRUG QUALITY AND LOWER PRICE

Studies show that many drugs sold in low- and middle-income countries are counterfeit or substandard, endangering patients’ health and leading to drug resistance. Pharmacies in markets with weak regulation have had little incentive to increase quality, since poorer consumers can’t easily observe drug quality and may choose lower priced medicine.

But recent economic growth in developing countries has increased consumer wealth and the demand for medicine. Economists Daniel Bennett and Wes Yin of the University of Chicago and University of California, Los Angeles, respectively, wondered what effect these changes were having on drug quality and price, especially in the context of growing retail pharmacy chains.

In India, where small mom-and-pop stores have traditionally dominated pharmaceutical markets, new pharmacy chains are now investing in cost-saving and quality-enhancing technologies. Chains are creating their own supply chains, and using advertising to signal quality to consumers. Researchers worked with CHMI-profiled MedPlus to study the chain’s entry in 20 markets within Hyderabad.

Results showed that the entry of MedPlus led to a five percent improvement in drug quality and a two percent decrease in prices throughout the market. The chain improved quality both directly through its own sales and indirectly through competition that led incumbents to both increase quality and lower prices. By deploying mystery shoppers, the economists also found that poorer appearing consumers got the same higher quality drugs. These results suggest that new pharmacy chains apply an organizational approach that has beneficial public health and financial outcomes for all. To learn more, visit bit.ly/1AVl5Ld.

PRIMARY CARE CLINICS

Pharmacy chains are not the only way CHMI innovators increase access to essential pharmaceuticals. Many chains of primary care clinics—such as Pathfinder Family Medical Health Centres in India or Sehat First in Pakistan—also provide pharmaceutical services. National Rural Health Mission-funded Boat Clinics along the Brahmaputra River in Assam, India, provide access to remote communities. A pharmacist prescribes medicine from a kit on board. Finally, Piramal’s eSwasthya program enables trained village women entrepreneurs to fill prescriptions approved by physicians via telemedicine.
Addressing Urgent Health Needs

Health services in low- and middle-income countries often lack tools to ensure quality control of health professionals and facilities. Several programs profiled by CHMI are introducing licensing and accreditation tools to these settings.

**TARGET ENTITIES FOR LICENSING AND ACCREDITATION PROGRAMS**

Licensing and accrediting bodies perform similar functions, but each have defining characteristics:

- **Licensing bodies** are legislative governmental bodies which provide healthcare workers the legal right to work, or in the case of facilities, the right to operate.

- **Accrediting bodies** are non-legal bodies which provide certificates to healthcare workers or facilities which meet certain quality standards, or have undergone training and testing by the accrediting body. Providers and facilities which are unaccredited may still have the legal right to provide services.

CHMI currently profiles 26 accrediting programs and three licensing programs. This may reflect a lack of capacity within governments to implement quality control through strict licensing, leaving space for private sector accrediting bodies to fill. Bidan Delima, for example, is a midwife accrediting organization in Indonesia, where no formal midwife licensing program exists. Greater analysis is needed to determine if accrediting bodies are filling voids in licensure in less developed countries.

CHMI has primarily profiled licensing and accreditation programs in East Africa (14) and Asia (7). Most licensing and accreditation programs focus on maternal, newborn, and child health (10), family planning and reproductive health (11), HIV/AIDS (7), and primary care (5).

Licensing and accreditation programs focus on various entities in health markets. Thirteen programs license or accredit healthcare workers, such as nurses, midwives and physicians, live target pharmaceutical vendors and producers, and six target health facilities. Examples of each type of licensure and accreditation program follow.

- **In Benin, physicians** may operate under the Profam seal if they regularly meet quality assurance and performance requirements, including quarterly site inspections, clinical audits, and client exit interviews. Benefits of participating in the PSI-affiliated network include refresher training, on-site coaching, and medical equipment. Physicians who fail to improve low performance are considered for disqualification from the network.

- **The Accredited Drug Dispensing Outlet (ADDO)** accredits privately operated retail drug outlets in poor, rural regions of Tanzania to sell essential medicines, including prescription drugs. Although ADDO is not a legal body, it demonstrates that accreditation programs are able to significantly improve the quality of services provided by pharmaceutical vendors. While baseline data showed that 39% of shopkeepers recommended incorrect medicines, only 14% of shopkeepers who participated in ADDO did.

- **The National Hospital Accreditation Program** in Zambia measures the quality of hospitals based on standardized quality indicators.

- **The Shasthya Sena health network** in Bangladesh provides health services under a common brand; however, network members must adhere to quality standards in safety, appropriateness of treatment, and avoidance of unnecessary costs to patients. The network is governed by members of government, civil society, and formal private practice.

**Franchises**

Ten CHMI-profiled accreditation programs operate under a franchise model. Under the health franchise model, providers are organized under a common brand. This brand is regulated for quality control by a governing body or a board interested in maintaining the brand’s name for commercial purposes.

- **Bidan Delima** in Indonesia trains midwives on best practices in midwifery services, reproductive health, and family planning. Midwives who pass the training and exam become certified Bidan Delima midwives, and are able to perform their services under the franchise’s trusted brand name. Currently Bidan Delima is operating in 21 of 33 provinces in Indonesia, with over 9,000 midwives.

**Health service networks**

Three programs operate under a health service network model. Providers operating within health networks are less centrally organized than those in franchises. Members retain their separate identities and do not provide health services under a common brand, however, membership in a network can still be marketed by health providers as a marker of quality assurance.

- **The Shasthya Sena health network** in Bangladesh has trained and accredited 135 informal providers. Network members must adhere to quality standards in safety, appropriateness of treatment, and avoidance of unnecessary costs to patients. The network is governed by members of government, civil society, and formal private practice.

**LICENSING AND ACCREDITATION PROGRAMS BY TARGET PRACTITIONER CATEGORY**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>NUMBER OF PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td></td>
</tr>
<tr>
<td>Facilities</td>
<td></td>
</tr>
<tr>
<td>Pharmacies</td>
<td></td>
</tr>
<tr>
<td>Midwives</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
</tr>
</tbody>
</table>

While accreditation can be used as a standalone approach, it is often used as an important ingredient of other models like social franchises and health service networks. Such approaches can be powerful in countries with limited capacity to implement and enforce quality standards of care through licensing.
When assessing the landscape of health programs experimenting with innovative approaches, funders, researchers, policy makers, and program managers want to know which ones really work. CHMI has been tracking programs’ self-reported statements of performance since 2011. Results reported to date have helped highlight which organizations and particular models have strong evidence of impact. Going forward, programs will share details on their Monitoring & Evaluation systems to encourage greater transparency and help others adopt effective performance monitoring systems.
BUILDING EVIDENCE ON PROGRAM PERFORMANCE

Global development stakeholders seek to understand which models, or components of these models, show promise and can offer promising and scalable solutions to fundamental quality and access challenges. CHMI has developed several mechanisms to increase the evidence base to inform funding, policy, and programmatic decisions.

In 2011, CHMI launched the Reported Results initiative, a platform for innovators to provide clear, quantifiable, and time-bound measures of program performance. CHMI then partnered with the Impact Reporting & Investment Standards (IRIS) initiative of the Global Impact Investing Network to build on Reported Results and develop a health metrics catalog for healthcare organizations, launched in 2014. With CHMI PLUS, launching in early 2015, a Monitoring & Evaluation Reporting Scale will classify programs by the practices they have in place and supporting evidence they share (read more on page 47).

The following section summarizes program performance data captured through Reported Results. The initiative has collected information from more than 290 programs working in 91 countries, reporting more than 1170 results (see bar illustrating increase in results reported to CHMI from 2013 to 2014).

Total results reported by programs

<table>
<thead>
<tr>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>770</td>
<td>1170</td>
</tr>
</tbody>
</table>

Programs from CHMI’s database reporting results in key performance dimensions, 2014

<table>
<thead>
<tr>
<th>RESULTS CATEGORY</th>
<th>NUMBER OF PROGRAMS REPORTING RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Output</td>
<td>104</td>
</tr>
<tr>
<td>Health Outcome</td>
<td>93</td>
</tr>
<tr>
<td>Affordability</td>
<td>74</td>
</tr>
<tr>
<td>Population Coverage</td>
<td>64</td>
</tr>
<tr>
<td>User Satisfaction</td>
<td>51</td>
</tr>
<tr>
<td>Availability</td>
<td>48</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>41</td>
</tr>
<tr>
<td>Efficiency</td>
<td>36</td>
</tr>
<tr>
<td>Pro-Poor Targeting</td>
<td>31</td>
</tr>
<tr>
<td>Financial Sustainability</td>
<td>19</td>
</tr>
</tbody>
</table>

WHO IS BEING SERVED?

Pro-poor targeting results indicate the proportion of a program’s clients that are poor or disadvantaged. Thirty-one programs have reported more than 55 results on pro-poor targeting.

- • PROSALUD, a private not-for-profit healthcare network in Bolivia, implements a system of cross subsidies on three levels to offer clients tiered pricing. Money paid for care related to existing conditions is used to subsidize preventive care. Centers in the network with a budget surplus subsidize centers with deficits. Finally, clients able to pay subsidize clients unable to pay. Since 2002, an average of 22% of PROSALUD’s 4,639,000 appointments have been offered free of charge to low-income clients.

Affordability is a measure of patients’ ability to pay for a given product or service and can serve as a measure of access. More than 70 programs have reported on affordability with over 100 reported results.

- • In 1975, Bhagwan Mahaveer Vikland Sahayata Samiti (BMVSS), an India-based non-profit, began fitting a modest 59 artificial limbs. Today, the organization fits an average of 20,000 artificial limbs and about 30,000 polio calipers every year through its centers and mobile camps. The Jaipur Foot, a low-cost highly functional lower-limb prosthesis which can be fitted in under three hours. The average cost of a limb is only US$45, whereas in developed countries the cost may be as high as US$100,000.

WHAT IS BEING DELIVERED?

Health Outcomes are demonstrated by improvements in the health of patients and populations. More than 90 programs report on health outcomes, for a total of 250 reported results.

- • Corporacion Kimirina, an Ecuadorian not-for-profit, aims to strengthen civil society’s capacity for sustainable public health programs. Corporacion Kimirina trains and educates community health facilitators in the Ministry of Health on malaria detection, prevention, and treatment, with an emphasis on vulnerable populations. The program has helped reduce malaria cases from approximately 9,000 per year in 2007 to less than 300 in 2010.

HOW IS IT BEING DELIVERED?

Clinical Quality refers to care that is safe and medically appropriate and is closely linked to health outputs and outcomes. Over 40 programs have reported on clinical quality with a total of 81 reported results.

- • In Kenya, Tegemeza Project reports that 1,492 women were screened for cervical cancer between 2012 and 2013. Of the women found to have precancerous lesions, 99% received cryotherapy to prevent progression to cancers.

Availability measures the ease with which communities, patients, or populations are able to receive health services. Over 45 programs report measures of availability of health services, with a total of 69 reported results.

- • The Lifebuoy Friendship Hospital, a boat hospital which provides essential primary care services to isolated riverbank communities in northern Bangladesh, positions permanent satellite clinics in the communities the hospital services. Satellite clinics are operated by Friendship Community Medics, individuals from the community trained by Lifebuoy Friendship Hospital. Between 2009 and 2010, Lifebuoy increased the number of medics from 74 to 154, leading to a significant increase in the availability of products such as basic medication and contraceptives.

To browse all programs with results, use CHMI’s newly enhanced Advanced Search to filter programs reporting in pro-poor targeting, affordability, health outcomes, quality, availability, and the five other dimensions listed at left.

Photo Top: The 1298 Ziqitza Healthcare Limited ambulance in action in Dadar, Mumbai.
NEW FINDINGS ON HOW TO SCALE UP IMPACT

CHMI WORKS WITH ACADEMICS AND PRACTITIONERS TO GENERATE PRACTICAL KNOWLEDGE THAT CAN BE APPLIED BY PROGRAM MANAGERS, POLICYMAKERS, DONORS, INVESTORS, AND OTHER HEALTH LEADERS TO INCREASE THE IMPACT OF HEALTH PROGRAMS, HELPING MILLIONS MORE OBTAIN ACCESS TO BETTER HEALTH SERVICES.

Three representative projects share insights and findings in the following section. The first explores core principles for designing patient-centered primary care businesses. Another project pinpoints the most important criteria to rapidly scale up primary care organizations. And another study examines innovative ways to empower women by investing in particular types of health business models. All research starts with a review of programs profiled on CHMI’s database to identify emerging practices and compelling models. Practitioners and researchers then go further, consulting and interviewing program managers about their work to identify core elements of success. All projects aim to generate knowledge that can be rapidly integrated to improve outcomes.
The Time Is Now For Patient-Centered Innovation
Perspectives from the Primary Care Learning Collaborative

Patient-centered or people-centered care is the idea that the patient should be at the center of the health system so that care “is respectful of and responsive to individual patient preferences, needs, and values.” This is not just “fluff;” new studies are showing that patient-centered care is associated with better recovery from discomfort, better emotional health, and fewer diagnostic tests and referrals.

Many of our colleagues in research agree, in fact, “the science and practice of people-centered health systems” was the theme of the Third Global Symposium on Health Systems Research in Cape Town, South Africa.

As managers of rapidly growing primary care organizations serving low-income and middle-income communities in India, Kenya, and Burundi, we share a firm commitment to achieve patient-centered care and keeping the patient at the center of every decision. Yet we recognize that, in reality, we and many others running health-care organizations risk losing sight of this in our day-to-day work. Patient-centered care is not a clear-cut prescription that can be applied to achieve the right outcomes—this aim will require continuous refinement, innovation, and testing.

To aid ourselves in refocusing on the patient, we worked together to develop a list of five key principles and tactics that we have personally found to be critical when working to achieve patient-centered care:

1. Include patients in the innovation process. If we really listen to patients, they will tell us what to improve and even how to improve. Let patients be your partner on services, quality improvements, treatment plans, and more. A key way to do this is simply by spending time with your patients, asking them questions, and truly listening, whether in focus groups or during informal conversations. We cannot measurably impact patients’ well-being unless we see the system from their eyes. We have all been patients ourselves. We are not serving cases or statistics, but people. Together, we have incorporated human-centered design and other methodologies to systematically improve care delivery processes. At the same time, we need to make sure that we don’t lose the personal touch, for each person walking into our facilities is unique. In short: know your patient.

2. Focus on primary care. A patient is not an AIDS patient one day and a TB patient another day. Their health cannot be siloed and neither can they. Primary care treats the patient as a person, as a whole, in the context of their family and their environment. The global health community is slowly returning to the idea of primary care as a family doctor, but we need to speed this recognition up, or we will perpetuate a system that treats only disease, too late, and too expensively. Let’s treat people with a focus on their health at the first point of contact to reduce the burden on the whole system.

3. Accelerate the innovation process. When developing new innovations and processes, many organizations tend to get caught up in long research and planning periods, pilots, and official evaluations to determine feasibility. Unfortunately, this can slow down innovation and perpetuate a system that treats only disease, too late, but we need to speed this recognition up, or we will keep patients in the wrong care for longer. How many patients will keep receiving poor, inadequate, out of date, or wrong medical advice during slow proof of concepts and slow evaluations? The cost of this is too high. Therefore, we should speed up the innovation process through rapid testing methods such as Plan-Do-Study-Act to develop effective, sustainable, patient-centered solutions. Don’t get stuck in endless planning. Keep moving forward!
Primary care is a core component of robust health systems and critical to delivering the benefits of universal health coverage. While many low- and middle-income countries (LMICs) have made improvements in some disease-specific areas, access to affordable, quality primary care services remains limited. Despite the challenges, there are quality private sector programs that are not only bridging this primary care gap but are ambitiously scaling up.

The Rapid Routes to Scale study aims to understand the critical factors that shape the scale-up of quality primary care programs in the developing world. The study was led by the International Centre for Social Franchising and conducted by the University of Toronto’s Toronto Health Organization Performance Evaluation (T-HOPE) team, with input from the International Partnership for Innovative Health Delivery and Results for Development, which manages the Center for Health Market Innovations.

Through in-depth qualitative and quantitative research, the study uncovered a range of innovative primary care programs, identified what factors support scale-up, and made recommendations with the potential to improve millions of lives.

Based on this review, researchers identified a group of innovative primary care programs with evidence of scaling up or promising scale-up strategies in Kenya and India, selecting these programs for interviews and field visits. Researchers also conducted phone interviews with programs in other locales, and in total, the team conducted interviews with 37 programs operating in 22 countries. This includes programs directly providing primary care to patients and programs strengthening existing services.

Identifying Critical Components to Scaling Up Primary Care Programs

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Through qualitative and quantitative analysis of data collected, researchers found that primary care programs are engaging in a variety of activities to overcome challenges to scaling up.

For each mobilizer, authors identified specific activities that primary care programs can engage in to support scale-up, such as: focusing on the patient experience; branding and marketing campaigns; social franchising; providing alternative options for patients to pay for treatments; generating additional revenue through selling products and services outside of consultations and medications; and partnering with organizations that give access to a customer base.

These findings suggest that successful scaling of primary care requires two management mindsets: deep attention on the demand side to the needs and lives of potential clients, together with equally deep attention on the supply side to building effective organizations that can operate in resource-constrained contexts to deliver reliable goods and services relevant to the lives of those clients. Simply opening a primary care clinic and offering affordable consultation fees is not enough to ensure sufficient patient volume and successful scale-up. Connecting with patient communities and developing innovative and efficient supply chains and operating models are both essential for scaling up primary care programs in LMICs.

The Rapid Routes to Scale group was convened to turn research into action through combined efforts of diverse stakeholders. The study has given rise to recommendations for primary care programs, funders, government, and policymakers. These include building relationships with patients and relevant partners, employing staffing innovations, providing management support and training for leadership, developing and facilitating efficient processes and technologies, and identifying and supporting high potential primary care programs.

While primary care scale-up is complex and challenging, research shows that with the right approach, donors, investors, policy makers, researchers, and programs themselves can harness their collective impact to help scale up primary care for those who need it most. Visit bit.ly/14yZgfF to read more.

Many donors and governments are investing in programs that empower women to lead and thrive in their communities. At the same time, opportunities for female health workers are placing nurses, clinical officers, and midwives in expanded roles. New business models hold tremendous potential for both health systems strengthening and women’s empowerment. CHMI partnered with the University of Washington to explore nurses’ and midwives’ roles and functions, factors that support their empowerment and growth, and relevant financing and organizational features. The analysis identified 94 programs that offer opportunities for women associated with empowerment, such as clinical training and mentorship, business training and support, access to capital, and participation in professional associations and political bodies. These programs operate across 56 countries and cover a range of health services.

Authors identified CHMI programs that offer inputs associated with women’s empowerment. Examples include the following programs:

- Garhwal Community Development and Welfare Society in India recruits young women from the community to serve as paramedics and receive training. Recruits can then attend an accredited nursing school, all costs covered, provided that they work for two years at the hospital following certification. These activities increase the capacity of the local hospital’s lean staff.
- CliniPAK enables providers in Kenya, Nigeria, and Tanzania to schedule automatic text message reminders for mothers requiring post-natal care for themselves and their infants.
- Access Aya Health kiosks, operated by nurse clinical officers, provide basic healthcare services in low-income Kenyan neighborhoods and slums. To generate referrals, they also pay community mobilizers who are community health workers.
- EntrepreNurse responded to the high unemployment rates among Filipino nurses by organizing self-employed member nurses to provide care in poor rural communities.

Many donors and governments are investing in programs that empower women to lead and thrive in their communities.
Diffusing Innovation

Wielding considerable data on promising practices, models with evidence, and operational lessons, CHMI works with regional and global partners to translate this knowledge to practice. We also help innovative organizations access opportunities to grow. CHMI links innovators with learning, operational, and funding opportunities—all means to extend access to quality healthcare in low-income communities.

We help innovative organizations access opportunities to grow.
CHMI diffuses innovation through three main approaches: fostering practical learning, connecting program managers to learning, operational, and funding opportunities, and building partnerships between governments and innovators. Through these approaches, CHMI helps unleash the potential of innovations in the private sector to improve access to quality healthcare for the poor worldwide.

Here, we’ve highlighted examples of these three approaches and resulting connections, partnerships, and opportunities for innovators and stakeholders.

Fostering practical learning about promising innovations to turn knowledge into action

CHMI develops and shares accumulated knowledge on promising programs and models in health markets with decision makers such as program managers, funders, and policy makers through events and learning exchanges. To further disseminate learning, participants create knowledge products and tools for use as a public good. Examples include:

1. The Primary Care Learning Collaborative: In 2013, CHMI convened managers running low-cost clinic chains and franchises in Burundi, India, and Kenya to form a peer-learning “Collaborative” (for a list of participating organizations see page 32). Members use the collaborative to share the challenges and successes of running pro-poor primary healthcare businesses. Members are co-creating the Primary Care Innovator’s Handbook to share their experiences running chains and franchises, and to give readers tools and ideas to test and adapt in their own work. Members realize that there is rarely a “one size fits all” solution for an organization’s challenges, but learning solutions from others is often useful in overcoming challenges in one’s own context. CHMI disseminates lessons from the Collaborative to all those working in primary care to ensure these lessons are shared widely.

2. The CHMI Learning Exchange: In Fall 2014 CHMI launched the Learning Exchange, which supports program managers pursuing peer learning in order to improve, replicate, or grow their model. Grantees visit other innovative health programs to learn from each others’ programs. The first round of trips will bring together organizations working in Afghanistan, Burundi, India, Kenya, Mexico, Nigeria, Rwanda, and Uganda. Grantees will focus on diverse health issues, from scaling up specialty eye care to using information and communication technology to track and treat TB cases. Many visits will focus on management practices to assess critical factors to achieving scale. For instance, leaders of LifeNet Burundi and Health Builders Rwanda will visit each other’s clinics to observe management training and quality processes, compare evaluation tools, and assess how each organization has overcome systematic barriers such as electricity shortages and low levels of education. Trip reports on practical knowledge shared will provide insight on how peer-to-peer collaboration between program managers can improve health systems.

PREVIEW: PROMOTING ADAPTATION AND GLOBAL EXCHANGE OF INNOVATION

CHMI’s Adaptation Framework for Global Exchange of Innovation, developed with funding from the Robert Wood Johnson Foundation, provides flexible guiding principles for identifying program activities that have the potential for knowledge transfer and impact. Rather than focus on the program as a whole, the new framework helps anyone seeking solutions to common health challenges to “crack open” an innovative program and view the core program attributes critical to achieving the program’s outcomes—the “active ingredients.” The framework is designed to help program managers and others identify the active ingredient in any program, and it has highlighted more than 25 active ingredients found in programs which CHMI profiles.

Active ingredients responding to health systems challenges. A guidebook developed by the framework’s authors groups sample ingredients by the health system challenge they address, such as place, provider, patient, product, or financing. For instance, ten ingredients represent creative responses to the limitations of formal health facilities, or “place.” One such active ingredient is “Retail health care clinics that provide convenient preventive and primary care.” Two programs that incorporate this ingredient are Sehat First, in Pakistan, and Por Ti, Familia, in Peru. As another example, five active ingredients CHMI identified help programs better utilize nontraditional medical workers. One such active ingredient is “Training community members in care management to support patient at-home care.” Narayana Healthcare in India and Rachel House in Indonesia both incorporate this innovative component in their organizations’ activities.

Applying the framework: By identifying the active ingredients in successful programs, the framework can enable managers and others to successfully address similar problems in different contexts. In partnership with the UBS Optimus Foundation, CHMI is now field-testing the framework in West Africa. CHMI, working with CEI, will assess the adaptability of health and education models for children. To learn more about the framework, visit HealthMarketInnovations.org/AdaptationFramework.

Connecting innovators to opportunities for vital support

With more than 500,000 website visitors to date, CHMI provides global visibility for profiled programs. CHMI then goes further to promote curated funding and learning opportunities to program managers. The project also nominates high-potential programs with up-to-date profiles to its partners offering especially relevant and beneficial opportunities for health innovators, with the goal of helping programs to improve, scale, and replicate their models.

• South-south partnership enabled: After nominating the nonprofit franchise network World Health Partners in India for a Skoll Foundation award, which they then won, CHMI connected World Health Partners to Kisumu Medical and Education Trust in Kenya. The two organizations are now partnering to build a telemedicine network that will bring healthcare to under-served communities in Western Kenya.

• Awards bring global visibility: Meanwhile, in Kenya, after winning “most promising innovation” at a forum hosted by the Africa Capacity Alliance, CHMI’s partner in the region, MicroClinic Technologies has attracted considerable global attention and accolades, including being short-listed for a Financial Times prize.
### Building effective partnerships between governments and the private sector to harness the power of innovations

CHMI helps policymakers identify promising new approaches to reach national health goals, and to develop coordinated and long-term approaches to harness all types of providers, facilities, technologies, products, and other solutions to improve health systems. CHMI’s regional partners are the primary agents in this work. Partners host workshops and forums to convene and connect key local and regional stakeholders, developing sustainable engagement mechanisms between private and public sector leaders that showcase innovations and support partnerships in line with national priorities. CHMI currently has active regional partners in East Africa, Nigeria, India, South Africa, and Pakistan, and has worked with partners in more than 15 countries since 2010 (see the map on page 44).

- **The Private Sector Health Alliance of Nigeria:** CHMI’s regional partner Solina Health provided technical assistance to the Private Sector Health Alliance, Nigeria’s foremost private sector mechanism to help bring health market innovations to scale and create sustainable public-private dialogue. With this support, the Alliance founded the Nigerian Health Innovation Marketplace, which hosts competitions and incubates promising programs for future partnership with the Nigerian government. To date, the Alliance has mobilized over $24 million from local business leaders to support innovations, partnerships, and advocacy to achieve the government’s core health priorities.

- **Public-private partnerships in two Indian states:** ACCESS Health International, one of CHMI’s two partners covering the dynamic Indian health market, is working with the Wadhwani Institute of Sustainable Healthcare (WISH) to support the state governments of Rajasthan and Uttar Pradesh in developing partnerships with private sector providers to offer quality, low-cost healthcare.

### Regional Innovation Partners 2014

<table>
<thead>
<tr>
<th>Region</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Africa</td>
<td>AFRICA CAPACITY ALLIANCE (ACA)</td>
</tr>
<tr>
<td>South Africa</td>
<td>BERTHA CENTRE FOR SOCIAL INNOVATION &amp; ENTREPRENEURSHIP</td>
</tr>
<tr>
<td>India</td>
<td>ACCESS HEALTH INTERNATIONAL</td>
</tr>
<tr>
<td>The Philippines</td>
<td>PHILIPPINE INSTITUTE FOR DEVELOPMENT STUDIES (PIDS)</td>
</tr>
<tr>
<td>Nigeria</td>
<td>INTERACTIVE RESEARCH &amp; DEVELOPMENT (IRD)</td>
</tr>
<tr>
<td>India</td>
<td>SWASTI HEALTH RESOURCE CENTER</td>
</tr>
</tbody>
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**Photo Top:** Dr. Devashish Saini of Ross Clinics speaks at a meeting of the Primary Care Learning Collaborative in Kenya.
CHMI’S WORK IN-COUNTRY

CHMI GLOBAL COLLABORATORS
A number of collaborators work alongside CHMI to help health innovators improve their work and reach more people.

- Abraaj Group
- Business Call to Action
- Devex
- East Africa Healthcare Federation
- GE Healthcare
- GlaxoSmithKline Healthcare Innovation Award
- GlobalGiving
- Ennovant
- Global Impact Investing Network
- Impact Investment Partners
- Indian School of Business
- Information Society Innovation Fund
- Intellecap / Sankalp Forum
- International Centre for Social Franchising
- International Partnership for Innovative Healthcare Delivery
- Merck for Mothers
- NextBillion Health Care
- Nigeria Private Sector Health Alliance
- Partnership for Maternal, Newborn & Child Health
- Private Sector Healthcare Initiative
- Health Systems Global Thematic Working Group on the Private Sector
- Robert Wood Johnson Foundation
- Saving Lives at Birth
- Skoll Foundation
- Stop TB Partnership
- The Tech Awards
- Tonic
- Total Impact Advisors
- UBS Optimus Foundation
- Toronto Health Organization Performance Evaluation
- Wadhwani Institute of Sustainable Healthcare (WISH)
- Abraaj Group
- Business Call to Action
- Devex
- East Africa Healthcare Federation
- GE Healthcare
- GlaxoSmithKline Healthcare Innovation Award
- GlobalGiving
- Ennovant
- Global Impact Investing Network
- Impact Investment Partners
- Indian School of Business
- Information Society Innovation Fund
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- Stop TB Partnership
- The Tech Awards
- Tonic
- Total Impact Advisors
- UBS Optimus Foundation
- Toronto Health Organization Performance Evaluation
- Wadhwani Institute of Sustainable Healthcare (WISH)

MAP KEY

- CHMI Partner Network Since 2009

Supporting Nigeria’s foremost public-private health alliance.

Supporting new public-private partnerships in two Indian states.

Generating global visibility and recognition for innovators.

Convening TB innovators in three countries to facilitate scale up.1

1 See page 16 to learn more about activities led by CHMI’s partner in Pakistan, the Interactive Research & Development group.

TO READ MORE ABOUT THESE STORIES SEE PAGE 40
TOPIC PORTALS

CHMI’s redesigned topic portals streamline access to synthesized information on maternal, newborn, and child health, franchising, and other high priority topics. Topic portals offer users customized views of the health innovation landscape. Ten new data visualizations on each portal show where and how programs are working around the world. Users can also easily browse news and resources from these programs. Topic pages provide a lens to focus in on areas of interest in CHMI’s extensive database. To learn more, visit healthmarketinnovations.org/topics.

CHMI PLUS

A new system launching in early 2015 will feature program profile completeness and monitoring and evaluation (M&E) ratings. Completed, up-to-date profiles reporting M&E systems in place will get higher ratings with CHMI PLUS and stand out more. Programs that upload evaluation documents from their M&E plans are also highlighted in this new rating scheme. CHMI PLUS increases visibility and spotlights programs that are focused on measuring their impact and are committed to transparency. To learn more, visit healthmarketinnovations.org/chmi-plus/learn-more.

NEW RESOURCES

THE PRIMARY CARE INNOVATOR’S HANDBOOK

In early 2015, CHMI will release the Primary Care Innovator’s Handbook. Written by members of the Primary Care Learning Collaborative, this piece will showcase experiences from innovators running primary care chains and franchises, covering key challenges that these organizations have faced, such as choosing clinic locations, deciding which services to offer, and improving patient experience. The Handbook is intended to launch greater conversation and collaboration among organizations using these business models to improve health outcomes for the poor.

Visit HealthMarketInnovations.org for more information on these resources and more.
New Research

In 2014, more than 20 publications used CHMI’s programs database and analysis to understand global health markets and explore the evidence for emerging practices. A selection of these publications can be found below. CHMI invites researchers to share publications that use CHMI data so the team can help disseminate the research through the project’s blog, newsletters, and social media. Contact chmi@r4d.org.

• The Bright Continent: Breaking Rules and Making Change in Modern Africa by Dayo Oladipo, Houghton Mifflin Harcourt 2014

• Delivering Social Protection in the Aftermath of a shock: Lessons from Bangladesh, Kenya, Pakistan and Viet Nam Bastogi; F; Holmes R. Overseas Development Institute May 2014

• Healthcare Information For All by 2015: Preliminary Findings and Future Direction by Chris Hagar, Heather Kartzinel. San Jose University, September 2014

• Clinical Social Franchising Compendium 2014: An annual survey of programs. The Global Health Group, University of California. Available at 4Health.org.1


• Leveraging Ubiquitous and Novel Technologies as Enablers to Address Africa’s Health Challenges, Dr. Arun Gowda and Marius O. Chabi. International Journal of Innovation and Applied Studies, 2014

• Trans-National Scale-Up of Services in Global Health Ilan Shahin, Raman Sahal, et al. PLOS One, 2014

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Cover (Bottom): Photo at Smiling Sun clinic by Nahiyan Kabir for CHMI
Page 4: Alex Robinson for CHMI
Page 8: Karen Dias for CHMI
Page 13 & 18: Courtesy of Bill & Melinda Gates Foundation
Pages 15 bottom: Akintunde Akinyele/Pathfinder International, courtesy of LifeWrap.

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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.

CHMI identifies social franchising programs in collaboration with The Global Health Group of the University of California, San Francisco (UCSF)
» INFORMING + CONNECTING
ALL THOSE WHO STRIVE TO IMPROVE THE HEALTH OF THE WORLD’S POOR.

HIGHLIGHTS
FINDINGS FROM 2014

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