

**SOCIAL
INNOVATION
IN HEALTH
INITIATIVE**

CASE COMPENDIUM

2015 - 2018



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INTRODUCTION

The Social Innovation in Health Initiative (SIHI) was launched in 2014 as a network of partners, comprised of academic institutions and the Special Programme for Research and Training in Tropical Diseases (co-sponsored by UNDP, UNICEF, the World Bank and WHO), hosted at the World Health Organization. SIHI was founded on the belief that across low- and middle-income countries (LMICs), actors from different backgrounds and disciplines are active in developing and implementing creative community-based solutions to overcome challenges in health care delivery.

The SIHI network of partners collaborates with grassroots innovators, Ministries of Health, funding agencies and international agencies to achieve its mission of advancing social innovation in health in low- and middle-income countries through research, capacity building and influence.

Over the past few years, the SIHI partners have celebrated the richness and scope of existing solutions. These solutions have contributed to increasing access to affordable and effective health care delivery, strengthening public health systems, and catalysing the achievement of the Sustainable Development Goals.

As the SIHI network, we are excited to share with you the cases of social innovations we have identified to date. We hope that this will spark a greater awareness and understanding of social innovation in health in your country.



WHAT IS SOCIAL INNOVATION IN HEALTH?

In the last century, the world has witnessed many great medical advances (drugs, devices, vaccines) and ambitious global health declarations. However, the reality of the health systems and services offered to millions of people across LMICs remains far from the actual needs and expectations. It is estimated that more than 400 million people globally, mainly in LMICs, lack access to essential primary health care services (World Health Organization & World Bank, 2015). Beyond the ‘what’ that gets developed to improve health, the ‘how’ of implementation remains an expert-driven, top-down processes, which fails to recognise community or frontline participation as a key feature of implementation (Walt & Gilson, 1994; Gillam, 2008; Penn-Kekana, Blaauw & Schneider, 2004; Adam & de Savigny, 2012). As expressed by Herbert and Best (2011), “We need new ways of thinking and of working in order to accommodate the complexity of the challenges, and urgent need for, health system innovation and change.”

Social innovation in health presents a lens or an approach through which countries can be supported to achieve sustainable, equitable and integrated people-centred health systems and health services. Contrary to commercially-focused innovation, the primary intended outcome of social innovation is enhanced quality of life, justice and equity for all members of society (Mulgan, 2006; Pol & Ville, 2009). Thus, the social innovation approach could hold the potential to breathe fresh life into the 1978 Alma Ata ideals of equity, social justice and community participation in basic health care delivery (WHO, 1978; Walley et al., 2008) and support the achievement of Universal Health Coverage and the Sustainable Development Goals.

Social innovation is both a process and an outcome. The social innovation process embodies a bottom-up view of design and implementation that starts with the belief that all members of society are competent interpreters of their own lives and have the capacity to solve their own problems (Mulgan et al., 2007). This is evident by the fact that community or civil society actors are the creators of a significant number of social innovations (Nicholls & Murdock, 2012; van Niekerk & Bonnici, 2014). It starts with the perspective of the person or community for which the solution is being created and not only engages those affected by the challenge but equips and empowers them. This inclusive nature of social innovation leads to communities with enhanced capacity to act and take ownership of implemented solutions and their own health (TEPSIE, 2015).

The outcome of social innovation can be two-fold: tangible and transformational. Tangible outcomes are new services, products, financial models, behaviours and policies that are more inclusive, effective and sustainable than the status quo. The systems transforming dimension of social innovation sets it apart from more common forms of innovation. By challenging social practices, rules and social relationships, social innovation does more than just address a problem. It provides an alternative that changes and makes systems more resilient. Social innovations can be regarded as transformations in complex adaptive systems (Westely, 2011).

The ongoing inquiry of the SIHI network is to better understand the value and contribution that social innovations can make to strengthen health systems for greater inclusiveness, equity and affordability of health care services for millions of people. (Written by: L van Niekerk, 2017)





WHAT IF

COMMUNITY-BASED SOCIAL INNOVATION WAS AN
ESSENTIAL ELEMENT TOWARDS THE ACHIEVEMENT OF
UNIVERSAL HEALTH COVERAGE AND THE SUSTAINABLE
DEVELOPMENT GOALS?

IDENTIFYING & LEARNING FROM SOCIAL INNOVATIONS IN HEALTH



The SIHI network of partners regularly engages in a process to identify and study local community-based and citizen-led social innovations in health. In 2015, the first round of identification and study occurred across Africa, Asia and Latin America resulting in the identification of 150 eligible projects and the selection of 23 social innovations from 15 countries. In 2017-18, a second round of identification and study occurred in three countries and one region: Malawi, Uganda, the Philippines, and Latin America and the Caribbean. This resulted in the identification of 79 eligible projects and study of 15 social innovations in health.

Step 1: Crowdsourcing from the public

To find and identify community-based and citizen-led social innovations, SIHI has adopted crowdsourcing as an approach. As per Babham et al (2014): “crowdsourcing is a distributed, problem-solving and production mechanism that uses the collective intelligence of networked communities and non-experts for specific purposes.” SIHI partners organise and host crowdsourcing calls, inviting individuals and organisations from all backgrounds and sectors to share their innovative solutions. SIHI crowdsourcing calls are usually open for 6 – 8 weeks. Nominations are received via a dedicated online platform or by the completion of paper nomination forms, as in certain countries internet access remains limited. Before and during the public call period, concentrated efforts are taken to promote and advertise the call via direct communication channels, online platforms, print media, radio and television.

Step 2: Review & Selection

To support the review and selection of social innovations in health, SIHI appoints independent panels comprised of local and/or international experts to support the review of all the projects received through the crowdsourcing call, and to select projects that will qualify as social innovations. The panel members review each nominated project against pre-defined criteria. These criteria are a composite of four standardised criteria (see below) and four country-defined criteria based on national priorities. Each project is reviewed by at least two-experts, one purposefully assigned based on the innovation’s focus area, and one randomly assigned.

High scoring projects go through a second round of review to determine which cases could contribute significant learning to advance knowledge about social innovation in health and inform key national or global health priority areas.

SELECTION CRITERIA



Degree of innovativeness

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



Inclusiveness

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



Effectiveness

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



Affordability

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



+ 4 Country-specific criteria

Each independent review panel identified four additional selection criteria that were country-specific based on national priorities.

Step 3: Case Study Research – site visits & data collection

In order to understand the value, investigate the mechanisms of operation and learn transferable lessons from social innovations, we use a descriptive and explorative case study research methodology. The social innovation case inquiry was structured according to 4 units of analyses: the context; the inventing actor; the solution/intervention, and the implementing organisation.

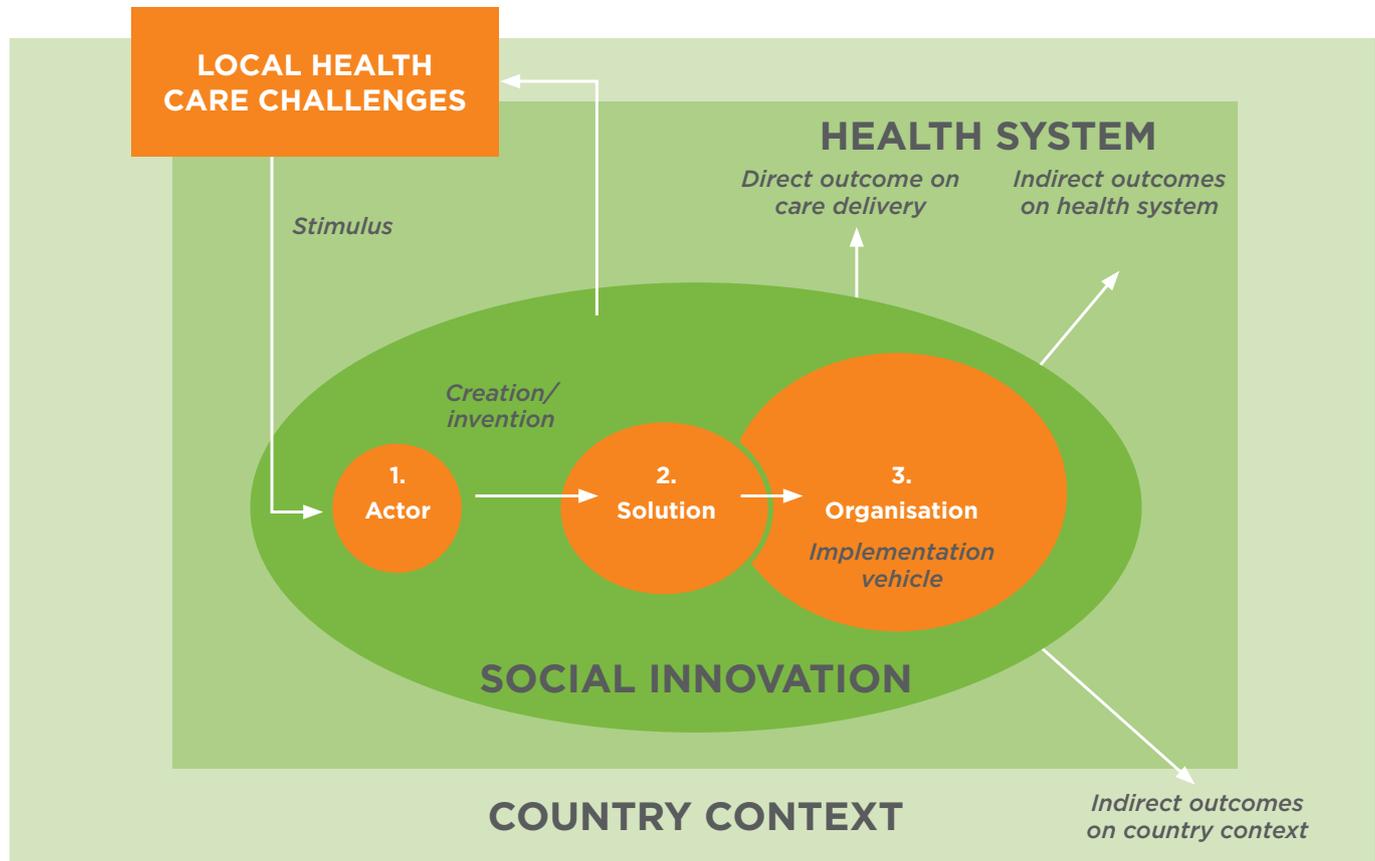


Figure: SIHI Case Study Framework, 2015

SIHI researchers invest time to travel to each selected social innovation to see implementation in action. An average of three days are spent per case and during this time data is gathered. Data collection methods consist of document reviews, participant observations and semi-structured interviews.

Step 4: Case Study Research – analysing data to find insights

All collected data are de-identified and recorded interviews are transcribed and translated. The case framework guides the descriptive analysis. Findings are presented in a structured format. Full-length descriptive cases can be found at: <https://socialinnovationinhealth.org/the-case-studies/>

Following the compilation of individual cases, a cross-case analysis was undertaken guided by several questions:

- Why is this an example of social innovation in health – what are its socially innovative characteristics?
- What are the key innovative components that have the potential to be replicated, transferred or scaled?
- What are the outcomes of this case on strengthening health care delivery or health systems?
- What are the enablers and inhibitors that facilitated or hindered its implementations?
- How has the local environment responded to this case?
- What relevance does this case hold for national and global health priorities?

The findings from cross-case analyses are published by SIHI researchers in peer-review publications.

Step 5: Promoting social innovation - learning dissemination and uptake

A final step in the SIHI identification and learning process is to disseminate the findings and promote the studied social innovations at an global and country-level. This is done in three ways:

1. **Sharing and promoting** online via the SIHI website, TDR-WHO newsletter & social media
2. **Hosting convenings** where social innovators in health receive the opportunity to share their work e.g. National Stakeholders Forum, Uganda, 2018; Global Social Innovation Convening, WHO, 2015.
3. **Producing key publications on lessons and learning** e.g. 2017 TDR-WHO Publication (Social Innovation in Health: Case Studies and Lessons Learned from Low- and Middle-income Countries); case brochures and peer-review articles

Summaries of the 38 cases that have been identified and studied through the SIHI network from 2015 - 2018 are presented here according to the countries where the innovations were studied.



AFRICA

WHAT IF A CULTURE OF SOCIAL INNOVATION CAN
BE CATALYZED SUCH THAT CREATIVE SOLUTIONS
CAN BE CREATED FOR HEALTH, BY THE PEOPLE?

BURUNDI

LIFENET INTERNATIONAL

Implementer: LifeNet International

Operations: Burundi, Democratic Republic of Congo, Uganda

Organisational structure: NGO

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

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



Credit: Lindi van Niekerk, SIHI, Burundi, 2015

ETHIOPIA

SCHISTOSOMIASIS CONTROL INITIATIVE (SCI)

Implementer: Schistosomiasis Control Initiative at Imperial College London

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

Organisational structure: University

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

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



Credit: Lindi van Niekerk, SIHI, Ethiopia, 2015

KENYA

LIVEWELL CLINICS LTD

Implementer: Viva Afya Limited

Operations: Kenya

Organisation structure: Company

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

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



Credit: Lindi van Niekerk, SIHI, Kenya, 2015

KENYA

SAFE WATER AND AIDS PROJECT (SWAP)

Implementer: Safe Water and AIDS Project (SWAP)

Operations: Kenya

Organisation structure: NGO

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

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



Credit: Rachel Hounsell, SIHI, Kenya, 2015

LESOTHO

RIDERS FOR HEALTH

Implementer: Riders for Health

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

Organisational structure: NGO (Social enterprise)

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

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



Credit: Rachel Hounsell, SIHI, Lesotho, 2015

LIBERIA

LAST MILE HEALTH

Implementer: Last Mile Health

Operations: Liberia

Organisational structure: NGO

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

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



Credit: Last Mile Health

MALAWI

CHIPATALA CHA PA FONI (CCPF) “HEALTH CENTRE BY PHONE”

Implementer: Malawi Ministry of Health in partnership with VillageReach

Operations: Malawi

Organisational structure: NGO and Partnership

CHALLENGE: In remote and rural communities, distance often prevents people from seeking health care when they need it.

SOLUTION: CCPF provides a toll-free hotline where callers can speak with trained health workers who provide information on a wide range of health issues, triage calls to doctors, and refer callers displaying “danger signs” for further care at a village clinic, health centre or hospital. It also provides a mobile message service for personal text or voice messages on maternal and child health topics, customized to a women’s month of pregnancy or a child’s age.



Credit: Lindi van Niekerk, SIHI, Malawi, 2017

MALAWI

LEARNER TREATMENT KIT

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

Operations: Malawi

Organisational structure: NGO and Partnership

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

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



Credit: Lindi van Niekerk, SIHI, Malawi, 2015

MALAWI

COMMUNITY-BASED HEALTH INSURANCE

Implementer: Kaundu Health Centre - Christian Health Association of Malawi (CHAM), Group Village Headmen Dzindebvu, Kaundu, Kabulika 2 and Traditional Authority Kachindamoto

Operations: Malawi

Organisational structure: NGO and Community

CHALLENGE: Communities living in rural areas, with pay-for-use health facilities, often have limited access to quality health services due to the cost barrier.

SOLUTION: Kaundu Health Centre is a CHAM health facility working with traditional leaders to facilitate a community-based health insurance aimed at providing financial protection against the unforeseen cost of illness for community members. Community members contribute a stipulated amount each month that is saved and used when need arises for health care at the nearest health centres and referral at the hospital. This is a bottom-up community-driven approach to expand access to quality health services.



Credit: Lindi van Nierkerk, SIHI, Malawi, 2017

MALAWI

SUSTAINABLE AND AFFORDABLE RURAL HEALTHCARE SYSTEM - RURAL HEALTHCARE PROTOTYPE

Implementer: Child Legacy International (CLI)

Operations: Malawi and Zimbabwe

Organisational structure: NGO

CHALLENGE: In Malawi, 84% of the population resides in rural areas and due to this, access to health services remain a challenge. This is coupled with shortages in basic resources such as electricity and clean water, as well as other social challenges such as unemployment.

SOLUTION: This integrated model leverages renewable energy, clean water, vocational services, sustainable agriculture and research that informs quality health care delivery in rural areas. With a foundation of wind and solar energy, the prototype health facility has adequate and reliable power and has pioneered access to life-saving surgeries including laser eye surgeries off the national electricity grid. Sustainable income generating activities offset some of the health care programme costs.



Credit: Lindi van Nierkerk, SIHI, Malawi, 2017

MOZAMBIQUE

SMS-HUB

Implementer: The Leprosy Mission Mozambique, , Mozambique Health Department.

Operations: Mozambique

Organisation structure: NGO

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

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



Credit: SMS-Hub

RWANDA

ONE FAMILY HEALTH

Implementer: One Family Health

Operations: Rwanda

Organisational structure: Low profit company

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

SOLUTION: One Family Health enhances access to essential quality health services in rural areas. Through a franchise model, nurses have full ownership of their health posts and operate as independent entrepreneurs while at the same time receiving the support and oversight from One Family Health. This model is an extension of the public health system and operationalised as a public-private partnership with the Rwandan Ministry of Health, leveraging the community based national health insurance scheme to reimburse OFH nurses for services rendered.



Credit: Lindi van Niekerk, SIHI, Rwanda, 2015

SOUTH AFRICA

GP DOWN-REFERRAL MODEL

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

Operations: South Africa

Organisational structure: Company and Provincial Government

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

SOLUTION: The General Practitioner (GP) referral model is a public-private partnership to increase access to antiretroviral treatment services. The model leverages the excess capacity of private GP's to provide services to public patients who are stable on their antiretroviral treatment. It aids to reduce the burden on over-crowded government hospitals, freeing up capacity of public hospitals to initiate treatment in new patients or manage complicated cases.



Credit: Rachel Hounsell, SIHI, South Africa, 2015

SOUTH AFRICA

PHARMACIST ASSISTANT PROGRAMME

Implementer: Keth'Impilo

Operations: South Africa

Organisational structure: NGO

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

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



Credit: Rachel Hounsell, SIHI, South Africa, 2015

UGANDA

ACTION FOR WOMEN AND AWAKENING IN RURAL ENVIRONMENT (AWARE)

Implementer: AWARE

Operations: Uganda

Organisational structure: NGO

CHALLENGE: Women in Karamoja suffer from high levels of gender-based violence; poor access to education; unemployment; poor financial services; limited access to health care; and a lower voice in decision-making compared to men.

SOLUTION: AWARE aims to advance the health, social, cultural and economic wellbeing of women and girls in Karamoja through utilizing a holistic approach to empower women and advocate for their rights in the community. Women are equipped with agricultural and business skills and are sensitized on their rights. AWARE has established a multi-purpose women's centre, which has a maternity waiting house where expectant mothers can receive health care services and life skill training.



Credit: Lindi van Niekerk, SIHI, Uganda, 2017

UGANDA

BWINDI MOTHERS' WAITING HOSTEL

Implementer: Bwindi Community Hospital

Operations: Uganda

Organisational structure: NGO

CHALLENGE: Although well-established medical care exists to prevent maternal deaths, most women in remote and hard-to-reach areas cannot access this care.

SOLUTION: Bwindi Mothers' Waiting Hostel identifies high-risk mothers living in hard-to-reach areas through the hospital's community nurse team. These women are then encouraged to come and stay in the hostel for up to a month before delivery, depending on the severity of their risk. Daily monitoring of the mothers is done by midwives. Supervised deliveries, antenatal services, counselling, emergency obstetric care, and education services are provided to the mothers.



Credit: Bwindi Community Hospital

UGANDA

DRUG SHOP INTEGRATED CARE

Implementer: Makerere University
Operations: Uganda
Organisational structure: University

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

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



Credit: Lindi van Niekerk, SIHI, Uganda, 2015

UGANDA

IMAGING THE WORLD, AFRICA

Implementer: Imaging the World, Africa
Operations: Uganda
Organisational structure: Social enterprise

CHALLENGE: Most rural pregnant mothers cannot access obstetric imaging service in Uganda, due to the insufficient number of radiologists and sonographers within the health system. Patients often travel long distances to access such services at public hospitals; or incur high costs at urban private clinics.

SOLUTION: Imaging the World, Africa trains registered nurses and midwives working in rural health facilities to be competent in performing antenatal ultrasound scans. Through new technology, the scans can be uploaded electronically and sent via a cellular data network to radiologists abroad to aid with real time interpretation.



Credit: Imaging the World, Africa

UGANDA

KYANINGA CHILD DEVELOPMENT CENTRE (KCDC)

Implementer: KCDC

Operations: Uganda

Organisational structure: NGO

CHALLENGE: In Uganda, more than 12% of children are living with disabilities (CWDs). The children have disproportionately unequal opportunities for basic needs and stigma is severe, which discourages them from seeking health care.

SOLUTION: KCDC provides a holistic approach to care for children living with disabilities, and their families, in rural western Uganda. KCDC provides rehabilitative services including physiotherapy, occupational therapy and speech therapy at a minimal or no cost to children. 70% of the services are delivered in the community - homes, schools or local health centres. Through training programmes and peer-support structures, parents are equipped with the skills and confidence to care for their child at home. Innovative funding mechanisms are adopted to contribute towards sustainability.



Credit: Rachel Hounsell, SIHI, Uganda, 2017

UGANDA

MAMATOTO APPROACH

Implementer: Healthy Child Uganda

Operations: Uganda

Organisational structure: University programme

CHALLENGE: Maternal and child mortality remain very high in Uganda, with 368 maternal deaths per 100,000 live births and 64 child deaths per 1000 live births occurring annually (UBoS 2016), most of which are preventable.

SOLUTION: MamaToto is a district-led programme that operationalizes the Village Health Team (VHT) strategy and includes health system strengthening to promote quality maternal, new-born and child health (MNCH) practices. The district leaders develop, implement and monitor their own MNCH priorities in partnership with a network of community health volunteers who conduct home visits, assess and refer patients, provide health education, and mobilize communities to participate in health activities.



Credit: Ilia Horsburgh

UGANDA

LIVING GOODS

Implementer: Living Goods

Operations: Kenya, Uganda

Organisational structure: NGO

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

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



Credit: Lindi van Niekerk, SIHI, Uganda, 2015

UGANDA

THE MEDICAL CONCIERGE GROUP

Implementer: The Medical Concierge Group Limited

Operations: Uganda

Organisation structure: Company

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

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



Credit: Lindi van Niekerk, SIHI, Uganda, 2015

A vibrant street scene in a tropical Asian city, likely in the Philippines. The street is lined with colorful, multi-story buildings, many of which have various signs and advertisements. A prominent yellow building with a green roof is visible in the background. The street is filled with people riding bicycles, many of which are loaded with goods and passengers. The scene is set against a backdrop of lush green hills and palm trees. The word "ASIA" is overlaid in large white letters in the center of the image.

ASIA

WHAT IF RESEARCH CAN BE EMBEDDED IN SOCIAL INNOVATION SUCH THAT IMPACT CAN BE SCALED, AND HEALTH OUTCOMES ACHIEVED?

PHILIPPINES

P6.60 EVERYDAY FAMILY HEALTH PLAN

Implementer: Philippine Health Insurance Corporation, Palawan Local Health Insurance Office (LHIO)

Operations: Philippines

Organisational structure: Government Agency

CHALLENGE: Despite a national health insurance programme in the Philippines (PhilHealth), there is low collection rate of health insurance premiums, and therefore low coverage, among members of the informal sector in the Philippines, translating to poor access to health services. This is precipitated by the informal sector's low and irregular income, and lack of technical capability to manage a savings mobilization program.

SOLUTION: "P6.60 Kada Araw na Hulog Para sa Kalusugan ng Pamilya" is a savings mobilization scheme that aims to increase the insured health coverage of informal sector workers under PhilHealth. In a month, TODA members are required to save a minimum amount of P6.60 per day, the equivalent of USD 0.13. Once their savings reach the required quarterly PhilHealth premium, the group treasurer remits the full amount to PhilHealth. Members also benefit from medical check-ups and financial management seminars.



Credit: Lindi van Niekerk, SIHI, Philippines, 2017

PHILIPPINES

INTER-ISLAND HEALTH SERVICE BOAT PROJECT

Implementer: Municipal Health Office of Zumarraga

Operations: Philippines

Organisational structure: Local Government Unit

CHALLENGE: Zumarraga is an island municipality composed of 25 coastal villages. Access to the municipality is only through passenger or private boats, which makes transporting high-risk pregnant women to an accredited birthing facility challenging.

SOLUTION: The Inter-island Health Boat Service Project provides a sea ambulance or a boat referral system that connects remote village health stations to the main birthing facility. The project ensures that a designated boat driver and fuel are always available and accessible for timely referral. The project is integrally linked to a national health insurance fund where the facility utilizes the claims reimbursements to sustain operations and maintenance of the boats.



Credit: Lindi van Niekerk, SIHI, Philippines, 2017

PHILIPPINES

NATIONAL TELEHEALTH SYSTEM (NTS)

Implementer: National Telehealth Center, National Institutes of Health, University of the Philippines Manila

Operations: Philippines

Organisational structure: University

CHALLENGE: There are approximately 4,720 communities in the Philippines that are considered geographically isolated and disadvantaged areas (GIDAs). Health professionals that work in GIDAs are not only faced with limited financial and logistical resources, but also a shortage of critical health human resources to ensure the delivery of quality health care services.

SOLUTION: NTS is a telemedicine platform and training programme that leverages ubiquitous technology such as short messaging services (SMS) or emails to improve access to specialist care among rural health workers. The innovation is in the secure referral network that the project created, linking rural health physicians to clinical specialists in selected regional hospitals nationwide.



Credit: National Telehealth Center

PHILIPPINES

PARTNERS IN LEPROSY ACTION (PILA)

Implementer: Philippine Leprosy Mission

Operations: Philippines

Organisational structure: NGO

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

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



Credit: Rachel Hounsell, SIHI, Philippines, 2015

PHILIPPINES

SEAL OF HEALTH GOVERNANCE (SOHG)

Implementer: Municipality of Del Carmen

Operations: Philippines

Organisational structure: Local Government Unit

CHALLENGE: Key health challenges faced by the island municipality of Surigao Del Norte include low facility-based delivery, high number of maternal deaths, malnutrition, poor nutrition, and high incidence of infectious and vector-borne diseases such as tuberculosis, schistosomiasis and dengue.

SOLUTION: The SOHG is a monitoring and evaluation program that ensures quality implementation and sustainability of health programmes of the municipality by empowering leadership and governance capacities of community leaders. The program provides annual financial and in-kind incentives to the best performing villages of the Municipality and awards the Seal of Health Governance to the winning barangays (districts).



Credit: Harroun Wong, SIHI, Philippines, 2018

INDIA

EMBRYYO TECHNOLOGIES

Implementer: Embryo Technologies Private Limited

Operations: India

Organisational structure: Company

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

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



Credit: Embryo Technologies

INDIA

MOBILE-BASED SURVEILLANCE QUEST USING IT (MOSQUIT)

Implementer: Centre for Development of Advanced Computing

Operations: India

Organisational structure: Government agency

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

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



Credit: Elina Naydenova, SIHI, India, 2015

INDIA

NOORA HEALTH

Implementer: Noora Health

Operations: India

Organisational structure: NGO

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

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



Credit: Elina Naydenova, SIHI, India, 2015

INDIA

OPERATION ASHA

Implementer: Operation ASHA

Operations: Cambodia, India

Organisational structure: NGO

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

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



Credit: Lindi van Niekerk, SIHI, India, 2015

INDIA

SPROXIL

Implementer: Sproxil

Operations: Ghana, India, Kenya, Nigeria, Pakistan, Tanzania

Organisational structure: Company

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

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



Credit: Sproxil

PEOPLE'S REPUBLIC OF CHINA

SOCIAL ENTREPRENEURSHIP FOR SEXUAL HEALTH (SESH)

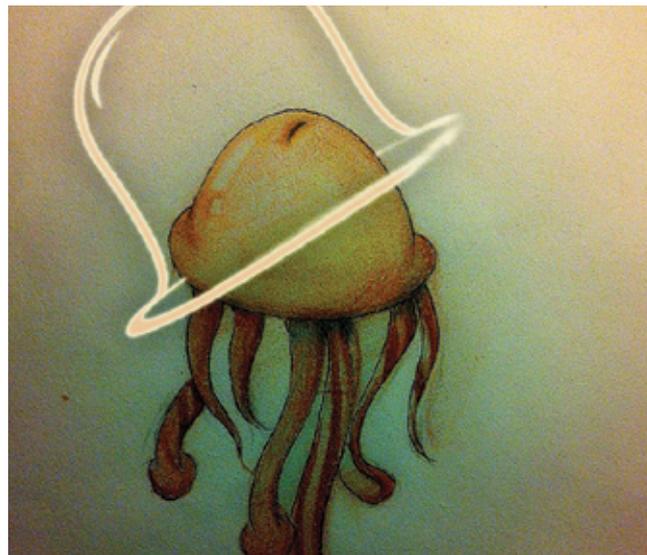
Implementer: Social Entrepreneurship for Sexual Health (SESH) Global

Operations: People's Republic of China

Organisational structure: University

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

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



Credit: SESH



LATIN AMERICA AND THE CARIBBEAN

WHAT IF ALL ACTORS COLLABORATE TO ADOPT
AND INSTITUTIONALISE SOCIAL INNOVATION AS
PART OF THE PUBLIC HEALTH SYSTEM?

BRAZIL

INDIGENOUS COMMUNITY HEALTH WORKER PROFESSIONALISATION PROGRAM

Implementer: Oswaldo Cruz Foundation

Operations: Brazil

Organisational structure: Government agency

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

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



Credit: Liliane Chamas, SIHI, Brazil, 2015

GUATEMALA

COMPREHENSIVE HEALTH APPROACH FOR CHAGAS DISEASE IN COMAPA

Implementer: Universidad del Valle de Guatemala (UVG)

Operations: Guatemala

Organisational structure: University Programme

CHALLENGE: Chagas is the deadliest parasitic disease in Latin America and affects around 8 million people in the world. It causes an estimated 10,000 deaths each year, especially in populations living in poverty and inequity.

SOLUTION: The programme offers a contextually acceptable and comprehensive approach to the awareness, prevention, diagnosis and treatment of Chagas disease. Through active engagement and participation, communities are facilitated through a process to identify their key needs and design solutions. This process takes place in partnership with state health institutions and NGO's in Comapa (Jutiapa, Guatemala).



Credit: SIHI LAC, 2017

GUATEMALA

ECO-HEALTH APPROACH TO FIGHT CHAGAS DISEASE

Implementer: Laboratory of Applied Entomology and Parasitology (LENAP) at Universidad de San Carlos

Operations: Guatemala

Organisational structure: University programme

CHALLENGE: Chagas disease is associated with conditions of extreme poverty because the insect transmitting the parasite infects households in poor rural communities where cheap, readily accessible materials such as adobe, wood and palm leaves are used for construction, and animals are reared inside houses.

SOLUTION: The Eco-health approach pursues sustainable prevention of Chagas' disease through: 1) the design of a strategy to fill the cracks in the floors and walls using a scientifically tested combination of locally available materials; and 2) increasing awareness of these risks through training of leaders and members of the community to repair and improve their own homes and to adopt the healthier practice of raising animals outside of the household.



Credit: SIHI LAC, 2017

PARAGUAY

CENTRO PARA EL DESARROLLO DE LA INVESTIGACIÓN CIENTÍFICA (CEDIC)

Implementer: Centro para el Desarrollo de la Investigación Científica (CEDIC)

Operations: Paraguay

Organisational structure: NGO

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

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



Credit: Liliane Chamas, SIHI, Paraguay, 2015

HONDURAS

MOSQUITIAMED: SHORTENING DISTANCES THROUGH TELEMEDICINE

Implementer: MosquitiaMed

Operations: Honduras

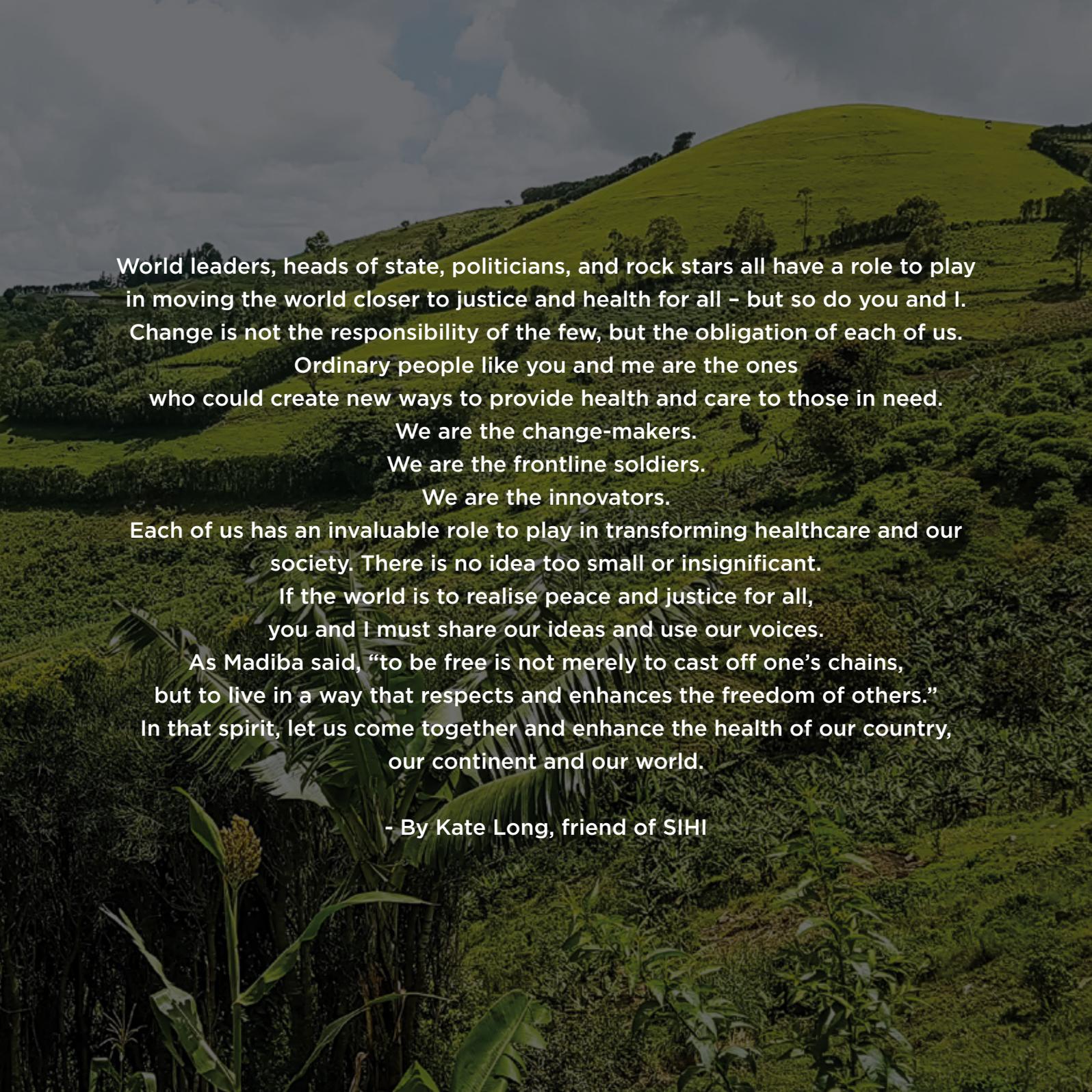
Organisational structure: NGO

CHALLENGE: The La Mosquitia Region has some of the worst health indicators in Honduras. The region has only one hospital (located in the capital) and extreme shortages of health workers.

SOLUTION: Developed by a team of physicians, MosquitiaMed provides alternative strategies to increase access to health knowledge and health services via: 1) the development of videos on health topics in the local language, which are disseminated via mobile phones; 2) A mobile application that enables remote information exchange with specialists and 3) crowdsourcing strategies to generate funding and resources.



Credit: SIHI LAC, 2017



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

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

We are the change-makers.

We are the frontline soldiers.

We are the innovators.

Each of us has an invaluable role to play in transforming healthcare and our society. There is no idea too small or insignificant.

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

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

- By Kate Long, friend of SIHI

WHAT IS SOCIAL INNOVATION IN HEALTH?

Social innovation gives us a new lens with which to approach healthcare delivery.

It is a solution to a **systemic health challenge**. The solution is developed by individuals, organisations and institutions from all backgrounds and sectors ,through engagement and **collaboration with communities**.

The solution provides a creative and unconventional approach to making healthcare more **inclusive, effective and affordable** for all people.

Social innovation improves the health and wellbeing of people and has **transformative potential to enhance resilience of the health system**

www.socialinnovationinhealth.org

