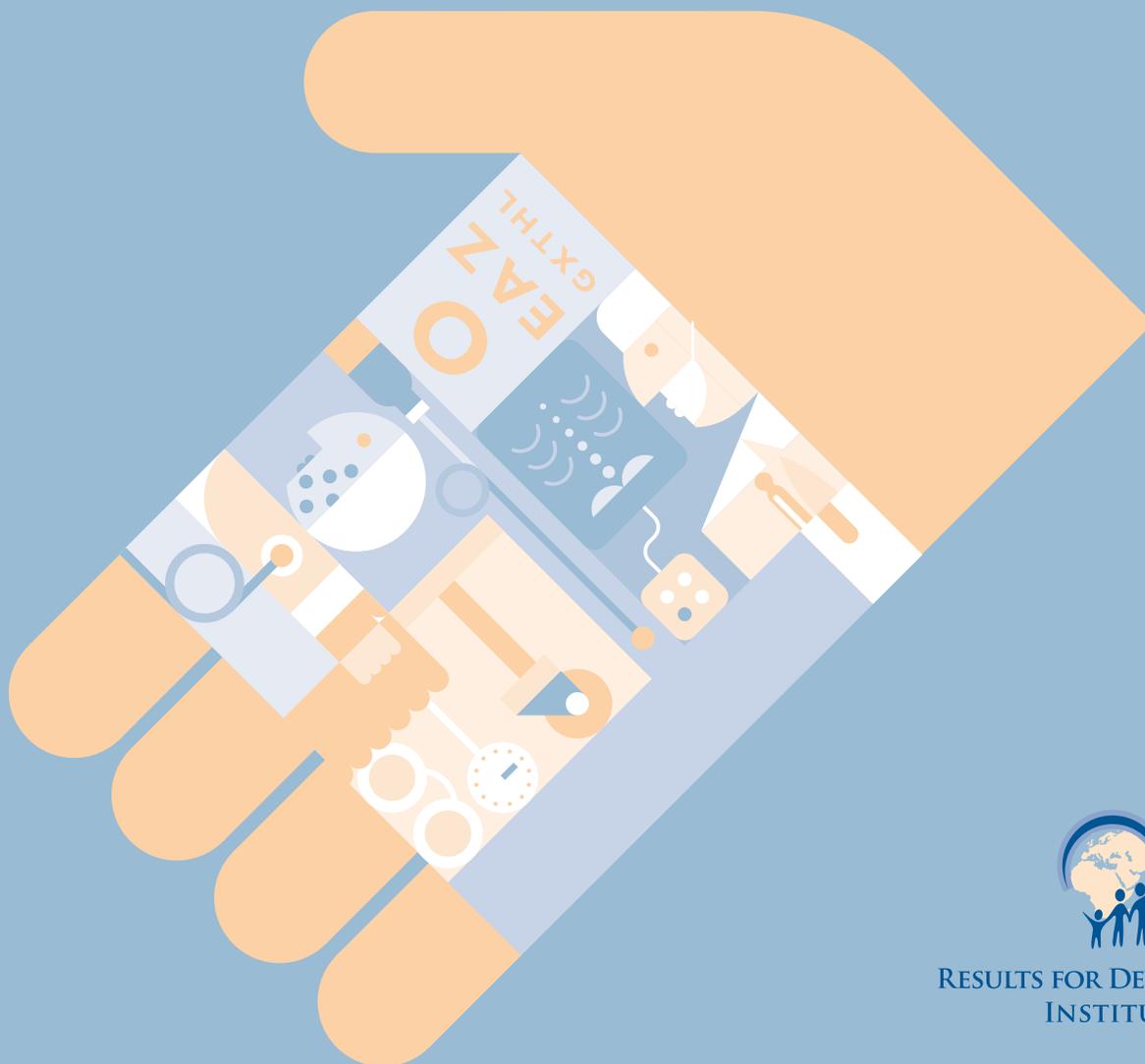


Innovative Pro-Poor Healthcare Financing and Delivery Models

Donika Dimovska
Stephanie Sealy
Sofi Bergkvist
Hanna Pernefeldt

Landscaping from the Rockefeller Foundation—Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries



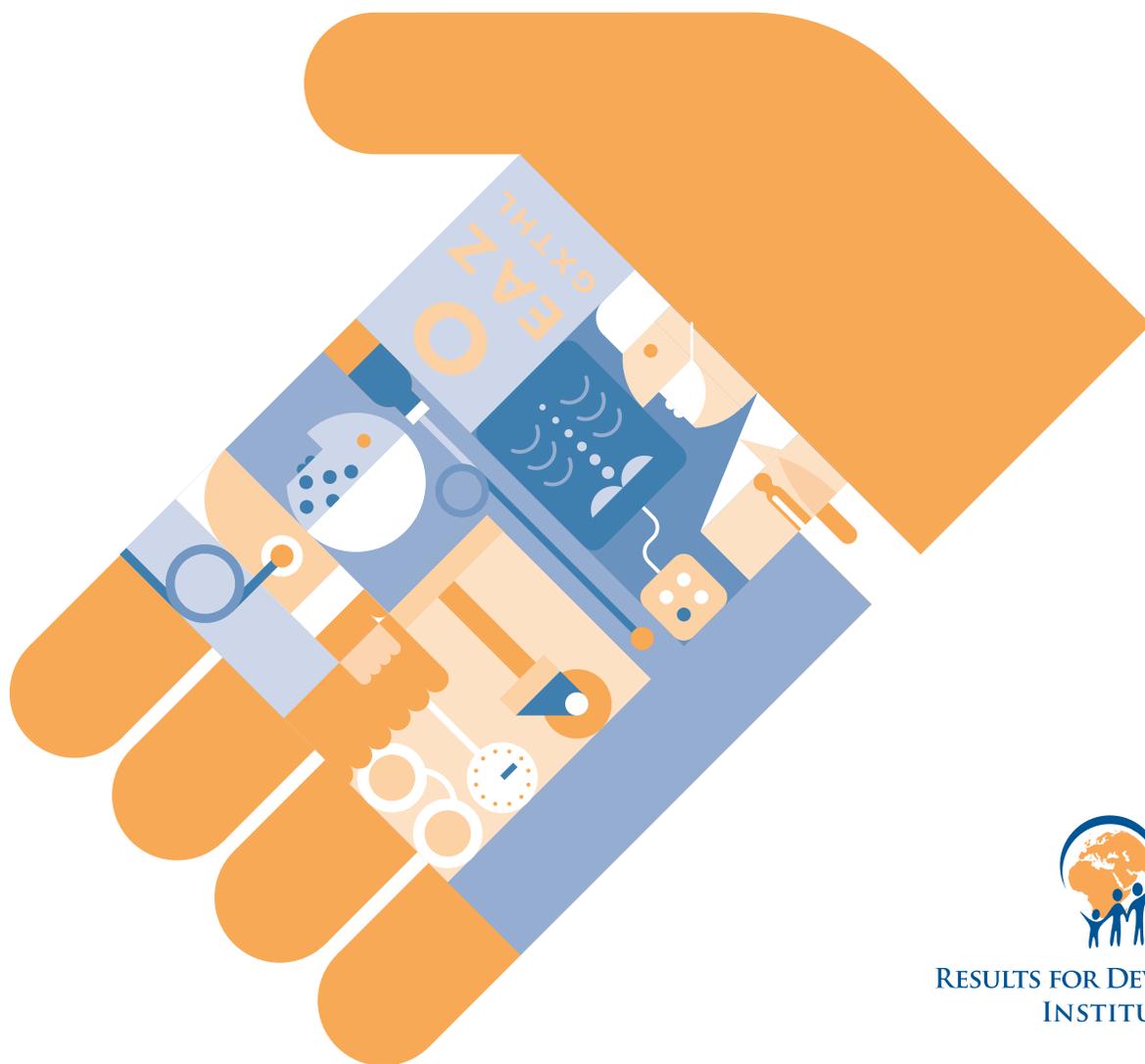
RESULTS FOR DEVELOPMENT
INSTITUTE

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Acknowledgments

This landscaping report includes contributions from a number of technical partners who provided reports commissioned by the 2008 Rockefeller Foundation effort on the role of the private sector in health systems in developing countries. These reports are available on CD-ROM or at www.resultsfordevelopment.org. The technical partner institutions include Branch Associates; Center for Global Development; Dalberg, USA; Future Health Systems Consortium; William A. Haseltine Foundation for Medical Sciences and the Arts; HLSP Institute; Institute of Development Studies; Johns Hopkins University; JSI Logistics Services; London School of Hygiene and Tropical Medicine; MIT-Zaragoza, USA/Spain; Results for Development Institute; Thai Ministry of Health's International Health Policy Program; University of California Berkeley; University of Toronto; and University of Zambia. Individual contributors from each technical partner organization are listed in appendix A.

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Introduction

Background and context

In their efforts to improve health systems, developing countries face the challenge of integrating traditional government health resources with a large and growing private health sector,¹ where many poor people seek care. In these “mixed health systems” centrally planned systems operated by government entities exist side-by-side with private markets for similar or complementary products and services.² However, most developing country ministries of health and the donors and technical experts that support them have not fully engaged the private health sector in harnessing innovation or mitigating market failures.

Recognizing the extent and neglect of this important component of health systems, the Rockefeller Foundation in 2008 invited proposals for a review and landscaping of key topics related to the private sector in health. Thirteen reports were produced along with a synthesis document, *Public Stewardship of Private Providers in Mixed Health Systems* (available in print or at www.resultsfordevelopment.org), a companion to this report.

A key component of this initiative was identifying innovative, pro-poor healthcare financing and delivery programs in South Asia and Sub-Saharan Africa that are led by or engage the private health sector in the context of mixed health systems. This landscaping effort, anchored by the Results for Development Institute with key contributions from the William A. Haseltine Foundation for Medical Sciences and the Arts and other technical partners, had a twofold goal: support the project’s broader research objectives of better understanding the global landscape of existing private health sector programs and identify opportunities

for potential support in future phases of the initiative.

This report describes 33 innovative financing and delivery programs selected based on their relevance to broader health systems and potential to achieve positive impact for poor people.³ While these programs range from donor-driven initiatives to large-scale government-subsidized efforts to for-profit businesses, they all involve active participation by the private health sector. These descriptions are not evaluations, as no rigorous third-party analysis of the impact of the profiled models has been conducted or commissioned, but most model descriptions have been reviewed by the implementing organization to ensure its accuracy.

The companion to this report (*Public Stewardship of Private Providers in Mixed Health Systems*) provides an overview of the Rockefeller Foundation’s broader initiative on the private sector. It focuses on how governments can better steward the large private health markets in developing countries. It assumes that ultimate responsibility for stewarding health systems lies with national governments but recognizes the challenges that many developing countries face in doing so.

One key recommendation is that governments should support innovative models that can be implemented in the face of capacity constraints and serve as stepping stones to broader reforms.

This report of current private sector health innovations identified programs that, while falling short of broad health systems reforms, have the potential to improve health markets and equity in those markets. These interventions typically build on existing structures,

attempting pragmatically to improve them rather than replace them.

Many of these programs have been implemented by private organizations with assistance from donor agencies. Some have been employed where there is weak government capacity, little transparency, and low priority on addressing existing private markets and where government reforms are still in progress and longer in term. Ideally, as countries increase capacity, governments will begin to drive these programs and lend them strong support in order to incorporate them into a broader health systems vision.

Landscaping methodology

The landscaping effort was funded by the Rockefeller Foundation, managed by the Results for Development Institute, and supported by the work of the William A. Haseltine Foundation for Medical Sciences and the Arts and several other technical partners. The programs in this report were identified through literature reviews, expert interviews, and in some cases, country visits. This innovation scan did not seek to generate new, comprehensive evidence on the impact of these programs; the goal was to better understand the current global landscape of pro-poor, financing and delivery healthcare models in mixed health systems. The hope is that this descriptive information will encourage further, more in-depth studies of the impact of these programs.

The search emphasized systemic interventions that could positively impact poor people and advance knowledge on managing and harnessing the private health sector. It focused on programs that actively engage the private health sector.

A vast body of literature exists on the private sector, including several highly valuable studies that have provided extensive documentation on private sector models according to specific mechanisms such as contracting and franchising (for example, the International

Labour Organization and Consultative Group to Assist the Poor's focus on microinsurance and DKT International's focus on social marketing)⁴ or vertically based health areas such as insecticide-treated bednets, tuberculosis treatment, and antiretroviral drugs (for example, the U.S. Agency for International Development PSP-One's focus on family planning and HIV/AIDS).⁵ While these studies have brought attention and resources to many programs, this landscaping effort builds on this work to show models that can strengthen broader health systems.

As noted, the landscaping effort did not identify new evidence on program effectiveness, nor did evidence already exist in all cases. Each program's potential was assessed based exclusively on information provided directly by the implementing organization, and where available, evaluations conducted by other institutions and programs. Several factors were considered for inclusion:

- *Scale.* How many lower income people are affected by this program?
- *Improvement in health outcomes.* To what extent does the model improve quality, affordability, and accessibility of healthcare for the poor?
- *Tie in to health systems.* Does the model comprehensively address a range of healthcare needs?
- *Layering of innovative mechanisms.* To what extent does the model use one or more mechanisms (such as service delivery, risk-pooling, regulation, supply chain, or contracting)?
- *Intersection between public and private sectors.* Does the model involve links between sectors?
- *Scalability.* To what extent is the model scalable?
- *Potential for visibility.* Is the model underfunded or unknown to the extent that greater exposure could lead to more donor support or shared learning?

Introduction

Although the landscaping effort was not restricted to specific geographical areas, the search focused on South Asia and Sub-Saharan Africa because of their high concentration of low-income populations and poor health outcomes and because of the areas of expertise and locations of the technical partners.

Categorization of programs

The models in this report have been categorized based on four criteria:

- The leading implementer (government or nonstate).⁶
- The stage of development.
- The specific mechanism employed in addressing a challenge.
- The particular goal each program seeks to achieve (table 1).

The landscaping effort produced an extensive mix of government- and nonstate-led programs that aim to provide accessible,

affordable, quality healthcare to the poor. Several programs are widely known and have already been studied, evaluated, and profiled. While the search focused on models with little international exposure, these few well known programs were selected for their insightful lessons for future interventions. This report attempts to present a diverse set of innovative programs, from interventions in the concept stage to well established, large-scale initiatives.

Five financing and delivery mechanisms are key instruments of mixed health systems that can improve access to, availability of, and quality of health services:

- *Service delivery mechanisms* to improve quality of and access to healthcare services.
- *Risk-pooling mechanisms* to improve access to health services and strengthen financial protection.

Table 1

Innovative models to make health markets more effective and equitable

Goal	Potential benefits	Examples of models
Reduce fragmentation of providers	<ul style="list-style-type: none"> • Increase transparency, reduce informality, and create visibility and legality • Make it easier and less costly to regulate (reduce both cost and potential principal-agent problems) • Reduce transaction costs/information costs • Increase oversight 	<ul style="list-style-type: none"> • Franchises • Provider networks • Integrated models (pharmacy or clinic chains) • Professional associations
Change provider incentives and increase monitoring	<ul style="list-style-type: none"> • Align provider incentives with patient need for quality, affordability, and access • Sharpen the focus on quality by making patient volumes and payments contingent on meeting standards • Strengthen the ethics and self-accountability of the private sector (foster ethical behavior, create standards) 	<ul style="list-style-type: none"> • Network (HMO) models • Accreditation or licensing through professional association or other independent entities • Franchises • Pay-for-performance mechanisms • Any public or private demand-side financing mechanism (insurance, vouchers), when coupled with purchasing mechanisms designed to improve quality
Provide subsidies for target populations and high-impact interventions	<ul style="list-style-type: none"> • Increase access to higher quality care for the poor, create incentives for private providers to serve the poor • Increase use of high-impact effective interventions 	<ul style="list-style-type: none"> • Insurance • Vouchers
Educate patients to demand the most beneficial services and reduce asymmetries of information	<ul style="list-style-type: none"> • Increase demand for effective interventions, which may in turn increase supply • Reduce asymmetries of information 	<ul style="list-style-type: none"> • Social marketing • Rural cooperatives • Conditional cash transfer programs • Trusted knowledge brokers (citizen report cards, citizen complaint lines, consumer associations)
Use technologies that provide access and improve quality	<ul style="list-style-type: none"> • Increase efficiency • Improve quality and consistency 	<ul style="list-style-type: none"> • Telemedicine • Call centers • Kiosks • Electronic medical records

- *Government and provider self-regulation mechanisms* to improve quality by setting and enforcing standards.
- *Provider purchasing and contracting mechanisms* to promote quality and availability of health services.
- *Supply chain mechanisms* to enable rapid scale-up, consistent quality, and improved access.

The companion report, *Public Stewardship of Private Providers in Mixed Health Systems*, discusses the government's potential role in implementing some of these mechanisms. Private sector actors can also employ these mechanisms, in partnership with government or as standalone efforts in cases of weak government capacity or unfilled gaps in the system. Private enterprises can use service delivery to reduce costs, increase access, and improve quality; risk-pooling to minimize out-of-pocket payments and increase access by pooling risks across populations; self-regulation to create a branding benefit for providers and incentivize greater quality; and supply chain mechanisms to ensure access to quality medicines and enable rapid scale-up.

The programs in this report have been categorized by these financing and delivery mechanisms, with the recognition that some programs exhibit characteristics of more than one mechanism (for example, a franchise may be considered a service delivery model, a self-regulation initiative, and the retail segment of a

supply chain). In the categorization framework at the conclusion of this introduction, programs that employ multiple mechanisms are ordered by their primary mechanism—that is, the mechanism that most defines the program.

The programs presented in this report cover a broad spectrum of interventions that address specific challenges common to many developing countries, including reducing the fragmentation of private providers (franchises and provider networks), changing provider incentives and improving monitoring (accreditation and licensing models and insurance or voucher programs), and providing subsidies for targeted populations and high-impact interventions (public and private risk-pooling programs). In addition, several models work on the demand side of health systems by educating patients to seek out the most beneficial health services (social marketing and conditional cash transfer programs). Others apply innovative uses of information and communication technology to expand access to care (telemedicine solutions and electronic medical records and databases).⁷

While unable to transform health systems as standalone interventions, these programs can complement key elements of countries' healthcare financing and delivery platforms. National governments, donors, and development agencies should consider these interventions as stepping stones toward longer term health systems reform.

Categorization framework for featured programs

Program	Innovation mechanism					Goal of intervention					Leading implementer	
	Service delivery	Risk-pooling	Regulation	Supply chain	Contracting	Reducing private provider fragmentation	Changing provider incentives and improving monitoring	Providing subsidies to target populations and high-impact interventions	Educating patients to demand better health services	Increasing access to care through information and communication technology	Government	Nonstate
Emergency Management Research Institute (EMRI), India Centralizing emergency response services	✓			✓						✓		✓
Health Management and Research Institute (HMRI), India Integrating health information services	✓			✓						✓		✓
Shasthya Sena (Health Force), Bangladesh Improving the performance of informal providers	✓		✓			✓	✓					✓
MicroBusiness for Health (MBH), Ghana Applying business solutions for better health	✓		✓			✓	✓		✓			✓
World Health Partners (WHP), India Building viable private sector health networks	✓		✓			✓	✓			✓		✓
LifeSpring Hospitals Private Limited (LHPL), India Providing highly customized affordable care	✓					✓	✓					✓
Greenstar Social Marketing (GSMP), Pakistan Building a private sector network to reach the poor	✓		✓			✓	✓		✓			✓
LivingGoods (LG), Uganda Delivering affordable health products door-to-door	✓		✓			✓	✓		✓			✓
Sun Network (SQH), Myanmar Delivering care through a network of private providers	✓		✓			✓	✓		✓			✓
Janani, India Providing low-cost family planning services	✓		✓			✓	✓		✓			✓
Byrraju Foundation Health Program, India Establishing self-reliant community health infrastructures	✓					✓	✓		✓			✓

(CONTINUED)

Categorization framework for featured programs (continued)

Innovative Pro-Poor Healthcare Financing and Delivery Models

Program	Innovation mechanism					Goal of intervention				Leading implementer		
	Service delivery	Risk-pooling	Regulation	Supply chain	Contracting	Reducing private provider fragmentation	Changing provider incentives and improving monitoring	Providing subsidies to target populations and high-impact interventions	Educating patients to demand better health services		Increasing access to care through information and communication technology	
Health Initiatives for the Private Sector (HIPS), Uganda Expanding access to services in the private sector	✓						✓		✓		Government	Nonstate
NICE Foundation, India Providing targeted healthcare to mother and child	✓	✓						✓			Government	Nonstate
AFFORD, Uganda Building vibrant health markets	✓								✓		Government	Nonstate
Smile-on-Wheels Program, India Reaching the poor through mobile solutions	✓								✓	✓	Government	Nonstate
KMET Revolving Loan Fund (RLF), Kenya Using microfinance to ensure franchise sustainability	✓								✓		Government	Nonstate
Rashtriya Swasthya Bima Yojana (RSBY), India Expanding state-managed health insurance		✓						✓			Government	Nonstate
Hygeia Community Health Plan (HCHP), Nigeria Minimizing healthcare coverage gaps among the poor	✓	✓						✓	✓		Government	Nonstate
UpliftHealth Mutual Fund (HMF), India Reducing the financial burden of paying for healthcare		✓						✓			Government	Nonstate
Micro Insurance Academy (MIA), India Facilitating the design of pro-poor insurance schemes		✓						✓			Government	Nonstate
Grameen Kalyan (GK), Bangladesh Expanding microcredit services to health insurance	✓	✓						✓			Government	Nonstate
Karuna Trust Community-Based Health Insurance Scheme, India Addressing the barriers to accessing care		✓						✓			Government	Nonstate
Yeshasvini, India Using social networks to expand health insurance		✓						✓			Government	Nonstate

(CONTINUED)

Categorization framework for featured programs (continued)

Program	Innovation mechanism					Goal of intervention					Leading implementer	
	Service delivery	Risk-pooling	Regulation	Supply chain	Contracting	Reducing private provider fragmentation	Changing provider incentives and improving monitoring	Providing subsidies to target populations and high-impact interventions	Educating patients to demand better health services	Increasing access to care through information and communication technology	Government	Nonstate
Microcare, Uganda Providing pro-poor group health insurance coverage	✓						✓	✓		✓		✓
Arogya Raksha, India Leveraging commercial experience for social benefits	✓						✓	✓				✓
Accredited Drug Dispensing Outlets (ADDO), Tanzania Accrediting private drug-dispensing outlets			✓			✓					✓	
NAFDAC, Nigeria Regulating the market for drugs and health products			✓				✓		✓			✓
Yunnan Province Township Health Centers, China Leveraging information and communication technology to monitor health center performance			✓				✓			✓		✓
VillageReach , Mozambique Integrating vertical health system infrastructures				✓			✓					✓
E-Choupal, India Building user-friendly rural information centers				✓						✓		✓
Chiranjeevi Yojana (CY), India Contracting the private sector for delivery services					✓						✓	
Performance-Based Contracting, Afghanistan Contracting for basic health services					✓						✓	
Initiative on Primary Healthcare, Pakistan Contracting primary health services to the private sector					✓							✓

CENTRALIZING EMERGENCY RESPONSE SERVICES

Program Emergency Management and Research Institute (EMRI), India

Description A centralized emergency response service addressing the challenge of poor or non-existent access to emergency support across India.

Stage Rollout (launched in 2005).

Reach Initially launched in Andhra Pradesh, EMRI has expanded to eight other Indian states: Assam, Goa, Gujarat, Karnataka, Meghalaya, Rajasthan, Tamil Nadu, and Uttarakhand. EMRI plans to reach national coverage, servicing more than 1 billion people by 2010.

Implementer *Nonstate.* EMRI was established by the founders of Satyam Computers. It is a not-for-profit organization operating in partnership with several Indian state governments. Satyam Computer Services Ltd. is a technology partner.

Funding EMRI's operations (over 95% of costs) are funded by the National Rural Health Mission of the government of India.

Service delivery

Situation

In developed countries centralized emergency management systems help save lives daily, but many developing countries such as India lag far behind in emergency services. In many Indian states lack of transportation and weak referral systems pose significant challenges to poor communities' ability to access health facilities when in need of urgent medical care.

Isolated attempts to provide emergency care in India have not been scaled up to cater to all segments of the community and address all kinds of emergencies. Where available, service levels are often primitive, suffering from severe legal, administrative, and financing operational challenges. In addition, weak demand for services due to lack of awareness of available facilities further exacerbates these challenges.

Program

EMRI's goal is to respond to 30 million emergencies and save 1 million lives a year using an innovative delivery model of emergency response services under a public-private partnership structure that provides emergency and pre-hospital care free of charge to the patient through a mix of private and government funding. In addition to a supportive government, the key to EMRI's well functioning system is an integrated emergency management infrastructure that includes a toll-free number accessible from landlines and mobile phones, a geographic information system to locate emergencies, a fleet of ambulances for quality care, trained personnel for pre-hospital care, and detailed maps and information about public and private healthcare facility locations and capacities. EMRI receives phone calls for medical (45%), police (50%), and fire (5%) emergencies, with the largest use of EMRI medical services being for child birth (22%), followed by road traffic accidents (18%).

Key program components include:

- *Innovative use of technology.* The single seamless solution of the EMRI model builds on a existing third-party systems and own-developed technology, including computer technology integration, a voice logger system, geographic information systems maps, geographical

Innovative service delivery

positioning systems, automatic vehicle location tracking, and a mobile communication system. It automates all call center activities and integrates all emergency responses via the toll-free number, providing ready access to any kind of emergency support. Based on the nature of the emergency, EMRI transfers information to the appropriate response team and identifies the most suitable route to the emergency scene, and if necessary, medical facility.

- *Quality pre-hospital care.* EMRI equips each ambulance with an emergency medical technician trained not only to provide medical care but also to handle emergency situations. The technician can get support over the phone from a qualified medical practitioner in the control center, and doctors are in the control center around the clock to provide support to the technician and to people at the emergency scene until the ambulance arrives.
- *Detailed process building.* EMRI has developed detailed process understanding and well defined responsibilities throughout the entire organization. All information related to the emergency is maintained in patient care records, and the patient information is shared with the hospital at arrival. EMRI conducts a 48-hour follow-up with patients that are admitted to a hospital.

Service delivery

Impact

- Integrating and strengthening emergency health services across India to save millions of lives each year.
- Increasing the reach of healthcare services in rural and remote areas.
- Building more trust in the health system as a whole and generating greater interest in and uptake of health insurance.
- Reducing maternal mortality rates from a significant increase in institutional deliveries due to increased and timelier access to medical facilities.
- Serving as a model for international replication in a developing country context.
- Strengthening the overall healthcare delivery system, by supporting the referral system and links between government hospitals and private healthcare providers.

Resources

People consulted:

- Venkat Changavalli, CEO, EMRI
- Uma Nath, Lead Partner Corporate

Website: www.emri.in

Source: William A. Haseltine Foundation for Medical Sciences and the Arts

INTEGRATING HEALTH INFORMATION SERVICES

Program	Health Management and Research Institute (HMRI), India
Description	An easily accessible digital health platform integrating a medical advice hotline, a mobile medical outreach component, and telemedicine solutions.
Stage	Rollout (established in 2007).
Reach	HMRI serves 80 million people in Andhra Pradesh, with plans to scale up medical advice services nationally. Mobile medical services cover approximately 3.9 million people a month, focusing on rural areas. Plans also include launching a television channel and radio network that provide comprehensive healthcare information and advice in different languages.
Implementer	<i>Nonstate.</i> HMRI is a not-for-profit organization working in partnership with the government of Andhra Pradesh and the National Rural Health Mission. Satyam Computer Services Ltd. is a technology partner.
Funding	HMRI's operations are financed by the government of Andhra Pradesh, which covers over 90% of costs (with support from the National Rural Health Mission of the government of India).

Service delivery

Situation

Among the major barriers to comprehensive healthcare services and better quality of care in rural India are long distances from services, lack of transportation, cost of services, and discriminatory treatment of users. More than 72.2% of Indians live in rural and semiurban areas⁸ and face the challenges of poor or nonexistent access to healthcare services. In fact, many qualified physicians (6 per 10,000 people⁹) practice in urban areas, creating a huge inequity in the distribution of qualified medical personnel. Moreover, when available, medical care is often provided by informal providers with inadequate skills, resulting in ineffective, or even harmful, treatment.

Several organizations have tried to address these challenges by developing mobile healthcare services that provide medical advice and care to rural communities through mobile vans and telemedicine solutions. However, many providers have become overwhelmed by the financial and operational magnitude of the task and have been unable to scale up their services. Even where the government covers all operational costs, little funding remains for new technologies or pilots of new concepts that sustainably address high demand and poor supply of primary healthcare services across India.

Program

After the success of the Emergency Management and Research Institute model, Andhra Pradesh's existing Health Information Hotline was restructured as HMRI to provide better access to and quality of services for the most vulnerable segments of society. To do so, HMRI and the government of Andhra Pradesh worked together to establish a 24/7 digital health platform. The HMRI program is built around two core components—technology and public education—effectively leveraged to create citizen-centered health services at no cost to the consumer. HMRI's 24/7 call center averages 50,000 calls a day, with most originating in small villages with no permanent medical facilities or staff. All calls are routed to the appropriate medical personnel (doctor, nurse practitioner, or psychologist) or in case of an emergency, linked to the EMRI emergency service.

Innovative service delivery

Key program components include:

- *Virtual health information platform.* HMRI's 104-Advice operates as a free 24/7 virtual medical advice hotline. The service offers health information and advice in three languages—English, Hindi, and Telugu—on all health delivery services across the state as well as counseling for HIV/AIDS, matrimonial discord, depression, and chronic diseases. For service improvement in government hospitals, patients can also file complaints through the helpline. The service employs specially trained counselors and proven state-of-the-art telecommunications equipment and technology. 104-Advice services are based on 140 directories, 400 algorithms, and 165 disease summaries. The virtual platform also serves as a contact center for field workers in monitoring epidemics and disease outbreaks.
- *Mobile medical units.* HMRI's 104-Mobile service provides healthcare services to communities in underserved rural areas using well equipped mobile van units that include medical equipment and a staff of three auxiliary nurse midwives, a pharmacist, a lab technician, and a data entry operator. The mobile medical units perform routine monitoring of children and pregnant women and dispense medicines for chronic ailments. The HMRI team is further linked with a local village health worker, the accredited social health activist worker appointed by the government. Accredited social health activist workers report on disease outbreaks in the villages and register important events such as birth, marriage, and death. They are the local anchor bringing the village population together for the monthly HMRI outreach visit. The HMRI 104-Mobile service currently covers the entire state of Andhra Pradesh.
- *Telemedicine services.* HMRI's 104-Telemedicine service uses new information technology, telecommunication, and medical electronics to collect and send data to a control center for interpretation. Virtual physical examinations are done through video conferences between patients and healthcare professionals to determine diagnoses and formulate treatment plans. Electronic health records for all patients are then filed in a central repository and made available for future reference and treatment. HMRI's innovation lab continues to develop many cutting-edge technologies.

Service delivery

Impact

- Integrating and strengthening preventive, curative, and emergency health services across India to save millions of lives each year.
- Increasing the potential to build more trust in the health system as a whole and generating greater interest in and uptake of health insurance.
- Increasing the reach of healthcare services in rural and remote areas.
- Reducing the cost of access to healthcare services (such as lost wages, travel costs, and the like).
- Providing increased access to regular preventive health checks and health education in remote communities.
- Strengthening the overall healthcare delivery system, by supporting the referral system and links between government hospitals and private healthcare providers.

Resources

People consulted:

- Balaji Uthla, CEO, HMRI
- Nitin Verma, CTO Information, HMRI

Website: www.hmri.in

Source: William A. Haseltine Foundation for Medical Sciences and the Arts

IMPROVING THE PERFORMANCE OF INFORMAL PROVIDERS

Program Shasthya Sena (Health Force), Bangladesh

Description A program designed to improve the quality of services provided by informal providers in rural Bangladesh and integrate them into the country's health system by networking the providers and establishing quality monitoring mechanisms.

Stage Startup (launched in 2008).

Reach The program is being piloted in Chakaria, a predominantly rural area of Bangladesh with a population of 400,000 people.

Implementer *Nonstate.* The Shasthya Sena program is implemented by the International Centre for Diarrheal Disease Research (ICDDR,B), an international health research institution in Dhaka, in collaboration with partners from academic and research institutions throughout the world.

Funding The Shasthya Sena program is supported by the U.K. Department for International Development (through Johns Hopkins University, United States) and the Swedish International Development Cooperation Agency's Department for Research Cooperation.

Situation

Formally trained providers account for only 5% of healthcare providers in Bangladesh, despite the huge infrastructure of Bangladesh's formal health sector, stretching from specialized hospitals to outreach activities at the village level. Nationally, per 10,000 people, there are 12 informal healthcare providers and 11 drug vendors but only 5 trained physicians and 2 nurses. The situation is worse in Chakaria, where 24 trained physicians and 8 trained nurses serve more than 400,000 people. Nearly 70% of the first-level contact for treatment of acute respiratory infections in rural areas is with informal providers. The private sector comprises about 180,000 informal healthcare providers practicing modern medicine as village doctors or drug vendors.¹⁰

Informal providers provide most frontline treatment but lack appropriate knowledge about sickness management, and some of their treatment practices can be harmful (such overprescribing and inappropriate prescribing). A recent ICDDR,B scoping study in the Chakaria district of Bangladesh found that 65% of healthcare services are provided by informal providers, irrespective of the type of disease. When 325 of the informal providers (village doctors) were interviewed to assess their knowledge of appropriate drug use in treating common health problems, only 18% of village doctors had correct knowledge about the management of diarrhea and 16.5% about the management of acute respiratory infection. Some 75% of the drugs prescribed by the village doctors for pneumonia among under-five children and for cold and fever and diarrhea among patients of any age were inappropriate, and 7% were not only inappropriate, but also harmful for the patients.

In addition to the problems of inappropriate and harmful drug treatments and lack of accountability, informal providers are insufficiently linked to the formal healthcare system through appropriate referral practices and information sharing.

Program

The Shasthya Sena model seeks to reduce harmful treatment and improve the overall performance of informal providers in Bangladesh by addressing two main challenges: the poor service quality of many informal providers and the lack of accountability and formal links to the healthcare system. The model aims to harness informal providers and effectively link them to the system by employing a three-pronged approach: training informal providers, establishing an association of informal providers to implement quality control, and involving the Bangladesh Health Watch (a civil society initiative) in monitoring informal provider performance.

Key program components include:

- *Informal providers network.* Shasthya Sena has created a network to establish accountability and brand identity for village doctors. Network members are expected to adhere to quality standards in safety, appropriateness of treatment, and avoidance of unnecessary costs to patients. The network is governed by members from government, civil society, and formal private practice, who set membership eligibility, which is verified and publicly announced twice a year.
- *Free provider trainings.* Shasthya Sena provides free training to informal providers, including clear guidelines on appropriate treatments (DO's and DON'T's for managing illnesses and prescribing drugs) and referral practices for serious cases (name, location, mode and cost of transport, estimated cost of treatment, estimated duration, telephone directory of contacts). Refresher trainings are provided every two months, and a 24-hour phone service is available. The training modalities, protocols, and incentive structures for providers are continuously refined based on feedback from trainees.
- *Performance monitoring.* Shasthya Sena has established community health watch committees in villages to monitor informal providers' performance. The committees include representatives of Shasthya Sena, local government, and formal healthcare providers from the public and private sectors. Findings from the ICDDR,B's Chakaria Health and Demographic Surveillance System will provide additional information on performance.

Impact

- Enhancing competence among informal sector providers, significantly reducing harmful and inappropriate practices, and increasing referrals to the formal sector.
- Improving service quality of informal providers to improve health outcomes of rural communities, with a strong focus on the poorest segments.
- Strengthening the national health system by harnessing the existing large number of informal providers and integrating them into the national framework.

Resources

People consulted:

- Dr. Mohammad Iqbal, Social and Behavioral Sciences Unit, Public Health Sciences Division, ICDDR,B

Website: www.icddr.org

Source: Institute of Development Studies, www.ids.org

APPLYING BUSINESS SOLUTIONS FOR BETTER HEALTH

Program **MicroBusiness for Health (MBH)/HealthKeepers, Ghana**

Description A social microfranchise program that applies tested business methods to provide poor rural communities with access to affordable healthcare products, services, and information.

Stage Rollout (launched in 2007).

Reach MBH/HealthKeepers operates in four southeastern regions of Ghana, serving more than 800,000 people. It plans to continue expanding to ultimately reach 50% of poor, rural communities in Ghana by 2012 and 80% by 2015.

Implementer *Nonstate.* MBH/HealthKeepers is a program of Freedom from Hunger, a U.S.-based international development organization working in 17 countries around the world.

Funding MBH/HealthKeepers receives funding from Caridad Partners, the David Weekley Family Fund, the Horace W. Goldsmith Foundation, the Rockefeller Foundation, and the Weyerhaeuser Family Foundation.

Service delivery

Situation

Of 22 million people in Ghana, 45% live on less than \$1 a day. And 70% of people in rural areas are poor. Most rural communities are severely affected by malaria, diarrhea, and childhood diseases. Despite recent government attempts to strengthen Ghana's health system by investing millions of dollars in infrastructure, poor people's health outcomes are still far from satisfactory.

Ghanaians continue to suffer from malnutrition, poor reproductive health, more noncommunicable diseases and HIV/AIDS, drug-resistant malaria and tuberculosis, and other diseases with high morbidity and mortality, such as acute respiratory infections and diarrhea. The rural poor are most severely affected, struggling to gain access to and the means to pay for even substandard health protection products and treatment. They also face loss of productivity and income as a result of personal health problems, caring for a sick family member, or death.

Program

MBH/HealthKeepers uses a social franchising model with an alternative distribution strategy. It recruits village women to build a growing network of franchisees. They distribute health products to their communities and provide health counseling while earning more than \$500 a year. All HealthKeepers receive initial and refresher trainings on health topics and have referral cards for nearby medical facilities. MBH/HealthKeepers has so far recruited and trained more than 200 active HealthKeepers and plans to reach self-sufficiency by 2012. It envisions working with the National Health Insurance Authority to eventually enable HealthKeepers to enroll clients in the national health insurance plan and collect annual premiums to increase income potential while strengthening the health system as a whole.

Key program components include:

- *Business entrepreneurship.* MBH/HealthKeepers recruits members of the franchise network based on a set of preestablished selection criteria: an energetic, outgoing woman ages 25–55,

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well respected in her community, able to read and write, and successful at running some type of small business. MBH/HealthKeepers training curricula are carefully designed to equip franchisees with the skills to successfully manage their businesses, counsel their customers, and sell more health-promoting products. They can earn recognition (badges, ribbons, and buttons) that show their customers that they have received special training on various products and health issues. Franchisees receive regular supervisory visits and unannounced spot checks coordinated by field support managers and receive incentives for their customers to boost sales, increase product use, and raise product awareness for enhanced healthy outcomes.

- *Targeted products and services.* MBH/HealthKeepers offers its franchisees a “business in a basket” franchise package to enhance their ability to earn a living while effectively serving their communities. All HealthKeepers acquire an inventory of products on a consignment basis for core health products (such as insecticide-treated mosquito nets, water purification tablets, contraceptives, oral rehydration salts, acceptable pain killers, vitamins, and safe-birth kits) and on a cash-and-carry basis for personal care products (such as bandages, moisturizing cream, feminine supplies, soap, toothpaste, brushes, and shampoo). Products are offered with minimal retail markup from MBH. In addition to product sales, HealthKeepers offer services that provide a competitive edge, such as references to health service providers, eye exams for reading glasses, and the like.
- *Effective supply and distribution.* MBH/HealthKeepers’ supply and distribution strategy is to provide social benefits by guaranteeing low prices, commodity quality and availability, and service quality of franchisees. MBH/HealthKeepers uses pooled procurement to obtain products directly from manufacturers and importers at reduced prices (quantity discounts). Products are then delivered to the franchisees at agreed prices at a common meeting place on a biweekly or monthly basis. This decentralized system saves travel time and costs. Maintaining a minimum stock level ensures regular and consistent lead time.

Service delivery

Impact

- Reducing disease morbidity and mortality from preventable and treatable diseases by providing community members with access to quality, affordable life-saving health protection products and information at their doorstep.
- Improving the standard of living of HealthKeepers and their families through the franchisee’s substantial financial contributions of more than \$500 a year.
- Increasing product suppliers’ brand awareness because of increased distribution channels.
- Increasing the potential for expansion of the national health insurance scheme by linking the community and the scheme.
- Decreasing the risks that microfinance institutions have to take in lending to community members because of clients’ improved health and income levels.

Resources

People consulted:

- Eden Rock, Freedom from Hunger
- Daniel Mensah, Freedom from Hunger–Ghana

Website: www.freedomfromhunger.org

Source: Results for Development Institute

BUILDING VIABLE PRIVATE SECTOR HEALTH NETWORKS

Program World Health Partners (WHP), India

Description An international collaboration working to bring healthcare and family planning services to rural areas by harnessing the existing private sector and incentivizing it to create viable health networks addressing communities' health needs.

Stage Startup (launched in 2008).

Reach A pilot program has been launched in three districts of Uttar Pradesh (whose population is 185 million), servicing an estimated 4 million people. WHP envisions expanding in India and replicating the model across developing countries.

Implementer *Nonstate.* WHP, a charitable organization, collaborates with Venture Strategies for Health and Development, a nonprofit organization closely tied to the School of Public Health at the University of California, Berkeley.

Funding WHP is funded by a large, anonymous U.S.-based donor.

Situation

Numerous studies have highlighted the plight of the poor in accessing reproductive health and general health services in developing countries. The unmet need for family planning—couples who want to space or limit pregnancies but are not using a modern contraceptive method—averages over 20% in developing countries. The demand for healthcare is even higher.

The main hurdle in global and reproductive healthcare is the disinterest of qualified providers in working in remote areas. Because of the cost of care, medical service provision is inadequate for the poor in both urban and rural settings. A staggering two-thirds of people in developing countries are both poor and remote, doubly affected by the lack of access to care. This extreme imbalance between medical and health need and response can be substantially reduced. New advances in managing labor, capital, materials, and information provide the tools to deliver much needed services almost seamlessly. Uttar Pradesh has some of the worst social and demographic indicators in India. Basic amenities of developed countries are sparse: 57% of households have no electricity, 90% lack water, and 67% do not have a toilet. Despite the intense poverty, the population is growing, further straining limited resources. Unmet need for family planning is 21.9%, but in rural areas, where three-fourths of the population lives, it is 23.8%. The need for limiting births (12.6% overall and 13.5% in rural areas) is greater than that for birth spacing (9.3% overall and 10.3% in rural areas).

Program

WHP is an innovative program that aspires to bring healthcare and family planning access to the most underserved parts of developing countries by organizing existing resources and creating viable health networks, training village providers, and encouraging broader community social development in addition to medical access. WHP organizes health network providers into subnetworks that are the units of operation for product supply and distribution as well as medical referrals. Each village practitioner that WHP works with belongs to the village health network, which provides the community access to four tiers of healthcare products and services: village shops, basic rural village health providers, centrally located telemedicine centers, and medical clinics in a nearby town. The four-tiered system allows providers to complement each other's package of services. For example, the telemedicine centers and the franchise clinics work closely with a central medical facility, consisting

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of a panel of medical specialists who are available only in the main cities to ensure the quality of services. As WHP creates access to reproductive healthcare on the ground, it simultaneously brings about policy change at the national level.

Key program components include:

- *Village-level resources.* WHP organizes existing village-level resources to create a more efficient health system. The four-tiered system includes 900 small shops in each village that sell a variety of low-cost family planning, pharmaceutical, and general health products and that refer patients to nearby rural health providers or telemedicine centers; 1,000 rural health providers who are formally trained in basic health services (such as basic diagnostic tests for pregnancy and blood pressure), who provide first aid, and who refer clients to telemedicine centers for formal medical consultations; 100 telemedicine centers (SKY health centers) for each cluster of 10 villages, which are staffed by local trained telemedicine operators who work with a small team of qualified physicians in a central medical facility (also the program management headquarters) to provide consultations ranging from physical exams to family planning counseling; and franchised medical clinics, which provide nine doctors in the project areas benefit from network referrals, aggressive marketing and advertising, and ongoing skills training.
- *Local program management.* WHP's unique and efficient program management system uses outsourced local management teams in urban centers near the villages that the program serves. Its seamless service delivery system relies on each local program management team to integrate inputs from the WHP head management team in New Delhi and specialist organizations—satellite communication, telemedicine, software, advertising, market research, financial systems, supply chain, and so on—into a highly sophisticated system. Local management teams are also responsible for ensuring quality by monitoring the systems to detect, incentivize, and reward quality care and to penalize poor care.
- *Innovative technologies.* Technology is a key component to establishing a workable village health network. WHP uses numerous innovative technologies suitable for rural settings. The most important is the ReMeDi telemedicine system from Neurosynaptic Communications, based in India. This comprehensive system allows doctors to visually examine patients, perform sophisticated diagnostic tests (such as measuring blood pressure and conducting electrocardiograms and stethoscopy), and offer therapeutic recommendations. ReMeDi was specifically designed for rural settings, with inconsistent power supply, durability, and ease of use in mind. Village telemedicine centers are connected to a central medical facility in New Delhi through a broadband or satellite connection. Other technologies being used and considered are medical diagnosis software, handheld devices for inventory tracking, low-energy LED lamps, and global positioning systems.

Impact

- Increasing access to and affordability of healthcare and family planning among underserved communities.
- Strengthening the health system on the whole by integrating the four-tiered infrastructure of healthcare provision already in place.

Resources

People consulted:

- Gopi Gopalakrishnan, Project Director, World Health Partners

Website: www.worldhealthpartners.org

Source: Results for Development Institute

Service delivery

PROVIDING HIGHLY CUSTOMIZED CARE TO THE POOR

Program LifeSpring Hospitals Private Limited (LHPL), India

Description A for-profit, high-volume, low-cost hospital providing quality and affordable healthcare to women and children from lower income households across India.

Stage Established (founded in 2005).

Reach LHPL operates six hospitals serving 23,000 patients, with plans to scale up to 30 hospitals by 2010 and 140 hospitals by 2014 in Andhra Pradesh, Karnataka, and Maharashtra.

Implementer *Nonstate.* LHPL is jointly operated by Hindustan Latex Limited and the Acumen Fund.

Funding LifeSpring is a for-profit hospital operated as a 50/50 equity partnership between the Acumen Fund and Hindustan Latex Limited.

Service delivery

Situation

India has very high levels of maternal mortality—more than 100,000 women die every year from pregnancy-related causes and an equal number suffer moderate to severe complications. These statistics are disconcerting because most maternal deaths can be prevented through adequate pre- and postnatal care. Furthermore, poor health has repercussions not only for women but also for their entire family. Women with poor health are more likely to give birth to low-birthweight infants, less likely to be able to feed and care adequately for their children, and less capable of pursuing gainful social, economic, or community activities. This situation is largely due to the high costs and unavailability of maternal and child healthcare services, especially in rural and periurban areas.

A very large private sector has emerged where the public sector was not present or could not meet the demand for services. However, most private sector facilities in urban slum areas have limited capacity to adequately care for those in need. They are almost always single-doctor institutions with very basic infrastructures and reach.

Program

LHPL addresses maternal and child healthcare in India through a chain of high-quality small private hospitals (20–25 beds) that offer efficient, affordable customized care to its customers (“guests”). LHPL’s strategy is to provide services at the lowest possible cost, focusing on the working-class poor in high-population-density urban areas. The delivery model consists of a chain of LifeSpring hospitals across India that provide care at 30%–50% of market prices and quality standard protocols (such as ISO 9001-2000 certification). LHPL’s niche is standardization of processes and specialized provision of maternal and child services, including antenatal care, postnatal care, deliveries, family planning services, medical termination of pregnancy, pediatric care (including immunization), diagnostic services, and pharmacy services. To maintain self-sustainability while serving low-income customers, LHPL applies internal cross-subsidization, with service rates based on accommodation and not quality of service. Under this model, hospitals are expected to become profitable within 21 months. To further reduce costs for services, LHPL is developing relationships with several government-sponsored voucher and insurance schemes (such as Janani Suraksha Yojna).

Innovative service delivery

Key program components include:

- *Customer relationship management.* LHPL has developed a unique protocol for customer care, LifeSpring CARES (courteous, attentive, respectful, enthusiastic, and safe), which all hospital employees are required to observe. To ensure high-quality service, client surveys and discussions with customers are used to obtain feedback, which is fed into the operational system to improve overall service.
- *High-quality services.* LHPL provides high-quality services at a low cost by leveraging information technology (they are now setting up a datacenter to link all hospitals) and working with national and international medical equipment vendors to negotiate better prices for equipment through economies of scale.

Impact

- Making a significant contribution to reducing maternal and child mortality rates by increasing the percentage of institutional deliveries.
- Enabling low-income populations to access quality maternal and child services through a viable cross-subsidization model.
- Raising the quality standards for commercial healthcare facilities across India through standardized treatment and process guidelines and protocols.

Resources

People consulted:

- Anant Kumar, CEO, LHPL
- K. Giridhar, Head of Projects, LHPL
- George Cheriyan, Head of Information Technology, LHPL
- Tricia Morente, Head of Marketing, LHPL

Website: www.lifespringhospitals.com

Source: William A. Haseltine Foundation for Medical Sciences and the Arts

Service delivery

HARNESSING THE PRIVATE SECTOR TO REACH THE POOR

Program Greenstar Social Marketing (GSMP), Pakistan

Description A comprehensive social franchising and marketing program increasing access to and use of health products, services, and information among low socioeconomic population groups through an extensive private provider network.

Stage Established (launched in 1991).

Reach GSMP runs programs on a national scale promoting products and services in 100 districts in Pakistan and operating a franchise network of more than 7,000 active providers.

Implementer *Nonstate.* GSMP was established by Population Services International, a U.S.-based health nongovernmental organization. Greenstar partners with the government of Pakistan, several international nongovernmental organizations and donors, and the private sector.

Funding Greenstar receives funding from the David and Lucille Packard Foundation, KfW, U.K. Department for International Development, United Nations Population Fund, and U.S. Agency for International Development.

Situation

With fertility at 4.1 births per woman and a growth rate of 1.9%, Pakistan's population doubling time is 37 years—much faster than that of other developing countries (India's, for example, is 44 years). This situation is not due to intentional decisionmaking by parents but to the challenges Pakistanis encounter in seeking reproductive healthcare services. With per capita GNP only \$689, most men and women are unable to afford quality healthcare and reproductive services and products. Rural populations also face poor access to medical facilities.

The result has been poor access to information about family planning and contraception (only 30% of couples use any form of contraception). Government services have been unable to satisfy the growing need, and many people have sought care from private pharmacies and clinics, where out-of-pocket payments are the most common financing mechanism (98%). The private sector provides as much as 70% of all health services in Pakistan.

Program

GSMP emphasizes family planning; maternal, neonatal, and child health; and infectious disease control. GSMP harnesses the existing large infrastructure of private sector providers (such as clinics and pharmacies) by creating a network of providers who receive a package of services that help them become more viable and expand their customer base. The program includes more than 18,000 male and 6,500 female doctors and female paramedics, who provide more than 19 products and services through more than 60,000 retail outlets and 20,000 pharmacies, making GSMP the second largest provider of reproductive health services after the government. In 2005 GSMP expanded its portfolio of services by launching the “GoodLife” brand to address a broader range of family health needs such as maternal and child health issues (such as nutrition, sanitation, malaria, HIV/AIDS, and tuberculosis). A recent Johns Hopkins University Bloomberg School of Public Health study found that care at Greenstar outlets was significantly higher quality than at other for-profit and nongovernmental organization providers in the country.

Innovative service delivery

Key program components include:

- *Network of private providers.* Greenstar network providers are selected based on need and availability. Special Greenstar zonal teams conduct mapping exercises to determine the location and distribution of private healthcare providers in a region. Once the providers are identified, predetermined criteria ensure that the capacity, ability, and quality of service providers are adequate. Most providers are located in low-income urban and periurban settings, but the franchise is expanding into rural areas as well. In addition, Greenstar is developing a research methodology to track the number of patients served by the franchise (current data indicate that 2.3 million households across Pakistan benefit from Greenstar's services).
- *Targeted medical training and products.* All members of the Greenstar network receive training specifically tailored to their needs. For example, female doctors (providing all gynecological services in Pakistan) undertake an intensive 40-hour course on all contraceptive methods, including intrauterine contraceptive device insertion, hormonal contraceptive prescription, drug side effects management, and counseling techniques. Male doctors receive a one-day training in reproductive health, counseling, and all contraceptive methods to encourage them to spread this information to their wives and other men. As the first point of contact for many low-income people seeking medical advice, pharmacists receive a half-day training. And female health visitors (women who make home calls or run small clinics) also receive training given their work with the poorest populations. Greenstar instructors make regular visits to Greenstar clinics to follow up on quality of services and product availability. All products (including contraceptive pills and condoms) are subsidized by donors, making the cost per couple year of protection as low as \$5.
- *Public education and communications.* Greenstar seeks to significantly increase demand for reproductive health services and products among low-income populations. As part of its communication strategy, Greenstar uses a variety of approaches, including large-scale mass media campaigns (television, radio, newspapers, billboards, and public relations) and neighborhood meetings and seminars. The aim is to increase awareness on a range of health issues and demand for reproductive services and products. Independent studies have shown that as many as 25% of attendees subsequently seek a family planning consultation with a Greenstar provider. In addition, Greenstar actively markets the clinics and providers in its network to increase the flow of customers to the providers and to ensure ongoing interest in joining the network.

Service delivery

Impact

- Making a significant contribution to women's reproductive health, family planning practices, and fertility reduction in Pakistan by expanding access to and improving quality of health products and services.
- Increasing awareness and motivating healthy behavior among low-income communities regarding reproductive health and family planning options.
- Strengthening the health system by harnessing the private sector and collaborating with the government.

Resources

People consulted:

- Dana Tilson, Executive Director, GSMP
- Dr. David Ali, CEO, GSMP

Website: www.greenstar.org.pk

Source: Results for Development Institute

DELIVERING AFFORDABLE BASIC HEALTH PRODUCTS DOOR-TO-DOOR

Program LivingGoods, Uganda

Description An “Avon-like” network of franchised community health promoters who provide health education and earn a living selling essential health products door-to-door.

Stage Rollout (launched in 2007).

Reach The program serves 200 communities in Uganda and will more than quadruple in scale to 900 communities by the end of 2009. LivingGoods plans to replicate aggressively in other countries through directly managed divisions, partnerships, and technical support to others.

Implementer *Nonstate.* LivingGoods and BRAC Uganda are partnering on the program in Uganda.

Funding LivingGoods receives funding from the David Weekley Family Foundation, the Draper Richards Foundation, the Mulago Foundation, and the Rockefeller Foundation (through BRAC Uganda). LivingGood’s long-term goal is to achieve financial self-sustainability.

Situation

Half of Uganda’s population lives more than 5 kilometers from the nearest public health facility, where frequent stockouts are the norm. Rural villagers often spend a day and up to \$2 in transport to a government dispensary only to find, after waiting in a long line, that vital medications are unavailable.

When public facilities are out of stock or too far, people turn to private drug shops, where prices can be inflated by markups passed on by the inefficient multilayered system of wholesalers, distributors, and agents. There are no pharmacy chains. The marketplace of private drug shops is fragmented, inefficient, and severely underregulated. This results in the widespread occurrence of untrained providers, inaccurate diagnoses and prescriptions, and counterfeit and expired drugs, all of which severely impair access to essential health products for millions of people in developing countries.

Program

LivingGoods aims to address the health challenges of Africa’s underserved communities by combining best practices from public health, microfranchising, and social marketing. The program’s ultimate goal is a fully financially sustainable, secure, and reliable system for delivering essential medical solutions to poor communities that can be easily adapted to other developing country contexts. LivingGoods operates Avon-like networks of community health promoters trained to provide basic health counseling on a variety of topics to their communities while making a modest living by selling health products such as mosquito nets, water purification tablets, oral rehydration salts, vitamin A, antimalarial drugs, dewormers, condoms, and the like at below-market prices. To boost sales and ensure long-term sustainability, community health promoters also sell personal care products such as soap, feminine pads, and toothpaste as well as products that support household income or savings, such as solar lanterns, efficient stoves, and high-yield seeds.

Key program components include:

- *Local partnerships.* LivingGoods has initiated a joint venture in Uganda with BRAC, which has brought many advantages. BRAC Uganda recruits community health promoters from

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its base of 50,000 borrower group members (its very selective process chooses only 1 in 90 members). Existing BRAC microfinance branches double as depots and field offices. Community health providers live within 6 kilometers of a supply point.

- *Public health training.* All franchisees are trained to give basic public health counseling on the use of products and to facilitate referrals to acutely ill patients. Field agents monitor franchisees and clients monthly to ensure that appropriate public health counseling takes place, that providers have key health items in stock, and that medicines are prescribed accurately and sold at listed prices.
- *Branding and communication.* LivingGoods strongly emphasizes branding. Community health promoters wear a branded uniform, carry a pack with a clearly visible logo, display a sign on their home, and have signage to use at market stalls. When LivingGoods launches in a new community, field agents arrange community meetings in partnership with schools, village elders, churches, and local nongovernmental organizations to introduce the new health promoters and give them an official imprimatur.
- *Financial sustainability.* The sustainability plan relies on each franchisee generating \$2,400 in annual sales with a 25% margin, yielding \$500 in annual net income—quite comfortable by Ugandan standards for individuals with no professional training. The wholesaler retains a 15%–20% margin, which at scale should cover the overhead back office, training, transport costs, and an adequate supervisor to franchisee ratio.
- *Below market pricing.* LivingGoods' buying power and ability to cut out intermediaries allow it to set prices 10%–30% below market. This provides an incentive for community health providers and gives the product greater perceived value to the consumer. The program also distributes some items obtained through the government for free.
- *Distribution and monitoring.* Field agents meet community health promoters at least once a month to resupply, collect payments, communicate current promotions, and provide ongoing health education and business coaching. Agents are required to keep detailed and accurate records of all patient contacts and transactions. Field agents collect these data and enter them in a central database. Community health promoters must strictly adhere to the core rules of the program, particularly with respect to storage, prescription, and sale of regulated items, or they risk losing their franchise. LivingGoods is conducting an independent randomized trial to accurately measure the model's impact on mortality and morbidity.

Service delivery

Impact

- Targeting a 25% reduction in all-cause mortality.
- Ensuring the consistent availability of quality health products and reducing the average prices that families pay for them.
- Increasing referrals to the public health system for secondary care, particularly for high-risk pregnancies, complicated malaria, and severe respiratory infections.
- Creating sustainable livelihoods for more than 3,000 community health promoters, who can earn \$300–\$500 a year.
- Reducing lost labor productivity due to illness and increasing productive life spans.

Resources

People consulted:

- Chuck Slaughter, President, LivingGoods

Website: www.livinggoods.org

Source: Institute of Development Studies, www.ids.org

DELIVERING CARE THROUGH A NETWORK OF PRIVATE PROVIDERS

Program Sun Network, Myanmar

Description A social franchise scheme that uses the private health sector and private sector techniques to provide low-cost and high-quality healthcare to treat malaria, tuberculosis, pneumonia, sexually transmitted infections, and diarrheal diseases as well as to provide family planning services.

Stage Established (launched in 2001).

Reach By December 2008 the Sun Network served 8% of Myanmar’s population (more than 55 million people), expanding from 125 townships in 2006 to 157 townships in 2008.

Implementer *Nonstate.* The Sun Network is implemented by Population Services International, Myanmar (PSI/Myanmar).

Funding The Sun Network is funded by the Bill and Melinda Gates Foundation, the United Nations Population Fund, and a large, anonymous donor.

Situation

Previously prosperous, today Myanmar is one of the poorest and least developed countries in Asia, with high prevalence of tuberculosis and the highest number of malaria deaths in Southeast Asia. Most of its people live in the country’s roughly 40,000 villages, while most of the urban population resides in the former political and current commercial capital, Yangon. The economy is largely stagnant, and public investment in education and healthcare combined is less than \$1 per person per year—one of the lowest in the world.

Poor people have traditionally had limited access to treatment facilities, and thus early diagnosis is often delayed. At the same time, there is a significant private health sector. The experience of PSI/Myanmar and other international nongovernmental organizations demonstrates that most health services are best delivered to the poor at scale by private and nongovernmental organizations, through independent, accountable, and transparent programs.

Program

The Sun Network social franchising model relies on a healthcare delivery system with two major categories: the Sun Quality Health (SQH) channel consists of a growing number of private doctors who are trained and monitored to adhere to strict quality standards and the Sun Primary Health (SPH) channel is comprised of community-based “Sun providers,” who are trained to deliver health messages and provide basic health products, services, and referrals. To support PSI’s standards, the Sun Network provides three services to its private doctors and village-based providers: training, accreditation, and supervision. Refresher trainings are held for franchisee providers, and continuous training is provided on the job and through seminars on special clinical issues (such as diagnostic challenges and management of drug side effects). The training modules are directed at reproductive health services and treatment for malaria, tuberculosis, pneumonia, sexually transmitted infections, and diarrheal diseases. Select private laboratories are accredited with laboratory supervisors to support these facilities. PSI/Myanmar’s franchise officers conduct regular follow-up visits to doctors

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and providers to ensure continuous resupply of products and to resolve any problems. Franchisees who fail to meet these standards are dissociated from the franchise.

Key program components include:

- *User of pro-poor private health sector.* SQH members are full-time licensed private doctors with existing clinics that serve low-income populations. Members are selected with the collaboration of local leaders based on education level and community commitment.
- *Comprehensive prescreening for quality control.* SQH's process for organizing and ensuring high-quality healthcare begins with an assessment of doctors' clinics and a premembership attitudinal test for the doctor. The test assesses commitment to learning, quality improvement, and the franchise's social objectives. Prescreened and short-listed providers attend a briefing session on the franchise, where a baseline knowledge test is administered. Doctors who pass formally apply to join the franchise, and those who perform satisfactorily in an initial training workshop are admitted.
- *Rate standardization.* Private doctors, providers, and laboratories in the Sun Network charge based on a payment scale that is prenegotiated by PSI/Myanmar and that emphasizes accessibility for low-income people. Products and services are subsidized to facilitate the franchisees' motivation and to sustain services for the poor. For example, tuberculosis services are free. SQH doctors receive an incentive of 2,000 kyats (approximately \$2) for all patients who test positive and are registered.
- *Effective product quality communication.* PSI/Myanmar developed a logo to help brand recognition of both Sun Network channels, which are displayed in a range of relevant communications materials, including patient kits, sign boards, leaflets, posters, promotional items, referral vouchers, and forms. PSI/Myanmar has also partnered with respected training institutes and provider associations and coordinates with the Ministry of Health to develop the credibility and breadth of the franchise.

Service delivery

Impact

- Improving the quality of services provided by private health facilities through prescreening and ongoing quality control and monitoring of activities.
- Increasing access for the poor by bringing into the network providers who have a track record of effectively engaging the poor.
- Improving the credibility of network doctors and providers through a consumer communication program and partnerships with trusted institutes, provider associations, and government offices.
- Improving healthcare affordability through negotiated low standard service fees and through subsidized service provision to a large pool of beneficiaries to achieve profitability.
- Alleviating the high out-of-pocket spending among rural communities.
- Reducing morbidity and maternal mortality from lack of care in reproductive health, malaria, tuberculosis, pneumonia, sexually transmitted infections, and diarrheal diseases.

Resources

People consulted:

- Social Franchising Technical Advisor and Program Coordinator, PSI/Myanmar

Website: www.psi.org/Where_We_Work/myanmar.html

Source: Results for Development

PROVIDING LOW-COST FAMILY PLANNING SERVICES

Program **Janani, India**

Description A nonprofit organization that uses a network of private health practitioners and health facilities to provide safe and low-cost options for family planning, health, and reproductive health services in rural areas through social marketing, a clinic-based service delivery program, and a social franchising program.

Stage Established (launched in 1995).

Reach Janani covers Bihar and Jharkland, two of India's poorest states comprising 118 million people, and 10 districts of Madhya Pradesh in central India. Future plans include expansion to Assam, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh, Uttranchal, and West Bengal, raising the target population to almost 600 million people.

Implementer *Nonstate.* Janani implements the social franchise through a network of partner health facilities.

Funding Janani is supported by the government of India, the David and Lucille Packard Foundation, and a large, anonymous donor.

Situation

India has a large public health sector, but much of India's population, especially poor people and people in rural areas, have limited access to good-quality health and reproductive health products and services. In the mid-1990s an estimated 16% of couples in reproductive union (about 25 million couples) wanted to either space or limit births but did not use modern methods of contraception because of lack of access. India has traditionally had a large private health sector, with an estimated 450,000 private doctors, 1.3 million rural health practitioners, and 12 million private retail shops (a third of them in rural areas). Rural health practitioners are most often the first provider consulted for a health problem that cannot be handled at home, but they are mostly untrained and unqualified as primary care providers and traditionally do not provide reproductive health or family planning services.

The government of India recently launched the National Rural Health Mission (2005–12) to provide integrated comprehensive primary healthcare services, especially to the poor and vulnerable sections of society. The mission focuses on 18 states, including Bihar and Jharkhand, and aims to bridge gaps in rural healthcare through increased community ownership, decentralization of programs to the district level, intersectoral convergence, and improved primary healthcare. Under the private-public partnership component of the mission, the government is providing financial support for nongovernmental organization and private sector clinics to provide free services, including family planning.

Program

Janani started a social marketing and social franchise program that uses India's large private health sector and its existing service delivery resources to provide family planning and reproductive health-care services. The conventional social marketing infrastructure of shops (more than 31,000 of them) and stockists sells products (such as contraceptives) in urban and semiurban areas and replenishes supplies to rural health franchisee centers and franchisee medical clinics. This is complemented by a social franchisee program through which doctors in rural areas provide low-cost clinic-based services. The social franchise has a network of rural health practitioners who work in partnership with a female family partner. She serves as the conduit between the clinics and rural communities. After receiving Janani training, rural practitioners are franchised as Titli (Butterfly) Centres, and they sell

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nonclinical products and over-the-counter tests. Clients needing clinical services are counseled and referred to the nearby Surya (Sun) Clinic, which earns the Titli Centres a commission. Under the private-public partnership of the National Rural Health Mission, the government has accredited 15 of Janani's Surya Clinics as authorized sterilization centers, which the government reimburses \$35 per sterilization. The plan is to set up 40 free clinics at the district headquarter town by the end of December 2009. The more than 40,000 trained networked rural providers are monitored by project field teams set up by entrepreneurs, and the 620 franchisee medical clinics are supervised by Janani.

Key program components include:

- *Social marketing for the underserved.* The conventional social marketing franchise uses shopkeepers (mostly in urban centers) to deliver development-sector, primarily nonclinical products (mainly condoms and oral contraceptives). In contrast, Janani's model focuses on expanding service delivery from urban to rural areas, integrating a strong clinical component, and catering to the poorest segments of the population.
- *Profitable franchisee product bundle.* The rural health providers find the franchise profitable and worth belonging to because of a broad mix of income-generating services including the sale of nonclinical products, charges for over-the-counter diagnostic tests, and commissions for referring clients needing clinical services to the Surya clinics.
- *Formalizing the private sector.* Janani has played an important role in bringing rural providers and private doctors into a formal operational framework. The Surya Health Promoters in the network receive training in nonclinical skills to function as the first contact point in villages, while the surgical skills of doctors in the Surya clinics are upgraded to provide quality family planning services and comprehensive abortion care services. This has effectively complemented the network of shops that have long worked with the well organized private sector.
- *Fostering community-level ownership.* Janani seeks to transform participants into stakeholders at both the village and urban levels. About half of Janani's budget is for communication and education campaigns, a critical component of which is empowering clients about quality services so they can maintain pressure on providers for good-quality care. To complement this, Surya health promoters are selected from within communities.

Service delivery

Impact

- Creating access to services and products in remote areas by providing affordable and quality family planning products and services.
- Using existing resources and integrating service delivery rather than creating parallel structures.
- Enhancing competence and reducing harmful and inappropriate practices through training programs.
- Improving the credibility of the referral system whereby patients consult trained rural health providers before seeing doctors at the medical clinics.
- Leveraging community engagement in the program as a social pressure tool for achieving high-quality care.
- Reducing morbidity and maternal mortality through family planning and safe abortion services.

Resources

People consulted:

- Preeti Anant, General Manager–Programs, Janani
- Shejo P. Bose, Program Manager, Janani

Website: www.janani.org/home.htm

Source: Results for Development and William A. Haseltine Foundation for Medical Sciences and the Arts

ESTABLISHING SELF-RELIANT COMMUNITY HEALTH INFRASTRUCTURES

Program Byrraju Foundation Health Program, India

Description A not-for-profit organization implementing holistic programs for sustainable rural transformation, including self-reliant, local healthcare infrastructure.

Stage Established (launched in 2001).

Reach The Byrraju Foundation currently works in 200 villages in six districts of Andhra Pradesh—East Godavari, Guntur, Krishna, Ranga Reddy, Visakhapatnam, and West Godavari—covering nearly 3 million people.

Implementer *Nonstate.* The Byrraju Foundation is a not-for-profit organization that works in partnership with rural communities and several public and private organizations.

Funding The Byrraju Foundation’s operations are supported through a mix of donor and partner funding, contributions from trustees, and individual user fees.

Service delivery

Situation

In India traditional healers and health practitioners lacking a formal degree have long been the customary healthcare providers in rural communities. The health of the entire village is often perceived as their sole responsibility. While a vital component of a village’s social milieu, this traditional health system is unable to ensure quality care for all members of the community—largely because of traditional healers’ lack of formal medical training in diagnosing and treating illness, outdated outlook and practices with no scientific background, and no regular referral of severe cases to a qualified provider.

Rural communities are thus rarely self-sufficient and rely heavily on outside support in securing health services. However, even with outside support, ensuring that medical personnel either reside within a village or make a daily visit remains difficult. Obtaining secondary healthcare is also a challenge because it requires specialist care that primary care providers normally cannot offer. This has resulted in abominable health indices in rural India, with under-five mortality at more than 72 in 1,000 live births and close to half of children under age five suffering from malnutrition.¹¹

Program

As part of its holistic approach to village development, the Byrraju Foundation considers quality health services at all levels of care to be a vital component of building progressive self-reliant rural communities. To improve the availability and quality of healthcare in underserved areas, the Byrraju Foundation capitalizes on all available resources by relying on local resources (the land for village health centers and part of the building expenses are generally donated by villages), harnessing village volunteer time (health volunteers and women in self-help groups), building partnerships with public and private providers in the area (government auxiliary nurse and midwives, nongovernmental organizations, local healers, and the like), and using knowledge and technology innovations such as tracking multiple metrics, telecardiology, comprehensive health worker training, research in morbidity trends, and so on. The foundation sets up a small primary health center (which approximately six neighboring villages can also access), arranging doctor visits by a qualified physician (two

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to three hours per day) and a full-time auxiliary nurse and midwife employed, trained, and based in the village. As part of the process, the Byrraju Foundation also identifies nine committed village volunteers for the village development committee, who become the vital link in promoting Byrraju programs. Most secondary care and specialized services (such as eye care, dental care, and treatment for HIV/AIDS and epilepsy) are carried out in partnership with alliance partners providing free services (such as cataract surgery). Secondary care is generally provided by referral to nearby hospitals with tieups for privileged treatment and discounts or by telemedicine. Tertiary care is offered by nearby medical colleges.

Key program components include:

- *Local resources.* Community buy-in and ownership are created at the outset when a village donates land and covers part of the building cost for the village health center. A visioning exercise with the village development committee identifies local health issues, needs, and priorities, which the program addresses in a structured way.
- *Local knowledge.* Byrraju focuses on working with a local doctor who is already settled in the village or a nearby village or town, enabling the program to harness resources already on the ground.
- *Partnerships.* Every individual health module and component in the program has a partner that provides services on a voluntary basis or at a discount (for example, eye care is provided by local Lions hospitals, and epilepsy care is provided by a neurologist from a leading city hospital).
- *Telemedicine.* A doctor is physically present in each village for two to three hours daily, treating patients at the health center, visiting schools to carry out a comprehensive school health program, and treating minor complications or referring the more complex cases to a nearby healthcare facility. In providing secondary care, Byrraju cooperates with Narayana Hrudayalaya Cardiac Hospital in Bangalore, using a telemedicine solution that provides printed electrocardiogram reports and medical advice as well as virtual cardiology consultation and interaction. Future plans focus on developing other specialty telemedicine solutions and using telemedicine for primary care on alternate days.

Service delivery

Impact

- Improving access to and quality of healthcare in underserved and remote rural areas.
- Promoting community self-sufficiency by leveraging existing resources and supporting community ownership of the programs.
- Strengthening local healthcare providers through partnerships and increasing their customer base to improve the efficiency of the health system as a whole.
- Leveraging technology to help advances in medical technology and expertise reach remote rural areas.

Resources

People interviewed:

- Dr. Srinivas Iyengar, Lead Partner for Health, Byrraju Foundation Health Program

Website: www.byrrajufoundation.org

Source: William A. Haseltine Foundation for Medical Sciences and the Arts

EXPANDING ACCESS TO SERVICES IN THE PRIVATE SECTOR

Program Health Initiatives for the Private Sector (HIPS), Uganda

Description A project that works with the Ugandan business community to find cost-effective ways to ensure access to and use of vital health services for company employees, their dependents, and the surrounding community.

Stage Startup (launched in April 2008).

Reach In its first year HIPS reached more than 180,000 Ugandans with prevention and treatment messages on HIV/AIDS, tuberculosis, malaria, and reproductive health and family planning, facilitated access to free antiretroviral drugs from the Ministry of Health for 3,000 people, and trained more than 350 healthcare providers in HIV/AIDS and tuberculosis treatment and palliative care.

Implementer *Nonstate.* HIPS is led by the Emerging Markets Group, an international development consulting firm, in partnership with Johns Hopkins University Bloomberg School of Public Health, the Mildmay Centre, O'Brien and Associates International, the Straighttalk Foundation, and the Uganda Health Marketing Group.

Funding HIPS is funded by the U.S. Agency for International Development.

Situation

The private sector has emerged as an important player in Uganda's health sector in recent years, with many private firms recognizing that healthy employees are productive employees and providing health services to employees and their communities. And awareness and commitment of corporate social responsibility have grown. A recent Uganda Manufacturers Association study of 50 medium-size to large companies found that 94% of companies were engaged in corporate social responsibility initiatives, mostly in health and education and programs for vulnerable children.

Program

The objective of HIPS is to expand health prevention, treatment, and training in the private sector by helping companies design and implement comprehensive workplace health programs in HIV/AIDS, tuberculosis, malaria, and reproductive health and family planning. The program is based on a public-private partnership model in which HIPS and companies share investment costs on at least 50-50 basis, with companies often contributing 70% of the costs (cash and in-kind). HIPS prevention activities include health information materials and peer education programs for employees and community members to increase knowledge and to encourage health-seeking behaviors. HIPS is expanding access to AIDS treatment through partnerships with companies and the Ministry of Health, which provides free antiretroviral drugs from the Global Fund to Fight AIDS, Tuberculosis and Malaria. HIPS also works closely with two major Ugandan business associations—the Federation of Ugandan Employers and the Uganda Manufacturers Association—to strengthen their member services through involvement in national health policy issues and capacity in workplace health programs. By transferring knowledge and skills, HIPS is fostering ownership and sustainability of workplace health programs among Ugandan companies.

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Key program components include:

- *Health fairs.* HIPS health fairs are an integrated entertainment education platform that sensitizes employees and the community on health issues. They use the Uganda Health Marketing Group’s established communication program “The Good Life at Work” to position a healthy lifestyle in a holistic way—not just as the absence of disease. Health fairs include employee education seminars, video shows, counseling and testing services, interactive community drama with forum theatre approaches, and live Good Life game shows.
- *Expanding community access.* HIPS serves as a broker between private clinics (including company clinics) and the Ministry of Health to facilitate accreditation of private clinics. First, HIPS provides direct technical assistance to private clinics so that they meet strict government standards regarding, storage, patient privacy, clinician training, health information materials, and basic equipment requirements. Then, HIPS helps the private clinics work with Ministry of Health officials to obtain official accreditation, which allows the clinics to receive free antiretroviral and tuberculosis drugs. HIPS also helps companies and private health providers attend training at the Mildmay Centre, an internationally recognized AIDS treatment and training center. HIPS pays for provider training and some testing materials and laboratory equipment, while companies pay for staff salaries, drugs, and other operating costs. Through this partnership, such companies as James Finlay’s, Kasese Cobalt, Limited Kinyara Sugar Works, Nile Breweries, Roofings Limited, and Royal Van Zanten have opened their clinics to neighboring communities and enabled access to free AIDS and tuberculosis treatment.
- *Access to health products.* HIPS facilitates access to lower cost health products such as long-lasting insecticide-treated mosquito nets, water purification tablets, and family planning products through its partner, the Uganda Health Marketing Group.
- *Support to orphans and vulnerable children.* HIPS is collaborating with companies to encourage support for orphans and vulnerable children in corporate social responsibility initiatives. Part of this strategy includes HIPS matching grants for programs for orphans and vulnerable children. One company, Nile Breweries, already supports orphans and vulnerable children among sorghum growers (part of Nile’s supply chain) in four regions of the country. Its partnership with HIPS allows comprehensive care and support for households of orphans and vulnerable children, training for community caregivers, a functional referral mechanism for orphans and vulnerable children, and collaboration with other partners.

Service delivery

Impact

- Expanding access to and use of health services in the private sector.
- Strengthening private sector employer organizations to support health initiatives.
- Expanding the number and improving the quality of qualified and accredited private sector health providers.
- Implementing innovative approaches to support orphans and vulnerable children through the private sector.

Resources

People consulted:

- Barbara Addy, Chief of Party, HIPS
- Jeanne Ellis, HIPS

Website: www.emergingmarketsgroup.com and www.emg-hips.com

Source: Results for Development

PROVIDING TARGETED HEALTHCARE TO MOTHER AND CHILD

Program NICE Foundation, India

Description A health program providing a wide range of targeted medical services to the most vulnerable segments of society through innovative service delivery and risk-pooling.

Stage Established (launched in 2002).

Reach The NICE Foundation operates programs in Andhra Pradesh and Rajasthan, with plans to expand to other states.

Implementer The NICE Foundation, a registered charitable trust based in Hyderabad, designs and implements all health programs in partnership with state governments, the private sector, and civil societies.

Funding The NICE Foundation's programs are financed through public funding sources (including state governments and the central government) and through private donations from individuals and grant-making organizations.

Service delivery

Situation

A major problem in India is high maternal, neonatal, and infant mortality.¹² India accounts for as much as a fourth of global infant deaths, and as many as 43% of women do not receive care during childbirth.¹³ The reasons behind these grim statistics are the lack of skilled health personnel and emergency services for obstetric care. Moreover, poor access to services and inadequate care continue well into a child's life, causing school-age children to miss school or drop out completely.

Major barriers to comprehensive health services and better quality care are long distances from health facilities, lack of transport, high cost of services, and discriminatory treatment of users. Other barriers derive mainly from shortages of personnel, inadequate skills of personnel, rapid turnover and loss of skilled workers, and inefficient use and distribution of personnel.

Program

The NICE Foundation aims to improve the health outcomes of the entire community by providing proper healthcare to mothers, children, and infants. The NICE Foundation targets each of these vulnerable populations through innovative healthcare service delivery and risk-pooling mechanisms and strategic alliances with public, private, and civil society actors. The NICE Foundation runs two health programs in Andhra Pradesh—the Schoolchild Healthcare Plan and the Tribal Reproductive Child Health—and operates the Institute for the Newborn in Hyderabad, which provides neonatal care and conducts training and research. The Schoolchild Healthcare Plan has been replicated in three districts of Rajasthan, and further rollout is planned in the state.

Key program components include:

- *Schoolchild Healthcare Plan.* The NICE Foundation's Schoolchild Healthcare Plan ensures comprehensive healthcare at no cost for poor children in urban and semiurban areas who attend government schools. The program has a unique public-private partnership with the Andhra Pradesh government that allows it to cover ailments ranging from common colds to cardiac surgery for \$4 per child per year. The program's main features are comprehensive

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health camps for all children, a reliable identification system (via photo identification cards), school-based patient clinics, a dedicated in-patient specialty hospital, and high-quality multispecialty care and links. The program now operates in Hyderabad (Andhra Pradesh) and Bikaner, Jodhpur, and Udaipur (Rajasthan), covering close to 200,000 children.

- *Tribal Reproductive Child Health.* This innovative intervention provides quality maternal, neonatal, and child health services to the most vulnerable and at-risk population in tribal regions at no cost to the families. The NICE Foundation works on a three-tier level. At the village level fixed day services and health awareness sessions on preventive aspects are conducted on a regular basis. At the mandal (county) level basic equipment and ambulance service are provided. And at the specialty hospital level all specialized care is given. The organization serves 453 tribal villages in Mahabubnagar and Visakhapatnam (Andhra Pradesh).
- *Institute for the Newborn.* The Institute for the Newborn is a first-of-its-kind institute providing affordable international-quality neonatal care to all segments of society, using a cross-subsidization model to benefit the poorest. The institute is a 120-bed facility that networks with all the maternity hospitals in the city and provides neonatal care and referral care to high-risk newborns. The institute runs several 24/7 mobile intensive care units staffed by a dedicated newborn transport team that have perinatal links with existing government maternity hospitals, private nursing homes, nongovernmental organizations, and the like. The institute and its clinical care also conduct training and research in of neonatology. Located in Hyderabad, it is the largest of its kind in South Asia.

Service delivery

Impact

- Reducing maternal neonatal, and infant mortality by increasing institutional deliveries and deliveries by skilled birth attendants.
- Reducing the financial burden and indebtedness in marginalized families.
- Increasing school enrollment, retention, and performance.
- Increasing health awareness and better health practices among women and children.
- Strengthening the overall healthcare delivery system by supporting the referral system and links between government hospitals and private healthcare providers.

Resources

Website: www.nicefoundation.in

Source: William A. Haseltine Foundation for Medical Sciences and the Arts

BUILDING VIBRANT HEALTH MARKETS

Program AFFORD, Uganda

Description A five-year health marketing and communications initiative that encourages private sector participation in health issues, increases access to and affordability of products and services, and brings about positive behavior change.

Stage Rollout (launched in 2006).

Reach AFFORD operates on a national scale, focusing on 31 priority districts.

Implementer *Nonstate.* AFFORD is led by the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs. The AFFORD consortium includes the Futures Group, the Malaria Consortium, and three Uganda-based organizations: Aclain Africa, the Communication for Development Foundation of Uganda, and Pulse Communication.

Funding AFFORD is funded by the U.S. Agency for International Development.

Situation

As in many developing countries, a large share of the population in Uganda seeks treatment through the private sector—even when public health facilities offer products and care at no cost. As a result, ensuring that the private sector is providing quality services and products is essential, especially where the prevalence of diseases such as malaria requires proper treatment within 24 hours of the onset of symptoms. Availability of affordable long-lasting insecticide-treated nets and artemisinin-based combination therapy is also vital to improving families' access to these drugs through the private sector.

Program

AFFORD's vision is to encourage healthy lifestyles and increase the accessibility and affordability of life-saving products and services in Uganda by creating vibrant healthcare markets that attract private sector participation. AFFORD employs innovative, consumer-driven marketing approaches: product-specific market research to determine consumer needs, preferences, and willingness to pay; an integrated multimedia strategy (television, radio, and community outreach) to raise awareness on health topics and products; and private sector partnerships to improve efficiency and sustainability. Specifically, AFFORD seeks to strengthen the capacity of the local private sector (both commercial and not-for-profit) by purchasing products from local distribution sectors, training private practitioners on new antimalarial drug policies, and delivering free products to vulnerable groups and communities through community-based organizations (and faith-based organizations). Together with its partners, AFFORD has established the Uganda Health Marketing Group, an autonomous not-for profit organization that will continue to implement social marketing activities beyond AFFORD's five-year duration. The group, with its own staff headed by a managing director, now delivers a sizeable portion of AFFORD.

Key program components include:

- *Targeted communication interventions.* AFFORD's communication strategy involves an integrated multimedia approach branded "The Good Life." It includes "The Good Life

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Show,” a television and radio quiz show that features a different health topic each week to position “a good life” as desirable and attainable, a basic right, and an individual and societal responsibility and to stimulate dialogue and change attitudes around social issues that influence wellness; Popular Opinion Leaders, an intervention at the village level that brings popular opinion leaders to interact and talk with their peers on a variety of health issues to stimulate positive change in behaviors and practices; Under the Mango Tree, an innovative community outreach program and reality radio show consisting of a live discussion with a health professional on one of AFFORD’s health topics; and Everyday Health Matters, a low-literacy newsletter (in English and several local languages) that focuses on one health intervention area per issue.

- *Strengthening the private sector.* AFFORD has established a distribution structure that relies on local distributors rather than on its own distribution force. A key element in its distribution strategy is a network of small-scale entrepreneurs, which is based on the community distribution model successfully used in other countries and emphasizes financial sustainability. To date, 75 small-scale entrepreneurs are carrying AFFORD’s 10 products (two combined oral pills, a progesterone pill, an injectable contraceptive, water purification tablets, cotromoxazole, acyclovir, oral rehydration salts, zinc supplements, multivitamins, and long-lasting insecticide-treated nets) to hard-to-reach areas. AFFORD is also working with Malaria Consortium to distribute free long-lasting insecticide-treated nets to children under age 5 and pregnant women at more than 400 antenatal clinics in northern Uganda, having already distributed more than 2 million over the last three years. Working with private commercial distributors, AFFORD has also sold 100,000 subsidized long-lasting insecticide-treated nets through regular retail outlets to people with disposable income. To provide private medical practitioners with knowledge about the new antimalaria policy, AFFORD trained more than 3,000 prescribers in the private sector to complement the effort of the Ministry of Health working through the public sector.

Impact

- Increasing accessibility and affordability of HIV/AIDS, reproductive health, child survival, and malaria products and services through innovative marketing approaches and increased private sector participation.
- Improving the efficiency and sustainability of the indigenous private sector through expanded markets and demand-creation activities.
- Enhancing knowledge and correct use of HIV/AIDS, reproductive health, child survival, and malaria products and services to encourage healthy lifestyles.

Resources

People consulted:

- Kojo Lokko, Chief of Party, AFFORD Health Marketing Initiative

Website: www.jhuccp.org/africa/uganda/afford.shtml

Source: Results for Development Institute

Service delivery

REACHING THE POOR THROUGH MOBILE SOLUTIONS

Program Smile-on-Wheels Program, India

Description A national mobile hospital program catering to underprivileged children and women in remote rural areas and urban slums using primarily volunteer physicians and nurses.

Stage Rollout (launched in June 2006).

Reach Smile-on-Wheels operates in several locations across India—Chhattisgarh, Delhi, Maharashtra, Orissa, Tamil Nadu, and Uttarakhand—reaching nearly 750,000 people in 249 villages and slums. Three more units are being added in Ahmadabad, Hyderabad, and Lucknow.

Implementer *Nonstate.* Smile-on-Wheels is implemented by the Smile Foundation, a not-for-profit organization working in education and healthcare for underprivileged children across India. The Smile Foundation partners with local organizations in each state to run Smile-on-Wheels, including: Ambuja Cement Foundation (Roorkee, Uttaranchal), Berojgar Mahila Sewa Samiti (Bhilai, Chhattisgarh), Operation Blessing India (Delhi), Orissa Institute of Medical Research and Health Services (Cuttack, Orissa), and Sevadham Trust (Pune, Maharashtra).

Funding The Smile Foundation receives funding from several domestic and international partner organizations.

Situation

In India healthcare facilities, both public and private, are generally concentrated in densely populated urban areas, making it difficult for them to serve remote communities. Public primary health facilities exist in rural remote areas based on population levels, but accessibility and availability of their services remain problematic.

Traditionally, women and children in remote areas are most vulnerable because of complications during pregnancy or childbirth and lack of immunization programs. Some 58% of children under age 2 are not fully vaccinated, and 24% of them lack any form of vaccination, making India's infant mortality rate as high as 56 per 1,000 live births.¹⁴

Program

Focusing on women and children, Smile-on-Wheels is a national multicentric mobile hospital program that provides medical care to rural and semirural areas and urban slums where governmental healthcare facilities are scarce, nonexistent, or nonfunctional. Under this program five vans travel through 25 kilometers of rural areas every day, visiting two to three villages on a rotating basis to deliver healthcare at a nominal (very marginal) cost to the community. The vans, run by the Smile Foundation's local partners in each district, are staffed by specialized medical personnel and are equipped with an x-ray machine, electrocardiogram machine, basic pathological services for blood and urine tests, antenatal and postnatal services, and an outpatient department for common ailments. The staff performs routine medical examinations, distributes condoms and oral contraceptive pills, and transports severe cases to super-specialist clinics. The team also carries out awareness

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activities on health and hygiene to encourage health-seeking behavior, focusing equally on preventive and promotive healthcare, including home-based care. The project receives deep community support through a cadre of health volunteers, who provide health education, provide counseling, and serve as depots for family planning kits, oral rehydration salts, iron tablets, and the like.

Key program components include:

- *Mobile hospital.* The Smile-on-Wheels mobile hospital is equipped to function as a modern medical facility that can provide both preventive and curative services to those in need, including outpatient, antenatal, and postnatal services, identification of difficult pregnancy and referral for institutional care, immunizations for mothers and children, minor surgery, blood pressure examinations, electrocardiograms, first aid, iron folic tablets, vitamin A prophylaxis, treatment of malnutrition, and so on.
- *Mobilization of resources.* After conducting rounds of the villages, Smile-on-Wheels medical staff can return to the urban areas where they reside and practice when they are not involved with the program. This approach enables qualified personnel to become engaged with the initiative without having to reside in the rural areas they serve. The underlying strategy is to import city-centric suitable (different) medical expertise and facilities, specific to varying health need.
- *Health camps.* Smile-on-Wheels runs health camps in rural and periurban communities on subjects such as reproductive health.
- *Sustainability model.* Smile-on-Wheels involves multiple partners to share risk and reduce the burden on any one organization. By charging the community nominal fees, an inbuilt sustainability model through community participation can evolve.

Service delivery

Impact

- Improving the health of women and children in underserved rural and semirural areas through access to essential healthcare services, bettering the health of the community as a whole.
- Solving the human resource problem in rural areas by enabling medical professionals to participate while residing in towns.
- Increasing community awareness on health-related matters and practices and promoting sustainable health-seeking behavior.

Resources

People consulted:

- K. K. Varma, Director of Programs, The Smile Foundation

Website: www.smilefoundationindia.org

Source: William A. Haseltine Foundation for Medical Sciences and the Arts

USING MICROFINANCE TO ENSURE FRANCHISE SUSTAINABILITY

Program	Kisumu Medical and Educational Trust (KMET) Revolving Loan Fund (RLF), Kenya
Description	A microfinance program available to the members of the KMET social franchise network and aimed at ensuring franchisee's financial sustainability and improving the value of KMET membership to its members.
Stage	Established (launched in 2004).
Reach	KMET operates in five provinces in Kenya with a network of 204 healthcare providers (65 private and 139 faith-based or public).
Implementer	<i>Nonstate</i> . RLF is a program of KMET, a nongovernmental organization in Kenya.
Funding	KMET's microfinance program is self-financed.

Service delivery

Situation

One of KMET's signature activities is to support the delivery of high-quality reproductive health services in a network of private primary healthcare clinics. The franchisees have traditionally paid a nominal fee in exchange for training, supervision, use of the KMET brand name, and access to medical supplies at discounted wholesale prices. Because the KMET product line accounts for only a small part of the private practitioner revenue, the value of KMET membership has been modest. Like most social franchises, the KMET central coordinating agency has relied on donor funding for sustainability.

The main barrier to effective social franchises in healthcare has been finding a way for the franchisor to add enough value to sustain central operations and stabilize franchisee partnerships. Closely related is the diminished bargaining power of central coordinating agencies to enforce standards when service providers are out of compliance. This underlines the need to develop innovative arrangements in social franchising that can simultaneously finance the central coordinating agency and empower it to perform its core functions.

Model

KMET launched RLF to improve its value proposition to members and to help sustain its core activities in four provinces by becoming the only medical-based social franchise in Kenya with a microfinance component. The model makes small loans available to network members, enabling them to improve their clinics (purchase beds, drugs, lab equipment, and other medical equipment; paint and renovate; and purchase furniture and fittings) and services to meet KMET quality standards. RLF has disbursed \$294,538 to 31 formal service providers and 441 community-based service providers. To cope with increased demand from members, strategies are in place to widen the financial capacity of RLF through fundraising.

Key model components include:

- *Microfinancing mechanism*. KMET obtains a primary loan at a subsidized rate of 5%, which the central coordinating agency disburses as secondary loans (ranging from \$2,000 to

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\$10,000) at a marked-up rate of 10%–20% to each primary care service provider. Interest payments cover 90% of administrative costs.

- *Self-financing mechanism.* The central coordinating agency has a vested interest in the economic viability of each primary care provider and in collecting payment from providers, so that it can pay off the primary loan.
- *Cost-sharing.* New network providers are responsible for their own transport, accommodation, and half of training tuition; KMET covers all other expenses.
- *Quality assurance measures.* KMET leverages the financial relationship between network members and the central coordinating agency to enforce provider compliance with agreed quality assurance measures and required outreach to the poor.

Impact

- Enhancing the value of membership in the KMET social franchise to ensure its long-term sustainability and future growth.
- Increasing the financial sustainability of individual private providers by initiating more financial savings and greater capacity for investment in infrastructure improvements and modern technology.
- Improving community access to quality reproductive health services to increase demand for information and utilization of such services, especially among the rural poor.

Resources

People consulted:

- Monica Oguttu, Executive Director, KMET

Website: www.kmet.co.ke

Source: Institute of Development Studies, www.ids.org

Service delivery

EXPANDING STATE-MANAGED HEALTH INSURANCE ACROSS INDIA

Program	Rashtriya Swasthya Bima Yojna (RSBY), India
Description	A state-managed national health insurance program designed to improve access to quality medical care for informal workers living below the poverty line.
Stage	Rollout (established in late 2007).
Reach	RSBY is being implemented in 22 states in India. Seventeen are already issuing smart cards, and five others have started implementation. About 3.7 million families (15 million people) are enrolled in the scheme. The government expects to enroll about 20 million households by the end of 2009, and all families living below the poverty line by 2012.
Implementer	<i>Government.</i> RSBY is a central government scheme, launched by the Ministry of Labor and Employment. The insurance scheme is being implemented by state governments with the participation of both public and private insurance companies.
Funding	RSBY receives 75% of its funding (90% in the northeastern states and Jammu and Kashmir) from the central government and the remainder from state governments.

Risk-pooling

Situation

Informal sector workers account for 93% of India's total workforce. The government has implemented social security measures for some occupational groups, but coverage is miniscule. Most workers still lack social security coverage. A major insecurity for workers in the informal sector and their families is high incidence of illness and need for medical care and hospitalization. Despite expanded health facilities, illness remains one of the most prevalent causes of human deprivation in India. Health insurance is one way to protect poor households against poverty from health spending. But most efforts to provide health insurance have faced difficulty in both design and implementation. Poor people are unable or unwilling to obtain health insurance because of its cost or its perceived lack of benefits. Organizing and administering health insurance, especially in rural areas, are also difficult.

Program

RSBY was launched by the government of India as a state-managed health insurance project targeting informal sector workers living below the poverty line. Beneficiaries pay only 30 rupees per family per year to register. Through competitive bidding state governments select a public or private insurance company to administer the scheme. This engages local intermediaries such as nongovernmental organizations and microfinance institutions to provide grassroots outreach and assist members in using services after enrollment. Healthcare services are delivered by a network of empanelled public and private hospitals, and payment is made using a cashless smart card. Enrollment entitles beneficiaries to most medical and surgical procedures that can be performed for 30,000 rupees or less. For 725 in-patient surgical procedures, the government has predefined package rates that include all hospital charges, including food. Preexisting diseases are covered from day one, and beginning in 2009/10 maternity and newborn care will also be included. The unit of enrollment in RSBY is a household, which includes up to five members. The smart card technology and key management system are unique features of the scheme; they make fraud very difficult while building accountability for different stakeholders.

Key program components include:

- *Targeted incentives.* RSBY uses an appropriate mix of incentives for each stakeholder to ensure the expansion and long-term sustainability of the scheme. Insurers are compensated for each household enrolled and smart card issued, and beneficiaries take ownership of their membership through the 30 rupee enrollment fee. The hospitals' incentive to attract the

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households living below the poverty line is a huge source of revenue, as public hospitals can retain a portion of revenue and distribute incentives to doctors and other staff. Insurers have an incentive to monitor participating hospitals to avoid excessive claims through fraudulent or unnecessary procedures. Even field agents and intermediaries have incentives for RSBY's success: improved outreach and expanded own membership and services.

- *Seamless enrollment.* RSBY has a seamless enrollment procedure where for the first time in India biometric-enabled smart cards are prepared and issued in the field. First insurers receive an electronic list of eligible households living below the poverty line that is posted in each village on designated schedule. On the day of enrollment, RSBY sends mobile enrollment units to the villages to collect biometric information (fingerprints) and photographs of the beneficiaries. The team prints smart cards with a photo on the spot, and beneficiaries pay the registration fee. The process takes less than 10 minutes. Three individuals must be present at each enrollment: a district-level state government officer, who inserts his or her own centrally issued smart card and fingerprint to verify the legitimacy of each enrollment (allowing each enrollee to be tracked to a particular state government official); a smart card vendor; and an insurance company representative. The list of households enrolled each day is then sent to the state government and centralized at the district level.
- *Cashless access to service through smart card.* RSBY uses a biometric smart card, making the scheme truly cashless, while the secure key management system reduces the chance of fraud and creates accountability. The smart card entitles members to certain prespecified in-patient services at a participating hospital after swiping their card and using their fingerprint to authenticate their identity. If a diagnosis leads to hospitalization, the appropriate prescribed package is selected in the software menu. The card is swiped again when members are released, and the prespecified cost of the procedure is deducted from the 30,000 rupee total on the card. If the procedure is not in the package rate list, the insurer specifies the amount to be deducted. A receipt is printed and provided to members.
- *Monitoring.* RSBY ensures that detailed information on all transactions at each hospital is uploaded through a phone line to a database on a district server. A separate set of preformatted tables are generated for the insurer and the government, allowing the insurer to track claims, transfer funds to the hospitals, and investigate suspicious claim patterns through onsite audits and allowing the government to monitor program use and impact. Rigorous monitoring and evaluation methods are being designed, and periodic reports will be made publicly available.

Impact

- Providing protection from catastrophic health expenditures to families living below the poverty line who would not receive the care they need or would become deeply indebted.
- Placing control of significant resources in beneficiaries' hands and allowing them to choose the provider, empowering households and creating healthy competition between providers.
- Promoting new opportunities for organizations at the grassroots level such as nongovernmental organizations and microfinance institutions to play an active role in healthcare management and provision, thus strengthening state health systems.
- Revitalizing the public healthcare delivery system by providing flexible money through insurance. Since part of the revenue can be used to provide cash incentives to doctors and other staff, it can improve their performance.

Resources

People consulted:

- Dr. Nishant Jain, GTZ Health Sector Support – New Delhi

Website: www.rsby.in

Source: Results for Development Institute

MINIMIZING HEALTHCARE COVERAGE GAPS AMONG THE POOR

Program Hygeia Community Health Plan (HCHP), Nigeria

Description A community-based health insurance scheme aimed at selected members of the informal sector in Lagos and the rural sector in Kwara State, Nigeria.

Stage Rollout (launched in 2007).

Reach The program has the potential to target 115,000 people in Nigeria. It currently targets 40,000 market women and their families in Lagos and 75,000 farmers and their families in the rural Shonga community in Kwara State. Future plans include scaling up the program across Nigeria.

Implementer *Nonstate.* HCHP is implemented by the Hygeia Health Maintenance Organization, with monitoring support from the Pharmaccess Foundation. The Amsterdam Institute for International Development conducts all the program's operational research.

Funding HCHP was launched with initial support from the Dutch government through the Health Insurance Fund and additional funding from the World Bank, through the Global Partnership for Output-Based Aid, and the government of Kwara State.

Risk-pooling

Situation

Nigeria follows similar health status trends as other African countries, but its health indicators are poorer than expected based on GDP.¹⁵ The country's infant mortality rate (as high as 99 per 1,000 live births) and maternal mortality ratio (1,100 women per 100,000 live births) are some of the worst health indicators in Africa.¹⁶ Life expectancy is only 44 years due to high prevalence of HIV/AIDS, malaria, and diarrheal diseases. As many as 3.5 million Nigerians live with HIV and have limited or no access to treatment and care. When care is sought, it is financed primarily through out-of-pocket payments that account for 90% of private expenditures.

To improve access to and quality of healthcare services in Nigeria, in 1999 the Nigerian government introduced the National Health Insurance Scheme, a centrally sponsored social health insurance scheme aimed at reducing the burden of high out-of-pocket expenditures through risk-pooling and cost-sharing. The scheme now covers 3 million people, but mostly members of the formal sector, leaving a large share of the informal sector uninsured.

Program

HCHP is designed to minimize healthcare coverage gaps among low-income populations and improve Nigeria's overall health indicators through innovative risk-pooling. HCHP is voluntary and operates on the principle of one payment per person per year (800 naira in Lagos and 200 naira in Kwara), with 95% of the cost borne by the Health Insurance Fund. This payment provides enrollees with access to medical care at any HCHP provider hospital and with a benefit package of primary care, limited secondary care, and medication, including HIV/AIDS drugs. HCHP providers are selected based on proximity to target populations and ability to meet standards for quality

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of care. HCHP strongly emphasizes several sensitization and mobilization recruitment strategies to create demand-driven enrollment.

Key program components include:

- *Direct investment in network infrastructure.* The Health Insurance Fund has provided support to Hygeia to improve its medical service capacity, resulting in 19 contracted clinics and hospitals (13 in Lagos and 6 in Kwara) where HCHP beneficiaries can obtain services. Quality control is carried out jointly by PharmAccess and Hygeia. Currently, 13 facilities (3 public and 10 private) are enrolled in the Health Insurance Fund quality improvement program to receive upgrades. In addition, the governor of Kwara State has allocated extra funds to two more clinics to be rehabilitated to meet standards.
- *Protocols, training, and monitoring.* PharmAccess and Hygeia hold organized medical and administrative trainings for staff participating in the program. Four monitoring and evaluation visits by PharmAccess have taken place (in June 2007, January 2008, July 2008, and January 2009).
- *Marketing and branding.* One of HCHP's main activities is to mobilize and enroll target group members. Hygeia marketing teams promote the scheme by reaching out to the community and assisting interested people with registration. Once members are registered, their personal details are entered into the system and they are immediately issued an ID card that allows them to access health services at selected HCHP facilities. Hygeia has already noticed increased enrollment because of the scheme's outreach marketing and branding strategy.

Risk-pooling

Impact

- Enhancing and optimizing primary healthcare delivery and capacity, access, quality of care, and ultimately the health and socioeconomic productivity of the community.
- Reducing out-of-pocket payments, the customary financing mechanism for medical care among low-income populations.
- Increasing demand for prepaid health schemes and thus improving investment opportunities in local health capacity.
- Facilitating the enforcement of quality standards by focusing on the output side of health-care and tying provider payments to performance.

Resources

People consulted:

- Fola Laoye, CEO, Hygeia Nigeria Ltd.

Source: Results for Development Institute

Website: <http://hygeiagroup.org/>, www.hifund.nl

REDUCING THE FINANCIAL BURDEN OF PAYING FOR HEALTHCARE

Program UpliftHealth Mutual Fund (HMF), India

Description A community-based health insurance scheme that relies on strong community structures in urban and periurban slums to build and maintain health insurance.

Stage Established (launched in 2003).

Reach The program originated in Pune slums and then spread to rural Marathwada and Mumbai slums. It has an ongoing membership of more than 65,000.

Implementer *Nonstate.* The Community Based Health Mutual Fund is a program of UpLift India Association, an Indian nonprofit organization.

Funding HMF's operations are 60% self-financed, with the remaining 40% financed by domestic and international organizations (Inter Aide, GTZ, Hivos, SSP) and private funders.

Risk-pooling

Situation

Despite significant improvements in basic social indicators, more than 400 million people (75 million households) in India live below the poverty line, and most belong to the informal sector. Statistics show annual credit use by urban poor households is 135,000 million rupees, 55% for consumption and 45% for production. Even if household need is fulfilled (and at present it is not), a sudden health crisis can disrupt a family's entire economy and hamper its social stability. HMF's target population are families in the informal sector and living in ghettos—mostly daily wage earners who lack access to social protection schemes.

With a daily income of \$2–\$6 for an average family of four, health is not the prime concern for families in the informal sector until a destabilizing event happens. Insurance products in the market are out of their reach because of high premiums, and government schemes exclude them by their very design (covering households living below the poverty line). Families that have access to government-sponsored health protection schemes rarely have a say in the design or delivery of the schemes.

Model

HMF is designed to reduce the financial shock of an unexpected health emergency through community risk-pooling. The insurance is introduced and marketed through local community groups (such as self-help groups and village microfinance organizations), which also process claims and reimbursements. Any organization working with the informal sector is eligible to join the program and receive support, including marketing, servicing, and funds management support. The program works with more than 150 public and private hospitals and clinics and conducts monthly demand-based health check-up camps and health talks. It also runs a 24-hour hotline staffed by qualified doctors, which assists in navigating the complex healthcare system. Where possible, patients are encouraged to use free public services to maximize the resources of the insurance pool. This allows the program to maintain a broad benefits package that includes inpatient surgical services, some outpatient services, and all primary healthcare consultations. Members are also entitled to a lost

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wages benefit. A claim committee composed of community members meets regularly to make claim settlement decisions, which has instilled a sense of community ownership of the scheme. The program is growing 5%–10% a month.

Key program components include:

- *Community ownership.* The insurance scheme is fully administered by the community. The “mutualism” principle makes communities responsible for their own health and for health-care providers and insurers. To help set up the fund, several tools are available: community needs analysis, capacity diagnosis, product design and pricing for health or life microinsurance, microinsurance software, budget and business planning, promotional materials, an operation manual with forms for enrollment, claim settlement, and health card. These tools can be given for free or along with UpliftHealth’s technical guidance to any community wishing to join the program.
- *Operational partnerships.* UpliftHealth has established partnerships at all levels of its operations. It works with public and private providers to ensure adequate provision of care by establishing quality standards and prices for services. It has networked with more than 150 healthcare providers, including specialty hospitals, clinics, pathology and diagnostic labs, medicine and surgical shops as well as general practitioners to provide outpatient services. Members can access a 24/7 helpline, and service executives on the ground provide referrals to network services and patient follow-ups. The scheme also works with technology partners and international donors and agencies—for example, collaborating with Tieto, a Finnish company, to develop a detailed microinsurance software program (SYSLIFT) that can provide extensive data for management and research.
- *Claim settlement.* Claim settlement is one of the effective elements of the program. Each claim is carefully reviewed by a committee of community representatives, who match the amount of funds available with the number of claims filed. Claims for services at facilities part of the network are paid more than those at non-network providers. Community claim management has allocated funds better than if individuals managed their personal insurance plans. As communities are involved in the scheme, the risk of adverse selection, moral hazard, and fraud is reduced.

Impact

- Increasing access to quality healthcare services for urban and periurban communities.
- Bringing financial security and relief to communities where every year 25% of families facing hospitalization fall below the poverty line.
- Reducing out-of-pocket expenditures (from 80% to 40%) using prenegotiated lower rates for products and services.
- Empowering communities and individuals by creating a community-based and transparent health insurance management system.

Resources

People consulted:

- François-Xavier Hay, Founder, UpliftHealth
- Kumar Shailabh, General Manager, UpliftHealth

Website: www.upliftindia.org/upliftindia/programmes/community-based-health-mutual-fund/

Source: Results for Development Institute

Risk-pooling

FACILITATING THE DESIGN OF PRO-POOR MICROINSURANCE SCHEMES

Program	Micro Insurance Academy (MIA), India
Description	An organization dedicated to evidence-based research, training, and advisory services for microinsurance units serving the poor.
Stage	Rollout (established in 2007).
Reach	Currently MIA is involved in providing microinsurance training and expertise to communities in the Indian states of Bihar, Madhya Pradesh, Orissa, and Uttar Pradesh as well as in two districts in Nepal. The current projects are expected to cover upward of 200,000 people by 2011. MIA plans to expand in 2009/10.
Implementer	<i>Nonstate.</i> MIA is implemented by Sarvajan Unnati Bodhini, an Indian public charitable trust based in New Delhi.
Funding	MIA is funded through institutional grants, research grants, and service fees. Notable donors and clients include the Erasmus University Rotterdam, the European Commission, GTZ, Humanistisch Instituut voor Ontwikkelingssamenwerking, Madhyam Foundation, and MISEREOR, among others.

Risk-pooling

Situation

The liberalization of India's previously nationalized insurance industry in the 1990s, which culminated in the creation of the Insurance Regulatory and Development Authority in 1999, laid the framework for the entry of private (including foreign) insurance companies. By the late 1990s numerous microcredit providers started adding microinsurance to their array of financial services. But most of these products failed to reach the poor, leaving half of India's poorest households spending 2,400 rupees (about \$50) or more per year, out-of-pocket, on healthcare. To address this, the Insurance Regulatory and Development Authority mandated that insurance companies conduct a certain amount of business in rural areas or face hefty fees. Constant challenges for providers in the microinsurance industry in poor rural communities were the lack of trust in insurance by many potential policyholders and too few and rigid products.

Program

MIA is a nonprofit organization that helps communities design context-specific health microinsurance schemes that are affordable for the poor, community based, and sustainably linked to reinsurance providers. It also builds capacity within communities to effectively implement the schemes. Unlike conventional microinsurance programs that are predesigned and administered by an outside organization, MIA provides advice and step-by-step stewardship to the target community and empowers the community to design and self-administer its own health microinsurance program. The community uses its local knowledge of supply (clinics and hospitals) and demand (through community representatives) to ensure effective microinsurance programs managed by local claims committees. MIA partners with grassroots organizations (such as Indian Grameen Services and BAIF Development Research Foundation), network institutions (such as the Madhyam Foundation), and research institutes and universities (such as Erasmus University Rotterdam). MIA draws

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from the *social re* concept to ensure sustainable operations of community-based health microinsurance schemes by linking microinsurance units to reinsurance and from Sarvajan Unnati Bodhini's extensive knowledge of the Indian insurance domain.

Key program components include:

- *Communitywide risk-pooling.* MIA bases subscriptions on community affiliation rather than individual characteristics, which effectively reduces adverse selection among all members regardless of preexisting conditions, age, or income. MIA thereby achieves better diversification of risk and better equity, lowering the overall costs of the microinsurance scheme.
- *Designing context-specific microinsurance schemes.* MIA is involved from the initiation workshop when a community decides to introduce a microinsurance scheme through implementation by facilitating communitywide discussions, providing information materials (including results from a baseline socioeconomic and demographic study that informs the design of the scheme), training promoters (local nongovernmental organizations) and facilitators (ground staff that educate community members on democratically selecting representatives, facilitate benefit package design, and undertake an awareness campaign that ensures that the community as a whole and its key stakeholders remain supportive and engaged).
- *An innovative tool for developing benefits packages.* MIA relies on self-administration, so communities can determine the most appropriate benefit package based on their needs. This model uses a field-tested tool called Choosing Healthplans All Together (CHAT) that enables poor communities to develop local solutions to their healthcare challenges. CHAT is a game-like tool that includes illiterate and innumerate people in defining the composition and price of their health insurance. This helps to reduce financial vulnerabilities using relevant solutions that protect livelihoods—making MIA truly responsive to local needs.

Risk-pooling

Impact

- Promoting community awareness on risk-pooling as a means to access a broad range of health products.
- Promoting high-quality health-seeking behavior by educating members of communities on the availability and affordability of high-quality care through microinsurance schemes.
- Improving rural communities' access to affordable, high-quality healthcare products and services.
- Increasing capacity to administer programs at the community level.
- Improving the health of underserved communities in rural areas by providing community-wide access to essential healthcare services and health protection products.
- Developing tools and techniques to measure the impact of the interventions.

Resources

People consulted:

- Dr. Iddo Dror, Director of Operations, MIA
- Prof. Dr. David M. Dror, Chairman, MIA
- Prof. Dharmendra Kumar, Chief Trustee, MIA

Website: www.microinsuranceacademy.org

Source: Results for Development

EXPANDING MICROCREDIT SERVICES TO HEALTH INSURANCE

Program	Grameen Kalyan Health Program (GK), Bangladesh
Description	A comprehensive health service financing and delivery program established to provide quality, affordable healthcare for Grameen Bank members and other villagers.
Stage	Established (launched in 1993).
Reach	GK operates 48 health centers in 14 districts and 50 upazilla (subdistricts) and provides primary healthcare services to 2.2 million people. The target population is low-income households (mostly headed by women) near Grameen Health Centers. GK plans to gradually expand into a countrywide program.
Implementer	<i>Nonstate.</i> GK is a not-for-profit organization and a member of the Grameen Family of Companies.
Funding	GK operates the program using its own funding.

Risk-pooling

Situation

Over the years evaluations of Grameen Bank's microcredit program revealed that ill health and the cost of healthcare are major obstacles to borrowers' breaking out of the poverty cycle. In 1992 Dr. David Gibbons and Helen Todd found that after 10 years of Grameen borrowing, 58% of the members had lifted themselves out of poverty, compared with only 18% of nonborrowers. Of the 42% of borrowers who failed to improve their socioeconomic condition, 60% had experienced a serious illness within the family that drained family resources.

Program

GK was created to remedy the grave financial burden of serious illness and general health conditions on poor members of Grameen Bank. GK's primary goal is cost-effective welfare and healthcare services for its members as well as nonmembers living within its operational area. As an insurer and health service provider, GK implements an affordable health microinsurance scheme, running a network of community-based health centers and satellite clinics, managing a referral system for secondary and tertiary care, and coordinating outreach health services (domiciliary service) by community-based female health workers. GK's operational cost recovery rate has reached 83% (at the stage of continuous expansion) in 2008, up from 38% in 1997.

Key program components include:

- *Health microinsurance.* Health microinsurance is pivotal in GK activities, ensuring target group participation and raising revenue for the program. The scheme employs a sliding scale fee structure. Nonmembers of Grameen Bank pay slightly more (300 taka or about \$4.28) than members (200 taka or about \$2.85), but there is no distinction in service and benefits, and each plan covers up to six members of a cardholder's family. The plan provides free preventive care, family planning, and health education services to all, irrespective of enrollment. For health center visits enrollees pay 20 taka or about \$0.29 and nonenrollees pay 50 taka or about \$0.71. Enrollees also receive a discount on medicine and laboratory tests. In

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catastrophic circumstances enrollees can receive a subsidy from GK of up to 2,000 taka or about \$29.

- *Primary healthcare.* GK's health centers are usually attached to a Grameen Bank branch and provide primary healthcare using a staff of doctors, paramedics, managers, lab technicians, and community health assistants. Each center's operational area corresponds to that of a Grameen Bank branch, an area with a radius of about eight kilometers. The center operates on an outpatient basis; providing treatment and advice and referring patients to a hospital when necessary. Medical staffs also organize weekly satellite camps for members in remote areas. The salary structure considers the distance of workplace from the capital city (that is, workers in more remote areas receive higher salaries).
- *Training and human resources development.* GK has received technical support from development partners to implement a range of human resources development activities, including capacity building and monitoring, annual work plans, training materials, accounting and reporting, and networking at home and abroad.

Impact

- Making healthcare services accessible at an affordable cost.
- Bringing state-of-the-art-technology to rural dwellers.
- Reducing self-treatment, harmful use of medicine, and delayed treatment by providing regular access to professional medical staff.
- Lowering the cost of curative treatment through ongoing prevention programs.
- Reducing maternal and neonatal mortality rates.
- Enabling poor communities to engage in income-generating activities in good health and effectively using microcredit through Grameen Bank.

Resources

People consulted:

- Tajbinur Rahman, Assistant General Manager, GK

Website: www.grameenkalyan.org

Source: Results for Development Institute

Risk-pooling

ADDRESSING THE BARRIERS TO ACCESSING CARE

Program Karuna Trust Community-Based Health Insurance Scheme, India

Description A public charitable trust operating a community-based health insurance scheme with the goal of promoting integrated community development.

Stage Established (established in 2002).

Reach The community-based health insurance scheme is operational in T. Narsipur Taluk and Yelandur Taluk, Karnataka, and has 278,000 beneficiaries.

Implementer *Nonstate.* Karuna Trust, a not-for-profit organization, established the program with support from the government of India, the government of Karnataka, the National Insurance Corporation, and the United Nations Development Programme. The Centre for Population Dynamics has been involved in the scheme's evaluation.

Funding Karuna Trust has received support from the United Nations Development Programme – India (2001–04) and the National Insurance Company, as the program's insurance partner.

Risk-pooling

Situation

India is a hotbed for innovation in health microinsurance design and implementation. Many microinsurance schemes have emerged thanks to, among other reasons, government regulation requiring companies to target some of their operations to people living below the poverty line. Having acknowledged the importance of developing risk management mechanisms for the poor, the Indian government has made policies addressing the healthcare needs of the poor a priority. Another important factor in the spread and growth of microinsurance in India is the country's long-established history with self-help groups and village health committees. These grassroots groups often act as microfinance institutions and important safety nets for the community.

Program

The Karuna Trust Community-Based Health Insurance Scheme was established to address the challenges of poor access and high costs of healthcare services in rural communities. Instead of directly covering healthcare costs, the model addresses the barriers to accessing care by offering a comprehensive hospitalization package, including compensation for lost wages, free medicines, and emergency transport. Medical care with no disease exclusions is provided at no cost at local public sector facilities. The National Insurance Corporation, a state-owned insurer, is the risk-bearer, accepting a claims to premium ratio of 150%. Local community organizations (self-help groups and village health committees) enroll members and collect premiums in their local area. To increase understanding and knowledge about the benefits of health insurance, the United Nations Development Programme subsidized the premium for the first two years.

Key program components include:

- *Compensation for lost wages.* Karuna Trust offers compensation when in hospital to cover informal workers, who often do not access care because they do not receive sick days. Patients who live below the poverty line receive 50 rupees (about \$1.10) a day for up to 25

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days. Patients who have surgery receive 10 days' wages to encourage them to rest and recover instead of going back to work right away. Patients are eligible for this compensation once a year.

- *Drug fund.* Karuna Trust has established a special drug fund to cover additional drugs not provided by public health facilities. The fund pays 50 rupees (about \$1.10) per person per day for up to 34 days. The drugs are provided by a generic supplier upon submission of a list of drugs needed by the facilities. Drugs for follow-up treatments beyond hospitalization are not covered.
- *Emergency transport.* Karuna Trust offers emergency ambulance transport to address the challenge of poor accessibility to services because of geographical distances. The costs for this service are paid through the drug fund. This service is available to all beneficiaries on an emergency basis.

Impact

- Increasing access to healthcare services for households who work in the informal sector and live below the poverty line.
- Reducing the financial burden of lost wages due to hospitalization and increasing health-seeking behavior.
- Increasing community awareness of the benefits of risk-sharing arrangements.

Resources

People consulted:

- Dr. N. Devadasan, District Health Management, Institute of Public Health
- Dr. Sudarshan, Honorary Secretary, Karuna Trust
- Dr. Prashanth

Website: www.karunatrust.org

Source: Results for Development and William A. Haseltine Foundation for Medical Sciences and the Arts

USING EXISTING SOCIAL NETWORKS TO EXPAND HEALTH INSURANCE

Program **Yeshasvini Cooperative Farmers Health Care Scheme, India**

Description A large microinsurance program run by a trust formed by the government of Karnataka, through a large and far-reaching network of cooperative societies, providing informal sector risk-pooling and access to affordable high-quality healthcare for agricultural households in Karnataka.

Stage Established (launched in 2002).

Reach The Yeshasvini Cooperative Farmers Health Care Trust targets more than 40 million farmers and their families in the Indian state of Karnataka.

Implementer *Nonstate.* The Yeshasvini Cooperative Farmers Health Care Trust appointed Family Health Plan Limited to implement the scheme.

Funding Yeshasvini is funded through patient contributions (50%) and support from the government of Karnataka (50%).

Risk-pooling

Situation

One of India's largest states and home to India's third most populous city (Bangalore), Karnataka in southern India has about 53 million people. Although not India's poorest state, Karnataka does have urban slums and poor rural communities. About 70% of the rural population in Karnataka is self-employed in agriculture, and traditional efforts to provide health microinsurance to this largely agrarian population have been challenging. These efforts have also seen limited reach (the largest scheme, the Raigarh Ambikapur Health Association in Madhya Pradesh, covers 400,000 people), restricted benefits because of limited financing and limited premiums, very high administrative costs (many schemes had to focus on establishing their own dispensaries, care facilities, and hospitals), and restricted access because of inadequate healthcare infrastructure for a large and highly dispersed rural population.

Program

The Yeshasvini Cooperative Farmers Health Care Trust leverages agricultural cooperatives as a distribution channel for health insurance to workers in the informal sector. About 78% of adults in Karnataka have access to the scheme because they are somehow connected to a cooperative society through which the scheme participants are identified and enrolled. The scheme also relies on the government of Karnataka for a partial subsidy of benefits, thereby expanding the funds available for the program while ensuring very low premiums. Administrative costs are kept low by involving the Karnataka state cooperative department for communicating about the plan, cooperative societies for enrolling members, cooperative banks for collecting premiums, Family Health Plan Limited for administering claims, and a network of existing hospitals for delivering the benefits. The scheme has expanded since inception, experimenting with new pricing methods and benefits packages. The scheme's approach has been very successful and is the basis for a state-led insurance scheme for surgical coverage in Andhra Pradesh (Aarogyasri). The government of Karnataka is devising plans to

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subsume the Yeshasvini scheme to make it a fully state-funded insurance option for the poor (like Aarogyasri in Andhra Pradesh).

Key program components include:

- *Innovative product distribution channel.* The product distribution channel leverages agricultural cooperatives and effectively pools risk by the sheer size of its membership. The scheme's insurance is distributed through the cooperative structure in Karnataka, which reaches out to about 19 million members (mainly in rural Karnataka). Since members of cooperative societies, their spouses, and children can join, the potential reach of the scheme is even greater. The widespread coverage of the scheme has permitted low premiums for a broad range of health services.
- *Effective premium collection mechanism.* All households enrolled in the scheme are in a business relationship with a cooperative society. By selling goods to the cooperative society, they generate income that is used to pay premiums. When members cannot pay in cash, the amount owed is deducted from the income they gain from selling goods to the cooperative society.
- *Leveraging underutilized private providers.* The scheme created a network of private health-care service providers. Private hospitals were required because public facilities were inadequate. The scheme presented a profitable business case to the private hospitals, which solved their own low-capacity utilization rate problem, and convinced 30–40 hospitals to sign up for a pilot. The successful pilot led to 350 certified private hospitals joining by June 2008.

Risk-pooling

Impact

- Leveraging the existing large network of private providers and taking advantage of the large pool of agricultural households to negotiate low and affordable premiums with providers.
- Increasing access to a large number of surgical procedures, maternity and neonatal care, and some medical emergencies by stimulating participation in the scheme through a far-reaching network of cooperative societies with which participants have already involved.
- Encouraging an appreciation for and embracing community-based risk-pooling.
- Reducing disease morbidity and mortality from preventable and treatable diseases and illnesses by providing rural poor with access to medical advice and quality, affordable, life-saving health protection procedures

Resources

People consulted:

- A.P.V. Reddy, Managing Director, Family Health Plan Limited

Website: www.yeshasvini.org

Source: Results for Development

PROVIDING PRO-POOR GROUP HEALTH INSURANCE COVERAGE

Program	Microcare, Uganda
Description	A for-profit insurer that seeks to leverage its proprietary information technology system, delivery network, and technical expertise to bring health insurance products to the poor.
Stage	Established (established in 2000).
Reach	Microcare services 76,000 formal and 29,000 informal sector clients and works with more than 150 health service providers in Uganda (government, private and mission hospitals, clinics, and pharmacies). Future plans include scaling-up nationally to further penetrate the informal sector by closely partnering with the Ugandan government's proposed National Health Insurance Scheme (planned for 2009).
Implementer	<i>Nonstate.</i> Microcare began as a not-for-profit action research initiative. In 2004 it was transformed into a commercial health management and insurance business.
Funding	Microcare is a for-profit insurance company. It has received support from the Austrian Regional Bureau for Development Cooperation, Cordaid – Netherlands, the U.K. Department for International Development–funded Financial Deepening Challenge Fund, the European Union' SUFFICE program, and the McKnight Foundation.

Risk-pooling

Situation

As in many other African countries, the most common reason that people fall into extreme poverty in Uganda is illness, especially in rural areas. Per capita public health expenditure does not even reach \$5, and health insurance coverage remains very limited. Uganda faces multiple challenges to effective health insurance delivery, including adverse selection, moral hazard, and potential fraud, which all increase risks to insurers and costs to prospective customers. High costs and widespread poverty and poor health lead to limited insurance coverage, high premiums, and limited affordability. Thus, most households are forced to pay user fees for healthcare that is often of substandard quality.

To address these shortcomings, in 1995 the Ugandan Ministry of Health introduced a regulation for community-based health financing, which empowers communities to meet their health financing needs by pooling resources. It is an alternative to a national insurance plan, favoring local management of health financing and coverage adjusted to community needs and resources.

Program

Microcare was created out of the community-based health financing initiative in Uganda and has grown into the largest provider of group health insurance in the country, servicing workers in both the formal and informal sectors and operating in both urban and rural areas. For a modest annual premium Microcare contracts with selected healthcare providers (both public and private) to provide quality medical treatment. A group (for example, burial societies, microfinance institutions,

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vendors association) must have at least 25 members to qualify. Microcare's insured base is composed of 70% formal sector workers and 30% informal sector workers, but the insurer hopes to flip the customer base to 30% formal workers and 70% informal workers over the next five years. Microcare has grown 300% a year since 2004.

Key program components include:

- *Custom product design.* Microcare negotiates every insurance plan with the customer community to ensure that community members have agreed on the services they want and the premium they are prepared to pay.
- *Product tangibility.* Microcare addresses low renewal rates by providing preventive health services to community members, so that they receive a tangible product in exchange for their contributions. These products specifically target malaria, HIV/AIDS, waterborne diseases, and maternal and child health.
- *Sophisticated information technology platform.* Microcare has efficient measures to reduce fraud, such as fingerprints with electronic recognition, allowing it to keep annual fees per person at \$90–\$250 for formal sector groups, \$10 for rural informal sector groups, and \$25–\$35 for urban informal sector groups. In addition, Microcare has a high-capacity information technology system to support its operations: photosmart ID cards with biometrics capabilities, a robust Oracle database, data connectivity through VSAT and GPRS (GSM), and real-time claims processing through a unique networked hospital check-in desk system.

Impact

- Increasing poor communities' access to affordable healthcare services by enabling ordinary people to benefit from health insurance.
- Enabling timely access to health services and thus significantly reducing vulnerability to serious household health crises.
- Providing broader benefits, contributing to health education and sensitizing community members to the value of long-term planning and saving.

Resources

People consulted:

- Francis Somerwell, Managing Director, Microcare

Website: www.microcare.co.ug

Source: Results for Development Institute

LEVERAGING COMMERCIAL EXPERIENCE FOR SOCIAL BENEFITS

Program **Arogya Raksha Yojana (ARY), India**

Description A health microinsurance scheme providing affordable, high-quality healthcare for the underserved in rural and urban areas of the Indian state of Karnataka through an accessible provider network of private hospitals and clinics supported by leading doctors and surgeons.

Stage Rollout (launched in 2005).

Reach ARY insures 70,000 people across seven districts of Karnataka.

Implementer *Nonstate.* The program is a joint project between Biocon Foundation (the foundation of Biocon Pharmaceuticals Ltd.) and Narayana Hrudayalaya Hospital. They are supported by several independent rural service providers. The risk is covered by ICICI Lombard.

Funding Funding for the program is provided through the Arogya Raksha Yojana Trust.

Situation

As recently as 2004, health was a loss-making portfolio for most general insurance companies in India, with claims ratios exceeding 100%. This was due in large part to a small customer base—approximately 2% of the population—and its attendant adverse selection problems. Minimum capital requirements were also prohibitively high for standalone health insurance providers (100 million rupees), so that no such provider existed until 2006.

Apart from the supply-side incentive of lower administrative costs associated with bulk business from corporations in urban areas, rural health insurance activity was low for demand-side reasons too: the lack of awareness about various schemes by the rural populace, inadequate provider distribution network suitable for a widely dispersed population, and costly premiums.

Program

ARY leverages the expertise of the commercial insurer to provide retail insurance to workers in the informal sector in nonrural areas by bearing the risk and undertaking all insurance administration. Local ARY clinics (run by the Biocon Foundation) create a presence in local communities and provide care to both the insured and uninsured and reduce the costs of insurance claims by providing good primary healthcare (thus reducing rates of hospitalization for surgical procedures). They also provide a platform for marketing the insurance program to the uninformed. ARY benefits are comprehensive and include free outpatient consultation; generic medicines at special rates from Biocare pharmacies; diagnostic tests at discounted rates at network hospitals, at Biocare Clinics, and approved diagnostic centers; hospitalization (not leading to surgery); and surgical treatment for more than 1,600 types of surgeries.

Key program components include:

- *Reaching the rural and urban poor.* ARY offers health insurance to workers in the informal sector in rural areas and in the slums of Bangalore (India's third largest city), who are reached through microfinance organizations and community-based organizations. In places

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where no strong community institutions exist, ARY sets up enrollment booths for a limited time each year.

- *Multiproduct and high-quality coverage.* Wide-ranging benefits from ARY—health insurance, free outpatient consultations, and discounted pharmaceutical products—are distributed through an accessible healthcare provider network. ARY has targeted easy-to-access areas to build a defined presence for its brand and thereby attract demand. Beneficiaries may seek care at any provider within the network of high-quality hospitals.
- *Expanding the retail distribution network.* ARY conducts retail sales of insurance through locally visible organizations as well as through new, proprietary clinics that serve both insured and uninsured patients for simple outpatient care and drug sales. At inception, ARY's cost of retailing insurance was close to 40% of the price of the premiums, but this has gradually been reduced with the construction of low-cost clinics in the slums and suburbs of Bangalore.
- *Medicine cost reduction.* ARY provides generic medicines at special rates through Biocare pharmacies as a result of backend subsidies on pharmaceuticals provided by the Biocon Foundation.
- *Prepaid risk-pooling.* ARY uses a prepaid risk-pooling approach, providing surgical treatment for more than 1,600 types of surgeries using a 100% cashless facility for surgical treatment and medical admissions up to the covered amount.

Impact

- Increasing community awareness of and access to high-quality healthcare services and products.
- Ensuring affordability of treatment for the rural and nonrural poor by reducing distance traveled to receive healthcare.
- Increasing capacity to administer programs at the community level.
- Improving the health of the underserved in rural and nonrural areas by providing access to essential healthcare services and health protection products.

Resources

People consulted:

- Rani Desai, Head, Biocon Foundation and ARY Trust

Website: www.arogyarakshayojana.org

Source: Results for Development

Risk-pooling

ACCREDITING PRIVATE DRUG-DISPENSING OUTLETS

Program Accredited Drug-Dispensing Outlets (ADDO), Tanzania

Description A regulated system of independent accredited retail drug dispensing outlets that provide affordable, quality drugs and services in rural and periurban areas where few or no registered pharmacies exist.

Stage Established (launched in 2003).

Reach The program was piloted in the Ruvuma region, with scale-up now complete in three additional regions—Morogoro, Mtwara, and Rukwa. Scale-up in another six regions is underway, with plans for coverage by 2011.

Implementer *Government.* The initiative was established by the Tanzania Food and Drug Authority and regional and local government authorities in collaboration with Management Sciences for Health through its Strategies for Enhancing Access to Medicines program.

Funding The Bill & Melinda Gates Foundation funded the conceptualization, pilot, and evaluation of the initiative. To date, scale-up in additional regions has been funded by the Danish International Development Agency, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the government of Tanzania, and the U.S. Agency for International Development. The Bill & Melinda Gates Foundation and the Rockefeller Foundation have provided additional funding for program review and strengthening.

Regulation

Situation

In rural and periurban areas, where almost 70% of Tanzanians live, access to health services through public health facilities is often limited because of poor infrastructure, long travel distance, and frequent stockout of basic medicines at public health facilities, among other factors. This has caused health-seeking behavior for basic medicine for common diseases to lean toward small community-based drug shops, known as *Duka la dawa baridi* (DLDBs). An estimated 35%–40% or more of the population use DLDBs for this purpose.

The DLDBs complement government efforts to improve access to quality medicines and pharmaceutical services for high-risk patients, but they face operational problems. In 2001 the Tanzanian Ministry of Health and Social Welfare in collaboration with the Strategies for Enhancing Access to Medicines program found severe problems with the country's 4,600-plus government authorized private drug stores, including ongoing stockouts of essential medicines at public health facilities, limited access to medicines in rural areas, poor dispensing practices, fragmented knowledge and competence, substandard medicines, illegal provision of prescription medicines, and inadequate regulatory framework and resources.

Program

In response to the problems outlined above, rather than closing the community-based drug shops, the Tanzania Food and Drug Authority leveraged the existing system by creating accredited drug-dispensing outlets. With support from public and private sector stakeholders, the initiative employs a holistic approach to change the behavior and expectations of individuals who buy from, own,

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regulate, or work in retail drug shops by building on existing infrastructures, developing new regulations and standards of practice, and introducing a combination of training, appropriate incentives, consumer pressure, monitoring and supervision, and regulatory coercion, with efforts to affect client demand.

Key program components include:

- *Broad-based stakeholder support.* The initiative uses a participatory approach in designing and implementing the program, including identifying the “owner” of the initiative as well as involving national and local authorities and professional and commercial associations.
- *Provider accreditation program.* The initiative introduced an accreditation program for community-based drug shops based on Ministry of Health’s standards and regulations and in accordance with the goals of the National Health Policy and Health Sector Reforms Program. Inspectors conduct mapping and preliminary preaccreditation inspections of community-based drug shops to assess individual needs. The initiative aims to develop quality standard requirements and build stewardship and governance capacity at the local and central levels.
- *Provider training and consumer awareness.* The initiative provides training in business skills, documentation, and recordkeeping and commercial incentives such as loans to drug dispensers. In addition, it promotes customer awareness of the quality of medicines and services through public education and marketing efforts (such as posters, flyers, billboards, and radio spots).
- *Monitoring and evaluation.* Ward and district inspectors conduct monitoring and evaluation inspections, and the initiative is working to strengthen local regulatory capacity. It also aims to ensure the availability and quality of products dispensed by requiring accurate recordkeeping and regular supervision of shop operations.

Impact

- Improving rural and periurban communities’ access to quality, safe, effective, and affordable medicines.
- Increasing rational drug use through adherence to requirements for dispensing prescription drugs.
- Creating reliable employment and income-generating opportunities for owners and dispensers.
- Creating a skilled pool of trainers, dispensers, and inspectors.
- Improving the referral system for patients who first consult drug outlets participating in the initiative.
- Establishing a reliable system for applying for and repaying loans through microfinancing institutions.
- Ensuring access to medicines through health financing schemes such as the National Health Insurance Fund and Community Health Funds.

Resources

People consulted:

- Keith Johnson, Management Sciences for Health
- Romuald Mbwasi, Senior Technical Advisor, Management Sciences for Health
- Edmund Rutta

Source: Results for Development Institute

Website: www.tfda.or.tz/Addopage1.html

REGULATING THE MARKET FOR DRUGS AND HEALTH PRODUCTS

Program	National Agency for Food and Drug Administration and Control (NAFDAC), Nigeria
Description	An independent government agency that regulates quality standards for imported and locally manufactured food and drug products.
Stage	Established (established in 1993, restructured in 2001).
Reach	NAFDAC has three special zonal offices in Abia State, Kaduna State, and Onitsha Anambra State, and it maintains 37 inspectorate and 6 zonal offices throughout Nigeria.
Implementer	<i>Government.</i> NAFDAC was established in 1993 as a state-owned enterprise of the Nigerian Ministry of Health.
Funding	NAFDAC is supported by the Nigerian government.

Regulation

Situation

Drug counterfeiting in Africa tends to be cruder and more widespread than in other parts of the world, with drugs such as painkillers and antibiotics common targets. Nigeria has struggled with adulterated and counterfeit drugs for decades. In 1989, 150 children died as a result of a drug formulation error, and thousands more have suffered from the negative side effects of counterfeit pharmaceuticals, including kidney failure, liver damage, heart failure, and other organ dysfunctions as well as worsening of chronic disease conditions, such as hypertension. In the 1980s and 1990s the problem was so serious that some neighboring countries banned imports of Nigerian drugs.

In 1993 NAFDAC was established in response to the 1988 World Health Assembly resolution calling for increased control over pharmaceuticals in the country. Despite improvements in the regulation and control of drugs, Nigeria continued to have one of the highest rates of fake and counterfeit drugs. The drug distribution system in the country was chaotic: there were no reliable statistics on fake drugs, and Nigerian companies did not conform to requirements of good manufacturing practice. Many imported drugs were registered without overseas factory inspection. Counterfeit drugs thereby eroded public confidence in healthcare systems, healthcare professionals, genuine drug suppliers and sellers, the pharmaceutical industry, and national drug regulatory authorities.

Program

Determined to solve Nigeria's persistent counterfeit drug problem, the government restructured NAFDAC's management and reorganized the agency in 2001. New directorates were created for registration and regulatory affairs, laboratory services, narcotics and controlled substances, planning research and statistics, administration and finance, ports inspection, establishment, and enforcement. New inspectorate offices were opened in all 36 states, including Abuja, and three special inspectorate offices, six zonal offices, and three narcotic offices were introduced. Since then, the agency has focused largely on enforcement, including imports and exports, standards specifications, product registration, and guidelines and relevant data. The agency has also reviewed existing laws and procedures to ensure that they are in line with global trends. These measures have

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increased seizures and destruction of counterfeit drugs, raised community awareness, and improved regulatory transparency .

Key program components include:

- *Public enlightenment campaign.* NAFDAC runs a far-reaching public awareness campaign to inform the public of the dangers of counterfeit drugs and provide guidelines on consumer safety. Public announcements run on radio stations (in English and other regional languages), and plans are under way to start a television and radio weekly discussion program. The agency also publishes a biannual newsmagazine and consumer safety bulletin and organizes regular public awareness workshops that focus on different stakeholders (such as water producers, proprietary medicine dealers associations, and the like).
- *Effective quality assurance system.* NAFDAC has launched an effective quality assurance initiative that engages all major stakeholders in ensuring that good manufacturing practices are observed and that pharmaceutical manufacturing facilities comply with established quality standards. All inspection and licensing are based on good manufacturing practices issued by the World Health Organization. In addition, NAFDAC inspects all overseas manufacturing and quality control facilities prior to granting marketing and importation authorization. NAFDAC also periodically publishes a list of blacklisted companies, both local and international, that do not comply with good manufacturing practices..
- *Inspection directorates.* NAFDAC has an enforcement directorate and a ports inspection directorate tasked with tracking counterfeit products; controlling and regulating the importation of food, drugs, cosmetics, and medical devices; inspecting all regulated products at the point of entry; and compiling guidelines and issuing quality certificates.
- *Improved working environment.* NAFDAC has improved the welfare of its staff by providing a more conducive working environment (such as generators, computers, air conditioners, and the like), introducing car refurbishing loans, and harmonizing the banking system for its staff.

Impact

- Achieving significant results in the fight against counterfeit drugs by reducing the importation, production, and distribution of illegal products.
- Raising awareness of counterfeit drugs not just in Nigeria, but globally.
- Increasing the production capacities of local pharmaceutical industries 35% in 2002 and reinforcing the confidence of international investors in the industry.
- Renewing confidence and increasing patronage of pharmaceutical products produced in Nigeria.

Resources

People consulted:

- Dora Akunyili, Former Director, NAFDAC

Website: www.nafdacnigeria.org

Source: Results for Development Institute

LEVERAGING INFORMATION AND COMMUNICATION TECHNOLOGY TO MONITOR HEALTH CENTERS' PERFORMANCE

Program Yunnan Province Township Health Centers, China

Description A program concept proposing to use existing information and communication technology to complement government's monitoring efforts of township health centers enrolled in rural health insurance schemes.

Stage Concept

Reach The pilot program is planned to launch in two Yunnan province counties in China.

Implementer *Nonstate.* The concept was developed by Kunming Medical College, the largest specialized medical university in Yunnan, China, in partnership with the program on Making Health Markets Work Better for Poor People of the Future Health Systems Consortium, and the Yunnan Provincial Health Department.

Funding Kunming Medical College is seeking funding to test the program.

Situation

Although most rural health centers and hospitals in China are owned by local governments, they operate under market conditions, generating up to 95% of their revenue from charges to patients. They pay their employees bonuses based on revenue, and they finance investments out of any surplus. In 2003 the Chinese government launched a new rural health insurance scheme financed through household contributions and payments by central and local governments, which covered equal amounts of subsidy per beneficiary. By 2008 almost all counties had a scheme to which government contributions would be at least 80 yuan (around \$12) per beneficiary.

Several studies have illustrated how government healthcare financing and public service pricing create perverse incentives to sell more drugs and perform more diagnostic tests and result in rapid rises in healthcare costs and high levels of pharmaceutical use. The government has become increasingly aware of this problem and has attempted to control costs through price reforms, routine monitoring of hospital performance, and elimination of corrupt practices such as under-the-counter payments from patients and kickbacks from pharmaceutical suppliers. Despite these efforts, healthcare costs continue to rise. In addition, local schemes are under pressure to cover secondary prevention of noncommunicable diseases common to aging populations. The Yunnan Provincial Health Department is looking for practical strategies for addressing these issues.

Program

The program leverages newly introduced information and communication systems currently used to track the diagnoses, treatments, and cost of township health centers in the rural health insurance program. The collected information has mainly been used to facilitate billing, but it can also be used to monitor differences in prescribing practices across facilities and individual practitioners, making it a powerful tool for supervising and influencing the performance of township health centers and hospitals.

Innovative regulation

Key program components include:

- *Monitoring and regulation.* Kunming Medical College proposes direct monitoring and regulation of provider behavior by managers of insurance schemes, in collaboration with the county health bureau, using detailed computerized information systems.
- *Information dissemination.* Kunming Medical College proposes providing reliable information and advice to clients and communities on selected diseases using a variety of media in order to better inform the community of appropriate treatments and reduce the opportunities for health workers to prescribe unnecessary medications.

Impact

- Improving the performance of township health centers by reducing perverse incentives and corruption practices.
- Enforcing adequate quality of service standards by closely monitoring performance and thus positively affecting health outcomes.
- Alleviating the burden of out-of-pocket expenditures among rural communities and reducing healthcare costs for rural health schemes.
- Enhancing the accountability of health workers and institutions to clients and communities.
- Strengthening the health system as a whole by complementing government's efforts to improve rural healthcare centers' performance.
- Demonstrating the potential beneficial uses of information and communication technologies in the context of health systems performance.

Resources

People consulted:

- Jing Fang, PhD, Professor at the Institute of Health and Development Studies Kunming Medical College

Website: www.kmmc.cn/kmmc/exxzl.html

Source: Institute of Development Studies, www.ids.org, and www.futurehealthsystems.org/themes/themes2008/healthmarkets/

INTEGRATING VERTICAL HEALTH SYSTEM INFRASTRUCTURES

Program VillageReach, Mozambique

Description A program strengthening health systems in developing countries by supporting and improving the health services already in place with a focus on service infrastructure, logistics, and community health worker support.

Stage Rollout (launched in 2002).

Reach The pilot program operates in the northern Mozambique provinces of Cabo Delgado and Nampula and serves 251 clinics covering a population of 5.2 million. VillageReach is refining its model for replication in Malawi and other developing countries.

Implementer *Nonstate.* VillageReach, a nonprofit organization founded in Seattle, Washington, United States, and the Mozambican Foundation for Community Development jointly launched the program through a partnership agreement with the Ministry of Health. In January 2007 the Foundation for Community Development assumed daily operational management of the program, though VillageReach still provides technical assistance.

Funding VillageReach has received support from the Bayview Foundation, the Bill & Melinda Gates Foundation, the BridgeWay Foundation, the Flora Foundation, Getty Images, the Mulago Foundation, PATH, the Skoll Foundation, the Stavros S. Niarchos Foundation, Thomas Hunter Foundation, World Bank Development Marketplace, the Mozambique and Dutch governments, and individuals from around the world.

Supply chain

Situation

In Mozambique healthcare delivery in remote areas is plagued by basic infrastructure problems that inhibit adequate service provision. Healthcare at this level suffers from gaps in transportation, supply chain management, and service infrastructure. For example, the challenges in delivering medical supplies to rural areas are significant due to poor infrastructure (such as roads, energy, and communication) and inadequate supply chain management (such as storage, distribution, and special handling). Health workers are thus faced with major challenges in maintaining functioning health centers, in part because of limited communication between rural health workers and the Ministry of Health.

Program

VillageReach's program establishes an integrated platform between parallel, vertical systems in the country, addressing the health system in the last mile and a social business that addresses gaps in community infrastructure. The health system component improves the management, reliability, and quality of the public health system, ultimately enabling the government to maintain the system without outside support. The social business component seeks to fill unmet gaps in the health system, including transportation, energy, communications, or other services needed by the Ministry of Health and underserved communities. VillageReach activities have four phases: assessment,

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implementation, transition to local ownership, and technical support. The VillageReach program in Mozambique is expected to be fully transitioned to local authorities by 2022. The Mozambican Ministry of Health has requested that the program expand nationally.

Key program components include:

- *Improving service infrastructure.* VillageReach improves service infrastructure by implementing a management information system to manage data processing, introducing an effective waste management system, outfitting health centers with alternative energy sources (such as propane-powered lamps and burners), providing radios to facilitate communication with the Ministry of Health and district hospitals, and providing bicycles and motorcycles for community outreach. Infrastructure improvements have increased the number of children fully immunized each year in participating districts of northern Mozambique by 40% and reduced stockout rates to 2%, down from 80%.
- *Supply chain management.* VillageReach improves the overall functioning of the health system's supply chain by tracking medical supplies to limit waste, improving forecasting and reporting throughout the entire supply chain, managing inventory, and maintaining equipment.
- *Community and health worker support.* VillageReach supports community health workers by introducing supportive supervision and ongoing training at all levels of the health system. As part of this strategy, VillageReach introduces proper protocols and procedures for all staff and conducts trainings for logistics officers and pharmacists.
- *Data analysis.* VillageReach recognizes that medical logistics and delivery systems require reliable data to make informed decisions and ensure quality services. In Mozambique VillageReach implemented a system to track nine key indicators to track vaccine stockouts and engaged field staff in useful data analysis.
- *Social businesses.* VillageReach establishes for-profit businesses that create positive social impact by filling critical infrastructure gaps. These businesses are not healthcare specific (such as propane providers and restaurants), but may be linked to the health system through contractual agreements that benefit the system while expanding their customer base. Social businesses become locally owned once they establish their commercial sustainability.

Supply chain

Impact

- Improving the quality of health services by building local capacity, improving infrastructure and management, and using data for informed decisionmaking.
- Improving access to and reach of health services by strengthening the last mile of the healthcare service delivery channel.
- Increasing trust and use of health services among the community.
- Ensuring sustainability by actively planning a transition to local ownership, engaging communities to broaden ownership, and filling infrastructure gaps by supporting social businesses.

Resources

People consulted:

- Allen Wilcox, President, VillageReach
- John Beale, Director External Affairs, VillageReach

Website: www.villagereach.org

Source: Results for Development Institute

BUILDING USER-FRIENDLY RURAL INFORMATION CENTERS

Program	E-Choupal Health (E-Choupal), India
Description	A network of rural kiosks that use information technology tools to cooperate with local doctors to provide information and communication-based health services for India's rural and farm-based populations.
Stage	Rollout (launched in 2005).
Reach	E-Choupal targets farming households in 10 Indian states—Andhra Pradesh, Haryana, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu, Uttarakhand, and Uttar Pradesh—and covers more than 17 million households or more than 85 million people. E-Choupal plans to expand to five more states.
Implementer	<i>Nonstate.</i> The E-Choupal network is implemented by the International Business Division of ITC Limited, a for-profit private sector firm in India.
Funding	E-Choupal is supported by ITC Limited and additional funding from the Indian government, donations from partner organizations, and user contributions.

Supply chain

Situation

Most of India's rural population is engaged in agricultural activity. Rural areas lack many of the amenities of urban centers, including adequate healthcare facilities. The limited reach of healthcare infrastructure poses significant challenges to rural communities, whose populations are often not only poor but also illiterate, which further exacerbates the information asymmetries of the health-care market.

Program

The E-Choupal model was originally introduced in 2000 to allow farmers direct access to markets, as an efficient and transparent alternative to the traditional intermediaries for marketing their farm produce. By 2005 the E-Choupal network extended to providing basic primary healthcare services. The E-Choupal model engages local human resources, creates information technology networks, and operates delivery centers. E-Choupal uses innovative technology to build rural information centers that serve about five villages, connecting them to a single district hub called a Choupal Saagar (rural mall), which is equipped with a clinic, a pharmacy, and an automated laboratory. The E-choupal network provides access to three services: preventive primary healthcare at the E-choupals (which serve as a central point of knowledge dissemination and communication); consultancy, diagnostic, and pharmacy services at the Choupal Saagar (a physician, good-quality affordable basic diagnostic services, and a well stocked institution-managed pharmacy a short distance from the Choupal village); and secondary and tertiary healthcare (through a telemedicine service that provides access to qualified doctors and specialists).

Key program components include:

- *Illiteracy-tolerant information technology.* E-Choupal uses information technology for preventive and curative health disorders. E-Choupal radio broadcasts information on preventive health measures and simple remedies for localized ailments. The message is delivered by

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a doctor and is accessible to illiterate people who can listen but cannot read. Through the telemedicine service, villagers are able to interact directly with specialists using videoconferencing for curative purposes.

- *Leveraging non-electricity-based technology.* E-Choupals are equipped with computers powered by solar-charged batteries and installed in the network kiosks with a VSAT Internet connection in selected villages. The computers can function regardless of the usual troubles of power and telecom facilities in rural areas.
- *Training and deployment of community members.* E-Choupal combines technology (facilitated through the E-Choupal infrastructure) with a community interface in the form of Sanchalak. The Sanchalak's revenue is based on interaction with the community. The Sanchalak is an opinion leader chosen from the village who identifies a village health champion from the community to facilitate use of the E-Choupal network. The village health champions are responsible for mobilizing the community, treating common ailments, conducting household surveys, monitoring health profiles, and improving public education and awareness. They are equipped with medicines and first aid kits, a kit for basic diagnosis, and a bicycle. They are screened and trained in social skills and communication skills, use of handheld devices, basic clinical service, recording and reporting protocols, and conducting public health interventions.
- *Access to affordable services.* The telemedicine service provides affordable access to specialists and allows villagers to avoid trips to cities or towns, which frequently involves loss of pay, food expenses, and the like. Patients gain inexpensive access to professional health specialists and receive regular follow-up through the telemedicine service.

Supply chain

Impact

- Increasing community awareness of and access to high-quality healthcare services and products.
- Ensuring affordable treatment for the rural poor by reducing distance traveled to receive care.
- Improving the quality of healthcare by training and educating community members and engaging them in service delivery.
- Improving the health of the underserved in rural areas by providing communitywide access to essential healthcare services and health protection products.
- Creating reliable employment and income-generating opportunities for the rural poor.
- Leveraging available information technology infrastructure in innovative ways that appeal to community members.

Resources

People consulted:

- Kavitha David, Manager of Rural Health and Education Services, ITC Limited International Business Division

Website: www.itcportal.com/sets/echoupal_frameset.htm

Source: Dalberg, www.dalberg.com

CONTRACTING THE PRIVATE SECTOR FOR DELIVERY SERVICES

Program Chiranjeevi Yojana (CY), India

Description	A government-organized, quality-driven voucher program contracting private obstetricians and gynecologists to provide delivery services to women who live below the poverty line to reduce maternal and infant mortality rates.
Stage	Rollout (established in 2005).
Reach	CY was launched in five poor districts of the state of Gujarat and has been extended to the entire state, with 892 participating providers who have performed 294,635 safe deliveries.
Implementer	<i>Government.</i> CY was established by the government of Gujarat, with support from the Indian Institute of Management Ahmedabad and Sewa Rural–Jhagadia and facilitation by GTZ.
Funding	CY is financed by the government of Gujarat, with support from the central government under the National Rural Health Mission.

Situation

Like many other emerging economies, India suffers from a very high maternal mortality ratios and infant mortality rates. As many as 25.7% of global maternal deaths occur in India. Gujarat sees more than 5,000 maternal deaths every year, mainly because of poor access, especially among low-income communities (whether urban or rural) to qualified health attendants and emergency obstetric care. India has more than 22,000 obstetricians and gynecologists, but fewer than 1,300 of them work in the public sector. Public health facilities (such as community health centers and district hospitals) often lack professional gynecologists and pediatricians trained to provide emergency obstetric care.

As many as three-fourths of registered doctors (approximately 17,738, of which 2,000 are gynecologists) work in the private sector, and many operate in low-income areas. But the availability of such care, especially to poor and tribal people, is limited by prohibitively high costs. Addressing availability of and access to services is important to India as it strives to meet the Millennium Development Goal targets of reducing its maternal mortality ratio from 389 per 100,000 live births in 1998 to 100 by 2010 and reducing its infant mortality rate from 60 per 1,000 live births to 30 by 2010.

Program

CY was created to significantly reduce maternal and infant mortality by harnessing the existing private sector and encouraging it to provide delivery and emergency obstetric care at no cost to families living below the poverty line. Under the scheme the government contracts private providers that volunteer to render their services by signing a memorandum of understanding with the district government. In return, they receive an advance payment to commence services and are compensated at about \$4,500 per 100 deliveries (normal, caesarean, or with other complications). Any qualified private provider with basic facilities, such as labor and operating rooms, and access to blood and anesthetists can enroll in the program after a thorough orientation. CY beneficiaries are enrolled through their family health workers. The scheme uses the existing cards issued to families living below the poverty line by the rural development department of the state government to access services. In the first six months since the launch of the scheme, each provider performed 116 deliveries

Innovative contracting/purchasing

on average. The institutional delivery rate has increased to more than 81% from about 54.7% in 2005–06. CY's long-term goal is to achieve an institutional delivery rate of 95% by 2012.

Key program components include:

- *Benefits package.* CY uses demand-side financing to provide families living below the poverty line with access to a comprehensive benefits package that covers both direct and indirect costs, including free delivery (with no condition exclusions), free medicines after delivery, and transport reimbursement. In addition, it offers support to the attendant in exchange for lost wages. The payment method and formula encourage providers to reach a certain volume of work, avoid complicated transaction costs, and create a disincentive for unnecessary Caesarian sections. The provider compensation package is designed to account for all potential complications during delivery (estimated at 15% of cases).
- *Contract management.* CY's district management authorities require participating doctors to maintain a case file for each patient they serve. Weekly records of the deliveries conducted by the providers are submitted to local authorities and the block (subdistrict) health officer, who regularly visits beneficiaries to monitor service quality and addresses grievances. Payment to providers is also made through block health officers based on instructions from district authorities. All districts send a monthly report to state authorities for review and feedback.
- *District management capacity.* CY employs a decentralized management model that engages health officials at four government levels (state, district, block, and village) as facilitators and organizers of health services. To implement the scheme statewide, officials at various levels play interlinked and overlapping roles. These roles are divided into state level (statewide planning, implementation, and monitoring of the scheme), district level (districtwide implementation, provider enrollment and orientation, provider compensation, and report collection), block level (registration of beneficiaries, bill collection from providers, and overall supervision), and village level (motivating expectant mothers to use institutional delivery and facilitating their visit).

Contracting

Impact

- Reducing maternal and neonatal deaths and significantly increasing newborn life expectancy in Gujarat.
- Enabling families living below the poverty line to access services at no cost, promoting health-seeking behavior, and empowering the community to exercise purchasing power in selecting a service provider.
- Widening the network for skilled services during delivery by involving private practitioners in the healthcare delivery system.
- Retaining qualified medical providers within their original area of operation to ensure community access to an essential workforce.
- Developing health markets in rural areas and making remote areas attractive for private health care providers.
- Expanding the range of services offered by private providers to include screening and counseling for HIV/AIDS and cervix cancer as well as carrying out sterilizations.

Resources

People consulted:

- Amarjit Singh, Principal Secretary, Family Welfare and Commissioner Health, Government of Gujarat.

Website: www.gujhealth.gov

Source: HLSP, www.hlsp.org

CONTRACTING FOR BASIC HEALTH SERVICES

Program Performance-Based Contracting, Afghanistan

Description A government- and donor-led contracting program that uses performance-based partnership agreements with nongovernmental organizations to deliver a basic package of health services to underserved populations.

Stage Established (launched in 2003).

Reach As of 2007, the program operates in 34 provinces of Afghanistan and reaches 82% of the population, according to World Bank estimates.

Implementer *Government.* The program is implemented by the Afghan Ministry of Public Health through national and international nongovernmental organizations.

Funding The program's major donors are the European Commission, the U.S. Agency for International Development, and the World Bank.

Situation

Following the collapse of the Taliban in 2001, Afghanistan was among the countries with the worst health indicators in the world (for example, under-five mortality was 256 per 1,000 births). Years of civil war had left the country's healthcare system severely weakened and unable to address the health needs of the population. To prevent a humanitarian crisis, many domestic and international nongovernmental organizations, supported by donor funding, assumed the role of healthcare providers.

Even after the election of a new government in 2002, the public health system remained limited in capacity and ability to retain qualified professionals. The nongovernmental organizations continued to provide basic healthcare services to most of the population, but there was very little coordination between their activities, and the distribution of services was chaotic and unequal. These inefficiencies combined with the lack of agreement on key priorities resulted in a shortage of health workers in remote areas, difficulty holding anybody accountable for specific catchments areas, and a focus on clinics rather than community services. While the nongovernmental organizations provided important services that the public system was unable to deliver, there were serious inequalities in access to services between urban and rural areas.¹⁷

Program

To assert its stewardship role and address the serious challenges of the Afghan health system, the Ministry of Public Health and its development partners established a formalized contracting program that works with nongovernmental organizations to deliver a basic package of health services. The ministry and donors agreed on the specific provinces to facilitate coordination and established a special grants and contracts management unit to independently manage the contracting process and channel donor funds. The nongovernmental organizations enter into performance-based agreements with the Ministry of Health or donors after being recruited based on availability of personnel and adequate facilities, quality of patient-provider interaction, staff knowledge, and patient satisfaction. Nongovernmental organizations are expected to provide a mix of preventive and promotive services for a nominal fee. The Ministry of Health retains responsibility for program planning and monitoring, while UN agencies provide substantial material support and technical assistance.

Innovative contracting/purchasing

Key program components include:

- *Basic package of health services.* The basic package of health services was developed in 2003 with the assistance of the World Health Organization and includes the services likely to have the most impact on the population and to be cost effective and equitable (deliverable to urban and rural areas equally). They include: maternal and newborn health, child health and immunization, public nutrition, communicable diseases, mental health, disability, and supply of essential drugs. The package will be expanded in 2009 to cover additional services, including community care for the disabled and mental health.
- *Performance-based contracts.* Performance-based partnership agreements were designed based on Cambodia's experience. The agreements operate in 34 provinces, with the World Bank supporting 8 of them, the European Union supporting 10, the U.S. Agency for International Development supporting 14, and other donors supporting 2. Providers are expected to cover a defined population and provide specified services. Nongovernmental organizations using the facilities of the public health ministry are free to recruit staff from within or outside the country.
- *Monitoring and evaluation.* Progress reports and site visits are part of all contracts. A third-party (Johns Hopkins University and the Indian Institute of Health Management Research) has been hired to undertake household surveys, inspect facilities, and conduct interviews using a balanced scorecard that rates facilities on a scale of 0 to 100. The assessment has been carried out annually since 2004, with more than 600 facilities sampled each year. The report of the third round of sampling (2006) found that in most provinces, the health system had improved between 2004 and 2006, including increased availability of services and products.

Impact

- Expanding the Ministry of Health's capacity and strengthening its role as a steward of the health system.
- Providing a basic package of health services to the majority of the population and improving Afghanistan's poor health indicators.
- Increasing the number of functioning health facilities in the country.
- Increasing the number of skilled female health workers, thereby increasing female patients.
- Achieving large improvements in the quality of care provided through performance-based partnerships arrangements, including increased availability of essential drugs and services, improved quality of patient care, and upgraded skills of health workers.

Resources

People consulted:

- Emanuele Capobianco, Health Specialist, World Bank, South Asia Region

Source: HLSP, www.hlsp.org

CONTRACTING PRIMARY HEALTH SERVICES TO THE PRIVATE SECTOR

Program Initiative on Primary Healthcare (IPH), Pakistan

Description	A government-led contracting program that transfers the management of all basic health units in a pilot district to a local nongovernmental organization with the goal of restructuring and significantly improving the quality of primary health-care services in rural Pakistan.
Stage	Established (launched in 2003).
Reach	The program was initially launched in one district of Punjab, with a population of 3.3 million, and was later expanded to 12 other districts in the state. The approach is currently being expanded nationally.
Implementer	<i>Government.</i> The program was implemented by the government of Rahim Yar Khan through the Punjab Rural Support Program, a public sector nongovernmental organizations operating in 20 districts of Punjab.
Funding	The program is financed by the government of Pakistan, with external donor support provided only for its evaluation.

Situation

For years Pakistan's health status has been characterized by a high population growth rate and high incidence of low birthweight babies and maternal mortality. The country's health indicators depict a dismal picture when compared with other countries at the same level of development. This situation is due largely to a long-lasting focus on developing high-end medical facilities in urban areas, while the primary healthcare and rural health services were ignored for years, leading to a high rural-urban disparity in health outcomes.

The major challenge facing the primary healthcare system is the lack of human resources and financial capacity in district health units (for example, shortage of staff (particularly managers, doctors, nurses, and female health workers), laboratory equipment, and drugs). Most of Pakistan's 5,308 basic health units were not functional for years due to widespread absenteeism, poor quality of services, and corruption. Despite a massive network of public primary and secondary health facilities, coverage of basic health services remained low. As a result, the poor suffered from protracted illnesses and were forced to use costly private providers, pushing families deeper into poverty and leading to a rapid rise in rural poverty during the 1990s.

Program

Recognizing the urgent need to strengthen the primary health system in rural areas, the government of Punjab launched a pilot project in the district of Rahim Yar Khan to restructure primary healthcare services by transferring the management of 104 basic health units to the Punjab Rural Support Program, a local nongovernmental organization. The initiative's goal was to drastically reorganize the system by employing innovative management techniques and performance-based incentives, while leaving basic health unit budgets the same. The program introduced several innovations, including recruiting personnel (managers and doctors) at market salaries, enhancing administrative supervision, improving the drug supply, and actively involving the community through support groups. After the encouraging results in Rahim Yar Khan, the project has been replicated in 80 more districts (out of 120).

Key program components include:

- *Innovative management.* The program organizes all basic health units in a district into clusters of two or three to ensure that the distance within a cluster is manageable (no more than

15–20 kilometers). The doctor is the administrative head of a cluster (rather than a single basic health unit) allowing for a higher salary (12,000–30,000 rupees per month), incentivizing the doctor to reside at the focal basic health unit, which is chosen based on residential facilities for the doctor and availability of electricity and water. Doctors also receive an interest-free loan of 100,000 rupees to buy a vehicle that allows them to visit each basic health unit in their cluster according to a timetable. Doctors are responsible for the overall discipline, records, and betterment of their cluster. A project management unit is established in the district and led by a project director and support staff. The project management unit is responsible for stocks and budget and for support and guidance to the doctors. A district support unit is established in the district and led by a district support manager and support staff. The district support unit is responsible for stocks and budgets received from the district government and for providing necessary supplies, ensuring staff discipline, establishing executive justice, and coordinating with line departments.

- *Customized services.* The preventive and curative health services that basic health units are already designated to provide address local health needs, targeting poor women and children especially. Increased outpatient attendance reflects relevant services to the local health-care needs. With the introduction of female doctors into the service and additional clinical facilities, the quality and scope of the services have been revitalized.
- *Monitoring system.* A monitoring system independent of the district health office is the essence of the initiative. The district support unit is responsible for monitoring, supervising, and collecting data. Each health facilities is visited at least once a month by the district support manager and executive monitoring. During a visit the doctor and the staff are motivated, patients are asked about the working of the basic health unit, and all records and stocks are inspected.
- *Community mobilization and education.* Mobilizing and educating the community is an integral component of the initiative. Support groups for all basic health units have been organized with 20–25 people that meet monthly. These groups have played a commendable role in organizing preventive and promotive activities, solving local issues concerning basic health units, and providing routine maintenance of basic health units. Their feedback helps the medical officer understand the functioning of basic health unit and its outreach staff. Community health education sessions in the community and at basic health units are regularly organized, and healthcare providers visit schools to impart health education to children. Doctors also talk to groups of women and children to provide health tips.

Impact

- Improving the quality of services provided by basic health units, with impact on health outcomes, patient satisfaction, and out-of-pocket payments.
- Achieving measurable impact on health Millennium Development Goals.
- Improving the physical condition of the basic health units and significantly reducing absenteeism (by as much as 96%).
- Increasing use of services, especially among women and children under age five.
- Decreasing rural populations' use of nonqualified, informal providers.
- Reducing the financial burden that families face in paying for healthcare outside of the public sector.

Resources

People consulted:

- Ijaz Munir, Program Director, Punjab Health Sector Reforms Programme
- Tahir Ali Javed, Provincial Minister for Health, Punjab

Source: HLSP, www.hlsp.org

Appendix A. Technical partners

Service delivery

- William A. Haseltine Foundation for Medical Sciences and the Arts, United States and India
Sofi Bergkvist and Hanna Pernefeldt
- Institute of Development Studies and Future Health Systems Consortium, United Kingdom
Gerald Bloom, Claire Champion, Henry Lucas, David Peters, and Hilary Standing
- University of Toronto, Canada
Onil Bhattacharyya, David Dunne, and Anita McGahan

Risk-pooling

- Results for Development Institute, United States
Gina Lagomarsino and Sapna Singh Kundra

Government and selfregulation

- Thai Ministry of Public Health, International Health Policy Program, Thailand
Viroj Tangcharoensathien
- London School of Hygiene and Tropical Medicine, United Kingdom

Dina Balabanova, Kara Hanson, and Valeria Oliveira-Cruz

Supply chain

- Massachusetts Institute of Technology–Zaragoza, United States and Spain, and Dalberg, United States
Daniella Ballou-Aares, Edwin Macharia, and Prashant Yadav
- Supporting partner: JSI Logistics Services, United States

Purchasing and contracting

- Broad Branch Associates, United States; Center for Global Development, United States; and University of California, Berkeley, United States
Rena Eichler and Ruth Levine with contributions from Paul Gertler
- HLSP Institute, United Kingdom
Roger England
- University of Zambia, Zambia
Bona Chita, Abson Chompolola, Christopher Mapoma, Dale Mudenda, and Webby Wake

Appendix B. Extended landscape of innovative models

Location	Mechanism	Program	Description	Website
Madagascar	Service delivery	Top Réseau	Top Réseau was launched in 2001 by PSI/Madagascar as a franchise network of youth-friendly private clinics. The franchise aims TO prevent transmission of sexually transmitted infections and unwanted pregnancies by improving sexually transmitted infection case management and promoting consistent condom use and modern family planning methods among sexually active youth. Top Réseau clinics are promoted among young people looking for confidential, quality, affordable, and youth-friendly services.	www.psi.org
Cameroon	Service delivery	100% Jeune	100% Jeune is a multichannel communication program that aims to motivate and enable sexually active, urban youth to use condoms consistently or to not have sex. The program targets approximately 600,000 youth ages 15–24 in the country's two largest cities, Douala and Yaoundé. Linked by the 100% Jeune brand, all communication activities are designed to promote images of youth who challenge social norms to protect their health.	www.reglo.org
India	Service delivery	Narayana Hrudayalaya (NH) Heart Hospital	Narayana Hrudayalaya is located in Bangalore and is one of the world's largest pediatric heart hospitals, performing approximately 24 open heart surgeries and 25 catheterization procedures a day, almost eight times the average at other Indian hospitals. NH is able to keep treatment costs low and quality of care high by implementing cost-saving methods, such as increasing the volume of patients served and accepting donations.	www.narayanahospitals.com
Rwanda	Service delivery	Phones for Health	Phones-for-Health is a \$10 million private-public partnership, which brings together the mobile phone industry, ministries of health, global health organizations, and other partners to use the widespread and increasing mobile phone coverage across developing countries to strengthen health systems. The system allows health workers to report data from the field which are made available to health authorities. The technology can also be used to order medicines, send alerts, and download guides.	www.pepfar.gov/press/80384.htm
Uganda	Service delivery	Nsambya Hospital	Nsambya is a tertiary referral hospital that aims to provide quality medical care to all at minimum cost without compromising the economically disadvantaged. It has a capacity of 361 beds. It is involved in patient care, research, and teaching.	Not available
Nepal	Service delivery	Tilganga Eye Care (TEC)	TEC is the implementing body of the Nepal Eye Program, a nonprofit, community-based, nongovernment organization that manufactures intraocular lenses locally and simplifies surgical techniques. Cost recovery is through cross-subsidization. TEC is taking training programs to different parts of the world.	www.tilganga.org
South Africa	Service delivery	On-Cue Compliance	On-Cue uses SMS text messages to remind patients with chronic conditions (including HIV and tuberculosis) to take their medication. The technology used to send out these messages is extremely low-cost; computer servers access the patient database every half hour to send messages to patients.	www.kiwanja.net/database/document/report_tb_compliance.pdf
Uganda	Service delivery	International Hospital	International Hospital uses a cross-subsidization model that provides free care to the poor in the Hope Ward, a 25-bed charity wing, funded by donors.	Not available
Various	Service delivery	Partners In Health (PIH)	PIH combines clinic- based care (hospitals and health centers) and community-based care (home visits and prevention campaigns) to bring quality healthcare to extremely poor, rural areas. It also engages in advocacy to change policy at top levels. In order to speed implementation in a new country, PIH adapts its model to be country specific.	www.pih.org

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Innovative Pro-Poor Healthcare Financing and Delivery Models

Location	Mechanism	Program	Description	Website
India	Service delivery	Bhagwan Mahaveer Viklang Sahayata Samiti (BMVSS)	Bhagwan Mahaveer Viklang Sahayata Samiti (BMVSS), Jaipur, was set up in 1975 as a nongovernmental organization that helps the physically challenged, particularly the financially weak among them. BMVSS provides artificial limbs, calipers, crutches, ambulatory aids such as wheelchairs, hand-paddled tricycles, and other aids and appliances free of charge to the physically challenged.	www.jaipurfoot.org
Ethiopia	Service delivery	Biruh Tesfah	Biruh Tesfah is a social franchise in Ethiopia with the mission of increasing access to reproductive and family planning services among women ages 10–19 who live away from their parents. It is a joint project of the Ethiopian Ministry of Youth and Sport and the Addis Ababa Youth and Sport Commission, with technical assistance from the Population Council and support from the Turner Foundation, the U.K. Department for International Development, and the United Nations Population Fund.	www.popcouncil.org
India	Service delivery	VisionSpring (formerly Scojo Foundation)	VisionSpring serves tens of thousands of poor customers in developing countries with affordable eyeglasses. Together with its partners, including some of the world's largest nongovernmental organizations and the most innovative base-of-the-pyramid organizations, VisionSpring is providing sustainable jobs and access to vision care to the world's poorest, most remote communities.	www.visionspring.org
Bangladesh	Service delivery	Jibon Tari	The Jibon Tari (Boat of Life) is a fully equipped hospital on a boat THAT takes medical care and surgery to restore sight, movement, and hearing to the very poorest people in remote communities of rural areas and offshore islands of Bangladesh.	www.impactfoundationbd.org/case_studies.html
Ghana South Africa	Service delivery	AngloGold Ashanti Health	AngloGold Ashanti sets up programs for employees that deal with the debilitating regional health threats: HIV/AIDS and tuberculosis management programs (identification, diagnosing, treatment, monitoring, and quality assurance) and malaria and cholera management. Treatment is free of charge.	www.ashantigold.com/default.htm
Nigeria	Service delivery	Mucas Hospital	A group practice combining several general practitioners and specialists based on an integrated network model (similar to Clinic Africa).	Not available
Peru	Service delivery	Redplan Salud	The program focuses on nurse-midwives and physicians to serve 30,000 women and their families living in five low-income districts of Lima. A network of midwives provides reproductive health products and services in an affordable and accessible way and receives free training.	www.inppares.org.pe/doc/Mrps.PDF
South Africa	Service delivery	Tsilitswa	The Tsilitwa Telehealth Project is a government-sponsored program that allows rural nurses to consult remotely with doctors on challenging cases by speaking and sending pictures through wireless telephony.	Not available
Tanzania	Service delivery	Nufaika	Nufaika combines pharmaceutical distribution with other consumer goods. It covers more than 5,000 outlets every month.	Not available
Various	Service delivery	Doc-in-a-Box	Doc-in-a-Box taps into the unrealized potential of nearly universally deliverable steel and aluminum containers and turns them into an instant primary care outpatient clinic, staffed daily by one or two paramedics drawn from the local community.	www.cfr.org/content/meetings/global_health_rt/doc_in_a_box.pdf
Various	Service delivery	Adopt-A-Doctor	The program aims to retain experienced physicians (reverse brain drain of doctors) in the poorest areas by increasing doctors' salaries, contingent on their agreement to stay in the country for at least seven years, and by providing a worldwide network through which doctors can access resources directly from donors. Donors are individuals and local community organizations.	www.adoptadoctor.org
Tanzania	Service delivery	APOPO	APOPO uses trained sniffer rats to detect tuberculosis bacteria-containing human sputum samples. A rat can evaluate 40 samples in 10 minutes, equal to what a skilled lab technician, using microscopy, can do in one day. Pilot research started in 2003.	www.apopo.org
India	Service delivery	Barefoot College	Barefoot College leverages the population and teaches young men and woman skills that are aimed at providing the basic health services that villagers need. Barefoot trains medical staff to assist and deliver care in remote areas. It also helps to implement health camps that address specific health needs. More than 200 health centers serve villages throughout India.	www.barefootcollege.org

Appendix B. Extended landscape of innovative models

Location	Mechanism	Program	Description	Website
Ghana	Service delivery	CareShops	CareShop is a franchise of licensed chemical sellers (retailers of over-the-counter drugs) designed to improve the quality, accessibility, and affordability of essential medicines across Ghana. Individual franchisees operate as profit centers, contractually bound by clearly defined, strict regulations on diagnosis, quality, and pricing of a specific list of drugs.	www.nextbillion.net/archive/files/CareShop%20Ghana.pdf
Kenya Rwanda	Service delivery	CFW (Child and Family Wellness)	The HealthStore Foundation's CFW model is a network of micro pharmacies and clinics whose mission is to provide access to essential medicines to marginalized populations in developing countries. The CFW outlets target the most common killer diseases, including malaria, respiratory infections, and dysentery, among others. They also provide health education and prevention services.	www.cfwhshops.org/overview.html
Uganda	Service delivery	Clear Seven	Clear Seven is a prepackaged treatment kit for men with urethral discharge in Uganda (contains a 14-day dose of tablets, condoms, partner referral cards, and an information leaflet in accordance with the Uganda sexually transmitted disease management guidelines). It promotes full-course treatment of sexually transmitted infections, supports condom use, strengthens partner referral, and provides health education.	www.who.int/inf-new/aids2.htm
Uganda	Service delivery	Clinic Africa	Clinic Africa is an integrated network of clinics providing primary and secondary care in both urban and rural areas in Uganda. Clinics are centrally owned but individually operated by local physicians. Physicians retain most profits (a small portion of urban clinics' profits are paid to cover in-country nongovernmental organization operations).	www.clinicafrika.org
Tanzania	Service delivery	Comprehensive Community Based Rehabilitation Tanzania (CCBRT)	CCBRT is a rehabilitation program based on a public-private partnership with the government. The government provides the land and pays the salaries. CCBRT manages the hospital and attracts international partners. Currently, 90% of patients are from very poor backgrounds.	www.ccbirt.or.tz
India	Service delivery	DISHA	The DISHA project is the first mobile telemedicine initiative conceived in India, combining imaging and medical diagnosis with satellite connectivity to offer online consultation. DISHA aims to improve the quality of family planning services by expanding the choice of contraceptive methods and improving the technical competence of personnel and promoting family planning by broadening support among leadership.	www.disha-india.org
Rwanda	Service delivery	D-Tree International	D-Tree provides healthcare workers with handheld devices to collect medical information and prescribe treatment.	www.d-tree.org
Honduras	Service delivery	Honduran Family Planning Association	This is a social marketing program that repackages and sells contraceptives to wholesalers who then redistribute products to pharmacies.	Not available
Tanzania	Service delivery	Kilombero and Ulanga Insecticide-Treated Net Project (KINET)	KINET is a social marketing scheme to promote the use of an sexually transmitted infection self-treatment kit (Clear Seven). The distribution system relies on the use of small retail outlets that are normally licensed to sell over-the-counter drugs but not antibiotics.	www.mimcom.org.uk/ifakara/KINET.htm
Uganda	Service delivery	Nsambya Hospital	Nsambya hospital was founded in 1903 as a Catholic Mission hospital providing specialist services in surgery, internal medicine, pediatrics, and obstetrics and gynecology. It pays special attention to women and children. It is a high-volume, low-cost practice with both general and private patient facilities.	Not available
Indonesia	Service delivery	PATH	PATH has developed a Uniject autodisposable injection device for vaccines (Hepatitis B) that is easy to use and has a one-way valve to expel the medicament and prevent uptake of other contents. Midwives are trained to use the vaccines in remote villages.	Not available
Various	Service delivery	Phones-for-Health	Phones-for-Health uses mobile phones to enter medical data, which allows governments to respond quickly to epidemics and help patients receive medical treatment faster. It takes advantage of Africa's surprisingly good mobile phone coverage. The data is used to build up national health information systems.	http://rwanda.usembassy.gov/feb_21_2007.html
Bolivia	Service delivery	ProSalud	PROSALUD's network of health services serves a population of 500,000 in nine periurban areas of Bolivia. The PROSALUD healthcare high-volume, low-cost delivery model can be described as a network of decentralized, multipurpose, and permanent clinics that provide integrated, comprehensive and continuous care.	www.pro-salud.org

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Innovative Pro-Poor Healthcare Financing and Delivery Models

Location	Mechanism	Program	Description	Website
Nigeria	Service delivery	R-Jolad Hospital	R-Jolad is a nonprofit, fully self-sustainable, physician-owned organization, including a hospital and clinic in Lagos. The hospital has high service volume, and its mission is to “serve the masses.”	http://rjoladhospitalnig.com
Brazil	Service delivery	Saude e Alegria (SA)	Saude e Alegria is a floating hospital that travels from village to village with a team of doctors, engineers, environmental experts, agronomists, and communications specialists. Using health as an entry point, SA began helping 16 communities improve their lives through solar-based electrification, environmental education, and access to information technology. It creates a health patrol in each community and trains individuals identified by the community in basic primary healthcare.	www.saudeealegria.org.br/portal/index.php
Uganda	Service delivery	Uganda Health Information Network	The network provides practitioners with real-time access to vital information through the use of personal digital assistants connected via the local GSM cellular telephone network. Provides consultation, real-time ordering of medicines, and access to medical journals.	http://pda.healthnet.org
Philippines	Service delivery	Well Family Mid-Wife Clinic	A network of private midwives who own and operate private midwife clinics. The clinics are mostly located in urban areas. Continuing training is provided to the providers.	www.wfmc.com.ph
India	Service delivery	Ziqitza Healthcare Services (1298) - Ambulance Access for All	Ambulance Access for All is an organization working to save lives by increasing awareness and education about the importance of emergency medical services. 1298 is the easy-to-dial number associated with this service. Patients are charged based on their ability to pay, and fees are cross-subsidized assuring financial sustainability	www.acumenfund.org/investment/1298.html
Bangladesh	Service delivery Risk-pooling	BRAC	The BRAC Micro Health Insurance for Poor Rural Women in Bangladesh (BRAC MHIB) started as a pilot project at Madhabdi in Narshingdi District in July 2001. Membership is open to all poor families living in its two areas of operation. The BRAC's Health Program offers beneficiaries access to three tiers of care: community health workers, a cadre of health paramedics, and a network of health clinics.	www.brac.net
Bangladesh	Service delivery Risk-pooling	Gonoshstha Kendra	GK provides a range of people-oriented healthcare services: their mobile clinics provide primary and school healthcare to rural communities; the 150-bed hospital provides a wide range of medical services for patients covered by GK's income-based health insurance program and the general public. The use of highly qualified paramedics ensures the delivery of health services to poor people living in rural areas	www.gkdb.org/aboutus.htm
India	Risk-pooling	BAIF	BAIF is a community-based health insurance scheme covering 1,500 women members living in the 22 villages around Uruli Kanchan Town. BAIF is the insurer and membership is voluntary.	www.baif.org.in/aspx_pages/recognition.asp
India	Risk-pooling	DHAN	DHAN is a community-based health insurance scheme with 19,040 members, mostly poor women members of the community banking scheme and living in the villages of Mayiladumparia block. Membership is voluntary, and the scheme is community-managed.	www.dhan.org/adhan.htm
India	Risk-pooling	Advasi Munnetra Sangam	Advasi Munnetra Sangam is a community-based health insurance scheme covering the population of a federation of village collectives initially formed to advocate land rights. First villagers contributed 2 rupees a year, then 4, then 8. By 2003 volunteers were able to collect 22 rupees a year.	Not available
India	Risk-pooling	Vimo SEWA	Vimo SEWA is an integrated insurance program aiming to provide social protection for SEWA members to cover their lifecycle. Vimo SEWA offers three different integrated insurance packages, which include coverage for death, sickness, and loss of assets. Under the hospital tie-up program, Vimo SEWA selects multispecialty hospitals run either by the government or by registered trusts. Private hospitals are included only after careful scrutiny of the quality of services provided.	www.sewainsurance.org
India	Risk-pooling	Shri Kshetra Dharamshala	The health insurance scheme was started by the Shri Kshetra Dharmasthala Rural Development Project, a local nongovernmental organization that had launched thousands of grassroots self-help groups. The scheme covers 77,000 people.	Not available

Appendix B. Extended landscape of innovative models

Location	Mechanism	Program	Description	Website
Pakistan	Risk-pooling	Adamjee	Adamjee, a commercial insurer, partners with National Rural Support Programme community organizations to provide hospital coverage to 500,000 rural poor. Adamjee brings size and experience to negotiate prices with hospitals. NRSP uses community institutions to market and deliver health insurance product.	www.adamjeeinsurance.com/contact_us.aspx
Peru	Risk-pooling	Servi Peru	ServiPeru is a former mutual insurance company that was forced to reinvent itself due to regulatory changes. Since it could not meet the higher capital requirements, it created a brokerage firm and a service delivery company (providing healthcare and funeral services).	www.serviperu.com
Uganda	Risk-pooling	The Cooperative Insurance CIC	CIC has partnered with the National Hospital Insurance Fund to provide a family package for inpatient services only in private, government, and mission hospitals. The CIC product is a comprehensive package that includes compensation in case of death and a weekly income for two years in case of total disability.	www.cic.co.ke
Uganda	Risk-pooling	Kadic Hospital	A 32-bed private hospital with approximately 5% profit margins serving middle-income patients in Kampala. It also serves low-income patients, primarily through outreach programs. Kadic first established an in-house insurance program to help patients finance healthcare at a time when most patients had no external source of insurance.	www.kadichealth.org
Kenya	Risk-pooling	CFC Life	CFC Life offers indemnity insurance with general insurance to the rural poor in Kenya with the aim of creating an insurance culture among the uninsured, informal sector. CFC believes that if properly scaled and managed, it can force efficiency gains within the network of service providers.	www.cfclife-kenya.com
Various	Risk-pooling	FINCA/AIG	In partnership with AIG, FINCA provides hundreds of thousands of clients with credit-life insurance. FINCA and AIG are exploring ways to bring other demand-driven products to clients such as health insurance and asset insurance.	www.villagebanking.org/site
Pakistan	Risk-pooling	Naya Jeevan for Kids	NJFK acts as intermediary between corporations and insurers in major urban areas. The model leverages existing distribution channels, driving down costs for corporations and end-users. Money goes into a large fund managed by an asset management company, making the model self-sustaining. The model allows corporations to enhance employee productivity and showcase corporate social responsibility.	http://njfk.org
India	Risk-pooling	Society for Elimination of Rural Poverty (SERP)	Under the SERP umbrella, there are a number of poverty reduction programs serving 630,000 members in India—these are community-based programs “run by the poor for the poor.” While there are several common threads that span the community programs, each community works to leverage the existing environment it faces.	http://203.200.212.139/SHG/
Rwanda	Risk-pooling	Mutuelles de Sante	To promote universal access to healthcare in post-genocide Rwanda, the government designed and implemented district-based health insurance schemes known as mutuelles de santé to raise revenue for health services for rural populations in a way that the population can afford. Services are provided through public, contracted facilities, and public providers are paid by mutuelles directly, either through monthly capitation rates, on a fee-for-service basis, or via (recently introduced) performance-based payments.	www.moh.gov.rw
Colombia	Regulation	Unified Accreditation System	The Colombian Ministry of Health established a registration system and later the Unified Accreditation System to improve quality and regulate the growing private medical sector. Law 100 modified health delivery in Colombia by changing subsidies to the supply side for a demand subsidy, which was proposed as a goal to attain universal coverage by 2001.	Not available
Zambia	Regulation	National Hospital Accreditation Program	Zambia is one of the first countries in Sub-Saharan Africa to launch a national hospital accreditation program. The country has successfully developed hospital standards that are relevant and potentially achievable by its hospitals. Half of Zambia’s 79 hospitals have received educational surveys, and 12 have also received the full accreditation survey.	www.qaproject.org/pubs/PDFs/zambiahosp.pdf

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Innovative Pro-Poor Healthcare Financing and Delivery Models

Location	Mechanism	Program	Description	Website
West Africa	Regulation	West Africa Drug Regulatory Authority Network (WADRAN)	The National Agency for Food and Drug Administration and Control of Nigeria has initiated the establishment of West African Drug Regulatory Authorities (WADRAN), with the aim of combating counterfeit drugs on a regional level through the exchange of information and strategies between countries and the creation of regionally harmonized regulatory efforts.	www.nafdacnigeria.org
Botswana	Supply chain	Sample Transportation	Sample Transportation aims to improve the logistic efficiency for laboratory testing (such as early infant HIV diagnosis and CD4 counts) by transporting samples to a central lab and faxing back results.	Not available
Ghana	Supply chain	Curatio	Curatio leverages excess capacity of other consumer product supply chains to reduce logistics cost of delivering to rural pharmacies that are set up in a franchise model. It also aims to deliver better margins at points of sale by providing an optimized mix of private labeled, generic, and branded products.	N/A
Ghana	Supply chain	Cell phone–assisted payment	Cell phone–assisted payment would enable people or organizations to make and receive payments without transporting money. This is particularly powerful when coupled with broader systems like national health insurance schemes for the purchase of goods and services and subsequent aggregation of money for transfer along the supply chain.	Not available
South Africa	Supply chain	Agent model for product registration	The program offers product registration services to pharma companies looking to access a particular market. It is able to build relevant knowledge of requirements as well as relationships.	Not available
South Africa	Supply chain	Disease monitoring and control hub	The disease monitoring and control hub would help identify trends and outbreaks and address them effectively by engaging both public and private sector health providers in South Africa.	Not available
South Africa	Supply chain	Allpay	The Allpay system (which uses a fingerprint reader and is currently used for the pension payouts) can be introduced in pharmacies as the system to identify the critically ill patients. It has the potential to improve monitoring of programs for critically ill people (such as distribution of antiretroviral drugs) and decrease traffic at hospitals.	Not available
Uganda	Supply chain	Vine Pharmacy	Vine Pharmacy is a growing pharmacy chain in Uganda with five outlets in urban Kampala and Entebbe. Vine Pharmacy is building a profitable chain and projects to grow at 23% a year over the next three to five years. Expansion to date has been largely internally financed.	Not available
Various	Supply chain	Riders for Health	Riders for Health is a nongovernmental organization providing healthcare to rural villages using motor vehicles. It employs 200 people in Africa and runs more than 1,000 vehicles, enabling health workers to reach more than 10 million people in rural areas. It runs in Gambia, Kenya, Lesotho, Nigeria, Tanzania, and Zimbabwe.	www.riders.org
Various	Supply chain	Affordable Medicines to Africa (AFMA)	AMFA operates as a social outreach program partner with Hollard Insurance Group, South Africa's largest independent insurance company. The results of AFMA's reduced lead times are less product obsolescence and lower inventory costs.	www.amfa.co.za
Bangladesh	Contracting	Urban Primary Health Care Project I & II (UPHCP)	UPHCP promotes improved access to and use of efficient, effective, and sustainable good-quality primary healthcare services for the poor in urban areas covered, with a particular focus on women and girls. Approximately 2.8 million clients (2.1 million female and 0.7 million male) attended UPHCP-II clinics from the start of the second phase in July 2005.	www.adb.org/Documents/Reports/Validation/BAN/in212-08.pdf
Cambodia	Contracting	Basic Health Services Project	This project is located in Cambodia's Kampong Cham Province and works with the Cambodian government to provide basic healthcare services in the districts of Memut and Cheung Prey. The project pilots two models for health service provision, allowing a comparison of two management styles: contracting out in Memut, where it recruits, manages, and trains all district health staff, and contracting in in Cheung Prey, where it trains and manages the district health staff already employed by Cambodia's Department of Health.	www.adb.org/Documents/PCRs/CAM/pcr_cam_27410.pdf

Notes

1. *Private health sector* is defined as all non-government actors in healthcare, including individuals and organizations engaging in nonprofit or for-profit work.
2. Nishtar 2007.
3. The longer list of landscaped programs is included in appendix A.
4. Montagu 2002; Hanson 2004; Marek et al. 2005; Berg 2000; Berg and Meeker 2005; Ruster, Yamamoto, and Rogo 2003; Brown and Chruchill 1999, 2000; Prata, Montagu, and Jefferys 2005; Huntington, Sulzbach, and O'Hanlon 2007; Brugha and Zwi 1998; Preker, Harding, and Travis 2000; Loevinsohn 2002; England 2004; Preker and Dror 2002; Bishai et al. 2008; PSP-One; HLSP Institute; CGAP Working Group on Microinsurance; and others
5. Brugha 2003; Loevinsohn 2006; Hanson 2004; Montagu et al. 2005; PSP-One; The Global Fund; PEPFAR; and others
6. *Nonstate* refers to all nongovernmental actors: domestic and international not-for-profit and for-profit organizations, professional organizations, bilateral and multilateral donor agencies, and civil society.
7. The companion report further explores how achieving these goals can support government stewardship.
8. www.censusindia.gov.in/Census_Data_2001/India_at_glance/rural.aspx
9. WHO 2004.
10. BRAC University, James P. Grant School of Public Health, 2009.
11. www.unicef.org/infobycountry/india_statistics.html#62
12. www.who.int/whosis/mort/profiles/mort_searo_ind_india.pdf
13. www.unicef.org/infobycountry/india_india_statistics.html#24
14. www.unicef.org/infobycountry/india_india_statistics.html#24
15. Van der Gaag and Wright, 2008
16. WHO 2006.
17. Loevinsohn 2008.

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A companion to *Public Stewardship of Private Providers in Mixed Health Systems*, this report by the Results for Development Institute, sponsored by the Rockefeller Foundation, describes 33 innovative financing and delivery programs selected based on their relevance to broader health systems and potential to achieve positive impact for poor people. While these programs range from donor-driven initiatives to large-scale government-subsidized efforts to for-profit businesses, they all involve active participation by the private health sector.

The report identifies five financing and delivery mechanisms as key instruments of mixed health systems that can improve access to, availability of, and quality of health services:

- *Service delivery mechanisms* to improve quality of and access to healthcare services.
- *Risk-pooling mechanisms* to improve access to health services and strengthen financial protection.
- *Government and provider self-regulation mechanisms* to improve quality by setting and enforcing standards.
- *Provider purchasing and contracting mechanisms* to promote quality and availability of health services.
- *Supply chain mechanisms* to enable rapid scale-up, consistent quality, and improved access.

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