INCLUSIVE INNOVATIONS

Reaching the Poor through Community Health Workers

HIGHLIGHTS

- Community health workers bring affordable health-related goods and services to the homes of people in underserved communities that have poor access to basic health services.
- Programs have reduced morbidity and mortality and increased the communities' use of health services.
- Most programs rely on donor funding.

Development Challenge

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

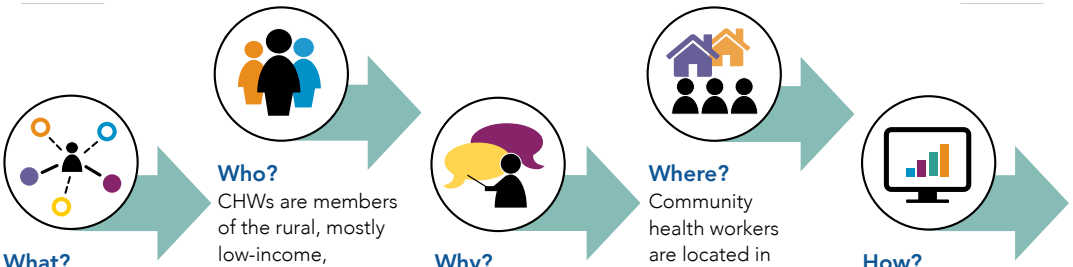
Business Model

Community health workers (CHWs)—largely local women, provided with only basic training—are providing health information, reminders, and basic healthcare services; selling health-related products, including medicines; and collecting valuable healthcare data. By going door to door to reach people, they are improving health outcomes among the rural poor, who are often unable to reach healthcare facilities.

CHWs are people from the community with some education who receive brief training. Although they can include men, most are women. Arogya, an Indian enterprise, recruits only young women with secondary education. The Real Medicine Foundation, which also works in India, places emphasis on local, rather than formal, knowledge.

Staff at local health facilities often supervise, mentor, and motivate CHWs, who refer patients to them. M-Afya gives local clinicians ownership stakes in kiosks the enterprise operates. Arogya partners with the Fortis Hospital chain, which co-develops the training of CHWs, provides pro bono consultations, and reviews the services provided by its physicians.

Features of the Community Health Care Worker Model



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

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

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

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

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

Implementation: Delivering Value to the Poor

Awareness

CHWs create awareness through health education and promotion and the creation of demand for specific health services. They have played a crucial role in building demand for reproductive health services in rural India, helping the Merrygold network expand, for example.

Acceptance

The model aims to maximize community acceptance in a number of ways. Arogya workers receive communication training that emphasizes the use of the local vernacular. It uses the term *panna* (named after a 16th century inspirational nursemaid) rather than *health worker*, which it believes lacks dignity. It uses television series and Bollywood films to impart patient-communication skills to *pannas*. Arogya also increases acceptance by hiring young people, who need the work.

Accessibility

By coming to where people live, including their homes, CHWs overcome the challenges and barriers faced by communities in accessing care. Living Goods' health entrepreneurs, Arogya's *pannas*, SAJIDA's *sajida bandhus*, and Bandhan Health's health volunteers all provide door-to-door services. M-Afya provides care through kiosks. The Real Medicine Foundation's community nutrition educators link families to services they are either underutilizing or unaware of, while providing service providers with inputs.

Affordability

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

CHWs receive salaries, stipends, or results-based payments or fees. They are also motivated by nonfinancial incentives, including mobile phones, free or preferential access to commodities, social interaction with peers, help transitioning into national health service or work with an NGO, and priority for paid jobs in health campaigns such as immunization days.

Social enterprises, such as Living Goods and M-Afya in Africa, offer income-generation opportunities through the sale of commodities. In addition to providing health education, its workers sell health-related products; personal care products; and products that support household income or savings (such as solar lanterns and high-yield seeds).

Mobile technology plays an important role in empowering CHWs. It facilitates patient monitoring, allows for the application of computerized treatment protocols, supports the collection and analysis of patient data, enables the sharing of patient data with health facilities, promotes results transparency and performance management, and reduces costs.

Results and Effectiveness

CommCare, which operates in India and South Africa, engages thousands of CHWs, serving up to one million beneficiaries. Living Goods reports that it has supported 154,000 pregnancies, treated 564,000 children for potentially deadly diseases, and sold more than 58,000 clean-burning cook stoves since 2007.

Robust evidence indicates that CHWs can contribute to improved health outcomes. A randomized controlled trial evaluation found that Living Goods reduced mortality among children under five by 25 percent and increased the likelihood of home visits in the first seven days after delivery by 72 percent.

Standardization and separability are instrumental to making the model cost-effective. Standardization allows tasks to be shifted from higher-qualified professionals to CHWs with little formal training. Medical conditions for which diagnosis and treatment are highly standardized, such as diarrhea and malaria, lend themselves to being delegated to CHWs. Separability means that a task can be performed without equipment and supplies, allowing services to provide at home.

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

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This series on Inclusive Innovations explores business models that improve the lives of those living in poverty. Editors are Elaine Tinsley and Natalia Agapitova. Written and researched by Endeva and Ashley Insight with additional contributions by Madhusmita Hazarika. *June 2017*