

**SOCIAL
INNOVATION
IN HEALTH
INITIATIVE**



WHAT IF

TOGETHER, WE CAN UNLOCK THE RICH POTENTIAL
PRESENT IN THE GLOBAL SOUTH?



OUR PARTNERS 2014/15

University of Cape Town, Graduate School of Business

THE BERTHA CENTRE FOR SOCIAL INNOVATION AND ENTREPRENEURSHIP



The Bertha Centre for Social Innovation and Entrepreneurship is the first academic centre to apply an innovation lens to Africa's pressing social challenges from within the African context. The Centre focuses on creating social impact through combining academia (research and teaching) with on-the-ground action (targeted initiatives and partnerships) to address the needs of the African community and to build innovation capacity.

With great advances in health and medical care came the formalisation and regulation of healthcare systems, models of healthcare delivery and healthcare workers. Social innovation represents an opportunity to identify new models, and build evidence for how traditional healthcare systems and actors can be complemented and partnered with community-based and alternative actors to address health delivery failure.

World Health Organization

SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES (TDR)

TDR is a global programme of scientific collaboration that helps facilitate, support and influence efforts to combat diseases of poverty. TDR is hosted at the World Health Organization (WHO), and is sponsored by the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP) and the World Bank.

Social innovation is critical to enhance local communities' access to interventions that can improve healthcare. It engages various actors to share their respective disciplines and to identify simple solutions to complex problems. The academic sector is a key player in the promotion of social innovation, fostering its application through research, and developing capacity for social innovators and innovations.



University of Oxford, Saïd Business School

THE SKOLL CENTRE FOR SOCIAL ENTREPRENEURSHIP

The Skoll Centre is based at Oxford University's Saïd Business School. It was one of the first adherents among academic institutions to wholly support innovation and entrepreneurial endeavour to address social and environmental challenges.

For the last 11 years, the Centre has provided full MBA scholarships to proven entrepreneurs who have realised that the impact of their organisations could be enhanced with a greater understanding of the elements of business concepts and practices. It promotes actionable insight through supporting research that contributes to innovation and entrepreneurial thinking. The Centre is focused on reshaping the conversation about how academic institutions support social innovation and entrepreneurship.



OUR TEAM



BEATRICE HALPAAP

Beatrice oversees TDR's portfolio and financial management, administration and human resources. She also manages innovative projects in social entrepreneurship. She holds a Pharm D in pharmaceutical product research and development.



ELINA NAYDENOVA

Elina is a scientist passionate about disruptive innovation. She holds a BSc in Mathematics and Physics from the University of Warwick and an MSc in Biomedical Engineering from the University of Oxford. She is currently a PhD candidate at the University of Oxford.



FRANCOIS BONNICI

Francois is the founding director of the Bertha Centre. Trained as a medical doctor in South Africa, he also holds a Master's degree in Public Health (University of London) and an MBA (University of Oxford).



JOHANNES SOMMERFELD

Johannes (DPhil, MPH) is a health social scientist and research manager at TDR. He has conducted research, taught and coordinated applied social science for public health research on a number of critical social issues in infectious diseases.



JOSEPH LIM

Joseph consults with the Health Team at the Bertha Centre. He holds BS degrees in Chemical Engineering and Biochemistry (University of Maryland) and an MS in Chemical Engineering Practice and ScD in Chemical Engineering (Massachusetts Institute of Technology).



LILIANE CHAMAS

Liliane has shifted from uncovering genomic techniques for the treatment of non-communicable diseases to exploring the role that broader innovation can play in health system strengthening. She holds a PhD in Clinical Genetics from the University of Oxford.



LINDI VAN NIEKERK

Lindi is the Health Innovation Lead for the Bertha Centre for Social Innovation, and has conceptualised and driven the Centre's health innovation work. She trained as a medical doctor and holds a Masters in Public Health (London).



NORA PETTY

Nora is currently doing her MBA at the Saïd Business School and hopes to launch a healthcare-focused social enterprise in the near future. She works with the private sector, developing solutions to pressing healthcare delivery challenges in Africa.



PAMELA HARTIGAN

Pamela is director of the Skoll Centre. She is widely recognised as a global leader in the field of social entrepreneurship. She holds two Master's degrees and a PhD in Developmental Psychology.



RACHEL CHATER

Rachel works on the Inclusive Healthcare Innovation Initiative at the Bertha Centre. She has a background in development economics and holds an MComm from UCT.





WHAT IF

COMMUNITY-BASED SOCIAL INNOVATIONS
CAN HAVE LARGE-SCALE IMPACT?

OUR JOURNEY THUS FAR

Advancing the application of social innovation in health

Over the past century, great advances have been achieved by innovation in medical and scientific domains, leading to many new ways to support the diagnosis and treatment of disease. However, despite this progress and availability of means and methods to treat and cure disease, over 1 billion people globally are unable to receive the benefits of these proven and existing advances. This is due to the absence of inclusive, effective and affordable healthcare delivery systems. Now more than ever, a new lens is required by all actors to address these basic systemic, organisational and individual challenges that hinder our communities from achieving their optimal potential.

A realisation from current approaches to improve healthcare delivery is the frequent failure of well-designed policies and programmes. One-size-fits-all strategies have failed to address the cultural and contextual nuances. They have often been centred on addressing the perceived and not the lived reality of people and communities. Sustainability and longevity of these interventions have been challenged and the desired impact has not been achieved.

Moving into the next decade, underpinned by the Sustainable Development Goals, new approaches and methods are imperative to engage communities and all sectors in a collaborative identification, creation and implementation process. Transformative change is possible. We have to challenge our existing paradigms, embrace new ways of doing and drive systemic progress through interventions and individuals.



Credit: L van Niekerk, SIHI Uganda, 2015

Community-based social innovation is a unique lens and approach to tackling complex healthcare delivery challenges. It combines best practices across a range of disciplines. **It finds novel ways to implement comprehensive solutions by engaging and collaborating with actors across hierarchies and sectors. The outputs are in interventions and process: interventions that make healthcare delivery more inclusive, effective and affordable and a process that fosters internalised change in people. The outcomes are sustainable and scalable social innovation that strengthens health systems globally.** (Van Niekerk, L; Halpaap, B; SIHI 2015)

Our journey began in October 2014, through a partnership united by the belief that social innovation does have application in and value for health systems. Our goal for 2014/15 was to illustrate this in three ways:

1

IDENTIFY & SELECT

Find social innovations in healthcare delivery across the Global South that have made an impact or hold potential to impact infectious diseases of poverty.

2

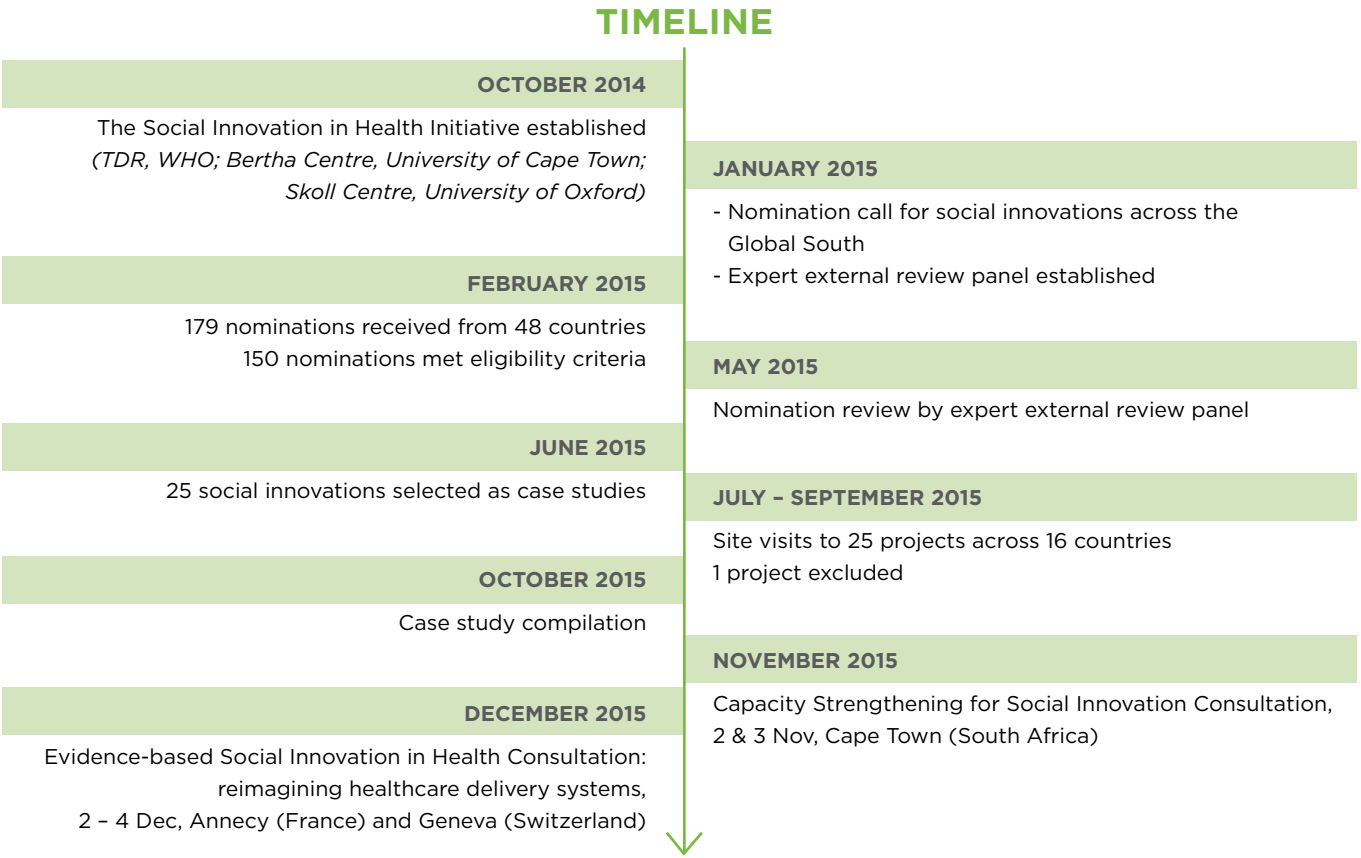
STUDY & LEARN

Conduct site visits to innovators and countries to experience and learn about case examples of social innovation in health.

3

MOBILISE

Catalyse a broader community movement of people who are passionate, interested and engaged in social innovation in health.



OUR PROCESS

Case studies in social innovation in health

1 IDENTIFICATION & SELECTION

To cast a wide net, we set out to find solutions or interventions that hold the potential impact to make healthcare delivery more **inclusive**, **effective** and **affordable** in the Global South – regardless of the type of innovation or inventor. The solutions could either meet a pressing need related to infectious diseases of poverty (including tuberculosis and malaria, but excluding HIV) or have indirect applicability or transferability to infectious diseases. These solutions also had to be implemented and sustained for more than one year.

A three-pronged identification strategy was adopted, including an academic and grey literature review; contacting international, regional and local network agencies directly and openly calling for nominations.

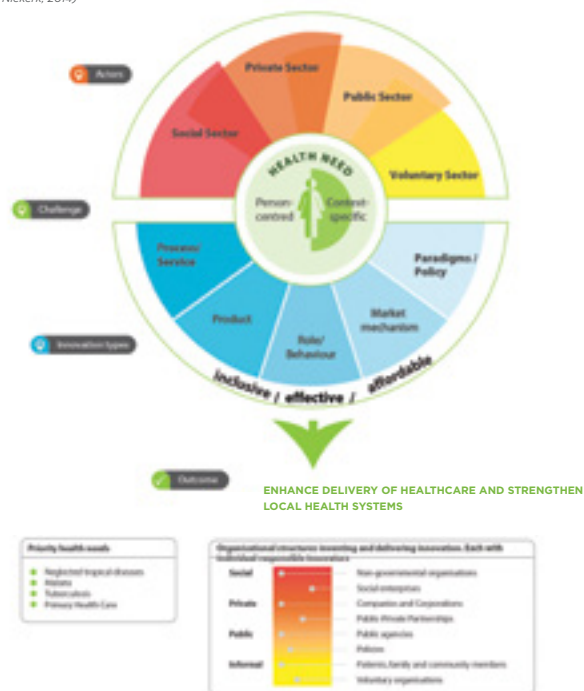
The most successful yield came from the 6-week nomination call. In that period, 179 solutions were submitted from 48 countries, operational across 68 countries. 46% of nominations came from Africa; 30% from the Asia region and 10% from Latin America. These were being implemented by NGOs (55%); public agencies (24%) and for-profit companies (11%). The main focus area of the solution, as selected by applicants, was addressing access and quality of care.

To support the selection of 25 potentially high impact social innovations in healthcare delivery from the 179 nominations received, an external expert review panel was established.

Members were selected for their individual technical expertise in infectious diseases, public health, innovation or implementation. They further had extensive experience working across contexts in Africa, Asia and South America.

SOCIAL INNOVATION IN HEALTHCARE DELIVERY IDENTIFICATION FRAMEWORK

(L. van Niekerk, 2014)



Following 4 rounds of paper review and a final round of verification calls, 25 social innovations across 16 countries were selected. The review panel supported the selection process by evaluating each submitted nomination against the following criteria:

Evaluation criteria



Appropriateness of the solution to the need

The approach addresses a healthcare delivery challenge that specifically deals with an infectious disease of poverty or could be applicable to this disease group.



Degree of innovativeness

The approach is new, different or a significant improvement within the context to which it is being applied.



Inclusiveness

The approach has the potential to be used by a large number of people, enhancing equity and access.



Affordability

The solution is affordable by the poor, who are otherwise excluded in the local context or the solution is more cost-effective than the status quo.



Effectiveness

The solution has demonstrated a positive outcome on the local population's health.



Scalability

Within and across cultural, resource and environmental contexts, the solution can be applied to reach many more people.



Sustainability

The financial, organisational and market aspects of the solution are sustainable.

EXPERT REVIEW PANEL

Dr Be-Nazir Ahmed - Line Director, Ministry of Health and Family Welfare, Bangladesh

Dr Uche Amazigo - Director (retired), African Programme for Onchocerciasis Control, WHO

Dr Mitchell Besser - Founder and Director, Mothers2mothers, South Africa

Prof Fred Binka - Vice Chancellor, University of Health and Allied Sciences, Ghana

Dr Vera Cordeiro - Founder, Child Health Association, Brazil

Dr Luis Gabriel Cuervo - Senior Advisor, Pan-American Health Organisation, USA

Sarah Gelfand - Deputy Director, International Partnership for Innovative Healthcare Delivery, USA

Prof Lucy Gilson - Professor, University of Cape Town, South Africa

Dr Lori Heise - Director, STRIVE, UK

Dana Hovig - Director of Integrated Delivery, Bill & Melinda Gates Foundation, USA

Prof Carel Ijsselmuiden - Executive Director, The COHRED Group, Switzerland

Dr Mary Ann Lansang - Professor of Medicine, University of the Philippines, Philippines

Dr Marlo Libel - Medical Epidemiologist and Global Health Consultant, Skoll Global Threats Fund, Brazil

Roger Mader - Co-founder, Ampersand, USA

Prof Lenore Manderson - Professor of Public Health and Medical Anthropology, University of the Witwatersrand, South Africa

Dr Patricia Mechael - Principal, HealthEnabled, USA

Dr Rosanna Peeling - Chair of Diagnostics Research, London School of Hygiene and Tropical Medicine, UK

Prof Christian Seelos - Chair of Business Model Innovation, University of Leuven, Belgium

Dr Cesar Veira - Advisor and Coordinator (retired), Pan-American Health Association (PAHO/WHO), Brazil

Dr Marc Ventresca - Economic Sociologist, University of Oxford, UK

2 STUDY & LEARN

In order for us to understand the value, investigate the mechanisms of operation and learn transferable lessons, a descriptive and explorative case study research methodology was adopted. The social innovation case inquiry was structured according to 4 units of analyses: the context; the inventing actor; the solution/intervention and the implementing organisation. From July to October 2015, our team set out on a journey to travel the continents. We spent two to four days in country with the actor or organisation responsible for creating and implementing the selected project.

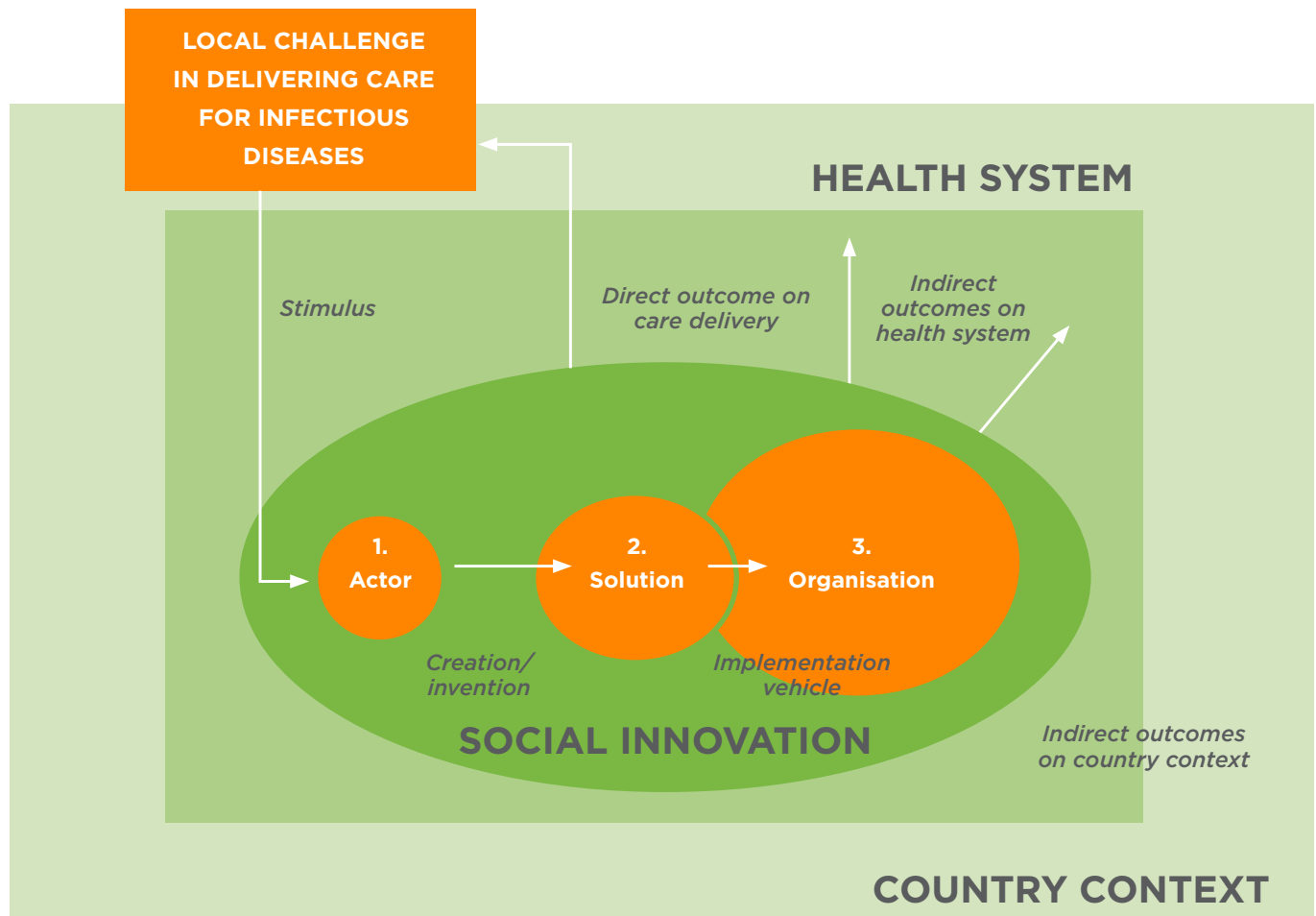


Figure: SIHI Case Study Framework, 2015

Different data collection methods, as presented in the table below, were used to support the inquiry.

UNIT OF ANALYSIS	DATA COLLECTION METHOD	DATA SOURCES
Context	<ul style="list-style-type: none">• Literature review• Semi-structured in-depth interviews• Participant observations	<ul style="list-style-type: none">• Peer-reviewed and grey literature• Government or senior country experts• Immediate environment, organisation, community
Inventing/implementing actor	In-depth interview	Inventor/founder of the organisation/CEO
Solution	<ul style="list-style-type: none">• Documentation review• Semi-structured in-depth interviews• Participant observation	<ul style="list-style-type: none">• Grey or published reports on the impact of the solution/organisation• Founder, CEO, employees, beneficiaries• Employees delivering the solution
Organisation	<ul style="list-style-type: none">• Documentation review• Semi-structured in-depth interviews• Participant observation	<ul style="list-style-type: none">• Annual reports of organisation• Founder, CEO, employees• Organisation operations and daily activities

A two-step data analysis process was adopted. The first: analysis by triangulation of data collected to support the development of a descriptive case study on each social innovation. The second: a cross-case synthesis of different theoretical propositions, as presented in the cohort of 24 cases, to better understand the generalisation of findings and the potential for translation across contexts.

This research was approved by the WHO Ethics Research Committee, as well as the Ethics Review Committee of the University of Cape Town Graduate School of Business

and the Departmental Research Ethics Committee at the Oxford Saïd Business School. It has been supported by an Academic Advisory Panel comprised of Prof Rosanna Peeling (London School of Hygiene and Tropical Medicine), Prof Lenore Manderson (University of the Witwatersrand) and Prof Lucy Gilson (University of Cape Town).

Following the site visits, one project was withdrawn from the Social Innovation in Health Initiative.

3 MOBILISE

The A, B, C of building community

Investigating the spreading of ideas is an interesting matter. Dissecting the different vehicles that propel them forward. Interrogating word choices. What is being said? And what is happening as a result of these conversations?

Words are powerful for many reasons, but mostly because they facilitate change. No idea can get far on its own. But the moment you put pen to paper, discuss or share it, the idea gathers momentum. It grows. Ideas become words. Words become movements. People unite to create change and leave the world a better place.

During our involvement with SIHI, we noticed a global interest in social innovation in health. A lively dialogue and growing sense of urgency have been spreading across the supply chain. We have identified a marked shift in attention towards the importance of implementation in healthcare delivery. It is the birth of a movement.

Allow me to explain with an analogy: imagine the statue of a president standing in a market square, and a group of people encircling it. Each person faces the statue, but each individual is privy to a unique viewpoint. Some individuals will be able to describe the statue's facial expression. Others the curve of his back. Another his profile or ears. All of these viewpoints are true, but there is a collective viewpoint that is more true, more accurate than any one individual's perception. A collective dialogue that should be encouraged and cultivated to accurately describe and understand the statue. This is true of social innovation as a whole. It is equally true of the SIHI

project and how we have aligned our early communication and collaboration efforts. We inch towards an in-depth understanding of a complex matter by welcoming many voices and viewpoints. We are better and stronger together.

We set out to create community. To find and connect like-minded souls. We come together in a digital and physical space. We document stories and aim to establish a unified body for social innovation in the Global South. Finding and introducing the change-makers of Africa, Asia and Latin America. So they can connect, share ideas and create their very own magic.

Nothing influences people more than other people. Rather than directing the dialogue, we set out from the start to relinquish full control, and to allow you, our participants, to help shape the message.

So here's to you. The contributors, the change-makers, the helpers, the unsung heroes and individuals surrounding our proverbial statue. Thank you for helping us improve healthcare globally.

Mia Smit

Communication Strategist – SIHI team



WHAT IF

WE CAN CREATE MOMENTUM TO
ENHANCE HEALTH SYSTEMS GLOBALLY?

24 CASES FROM THE GLOBAL SOUTH

1. DRUG SHOP INTEGRATED CARE

Country(s) of operation:

Uganda

Implementer:

Makerere University

Organisational structure:

University

CHALLENGE: Many households receive care from local drug shops, which vary in quality and ability to offer health services.

SOLUTION: The Drug Shop Integrated Care programme aims to improve the quality of services in private drug shops by adopting the WHO/UNICEF strategy for integrated Community Case Management in standardising care. Through the programme, shop attendants are trained to recognise malaria, pneumonia and diarrhoea. They can then deliver the appropriate diagnostics and treatment that is affordable and accessible to families.



Credit: L van Niekerk, Uganda, SIHI 2015

2. EMBRYYO TECHNOLOGIES

Country(s) of operation:

India

Implementer:

Embryyo Technologies Private Limited

Organisational structure:

Company

CHALLENGE: India has the highest TB burden in the world and struggles with drug adherence and resistance.

SOLUTION: Embryyo has created TB-CCTV – a drug adherence monitoring system for TB patients in India. A digital pillbox automatically registers when pills are taken. This information is available via mobile and web-based applications to all layers of DOTS staff, so they can effectively monitor patient compliance in real-time.



Credit: Embryyo Technologies

3. GP DOWN-REFERRAL MODEL

Country(s) of operation:

South Africa

Implementer:

BroadReach Healthcare, North-West Province Department of Health and KOSHMED

Organisational structure:

Company, Government agency

CHALLENGE: About 6.4 million South Africans are living with HIV, of which 2 million are eligible for antiretroviral therapy but not yet on treatment.

SOLUTION: The Private General Practitioner Referral Model is a public-private partnership to reduce overburdened public health resources by leveraging private sector capacity in treatment delivery. The programme shifts the delivery of ART in stable patients from hospitals to lower-level private health facilities ('down referral'), allowing hospital staff to focus on initiating new ART-eligible patients and managing complicated cases.



Credit: RA Chater, South Africa, SIHI 2015

4. KHETH'IMPILO

Country(s) of operation:

South Africa

Implementer:

Keth'Impilo

Organisational structure:

NGO, Not-for-profit

CHALLENGE: South Africa currently has 1 pharmacist for every 3 849 people, with less than 30% practicing in the overburdened public sector.

SOLUTION: Kheth'Impilo's Pharmacist Assistant Programme trains and mentors pharmacist assistants, placing candidates in government facilities where they provide a service from day one. The addition of learners assists facilities to improve patient care and reduce waiting times in overburdened public sector health centres. Pharmacist assistants focus on the lower level pharmacist tasks, allowing the specialised pharmacist to operate at the higher skill level, increasing human resource efficiency.



Credit: RA Chater, South Africa, SIHI 2015

5. LAST MILE HEALTH

Country(s) of operation:

Liberia

Implementer:

Last Mile Health

Organisational structure:

NGO

CHALLENGE: In Liberia, people often lack access to basic healthcare because they live too far from a health facility, up to 30 kilometres away across difficult terrain.

SOLUTION: Last Mile Health recruits, trains, equips, manages and pays professionalised community health workers (CHWs) to provide primary healthcare in the last mile. CHWs are members of the communities they serve, selected by their own leaders to receive training because of their talent, commitment and ability. Last Mile Health works closely with community members, local government officials, national policymakers, private sector and global partners to develop and scale the model sustainably.



Credit: Dollarphoto

6. LIFENET INTERNATIONAL

Country(s) of operation:

Burundi, Democratic Republic of Congo, Uganda

Implementer:

LifeNet International

Organisational structure:

NGO, Not-for-profit

CHALLENGE: Burundi suffers from poor quality of basic healthcare service provision.

SOLUTION: LifeNet partners with church-based health centres to provide them with the necessary tools to expand the scope of their services, while holding them accountable to quality standards. Each LifeNet partner health centre retains full ownership of their facility and works with the LifeNet team to implement programme components specific to their needs. The LifeNet franchise bundle includes medical and management staff training, quality evaluations, supply of essential pharmaceuticals and growth financing through an affordable loan scheme.



Credit: L van Niekerk, Burundi, SIHI 2015

7. LIVING GOODS

Country(s) of operation:

Kenya, Uganda

Implementer:

Living Goods

Organisational structure:

NGO

CHALLENGE: Community health workers (CHWs) play a critical role in low-resource settings, but volunteer CHW programmes often suffer from low productivity and high attrition rates.

SOLUTION: Living Goods provides ongoing training, financial support, access to quality treatments and products, performance incentives and mobile technology to village-based health entrepreneurs. They go door-to-door offering relevant health information and selling health-orientated products. An initial loan from Living Goods allows them to earn a modest income, whilst delivering basic healthcare services.



Credit: L. van Niekerk, Uganda, SIHI 2015

8. CENTRO PARA EL DESARROLLO DE LA INVESTIGACIÓN CIENTÍFICA (CEDIC)

Country(s) of operation:

Paraguay

Implementer:

Centro para el Desarrollo de la Investigación Científica (CEDIC)

Organisational structure:

NGO

CHALLENGE: Indigenous communities of the Paraguayan Chaco have a high prevalence of Chagas disease and poor living conditions.

SOLUTION: CEDIC uses the living labs methodology to engage community members, public administration, universities, research centres and industry partners to co-design social innovations that tackle Chagas disease health challenges. Projects include building vector-resistant housing, distributing games to teach children about Chagas prevention and partnering with a local enterprise to deliver safe drinking water and drought-resistant agricultural practices.



Credit: CEDIC

9. MDOC

Country(s) of operation:

Bangladesh

Implementer:

mDoc LLC

Organisational structure:

Social enterprise

CHALLENGE: Bangladesh faces a critical shortage of doctors, especially in rural areas.

SOLUTION: mDoc trains existing rural pharmacists to use a tablet to facilitate telemedicine consultations with urban doctors. The trained pharmacist records the patient's medical data, performs a basic physical exam, intermediates the conversation between the patient and the remote doctor, explains the prescription and dispenses medicines to the patient.



Credit: Dollarphoto

10. MOBILE-BASED SURVEILLANCE QUEST USING IT (MOSQUIT)

Country(s) of operation:

India

Implementer:

Centre for Development of Advanced Computing

Organisational structure:

Government agency

CHALLENGE: Over 90% of India's population is exposed to malaria, therefore actionable data is needed to inform relevant public health decision-making.

SOLUTION: MoSQuIT is a government initiated mobile-based disease surveillance system for malaria. It facilitates various steps of malaria surveillance through data-collection, data transfer to a centralised system and data analytics. MoSQuIT improves the management of clinical information and provides insights to help understand, forecast and evaluate complex, multiple-organisation efforts in eliminating malaria.



Credit: E Naydenova, India, SIHI 2015

11. NOORA HEALTH

Country(s) of operation:

India

Implementer:

Noora Health

Organisational structure:

NGO

CHALLENGE: In resource-constrained settings, relapse and complications following discharge from hospital is common.

SOLUTION: Noora Health trains patients and their families with high-impact health skills to improve outcomes and save lives. They turn hospital hallways and waiting rooms into classrooms. Through engaging, skill-based learning, Noora Health ensures that patients' families are equipped to deal with the consequences of severe diagnoses, surgery or childbirth, replacing anxiety with competency and easing the transition from hospital to home. They rely on nurse educators, ensuring continuity through a 'train-the-trainer' approach.



Credit: E Naydenova, India, SIHI 2015

12. ONE FAMILY HEALTH

Country(s) of operation:

Rwanda

Implementer:

One Family Health

Organisational structure:

Hybrid, NGO

CHALLENGE: Currently, 80% of Rwandans live in rural areas, most of which are beyond a three-hour walk to a healthcare facility.

SOLUTION: One Family Health enhances access to essential primary care services in rural Rwanda by establishing franchised nurse-owned health posts. These private providers are integrated as part of the formal health system by means of a public-private community partnership. They leverage the national health insurance scheme to deliver sustainable care.



Credit: L van Niekerk, Rwanda, SIHI 2015

13. OPERATION ASHA

Country(s) of operation:

Cambodia, India

Implementer:

Operation ASHA

Organisational structure:

NGO, Not-for-profit

CHALLENGE: TB treatment is challenging and time consuming – patients have to visit a designated treatment centre 60 times over a period of 6 months.

SOLUTION: Operation ASHA's last-mile healthcare delivery model leverages a public-private partnership with the Indian government to use existing community infrastructure to deliver free medicines and services for TB patients. Healthcare workers are recruited from local communities, incentivised with performance-based income, and equipped with novel in-house eCompliance technology developed in partnership with Microsoft Research to track treatment adherence.



Credit: L van Niekerk, India, SIHI 2015

14. OSWALDO CRUZ FOUNDATION

Country(s) of operation:

Brazil

Implementer:

Oswaldo Cruz Foundation

Organisational structure:

Government agency

CHALLENGE: Despite government efforts, indigenous communities in Brazil have irregular access to health services.

SOLUTION: The programme provides indigenous community health workers with formal education and health professionalisation, empowering them to play an important role in health promotion and the prevention of diseases in their communities. The education process has been adapted to include socio-cultural and territorial relevant information, and has been designed collaboratively with the indigenous communities.



Credit: Oswaldo Cruz Foundation

15. PARTNERS IN LEPROSY ACTION (PILA)

Country(s) of operation:

Philippines

Implementer:

Philippine Leprosy Mission

Organisational structure:

NGO

CHALLENGE: Despite the curability of leprosy and availability of free medication, stigma and delays in consultation, diagnosis and treatment have contributed to disability and deformity caused by the disease.

SOLUTION: PILA is the response of the Philippine Leprosy Mission to the global strategy recommended by WHO to put in place sustained, integrated and quality services to detect, diagnose, successfully treat and reduce disability from leprosy. The core components of the programme are 1) information sessions and training for health workers and teachers; 2) pre-screening of households for any skin diseases by students as part of a school activity or by village health workers for households not covered by the school programme; and 3) treatment of confirmed leprosy cases via free skin clinics or local health centres for multi-drug therapy.



Credit: RA Chater, Philippines, SIHI 2015

16. RIDERS FOR HEALTH

Country(s) of operation:

Kenya, Lesotho, Malawi, Nigeria, The Gambia, Zambia, Zimbabwe

Implementer:

Riders for Health

Organisational structure:

Social enterprise

CHALLENGE: One of the most overlooked barriers to healthcare delivery is a lack of reliable, well-maintained transport.

SOLUTION: Riders for Health works with partner organisations to manage fleets of motorcycles and four-wheeled vehicles that are used by health workers to reach the most remote communities with healthcare. These workers are trained and mobilised to cover large distances, taking healthcare directly to these communities rather than waiting for them to come to the health facility. Training equips them to ride, maintain and repair their own motorcycles. Riders for Health also utilises its transport network to facilitate supply chain distribution.



Credit: RA Chater, Lesotho, SIHI 2015

17. SAFE WATER AND AIDS PROJECT (SWAP)

Country(s) of operation:

Kenya

Implementer:

Safe Water and AIDS Project (SWAP)

Organisation structure:

NGO

CHALLENGE: Kenya has a high burden of disease where poor health is exacerbated by poor water quality and inadequate sanitation.

SOLUTION: SWAP enables community health promoters (CHPs) to conduct door-to-door sales and health education to improve health. They also increase access to health and hygiene products for vulnerable communities. SWAP provides training and support for CHPs to promote healthy practices and generate income. The product mix includes water treatment, ceramic filters, hand wash soaps, detergents, diapers, sanitary pads, de-worming tablets, fortified flour, micro-nutrient powder, clean cook stoves, mosquito nets and condoms.



Credit: RA Chater, Kenya, SIHI 2015

18. SAVE THE CHILDREN MALARIA PROGRAMME

Country(s) of operation:

Malawi

Implementer:

Save the Children Malawi, London School of Hygiene & Tropical Medicine, Malaria Alert Centre (University of Malawi), Malawi Ministries of Health and Education

Organisational structure:

NGO

CHALLENGE: Malaria is a major contributor to school absenteeism with schoolchildren being most commonly infected, but least likely to have access to treatment.

SOLUTION: Teachers are trained to use rapid diagnostic tests to identify and treat schoolchildren for malaria infections and other common illnesses through Learner Treatment Kits. These kits contain rapid diagnostic tests for malaria, antimalarial medicines and other treatments for common health problems.



Credit: L van Niekerk, Malawi, SIHI 2015

19. SCHISTOSOMIASIS CONTROL INITIATIVE (SCI)

Country(s) of operation:

Burundi, Cote D'Ivoire, Democratic Republic of Congo, Ethiopia, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Niger, Rwanda, Senegal, Sudan, Tanzania, Uganda, Yemen, Zambia, Zanzibar

Implementer:

Schistosomiasis Control Initiative at Imperial College London

Organisational structure:

University

CHALLENGE: Even though 200 million people in Africa are infected with schistosomiasis, awareness of its consequences is low and access to medication is limited.

SOLUTION: The SCI works to decrease the incidence of schistosomiasis in Africa by mapping the distribution of the disease across the continent in order to inform and advocate appropriate policies in partnership with the ministries of health. The SCI advocates for free treatment, often provided through drug donations by pharmaceutical companies and raises funds to facilitate free delivery of the drugs to patients. The initiative includes training of healthcare workers and teachers to deliver the drugs and health education to communities.



Credit: L. van Niekerk, Ethiopia, SIHI 2015

20. SMS-HUB

Country(s) of operation:

Mozambique

Implementer:

The Leprosy Mission Mozambique, along with Mozambique Health Department

Organisation structure:

NGO

CHALLENGE: In Mozambique, hand-written records (often disorganised or incomplete) are used to monitor the management of people with leprosy, making the flow of information difficult and unreliable.

SOLUTION: The SMS-Hub is an SMS-based notification system that improves the management, monitoring and evaluation of leprosy. It allows district, provincial and national leprosy supervisors to track cases using their own phone. They can gather data to improve case management, planning and resource allocation, and monitor stock levels at district facilities to prevent drug stock-outs. The system can be accessed from any place with mobile reception and can send detailed information to mobile or email.



Credit: Dollarphoto

21. SOCIAL ENTREPRENEURSHIP FOR SEXUAL HEALTH (SESH)

Country(s) of operation:

People's Republic of China

Implementer:

Social Entrepreneurship for Sexual Health (SESH) Global

Organisational structure:

Research programme

CHALLENGE: HIV testing rates are low in China and sexual health messaging tends to be old fashioned and unengaging.

SOLUTION: SESH is a multi-sectoral research collaboration that utilises creative contributory contests to crowdsource sexual health messaging that is directly informed by the lives and experiences of the target population. This 'bottom-up' approach taps into the wisdom of crowds to generate appropriate and engaging materials. It allows for greater inclusion of perspectives from diverse community members and possesses higher potential for innovation – compared to conventional expert-led approaches.



Credit: SESH

22. SPROXIL

Country(s) of operation:

Ghana, India, Kenya, Nigeria, Pakistan, Tanzania

Implementer:

Sproxil

Organisational structure:

Company

CHALLENGE: If patients ingest drugs with the wrong mixture of active ingredients, it results in drug resistance, super-strains and poor health outcomes.

SOLUTION: Sproxil combines mobile phone SMS capabilities and scratch-off security ID labels on products to allow patients to verify whether the drug purchased is genuine, fake or stolen. Information about the products is shared with government regulatory authorities, who are responsible for identifying and arresting counterfeiters. It is free to the end-user. Sproxil only charges manufacturers, who pay into the system to have their products protected.



Credit: Sproxil

23. THE MEDICAL CONCIERGE CALL CENTRE

Country(s) of operation:

Uganda

Implementer:

The Medical Concierge Group Limited

Organisation structure:

Company

CHALLENGE: In Uganda, the lack of qualified medical personnel (especially in rural areas), along with rising costs of out-of-pocket expenses, present significant barriers for many to accessing healthcare.

SOLUTION: The Medical Concierge Call Centre provides telemedicine consultations and social media health messaging that is free, accessible anytime and operates in multiple languages through multiple platforms such as voice, SMS, Facebook, Twitter, WhatsApp, Skype and email. Through the call centre, people in urban and rural areas have access to healthcare information and services provided by licensed doctors and pharmacists.



Credit: L van Niekerk, Uganda, SIHI 2015

24. VIVA AFYA

Country(s) of operation:

Kenya

Implementer:

Viva Afya Limited

Organisation structure:

Company

CHALLENGE: Low-income populations living in dense suburban areas in Kenya often have poor access to quality healthcare.

SOLUTION: Viva Afya runs a network of outpatient clinics in Nairobi's low-income suburbs, providing affordable care for both non-communicable and communicable diseases. Each Viva Afya clinic is staffed with licensed professionals (clinical officers, nurses, technologists), offering a one-stop shop for access to consultation, diagnostic and pharmacy services. Viva Afya also employs local community health workers who serve as agents between the clinics and community.



Credit: L van Niekerk, Kenya, SIHI 2015





WHAT IF

WE CAN CATALYSE SOCIAL INNOVATION IN ALL
COUNTRIES ACROSS THE GLOBAL SOUTH

OUR COLLECTIVE FUTURE VISION

Our journey thus far has made one thing certain: across the Global South there are multiple actors – the front line health worker, researcher, community member or national health implementer – who are passionate about and committed to changing healthcare systems. Collectively, those we met expressed their hopes, desires and dreams to see a different reality come into being for every woman, man and child living in the Global South.

Energised by what we have heard, seen and learned, we are ready to harness a greater collective effort. We are prepared to unlock the potential of all the health system actors to enhance and advance social innovation in health. We hope to see grassroots community innovations influence policy and practice, such that the impact can be scaled. When actors unite – communities, policymakers and researchers – even more new and sustainable innovations can be created and implemented to serve those in need.



Credit: L van Niekerk, Malawi, SIHI 2015

THE ROAD AHEAD

In 2016/17, we will work towards strengthening the capacity of health system actors to advance the application of social innovation at country-level.

Our work will continue in three main areas:

1. RESEARCH

The outcome of the case study learning and collaborative consultation in December 2015 will guide us to the future research agenda for social innovation and where further evidence is required. We will ask the global community to contribute the evidence they have developed on the field to facilitate an open-knowledge sharing repository.

OUR NEW PARTNERS 2016/17

The London School of Hygiene & Tropical Medicine

The London School of Hygiene & Tropical Medicine is a world-leading centre for research and postgraduate education in public and global health. Their mission is to improve health and health equity in the United Kingdom and worldwide; working in partnership to achieve excellence in public and global health research, education and translation of knowledge into policy and practice.

The Centre has been advancing social innovation in healthcare delivery through applied research. As an example, their Social Entrepreneurship for Sexual Health Initiative uses creative contributory contests to crowdsource sexual health messaging to enhance uptake of HIV and syphilis testing. They are especially passionate about working in partnership to achieve excellence and are excited to be part of the Social Innovation in Health Initiative.



2. PRACTICE

To truly strengthen capacity of local health systems, we will embark on a country-embedded approach. In 2016, we will focus on better understanding the needs of academic institutions, innovators and ministries of health across the Global South. In 2017, we will collaborate with two to three countries to unlock the capacity of their local actors to catalyse, grow and integrate social innovation locally.

3. INFLUENCE

SIHI is but one part of the global innovation eco-system. By creating a platform for actors to engage, new partnerships can be formed, influence can be exerted in different spheres and resources can be harnessed and mobilised.

Fondation Mérieux

Established in 1967, Fondation Mérieux is an independent family foundation that has public interest status. Its mission is to enhance local capacities in developing countries to reduce the impact of infectious diseases on vulnerable populations.

They are pleased to partner with the Social Innovation in Health Initiative in furthering their mission to fight infectious diseases in developing countries. Poverty has a significant impact on the development and spread of infectious disease and the need for improved access to healthcare must be addressed in close partnership with local, community-based organisations.



World leaders, heads of state, politicians, and rock stars all have a role to play in moving the world closer to justice and health for all – but so do you and I. Change is not the responsibility of the few, but the obligation of each of us.

Ordinary people like you and me are the ones who could create new ways to provide health and care to those in need.

We are the change-makers.

We are the front line soldiers.

We are the innovators.

Each of us has an invaluable role to play in transforming healthcare and our society.

There is no idea too small or insignificant.

If the world is to realise peace and justice for all, you and I must share our ideas and use our voices.

As Madiba said, “to be free is not merely to cast off one’s chains, but to live in a way that respects and enhances the freedom of others.” In that spirit, let us come together and enhance the health of our country, our continent and our world.

- By Kate Long, friend of SIHI



WHAT IF

COMMUNITY-BASED SOCIAL INNOVATIONS
CAN HAVE LARGE-SCALE IMPACT?

TOP 100 PROJECTS SUBMITTED TO SIHI

Now, more than ever, new innovative solutions are required to allow all people access to quality healthcare. An abundance of existing solutions have been developed and implemented in different contexts and environments. Here are the top 150 projects that came to our attention.



SOUTH AMERICA

- Aurum Institute TB Programmes Unit
- EpiTrack
- Faculdade de Medicina de Ribeirão Preto, University Sao Paulo
- Fundación EHAS
- Hospital de Clínicas de Porto Alegre (HCPA)
- Indigenous Community Health Workers Professionalisation, Oswaldo Cruz Foundation
- Laboratório Central de Saúde Pública “Dr. Costa Alvarenga” - LACEN-PI
- Living Labs, Centro para el Desarrollo de la Investigación Científica
- Marli Marques
- Men Health Group for Behavioural Changes in the Community, Government of Brazil
- Pan-American Health Organization (KBR)
- Partners In Health
- Strategies and Didactic Resources to Approach Chagas's Problematic, Mariana Sanmartino
- Participatory Epidemiology Network for Animal and Public Health (PENAPH)

ASIA

- Akros Global Health
- AMRIT Clinics, Basic Health Care Services
- Angkor Hospital for Children
- Anti Malaria Campaign Regional Office, Sri Lanka
- ayzh
- Blue Torch Home Care Limited
- Breaking the Barriers, Government of Himachal Pradesh
- Center for Health Policy and Social Change, Indonesia
- Chama cha MamaToto/Academic Model Providing Access to Healthcare (AMPATH)
- Cheick Ouamar, Bagayoko
- Clinton Health Access Initiative
- Community participation for introducing Guppy fish in Breeding Places
- Defence Services Medical Research Centre
- Doctor Gratis
- Embryo Technologies Private Limited
- Equipe Medicale Des Volontaires
- GRAVIS
- Healthy Family Network
- Immunizing Vulnerable Populations, Government of Himachal Pradesh
- Institute of Public Health, India
- Integrated surveillance using the Ecohealth approach
- Japan-Nepal Health and Tuberculosis Research Association
- Lake Tanganyika Floating Health Clinic(LTFHC)/ WAVE
- Malaria Consortium
- Maya Health Network
- mDoc LLC
- MedSted Nepal
- Metahelix
- Miti Health
- Mobile based Surveillance Quest using IT (MoSQuIT), Centre for Development of Advanced Computing
- mPower Social Enterprises Ltd.
- mSpray
- mTatva
- Mutual Education for Empowerment and Rural Action (MEERA) Foundation
- National Institute for Research in Tuberculosis, India (x2)
- National Institute of Public Health, Lao PDR
- National Malaria Control Program of Nepal
- Noora Health
- One Family Health
- Operation ASHA
- Participatory open contests, Social Entrepreneurship for Sexual Health (SESH)
- Philippine Leprosy Mission
- Public Health Research Institute of India
- Serve Train Educate People's Society (STEPS)
- SHAR Technologies Group
- Shiv Physical Education and Environment Development (SPEED) Society Jhansi
- Specific Union for Farmer Women in Jordan
- Stop Tuberculose Bouaké
- Sulianti Saroso Infectious Diseases Hospital, Indonesia
- TB Control Program, Pakistan
- TB prevention for child contacts in Timor-Leste, Bairro Pite Clinic
- The Catholic Health Association of India
- The Doctors United Charitable Trust
- Vasavya Mahila Mandali (VMM)
- Wonder Soap
- World Health Partners Urban TB Initiative
- YAKKUM Emergency Unit
- Yayasan Orangtua Peduli (Foundation of Concerned and Caring Parents)
- TTC
- The Catholic Health Association, India
- Enlace Hispano Americano de Salud
- Leomedix LTD - asia

AFRICA

- Active case finding, The Good Neighbour Inc.
- Africa Queen of Hearts Foundation LTD
- Africa Goal
- AfricaSys
- Aidspan
- APOPO
- Aviro Health
- Bettercare
- Bright Generation Community Foundation
- Centre for Communities Education and Youth Development (CCEYD)
- ColaLife
- Community engagement towards malaria elimination in Rwanda
- Concern Health Education Project
- Creating a market for mRDTs in the Private sector
- Cycling out of Poverty Foundation: Bike4Care
- Dimagi South Africa
- D-tree International
- Daystar University Leishmaniasis prevention
- Department of Community Medicine, Abia State University Teaching Hospital
- Desmond Tutu HIV Foundation, Tutu Tester Mobile Clinic Project - Health on Wheels
- Diagnostic Pattern Recognition and Reporting for Radiographers (DP3R)
- Ebonyi State University, Nigeria
- Electronic Medical Records for the Developing World (EMR4DW)
- Epidemiology Department - Ministry of Health in Sudan
- Free Medical Screening and Referral Project, Jakin
- The GP Down Referral Model, BroadReach Healthcare
- Grassroots Development and Empowerment (GRADE) Foundation
- Health-E-Net Limited
- Hermon Development Foundation
- Hope Care Foundation
- IICD (International Institute for Communication and Development)
- Imaging The World
- InSCALE APE CommCare app
- InstaHealth
- Kamwokya Christian Caring Community (x2)
- Kheth'Impilo Jamboree
- Kheth'Impilo Patient Advocates
- Kheth'Impilo Pharmacy Assistant Program
- Last Mile Health
- LifeNet International
- Living Goods
- Local Public and Private Partnership in Health Service Delivery
- Drug Shop Integrated Care, Makerere University
- Learner Treatment Kit, Save the Children US
- Medical Camp, Special Pathogens Research Network Limited
- MediLoan/Finrad Limited
- Mobilization and Action Against Bilharziasis in Nigeria.
- MobiQube-LifeQube Platform
- Moxafrica
- National Institute for Medical Research, Korogwe site
- Observatoire Communautaire d'accès aux services de santé
- Optimization of Malaria Treatment (OMaT)
- PAN-Somalia Community-Based Primary Healthcare Project
- Put Counsel First
- Reach Ethiopia
- Riders for Health
- Safe Water and AIDS Project (SWAP)
- Schisto and Ladder health Educational game, Federal University of Agriculture
- Schistosomiasis Control initiative
- SMS-Hub Leprosy case management system
- SUMMO
- TB and Plasmodium species microscopy, Special Pathogens Research Network Limited
- The Medical Concierge Group Limited
- University of Nairobi - Vaccination Card programme
- Viva Afya Ltd
- Youth Patch

www.healthinnovationproject.org

