SOCIAL INNOVATION IN HEALTH INITIATIVE

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LIVING GOODS

CONTINENT	Africa
COUNTRY	Uganda
HEALTH FOCUS	Maternal and child health, Malaria
AREAS OF INTEREST	Community health workers, Digital technology, Franchising
HEALTH SYSTEM FOCUS	Health workforce, Information systems, Health care financing

LIVING GOODS, UGANDA

Living Goods has adopted best practices in entrepreneurship and performance management to deliver a community health worker programme which has been effective in reducing child mortality by 27%.

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CONTENTS

ABBREVIATIONS

BRAC	Building Resources Across Communities
CARE	Cooperative for Assistance and Relief Everywhere
CHP	Community health promoter
CHW	Community health worker
iCCM	Integrated community case management
J-PAL	The Abdul Latif Jameel Poverty Action Lab
MDG	Millennium Development Goals
MOH	Ministry of Health
NGO	Nongovernmental organization
PSI	Population Services International
UGX	Ugandan shilling
US$	United States dollar
VHT	Village Health Team

CASE INTRODUCTION

Living Goods is a nongovernmental organization with a vision to decrease maternal and child mortality from preventable diseases in low-income countries, such as Uganda. Recognizing the value of community members in addressing health issues and preventing ill health at a grassroots level, it has pioneered an entrepreneurial community health worker (CHW) platform that combines best practices in entrepreneurship and performance management. Living Goods selects and trains community health promoters (CHPs), who then go door-to-door providing basic health services, focusing on diagnosis and treatment for childhood diseases; free pregnancy and new-born check-ups; improving nutrition; and referring acute cases to qualified facilities. CHPs are also enabled as microentrepreneurs and equipped with a basket of health products to sell while they provide their door-to-door health promotion services. Products include treatments for diarrhoea, safe delivery kits, fortified foods, clean cook stoves, water filters and solar lights. Although CHPs earn most of their income through product sales, Living Goods uses targets and associated financial incentives to encourage activity and drive performance. All CHPs are also given a smartphone equipped with mobile tools for registering households visited; sending and receiving reminders; generating checklists of task to perform during visits with protocols to support decision making; and monitoring their own performance.

Living Goods has achieved significant impact in reducing child mortality by up to 27%. Through revenue generation from product sales, Living Goods is able to sustain 60% of its operations and deliver services at under US$ 2 per person per year. Launched in Uganda in 2007, Living Goods has since scaled its model to Kenya, and has replicated it in Zambia and Myanmar in partnership with CARE International and Population Health Services respectively.

The Living Goods case study illustrates how combining entrepreneurial approaches with community health provision not only supports the achievement of health outcomes in a sustainable way, but also enhances economic and gender empowerment of community members. In addition, entrepreneurial models reduce the financial investment required by national governments to support the scale up of CHW programmes. It also demonstrates how best practice management techniques increase the impact and affordability of such programmes. The real-time monitoring of performance becomes an easy and efficient process if data collection, by means of mobile phones, is integrated into the daily tasks of frontline health workers. Mobile data tools enable the organization to assess its performance on a continual basis, make data-driven decisions, and address challenges without delay.

Health is coming to the home. I think that's what happening as we speak. I think it's beautiful how we're taking this centralized idea of a community health worker, a village where you went to someone who you know next door for help. (Charles Slaughter, Founder and CEO, Living Goods)

1. INNOVATION AT A GLANCE

Organization Details

Organization name	Living Goods
Founding year	2007
Founder's name	Charles Slaughter (American)
Current head of organisation	Charles Slaughter
Organizational structure	Nongovernmental organization
Size	115 employees across Uganda, Kenya and America 1005 Living Goods Community Health Promoters (CHPs) in Uganda and Kenya 2 733 CHPs in partnership with BRAC Uganda

Innovation Value

Value proposition	An organization that has adopted best practices in entrepreneurship and performance management to deliver a community health worker programme which has been effective in reducing child mortality by 27%.
Beneficiaries	Pregnant women, newborns and children under five years.
Key components	• Community members are enabled as health entrepreneurs and equipped with a basket of health products • Clear targets, incentives and novel support mechanisms leveraging mobile technology • A 60% self-sustaining organization operating in partnership with the Ugandan Ministry of Health

Operational Details

Main income streams	Product sales, unrestricted donor grants
Annual expenditure	Total for 2015: US$ 9 727 842 (includes cost of goods)
Cost per person served	US$ 1 to US$ 2 per person per year (Living Goods, 2015c)

Scale and Transferability

Scope of operations	8 branches in Uganda; 2 branches in Kenya 128 branches in partnership with BRAC in Uganda Partnership with CARE International in Zambia and Population Health Services in Myanmar
Local engagement	Memoranda of Understanding with the Central and District Ministry of Health (Uganda) and Country Government (Kenya)
Scalability	This model will be effective under the following conditions: • A country context with high maternal and child mortality attributed to pneumonia, malaria, diarrhoea and malnutrition, and with shortages of health workers • Regulatory frameworks permitting community health workers to dispense selected medication • A local non-governmental organization or government willing to adopt the entrepreneurial Living Goods model • Political permission and will from the National Ministry of Health
Sustainability	Through revenue generation from product sales, Living Goods is able to sustain 60% of its operations and deliver services at under US$ 2 per person per year.

2. CHALLENGES

Over the past decade, Uganda has seen a reduction in under-five mortality from 156 per 1 000 live births in 1995 to 64 per 1 000 live births in 2013 (Liu et al., 2015). Despite this progress, the country failed to achieve the 2015 Millennium Development Goal (MDG) under-five mortality target of below 56 per 1000 live births (UNDP Report, 2015). The most common diseases responsible for under-five mortality in Uganda include pneumonia (20,6%), malaria (19,3%) and diarrhoea (12,3%) (Liu et al., 2015). Maternal mortality also remains a challenge in Uganda. Data from 2011 shows maternal mortality to be at 438 per 100 000 live births (UDHS, 2012), far from the 131 per 100 000 live births MDG target (UNDP Report, 2015). The new Sustainable Development Goals emphasise that continued efforts and focus are required to reduce under-five mortality to 12 per 1 000 live births and maternal mortality to 70 per 100 000 live births by 2030 (United Nations, 2015).

The 1978 Alma Ata Declaration started a global focus on the importance of a strong primary health care system as the foundation to achieve health for all (WHO, 1978). However, even prior to Alma Ata, community health worker (CHW) models started emerging in nongovernmental settings, often pioneered by faith-based groups (Olivier et al., 2015). The more recent call for universal health coverage has seen international health actors promoting the engagement and participation of communities to improve access to health care services and address the substantial shortages of human resources in most developing countries (Tulenko et al., 2013). Uganda, under the Health Sector Strategic Plan 1, adopted a community health strategy (called Village Health Teams) in 2001 as a way of improving health care services for the underserved population (Ministry of Health, 2000). Alongside this, the strategy on integrated community case management (iCCM) of childhood illnesses was permitted for use by CHWs (Ministry of Health, 2015). The iCCM approach has resulted in a 70% reduction in mortality from pneumonia in children under-five (Theodoratou et al., 2010) and between 40% to 60% reduction in malaria mortality (Kidane and Morrow 2000).

Despite its popularity and the associated hope of CHW programmes to address various community health issues, many countries are experiencing challenges in maintaining or scaling up these programmes. Some of the common challenges experienced include poor coordination, supervision and support, vertical donor driven funding and a lack of appropriate incentives to ensure CHW performance and retention (de Sousa et al., 2012). A recent audit found a total of 179 175 Village Health Team (VHT) members in Uganda, with coordination by 109 different implementing partners (Ministry of Health, 2015).

From 2001 to 2010, the rollout of the VHT strategy faced multiple challenges including ownership, financial sustainability, governance, selection and training. In addition, the Ugandan VHT strategy relies heavily on volunteers, which raises challenges for retention (Kimbugwe et al., 2014). Drug availability is also problematic. In a recent study in central Uganda, less than 10% of CHWs had the four drugs required for iCCM. Drug availability was mainly influenced by the lack of timely submission of monthly drug reports, with challenges in supervision and access to diagnostic tools (Bagonza et al., 2015).

Increasingly, it is becoming important to examine the conditions that make programmes work in different contexts, and to identify creative ways to financially sustain these programmes.

3. INNOVATION IN INTERVENTION

Living Goods is a nongovernmental organization with a vision to decrease maternal and child mortality from preventable diseases in low-income countries such as Uganda. Recognizing the value of community members in addressing health issues and preventing ill health at a grassroots level, Living Goods has pioneered an entrepreneurial CHW platform. CHWs are often the first point of access to the health care system, and through vigilant pre-emptive screening and assessment, complications can be prevented or referred. Living Goods has overcome many of the managerial and operational challenges encountered by CHW platforms, and achieved significant impact in reducing child mortality.

The Living Goods CHW platform consists of three key elements: community health entrepreneurs, a comprehensive product mix, and mobile technology tools.

3.1. COMMUNITY HEALTH ENTREPRENEURS

You know, one thing I liked about Living Goods is they gave me a starting capital. Because I told them by the time I met them, I was really depressed. I had no capital, I had no money, I had no job, you know? I've just moved out of the ma's house, I have four children. We have to eat, they fall sick. You know, being a single mother is not easy. So when they gave me [the chance of] starting business I was like, "Wow!" Life really changed. I can feed my children; I can treat people when they are sick. (Living Goods Community Health Promoter)

Living Goods supports health and economic development, two interrelated issues in low-income settings. The Living Goods model equips community members in two ways. Firstly, it provides them with the necessary knowledge and skills to promote and improve the health of the mothers and children in their own village. Secondly, it enables them to earn an income as self-employed microentrepreneurs. Living Goods community health promoters (CHPs) have the capacity to generate an annual income of approximately US$ 150. This acts as a strong incentive towards motivation, retention and the provision of quality services.

By the end of 2015, Living Goods Uganda had 1 005 CHPs. The network is sub-divided into clusters through the presence of Living Goods branch offices, with an average of 100 CHPs linked to one branch and a total of eight branches. The branch serves as the local connecting point for CHPs where they can receive supervision, support and restock of the necessary health products. Each CHP serves around 800 people (100 to 200 households) per year, and commits to working at least two hours per day (10 hours per week).

Living Goods CHPs spend their working time moving from house to house in their home surrounding areas. They engage in the following health activities:

- **Integrated Community Case Management of Childhood Disease:** CHPs diagnose and provide treatment for pneumonia, malaria and diarrhoea. Referral links are in place for urgent or high-risk cases and the CHP conducts post-referral follow-ups.
- **Pregnancy and Newborn Care**: CHPs identify and register pregnant women in their communities and provide supportive antenatal care in conjunction with the local health centre. Following delivery, CHPs visit the mother in the first week after birth to educate her on healthy newborn care practices such as breastfeeding, cord care and 'kangaroo' care.
- **Nutritional Assessments and Supplementation**: Agents screen children for malnutrition and provide necessary education on healthy dietary practices for children, especially those aged 6 to 24 months.

3.2. IMPACT AND INCOME GENERATING PRODUCTS

Over the past nine years, Living Goods has invested in identifying and market testing a limited number of products that support health and healthy behaviours, while at the same time

generating a profit margin to support the CHPs and the operating cost of the overall model.

On joining the network, each CHP has access to the full Living Goods product range, including an initial inventory loan: a branded bag, T-shirt and cap; diagnostic equipment (malaria rapid diagnostic tests, respiratory rate counters; thermometer); medical products (artemisinin-based combination therapy (ACTs), amoxicillin, oral rehydration solution, oral contraceptives); health education guides; health promotional products (fortified porridge, vitamins, water filters, water treatment tablets, birth delivery kits, reusable sanitary pads); and home products (solar lights, cook stoves).

3.3. SMART MOBILE TOOLS

It reminds us of the treatments that we have to do. The follow-ups, it reminds us just on time. Even when you have forgotten that you have to do a follow-up, it always reminds you. So you don't need to do a lot of paperwork, we don't need to think of so many other things, we just refer everything to the phone. (Living Goods Community Health Promoter)

In May 2014, Living Goods started rolling out basic Android smartphones to a subset of CHPs and pilot testing mobile tools to facilitate better support, ongoing monitoring and evaluation. By August 2014, the phone uptake had increased to 100%. Each CHP now has a phone equipped with mobile tools for:

- **Registration of household contacts:** all mothers and children seen by the CHP are captured, along with their location and key information.
- **Tasks and reminders:** this is an easy-to-access, automated creation of a prioritized list of all activities required by the CHP per each household under their care, and reminders are sent when repeat household visits are due.
- **Protocols and actions:** CHPs are guided step-by-step through an iCCM application to accurately assess, diagnose and treat or refer childhood illnesses. The application alerts the CHP to danger signs, recommends follow up actions, and provides key health promotion information, such as sick child feeding messages or treatment adherence messages. The mobile platform provides steps of action in the case of an emergency.
- **Target monitoring:** each CHP works to meet a set of Living Good targets of care. The tool enables them to track and monitor their own performance.

In 2016, Living Goods is deploying a major upgrade to the tools in collaboration with Medic Mobile (a not-for-profit mobile health organization). The mobile phone platforms have become a valuable source of data collection for the organization to facilitate performance management, learning and adaptation.

4. IMPLEMENTATION

4.1. INNOVATION IN IMPLEMENTATION

What we are doing is taking some of the best practices in community public health, and applying some business principles around motivation, incentives, monitoring and tracking and around logistics and supply to ensure that we have [effective] last mile distribution. (Alfred Wise, Uganda Country Director for Living Goods)

Recruitment and Selection

The Living Goods management team has recognized the importance of recruiting and selecting CHPs who will be dedicated to serving their community, competent in executing their tasks, and who will resonate with the vision and culture of the organization.

New CHPs are recruited on a referral basis from either community or religious leaders, and via

existing CHPs. The ideal candidate for this type of community work has been found to be a female or male from a local community, between 30 to 55 years, with a minimum primary school completion but not post-secondary school completion. A preliminary selection process includes a maths and English test, followed by an interview. For every four to five people interviewed, approximately one person proceeds to be included in the introductory training course. The training is a 13-day programme comprised of modules on health and business management. Health modules include pregnancy, newborn care, nutrition and iCCM. Business management modules include salesmanship, communication and mobile phone literacy. CHPs also do a practical training component that includes spending time in a local public health facility and two weeks in the community, identifying and registering new pregnant women. Following the theoretical and practical training, CHPs take a final test. This test results in a 10% drop-out rate. For those who are successful, their accomplishment is celebrated with a community ceremony, with their family members and friends.

A dedicated process for the recruitment and selection of branch managers or assistants consists of an interactive skills-testing interview. Those successful are invited to a six-week management training programme and practicum period. During this period branch assistants and managers gain a detailed sense of the duties involved. If they perform well in the training programme and pass the post-training test, they are offered an employment contract.

Performance Management and Incentives

Living Goods aims to be the most impactful and cost-effective CHW platform worldwide. Strong performance management is central to achieving this goal.

- **Targets and Financial Incentives**: Living Goods uses targets and associated incentives to encourage activity and drive performance. CHPs earn most of their income through product sales but in addition to profit earnings, they have dedicated monthly targets of sales worth UGX 165 000 (US$ 50); 21 under-five treatments per month including 13 malaria treatments; 6 diarrhea treatments and 2 pneumonia treatments. In addition, they can receive an incentive of UGX 500 for each new pregnancy identification and registration, and UGX 500 for a newborn follow-up 48 hours post-delivery. Field staff are also partially compensated based on the performance of their CHPs.

- **Non-financial incentives**: *"Doing Living Goods work is an inspiration. You have to have the willingness to go out to face the people and their challenges when we are out there supporting them. We work as a large team is to support these CHPs in whatever way you can."* (Branch Manager, Living Goods) The Living Goods management team have incorporated a range of non-financial incentives to ensure that CHPs are motivated and active, and that retention rates are high. As mentioned above, each CHP undergoes introductory health and business training. They are given all the tools and products they need to successfully perform as a CHP, including a mobile phone. On a monthly basis, CHPs receive refresher-training modules, designed around different health and business topics, and regular support from field staff. Organizational and community recognition is an important motivational factor. Living Goods employs recognition such as "CHP of the month" and other awards. Clear career paths have also been designed for high-performing CHPs, which could lead to becoming branch assistants, managers or field supervisors. Finally, CHPs are proud to be trained by and associated with Living Goods, and to be able to provide impactful high quality, low-cost health products and services to their community. CHPs proudly wear their Living Goods T-shirts and carry their Living Goods bag: *"Ever since I joined Living Goods ...[and] because I was trained and given the techniques of handling people in the community, my status and my prestige in the community [has grown]. People are approaching me now."* (Living Goods Community Health Promoter)

Supply chain

Ensuring 100% stock availability and access for CHPs to essential medicines and products is a core

competency of the Living Goods model. Living Goods utilizes its branches for product storage and dispensing. Stocks are replenished at three-monthly intervals but dynamic stock monitoring systems are in place between the branches and head office. CHPs can restock their supplies by visiting the branch. The branch is usually within a 3- to 5-mile radius of the area they serve. All CHPs are obliged to have stock of the essential medicines, but other products, e.g. solar lamps, are left to their discretion.

Two new distribution mechanisms are being piloted to facilitate easier access for CHPs to restock and allow branch hubs to reach into more communities. The first is a "boda boda" (motorbike) delivery service to the CHP's home at a small extra charge. The second is a "mini-hub" in a central community site where stock is delivered once a week.

Data-driven decision making

"Our mobile system, it is becoming the 'central nervous system' of the LG model." (Molly Christiansen, Director of Impact and Advocacy, Living Goods) Moving from a traditional paper-based system of capturing data, tracking stock and monitoring performance, to an integrated mobile platform has enabled Living Goods to become a learning organization. Real-time data from the CHPs' mobile phones flows into analytics dashboards that all staff – from field managers to country directors – can see at any time on any device. Customized action lists, and protocols for field supervision, provide quick, effective and tailored support to CHPs as needed. The analytics system enables senior leadership to drive performance across the organization, and to test and learn from new initiatives quickly.

4.2. ORGANIZATION AND PEOPLE

The vision from the beginning has been to achieve systemic change in improving health and wealth of the poor, and this gets to your last question to tie the two together. (Charles Slaughter, Founder and CEO, Living Goods)

Entrepreneur Charles Slaughter founded Living Goods in 2007. Slaughter initially studied architecture before becoming the founder of TravelSmith, a company providing a range of products required by travellers. He grew the business to reach US$ 100 million in sales, with 2 million customers. In 2004, he sold the business and subsequently was asked by a good friend to provide his expertise to turn around the struggling Health Store/CHW Shops network in Kenya. Slaughter immediately noticed the limitations of fixed location drug stores in areas where transport was poor, and saw an opportunity to take products and services to people's homes. The idea arose to adapt the Avon cosmetics door-to-door sale model to improve the health of communities in hard to reach rural areas. The same focussed passion and vision that Slaughter used to launch Living Goods in Uganda in 2007 has remained the driving force for all 115 employees currently employed at Living Goods.

Yeah, you actually see the actual impact. You see 1 000 treatments just happening, know that those are like 1 000 lives saved. Now we have over 20 000 pregnancies that are active. From what we are doing is like we are helping these 20 000 pregnant mothers to handle their pregnancies well and potentially we are seeing 20 000 saved deliveries. It is really exciting. (Technology and Operations Manager, Uganda)

4.3. BUSINESS MODEL

Living Goods adopted a hybrid business model that combines best practice in public health and direct selling techniques of organizations like Avon. The effectiveness of this model is based on leveraging community members to market and sell into their own social network. Living Goods franchises its brand and provides a 'business in a bag' to a network of microentrepreneurs who work as CHPs. Through this approach, Living Goods covers the majority of its product and distribution costs and generates an income for CHPs.

On product sale earnings, CHPs earn 18% to 20% profit margin (Living Goods, 2015a; Living Goods 2015b). The total country net income for Living Goods Uganda in 2015 (excluding BRAC Uganda) was US$ 1 730 877 and the total expenditure was US$ 2 429 489.

Based on lessons learned about 'bottom of the pyramid' purchasing behaviour, Living Goods has started developing and selling its own private label products, such as fortified complementary feeding

porridge. CHPs are proud of marketing their own Living Goods products, and this has seen an increase in sales revenue. Uniquely developed products hold a better profit margin for both the CHPs and Living Goods. Other key products driving sales have been medicines and household durables like solar lights and cook stoves.

The organization has received donor and grant funding from the Children's Investment Fund, Omidyar Network, UBS Optimus Foundation and the Barr Foundation. This funding has enabled it to expand operations.

5. OUTPUTS AND OUTCOMES

5.1. IMPACT ON HEALTH CARE DELIVERY

Living Goods is a target- and output-driven organization. *"Awards are diamond dust. The only thing that matters is impact."* (Charles Slaughter, Founder and CEO, Living Goods) Clear targets are set for CHPs and branch management staff performance. Data from the second quarter of 2015 showed under-five treatments per agent reaching 23 against the target of 17, and within the quarter 15 000 pregnancies were supported – a 2.5 times increase from 2014 (Living Goods, 2015b).

Outcome data from a three-year cluster randomized controlled trial conducted by the Abdul Latif Jameel Poverty Action Lab (J-PAL), in collaboration with researchers from Harvard University, Stockholm University, and Innovations for Poverty Action, have found strong evidence of impact. The study, covering 214 villages in 10 districts in Uganda, including 8 119 households, showed a 27% reduction in under-five mortality in intervention sites as compared to controlled sites. Mortality reduction was experienced in households of different wealth quintiles (Bjorkman-Nykvist, Guariso, Svensson, Yanagizawa-Drott, submitted for publication). On treatment indicators, an 17% improvement in diarrhoea treatment with ORS and zinc was found; an 54% increase, albeit starting from low levels, in follow-up visits for under-five children falling sick with malaria; and an 72% increase, again starting from a low level, in home visits in the first seven postnatal days (Bjorkman-Nykvist, Guariso, Svensson, Yanagizawa-Drott, submitted for publication). While the likelihood of treatment with ACTs and antibiotics are similar across assignment arms, households in treatment villages are significantly more likely to purchase ACTs, antibiotics and ORS/zinc from CHPs.

Not only does the Living Goods model achieve a direct health impact, it also reduces the economic costs per household. Marked cost reductions are associated for households with savings in transport to public health centres; incorrect drug purchases from drug shops; and savings due to efficient cook stoves and solar light products (Living Goods, 2015c). *"It's [the clinic] some distance from here. Like, it is right in town. It's expensive to board the to and from; you have to buy the transport for to and fro. But for her [CHP], she comes up to the place so there is a way she saves me money."* (Beneficiary, Mother)

5.2. ORGANIZATIONAL MILESTONES

Living Goods has achieved several successes and milestones:

- **Government support**: Within Uganda, it has fostered a strong acceptance from the Ministry of Health and work in partnership with them to deliver maternal and child health services. The Ugandan Ministry of Health approves the sale and dispensing of medicines by community health promoters trained in iCCM.
- **Impact data**: Rigorous outcome data from the randomized controlled trial has increased the credibility of and support for Living Goods' work.
- **Collaboration partners**: Partnership with three of the largest global health delivery NGOs – Population Services International, Care International and BRAC.

- **Expansion**: In 2015, Living Goods launched its model in Busia County, Kenya. At the end of 2015, there were 170 CHPs in Kenya.
- **Public acknowledgement**: Skoll Award for Social Entrepreneurship 2016; GSK-Save the Children Health care Innovation Award 2015; GiveWell Standout Charity; BNP Paribas Prize for Individual in Philanthropy and DUKE CASE Award for Enterprising Social Innovation 2014; Schwab Foundation Social Entrepreneur Award 2013.

5.3. COMMUNITY AND PATIENT EXPERIENCES

There are two main beneficiaries of the Living Goods model: CHPs, and mothers and children in rural villages.

The experience of CHPs working with Living Goods is overwhelmingly positive. The work contributes to a social, psychological and economic change for each CHP. After training, and appearing in their community now as a "masawo" [health worker], there is a marked improvement in their social status. For many, there has been psychological gain as they now connect with others in their community and provide treatment for their own families.

It's really improved my status in the community. The depression I had went away. The problems I had have really reduced. Even my children, they get treatment just on time you know? I can treat them on time, and the community respects me because of what I'm doing. (Living Goods Community Health Promoter)

The economic gains enable them to meet some of the basic needs of their families. This is especially important for women of single-headed households. In addition, through training, the CHPs feel empowered to use the health, management and sales skills they acquire to further grow in their careers. *"What I've learnt from Living Goods is that when you are setting your goal, begin working from the extreme end, from the finishing end, so that you can see what you want to be in the next five years, one year, one month, one week or the next day."* (Field Supervisor, Living Goods)

Mothers in rural villages report satisfaction and gratitude for the services they receive from Living Goods CHPs. The doorstep service not only saves them a considerable amount on transport costs to local facilities, but also allows a supportive relationship to form. This enables babies and children to receive the necessary treatment in a timely way, and mothers to be educated on preventing illness.

The week after delivery, as she was moving around checking on people, she came across me. We met. We became good friends and she introduced the work she does to me. So, from that time, I've been working together. Like, if I get any sickness, any complication with the baby, I will work together. There is a time the baby got flu and cough. She bought some drugs, which had helped the baby. I got malaria, she got malaria treatment. (Beneficiary)

6. SUSTAINABILITY

The regularly changing global health funding priorities, along with calls for universal health coverage, are strong stimuli to both NGOs and governments to adopt different models to allow for sustainable service delivery. The focus for Living Goods has always been impact, but with a strong entrepreneurial spirit of its founder, the original goal was to strive for full sustainability. When Alfred Wise joined as the Uganda country director in 2013, his main objective was to streamline organizational processes to allow for sustainability. However, the significant reduction in under-five mortality, as found by the randomized controlled trial, drove a strategic shift in the organization's approach. It did not want to compromise sustainable impact for financial sustainability. Increased attention has since been given to identify the key elements of the model responsible for achieving impact such that they can be promoted and replicated in other settings.

The entrepreneurial approach of Living Goods to enable CHPs to generate their own revenue and income has supported several positive effects. Firstly, the Living Goods community health promoters have high rates of retention and motivation to achieve good performance. Secondly, the organization can cover 60% of operating costs through CHP product sales. Thirdly, the model is very attractive to decision-makers in the Ugandan Ministry of Health as it removes many of the managerial and product costs for country governments in implementing such programmes.

The additional value with the Living Goods is enough. We are saving life but how do you sustain? How do you ensure that you have the products to continue saving life? That's the component of cost recovery. Basic, basic minimal cost, which will ensure that the service and the products that you are using are always available. You are able to go and get more replenishment and whoever is giving you that replenishment is able to go and restock. But that is not enough. As I said, it's motivation on the patient or the caretaker because you have helped her. You actually, you have halted more expenditure in terms of money and the time. (Commissioner Health Services and Promotion, Ugandan Ministry of Health)

7. SCALABILITY

Living Goods has an ambitious vision to scale its work. By 2018, the organization plans to grow to 25 branches with 2 500 CHPs in Uganda, reaching 2 million people. In partnership with BRAC (a large international nongovernmental organization), the goal in Uganda is to reach 4 000 CHPs serving 4.5 million people, and to grow its network in Kenya to 18 branches and 1 800 community CHPs reaching 1.4 million people. In addition, Living Goods is supporting global NGOs in Zambia and Myanmar to replicate its model. It plans to replicate their model in two to three new countries, with the aim of reaching an additional 5 million people in each country. In preparation, the Uganda country team is packaging each component (recruitment, training, management, etc.) of its model to be replicated while maintaining quality and impact.

Living Goods' expansion and replication strategy identifies areas with 1) a clear need to address high rates of under-five mortality; 2) a stable political situation, openness by the government to work with nongovernmental partners, permission for community providers to dispense medicines, and support from the government, even if operating with limited resources; and 3) a sizable population (greater than 10 million) to support economies of scale, high population density and reasonable purchasing power to ensure sustainability. Finding top talent in the region is also a critical driver of scale. Living Goods is considering expansion into Nigeria, Ghana and India. *"In Uganda, LG's success grew in a context of a 'weak but willing' health system – i.e. where government is failing to deliver adequate community health services, but open to try new approaches."* (Living Goods, 2015d)

The organization's scaling strategy is defined around three main pillars: 1) integration with government; 2) replication through partnerships; and 3) leverage of large scale funding.

Integration with government

Living Goods works in close partnership with the governments of Uganda and Kenya, and is seen as the de facto government community health network in some areas. A memorandum of understanding allows Living Goods to recruit, train and support members of the government Village Health Teams, thus strengthening the existing government system. In Kenya, Living Goods has signed agreements with country governments to strengthen existing networks of Community Health Volunteers and to recruit and support new Community Health Volunteers into the system. Each country team has a dedicated government liaison officer. In time, Living Goods would hope to mature the relationship with government to allow it to become a funded service provider.

What we've learned is working closely with the government has been an essential part of how we

both deepen our work, but also allowed us to scale. Working with the Ministry of Health [is important] and making sure that we're both communicating, sharing our results, but also participating and some of the other technical working groups. (Alfred Wise, Uganda Country Director, Living Goods)

Replication through partnerships

Partnerships have been key to Living Goods. It has worked closely with BRAC since 2008. To replicate its work into other health markets, Living Goods have been searching for strong operating partners in different settings and establishing their own internal consulting division. An ideal partner has strong operating systems in place, an enthusiastic internal champion and private sector expertise. Currently, Living Goods has formed a partnership with Population Health Services International (PSI) in Myanmar, and with CARE International in Zambia. PSI launched its Living Goods replication model, the Win Win agent network, in April 2015, and Zambia is expected to launch in 2016. Living Goods has assembled a skilled four-person advisory team to bring public health, business, partnership, consulting and communication expertise to its partners.

Leverage of large-scale funding

To support scaling to new territories, active effort is undertaken to engage with bilateral and multilateral donors and private sources. Through donor support, Living Goods has been able to successfully operate as a part of the District Health Team in Lira, Uganda.

8. KEY LESSONS

8.1. IMPLEMENTATION LESSONS

Getting Started

Living Goods entered Uganda in 2008 through an initial partnership with BRAC. From its work in Bangladesh, BRAC brought with it a wealth of expertise and experience in community-run health provision models. Growth in the first four years was largely organic and the BRAC partnership enabled it to test concepts and learn from each other. As with any big organization, agility and quick change is limited and it became a natural evolution for Living Goods to spin off and set up its own operations.

A culture of learning, innovating and adapting is a key part of the Living Goods. The initial years included a lot of experimentation to find the optimal product mix, selection criteria for CHPs, and an effective distribution system. Technology and data analytics have become an area of experimentation for Living Goods, and continual testing and feedback from CHPs is assisting in refining and adapting the model for the local contexts.

Living Goods started with a vision of scale already firmly in place. Strong leadership from Slaughter and the rest of the management team has enabled Living Goods to operate more like a venture 'start-up' than a more traditional community based organization. Elements such as a robust business plan, marketing strategy, and sustainability plan have always been in place.

Maintaining Efforts

Living Goods' efforts are fuelled by people (funders, employees and partners) who believe in the vision and mission of its work. The organization recognizes the importance of its private funders in supporting it through undesignated capital to innovate and improve its model and operations in an ongoing manner. This type of funding stimulates the team to not only provide services, but also constantly work on how it could be done even better. The organization also acknowledges the value of its employees. With conscious consideration, the new team members from different sectors or disciplines have been welcomed into the organization. This vast skills and expertise complement supports the

organization growing and overcoming challenges experienced along the way.

Living Goods strongly believes in working with collaborative partners to advance its work. Its technology and data analytics developments have been supported by Medic Mobile, a San Francisco-based mobile health NGO. In collaboration, many hours of field development and testing have occurred to result in user-friendly smart mobile tools capable of transforming performance management.

In generating evidence of its impact, Living Goods partnered with the Abdul Latif Jameel Poverty Action Lab (J-PAL). From the beginning, Slaughter wanted to adopt the best in class evidence methodology to assess the outcome and impact of Living Goods' work. Its partnership with J-PAL has enabled it to conduct a large scale randomised controlled study. The resulting evidence from this study has become a key lever and driver of momentum, support and influence.

Overcoming Challenges

A natural challenge for all organizations who work at grassroots level is to stay true to its mission. Staying focussed without becoming distracted by other potential avenues of development or activities is key. Living Goods overcame this challenge by going back to its original impact goal of reducing under-five mortality. Increasingly, the team has learned that more activities may account for a higher opportunity cost on CHPs and on the time and focus of the field team. By keeping its key performance indicators focussed and aligned on three areas – impact, growth and cost-effectiveness – Living Goods is able to distinguish value-adding processes and products from those that were rather distracting, timely and costly.

8.2. PERSONAL LESSONS

Living Goods founder Charles Slaughter is a passionate entrepreneur wanting to see radical and systemic change so that the health and wealth of the poor can be improved. In pursuing that vision, Slaughter knew the importance of developing a community health model that was highly sustainable and represented the best possible economic value. Perhaps the most striking lesson Slaughter presents is the *"radical notion... that it is okay to charge customers as long as you provide good value by bringing the product to their door".*

Slaughter recognizes that Living Goods alone cannot achieve systemic change; rather he identifies: *"You have to change how the biggest institutions in the sector work, whether they be NGOs, governments, funders, philanthropists"* (Charles Slaughter, Founder and CEO, Living Goods) Furthermore, in seeking engagements with stakeholders and funders, it is important to recognize each person's value. *"They each bring important intellectual resources to [their] endeavour... The experience and intellectual power of those financial partners [are] as valuable as their money."* (Charles Slaughter, Founder and CEO, Living Goods) Still, the financial contributions, particularly in the form of unrestricted funding, have been key to its success because it enables Living Goods to try new things and experiment with better way of doing things without being constrained by funding stipulations.

The values that Living Goods embodies are clear in the undistracted focus, perseverance and humility with which they approach their work. Slaughter prizes personal leadership over professional leadership as this recognizes the important influence of everyone, on those above, below and at the same level. In the quest to save lives, it is important for Slaughter and his team to embrace the lighter side of life.

This is very hard work. There are challenges every day. Things go bad and things go wrong. The days and the hours and the weeks are long, and if you can't face those impairments with some levity, you're going to be a little miserable. So we really try to have a sense of humour and not take ourselves too seriously and approach those challenges with a little light. (Charles Slaughter, Founder and CEO, Living Goods)

Yet, perhaps just as important to the organization's success is its embrace of the idea that *"there's no limit to what you're going to accomplish when you give credit to the other person."* (Charles Slaughter, Founder and CEO, Living Goods)

CASE INSIGHTS

1. Combining entrepreneurial approaches with community health provision not only supports the achievement of health outcomes in a sustainable way, but also enhances economic and gender empowerment of community members. In addition, entrepreneurial models reduce the financial investment required by national governments to support the scale up of community health worker programmes.

2. The impact and affordability of community health worker programmes is dependent on the standardized adoption of best practice management approaches across all aspects of the programme.

3. The real-time monitoring of performance becomes an easy and efficient process if data collection, by means of mobile phones, is integrated into the daily tasks of frontline health workers. Mobile data tools enable the organization to assess its performance on a continual basis, make data-driven decisions, and address challenges without delay. It further serves to motivate frontline health workers who can track their individual performance.

REFERENCE LIST

Bagonza J et al. (2015). What influences availability of medicines for the community management of childhood illnesses in central Uganda? Implications for scaling up the integrated community case management programme. *BMC Public Health*, 15(1):1180. http://doi.org/10.1186/s12889-015-2525-4.

De Sousa A et al. (2012) Community case management of childhood illnesses: policy and implementation in Countdown to 2015 countries. *Bulletin of the World Health Organization*, 90(3):183-190.

Kidane G & Morrow RH (2000). Teaching mothers to provide home treatment of malaria in Tigray, Ethiopia: a randomised trial. *Lancet,* 356(9229):550–55. doi:10.1016/S0140-6736(00)02580-0.

Kimbugwe G et al. (2014). Challenges faced by village health teams (VHTs) in Amuru, Gulu and Pader districts in Northern Uganda. *Open Journal of Preventive Medicine*, 4(9):740-750, doi: 10.4236/ojpm.2014.49084

Litsios S (2004). The Christian Medical Commission and the development of the World Health Organization's primary health care approach. *American Journal of Public Health,* 94:1884-93, http://dx.doi.org/10.2105/AJPH.94.11.1884.

Liu L et al. (2015). Deriving causes of child mortality by re–analyzing national verbal autopsy data applying a standardized computer algorithm in Uganda, Rwanda and Ghana. *Journal of Global Health*, 5(1):010414. doi:10.7189/jogh.05.010414.

Living Goods (2015a.) *Living Goods' Four-Year Plan: Empowered Entrepreneurs Saving Lives Door-to-Door.*

——— (2015b). *2015 Q2 Stakeholder Report.*

Ministry of Health, Republic of Uganda (2000). *Health Sector Strategic Plan 2000/01 – 2004/05.* (http://siteresources.worldbank.org/INTPRS1/Resources/383606-1201883571938/Uganda_HSSP.pdf, accessed 11 October 2016).

Ministry of Health, Republic of Uganda (2010). *Integrated Community Case Management of Malaria, Pneumonia and Diarrhea, Implementation Guidelines 2010.* Kampala, Ministry of Health, May 2010. (https://www.k4health.org/sites/default/files/ICCM%20Implementation%20Guidelines.pdf, accessed 11 October 2016).

Ministry of Health, Republic of Uganda (2015). *National Village Health Teams Assessment in Uganda, report 2015.* Kampala, Ministry of Health, 2015.

Theodoratou E et al. (2010) The effect of case management on childhood pneumonia mortality in developing countries. *International Journal of Epidemoliogy,* 39(Suppl 1):i155–71.doi:10.1093/ije/dyq032

Tulenko et al. (2013). Community health workers for universal health-care coverage: from fragmentation to synergy. *Bulletin of the World Health Organization*, 91:847–852, doi: http://dx.doi.org/10.2471/BLT.13.118745

Uganda Bureau of Statistics (UBOS) (2011). *Uganda Demographic and Health Survey 2011.* Kampala, UBOS & Calverton, ICF International Inc., 2011.

United Nations (2016). *Sustainable development goal 3.* Sustainable Development Knowledge platform [online]. Department of Economic and Social Affairs, United Nations.

United Nations Development Program (2015). *Human Development Report.* New York, United Nations Development Programme, 2015.

United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) (2015). *Levels & Trends in Child Mortality Report 2015.* United Nations Children's Fund, 2015.

World Health Organization (1978). *Declaration of Alma-Ata. International Conference on Primary Health Care.* Alma-Ata, USSR, 6-12 September. (http://www.who.int/publications/almaata_declaration_en.pdf, accessed 25 April 2016).