Social Enterprise and Healthcare Service Delivery

Caroline Humphries – Winston Churchill Fellowship 2011 Report

Executive Summary

What is the most effective way of making a sustainable difference in a developing country? This is the tough question being asked by a new generation of entrepreneurs, who are not satisfied with the slow progress being delivered by government services, while standing firm against the temptation to choose a career in mainstream business.

In developing economies, state provision of public services (such as healthcare, education, water and sanitation) is often weak, under-resourced, inefficient, and compromised by corruption. Meanwhile the private sector is also weak: there is a lack of products and services catering to the low-income majority; financial services are prohibitively expensive with high interest rates, high collateral requirements and multiple high service charges; and price fixing and monopolies often flourish with political support – stifling competition. The regulatory framework for commercial activity is often weak and under-enforced, meaning unscrupulous companies can flout health and safety standards and sell sub-standard products, cheating the consumer. The weak regulatory and legal environment puts reputable companies off entering the country, so that the basic economy fails to develop.

Social enterprise is a solution developed by visionary business leaders and entrepreneurs to bridge the gap in an environment of weak public services and underdeveloped markets. A social enterprise is a business with a double bottom line: to make a financial profit and to deliver a targeted social objective. Social Enterprise UK describes social enterprises as “businesses that trade to tackle social problems, improve communities, people’s life chances, or the environment. They make their money from selling goods and services in the open market, but they reinvest their profits back into the business or the local community” (Social Enterprise UK, not dated). In this research, ‘social enterprise’ and ‘social business’ refer to organisations delivering targeted social objectives or impact, whose core business is financially viable (i.e. funded primarily through commercial activity as opposed to public sector contracts or donor funding).

The social entrepreneurs interviewed bring business skills and ethical principles to bear on social problems, demonstrating that profitable businesses can be made to serve low-income consumers without exploitation. They reject corruption and inefficiency by driving change through agile, flexible, well-run businesses which sink or swim in the market environment. Independent of obligations to donors or the state, they are free, and obliged for survival to prioritise meeting the customer’s needs to sell their services. And, with committed moral leadership, they plough profits back into the business to bring internationally recognised quality standards to the poor at
an affordable price. They perceive social enterprise as the only viable option for the individual to bring to bear his or her passion, expertise and commitment to combat poverty and to make services available to low-income groups.

Social enterprise is driving improvements in healthcare services in India and Kenya. By achieving high quality standards while serving low-income clients at an affordable price, they raise public expectations. This challenges the government to improve the quality and coverage of public services, and challenges private providers to increase accessibility.

This research looks at how they are doing it: the unique set of challenges social enterprises face, leadership traits they have in common, and characteristics that make them succeed. In 2011 I spent four weeks in India and six weeks in Kenya as a Churchill Fellow researching social enterprises that are delivering or improving access to health services for low-income communities. I originally proposed to evaluate different business models and identify which were more effective. However in practice it turned out that the specifics of the model were not the defining feature of its success. Instead it was the people behind the process - their persistence and unrelenting commitment to achieving high standards in highly challenging environments - that really made a difference.

Using the social enterprise business model to address the problems of wholesale state provision is a new and emergent field. It is no surprise, therefore, that a wide array of different approaches are taking shape. Every leader and organisation is engaged in a process of trial and experimentation to find what works, what doesn’t and why, and to refine the answers they find. This report aims to share the great ideas, best practice, and inspirational leadership that I encountered along the way.

**Section one** (pages 6-8) gives an introduction.

**Section two** (pages 9-23) identifies the specific challenges of leading a social enterprise in the tough environment of a developing country, and the shared leadership traits exhibited by the most successful organisations. Seven leadership qualities were identified as being key to success:

1. Understanding the needs and preferences of low-income consumers,
2. Facilitating behaviour change,
3. Designing the service around the needs of the client,
4. Relentless experimentation to achieve results,
5. Balancing ethical principles against business priorities,
6. Building complex, multi-level partnerships, and
7. Local ownership, by extraordinary individuals.
Section three (pages 24-36) looks at how they make things work, examining key operational characteristics, such as how the organisation was set up and how it delivers high-quality outcomes. Seven vital operational qualities were identified:

1. Flexible approach to start-up capital,
2. Flexible approach to human resources,
3. Diversification of income streams,
4. Faultless governance,
5. Aim to scale-up,
6. Evidencing high-quality outcomes, and
7. Extraordinary individuals.

Section four (pages 37-47) reflects on lessons that can be learnt for the UK: both to improve international development policy and practice, and to develop the UK social enterprise sector.

It is recommended that the UK Department for International Development and its delivery partners:

1. Improve access to capital for social enterprise abroad, to support both start-up and expansion of social business ventures. This could be achieved by expanding the scope of the UK Department for International Development’s Development Finance Institution (CDC) to include strategic grant-making to support new social enterprises in their early stages of development, and impact investment (i.e. investing in viable social businesses with the primary aim of achieving social impact) to support taking enterprises to scale.
2. Source and fund technical assistance to help new social enterprises in developing countries become ‘investment ready’.
3. Advocate for government funding mechanisms to support social enterprise such as open tendering of contracts, Public-Private Partnerships, and government subsidy schemes for services to low-income communities.
4. Improve access to financial products for low-income communities. This needs to include commercial products such as business loans at competitive interest rates, as well as small-scale products such as micro-finance, mutual aid funds and facilitated peer lending.
5. Maximise the beneficial knock-on effects of social enterprise in development by commissioning research to evidence the success of new models of service provision, by identifying and sharing best practice between different organisations, sectors and countries, and by supporting and funding high calibre leadership training programmes for social entrepreneurs abroad.
It is recommended that UK social enterprises:

1. **Seize the opportunities provided by the new NHS ‘Right to Provide’ and Community ‘Right to Build’, ‘Right to Challenge’ and ‘Right to Bid’,** to take a greater role in shaping local services, amenities and developments that are innovative, community-centred and sustainable.

2. **Learn from the leadership and operational qualities** of successful social enterprises abroad to better position themselves to bid for public service contracts, and specifically:
   a. **Demonstrate additional value through re-investment of profit**, using cross-subsidy models to provide private medical insurance and treatment services alongside contracts for NHS services, fee-paying services for treatments unavailable on the NHS, and fee-paying social care services under the new ‘direct payments’ and ‘personal budgets’ system, amongst many other options – to deliver additional profits for re-investment and enable a higher quality of care across the organisation’s services,
   b. **Demonstrate services tailored to meet local need through community-driven service development and provision**, and
   c. **Demonstrate innovation through agile, entrepreneurial organisations**, proactively identifying need and developing new solutions to meet it.

**Section 5** (pages 48-49) provides a conclusion.

Throughout the report, case studies from the profiled organisations are provided in boxes, in blue text.

**Annex A** (pages 50-89) provides the interview questions and a detailed profile for each organisation visited. This includes a description of each organisation’s business model, and an evaluation of the benefits and disadvantages of different models.

**Annex B** (pages 90-91) provides a list of acronyms and abbreviations.

**Annex C** (pages 92-94) provides a list of useful resources.

The **bibliography** is presented at the end (pages 95-100).

I was highly impressed by the talent, passion and dedication of the entrepreneurs and social business leaders who hosted my visits. I’m proud to showcase their work in this report, and I hope their stories provide inspiration and models of good practice for others as they have for me.
Acknowledgments

I am immensely grateful to all the organisations who gave up their time to host my visits and answer my never-ending lists of questions! I was taken aback by the tremendous hospitality and welcome that I was shown. Temi Mutia, Philip Mwangangi, Angeline Kitani, Joseph Ndii, Joel Mathu, Janet Ndumbu, Dr. Kibata Githeko, Samson Ababu Gimongo, Heidi Pidcoke, Beatrice Omondi, Joel Kinuthia, Ramadhan Obiero, R. Shrinivasan, Dr. Vishwanath, Sweta Mangal, Rajiv Vasudevan, Sajan Ganapathy, Geetha Srinivasan, Vijaybhasker Srinivas: you made my research a pleasure and left me buzzing with energy, ideas and enthusiasm to take forward.

A big thank you also to my parents, family, friends and boyfriend, for supporting my crazy scheme to abandon my home, job and loved ones in search of inspiration. In particular, thanks to John Musina who provided me with a comfortable place to live and helped me settle into all of Kenya’s bustle and confusion! Thanks also to Westminster Quaker Meeting, for support and encouragement throughout.

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In the course of my travels I visited a number of organisations which I have not ended up including in this report. In many cases this was because the organisation turned out not to be relevant to my area of interest. Some, for example, were Trusts or NGOs dependent on donations or aid funding, rather than social businesses. Others were delivering services or products that were not connected to healthcare. Some found they were unable to host my visit as planned due to unforeseen operational pressures. In a very few cases, I have excluded organisations where I had concerns about service quality or insufficient information to form a fully reliable opinion. Nonetheless, I am grateful to all for their help and the background information they have contributed to my understanding of the context and issues.
1. Introduction

Purpose: This research identifies key leadership and operational qualities shared across a sample of eleven successful social enterprises in India and Kenya. The aim is to identify lessons that can be learnt to support social enterprise both in developing countries and the UK, particularly in the healthcare sector.

The original objective of the research was to identify and evaluate innovative business models as well as key characteristics of a successful social business. I had aimed to identify which social enterprise business models were more effective and why. However in practice it turned out that the specifics of the model were not the defining feature of an organisation’s success. This led me to revise the objective, focussing instead on identifying the key qualities that were shared across successful organisations.

I have used a broad definition of social enterprise or social business: an organisation delivering targeted social objectives or impact, whose core business is financially viable. This excludes any organisation that relies primarily on donor or state funding. However it includes organisations that make sustainable use of donor funding - for example:

- Microfinance organisations whose initial loans are repaid and lent out again in the community;
- Non-Governmental Organisations that facilitate access to financially self-sustaining community-based health insurance schemes;
- Corporate Social Responsibility initiatives;
- Social businesses which received donor funded to meet their start-up costs and are now financially self-sustaining;
- Community Based Organisations which are self-sustaining through their members’ contributions.

Method: Eleven successful organisations with innovative business models that provide low-income customers with health services or help them to access health services were identified.

India (four weeks):

- LifeSpring maternity hospitals (LifeSpring, 2011: http://www.lifespring.in/)
- Ziqitza Health Care: 1298 and 108 ambulances (ZHL Ltd, not dated: http://zhl.org.in/)

Kenya (six weeks):

- Upperhill Eye and Laser Centre (UHEAL, 2011: http://uhealth.or.ke/)
- Healing and Rebuilding our Communities (AVP Kenya, not dated: http://www.avpkenya.org/trauma.html)
- Support for Tropical Initiatives in Poverty Alleviation (STIPA, 2012: www.stipakenya.org) – a member and delivery partner of the Kenya Community Based Health Financing Association (KCBHFA, 2010: www.kcbhfa.org)
- We Are Watching You – campaign for political accountability (We Are Watching You, 2012: http://wearewatchingu.wordpress.com/).

Visits were made to head offices and to field sites. Semi-structured interviews were undertaken with founders and executive team members responsible for strategy, and operational staff responsible for service delivery (interview questions available at Annex A).

Semi-structured interviews were also held with organisations engaged in building capacity in social enterprise in the UK and abroad. These included:

- The School for Social Entrepreneurs (SSE, 2012a: http://www.the-sse.org/)
- ClearlySo (ClearlySo, not dated: http://www.clearlyso.com/)
- Community Interest Company Association (CICA, not dated: http://www.cicassociation.org.uk/)

It was found that seven leadership qualities (understanding the needs and preferences of low-income consumers, facilitating behaviour change, designing the service around the needs of the client, relentless experimentation to achieve results, balancing ethical principles against business priorities, building complex, multi-level partnerships, and local ownership, by extraordinary individuals) were identified as vital to success across the eleven organisations profiled. Seven operational qualities (flexible approach to start-up capital, flexible approach to human resources, diversification of income streams, faultless governance, aim to scale-up, evidencing high-quality outcomes, and extraordinary individuals) were likewise shared across the organisations and cited as crucial to ensure the organisations’ sustainability and effectiveness.
Recommendations were formulated to improve both UK international development policy and practice, and to develop the UK social enterprise sector. It is recommended that UK international development agencies improve access to capital for social enterprise abroad, source and fund technical assistance to help new social enterprises become ‘investment ready’, advocate for government funding mechanisms to support social enterprises to participate in public service delivery, improve access to financial products for low-income communities and maximise the beneficial knock-on effects of social enterprise in development by commissioning research, sharing best practice and supporting high calibre leadership training programmes for social entrepreneurs. It is recommended that UK social enterprises seize the opportunities provided by the new NHS ‘Right to Provide’ and Community ‘Right to Build’, ‘Right to Challenge’ and ‘Right to Bid’, and learn from the leadership and operational qualities of successful social enterprises abroad to better position themselves to bid for public service contracts. Specifically it is recommended that they demonstrate additional value through re-investment of profit, tailor services to meet local need through a community-driven approach and demonstrate innovation through agile, entrepreneurial organisations, proactively identifying need and developing new solutions to meet it.
2. Leadership in a highly challenging environment

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These were the words that came up consistently in interviews with leaders from each of the eleven organisations profiled.

Running a successful business in a developing country is tough. The infrastructure we take for granted in the UK such as electricity, water, plumbing, good roads, internet connection and online security is often lacking or irregular. Even the best-run business has to devote a disproportionate amount of time to resolving day-to-day operational issues to make these basic resources work as they should, before they can get on with their core work.

On top of the practical challenges, there are interpersonal challenges. The pressure of poverty can create a set of perverse incentives for people to put obstacles in your way. The mechanic you call out to fix your equipment breaks one component while fixing another, to ensure his next day’s work. The government official who licences your business needs a bribe to make ends meet to feed his family. Corruption, petty theft, cheating and dishonesty can become normalised and expected behaviour in an economy where survival is a day-to-day challenge for most (Transparency International, 2012).

The social enterprise leaders interviewed described a double challenge when looking to deliver a double bottom line: social impact as well as profits. Like any business, they have to take a tough approach to succeed, with every process sharply supervised and no second chances for those who don’t deliver. But they also have to remain open to compassion, so they identify the most pressing needs relating to their social objective and focus resources accordingly. They must listen and get into the shoes of low-income people, so as to be able to design solutions that work for them. And they must remain open to failure, so they persist at the cutting edge of innovation, trying and refining products and services until they find what works.

They face a specific challenge: finding products that low-income communities are willing to pay for, then designing services that meet their needs at an affordable price.

This is no mean feat. In the healthcare sector, fixed unit costs are high. The high-calibre clinical staff needed to provide a quality health service come at a steep price, or need compelling motivation to accept lower wages than they could earn in private sector or international NGO-provided services. Equipment and infrastructure are
expensive and a prerequisite to high-quality care. And then come the additional operational costs of running a critical service: back-up generators in case of power failure, water storage to ensure a continuous supply.

And on the consumer side, ability to pay is rock bottom. Poverty Action Lab research (Poverty Action Lab, April 2011) shows that “relative to free distribution, charging even very small user fees substantially reduces adoption” of health products such as deworming tablets, water disinfectant, and long-lasting insecticidal bed nets. The many competing demands on limited family funds – food, children, school fees, transport – often push health needs down the list.

The problem is exacerbated by lack of awareness and distrust of medical authorities. Experience of over-stretched government hospitals - where basic drugs and resources are often lacking, and staff are often absent supplementing their meagre salary through private practice – teaches low-income communities that hospitals are a place to go to die rather than to recover. The low salaries offered by government facilities attract less motivated and talented staff. Under-resourced facilities lack the equipment to carry out key tests. Uninformed and incompetent diagnoses lead to irreversible injury or death from conditions that could be easily treated.

The story in private practice is not much better: quacks and opportunists exploit the public fear of government services, and the lack of effective sector regulation, for their own profit. Unlicensed practices over-charge and over-prescribe; offer services they are unqualified to perform, in unhygienic and under-resourced settings; misdiagnose and perform unnecessary or misinformed treatment. Often customers are left with no choice: seeking help is often deferred until the patient reaches critical condition, at which point they are rushed to the nearest facility. In particular low-income women often choose to give birth at home with a traditional healer in attendance, and then are rushed to the nearest facility when things go wrong (incurring costs they are ill-equipped to meet). One-off unforeseen healthcare expenditure can “push households into poverty – or further into it if they are already there” (World Bank, not dated).

Leadership Quality #1: Understanding the needs and preferences of low-income consumers

The social enterprises interviewed that are competing to provide health services in this environment described facing massive barriers of distrust. Patients are reluctant to believe their diagnosis and accept the implications, let alone undergo treatment and still less pay for it. Highly qualified clinicians have to overcome their own frustration at not being taken seriously, and invest time, effort and energy in building relationships, winning trust and developing a word-of-mouth reputation in the communities they seek to serve.
A new social business faces the usual challenge of building brand awareness, trust and loyalty. Many cited the need to develop the market for their services.

The Pushpagiri Eye Institute (PVRI) and Upperhill Eye and Laser Centre (UHEAL) are social businesses delivering high-quality eye care to low-income communities in India and Kenya respectively. Both have found that the majority of communities in their countries were unaware of eye conditions that could cause serious sight loss or blindness. Not only were people reluctant to undergo treatment, in the early days of both organisations very few people attended their eye screening camps – even when these were offered very cheaply or for free. Both have had to invest significantly in communications campaigns to raise awareness of eye conditions and the potential risks. Both have had to find effective ways of publicising their eye screening camps to persuade people to attend, and to build brand recognition and trust before patient volumes would significantly increase.

Understanding their target group has been key to maximising attendance. Both have experimented with a wide range of media and promotions. PVRI has a policy of trialling marketing methods for up to six months and then adopting them as standard practice if they are successful. They have advertised through billboards, pamphlets, newspapers, internet sites, information tickers on cable TV in nearby areas, cinemas, and posters in other eye clinics.

UHEAL promotes its camps through posters and word of mouth at the hosting venue, through asking local clinicians to tell diabetic patients to attend, through advertising on local radio stations and through churches. Both found that the best way to attract low-income patients was not through slick, expensive TV adverts or billboards as it might be for affluent communities – low-income people see these media as being outside of their world and the messages not for them. Instead the key is gaining the support of trusted people in the local community and providing direct, personalised information.

As a new initiative PVRI sends its Business Managers to rural areas 3-4 days in advance of a camp. The managers make speeches in the public forum (promoted in advance by a local drummer), give out leaflets, tour all surrounding villages in a 50-75km radius announcing the camp through a loudspeaker in an autorickshaw, and call on people door-to-door to talk to them personally about the benefits of attending.

PVRI organises seminars for local doctors and healthcare staff to encourage referrals and raise awareness of community outreach screening camps. It promotes its camps through key people such as teachers, organisations, employers, and employee associations in the local community. It uses a local group of volunteers to act as community champions to raise awareness and encourage people to attend the camp. Usually one community champion organises the venue for the camp and the logistical arrangements, using their position in the community to promote it and secure a high-profile time and place.
UHEAL similarly finds that locally trusted sources of information work best for promoting their camps, particularly local radio stations and diabetic support groups. The diabetic support groups are proactive in raising awareness of the risk of diabetic retinopathy, and organising their members to attend for screening and treatment – which UHEAL in turn can reward with large discounts as the volume of patients is high.

R. Shrinivasan, Chief Strategy Officer for PVRI, emphasised the importance of people’s perceptions; to be successful it is crucial that the organisation positions itself carefully, earns people’s trust and credibility at all levels, and demonstrates that it is doing what it says it will do.

**Leadership Quality #2: Facilitating behaviour change**

Sometimes it is not just a shift in perception or a development of trust that is needed, but a wholesale change in culture. In communities where awareness of health conditions is low, people can’t afford to attend health facilities and often have no experience of doing so. The idea of taking a proactive approach to managing your own health, and investing your time and energy in doing so rather than accepting what life deals to you with resignation, is a new behaviour pattern that needs encouragement if it is to take root. The public health Stages of Change model (Prochaska and DiClemente, 1983) proposes six stages to behaviour change: pre-contemplation, contemplation, preparation, action, maintenance and relapse. Targeted messages can help people progress between stages.

**Alive and Kicking**, a social business selling sports balls in Kenya, disseminates health promotion messages on HIV / AIDS and malaria prevention on its balls, on posters starring celebrity sportspeople, and at school and community events. The messages are clear, easy to understand and repeated across a wide range of media that appeal to young people to ensure coverage and maximum impact.

Targeted messages to encourage behaviour change can also be helpful to support people to stand up for their rights and put pressure on the state. Civic engagement campaigns can support communities to demand that the government provide or commission health services that meet people’s needs – in terms of both coverage and quality.
We Are Watching You, a campaign to improve political accountability and civic engagement in Kenya, uses music, theatre, art and film events, as well as social media, blogs, t-shirts and other printed media, to convey key messages about holding leaders to account. By prompting people to think about their expectations of their leaders, and how they can use their vote and their voice to drive change, the campaign is empowering young people in disadvantaged communities such as Nairobi’s slums. The campaign was started by a local community leader from Nairobi’s Baba Ndogo slum, and thus carries credibility, which is enhanced through the use of messages and images that resonate with young Kenyans. Where politicians have previously been able to manipulate the youth into violence based along tribal lines, the campaign is now encouraging them to recognise and reject these attempts and instead unite around constructive activism.

The same principles of culture change apply when it comes to dealing with money. Four of the organisations profiled facilitate access to healthcare through improving income levels and health awareness: through a community health insurance scheme (Support for Tropical Initiatives in Poverty Alleviation), through income-generating activities such as micro-finance and enterprise (Right Sharing of World Resources, the Regional Institute for Social Enterprise Kenya, and Alive and Kicking), and through health promotion awareness-raising campaigns (Alive and Kicking and the Regional Institute for Social Enterprise Kenya). These organisations seek to develop a culture of saving among their members and employees, which may be new and hard to grasp for people who are used to living hand-to-mouth, day by day.

Right Sharing of World Resources Kenya (RSWR) provides microfinance. It funds loans to new and small women’s groups of 20 to 30 low-income women belonging to the Quaker church, usually in rural areas, to start or upscale their micro-businesses. Its philosophy is to empower women and tackle poverty by increasing their income through revenue from their business activities to meet family needs – food, education and healthcare.

RSWR supports women to develop finance and business skills before making each loan. Samson Ababu, in-country field representative, describes the investment as ‘seed money’, explaining to the women that they must nurture it to ensure growth. When farming, women are used to preparing the land, weeding, watering and caring for the crop. After harvest, some is taken to eat and some to use as seed again for next year’s crop. In the same way, the women learn that their loan is a seed. They must check the conditions are right for launching their business, prepare, and nurture it to fruition. Once it is generating a profit, some of the income can be used for living expenses, but some must also be set aside for repayment of the loan and some for re-investment.
Not only does RSWR seek to develop business acumen, it is also encouraging a culture of saving, accountability and responsibility. It is challenging dependence by offering a path to sustainable income and dignity.

Leadership Quality #3: Designing the service around the needs of the client

Once trust is established and the quality of the service is accepted, the next challenge is persuading people that it’s worth paying for. Most of the organisations profiled rely on income direct from charging customers. This has the advantage of providing a strong link between consumer and product: if the product doesn’t meet the consumer’s needs, then they won’t be willing to pay.

AyurVAID, a chain of Ayurveda hospitals in India, have been keen from the outset to improve access to high-quality Ayurveda services for everyone – regardless of income. They set up an AyurSEVA branch: a subsidised low-cost hospital for low-income patients, with identical care quality standards.

However, it ran up against a series of obstacles. Low-income patients simply could not afford to pay for in-patient treatment for chronic illnesses. Often they did not recognise their own need for care or the benefits of paying for early treatment rather than waiting for a problem to escalate into something potentially more complicated. Except in an emergency, they simply weren’t able or willing to take time off work for treatment. The AyurSEVA hospital was regularly operating significantly under its in-patient bed capacity, incurring disproportionate overhead costs and failing to break even.

AyurVAID changed tack: it integrated the subsidised side of its business into its mainstream hospital chain at unit level. The AyurSEVA branches were rechristened AyurVAID for brand consistency and all hospitals now accept a mixed economy of patients. Income from full-fee-paying patients subsidises access for low-income patients who can apply for preferential pricing based on means assessment.

The new model enables AyurVAID to operate more flexibly and manage capacity more effectively. It has the knock-on advantage that low-income patients are integrated into mainstream patient flows, ensuring a standardised quality of patient experience.

Recognising the barrier that taking time off work represents to low-income workers, AyurVAID has also adapted its approach to take their services out of the hospital to people in their place of work. It developed a partnership with the NGO Labour Net to target casual workers around the Bangalore area, such as labourers, who tend to have nomadic, unorganised, day-to-day employment and are rarely covered by any form of sick pay or cover for healthcare costs. It now provides assessments, advice
and medicines to these workers on building sites, thus reaching over 2,500 people in a year.

The product has to be clearly effective, convenient and affordable for a low-income consumer to part with their money, in the context of competing priorities such as paying for food, water and basic necessities to stay alive.

State services often treat low-income customers as though they are time rich. However, the opposite is often true. In Kenya and India, such customers may have more calls on their time as a result of not being able to afford convenience. They may be walking miles to fetch water, spending hours in low-paid work or domestic labour, and looking after large extended families. So a highly affordable service still may not be a viable option unless it is convenient as well as effective.

In India, public maternity services are often concentrated in large public hospitals which may be 30 to 40 kilometres from women in rural communities. This imposes multiple costs for attending routine check-ups: loss of income from work, travel costs, out of pocket expenses and household costs, as women are usually expected to fetch water, cook and clean. These add to the usual costs such as informal appointment charges and the cost of medicines. The distance involved also makes care hard to access in case of emergency.

LifeSpring maternity hospitals is a social business that aims to make maternity services accessible to families earning $2-4 a day. In addition to highly competitive price structures for packages of care, the chain makes its services accessible by ensuring they are convenient. It runs small 20 – 25 bed branches across multiple locations to bring care closer to women’s homes. Its branches are mostly based on the fringes of the city to be accessible to both urban and nearby rural communities. It provides an outreach service where community health workers travel to surrounding rural areas to bring health education and ante-natal services to women in their home villages and towns. In addition to facilitating access, the business model is based on best clinical practice and keeping costs low: the more check-ups the mother attends, the higher the chance of identifying complications early and the easier and more cost effective they are to address.

To succeed, and win customer loyalty, all patients must be treated with care and respect – regardless of their social status. Rajiv Vasudevan, Chief Executive of the AyurVAID chain of Ayurveda hospitals, stressed that healthcare is a service industry: the patient must be at the heart of all the organisation does, and must be shown care, respect and value by the whole service team.

Often a new, imaginative, radical approach is needed to bridge a gap where traditional approaches fail. Healing and Rebuilding Our Communities (HROC) in Kenya takes a radical and creative approach to addressing trauma after conflict. It works with victims and perpetrators of violence to effect reconciliation, helping both
sides to see and feel events from the other’s perspective, and to re-engage with life after the conflict. It was developed in Rwanda and Burundi after the genocide and later in 2008 brought to Kenya to bring about healing in communities affected by the 2007-08 post-election violence. By acknowledging the trauma and woundedness of perpetrators as well as victims, the approach helps healing to take place for all involved, and assists the community in the process of moving on. It helps participants move towards reconciliation at the personal, family, and community levels.

The successful social businesses interviewed described needing to develop products and services that work around the needs of low-income consumers – in the same way that any business must tailor its products to its target audience. The difference is that while extensive market research is available detailing the every behaviour, lifestyle and consumer preference of middle- and high-income consumer groups, the constraints and preferences of low-income consumers are unchartered territory. This work to map consumer trends has to be done from scratch – and requires a high degree of stamina, persistence and creativity. Businesses need to set aside their usual expectations and listen carefully to get into the shoes of these consumers. They must follow their daily routines and identify their motivations, challenges, life pressures and aspirations, to build up a picture of their needs and expectations.

Effective social businesses take this analysis and use it to create an innovative new type of product that meets this new set of consumer parameters. The best solutions are not just business as usual, adapted slightly to accommodate a different audience, but a paradigm shift: radically different services that have been built from scratch with their needs at the heart. These services are effective, convenient, highly affordable, and customer-centred. Successful social entrepreneurs package their products as aspirational and empowering; as markers of status rather than charity or hand-outs.

Leadership Quality #4: Relentless experimentation to achieve results

Finding products and services which work takes extraordinary patience. In this new territory, it isn’t always clear what will work and what won’t. Bold innovators are needed who have the courage to try out a new idea, learn from failure, recalibrate, and try again. This can be a long journey with multiple iterations. Creative new solutions are tried, found to fail, adapted, tried, refined, and tried again, before being found to succeed, and taken to scale.

Many interviewees talked about needing a tolerance for being mocked. Ideas that seem counter-intuitive and risky can be the ones that break through to new successes.
Sweta Mangal, Chief Executive of Ziqitza Health Care, emphasised the need for patience: proving that the business model works may take longer than you expect; the key is to wait until it is fully tested before scaling up, to avoid early losses. R. Shrinivasan, Chief Strategy Officer at the Pushpagiri Eye Institute (PVRI), described a slow process of innovation that requires exploration of new ideas, patience to win people over slowly to new ways of working and letting an idea evolve rather than pushing it through, and a process of trialling, discarding, and refining ideas until they work in practice. He stressed the importance of not becoming so attached to an idea that your initial investment makes you unable to accept its failure.

The Regional Institute for Social Enterprise Kenya (RISE) has gone through a process of trial and error to find successful micro-business ventures for its Community Based Organisations (CBOs) in drought-ridden Mwingi district. In the immediate period after the drought began, it experimented with many different types of income-generating project to help local communities earn enough to survive. One advantage of being part of the RISE network was that risk was shared between CBOs. RISE provides the start-up materials so CBOs can try out various different ventures at no (or significantly reduced) cost, and then run with the most successful ones.

The organisation has matured, and RISE is now ensuring that all CBOs are financially sustainable and self-sufficient, with strong business discipline across all their activities. At the time of visiting, roughly 1 in 4 CBOs were financially viable. RISE is conducting a cost-benefit analysis on its activities to identify which are the most cost-effective and profitable, so that CBOs can focus on the most lucrative ventures. It uses its ‘Train the Trainer’ network to cascade this information between CBOs. It is also identifying opportunities to scale up CBOs’ business ventures. For example, all CBOs are currently growing aloe and making aloe-based toiletries such as soap, shampoo and moisturiser.

A company has expressed an interest in buying the aloe sap in bulk to export abroad to the toiletries industry. However, RISE is aware that the best mark-up can be made
on sales of the final toiletries products. RISE is exploring market opportunities to sell these products in bulk, both as high-end store products and in volume to hairdressers, beauticians and supermarkets. It is establishing the business case to attract the investment needed to achieve the required level of health and safety certification and to buy the machinery to industrialise the operation.

Leadership Quality #5: Balancing ethical principles against business priorities

Social businesses have a slew of ethical issues to grapple with. Which of the “double bottom lines” should take priority: securing income or delivering social objectives? When is it right to charge patients and in what cases should exceptions be made?

The question of when to charge patients was often thrown into sharp focus where an organisation had to justify charging a different price to different patients for the same treatment. All organisations providing clinical services (PVRI, AyurVAID, 1298 ambulances, UHEAL and Life Spring) were clear that there was no difference in the quality of clinical care provided, including availability of high-cost treatments, regardless of the patient’s paying capacity. These organisations were also clear that charging different prices on the basis of ability to pay was justifiable - and essential to a viable cross-subsidy model. The challenge was often how to present this differential pricing to patients in such a way that they felt it was fair.

Only one organisation simply provides the same service regardless of payment type. 1298 ambulances (part of Ziqitza Health Care) relies on the patient’s choice of destination – whether a government hospital or a private one – as a determinant of how much to charge, and provides the same transport service to all patients.

The others (PVRI, AyurVAID, UHEAL and Life Spring) have introduced customer experience “Benefits/Perks” for higher-fee-paying customers, which help to justify the price difference and maintain their brand as high-quality healthcare providers. All four asserted the importance of higher-fee-paying patients feeling they are treated as valued customers, to ensure high levels of patient satisfaction, brand loyalty, and avoiding dissatisfaction that other patients are receiving the same treatment for free or a substantially reduced price.

Benefits/Perks include: more convenient appointment times (UHEAL and PVRI arrange appointments at a convenient time for private patients, whereas patients receiving free and subsidised treatment arrive together and wait their turn, allowing for more efficient use of clinical time); separate ‘VIP’ waiting rooms (PVRI), private one-bed rooms (Life Spring, AyurVAID and PVRI hospitals provide private rooms for higher-fee-paying patients and general ward accommodation for everyone else; UHEAL provides surgery for private patients in the comfortable surroundings of its Nairobi eye centre and for low-income clients at its mobile laser surgery units); and luxury of accommodation (Life Spring and AyurVAID provide a higher-charged luxury
room option, with large flat screen television, ensuite bathroom, air conditioning etc). Providing shorter waiting times in exchange for higher fees was considered in organisations such as PVRI and it was decided not to offer differentiated waiting times.

Interestingly, no organisation chose to charge an inflated price to private customers to help fund subsidised activity. The model used by Fair Trade, where customers pay a premium in exchange for a product certified to comply with certain ethical principles, was not found. All four organisations preferred to charge their private patients at generally below market rate for care that is equivalent in quality to competitor private healthcare providers.

Some social businesses face dilemmas about who to accept as customers and where to sell their products.

**Alive and Kicking**, a social enterprise that sells sports balls, is committed to securing social impact for every ball it sells. It prefers not to sell generic balls (i.e. balls without printed health promotion messages) through sports shops, preferring to focus on selling balls with health promotion messages (for example on HIV / AIDS and malaria prevention) through CSR programmes and NGOs. It negotiated a compromise with Nakumatt supermarkets whereby the generic balls are sold at a 25% surcharge, half of which goes towards Nakumatt’s running costs and half of which is donated to a charity or CSR project of the supermarket’s choice.

A&K is keen for profits to be passed on to its staff and therefore does not employ agents to sell the balls on commission. It evaluates the ethical policies of the companies whose CSR programmes it sells to. Joel Kinuthia, Country Director Kenya, identified a difficult line to tread between thinking like a business and maximising profit, and thinking about social objectives to deliver maximum impact.

Another issue raised was whether it is acceptable to pay healthcare providers a commission for referring patients.

**Ziqitza Health Care** pays a small referral fee to incentivise hospitals to use its 1298 ambulance service for patient transfers, for example to take a patient home after discharge.

**The Pushpagiri Eye Institute (PVRI)** employs Business Development Managers who are incentivised from mobilising new patients. They identify the majority of these from healthcare providers in remote areas – in particular from doctors, optical shops and opticians who are not equipped to treat complex eye problems. However, PVRI does not currently pay incentive commissions to these referrers (unlike other hospitals competing in the local health economy); it fears undermining its brand integrity if it is seen to compromise the integrity of other health sector providers and their referral processes. It is piloting an incentivised referral scheme with a small number of optical shops in one area, to test whether it can increase the number of
patient referrals with a formal, transparent referral process that can be managed by a small number of independent referring agencies (rather than accepting referrals direct from government service providers, which could be considered to have a conflict of interest). If successful this may be rolled out more widely.

Most organisations interviewed were grappling with issues around charging and maximising use of resources: how much to charge their customers, how to implement a cross-subsidy model balancing full-fee-paying and subsidised customers, how much to charge members and how to use the funds raised for maximum benefit, how to balance profit against social impact, how to scale up a business and remain affordable to low-income communities, how much profit to reinvest in income generation and how much to spend on low-income customer subsidy, when and how to hold low-income customers accountable when they fall behind on payments.

There is no ‘one size fits all’ solution. The interviews highlighted the need to have a defined process in place for making decisions on ethical issues in a way that is clear, transparent, accountable, and puts the customer’s interests first. It is an iterative process, refined as new scenarios emerge and responses are reality tested.

**Leadership Quality #6: Building complex, multi-level partnerships**

Social businesses span the gap between public and private sectors. They need to take the best from both to succeed. Rather than re-invent the wheel, it helps to stay flexible and leverage expertise from both sides. Often these organisations have partnerships at multiple levels, with businesses, NGOs, State Organisations and community leaders. These include joint marketing and branding ventures with other sector players, locums and consultants providing external expertise, and jointly delivered projects.

*The Pushpagiri Eye Institute (PVRI)*, a super-specialty hospital providing eye care in India, made use of its Medical Chair’s contacts and his strong credibility as a long-time superintendent of one of the most well-known and reputed Government Eye Hospitals, to lobby the Andhra Pradesh State Government for a Insurance Scheme for low-income patients to cover eye care. The government now reimburses approved healthcare providers for treating customers holding the Insurance Card (Rajiv Aarogyasri Card) certifying them to be living below the poverty line.

It also has strong partnerships with various NGOs. For example, the Lions Club International subsidised 10% of PVRI’s camp costs for a programme of School Eye Screening Camps. PVRI partners with other NGOs to provide glasses, or funds them from its charity ‘Gift of Vision’ fund. PVRI is also exploring a partnership deal to manage one of the Lions Club Eye Hospitals under a franchise arrangement,
providing a high-quality clinical service and delivering a set number of operations using PVRI staff at a fixed fee.

PVRI has ambitious plans to work in partnership with a major NGO, to set up a range of projects including:

a. Public Advocacy  
b. Diabetic Retinopathy Research  
c. Graduate Programme in Optometry  
d. A Public Affairs and Administration Institute, to develop tools to improve governance, measure impact and quality of services, track resources such as medical supplies, and audit service providers.

PVRI builds links to communities across the state of Andhra Pradesh. It recruits champions in the local community to work as volunteers to promote its eye camp. The PVRI eye screening camp I attended in Mallapur was coordinated by the father of a nine-year-old boy whose sight had been restored through surgery at PVRI and who was now promoting their work in his home town.

Often developing reputation and building patient trust requires working with partners at all levels of the community: a network of relationships and arrangements that takes time to build.

By leveraging the resources and influence of partner organisations, social businesses can deliver beyond their own capacity and capabilities.

**Leadership Quality #7: Local ownership, by extraordinary individuals**

Perseverance. Humour. Courage. Innovation. Conviction. Patience. Passion. Integrity. Vision. It all starts and ends with these personal qualities. The challenges are too hard, the barriers too high, the time, effort and energy required too demanding, for success to be possible with anything less.

The best solutions often come from people who know and understand the problem. Eight of the eleven organisations profiled were set up by Indian and Kenyan people who felt impelled to use their skills and expertise to address the pressing needs of their own communities. Many studied or worked abroad and wanted to give
something back. Others simply had the insight and moral clarity to see that a radically different approach was needed. In all eleven organisations, the day-to-day operations are managed by nationals who know their communities and have the relationships, language, cultural background and inside knowledge to make things happen in an often chaotic operating environment.

The leaders I met were often moved to action in response to the suffering of their families, friends, neighbours and communities.

Ramadhan Oberio, founder of We Are Watching You – a community organisation dedicated to improving political accountability in Kenya – began his work in the informal settlement area of Baba Ndogo, where he lived and grew up. The area struggles with numerous challenges, including poor sanitation, compromised water supply and high rates of disease such as diarrhoea, cholera, dysentery and malaria. Ramadhan was one of twelve friends who worked for a year saving all their wages so that together they could buy a plot of land and start the African Cultural Research and Education Foundation (ACREF), a community-based organisation. They then volunteered their time to run the organisation and successfully approached partner organisations to raise funds to build a community centre, pay-per-use toilets and showers, theatre, school and gym to provide resources to their home community.

Temi Mutia, a successful Kenyan businessman in Nairobi, returned to help his home community in Mwingi District after the death of a close relative brought him face to face with the tragic impact of poverty and disease. He worked closely with local leaders, family networks and existing Community Based Organisations (CBOs) to set up the Regional Institute for Social Enterprise to promote an entrepreneurial culture and develop income-generating ventures that help people to survive their tough environment of chronic food shortage after a longstanding drought. Throughout, he has been careful to work through local leaders and empower the community to take action and find solutions.

The women I met who were involved in leading CBOs in the RISE network were dynamic, entrepreneurial, and confident. They were proud to be businesswomen taking a proactive approach to solving their common problems, rather than depending on charitable hand-outs. Their self-confidence came from their achievements.

The leaders interviewed were all entrepreneurs with the skills, talent and passion to succeed in business. Instead they have accepted greater challenges, frustrations and lower financial returns in return for the personal reward of making a genuine and
sustainable difference. When asked what achievement he was most proud of, the Medical Chair of the Pushpagiri Eye Institute (PVRI) summed it up with his answer: “Watching a little five-year-old girl run around in excitement, able to see again for the first time in three years, after surgery restored her sight”.

By demonstrating that social businesses can thrive in tough environments, make a profit and deliver social impact, social entrepreneurs are changing the way people think about development (The Economist, 2009). They challenge governments to reform public services and improve regulation on private practice; high-quality private healthcare providers to improve accessibility and offer increased outreach services; NGOs to consider alternative models to donor funding to scale-up services (Ghosh and Talgeri, 2010); and talented young leaders to follow their example.
3. Making things work: key operational characteristics

Is social enterprise accountable? Is it effective? How can it make a service or product available to low-income communities without compromising quality standards? How can social businesses raise the investment capital needed to get started when the business model is predicated on reinvesting profits to maximise social impact? How can a social business be trusted not to turn fully commercial? How can we know they are prioritising the needs of the poor and marginalised? How can the organisation sustain its vision and impetus after the founders move on?

These challenging questions shape and mould the day-to-day operations of this new breed of organisation. The social entrepreneurs interviewed described being under a double pressure: to prove their business acumen and product viability, and simultaneously their integrity. As this is a relatively new sector, potential investors and development partners are keen to have impact and effectiveness quantified. A robust approach to data collection to evidence social impact, and to inform decisions on resource allocation, is characteristic of the organisations profiled.

Operational Quality #1: Flexible approach to start-up capital

When it comes to start-up capital, social businesses leaders often described being caught between a rock and a hard place. Banks and venture capital investors are less likely to back the lower returns of a business that re-invests its profits to help the poor, while donor funding carries unwanted strings and can be hard to attract when there is a perceived risk that the recipient may one day go fully commercial. Over the last ten years, there has been a big rise in impact investors: not-for-profit organisations that invest in business to achieve social impact. Acumen Fund estimates that the sector has grown from a few organisations in 2002 to at least 199 in 2012 (Acumen Fund, 2012a). But funding is still relatively thin on the ground.

Of the organisations profiled, seven of eleven secured part or all of their start-up capital from the founder’s personal resources. Many described a challenging struggle to secure the funding they needed.

The Upperhill Eye and Laser Centre (UHEAL) experienced a rocky journey in its early days. Dr. Kibata entered his business plan to set up a private high-quality eye care centre into a World Bank competition, and won the first prize of 1,000,000 KSH. Having used this to rent and refurbish the clinic, he looked for an investment partner to support the remaining start-up costs. He received an offer from a firm to pay 60% of the start-up costs in exchange for a 40% stake in the company. He narrowly escaped disaster by buying out these partners when the firm reneged on their deal and instead offered to guarantee a bank loan to cover their share of the start-up costs. He approached the banks for a loan himself, but struggled to convince them of the viability of his business plan, due to the lack of any comparable private eye care
services in Kenya at that time and scepticism that such a venture would succeed. He was turned away from asset investment funds as medical equipment was not deemed to be an asset. Eventually he was approached by the impact investment organisation Acumen Fund, which provided him with a four-year loan at 10% for the start-up capital, enabling him to buy the state-of-the-art equipment needed to run a high-quality service. The business has flourished, with a steady and increasing stream of patients – at first brought across from Dr. Kibata’s previous practice at the Presbyterian Church of East Africa (PCEA) Kikuyu Hospital Eye Unit, which he has now left to focus on growing UHEAL full-time; and others attracted through word of mouth and referrals from primary care clinicians, as the service has built up its reputation.

The entrepreneurs interviewed all showed intense personal commitment to realising their vision, staking their time, effort and personal resources to bring it about. Many have written the social mission into the organisation’s structure, for example with an asset lock preventing infrastructure from being liquidated in the event of the organisation turning commercial, or an upfront statement of commitment to a certain proportion of activity being provided to low-income communities for free.

**Operational Quality #2: Flexible approach to human resources**

Social enterprise leaders also described challenges in attracting the right human resources. Delivering high-quality services at low cost requires creative HR solutions to attract and retain a high-calibre staff while keeping costs low, which is necessary to remain affordable and reinvest the most possible back into the business. The successful social businesses interviewed reduce costs without impacting on quality through innovative use of staff and skill mix at each stage of the delivery chain.

Both Rajiv Vasudevan, Chief Executive of AyurVAID, and Dr. Vishwanath, Medical Chair of the Pushpagiri Eye Institute (PVRI), cited finding the right people to staff their hospitals as the biggest challenge they faced in setting up their organisations – a sentiment echoed across many interviewees.

PVRI, a Super-speciality Eye Hospital in India, uses a creative mix of full- and part-time staff and locums to meet peaks and troughs in demand. It contracts with a range of high-calibre clinical staff from both private and government facilities, identified through the Medical Chair’s extensive contact base, to provide extra clinical sessions at peak times. It offers flexible working arrangements to women with families and provides long-term job security in exchange for a lower than market rate of pay. Patient flows are tightly managed to ensure maximum clinical efficiency. PVRI Medical Chair Dr. Vishwanath was previously a well-known Government Eye Hospital Superintendent and has close links with over half of the ophthalmologists in Andhra Pradesh (many of whom are his former students). This has been invaluable to the organisation for staff recruitment and locum support, enlisting community
champions, building brand credibility and developing partnerships with like-minded organisations. In particular, PVRI often employs opticians or ophthalmologists from the local government hospital as locums to assist with its eye screening camps, to build partnerships with the local eye care services and to build credibility with the community. This in turn helps to develop its referral networks.

PVRI also takes an innovative approach to non-clinical HR issues. It has been very successful in increasing patient volumes by linking Business Development Managers’ incentives to the number of patients they counsel and bring to the Hospital.

It offers Summer Placements to MBA students who provide support to one-off projects such as re-writing the organisation’s HR handbook and redesigning its website.

Similarly LifeSpring, a chain of maternity hospitals in India, uses complex timetabling of clinical staff to fine-tune its services to meet peak demand whilst minimising staff levels at low demand. This requires multi-skilled nurses who are equally able to provide support in the wards, labour rooms and out-patient department. Staff rotate through different parts of the hospital and responsibilities may stretch across different areas to make full use of their capacity through the day. They provide the first point of contact at reception and process customer administration, so that all customer interaction is with clinically trained staff who are able to spot problems and offer support quickly. Nurses are resident in on-site accommodation where they can be drawn on in an emergency to support the consultant on-call. LifeSpring aims to recruit recent graduates from nursing colleges and provides its own tailored in-house training programme, including residential resources such as video-based skills training, so that staff are assimilated quickly into the organisation’s culture and practices.

LifeSpring uses flexible working arrangements to ensure there is always a gynaecologist available on-call. It offers part-time contracts to women who have families and therefore appreciate flexible working arrangements. They work on a rota to provide morning and afternoon shifts, and alternate nights on-call. Staff provide cover for each other for holidays and sick leave, ensuring the hospital is always covered in case of an emergency.

**Operational Quality #3: Diversification of income streams**

Businesses in developing countries are doubly vulnerable. They are vulnerable to shocks in the market, such as reduced consumer income or technological innovation rendering their services out of date. And they are vulnerable to shocks to the social market, such as government failure to invest in infrastructure, or NGOs starting up a similar service free of charge. Social businesses often combine commercial revenue
streams from individual customers alongside public revenue streams such as
government contracts – which may be withdrawn at short notice, or be paid late.
Where low-income customers provide a major revenue stream, there is dangerous
exposure to seemingly slight environmental variations – for example a small rise in
the price of basic foods could seriously affect the ability of customers on $2 a day to
afford health services.

Ziqitza Health Care is focussing on expanding its ‘dial 1298’ ambulance service. It is
keen to ensure its financial viability through the self-sustaining, fee for service, cross-
subsidy model before it takes on further state government contracts to provide free
‘dial 108’ emergency services. Experience has shown that government contracts
often pay late, leading to operational difficulties in paying staff salaries on time.
There is also concern that having too many government contracts may leave the
organisation over-exposed when these contracts come up for re-tender. Sweta
Mangal, Chief Executive, emphasised the importance of focussing on profitability.
Although Ziqitza’s overall mission is to deliver social impact, the business model
needs to be financially viable and sustainable for the organisation to survive and
grow.

Diversification of income streams is important to social businesses to mitigate risk.
The most successful social businesses interviewed continually experiment and
explore alternative potential revenue streams to maximise income and protect
against any one income source drying up. Often commercial services charged to
patients are combined with state contracts for delivering services, state subsidy
schemes for low-income clients, NGO and charity tie-ins and partnership schemes,
and wider revenue streams such as advertising in high-volume patient areas.

Alive and Kicking (A&K), a social
enterprise selling sports balls,
continually adapts its business model
to maximise income and meet the
challenges of its environment.

Its original goal was to sell four sports
balls to each of Kenya’s 20,000 state
schools, each carrying health
promotion messages on key issues
such as HIV / AIDS and malaria.

But it soon found the schools could not afford them. It quickly changed to targeting
Corporate Social Responsibility (CSR) programmes to buy balls for schools.

In 2008/09, the global recession resulted in big cuts to CSR programmes. A&K
formed a partnership with Nakumatt, one of Kenya’s leading supermarket chains.
Nakumatt sells the balls at a 25% surcharge, half of which goes towards Nakumatt’s
running costs and half of which is donated to a charity or CSR project of the
supermarket’s choice. A&K also refocused sales to target NGOs, which buy the balls
to promote their brand and key social messages.
Through diversifying its income streams, A&K stays profitable in a changing environment, whilst also ensuring social impact for every ball sold.

Combining these very different approaches to income generation requires a high degree of flexibility, innovation and opportunity scanning. This relentless focus on financial sustainability, delicately balanced against the imperative to deliver the maximum social benefit, is a driving force and tension at the heart of social business.

**Operational Quality #4: Faultless governance**

Social businesses need to have faultless governance arrangements if they are going to be credible. They need to demonstrate unequivocally that their processes are transparent and accountable.

Ziqitza Health Care is contracted by three State governments to provide free or pay-per-use ‘dial 108 in emergency’ ambulance services. The practice of paying informal charges (or bribes) in exchange for government contracts, and to expedite day-to-day transactions, is widespread and normalised. However, Ziqitza operates a strict no tolerance approach to corruption. The company often experiences extreme delays in receiving payments due under its contracts, as a result of refusing to pay informal charges to expedite payment. This has a knock-on effect across the organisation, with salaries being paid late to over 100 employees each month as a result of its principled stance.

Similarly, the company is aware that it loses business as it is not prepared to pay large informal charges to healthcare facilities such as nursing homes in order to win fixed contracts for patient transfers. Ziqitza offers a formalised, proportional, transparent referral fee to all referring agencies.

Sweta Mangal, Chief Executive, identified three key factors in the organisation’s success and trusted brand recognition: first, being ethical and transparent; secondly, providing free support in disasters, accidents and emergencies; and thirdly, providing clear and transparent pricing.

By rejecting cultural norms and insisting on conducting their business with integrity, social businesses can set a new standard and encourage others to play fair. If they can establish a reputation for integrity, they may be able to encourage other partners and work with government to improve integrity across the sector.

The Pushpagiri Eye Institute (PVRI) has developed close links with the Andhra Pradesh State Government. It is capitalising on the political appetite to tackle corruption and leakage of public funds by developing a partnership initiative to address these issues in the eye care sector. It intends to setup a Public Affairs & Administration Training Institute which will develop tools that can be rolled out at scale, to improve governance, measure impact and quality of services provided.
under government funding, track resources such as medical supplies, and audit service providers. For example, it is exploring the scope for electronic staff identification cards for use in public hospitals to track attendance and take action on absentee clinicians. While contributing to the social objective of improving eye care services across Andhra Pradesh, these projects will also generate income and scale for the organisation, through sale of new technologies and performance-based partnership funding incentives.

Leading by example, they can use their market position to encourage wider culture change.

Operational Quality #5: Aim to scale-up

Social enterprise represents a particularly exciting opportunity for extensive achievement of development goals when a viable social business can be taken to scale.

Charities and state providers are typically limited in the scale of the social impact that they can deliver by the amount they can raise in donations or public funding. The growth of a social business is not restricted in this way – provided that its business model is financially viable and its structure enables it to scale up easily.

Thinking about how the organisation can achieve scale-up when setting it up provides an opportunity to get the structure right from the start.

Support for Tropical Initiatives in Poverty Alleviation (STIPA) develops community-based health insurance schemes with low-income community groups. It supports the group to identify hospitals whose healthcare services they want to have included under the scheme, assess the hospitals to ensure they meet appropriate quality standards, negotiate the cost of the services to be covered, and thus determine the premiums to be paid to qualify for membership and thus treatment under the scheme. A Memorandum of Understanding is then drawn up, entitling card-carrying members of the insurance scheme access to care within the defined parameters.

The group must include at least 100 households of five people each to be viable. The bigger the group, the lower the household premiums that can be negotiated. In some groups a household premium as low as 50 KSH a month has been negotiated (£0.38), an easily affordable price for most families. Premiums are higher for households with more than five members, to reflect greater potential usage. The household premium also varies between different insurance schemes, depending on the services included and risk factors present within the group (for example, fishermen are more prone to disease and thus attract higher costs).
While the insurance scheme is affordable for most households, it is still out of reach for the very poor. As coverage expands to include more community groups, premiums will reduce and a wider range of services will be covered – increasing accessibility for the very poor and those with greater health needs.

While the plan to scale up the insurance scheme is robust, the overall structural constraints are inhibiting growth. STIPA itself is reliant on donor funding to support the community groups and negotiate the insurance schemes on their behalf. Similarly, the Kenya Community Based Health Finance Association (KCBHFA) is reliant on donor funding for supervision and coordination of its member organisations’ health finance initiatives. The Community Based Health Financing concept is gaining more recognition from government as one of the innovative strategies to address the issue of healthcare financing in Kenya, and is referenced in the second Kenya Health Policy Framework 2011 – 2030 (Ministry of Medical Services, Government of Kenya 2012). However, while there is no sustainable funding source for this activity, scale-up of the schemes will be limited.

As with any business, there is a risk that social businesses may lose their close relationships with their customers when they take their services to scale. Many of the social entrepreneurs interviewed who were in the initial stages of taking their organisation to scale described plans to take a ‘cluster’ approach to scaling up. Rather than run a significantly larger number of branches from a single head office, and risk becoming remote and unresponsive, these leaders planned to establish regional head offices which would take operational responsibility for the running of branches within their geographic ‘cluster’, with clearly defined parameters of autonomy. The overall head office would maintain responsibility for setting the overarching policy for the organisation, and would focus on performance management of regional head offices to ensure delivery across all cluster geographies.

**LifeSpring** is a chain of maternity hospitals in India that is starting an ambitious plan to scale up. It aims to expand from its current 12 branches to 100 over the next five years. Its financial viability is based on a rigorous approach to providing basic, no-frills services with high-quality clinical care, with a strict policy of regular check-ups and early intervention to identify and resolve complications in a timely and cost-effective manner. Its lean methodology and standardised, protocol-based approach to service provision makes the clinical model easy to replicate and roll out. Hospital branch managers implement a standard model and set of operational policies, reporting to head office.

LifeSpring’s focus to date has been on demonstrating the high quality of its clinical care and the viability of its business model, and establishing its brand. This has been vital to establishing its credibility with external agencies and attracting the necessary investment to take it to scale. The start-up costs for new branches will be met...
through commercial bank loans which will be repaid over a five-year period. Each branch is financially independent and self-sustaining, breaking even on operating costs with sufficient surplus to repay capital investment loans.

The other key opportunity for social businesses to achieve scale-up is through state recognition and support. Having established their reputation for delivering high-quality services, some organisations interviewed described a willingness of state or national government agencies to provide subsidy schemes for low-income communities accessing their services. These help to offset costs and increase the coverage that can be achieved. Similarly, social businesses with established credibility are strongly positioned to bid for public sector service delivery contracts.

Ziqitza Health Care’s 1298 ambulance service in India is another example of an organisation whose business model easily enables it to scale up. It was set up in 2005, when ambulance services were patchy or non-existent. It operates a fee for service, cross-subsidy business model. Charges for patients taken to private hospitals subsidise lower charges for patients taken to government hospitals, and free service for accident victims, unaccompanied unconscious individuals and victims of mass casualty incidents. Now the company has been contracted by four Indian State Governments to provide a free ‘Dial 108 in Emergency’ scheme.

Operational Quality #6: Evidencing high-quality outcomes

Effective social businesses not only want to deliver high-quality products and services at affordable prices, they need to market themselves as doing so. This isn’t just about building customer trust and loyalty: it is also about building their brand to wider stakeholders, and positioning themselves as a trustworthy provider with integrity.

The five organisations profiled which directly provide clinical services to patients – PVRI, LifeSpring, AyurVAID, Ziqitza Health Care and UHEAL – had a tightly honed attention to detail in collection of data and analysis of both clinical outcomes and business results.

Their determination to demonstrate that they are the best at what they do results in a similar, hard-headed business approach in each: clearly defined targets flowing from the organisation’s strategic priorities; honed data collection and analysis; strong operational grip informed by real-time information flows; feedback to customers and stakeholders on outcomes. Rajiv Vasudevan, Chief Executive of the AyurVAID chain of Ayurveda hospitals, emphasised the importance of rooting the service in a culture of data-driven performance management from the start, so it is the driving force of the organisation; introducing it later would encourage staff to feel that it is an irrelevant add-on. Data plays a key role in planning, helping to shape the delivery of services and fine-tune processes to ensure maximum impact.
Targets translate the overarching corporate strategy into tangible operational goals. As in any business, it is vital that these are SMART: Specific, Measurable, Achievable, Realistic, and Time-bound. Key Performance Indicators keep the core business on track and monitor the viability of the business model. For the social business leaders interviewed, they serve a dual function: they also demonstrate achievement of social impact. This helps articulate the organisation’s vision and demonstrate its brand credibility. It sustains team cohesion and motivation to deliver. Social businesses function most effectively when each staff member’s activity and achievements can be directly related back to the overall social objective.

To provide high-quality clinical services at an affordable price requires a high degree of efficiency. Lean, streamlined processes that rely on the consistent implementation of standardised clinical protocols keep things clear, simple, consistent and cost-effective. Responsibility for administrative and preliminary clinical tasks can be delegated to more junior staff with the appropriate level of expertise for the task, keeping costs low and maximising the number of patients seen by the most specialised clinicians.

UHEAL in Kenya and PVRI in India are both Eye Hospitals which hold community outreach eye screening camps in rural areas. Everyone who attends the camp is screened and given a prescription for glasses, eye drops or a referral for surgery as needed.

Both organisations send staff long distances to reach patients in remote areas where limited eye care services are available. During my research I attended an eye screening camp with UHEAL in Kerugoya, around 100km from its eye centre in Nairobi, Kenya, and with PVRI at Mallapur, around 200km from its eye hospital in Secunderabad, India.

To make most effective use of staff time to see the most patients possible, a tight, streamlined process is operated by both organisations at the eye camps to ensure the patients are seen quickly and effectively. After their administrative details are collected, and blood sugar, blood pressure, sight tests and basic checks are carried out by a nurse (UHEAL only), patients are then triaged by opticians and junior staff who direct the more complicated and problematic cases to the ophthalmologist, who can then refer the patient for surgery or a second opinion. Patients identified as needing surgery are offered transportation at the end of the camp to the hospital direct on a PVRI bus, or given a referral to the next UHEAL mobile laser surgery clinic. All patient details are recorded manually and later entered into a database so that they can be contacted for follow-up.

Where a disciplined approach to adherence to clinical protocols is embedded in the team, error and variation is minimised (see Cape and Humphries, 2012). This improves clinical outcomes, and helps problems to be identified and resolved early. Not only is early intervention better for patients, minimising risk and complications by
addressing problems in their early stages before they become serious, it is also cost-effective – often requiring less intensive treatment interventions, with less time input from senior clinicians. Protocol-based pathways enable the patient to move through the treatment process swiftly and with the least contact time required to ensure an optimal outcome. It is both cost-effective for the provider and convenient for the patient.

LifeSpring hospitals offer a core package of maternity services at an affordable price for people earning $2-4 a day. This low-cost package is achieved by minimising complications (and thus expensive treatment) through early and regular patient check-ups throughout pregnancy. A consultant is always on call, and skilled staff attend at the birth to ensure complications are dealt with immediately as they arise. The hospitals are clean, basic and no-frills, keeping expense to a minimum. Lean methodology is used to ensure an efficient, standardised, process driven approach which can be accurately costed. The pressure to keep the service affordable results in a tight focus on clinical quality. Rigorous cleanliness and hygiene standards are maintained to avoid healthcare-acquired infections which extend high-cost in-patient treatment. Intensive effort is made to identify risk factors and resolve complications early. Patients are monitored closely, particularly in the high-risk period immediately after delivery, to ensure swift recovery and minimise infections, keeping length of stay to a clinically appropriate minimum. Efficient processes are in place to ensure discharge of customers within set timeframes. The approach has a triple advantage: it reduces costs, improves clinical outcomes and improves customer satisfaction.

Well-designed protocols help businesses operate smoothly, providing clarity on tasks and processes. They should provide the necessary amount of information to inform decision making while remaining easy to follow and operate at all levels. A well-thought-through protocol makes training focussed and effective. Crucially, a strongly protocol-based health service delivery business is easier to scale up, as it enables swift replication of the efficiency of the original service while maintaining the high clinical standards and cost-effectiveness.

Data collection must be targeted to provide sufficient information to show progress against performance indicators and to highlight trends that may impact on performance, whilst not over-burdening frontline staff who are delivering high-volume care to tight timescales. Highly protocol-based models of service delivery allow regular opportunity for integrated data collection as part of the standardised patient pathway.

Attention to data is key at all levels from floor to Board. Operational data provides vital clues to service performance and potential improvements. The most successful social businesses interviewed embed data scrutiny into all staff roles and incentivise performance improvements that maximise both income and social outcomes.
Trends in data and performance against SMART targets should be monitored at all levels. Healthy competition results when operational staff can map their performance against their peers, particularly when performance-linked incentives are available. For managers, data analysis provides vital information to focus resources to deliver on key targets. At Board level, sophisticated scrutiny of data is key to assessing the organisation’s delivery against strategic vision and objectives.

**PVRI embeds data analysis at all levels of the organisation.**

Business Development Managers are offered incentives based on the number of patients they counsel and bring into the Hospital for treatment – both low-income and fee-paying.

Daily, weekly, monthly, quarterly and annual reports are produced tracking financial and quality indicators.

Operational Managers analyse data on a range of clinical indicators including near misses, infection rates and root cause analysis to maximise successful clinical outcomes and improve patient experience.

The Board reviews reports on key indicators to ensure the organisation is on track and delivering.

**Operational Quality #7: Extraordinary individuals**

The social businesses profiled demand a lot from their staff. They demand top quality business standards while offering lower financial rewards than could be earned in the private or international NGO sector. The pay-off is the personal reward of delivering social impact (The Daily Stat, 17 May 2011). To attract the extraordinary individuals needed to make this work, the organisation needs to articulate a clear and compelling vision that inspires and motivates its staff, and it needs to deliver on what it promises. Sweta Mangal, Chief Executive of Ziqitza Health Care, stressed the importance of having a compelling story to tell about delivering social impact, to motivate high-calibre staff to join. The organisation’s strategic vision and objectives must be underpinned by a robust evaluation of local needs, and interventions must be credible and effective, based on a supporting evidence base or developing one through robust data collection, record-keeping and analysis.

**AyurVAID is determined to develop the evidence base for Ayurveda and build the credibility of the discipline.** It insists on the highest quality of practitioners, and the consistent, well-regulated application of Ayurveda processes and techniques throughout its chain of hospitals in India. By rolling out Ayurveda interventions according to strict protocols, collecting data against a range of metrics and documenting clinical outcomes, it is building the evidence base to demonstrate its success. It monitors performance against 77 indicators including clinical, operational,
and infection control measures, and operates a tightly run performance management system. In addition, it collects patient feedback on all aspects of care, including how the diagnosis was arrived at and whether this was communicated effectively to the patient; cleanliness of the hospital; and satisfaction with the treatment intervention and outcome. Performance related pay incentives for nurses are linked to patient feedback scores.

The passion to get high-quality Ayurveda care on the map is the driving force across the management team and gives a strong uniting sense of team morale and camaraderie. The founder, Rajiv Vasudevan, left a high-profile role in telecommunications to set up the organisation, motivated by his passion for Ayurveda and determination to prove its efficacy. His sense of mission is compelling and infectious, inspiring a wide range of senior managers to leave prestigious private sector roles to join him at AyurVAID.

In August 2011 AyurVAID set up a research foundation, to build the evidence base for Ayurveda medicine. It is setting up a 3 – 5 year community health programme to benchmark and analyse the health status of a fixed group before, during and after regular Ayurveda assessment and treatment interventions. It will work with a slum community comprising around 2,000 people in 375 families, working with them to introduce a plan for maximising and maintaining health. Outcome monitoring every six months will include measurement of key clinical indicators of both conventional and Ayurveda medicine, alongside disease-specific parameters. Economic parameters such as number of days lost to work in a year, intervention costs, associated savings in avoided healthcare expenditure etc will also be measured to build the case for the cost-effectiveness of early intervention and the Ayurveda treatment model. AyurVAID is looking to set up a partnership with a university to conduct research and disseminate its findings.

Confidence in the products and services they are delivering for low-income communities is paramount. For healthcare delivery organisations, it must be clear that the patient’s needs and well-being is at the heart of decision making. Organisations that champion the patient or customer at the heart of all they do at Board level communicate this passion and urgency to their workforce at all other levels of the organisation. Staff feel proud to be part of something bigger and greater than themselves.

The successful social businesses interviewed generate their own self-supporting culture. Employees are motivated by a shared inspiration from the corporate ideals they are working towards (Hutton, 2011; Dixon and Alakeson, 2010). They foster a cohesive atmosphere where staff feel a shared sense of pulling together and responsibility for playing their individual parts to deliver a greater good.

The key to effective social enterprise is combining leadership and operational effectiveness that inspires and motivates through results, cultivating a sense of
vocation amongst staff and providing the organisation with the energy to sustain it through setbacks and challenges. This sense of shared vocation will nurture new leaders to grow within the organisation, handing over the baton to keep the organisation energised and focused into the future.
4. Lessons for the UK

UK international development policy

The UK is one of the largest donors in Europe of overseas aid. Its Gross Public Expenditure on Development (GPEX) amounted to £9,007m in 2010/11. The UK Department for International Development (DFID) aid programme accounted for £7,689m (85%) of this expenditure. The majority of these funds are spent on multilateral assistance (to international organisations such as the World Bank and United Nations) and bilateral assistance (to individual countries). In 2010/11, India received the most DFID bilateral aid (£279m) and Kenya the 15th highest (£69m). Within bilateral aid, funds are dispersed through a broad range of channels, including budget support to national governments, provision of technical assistance and humanitarian assistance, and bilateral aid provided through a multilateral organisation or NGO (all statistics and a detailed account of UK public expenditure on development are available from DFID, 2011a).

Recently the UK press has sharply criticised high levels of waste and misspending of aid funds (e.g. The Telegraph, 2012; Daily Mail, 2012). Budget support to national governments is highly fungible and thus vulnerable to theft by corrupt regimes and individuals (Collier, 2007). Much of the funding is directly or indirectly allocated to public sector or NGO service providers which are also vulnerable to misappropriation of funds and are not always efficient. The lack of an effective feedback mechanism between consumer and provider often means that services do not meet local need. Humanitarian assistance can exacerbate the underlying issues in the long term – for example where food aid puts local farmers out of business and thus reduces the country’s capacity to grow enough food for the future.

Social enterprise represents a huge under-explored opportunity for achieving international development goals. Commercial discipline and due diligence checks on the part of investors prevent leakage of funds and market pressure tunes products and services to meet local need. Investment in community-driven organisations leads to organic growth of a provider landscape that is both economically and socially beneficial to low-income communities.

There are a number of ways in which international development policy and funding could be reoriented to capitalise on the potential for social enterprise to deliver development objectives. Learning from the experience of social enterprise in India and Kenya, it is recommended that DFID and its delivery partners:

1. Improve access to capital for social enterprise abroad, to support both start-up and expansion of social business ventures.
2. Source and fund technical assistance to help new social enterprises in developing countries become ‘investment ready’.
3. Advocate for government funding mechanisms to support social enterprise such as open tendering of contracts, Public-Private Partnerships, and government subsidy schemes for services to low-income communities.

4. Improve access to financial products for low-income communities. This needs to include commercial products such as business loans at competitive interest rates, as well as small-scale products such as micro-finance, mutual aid funds and facilitated peer lending.

5. Maximise the beneficial knock-on effects of social enterprise in development by commissioning research to evidence the success of new models of service provision, by identifying and sharing best practice between different organisations, sectors and countries and by supporting and funding high calibre leadership training programmes for social entrepreneurs abroad.

These recommendations are explored in detail below.

1) Improve access to capital for social enterprise abroad

While the last ten years has seen substantial growth in the impact investment sector, start-up capital is still hard for a new social enterprise to come by. A substantial loan or grant facility to cover start-up costs for new ventures, with a robust process for quality-assuring business cases and conducting due diligence checks, would help encourage new social enterprises to get established. A similar facility to assist with capital for ventures looking to scale-up has potential to deliver exponential social impact. More accessible loans are needed at competitive interest rates to provide working capital for larger-scale social business start-ups. UK aid could be used to fund these.

Monitor, a management consultancy firm which has conducted research into more than 700 inclusive firms (businesses that engage low-income people as customers and suppliers) in Africa and India, and Acumen Fund, an impact investor with ten years experience in the sector, published a report in April 2012 evidencing that “philanthropy is the essential but often overlooked catalyst that unlocks the impact potential of inclusive business and impact investing” (Koh et al., 2012, pii). The report sets out a clear mandate for grant funding to support the blueprinting, validation and preparation stages of a new social business – i.e. to support ventures to develop and validate the initial business plan, and prepare the conditions in the market, for example through developing supplier skills and raising consumer awareness of new products, before scaling-up operations. Grant rather than investor funding is preferable at this early stage because benefits are likely to be realised across the sector as a whole rather than for the individual venture. Expensive awareness-raising campaigns, which may be needed for new products and services, stimulate demand across the sector for all competitors and are a useful public good in their own right. The early-stage process of developing the product or proof of
concept generates wider learning for the field even if the specific business in question turns out not to be viable. And work to develop supply chains and prepare the market is likely to benefit all market entrants. These early-stage objectives are more appealing to a philanthropic funder looking to maximise social impact than to an investor looking to ensure a return on investment. The report points to the estimated $20billion that the microfinance sector received in subsidies to refine its business model before it became viable and began attracting significant commercial investment (Koh et al., 2012, p8).

In order to provide this kind of funding at a large scale, there is a need for intermediary organisations. DFID’s planned repositioning of its Development Finance Institution (DFID, 2011b), which currently provides capital and assistance for businesses in developing countries, may provide an ideal opportunity for taking this forward by expanding the organisation’s remit to include strategic grant-making to support new social enterprises through the blueprinting, validation and preparation stages, and impact investment to support launching and taking enterprises to scale. Alternatively DFID could look at partnering with an established impact investor to develop a grant-making arm, potentially combining funding and technical assistance through a new social enterprise’s early stages of development.

2) **Source and fund technical assistance to help new social enterprises in developing countries become ‘investment ready’**

Impact investors such as Acumen Fund currently provide funding, in the form of both debt and equity, and technical assistance to support social businesses with a validated business plan to launch their product or service and take it to scale. During visits to Acumen Fund’s East Africa and India offices, interviewees identified a gap between the large number of social businesses seeking funding and the small handful that are ‘investment ready’. Acumen Fund assesses organisations against four criteria to establish whether they are investment ready: financial viability (organisations are expected to break even within 2-3 years), social impact (in terms of providing goods or services to low-income communities, or addressing a social problem), potential to scale-up (financially and in terms of the customer base) and management quality (track record, commitment, and due diligence checks).

Often organisations struggle to meet the rigorous tests applied to ensure the business case is financially robust, the scope for social impact appropriately evidenced, and due diligence proven. Provision of technical assistance at this stage could have a huge impact to help organisations evidence their ability to deliver against these criteria. There is a strong opportunity for DFID and its delivery partners to source and fund this technical assistance. DFID has a long history of funding the provision of technical assistance to build capacity in public sector organisations and NGOs in developing countries – for example in 2010/11 DFID provided £31m to
Voluntary Service Overseas to source and send UK professionals to build capacity in developing countries. This mission could easily be refocused in part towards recruiting and sending skilled professionals to support new social enterprises to develop their business plans, test markets, build supply chains and evidence their readiness for investment.

Such an intervention would help grow the social enterprise sector by bridging the gap between organisations seeking and successfully attracting investment from both commercial and impact investment sources.

3) Advocate for government funding mechanisms to support social enterprise

Scale-up of successful social businesses can be easier to achieve where government funding is available. Opportunities can be made available for social enterprises to enter the market for provision of public services through open tendering of contracts, Public-Private Partnerships, or through government subsidy schemes for services provided to low-income customers.

DFID and its delivery partners such as major NGOs are often respected stakeholders for governments in developing countries. While respecting the importance of foreign governments making decisions that are right for their individual circumstances, there is a role for these development agencies to flag the potential benefits of funding mechanisms that support successful social enterprises to enter the market for provision of public services. Development agencies can help advocate for these funding mechanisms, and can commission and disseminate research that evaluates the impact of having a wider range of providers involved in public service provision including social enterprise, and share good practice.

4) Improve access to financial products for low-income communities

Improving the financial sector in developing countries is another area that would benefit from a greater focus in development policy-making. Improving household income levels was repeatedly cited by interviewees as the most effective means to improve health outcomes.

More work is needed to improve access to financial products for low-income communities to assist families to cope with unpredictable income and expenses, save, buy insurance to cover unforeseen healthcare costs and access affordable loans. More flexible and accessible financial products are needed to help people start and expand their own businesses (Ferrand et al., 2004). Micro-finance is one way of doing this, although its scale is often limited to the availability of donor funding for the initial round of lending. Mutual aid funds can provide another route to supporting small businesses although, again, their scale is often limited. Peer
lending may provide a mechanism for expanding access to financial services, leveraging private capital available in-country. The UK company Zopa, which facilitates online peer lending between people who have spare money and people who want to borrow, could provide a model (Zopa Ltd, 2011).

There is a need to build on existing work to support the financial services industry in developing countries, such as DfID’s support for the Kenyan Equity Bank and for Enhancing Financial Innovation and Access in Nigeria (DfID, 2011), to achieve these goals.

5) Maximise the beneficial knock-on effects of social enterprise in development

Social enterprises deliver impact beyond their own business achievements through challenging government to improve the quality of its service provision, challenging private healthcare providers to improve their accessibility for low-income communities, challenging NGOs to consider alternative funding models to achieve scale-up, and encouraging talented young leaders to follow their example. Development agencies can maximise these beneficial knock-on effects by commissioning research to evidence the success of new models of service provision; by identifying and sharing best practice between different organisations, sectors and countries; and by supporting and funding high calibre leadership training programmes for social entrepreneurs.

In the UK, the School for Social Entrepreneurs (SSE) benefits from public funding subsidies for scholarships on its intensive one-year training programme for social entrepreneurs (SSE, 2012a). Similarly the On Purpose training scheme provides a one year leadership programme that combines paid work placements with weekly training and regular one-to-one mentoring and coaching (On Purpose, 2012). It is recommended that DfID and its delivery partners should similarly explore the potential to support and fund local leadership training programmes to grow a pool of talented social entrepreneurs in developing countries. The Acumen Fund East Africa Fellows Programme, which attracted over 1,000 applications for 20 places in its first year, provides a model (Acumen Fund, 2012b).
UK social enterprise

In developing countries, social enterprise is a solution developed by visionary business leaders and entrepreneurs to bridge the gap in an environment of weak public services and underdeveloped markets.

Visionary business leaders feel driven down this route as a matter of necessity. They perceive it as the only viable option for the individual to bring to bear his or her passion, expertise and commitment to combat poverty and make services available to low-income groups. They:

- Provide key services to low-income communities at an affordable price;
- Facilitate access to healthcare through public health campaigns, advocacy, financial products such as community-based health insurance, and income generation through enterprise and microfinance;
- Supplement or replace the ‘gap filling’ role of NGOs;
- Lead a social movement: inspiring others to try a new approach to tackling poverty; fostering an entrepreneurial culture; leading by example; putting pressure on government to both improve the operating environment for businesses and to improve health service standards, provide resources and commission more services, by demonstrating what can be done; and
- Model excellence in businesses: delivering high-quality, cost-effective outcomes, challenging corruption, and demonstrating ethical rigour.

Developed economies are in a different position. Many governments in developed countries provide health services free of charge – whether as universal service provision, social health insurance schemes, means-tested service provision, or a safety net for the most vulnerable. Additionally there is a thriving charitable sector which provides services, advocacy and awareness campaigns, and lobbies hard to hold governments to account. The driving impetus to bridge the gap between public and private sectors to meet the urgent needs of the poor is not present.

The opportunity for UK social enterprise lies primarily in the new opportunities being made available under what might be seen in broad terms as the government’s new ‘Big Society’ policy agenda. The idea here is to promote community involvement and decision-making in matters that directly affect people’s day-to-day lives, and to broaden the range of providers involved in UK public service delivery (Cabinet Office, not dated).

Recent changes to UK community rights have brought opportunities for community-driven social enterprise to take a key role in shaping local services, amenities and developments. The Community Right to Build came into effect in April 2012, and gives communities “the right to build small-scale, site-specific projects without going through the normal planning application process” (Directgov, 3 October 2012). The Community Right to Challenge came into effect in June 2012, and gives
communities “the right to bid to run local council and fire and rescue authority services where they think they can do it differently and better” (ibid). And in Autumn 2012, the Community Right to Bid is scheduled to come into effect, which will give communities “the right to bid to buy and take over the running of local assets that are important to them” (ibid). This unprecedented move to put control of assets and services into the hands of communities represents an ideal opportunity for UK social enterprise to demonstrate its capacity to provide sustainable and effective services that centre on meeting local need.

Similarly, new opportunities are arising for different types of health service provider to bid for contracts to deliver NHS services. From April 2012, a range of NHS community and mental health services were designated open to ‘Any Qualified Provider’ – meaning that contracts are commissioned through an open tender process that is open to any healthcare provider meeting the stipulated regulatory requirements. Competition is on the basis of quality of care, with contract prices set according to the type of service and volume of patients required. The aim is to drive improvements in care quality, while reducing bureaucracy and fostering an entrepreneurial culture of innovative service delivery (Department of Health, 2011a). This represents a major opportunity for social enterprises to demonstrate their ability to deliver high-quality services and to compete for NHS contracts. Furthermore, the policy intention is to give patients the right to choose between ‘Any Qualified Provider’ (DH, 2011a) – giving social enterprises the opportunity to market their high-quality services to patients direct and to receive appropriate reimbursement from NHS commissioners when patients take them up.

The government’s ‘Right to Provide’ policy allows NHS staff working in health and social care to bid to take over the services they deliver and run them as an employee-owned mutual (Department of Health, 2011b). This provides a significant opportunity for services to ‘spin-off’ from the NHS as new social enterprises, with greater freedom to innovate, to develop more responsive models of care to meet patient need, and to develop a more sustainable and diverse set of income streams (Klaushofer, 2010).

The new system of direct payments and personal budgets for social care, where service users are given a cash payment to purchase the community care services that they have been assessed as needing, also opens up the potential for these services to be provided by a broader range of organisations (Community Care, 25 July 2012). Opportunities exist for social enterprises to develop high-quality, value-for-money, fee-paying services in these areas, thus developing their reputation for effective service delivery.

The challenge for UK social enterprise is to demonstrate that not only are they as effective, as credible and as high-quality as the best of the NHS and private sector players, but that they also deliver significant added-value. Research suggests that UK social enterprise can offer substantial benefits. An independent evaluation
commissioned by the School for Social Entrepreneurs (SSE) found that UK social enterprises, and in particular the organisations run by graduates (Fellows) of the SSE intensive one-year training programme, are delivering significant social impact. Fellows’ organisations are 20% more likely to survive for five years than the average UK business, experience rapid growth in turnover, are most commonly funded through commercial activity, and create an estimated £13m in staff salaries per year. The evaluation estimated that the Fellows’ organisations delivered social impact for nearly 900,000 beneficiaries over the previous year, creating £12m in social value (calculated through financial proxies for increased employment, better mental health and lower crime), with 70% working in the 20% most deprived areas in the UK (Heady et al., 2011). A 2011 report from the Kings Fund cites that there are around 62,000 social enterprises in the UK, contributing more than £24 billion to the economy, employing approximately 800,000 people – and an estimated 9% operate in the health and social care sectors (Kings Fund, 2011).

Social enterprise offers a distinctive contribution to the provider landscape. Specifically, they combine a focus on delivering targeted social impact with the financial reinvestment of profits. They offer a community-driven approach to service development and provision which ensures their services are tailored to local need and local people are involved in decision-making. This fits well with current government policy objectives.

A number of recommendations can be made to support UK social enterprise to demonstrate its advantages over other providers so as best to position itself to bid for new public service delivery opportunities. It is recommended that UK social enterprises:

1. **Seize the opportunities provided by the new NHS ‘Right to Provide’ and Community ‘Right to Build’, ‘Right to Challenge’ and ‘Right to Bid’,** to take a greater role in shaping local services, amenities and developments that are innovative, community-centred and sustainable.

2. **Learn from the leadership and operational qualities** of successful social enterprises abroad to better position themselves to bid for public service contracts, and specifically:
   a. **Demonstrate additional value through re-investment of profit,** using cross-subsidy models to provide private medical insurance and treatment services alongside contracts for NHS services, fee-paying services for treatments unavailable on the NHS, and fee-paying social care services under the new ‘direct payments’ and ‘personal budgets’ system, amongst many other options – to deliver additional profits for re-investment and enable a higher quality of care across the organisation’s services.
   b. **Demonstrate services tailored to meet local need through community-driven service development and provision.**
c. **Demonstrate innovation through agile, entrepreneurial organisations**, proactively identifying need and developing new solutions to meet it.

The specifics of the latter recommendation are considered in detail below.

1) **Demonstrate additional value through re-investment of profit**

Social enterprises committing to reinvest profits back into services will have a significant advantage over private providers when bidding for UK public service contracts. If, like social enterprises in developing countries, they provide fee-paying services to private customers and commit to reinvesting profit from those services into their NHS contracted service delivery, then they will demonstrate unique added value over both NHS and private sector competitors. In this context, the cross-subsidy funding models from social enterprise in developing countries may be worth exploring.

Social enterprises in the UK health sector currently focus on securing government contracts. This isn’t surprising: we are lucky enough to have a National Health Service (NHS), and any high-quality, cost-effective healthcare provider with an interest in serving low-income communities will naturally focus on winning NHS contracts.

But there is a risk here. One of the strengths of social enterprise is its sharp business focus: its sink or swim attitude to delivery in a market environment and its ability to respond to the pressure to provide products fine-tuned to the needs of consumers — demonstrated by customers’ willingness to pay.

However, if a social enterprise secures all its income from government contracts, what is there to differentiate it from a charity or public sector service provider that is also commissioned to provide services by government? Where is its added value?

I asked this question to a number of UK social enterprise support agencies: Social Enterprise London, the School for Social Entrepreneurs, ClearlySo and the Community Interest Company Association. They pointed to the business skills and entrepreneurial attitude of social enterprise leaders. But what drives those skills and keeps them fresh, if the core work of the organisation has moved out of the sphere of commercial activity and into state or charitable provision?

Charging patients isn’t always appropriate, especially in the UK context where the expectation is that high-quality services should be offered to all without charge. However, this shouldn’t stop UK social enterprise from thinking creatively about what services it provides and to whom, and where it might be appropriate to charge.

There are strong opportunities for UK social businesses to provide high-quality private medical insurance and treatment services, and reinvest profits back into free
NHS contract delivery. Furthermore, there is a market for treatments deemed too expensive for unrestricted provision on the NHS: for example IVF, cutting-edge specialist treatments for cancer, certain types of mental health psychological therapies. There are also emerging opportunities in the interface between health and social care services, where service users are willing to pay for additional services over and above their NHS needs assessment. This activity would establish a revenue stream that can be used to subsidise the organisation’s core costs and re-invest in NHS contract delivery, enabling the organisation to provide higher quality care and demonstrate added value.

The challenge of delivering high-quality services at low cost in developing countries drives social businesses to be lean and efficient in their activity, while maintaining a strong focus on clinical outcomes. Integrating commercial activity into a UK social enterprise delivering health services has potential to have a similar effect – driving the focus on efficient, results-oriented delivery. Furthermore, the diversification of income streams would provide protection against shocks such as potential turnover in NHS contracts.

2) Demonstrate services tailored to meet local need through community driven service development and provision

Many of the social enterprises profiled have strong roots in their local communities, ensuring their services are tailored to local need and involving local people in decision making. The business models of grassroots, co-operative, community-led social enterprises in developing countries may be worth examining in this regard. The shared qualities identified across the profiled social enterprises provide helpful lessons for UK social enterprises wanting to take a strong community-driven approach to public service design and delivery.

A community-led approach to understanding the needs and preferences of low-income consumers, facilitating behaviour change to improve healthy lifestyle choices and designing services around the needs of the service user, provide a significant advantage to social enterprises in demonstrating added value over competitor service providers.

3) Demonstrate innovation through agile, entrepreneurial organisations

Social enterprise provides an opportunity for visionary leaders to think outside the box, experiment and innovate. The social enterprise space provides an opportunity for greater staff involvement in decision-making and creative thinking outside of the often risk-averse, slow-moving world of NHS service provision (Kings Fund, 2011). With flexibility to diversify their income streams, unlike NHS providers, social enterprises may benefit from considering the full range of alternative funding models.
that have been shown to work in developing countries – for example business models which are cross-subsidy; low-cost, high-volume; and business-funded (as with CSR programmes).

The entrepreneurial culture combined with the social mission of a social business leaves it well-placed to identify local need and develop innovative solutions. The social entrepreneurs interviewed in India and Kenya don’t wait for government to commission services before getting stuck in to meet a need. Their businesses are born out of determination to address a problem, and they find innovative, workable ways of doing so. They proactively approach government and lobby for state funding to meet pressing needs in the community.

PVRI, a social businesses delivering high-quality eye care to low-income communities in India, identifies three crucial steps for a social business seeking to leverage new government funding:

1) Demonstrate the need amongst a specific population group
2) Raise awareness of the problem and need for intervention – amongst the public, NGOs and government
3) Establish the credibility of the organisation to meet that need – through independent audit of finances, clinical outcomes and track record in reaching the relevant population group.

Working with civil society organisations can help to bring pressure to bear for services to be appropriately commissioned.

Social enterprises in the UK are ideally placed to identify new social problems as they emerge and similarly innovate to provide solutions, and then lobby government to provide the funding to support effective and innovative initiatives that are proactively addressing the need. In the context of patients being able to choose ‘Any Qualified Provider’, social enterprises are well positioned to develop high-value, innovative services that attract patients and thus NHS funding.
5. Conclusion

Both developed and developing economies are gearing up for a step-change in public service delivery, characterised by an increasingly diverse range of service providers and innovative new business models that combine the best of traditional commercial and non-profit approaches.

The social enterprise sector is ideally placed to capitalise on these changes. Over the next ten years, there is likely to be exponential growth in the social business sector, as both philanthropic and commercial capital is increasingly channelled into profitable social impact investments.

The current sharp focus on how aid money is being spent is an opportunity for UK donors and NGOs to consider the cost-effectiveness of their spending and options for ensuring maximum impact. The UK Department for International Development (DfID) has an opportunity to engage early and align its policies to support the emerging evidence base for impact investment.

Key interventions to improve access to capital for social enterprise abroad, and to source and fund technical assistance to help new social enterprises become ‘investment ready’, will be pivotal in supporting the fledgling sector to grow and flourish. Advocacy by development agencies in low-income countries for government funding mechanisms to support high-quality social enterprises to participate in public service delivery would help these ventures to achieve scale-up through public sector funding and brand recognition. More work is needed to improve access to financial products for low-income communities, through micro-finance, micro-insurance, mutual aid funds, peer lending schemes and other accessible banking initiatives, in order to empower low-income people to become agents of change in their own lives. There is also a significant potential role for DfID and international development agencies to support the sector by identifying and sharing good practice and lessons learnt. By commissioning and publishing research, these agencies can expedite the development of models that work best. And by supporting high calibre leadership training programmes for social entrepreneurs, they can encourage new talented leaders to become the architects of growth in the sector.

Similar opportunities are presenting themselves in the UK. The government’s new policies to increase community involvement and decision-making in matters that directly affect people’s day-to-day lives, and to broaden the range of providers involved in UK public service delivery, provide ideal opportunities for social enterprises. Social enterprises should aim to showcase innovation, community-focus and high-quality service provision, and to step up to a greater role in the UK public service provider landscape. By learning from the leadership and operational qualities of successful social enterprises abroad, they will be better able to position themselves to bid for public service contracts. They will need to show evidence that they can successfully understand the needs and preferences of low-income
consumers, facilitate behaviour change, design their products and services around the needs of the client, persevere to achieve results, balance ethical principles against business priorities, build complex multi-level partnerships and provide strong local ownership by extraordinary individuals. They will face similar operational challenges to social businesses abroad. In order to succeed, they will need to have a flexible approach to start-up capital and human resources, to diversify their income streams, demonstrate high quality governance, plan and manage scale-up and demonstrate high-quality outcomes. In the UK context, they will need to demonstrate additional value over other providers through re-investment of profit, through tailoring services to meet local need by means of a community-driven approach and by demonstrating innovation through agile, entrepreneurial organisations that identify need proactively and develop new solutions to meet it.
Annex A: Interview Questions and Organisation Profiles

Interview questions

The following questions were used as a template:

1) **Set-up: structure and finance**

- Who started the organisation and what was their vision?
- How many branches do you have and in what locations? What is the rationale for this?
- Where are your services provided and to whom?
- Are customers charged directly? What is the fee structure? Do you charge private patients at full market rate? When is treatment provided at a subsidised rate?
- What other sources of income do you have? Do you have government contracts?
- How did you secure start-up capital? Was it a grant, loan, or equity investment?
- What structure was the organisation set up with? Did this change and if so, why? Are there any restrictions in place to prevent the organisation from going fully commercial, e.g. an asset lock?
- What are the governance arrangements?
- Is profit re-invested?
- What proportion of income comes from donation and what proportion from commercial activity?
- How long did it take to reach break-even?
- What has been your annual financial and activity growth rate to date?

2) **Development of model**

- What challenges did you face and how were these overcome? How has the model evolved? What worked and what didn’t?
- What proportion of activity is fee-paying and what proportion free or subsidised?
- How does the treatment or patient experience provided differ depending on whether the customer is full-fee-paying or subsidised?
- What proportion of private patients are self-funded / insured / covered by employer schemes?
- What partnerships do you have in place, who with, and how do these assist in delivering your objectives?
- What is the vision for the next five years? How has it changed? What is the planned growth rate and how do you plan to achieve this?

3) **Marketing and outreach**

- Who are your target audience? – age, gender, area, conditions, income / profession groups?
- How do you attract customers – private and low-income?
- Is the service accessible to the lowest income customers? How do you know if this group are accessing the service?
• Which geographic areas are covered by the service? Which are targeted by the marketing?
• Do you fund transport services to help low-income patients travel from remote areas for treatment? Or mobile treatment services?
• What other organisations do you work with to market your service?
• Do you run social marketing / public health / awareness-raising campaigns?
• What have you found to be the most effective marketing tool?

4) Operational issues

• What specific services do you offer? What is your clinical casemix?
• Describe the patient journey, from arrival to discharge.
• What are your Key Performance Indicators (KPIs) and what data do you collect?
• What is your approach to performance management?
• What are your average bed capacity, bed occupancy and activity rates?
• What is the ‘DNA’ (Did Not Attend) rate? What proportion of potential customers identified during outreach activities attend for screening appointments and treatment?
• What staff and skill mix do you employ?
• What other organisations, in the public, private or third sector, provide similar or linked services to yours? How do you work with the wider healthcare system? Do you accept or make referrals to other healthcare providers?

5) Community links and accountability

• Do you run community outreach programmes and what do these involve?
• How are your services linked with and accountable to the customer’s community?
• How is the health system and your organisation regulated externally?
• How do you think healthcare can be made more accessible?

6) Learning

• What top tips would you offer for a new social entrepreneur?
• What makes a social enterprise successful in the health sector?
• What do you see as the role of social enterprise in healthcare / development, and what value do you think it adds?
• What are the biggest challenges you’ve faced and how have you overcome these?
• What have been the most successful / rewarding parts of the journey?
Organisation profiles

A. Direct providers of health services

A.1 Cross-subsidy model

Social businesses operating a cross-subsidy model offer differential pricing for identical products and services based on the customer’s ability to pay. Profits from fee-paying customers subsidise services to low-income communities. In some cases the organisation offers a ‘middle tier’ option of a subsidised service for the working poor, complementing a free service for the very poor.

A key issue is whether it is most effective to run the organisation as a single, integrated whole or to separate it into a private, unambiguously for-profit company whose profits then fund a separate charitable organisation (potentially formalised under a Corporate Social Responsibility agreement). All four cross-subsidy organisations visited (Pushpagiri Eye Institute, AyurVAID hospitals, 1298 ambulances and Upperhill Eye and Laser Centre) were grappling with this issue or had addressed it in the past.

Advantages of running the organisation as a single integrated whole were identified as:

- economies of scale where both organisations are providing the same service, for example eye care for private and low-income customers respectively;
- high quality of professional skills and experience across the organisation, preventing the charitable organisation from becoming a lesser quality ‘poor sister’ resulting in potentially lower standards for patients;
- clarity of social purpose, that all patients are receiving the same quality of treatment;
- reputation and branding opportunities as a distinctly ethical organisation that can be trusted by private and low-income customers alike.

Advantages of separating the business and charitable aspects were identified as:

- financial separation leads to greater clarity – the business side sets the budget for the charitable side, reducing the risk that the activity of the one could put at risk the viability of the other;
- separation allows for greater definition between the experience of a private and subsidised patient: it is easier to provide lower waiting times, booked appointments, more comfortable waiting rooms, private rooms, ‘VIP’ rooms etc when services are provided separately. Separation allows the business side to charge private patients at full market rate – this can be questioned when treatment is provided alongside patients who receive it for free or low cost;
- opportunities for clearer branding to market the different organisations to different target customer groups.

To date, the four organisations profiled have chosen to remain as a single, integrated organisation. Of all the advantages, the issue of brand and being able to position themselves as distinctive, ethical organisations was identified by all as the most important reason.
A.1.1. Ziqitza Health Care (Dial ‘1298’ and ‘108’ ambulances)

Interviewed:

- Sweta Mangal – Chief Executive Ziqitza Health Care
- Contact details: +91-22-26578800 / +91 22 395 712 98 / www.zhl.org.in

Overview and business model

Ziqitza Health Care operates two ambulance services:

- Dial ‘1298’ – a fee for service, cross-subsidy ambulance service, where charges for patients taken to private hospitals subsidise lower charges for patients taken to government hospitals, and free service for accident victims, unaccompanied unconscious individuals and victims of mass casualty incidents (operates in Mumbai, Punjab and Kerala).
- Dial ‘108’ – an emergency ambulance service commissioned by four Indian State Governments (Bihar, Trivandrum, Punjab and Rajasthan). The service is either free or cost-per-use depending on the terms of the State Government contract.

In 2003 there was no functional ambulance service operating in India. Responsibility lay with individuals to get themselves to hospital. Ziqitza was set up by a group of five friends who had returned to India after being educated in the USA. Comparing their experiences at home and abroad of helping elderly relatives to hospital in an emergency, they recognised the poor state of provision and urgent need for high-quality ambulance services in India.

All Ziqitza ambulances are equipped with state of the art technology and manned by trained clinical staff (usually intensive care unit nurses who are given one month’s paramedic training, due to a shortage of paramedics) to provide high-quality care while the patient is transferred to hospital. This is in stark contrast to most so-called ‘ambulance’ services in India, which are often simply standard vehicles driven by clinically untrained personnel, and often end up functioning as a hearse.

Ziqitza has benefited from training and shared protocols from London Ambulance Service, with whom a Memorandum of Understanding was developed at the company’s inception. It operates state-of-the-art equipment in its call centres, with ambulances tracked by GPS and dispatched efficiently to minimise response times. Comprehensive performance data is collected and analysed to monitor times of peak use, response times, and capacity, to ensure resources are deployed effectively.

The original plan was to provide a charitable service, asking customers to pay what they thought was appropriate. This was unsuccessful: very few people paid, and the organisation was at risk of collapse.

Ziqitza had to adopt a hard-headed business approach to ensure its financial viability. Analysis of early activity showed that most patients requested to be taken to private hospitals. The business model was revised to charge patients a flat fee based on their choice of destination and length of journey, with higher charges for patients asking to be taken to private hospitals subsidising lower charges for government hospitals, and a free service for the very poor, accidents and emergencies.
Additionally, Ziqitza raises further income by selling advertising space on its vehicles to socially responsible companies. 25% of the ambulance running costs is funded from advertising revenue. Ziqitza reached break-even in terms of cash flow within one year of operations. The company is financially self-sustaining and does not accept donations.

Currently around 95% of patients choose to be taken to private hospitals, subsidising 10-15% of the service’s costs for low-income customers. Ziqitza is working to address a perception issue: low-income communities don’t identify that the 1298 service is accessible to them, and uptake is therefore lower than it should be given the widespread need.

40-50% of calls to the 1298 service come direct from members of the public. The rest come from referrers such as hospitals. A small referral fee is paid to incentivise uptake. Many hospitals have a fixed monthly contract with the 1298 service to provide a set volume of patient transfers. The hospital then recovers the costs through patient charges, often including the transfers in the cost of a package of treatment, or from patients’ insurance cover.

Ziqitza takes a cautious approach to marketing the 1298 service as it doesn’t want to be overwhelmed by demand it can’t meet. It only advertises in areas where it has enough ambulances available to take extra calls and where hospitals have contracted with them to provide a transfer service. It plans to gradually expand the number of ambulances in operation, and will broaden its marketing campaign as it expands. It relies primarily on referrals from healthcare providers and word of mouth to promote its service.

The high clinical standards and increasing recognition earned by the ‘dial 1298’ service placed Ziqitza in a strong position to lobby state governments to commission better public ambulance services, and to bid for contracts. Its resulting ‘dial 108 in emergency’ service is administered separately from the 1298 service. The two services are kept financially independent, and are run operationally from separate premises. The service thus maintains complete transparency and accountability with regards use of public funding.

**Wider impact**

Ziqitza’s 1298 ambulance service provides a broad range of social initiatives, including:

- Health camps to targeted groups such as schools, marathons and early morning joggers. A basic medical check-up, including measurement of blood pressure, blood sugar, and weight, is provided in the company’s ambulances. As well as providing a useful social service, the camps act as informal publicity, as participants can see the high quality of clinical care and equipment on offer inside.
- Helpline services connecting women and senior citizens in distress to relevant NGOs to provide advice, support and assurance.
- First aid training, providing over 300 registered medical practitioners with emergency medical service skills training.

During the floods in Bihar and the 7/11 Mumbai bombings, Ziqitza sent out the Mumbai fleet of 1298 ambulances free of charge to provide support to the relief effort. This won the company strong recognition and support.
Fact file

- Ziqitza was set up in 2005 by five friends who had returned to work in India after being educated / trained in the USA.
- The company aims to meet international quality standards for emergency medical services and to be accessible to everyone regardless of income.
- Currently Ziqitza operates more than 800 ambulances across five states. The 1298 service operates in Mumbai, Punjab and Kerala, and the 108 service is commissioned by State Governments in Bihar, Trivandrum, Punjab and Rajasthan. Its corporate office is located in Mumbai.
- The company’s current focus in India is to make the 1298 service available in all major cities, and increase uptake in its current geographies. It has grown from 20 employees in 2004-5 to 4500 in 2011-12.
- Ziqitza is looking at expansion opportunities across the developing world, and in particular in Sri Lanka, Bangladesh and Africa.
- Ziqitza’s investors are Acumen Fund, Global Medical Response / American Medical Response (AMR), Housing Development Finance Corporation (HDFC), The Infrastructure Development Finance Company Limited (IDFC), and India Value Fund. Its strategic partners are London Ambulance Services, Life Supporters Institute of Health Science and New York –Presbyterian Emergency Medical Service (NYP-EMS).

A.1.2. Pushpagiri Eye Institute (PVRI)

Interviewed:

- Dr. Vishwanath – Medical Chair
- R. Shrinivasan – Chief Strategy Officer
- Mr. Karunakar – Business Development Manager
- Sathish Bhavani – Swamiji and community champion / eye screening camp co-ordinator
- Dr. Ravi Kumas – Eye screening camp ophthalmologist (locum clinician from nearby government hospital)
- Website: www.pvri.org. E-mail: shrinivasan@pvri.org

Overview and business model

The Pushpagiri Eye Institute, a Division of Pushpagiri Vitreo Retina Institute (PVRI), seeks to raise the quality of eye care available in the state of Andhra Pradesh for everyone — regardless of ability to pay. It runs a Super Specialty Eye hospital in Secunderabad and also provides a range of community outreach programmes within the state of Andhra Pradesh. It provides 55% of its activity to low-income patients free of charge.

It is a non-profit organisation which works on a cross-subsidy model. Private patients are charged 60% of the market rate; subsidised patients are asked to pay what they can. The income from private patients subsidises the following activity:
• **Community Outreach Eye Screening Camps.** Held across the state of Andhra Pradesh, to screen all members of the community who attend on a given day. Screening, prescriptions and glasses are provided free of charge to all. Patients in need of further investigations are referred to visit the PVRI hospital and are treated as private fee-paying patients – with options available for low-income clients as below.

• **School Eye Screening Camps.** As above, provided free for school children only. Under this Screening Camp, there are many variants where either PVRI itself conducts these camps from its own resources or there is a sponsor who partly or fully supports the Eye Camp. For example, the Lions Club International subsidised 10% of PVRI’s camp costs for one such programme of Camps. PVRI partners with other NGOs to provide glasses, or funds them from its charity ‘Gift of Vision’ fund.

• **Government Scheme.** PVRI offers free treatment to low-income patients holding a Health Card issued by the Government of Andhra Pradesh. The government reimburses a substantial portion of the cost of the treatment, including surgery, for the Health card holders, and funds their transport back to home. PVRI also assist the patients to apply for the Health card where they are eligible but don’t already have one.

• **Discounts for non-card holding low-income patients.** Where a patient can prove they are unable to pay, but are unable to get a Health card, a discounted rate is offered by PVRI at the discretion of the Chairman.

Other sources of income are as follows:

• **Student Tuition Fees:** PVRI runs primary and secondary care Diploma programmes for Ophthalmic Assistants and Optometrists, made up of fee-paying students and government funded course. The courses are accredited by Andhra Pradesh Paramedical Board.

• **Research funding:** From government or NGOs, to undertake research in the eye care field. This is sometimes secured through lobbying, application for specific grants, or match funding.

• **PVRI Charity Fund:** “The Gift of Vision”. This small subsidiary revenue stream funds extras rather than core business; for example it might pay for glasses for low-income patients where there is no partner NGO providing these for free. It is promoted via PVRI’s Business Development Managers and its website.
• **Advertising space**: PVRI is exploring options to sell advertising space in its hospital out-patient waiting room, and at its Community Outreach Camp locations. It is considering renting space for stalls at the camps, so that companies can target people waiting to be screened with their products, for example with mobile phone deals, bank accounts, refreshments, glasses, medicines etc.

PVRI has focussed over the last 18 months on matching its growth in charitable (free and subsidised) activity with corresponding growth in full-fee-paying patient volumes, to ensure the business model is sustainable.

Many areas of India have little or no eye care service provision, and where services are available the quality is highly variable. The eye care need is growing day by day. The WHO’s *World Health Statistics 2012* report (WHO, 2012) highlights the dramatic increase in non-communicable diseases in low- and middle-income countries, and in particular the increase in diabetes prevalence to 1 in 10 adults worldwide. This means increased rates of diabetic retinopathy (damage to the retina caused by diabetes, which left untreated causes blindness) – exacerbated by lack of awareness of the condition.

PVRI has taken on three Business Development Managers who work within a 7 hour radius of its hospital, to identify people with eye conditions who aren’t accessing eye care, and bring them to PVRI for treatment. They identify potential customers through primary care eye service providers that need to refer patients on to a secondary care provider, such as public eye clinics, opticians, ophthalmic assistants, optical shops, and GPs. These patients are a mixture of those who have attended private primary care services and are therefore more able to pay; and those in need at public clinics who are not.

At the same time PVRI has implemented a robust, streamlined data collection system to evidence the high quality of its clinical outcomes. Regular reports are now scrutinised by operational managers and at Board level. These track quality indicators such as clinical outcomes, near misses, infection rates, hygiene standards, patient experience, pharmacy stock-takes, health and safety issues, as well as financial and administrative indicators, giving a holistic picture of organisational performance.

The PVRI model is financially self-sustaining and ready to scale. In March 2012 it has opened one new hospital in Vizianagaram and another hospital is planned for opening in Kadappa in November 2012, to expand coverage across the state of Andhra Pradesh. PVRI is exploring options for opening tertiary centres at another three locations. The new hospitals are expected to break even within 4 – 5 years. Each hospital will be financially independent and self-sustaining, reporting to the existing head office. PVRI projects a 40% year on year increase in activity across all its areas of work. It has set itself ambitious targets of reaching 1.5 million people and reducing blindness from 1.84% to 1.02% in Andhra Pradesh over the next ten years.

Its expansion is supported by Acumen Fund, a non-profit impact investment fund, and through commercial bank loans. As PVRI was set up as a not for profit Society, it formed a company as an investment vehicle for expansion, with the PVRI founders and Acumen Fund each taking a 50% equity stake in preference shares.
The company has two commitments that retain its charitable focus: firstly that 50% of its activity should remain free or subsidised for low-income customers and secondly that the company will never go fully commercial.

**Wider impact**

In addition to providing much needed high-quality eye care services, PVRI works to shape the eye-care arena in India more broadly. It approaches eye care holistically as a whole system issue. It runs an Andhra Pradesh Paramedical Board accredited in-house primary and secondary care Diploma programme for Ophthalmic Assistants and Optometrists, and fellowship programmes for doctors and surgeons to gain enhanced skills in eye care. This aims to address the national shortage of trained staff, a problem set to increase with nearly one in four ophthalmologists in India reaching retirement age. It is engaged in a one-year research project in partnership with the London School of Hygiene and Tropical Medicine on improvement in cataract surgeries. It runs an Eye Bank for transplants and a ‘pledge your eyes’ campaign to improve supplies of corneas.

PVRI has further plans for expansion in the pipeline, combining government funding and partnership with a major NGO. It aims to

a. Set up a Public Advocacy Project, to raise awareness of blindness in general and diabetic retinopathy in particular, and the importance of regular eye checks and corrective treatment;

b. Start a graduate level course for eye-care professionals, to staff a much broader community outreach ophthalmology programme;

c. Establish a research centre for diabetic retinopathy, to research prevalence, and develop new technologies and cost-effective treatment models; and

d. A Public Affairs and Public Administration Institute, to develop tools in partnership with government to improve governance, measure impact and quality of services provided under government funding, track resources such as medical supplies, and audit service providers.

While contributing to the social objective of improving eye care services across Andhra Pradesh, these projects will also generate income and scale for the organisation, through increased patient volumes, graduate course fees, use of new technologies, performance-based partnership funding incentives etc.

**Fact file**

- Started in 2007 as a joint enterprise by a group of 6 Ophthalmologists and Entrepreneurs.
- Led by 2 Chairmen: Dr. Vishwanath (Medical) and Mr. Govind Hari (Administrative), and a Board of Directors.
- Applying for the prestigious Indian NABH (National Accreditation Board for Hospitals) accreditation.
- 1 Super Specialty Eye Hospital in Secunderabad since 2007, 1 in Vizianagaram since March 2012, and another to be opened in Kadappa in November 2012. Between the three hospitals, and its outreach camps, PVRI has capacity to cover 35% of the population of Andhra Pradesh.
- Accelerating rate of growth. 100,000 patients seen in the four years up to June 2011, and 10,000 surgeries undertaken. Projecting 40% year on year increase in activity across all its areas of work.
- Growing numbers of outreach eye screening camps each year, with 400 in its first four years, and now around 10 a month to support its expansion.
- 55% activity provided for free – mostly to low-income patients.
- First approved facility to provide treatment for low-income patients under the Andhra Pradesh State Government Rajiv Aarogyasri Insurance Scheme for patients holding a Health card, and one of the first Super Specialty Eye Care Service providers under the scheme.

A.1.3. Upperhill Eye and Laser Centre (UHEAL)

Interviewed:

- Dr. Kibata Githeko – Consultant ophthalmologist and founder of UHEAL (pictured in photo far left)
- Website: http://uheal.or.ke/, E-mail: office@uheal.or.ke, Phone: +254 20 271 3232 / +254 (0)714 617 782 / / +254 (0)736 329 348

Overview and business model

UHEAL is a social business committed to providing high-quality eye care in Kenya, and to making eye care accessible for all. It provides the full range of primary and secondary eye care services from its Upper Hill Eye and Laser Centre in Nairobi.

Dr. Kibata identifies a huge need for quality retina services in Kenya. As in India, diabetes prevalence is rising dramatically (WHO, 2012), leading to higher rates of diabetic retinopathy (damage to the retina caused by diabetes, which left untreated causes blindness). This adds to the existing burden of eye disease, such as cataracts. Eye care services lack equipment, are badly run, have long waits for treatment, and are under-resourced. People with a middle to high income can afford to pay or are covered by insurance schemes, and a market exists for high-quality clinical treatment with low waits and convenient appointments. He started UHEAL to meet that need. From the start, he has had a vision to extend the service to make it accessible for low-income customers.

Initially UHEAL provided free outreach eye screening services and follow up treatment to low-income communities, meeting all running costs from the eye centre’s profit margins. The
company was not well-known and faced an uphill struggle. It began charging low-income patients a small fee to help meet its costs – 300 KSH for an eye examination (including taking the patient’s blood sugar and providing eye drops where needed).

The service to low-income customers was breaking even in Central Province, an area with a relatively strong economy. It continued to run at a loss in other areas – people couldn’t afford even this minimal charge, and awareness of the risks of diabetic retinopathy and the importance of eye screening was low. Laser surgery is preventative: it can prevent deterioration of eye sight but cannot restore damage that has already been done. Despite offering laser treatment at a highly subsidised cost of 1,500 KSH per eye, only 20% of people identified as being at risk of going blind came forward for surgery with UHEAL. The treatment was still too expensive to be affordable, and people did not trust or take seriously the diagnosis of degenerating eyesight. People were wary of a diagnosis from a company they hadn’t heard of. Additionally, low-income communities lack a culture of taking responsibility for their own health and proactively seeking treatment.

From July 2011, UHEAL decided to waive the initial 300 KSH consultation fee in order to provide its screening service in government hospitals and health clinics (which prohibit patient charges over and above the government healthcare registration fee). It has subsequently seen a dramatic rise in the number of patients screened each month. Patients diagnosed with diabetic related eye problems are then referred for laser surgery at UHEAL’s mobile clinic, where the 1,500 charge still applies (cataract cases can be referred to local hospitals and the Lions Club clinic for free treatment). Where a patient can’t afford this rate, they are asked to contribute what they can afford towards the cost of treatment. The mobile laser surgery clinic is held around once a month, in a location near to the last three or four eye screening camps.

The mobile laser used to perform eye surgery across the different provinces where UHEAL screens low-income communities was funded through a grant from the World Diabetes Foundation. It is aiming to use some of these funds to buy other new equipment to support expanded outreach services, e.g. to screen for glaucoma.

UHEAL is exploring options to engage local ophthalmologists, such as loaning out the UHEAL mobile laser and asking them to carry out the screening and keep 50% of the treatment fees charged for surgery. The aim is to improve the coverage of the screening programme, motivate ophthalmologists to screen patients, and raise awareness of the UHEAL brand. Joint ventures like this help boost the image of the local ophthalmologist in the community, and helps UHEAL form links and partnerships with the local eye care service network. Dr Kibata prefers this approach to working in areas with no local ophthalmologist.

Over the course of the first year of operations, UHEAL has found that it is not possible to run the service for low-income patients as a financially self-sustaining service. Treatment activity for low-income patients is currently limited to what can be funded through subsidy from the eye centre’s profits, and as the centre is new and relatively small, this significantly inhibits what can be achieved.

There is no current option for private sector providers to contract with the government to provide low-cost services, and private companies are similarly often excluded from bidding
for grant funding. UHEAL is now registering a not-for-profit Foundation in order to take its low-income work to scale. This will formalise its charitable work and combine subsidy funding from the eye centre with charitable donations, grant funding, and partnerships with NGOs.

The UHEAL business model is therefore in a state of transition and evolution as it moves to this new mixed funding approach. The main focus will be to launch an extensive public health awareness campaign on the risks of eye disease such as diabetic retinopathy. This will target the public and also eye care providers, who are often unaware of the problem and don’t offer screening.

While also keen to expand the coverage of UHEAL’s screening service for low-income communities, Dr. Kibata is wary of creating an expectation of a free service. To be sustainable, and independent from donor fluctuations, the long-term goal is to grow the market so that people seek help for eye problems in sufficient volumes that eye care services such as UHEAL can charge a small fee for screening and treatment to break even independently.

**Wider impact**

UHEAL is exploring a range of approaches to tackle the rising epidemic of diabetic related eye problems in Kenya. As well as launching a wide-ranging public awareness-raising campaign, it is considering options for working in partnership with other organisations to set up comprehensive diabetic treatment centres. In the longer term it aims to increase its service coverage by opening branches in more locations.

UHEAL also has the camera equipment needed to carry out remote eye screening. However, it is limited by the lack of high-speed internet connectivity, and skilled staff in the screening locations to operate the equipment. In the future it hopes to be able to make more use of technology to conduct remote routine screening and follow up checks from its Nairobi eye centre.

**Fact file**

- UHEAL was started in 2007 by Dr. Kibata Githeko. It employs ten staff based out of its Upper Hill Eye and Laser Centre in Nairobi.
- It provides roughly one eye screening camp for low-income communities each week, and one mobile laser surgery clinic a month, in locations across the country – bringing diabetic retinopathy screening and high-quality care to near where people live.

**A.1.4. AyurVAID hospitals**

**Interviewed:**

- Rajiv Vasudevan – Founder and Chief Executive AyurVAID hospitals
Overview and business model

AyurVAID is a chain of Ayurveda hospitals. It provides high-quality, standardised Ayurveda treatment to address chronic illness – an often under-emphasised cause of ill health.

The private sector healthcare industry in India is geared towards acute and emergency care, and in-patient admissions. This is where the money is: long stays in hospital requiring intensive clinical care are expensive. There is little financial incentive for provision of high-quality primary care and preventative medicine to keep patients fit, healthy and out of hospital.

But chronic conditions are on the rise in developing countries. There is, for example, increasing recognition of the sudden rise in diabetes prevalence amongst low-income communities (Bloomberg, 2012), in large part due to poor nutrition and the ever-increasing availability of sugary drinks and snacks.

Chronic conditions often have complex causes and an array of inter-related symptoms. Providing high-quality care requires a holistic approach: assessing the patient’s individual needs, lifestyle, and symptoms, and prescribing a treatment approach that includes long-term changes to diet, sleep, work and exercise habits, lifestyle and behaviours, as well as the treatment itself. This holistic approach is not the first instinct of conventional medicine, which tends to focus on symptoms in isolation. It is however at the heart of Ayurveda, which takes a whole-person approach, factoring in all information about the person and their context to form a picture of their health, and including a long-term plan to build immunity and resilience as part of the standard treatment approach.
AyurVAID seeks to blend Ayurveda with conventional medicine. Each patient is given a comprehensive, detailed assessment and a “lifestyle prescription” along with their Ayurveda treatment and conventional medicine where needed. The hospital follows up with patients after discharge to ensure their health is maintained over the following year.

By delivering top quality, well-regulated Ayurveda care, according to strict protocols and medical management, recording data against a range of metrics and documenting clinical outcomes, AyurVAID aims to develop the evidence base for Ayurveda and build the credibility of the discipline. It is building up a database of clinical case studies, testing and evidencing methodologies, and developing research proposals to further this work. It operates according to strict safety standards, both with regards to the quality of medicines it provides and the integration of conventional medicine into consultations and treatment regimes where appropriate. AyurVAID does not provide treatment in emergency or acute cases, which are referred on should they arise.

It is a for-profit organisation which offers its services for the poor on a cross-subsidy model. The original business model enabled access for low-income communities through a separate ‘AyurSEVA’ sub-brand, which included preferential pricing for low-income patients (at 40-45% of the standard rate), with an equal standard of clinical care, and with accommodation offered in general wards rather than private rooms. However, the model was unsuccessful. While the out-patient department flourished, the AyurSEVA branch was regularly operating significantly under its in-patient bed capacity and incurring disproportionate overhead costs. It was achieving around 30-40% bed occupancy where 60-70% would have been needed to achieve break-even. Demand for the service from low-income communities was much lower than expected: they were unable and unwilling to commit the money and the time off work for in-patient treatment for chronic, non-emergency care.

AyurVAID revised its business model to integrate the subsidised side of its business into its mainstream hospital chain at unit level. The AyurSEVA branches were rechristened AyurVAID for brand consistency and all hospitals now accept a mixed economy of patients. Income from full-fee-paying patients subsidises the following activity:

- AyurSEVA preferential pricing scheme for individual low-income patients accessing AyurVAID hospitals, following approval by a means assessment panel, up to a monthly financial ceiling. Applicants holding a card from the Indian government certifying that they are below the poverty line are automatically eligible; non-card holders’ eligibility is assessed according to a questionnaire which evaluates the applicant’s economic and social vulnerabilities, their education, occupation, assets and income level. Currently 10-15% of activity is provided to low-income patients under the AyurSEVA subsidised scheme.
- AyurVAID is applying for approved provider status under the Indian government’s ‘below the poverty line’ card reimbursement scheme. This will qualify card holding patients for free treatment, with government underwriting medical expenses up to a significant amount (currently Rs. 30,000/- or about 425 UKP per family). This will enable AyurVAID to expand their accessibility further. The aim is to achieve 20-30% activity catering to low-income patients.
Outreach work in partnership with the NGO LabourNet targeting casual workers around the Bangalore area, providing assessments, advice and medicines to these workers on building sites, thus reaching over 2,500 people in a year.

A planned community health programme, working over 3 to 5 years with a fixed population group, benchmarking their health status at six month intervals while providing a comprehensive care and lifestyle management plan. The programme will work with a slum community comprising around 2,000 people in 375 families.

Each hospital is financially self-sustaining at a unit level, achieving break-even point after an average of one year. The chain operates on a 'small is beautiful' boutique hospital model, offering a tailored patient-centric service while achieving sufficient volumes to be financially viable. To fund the organisation's corporate overheads, the chain is expanding to increase its volume of hospitals. It is seeking private equity funding with the aim of scaling up to 50 points of presence (hospitals and day-care centres) in the next five years. Acumen Fund is currently an equity partner, supporting the chain to improve access for low-income groups.

AyurVAID relies primarily on word of mouth as the principal means of referral. On average each patient refers two more; the goal is to increase this to five more. The organisation prefers to showcase its work through medical camps offering basic check-ups, screening and advice on diet and lifestyle (some independent, some in collaboration with companies, residents associations and NGOs), community outreach work, and awareness-raising talks, rather than direct marketing. Some branches in prominent locations attract walk-in referrals. It also receives some referrals, in particular for orthopaedic, muscular and neurological conditions, from conventional medical practices, as well as from local small-scale independent Ayurveda practitioners.

Wider impact

In the long-term, AyurVAID aims to reduce the cost of providing healthcare, by intervening early with patients and resolving issues in primary care, helping patients to take responsibility for their own health and effect change through diet and lifestyle rather than waiting for problems to escalate and require expensive in-patient care. It aims to improve support for chronic conditions and rehabilitation, for example after stroke, areas of healthcare which are currently under-provided for in the Indian health system.

Fact file

- The first AyurVAID hospital opened in Kerala in 2006. The chain now has four hospitals: another in Kerala (opened in 2007), Bangalore (2008), and Chennai (2009). It has an average of 20 beds per hospital. AyurVAID is now looking to consolidate bed occupancy rates and market reach within its current geographies before expanding to new states.
- The hospital chain is managed from its corporate office in Bangalore, which monitors data from all four hospitals in real time and supports the smooth operational running of the chain. As it expands, the plan is for hospitals to be managed in regional clusters.
- An increasing number of private medical insurance schemes cover care from AyurVAID, albeit with limitations (e.g. for certain conditions only, or up to a set cost
For many insurance partners AyurVAID is the first and only Ayurveda hospital on their nationwide network. AyurVAID is lobbying government to approve Ayurveda treatment under the national health insurance scheme for government employees.

- AyurVAID’s Domlur hospital was the first and only Ayurveda hospital to receive the prestigious Indian NABH (National Accreditation Board for Hospitals) accreditation in 2010. Only 131 hospitals across India have achieved accredited status and Domlur is the only one which provides alternative medicine. Other branches of the AyurVAID chain are now applying for accreditation.

- AyurVAID hospitals provide treatment for a broad range of chronic conditions, including neurological and orthopaedic conditions, respiratory disorders, women’s health problems, pain management, gastrointestinal problems, post-stroke rehabilitation, migraine, carpal tunnel syndrome, lower back pain, muscle and joint disorders, skin problems, ulcers, infertility, MS, metabolic functions, thyroid conditions, and lifestyle disorders (hypertension, diabetes, obesity, cholesterol, stress and sleep disorders), as well as surgical treatment interventions for wounds, piles, fissure, fistula, and haemorrhoids.

- The hospitals use leapfrog technology with a best in class integrated CRM cum ERP cum eCOM solution on the Cloud, as well as using the common platform Yammer as an internal communications social enterprise collaboration platform to facilitate collaborative team work.
A.2 Low-cost, high-volume model

Social businesses operating a low-cost, high-volume model offer a product or service to low-income communities that breaks even at unit level. They are characterised by high customer volumes to achieve the necessary reduction in unit costs to make the service affordable. To keep costs down, they operate a ‘no frills’ approach and lean, streamlined systems. In healthcare services, this can result in effective patient pathways with a strong focus on resolving clinical problems at an early stage to ensure expensive complications are minimised. Such services are targeted at the working poor, who have access to a small income stream.

The low-cost, high-volume model is attractive as it is financially viable at unit level and therefore easy to scale. It enables the organisation to clearly position itself as focussed exclusively or primarily on meeting the needs of low-income customers. However it is also a difficult model to set up as it relies on attracting high volumes of low-income customers. This is particularly challenging in the first few years when a new organisation is struggling to establish its brand and reputation. In healthcare, start-up costs for equipment and infrastructure are high, and it may be difficult to attract the necessary capital. The running costs for a high-calibre clinical staff team are also high, so margins are tight, leaving little space for loan repayments to cover start-up costs. Even for a low-cost service, low-income customers may struggle to raise the immediate capital for unforeseen healthcare expenditure. This model may be most effective for healthcare services where care is planned in advance and customers have time to save – for example maternity services or elective surgery.

A.2.1. LifeSpring maternity hospitals

Interviewed:

- Vijaybhasker Srinivas – Head of Process Control at LifeSpring maternity hospitals
- Website: http://www.lifespring.in/, E-mail: info@lifespring.in, vijaybhasker.srinivas@gmail.com

Overview and business model

The LifeSpring hospital chain provides an affordable core maternity service to low-income communities in and around Hyderabad. It currently has 12 branches which provide maternity (pre-, intra-, and post-natal), family planning, immunisations, pediatrics, diagnostics, and pharmacy services, as well as health education to surrounding communities.

The business model is low-cost, high-volume rather than cross-subsidy. It offers maternity packages at 30 – 50% of market rate, an affordable price for its target market of families earning $2-4 a day. Customers can opt to pay more for a private or deluxe room (with 1 bed) rather than stay on the general ward (10 – 20 beds).

The service is made more accessible through the practice of quoting a single, all-inclusive price which covers all core maternal services, including for any complications arising during the birth process. The price is kept as stable as possible, prioritising affordability. This means that women and families can plan in advance for the total cost. Where families need to take out a loan, the single package price avoids the need to take out a larger loan than
needed (at high interest if they are a high credit risk) in order to cover potential “hidden extra” costs as additional treatment needs emerge. LifeSpring tries to keep its service package prices consistent so that women can budget and plan ahead.

The tight margins required to deliver this low-cost package are achieved through a rigorous focus on providing high-quality clinical care. Strong focus on infection control, early and regular antenatal check-ups, early intervention to identify and minimise complications, and efficient patient pathways, result in reduced expensive treatment and in-patient stays. The service is tightly managed according to lean methodology and strict operating protocols to deliver within care package cost parameters. The hospitals are clean, basic and no-frills, keeping expense to a minimum. For example, most have ramps instead of stairs, so that patients can be wheeled between floors instead of using a lift, and generator power is used for vital medical equipment only during power cuts.

The hospitals do not provide intensive care facilities. They have basic facilities available to stabilise patients in case of emergency before transferring them to a tertiary centre if needed. This event has never occurred at LifeSpring to date as a result of the rigorous system of antenatal check-ups, and because customers with complications requiring tertiary care are diagnosed early and referred out before starting treatment.

As of February 2012, more than 14,000 healthy babies have been delivered across all LifeSpring’s hospitals (LifeSpring, 2011).

Each LifeSpring hospital includes at least one private room charged at a higher rate. This provides some additional revenue for the hospital, and more importantly, encourages staff to maintain high standards of customer service across the hospital to ensure its competitiveness as a market rate provider. LifeSpring Hospitals use this as a pseudo-indicator of quality of service. If people who can afford to pay a higher price also opt for LifeSpring instead of other hospitals that charge higher prices, this indicates their confidence on LifeSpring’s care and service.

The LifeSpring Foundation is a charity which receives donations. The charity funding received is low and is used to very occasionally subsidise maternity package costs for customers with very high need or unexpected financial constraints. The focus of LifeSpring is on achieving a viable business model, rather than growing the charitable element. Equally it does not apply for government subsidies as it does not want to divert government funding from under-resourced public hospitals. It serves the niche market of the working poor who earn $2-4 a day, relieving pressure on over-stretched resources serving the very poor.

LifeSpring has 12 branches based in the Hyderabad area. Most are located on the fringes of the city, drawing in customers from the surrounding urban area, suburbs and industrial areas, as well as nearby rural areas. The hospitals target low-income families: construction workers, casual labourers, taxi and rickshaw drivers, people in the informal labour market, and small scale farmers. They map existing customers and target high-density communities for intensive outreach by community health workers. The outreach programme aims to:

- Provide health education and raise community awareness of key public health issues such as the importance of nutrition, self-care, and accessing high-quality clinical services throughout pregnancy and childbirth.
- Visit existing customers in their own homes at the antenatal stage to provide advice and encouragement on self care and nutrition, and informal check-ups; and motivate them to attend hospital check-up appointments and engage with the hospital team early in case of problems.
- Visit existing customers at the post-natal stage to check infant and maternal health and progress.
- Capitalise on word-of-mouth recommendations to maximise new customers, identifying new pregnant women in the local community and engaging with them on the benefits of LifeSpring maternity care services.

LifeSpring centres its services on meeting customer needs and facilitating their preferences, to maximise customer satisfaction, repeat business and word of mouth referrals. The small size of hospital branches (20-25 beds each) allows for individual focus. It attracts new customers from its outreach programme, customer incentive schemes for referring family and friends, and occasional GP referrals, and undertakes little direct marketing. It has found the crucial factors to customer retention are price stability, all-inclusive price packages, and strong relationship building between clinical staff and customers.

Patient feedback is collected at three levels: first, at hospital level through written questionnaires or interviews by nurse managers who visit the patient after discharge; secondly, by corporate head office staff telephoning 15-20% of customers each month across all hospital branches to seek feedback; and thirdly, by visits from corporate head office staff to spot check hospital branches and talk to patients on-site. There is a constant focus on the quality of interaction between staff and patients at all stages of the patient journey.

LifeSpring has an ambitious plan to expand from 12 to 100 hospitals in the next five years. New hospital sites are chosen on the basis of geographical spread, in areas with a high proportion of industrial activity and low-income communities. The start-up costs for new branches are met through commercial bank loans which are repaid over a five-year period. Each branch is financially independent and self-sustaining. Individual hospitals are run by branch managers who report to a single corporate head office in Hyderabad, which sets the model and operating policies. As the chain expands, it will move to a cluster model with branches reporting on operations and finance to cluster head offices, and the corporate head office retaining overall policy responsibility.

**Wider impact**

LifeSpring’s services help to address the low priority often accorded to women’s health needs in India. Through the provision of high-quality maternity services to low-income communities, including ante-natal visits and nutrition advice which are insufficiently provided, it is raising expectations and encouraging a culture of health service seeking behaviour. It aims to contribute towards reducing India’s high maternal mortality rate, which to date has remained broadly constant despite the country's impressive economic growth.

LifeSpring aims to recruit recent graduates from nursing colleges and provides in-house training. Staff retention tends to range between 2 – 5 years. The organisation is contributing to a pool of effective and well-trained maternity nurses who will impact to improve standards across the sector as they move on. It is looking at opportunities to provide placements to nursing and midwifery students in the future as part of clinical training programmes.
Fact file

- 50% owned by HLL LifeCare Ltd. (a government of India enterprise) and 50% by Acumen Fund (an impact investor).
- Corporate office in Chilkalguda, Hyderabad. 12 hospital branches in Hyderabad with 20 - 25 beds each, 7 of which are on the fringes of the city, providing around 400 deliveries each month to urban, suburban and rural customers.
- Ambitious expansion plan: aims to expand from 12 to 100 hospitals in next five years, and increase its patient volumes by 350% to serve 82,000 women in this period. Plans for 2012 include opening branches in Delhi, Mumbai, Kolkata and Chennai.
- Uses open source IT solutions to meet e-mail, database and content management needs.
- Previously achieved the prestigious Indian NABH (National Accreditation Board for Hospitals) accreditation. This lapsed due to LifeSpring’s reluctance to pass significant ongoing accreditation costs on to customers. Regular independent clinical audit provides ongoing assurance on quality standards.
- First healthcare chain to join the UNDP Business Call to Action, a global initiative challenging companies to combine a focus on achieving development impact with commercial success, to accelerate progress towards the Millennium Development Goals.
A.3. Corporate Social Responsibility

Corporate Social Responsibility (CSR) initiatives of companies fund delivery of social impact through a wide range of delivery vehicles. This can include projects delivered by charities and NGOs, by social businesses, by community groups, or run by the company itself. In general the principle is that company profits are invested in products and services delivered to low-income communities free of charge. Susan McPherson, Senior Vice President at Fenton, predicts a growing CSR sector as corporates realise the benefits of employee engagement, cause-marketing, engaging with sceptical consumers, and showing Board-level commitment to social objectives (Harvard Business Review Blog Network, 2012).

A.3.1. Healing and Rebuilding Our Communities (HROC)

Interviewed:
- Heidi Pidcoke – Psychotherapist and HROC coordinator
- Website: [http://www.avpkenya.org/trauma.html](http://www.avpkenya.org/trauma.html)

Overview and business model

The Healing and Rebuilding Our Communities project was developed in Rwanda and Burundi after the genocide and later in 2008 brought to Kenya to bring about healing in communities affected by the 2007-08 post-election violence. Its aim is to bring clinically proven psychological treatments to people living with trauma – as a result of the violence, and often from having to live closely alongside the perpetrators of violence in their communities without any form of reconciliation having taken place.

HROC provides a specialised workshop for trauma, developed in 2003 by Alternatives to Violence Project facilitators in Rwanda and Burundi. Participants learn how to:
- Recognise and understand trauma and the symptoms of Post Traumatic Stress Disorder (PTSD);
- Access skills to overcome trauma;
- Re-engage with life after a traumatic event;
- Re-connect with community members and rebuild their societies.

Participants are assessed for levels of trauma and all are offered free counselling with specialised trauma therapists trained in Eye Movement Desensitisation Reprocessing (EMDR) (AVP, not dated). This is a clinically proven, evidence based treatment for post-traumatic stress.

The service is funded by a local private psychotherapy practice. It is available to people living in low-income areas such as informal settlement / ‘slum’ areas of Nairobi free of charge.

Wider impact

The HROC initiative is part of a wider programme of work carried out by the Alternatives to Violence Project (AVP) in Kenya. AVP Kenya provides workshops for people wanting to find ways of resolving conflict in new and creative ways, without violence. They work in prisons
and in the community. Participants practice skills in communication, affirmation, cooperation, community building, and pre-emptive conflict resolution through creative transformation of relationships.

Fact file

- The HROC programme was developed from AVP in Rwanda and Burundi in 2003, in response to the genocide. Its focus is on trauma and healing (AVP, not dated).
- AVP is a charity operating in 50 countries worldwide.
B. Indirect providers of healthcare (i.e. organisations facilitating access to healthcare through income generation, health awareness-raising, advocacy and campaigning)

B.1. Income generation

Markets often fail the poor as they see them as a high credit risk and exclude them from accessing the financial products that can help them improve their lives. They struggle to get credit which can help a business get off the ground. They are often ineligible for bank accounts, or subjected to disproportionate transaction charges. Products such as health insurance are rarely designed with their needs in mind. As a result, the financial tools which make budgeting and dealing with peaks and troughs in expenditure easy for more affluent consumers are unavailable, leaving low-income communities doubly vulnerable to problems when they arise.

The organisations below are

- helping low-income families support themselves with a fair wage or through setting up small businesses; and / or
- designing financial tools with low-income customers in mind.

B.1.1. Alive and Kicking, Kenya

**Interviewed:**

- Joel Kinuthia – Country Director Kenya
- Website: [http://www.aliveandkicking.org/](http://www.aliveandkicking.org/) / E-mail: info.kenya@aliveandkicking.org / Office Tel: +254 (0)20 204 5481 / Mob: +254 (0)714 613377

**Overview and business model**

Alive and Kicking (A&K) Kenya is a social enterprise that makes sports balls. It has three social aims: first, to provide employment to the people who hand-make the balls, at a reasonable rate of pay; secondly, to provide high-quality sports balls to children across the country; and thirdly, to educate people on health issues, by printing public health messages on the balls and through tie-ins with Non-Governmental Organisations (NGOs), Corporate Social Responsibility (CSR) programmes, and sports celebrities.

It was set up by the UK charity Alive and Kicking. The charity raised seed money, and provided it as a grant to cover the first two years of operations, with the long-term aim of establishing it as a self-sustaining social enterprise. The charity sets the overall objectives of the company, and its sister company in Zambia, and provides governance and advisory services. The company is independent operationally but is accountable to the charity for delivering both financial and social objectives. The company has a Board of Trustees and its Chair sits on the UK charity’s Board. The commercial activity of the company – making and selling sports balls – has been financially independent since early 2006. A&K Kenya generates income through selling balls to schools, CSR programmes, NGOs, and the public,
through Nakumatt supermarkets. It also raises funds for the company’s health education roadshows and awareness-raising work.

Balls sold to CSR programmes and NGOs are branded with the organisation’s logo and printed with key PR and social impact messages on topics such as health promotion, road safety, non-violence, drug abuse etc. The commissioning organisation is charged for the one-off costs of creating the art work, which is hand-painted onto the balls’ panels using a stencil before assembly. They are distributed to communities specified by the CSR / NGO: sometimes to under-resourced state schools that can’t afford them, or to other low-income groups in Kenya e.g. community groups in slum areas. A&K tries to ensure that health promotion messages about HIV / AIDS and malaria are included on all its balls, and in particular those distributed to schools.

A&K is the only company making hand-stitched, leather sports balls in Kenya. Its competitors make and import machine made balls from abroad using cheaper synthetic materials and paying low wages to their staff. The cost of an imported football ranges from 600 to 3,000 KSH (£4.60 to £23.10). A&K’s unique selling point is the quality of its balls. An A&K footballs costs 1800 KSH (£13.90) for a luxury design and 1,500 (£11.60) for a standard design. The advantage of the superior materials and craftsmanship is that the balls are more robust and long-lasting.

A&K has to sell 3,500 balls each month to break even. It sets itself an ambitious stretch target of selling 6,000 balls each month, and progress towards achieving this is kept under regular tight review. Sales go in peaks and troughs, with more balls being sold in summer, and fluctuations in demand from CSR programmes and NGOs. The company’s running costs are fixed, with most materials sourced locally and bought in bulk. The company is vulnerable to increases in prices by supply chain partners, which are common due to current rises in basic commodity prices such as food and fuel. A&K is unwilling to increase the price of its balls as it feels the pressure to remain competitive against companies which import balls from abroad, so it is pushed to cost share or negotiate.

Over time, it has found the optimum number of stitchers to make the balls. Rather than maintain a large staff to deal with times of peak demand, it retains a medium sized staff and stockpiles the balls made in the low season to meet demand in the peak months. Profits are split three ways: one third goes to the staff, through bonuses and contributions to health schemes etc; one third is re-invested in the business; and one third is set aside as a ‘rainy day’ fund. There are no dividends or allowances for the directors.

A&K’s health education work is financed through fundraising, and activity fluctuates depending on donor funding. Donors such as the Safaricom Foundation, a charity funded by Safaricom Limited (Kenya’s leading mobile phone network) and the Vodafone Group Foundation, provide charitable funding which is used primarily (95%) for health education road shows in secondary schools.
Wider impact

As a socially responsible employer, A&K is proud of offering a good rate of pay. It provides jobs in areas of high unemployment, with 55% of its stitchers entering formal employment for the first time. It pays a standard rate to the stitcher for each ball that meets its quality standards. This money is paid on the day, and a further sum per ball is paid as a bonus at the end of the year. Stitchers can make between 3 and 6 balls a day. They earn a very good wage for manual labour in Kenya – with each stitcher supporting an average of 6 dependents on their individual salary. The ethos is to provide opportunity for its staff and to pay a fair wage.

Alive and Kicking raises awareness on public health issues by promoting key messages through sports celebrities who are popular and carry high credibility amongst Kenyans. They give away sets of 10 posters to every school that buys their sports balls, and at their health education road shows. Each poster features a sports celebrity with a punchy, hard-hitting message about HIV and AIDS. The posters are tested with peer educators in slum areas of Nairobi to ensure they have maximum impact for young people. The aim is to dispel myths, challenge popular misconceptions, and educate people to keep themselves healthy. They also promote women’s empowerment and encourage communities to support people who have been diagnosed. In the future the company hopes to produce celebrity posters on other health issues such as malaria and TB.

The messages on the posters complement the health messages that are printed on the balls and form part of the Alive and Kicking branding. They are promoted at the road-shows through educational theatre and performances, inter-regional football tournaments, and on t-shirts and donated balls which are distributed at the events.

A&K Kenya has partnered with Tackle Africa to train its own stitchers as peer educators on HIV and AIDS. They learn about health promotion, as well as public speaking skills, so that they can help run the health education roadshows. This means the stitchers have opportunity to contribute to the wider work of the company, and gain skills and experience
which may lead to greater career opportunities. A&K also partners with local hospitals for the roadshows to provide expertise on technical questions.

Fact file

- Alive and Kicking was started in 2004 by Jim Cogan, a British former Deputy Headmaster. When 900 people were made redundant from Orbits Sports, a franchise football factory of Adidas' in Nairobi, he took advantage of the opportunity to recruit people with the skills to make high-quality footballs.

- Alive and Kicking was set up as a UK charity, and secured seed money from the Department for International Development, the Elton John AIDS Foundation, and Football Association UK. The charity supported the set up of Alive and Kicking in Kenya as a company limited by guarantee with no share capital. This structure was advised by KPMG to enable it to function as a company without going fully commercial – ensuring its focus on its social objectives.

- Alive and Kicking has self-sustaining companies operating in Kenya and Zambia. It aims to replicate the model in other countries in Africa, starting with Ghana.

- Alive and Kicking Kenya stitched over 35,000 balls in 2011, sustaining employment for 70 people. Its footballs conform fully to FIFA specifications on size and weight, and have been endorsed by UEFA and the UK’s Football Association.

B.1.2. Right Sharing of World Resources (RSWR), Kenya

Interviewed:

- Samson Ababu Gimongo – In-country field representative, East Africa - primarily Kenya
- Website: [http://www.rswr.org/projects/kenya/](http://www.rswr.org/projects/kenya/) / E-mail: rswr@rswr.org

Overview and business model

Right Sharing of World Resources Kenya (RSWR) provides microfinance. It funds loans to new and small women’s groups of 20 to 30 of low-income women belonging to the Quaker church, usually in rural areas, to start or upscale their micro-businesses.

In Kenya, low-income women struggle to get credit. They don’t have the authority to get loans from banks, in particular because they don’t own land which can be used as surety. Bank loans, where they are available, come at unaffordable interest rates – often as high as 20% per annum. Micro-finance addresses this by using community relations instead of assets as a guarantee of repayment.

RSWR lends to groups of women who support each other’s business ventures and hold each other accountable for repayment. The capital is provided by donors in North America. The initial loan is usually provided at a very low interest rate of 1 or 2% per annum. Some groups are made up of women in the same area of business; other groups split into smaller sub-sets according to their different business interests. Typical businesses include: small scale agriculture, crop speculation (buying at harvest and storage for sale at a time of crop scarcity), food vendors, basketry, clay pot making and reed mattress making.
The process is as follows:

a) Samson addresses large church groups to raise awareness of RSWR and identify potential interest. Follow up for those who want more details (program development).

b) Women are asked to form lending groups and each group is asked to develop a project proposal, and then write a business plan, including a detailed budget setting out how they plan to use the funds (proposal preparation).

c) 2 week assessment process to test commitment and viability of business proposal. Samson supports the group to develop business plans that are investment-ready (implementation of workshops – capacity building).

d) On the basis of the assessment process, Samson provides a project appraisal report which is forwarded to the RSWR Board for approval. The report ranks the business plan according to the following criteria: viability and long-term sustainability of the business proposal; leadership and management skills of the group; credibility of the loan repayment schedule; wider project benefits; and potential to scale the business within the community.

e) The business plan and recommendation report are independently assessed, a site visit is conducted by AQUAVIS (African Quaker Vision), and a final report is prepared for approval by the RSWR Board.

f) RSWR Board sits twice a year to consider reports and approve loans.

g) After loan approval, training is provided to the group before and after funds are dispersed, to strengthen business and financial management skills.

h) Funds are dispersed to the loan committee of the group, which allocates them according to the business plan. Loans are allocated to sub-groups commonly of five women who mutually guarantee the loan and hold each other accountable for repayment. Some is kept in reserve, for continuity.

i) Loan repayments are made to the loan committee of the group. As repayments are made, the group builds up a reserve, and acts co-operatively to loan the money out again – either within the group or to members of the wider community, at its own discretion. The group can decide to increase the interest rate as members’ businesses become more established and successful.

j) Groups provide monitoring and evaluation reports to RSWR. Learning informs future loan assessments and training provision to groups.

k) Groups can also write a follow-up business plan and apply for a further loan from RSWR, for a period of one-year loan funding. Where profits were not realised from the initial loan, the group’s revised business plan must provide a robust analysis and credible new business proposal to support a further loan.

l) Thriving businesses seeking larger loans are encouraged to use their assets as surety for a commercial loan from the banks.

Groups are held accountable through scrutiny of plans, monitoring and evaluation reports to RSWR, and oversight from the local church that the group belongs to. They are expected to engage the services of an accounts clerk to keep their books and an auditor to audit the accounts at the end of the year. RSWR works in partnership with church organisations, in particular AQUAVIS (African Quaker Vision) and USFWI (United Society of Friends Women International), to deliver oversight and governance of the programme.
RSWR keeps overheads to a minimum with a very lean structure. It has one member of staff in each country that it works, overseeing roll-out of the programme. Field staff are continually on the move, identifying new groups, supporting business plan development, and providing training. They work on the go and do not have a fixed office – again keeping running costs to a minimum.

**Wider impact**

RSWR's philosophy is to empower women and tackle poverty by increasing their income to meet family needs – food, education and healthcare. Its vision is that by supporting women, it is supporting their children too. This fits with research which shows that “women are more likely than men to spend their profits on household and family needs” (Deshpanda, 2001 p.15). It is also in line with broader development aims, given research shows that gender inequalities inhibit economic growth in developing countries, and women are disproportionately represented amongst the poor, making up the majority of the informal working sector (Cheston and Kuhn, not dated).

In addition to helping women develop sustainable incomes through micro-businesses, RSWR empowers women by supporting them to take on leadership roles within their lending groups and wider community. In mixed gender groups, women often feel intimidated and keep quiet. There is a culture of male leadership which women defer to. Often rural women have only a basic level of education, but they have developed strong leadership skills in their churches, where they may have already formed a support group which is developed into a RSWR lending group. RSWR funding enables women to take on a greater leadership role in the community, grow their businesses, apply their practical skills, and develop their confidence as businesswomen.

The financial culture in Kenya is co-operative rather than competitive. People are expected to share the rewards of their success with family, neighbours, and friends. This has many positive effects: it provides a safety net for the vulnerable; it has a levelling effect, helping quality of life to improve more evenly across the community; it can enable successful business models to spread quickly, improving income levels for more people. However, it also inhibits the accumulation of capital that is needed for successful businesses to flourish and grow (Maranz, 2001).

RSWR’s microfinance model is successful because it adapts the co-operative approach to include successful business management. Samson invests significant time in training groups in business and finance skills. The biggest challenge has been moving from a culture of dependence and hand-outs to a micro-business culture. Experience has taught him that the groups are most successful when training happens before and after the loan money arrives. Successful groups often include at least one business-minded member with more education or experience, who can provide leadership, internal support and a role model for other members.

Group members pay a monthly contribution as personal shares. Membership is made once upon joining the group. These contributions are pooled to enhance the group’s resources, and are invested or held in reserve according to the group’s discretion. However, it remains the member’s property and can be reclaimed, in full or in part, at the end of the year. This
encourages the women to save, and keeps them engaged in the group and its use of funds, as well as providing the group with working capital.

The co-operative, mutually supportive group structure helps protect the women against the ‘shocks’ of daily living. For example, it is difficult for an individual to maintain loan repayments when faced with urgent immediate needs such as healthcare costs for a sick child. In the context of a supportive group, members pull together to help individuals who are struggling with unexpected costs – perhaps by agreeing a temporary pause on loan repayments, or an early repayment of the member’s group contributions to mitigate against short term cost pressures. The cohesiveness of the group is a major factor influencing success.

Many groups co-operate together across a range of other activities outside of the main micro-finance programme. They look after each other’s welfare and homes. They collaborate on community projects, such as children’s education, keeping children in school, and HIV/AIDS support groups that combat stigma, and help people affected to maintain morale and their place in the community. The groups share and develop skills such as how to make high-quality manual compost for use in agriculture. They also undertake joint business ventures, maximising economies of scale and helping their businesses to thrive.

**Fact file**

- Operates in Kenya, India and Sierra Leone. In Kenya, RSWR works directly with groups of women at the grassroots level. In India and Sierra Leone, it works through local NGOs.
- Loans range in value according to the business plan and capital needs of the group. The average loan approved is $450. The maximum loan available for a group is $5,500.
- Initial loans are provided at 1 or 2% p.a. interest. Most successful mature groups lend the repaid money out again in the wider community at higher interest rates, up to 12% p.a.
- RSWR Kenya supports over 60 groups of women, mostly based in Western Province.
- RSWR Kenya is in the early stages of developing microfinance groups to support young entrepreneurs. Its aim is to combat widespread youth unemployment – including amongst graduates. It has 3 mixed gender youth groups: in Nairobi, the Rift Valley, and Western Province. It is also hoping to develop a partnership with another organisation to provide microfinance to groups of men.
- RSWR cites three guiding principles on its website (RSWR, 2011b):
  - Local Self-Reliance – Economies, to the extent possible, should be locally-based. Production would be geared toward local consumption.
  - Sustainability – Economies should be sustainable in a number of ways including environmental, fiscal, social, political, and cultural. Economies should serve the community.
  - Mutual Support and Accountability – Beneficiaries must be part of a group which offers support and accountability to its members.
B.1.3. Regional Institute for Social Enterprise (RISE) Kenya

Interviewed:

- Temi Mutia (pictured right) – CEO
- Members of RISE staff:
  - Philip Mwangangi (overall co-ordinator and head of finance),
  - Isaiah Muthanyga (accountant),
  - Angeline Kitani (chair and micro-loans co-ordinator),
  - Joseph Ndii (HIV / AIDS co-ordinator),
  - Joel Mathu (leather department),
  - Janet Ndumbu (youth programmes and administration),
  - Mumo Shaa (administration),
  - Michael Katembu Soloo (IT support).
- Members of the following Community Based Organisations (CBOs), including: Kitulani CBO (Victor, Lydia, Assumptor); MEPA CBO – meaning ‘Muivu Education and Poverty Alleviation’ (Angeline, Juliana); Musyia wa Syana CBO – meaning ‘Home of Children’ (Samuel, Tabitha, Monnea, Mutethyo, Wilson, and Nelson); Wasya wa Mwaitu CBO – meaning ‘Voice of Women’ (Christine); Bazaar CBO; Thana CBO; Kavililo CBO; Kanyaa CBO; Wasya Wa Mwaitu CBO (Grace, Christine); 4K CBO (Joseph).
  Cell: 254-0722521 987; E-mail: info@risekenya.org

Overview and business model

The Regional Institute for Social Enterprise (RISE) Kenya is a network of 25 Community Based Organisations (CBOs) with over 10,000 members in rural Mwingi district. Mwingi district is an area that has suffered chronic food shortages as the twice-yearly rains have failed for the last four years. Food and fuel prices were rising dramatically in the four months running up to my visit, making them more unaffordable for more people – for example the price of maize, Kenya’s staple food, had increased by 70% from 45 to 80 KSH for a day’s supply. 80% of the local population lives on less than $1 a day – barely enough for a single meal. RISE supports its CBOs (with memberships ranging from 100 to 1,200 members) to set up income-generating activities such as microfinance and microenterprise, and thus improve their members’ quality of life by being able to afford food, school fees and healthcare costs.

The CBOs are supported to undertake a variety of micro-business activities which include: basket weaving; rope making; aloe-based soap, shampoo, and hand lotion making; farming techniques and crops (such as mangoes and aloe) for drought environments, livestock...
breeding (including bees, goats, poultry, rabbits) and agroforestry; silk farming; sanitary towel making; import and sales of second hand clothes.

The CBOs also provide small scale financial services to their members, including merry-go-round (members all provide a small financial contribution which is given in full to a different member each week or month as a one-off windfall); table banking (members all provide a small financial contribution which is lent out to a few members each week at a low rate of interest and repaid the following week; the interest is shared between the group at the end of the year); and microfinance (a larger sum is lent by an external NGO to members who can provide a robust business case, and repaid at low interest rates over the course of the year; the repaid funds and interest are used to finance subsequent loans to other members of the group). Some CBOs also provide short term hardship loans to members who are struggling financially, using the group’s membership fees as capital for the loan.

Different CBOs operate different business models. Some carry out the work together but leave each individual member with responsibility for selling their own products and each keeps their own profits – for example each has a plot in a shared farm; or members come together to weave baskets socially and then sell their own products individually. Others pool their products for sale together in a shop or a market stall, and distribute the profits evenly through the group, or prioritise funds for those in greatest need. All charge their members an annual membership fee and most charge a commission on sales, which fund the cost of raw materials, training workshops, and fees for membership of the RISE network, as well as providing a contingency fund for its members in an emergency. The structure enables knowledge sharing and learning across the RISE network without losing the distinctive identity and autonomy of each individual CBO.

RISE provides the following:

- Training and skills sharing for CBOs. RISE uses a ‘train the trainer’ approach to cascade training across CBOs. Sometimes this involves bringing in external expertise, for example in digging wells.
- A shop in Bazaar village where products made by member CBOs are sold, at the front of the RISE office building. Many CBOs also run their own shops, and sell their goods in the local markets, to local shops and businesses e.g. selling aloe shampoo to hairdressers, and door-to-door in the community.
- Market development. RISE scopes potential customers for bulk orders and negotiates supply for shops in Nairobi. It runs a website and is planning to develop an on-line shop. It investigates opportunities for CBOs to scale-up their operations, and scopes internal and export market opportunities. It showcases the products at trade exhibitions.
- Marketing and promotion. It raises charitable funds which can be used as seed money for new micro-business ventures. It provides a single point of contact for partners and donors to relate to.
- Back-office support. It provides assistance with the administrative and financial running of the CBOs. It also scopes and supports the necessary business and health and safety certifications.
- Financial support. It offers loans to member CBOs through a micro-lending scheme. It also provides start-up capital and materials for CBOs to try out various different ventures at no (or significantly reduced) cost, and then run with the most successful ones.
- Community cohesion and leadership building. RISE facilitates community leaders to come together and take a proactive approach to address the substantial challenges that face their communities. The CBOs involve everyone in the community, from local business owners to farmers to the very poor – meaning everyone benefits and skills are shared.
- Expansion. RISE promotes the CBO network to nearby villages and towns, encouraging them to form their own CBO and join, to achieve economies of scale, greater production volumes, and mutual benefits across the network.

RISE was set up by Temi Mutia in response to the growing problem of HIV / AIDS in his home community. He realised that the main determining factor of life expectancy for people with HIV / AIDS was poverty. Being able to afford a healthy diet, sufficient food, anti-retroviral drugs and medical care when needed were key to survival. Temi worked with local community leaders, family networks, and existing community groups, some of whom were already engaged with NGOs, to set up the RISE network of CBOs. The network focussed efforts on income generation to help improve quality of life and access to healthcare across the board. The CBO network is used as a platform for training members on health issues such as good diet, sanitation and hand washing with soap, sexual health, and other public health issues.

Lack of education and awareness, combined with stigma and unwillingness to talk about the issues, are major contributing factors to HIV / AIDS survival. RISE tackled these through setting up a dedicated CBO self-help group for people living with HIV / AIDS, which spans all the districts where RISE has a presence. 4K is an umbrella CBO and its members are often also members of their other local CBOs, many of which run their own activities on HIV / AIDS sensitisation. In addition to the income-generating activities, the 4K group shares stories, information and awareness on how to keep healthy, alleviating fear and providing support for the newly diagnosed, and helping protect others from the spread of the disease. It challenges the prevailing culture of blaming and ostracising the woman when a family tests positive, and encourages the community to focus on supporting everyone in the family. It promotes the use of condoms. It links with local health services to ensure clinical care is dovetailed with counselling and support from the group. By developing a culture of openness and support across society, the group encourages people to go for testing, disclose their
status, take up counselling, and participate in mutually supportive activities. People with HIV become role models in the community – helping others (and particularly men, who are most reluctant) to brave going for testing, come to terms with their status, and learn to manage their condition. Community leaders are encouraged to attend training and awareness-raising sessions to improve openness and discussion at all levels of society – although progress is slow as the subject is still stigmatised. The CBOs also provide support to families who care for AIDS orphans. As the group has become established and membership increased to 300, death rates in the local community from HIV / AIDS have reduced.

RISE has plans to significantly expand its coverage. It is in the advanced stages of registering as a formal NGO. It aims to encourage further CBOs to set up across neighbouring districts and join the RISE network to share best practice and increased collective bargaining power. It is conducting a cost-benefit analysis on CBOs’ various activities to identify which are the most cost-effective and profitable, and scoping opportunities to take these to scale.

RISE is funded through contributions from its member CBOs. CBOs pay an annual membership fee, a percentage commission on sales of products, and one-off fees towards training sessions, workshops and other activities. Over time RISE has been able to increase its membership fees as its CBOs have become more successful and profitable. Occasional funding from NGOs helps provide the start-up capital for some of the micro-business ventures.

**Wider impact**

RISE promotes an entrepreneurial culture which is empowering for its members. It brings people together to take a proactive approach to solving their common problems rather than relying on hand-outs. It provides a supportive and co-operative approach to kick-start the local economy.

90% of CBO members are women, as the men often leave the rural areas in search of work in cities, and women fill most of the CBO leadership positions. The CBOs are democratically structured, with all leadership positions elected by the group’s members. There are opportunities for specialisation within each CBO; for example, as the leader of the group’s aloe farming or table banking activities. Participation gives women the skills and opportunity to earn their own living, look after their families, and thus have more say in family decision making. In a culture where women traditionally take care of the home while men make the decisions, participation in RISE helps to grow women’s confidence and encourages them to stand up for their rights.

One CBO, Wasya wa Mwaitu (meaning ‘Voice of Women’), focuses specifically on advocacy and empowerment for women. It trains women in civic education, encouraging them to engage with politics and demand their rights. It shares information on women’s rights with respect to land, children, property, marriage, and inheritance. Members are involved in a micro-business making sanitary pads, to encourage girls to stay in school during their period. The group calculates that currently girls lose one month of education each year while missing school due to their period. The enterprise is currently not profitable as people don’t see the need and there is limited take-up; the group is targeting parents to educate and raise awareness to encourage a rise in demand. The group also offers protection and sanctuary to
women who are victims of rape and domestic violence, links women and children with
sources of support, and advocates their cause with the police, courts, and other authorities.
As the group has become established, rates of crime against women have gone down
locally, which may be because the community is aware that the group is acting as a form of
‘watchdog’. Prevalence of early marriage and circumcision has markedly decreased too.
Other CBOs have started up their own gender sensitisation activities, helping to spread the
impact across a wider area.

RISE raises funds for initiatives to support the wider community, beyond the CBOs’ micro-
business ventures. For example, the Zeeland Lions Club organised a fund-raising golf
tournament to raise 90% of the funds needed for RISE to install solar lighting in surrounding
schools (with the remaining 10% coming from local CBOs to ensure ownership and
engagement in decision making). This makes it possible for children to stay late or arrive
early to do their homework, and teachers to prepare lessons. The school uses the solar
power to offer a phone-charging service for parents, charging a small fee which is then used
to cover maintenance costs.

The CBOs are keen to tackle high school drop-out rates (often due to pressure to start
earning money, or to help with domestic tasks, or parents’ inability to afford school fees and
materials), and they work to support parents and encourage more children to complete their
school education. MEPA CBO, for example, combines contributions from its members,
outside donations, and government subsidies, to offer bursaries towards school fees for both
parents in need and children excelling at school. The CBOs also run youth programmes to
help engage young people with local income generation activities.

Some CBOs are active in other areas to support local infrastructure – for example digging
wells, repairing feeder roads, developing water harvesting facilities, trialling drip irrigation,
planning to build greenhouses to maximise agricultural production, and helping to construct
a local dam to maximise gains from rainfall.

In crisis situations such as acute famine, RISE seeks to raise charitable donations
and distributes food to help the community survive. In the longer term, with support
from the Kenyan government, CBOs in the RISE network are setting up tree nurseries
to gradually replant the forests in the area, with the aim of improving levels of rainfall,
combating soil erosion, and preventing flash flooding.

Fact file

- RISE was set up in 2008 by Temi Mutia to address poverty and HIV / AIDS in
drought-ridden Mwingi District. It is located at Bazaar Market, Migwani, in the Mwingi
area (approx. 190km from Nairobi, and 18km to the south of Mwingi town). RISE
Kenya is registered as a network of 25 CBOs with plans at an advanced stage to
register it as an NGO.
• RISE is owned and managed by the community through the CBOs and their elected leaders. Its day-to-day operations are handled by a team of five volunteers.

• RISE works with a broad range of partners for technical assistance: Achmea Foundation (Netherlands), Helping Humans (USA), Lions Club of Schouwen (Netherlands), Cordaid (Netherlands), Lighten Their Future (Netherlands), Agriculture Sector Coordination Unit / MESPT, JKUAT University, Davis and Shirtliff, Broad Base Promotions Ltd.

• RISE was a 2011 SEED Initiative Award winner.

B.1.4 Support for Tropical Initiatives in Poverty Alleviation (STIPA)

Interviewed:

• Beatrice Omondi – Project Officer
• Gordon Obonyo – Micro-finance Officer
• Contact details for Support for Tropical Initiatives in Poverty Alleviation (STIPA): E-mail: infoksm@stipakenya.org / beatriceomondi@stipakenya.org, Telephone: +254 57 202 7063 / +254 720 826 347, Website: www.stipakenya.org
• Contact details for the Kenya Community Based Health Financing Association (KCBHFA): Noreen Hungu, National Coordinator - Tel: 020-2035525, Cell: 0724223363, Email: info@kcbhfa.org / noreenhungu@yahoo.com, Website: www.kcbhfa.org

Overview and business model

Support for Tropical Initiatives in Poverty Alleviation (STIPA) is a member organisation and delivery partner of the Kenya Community Based Health Financing Association (KCBHFA), a network of organisations that improve access to healthcare for the poor through community health finance schemes, mainly health insurance schemes.

Low-income families often struggle to meet unexpected healthcare costs. Even routine healthcare appointments at government or mission facilities carry doctors fees and drugs charges that can be hard to predict and difficult to afford. Community health insurance schemes are a way of levelling out these costs, as well as quality assuring the healthcare that is provided.

The schemes are primarily aimed at people working in the informal and rural sectors, who aren’t covered by employers’ health insurance schemes or National Health Insurance schemes for those in formal employment, and are unable to access private health insurance.

STIPA approaches existing groups in low-income communities across the eastern region of Kenya, and encourages them to sign up for participation in a community-based health insurance scheme, until they have sufficient members to negotiate a healthcare package effectively. STIPA mobilises the communities through raising awareness of the community-based health finance concept with organised social groups, cooperative societies, and
commercial groups. If they buy the idea, then training is conducted to them to help them understand more.

The group identifies local hospitals whose healthcare services they want to have included under the scheme. The hospitals selected are mostly government and mission facilities, although there are some private providers too. STIPA, together with the scheme officials, assesses the hospitals that have been identified by the members to ensure they meet appropriate quality standards. They are selected after a process of inspections and checks to provide assurance on the quality of care offered. STIPA then negotiates the cost of the services to be covered by the scheme on their behalf, and other services that can be offered freely by the hospitals to the scheme members. A Memorandum of Understanding is then drawn up, entitling card-carrying members of the insurance scheme access to care within the defined parameters.

To form a scheme, the group participants have to register to become members and then pay premiums for treatment. The premiums are calculated by STIPA, guided by the average cost of treatment from the chosen hospitals. The bigger the group, the lower the household premium that can be negotiated. The group is consulted as to the maximum premium they can afford or want to pay, and the services that will be covered. Each household has a ceiling for expenditure; if they incur costs for treatment beyond this ceiling then the hospital will charge them for the excess direct. This means that certain population groups remain excluded from reliable access to healthcare. For example, elderly people need to access health services more often and so are more likely to exceed the threshold. Also treatment for some expensive diseases such as cancer are excluded from the insurance package. Similarly, patients with HIV/AIDS are regular users of the health service who regularly exceed the thresholds of the scheme and have to pay extra. While ARV drugs are free, the regular doctors’ fees and other medication costs are expensive. Where possible, STIPA directs people living with HIV and AIDS to hospitals that are contracted by NGOs to provide care for this population group for free. The aim is to expand the schemes to include more community groups, which should result in lower premiums and a wider range of services being covered.

The scheme members are given a period of time (for example, three months) to pay the premium. The premium paid covers a period of one calendar year. Once paid, members are issued with a card making them eligible for treatment under the scheme with the affiliated healthcare providers. The scheme members elect a Board of directors to manage the scheme, which includes the executive committee who run the day to day activities of the scheme, with support and training from STIPA. They collect the monthly bills from the healthcare providers and pay the invoices on a monthly basis. They collect premium payments from new members and issue membership cards. The groups are led by unpaid volunteers, and have to evidence community participation in decision making. STIPA has found that the model only works where a group is both committed and takes ownership, ideally with a vibrant and engaged community led by elected leaders. The group has to decide how to manage a situation where a household is unable to meet its premiums; in some cases they are excluded until payment is achieved, and in other cases a payment ‘pause’ can be agreed where a family is going through financial difficulties.
STIPA has brokered 9 such community insurance schemes to date. 6 of these are currently operational. The rest are in the process of paying the initial premiums and developing MOUs.

KCBHFA has a small not-for-profit head office in Nairobi which provides technical support and capacity building to its member organisations such as STIPA, and supervises their community health finance activities. It co-ordinates member organisations at the national level, promotes community health finance initiatives in Kenya, and shares best practice and new initiatives for improving the accessibility of quality healthcare. It raises awareness amongst the public of the advantages of health insurance, carries out research, feasibility studies and workshops, and liaises with central government and donor agencies with an interest in health financing.

Wider impact

The vision is to promote a culture of saving to meet the unexpected, one-off expenses of life. Healthcare is an important example as it is a one-off cost that everyone will incur at some point, often with devastating consequences for families which end up taking on unaffordable debts to meet immediate unexpected costs.

STIPA uses the group structure to deliver other development projects. It provides micro-finance loans to people setting up small businesses. The capital for the loans is provided in part from STIPA (from donors) and in part through group members' contributions, and repayments with interest are split between STIPA and the group, and used to loan out again. It provides training to develop business skills and management capacity. It also facilitates table banking, a co-operative small loan system where members of a group contribute 50 KSH (£0.38) each when they meet, and the whole sum is lent to one person selected on a rota, who repays the loan in full at a low interest rate at the next meeting of the group.

It provides training to change attitudes on gender roles. It runs a single parent support project including counselling and parent skills training. It runs HIV/AIDS support groups, training and awareness-raising activities amongst young people inside and outside of school, and support services for orphans. In 2011 it organised the first Kisumu Peace Festival, using theatre, music and sport to promote dialogue, respect and unity between different ethnic groups in the run up to the 2012 elections (now rescheduled for 2013).
Fact file

- Community health financing and insurance schemes have been provided by member organisations in Kenya since 1999. The KCBHFA network was created in 2002 and registered as an NGO in 2007. The schemes are provided in all provinces of Kenya.

- KCBHFA has 6 member organisations that deliver health insurance schemes to low-income communities:
  - Support for Tropical Initiative in Poverty Alleviation (STIPA),
  - Anglican Development Services (ADS),
  - Western Region Christian Community Services (WRCCS),
  - Eldoret Christian Community Services (ELRECO),
  - Afya Yetu Initiatives (AYI)
  - Jamii Bora Trust

In addition KCBHFA has a further 3 members who are not implementing community-based health finance initiatives but have other functions within the network:

  - Research Institution(s): Great Lakes University of Kisumu (GLUK).
  - Service Provider(s): Christian Health Association of Kenya (CHAK).

- STIPA works in partnership with a variety of organisations, including the following, some of which provide funding to support its activities:
  - AMREF (African Medical and Research Foundation)
  - Kenya Community Based Health Financing Association (KCBHFA) and other member organisations
  - Government universities
  - Kenya National AIDS Control Council
  - AGEH Germany (Association for Development Cooperation)
  - Evangelischer Entwicklungsdienst (EED Church Development Service)
  - Austrian Development Agency (ADA)
  - Catholic Men’s Movement (KMB) Austria through Horizont3000 Uganda
  - UNICEF Somalia Kenya

B.2. Advocacy and Campaigning

In an environment of endemic government and market failure, civil society organisations have a key role to play in advocating for improved quality and availability of public services, and for increased accessibility and relevance of commercial products and services to the low-income majority. Civil society organisations lobby for government accountability, and help to drive anti-corruption and more effective use of public resources.

B.2.1. We Are Watching You

Interviewed:

- Ramadhan Obiero – Director of ACREF (African Cultural Research and Education Foundation) and founder of We Are Watching You
- Website: http://wearewatchingu.wordpress.com/
- E-mail: ramadhanobiero@yahoo.com, phone: 0723 395 008
Overview and business model

We Are Watching You is a community organisation working to improve political accountability in Kenya. It raises awareness on political issues – particularly amongst young people – through art, music, concerts, performances, youth forums and discussions. It encourages people to take constructive action to tackle problems in their own communities. In the run up to the March 2013 Kenyan elections, it is working with civil society leaders to challenge political candidates to pledge to address key issues affecting their constituents if they are elected. After the elections, it will keep a spotlight on the politicians and encourage communities to track whether they have delivered on their promises, and actively hold them to account. The campaign aims to support and develop leaders – both in politics and in local communities – who are accountable, responsible and free from corruption.

The campaign raises awareness about how some previous and current politicians manipulate loyalties and tensions along tribal lines. It encourages people to vote based on politicians’ pledges and then their subsequent actions, rather than based on tribal loyalties. The campaign seeks to strengthen demand for accountability, keeping the public informed and thus leveraging the threat of losing office to incentivise politicians to get real about meeting their constituents’ pressing needs. In Kenya’s informal settlement areas (slums), the traditional link between paying tax and demanding results from government is weakened, as unemployment is high and most people make a living through the informal market. The campaign brings the voice of slum residents into the public forum and empowers them to make their voice heard – to see that they can have an impact, and that it is worth their while to demand more from their leaders. It is tackling corruption – by showing politicians that people are watching their actions and are committed to holding them to account.

We Are Watching You was set up in response to the post-election violence in 2007/8. The founder, Ramadhan Obiero, experienced violence first hand in his home area, Baba Ndogo, an informal settlement which was split between two conflicting ethnic groups. He helped promote peace by using the community centre he had set up for ACREF (the African Cultural Research and Education Foundation) as a base for distributing food and medical aid. Afterwards, he worked with Sisi Ni Amani (We Are Peace) to develop a network of people in the community to monitor for potential conflict and intervene early. He leads grassroots civic education and outreach to build community cohesion and resistance to political attempts to stir up ethnic conflict.

We Are Watching You has plans to significantly expand its coverage. It aims to develop We Are Watching You TV in collaboration with the Hot Sun Foundation. Its goal is to develop a
network of centres for its campaign in the run up to the elections, and spread its message through music, theatre, art, and film events.

It is funded through commercial activity such as sale of ‘We Are Watching You’ t-shirts, and ticket sales for concerts and theatre events at Ramadhan’s ACREF community centre theatre. It is also supported by the Hot Sun Foundation and Acumen Fund.

**Wider impact**

We Are Watching You began as a campaign by ACREF (African Cultural Research and Education Foundation). ACREF was founded by twelve friends including Ramadhan Oberio, to develop initiatives to support the local community in the Baba Ndogo informal settlement area. They raised funds and built a community centre, theatre (with a capacity of 400), school, and gym.

The ACREF centre supports families with disabled children and aims to combat the stigma around disability. It provides a physiotherapy clinic twice a week in its gym for children with disabilities. It supports women with disabled children to earn a living through a tailoring micro-business. The women use sewing machines at the centre to repair clothes that are brought in by people living nearby, and make clothes – for example they have a contract to provide hospital uniforms.

ACREF raises awareness in the community on a wide range of health issues, including STDs, HIV / AIDS, and pregnancy.

The centre also provides affordable pay-per-use toilets and showers, with the small 5 KSH charge contributing towards cleaning and maintenance costs.

**Fact file**

- We Are Watching You is a campaign based on education by the community, for the community. It is supported through partnership work with grassroots community organisations such as Sisi Ni Amani and ACREF (African Cultural Research and Education Foundation).

- It was originally developed as a campaign by ACREF (African Cultural Research and Education Foundation) in the run-up to the Kenyan elections. It was registered as a separate organisation in 2012.

- ACREF works with a range of partner community organisations, including: Baba Dogo Catholic Church, Boma Rescue Street Children Centre, National Book Development Council of Kenya (NBDCK), Social Ministry Research Network Centre (SOMIRENEC), Social Ministry Institute (Tangaza College), Baba Dogo youth council. Its main funding partner is World Friends.

- Ramadhan Obiero, Director of We Are Watching You, was an Acumen Fund East Africa Fellow in the class of 2011-12.
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<tr>
<th>Acronym</th>
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<tr>
<td>A&amp;K</td>
<td>Alive and Kicking (Kenya)</td>
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<tr>
<td>ACREF</td>
<td>African Cultural Research and Education Foundation (Kenya)</td>
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<td>ADA</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AusAID</td>
<td>Australian Government Overseas Aid Programme (Australia)</td>
</tr>
<tr>
<td>AYI</td>
<td>Afya Yetu Initiatives (Kenya)</td>
</tr>
<tr>
<td>CAN</td>
<td>Community Action Network (UK)</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CDC</td>
<td>Colonial Development Corporation (DfID’s Development Finance Institution)</td>
</tr>
<tr>
<td>CHAK</td>
<td>Christian Health Association of Kenya (Kenya)</td>
</tr>
<tr>
<td>CICA</td>
<td>Community Interest Company Association (UK)</td>
</tr>
<tr>
<td>CORAT</td>
<td>Christian Organization Research and Advisory Trust of Africa (Kenya)</td>
</tr>
<tr>
<td>CRM</td>
<td>Customer Relationship Management</td>
</tr>
<tr>
<td>CSR</td>
<td>Corporate Social Responsibility</td>
</tr>
<tr>
<td>DIID</td>
<td>Department for International Development (UK)</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health (UK)</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>eCOM</td>
<td>Electronic Commerce</td>
</tr>
<tr>
<td>EED</td>
<td>Evangelischer Entwicklungsdienst (Germany)</td>
</tr>
<tr>
<td>ELRECO</td>
<td>Eldoret Christian Community Services (Kenya)</td>
</tr>
<tr>
<td>ERP</td>
<td>Enterprise Resource Planning</td>
</tr>
<tr>
<td>EMDR</td>
<td>Eye Movement Desensitisation Reprocessing (treatment for PTSD)</td>
</tr>
<tr>
<td>FIFA</td>
<td>Federation of International Football Associations</td>
</tr>
<tr>
<td>GLUK</td>
<td>Great Lakes University of Kisumu (Kenya)</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GPEX</td>
<td>Gross Public Expenditure on Development</td>
</tr>
<tr>
<td>GPS</td>
<td>Global Positioning System</td>
</tr>
<tr>
<td>HANSHEP</td>
<td>The Group for Harnessing Non-State Actors for Better Health for the Poor</td>
</tr>
<tr>
<td>HDFC</td>
<td>Housing Development Finance Corporation (USA)</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HLL</td>
<td>Hindustan Latex Limited (India - now HLL Lifecare Ltd)</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HROC</td>
<td>Healing and Rebuilding Our Communities (Kenya)</td>
</tr>
<tr>
<td>IDFC</td>
<td>The Infrastructure Development Finance Company Limited (India)</td>
</tr>
<tr>
<td>IFC</td>
<td>International Finance Corporation</td>
</tr>
<tr>
<td>IVF</td>
<td>In Vitro Fertilisation (fertility treatment)</td>
</tr>
<tr>
<td>JKUAT</td>
<td>Jomo Kenyatta University of Agriculture and Technology (Kenya)</td>
</tr>
<tr>
<td>KCBHFA</td>
<td>Kenya Community Based Health Financing Association (Kenya)</td>
</tr>
<tr>
<td>KIW</td>
<td>Kreditanstalt für Wiederaufbau (Germany)</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>KMB</td>
<td>Catholic Men’s Movement (Austria)</td>
</tr>
<tr>
<td>KPMG</td>
<td>Klynveld, Peat, Marwick and Goerdeler - after its four partners</td>
</tr>
<tr>
<td></td>
<td>(international auditor and consultancy firm)</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>KSH</td>
<td>Kenyan Shilling</td>
</tr>
<tr>
<td>MBA</td>
<td>Master of Business Administration</td>
</tr>
<tr>
<td>MEPA CBO</td>
<td>Muivu Education and Poverty Alleviation Community Based Organisation</td>
</tr>
<tr>
<td>MESPT</td>
<td>Micro-Enterprise Support Programme Trust (Kenya)</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MS</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>NABH</td>
<td>National Accreditation Board for Hospitals (India)</td>
</tr>
<tr>
<td>NBDCK</td>
<td>National Book Development Council of Kenya (Kenya)</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service (UK)</td>
</tr>
<tr>
<td>NYEPS-EMS</td>
<td>New York –Presbyterian Emergency Medical Service (USA)</td>
</tr>
<tr>
<td>PCEA</td>
<td>Presbyterian Church of East Africa (Kenya)</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>PR</td>
<td>Public Relations</td>
</tr>
<tr>
<td>PVRI</td>
<td>Pushpagiri Vitreo Retina Institute – of which the Pushpagiri Eye Institute is a Division (India)</td>
</tr>
<tr>
<td>RISE</td>
<td>Regional Institute for Social Enterprise (Kenya)</td>
</tr>
<tr>
<td>Rs.</td>
<td>Indian Rupees</td>
</tr>
<tr>
<td>RSWR</td>
<td>Right Sharing of World Resources (Kenya)</td>
</tr>
<tr>
<td>SEIF</td>
<td>Social Enterprise Investment Fund (UK)</td>
</tr>
<tr>
<td>SEL</td>
<td>Social Enterprise London (UK)</td>
</tr>
<tr>
<td>SE UK</td>
<td>Social Enterprise UK (UK)</td>
</tr>
<tr>
<td>SHOPS</td>
<td>Strengthening Health Outcomes through the Private Sector</td>
</tr>
<tr>
<td>SIB</td>
<td>Social Investment Business (UK)</td>
</tr>
<tr>
<td>SMART</td>
<td>Specific, Measurable, Achievable, Realistic, and Time-bound</td>
</tr>
<tr>
<td>SOMIRENEC</td>
<td>Social Ministry Research Network Centre (Kenya)</td>
</tr>
<tr>
<td>SSE</td>
<td>School for Social Entrepreneurs (UK)</td>
</tr>
<tr>
<td>STPs</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>STIPA</td>
<td>Support for Tropical Initiatives in Poverty Alleviation (Kenya)</td>
</tr>
<tr>
<td>UEFA</td>
<td>Union of European Football Associations</td>
</tr>
<tr>
<td>UHEAL</td>
<td>Upperhill Eye and Laser Centre (Kenya)</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UKP</td>
<td>British Pounds</td>
</tr>
<tr>
<td>USFWI</td>
<td>United Society of Friends Women International</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VIP</td>
<td>Very Important Person</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WRCCS</td>
<td>Western Region Christian Community Services (Kenya)</td>
</tr>
<tr>
<td>ZHL</td>
<td>Ziqitza Healthcare Ltd. (India)</td>
</tr>
</tbody>
</table>
Annex C: Useful Resources

Social Enterprise in the UK

- The following organisations provide a wealth of advice and information on social enterprise in the UK, including on raising capital, starting-up and scaling-up:
  - Social Enterprise UK (SE UK, not dated: http://www.socialenterprise.org.uk/)
  - The School for Social Entrepreneurs (SSE, 2012a: http://www.the-sse.org/)
  - ClearlySo (ClearlySo, not dated: http://www.clearlyso.com/)
  - Community Action Network (CAN, 2009: http://www.can-online.org.uk/)
  - UnLtd (UnLtd, not dated: http://unltd.org.uk/)
  - 3SC (3SC, 2012: http://www.3sc.org/)
  - Community Interest Company Association (CICA, not dated: http://www.cicassociation.org.uk/).

- Social Enterprise UK published a short paper setting out the main characteristics of a social enterprise. It contains useful suggestions on ways to ensure the organisation is controlled in the interests of its social or environmental mission. It is available here: http://www.socialenterprise.org.uk/uploads/files/2012/04/what_makes_a_social_enterprise_a_social_enterprise_april_2012.pdf (Social Enterprise UK, 2012).

Leadership training programmes for social entrepreneurs

- The UK School for Social Entrepreneurs provides a range of different courses designed to support and train social entrepreneurs at different stages of their ventures: http://www.the-sse.org/our-courses (SSE, 2012b).

- The On Purpose training scheme provides a one year UK leadership programme that combines paid work placements with weekly training and regular one-to-one mentoring and coaching: http://onpurpose.uk.com/ (On Purpose, 2012).

- The Skoll Centre for Social Entrepreneurship is a leading academic centre that fosters social transformation through education, research and collaboration: http://www.sbs.ox.ac.uk/centres/skoll/Pages/default.aspx (Said Business School, 2009).

Research and learning on the social enterprise sector in developing countries

- The impact investor Acumen Fund has published a list of ten things it has learnt from tackling global poverty over the last 10 years: http://www.acumenfund.org/ten/_media/downloads/10things.pdf (Acumen Fund, 2012e).

- Monitor and Acumen Fund collaborated to publish a report in April 2012 which sets out a mandate for grant funding to support the blueprinting, validation and preparation stages of a new social business – i.e. to support ventures to develop and validate the initial business plan, and prepare the conditions in the market, before taking a product or service to scale. It makes the case for enterprise philanthropy, includes recommendations for funders and impact investors and includes a blueprint for how enterprise philanthropy should be applied in practice: http://www.mim.monitor.com/blueprinttoscale.html (Koh et al., 2012).

- The Group for Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) is a group of development agencies and countries, established by its members in 2010, seeking to improve the performance of the non-state sector in delivering better healthcare to the poor by working together, learning from each other, and sharing this learning with others. Its founding members are the Australian Government Overseas Aid Programme (AusAID), the Bill and Melinda Gates Foundation, the UK Department for International Development, the International Finance Corporation (IFC), Kreditanstalt fur Wiederaufbau (KfW), the Rockefeller Foundation, the Government of Rwanda, the United States Agency for International Development (USAID), and the World Bank (WB): http://www.hanshep.org/ (HANSHEP, 2012).

Funding opportunities

- The UK Department of Health has announced £19m investment for social enterprises involved in the delivery of UK health and social care services over the next year (2012-13). This is available through the Social Enterprise Investment Fund (SEIF): http://www.dh.gov.uk/health/2012/06/seif2012/ (DH, 2012).

- The Health Innovation Challenge Fund provides funding for innovative products, technologies and interventions for the benefit of patients in the NHS and other healthcare systems: http://www.wellcome.ac.uk/funding/technology-transfer/awards/health-innovation-challenge-fund/index.htm (Wellcome Trust, not dated).


- Funding opportunities are available through the Department for International Development here: http://www.dfid.gov.uk/Work-with-us/Funding-opportunities/ (DfID, 2012b).
• Spark the rise is a funding opportunity for projects or ideas that aim to drive positive change in India: [http://www.sparktherise.com/](http://www.sparktherise.com/) (Mahindra & Mahindra Ltd, 2012).
Bibliography


