



Center for  
Health Market Innovations

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**HIGHLIGHTS: 2011**

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## Center for Health Market Innovations

### ABOUT THE CENTER FOR HEALTH MARKET INNOVATIONS:

The Center for Health Market Innovations (CHMI) accelerates innovative health initiatives by informing and connecting program managers, funders, researchers, and policy makers who strive to create better health markets for the poor. CHMI is the world's largest freely accessible web platform on programs improving the access, quality, and affordability of privately delivered health care for the poor. Funded by the Bill & Melinda Gates Foundation and the Rockefeller Foundation, CHMI is a [global network of partners](#) coordinated by the Results for Development Institute.

### ABOUT THIS REPORT:

This report was compiled by the Center for Health Market Innovations team at the Results for Development Institute with contributions from CHMI partners (below). Maria Belenky, Donika Dimovska, Gina Lagomarsino, Trevor Lewis, and Rose Reis contributed content. The observations highlighted in this report are valid as of September 2011. For more up-to-date figures, please visit [www.HealthMarketInnovations.org](http://www.HealthMarketInnovations.org).



Dear Colleagues,

In July 2010, we launched the Center for Health Market Innovations (CHMI; [www.healthmarketinnovations.org](http://www.healthmarketinnovations.org)). Today, with more than 75,000 visitors from 190 countries, CHMI is the world's largest freely accessible web platform on programs improving the access, quality, and affordability of privately delivered health care for the poor.

This report highlights key observations about innovative, market-based health programs based on CHMI's initial phase of operation. We hope you will find this information useful in advancing your work.

Our recent progress includes:

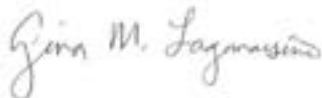
- **Over 1000 promising Health Market Innovations identified in more than 100 countries.** CHMI's [partners](#) in 16 countries identify programs that are aggregated on our [website](#) in an interactive, downloadable [Programs Database](#).
- **Reported Results initiative launched to discover what's working.** CHMI is beginning to create an evidence base to identify effective programs through our new [Reported Results](#) initiative. [Programs now report their results](#) in such areas as quality, cost, and efficiency.
- **New insights about health markets.** We've identified promising practices and [new program models spreading](#) around the world. CHMI also commissions research about market challenges like [drug quality in India](#) and [informal providers](#) practicing in Bangladesh, India, and Nigeria.
- **Networks of key stakeholders created.** More than 300 program managers, funders, researchers, and policy makers have attended CHMI events in [Indonesia](#), [Brazil](#), [Pakistan](#), the [Philippines](#), and [Kenya](#) to discuss innovations in their countries.

CHMI will continue to identify and analyze market-based innovations and connect people to facilitate the scale up of what's working. We invite you to:

- **Learn more about new market-based programs.** [Search our Programs Database](#) to locate health initiatives by Program Type, Health Focus, Target Population, or Legal Status. **Know of an innovative program?** [Add a new program profile](#), [update a listing](#), or write about it on the [CHMI Blog](#).
- **Let us know what works.** [Report results](#) for programs that you manage, fund, or study.
- **Connect with innovators.** [Join CHMI to directly contact](#) people running programs listed in [CHMI's database](#). Have conversations with the Health Market Innovations community on [CHMI's Blog](#).
- **Download our data.** The CHMI database is freely available for the public. Use CHMI filters to [browse the Programs Database](#) for a slice of interest, or [download the entire database](#) to conduct analysis.

We welcome your suggestions and feedback and look forward to sharing future updates on topics relevant to health markets in developing countries.

Sincerely,



Gina Lagomarsino  
Results for Development Institute (R4D)  
On behalf of the CHMI Network

# TABLE OF CONTENTS

## 5 MAPPING HEALTH MARKET INNOVATIONS

## 7 OVERVIEW OF HEALTH MARKET INNOVATIONS

## 10 OBSERVATIONS ABOUT HEALTH MARKETS

- 10 Organizing private providers to deliver priority health interventions
- 12 Giving purchasing power to the poor
- 14 Using technology to improve access, quality, and efficiency of care
- 18 Funding for innovative programs

## 20 FIVE INNOVATIVE MODELS APPEARING AROUND THE WORLD

## 24 BUILDING THE EVIDENCE BASE ABOUT WHAT WORKS

## 26 CREATING A GLOBAL NETWORK

- 26 Personal connections
- 26 Virtual connections

## 28 USE CHMI TO SUPPORT YOUR WORK

# MAPPING HEALTH MARKET INNOVATIONS

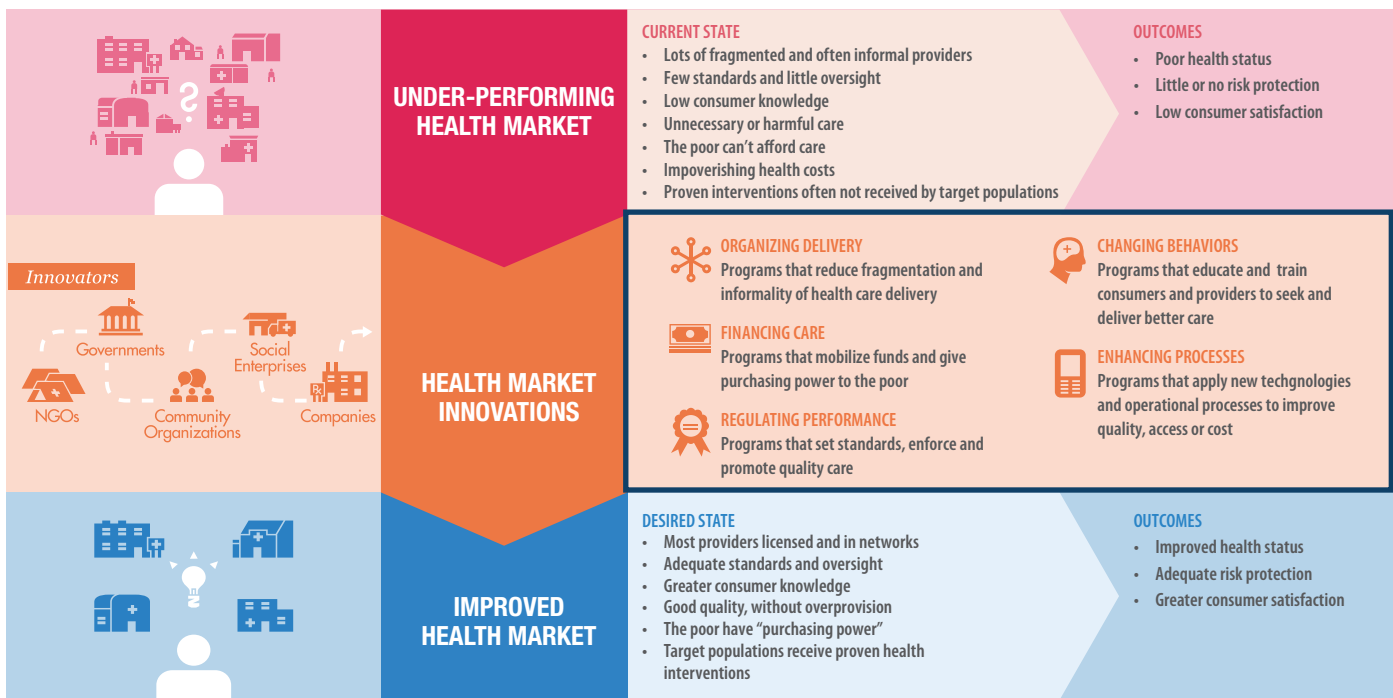
The Center for Health Market Innovations (CHMI) was established in 2010 to accelerate innovative health initiatives around the world by informing and connecting program managers, funders, researchers, and policy makers who strive to create better health markets for the poor. CHMI's long-term aspiration is to improve the access, quality, and affordability of privately delivered health care for the poor.

CHMI works through a network of in-country partners<sup>1</sup> to identify, document, and promote the diffusion of **Health Market Innovations**. These are promising programs and policies—implemented by governments, non-governmental organizations (NGOs), social entrepreneurs, or private companies—that have the potential to improve the way health markets operate for the poor.

## WHY FOCUS ON IMPROVING HEALTH MARKETS?

- **Health markets are big.** In many countries, most health care expenditures occur through private transactions—even when governments offer free care at public facilities. In at least 17 countries in Asia and 16 countries in Africa, more than half of all health spending is made up of out-of-pocket payments from consumers.<sup>2</sup>
- **The poor often rely on health markets.** In most developing countries, the poor rely on private health care providers for a large portion of their care. In Sub-Saharan Africa and South Asia, they use the private sector just as much as the rich.
- **Health markets can create many challenges.** Patients do not always seek the kind of care that will make them healthier, and providers do not always act in patients' best interests.<sup>4</sup> Appropriate care is often expensive and pushes people further into poverty. According to the World Health Organization, each year, 150 million people globally face severe financial hardship, 100 million are forced into poverty, and many forgo or delay care because they lack financial resources.<sup>3</sup>
- **Health markets can be harnessed to improve health for the poor.** When well-monitored and regulated, health markets can be a source of creative new approaches with the potential to achieve greater efficiencies, improved quality, and increased access to care for underserved populations.

**Figure 1:** CHMI documents five types of Health Market Innovations



CHMI documents five categories of Health Market Innovations: **Organizing Delivery, Financing Care, Regulating Performance, Changing Behaviors, and Enhancing Processes** (Figure 1). Examples of programs CHMI catalogues include social franchising programs that provide high-quality private health services, voucher programs that help poor consumers pay for care, and accreditation standards that establish quality norms and monitor providers. See [CHMI Definitions](#) for complete descriptions of documented program types.<sup>5</sup>

CHMI's web hub, [www.healthmarketinnovations.org](http://www.healthmarketinnovations.org), is the largest virtual resource of information on Health Market Innovations. CHMI's free, publicly available [Programs Database](#) currently offers interactive and comparable information about more than 1000 programs. Web visitors search in categories like **Program Type, Health Focus, Country of Operation, Target Population, Source of Funding, and Technology Used**.

The database is maintained by partner organizations in 16 countries<sup>6</sup> and the global health community—including program managers, funders, and researchers—through web-based program submissions and updates. All submissions and updates are reviewed by the CHMI team for quality and relevance. For information about the CHMI data collection process, visit [www.healthmarketinnovations.org/about/chmi-approach](http://www.healthmarketinnovations.org/about/chmi-approach).

CHMI strives to provide accurate and timely information on health marketplaces. The data can help illuminate what's working and facilitate the scale up and replication of successful initiatives. This report shares initial insights and highlights from CHMI's first phase.

# OVERVIEW OF HEALTH MARKET INNOVATIONS

The CHMI database contains online profiles of more than 1000 programs and policies with the potential to improve the quality and affordability of privately delivered health care for the poor in low- and middle-income countries (Figure 2). Each profile provides information about the program's operational design, including health focus areas, targeted populations, funding sources, and where available, results to date. **In the aggregate, CHMI program profiles yield macro-level information about innovations in health markets globally.** With the collection of data over time, CHMI will continue to identify, analyze, and report on Health Market Innovations and provide insights into patterns observed.

**Figure 2:** CHMI Database Overview (September 2011)

Number of Profiled Programs	1015
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Number of Countries represented	107
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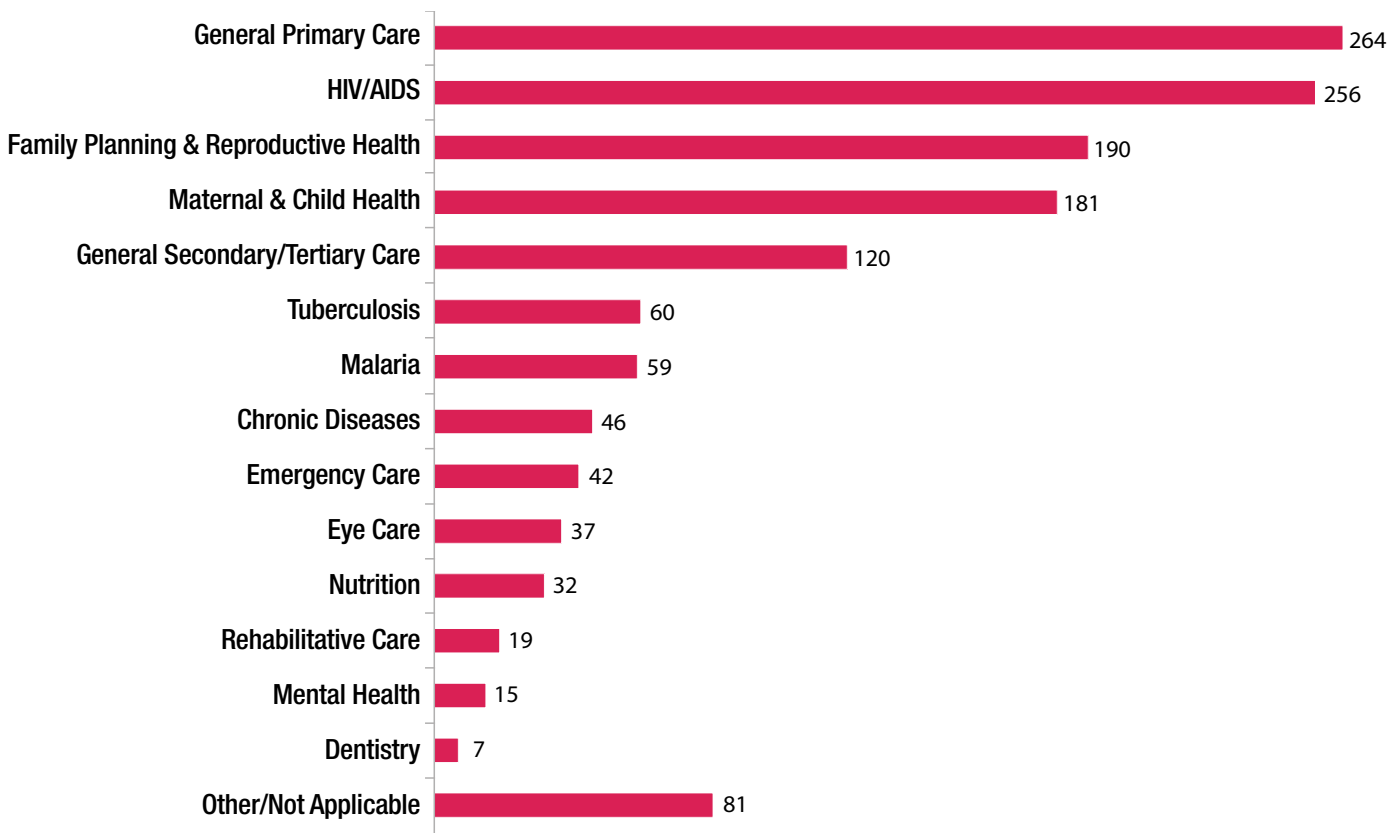
- **Program Type:** CHMI's first year of scanning has yielded more than 1000 programs in 107 countries. Most programs organize delivery, change consumer and provider behavior, or enhance operational processes (Figure 3); some multi-faceted programs do all three. Programs that leverage information technology for health represent more than a quarter of all documented programs.

**Figure 3:** Number of CHMI Programs by program type\*



\*Some programs are categorized into more than one program type.

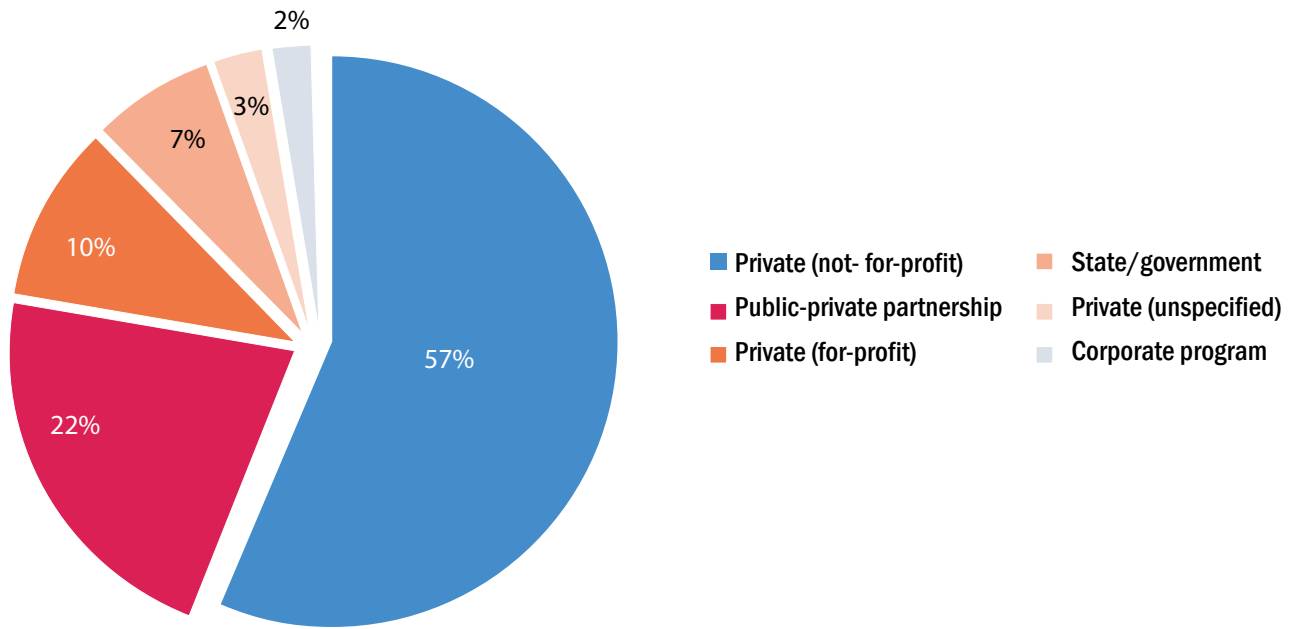
**Figure 4:** Number of CHMI-profiled programs by health focus



- **Health Focus:** Health Market Innovations cover a wide array of health areas. Programs focusing on general primary care are prevalent among those profiled by CHMI in its first year. Programs targeting HIV/AIDS, family planning and reproductive health, and maternal and child health make up about half of the database. CHMI identified fewer market-based programs focusing on infectious diseases such as malaria and tuberculosis, though some large and influential initiatives, such as the [Affordable Medicines Facility for Malaria \(AMFM\)](#) have recently launched.<sup>7</sup> Chronic disease care, emergency care, eye care, nutrition, dental care, rehabilitative care, and mental health were also identified as areas of market-based activity in health (Figure 4).
- **Legal Status:** A little over half of CHMI-profiled programs are operated by private, not-for-profit organizations, and one out of five operates as a public-private partnership. Pro-poor, for-profit health care models represent 10% of the database. Programs in this category are largely service delivery organizations (e.g., hospital chains and retail pharmacies) and technology-enabled programs (e.g., telemedicine networks and health hotlines). Government-led initiatives such as health financing programs and accreditation policies make up 7% of all profiled innovations (Figure 5).
- **Country of Operation:** CHMI has identified innovation in all regions, particularly in South Asia and East Africa, with many programs in [India](#) and [Kenya](#), reflecting high private-sector activity as well as the presence of CHMI partners. However, a variety of innovative models can be found across all countries scanned by CHMI: from [Vietnam](#) to [Uganda](#), from [Pakistan](#) to [Peru](#), and from [Indonesia](#) to [Brazil](#) (Figure 6). An interactive map of all CHMI programs is online at [tinyurl.com/CHMImap](http://tinyurl.com/CHMImap).



**Figure 5:** Percentage of CHMI-profiled programs by legal status



**Figure 6:** Geographic distribution of programs\*



\* Numbers and sizes of dots indicate number of programs by country. An interactive version of the map can be found online at [www.healthmarketinnovations.org](http://www.healthmarketinnovations.org).

# OBSERVATIONS ABOUT HEALTH MARKETS

## Organizing private providers to deliver priority health interventions

More than 300 programs in the CHMI database, or about one-third of all programs profiled, are categorized as **Organizing Delivery**. These programs work to overcome the challenges of inaccessible, unaffordable, or poor-quality health services in low- and middle-income countries. A common strategy includes organizing small-scale, unconnected private providers into networks to train and regulate them and to introduce innovative technologies and payment systems. Other programs focus on standardizing processes to improve their efficiency and quality (many of these programs are also categorized as Enhancing Processes). Programs in the Organizing Delivery category include social franchises, service delivery networks and chains, pro-poor hospitals and clinics, retail pharmacies, and integrated delivery systems. Figure 7 shows how each of these mechanisms breaks down by health focus. Descriptions of the three most common ways programs organize care to better deliver priority health interventions are as follows:

**Figure 7:** Number of programs organizing delivery by health focus



- **Social franchises.** CHMI documents over 60 social franchises operating in over 30 countries around the world. Franchising has gained popularity in recent years as an effective mechanism to organize independent private providers to offer a range of quality health services. Family planning and reproductive health services are key areas of focus for most documented franchises, but many programs are beginning to expand beyond these two areas, leveraging their platforms to deliver TB, HIV/AIDS, and malaria interventions. Franchises are also emerging as a potential service delivery mechanism for the screening and treatment of chronic diseases. In Myanmar, [Sun Quality Health](#) is beginning to offer low-cost cervical cancer screenings and cryotherapy (the use of cold temperatures to destroy abnormal tissue) through its network of franchised clinics. Similar initiatives are underway in Kenya and Uganda.<sup>8</sup>
- **Affordable provider chains.** Over 150 programs documented by CHMI are service delivery chains managing multiple sites that rely on standardized operational processes. The majority of these programs provide general primary care at rates affordable to the poor—[Akhawat Clinics](#) in Pakistan and [Kriti Arogyam Kendram](#) in India are two recently launched examples of this model. Other chains choose to focus on low-cost specialized services. [Jacaranda Health](#) in Kenya and [LifeSpring](#) in India provide safe delivery services. [Eye-Q Hospitals](#) in India and [ASEMBIS](#) in Costa Rica offer eye care services while [Sorridents](#) and [Dentista do Bem](#) provide dental care in Brazil.
- **Pro-poor hospitals and clinics.** Close to 90 programs in the CHMI database are standalone hospitals and clinics that aspire to serve the poor. Many of these programs work in the areas of chronic disease and secondary and tertiary care, but a large number also provide general primary care and maternal and child health services. Specialized service models such as [Narayana Hrudayalaya Cardiac Hospital](#) in India, the [NICE Foundation Institute of Newborn Care](#) also in India, and the [Lumbini Eye Institute](#) in Nepal use standardized operational processes to allow more patients to receive care while keeping costs low. Some of these institutions pair the high-volume approach with cross subsidization, directing revenue from wealthy patients to cover the cost of care for the poor.

More information about innovative delivery models, including retail pharmacy chains, telemedicine models, affordable primary care models, and health hotlines, is provided on page 20.



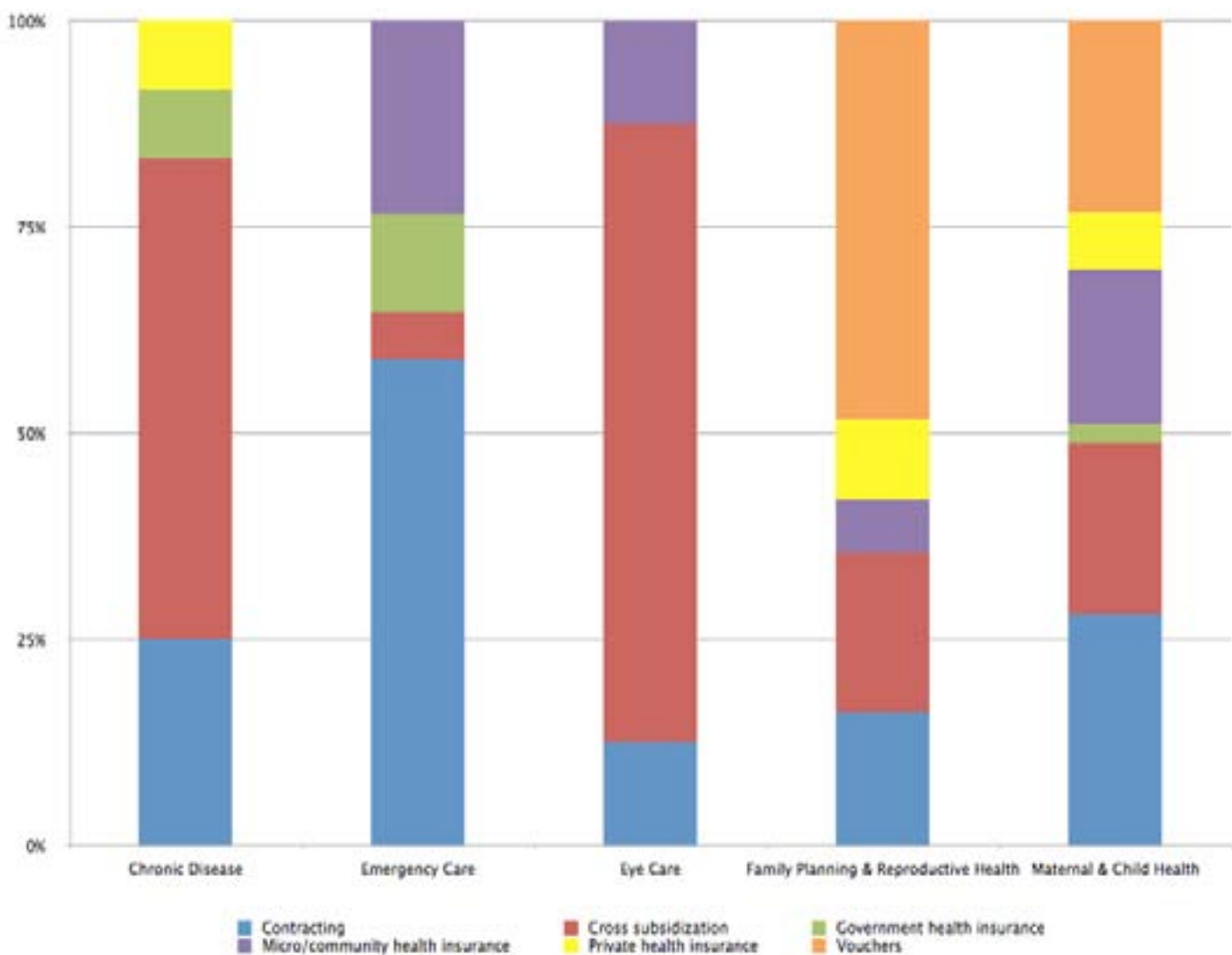
Providers treat the poor alongside the rich in the NICE Foundation Institute of Newborn Care in Hyderabad, India.

## Giving purchasing power to the poor

Approximately 200 programs in the CHMI database are categorized as **Financing Care** (Figure 8). Demand-side financing programs such as **government health insurance, private insurance, micro and community health insurance, and vouchers** decrease financial barriers to care by enabling consumers to access services from their choice of provider, who is then reimbursed. Other financing tools include **contracting**, a supply-side intervention that channels government funds directly to selected private providers to expand their reach, **cross-subsidization**, making care affordable for the poor by channeling funds from wealthier patients, and **mHealth savings** programs that encourage consumers to save for future health care needs, often through cell phone payment plans. Figure 8 shows how programs use different kinds of financing tools to improve access to health services for the poor.

A closer look at five common types of financing care programs documented by CHMI provides more insight into promising initiatives that help poor families to pay for care:

**Figure 8:** Percentage of programs financing care by select health focus areas



- **Government health insurance.** CHMI profiles 27 national insurance schemes that target the poor to move toward universal health coverage. While some schemes, such as Ghana's [National Health Insurance Scheme](#) and Indonesia's [Jamkesmas](#), offer comprehensive benefits, others—such as India's [RSBY scheme](#), the Philippines's [PhilHealth](#),<sup>9</sup> and Kenya's [National Hospital Insurance Fund](#)—cover primarily inpatient services, though each of these schemes is now working to expand to outpatient benefits. (The [Joint Learning Network for Universal Health Coverage](#) has produced case studies on national health insurance reforms being implemented by low- and middle-income countries.<sup>10</sup>)
- **Micro and community health insurance.** CHMI documents 53 micro and community health insurance programs. They are common throughout parts of Sub-Saharan Africa, South Asia, and Latin America. Though they remain small in scale, schemes such as those offered by [MicroEnsure](#), which recently expanded into Tanzania, and [SKY Microinsurance](#), operating in Cambodia since 2007, often target specific geographic or economically linked communities like farmers' cooperatives. Micro health insurance programs may have the potential to complement or become integrated with national schemes. Twenty-two programs are **pro-poor, private insurance schemes**, allowing employers, various organized groups, and families to purchase health insurance at low rates.
- **Cross-subsidization.** Forty-two programs use this popular pro-poor pricing model that redirects revenue from wealthy patients to cover those unable to pay. Specialty eye hospitals, such as [Aravind](#) and [L. V. Prasad Eye Institute](#) in India, offer vision screening and treatment at tiered rates so that better off patients subsidize the care of lower income patients. Cross-subsidization is also commonly used to provide access to chronic diseases and in-patient health services.
- **Vouchers.** Twenty-nine programs use vouchers to help the poor access reproductive health and maternal and child-care services. Of all CHMI-profiled programs financing reproductive health services, about 50% are vouchers that women can redeem for services like family planning. Of all financing programs improving access to maternal and child care, about 25% are voucher programs. While they are still small in scale, the number of CHMI-profiled voucher programs launched after 2006 is more than double the number of voucher programs started between 2000 and 2006. The [Kenya Output-Based Aid Voucher Program](#) for family planning and reproductive health services is a well-known example of this model.
- **Government contracting.** CHMI profiles 73 programs that contract with private providers. Contracting is often used to finance emergency care, particularly in India where state governments have contracted companies such as Ziqitza—or groups of private providers such as the Janani Express model in Madhya Pradesh—to operate ambulance networks. Contracting is also often used to expand the availability of key health interventions such as basic primary care and maternal and child health services, health areas accounting for half of all contracting initiatives. In Bangladesh, the government implements the [Urban Primary Health Care Project](#), which contracts out primary health care services to non-governmental organizations working in low-income urban areas.

## Using technology to improve access, quality, and efficiency of care

eHealth, the use of information and communication technology for health, has become increasingly common in recent years. CHMI has identified more than 260 “technology-enabled” programs, such as a health insurance scheme whose client interactions are entirely through smart cards and primary care clinics that use cell phones for patient follow-ups. CHMI analyzed these 260 programs to better understand the types of technologies most commonly used and the reasons technology was employed. These programs can be found worldwide with larger clusters in South and Southeast Asia and East Africa (Figure 9).

### Devices That Programs Use

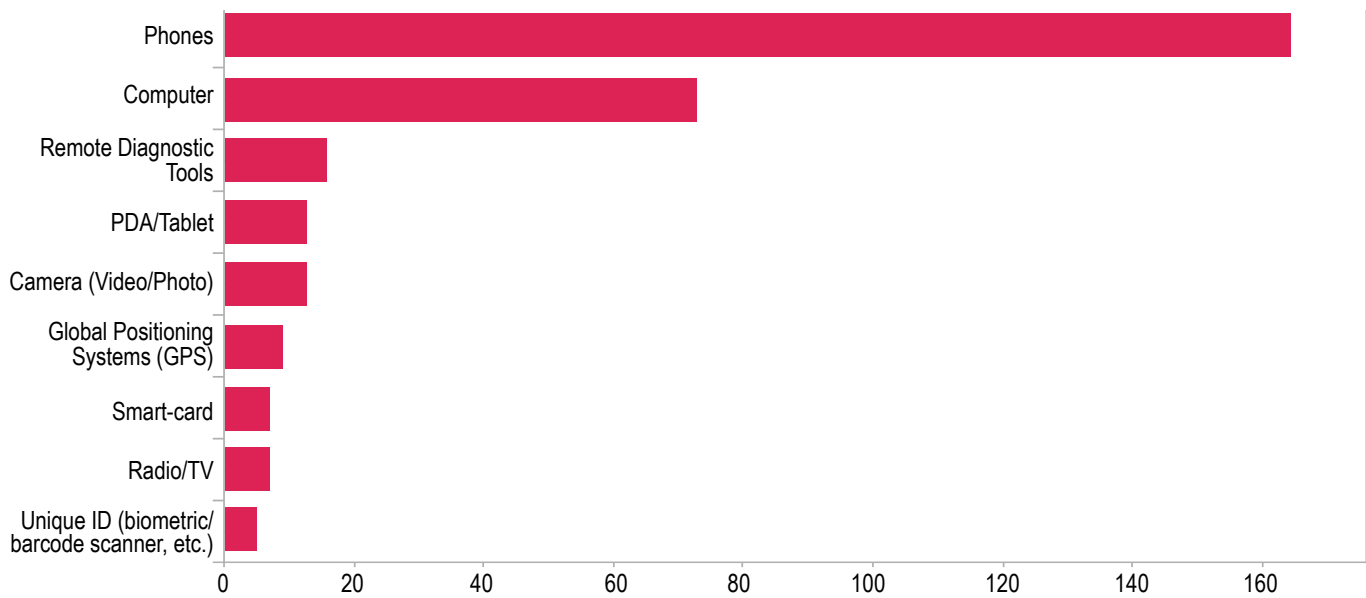
In recent years, mHealth, the use of mobile technologies for health, has sparked much interest due to the penetration of cell phones in developing countries. As Figure 10 shows, the cell phone is the most commonly used device, but programs also use other devices. [Operation ASHA](#) uses fingerprint scanners to help monitor compliance with TB treatment. [Comprehensive Medical Emergency Response Services](#) in Punjab, India, uses GPS to coordinate its ambulances. [Changamka](#) uses smart cards to help pregnant women save for care.

**Figure 9:** Geographic distribution of programs using technology\*



\*The size of the dots indicates number programs by country. An interactive version of the map can be found online at [www.healthmarketinnovations.org](http://www.healthmarketinnovations.org).

**Figure 10:** Number of technology-enabled programs by type of device used



In the Philippines, Felipe Canlas teaches nurses how to use a new electronic medical record system, Wireless Access for Health.

## How technology improves program effectiveness

eHealth has garnered much interest from the global health community in recent years, yet there has not been a systematic effort to examine why health programs use technology. CHMI identified six reasons programs choose to use technology (Figure 11). Increasingly, program managers and policy makers can use technology to improve program effectiveness in these areas.

- Many programs extend **geographic access to care** by connecting remote rural populations to trained health professionals in urban areas. [OTTET Telemedicine](#) in India enables doctor visits via video. Medical help lines, such as [Healthline](#) in Bangladesh and [MeraDoctor](#) in India, provide phone access to health professionals (more examples can be found on p. 23).
- Programs such as [Cell-PREVEN](#) in Peru, [GATHER](#) in Uganda, and [Handhelds for Health](#) in India **improve data collection and management** by replacing paper forms with remote data collection devices and software.
- [WelTel](#) in Kenya and other similar programs use text messages to **facilitate patient communications** by allowing health professionals to maintain contact with patients outside of traditional office visits.
- [D-Tree International](#) and others use clinical decision support software to **improve diagnosis and treatment** of minimally trained health workers.
- Programs aiming to **mitigate fraud and abuse** through the use of innovative technologies are beginning to appear. Initiatives using cell phones to help detect counterfeit medications, such as [Unique Identification Mobile Verification](#), [Sproxil](#), and [mPedigree](#), have launched recently.
- A handful of programs such as [Mamakiba](#) in Kenya, which uses text messaging to help women save money for health care during pregnancy, **streamline financial transactions** by enabling payment for care.



A nurse in the Philippines uses Wireless Access for Health to pull up patient records. It is an enhancement to the CHITS electronic record system, which decreases record retrieval time.



## Figure 11: Six reasons health programs use information technology

### 1. EXTENDING GEOGRAPHIC ACCESS

Technology is used to overcome distance between doctor and patient and replaces a traditional visit to the doctor. It includes what is often called telemedicine. Examples include videoconferencing with patients in rural areas, automated helplines, and instant messaging with a health practitioner for medical advice.

### 2. FACILITATING PATIENT COMMUNICATIONS

Technology is used to facilitate communications between health workers/programs and patients outside of regular visits. Examples include using technology for general health education, texting patients to encourage drug compliance and to follow up after an appointment. Subcategories in CHMI's database include:

- General health education
- Encouraging patient compliance
- Protecting patient privacy

### 3. IMPROVING DATA MANAGEMENT

Technology is used to improve the collection, organization or analysis of data, resulting in increased speed, enhanced transmission of data, and the enabling of remote collection. Examples include using PDAs to electronically collect information about certain diseases or for tracking patient records. Subcategories in CHMI's database include:

- Data collection
- Data organization and analysis

### 4. IMPROVING DIAGNOSIS AND TREATMENT

Technology is used to allow a health worker to improve clinical performance, during training or in real-time in the field. Examples include the use of technology to enhance actual training or connect health workers to a clinical decision-support application to assist with patient diagnosis.

### 5. STREAMLINING FINANCIAL TRANSACTIONS

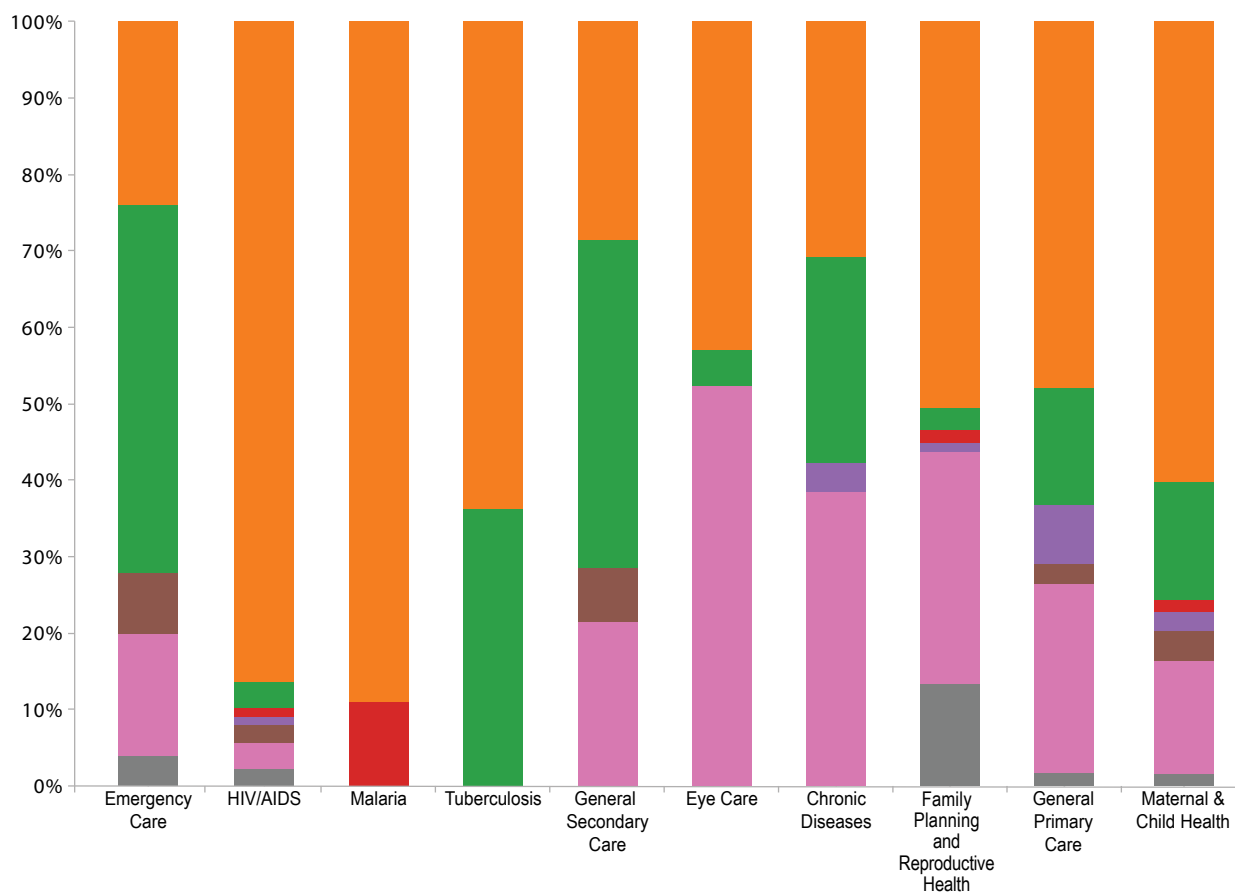
Technology is used to increase the efficiency of financial transactions, allowing the patient to pay for care more easily and the doctor to receive payments more easily. Examples include mobile insurance premium payments and phone-based vouchers.

### 6. MITIGATING FRAUD AND ABUSE

Technology is used to prevent fraud and abuse. (e.g., using texts and pin codes to verify a drug is not counterfeit; using biometric data to confirm that a health worker has actually visited a patient). Subcategories in CHMI's database include:

- Verification of: medical product, patient identity, financial transactions
- Tracking human resources or operations

**Figure 12:** Percentage of programs by primary source of funding, by health focus area



Funding (primary)

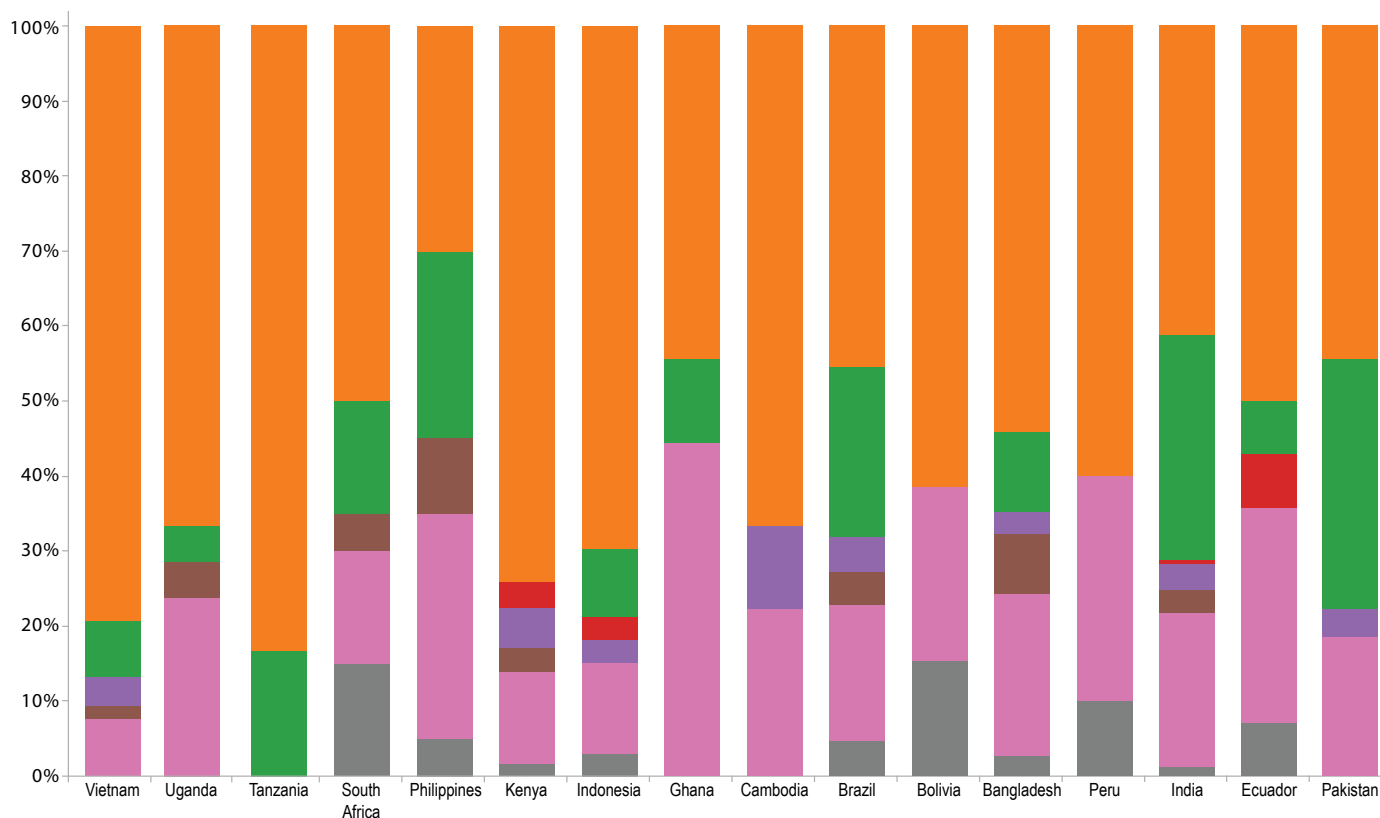
- Donor
- Government
- In-kind contributions
- Membership/subscription fees
- Other 3rd party (e.g., debt, equity)
- Out-of-pocket payments
- Revenue (e.g., interest on loans)

## Funding for innovative programs

Of the 667 programs that have reported a primary source of funding (Figure 12), about 50% receive a **significant portion of their funding from one or both of two sources: bilateral donor agencies and private foundations**. 34% of all programs are funded primarily by government contracts or through out-of-pocket payments by patients. The remaining 16% are funded through a mix of debt and equity investments, membership fees, and in-kind contributions. The large number of donor-funded programs may indicate their greater visibility, which has made information about them easier to capture during CHMI's first year of operation. Going forward, CHMI will continue to focus efforts on identifying non-donor-dependent and lesser known programs, which may lead to different conclusions about the prevalence of donor funding for health market innovations. However, CHMI's initial data suggest that a large proportion of health market innovations in almost all 16 countries where its partners are present are donor-dependent.

- Donors** are the primary source of funding for 82% of CHMI-profiled HIV/AIDS programs, 75% of malaria programs, and 72% of TB programs, representing donor priorities around the prevention, diagnosis, and treatment of high-burden communicable diseases.<sup>11</sup> Donor funding is a less prevalent source of funding for secondary care, including chronic diseases and specialized services such as eye care. While grants and donations are the main source of funding for a relatively small portion of emergency care programs, donor funding supports innovative ambulatory transportation initiatives such as [Bike4Care](#), a bicycle-based system aimed at helping patients reach health facilities in rural Kenya, and [Riders for Health](#), a program that manages and maintains the vehicles used in the delivery of health care across Sub-Saharan Africa.

**Figure 13:** Percentage of programs by primary funding source, by country



- **Governments** are a primary source of funding for many CHMI-profiled programs focusing on emergency care (48%), secondary care (43%), and care for chronic diseases (26%). Although largely donor-funded, 10% of TB programs receive their primary funding from government sources. [Operation ASHA](#), for example, is channeling funds provided by the government of India to establish local TB treatment centers in slum areas. These subsidies allow patients to seek care for free.
- **Out-of-pocket payments** are the primary source of revenue for approximately 30% of programs delivering family planning and reproductive health services. They are also the primary funding source for 15% of maternal and child health programs and 25% of primary care programs. Over 50% of specialty eye care programs receive most of their funding from out-of-pocket payments, whereas TB and malaria programs are much less likely to be financed by consumer payments.
- **Debt and equity financing** are generally used by programs focusing on secondary and tertiary services to support investments in growth, capital equipment, or information technology. Capital financing is also used in emergency care, general primary care and maternal and child care.

In nearly all countries where CHMI partner organizations operate, **donor funding is the primary source of financing for a significant portion of programs—in most cases more than 50%**. Yet the most common sources of primary funding vary slightly from country to country (Figure 13).

# FIVE INNOVATIVE MODELS APPEARING AROUND THE WORLD

CHMI identifies and tracks the development of innovative market-based models in health. A new model is uncovered when CHMI identifies multiple programs in different countries with similar goals, services, organizational structures, and operational processes. Examples of well-known models include social marketing, social franchising, and micro insurance, which have existed for some time and have increased their global scale in recent years. Others, like technology-based programs offering telemedicine, have more recently begun operating in low- and middle-income countries.

Below, we profile five innovative models that have emerged during the past decade, with examples of specific programs and details on their dates of launch, countries of operation, legal status, and some indicators of their scale. CHMI will continue to identify and track the development of these and other new health market models. More groupings of noteworthy program models are online at [www.healthmarketinnovations.org/Analysis](http://www.healthmarketinnovations.org/Analysis).

## 1. LOW-COST RETAIL PHARMACIES



Low-cost pharmacy chains and franchise networks improve operational efficiency while keeping prices low. Many operate through a for-profit model, generating revenue by adding on low-cost clinical and laboratory services and lowering prices by substituting expensive brands with low-cost generic drugs.

### The Generics Pharmacy

Launched in 2007 | Philippines

For-profit | 1160 outlets

Generics is a growing pharmacy franchise providing access to quality and affordable generic drugs throughout the Philippines. Drugs are provided on consignment and sourced through a network of domestic manufacturers.

### MedPlus

Launched in 2006 | India

For-profit | 880 outlets

MedPlus is a pharmacy chain operating in five Indian states. MedPlus has also launched diagnostic lab services to aid in the prevention, detection, or management of a wide range of illnesses and started clinic services to provide one-stop access to health consultation.

### Mi Farmacita Nacional

Launched in 2003 | Mexico

For-profit | 57 outlets

Mi Farmacita Nacional is a pharmacy franchise providing access to generic drugs for common conditions. The franchise supplements revenue by selling beauty and hygiene products. Some outlets also offer medical consultations for \$2.

Similar programs: [Farmacias Similares](#) in Mexico and [Botika ng Bayan](#) in the Philippines.

## 2. AFFORDABLE PRIMARY CARE CLINIC CHAINS



Chains of affordable primary care clinics expand access to quality care for low-income groups. Many operate in urban and peri-urban areas, generating revenue from higher patient volumes and targeting those able to pay a small sum for services. A number of for-profit examples of this model have launched over the past few years.

### Carego LiveWell

Launched in 2008 | Kenya  
For-profit | 1 Anchor Clinic, 3 Satellite Clinics

LiveWell uses a hub-and-spoke primary care clinic model to serve densely populated, low-income areas. The anchor clinic is fully automated to reduce waiting times and provides consultation, diagnosis, and treatment for a wide range of illnesses, while the satellite clinics are run by qualified clinical officers and registered nurses. The satellites are electronically linked to the anchor clinic for medical referrals and advice.

### Saúde 10

Launched in 2010 | Brazil  
For-profit

Saúde 10 is a start-up chain of primary health clinics in Rio de Janeiro that offer low-cost, high quality medical services. Clinics are located in densely populated areas and are easily accessible through public transportation. Units have four medical offices designed to serve up to 200 people per day. Services offered include pediatrics, geriatrics, general practice, gynecology and otorhinolaryngology (ENT).

### ComHealth

Launched in 2011 | South Africa  
For-profit

The ComHealth initiative aims to make high-quality health services accessible and affordable for the people of South Africa's townships. ComHealth will build and operate facilities (beginning in 2011/2012 in Soweto) that focus on basic care. The facilities will include a clinic for primary care, maternity wards, ENT and ophthalmology specialist services, and theaters for simple procedures that can be done on an outpatient basis or that require less than 24 hours' hospitalization.

Similar programs: [Kriti Arogyam Kendram](#) and [Glocal Health Care](#), India, [Por Ti](#), Familia, Peru.



A woman receiving patients at LiveWell's anchor clinic in Nairobi.

### 3. VOUCHERS FOR HEALTH SERVICES



Vouchers—distributed for free or sold for a small fee— increase access to key health services, such as family planning and reproductive health, by allowing individuals to “purchase” a specific package of services from a network of clinics. The networks often include both public and private facilities.

#### Sehat Sahulat Card

Launched in 2009 | Pakistan  
Public-Private Partnership | Vouchers are redeemable in over 100 facilities across two districts

Sehat Sahulat Card, or Health Facilities Card, is a public-private partnership model between the district governments of Kasur and Rawalpindi and Contech International. It is a voucher scheme that increases accessibility to quality maternal, newborn, and child health services for expecting mothers from disadvantaged backgrounds. The service package covers antenatal care, delivery, and postnatal care.

#### Chiranjeevi Yojana

Launched in 2005 | India  
Public-Private Partnership | 294,635 clients served

Chiranjeevi Yojana was created to significantly reduce maternal and infant mortality by working with the private sector to provide delivery and emergency obstetric care at no cost to families living below the poverty line. Under the scheme, the government contracts with private providers that volunteer to render their services by signing a memorandum of understanding with the district government.

#### Reproductive Health Output-Based Aid Program

Launched in 2005 | Kenya  
Government | 145,333 vouchers used

The Reproductive Health Output-Based Aid Voucher Program is a performance-based reproductive health program that incentivizes access to women's health care. The program is currently in its second phase (2009-2012) and is being implemented in rural and peri-urban districts in Kenya, representing a population of approximately three million. The program works with both private and public sector facilities, allowing for greater competition and better service coverage.

Similar programs: [Bangladesh Demand Side Financing Pilot Program](#), [Uganda Reproductive Health Voucher Program](#), [Tanzania National Voucher Scheme](#).

### 4. TELEMEDICINE



Technology-enabled networks help increase access to primary care for the poor by bridging the distance between doctors and patients through Internet and other telecommunication technologies. Some offer patients video consultations with distant doctors, others work to support health professionals in rural areas through tele-advice, and yet others offer chat-based virtual clinic services with round-the-clock access to health information.

#### World Health Partners

Launched in 2008 | India  
Non-profit | 1300 shops, 120 telemedicine centers, 9 diagnostic centers, 16 franchisee clinics

World Health Partners (WHP) uses telemedicine to connect rural patients with little access to formal health care to trained doctors based remotely. The four-tiered network includes small village shops, franchised telemedicine “Sky” centers connected to a central medical facility in Delhi, diagnostic centers, and franchised clinics for referrals. Initially launching in Uttar Pradesh, WHP is replicating the model in Bihar, focusing on management of infectious diseases like TB and childhood pneumonia.

#### E Health Point

Launched in 2009 | India  
Non-profit | 8 E Health Points

E Health Point is a chain of clinics that provide families in rural villages with clean drinking water, medicines, comprehensive diagnostic tools, and advanced tele-medical services that “bring” doctors and modern health care to their communities. Tele-medical consultations are assisted by local health workers at the village level. The program connects patients with licensed medical doctors in the urban telemedicine center operated by HealthPoint Services India.

#### Sehat First

Launched in 2010 | Pakistan  
For-profit | 3 centers

Sehat First provides access to basic health care and pharmaceutical services in Sindh province through self-financing franchised tele-health centers. The model consists of a health clinic, pharmacy, multipurpose tele-center, and general store, with 80-90% of revenues coming from the pharmacy and general store. Sehat First has plans to expand in 2012.

Similar programs: [OncoNET](#) in India, [Buddy Works](#) in the Philippines, [Markle Telemedicine Clinic](#) in Cambodia.

## 5. HEALTH HOTLINES



Health hotlines connect people in communities with few trained doctors to health professionals via phone-based consultations. Many develop partnerships with local mobile networks to offer reduced prices per call to subscribers and, when necessary, refer callers to nearby facilities for emergencies and specialized care.

### MeraDoctor

Launched in 2011 | India  
For-profit | Serving 9000 individuals

MeraDoctor is a newly launched doctor helpline and medical discount network that helps families stay connected with qualified medical professionals. MeraDoctor providers consult on primary care questions over the phone. The service partners with diagnostic centers and labs across India to provide discounted services to its customers. MeraDoctor plans to reach national scale in the next few years.

### TeleDoctor

Launched in 2007 | Pakistan  
For-profit | Approximately 1,500 calls/day

The TeleDoctor 24/7 service allows users to have telephone discussions with certified doctors regarding their health questions and lab results and obtain advice for further investigations when necessary. TeleDoctor provides information about health care facilities and advice about various health-related issues. The service also provides access to emergency medical response services.

### HealthLine

Launched in 2006 | Bangladesh  
For-profit | 3.5 million unique calls; about 10,000 calls/day

HealthLine is an interactive teleconference service between a Grameenphone mobile user and a licensed physician, available round the clock. Grameenphone subscribers can seek medical advice by dialing “789.” In particular, the village doctors—who play a vital role in the medical care in rural areas—find it useful to consult the doctors at the HealthLine call center for additional advice.

Similar programs: [LiveConsult](#) in Indonesia, [Health Management Research Institute \(HMRI\)](#) in India, [MedicalHome](#) in Mexico.



A woman in Kenya learns about vouchers as part of the Reproductive Health Output-Based Aid program co-funded by the German Development Bank (KfW) and the Kenyan government.

# BUILDING THE EVIDENCE BASE ABOUT WHAT WORKS

For the past year, CHMI has been documenting health market innovations across the developing world. The CHMI database currently profiles more than 1000 programs from 107 countries. While much rich descriptive information has been captured, **it is also important to understand which programs are actually “working”—improving the access, quality, and affordability of privately delivered health care for the poor.** These results are important to national and global health policy makers, donors, investors, and other program managers wanting to replicate proven models. Ideally, each CHMI-profiled program would have a rigorous third-party evaluation, including baseline data and/or a control group. However, given the cost of such studies, the reality is that few innovative programs are or ever will be evaluated to academic standards.

But this does not mean that no information exists about how well programs are working. Many initiatives track performance through in-house monitoring. While this type of information is imperfect and may be unreliable at times, it is better than no information at all. Frequently, these data are lost in internal documents and grey literature, thus becoming a missed opportunity to promote the growth of successful programs.

Recognizing these realities, in June 2011, CHMI launched an initiative to collect, record, and publicize programmatic results—clear, quantifiable, and self-reported measures of program performance across key dimensions. This initiative will inform longer term activities such as the development of program performance metrics and the facilitation of formal program evaluation. Since June, more than **80 programs have reported results** to CHMI. See Figure 14 for more information about the types of results captured by CHMI and visit the website to participate in the Reported Results initiative.



Counselors from Operation ASHA hold up a record showing a patient has been cured of TB. The program has decreased TB default rates in slum areas in Delhi.



**Figure 14:** Categories used in CHMI's Reported Results Initiative

AVAILABILITY	Evidence of increased availability of services in previously underserved areas.
UTILIZATION	Evidence of increased use of key health interventions at the population level (e.g., increase in institutional deliveries).
HEALTH OUTPUT	Quantitative evidence about services provided, including change in service provision over time and modeled estimates of impact based on number of products sold.
HEALTH OUTCOME	Evidence of impact as demonstrated by improvements in health indicators.
QUALITY	Evidence of improvements in the quality of services to the patient, possibly including improved adherence to established protocols, increased appropriate diagnoses, and/or decreased issuance of incorrect prescriptions.
USER SATISFACTION	Evidence of good service quality as perceived by the patient.
COST	Evidence of a decrease in the price of products or services to the patient.
PRO-POOR TARGETING	Quantitative evidence that (1) a large portion of a program's clients come from lower income brackets and/or (2) the proportion of poor clients served has increased over a given time period.
EFFICIENCY	Evidence of a decrease in operational cost or time to providers of health care services or improvements in operational processes leading to the provision of better or less expensive care.
SUSTAINABILITY	Quantitative evidence of ability to cover costs in the long-term, including a broad donor base or other secure revenue streams.

# CREATING A GLOBAL NETWORK

CHMI is creating a global network that connects organizations and people working to improve health marketplaces. Below are highlights of CHMI's efforts to foster greater connections among program managers, funders, researchers, and policy makers and encourage virtual interactions through the CHMI web platform.

## Personal connections

CHMI's partner institutions often host small, focused interactions in their countries of operation to promote greater awareness, open discussion, and connections among innovators, policy makers, and private care providers. In the past year, more than 300 people attended CHMI events around the world. Highlights include:

- **Engaging public and private sectors to assess Health Market Innovations.** A competition held in Manila by the Philippine Institute of Development Studies—CHMI's partner in the Philippines—brought together government health officials, academics, HMO representatives, and program managers to present and review [twenty programs](#) considered highly promising in the Filipino context. Selection criteria included measurable impact, sustainability, use of appropriate technology, and a demonstrated ability to target the poor. PIDS researchers presented their findings at several national and international conferences.
- **Connecting hospital managers to improve operational processes.** ACCESS Health International-India connected doctors, nurses, and quality managers from eleven Hyderabad hospitals seeking to improve service delivery. Managers from [L.V. Prasad](#), [Care](#), and [LifeSpring](#) were among those who gathered to learn about ways to improve operations and boost efficiency.
- **Exploring links between microfinance and health.** After documenting numerous microfinance institutions providing health services, Freedom from Hunger is designing a community of practice for microfinance and health, initially in the Andean region and later, globally. The group will publish a report on its findings and organize a regional workshop on the subject in early 2012.

For reports from other activities in [Indonesia](#), [Brazil](#), [Pakistan](#), [Kenya](#), and more, visit the CHMI blog.

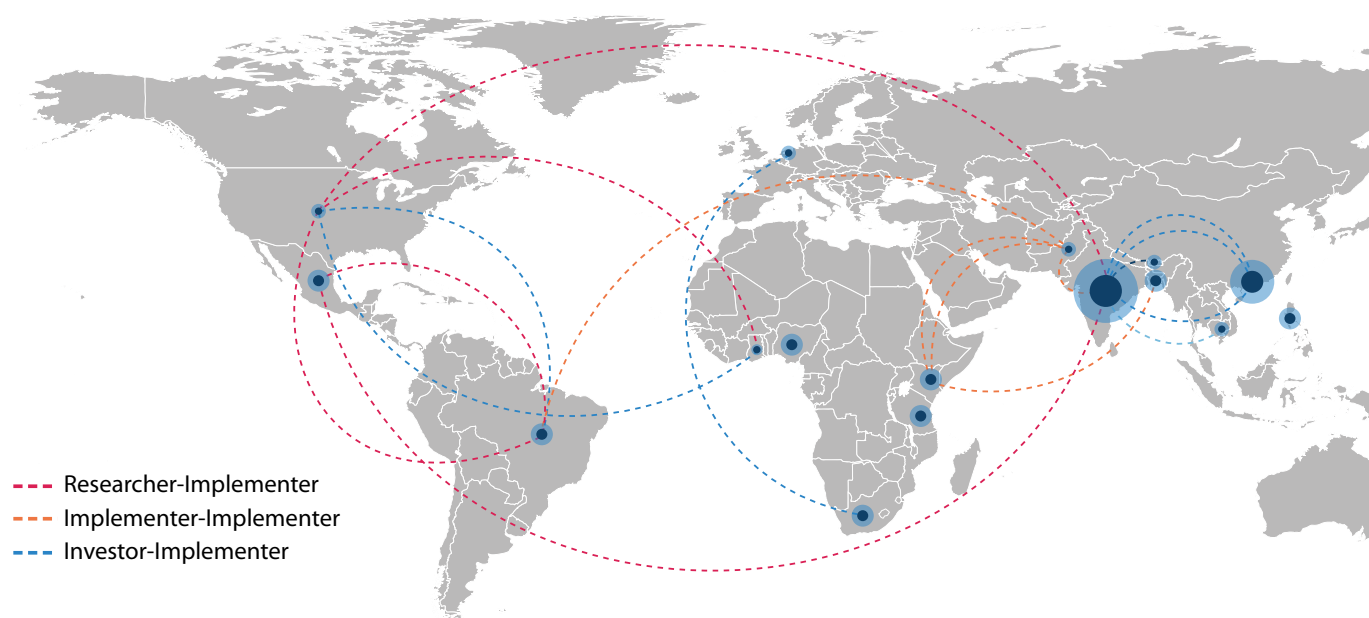
## Virtual connections

To encourage networking that promotes the growth and adaptation of promising programs and practices, CHMI allows web visitors to contact program managers through its website. This function has produced many virtual interactions. See Figure 15 for a map showing some of the connections made globally. **Program managers** connected with others running similar programs to exchange information about sustaining revenue, overcoming technical challenges, and assuring quality. **Investors** connected with candidates for funding. **Researchers** connected with program managers and technical experts to exchange detailed information about input cost and program design issues.



Representatives of Kenya's government, donors, and research organizations convened with innovative program managers in 2011.

**Figure 15:** Connections made through CHMI's website



### Examples of connections made through CHMI

- A program manager in India contacted [DISHA](#)—a pilot program running a mobile clinic in India's rural south—for **advice about starting a similar program** in villages around the Kancheepuram and Vellore districts of Tamil Nadu. ACCESS Health International, CHMI's India partner, responded with detailed specifications on the execution of the DISHA pilot and then connected the program manager to potential partners from various organizations, including the [Apollo Telemedicine Foundation](#) and [Smile on Wheels](#).
- A non-profit foundation in India contacted [Sehat First](#), a telemedicine franchise network in Pakistan, to **gather non-public information about the program's business model**, which was readily shared. Topics covered included set-up costs, the quality assurance plan, technology specifications, and franchising agreements. The foundation will use this information to better serve 200 villages near Hyderabad, India.
- An innovator starting up a diabetes management program for low-income people in Mexico contacted [Nefrocare's managers in Brazil](#) and a similar program in [India](#) to learn about their government partnership structure and the costs of providing diabetes treatment over time.

CHMI will continue to facilitate in-person and virtual stakeholder interactions to enable the scale-up and replication of promising Health Market Innovations. Follow the [CHMI blog](#) for daily updates on new partnerships and linkages among CHMI stakeholders.

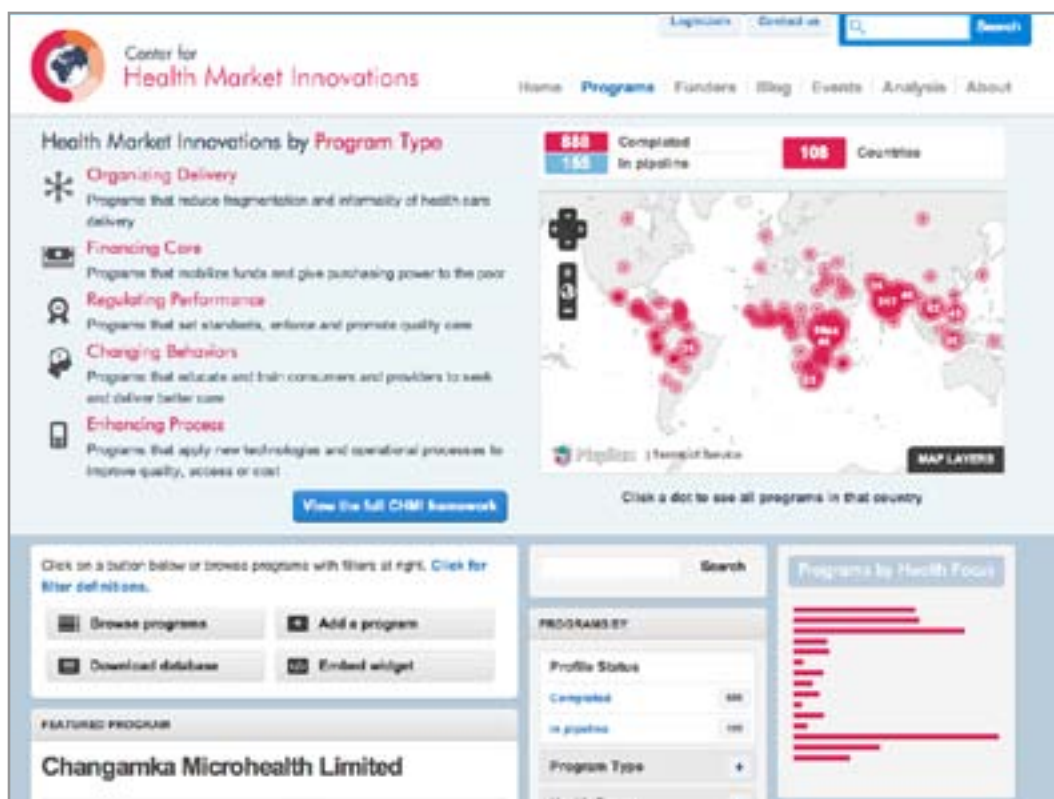
# USE CHMI TO SUPPORT YOUR WORK

CHMI can support your work, and you can contribute to make this resource even more useful:

- **Stay on top of CHMI news.** Sign up for CHMI's [newsletter](#) to receive the latest updates from the CHMI network, including program developments, analyses, and upcoming events. Read CHMI's active [blog](#), featuring commentary from CHMI partners, program managers, researchers, and others in the global health community.
- **Learn more about market-based programs.** [Search in Programs](#) to locate innovative health initiatives in your area of interest (Figure 16). [Case studies](#), produced by CHMI partner organizations, offer a deeper look at the structure, activities, and impact of profiled Health Market Innovations, and explore program successes, challenges, and lessons learned. Know about an innovative program? [Add](#) a new program profile, [update an existing listing](#), or write about it on the [CHMI Blog](#).
- **Let us know what works.** CHMI is collecting Reported Results to create a preliminary evidence base about what works and encourage programs to track and share their performance. [Report results](#) for programs that you manage, fund, or study.
- **Check up on marketplace studies.** CHMI commissions thematic studies to take a deeper look at health markets. [Two studies of health marketplace challenges are currently underway](#): 1) A study on the dynamics of the informal provision of care in Bangladesh, India, and Nigeria and 2) an evaluation of the effect of MedPlus, a new high-quality chain pharmacy, on drug quality in the broader health marketplace in Andhra Pradesh, India.
- **Connect with innovators.** [Join CHMI to directly contact](#) people running programs listed in [CHMI's database](#). Have conversations with the Health Market Innovations community on [CHMI's Blog](#).
- **Download the data.** The CHMI database of more than 1000 programs can be downloaded for free. [Browse in Programs](#) for a topic of interest—like for-profit primary care enterprises or emergency helplines operated under government contracts—or [download the entire Programs database](#). Data can be combined with additional variables, adapted or modified, with citations. See box at right for an example of how researchers have used CHMI.

**Tell us how CHMI can better support your work.** CHMI strives to provide relevant, timely, and useful information to the Health Market Innovation community. We welcome feedback on the content of this report, the CHMI website, or the initiative more broadly. Please send comments to [chmi@resultsfordevelopment.org](mailto:chmi@resultsfordevelopment.org).

**Figure 16:** CHMI's program search interface



## HOW PEOPLE ARE USING CHMI

- **Programs gain global visibility and opportunities to expand:** “The CHMI website is one of the [reasons why] we are known outside India,” said Rajeev Kumar of the health technology company Neurosynaptic. “We have been receiving inquiries from hospitals and individuals outside India to know more about the [ReMeDi telemedicine kit](#),” the Bangalore-based business leader continued. Because of CHMI, Kumar’s company was featured in the [BBC Horizon program on innovations](#).
- **Funders identify promising investment candidates:** Impact Investment Partners, of Mumbai, used CHMI’s database to **identify and contact promising pro-poor, for-profit health programs operating in India**. “CHMI helps educate everyone on what is happening in the sector and can help industry participants identify channel partners,” said Amit Sharma.
- **Researchers access aggregate data on market-based health programs:** Onil Bhattacharyya, a researcher at the University of Toronto, used CHMI’s database to identify the percentage of **programs measuring impact in categories like inputs, efficiency, outputs, and outcomes**. In a presentation at the 2011 International Health Economics Association (iHEA) meeting, Bhattacharyya noted the difficulty of assessing programmatic performance without strategic indicators. (See page 24 to learn how CHMI is tracking results.)
- **Policy makers exchange ideas about how to better steward the private sector:** In Islamabad, a roundtable organized by CHMI’s Pakistan-based partner, the Asia Foundation, provided a unique opportunity for government and private sector practitioners to meet and discuss policy issues. The forum served as a neutral platform to frankly discuss issues such as **private health regulation and market-led innovations**, which are being debated by at least two provincial governments.

## Get connected to a CHMI Hub near you

CHMI works with a **network of in-country and global analytic partners** to identify, document, and disseminate information on Health Market Innovations. The list of CHMI partners can be found below.

### Global coordinating partner

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### Analytic partners

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Garhwal Community Development and Welfare Society, India  
Global Health Group at UCSF, USA  
Institute for Economic Development at Boston University, USA  
ICDDR,B, Bangladesh

\*CHMI partner from 2009 to 2011

## END NOTES

1. CHMI partners operate in the following countries: Bangladesh, Bolivia, Brazil, Cambodia, Ecuador, India, Indonesia, Kenya, Pakistan, Peru, the Philippines, Rwanda, South Africa, Tanzania, Uganda, and Vietnam. See list at left.
2. WHO National Health Accounts data for 2006.
3. Van Doorslaer E., et al. (2006). Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. *Lancet*, 368:1357-1364.
4. Goodman C, Kachur SP, Abdulla S, Bloland P, Mills A. (2007). Drug shop regulation and malaria treatment in Tanzania—why do shops break the rules, and does it matter? *Health Policy Plan*, 22:393–403.
5. CHMI does not document private practices of individual providers, instead profiling organizations that make health care delivery less fragmented. For an explanation of the kinds of programs included in and excluded from CHMI's Programs Database, visit [www.HealthMarketInnovations.org/about](http://www.HealthMarketInnovations.org/about)
6. CHMI strives to collect information about innovative programs in all low- and middle-income countries. In practice, the database contains more comprehensive information for countries in which CHMI partners operate. See all at [www.tinyurl.com/CHMIpartners](http://www.tinyurl.com/CHMIpartners).
7. Currently, CHMI statistics are primarily based on numbers of programs. This measurement is imperfect because some programs are small and others are large. CHMI aims to collect more data on scale in the coming years.
8. More information about social franchising can be found on [sf4health.org](http://sf4health.org).
9. PhilHealth beneficiaries have access to a package of services that include inpatient care, catastrophic coverage, ambulatory surgeries, deliveries, and outpatient treatment for malaria and tuberculosis. Those identified as indigent and Overseas Filipino Workers are also entitled to outpatient primary care.
10. The Joint Learning Network for Universal Health Coverage is a network of low- and middle-income countries in the midst of demand-side health financing reforms aimed at achieving universal health coverage. The JLN is focused on linking practitioners and policy makers to help disseminate best practices and provide targeted assistance in specific technical areas. More information is available at [jointlearningnetwork.org](http://jointlearningnetwork.org).
11. Percentages in this section correspond to the number of programs reporting a particular source of funding as their primary source rather than percentages of overall revenues coming from that source.

## PHOTO CREDITS

COVER PHOTO: A young mother at the Nice Foundation's Institute for Newborn Care, taken by André J.P. Fathome for CHMI.

Page 11 and 24: Photos by André J.P. Fathome for CHMI.

Page 15 and 16: Photo by Nacho Hernandez for CHMI.

Page 20: Photo by Ida Marie Pantig/PIDS for CHMI.

Page 21 (top left): Advertisement for Saúde 10, courtesy of program.

Page 21 (bottom): Photo by Chris Whiteman for CHMI.

Page 22 (top left), 23 (bottom): Photos by Richard Lord, used courtesy of the Population Council.

Page 23: Photo from MeraDoctor.co.

Page 26: Photo by Alex Kamweru for CHMI.

Page 27: Map design by Gizelle Gutierrez for CHMI.



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