INNOVATIVE AND INCLUSIVE SOCIAL ENTERPRISE MODELS

Reaching the Poor in Underserved Areas through Community Health Workers

HIGHLIGHTS

- Community health workers provide health services in communities with poor access to basic health services, delivering affordable health-related goods and services in the homes of people in underserved communities.
- These programs have been shown to lead to improved health outcomes, reducing morbidity and mortality and increasing the overall usage of health services.
- Most models rely on donor funding.

Development Challenge

Accessing basic health services is difficult in rural and poor communities, in part because of the shortage of skilled professionals. Even where services are provided free of charge, poor people often fail to access them because they lack the means to reach the facilities. The result is poor health and nutrition outcomes and high morbidity and mortality from preventable causes.

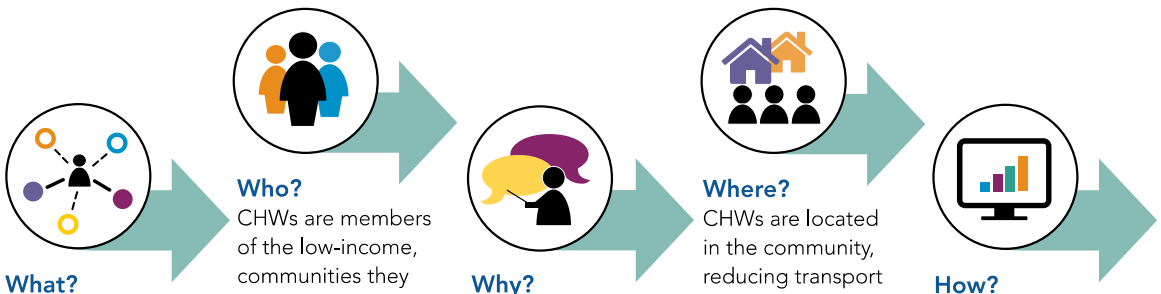
Business Model

Community health worker (CHW) programs address a number of key challenges health systems in developing countries face, including an acute shortage of professional health workers, health workers' unwillingness to spend extended time in remote and rural areas, and the inability of most formal health sector institutions to reach the poorest people within those communities. Evidence indicates that CHWs lead to improved health outcomes, particularly in maternal and child health.

There is no universally accepted definition of CHWs; their roles, profiles, and titles vary across and within countries, where they are known by some 40 different terms. The plethora of terms reflects the diverse roles these people play, from promoting healthy practices to providing specialist services and selling health and sanitary products.

Because they live in the communities they serve, CHWs are culturally aware and able to deliver key health messages in ways that recognize the local cultural context. They help other community members navigate the formal health system, providing a crucial link between people and facilities.

Features of Community Health Workers Business Model



What?
Social enterprise business models engage community health workers (CHWs) to improve equitable access to basic health services, particularly in remote and rural areas.

Who?
CHWs are members of the low-income, communities they serve and are not professional health workers. Becoming a CHW offers income-generation opportunities, especially for youth and women.

Why?
CHWs help outreach and create demand. CHWs maximize affordability by offering low and often subsidized prices for health products and services as well as cross-subsidization.

Where?
CHWs are located in the community, reducing transport costs. They are also culturally aware and able to translate key health messages into a local context.

How?
Training and information and communications technology, especially mobile technology, help CHWs follow treatment protocols, monitor patients, and collect data.

Implementation: Delivering Value to the Poor

Awareness

CHWs create awareness through health education, promotion, and creation of demand for specific health services. They have played a crucial role in building demand for reproductive health services in rural India, helping to expand networks such as the Merrygold Health Network.

Acceptance

CHWs aim to maximize community acceptance in a number of ways. Arogya workers receive communication training in vernacular. They use the term *panna* (named after a 16th century inspirational nursemaid) due to perceived high dignity and also use television series and Bollywood films to impart patient-communication skills. To deliver immediate benefits, Arogya started offering vision and hearing tests. Some models (such as CommCare) design software applications to be adaptable in different contexts and operated through locally available, inexpensive, Java-enabled phones and Android smartphones.

Accessibility

By coming to people's homes, CHWs overcome challenges and barriers faced by communities in accessing care. Living Goods' health entrepreneurs, Arogya's pannas, SAJIDA's sajida bandhus, and Bandhan Health's health volunteers all provide door-to-door services. M-Afya provides care through kiosks. The Real Medicine Foundation's community nutrition educators link families to services they are unaware of and support healthcare providers as well.

Affordability

CHW services are usually free or subsidized. Arogya facilitates access to free medicine (using the government of India's free medicine database) to help poor patients save on prescription drug costs. Living Goods cuts out unnecessary layers of resellers and harnesses the buying power of a network of 1,200 health entrepreneurs to increase availability and decrease the price of high-impact products. M-Afya kiosks use the M-Pesa mobile money system for client payments, reducing transaction costs.

Both for-profit and nonprofit enterprises use CHWs. For instance, Merrygold is a profitable private enterprise in India and Living Goods' microfranchisees in Kenya and Uganda are financially viable with highly cost-effective organization (at a net cost of less than $2 per client per year). Nonetheless, Living Goods still relies on grant funding to cover its annual budget. Arogya in India generates revenues from selling the aggregated data it collects and analyzes. Other initiatives, such as the Bandhan Health Program and SAJIDA Bandhu (in India and Bangladesh respectively) use revenue from microfinance loans to cross-subsidize health programs. Living Goods recruits workers from the BRAC borrower base, and BRAC branches double as depots and field offices.

Results and Effectiveness

CommCare, which operates in India and South Africa, engages thousands of CHWs, serving up to one million beneficiaries. Living Goods reports that it has supported 154,000 pregnancies, treated 564,000 children for potentially deadly diseases, and sold more than 58,000 clean-burning cook stoves since 2007. M-Afya kiosks in Kenya served 2,500 clients (almost 300 per kiosk) between September 2013 and March 2014. Bandhan Health Program in India reports almost 600,000 beneficiaries.

Evidence indicates that CHWs can contribute to improved health outcomes. A randomized controlled trial evaluation found that Living Goods reduced mortality among children under five by 25 percent and increased the likelihood of home visits in the first seven days after delivery by 72 percent. Furthermore, a review of 132 randomized control trials from around the world shows that CHW programs increased immunization uptake, proper breastfeeding practices, and care-seeking for childhood illnesses; increased tuberculosis cure rates; and reduced child morbidity and mortality.

CHW initiatives can also reduce prices. The arrival of Living Goods in Kenya and Uganda forced private pharmacies and medicine shops to improve the quality and reduce the prices of their offerings. After Living Goods entered a market, the price of antimalarial drugs fell by 18 percent, there was a 20 percent reduction in counterfeit drug sales, and use of antimalarial medicine rose 39 percent.

Community health workers collect data that are often shared with other public health stakeholders. These data improve health management and planning. Health facilities in India, for example, used data generated by Arogya's CHWs to meet their monthly reporting obligations and provide early warnings about health epidemics.

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